NHS HWE ICB Primary Care Transformation Committee meeting held in Public

Thursday 28 November 2024

Conference Room 2

The Forum

Herts, HP1 1 DN

09:30 - 12:00

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

Agenda

09:30	1. Welcome and apologies		Chair
	2. Declarations of interest		Chair
09:35	3. Minutes of the last meeting held on: Thursday 25 July 2024	Approval	Chair
09:35	4. Action Tracker	Approval	Chair
09:40	5. Questions from the Public		Chair
09:45	6. COVID-19 booster vaccine uptake in the immunosuppressed population	Discussion	HCC Penny
10:00	7. HWEICB Primary Care Strategic Delivery Plan 2023 – 2026: Progress Against Year One Priorities & Deep Dive	Discussion/Information	James Gleed/Emily Perry
	7.1 Enabling		
	Community Pharmacy PCN Leads		Mefino Ogedegbe
	7.2 Access		
	HCT Hertfordshire Special Care Dental Service - Nurse Led Anxiety Management Pathway		Michelle Campbell/Leah Adams
	Stevenage PCNs Same Day Access Hub		Sue Lincoln,/Matt Charles
	Stevenage – Same Day Access hub evaluation		Cathy Galione
	7.3 Proactive management		
	Lower Lea Valley community working together at Broxbourne Volunteers fair [Video]		Alison Jackson
11:05 - 11:15	Comfort Break		
11:15	8. Directorate Highlight Report	Information	Avni Shah
11:30	9. Primary Care – System Access Improvement Plan	Information	Andrew Tarry/Place Leads
11:40	10. Primary Care Risk Register	Assurance	Andrew Tarry
	For information only		
	11. Evaluation of Community Pharmacy Project		Mefino Ogedegbe

	12. Minutes from subgroups	Avni Shah
11:50	13. Reflections and feedback from the meeting	All
12:00	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 Transformation Committee held in Public**			
	Meeting in public	☒	*Meeting in private (confidential)*	☐
Date:	**Thursday 25 July 2024**			
Time:	**09:30 – 12 noon**			
Venue:	**The Forum, Conference Room 2/MS Teams**			

MINUTES

Name	Title	Organisation
Members present:		
Prag Moodley (PM) **(Meeting Chair)**	Partner Member (Primary Medical Services)	Herts and West Essex ICB
Amik Anjela (AA) Via MS Teams	GP Lead West Essex	Herts and West Essex ICB
Rami Eliad (RE)	GP Lead – South & West Herts	Herts and West Essex ICB
Trevor Fernandes (TF)	Partner Member (Primary Medical Services)	Herts and West Essex ICB
Rachel Joyce (RJ) Via MS Teams	Medical Director	Herts and West Essex ICB
Rob Mayson (RM) Via MS Teams	Primary Care Locality Lead – East & North Herts	Herts and West Essex ICB
Ian Perry (IP) Via MS Teams	Partner member (Primary Medical Services)	Herts and West Essex ICB
In attendance:		
Alice Baldock (AB) Via MS Teams	Medical Director	Bedfordshire & Herts Local Medical Committee
Jane Bunker (JB) Via MS Teams	Chair	Hertfordshire Local Optical Committee
Amanda Burfot (AB) Via MS Teams	Senior Primary Care Manager for Transformation, Integration Development and Delivery (deputising Roshina Khan)	Herts and West Essex ICB
Michelle Campbell (MC)	Head of Primary Care Contracts	Herts and West Essex ICB
Corina Ciobanu (CC) Via MS Teams	Primary Care Lead for Transformation – South & West Herts	Herts and West Essex ICB

Fiona Corcoran (FC) Via MS Teams	Deputy CEO	Healthwatch, Hertfordshire
Sam Glover (SG) Via MS Teams	CEO	Healthwatch, Essex
Leighton Colegrave (LC)	Citizen Representative, East & North Herts	Herts and West Essex ICB
Joy Das (JD)	Citizen Representative, West Essex	Herts and West Essex ICB
Sarah Dixon (SD) Via MS Teams	Primary Care Workforce Lead – West Essex	Herts and West Essex ICB
Gopesh Farmah (GF) Via MS Teams	Clinical Lead – Digital	Herts and West Essex ICB
Cath Fenton (CF) Via MS Teams	Consultant in Public Health	Herts County Council
Clint Foreman (CFo) Via MS Teams	Assistant Secretary	Essex Local Dental Committee
James Gleed (JG)	Associate Director Primary Care Strategy and Transformation	Herts and West Essex ICB
Sam Glover (SG) Via MS Teams	CEO	Healthwatch
Michelle Hicks (MHi)	Senior Primary Care Manager – East & North Herts (deputising Cathy Galione)	Herts and West Essex ICB
Marianne Hiley (MH)	Citizen Representative, South & West Herts	Herts and West Essex ICB
Parul Karia (PK) Via Teams	Primary Care Digital Lead – South & West Herts	Herts and West Essex ICB
Iram Khan (IK)	Corporate Governance Manager	Herts and West Essex ICB
Roshina Khan (RK) Via MS Teams	Head of Primary Care Transformation and Integration – South & West Herts	Herts and West Essex ICB
Louise Manders (LM) Via MS Teams	Head of Programme Communication and Engagement	Herts and West Essex ICB
Trudi Mount (TM)	Head of Primary Care Digital	Herts and West Essex ICB
Helen Musson Via MS Teams	Chief Officer	Hertfordshire Local Pharmaceutical Committee
Emily Perry (EP)	Primary Care Manager – Strategy and Transformation	Herts and West Essex ICB
Annette Pullen (AP) Minutes	EA to Avni Shah	Herts and West Essex ICB
Sheila Purser (SP) Via MS Teams	Chair	Essex Local Optical Committee
Steve Roberts (SR) Via MS Teams	Vice Chair	Hertfordshire Local Optical Committee
Josephine Smit (JS) Via MS Teams	Senior Primary Care Manager for Transformation, Integration Development and Delivery – West Essex (deputising Philip Sweeney)	Herts and West Essex ICB
Karen Samuel-Smith (KSs) Via MS Teams	Chief Officer	Essex Local Pharmaceutical Committee

Andrew Tarry (AT)	Head of Primary Care Contracts	Herts and West Essex ICB
Peter Tatton (PT) Via MS Teams	Secretary	Hertfordshire Local Dental Committee
Sam Williamson (SW)	Associate Medical Director	Herts and West Essex ICB

PCTC/14/24	**Welcome, apologies and housekeeping**
14.1	Prag Moodley (PM) welcomed all to the meeting. Introductions made including new Partner member, Trevor Fernandes. 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 explaining how to submit these.
14.2	Apologies for absence had been received from: • Avni Shah • Anurita Rohilla • Alison Jackson • Elizabeth Disney • Chris French • Neil Tester • Raja Vaiyapuri The meeting was declared quorate.
PCTC/15/24	**Declarations of interest**
15.1	The Chair invited members to declare any declarations relating to matters on the agenda: All members were required to keep their declarations accurate and up to date on the register, which was made available on the website: Declaration of interests – Hertfordshire and West Essex NHS ICB
PCTC/16/24	**Minutes from the previous meeting**
16.1	The minutes were approved subject to amendment under section7.7
16.2	**The minutes of the last meeting held on 23 May 2024 were agreed as an accurate**
PCTC/17/24	**Action tracker**
17.1	There was one outstanding action on the tracker PCTC/05/24, relating to clarifying Social Care/Public Health Leads attendance at meetings. Tracker updated to reflect open action.
PCTC/18/24	**Questions from the Public**
18.1	• No questions received. • Questions submitted to the ICB Board shared via appendix 1.
PCTC/19/24	**Directorate Highlight Report**
19.1	Michelle Campbell (MC) introduced the Directorate report (see pages 25-44 of the document pack) and highlighted the following:

	• Successful pilot Sunflower Unit, options appraisal paper to be shared with relevant committees. • NHSE Primary Care validation project, ENH place. Good support from Practice teams. Await final evaluation. • Migrant health update across ICB, outlining closures, current position. • Positive engagement towards Veteran accreditation, outlining number of practices accredited. • Dental access recovery plan update. • DNA pilot, SWH highlighting impact on costs, patient expectations. • Blood pressure pathway discussed, implementation with community pharmacies. • GP Contracting update, mergers outlined – number of practices reducing – positive good business models. • Workforce update outlining learning time, forthcoming awards events.
19.2	Questions and comments were invited: • Hypertension pathway discussed, outlining managing identifying high blood pressure within dental surgeries and Optical Practices. • Feeds into Long Term Conditions. • Community Pharmacy requested inclusion to enable support on current projects. • SW offered assurance LPC colleagues will continue to be kept informed where affected although currently unclear around national guidance which affects everyone. • Utilisation of dental appointments. • DNA pilot sites, designing model to roll out with local access. • Domiciliary service available purely for housebound patients. • Community Pharmacy requested information relating to awards.
19.3	**Action: Sam Williamson – liaise with LPC to clarify national guidance**
19.4	**Action: Sarah Dixon to share communication relating to awards**
19.5	**Action: Sarah Dixon to clarify nomination process around Patient Participation Groups (PPG)**
19.6	**The Primary Care Transformation Committee noted the Directorate Highlight Report**
PCTC/20/24	**Primary Care Transformation Integrated reports**
20.1 20.2 20.3	Amanda Burfot (AB), Josephine Smit (JS) and Michelle Hicks (MH) introduced their respective sections of the integrated report (see pages of the document pack) highlighting the following points: **<u>South & West Herts: AB (pages 49-51)</u>** • Visiting practices received well with positive outcomes. • Pre-pack, appointment data used to drive relevant conversations at practice level. **<u>East & North Herts: MH (pages 52-53)</u>**

	• Continued practice visits. • Support level framework, certain practices. • Successful face to face with a practice since Covid. • Webinars particularly receiving positive feedback.
20.4	**West Essex: JS (pages 54-55)** • Continued Practice visits supporting specific areas where required. • Progress health checks programme also continuing, practices achieved targets set by West Essex County Council. • Integrated neighbourhood teams agreeing plans working with system partners • Alignment with Primary Care Network (PCN) footprint proving successful. • Highlighted within slides specific positive outcome areas.
20.5	Questions and comments were invited: • Assurance Patient survey feedback considered. • Assurance continuity of care essential providing adequate support avoiding hospital as links into various programmes including Integrated Neighbourhood teams, ECF focus. • Sharing of information, communication packs to support. • Essex County working collaboratively with LPC on healthy living programmes. • LC requested alignment of headings, creating standardised reports. • Assurance, directorate continually working collectively in all areas.
20.6	**Action: Primary Care Team: Reports to be standardised.**
20.7	**The Primary Care Transformation Committee noted the Primary Care Transformation Integrated reports**
PCTC/21/24	**Evaluation of winter 23/24 and plans for 24/25**
21.5	Josephine Smit (JS) presented this item (see pages 56-65 of the document pack) • Annually ICB fund general practice to provide additional appointments over the winter months. • Continued system working to prevent any individual service being overwhelmed. • All areas experience increased activity within the winter months. • Planning outlined in paper, working with practices, patients. • Funding supports additional appointments, access system. • Funding figures as per paper outlined. • Figures suggest stabilising across system to avoid pressure elsewhere. • Enables continuity of care to be maintained for patients with complex needs, avoiding other areas being overwhelmed by capacity.
21.6	Questions and comments were invited: • Pharmacies to be included in conversations to utilise service whilst planning of winter. • Approach can be amended to provide in depth analysis support. • Constraints of funding challenging.

	• Examples of good practice discussed including websites for patients offering guidance. • Digital telephony provides clear data demand areas. • Discussed high demand not restricted to winter and how digital can support.
PCTC/22/24	**Digital Update**
22.1	Trudi Mount /Parul Karia (TM/PK) presented this item (see pages 66-81 of the document pack) • Continued progression of NHS App with figures outlined in documents. • Reaching patients via community events across ICB. • Posters provided across all services. • Work completed March/April supporting practices with promoting via websites. websites. • Number practices received visits to evaluate uptake of the tools. • Modern General Practice model outlined as per slide.
22.2	Questions and comments invited**:** • Acknowledgement from GP's various challenges including recognising not one size fits all. • Positive feedback from practices, webinars helpful. • Digital team supporting use of tools and technology although this is organisational transformation. • Change of approach key to support digital.
PCTC/23/24	**Enhanced Commissioning Framework (ECF) Evaluation**
23.1	Sam Williamson (SW) presented this item (see pages 82-142) of the document pack • Outlined ECF purpose/delivery as per report. • Highlighted achievements and future development to take forward. • Significant variation at practice level. • Several improvements since inception outlined in report. • Continued sharing of transformational work across ICS. • Case studies demonstrate initiative from practices. • Priorities outlined, including continuation of management to support trajectory.
23.2	Questions and comments invited: • Guidance welcomed to de-prescribe. • ECF onerous, possible short cuts to achieve targets should be avoided. • Important to utilise correct resource appropriately. • Several components to consider, huge amount of work. • ECF evidence based, fits in with wider strategic direction around patient care/outcomes. • Continually tweaking, managing effectiveness with integrated working. • LOC offered support via several pathways with examples in South Essex currently involving Optometry working well. • Effectiveness of various tools including templates from Arden discussed.

	• Training resources available via PCN's which provide education around individual areas during protected learning time. • Changed frequently, many components. Could annual changes be reduced? Overall view was positive, frequency of changes will be considered. Significant GP input and engagement to develop the ECF. • Useful overlap with some INT aims. Wide workforce to meet ECF requirements. • Mental health/LD figures lower – being addressed through the ECF, training and support. We perform well compared to other ICS areas.
PCTC/24/24	**Progress on Recommendations from the Healthwatch Commissioned Reports**
24.1	Emily Perry (EP) presented this agenda item (see pages 143-148 of the document pack) and highlighted the following: • Outlined key areas of focus. • Note Chronic Obstructive Pulmonary Disease (COPD) paper focused on WE approach. • Going forward focus to be across all areas of ICB. • Focus in areas deprivation on hypertension. • Continue extensive campaigns all areas. • Explore areas of service provision for local population
24.2	Questions and comments were invited: • Reports iterating to reach communities inclusive of all patient cohorts. • Programme subject to internal financial scrutiny panel exploring areas of investment.
24.3	**The Primary Care Transformation Committee noted the update on progress to date of recommendations from Healthwatch reports**
PCTC/25/24	**Primary Care Risk Register**
25.1	Andrew Tarry (AT) introduced Risk Register (see pages 149-147) of the document pack and highlighted the following: • Further consideration required on previous risks. • Proposing merging several risks. • Considerable potential risk relating to GMS contract 24/25
25.2	Questions and comments were invited: • Digital risk to be reviewed following outage/connectivity issues last week. • Pharmacy closures, pressures excluded from register.
25.3	**The Primary Care Transformation Committee noted the latest iteration of the risk register**
PCTC/26/24	**National GP Patient Survey Results**
26.1	Michelle Campbell (MC) summarised • Published 11 July. • Deep dive analysis to follow. • Note survey has changed, making comparative analysis challenging. • Further update to be provided future meeting.
26.2	Questions and comments were invited:

	• No questions raised
PCTC/27/24	**Minutes from subgroups**
27.1	The following reports were noted for information: Primary care digital (pages 174-182 of the document pack)
27.2	**The Primary Care Transformation Committee noted the sub-group minutes**
PCTC/28/24	**Reflections and feedback from the meeting**
28.1	• Informative updates. • Important PPG's cascade key messages to communicate to population. • Time management required as meeting ran over.
The meeting closed at 12.20pm	

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Herts and West Essex Integrated Care Board PRIMARY CARE TRANSFORMATION GROUP Action Tracker Last updated on 21 November 2024								
Private / Public	Action Tracker Ref No	Date of Meeting	Subject	Action	Responsible Lead	Deadline Date	Comments and Updates	Status
Public	PCTC/05/24	23/05/2024	Governance	Liaise with Leads to clarfy Social Care/Public Health involvement	Avni Shah	28/11/2024	To be updated next meeting	Open
Public	PCTC/19/24	25/07/2024	Directorate Highlight Report	Liaise with LPC to clarify national guidance	Sam Williamson	TBC		Open
Public	PCTC/19/24	25/07/2024	Directorate Highlight Report	Share communication relating to awards	Sarah Dixon	TBC		Open
Public	PCTC/19/24	25/07/2024	Directorate Highlight Report	Clarify nomination process around Patient Participation Groups	Sarah Dixon	TBC		Open
Public	PCTC/20/24	25/07/2024	Primary Care Transformation Integrated Reports	Reports to be standardised	PC Team	TBC		Open

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

Hertfordshire and West Essex Integrated Care System

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Primary Care Transformation Committee

Terms of Reference_2024 v1.1

1. Constitution

1.1 These Terms of Reference (ToR), set out the membership, remit, responsibilities and reporting arrangements of the Hertfordshire and West Essex (HWE) Integrated Care Board (ICB) Primary Care Transformation Committee.

1.2 Definition of Primary Care – Primary care services provide the first point of contact in healthcare system, acting as the 'front door' of the NHS. Primary care includes general practice, community pharmacy, dental, optometry (eye health) services.

2. Purpose and Remit

2.1 The Primary Care Transformation Committee is the key HWE ICS Primary Care forum supporting the ICB with the remit to:

- Propose the strategic direction for all primary care services;
- Identify the key priority areas needing change;
- Enable local clinical perspectives to inform strategic decision-making;
- Set the strategic context for primary care transformation and take oversight of its implementation and measuring success.
- Enable codesign/co-production across areas of primary care transformation and redesign in partnership with patients/citizens and all partners across the wider system.

2.2 The Primary Care Transformation Committee will play a key role in ensuring delivery of key national policy areas such as Long term Plan (LTP) requirements, Fuller Recommendations, GP Community, Pharmacy, Dental and Optometry contractual requirements and strategic direction; and will continuously review the annual plan and oversight of delivery of the of the HWE approved Primary Care Strategic Delivery Plan aligned to national and local strategies of ICS framework, Joint Strategic Plan, People Plan, Digital, Quality, UEC strategy and Medium Term Financial Plan.

2.3 The Committee will set out the principles and methodology for transformation in the strategic delivery plan.

3. Role and Responsibility

3.1 Strategic Oversight and Transformation:

- Oversee the implementation, delivery and monitoring of the primary care strategic delivery plan.
- Provide a single forum for the oversight of all primary care services (GP, Dental, Optometry and Community Pharmacy) transformation and innovation across the Integrated Care System, using best practice and a population health management approach to the

development and integration of services at a system, place and neighbourhood level. This includes enabling functions including workforce, digital and estates where appropriate.

- It is essential for the forum to scope opportunities of transformation through integration of primary care services with partners and oversight of delivery of transformation plan through developing Health and Care Partnerships
- To drive quality and reduce unwarranted variation in outcomes for patients in primary care across HWE using quantitative data and appropriate qualitative data from partners including Healthwatch, patient feedback through Health and Care Partnerships
- To ensure there is alignment of plans across HWE ICB system and place work programmes.

3.2 Communication and Engagement:

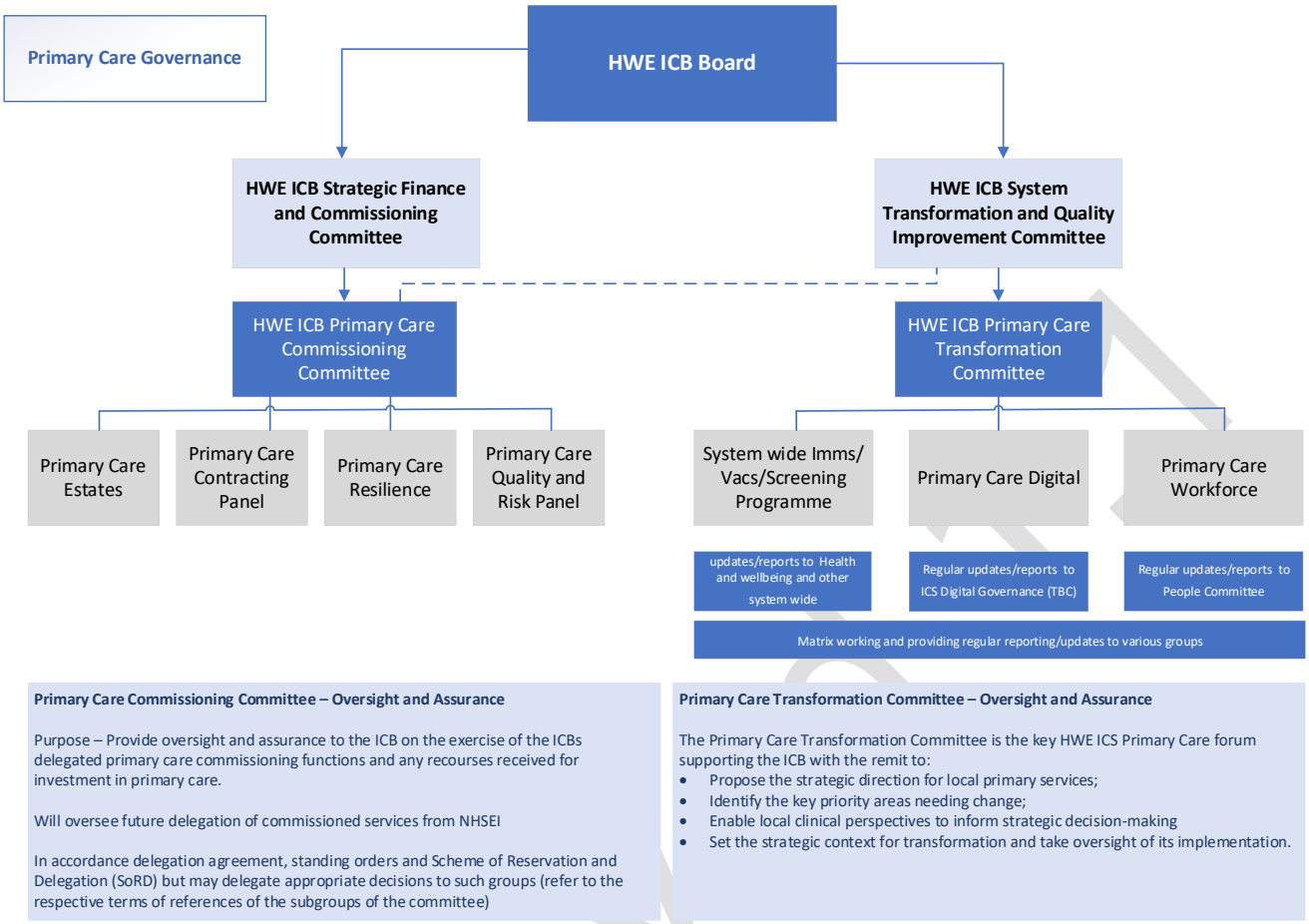
- To be the 'go-to group' to which any transformational change goes to engage primary care across HWE ICS work streams and ensure there is alignment to each place.
- Ensuring patient/citizen engagement and lived experience is at heart of transformational change through co-design using a population health management approach based on need. This needs to be practice/primary care network/Neighbourhood/locality/place/system.
- To facilitate clear communication between the HWE ICB Board, ICB System Transformation and Quality Improvement Committee, Primary Care Providers and partners across system and place and all our partner on matters relating to System development.
- Ensuring clinical debate about the key priority areas including impact on primary care in terms of workload, quality which will feed into strategic decision-making.

4. Accountability and Governance Structure

4.1 The Primary Care Transformation Committee will be underpinned by good governance principles and robust assurance processes, to ensure accountability to the public as patients, citizens or taxpayers.

The Primary Care Transformation Committee is accountable to the ICB System Transformation and Quality Improvement Committee and HWE ICB Board. Where there are financial and contractual implications of strategic decisions related to primary care providers, in line with the organisation's SFIs these will be referred to the Primary Care Commissioning Committee for a decision.

Primary Care Transformation Committee will have specific working groups reporting progress into the group in particular these will include primary care workforce and primary care digital.



5. Operating Principles

5.1 Each member on the Committee is there in an individual capacity bringing in the experience and acting for the benefit of the system as a whole and not for any organisation that they may also be employed by.

6. Reporting and Responsibilities

6.1 The Primary Care Transformation Committee is accountable to the HWE ICB System Transformation and Quality Improvement Committee.

- The Group will be supported by a number of work stream delivery groups, chaired by appropriate senior responsible officers (SROs) focussed on the improvement areas to deliver the required system wide benefits.
- On behalf of the ICB System Transformation and Quality Improvement Committee, the Chair is responsible for ensuring that workstream Senior Responsible Officer's are held to account for the successful implementation of agreed schemes to support financial, quality and operational improvements.
- Work streams are accountable to the Primary Care Transformation Committee, which reports into the ICB System Transformation and Quality Improvement Committee.
- Workstreams will provide regular highlight reports and where necessary exception reports, or in-depth reports as required by the Committee.

- The Group will have 2-way relationship with the Primary Care Commissioning Committee of the ICB.
- The Committee will receive regular updates from its subgroups and from representatives of the committee from place including locality leadership.

7. Composition and Quoracy

7.1 This section sets out the meeting composition and quoracy arrangements:

Arrangement	Description of expectation
Chair and Vice Chair	The Committee shall satisfy itself that the ICB's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the ICB policy and procedures relating to conflicts of interest. If a Chair has a conflict of interest, then the co-chair or, if necessary, another member of the Committee will be responsible for deciding the appropriate course of action.
Membership	The members will be representative of the HWE health and social care community to ensure diverse input and decision making. When determining the membership, active consideration will be made to equality, diversity and inclusion. The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters. **Committee Members:** • ICB Primary Care Partner Members (x3) • ICB Director of Primary Care Transformation • ICB Medical Director • Independent Clinical advisor for Dental • Chief Pharmacist AD for Primary Care Strategy and Planning • Representative from Community Provider • Representative from Mental Health • Representative from Local Authority (1 HCC / 1 ECC) • HCP Care Closer to Home GP Leads one from each place • Citizen representatives from each place X3 • PC Workforce Clinical lead • PC Digital Clinical lead • Senior Primary Care Management • Community Pharmacy PCN Engagement Clinical lead
Attendees	• Healthwatch Representative 1 representative for Hertfordshire and

	1 for Essex • Local Professional Committee representatives Hertfordshire and Essex (LMC, LPC, LOC, LDC) • Voluntary Community and Social Enterprise (VCSE) representative • ICS Clinical leads for Strategic Programmes/Enablers as appropriate –primary care transformation, primary care prescribing, workforce and digital • ICB Communications lead • Other leads including Health Education England; Education sectors; digital and other managerial leads as appropriate.
Member roles and responsibilities	All members are required to attend or send a deputy. Workstream and Portfolio leads must ensure that reports and papers are submitted to enable circulation 5 days before the meeting. All members are required to complete assigned actions and provide updates to the Group in line with the action log. All members are required to be full and active participants, to ensure that relevant expertise is available to the Board to facilitate effective management of the workstreams.
Meeting frequency and Quorum	The Primary Care Transformation Committee will meet every other month. Additional meetings may be convened on an exceptional basis and at the discretion of the Chair. This meeting provides strategic oversight and is not a forum for decision-making. A meeting will be considered quorate if 50 per cent of members are present, which must include either the Chair or Vice-Chair and one Executive Director. No formal business shall be transacted where a quorum is not reached.
Meeting Arrangements	The full membership of the Primary Care Transformation Committee will meet on a bi-monthly basis, with work stream Senior Responsible Officer's and members supporting programme delivery joining working group meetings in the intervening months. Meetings will be held in public and will be online or hybrid and in-person to ensure maximum attendance. Members who cannot attend will be expected to send deputies.

8. Behaviours and Conduct

8.1 ICB values

Members will be expected to conduct business in line with the ICB values and objectives.

Members of, and those attending, the Primary Care Transformation Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

8.2 Equality and diversity

Members must demonstrably consider the equality and diversity implications of decisions they make.

9. Secretariat, Administration and Review

The Primary Care Transformation Group shall be supported with a secretariat function which will include ensuring that:

Distribution of papers	The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead.
Monitor attendance	Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements.
Minute taking	Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept.
Updates	The Group is updated on pertinent issues/ areas of interest/ policy developments. Action points are taken forward between meetings and progress against those actions is monitored.
Review	The Primary Care Transformation Group will review its effectiveness at least annually. These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the ICB Board for approval.

Document Control:

Version	Date	Approved By	Review	Change made
V1	Friday 26 April 2024	HWE ICB Board	Annually	n/a
V1.1	Thursday 26 September 2024	ICB Primary Care Transformation Committee		Membership updated

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

NHS Hertfordshire & West Essex Integrated Care Board

Primary Care Workforce Implementation Group (WIG)

Terms of Reference

1. Introduction

1.1. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Hertfordshire and West Essex (HWE) Integrated Care Board (ICB) Primary Care Workforce Implementation Group (WIG).

2. Purpose and Remit

2.1. The Primary Care WIG is a multi-professional body which operates at ICB level and brings together key stakeholders and organisations and other agreed stakeholders to:

- Lead on the development of primary care workforce planning in line with the long-term workforce plan and annual operating model.
- Oversee the development and delivery of primary medical services education and training in line with the national and local priorities including leadership and where appropriate organisational development.
- Identify and test where appropriate new models of workforce across primary care.
- Identify the key priority areas to support GP workforce recruitment and retention.
- Identify the key priority areas to support recruitment, retention, training, development, and succession planning for all staff groups across providers, including general practice, pharmacy, dental and optometry – working closely with NHS England colleagues as appropriate.
- Identify the key priority areas to support the wider team development, including practice management, from frontline to back-end office staff.
- Identify the key priority areas to develop, test, support and embed the new roles within primary care and where appropriate create opportunities to test roles across providers/partners reducing organisation boundary.
- Enable clinical/non-clinical perspectives to inform strategic decision-making.

2.2. The Primary Care WIG will play a key role in supporting the delivery of key national policy areas such as the NHS Long Term Workforce Plan (LTWP) and NHS Long term Plan (LTP) and will support the delivery of local strategies such as the ICS People Strategy (2023-2025) and ICS Primary Care Strategic Delivery Plan (2023-2026), ensuring alignment to ICB priorities.

2.3. The Primary Care WIG will have a multi-professional focus, agreed terms of reference and accountability needs to reflect the nature of the collaboration between NHSE and the ICB, and thus a mechanism developed to ensure robust reporting to the appropriate organisation responsible for the “commissioning” of any given workstream.

2.4. To collaborate with Higher Education Institutions (HEIs), acute and community trusts, Primary Care Networks (PCNs), Integrated Neighbourhood Teams (INTs), and other system partners and provider organisations to develop, implement, and test innovative models aimed at enhancing the recruitment, retention, and development of the primary care workforce.

3. Roles and Responsibility

3.1. The groups duties are as follows:

- Lead on the strategic development, implementation, and delivery of the primary care workforce component within the overarching HWE primary care strategy and people plan.
- Develop, monitor, review the annual Primary Care workforce plan including having robust prioritisation with regular reporting and assurance to the Primary Care Transformation Committee, Primary Care Commissioning Committee, People's Board and other relevant committees in the ICB and in addition to other external partners as appropriately requested.
- Oversee the implementation of national requirements from NHS England in relation to primary care workforce.
- The group will receive regular reports from the subgroups/task to finish groups as appropriate.
- Lead on workforce planning, education and training opportunities, testing new ways of working through the development of innovative plans such as portfolio roles, enhancing the development of new roles, career pathways and leadership development.
- Oversee the development of the primary care workforce including the introduction of new additional roles within PCNs.
- Recognise that new models of care in primary care shape the workforce required and impact estates and digital infrastructure. Therefore, a matrix approach, working across other primary care functions, is essential.
- To review Primary Care workforce risks.
- The group will adhere to the ICB procurement and financial limits.

3.2. The group's communication and engagement responsibilities include:

- Proactive engagement in responding to items and presenting data or information as part of the group.
- Two-way communication of information both at and between meetings.
- Acting as a representative of their organisation/department/expertise and ensuring appropriate links with other relevant groups such as Peoples Board and The HWE Pharmacy Workforce Group
- To disseminate information from the group across their stakeholder area regarding organisational and directional change of innovation.
- To review and share operational experience across the group to promote best practice and spread solutions.
- To declare any conflict of interest as items arise.

4. Accountability and Governance Structure

4.1. The HWE Primary Care Workforce Implementation Group is accountable to the Primary Care Transformation Committee (PCTC).

4.2. Decision making will be undertaken by the HWE WIG in accordance with processes outlined within these policies and strategic/operating plans:

- HWE Procurement Strategy and Standard of Business Conduct and Conflict of Interest Policy
- HWE Primary Care Strategic Delivery Plan
- HWE People Strategy
- NHS England Quality Framework
- Primary Care Training Hub – Common Operating Guidance
- HWE Operating Plan

5. Operating Principles

5.1. The meeting will take place in two parts:

- **Part 1: Core Membership** – Focus on national and local initiatives, strategic planning, delivery, and monitoring of programme and/or financial performance against available budget. Allocation of resources and monitoring and recording risks.
- **Part 2: Core membership and in attendance representatives** – Discussion of primary care challenges and opportunities for greater integration and cross-sector, multi-professional working, along with resources and support.

5.2. **Recording of Interests:** On appointment and at the start of every WIG meeting, members will be required to declare any interests of relevance, financial, professional, personal and indirect interests.

5.3. **Confidentiality:** All members of the group shall not reveal or disclose any information identified as confidential without the permission of the Chair. This applies to the content of any discussion as well as papers and records.

6. Reporting Responsibilities

6.1. The Hertfordshire and West Essex Primary Care Workforce Implementation Group will provide regular reports and assurance to the Primary Care Transformation Committee, Primary Care Commissioning Committee, People's Board and other relevant committees in the ICB and in addition to other external partners as appropriately requested. This WIG will receive and oversee the production of a quarterly primary care workforce dashboard.

6.2. The Primary Care Workforce Implementation Group will be supported by various clinical and non-clinical workforce leads and chaired by the HWE ICB Training Hub Clinical Lead.

6.3. Workforce leads will provide regular highlight reports and where necessary exception reports or in-depth reports as required by the WIG.

6.4. The Group will provide the forum for discussing and agreeing ICB level primary care workforce and education initiatives and funding requests; although, it is accepted that due to time constraints associated with external funding opportunities, decisions may need to be made by email between meetings. It is expected that a final sign off decision will be made by Director level and finance lead and reported to Primary Care Commissioning Committee (PCCC) as appropriate.

7. Membership and Chairing Arrangements

7.1. Core membership:

- HWE Primary Care Workforce GP Clinical Lead – Chair
- Director of Primary Care Transformation
- Associate Director Primary Care Strategy and Transformation
- HWE Primary Care Workforce GP Clinical Leads
- Head of Primary Care Workforce
- Primary Care Workforce Programme Manager
- Primary Care Workforce Operational Manager
- Lead Pharmacist – Workforce Strategy and Pharmacy Workforce Development
- ICB Peoples Board Representative

7.2. In attendance:

- NHS England Representative
- Representatives from Local Professional Committees (LMC, LOC, LDC, LPC)
- Practice Manager Representative
- PCN Pharmacy Engagement Lead Representative
- Representatives from Higher Education Institutes (e.g. university partners)
- Patient Representative
- Other leads and ICB representatives as appropriate/exception

8. Quorum

8.1. The group will be quorate when at least four members are present. At least two Clinical Leads and ICB Director/Deputy must be present.

9. Member Roles and Responsibilities

9.1. All members are required to attend or send a deputy.

9.2. Workstream and Portfolio leads must ensure that reports and papers are submitted to enable circulation 5 days before the meeting.

9.3. All members are required to complete assigned actions and provide updates to the group in line with the action log.

9.4. All members are required to be full and active participants, to ensure that relevant expertise is available to the WIG to facilitate effective management of the workstreams.

10. Meeting Arrangements

10.1. The Group will meet quarterly.

10.2. The meeting will take place in two parts (part one for core membership and part two for core membership and in attendance representatives).

10.3. Members who cannot attend will be expected to send deputies where appropriate.

10.4. Papers will be circulated at least five working days before each meeting.

10.5. Action logs will be circulated within 10 working days of each meeting.

10.6. The secretariat will minute the outcome and the actions of the group including recording the names of those present and in attendance.

10.7. Members and those present should state any conflicts of interest in relation to agenda items to the Chair prior to the meeting.

10.8. Any new relevant interests declared at a meeting will be confirmed in writing to the Head of Corporate Governance and added to the ICB's Register of Interests

11. Monitoring and Review

11.1. The Terms of Reference will be reviewed on an annual basis, or sooner if required. The next review will take place one year from the date of approval stated below.

Date of Approval: December 2024

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 Transformation Committee meeting held in Public		**Meeting Date:**	**28/11/2024**
Report Title:	**A "stepped care" delivery model of two behavioural interventions to increase COVID-19 booster vaccine uptake in the immunosuppressed population.**		**Agenda Item:**	**06**
Report Author(s):	From Hertfordshire County Council's Public Health Evidence and Intelligence (PHEI) team: • Maree Brennan, Strategic Lead for Epidemiology • Victor Yu, Senior Public Health Research Analyst • Will Yuill, Principal Epidemiologist From Hertfordshire County Council's Behaviour Change Unit (BCU) team: • Dr Michelle Constable, Head of Behaviour Change Unit • Ludovico Nocco, Behavioural Science Specialist • Roshni Deo, Behavioural Science Specialist • Valasia Savvidou, Senior Research and Evaluation Officer			
Report Presented by:	Ludovico Nocco, Behavioural Science Specialist, Behaviour Change Unit (BCU) team, Hertfordshire County Council Victor Yu, Senior Public Health Research Analyst, Public Health Evidence and Intelligence (PHEI) team, Hertfordshire County Council			
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]**	< Please identify from the five ICB Strategic Objectives and list below > ▪ Improve outcomes in population health and healthcare. ▪ Enhance productivity and value for money. ▪ Tackle inequalities in outcomes, experience and access.			
Key questions for the ICB Board / Committee:	▪ The committee is asked to note the recommendations made in the report and suggest any further learnings and points for improvement in this area of work.			

<table>
<tr><td>Report History:</td><td colspan="4">< Group/Committee where previously reported, including date and any recommendations, if none then state N/A >
▪ N/A</td></tr>
<tr><td>Executive Summary:</td><td colspan="4">The Public Health Evidence and Intelligence team at Hertfordshire County Council, in collaboration with the Hertfordshire and West Essex Integrated Care Board, piloted two behavioural interventions to boost COVID-19 booster vaccine uptake among immunosuppressed individuals in Hertfordshire during Spring 2024.

Historical data indicated a significant decline in booster uptake among this high-risk group. Using a mixed-methods approach, including surveys and interviews, the team identified barriers to vaccine such as fear of side effects and lack of knowledge. A “stepped care” model was developed and delivered through GP surgeries, comprising an online FAQ guide and behaviourally informed text messages (Intervention 1), and personalised calls from specialist nurses (Intervention 2).

An interrupted time series analysis showed a small (but not statistically significant) improvement in uptake for Intervention 1 (0.74% overall (95% CI: -1.6% - 3.09%). Despite not reaching statistical significance, the findings are relevant for clinical practice: the observed increased in uptake could lead to potential cost savings estimated between £128,664 and £393,210 if Intervention 1 was scaled nationally, highlighting its pragmatic value despite statistical limitations.</td></tr>
<tr><td>Recommendations:</td><td colspan="4">▪ Deliver the FAQ online guide to immunosuppressed patients in future COVID-19 booster campaign, given its extremely low cost and high ease of delivery to the target audience.</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">< Provide details here - review the Register of Interests (Board/relevant committee membership), and highlight any potential conflicts, which the Chair needs to manage or state N/A if none ></td></tr>
<tr><td colspan="5">Implications / Impact:</td></tr>
<tr><td>Patient Safety:</td><td colspan="4">NA</td></tr>
</table>

Risk: *Link to Risk Register*	*[Refer to latest Risk Register when completing]*	
Financial Implications:	Potential cost savings estimated between £128,664 and £393,210 if Intervention 1 was scaled nationally.	
Impact Assessments: *(Completed and attached)*	***Equality Impact Assessment:***	<Yes / No / N/A >
	Quality Impact Assessment:	<Yes / No / N/A >
	Data Protection Impact Assessment:	<Yes / No / N/A >

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Executive Summary

Background

The project was led by the Public Health Evidence and Intelligence (PHEI) and the Behaviour Change Unit (BCU) teams and was delivered in collaboration with the Hertfordshire and West Essex Integrated Care Board (HWE ICB), with funding from NHS East of England. The project team developed an intervention programme to increase COVID-19 booster vaccine uptake among immunosuppressed patients (ISPs) aged 18 and over in Hertfordshire. Historical data in Hertfordshire showed a significant decline in booster uptake among this population, with around 89% receiving the first booster, but only 46.5% receiving the third booster (as of March 2023). This decline poses a considerable risk to immunosuppressed individuals, who are at a higher risk of severe COVID-19 outcomes. The success of such a programme could yield tangible benefits for patients and healthcare providers, while reducing health inequalities by ensuring that ISPs receive the necessary vaccinations to protect them from severe COVID-19 outcomes.

Objectives

The project focused on exploring barriers and facilitators affecting vaccine uptake in the ISP population in Hertfordshire and developing behaviourally informed interventions to address these barriers. The goal was to pilot the interventions with the aim to improve booster vaccine uptake in the spring 2024 COVID-19 campaign, while reducing the cost associated with severe COVID-19 cases in ISPs.

Methodology

Using a mixed-methods approach, ISPs and health professionals were recruited to explore ISP attitudes towards the COVID-19 booster vaccine and understand the barriers and facilitators to uptake. Additionally, a literature review was conducted to identify the efficacy of previously developed behavioural interventions to increase vaccine uptake.

The research activities informed the design of a “stepped care” model of delivery composed of two behavioural interventions: firstly, an online Frequently Asked Questions (FAQ) guide delivered through behaviourally informed text messages (Intervention 1); and secondly, a personalised telephone call from a specialist nurse (Intervention 2).

The interventions were piloted with 12 General Practitioner (GP) practices (reduced from 14 originally planned) within Hertfordshire and to evaluate their impact, a two-stage controlled interrupted time series (ITS) analysis was conducted. ISPs over 18 years old registered with the participating GP practices in Hertfordshire were used for the purposes of the analysis, with the equivalent population at non-participating GP practices within Hertfordshire originally planned to serve as controls, but due to data acquisition issues, all Hertfordshire residents aged 18-75 who were defined as immunosuppressed were used as an alternative.

An additional process evaluation was undertaken to understand the experiences of the nurses delivering the second intervention and to incorporate learnings from working with GP practices and the HWE ICB.

Key Findings

The interventions, guided by the COM-B (capability, opportunity, motivation, behaviour) model (Michie et al., 2011), targeted key behavioural factors influencing vaccine uptake. The main barriers identified were fear of side effects, perceived low risk of severe illness, and lack of knowledge about the necessity and effectiveness of the booster vaccine.

The ITS analysis suggested a small improvement in vaccine uptake during the delivery of Intervention 1 (0.74% overall (95% CI: -1.6% - 3.09%), broken down to 0.053% improved cumulative percentage uptake per day over 14 days) compared to the control data in the first intervention, however this effect was not statistically significant. Similarly, a small negative effect size was found for the second intervention but was again not found to be statistically significant.

Challenges related to data collection and GP practice participation affected the overall evaluation: these issues led to collinearity between the pilot practice data and the control data, and the withdrawal of two practices involved in the pilot programme. In addition, a large vaccine clinic hosted by one of the participating pilot practices during the pre-intervention phase reduced the number of potential ISPs who could have been exposed to the subsequent interventions.

Caution also has to be given to the interpretation of the negative effect size found for the second intervention – as the ISPs who have been vaccinated in the pre-intervention phase and intervention 1 would likely have greater propensity to being influenced to receive the booster, this would have given an opportunity for ISPs in the control group to ‘catch up’ to the pilot group in terms of the outcome of interest. These issues could have attenuated the effect sizes found, and likely resulted in the lack of statistical significance found in the interventions, complicating any causal inference that could be gained from the analysis.

If the first intervention was rolled out to the East of England 18+ immunosuppressed population, cost-savings estimates could amount to £54,978 (95% CI: £0 - £202,194) as a result of reduced hospitalisations and post-hospitalisation care owning to the protective effect of the booster.

This project highlights the effectiveness of using mixed methods techniques, in conjunction with behavioural science approaches, to design and assess public health interventions aimed at improving outcomes in immunosuppressed populations and supports efforts to reduce health inequalities for a vulnerable population with high healthcare utilisation.

For future studies, further resources invested in more regular engagement with primary care stakeholders involved could result in more consistent data sharing practices, thus improving the reliability of the outcome evaluation and the quality of the calls with nurses. Despite not finding statistical significance in this analysis, future programmes may wish to replicate the FAQs and text messages intervention, given its relatively low implementation costs and potential cost-savings.

Challenges related to data collection and GP practice participation affected the overall evaluation. These attenuated the effect sizes found, have contributed to the lack of statistical significance, and reduced any causal inference that could be drawn

from the analysis. In addition, the extension of the intervention 2 period, from 21 days to 42 days, potentially weakened any possible effect size found in this period and allowed the population of the control data to ‘catch up’ in terms of cumulative uptake.

Introduction

The Public Health Evidence and Intelligence (PHEI) team at Hertfordshire County Council (HCC), in collaboration with the Hertfordshire and West Essex Integrated Care Board (HWE ICB), designed an intervention programme with the goal of increasing the uptake of the COVID-19 booster vaccine in immunosuppressed patients (ISPs) aged 18+ in Hertfordshire.

ISPs are at a markedly increased risk of developing severe symptoms after COVID-19 infection, resulting in longer hospital stays and higher rates of admission to Accident & Emergency (A&E) and Intensive Care Units (ICUs) (Turtle et al. 2023). In addition, compared to the general population, ISPs are more likely to be considered clinically extremely vulnerable and given priority for initial and subsequent booster vaccinations against COVID-19.

Historical data has indicated a considerable decline in vaccine uptake for multiple immunisation programmes (Iacobucci 2022), including COVID-19 booster doses in the immunosuppressed population (Kerr et al. 2024). Data from the National Immunisation Management System (NIMS) reveal that whilst 93.4% of ISPs in Hertfordshire have completed their primary vaccination course, uptake for subsequent boosters is significantly lower, with 88.5% receiving the first booster, 73.2% receiving the second booster, and 46.5% receiving the third one (figure 1, NIMS, as of 06 March 2023). This trend presents a critical gap in immunisation coverage, leaving a substantial proportion of ISPs in Hertfordshire with inadequate protection.

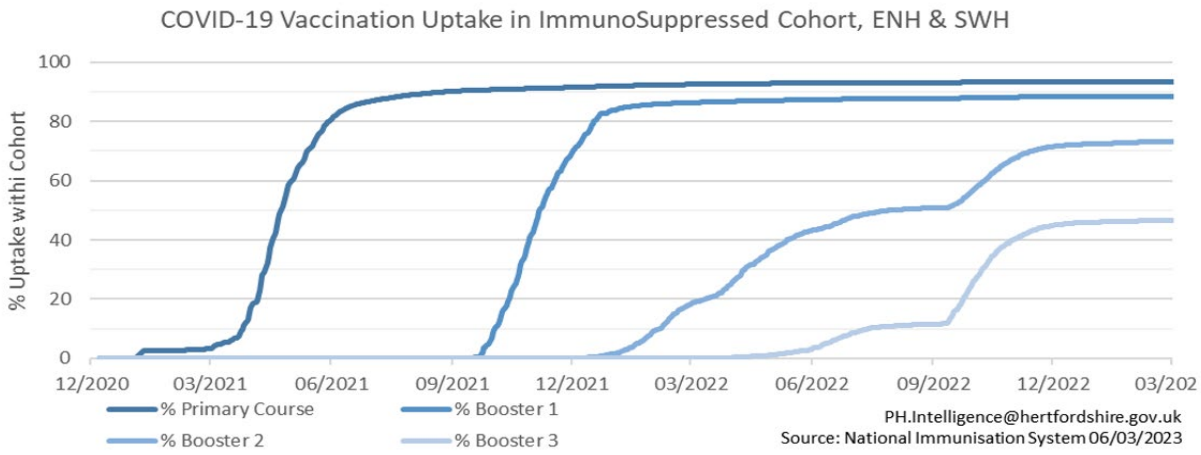

Figure 1. COVID-19 Vaccination Uptake Rates in Immunosuppressed Patients, for East and North Herts and South West Herts, as of Spring 2023.

In response to these concerns, and as the barriers and facilitators to uptake for ICPs were not well understood, a behaviourally informed, targeted intervention was developed to complement the existing spring booster campaign for 2024. Research was undertaken with both ISPs and health professionals to inform decision making and the design of the interventions aiming to enhance patient knowledge about the effectiveness, safety, and benefits of the vaccination and subsequent boosters, with the aim of improving uptake rates through behaviourally informed strategies.

The success of this programme could yield tangible benefits for patients and healthcare providers. It could reduce health inequalities by ensuring that ISPs receive the necessary vaccinations to protect them from relatively worse COVID-19 outcomes compared to the non-immunosuppressed population. Additionally, by improving vaccination coverage, the intervention supports broader health protection objectives, potentially mitigating the risk of COVID-19 transmission and reducing the overall burden on the healthcare system. Lastly, increased vaccination uptake among ISPs may result in cost savings by decreasing the incidence of severe COVID-19 cases and subsequent hospitalisations, thus alleviating some of the financial pressures associated with managing COVID-19 in this high-risk group.

Methodology

The project involved two stages.

Stage 1. **Intervention development using Behavioural Science**

A literature review was completed to identify the efficacy of behavioural interventions previously developed to increase vaccine uptake. Subsequently, the primary research was conducted using a mixed-methods approach, where ISPs and specialist consultants were recruited to explore attitudes towards the COVID-19 booster vaccine and understand the barriers and facilitators to uptake. Lastly, the findings from the literature review, together with the behavioural analysis of the findings from the primary research, were applied to develop the intervention design for the pilot study.

Stage 2. **Pilot study**

The pilot study aimed to test the interventions developed to increase the booster vaccine uptake of ISPs as part of the NHS Spring 2024 COVID-19 booster campaign.

Stage 1. Intervention development using Behavioural Science

Literature review

A literature review was conducted to identify and compare the efficacy of prominent behavioural interventions which have been employed to improve vaccine uptake in a given population. The evidence pointed to a range of behavioural interventions that were shown to be successful in increasing COVID-19 vaccine uptake in people with a weakened immune system. These include:

I) Tailored messaging (Freeman et al., 2021; Viswanath et al., 2021)
II) Endorsement from specialist healthcare providers (Fisher et al., 2021)
III) Educational materials e.g. podcasts (Gagneux-Brunon et al., 2021; Khubchandani et al., 2021)
IV) Reminder and recall systems (Nowak et al., 2021)
V) Peer support (Peretti-Watel et al., 2021)
VI) Incentives e.g. transportation vouchers (Schmidt et al., 2021)

These findings were included in the full list of intervention recommendations assessed at the intervention design stage.

Primary research

The primary research employed a mixed methods approach, which consisted in the following research activities:

- An **online survey** completed by 160 ISPs (67% Female, 73% aged 50+ years and 81% White). The survey assessed information needs, intentions to receive further boosters and the barriers and facilitators towards receiving boosters, as well as suggestions for service improvement (see Appendix 1 for the survey questions). At the end of the survey, participants had the opportunity to express an interest in participating in an interview.

- **Semi-structured interviews,** lasting up to 60 minutes, were conducted with 30 ISPs. Eligible ISPs were asked to submit an expressions of interest form to take part in the interviews and all those who completed this were contacted and interviewed. The interviews aimed to explore barriers to vaccine uptake with specific focus on the patients' experiences of the COVID-19 booster vaccines (see Appendix 1 for topic guide). Participants received a £25 shopping voucher for their time.

- **Semi-structured interviews,** lasting up to 30 minutes, with three specialist consultants working with ISPs in the East of England region, and with specialisms in the areas of Cancer Treatment, Haematology and Rheumatology. The interviews focused on understanding the barriers to uptake from the perspective of service providers.

Recruitment

The recruitment of specialist consultants for the interviews took place via the medical directors of trusts in the East of England region, while the recruitment of participants for the survey and interviews were achieved via the following channels:

i. 18 patient organisations working with immunocompromised/immunosuppressed people in Hertfordshire and West Essex helped to promote the survey and interviews through their social media platforms.
ii. Newsletters and Yammer posts to communicate the survey and interviews among Hertfordshire County Council employees.
iii. GP practices in Hertfordshire and West Essex circulated among their immunosuppressed patients two text messages; one including the survey link and another one including a link to express an interest for the interviews. A total of 131 GP practices were contacted (101 in Hertfordshire and 30 in West Essex), out of which 27 agreed to share the survey and 16 to share a link to express an interest in the interviews. All GP practices that shared the survey received a £44 payment/incentive (GP practices that shared both links received a total of £88).

Eligibility criteria

ISPs were eligible to participate in the survey and interviews if they met the following eligibility criteria:

- Are aged 18+
- They were accessing care in the East of England
- They have received the primary doses of the Covid-19 vaccination but not all booster vaccines offered to them.

Theoretical frameworks

The COM-B model of behaviour change

Figure 2 shows the COM-B model (Michie et al., 2011), a behavioural framework that was selected to conduct a behaviour analysis and the resulting intervention design. This rigorous scientific method generated actionable insights within a condensed timeframe, which were used to inform the design of behavioural interventions implemented as part of the pilot study.

The COM-B model encompasses three components (**C**apability, **O**pportunity, and **M**otivation), believed to interact and influence human behaviour. Capability refers to an individual's psychological and physical capacity to engage in the behaviour. Opportunity refers to the external factors that prompt or hinder behaviour, including environmental and social cues. Motivation considers the psychological processes that drive behaviour, such as desires, beliefs, and emotional responses.

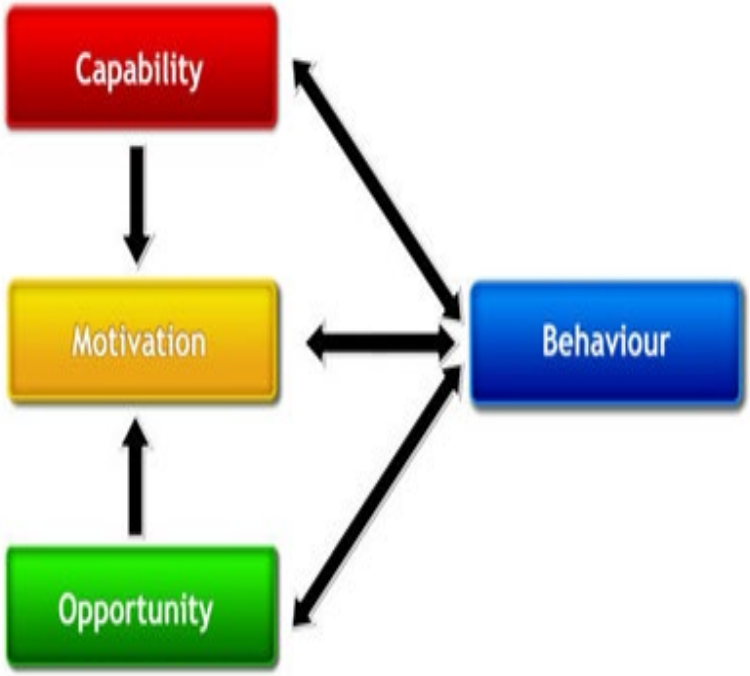

Figure 2. The COM-B model

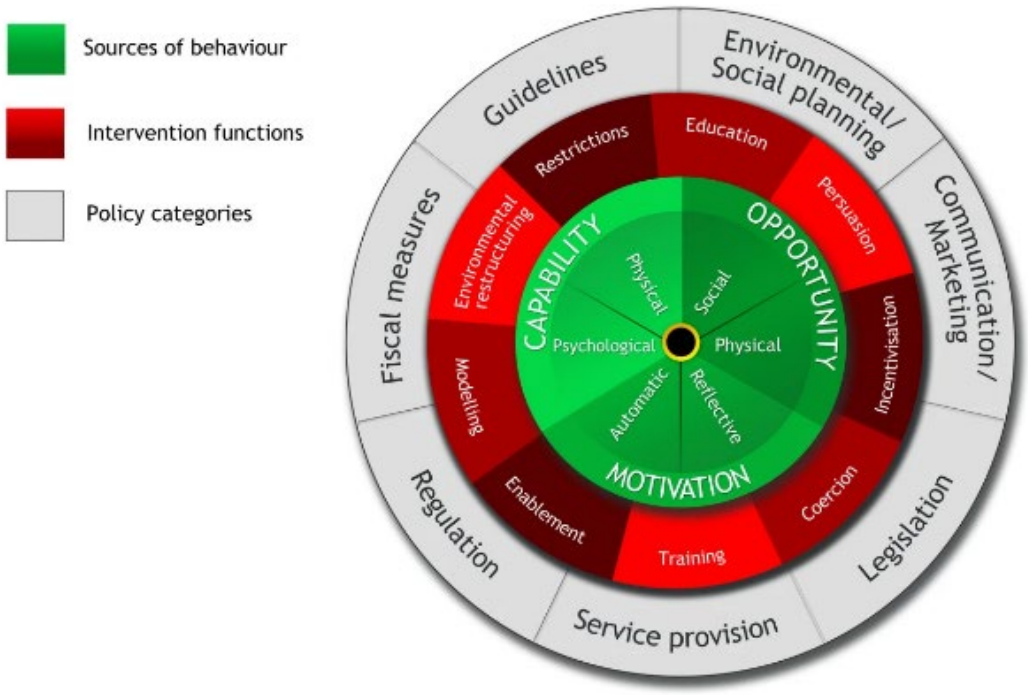

Figure 3. The Behaviour Change Wheel

The Behaviour Change Wheel

The Behaviour Change Wheel (BCW, Figure 3 above) is a versatile framework designed to create and assess behaviour change interventions and was used by the BCU while selecting and developing the interventions. BCW integrates insights from 19 different frameworks and is structured into three layers:

1. the core, which uses the COM-B model to pinpoint behavioural influences;
2. the middle layer, which details nine intervention functions to choose from and apply in order to influence the target behaviour; and
3. the outer layer, which includes seven policy categories, which are ways in which interventions can be delivered.

The Behaviour Change Techniques Taxonomy

The Behaviour Change Techniques Taxonomy (BCTT) is a systematic classification of behaviour change techniques aimed at enhancing the clarity and reporting of behaviour change interventions. Similarly to the BCW, BCTT was used for the intervention development and selection.

The BCTT comprises of 93 distinct behaviour change techniques, grouped into 16 categories based on their function, such as goal setting, feedback and social support. This taxonomy provides a unified language for researchers and practitioners to describe the “active” elements of interventions. The word “active” is used to indicate that behaviour change techniques are the observable and replicable components of interventions that are designed to change behaviour.

Behavioural analysis

Data collected via the surveys and interviews allowed the identification of a total of 73 unique behavioural barriers. Of the barriers identified, 51% related to *Motivational* influences, 38% to *Capability* influences and 11% to *Opportunity* influences. A few

barriers were mentioned quite frequently in the interviews; hence frequencies were calculated for how often the same barriers were encountered in the interview transcripts. The most recurring influences affecting participants' decision not to accept a COVID-19 booster vaccine were as follows:

- Fear of experiencing negative side effects of the vaccine again (with 49.6% frequency)
- Perceived low risk of experiencing severe symptoms should the virus be contracted (with 34.2% frequency)
- Personally researched the booster vaccine and determined not needing it (with 32.9% frequency)

Other barriers identified included:

- Lack of suitable appointment times
- Inconvenient location of vaccine centre
- Lack of resources (e.g. transportation, childcare)
- Lack of understanding of necessity of booster
- Lack of knowledge on how to report side-effects.

A complete list of behavioural barriers identified at the research stage is available in Appendix 2.

Behavioural intervention design

Shortlisting intervention options

The findings from the literature review and the behavioural analysis of the primary research findings resulted in a total of 14 intervention recommendations (see Appendix 2). To determine which of these to take forward to the intervention development stage, a three-step systematic process was followed, in line with the Behaviour Change Wheel (BCW) framework (Michie et al., 2014).

Step 1. A rapid cost-effectiveness analysis was conducted with the project sponsors from HWE ICB to explore the viability of a range of intervention options, with the aim of shortlisting those deemed as both most promising and least costly.

Step 2. A series of process mapping meetings were held with ICB and Hertfordshire Community Trust (HCT) to identify key touchpoints for intervention delivery within both patient and provider pathways, from invitation through to appointment booking and ultimately receiving the vaccine.

Step 3. The content of the recommendations was revised following steps 1 and 2. At this stage, the options were evaluated using the APEASE criteria (Michie, Atkins, & West, 2014) in a workshop with 8 key stakeholders from the HWE ICB, HCT and HCC. APEASE is a framework for assessing interventions on six criteria and ensuring that interventions that are taken forward for development and delivery are acceptable to the target group, practical, effective, affordable, equitable and with minimal unintended consequences.

As a result of this process, two intervention options met the cost-effectiveness criteria, were feasible to roll out at the intended touchpoints and scored the highest APEASE scores. These were:

1) **A "Frequently Asked Questions" (FAQ) online guide**, addressing recurrent concerns from the immunosuppressed cohort (Phase 1).
2) **A personalised telephone call by a specialist nurse** to address individual concerns on a case-by-case basis (Phase 2). This conversation was supported by a behavioural script that was provided to the nurses.

These two interventions were progressed to the intervention development stage.

Intervention development: Behaviour Change Wheel (BCW) framework and Behaviour Change Techniques (BCTs)

The selected intervention options were developed further, and key Behaviour Change Techniques (BCTs) were selected to be included in the intervention content. The selected interventions were mapped against the domains of the COM-B and BCW intervention and policy functions as seen in Table 1.

Interventions	Targeted COM-B domains	Intervention type (BCW)	Policy category (BCW)
FAQ online guide	Psychological capability	Education	Comms & marketing
	Reflective motivation	Persuasion	
Personalised phone call by Specialist Nurse	Psychological capability	Education and Enablement	Service provision
	Reflective motivation	Persuasion and enablement	

Table 1. Intervention development using the BCW framework

The intervention types and policy categories are explained in further detail below:

- for the "**FAQ online guide**", the intervention types were "Education" and "Persuasion", aligning with "Comms & Marketing" in terms of policy category, as it relied on electronic media to be delivered to eligible patients. The "FAQ online guide" was developed to ensure that patients had the baseline level of knowledge needed to perform the target behaviour ("education" intervention type), with the assumption that increased knowledge would be a necessary condition for change. The content was also written in a persuasive way, highlighting both the positive/negative consequences of performing/not performing the target behaviour ("persuasion" intervention type).
- for the "**Personalised phone call by a specialist nurse**", the intervention types were "Education", "Persuasion" and "Enablement", aligning with "Service Provision" in terms of policy category, as this was not part of the standard NHS offer and was a service specifically financed and provided as part of this pilot project. The "enablement" part of this intervention can be explained by the fact that during the phone calls, the nurses would provide practical assistance to patients with regards to booking and receiving the vaccine. Moreover, the phone calls acted to reinforce the knowledge provided in the FAQ guide, but also enabled nurses to address personal beliefs/concerns and provide practical support in addition to the information available in the FAQ.

As part of the two abovementioned interventions, behaviourally informed text messages were developed and delivered to patients. The text messages served a supporting role for the delivery of Intervention 1 and Intervention 2, and achieved the following goals:

- deliver the FAQ to patients,
- remind them of the importance of booking the vaccine, and

- informing patients who still showed up as unvaccinated after delivery of the FAQ of the upcoming phone call by the Specialist Nurse.

As for BCW intervention types and included BCTs, the behavioural text messages had significant overlap with the characteristics of Intervention 1 and 2. More specifically:

- they were developed with the assumption that text reminders would facilitate and increase both access and use of the interventions ("education" intervention type), thus increasing their knowledge and persuading them to receive the booster ("persuasion" intervention type).
- They included some of the same exact BCTs selected for Intervention 1 and 2.

The content of the interventions is outlined in further detail below, however for the full content of the interventions and the behavioural text messages, see Appendix 4. In terms of the Behaviour Change Techniques incorporated in the two interventions and the behavioural text messages see Table 2. A full description of each of the BCTs delivered in each intervention and in the text messages, see Appendix 3.

FAQ online guide (Intervention 1)

An educational resource in the form of an online FAQs guide was developed to improve knowledge and address common concerns about the COVID-19 booster vaccine. A text message including a URL to the FAQs was disseminated to eligible patients from 12 participating GP surgeries with the aim of enabling individuals to make more informed decisions about the booster vaccine.

Based on the findings of the qualitative research, the FAQ resource provided information pertaining to 14 topics:

- Booking your appointment
- Who is being offered a COVID-19 booster?
- Why do I need two booster vaccines every year?
- Do I need a booster vaccine if I recently had a COVID-19 infection?
- What is a dual vaccine, bivalent vaccine, or omicron booster?
- How long does the booster last, and how effective is it?
- What are the side effects of the booster and how long do they last?
- Which booster vaccine is right for me and/or most effective for my condition?
- I previously had bad/very bad side effects from a booster vaccine.
- Should I get another booster vaccine?
- Is myocarditis more common after the booster vaccine?
- How do I report side effects?

- Can I opt out of booster invitation communications?
- I am pregnant. Can I have the vaccine?
- Should people with cancer or receiving chemotherapy get the COVID-19 booster?

The FAQ webpage was hosted on the Hertfordshire Community Trust (HCT) website to build trust in the target population by providing consistency, given that the nurses due to phone patients in Phase 2 of the intervention were going to introduce themselves as HCT staff. In terms of the development of this phase of the intervention, iterative feedback was sought from a small sample of immunosuppressed people to ensure acceptability of the content and a positive user experience. Several BCTs were incorporated in the FAQs guide and can be viewed in Table 2. An example is provided below:

> *"What are the side effects of the booster vaccination and how long do they last?"*
> *(…)*
> *If you have specific concerns about the side effects of a particular booster vaccine, it is advisable to consult with your healthcare professional. They can provide guidance based on your individual health status and the immune response you had to previous vaccinations. They can help you make an informed decision about receiving a booster vaccine.*
>
> *BCT 1.2: "Problem solving"*

In this example, to address barriers arising from concerns around side effects, the reader is prompted to analyse any negative beliefs that may be influencing the behaviour and to speak to a healthcare professional as a strategy to overcome barriers.

Personalised phone call by a specialist nurse (Intervention 2)

Specialist nurses, experienced in vaccinations (Band 5 and Band 7), were employed through HCT to deliver a 'recall' service. This involved making personalised telephone calls to all eligible patients who had not yet taken up the offer within four weeks of the launch of the campaign. Patients received tailored advice and support from a qualified healthcare professional with sight of their medical history enabling them to discuss complex concerns in context. A behaviourally informed telephone script was developed to support these vaccine engagement conversations by fostering trust through credibility. The BCTs incorporated in the telephone script can be viewed in Table 2. An example is provided below:

> *Patient recently had COVID-19 but without severe symptoms.*
>
> *I can see you received your last dose on [Date from medical records]. If your COVID-19 symptoms were mild, that's probably because the vaccine doses you've had before worked really well.*
>
> *BCT 13.2: "Framing/reframing"*

In this example, to address barriers arising from experiences of having COVID-19 without severe symptoms, nurses were instructed in the script to respond in a way

which framed this experience as being a result of the beneficial effects of the vaccine, rather than constituting evidence that the booster is not needed nor effective.

The BCTs incorporated in Intervention 1 and 2, and in the behaviourally informed text messages, can be viewed in Table 2 below.

Code	Behaviour Change Technique	FAQs	Personalised conversation with specialist nurse	Behavioural text messages
1.2	Problem-solving	✓	✓	
1.4	Action Planning		✓	
3.2	Social support (practical)		✓	
4.1	Instruction on how to perform a behaviour	✓	✓	
5.1	Information about health consequences	✓	✓	
5.2	Salience about consequences		✓	
5.3	Information about social and environmental consequences	✓	✓	
5.6	Information about emotional consequences	✓		
6.1	Prompts/cues	✓		✓
9.1	Credible source	✓	✓	✓
9.3	Comparative imagining of future outcomes	✓	✓	
10.11	Future punishment	✓	✓	
13.2	Framing/reframing	✓		✓

Table 2. Behaviour Change Techniques incorporated in the two interventions and the behaviourally informed text messages.

To maximise efficiency in terms of resources and costs, the BCU recommended a "Stepped care model" of intervention delivery (Richard et al., 2012), which consists of a phased approach in the roll out of the interventions. Interventions of a lower intensity (and greater accessibility) were deployed first, in an endeavour to encourage behaviour change. For individuals where this was insufficient, higher

intensity (and lower accessibility) interventions were deployed. A timeline of the intervention phases can be viewed in Figure 4.

The instructions for intervention delivery and the intervention materials were shared with Practice Managers at participating surgeries, who were invited to provide their comments and feedback during an online session. A protocol for delivery was developed and formally agreed by all stakeholders involved in the delivery of the project.

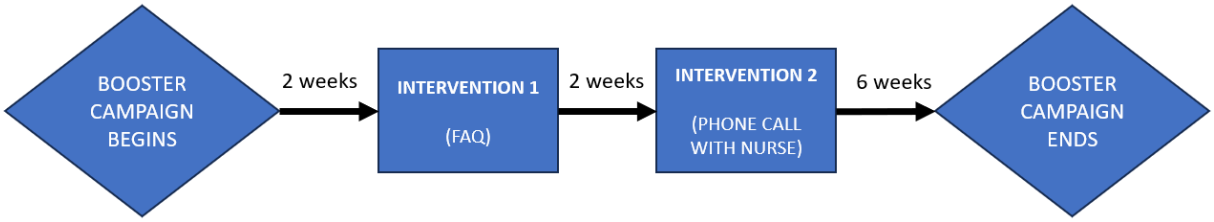

Figure 4. Timeline of intervention phases

Stage 2. Pilot study

Recruitment of primary care practices

The primary care practices were recruited to be broadly representative of the demographic profile of Hertfordshire and to have similar uptake with the autumn 2023 booster campaign in the region (~35%). An initial invitation was sent out to 18 GP practices, with 14 signing up to participate in the pilot programme. However, two practices ended up withdrawing during the programme. Data from these two practices are included in the table (table 3) and map (figure 5) below but omitted in the interrupted time-series analysis.

GP Practice	Sub-ICB	PRACTICE SIZE	% Registered Patient List Estimated White
BANCROFT MEDICAL CENTRE	East and North (06K)	18163	84.6
BEDWELL MEDICAL CENTRE	East and North (06K)	13347	83.0
CHURCH STREET PARTNERSHIP	East and North (06K)	16629	89.3
CUFFLEY AND GOFFS OAK MEDICAL PRACTICE	East and North (06K)	13214	82.9
DOLPHIN HOUSE SURGERY	East and North (06K)	15905	93.0
FAIRBROOK MEDICAL CENTRE	South West (06N)	14162	76.4
GARSTON MEDICAL CENTRE	South West (06N)	12319	68.4
HARVEY GROUP PRACTICE	South West (06N)	14518	82.3
SHEEPCOT MEDICAL CENTRE	South West (06N)	10851	72.7
SOUTH STREET SURGERY	East and North (06K)	23035	89.3
STANMORE MEDICAL GROUP	East and North (06K)	51016	82.7
THE GARDEN CITY PRACTICE	East and North (06K)	12408	86.4
THE GROVE MEDICAL CENTRE	South West (06N)	13028	76.4
VINE HOUSE HEALTH CENTRE	South West (06N)	10954	83.9

Table 3. Basic information of the 14 GP practices involved in the pilot

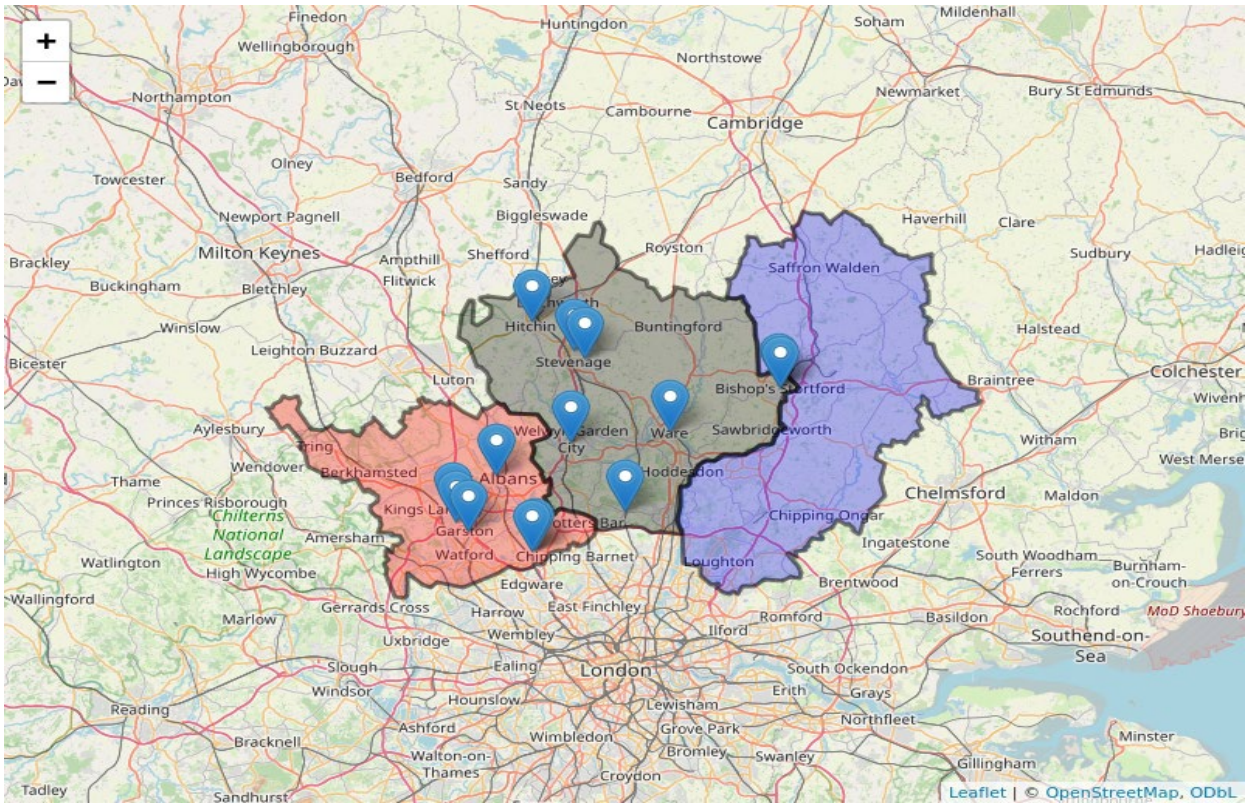

Figure 5. Map Showing Location of the 14 Participating Practices. Colours indicate sub-ICB locations within HWE ICB. Pink = Southwest (06N). Grey = East and North (06K). Purple = West Essex (07H)

Data collection

A detailed timeline for the pilot is shown in Figure 6. Data from the primary care practices was agreed to be collected on a weekly basis from April 22nd to June 30th 2024 and included a daily breakdown of the following variables:

- Number of vaccinations booked on the day
- Number of vaccinations given on the day
- Number of vaccinations where patients did not attend (DNA) on the day
- Number of texts to the FAQ page sent out during Intervention 1
- Number of slots available to speak to a nurse through a phone call (defines availability for Intervention 2)
- Number of conversations which were successfully completed during the slot.

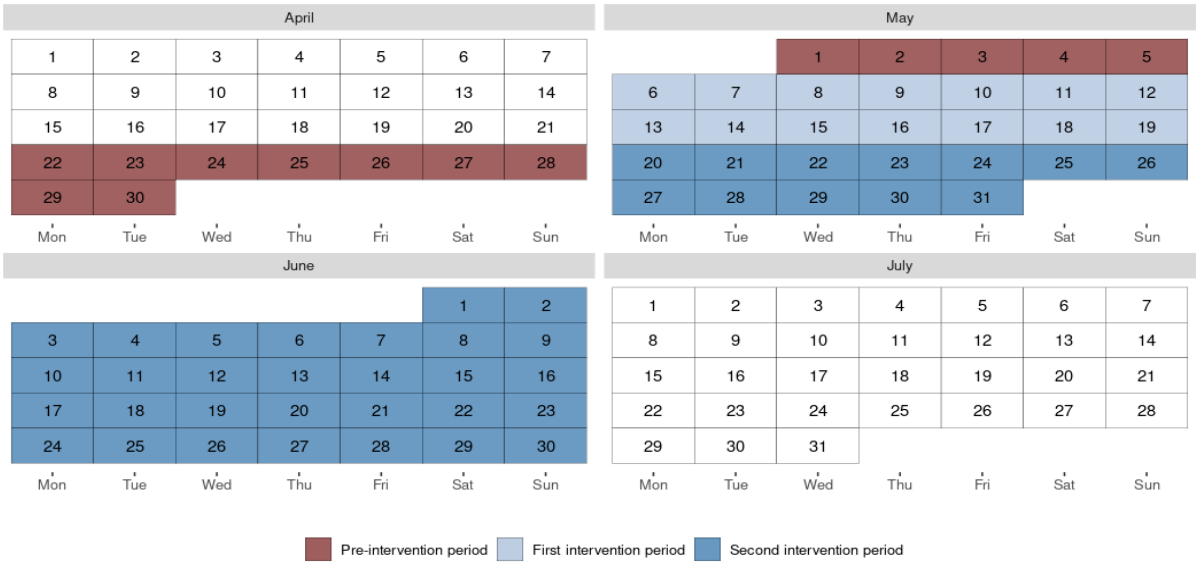

Figure 6.Calendar Plot Showing Dates of the Spring Booster Campaign and Intervention Periods

Data analysis: Interrupted Time Series

Background, justification, and assumptions

Interrupted-time series (ITS) is a quasi-experimental study design for evaluating the impact of an intervention or successive interventions that are implemented at defined moments in time. This is much more informative than an end-point analysis which only allows an understanding of differences between the final situations, rather than establishing *how* the different interventions influenced an outcome. In practice, ITS models are useful to establish an underlying trend over time and understand the effect of "interrupting" this trend with the interventions that are implemented. The trend that would have been expected to continue occurring without the intervention is called the "counterfactual" scenario, and the impact of introducing the intervention is typically determined by comparing whether there was a difference in this counterfactual trend, and the trend that arose after the intervention. In a more complex situation however, a second counterfactual scenario can be considered by

introducing a “control” group that is not subject to the intervention. A controlled ITS study helps in understanding the effect of interventions when the underlying trend is expected to change in a time-varied manner that has not been, or cannot be, accounted for. For example, a possible scenario could be that the underlying trend will change due to seasonality, or in the case of the current study, that the potential to influence and increase vaccine uptake decreases over time as those who are more likely to engage with the programme are vaccinated first, meaning that individuals who are harder to influence make up a higher proportion of the population. More information on ITS models and controlled ITS models can be found in Lopez Bernal, Cummins, and Gasparrini (2016, 2018).

As this campaign comprises of two successive interventions, and the expectation for the underlying trend over time is to be nonlinear, this study planned to use a two-stage controlled interrupted time series design, with non-participating GP practices within Hertfordshire as controls to monitor trends in booster uptake without the interventions taking place. To successfully implement an ITS model, data must be collected consistently before and after the intervention, which must be implemented at a defined point in time. Additionally, an adequate sample size (in our case, the number of ISPs) is needed to provide sufficient statistical power to be able to detect the size of the effect of the interventions. To calculate the sample size needed, it was necessary to make some *a priori* assumptions that are described below:

1. *Number and frequency of time points that data can be collected for* – The number of time points will be 14 for the pre-intervention period, 14 for intervention 1, and 21 for intervention 2 (depending on the time taken for conversations to occur), with the time points representing days.

2. *Expected effect size of each of the interventions* – It was estimated to be a 5% increase in uptake within the 14 days post Intervention 1, followed by a further 10% uptake post Intervention 2

3. *The speed at which the interventions would take effect and whether the interventions were expected to result in a sudden change (a “level” or “step” change), a change to the relationship between uptake and time (a “slope” change), or both* – In ITS, the focus is on how the measured outcome (vaccine uptake) changes over time before and after the “interruptions” (interventions).If vaccine uptake is improving over time, a plot of uptake over time will show an upward-trending slope. If an intervention is introduced that improves this uptake, the steepness of the slope will increase (a “slope change”) as seen in Figure 7 (scenario B) below. Depending on the intervention there is also the potential to have a sudden effect which will result in a “level change”, this can either be in conjunction with a slope change (Figure 7, scenario C) or an effect in isolation (Figure 7, scenario A). More complex effects can also occur in combination (Figure 7, scenarios D and F). The hypothesis for this pilot was that, for both interventions, the effect on the outcome would lead to a slope change with a lag effect (Figure 7, D), to account for the time differential between booking and receiving the booster. However, due to issues in some pilot practices with collating data on when ISPs booked to receive the booster (i.e., the date they made the appointment), a simpler outcome impact of choice B in Figure 7 was used, with the hypothesis that a slope effect occurs, without a step change. To

model the primary hypothesis, the following variable were tested to mitigate the absolute differences between the pilot data and the control data and allow for relative comparison:

- Cumulative uptake as a percentage of total eligible 18+ immunosuppressed patients in the participating GP practices at the start of the pilot programme

4. *Intra-cluster coefficient, the similarity of uptake behaviour within a GP practice compared to uptake behaviour among different practices* – The ICC has been assessed in prior literature and local vaccination campaigns. The wider literature suggests an ICC range of 0.01-0.05 and analysis of local data 0.00-0.06. Therefore, 0.06 was used as a worst case and 0.025 as a likely medium.
5. *The GP patient list size and proportion of ISPs on their record* – based on effective sample size and clusters needed, this number had to be scaled up to match the average GP patient list size within potential participating practices.

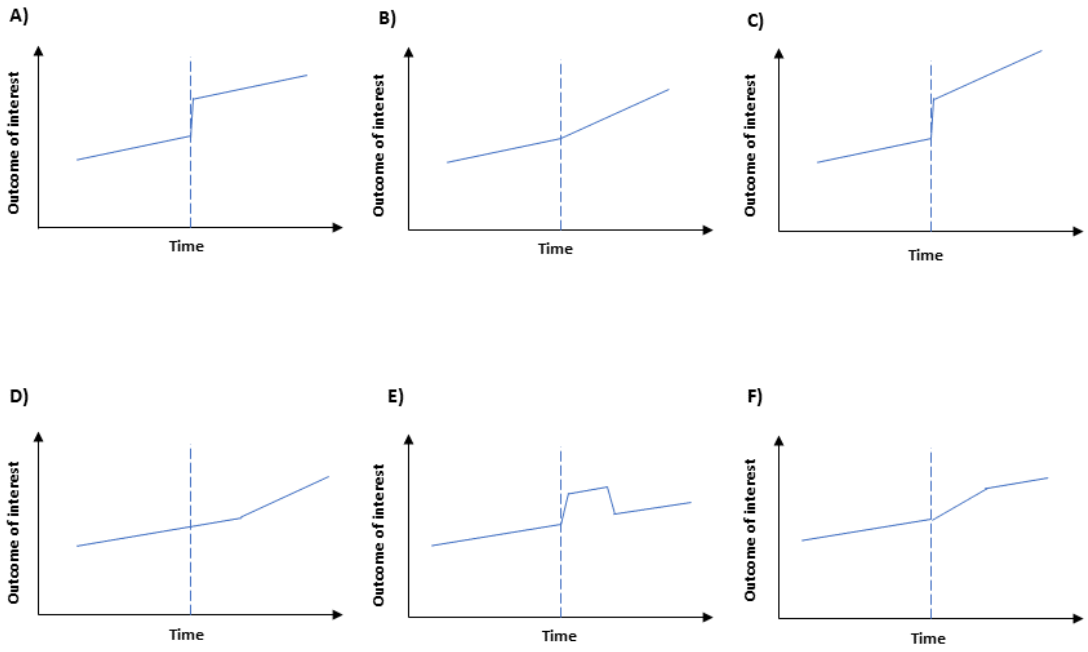

Figure 7. Examples of potential ITS outcome impacts. A) Level change, no slope change B) Slope change, no level change C) Level and slope change D) Slope change with a lag effect E) Temporary Level Change F) Temporary Slope Change Resulting in Level Change

Based on the above assumptions, a minimum sample size of approximately 1250-1500 immunosuppressed patients was required, split across at minimum 6-7 participating GP practices for sufficient statistical power.

These assumptions also shaped the primary research question: *Does each of the interventions improve booster uptake compared to the pre-intervention period?*

Additionally with this study design, the following secondary question was also answered: *Do each of the interventions improve booster uptake in the pilot compared to the control?*

Data limitations and model implementation

At the beginning of the pilot, a plan was created to collate aggregate figures from non-participating GP practices located within Hertfordshire to be used as control data, collected via NHS Foundry for the same time-period as the pilot data. However, during the pilot, it was ascertained that the planned daily control data could not be collected retrospectively through NHS Foundry as initially intended. This was due to the data reports needing to be downloaded 'at-time', with protocols for this collection not being established at the start of the programme.

Alternative daily data for booster uptake within Hertfordshire were sourced via the National Immunisation Management System (NIMS) dashboard. These data were restricted to immunosuppressed patients, allowing for some level of control for the vaccine uptake behaviour among ISPs. However, the data still present some limitations to be aware of when interpreting the results:

- The control data cover all practices, including those who took part in the pilot study. This means that the control data also include ISPs from the pilot, leading to increased collinearity[1] between our control and pilot data. As a result, the uptake behaviours in the control data are likely to be related to the uptake behaviours in the pilot, which complicates distinguishing the effect of the interventions.
- Only accounted for 18-75 year-old immunosuppressed patients, and did not include those aged 75+.
- The data is for the Hertfordshire residents as opposed to those registered with GPs. This model does not account for potential differences in vaccine uptake behaviors among residents or those registered.

Given that the first outcome of interest (booster uptake) is a cumulative and time-series variable, there is a likelihood that the residuals[2] are not independent of each other (autocorrelation). Accounting for autocorrelation improves model accuracy and validity of the inferences derived from the results. Therefore, an ARMA (autoregressive moving average) correlation structure was incorporated in the model, selecting parameters which returned the lowest AIC (Akaike Information Criterion) values. Further discussion is beyond the scope of this report, but information can be found at Schaffer et al. (Schaffer, Dobbins, and Pearson 2021).

Restricted maximum likelihood (REML) was chosen as the method for estimation of the ITS parameters, using a generalised least squares model. REML estimation is considered less biased than maximum likelihood when there is potential

[1] Collinearity refers to a situation in statistical modeling where two or more predictor variables are highly linearly related, meaning one variable can be almost perfectly predicted from the others. This makes it difficult to determine the unique contribution of each predictor to the model.

[2] Residuals are the differences between actual and predicted values.

autocorrelation and the sample size is not large (Cheang and Reinsel 2000), leading to more accurate inferences for ITS models.

The quantitative analysis was performed using R statistical programming language 4.3.3 in RStudio cloud, using the *nlme* package.

Results

Descriptive Analysis

End-points of the two interventions

There was a total of 2,953 18+ immunosuppressed patients identified as eligible for the pilot programme in the 12 participating GP practices which completed the intervention programme. This satisfied the initial sample size requirements calculated *a priori*.

The following stacked bar graph (Figure 8) shows the total vaccinated numbers in each of the participating practices which completed the project, broken down by each stage of the programme, along with their total number of 18+ immunosuppressed patients at the start of the programme. More detailed figures can be found in appendix 8.

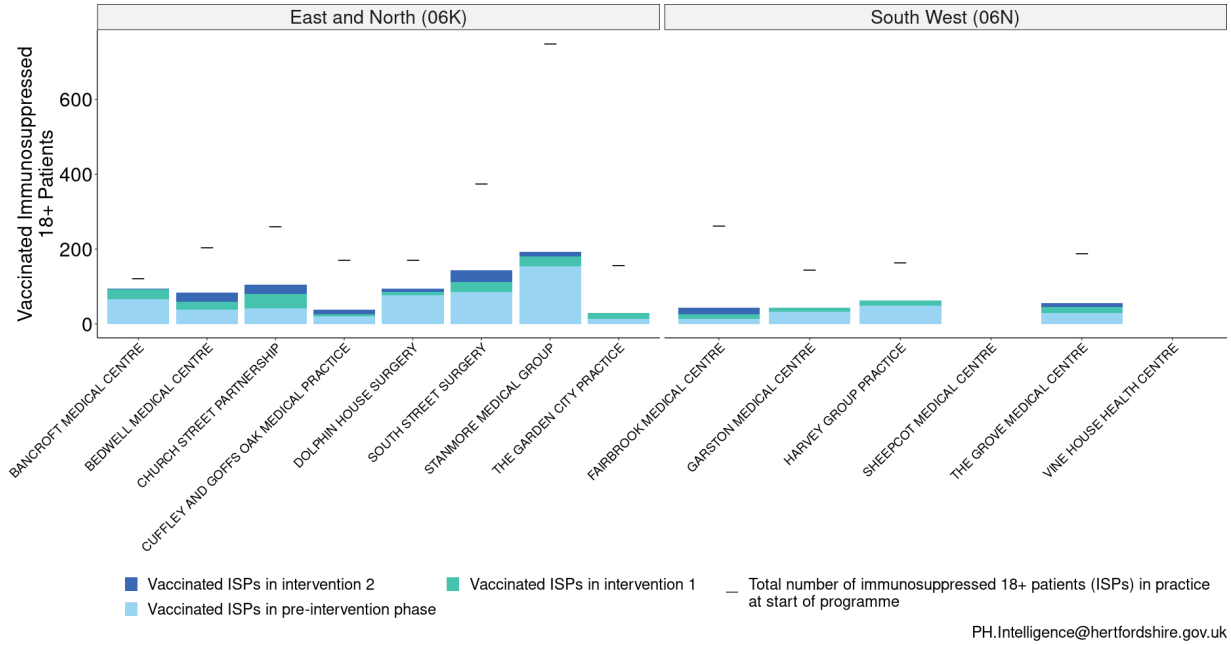

Figure 8. Stacked Bar Plot Showing Total Vaccinated Patients in Each Period for Participating Practices of the Spring 2024 COVID-19 Booster Programme

During the campaign, two practices (Sheepcot Medical Centre, Vine House Health Centre), under the same primary care network (PCN) and in the same sub-ICB, withdrew from the intervention programme due to lack of staff resource.

Figure 9 presents a visual timeline of the cumulative percentage uptake of the vaccine by ISPs across pilot participating GP practices along with the equivalent cumulative percentage of uptake of ISPs across Hertfordshire (control variable). The cumulative percentage of uptake by ISPs across the pilot area was and remained higher before and during the interventions.

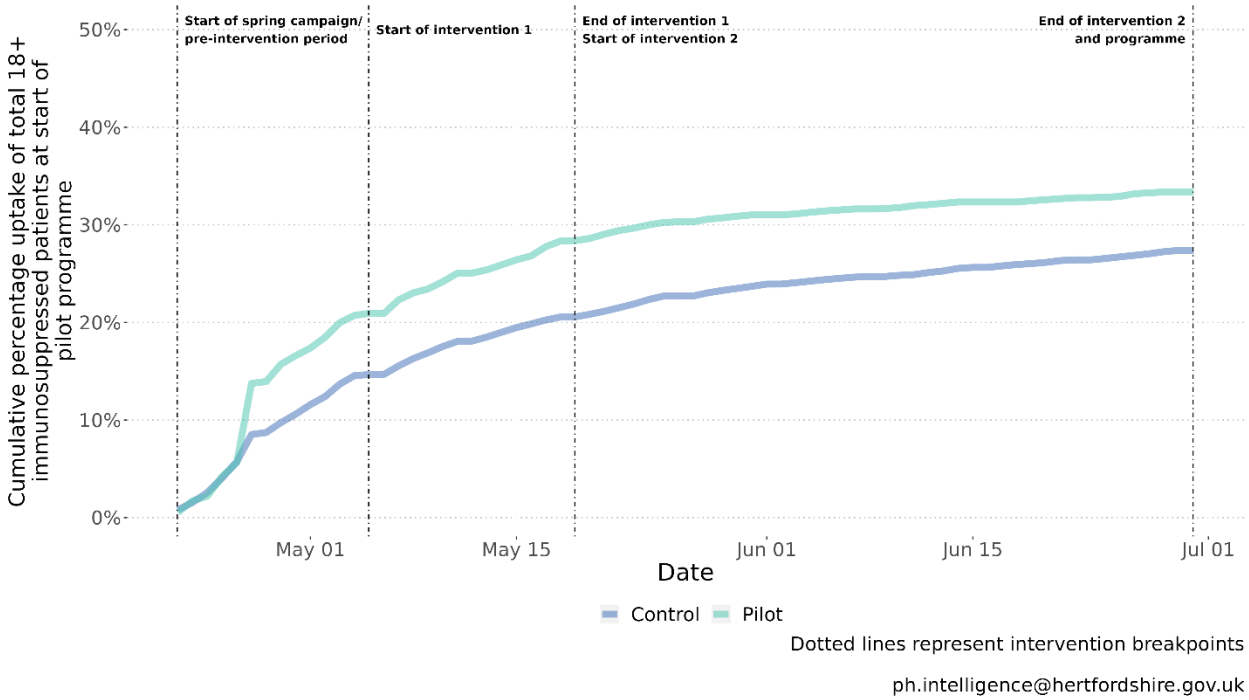

Figure 9. Line plot of cumulative booster uptake for pilot and control data throughout the programme. Vertical dotted lines represent intervention breakpoints

Vaccination uptake changes over time

Before conducting and interpreting any statistical modelling, it is useful to first examine the data that were collected. This allows for an improved understanding of *what actually happened*, particularly in relation to any assumptions that were made prior to the study.

By looking at the cumulative uptake of the booster over time for the pilot (green line) and control (blue line) data (Figure 9), it becomes apparent that there was a sharp rise in booster vaccination uptake a third of the way into this phase. This came as a result of one practice holding a large vaccination clinic. The sharp rise can be seen in both the pilot and control, although the effect is larger within the pilot data (as one practice represents a higher proportion of the data for the pilot compared to the control data). This practice was left in the data for the modelling for the following reasons:

- Reducing the number of practices would have reduced the required statistical power to understand the differences in effect sizes of the interventions
- It is assumed that a reasonable proportion of the individuals who took up the vaccine during this clinic would have taken up the vaccine as a result of the first intervention (had the clinic not happened) and removing them from the data would then weaken the overall endpoint of the pilot data
- As ITS is a quasi-experimental methodology, and the simultaneous use of two counterfactual scenarios with a trend known *a priori* to be non-linear is a complex application of this methodology, the results of the model would in any case need to be interpreted with caution and a good deal of logic.

The trends between the control and the pilot data after this vaccination clinic are parallel, indicating that the control data are a sensible choice of control for this situation. Nevertheless, it is important to bear in mind the potential effect of collinearity, as discussed previously.

In the period between the first and before the second intervention, the slope of the pilot study is only slightly steeper than that of the control. It could be assumed that the large proportion of the ISPs who were vaccinated on the day of the booster clinic (and which appears to have accounted for a ~5% increase in cumulative uptake) were individuals that were more likely to engage with the vaccination programme, and had the clinic not be held, would likely have taken up the vaccine in response to the first intervention. Had this been the case, and the point at which the slope starts in the pilot study at intervention one was lower, the difference in slope steepness between the pilot and control data would have been much more noticeable. If it is reasonable to assume that a portion of these individuals would have benefited from the first intervention if the clinic had not occurred, then it is important to consider any model results for this phase in the context of the clinic's effects.

During the final phase, post intervention two, the pilot slope is less steep than that of the control, indicating that uptake over time is not increasing as quickly. To understand this difference, the following need to be considered:

- The probable vaccine uptake behaviour of individuals who remain to take up the vaccine within each of the two populations
- The realistic expected effect size of the second intervention given likely vaccine behaviours in the remaining group.

With respect to the probable vaccine behaviour between the two groups, one of the assumptions made is that the remaining unvaccinated ISPs are less likely to engage with the vaccination programme over time, as those who were more likely to engage are removed from the pool of remaining candidates once they are vaccinated. This means that in the pilot population, a more effective first intervention (and the vaccine clinic) has left a relatively less-likely-to-engage group of people who possibly have stronger feelings about not taking up the vaccine. Additionally, the control population will likely have a higher proportion of people remaining who were always going to take up the vaccine over time.

The trend of a less steep slope in the pilot compared to the control, indicates that the effect size of the second intervention is unlikely to have been sufficient to overcome the vaccine uptake behaviours of the individuals remaining to be vaccinated. Due to the likely differences in vaccine behavior between the remaining pilot and control populations, the effect of the second intervention cannot be ruled out. It is possible that, without the second intervention, the slope could have been shallower than what was actually observed as a result of the intervention.

Interrupted Time Series results

In this section the ITS model is considered as *a statistical description of the outcome over time*, in the context of the information outlined in the descriptive analysis section above. Interpreting these results without taking that contextual information into

account could result in misinterpretation of the intervention effects. Of particular importance to note is that the model serves as the *best-fitting statistical description of the data*, informed by a series of *a priori* assumptions and caveats highlighted below:

- The control includes the pilot data and so is not entirely independent
- The shape of the relationship between the outcome and time changes over time (it is not linear) and this shape is highly influenced by vaccine uptake behaviours of the remaining population which is changing over time
- The model imposed on the data assumes that the behaviours of the control and pilot group are similar when the interventions are implemented. It is reasonable to assume that these behaviours change as the pilot progresses
- Whilst ITS with control does not rely on parallel pre-intervention trends, the difference in slope during this phase is required to be taken into account when interpreting the model results.

Regression Coefficients

Table 4 below shows the estimated effect size that each of the predictor variables has on the outcome. The predictor variables relate to whether the data being described come from the pilot or control data, and what phase of the intervention is being considered. Some of these effect sizes pertain to the intercept, that is, the size of the outcome at the start of data collection. Other effect sizes pertain to the steepness of the slope, that is, to what extent uptake improved or declined over time. Note that these are individual *effect sizes*, and that to understand the overall *effect*, the corresponding effect sizes need to be summated. For example, the baseline cumulative uptake for the control group was 0.48%, and the baseline cumulative uptake for the pilot was 0.48 – 0.59 = -0.11%. As a second example, during the pre-intervention phase, the rate of change of the cumulative uptake (slope) for the control was 1.06%, whereas for the pilot group it was 1.06% + 0.54% = 1.6%.

	Cumulative Uptake (%)		
Predictors	*Estimated effect (std. error)*	*95% CI*	*p-value*
A) Control y-axis intercept	0.48 (0.80)	-1.11 – 2.07	0.549
B) Pilot y-axis intercept difference to control	-0.59 (1.14)	-2.83 – 1.66	0.606
C) Control slope pre-intervention	1.06 (0.08)	0.89 – 1.22	**<0.001**
D) Control intervention 1 slope	-0.62 (0.13)	-0.87 – -0.37	**<0.001**
E) Control intervention 2 slope	-0.29 (0.07)	-0.43 – -0.15	**<0.001**
F) Pilot slope pre-intervention difference to control	0.54 (0.12)	0.31 – 0.77	**<0.001**
G) Pilot intervention 1 slope	-0.49 (0.18)	-0.84 – -0.13	**0.008**
H) Pilot intervention 2 slope	-0.09 (0.10)	-0.29 – 0.11	0.375
Observations (n = 140)			

Table 4. Regression output of the model for cumulative uptake percentage across the interventions and campaign. Statistically significant coefficients are in bold in the p-value column

The table above shows that the two groups had statistically similar cumulative uptake percentages at the start of data collection (Table 4, A and B). Additionally, both groups had a statistically significant positive relationship between cumulative uptake % and time (both groups had increasing uptake over time, Table 4 C and F). The slopes between these two groups during the pre-intervention phase differed unexpectedly, which can be explained by the vaccination clinic that was held. After this point, the slopes appear to be essentially parallel, providing confidence to continue using this control.

Both the control and pilot group had a significant decrease in the rate of cumulative uptake % compared to the pre-intervention phase however (Table 4, D and G), which might initially seem surprising. However, this was anticipated due to the typical non-linear trend in vaccine uptake. It was assumed that this trend would occur because the individuals more likely to engage with the vaccination campaign or those who were going to be vaccinated anyway constitute a smaller proportion of the group over time, while those less inclined to be vaccinated make up a larger proportion. This rationale led to the inclusion of a control in the study, allowing for the consideration of changes in slope between the pre-intervention and post-intervention phases within the context of a second counterfactual scenario (i.e., what would have happened without the intervention).

The decrease in rates between the pre-intervention and post-intervention 1 phases of this study can be seen in Figure 10. The rate of cumulative uptake for the control in the post-intervention 1 phase showed a statistically significant decrease of 0.62% (leaving a final rate of cumulative uptake % of 0.44). The pilot intervention slope also showed a statistically significant decrease; the decrease was 1.11%, which is larger than the decrease observed in the control group, resulting in a final rate of cumulative uptake % of 0.49. A t-test was carried out to investigate whether the pilot

rate of cumulative uptake (0.49%) was different to the control rate of cumulative uptake (0.44%), with the difference in the two rates not being statistically significant (0.053, 91% CI: -0.11 - 0.22, p = 0.53).

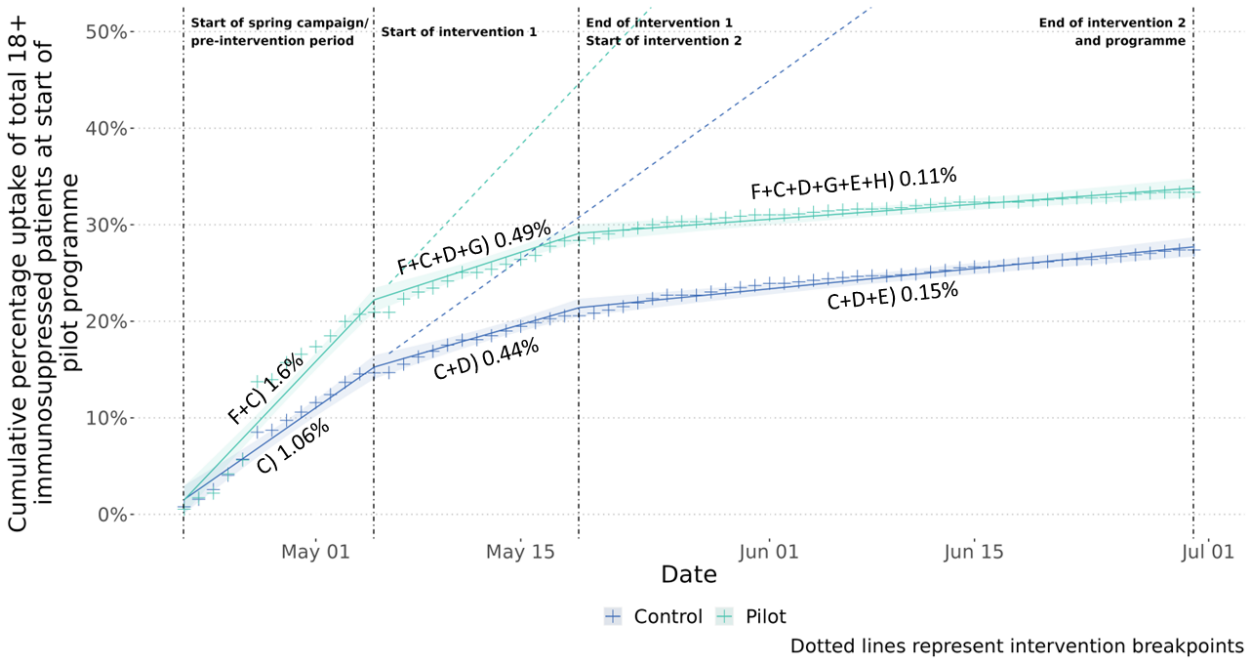

Figure 10. Plot showing predictions from ITS model (solid line), overlayed against their actual data points (+). Dash lines represent a projection of the pre-intervention trends. Vertical dash lines represent intervention breakpoints

The comparatively greater decrease in the uptake rate for the pilot than the one for the control may also at first seem surprising. However, the intercept of the pilot group at the start of the intervention was much higher as a result of the vaccination clinic held in one of the pilot practices. This contributed to both the higher rate of cumulative uptake observed in the pre-intervention phase and the rate of cumulative uptake in the post-intervention 1 phase, resulting in a greater difference in uptake rates of the pilot group between those two phases. Despite this, the overall uptake rate was still higher in the pilot compared to the control. It is reasonable to assume that, had the clinic not taken place, a proportion of those vaccinated during the pre-intervention phase would have instead been vaccinated during phase 1. If this was the case, the slope of the pilot uptake rate during this phase would have started from a lower point, and the uptake rate would have been greater than observed here. It is therefore likely that intervention 1 improved the rate of vaccine uptake compared to what would have happened without it. However, the exact size of this improvement is uncertain because it is unclear what proportion of people vaccinated in the clinic would have been vaccinated as part of intervention 1 if the clinic had not taken place. Over a 14-day period, a difference of 0.053% cumulative uptake rate resulted in an aggregate effect size of 0.74% (95% CI: -1.60% - 3.09%), although this would likely have been higher without the clinic.

During the post-intervention 2 phase, the cumulative uptake rate of both the control and pilot groups decreased further. The control group had a decrease of 0.29% compared to the post-intervention 1 phase which was statistically significant, giving a final rate of cumulative uptake %

during this time period of 0.15%. The pilot group had a statistically non-significant decrease of 0.38%, resulting in a final rate of cumulative uptake percentage of 0.11%.

Although these rates are different between the pilot and control, they are more similar to each other than during the post-intervention 1 phase. As the pilot progresses, people who are more resistant to getting the vaccine make a higher proportion of the remaining group of people within the pilot data who have not been vaccinated. Therefore, although the decrease in the rate was larger for the pilot study, it is possible that without the second intervention, the uptake rate would have decreased further than seen here.

A more in-depth interpretation of the coefficients and the calculations can be found in Appendix 7.

Process evaluation

The purpose of this process evaluation is to recognise what did or did not work well and identify ways of improvement. During the pilot there have been several issues that inhibited the application and evaluation of the interventions and, at times, have required a change of plans. Although these have been highlighted throughout the report, in this section they are brought together to focus on learnings. Additionally, feedback from the nurses who conducted the calls in the second intervention is incorporated.

Learnings

- Control data
  The limitation of not receiving the planned control data presented significant challenges, not only in terms of statistical power, but also in terms of validity in our findings. It is a possibility that the effect sizes found as a result of the interventions were reduced as a result of this collinearity and could potentially have been greater in producing an effect if the planned control data was acquired.

- Data returns
  During the first intervention a number of practices frequently missed deadlines for submitting returns. This was approached by the lead analyst of the project first emailing the Practice Managers with a reminder, then if later action was required, prompted intervention from participating stakeholders of the ICB.

- Nurses staffing issues
  Intervention 2, representing the second step in the ITS analysis, was initially planned to be delivered within 2 weeks, to ensure comparable time periods with the first intervention. However, due to staffing issues, the second intervention extended beyond the 2 weeks up to a total of 6 weeks (42 days). This could have contributed to the lack of statistical significance for the second intervention, compared to the first intervention. The extended duration possibly diluted its impact: as there was a set maximum number of calls that the nurses had to make, taking longer to make those same calls could account for the slightly negative effect during the second intervention (-0.038% daily cumulative intake over 41 days). In other words, had all calls

been placed within the intended 2-week period, a more positive trend might have been observed, along with a steeper rise in uptake.

- Feedback from nurses (more details on the feedback received from nurses can be found in Appendix 5):
    - The main point raised by the nurses delivering the calls was the importance of ensuring that patient lists are up to date, providing an accurate picture of eligibility. This suggestion is based on the conversations nurses had with patients and patients' self-evaluation of their eligibility. Nevertheless, literature review findings indicate that sometimes patients are unaware of having a weakened immune system, creating a barrier in seeking a booster. Additionally, nurses did not have full access to all patients' records and as such were unable to verify patient claims of ineligibility. As a result, at this point it is not possible to objectively assess the extent of inaccurate records. A solution that could be applied to future iterations of the intervention is to have the nurses call patients from the practice, allowing them full access to records.
    - Nurses suggested employing lower-level clinicians or even admin staff with clinician oversight to conduct the calls. At the same time, nurses mentioned that most of the patients' individual circumstances were not covered by the script provided as part of the second intervention. Nevertheless, nurses were still able to have the conversations and help patients make informed decisions, which might have been challenging if the calls were to be conducted by less experienced or knowledgeable professionals.
    - The design of the second intervention accounted for a reminder text sent to patients the day before the call, to inform them of the upcoming call scheduled for the following day. Nevertheless, nurses mentioned that a number of patients were not expecting their call and highlighted the importance of ensuring that they do. For future iterations of the second intervention an additional control could be put in place to ensure that patients receive the text and expect the call.

Estimating cost savings

Additional booster uptake can provide potential cost savings through two channels: firstly, by preventing direct COVID-19 hospitalisations, which are more likely for ISPs; and secondly, by preventing complications arising from post-COVID syndrome (also known as long COVID) and post-COVID hospitalisation recovery.

Despite not finding statistical significance in the first intervention, there is still a practical significance as to the effect size and what this means in reality, i.e. the number of additional people who have been boosted as a result of the intervention, and the cost-savings potential this brings. Moreover, considering the lack of statistical significance, more conservative figures were used in the assumptions.

According to an impact assessment from the Department of Health and Social Care (DHSC), for the autumn 2023 COVID-19 vaccination programme, estimates from NHS England indicate that each hospitalisation from COVID-19 costs a total of £2,592 (Patel and Scholes 2023). An assumption is made in the impact assessment that without a booster jab (regardless of previous uptake status), all hospitalised patients who survive will endure a further average cost of £1,134 for post-hospitalisation treatment. This means that for every hospitalisation prevented by the booster, there are cost savings of an average of ~£3,726 from hospital care and rehabilitation services.

In addition, some hospitalised patients will require ICU/CCU hospitalisation, costing a further £1,787 per day per patient. There are also wider economical, societal and psychological consequences, which are worth acknowledging, even though quantifying them is outside the scope of this report. These are: impacts to the economy due to people being out of the work, societal impacts as anyone affected will not be able to care for others, as well as wider impacts on people's mental health as a result of all the abovementioned factors. It is also worth noting that sadly a small percentage of hospitalised patients will not survive, resulting in an additional human cost as a result of COVID-19.

For the purposes of the cost savings calculations, assumptions are also made for the ISP hospitalisation rate and the subsequent ICU/CCU hospitalisation rate. The hospitalisation rate used is 0.44% (UKHSA 2024b). Using this figure is a conservative approach that does not account for the patient's immune system or age. As a result, cost-savings figures for ISPs will likely be higher. The rate of entry to ICU/CCU if hospitalised is given at 8.3%, (DHSC Impact Assessment Patel and Scholes 2023). Assumed length of stay in ICU/CCU is 12 days based on literature (Thompson et al 2020, Vekaria et al. 2021). Appendix 6 includes more information about the assumptions and calculations for these estimates.

By applying these assumptions along with the effect size achieved in Intervention 1, the cost savings can be extrapolated to larger geographical regions to ascertain potential cost-savings if the interventions were rolled out more widely (table 5).

The second intervention took longer than intended, minimising any potential positive effect size by giving the control group the chance to 'catch up' in terms of cumulative uptake. Due to these factors, cost savings calculations were not performed for the second intervention.

Geography	Initial ISP population	Predicted Increase in Booster Uptake From First Intervention	Hospitalisations Prevented by Intervention	Associated Cost of Hospitalisations Avoided by Intervention	Avoided ISPs in ICU/CCU	Associated Cost of Additional ICU/CCU services	Total Cost-savings
Hertfordshire	30000	222 (0 - 927)	1 (0 - 4)	£3,726 (£0 - £14,904)	0 (0 - 0)	£0 (£0 - £0)	£3,726 (£0 - £14,904)
HWEICS	55363	410 (0 - 1711)	2 (0 - 8)	£7,452 (£0 - £29,808)	0 (0 - 1)	£0 (£0 - £21,444)	£7,452 (£0 - £51,252)
East of England	269533	1995 (0 - 8329)	9 (0 - 37)	£33,534 (£0 - £137,862)	1 (0 - 3)	£21,444 (£0 - £64,332)	£54,978 (£0 - £202,194)
England	2166260	16030 (0 - 66937)	71 (0 - 295)	£264,546 (£0 - £1,099,170)	6 (0 - 24)	£128,664 (£0 - £514,656)	£393,210 (£0 - £1,613,826)

Table 5. Cost-savings estimates with the effect size of the first intervention extrapolated to larger geographies. Upper estimates are given based on 95% confidence intervals of the aggregate effect of the first intervention, with the lower boundary constrained constrained to £0. ISP figures for East of England and England ISP sources from DPS (Data Processing Service) Direct Flow, NHS England 2024.

Discussion

The booster campaigns in the UK have been a crucial part of the public health response to the COVID-19 pandemic, especially for cohorts considered at high-risk, such as those who are immunosuppressed. These campaigns have focused on administering additional doses of the vaccine to enhance immunity, which can wane over time, particularly in clinically extremely vulnerable populations. The booster doses are designed to provide a stronger and longer-lasting immune response, which is vital for those with weakened immune systems.

Early booster programs were characterised by high participation rates, particularly among high-risk groups; however, recent campaigns have seen diminishing engagement. This downward trend may be attributed to several factors, including increased public complacency due to newer variants having perceived lower risk, pandemic fatigue, and concerns regarding potential vaccine-related adverse effects. The decrease in booster uptake poses a significant challenge for public health efforts aimed at maintaining long-term immunity and mitigating the impact of potential future COVID-19 waves.

This pilot programme was designed to test the efficacy of two successive behavioural interventions. Despite not finding a statistically significant effect for the interventions in this ITS analysis, if they were to be rolled out after having taken into account feedback and key findings from this pilot, the effect sizes could become significant, and result in an increased uptake.

For the first intervention (FAQs) our analysis suggests an aggregate effect size of 0.74% (95% CI: -1.60% - 3.09%) increase in cumulative uptake. A scale up across Hertfordshire and West Essex ICS, with an estimated figure of around 55,363 immunosuppressed patients, could potentially result in an increased uptake of 410 immunosuppressed patients during a 14-day period with cost savings amounting to £7452 (95% CI: £0 to £51,252). This broader application of the first intervention, would be feasible at low cost and ease of local delivery. The second intervention (calls from a health professional), in comparison, would involve additional labour, resources, time and cost. However, whether this would be considered cost-effective would depend on the scale of the project.

The aggregate effect size for intervention 1 (0.74% after 14 days) is much lower than the initially assumed 5% improvement (see assumptions, p.21). This was even more extreme for intervention 2, where a 10% improvement was assumed. Therefore, the minimum sample size needed to see a statistically significant effect was far underestimated. Even if the pilot practice which hosted a large vaccination clinic during the pre-intervention period did not happen, it was unlikely that statistical significance would have been achieved.

Potential extensions to this project include: Inclusion of non-linear terms to model the curvature of the main outcome variable of interest: cumulative percentage of booster uptake. Interrupted-time series is more frequently done with linear models which

allow for easier interpretation, but a non-linear model, in the case of cumulative uptake, can better represent reality.

As seen in Figure 1 and in other reports examining cumulative uptake of boosters (Magee et al. 2023), the trajectory curve typically sees a sharp increase in uptake at the start of a campaign, before slowing down and approaching a horizontal asymptote. Interventions which rely on patient agency, to some extent will always be more about reducing this 'slowdown', rather than radically interrupting the curve. Although the linear predictions in the ITS are a simplification of reality, they enable inferences about the general effects of the trialed interventions. Using a control, even if not optimal in this scenario, helps strengthen any causal conclusions drawn from the results.

This work contributes to the literature on COVID-19 booster vaccine uptake, demonstrating the added value that behavioural science can bring to intervention design and delivery, as well as the value of mixed-methods and ITS analysis in terms of uptake rates. During the early days of the pandemic, many articles used the initial and subsequent COVID-19 waves as the interruption of interest (Shah et al. 2022), or the non-vaccine related public health policies as the interruption, such as the "stay-at-home"/lockdown policies (Voko and Pitter 2020). More recent articles, such as Jones et al. 2024, have started to test interventions which seek to improve vaccine uptake; in this case, outreach clinics in the Bristol, North Somerset, and South Gloucestershire ICB through controlled ITS.

Improving booster uptake amongst ISPs could help reduce health inequalities. A previous Joint Strategic Needs Assessment (JSNA) analysis for ISPs in Hertfordshire showed that ISPs tend to live in more deprived areas and are more likely to come from non-white backgrounds (Hertfordshire Public Health Evidence and Intelligence: JSNA 2023).

However, it should be noted that Hertfordshire has a unique demographic profile, with more residents being affluent and identifying as White, compared to other regions in the UK. Any intervention looking to improve vaccine uptake will require careful planning with all stakeholders involved, be it ICB, public health, local authority, or NHS trusts. An understanding of patient behaviour and local demographic characteristics is essential for scaling these interventions regionally or nationally.

Conclusion

The findings from this pilot study highlight the complexities and challenges inherent in increasing COVID-19 booster vaccine uptake among the immunosuppressed population. Despite the modest improvements observed with the first intervention, the results were not statistically significant, highlighting the need for more robust and scalable strategies. The impact of the vaccination clinic on pre-intervention rates suggests that external factors can significantly influence outcomes, complicating the interpretation of intervention effectiveness.

However, the pragmatic significance of the first intervention cannot be overlooked. If scaled nationally, even small improvements in vaccine uptake could translate into substantial public health benefits and cost savings, estimated between £128,664 and £393,210. This underscores the value of continued investment in behavioural interventions, particularly those that are evidence-based and tailored to address specific barriers identified through comprehensive behavioural analysis and behavioural intervention design.

Future research should focus on refining these interventions by addressing data limitations and addressing methodological challenges found during the campaign, especially during the second intervention. Overall, this study provides valuable insights and a foundation for developing more effective strategies to protect vulnerable populations through increased vaccine uptake.

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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 Transformation Committee meeting held in Public		**Meeting Date:**	**28/11/2024**
Report Title:	**HWEICB Primary Care Strategic Delivery Plan 2023 – 2026: Progress Against Year One Priorities & Deep Dive**		**Agenda Item:**	**07**
Report Author(s):	James Gleed, Associate Director Primary Care Strategy and Transformation HWEICB Emily Perry – Primary Care Manager, Strategy and Transformation HWEICB **Case Studies:** Mefino Ogedegbe Community Pharmacy Clinical Lead HWEICB Michelle Campbell, Head of Primary Care Contracting HWEICB Leah Adams Clinical Director (Acting) Special Care Dental Service HCT Dr Alison Jackson Clinical Director Broxbourne Alliance PCN Cathy Galione Head of Primary Care Transformation, Integration, Development & Delivery – East & North Hertfordshire HWEICB			
Report Presented by:	As listed above			
Report Signed off by:	Avni Shah, Director of Primary Care Transformation, HWEICB			
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 ICB Board / Committee:	• Do the findings from Lord Darzi's report on the state of the National Health Service in England (September 2024) highlight any gaps in the current Primary Care Strategic Delivery Plan for HWE?			

Report History:	The Hertfordshire and West Essex (HWEICB) Primary Care Strategic Delivery Plan was approved by the ICB Board on 28 July 2023 and outlines the direction of travel for primary care transformation (general practice, pharmacy, dental and optometry) across Hertfordshire and West Essex from 2023- 2026. The plan sets out three broad key transformation objectives: ○ Continued focus on prevention and health inequalities ○ Proactive care – Person centred, team-based approach to Chronic Disease Management and Complex care management through establishment of integrated neighbourhood teams (INTs) ○ Simplifying & enhancing access for urgent primary health needs The full Primary Care Strategic Delivery Plan can be viewed on the ICB website: Primary Care Strategic Delivery Plan 2023-2026 – Hertfordshire and West Essex NHS ICB
Executive Summary:	This report is divided into 3 sections: 1. An update against the year one priorities in the plan Some of the key updates to note include: • Integrated Neighbourhood teams are progressing across all three places – with each INT having membership from across the system in place, and patient cohorts having been defined. Whilst work is progressing, there is variation across the INTs and more to be done to ensure they align with the Fuller vision. • Pilots have been put in place to support access to urgent care in both Harlow and Stevenage. Work is also in place and progressing to support urgent dental access. • Work continues to progress on the prevention agenda, particularly around the Enhanced Commissioning Framework (ECF) under which there was more activity delivered last year and a reduction in variation across practices when compared to 2022/23. • Some objectives within the plan are RAG rated red, due to various reasons such as lack of funding, change in workplans or capacity, these chiefly relate to POD workforce and digital innovation. • It has been agreed that where there have been financial impediments to making progress, work will continue as far as possible in order that we can move at speed should additional resource become available 2. A deep dive through 4 case studies (including a video): ➢ Community pharmacy PCN leads project ➢ Lower Lea Valley community working together at Broxbourne volunteers fair ➢ HCT Hertfordshire Special Care Dental Service - nurse led anxiety management pathway ➢ Stevenage same day access PCN hubs

<table>
<tr><td></td><td colspan="4">3. A precis of Lord Darzi's report on the state of the National Health Service in England - September 2024</td></tr>
<tr><td>Recommendations:</td><td colspan="4">To receive further progress updates on the strategic delivery plan via:
1. An annual update on progress made against priorities within the plan

2. Case studies highlighting new developments and innovation, as a standing item</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>
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<tr><td colspan="5">Implications / Impact:</td></tr>
<tr><td>Patient Safety:</td><td colspan="4">To be evaluated individually as part of delivery related to specific projects to transform access and service provision</td></tr>
<tr><td>Risk: Link to Risk Register</td><td colspan="4">To be evaluated individually as part of delivery related to specific projects to transform access and service provision</td></tr>
<tr><td>Financial Implications:</td><td colspan="4">Funding originally aligned with the Primary Care Strategic Deliver Plan can be found within the plan itself, however it should be noted that the financial position across HWEICB has changed and the constraints have impacted on some areas of plan delivery.</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>
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Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Deep Dive into Key Areas of Primary Care Strategic Delivery Plan

Primary Care Transformation Committee in Public

Thursday 28 November 2024

Working together
for a healthier future

Background

- The Hertfordshire and West Essex (HWEICB) Primary Care Strategic Delivery Plan was approved by the ICB Board on 28 July 2023

- The strategy outlines the direction of travel for primary care transformation (general practice, pharmacy, dental and optometry) across Hertfordshire and West Essex from 2023- 2026. The plan sets out three broad key transformation objectives:

    - Continued focus on prevention and health inequalities
    - Proactive care – Person centred, team-based approach to Chronic Disease Management and Complex care management through establishment of integrated neighbourhood teams (INTs)
    - Simplifying & enhancing access for urgent primary health needs.

- The full Primary Care Strategic Delivery Plan can be viewed on the ICB website: Primary Care Strategic Delivery Plan 2023-2026 – Hertfordshire and West Essex NHS ICB

- These slides provides a summary of the position of the areas of priority for year 1 within each section of the plan, as well as a number of case studies showcasing work that has taken place.

- Objectives have been RAG rated in line with the following table - Some objectives within the plan are RAG rated red, due to various reasons such as funding, change in workplans or capacity:

On track
Delayed but achievable
On hold/deadline missed
Complete

Prevention and Health Inequalities

"Primary care has an essential role to play in preventing ill health and tackling health inequalities, working in partnershipwith all health and care including VCFSE partners to prevent ill health and manage long-term conditions" – Fuller Stocktake report (May 2022)

Areas of priority for year one	Progress / achievement to date	RAG rating
Enhanced Commissioning Framework (ECF) for GP practices as lever to commission general practice in prevention – Year 1	• The ECF is designed using a Population Health Management (PHM) approach, delivers proactive care and supports the delivery of the ICB's priorities set out in the Medium-Term Plan • In 2023/24 there were significant improvements in the activity delivered as a result of the ECF, when compared to 2022/23. • There has also been a reduction in variation across practices.	
Dental – commission enhanced oral support and scope commission outreach to care homes across HWE – Year 1	• The ICB is continuing to work with providers and local authorities to identify and scope a plan to deliver improvements in oral health – work is ongoing. • The Oral Health Alliance group has been reignited, which is a jointly chaired group between ICB and local authority. The developing workplan will support the recommendations in the Oral Health Joint Strategic Needs Assessment. • The ICB is working to improve domiciliary dental care and housebound and residential nursing homes services - a pilot has been expanded across further care homes and an evaluation will take place in March 2025.	
Scope future opportunities through prevention programme – Year 1	• Several projects focused on prevention across the ICB footprint are currently taking place • This includes 29 projects funded to the end of March 2025 by Assura PLC and primary care.	
Development of personalised care and social prescribing for children and young people – ambition for each PCN to have a CYP Social Prescriber / personalised care practitioner by end of Year 2	• Current data available shows that there is still work to be done to ensure each PCN has a Social Prescribing Link Worker that can see children (currently in place in 8/35 PCNs in HWE). • A majority of PCNs have at least one SPLW in place who can see adults or whose area of focus is currently unknown. • Personalised care is also delivered via Health and Wellbeing Coaches (HWBC)– the ICB are aware of 15 HWBC's in place across PCNs in HWE.	
Ongoing training and development of the 3 personalised care roles (social prescribing link worker, health and wellbeing coach and care coordinators) – Years 1 – 3	• Since April 2024, 49 personalised care roles have participated in training and development programmes through the HWE Training Hub. These roles include 39 Care Coordinators, 8 Social Prescribing Link Workers, and 2 Health and Wellbeing Coaches - representing 20% of the personalised care workforce employed via ARRS in HWE. Participants have undertaken a variety of courses to increase skills and experience. The Training Hub continues to review and promote the training offer to increase the uptake of courses. • The ICB also lead on the Personalised Care Collaborative which is a peer support network for Social Prescribing Link Workers (SPLW), Care Co-ordinators and Health and Wellbeing Coaches (HWBC). The ICB also have a Children and Young People's SPLW Peer Support Network in place, as well as a HWBC practitioners meeting and a Health Inequalities Community of Practice which is an open forum to all.	
Investment in the VCSFE sector in prevention and reducing inequalities, including digital and how VCSFE are embedded in INTs – Year 1 - 3	• Whilst investment opportunities are limited given the financial constraints on the ICB at present, alongside the Assura PLC funding noted above, there are a number of smaller locally focused projects taking place that are supporting digital inclusion • Work is ongoing to embed the VCFSE sector into Integrated Neighbourhood Teams (INTs).	

Proactive Care, Chronic Disease Management and Complex Care through Integrated Neighbourhood Teams (INTs)

INT 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.*

Areas of priority for year one	Progress / achievement to date update	RAG rating
Implementation of the Asthma Hubs at PCN/locality level – Year 1	• As of July 2024, 9 PCNs had gone live across all three places • The second tranche of mobilisation is now underway with another 13 Primary Care Networks	
Scope test other chronic disease at scale - By June 24	• Scoping is taking place to look at others disease areas that could potentially be dealt with in a primary care hub, such as dermatology and minor surgery. This is being led by Planned Care at the ICB.	
Commencement of Organisational Development (OD) programme to support leadership of the Integrated Neighbourhood Teams (INTs) – Year 1	• Organisational Development for the leadership teams within INTs is being supported via the ICBs Training Hub programme of courses. • INTs in West Essex were established ahead of those in South West Herts and East and North Herts and benefited from external training and guidance that was put in place to support OD for the leadership teams.	
Development of Integrated Neighbourhood Teams (INTs) – Year 1	• Establishment of INTs is continuing across each Place • 6 INTs established in West Essex (on the same geographical footprints as West Essex PCNs) • 6 INTs have been established in East and North Herts, in line with the localities, and are at various stages of development • 4 INTs are in development in South West Herts that mirror the geographic area of the localities • Patient cohorts are being confirmed across each INT who are working with a variety of stakeholders from across the system to plan and deliver care.	

Simplifying & Enhancing Access for Urgent Primary Health Needs

The establishment of new access models for those (of all ages) who have an urgent primary healthcare need, led by a multidisciplinary team of colleagues will be key to ensuring the national direction of travel is implemented across Hertfordshire and West Essex (HWE). Enhancing and changing the model of access for urgent healthcare needs applies to all providers including; general practice, dental, pharmacy, optometry, community, acute, UTC, Integrated Urgent Care, mental health, community care –e.g rapid response/ virtual ward, social care, VCFSE and self referral. Improving the pathway for those with urgent healthcare needs will free up capacity and time to see those who have routine healthcare needs.

Areas of priority for year one	Progress / achievement to date update	RAG rating
Mapping of all access points and review of relevant data to determine where access is most challenged – Year 1	• Harlow, Stevenage and Hertsmere have been identified as needing additional UEC support. • Projects have been put in place to support Primary Care Urgent Emergency Care in Stevenage and Harlow (further information below) • A project in Hertsmere is currently in the process of seeking funding for 6 months over the winter period – this is pending final approval	
Plans implemented that are expected to improve access in a key area where there is the greatest potential to have a positive impact on access – Year 1 onwards	• To tackle increased demand for same day access appointments in **Stevenage two pilot hubs** (one per PCN) were established in July 2023 with slightly differing operational models. Further information on this is presented later in this meeting pack within a case study and review paper. • An Integrated **Urgent Assessment and Treatment Centre (iUTC) in Harlow** went live on 1st November 2023 based at PAH delivering an integrated model for triage, assessment and treatment of minor illness and minor injury. The lead provider is Stellar Healthcare GP Federation, working alongside Stort Valley Healthcare GP Federation, Princess Alexandra Hospital (PAH), Essex Partnership University Trust (EPUT), Hertfordshire Community Trust, (HCT) and HUC. The service runs via a GP Consultant Model where ACPs are overseen by a supernumerary GP Consultant. Up to 144 slots are available per day (average 125), with an average waiting time of 22 minutes. Patients are booked into the iUTC via 111 or streamed from ED – there are no direct referrals from Primary Care at this stage, however the service has a Primary care IT system with FULL access to records on SystmOne with Ardens, and ACPs record directly into a patient's GP record. Data from April 2024 shows that the iUTC has meant there has been a significant reduction in diagnostics tests requested – with primary care experience being invaluable.	Steven age / Harlow
Review of MECs Service and develop options working with Planned Care – Year 1	• The ICB took over the commissioning of optometry from 2023/24 which provides an opportunity to scope the role of optometrists in the delivery of eye care ophthalmology pathway across primary care, community and hospital services.	
Implementation of national community Pharmacy First across HWE – Year 1 (from December 23)	• According to the national Pharmacy First operational report, HWE had the highest % of ICB GP practices referring patients to Pharmacy First across East of England (EOE). • HWE ICB also had the highest proportion of total number of Pharmacy First consultations across EOE. • The vast majority of consultations are resolved by the pharmacy and need no onward referral as per the Pharmacy First operational report.	
Extend current urgent in and out hours dental services contracts whilst preparing the commissioning model of care aligned to the UEC strategic outcomes and ICB and Primary care objectives of same day access or urgent primary care (dental needs) – Year 1	• In December 2023, the ICB commissioned an enhanced dental access pilot in locations targeted to support areas of high need. • The pilot was initially for 6 months, but has now been extended to March 2025 • Urgent access sessions available 7-days a week both in and out of hours, including Bank Holidays. To date, circa 6900 appointments have been booked same day or next day following clinical triage by NHS111.	

Simplifying & Enhancing Access for Urgent Primary Health Needs continued

Areas of priority for year one	Progress / achievement to date update	RAG rating
Impact on Planned Routine Access: Dental – through improvement in planned dental activity and proactive care reducing need for urgent on the day - Year 1 – 3	• In February 2024, the Dental Recovery Plan was published which introduced several initiatives to improve access to NHS dental services, as well as supporting recruitment and retention of dentists in the local area. One initiative was the introduction of a "New Patient Premium" to encourage dentists to see new patients who meet the eligibility criteria for the scheme. We are awaiting data on the number of new patients seen, however the number of UDAs delivered at mid-year compared to previous year was an additional 50,861 • Overall delivery of dental contracts has improved post-covid and we expect to exceed pre-covid levels by end of 2024-25. Since taking on the dental delegated responsibilities, the delivery of activity in 23-24 increased by 17% (89%) compared to 22-23 (72%) and 4% less than pre-covid levels.	
Impact on Planned Routine Access: Community Pharmacy – Increased use of Electronic Prescription Service, integrated chronic disease management pathways with community pharmacy with New Medicines Review, monitoring of conditions – hypertension etc. Year 1	• HWE ICB regularly monitors Electronic Prescription Service (EPS) at a GP practice level - we are consistently maintaining high levels of EPS. • The ICB continues to work with primary care clinicians to integrate disease management pathways. • There is a plan to increase the uptake of CP commissioned services from the baseline for each of the services below - baseline figures for uptake of each of the below CP advanced service in April 2023 (based on NHSBSA claims): ➢ NHS New Medicines Service (NMS) - Uptake of 82% of CPs across HWE ➢ Clinic Blood Pressure (BP) checks (Part of NHS Community Pharmacy Blood Pressure Check Service) – 45% of CPs within HWE ➢ Ambulatory Blood Pressure Monitoring (ABPM) checks (Part of NHS Community Pharmacy Blood Pressure Check Service) - 17% of CPs claimed for this across HWE in April 2023 May 2024 data shows an increase from the baseline for the following services: • New Medicine Service (NMS) – 92% • Clinic Blood Pressure (BP) checks - 68% • Ambulatory Blood Pressure Monitoring (ABPM) checks – 28%	

Patient empowerment and education

Areas of priority for year one	Progress / achievement to date update	RAG rating
Development of local patient surveys for GP practices/PCNs to survey patients to measure improvement in patient experience – year 1 onwards	• Local patient surveys to measure improvement in patient experience took place at individual PCN level as part of Access Improvement Plans for 23/24.	
Proactive ICB wide series of patient feedback working with Healthwatch Hertfordshire and Essex – year 1 - 3	• The Primary Care Directorate continue to work through the recommendations from previously commissioned Healthwatch reports • Reports also continue to be commissioned from Healthwatch, with orthodontic services across HWE and e-consultation being recent areas of focus.	
Develop a model GP practice website to best practice standards defined by NHSE. Phase 1 was to pilot model website with 5 practices in ENH – this took place end of May 2023. Year 1 onwards	• The pilot ended in May 2024 • All practices have now commissioned their own websites.	
Phase 2 roll out model website content across HWE practices – Year 1 onwards	• All GP practice websites across HWE were audited by the ICB and websites assessed using a national tool based on NHSE guidance – this concluded in April 2024. • The audit informed the creation of a plan with next steps, including how the ICB work with PCNs/Practices to ensure websites meet suggested guidance. Key updates from this work are as follows: •Individual practice results have been shared with practices to enable them to look at areas for improvement • Some practices were already developing websites in line with access plans – they have been given access to the assessment tool to ensure alignment with that • Some practices have asked for a re-assessment post development work which the ICB are working through • The primary care digital team is planning on re-visiting lowest achieving websites in autumn to see if improvements have been made.	
Promotion of range of roles in Primary Care – promoting the importance and value of additional roles in GP. Year 1-3	• A toolkit supporting practices to promote the additional roles in primary care has been developed • The ICB will roll out promotion of the toolkit during autumn 2024. • The ICB website has been developed to provide information about the roles contained within the extended professional team at GP practices: https://www.hertsandwestessex.ics.nhs.uk/your-health-and-care/support/gp-practice/professional-team/	
Promote different ways that patients can contact their general practice with a particular emphasis on promoting and increasing the take-up of online services. Year 1 – 3	The communications and engagement and primary care digital teams at the ICB have rolled out communications, in line with the national programme, to help practices inform patients of the benefits of the NHS App. This has included: • Website resources for patients and practices being created - using national material to ensure up-to-date. See NHS App page on public website: https://www.hertsandwestessex.ics.nhs.uk/your-health-and-care/support/nhs-app/ • Patient facing – links to helpful videos on how to use the NHS App, leaflets on key features • Practice – resources such as posters, FAQs, media for use on waiting room screens • Posters have been sent to all Community Pharmacies and Dentists in HWE to be displayed to continue to publicise NHS App • Attendance at many PPG meetings, community events, practice open days to provide information and support to patients in use of the NHS App Continue awareness raising of App at primary care meetings also via PCN Digital and Transformation leads	

Patient empowerment and education

Areas of priority for year one	Progress / achievement to date update	RAG rating
Promotion of preventative and self care options – linking in with the ICS 'Lifestyle medicine' workstream for improving overall wellbeing as well as promoting screening, vaccination-take up etc, particularly amongst those who experience health inequalities. Linking with work below to involve PPGs and VCSFE in this work to boost self-care and wellbeing Year 1 – 3	• The ICB's hypertension campaign launched in May 2024 and ran in 15 PCN areas with low hypertension detection, high deprivation and/or diverse communities • People aged 40+ were encouraged to get a blood pressure check at a pharmacy • Engagement has also taken place with GPs, pharmacists and nurses in areas feeding into PAH in Harlow to support a stroke awareness campaign which sought to discourage people from driving someone displaying stroke symptoms to PAH as it doesn't have a stroke unit. • Other work that has taken place focuses around the 'Minuteful Kidney' programme, targeted lung health checks, and targeted vaccine uptake programmes.	
Continue to support development of GP practice/PCN patient groups - ensuring that pharmacists, dentists and optometrists are linked into patient groups to support community primary care engagement.	• The support offered from the Patients Association, which ended at the end of March 2024, through one-to-one discussions and workshops, has provided advice and guidance to PPGs to broaden their membership • Support to PPGs is continuing via the ICB Communications and Engagement team and Patient Engagement Forum.	

Workforce

Areas of priority for year one	Progress / achievement to date update	RAG rating
Emerging Leaders Programme - establish links between primary care and the system's leadership programme. – Year 1	• The next cohort of emerging system leaders is due to start advertising and recruiting in Q3 • The programme is looking to expand its membership to be inclusive of PC, VCFSE and blue light colleagues.	
Implementation and Evaluation with a view to evolve the Community Pharmacy PCN Liaison Leadership Role across 35 PCNs – Year 1	• The initial Community Pharmacy (CP) PCN Integration Leads completed in June 2024 and CP PCN Engagement Leads have been embedded within the ICB for the next year – a full evaluation and case study can be found further down in this meeting pack.	
Enhanced workforce data collection and reporting across PCNs and General Practice and evaluation of training programmes – Year 1	• The workforce transformation programme is seeking to enhance its understanding of the workforce through implementation of Qlik Sense. • Currently this is supporting the input of secondary care workforce, but we are keen to expand this to primary care, social care and the VCFSE sector. • Quarterly reporting on workforce data has started and is presented regularly at Workforce Implementation Group (WIG).	
Clinical placements and work experience – Year 1: • Increase undergraduate pharmacy clinical placements capacity & quality of placements across all pharmacy sectors, and other roles such as paramedic, podiatrist, physician associate, nurses. • Increase school work experience opportunities in primary care	• The transformation programme is supporting the delivery of the regional clinical education expansion strategy • The Health and Care Academy promotes primary care opportunities and is in talks to procure a new work experience portal that will be available to all ICS partners to advertise and manage their work experience opportunities in. • The Academy also has an ambassador network made up of colleagues from across the system from clinical and non-clinical backgrounds • Clinical placement capacity & quality for undergraduate pharmacy students: 9 MPharm placement champions (to represent community pharmacy, GP & hospitals) engaged in September 2023. Contracts ran for 10 months - finished at end of July 2024. The evaluation is now complete & work is continuing with University of Herts to progress.	
Develop system-wide pharmacy/dental and optometry recruitment & retention plan including skill mix – Year 1	Pharmacy workforce strategy and implementation plan for Q1&2 2024/25 developed. Key priorities and updates for first half of 2024/25 are: • supporting foundation pharmacist training - a webinar took place on 1st October to support training planning for the 25/26 cohort of students • a 'matching survey' ran to match employers with possible prescribing training/Designated Prescribing Practitioners – closed end October • another webinar & matching survey is planned for January 2025 to support planning for the 2026/27 cohort of students. • The ICB Pharmacy, Medicines Optimisation Team have been awarded the NHSE Teach & Treat pilot funding to increase the number of Independent Prescribers (IPs) in CP. Currently in the planning stages; aiming to have IPs enrolled in training by March 2025. • supporting pre-registration pharmacy technician workforce expansion – NHS England withdrew their regional and national funded training places (July 24), but the new ARRS funded pharmacy roles have been announced, which includes pharmacy technician apprentices, which the ICB are actively promoting. • NHSE also recently announced a Community Pharmacy Technician Apprenticeship Programme – which provides funding for 530 pre-registration trainee pharmacy technicians across England; funding offers £15,053 per trainee per year (total of 2 years per trainee). Applications closed on 13th October. ICB worked with CPH to promote. Information on the outcome is being sought from NHSE. • attracting & retaining pharmacy staff – a number of initiatives such as working with 'Indeed' to promote targeted job adverts and sponsored jobs, as well as working with 'Career Camp' to investigate ways to attract people into pharmacy support roles are taking place. The ICB are also working with the 'Inclusive Career Development Programme' as a means of retaining pharmacy staff from minority ethnics groups.	

Workforce

Areas of priority for year one	Progress / achievement to date update	RAG rating
Retention Pathfinder – engagement with system's pathfinder programme exploring areas of support such as flexible working, onboarding and career development pathways. Year 1	• The retention pathfinder programme has now come to a close due to the end of funding being received from the regional/national team. The workforce transformation programme has now incorporated the requirements of the 'retain' stream of the long-term workforce plan to improve our turnover and leaver rates across the system. There will be continued engagement with primary care colleagues through the work streams' governance process and the People Committee.	
Review opportunities to establish the new health and wellbeing level 3 apprenticeship to support community wellbeing – Year 1	• Apprenticeships are a key tenet of the system's requirement to meet the long-term workforce plan relating to clinical education and expansion and a number of pieces of work are taking place to support this, including: ○ Levy payments for new apprenticeships - liaising with Hospital Trusts ○ Developing a prospectus for Primary Care. The aim is to provide an understanding of apprenticeships benefits and funding, employer responsibilities, and outline the different apprenticeship roles ○ Setting up a schedule of webinars to promote apprenticeships ○ Setting up drop-in sessions to support Practices/PCNs with apprenticeship queries ○ The system is seeking to support the regional practice in improving our understanding of apprenticeship use across the system. The programme is supporting the development of four new clinical apprenticeship programmes within the University of Hertfordshire.	
Equality, Diversity and Inclusion – align activity in primary care with the wider ICS to support and achieve the high-impact actions identified as part of the national EDI improvement plan, and supporting the region's commitment in delivering the anti-racism strategy.– Year 1	• The system continues to prioritise actions relating to equality, diversity and inclusivity. • 90 day challenge undertaken withing the nursing and midwifery profession to improve inclusive recruitment and retention practices across the system. • The development of a system-wider EDI plan is underway to improve the respective Workforce Race Equality Standards and Workforce Disability Equality Standards reports across the system - including actions supporting the regional anti-racism strategy. The system is seeking to provide continued support through the inclusive career development programme.	
PCN Training teams supporting PC workforce – Year 1 - 3	• PCN Training Teams funding ended on 30 September 2024 with further funding not currently available due to financial constraints. Feedback received about the roles when they were in place was positive.	
Training Hub to have a comprehensive array of multi-disciplinary programmes for all primary care disciplines and at all career stages. Year 1 - 3	• The programme for general practice training for 24/25 is available on the ICBs Training Hub website • The ICB have not yet been able to make any significant progress with a substantive programme for pharmacy, Optom and dental (POD), in the absence of any additional funding for this purpose, however have provided training that has been aligned with specific initiatives such as blood pressure training, and Pharmacy First training	GP / POD
Supporting the upskilling of existing community-based optometrists to become independent prescribers – Year 1 - 3	• The ICB recently met with Hertfordshire and West Essex Local Optical Committees to understand the challenges being faced. • There are quite strict requirements around independent prescribing - supervisors need to be specialists within hospitals which is likely to cause some challenges in terms of finding suitable supervisors • Further discussions will take place to discuss this and wider training / workforce requirements.	
Staff wellbeing & experience - Implement strategies to promote job satisfaction, work-life balance, & a positive work environment. Year 1 - 3	• The ICB continues to promote training & development opportunities, career conversations, GP conferences, networking and support forums • The system continues to offer broader offerings relating to staff wellbeing • The retain workstream is seeking to reprioritise and understand where it can support impact in relation to flexible working and improve the working environment.	

Workforce

Areas of priority for year one	Progress / achievement to date update	RAG rating
Develop skills mix and scope the development of dental workforce. Year 1	• No progress currently	
Cross sector working / career pathways development: - increase number of rotational & hybrid roles working across secondary care, community pharmacy and PCNs – Year 1 - 3	• AHP/GPN/Clinical Pharmacist Fellowship Programme - Supporting Career Progression/Enhanced GP Fellowships/Mid-Career Fellowships • Liaising with community and hospital trusts, hospices as part of the specialist placement offer for the fellows on the programme • Challenges have been persuading trusts of the benefits of fellows in some of the specialities.	
Pharmacy: Independent prescribing - maximise the value of independent prescribers in all pharmacy sectors in preparation for when all new pharmacist graduates will be Independent Prescribers in 25/26. Year 1.	• Possible opportunities include progression of the Pharmacy First programme to include independent prescribing & completion/roll out of the NHSE independent prescribing pathfinder programme. Both subject to external control. • CPD Programme 2024/25 – Currently the HWEICB training hub do not have provision for CPD for pharmacy, however national funding is available for pharmacy for specific programmes as per the NHSE website. • A successful regional bid was recently led by HWEICB to be a pilot site for an NHSE programme around designated prescribing practitioners. The ‘Teach and Treat’ bid looks to increase access to DPPs for current community pharmacists.	

Premises and Sustainability

Areas of priority for year one	Progress / achievement to date update	RAG rating
Deliver the HWE ICB/ICS Infrastructure Strategy. Year 1	• The HWE ICS Estate Infrastructure Strategy (Private Version) went to ICB Board in private on 27 September 2024.	N/A – monitored elsewhere
The ICB continues to work to reduce void costs on NHS Property Service assets by using the voids for occupation by primary care? Year 1- 2	• This work is ongoing and sits with the System Capital and Estates Group.	N/A – monitored elsewhere
The ICB Premises Team continue to work with many practices and PCNs across the ICB on a variable range of premises projects – Year 1 – 3	• The primary care estate across HWE has faced pressures in some areas due to a variety of factors including an increase in workforce in general practice via the ARRS programme – with some practices and PCNs saying they are struggling to accommodate some of the staff and activities. • Other factors impacting on healthcare premises include local authorities continuing to be tasked with delivering their local plans, addressing housing supply, limited NHS capital funding and developers seeking higher market rents to meet higher construction costs. • It is important that as a health and care system we capitalise on all opportunities to share premises space, ensuring the very best use of all available infrastructure. • HWE aims to support these pressures and the delivery of primary care through extension and improvement projects, grants and new premises projects. • The HWE Primary Care Estates team currently have 23 PIDs in progress / 14 PIDs approved and 23 FBC/OBCs.	
From 1 April 2023 the ICB Premises Team have taken on the reimbursement scheme from NHSE and have already had positive feedback. Year 1 – 3	• The reimbursement scheme continues to sit with the HWEICB Estates team and oversight of this sits under the relevant governance framework.	N/A – monitored elsewhere

Data, information and digital technology

Areas of priority for year one	Progress / achievement to date update	RAG rating
Advanced Telephony - identify, validate, and prioritise those practices that still have an analogue system. Year 1 - 3	• The ICB received funding to upgrade a total of 34 practices to advanced Cloud Based Telephony – 100% of HWE GP practices have now moved from analogue lines to a digital system. • This autumn a national collection of telephony data will be instigated which we believe will allow us to start to understand how this is being utilised in practices, along with triangulating other data sources such as the patient surveys.	
Support promotion of the NHS App and optimise system partner / practice interfaces with the App. Year 1- 2	• Month on month increase in usage of the NHS App seen (with some seasonal dips consistent with previous years / the national trend) and currently have 62% of our eligible population registered with the NHS App. • Local promotion of App is taking place / national communication campaign in early 2024 and we understand there is more to follow, including recent announcement of partnership between NHS and libraries across England. • Latest app information continues to be shared with practices • Data being triangulated with patient survey to try to see impact on access if possible.	
Look to develop a suite of automation tools that tackle both back-office tasks and some administrative components of clinical tasks around Long Term Conditions. Part of this should be making sure Primary Care Electronic Patient Records (EPRs) are configured to automate as many tasks and processes as possible. - Year 1 - 2	• This has not progressed due to funding. • Some work has been done on local solutions to automation at a small scale with HBL ICT but it is currently not a priority; this position may change later in the year.	
Digital workforce – we will identify and work with PCN Digital Leads to bring together best practice ideas and ensure understanding of how to work within the GP IT Operating Framework as well as considering staff training and support of digital skills to optimise the use of the digital tools available– Year 1 – 2	• The ICB held 2 PCN Digital Lead workshops where various topics were discussed - these were well received more will follow. • The ICB have also held 2 webinars to share best practices on Modern General Practice - these were also very well received	
Digital Inclusion - Work with partner organisations, such as local authorities and VCSFE organisations, who have programmes specifically aimed at either helping people become digitally skilled or can help with equipment or access to the internet. We will look to create a resource hub for primary care that will allow them to signpost patients to appropriate services. Year 1-3	• A 'Digital Skills Support Hub' , that offers a variety of support options to help residents get online (most resources within the hub site are free or low-cost) was launched this November and can be found via the following website: https://www.hertsandwestessex.ics.nhs.uk/your-health-and-care/support/digital-skills-support-hub/#h-hertfordshire-at-home-support	
Look to understand where the current challenges are re pharmacy and digital position. Year 1 – 3	• Not progressed currently due to lack of funding for community pharmacy IT – however this remains a priority for the ICB.	

Data, information and digital technology

Areas of priority for year one	Progress / achievement to date update	RAG rating
Conduct a review of laptops currently deployed and those in use / develop a standard policy for how laptops are managed and allocated. This must all be managed with the budget available to us so may require a bidding type process. We will continue to look to develop the Virtual Desktop Infrastructure (VDI) option which allows access to clinical systems securely on personal devices so that general practice staff are supported to work in an agile way that doesn't need them to be 'in the office'– Year 1-3.	• Initial gathering of laptop and workforce data has taken place and is to be reviewed.	
Access to GP records – this is a national programme that is now part of the GP contract, and practices must enable this functionality by end of October 2023. This will allow patients to have prospective access to their records - only data from the date the practice goes live and moving forward will be visible. 19 GP practices across HWE ICB are live so far and we will work with practices to support them to enable this function over the coming months. Year 1	Support has been provided locally to practices - technical (patient record systems) and information governance guidance, since this programme was first announced. The ICB continues to work with practices and all practices are configured to allow access – the ICB continue to monitor data and support practices where: • The practice has more than 10% of patients opted-out as it is expected that opt-outs will constitute a minority of patients. • The practice has less than 90% of online accounts with full prospective access enabled. Over 60% of practices have reached the 90% patient access level, with the vast majority (83%) at least at the 80% level The support provided includes sign posting to resources to assist practices and request for information to support >10% opt outs and actions planned to increase the number of online accounts with full prospective access. Support from the Clinical Digital Leads is planned to engage with the small proportion of practices still to fully progress.	
Launch of data platform and updated PHM tools to support patient care. Year 1 - 3	• New data platform is in an implementation phase • Refreshed PHM data packs have been shared with PCNs with a particular focus on frailty across all 3 places, in line with the ICS Medium to Long Term Plan, with an ambition to reduce frailty non elective activity by 25%. • PCNs continue with localised proactive and preventative work within their neighbourhood areas based on the local needs of their population e.g. targeting childhood obesity rates and developing carer's cafes to provide support to these groups.	
Dental and optometry:– ensure digital is key enabler as we progress with the dental workplan on procurement/commissioning of a number of areas including, in and out of hours urgent on the day, community dental services, domiciliary dental and optometry care. Work to understand the challenges being faced, look to see if any 'quick wins' are possible and develop a longer-term strategy to digitally support these areas. Year 1- 2	• Not progressed due to lack of funding for optometry IT	
Additional broader primary care programmes of work such as reviewing digital solutions between primary and secondary care interface, NHS app interface with patient portals, onward referrals within secondary care & remote monitoring, & resident-owned devices. Yr 1-3	• No progress currently	

Investment and Contracting

Areas of priority for year one	Progress / achievement to date update	RAG rating
Where possible, seek alternative contracting mechanisms to Alternative Provider Medical Services (APMS) contracts for primary medical services with a view to commission longer term contracts, increasing sustainability and allows the flex in partnership working Year 1-3	• The ICB have worked to review APMS contracts that were in place (all due for re-procurement in 23/24), and, where appropriate has moved these to alternative contracts, such as a General Medical Services (GMS) contract.	
Explore different contracting models with the objective of increasing resilience, capacity and value for money. such as contracts held by incorporated PCNs, federations and partnership models such as primary/community etc. Year 1-3	• As noted above, the ICB has sought for each APMS contract the best solution available to secure resilient and sustainable service. • There is no one single answer for all practices as each service and population served is different. However, the range of new models allows the ICB to consider over time where such models can be deployed effectively as the provider landscape changes over time.	
Through our contracting approach – we will aim to ensure consistency of service offer and access across HWE and not create inequality. Year 1-3	• The ICB have worked over the past couple of years to bring greater consistency to the service offer in general practice, primarily through a single offer across all 3 former CCG areas of the Enhanced Commissioning Framework (ECF). This Local Enhanced Service sets out a single specification with targets and performance metrics which is available to all practices in the ICB for the benefit of their patients. • The ICB is also working to ensure that GP practices and PCNs take up national programmes and incentives to improve access and transition to Modern General Practice models.	
A commitment to work with a wide range of providers to explore innovative solutions to service delivery that support our strategic plan for delivery of services, in an integrated way tailored to the local population. Yr 1-3	• Enhanced Health in Care Homes framework updated in Nov 2023 - existing contracted services with the 4 providers due to expire March 25. • Evaluation and review of the service identified opportunity to refresh the Service Specification and drive consistent delivery with a proposed local primary care lead provider model working collaboratively with partners across ENH place to deliver the service to Care Home residents • This forms part of the ENH HCP delivery plan for Care Closer to Home & frailty programmes – supporting the 25% reduction target for non-elective admissions.	

Investment and Contracting

Areas of priority for year one	Progress / achievement to date update	RAG rating
We will ensure ongoing quality assurance of all primary care contracts through a standardised approach. Yr 1-3	• The ICB follows the process set out in the Policy Guidance Manual and regularly reviews data for each GP practice, with a view to identifying any emergent trends or concerns to ensure that services remain sustainable and if necessary, undertakes a contract and quality review visit – these are supportive in nature. The goal is to ensure that practices are aware of the required standards, have tools and support to meet those. These visits are currently being updated and piloted with practices to ensure a standardised approach. The ICB meets regularly with the Care Quality Commission (CQC) inspection team. • For dental services, the ICB receive regular data from the Business Services Authority which shows delivery of the contracted activity and the ICB is in the process of designing a contract visit programme - this will be based on the principles used for GP visits, to review information held to develop a risk based programme of review which may be desktop, virtual or in person with input from the contracting team and the Dental Clinical Advisor, and other teams as required. The ICB meets regularly with the CQC dental inspection team. • Pharmacy contracting - Pharmacy contracting follows the guidance set out in the Pharmacy Manual. There is a national Community Pharmacy Assurance Framework which is mandatory for all providers to complete. • Completed questionnaires are reviewed - providers may be asked to provide more detail via a second return or a site visit may take place • Actions arising from this are followed up through the contracting team and where necessary escalated through the Pharmaceutical Services Regulations Committee. • The ICB has good relationships with the Controlled Drugs Accountable Officer at Region and systems in place to monitor and receive updates from the GPHC on premises or performer issues. • For all contractor groups, the ICB monitors complaints received and takes action as necessary.	
We will encourage providers to offer the full range of additional services within the national contracts and enhanced where commissioned beyond core contracts across all primary care providers as appropriate.	• Good uptake of national enhanced services, with all practices, members of a PCN & taking part in the PCN Directed Enhanced Service • Also a good uptake of locally commissioned services, with 100% of practices taking part in the ECF.	
Look at opportunities of how new local contracts aim to address the inequality in health and care outcomes and how by integrating primary care, creates opportunities to develop commissioning and contracting options through a population health lens.	• The design of the ECF ensures that practices identify patients in key disease groups who therefore receive the correct interventions at the right time helping to reduce health inequalities.	

Case Studies

HCT Hertfordshire Special Care Dental Service - Nurse Led Anxiety Management Pathway

Situation/Setting

- 2023 – Gap identified - lack of access for anxious children to a community dentistry pathway.
- The latter has resulted in Hertfordshire children being referred and treated out of county in other community dental services and in secondary care with increased waiting times and not receiving the care at the right time/place.
- This is outlined in the LEDER report - Poor oral health is associated with increased risk of aspiration pneumonia; the leading cause of death for patients with learning disability .
- These out of county avoidable general anaesthetic procedures in secondary care, are currently estimated as costing £1.26m annually.

Case Study is to bring this to life of the type of the service commissioned from Hertfordshire Specialist Care Dental Service -

- **General Dental Practitioner (GDP) referral of a 12 yr old patient with severe dental anxiety, generalised anxiety, ASD and Sensory Processing Disorder for dental treatment within Hertfordshire Special Care Dental Service (HSCDS)**
- **Patient unable to tolerate dental treatment due to severe anxiety and sensory processing disorder**

Actions/Activity

- Use of Nurse Led Anxiety Management Pathway (AMP), led by Band 5 Oral Health and Sedation nurses to help address and reduce dental anxiety prior to seeing dentist for treatment.
- AMP uses acclimatisation and a Cognitive Behavioural Therapy (CBT) approach to care, to build rapport and trust and help patients address dental anxiety and coping strategies to manage this.
- Innovative approach enables the child's voice to be heard, specific fears, triggers and concerns highlighted and collaborative working addresses coping strategies for managing dental treatment..
- Due to level of anxiety, sedation was also required but use of alternative sedation delivery system addressed patients anxiety around claustrophobia and Innovative use of The Wand (anaesthetic delivery system) enabled painless local anaesthetic delivery rather than general anaesthesia.

Impact

- AMP approach enabled the child's voice to be heard, anxieties to be addressed and coping strategies to be implemented. These were utilised alongside innovative treatment techniques (using alternative sedation delivery system, use of innovative local anaesthetic delivery systems (The Wand)) to enable dental treatment to be carried out successfully.
- In utilising the AMP -The patient was able to address their dental fears, utilise coping strategies to manage anxieties and enable restorative dental treatment to address decay.
- The sense of pride and accomplishment felt by the patient (and parent), will enable these coping strategies to be utilised for future dental care.
- Utilization of Nurse Led AMP for all paediatric referrals will be embedded within all new patient referral pathways within HSCDS.

Learning

- Utilization of Nurse Led Anxiety Management Pathway enables appropriate use of Dental care Professionals (DCP) skill sets and scope of practice to address patient need and care pathways and improves efficiency.
- Behavioural management is an essential adjunct to anxiety management and treatment planning and ensures appropriate patient centred care
- The value can be seen in recorded outcome measures and patient experience measures – both in terms of treatment completed and the child and parents experience and feedback

Feedback from the parent:

"From the moment we went into the clinic J was treated with such care and kindness….. for the first time ever, I really felt someone completely understood J and they were so patient and considerate of him and his needs……They explained everything in detail of what they'd be doing, what things might taste and feel like, how he might feel, what the machines were, showing them each one and the noises that they might make, how long each part might take, listened to his worries and concerns and didn't rush through anything. All these things are hugely important to J….. All the staff there are completely amazing, and can't speak highly enough of them"

Following agreement of primary care investment into this pathway; aim is to reduce the wa Service will be monitored and innovation and transformation within the service will be reported regularly at the transformation committee.

Hertfordshire and West Essex Integrated Care System

Stevenage: Same Day Access PCN Hubs

Setting

Stevenage was identified as one of three priority areas across the ICB requiring more same day access appointments within primary care due to high levels of increasing demand.
This was evidenced by the number of in hours ED attendance rates & associated impact & pressures.

Early modelling work also showed that approximately 50% of patient contacts into the practices required a same day appointment. The in hours call rate to the 111 service were also significantly higher than average across place.
Over 50% of the Stevenage population live within the 5 most deprived deciles for depravation.

Both PCN's have previous experience of operationalising same day access hubs as had previously set up dedicated acute respiratory hubs to help support.

The hubs also support the recommendations and commitments in the Herts & West Essex Integrated Care System, Urgent and Emergency Care 5-year Strategy document which outlines; a greater resilience of integrated urgent care system by scale-up of PCN-level same day access hubs. The hubs will match population need and have integrated pathways with other services (NHS 111, ED, SDEC, UTC, and virtual wards) to support referrals, diagnostics, treatment, and monitoring. There would be flex to support seasonal demand for example acute respiratory illness.

Activity

The implementation of the total triage model has been transformative in terms of reduction in number of telephone calls into the Stevenage North hub and practices.

Reception & admin staff are now better trained in care navigation which allows patients to be allocated appointments in terms of need not want & helps support with better signposting to alternative community provision such as Pharmacy First.

Across the two hubs on average there are an additional (circa) 1200 appts per week available; these are a mix of face to face, telephone & virtual.

Staff morale has improved as they are able to offer patients something extra given the demand for on the day appointments is high .

Dedicated number of 111 slots per week – directly bookable

Training & Development for staff – staff empowerment

Hubs use a multi skilled workforce including Gp, ENP, Paramedics, ANP's MH worker, Physiotherapists

Learning

Review of the booking system & staff resource/rotas to be able to offer patients appointments earlier in the day.
Premises limitation – hard to find space to work hub at scale
Lessons have been learnt re demand and capacity
IT would need review & solution for a locality hub

GP feedback for those working in the hub is positive. They comment that the service is very efficient, and they get to see and treat a higher number of patients in a shorter time. The admin & clinical pathways are robust and responsive.

There is a keenness from both PCN's to work as a locality. This would bring great benefits to the local population and the opportunity to look at the expansion of other services into the hub such as dental and Optometry. This would need dedicated premises & IT support to scope.

Impact (*to note the hubs evaluation report on agenda today*)

- 111 in hours call reduction for Stevenage North PCN
- More same day access appointments in primary care
- Patients seen by the right professional at the right time for their specific concern care closer to home.
- Patients survey & comments very supportive of hubs – excellent feedback; Patient Participation Group consulted and updated during all stages of development and implementation.
- Low DNA rates
- Able to offer more appointments to support patients with Long Term Conditions

Hertfordshire and West Essex Integrated Care System

Community Pharmacy PCN Leads project

Situation/Setting

A brief outline of what the situation was before the intervention was put in to place, including any issues and challenges.

East of England's Primary Care Public Health Transformation Programme Board reviewed local enablers and barriers to integrated working between community pharmacies and Primary Care Networks (PCNs). The Board concluded that:

- there was a lack of understanding within PCNs and general practices about what community pharmacy can offer
- PCNs and community pharmacies did not have enough time and capacity to build relationships and have constructive dialogue
- it was difficult for community pharmacy teams to take part in PCN discussions due to legal and contractual requirements that mean pharmacists cannot leave their workplace without backfill
- funding models drove competition between providers

As part of a wider set of actions to support integrated working, the East of England region tested having liaison roles to build relationships between pharmacies and their local PCN and general practices between June 2023 and June 2024. The East of England region tested whether having part-time 'Integration Leads' based in community pharmacies would increase communication and joint working between pharmacies and Primary Care Networks. The 6 Integrated Care Boards (ICBs) each recruited between 2 and 32 Integration Leads.

Actions/Activity

- **What did the practice/INT/pharmacy/ dental provider etc do to address the situation ? Who led on this?** Hertfordshire and West Essex recruited a Lead for every PCN area. Integration Leads logged 2,562 activities during the year. The Leads described activities such as telephone calls, emails, meetings and taking part in training. In the final 6 months, regular training sessions were coming to an end for most Leads and they spent more time liaising with community pharmacies, PCNs and general practices.
- **Were there any innovative solutions?** Leads trained practices to make referrals to pharmacies, made sure that pharmacy was a regular item on PCN meeting agendas and set up WhatsApp groups so stakeholders could discuss issues like medication stock shortages.
- **Did the provider develop any new or existing processes?** After Pharmacy First was launched on 31 January 2024, a greater number of activities focused on implementing these services. Pharmacy First is a national programme enabling community pharmacists to treat seven common health conditions: earache, infected insect bites, a bacterial skin infection called impetigo, sinusitis, sore throat, shingles and uncomplicated urinary tract infections in women. This includes supplying prescription-only medicines to patients on the NHS, without needing to visit a GP.

Impact

- **Highlight the outcomes that have been seen as a result of this.** Approximately one third more pharmacy representatives said they felt more informed and engaged than a year ago. Many specifically attribute this to Integration Lead role.
- **What changes have been seen?** Stakeholders from PCN areas without Integration Leads did not report as much change in knowledge or joint working as the areas with Integration Leads.
- **Any change to pre-intervention baseline data?** There was an increased uptake of various national NHS community pharmacy commissioned clinical advanced services by local pharmacies from the baseline from April 2023 to May 2024, based on NHSBSA data, including Clinic Blood Pressure (BP) checks (as Part of NHS Community Pharmacy Blood Pressure Check Service), New Medicine Service, and Pharmacy First service (replaced the Community Pharmacist Consultation Service).

Learning /what hasn't worked

- **Are there any reflections on the case study?** On average, stakeholders reported an increase in joint working between community pharmacies and PCNs / general practices. Many stakeholders described how Integration Leads had facilitated this increased communication and collaboration.
- **What learning has taken from this case study?** The evaluation report highlighted useful recommendations that have already been implemented within HWE ICB. A new recruitment process was undertaken for CP PCN Engagement Leads across HWE. The HWE posts were advertised with an updated role description for the Lead posts for recruitment across system and interviews were completed in July 2024. A revised model for the PCN Engagement leads was rolled out with recruitment of 16 leads, to align with Integrated Neighbourhood Teams and localities within HWE, starting in post on 30 September 2024.
- **Has the learning been shared with any other practices in the PCN/locality/HCP?** Learning has been shared with PCNs through various local and national meetings.

VIDEO: Lower Lea Valley community working together at Broxbourne volunteers fair – October 2024

[LINK: Lower Lea Valley community working together at Broxbourne volunteers fair - YouTube]

Hertfordshire and West Essex Integrated Care System

Independent investigation of the NHS in England - Lord Darzi's report on the state of the National Health Service in England - September 2024

What are the implications of the recent Darzi report for primary care?

- **Clear direction of travel outlined in Darzi report that highlights the importance of care being delivered closer to home** – '*Lock in the shift of care closer to home by hardwiring financial flows. General practice, mental health and community services will need to expand and adapt to the needs of those with long-term conditions whose prevalence is growing rapidly as the population age. Financial flows must lock-in this change irreversibly or it will not happen'*

- **Importance of technology** – '*there must be a major tilt towards technology to unlock productivity. In particular, the hundreds of thousands of NHS staff working outside hospitals urgently need the benefits of digital systems. There is enormous potential in AI to transform care and for life sciences breakthroughs to create new treatments.'*

- **Working together as a Neighbourhood NHS** – '*The best way to work as a team is to work in a team: we need to embrace new multidisciplinary models of care that bring together primary, community and mental health services.'* – likely to be in line with INT work already in place.

- **Funding** – *'While there have been some impressive programmes to support GP innovation, such as the GP Pathfinders, I* (Lord Darzi) *also heard how the current GP standard contracts are complex and can mean that doing the right thing for patients can require doing the wrong thing for GP income. That cannot be right.'*

- **Pharmacies** – *'One of the great strengths of the health service in England has been the accessibility of community pharmacy.'* and *'There is the potential for community pharmacy to provide even more value-added services for the NHS and there have been notable successes already, such as the Pharmacy First programme'*

- **Dentistry** – '*Dental access was particularly badly hit by the Covid-19 pandemic and is still recovering. If dentistry is to continue as a core NHS service, urgent action is needed to develop a contract that balances activity and prevention, is attractive to dentists and rewards those dentists who practice in less served areas. There are enough dentists in England, just not enough dentists willing to do enough NHS work, which impacts provision for the poorest in society.'*

- **10 year plan for the NHS expected in Spring 2025** - '*Something so different from anything that has gone before'* – Sir Kier Starmer 12 September 2024 – the plan will be framed around three fundamental reforms, rooted in what Lord Darzi has set out in his report:
  - moving from an analogue to a digital NHS
  - shift more care from hospitals to communities
  - moving from sickness to prevention.

It is expected that the 10 year plan will outline how the above points will be taken forward.

Next Steps

- We plan to continue to bring case studies to Primary Care Transformation Committee, to showcase the work that is taking place in relation to the Primary Care Strategic Delivery Plan, across Hertfordshire and West Essex

- Which case studies would the Committee like to see presented at the next meeting? A list of case studies and the areas they align to within the Primary Care Strategic Delivery Plan that are either currently available or expected to be finalised/ received in the near future can be found on the following slide

Future case studies to showcase at Primary Care Transformation Committee

Case study name/ area of focus	PC Strategy objective case study is related to	Final received - Y/ N	Draft received Y/N	To follow
Pharmacy First	Access	Y		
Dental Access Pilot	Access			Y
Modern General Practice - Digital	Access			Y
Harlow UATC	Access			Y
Ongar Health Centre patient experience improvement	Access	Y		
Pharmacy - Independent Pathfinder	Access	Y		
Supporting development of GP Patient Participation Groups (PPGs) – Patient Led Buddy Scheme	Enabling	Y		
Estates - Recent Primary Care Estate Achievements	Enabling	Y		
Hospital and Community Navigation Service (HCNS) Link Worker support	Proactive Management		Y	
Carers Café in Hitchin and Whitwell PCN	Proactive Management			Y
Hatfield PCN – Active Practice Status	Proactive Management			Y
Social prescriber in GP practice - ENH	Proactive Management			Y
Loughton Buckhurst Hill and Chigwell Care Home Hub Pilot	Proactive Management	Y		
North Uttlesford Integrated Neighbourhood Team	Proactive Management	Y		
Younger people's Mental Health - SVV	Proactive Management / Health Inequalities			Y
Chorleywood Health Centre	Access		Y	
St Albans and Harpenden Locality Based District Nurse	Proactive Management		Y	
Cancer Screening SWH	Proactive Management / Health Inequalities			Y
Contracting	Contracting			Y

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐
	NHS Primary Care Transformation Committee meeting held in Public		**Meeting Date:**	**28/11/2024**
Report Title:	**Stevenage Same Day Access hub evaluation**		**Agenda Item:**	**7.2**
Report Author(s):	Michelle Hicks, Senior Primary Care & Kathryn Sharp, Primary Care Manager – East & North Hertfordshire place			
Report Presented by:	Michelle Hicks, Senior Primary Care Manager Dr Kolade Daodu, GP Locality Lead for Stevenage, PCN Clinical Director, Stevenage South PCN & GP Partner Shephall Medical Centre. Matthew Charles, PCN Business Manager, Stevenage South PCN Sue Lincoln, PCN Business Manager - Stevenage North PCN, Managing Partner - Stanmore Medical Group			
Report Signed off by:	Avni Shah, Director Primary Care Transformation			
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			
Key questions for the ICB Board / Committee:	Board is asked to discuss the content and how we ensure we through this and wider channels information on progress is shared with the population we serve.			
Report History:	N/A To note this report is also being presented at the Clinical Professional Transformation Committee of the East & North Hertfordshire Health & Care Partnership.			
Executive Summary:	The Stevenage locality was identified as one of the three priority areas within the ICB Primary Care Strategy (Harlow (WE) and Hertsmere (SWH)			

	being the other 2 areas) requiring more same day access appointments within primary care due to high levels of increasing demand and associated impact on secondary care. The same day access hubs for Stevenage South & Stevenage North PCNs have been operational in differing formats since July 2023. The hubs were funded for a set period utilising service development funding in support of the ICB Primary Care Strategy implementation It was agreed that an evaluation would be conducted in April 2024 to see whether the introduction of the hubs has provided tangible benefits to the local population and wider healthcare system and helped to reduce pressure on our system partners. Patient feedback and satisfaction has also been sought on the hub models.
Recommendations:	The Primary Care Transformation Committee is asked to provide their views on the proposed next steps and points for discussion for the future provision of the same day access hubs; **<u>Next steps and further discussion points for consideration;</u>** ➢ The Lister Hospital urgent treatment centre phase 2 plan is vital in supporting further discussions in relation to an ongoing viable primary care hub in Stevenage. Without understanding the direction of travel for this and associated partner working any future options and potential funding considerations are difficult to progress with regards to same day access appointments in primary care. When the transformation funding was released for the pilot it was not known that E&NH Trust would set up an urgent treatment centre unilaterally. ➢ The place team have recently met with Public Health colleagues who have been commissioned by the Trust to evaluate the UTC services and we therefore await outcome of these details and an opportunity to progress with integration with primary care discussions. A copy of this evaluation was shared with the Trust and agreement that we should re convene after both evaluation reports are completed and presented at respective committees. ➢ In terms of value for money should the hubs cease to function there will be a cost implication to the wider system with a GP face to face appointment being far more cost effective than a visit to ED or the UTC. *Source The Kings Fund cost of ED attendance £137-£445 (24/25), UCC £91(24/25), GP face to face appointment £56 (22/23) & NHS 111 £55 (source local ICB).* This will need to form part of any ongoing partner discussion given the current financial scrutiny across all healthcare systems. ➢ There remains a need to clarify the opportunity for integration of services, taking the learning from the Integrated Urgent Treatment Centre (iUTC) model at Princess Alexandra Hospital (PAH) in West Essex place. A hub model in the Hertsmere locality of SWH place

	is planned for winter 24/25 utilising primary care winter funding monies. It should also be noted that within the ICB there are other PCN's who have managed to set up hub models within the realms of a business-as-usual approach without additional funding. It is important to understand their successes and challenges and where they have managed to achieve clear benefits and service improvements. ➢ This is a place wide conversation that all partners need to be involved in, also a need to ensure that we are continuously learning from the same day access models which are implemented across the Integrated Care System. ➢ There is a commitment from both PCN's to bring together the same day access hub models as a Locality model. This is an opportunity to bring great benefits to the local population and to potentially look at the expansion of other primary care and community services into a 'neighbourhood health' hub model. This would of course need dedicated estates and digital support. ➢ This evaluation paper is being presented for discussion at the Clinical Professional Transformation Committee (CPTC) of the East & North Hertfordshire Health and Care Partnership on Thursday 28 November 2024 to ensure partnership engagement and to seek views and consideration on recommended next steps to be presented to the next Primary Care Commissioning Committee for a decision on the future funding of the same day access hubs.

Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***	☐
	Financial	☐	***Non-Financial Personal***	☐
	None identified			☒
	N/A as decisions on where funding is approved is with Primary Care Commissioning Committee which manages the conflict of interest with independent clinicians from primary care professionals as appropriate.			
Implications / Impact:				
Patient Safety:	*Yes this is key to when considering improvement in access in primary care*			
Risk: *Link to Risk Register*	*Link to Risk Register The Primary Care Risk Register outlines the key keys associated with Primary Care Access.*			

Financial Implications:	As detailed within this report should the hubs cease to function there will be a cost implication to the wider system with a GP face to face appointment being far more cost effective than a visit to ED or the UTC. *Source The Kings Fund cost of ED attendance £137-£445 (24/25), UCC £91(24/25), GP face to face appointment £56 (22/23) & NHS 111 £55 (source local ICB).* This will need to form part of any ongoing partner discussion given the current financial scrutiny across all healthcare systems.	
Impact Assessments: *(Completed and attached)*	***Equality Impact Assessment:***	N/A
	Quality Impact Assessment:	N/A
	Data Protection Impact Assessment:	N/A

Same Day Access Hubs – Stevenage North & Stevenage South

Primary Care Networks

Evaluation paper dated; April 2024

Introduction

The Stevenage locality was identified as one of the three priority areas within the ICB Primary Care Strategy (Harlow (WE) and Hertsmere (SWH) being the other 2 areas) requiring more same day access appointments within primary care due to high levels of increasing demand and associated impact on secondary care.

The same day access hubs for Stevenage South & Stevenage North PCNs have been operational in differing formats since July 2023.

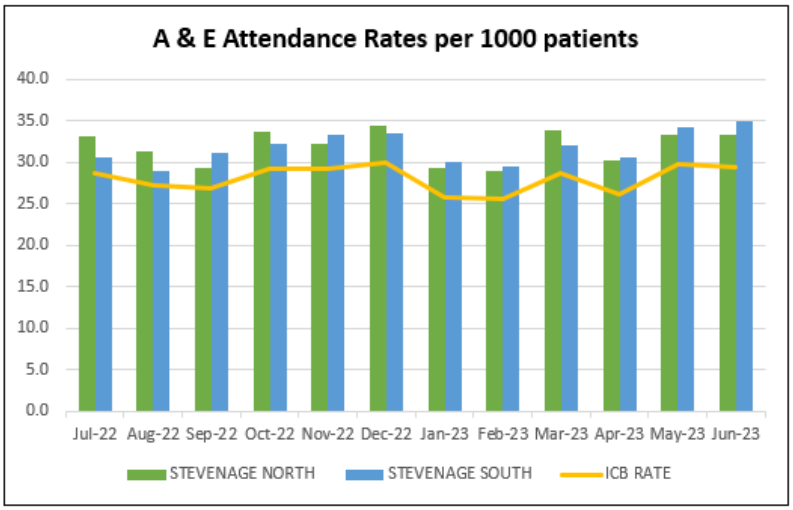
The hubs were funded for a set period utilising service development funding in support of the ICB Primary Care Strategy implementation. *For information both Stevenage North & Stevenage South PCNs commenced their hub pilots, at risk, until confirmation of finances were approved by the ICB in November 2023.*

The two hubs have operated slightly varying models of concept (*as detailed at appendix one*).

It was agreed that an evaluation would be conducted in April 2024 to see whether the introduction of the hubs has provided tangible benefits to the local population and wider healthcare system and helped to reduce pressure on our system partners. Patient feedback and satisfaction has also been sought on the hub models.

Background

Prior to the commencement of the pilots the attendance rates for the Stevenage patient population indicated higher than average attendance rates to the Lister Hospital Emergency Department in comparison to the rest of the ICB.



Stevenage North

The PCN was aware of the increased demand for unplanned care and of the higher-than-average volume of their patients attending Urgent & Emergency Care appointments . Some early modelling work conducted in June/July 2023 indicated that almost 50% of patient contacts into the practices required a same day appointment with a recognition of increased numbers across the winter months.

Meeting this demand without a dedicated same day service providing additional workforce puts extreme pressure on other primary care services and risks a reduction in efforts towards preventive medicine and management of long-term conditions which had already been compromised during/post-pandemic.

The PCN decided to split the same day access service from the more proactive care, having clearly defined clinics/workforce to cater for the needs of their acute/chronic patients in a more focussed way.

The funding of this pilot meant the model could been delivered without detriment to existing services. The aim was to allow other services to thrive alongside daily demand without the unplanned care demand monopolising resources.

Stevenage South

Stevenage South PCN has seen an increase in demand for unplanned care and has been looking at data and developing a plan of action since Autumn 2022. Similar to their Stevenage North colleagues the PCN has an above average volume of patients attending the local Emergency Department. Urgent & Emergency Care and have seen an increase in attendance over the last couple of years.

The PCN have provided training to fully embed an access active signposting approach across all practices to ensure appropriate use of the Same Day Access services.

The development of new processes and protocols to support a step change in the use of care navigation is ongoing. They believe that providing active signposting support, mentoring and development for reception and admin teams will help maximise access and the utilisation of wider support and healthcare services that are available to patients.

Methodology

The PCN's provided a monthly dataset from systmone during the pilot & beyond which details the following:-

- Number of attendances
- Number of appointment offered
- Type of appointments offered e.g GP, ANP, ECP
- Available slots
- 111 bookable slots
- Utilisation rates
- DNA rates
- Patient survey feedback

With the support of our BI team we have been able to look at and analyse trends for the following:-

- Attendance rates into ED
- Practice level In hours attendance rates
- ED 4 hour targets
- ED 12 hour targets
- Inappropriate attendances VB11Z
- Impact on calls into the 111 service
- OPEL impact
- UTC – E&NHT attendance data

We have also conducted individual discussions with the PCN's to understand day to day operational impact, associated benefits & challenges.

There have been challenges to the accuracy of some of the data provided which required considerable resource to rectify and in the meeting of deadlines for obtaining relevant information.

Of particular note is that since the hubs became operational the East & North Herts Trust opened an urgent treatment centre (UTC) at the Lister Hospital site commencing January 15th 2024.

Evaluation

Findings from Stevenage North PCN;

Utilisation & **Data provided**

The PCN are recording hub utilisation data extracted from their clinical system with some steer from the ICB and are periodically sharing it with the PC team to show impact of the service on their patient population and demonstrate value-for-money.

STEVENAGE NORTH PCN	July
AVAILABLE SLOTS	4629
GP	762
TRAINEE GP	21
ANP	272
ECP	1358
MH	42
PHYSIO	709
MEDLOOP	1290
TOTAL	4454
UNUSED	75
DNA	106
UTLISATION %	98.50%
DNA %	2.30%

- This shows the first month of service in Stevenage North.
- They are offering a substantial number of appointments with a wide range of clinicians with a varied skill mix.
- They have also commissioned Medloop to provide an extra 300 remote appointments per week.
- They have a very high utilisation rate of 98.5% and low DNA rate of 2.3%.

STEVENAGE NORTH PCN	Oct '23	Nov '23	Dec '23
AVAILABLE SLOTS	8129	7201	6185
111 SLOTS	409	409	361
BOOKED SLOTS	7979	7110	6144
UTILISATION RATE	98.20%	98.70%	99.30%
DNA RATE	2.30%	3.30%	2.80%

- This shows a summary of Q3 in the Stevenage North Hub without the clinician breakdown, but instead it shows the proportion of slots allocation to 111 which is approximately 100 per week.
- They have maintained their strong utilisation/DNA rates.

STEVENAGE NORTH PCN	Jan-24	Feb-24	Mar-24	Q4 Total
AVAILABLE SLOTS	11492	10986	11797	34275
GP	6807	5002	6164	17973
PHYSICIAN ASSOCIATE	313	305	341	959
ANP	25	43	230	298
PRACTICE NURSE	194	107	130	431
PHARMACIST	281	2021	1843	4145
ECP	1923	1857	1497	5277
MENTAL HEALTH PRACTITIONER	90	61	61	212
PHYSIO	292	251	258	801
MEDLOOP	924	804	917	2645
TOTAL BOOKED	10849	10451	11441	32741
UNUSED/CANCELLED	333	349	96	778
DNA	310	186	260	756
UTLISATION %	94.4%	95.1%	97.0%	95.5%
DNA %	2.90%	1.80%	2.3%	2.2%

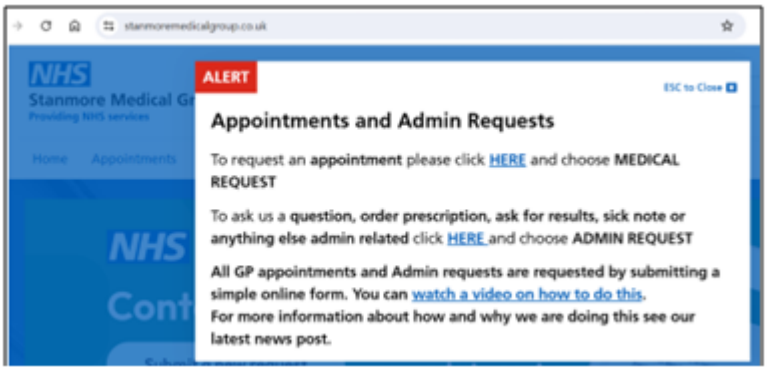
Working with BI and the PHM team they have utilised this and other information resources to drill down into the data to assess utilisation of services across various demographics to ensure the service is far-reaching into all communities considering health inequalities and areas of deprivation.

They have asked receptionists to consider the number of patients they turn away and have involved them in discussions around general patient satisfaction & feedback of their experience in being able to secure appointments for patients alongside the data.

The PCN has been monitoring numbers of patients seen for long term condition (LTC) management to assess the positive impact on more proactive care now the unplanned care is separated.

Patient engagement & feedback

The PPG were consulted with during the planning and prior to commencement of the service and have been extremely supportive of the pilot. They have also provided some very positive patient feedback from patients who have used the service since. An SMS campaign was launched to inform patients of the service and information was added to the practice websites. Stanmore Medical Group have also launched their Total Triage model which directs patients to complete an online request for medical (or admin) support. One of the new outcomes from this service would be to book an appointment within the SDA hub.



Patient experience surveys have been sent to patients visiting the hub via SMS and monitored regularly. They also conduct surveys which include questions about access (in line with the national patient survey) so they have been able to assess the impact.

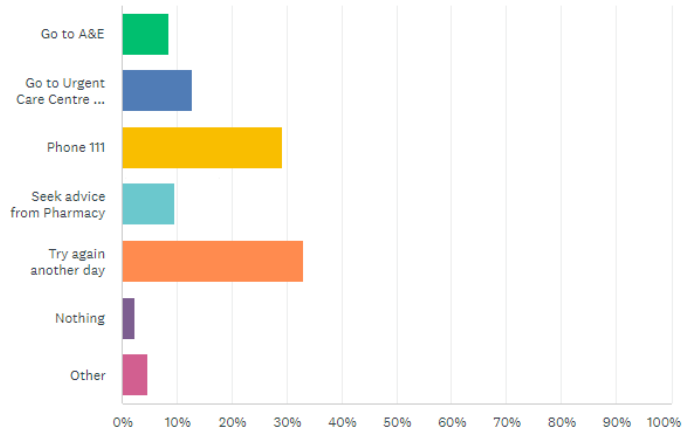
We also asked the PCN to gather information from patients relating to what they would have done it the hub appointment had not been available, e.g. Would they have visited A&E/called 111 etc to help gauge the reduction in pressure from the Stevenage North patients:

Q1

Customize Save as

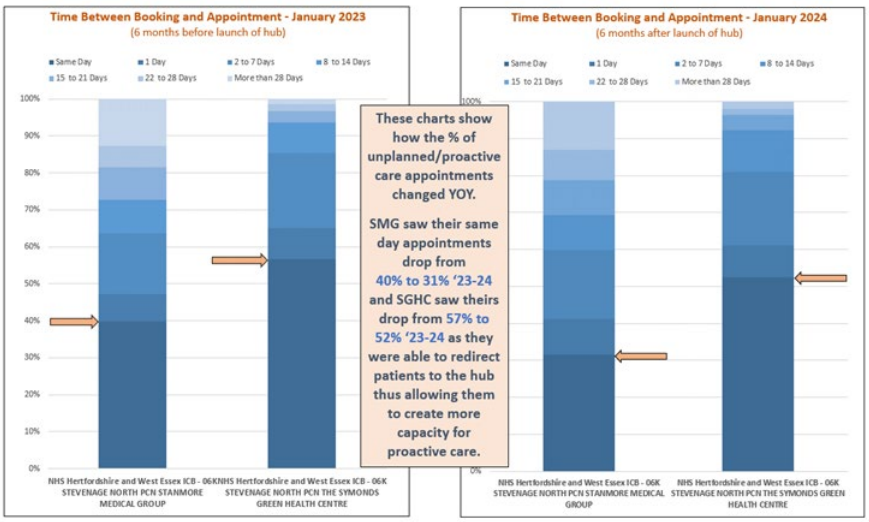
What would you have done if we could not offer you a 'same day' appointment with us?

Answered: 260 Skipped: 0



ANSWER CHOICES	RESPONSES	
Go to A&E	8.46%	22
Go to Urgent Care Centre @ Lister or WGC	12.69%	33
Phone 111	29.23%	76
Seek advice from Pharmacy	9.62%	25
Try again another day	33.08%	86
Nothing	2.31%	6
Other	4.62%	12
TOTAL		260

Appointment type change



Long Term Plan

The PCN considered this a pilot, and, as it proved a success, have continued to self-fund now the ICB commissioned period has come to an end (October 2023). If there is any national/local direction over the winter period for same day access/respiratory hubs, they will have a tried and tested, staffed model which can be morphed into the desired service. If there is further funding available for same, as an experienced provider, they will be able to utilise it effectively, offering value-for-money and providing a lower risk solution.

The intention is to work as a locality with Stevenage South PCN in the long term, once they have considered the uptake and outcomes of this service.

Findings from Stevenage South PCN;

Utilisation & **Data provided**

STEVENAGE SOUTH PCN	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	YTD
AVAILABLE SLOTS	525	500	477	322	553	407	673	592	4049
GP	235	229	224	261	285	231	309	280	2054
ANP	43	64	90	0	14	27	95	81	414
ECP	213	174	130	45	229	133	236	201	1361
TOTAL PATIENTS BOOKED	491	467	444	306	528	391	640	562	3829
UNUSED	34	33	33	16	25	16	33	30	220
DNA	26	16	18	16	23	15	33	15	162
UTILISATION %	93.5%	93.4%	93.1%	95.0%	95.5%	96.1%	95.10%	94.90%	94.60%
DNA %	5.0%	3.2%	3.8%	5.0%	4.2%	3.7%	4.9%	2.50%	4.20%

The PCN are recording utilisation data and are sharing it with the ICB to show impact of the service on their patient population and demonstrate value-for-money. This shows the first 8 month's appointments were well-utilised, averaging 94.6% with a low DNA rate of 4.2%.

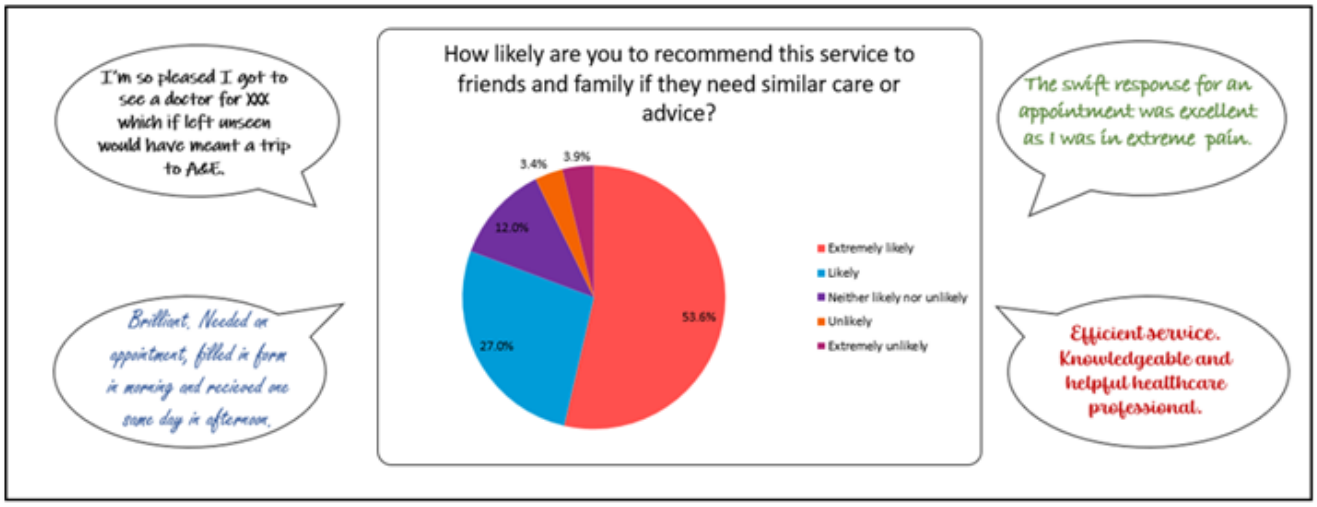
There are collective plans to drill down into the data to assess utilisation of services by different age groups and ethnicities to identify health inequalities. There was concern about South patients in the more deprived areas being at a disadvantage if the service was shared with North patients so uptake in the various wards will be monitored and considered when working on a plan to join forces with North at a later date.

Patient engagement & feedback

Sample of questionnaire

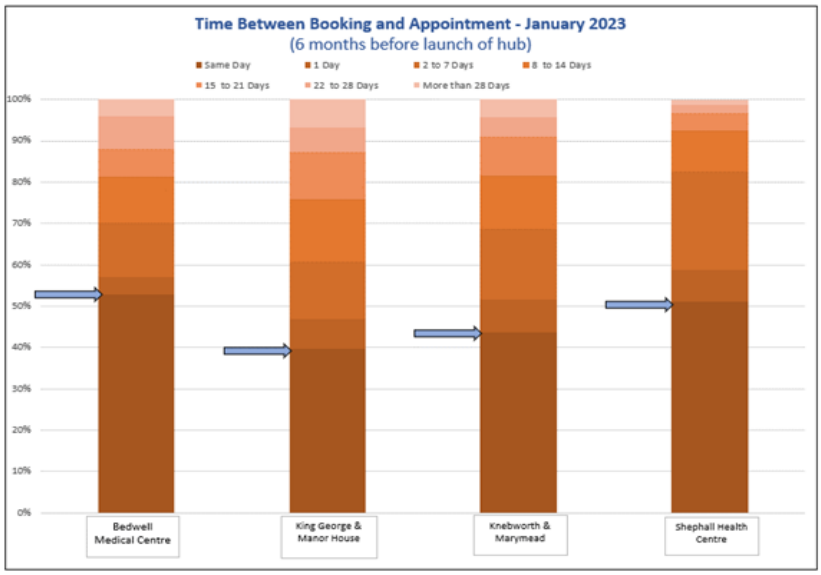
Question Detail		Responses
Q1	Thinking about the service we provide, overall, how was your experience of our service?	89% Good or Very Good
Q2.	How would you rate the booking process for your appointment?	90% Good or Very Good
Q3.	How would you rate the clinician at your appointment?	85% Good or Very Good
Q4.	Seven days after your appointment, had the issue you consulted about resolved or improved?	67% Yes
Q5.	In the week after your appointment, did you have contact with the GP practice, 111 or A&E for the same problem?	80% No
Q6.	Would you have contacted 111 for support if you had not been able to access this service?	56% Yes
Q7.	Would you have contacted accident and emergency for support if you had not been able to access this service?	28% Yes
F&F	How likely are you to recommend this service to friends and family if they need similar care or advice?	81% Likely or Very Likely

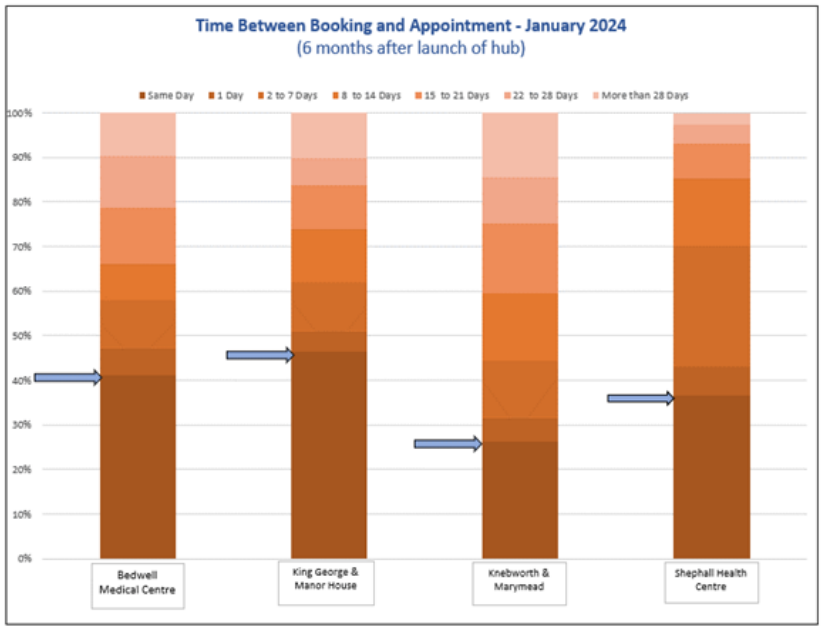
Surveys are sent to every patient visiting the hub via SMS and paper copies have also been available for patients. Following discussions with the ICB, they have now included questions about whether the patient would have called 111/ visited A&E if they had not been given the appointment in the hub to attempt to gauge the reduced impact on these acute services and have shared the responses to date:



In addition to the survey, patients are randomly selected to receive a text message after their appointment, asking them the question below and inviting their comments. 81% of patients said they were likely or extremely likely to recommend the service to friends and family.

Same day appointments in practice





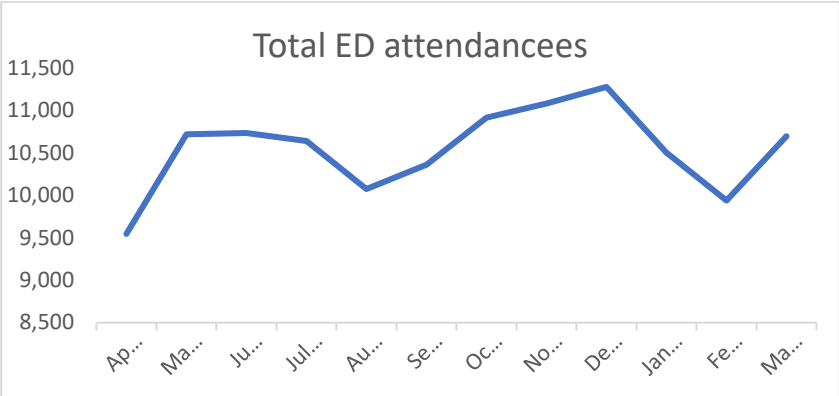
These charts show how the % of unplanned/proactive care appointment numbers in member practices have changed year on year Jan 23 to Jan 24

Bedwell saw their same day appointments drop from 53% to 41%
King Georges saw an increase from 40% to 46%
Knebworth & Marymead saw a drop from 44% to 26%
Shepall saw a drop from 51% to 37%

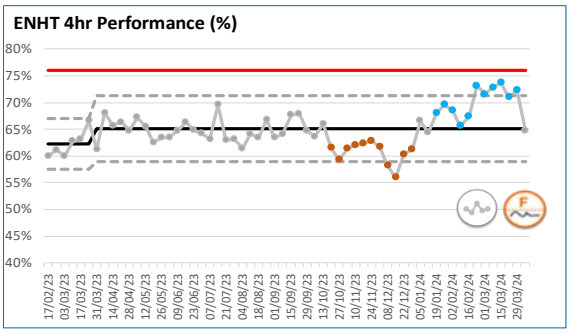
As more patients directed to the hub this allowed more capacity for proactive care.

Assessing impact on Acute services

ED Data



The table above shows comparisons in A&E data with particular focus on the months the hubs have been running. There is some improvement in places, but it is difficult to prove this is due to the availability of more SDA appointments at practice level as there are also months of increased A&E activity.



The improvement in the 4 hour target has been recognised since the implementation in mid January 2024 of the on site urgent treatment centre & expansion of SDEC.

Number of In Hours A&E Attendances (per 1000 Reg Population)		Jul 22	Jul 23	Aug 22	Aug 23	Sep 22	Sep 23	Oct 22	Oct 23	Nov 22	Nov 23	Dec 22	Dec 23	Jan 23	Jan 24	Feb 23	Feb 24
STEVENAGE NORTH	STANMORE MEDICAL GROUP	17.2	14.6	17.2	14.6	17.2	14.6	17.2	14.6	16.5	17.7	15.9	16.6	13.2	20.1	15.0	13.4
	SYMONDS GREEN HEALTH CENTRE	17.6	15.6	17.6	15.6	17.6	15.6	17.6	15.6	12.7	15.6	13.4	13.9	11.1	19.3	13.9	13.7
	CHELLS SURGERY	15.6		15.6		15.6		15.6									

The table above shows YOY A&E attendance broken down by practice. (NB: Chells merged with Stanmore back in Autumn 2022.) The numbers per 1000 reduced July to October '23 but started increasing since November 23 this would not be unexpected given the increase in overall ED admission attendances

	Number of In Hours A&E Attendances (per 1000 Reg Population)	Jul 22	Jul 23	Aug 22	Aug 23	Sep 22	Sep 23	Oct 22	Oct 23	Nov 22	Nov 23	Dec 22	Dec 23	Jan 23	Jan 24	Feb 23	Feb 24
STEVENAGE SOUTH	BEDWELL MEDICAL CENTRE	16.4	14.6	14.9	13.3	19.1	13.9	14.9	15.8	16.6	17.1	12.8	14.8	11.9	17.4	14.9	12.8
	KING GEORGE & MANOR HOUSE	14.6	16.1	14.9	14.7	17.5	15.3	15.6	17.0	16.6	18.5	16.0	17.7	12.7	18.3	13.6	14.8
	KNEBWORTH & MARYMEAD	15.8	17.1	16.6	16.3	18.8	17.0	14.5	16.7	17.5	20.2	18.9	16.8	17.7	17.4	14.3	13.4
	SHEPHALL HEALTH CENTRE	13.4	13.9	17.0	13.0	17.3	13.3	14.0	15.5	15.2	15.1	12.1	17.5	11.7	16.9	12.0	13.5

The table above shows YOY A&E attendance broken down by practice. The numbers per 1000 reduced August to September. In October 23 there were staff shortages in the hub. From November to February the data and impact is mixed & difficult to gauge an overall benefit or otherwise. The improvement to Knebworth & Marymead could be linked to their total triage model. Once again given the overall increase in ED admissions year on year the increase is not surprising.

VB11Z data

STEVENAGE NORTH	Month	Number of In Hours A&E Appointments	Number of VB11Z	%VB11Z	Number of In Hours A&E Appointments /1000 Reg Pop	Number of VB11Z/1000 Reg Pop
	Apr 2022	701	72	10%	33.0	3.3
	May 2022	777	106	14%	38.5	5.6
	Jun 2022	657	75	11%	32.1	2.8
	Jul 2022	704	69	10%	34.8	3.2
	Aug 2022	735	103	14%	36.5	5.6
	Sep 2022	933	120	13%	34.6	4.3
	Oct 2022	881	112	13%	27.8	3.3
	Nov 2022	908	157	17%	29.2	5.2
	Dec 2022	880	138	16%	29.3	4.8
	Jan 2023	735	87	12%	24.3	3.4
	Feb 2023	841	109	13%	28.9	3.8
	Mar 2023	1015	127	13%	36.7	4.9
	Apr 2023	722	103	14%	26.1	3.7
	May 2023	876	106	12%	30.5	3.9
	Jun 2023	920	120	13%	29.6	3.8
	Jul 2023	828	106	13%	30.2	4.5
	Aug 2023	774	93	12%	28.5	3.1
	Sep 2023	901	123	14%	34.4	5.1
	Oct 2023	912	119	13%	32.2	3.6
	Nov 2023	990	139	14%	33.3	4.8
	Dec 2023	921	129	14%	30.5	3.7
	Jan 2024	1131	168	15%	39.4	6.7
	Feb 2024	1140	169	15	37.8	6.5

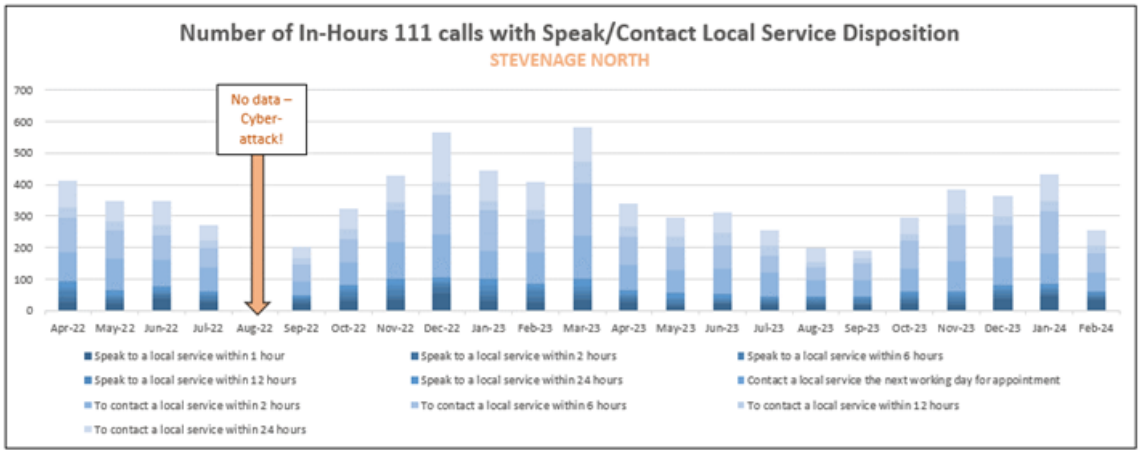
	Month	Number of In Hours A&E Appointments	Number of VB11Z	%VB11Z	Number of In Hours A&E Appointments /1000 Reg Pop	Number of VB11Z/1000 Reg Pop
STEVENAGE SOUTH	Apr 2022	856	84	10%	59.5	5.8
	May 2022	1014	119	12%	71.4	8.5
	Jun 2022	965	113	12%	67.4	7.7
	Jul 2022	868	87	10%	60.2	5.8
	Aug 2022	900	126	14%	63.4	8.3
	Sep 2022	1047	125	12%	72.6	8.9
	Oct 2022	865	124	14%	59.0	8.4
	Nov 2022	963	139	14%	65.9	9.6
	Dec 2022	893	147	16%	59.7	9.8
	Jan 2023	789	99	13%	53.9	6.7
	Feb 2023	808	108	13%	54.9	7.3
	Mar 2023	976	121	12%	65.8	8.6
	Apr 2023	770	98	13%	51.8	6.6
	May 2023	933	125	13%	65.2	8.4
	Jun 2023	1047	141	13%	71.8	9.7
	Jul 2023	922	115	12%	61.7	7.4
	Aug 2023	856	131	15%	57.3	8.7
	Sep 2023	892	118	13%	59.5	7.4
	Oct 2023	972	129	13%	64.9	8.6
	Nov 2023	1071	142	13%	71.0	9.5
	Dec 2023	1002	142	14%	66.8	9.3
	Jan 2024	1051	138	13%	69.9	9.4
	Feb 2024	1179	187	16%	78.0	12.1

The PCN have also been looking at inappropriate attendances and, if/when issues are identified, will consider some further patient education in the form of a survey into use of services.

The ICB are working with the PCN and BI team to gather data on the practices missed opportunities, looking at those patients attending A&E who require no treatment nor investigation who could have potentially been managed in practice.

NHS 111 - impact

Stevenage North



The PCN offered a proportion of their appointments to the 111 service, as they have done in previous projects, monitoring the uptake of appointments, and engaging with the 111 team if they are not utilising them, Approximately 100 slots per week were allocated. Data has been sourced on the number of calls received by 111 from Stevenage North patients and have drilled down into this data to find the rate of calls which could have been dealt with in primary care which is more relevant to this project. All below have been advised to contact local services.

In Hours 111 Calls by Disposition								STEVENAGE NORTH PCN								
	Speak to a local service within:							To contact a local service within:								
Month	1 hour (pall'tv care)	6 hours (Expct'd Death)	1 hour	2 hours	6 hours	12 hours	24 hours	Next wrkng day for appt	2 hours	6 hours	12 hours	24 hours	For Non-Urgent Appt	3 wrkng days	Total	Difference in same month '22-'23
Jul 2022	0	0	30	8	13	2	7	0	76	62	23	51	3	16	291	-
Sep 2022	0	0	26	7	8	2	6	0	44	54	20	35	4	12	218	-
Oct 2022	0	1	34	13	15	6	12	0	73	72	33	65	4	18	345	-
Nov 2022	0	0	39	12	19	12	19	0	117	100	24	87	6	21	456	-
Dec 2022	0	0	59	20	10	4	14	0	134	126	40	157	11	21	596	-
Jan 2022	0	0	34	15	18	14	20	1	89	127	29	96	5	26	474	-
Feb 2023	0	0	28	17	21	8	12	0	102	102	31	87	6	28	442	
Jul 2023	0	1	20	9	10	1	6	0	74	53	33	48	2	19	275	- 5.5%
Aug 2023	0	1	21	10	8	1	6	0	50	40	18	44	3	7	208	N/A
Sep 2023	0	1	19	8	9	4	7	0	49	54	18	24	5	10	207	- 5%
Oct 2023	0	1	24	14	8	6	8	0	75	88	21	50	6	10	310	- 10%
Nov 2023	0	0	20	14	12	7	9	1	94	114	35	78	5	26	415	- 9%
Dec 2023	0	0	42	13	10	6	10	0	90	99	30	62	1	15	378	-36.5%
Jan 2024	0	1	48	10	10	6	13	0	97	130	32	88	3	21	458	-3.5%
Feb 2024	0	0	38	6	5	7	4	0	60	62	26	47	2	19	276	-37.5%

There is a small reduction in calls with type of disposition July ’23 to January ’24 compared to the same period in ’22/23 - Detail below.

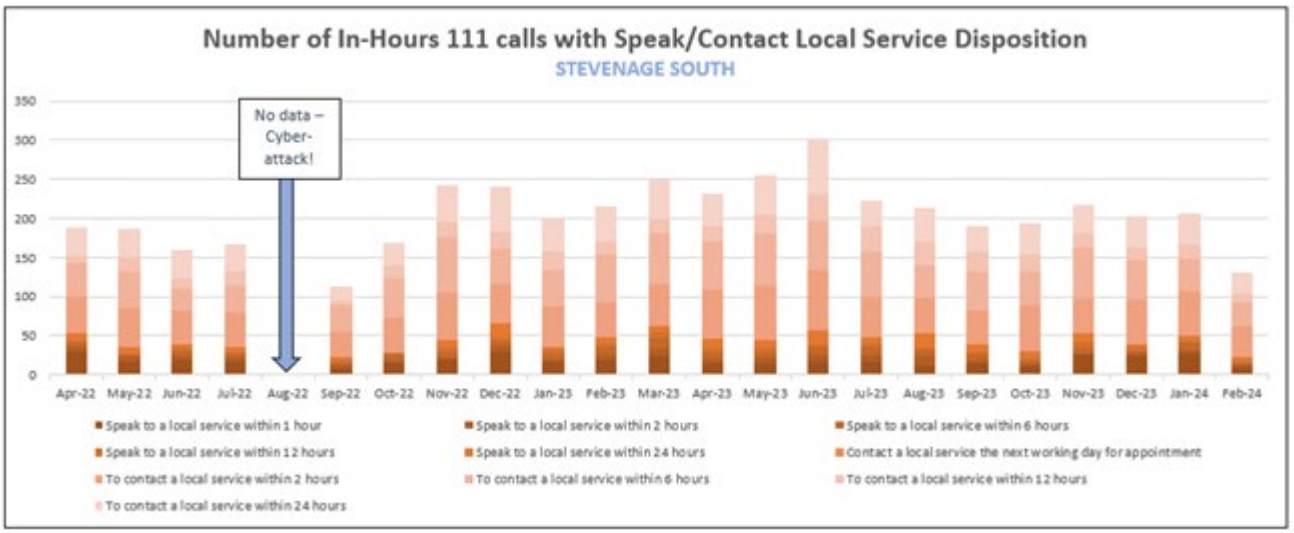
Whilst the calls increase towards winter, the year-on-year comparison 22-23 shows a reduction in total calls for issues which could have been handled in primary care.

The table above shows a reduction of 3.5 to 37.5% (compared to the same months the previous year) since the SNPCN hub has been open. NB: there is no Aug ’22 111 data due to a cyber-attack.

Stevenage South

The PCN offer their appointments to the 111 service and have set up their clinics to allow call handlers to book directly into slots – they have monitored usage of these slots by 111 and

have discussed with the ICB how they can obtain UEC data on number of calls received by their patients to identify level of improvement.



This data show calls that could have been dealt with in primary care. All have been advised to contact local services.

In Hours 111 Calls by Disposition									STEVENAGE SOUTH PCN							
	Speak to a local service within:							To contact a local service within:								
Month	1 hour (pall'tv care)	6 hours (Expct'd Death)	1 hour	2 hours	6 hours	12 hours	24 hours	Next working day for appt	2 hours	6 hours	12 hours	24 hours	For Non-Urgent Appt	3 working days	Total	Difference in same month '22 '23
Jul 2022	0	0	18	5	5	1	6	0	45	35	17	34	1	10	177	-
Sep 2022	0	0	8	6	1	5	3	0	33	33	6	18	0	13	126	-
Oct 2022	0	1	15	4	7	3	0	0	45	50	15	29	2	11	181	-
Nov 2022	0	1	19	4	7	6	8	0	61	70	20	48	2	15	260	-
Dec 2022	0	0	30	7	7	5	17	0	51	44	22	57	4	12	256	-
Jan 2023	1	1	18	4	6	5	3	0	51	48	22	43	0	8	208	-
Feb 2023	0	0	20	7	10	4	7	0	45	61	16	45	3	7	225	-
Jul 2023	0	0	17	10	11	3	7	0	52	57	34	32	6	8	237	+ 34%
Aug 2023	0	0	13	11	9	3	18	0	44	41	32	42	3	9	225	N/A
Sep 2023	0	0	15	5	8	2	9	0	44	50	24	34	2	15	208	+ 65%
Oct 2023	1	0	13	3	3	4	7	0	59	43	23	38	0	13	206	+ 14%
Nov 2023	0	1	26	3	6	7	11	0	45	66	17	37	2	19	239	- 8%
Dec 2023	0	1	25	3	4	5	3	0	56	51	16	39	1	4	207	- 19%
Jan 2024	0	0	28	4	10	1	7	0	57	42	18	40	2	11	220	+ 6%
Feb 2024	0	0	10	4	2	1	6	0	39	32	10	26	0	9	139	- 38%

There is actual increase in calls with type of disposition July to November ’23 compared to the same period in ’22. This shows a greater need for SDA in Stevenage South than the current provision. NB: there is no Aug ’22 111 data due to a cyber-attack.

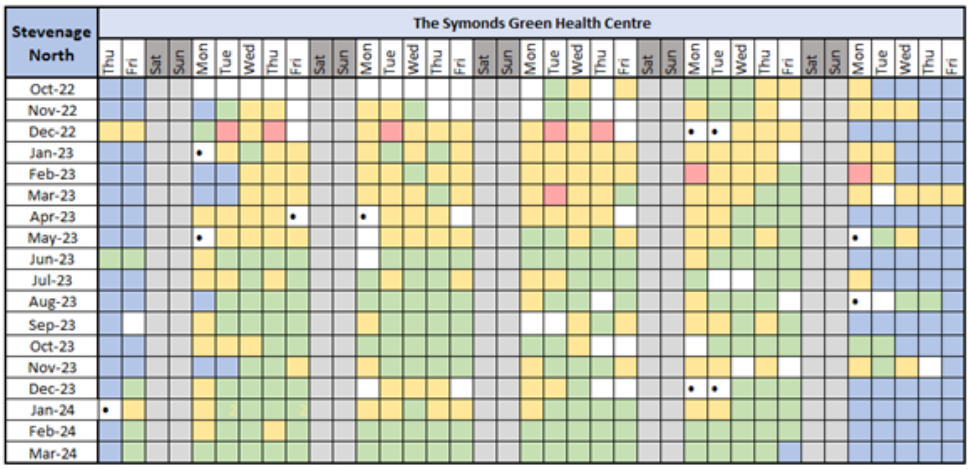
As well as calls increasing towards winter, the YOY comparison 22-23 also shows a significant increase in calls for issues which could have been handled in primary care from July to October and a progressive decrease from November to February (apart from a 6% rise in January). South PCN are offering a much smaller service than North but plan to run it over a longer period. This data shows a greater need for SDA than they are currently providing.

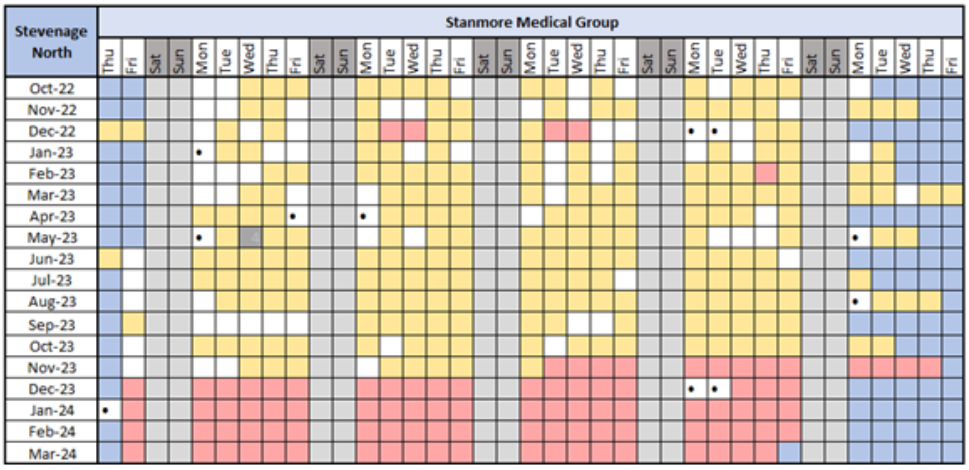
Long Term Plan

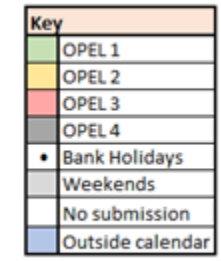
The PCN understand the money to fund the proposal is non-recurrent at this stage but hope to maintain the service after commissioning timeframe lapses i.e. from Q2 24/25.
The main cost of the hub is to fund the GPs, other roles can be funded via the existing and recurrent ARRS budget so this makes the service more resilient. They are also in the process of becoming a PCN Learning Organisation so will have the potential to support new GP trainees through this approach.

OPEL – Impact

Stevenage North



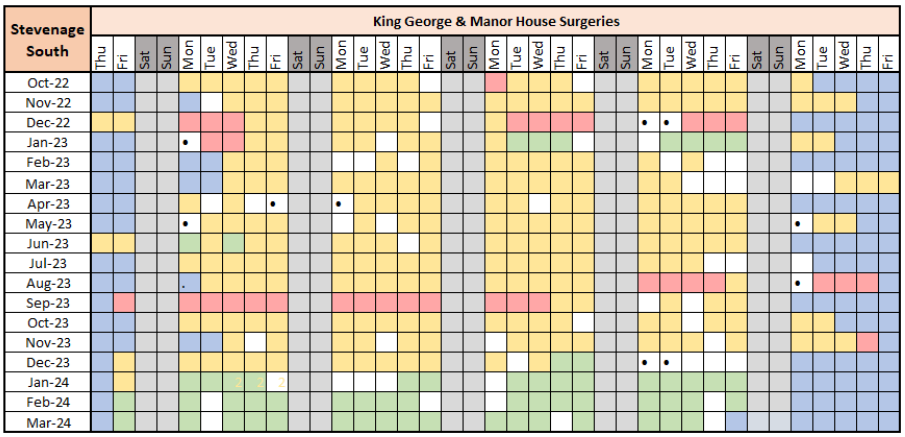


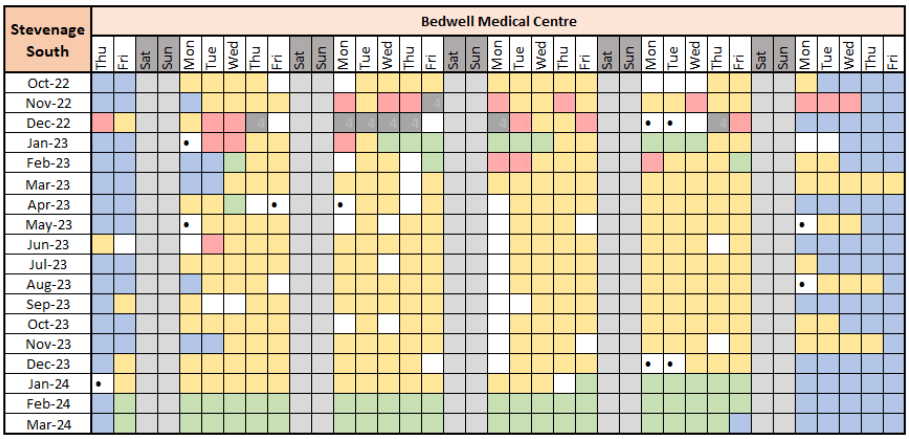


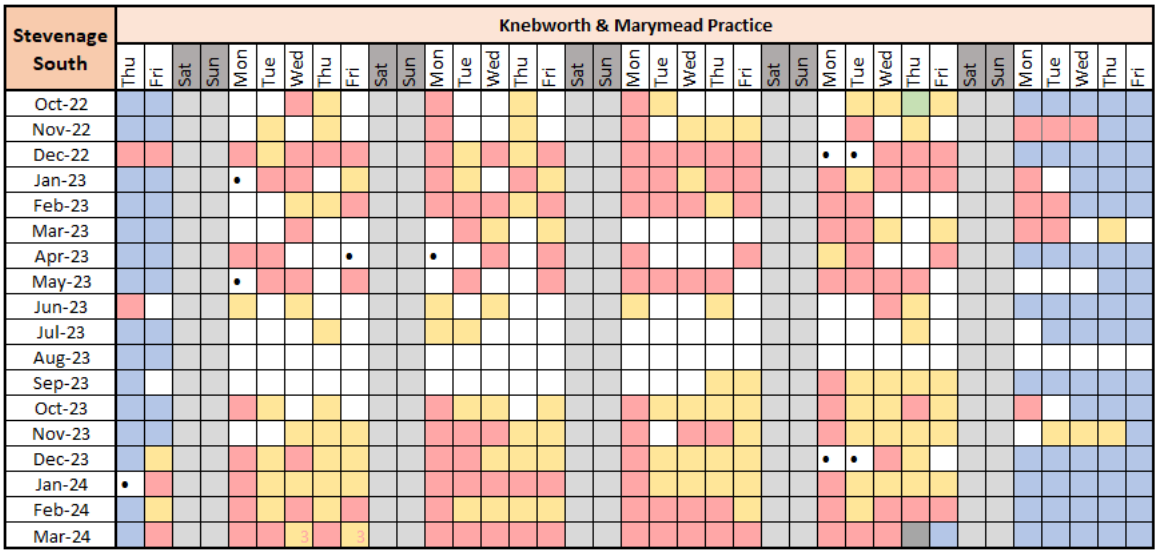
The OPEL position has been monitored to see if escalation levels have reduced for Primary Care.

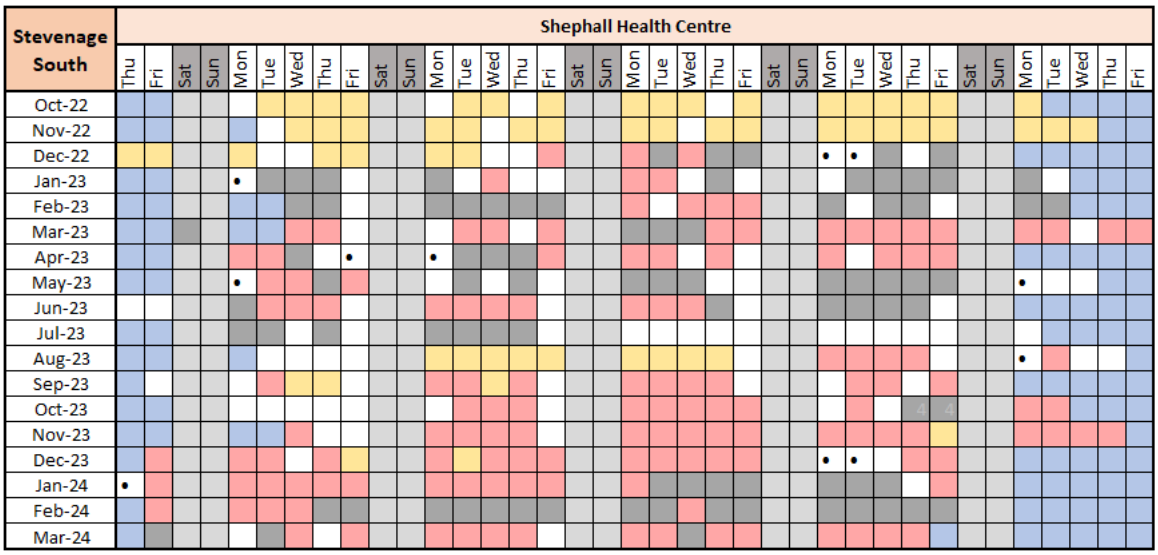
The PCN has been making a conscious effort to ensure regular reporting throughout the pilot (and beyond). Previously, the average reporting rate was in the region of 40% but we have seen a significant increase in this figure which is consistently over 90% now. The team are aware of the daily pressures on the Acute Trust from the system level SHREWD data. They hope they can support Lister ED effectively, particularly when they are under increased pressure.

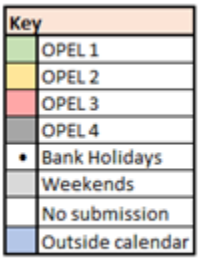
Stevenage South







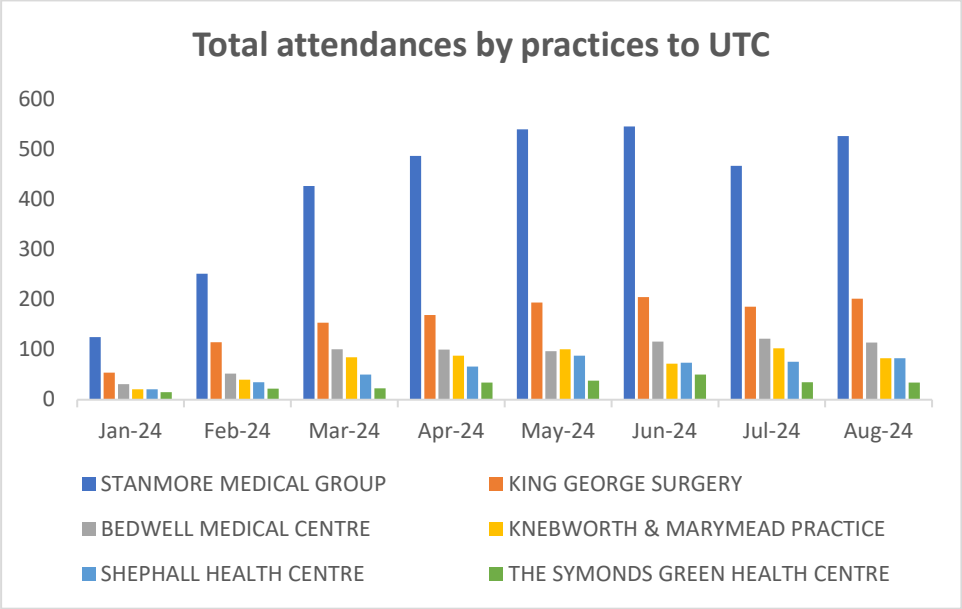


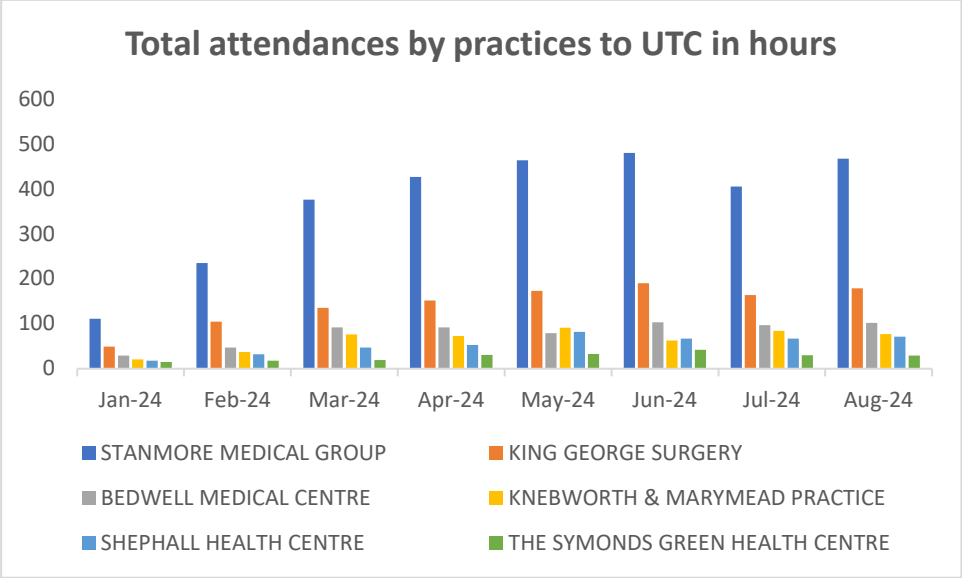


The PCN have been working with practices to ensure regular reporting throughout the pilot (and beyond). They strive to have more awareness of OPEL status in Secondary care and seek avenues to better communicate with the trusts to ensure that their services are signposted and indeed referred into. They have offered mutual aid to ENHT in the form of directly bookable appointments when the scale of pressure is high although the Stevenage South practices report often feeling pressured themselves.

Urgent Treatment Centre at East & North Hertfordshire NHS Trust

The urgent treatment centre at the Lister Hospital was operationalised from 15th January 2024. Below is attendance data relating to all Stevenage practices:-





Top 10 recorded conditions:

Injury of lower extremity

Injury of upper extremity

Pain in lower limb

Skin problem

Abdominal Pain

Dysuria

Cough

Headache

Sore Throat

Laceration

Within the presenting condition types there is the possibility that some of these could have been seen by the community pharmacists through the Pharmacy First programme e.g sore throat. Without further clinical analysis of the data codes attributed to the attendance type it is difficult to ascertain what is true UTC activity & what could have been seen in the community.

Stevenage North & South PCN reflections;

Benefits which have been noticed since the inception of the hub include:

- Staff morale has improved as they are able to offer patients something extra given the demand for on the day appointments is high
- Hub appointments are well attended with limited DNA rates
- Feedback from patients is extremely positive
- Patients are given additional option before calling 111 or attending A&E unnecessarily
- Reception & admin staff are now better trained in care navigation which allows patients to be allocated appointments in terms of need not want.
- The implementation of the total triage model has been transformative in terms of reduction in number of telephone calls into the hub and practices.
- GP feedback for those working in the hub is positive. They comment that the service is very efficient and they get to see and treat a higher number of patients in a shorter time. The admin & clinical pathways are robust and responsive.
- GP feedback for those working outside of the hub has been positive in that they are able to focus on proactive care and complex care as opposed to the plethora of minor illness complaints which can be seen at the hub.

Challenges & Improvements

- Review of the booking system & staff resource/rotas to be able to offer patients appointments earlier in the day.
- Delays in funding led to difficulties in initial planning as was hard to engage workforce and the PCN were concerned they were operating the model at financial risk.
- Premises limitation – hard to find space to work hub at scale
- Lessons have been learnt re demand and capacity
- Securing additional monies prior to continuation and to be able to expand the hub model will be required.
- IT would need review & solution for a locality hub

Summary & Analysis

The benefits which have been identified during the evaluation are that the hubs are extremely popular with patients and have clearly demonstrated that by the redirection of the same day activity to a central point this has freed up appointment capacity to help treat patients with long term medical conditions more effectively.

The morale of staff both clinical and admin has greatly improved as all feel that patients are being seen swiftly and more importantly in the right place. The Reception (or Care Navigation) staff have a greater sense of being able to help support and assist patients in getting to see the appropriate professionals & they are empowered & confident following additional training in their roles. With the varied skill mix of staff in the hubs this has allowed for beneficial peer to peer support and associated training.

The Lister ED department were engaged at the start of the pilot with relevant communications circulated as to how they could use the hub. The uptake of this support has been relatively low; although not captured it is thought <10 patients have been redirected in this way. With the inception of the UTC mid January 2024 this will not have supported the primary care hub model

for utilisation. Reminder communications were circulated via the SRG (System resilience group) committee and promoted at SPACE events to support.

The in-hours attendance rates per 1,000 patients into Lister ED has seen a fluctuation success wise. There are pockets of improvements across some months but again in line with winter demand and the numbers going through the ED department there is not a significant indication that the hubs alleviated this in anyway; nothwithstanding the question without the hubs being operational is that arguably the ED attendance data could have been higher. This also illustrates the need within primary care for the additional requirement of SDA appointments during the winter months.

With regards to the impact on 111 services there is a clear divide between how the North and South PCN's have been able to support this. The hub model being so much larger in Stevenage North shows benefits; this would support the need for expansion capacity wise for patients in the South. The data indicates that there has been a decrease for the North in terms of 111 usage and an increase for the South.

The information regarding the attendance data into the UTC provides an overall context of activity but as detailed above is difficult to determine true primary care activity without further clinical review/analysis.

Both PCNs have already implemented their pilots for the agreed term as set out in their original proposals.

The Stevenage North pilot was conducted from July 2023 – September 2023 and this has since been operational with ongoing monies invested directly by the PCN whilst awaiting further decision on financial funding from the ICB.

The Stevenage South pilot was from June 2023 - June 2024; there was however sufficient data to provide an interim evaluation as at April 2024. The hub service remains ongoing at the current time through utilisation of PCN funding, however this is not a sustainable position, whilst awaiting further decision on financial funding from the ICB.

Impact on system if no future funding to the hubs

Stevenage South have estimated that if the hub were to cease being operational this would have the following impact on the wider healthcare system.

- 250 less same day appointments per week for the system, directly reducing capacity, at a time where primary care and wider healthcare are being tasked with increasing capacity.
- 63 more patients per week attending ED (estimation based on feedback from patient surveys)
- 125 more patients per week calling 111 (estimation based on feedback from patient surveys)
- 250 more patients per week requiring appointments within their GP practice

Stevenage North have advised that if their hub was discontinued the impact would be:-

- 50% of our same day appointment would be moved to deal with LTC.

Weekly, this equates to:

- 99 patients attending ED
- 133 patients attending UCC
- 266 patients calling 111
- 410 patients requiring GP appointment

Next steps and further discussion points for consideration;

- The Lister Hospital urgent treatment centre phase 2 plan is vital in supporting further discussions in relation to an ongoing viable primary care hub in Stevenage. Without understanding the direction of travel for this and associated partner working any future options and potential funding considerations are difficult to progress with regards to same day access appointments in primary care. When the transformation funding was released for the pilot it was not known that E&NH Trust would set up an urgent treatment centre unilaterally.

- The place team have recently met with Public Health colleagues who have been commissioned by the Trust to evaluate the UTC services and we therefore await outcome of these details and an opportunity to progress with integration with primary care discussions. A copy of this evaluation was shared with the Trust and agreement that we should re convene after both evaluation reports are completed and presented at respective committees.

- In terms of value for money should the hubs cease to function there will be a cost implication to the wider system with a GP face to face appointment being far more cost effective than a visit to ED or the UTC. *Source The Kings Fund cost of ED attendance £137-£445 (24/25), UCC £91(24/25), GP face to face appointment £56 (22/23) & NHS 111 £55 (source local ICB).* This will need to form part of any ongoing partner discussion given the current financial scrutiny across all healthcare systems.

- There remains a need to clarify the opportunity for integration of services, taking the learning from the Integrated Urgent Treatment Centre (iUTC) model at Princess Alexandra Hospital (PAH) in West Essex place. A hub model in the Hertsmere locality of SWH place is planned for winter 24/25 utilising primary care winter funding monies. It should also be noted that within the ICB there are other PCN's who have managed to set up hub models within the realms of a business-as-usual approach without additional funding. It is important to understand their successes and challenges and where they have managed to achieve clear benefits and service improvements.

- This is a place wide conversation that all partners need to be involved in, also a need to ensure that we are continuously learning from the same day access models which are implemented across the Integrated Care System.

- There is a commitment from both PCN's to bring together the same day access hub models as a Locality model. This is an opportunity to bring great benefits to the local population and to potentially look at the expansion of other primary care and community services into a 'neighbourhood health' hub model. This would of course need dedicated estates and digital support.

- This evaluation paper is being presented for discussion at the Clinical Professional Transformation Committee (CPTC) of the East & North Hertfordshire Health and Care Partnership on Thursday 28 November 2024 to ensure partnership engagement and to seek views and consideration on recommended next steps to be presented to the next Primary Care Commissioning Committee for a decision on the future funding of the same day access hubs.

APPENDIX ONE;

Same Day Access Hubs to cover the Stevenage locality; Stevenage North & Stevenage South PCNs

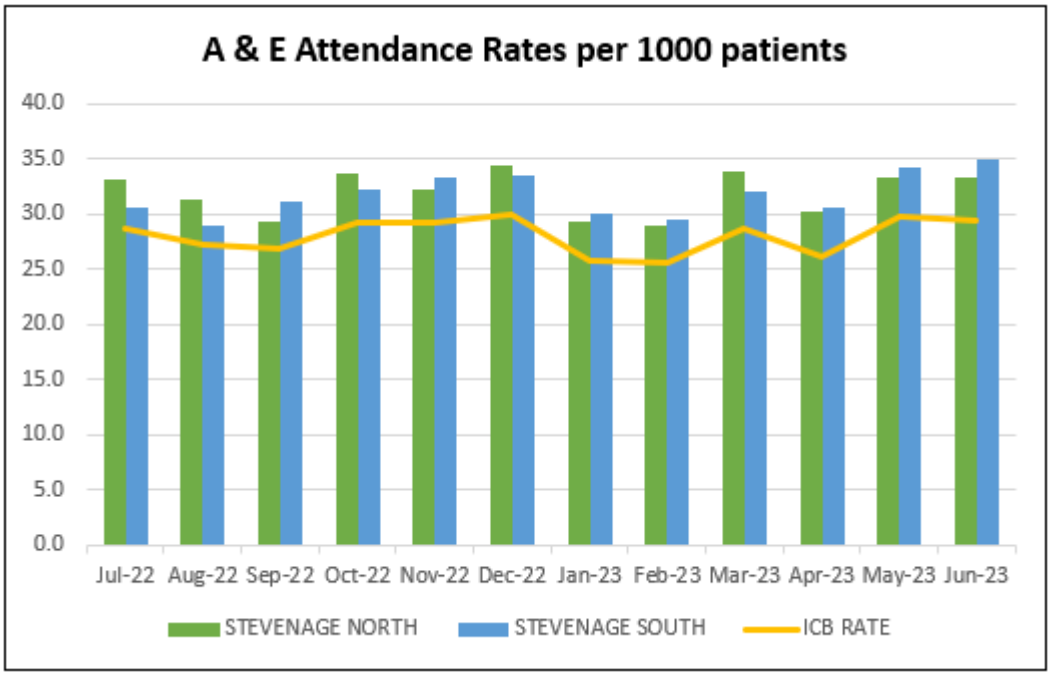
Introduction

As outlined in the approved primary care strategic delivery plan and urgent care strategy, Stevenage is one of the areas of priority with Harlow and Hertsmere. To support the direction of same day access and have an impact on primary urgent care the 2 PCNs have proposed same day access hub outlined in Appendix 1. This not only provides care in patients' neighbourhoods (care closer to home) but also allows more appropriate use of secondary care capacity.

The proposals also support the recommendations and commitments in the current Herts & West Essex Integrated Care System, Urgent and Emergency Care '*draft'* 5 year Strategy document which outlines*; a greater resilience of integrated urgent care system by scale-up of PCN-level same day access hubs. The hubs will match population need and have integrated pathways with other services (NHS 111, ED, SDEC, UTC, and virtual wards) to support referrals, diagnostics, treatment, and monitoring. There would be flex to support seasonal demand for example acute respiratory illness.*

The PCNs are already working collaboratively with system partners ENHT and HCT to help to reduce inappropriate ED attendances by providing extra same day appointments, and collectively strive to reduce system pressures.

The Stevenage practices' registered population (approximately 115,000 and growing[1]) are particularly high users of their local A&E services.



The graph shows the rate per 1000 attendances is consistently 10-15% higher than the ICB overall rate

Background

Stevenage North PCN have already started to implement their plans to increase same day access services at their own financial risk.

The PCN were approached in December 2022 to urgently stand up a 3-month pilot Acute Respiratory Hub in response to the sudden increase in demand for same day appointments at that time, during the Strep A outbreak, this helped relieve pressure on acute services. The PCN were asked to make their appointments available to 111 via direct booking into their clinical system and ED were also able to call a designated phone line to refer patients in. The service was stood up in a matter of days and was well-utilised. The service ran from mid-December '22 to the end of March '23 and provided approximately 330 GP locum hours, offering nearly 1,350 same day appointments.

The service utilisation rate averaged around 86% but was a slow start due to IT issues and fairly limited referral criteria. Once the systems were fully configured and the scope widened, utilisation reached 98%. This was taken up by local practices in the main who accounted for approximately 80% of the bookings, 111 booked approximately 18% and ED just under 2%.

In December/January, last Winter, there was also the opportunity to submit GP Transformation Plans (formerly known as PCN Development Plans) to utilise pre-agreed funding to support Primary Care Transformation priorities. All PCNs were

invited to pick from a list of priorities; Urgent on-the-day access ,INT development, Patient Engagement/PPG development and a move to shared PCN services/back office functions. The PCN opted for Urgent on-the-day access and PPG development and. The funding was to be used to plan, develop and implement the same day access service, working with key stakeholders to assess processes, capacity and demand. This plan did not request support for the clinical workforce in the hub but (as per the aforementioned T & R bid) did cover some backfill of staff involved in the scoping of the project.

Stevenage South PCN produced a business case for their proposed Same Day Access Hub which was originally going to be submitted as a bid for Transformation & Resilience funding; unfortunately the funding stream came to a close (as it was an East & North Herts CCG-specific fund) before they had the opportunity.

With Same Day Access featuring in the Primary Care Strategy, Stevenage South PCN saw another opportunity to put forward their business case for their hub as they felt the need for this type of transformational work was being more widely recognised.

The PCN were approached last December to urgently stand up a 2-week pilot respiratory hub in response to the sudden increase in demand for same day appointments during the Step A outbreak to relieve pressure on acute services who had suffered a huge influx of call/attendances. The PCN were asked to make their appointments available to 111 via direct booking into their clinical system and also the ED who were able to call a designated phone line to refer patients in. The service was stood up in a matter of days and was well-utilised. There was scope to continue to run the hub January-March but due to lack of confirmation regarding funding into the new year, they were unable to retain staff. This proposal seeks to build on the success of that tried and tested pilot.

It is noted that Stevenage North and South were the only two PCN's who bid for same day access hubs from the original proposed funding. Over the last few months, the Stevenage access hub has been discussed at numerous ICB & partner wide meetings in varying context to support winter pressures across the system.

STEVENAGE NORTH PCN

Key Information

The PCN practices' population is approximately 56,370 patients across two practices – Stanmore Medical Group (recently merged with Chells Surgery) and Symonds Green Health Centre.

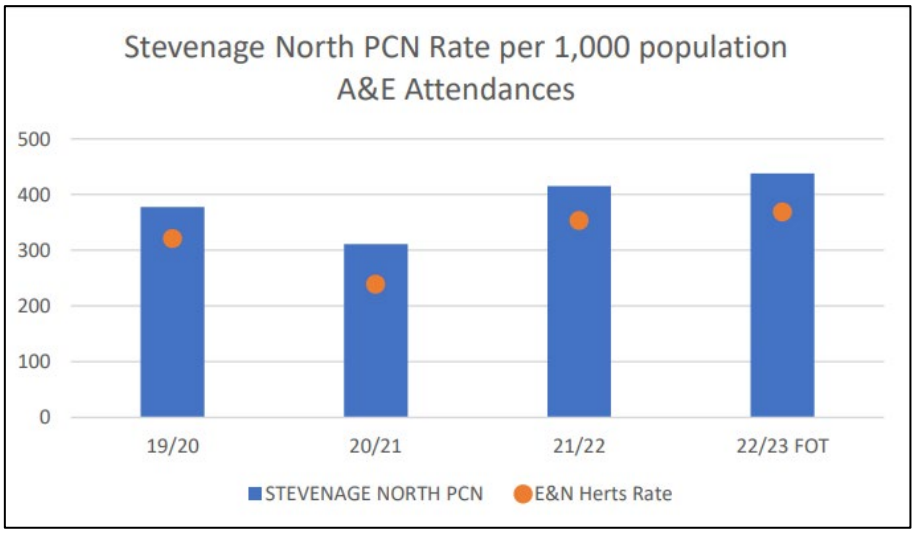
A large proportion of their patients live within a 2 mile radius of Lister Hospital which can be reached by car in 5-10 minutes and on foot in under half an hour.

Approximately 50% of the Stevenage population live within the 5 most deprived deciles for deprivation.

Rationale

The PCN is aware of the increased demand for unplanned care and of the higher-than-average volume of patients attending Urgent & Emergency Care.

Rates of A&E attendances across the ICB have returned to pre-covid levels and above, and the overall attendance rate per 1,000 population in Stevenage North is consistently higher than the place rate and increasing.



The demand for general practice appointments continues to increase. A recent example given showed 20,884 patient contacts at Stevenage North member practices from the period 2nd July to 2nd August 2023 and it was estimated that almost 50% of these contacts required a same day service. These numbers will almost certainly increase over winter. Meeting this demand puts extreme pressure on other primary care services and risks a reduction in efforts towards preventive medicine and management of long-term conditions which has already been compromised during/post-pandemic.

The PCN has decided to split the same day access service from the more proactive care, implementing clearly defined clinics/workforce to cater for the needs of their acute/chronic patients in a structured way.

Proposed model

A 13-week service providing same day appointments to the Stevenage North population.

Timeframe: Initially 3 months (July-September)

Operating Hours: Monday - Friday 9:00-5:00pm

Location: St.Nicholas Health Centre, Stevenage.

Provision: Additional 910 appointments per week (approximately a 20% increase in same day appointments). This will be a mix of Face-to-face and remote (telephone/video) consultation.

Staff/skill mix: GP, AHP and ECP in the main, alongside a smaller Paediatric Nurse, MH Support Worker and Physio offer.

There will be 36 appointments per day bookable by 111 Call handlers via their in-house system (Adastra) which has been configured to link with the PCN's SystmOne unit. There will be 10 appointments available for A&E redirects which can be booked over the phone via a designated mobile phone line. This will be reviewed over the 13-week period.

Capacity wise winter funding monies will also support the following:

Winter monies £1.43								
PCN	Weighted List Size	ICB additional Capacity Budget	Total number of appts	Appt/week	Delivery Model	Planned Workforce	Phasing	Any other useful comments
STEVENAGE NORTH	51,298.62	£73,357.03	1456	56	Practice and hub	GP Main, ANP,HCA,GP Current workforce, GP Locum	Oct - March, including xmas period as requested	Both practice and Hub model; additional capacity to provided through locums for each practice. Deliver unplanned care as a hub for all practices in the PCN. We are looking to purchase additional remote capacity through Medloop.

Mobilisation

The need for this service has already been quantified by the practice and mindful of their patients' best interests, they have already started the phase-in process and have self-funded Medloop. They did not wish to delay roll-out whilst they await confirmation of funding from the ICB.

Workforce

Recruitment is underway for new clinical staff to provide extra capacity for the hub and is in its final stages. There has also been opportunity for existing clinicians to increase their hours by extending shifts to offer more support during busier times or forgoing their non-working days. Medloop have also been commissioned to provide extra remote appointments to the service for those patients who do not require face-to-face consultations. This will allow them to offer up to 300 appointments per week without impacting on the limited estate available nor the existing workforce.

The service will provide a wide skill mix including GPs, ANPs, ECPs, MH Support Works, Paediatric Nurses and Physiotherapists.

Discussions have taken place with regards to Paediatric Nursing Support into the Stevenage North hub with E&NH Trust. This would support demand during periods of winter pressure & help to deflect referrals into paeds ED. One full or half day session was discussed. The Trust are looking into the request. The HCT community respiratory team are another source who could be approached for support and this will be investigated.

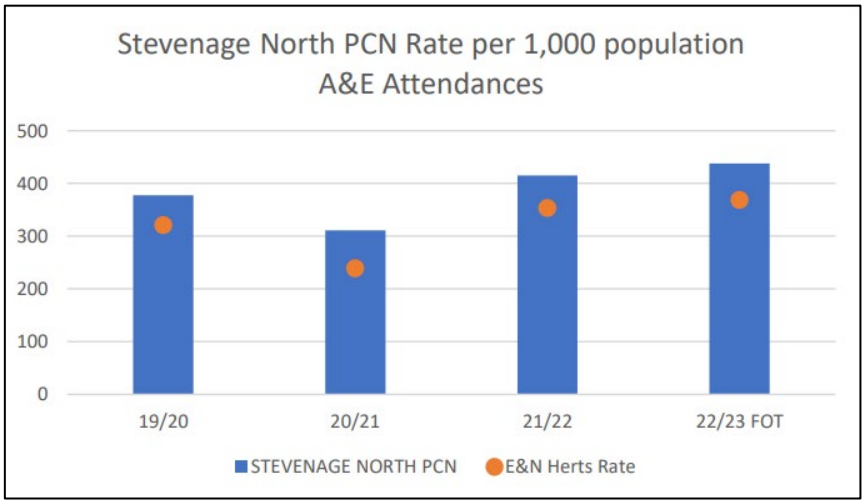
Patient Engagement

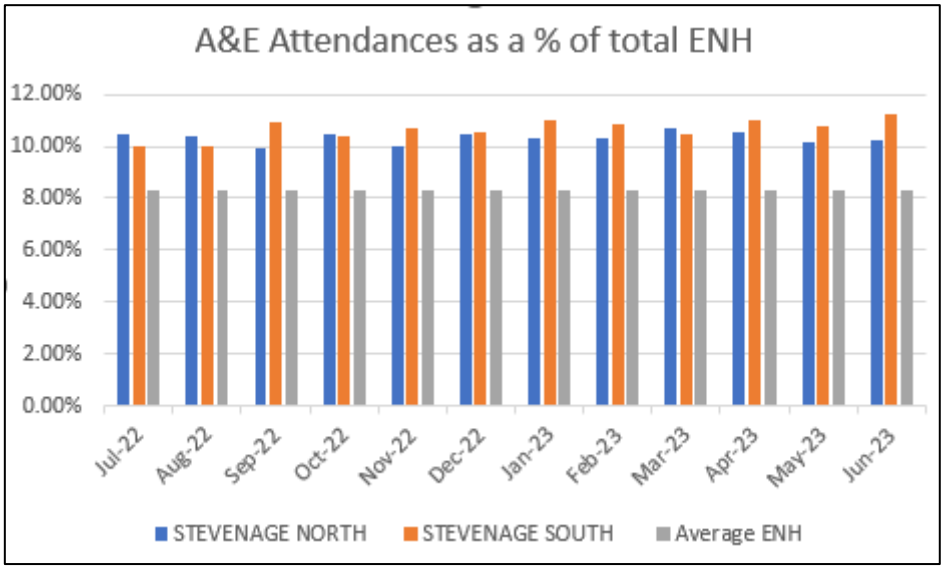
The PPG have been consulted with during the planning and pre-roll-out of the service and are extremely supportive of the pilot. An SMS campaign will be launched to inform patients of the service and information will be added to the practice websites.

Measurables

A&E

Stevenage North patients have shown a consistently higher than average A&E attendance rate. The PCN strives to make a positive influence on this consistent trend and will work with the ICB Primary Care, BI and PHM colleague to best drill down into and understand the data, measuring the impact going forward.





Looking at the pattern over the year, it's fairly steady and Stevenage attendances are consistently 25-30% higher in number than the ENH average in terms of % of all ENH attendances.

Working with the ICB, supported by the BI team the PCN will obtain and monitor A&E data, hoping to see a decline in the number of attendances, particularly those resulting in no significant treatment nor investigation (coded as VB11Z), attending in-hours. They hope to capture this initially as backdated data, i.e. the full financial year prior to launch, as a baseline, then throughout t the project, and afterwards, for comparison.

They will also be looking at inappropriate attendances which they have attempted to avoid in part through better patient education. They will provide ongoing expert signposting via Care Coordinators, with a view to reducing these numbers further whilst empowering patients on the way.

OPEL

The OPEL position will also be monitored to see if escalation levels are reduced for Primary Care. The PCN will work with practices to ensure regular reporting throughout the pilot (and beyond). The team are aware of the daily pressures on the Acute Trust from the system level SHREWD data. They hope they can support Lister ED effectively, particularly when they are under increased pressure.

111

The PCN will offer their appointments to the 111 service as they have done in previous projects, monitoring the uptake of appointments, and engaging with the 111 team if they don't see them taking advantage of the slots made available to them. They will record usage of the slots by 111 and will share with the ICB. They now understand that the ICB could share data on number of calls received by their patients to identify level of improvement which they would welcome as a key measurable.

Patient Satisfaction Surveys

Surveys will be sent to every patient visiting the hub via SMS and monitored regularly. They will also conduct surveys which include questions about access (in line with the national patient survey) so they will be able to assess the impact on this too. The plan is to also ask carers as part of this survey for their feedback.

Vulnerable patients are well supported and will have equal access to the hub. There is close partner working with HPFT and HCC to support hard to reach or patients from these cohorts who do not engage with annual health checks. Care coordinators act as first port of call for LD and SMI patients and support them to be seen in whatever setting is best for them.

Utilisation

The PCN are recording hub utilisation data extracted from their clinical system with some steer from the ICB and will share it with the PC team to show impact of the service on their patient population and demonstrate value-for-money.

Stevenage North SDA Hub July Data	Available Slots	CONSULTATION WITH:							Total DNA	Unused Slots
		GP	Trainee GP	ANP	ECP	MH	Physio	Medloop		
Total appointments	4629	762	21	272	1358	42	709	1290	106	69
Utilisation Rate	98.5%									
DNA %	2.3%									

This shows the first month's appointments were very well-utilised at over 98% with a low DNA rate of 2.3%.

Working with BI and the PHM team they will utilise this and other information resources and will drill down into the data to assess utilisation of services across various demographics to ensure the service is far-reaching into all communities considering health inequalities and areas of deprivation.

The are going to ask receptionists to consider the number of patients they turn away and involve them in discussions around general patient satisfaction & feedback of their experience in being able to secure appointments for patients alongside the data.

The PCN is going to monitor number of patients seen for LTC management to assess the positive impact on more proactive care once the unplanned care is separated.

Long Term Plan

The PCN consider this a pilot, and, if it proves a success, will self-fund after the ICB commissioned period comes to an end. If there is any national/local direction over the winter period for same day access/respiratory hubs, they will have a tried & tested, staffed model which can be morphed into the desired service. If there is further funding available for same, as an experienced provider they will be able to make good use of it, offering value-for-money and providing a lower risk solution.

The intention is to work as a locality with Stevenage South PCN in the long term, once they have considered the uptake and outcomes of this service.

Assurance

This model will be delivered without detriment to currently provided services. The aim is to allow other services to thrive alongside daily demand without the urgent on the day demand monopolising resources.

Finance

Reception	£ 14,300.00
Admin/Training	£4,550.00
GP Consultant x 10 sessions	£47,775.00
ANP 10 sessions	£17,958.85
Paramedic x 10 sessions	£19,041.75

HCT Paediatric Nurses x 20 sessions	£29,393.00
HWBC	£5,592.61
Physiotherapist x 5 sessions	£9,519.75
Mental Health support worker X 5 session	£7,348.25
TOTAL	£155,479.21
SMG FUNDING	£ 61,975.08
ADDITIONAL FUNDING REQUIRED management and clinical governance role	£ 93,504.13 excludes

GP Transformation: **£24,521**

Transformation & Resilience (T&R) Fund: **£93,504.13**

(plus PCN contribution of **£61,975**)

Total £118,025.13

STEVENAGE SOUTH PCN

Key Information

The PCN practices' population is approximately 58,480 patients across four practices – Bedwell Medical Centre, King George Surgery, Knebworth and Marymead Medical Practice and Shephall Health Centre.

A large proportion of their patients live within a 3 mile radius of Lister Hospital which can be reached by car within 10 minutes but on foot it could be up to an hour. It is very well connected by regular bus services so seems an attractive choice for some patients struggling to receive same day access to care.

Over 50% of the Stevenage population live within the 5 most deprived deciles for deprivation.

Rationale

Stevenage South PCN has seen an increase in demand for unplanned care and has been looking at data and developing a plan of action since last Autumn. The are aware of the higher-than-average volume of patients attending Urgent & Emergency Care

and have seen an increase in attendance over the last couple of years. As part of this plan, the PCN are going to provide training and fully embed an access active signposting approach across all practices within the PCN which will ensure appropriate use of the Same Day Access services. Rather than a one-off training session, they aim to develop new processes and protocols to support a step change in the use of care navigation. This will be supported on an ongoing basis with follow up sessions as well as cross practice learning across the PCN. They believe that providing active signposting support, mentoring and development for reception and admin teams will help maximise access and the utilisation of wider support and healthcare services that are available to patients.

Proposed model

A 12-month service with increasing capacity over the year.

First Stage: Timeframe: Initial 3 months (Proposed July-September ’23)

Operating Hours: Monday - Friday 1:30-5:30pm

Location: Roebuck Surgery, Stevenage

Provision: Additional 140 appointments per week

Staff/skill mix: GP and ECP

Second Stage: Timeframe: Months 4-6

Operating Hours: Monday - Friday 1:30-5:30pm

Location: Roebuck Surgery, Stevenage

Provision: Additional 220 appointments per week

Staff/skill mix: GP, ECP & ANP

Third Stage: Timeframe: After 6 months

Operating Hours: Monday - Friday 1:30-5:30pm

Location: Roebuck Surgery, Stevenage

Provision: Additional 140 appointments per week

Staff/skill mix: Review usage and progress and decide on further staffing as appropriate.

The above is a changeable plan based on the needs of the service and other potential priority areas that may arise which the hub structure can support. (e.g. For strep A, Covid surge, new infection, increased demand in acutes etc.)

Capacity wise winter funding monies will also support the following:

Winter monies £1.43								
PCN	Weighted List Size	ICB additional Capacity Budget	Total number of appts	Appt/week	Delivery Model	Planned Workforce	Phasing	Any other useful comments
STEVENAGE SOUTH	55,408.65	£79,234.37	2275	87.5	Hub	GP Main, ANP,HCA,GP Current workforce, GP Locum	Oct - March, including xmas period as requested	PCN Hub based model supporting on the day demand. Practices reporting OPEL 3/4 = additional support where required. IA support provided via separate ICB locality funding, providing additional appointments via hub model (separate to Winter pressures Hub). All appointments held on hub and accessible to all PCN practices.

Mobilisation

The PCN have already stood up their hub as they did not want to lose momentum and were keen to make an impact. They started on 3rd July with the initial phase.

Workforce

The workforce will be a mix of GP and ARRS roles and capacity of each role will increase/flex as time goes on as previously mentioned. The plan as it stands:

First Stage: Staff/skill mix: GP and ECP

Second Stage: Staff/skill mix: GP, ECP & ANP

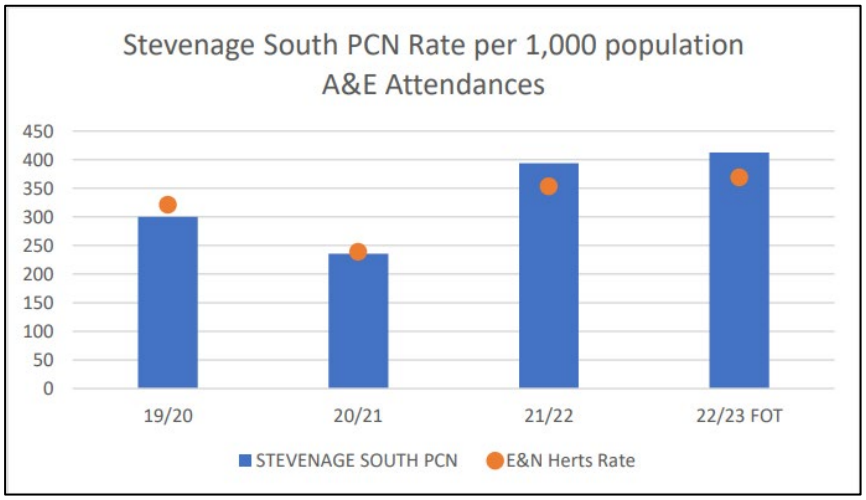
Third Stage: Staff/skill mix: Review usage and progress and decide on further staffing as appropriate.

The PCN have a flexible GP bank staff that prefer shift working and satisfaction will be measured with survey & supportive focus groups.

Patient Engagement

The PCN PPG have been consulted as part of the regular meetings and they are fully supportive of the proposal and approach.

Measurables



A&E

Rates of A&E attendances across the ICB have returned to pre covid levels and above and the overall attendance rate per 1,000 population in Stevenage South has been increasing above the ENH average.

The PCN will work with the ICB who will be supported by the BI team to obtain and monitor A&E data going forward hoping to see a slow in growth of number of attendances. They want to capture this data as a baseline (looking at historical data if required), then at monthly points during the pilot and afterwards for comparison. They have discussed with the ICB how they can obtain data on ED wait times and 4 hour & 12 hour targets for ENH as they have not seen this data previously.

They will also be looking at inappropriate attendances and, if an issue is identified, will consider some further patient education into use of services.

The ICB are working with the PCN and BI team to gather data on the practices missed opportunities, looking at those patients attending A&E who require no treatment nor investigation who could have potentially been managed in practice.

OPEL

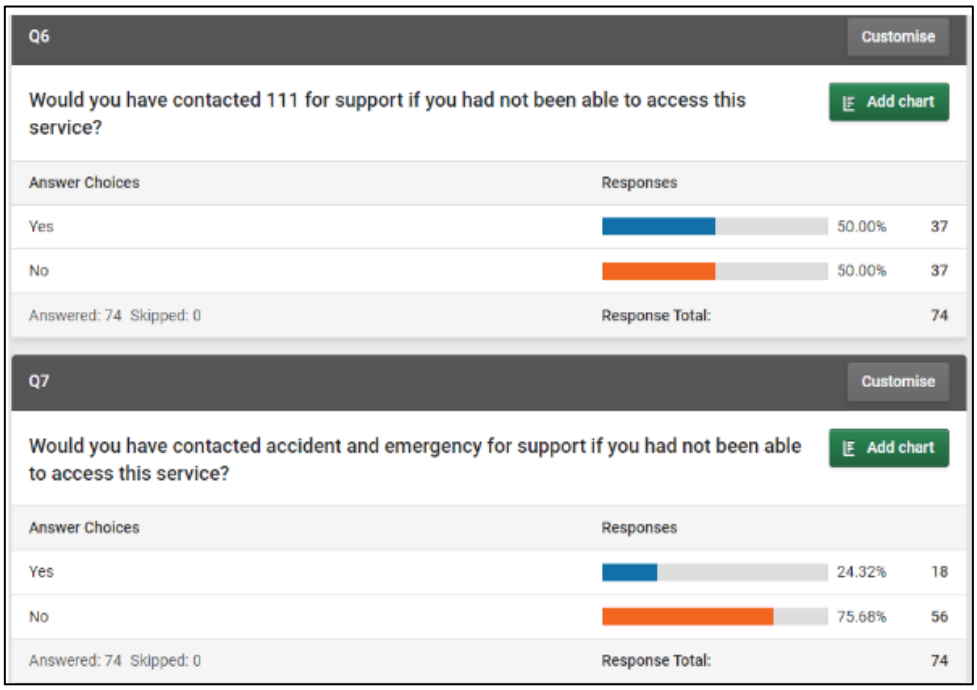
They hope to see improved OPEL position for Primary Care and will work with practices to ensure regular reporting throughout the pilot (and beyond). They will strive to have more awareness of OPEL status in Secondary care and will seek avenues to better communicate with the trusts to ensure that their services are signposted and indeed referred into. They will offer mutual aid to ENHT in the form of directly bookable appointments when the scale of pressure is high

111

The PCN will offer their appointments to the 111 service and have set up their clinics to allow call handlers to book directly into their slots – they will monitor usage of these slots by 111 and have discussed with the ICB how they can obtain UEC data on number of calls received by their patients to identify level of improvement.

Patient Satisfaction Surveys

Surveys are being sent to every patient visiting the hub via SMS and paper copies will be available also. They have sent 5-600 surveys in the last 6 weeks already. Following discussions with the ICB, they have now included questions about whether the patient would have called 111/ visited A&E if they had not been given the appointment in the hub to attempt to gauge the reduced impact on these acute services and have shared the responses to date:



The plan is to also ask carer's as part of this survey for their feedback.

Vulnerable patients are well supported and will have equal access to the hub. There is close partner working with HPFT and HCC to support hard to reach or patients from these cohorts who do not engage with annual health checks. Care coordinators act as first port of call for LD and SMI patients and support them to be seen in whatever setting is best for them.

Utilisation

The PCN are recording utilisation data and will share it with the ICB to show impact of the service on their patient population and demonstrate value-for-money. This shows the first month's appointments were well-utilised at nearly 88% with a low DNA rate of <5%.

Stevenage South SDA Hub July Data	Available Slots	PATIENTS SEEN BY:				Total DNA	Unused Slots
		GP	ANP	ECP	ALL		
Total appointments	632	262	54	238	554	31	47
Utilisation Rate	87.65%						
DNA %	4.91%						

There are collective plans to drill down into the data to assess utilisation of services by different age groups and ethnicities to identify health inequalities. There was concern about South patients in the more deprived areas being at a disadvantage if the service was shared with North patients so uptake in the various wards will be monitored and considered when working on a plan to join forces with North at a later date.

Long Term Plan

They appreciate that the money to fund the proposal is non-recurrent at this stage but hope to maintain the service after commissioning timeframe lapses.

The main cost of the hub is to fund the GP, other roles can be funded via the existing and recurrent ARRS budget. They are also in the process of becoming a PCN Learning Organisation so will have the potential to support new GP trainees through this approach. Ongoing costs (mainly GP, but some venue and consumables also) would be brought to the PCN board for consideration for ongoing funding.

Assurance

This model will be delivered without any detriment to current services provided. The service will be in addition to current practice appointments offered to patients.

Finance

Item	Rate	Weekly Cost	1 Month	6 Month	12 Month
GP	105p/h	£2,100	£9,100	£54,600	£109,200
ANP	55 p/h	£963	£4,170	£25,025	£50,050
Reception	£16p/h	£320	£1,387	£8,320	£16,640
Venue Cost	£10p/rp/h	£120	£520	£3,120	£6,240
GP Oversight/Management Costs	100p/h				£1,200
Total		**£3,503**	**£15,177**	**£91,065**	**£183,330**

Business Case: **£109,200** (plus PCN Contribution of **£74,130**)

Implementation of Total Triage model in Stevenage South PCN

Knebworth & Marymead implemented their total triage system from September 2023. The acute hub would be one of the options for the triage team to refer/book patients into directly.

The wider PCN are now engaging in discussions to support how this could potentially be rolled out across the remaining practices within the PCN and Knebworth & Marymead, as the first implementer, providing valuable assistance. The primary care place team will support the PCN as required with the relevant meetings and timelines for this PCN wide implementation.

Access recovery plan

In addition both hub models will help support the following areas of the access recovery plan:

- A review of the GPPS 5 year trend data action and priorities from across both PCN's identified some challenges in recent years regarding access and patient satisfaction which has been driven by the Covid-19 pandemic and sheer demand for healthcare services. Additional appointments offered by the hubs will support the improvement to access and help to improve patient satisfaction scores.
- As part of the GP transformation and QI modules the shared learning and best practice from the hubs can be cascaded to other PCNs within the ICB to provide support and share learning.
- Working with system partners to improve same day access – As already outlined in this proposal the hubs will also support other local providers and system partners such as HCT, 111, secondary care and A&E by providing more 'in house' appointments for patients who may previously have needed to utilize these services on a 'same day' basis.

Recommendations

Based on the information contained within this paper it is recommended that;

1. Stevenage North PCN are awarded £93,504 for their same day access hub.
2. Stevenage South PCN are awarded £109,200.00 for their same day access hub.
3. The primary care place team continue to work with both PCN's to evaluate outcomes from the hubs and support improvements.
4. The PCNs evaluate and consider next steps to working these hubs, once fully established, in a locality model serving the whole population of Stevenage and integrating with the proposed UTC at ENHT working in partnership across ENHHCP.

It is acknowledged that both PCN's have already implemented their hub models.

Both PCN's see this as an opportunity to try and test their individual proposals with a long-term plan of working as a locality once service outcomes have been evaluated or earlier if successful and winter pressures dictate.

There is a clear commitment from Stevenage North PCN that they would continue to self-fund if the pilot is a success. They would of course bid if further national monies become available.

Stevenage South PCN are aware of the non-recurrent status of the money and would hope to maintain the service after the initial funding expires. The proposal states a commitment of 12 months service provision.

Next steps

Provide confirmation of the support for both proposals to the respective PCN's and transfer of transformation funds to the PCNs.

There is a further opportunity to link the work within the hubs with the East and North Herts NHS Trust UEC Strategy, which is currently an active ongoing discussion, more recently at the Virtual Transformation Team meeting of the ENH Health and Care Partnership.

Integrate community pharmacy into the UEC system so that low acuity conditions can be redirected to pharmacies for management. Patients will be supported in self-management of minor ailments through implementation of the Pharmacy First scheme and optimised use of the Community Pharmacist Consultation Service (CPCS) across the UEC system.

There has been great engagement with the E&NH Trust Medical Director and PCN clinical leads as to how collaborative working is vital with measurable parameters and outcomes as to how the hubs can support acute care.

The primary care place team will continue to work with both PCN's to evaluate outcomes from the hubs and support improvements.

The PCNs evaluate and consider next steps to working these hubs, once fully established, in a locality model serving the whole population of Stevenage.

A regular update on the same day access hubs will be provided as assurance to both ICB Primary Care Board and the ICB Transformation group

Appendix 1

Stevenage South PCN
Acute Care Hub Busin

Stevenage North
PCN - TR Fund - Same

Appendix:2

Stevenage North & South PCNs - Same Day Access Hubs - Key Measurables

	Pre-launch (Baseline)	Midway	End	Comments
ENHT				
Total ED Attendances (For SS/SN PCN Patients)	Obtain '22-23 data	Record/Review Data Monthly	Compare data at end of pilot.	Obtain monthly data from previous full year(s) for comparison to assess true impact of Sameday Access service whilst considering previous seasonal fluctuation.
ED Attendances (per 1000 patients)	Obtain '22-23 data	Record/Review Data Monthly	Compare data at end of pilot.	
Inappropriate ED Attendances	Obtain '22-23 data	Record/Review Data Monthly	Compare data at end of pilot.	
ED Wait Times (4 Hour Target)	Obtain '22-23 data	Record/Review Data Monthly	Compare data at end of pilot.	
ED Wait Times (12 Hour Target)	Obtain '22-23 data	Record/Review Data Monthly	Compare data at end of pilot.	
111				
Call Volume (Total)	Obtain '22-23 data	Record/Review Data Monthly	Compare data at end of pilot.	Obtain data from previous year(s) for comparison to assess true impact of Sameday Access service whilst considering previous seasonal fluctuation. May not be worth looking at 20/21 due to impact of COVID.
Call Volume (SN/SS PCN patients only)	Obtain '22-23 data	Record/Review Data Monthly	Compare data at end of pilot.	
Patients booked directly into GP appointment	Obtain '22-23 data	Record/Review Data Monthly	Compare data at end of pilot.	
OPEL				
Practice Status	Consider Opel Status Reporting (particularly for Demand) for year leading up to launch.	Will encourage daily reporting by practices.	Assess OPEL trends at end of pilot	Consider Opel Status Reporting (particularly for Demand) for month leading up to launch.
ENHT Status	Consider Opel Status Reporting (particularly for Demand) for year leading up to launch.	Will also look at trust reporting every week during pilot.	Assess OPEL trends at end of pilot	If the notice Increased scale of pressure for ENHT will ensure the hub is well advertised to them.
PCN Data				
No. of Appointments (SameDay)	Gather data from practices re no of slots to obtain baseline.	Record Data Week on week.	Collate all data and compare to baseline	Check age ranges, deprivation decile and ethnic origin of those attending service. Highlight hard-to-reach groups and target for future patient engagement.
No. of Appointments (Proactive Care/LTC Management etc)	Gather data from practices re no of slots to obtain baseline.	Record Data Week on week.	Collate all data and compare to baseline	
Demographics of Service Users	Look at historic data over last year to see true picture of service utilisation.	Assess monthly	Compare findings at end of pilot.	
Patient Satisfaction				
National Survey	View last surveys data published in July '23.	Run survey at midway point in pilot using same key questions from national survey.	Run again at the end.	Also compare with next National Survey.
Friends & Family	View previous year's data	Continuous gathering of data	Collate at the end and compare to before and after.	
Satisfaction Survey (Post hub appointment)	N/A	Continuous gathering of data	Collate at end and compare to other internal satisfaction surveys.	Daily invitations to participate in survey - patients sent SMS after appointment.

The majority of the above measurables are already available through existing reporting formats & we will work jointly with colleagues in ENH Trust to provide these.

The Primary Care Support Manager at ENH place will be responsible for monthly update reports and pilot summary report.

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 Transformation Committee meeting held in Public		**Meeting Date:**	**28/11/2024**
Report Title:	**Primary Care Transformation– Directorate Report**		**Agenda Item:**	**08**
Report Author(s):	Updates incorporated from various leads across Primary Care Avni Shah, Director Primary Care Transformation			
Report Presented by:	Avni Shah, Director Primary Care Transformation			
Report Signed off by:	Avni Shah, Director Primary Care Transformation			

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

Which Strategic Objectives are relevant to this report	• 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
Key questions for the ICB Board / Committee:	Committee is given a progress update on a range of areas not including updates on: a. Additional Capacity across Primary Care Networks for 24/25 winter and vaccinations b. Primary Care workforce in particular the recent primary care awards; work with the University of Hertfordshire on the medical school and new to practice programme c. Launch of the Digital Skills Support web page as one of the key areas of digital inclusion d. Progress on Community pharmacy projects – including Pharmacy First, Hypertension and Pathfinder programme e. Place updates f. Progress update on Hypertension pilot with dental and optometrists
Report History:	N/A
Executive Summary:	Highlight Report provides a brief overview on the progress since last Primary Care Board meeting with a view of not duplicating areas of

<table>
<tr><td></td><td colspan="4">discussion on the agenda and to give a flavour of the forward look of some of the key areas of focus.</td></tr>
<tr><td>Recommendations:</td><td colspan="4">The Board is asked to
Note and discuss the key 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"></td></tr>
<tr><td colspan="5">Implications / Impact:</td></tr>
<tr><td>Patient Safety:</td><td colspan="4">Areas of progress which will impact on improving patient outcomes and patient safety.</td></tr>
<tr><td>Risk: Link to Risk Register</td><td colspan="4">No new risks identified through this report which are not already on the directorate risk register</td></tr>
<tr><td>Financial Implications:</td><td colspan="4">Not applicable</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>

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Primary Care Transformation– Directorate Report November 2024

Avni Shah, Director of Primary Care Transformation

Contribution from a number of leads across the directorate

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Update on Additional Capacity over winter

Phillip Sweeney, Head of Primary Care Transformation

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The approach 24/25

PCN plans need to demonstrate the approach of working differently, (including with system partners) and how outcomes can be measured

Priority 1: Prevention, frail population, those living with multiple long-term conditions or at end of life.
A focus on disease groups by supporting people to manage their complexities and long-term conditions and reduce acute admissions. This includes patients in care home settings, those with severe frailty, multiple long-term conditions and those reaching end of life. (some example could be additional ward rounds, <48 hour follow up post frailty discharges, flu/covid/RSV vaccines of which up to 50% of EA capacity can be utilised for these)

Flavour or returns include;

- Using Enhanced Access minutes on Saturdays to proactively support care homes to prevent admissions.
- Focus on isolated elderly, a winter proactive care visiting programme with a winter checklist of preventative care.
- 48 hours post discharge reviews of patients.
- Support our care home, house bound and those who are severely frail patients with access to Virtual Ward to reduce readmission.

The approach 24/25

Priority 2: Community Urgent/Same Day Access
Improve access to urgent same day access care appointments. (an example of creating capacity as a PCN hub, or integrating with the local MIU/UTC)

Flavour of returns include;

- Extra care home round per week for each of the care homes to improve confidence with more frequent medical input, aiming to reduce unnecessary ambulance calls.
- Targeting patient cohorts ie, children and frailty groups.
- Increase the amount of same day appointments available for patients.
- Proactive use and promotion of the CCC and utilising community capacity.
- Patient Services capacity as appropriate to minimise peaks in phone or eConsult demand.
- Social prescribers will provide additional support to vulnerable and lonely patients.

Impact/metrics

The following metrics are being used this year to measure the impact of PCN plans against, not just, practice improvements but what impact this has across the system.

Baseline/metrics
Non-elective admissions
A&E attendances
In hour A&E attendances
Same day access appointments
Re-admissions rates within 30 days
In hour 111 calls
Pharmacy 1st referrals
CCC referrals
Patient feedback / surveys

Ongoing support/review

- Confirm start dates with each PCN
- Share plans with Care Closer to Home clinical lead and clinical locality leads
- Share plans at INT meetings to increase awareness of schemes, joint working across the system and impact as part of wider INT plans
- Support PCNs with ongoing review of impact, monthly over winter e.g. via data sets/INT data packs etc so it can feed into wider
- Discuss and support at monthly CD 121s
- Share at INT programme group and any other relevant HCP meetings
- Share with others as appropriate

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Update Vaccination Programme

Penny Thomas, Senior Transformation Manager

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Vaccination Update

- COVID and flu programme commenced 3rd October. Onboarded 150 pharmacies and 32 PCNs for covid-19 in AW24 - good geographical coverage including across our areas of deprivation in Watford, Stevenage, Harlow, Hemel and Borehamwood.
- FLU - this year's uptake lags the past 3 years due to the one month delayed start for the adult programme however good progress made week on week.
- COVID – provisional data available. Uptake so far has matched uptake at the same point last winter, noting that unpaid carers and household contacts of the immunosuppressed are excluded this year.
- To date, 64% (136 out of 214) care homes in HWE have had a COVID vaccination visit.
- This year new vaccine introduced – RSV vaccine.

Eligible cohorts – **adults reaching their 75th birthday** (remain eligible until they turn 80) with catch up programme this year for those aged 75-79 and **pregnant women** (more than 28 weeks pregnant)

Current delivery model is via GP practices, CSAIS and maternity services. Pathfinder work currently being undertaken to roll out across community pharmacies in due course.

Outreach work

- Hertfordshire Community Trust are running children's vaccination clinics at weekends – from 26th October and are also working jointly with system partners to encourage all vaccination uptake among Gypsy Roma Travellers and homeless. The 'Off the grid' team also do drop ins to vaccinate at food banks, festivals and other events organised in deprived areas by system partners.
- Designated call and recall service launched in April 24 to contact parents of children who are missing either dose of MMR vaccine. Service is run by HCT and currently funded up to March 25.

Vaccination Update

- Practices with babies having had delayed first immunisations are being targeted to improve adherence to vaccination schedule.
- 'Ready for Reception' campaign – aimed at parents of children starting school reminding of vaccinations and other public health messaging. Supported by HCC.
- 'Be prepared' social media campaign to be launched across HWE and MSE – including vaccinations information. Revised webpages aimed at pregnant women and featuring photos and case studies from local women who are advocates for vaccinations.
- Website updated with information about flu and COVID-19 divided by district council area. Rolling programme of social media posts on Facebook, X and 'NextDoor' using national messaging on RSV, pertussis, flu and COVID.
- LTC postcards (heart, liver, lung and diabetes) mailed out to consultant teams to help initiate conversations with patients about why vaccines are important.
- Video produced with leading local midwife to encourage pregnant women to take up the vaccinations they are entitled to. Sharing on social media and through Maternity Voices Partnerships.
- Project to increase uptake of COVID vaccination in immunosuppressed – report drafted by HCC team and on agenda for discussion

- Planning for spring 25 programme for COVID has already started

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Update on Primary Care Workforce

Joyce Sweeney, Head of Primary Care Workforce

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HWE Primary Care Awards

- The HWE Celebrating Primary Care Achievement awards will take place on Wednesday 6 November 2024, at 7pm, via teams. It is a celebration of all the amazing work being done in primary care to improve both staff health and wellbeing and patient care.

- A total of 65 nominations have been received, across 10 categories and the top 3 were shortlisted for each category.

- The quality of entries received has been fantastically high and the judges had a very tough challenge when it came to the scoring. The nominations have been really inspiring and the fact that the second highest number were received in the category of '*Excellence in Innovation and Transformation*' really demonstrates the way in which primary care are exploring opportunities to collaborate with system partners and deliver care in new ways that better meet the needs of our population, within the available resources and constraints that we face.

Award Title	Nominee	Winner / Runner Up
Excellence in Supporting Staff Health and Wellbeing	Sheetal Shah	Runner Up
Excellence in Supporting Staff Health and Wellbeing	Midway Movers @ Midway Surgery	Runner Up
Excellence in Supporting Staff Health and Wellbeing	**Stockwell Lodge Medical Centre Management Team**	**Winner**
Excellence in Training and Development	Elizabeth Steer	Runner Up
Excellence in Training and Development	**Attenborough Surgery**	**Winner**
Excellence in Patient Engagement	Hoddesdon & Broxbourne PCN Social Prescribing Link Workers	Runner Up
Excellence in Patient Engagement	Attenborough PCN	Runner Up
Excellence in Patient Engagement	**Stevenage South PCN Patient Participation Group**	**Winner**
Excellence in Innovation and Transformation	The Lodge Health Partnership Senior Clinical Assistant Team	Runner Up
Excellence in Innovation and Transformation	Attenborough PCN Complex Care Service	Runner Up
Excellence in Innovation and Transformation	**Hertsmere Cancer Screening Initiative**	**Winner**
Excellence in Integration and Collaboration	Ware and Rurals Social Prescribing Team	Runner Up
Excellence in Integration and Collaboration	The Lodge Health Partnership Frailty Team	Runner Up
Excellence in Integration and Collaboration	Broxbourne Alliance PCN personalised care team	Runner Up
Excellence in Integration and Collaboration	Dacorum Healthcare Providers Ltd Asylum Seekers Team	Runner Up
Excellence in Integration and Collaboration	**Loughton, Buckhurst Hill &Chigwell PCN - Centralised Care Home Hub**	**Joint Winner**
Excellence in Integration and Collaboration	**Hitchin & Whitwell PCN Carers' Cafe Team**	**Joint Winner**
The HWE Primary Care Dental Practice of the Year 2024	**Watford Blue Cross Dental Care Team**	**Winner**
The HWE Primary Care Ophthalmic Service of the Year 2024	**Hertford Optometry**	**Winner**
The HWE Primary Care General Practice of the Year 2024	Warden Lodge Medical Practice	Runner Up
The HWE Primary Care General Practice of the Year 2024	Peacock Surgery	Runner Up
The HWE Primary Care General Practice of the Year 2024	**Much Hadham Health Centre**	**Winner**
The HWE Primary Care Network (PCN) of the Year 2024	Hatfield PCN	Runner Up
The HWE Primary Care Network (PCN) of the Year 2024	Abbey Health PCN	Runner Up
The HWE Primary Care Network (PCN) of the Year 2024	**Hitchin & Whitwell PCN**	**Winner**

Progress update on University of Hertfordshire – Medical School

- The Primary Care Workforce team have been involved in the external stakeholder groups to learn more about the whole process of the medical school approval process. The University is working with St George's Medical School to develop their curriculum and are developing a Primary Care faculty.
- The University is looking at international recruitment as their first intake of students to start in 2026 but the long-term plan is to be a medical school for local people and with a focus on widening participation as with their other courses.
- To ensure a comprehensive implementation plan is in place an internal validation event is planned for the Bachelor of Medicine, Bachelor of Surgery (MBBS) programme at the University, scheduled for 11 December 2024. The University has asked the ICB to affirm a commitment to providing clinical placements for the medical students from the Medical School.
- The University is preparing to submit a full application to the GMC in January 2025.

New to Practice Programme 2024/25

- The Training Hub remodelled the *New to Practice Programme* following cessation of national funding, since making these changes the programme has grown with 19 new applicants joining the scheme.
- The programme is designed to support newly qualified GPs and practice nurses to start and succeed in their primary care careers.
- The programme includes educational webinars including group discussions on relevant topics.
- In collaboration with the BLMK Training Hub, a networking and learning day is to take place in January 2025 for all newly qualified GPs on the programme.
- This event aims to provide a platform for new GPs to connect, share experiences, and gain insights into the resources and support available to them.

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Update on Primary Care Digital

Trudi Mount, Head of Primary Care Digital

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Digital skills support resources

One of the areas of priority identified in the HWE Primary Care Strategic Delivery plan was Digital Inclusion and the need to create a resource hub to allow people to be signposted to potential opportunities for assistance.

The Primary Care Digital team working in partnership with the ICB Communications Team have launched a new 'Digital Skills Support' webpage - a centralised platform designed to promote digital inclusion across Hertfordshire and West Essex.

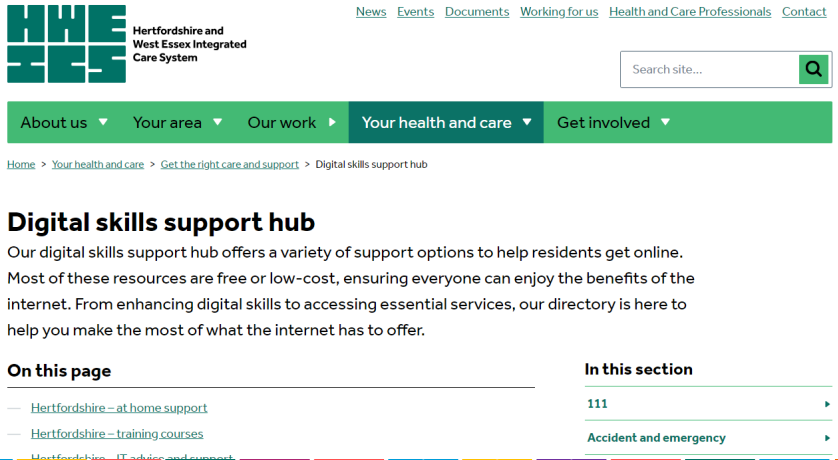
This one-stop shop provides residents and professionals with easy access to information about local digital inclusion services.

This initiative has been made possible through the collaborative efforts of our partners across the patch, including various voluntary sector organisations, Essex County Council, and Hertfordshire County Council.

These partnerships are highlighted on the Digital Skills Support page, showcasing the extensive network of support available to our community.

The resource hub is hosted on the ICB public facing website. We are about to embark on a communications programme to ensure partners and the public are aware of the resource hub. We will also be working with contributing organisations to ensure we keep the resources current, and through the connections we have made in creatin the hub, highlight any new services that become available.

The hub is available at Digital skills support hub - Herts and West Essex ICS



Updated: 17 Nov

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Update on Community Pharmacy

Mefino, Head of Primary Care Digital

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Pharmacy First

- According to the national Pharmacy First operational report, Hertfordshire and West Essex had the highest percentage of ICB GP practices referring patients to Pharmacy First across East of England (increased from 45% in May 2024 to 78% in June 2024).
- HWE ICB also had the highest proportion of total number of Pharmacy first consultations across EOE. The vast majority of consultations are resolved by the pharmacy and need no onward referral as per the Pharmacy First operational report.
    - The expectation is to continue encouraging GP Practices within HWE ICB to refer to the Pharmacy First service
- Community Pharmacy (CP) PCN integration leads across Hertfordshire and West Essex (HWE) supported with Pharmacy First resources and were the first point of contact for PCNs post launch. For example, they provided PCNs with information about the Pharmacy First service and encouraged GP referrals and community pharmacy readiness within their local area.
    - A revised model for the PCN Engagement leads was rolled out with recruitment of 16 leads, to align with Integrated Neighbourhood Teams and localities within HWE, commencing in post on 30 September 2024. The role also aims to support implementation and integration of community pharmacy services as part of the local and national delivery plan for recovering access to primary care.
- A HWE Pharmacy First website page has been created locally which includes various resources for GP practices such as leaflets, posters and EMIS & SystmOne demo videos. Pharmacy First
    - The plan is to provide continuous updates and resources to increase uptake of the service.
- There were a total 11472 consultations including clinical pathways, urgent medication supply and minor illness referrals within HWE in July 2024. The Pharmacy First service continues to be promoted at a local and national level to support implementation.
- Primary Care Funded for EMIS integrated referrals for Pharmacy First via Pharma outcomes and development of Ardens template for SystmOne.
- HWE ICB offered 250 blended training places in partnership with ECG Healthcare to local CPs including otoscope training and all 7 clinical pathways offered during January and February 2024 via HWE ICB Training Hub.
- Approximately 97% of community pharmacies across HWE ICB have opted in to provide the national Pharmacy First service as of 6 November 2024.

NHS Community Pharmacy Blood Pressure Check service

- This service supports risk identification and prevention of cardiovascular disease (CVD) to generally identify people over the age of 40 who have previously not been diagnosed with hypertension and to refer those with suspected hypertension for appropriate management & promote healthy behaviours to service users.

- Locally, there has been increased uptake of this service from baseline figures based on national NHSBSA claims data. For example, 45% of community pharmacies (CPs) actively claimed for Clinic Blood Pressure (BP) checks in April 2023 which increased to 70% of CPs within HWE in June 2024 & 17% of CPs for Ambulatory Blood Pressure Monitoring (ABPM) checks increasing to 26% in June 2024. The expectation is to continue increasing uptake of this service across HWE.

- A local EMIS/PharmOutcomes pilot service was undertaken with an IT platform to support direct referrals from GP practices to community pharmacies using their GP practice system EMIS. Residual funding from other projects within Hertsmere and Dacorum localities was used to fund until 1 October 2023. 436 GP referrals were made for a BP Clinic check to Community Pharmacies. 260 (60%) referrals were completed by community pharmacies. Out of the 260 completed referrals 103 patients (40%) were identified with high BP over 140/90. The remaining patients had normal BP readings and were given lifestyle advice.

Community Pharmacy Independent Prescribing Pathfinder Programme

- NHS England announced that we can commence implementation of the Pathfinder programme for testing independent prescribing (IP) in community pharmacy. The programme currently includes 5 community pharmacy sites across Hertfordshire and West Essex (HWE) which start delivering their clinical services from September 2024. The Pathfinder programme is expected to run until March 2025. There are three clinical models including minor illness, hypertension and respiratory within HWE.

- This programme would ensure we maximise the opportunities for service delivery available from 2026 when all newly qualified pharmacists will become independent prescribers at qualification. The pathfinder programme aims to establish a framework for the future commissioning of NHS community pharmacy clinical services incorporating independent prescribing for patients in primary care

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Place Updates

Phillip Sweeney, Head of Primary Care – WE

Cathy Galione, Head of Primary Care – ENH

Roshina Khan, Head of Primary Care - SWH

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West Essex Place primary care update

November 24

Key Information:

6 PCNs and 6 INTs
29 practices
48 community pharmacies
332,551 registered population
323,95 weighted population

Vaccinations

- COVID – 45,340 vaccinations to date (41% compared to 39% last year), noting that unpaid carers and household contacts of the immunosuppressed are excluded this year. All PCNs signed up for Covid and flu till March 2026
- RSV – uptake across HWE for 75-79s is currently 29%, based on 17,945 out of an eligible cohort of 61,481. LES launched Nov 24

HWE Primary care awards

- LB&C Care Home Hub was joint winner in the "Excellence in Integration and Collaboration" category.
- Peacock Surgery was runner up in the "Practice of the year" category.

Primary care access recovery and modern general practice

- More practices adopting clinical triage as part of their daily management of patient demand, with several using the total triage model.
- Current online consultation data (Sept 24) shows the majority of practices are using online triage for admin and clinical requests and vols suggest it is embedded as business as usual.
- 23 transition support fund bids received and being used to further implement/maximise use of Cloud Based Telephony (5 practices), expanding use of Online consultation tools (4), further work within the practice to make triage process more consistent (8) and miscellaneous improvement work (3)
- The national GPIP programme has involved 8 practices and one PCN and a schedule of 18 SLF visits is now complete.

Locality Clinical Leadership appointed

- Health Care Partnership primary care clinical leadership appointed Oct 24.
- David Tideswell (Care Closer to Home clinical lead), Michael Napal-David (Harlow), Richard Boyce (Uttlesford) and Stephen Rebel (Epping Forest).
- Community pharmacy locality leads – Mo Raje (Harlow), Navin Solanki (Uttlesford) and Tunde Sokoya (Epping Forest).

Health Checks, prevention and long-term conditions

- **Weight management** - 2 month pop up pilot has finished. We are awaiting October data from EWS. However, referral data we have received shows referrals have increased by more than 100% from August 78 to September 177.
- **Smoking cessation** – Practices are starting to receive training to deliver Vapes free of charge to patients as part of smoking cessation plan. Epping Forrest council are running swap to stop in their locality.
- **Health checks –** EWS are offering outreach support to 6 GP practices. Year on year comparison for September shows 10 practices have completed more health checks than last year
- **LD AHC –** Ardens data shows 6 practices have completed 60% of their LD reviews and action plans. All practices have completed some reviews, looking back on previous years data, activity should pick up now.
- **SMI HC -** Ardens data shows 12 practices are over 50% compliant with SMI reviews.

Carers

- PCN support pack complete, bringing together data, resources, support agencies and material
- Ongoing promotion with practices (PM and carers champion), PCNs and within INTs.
- Follow up Carers event planned for 6mths time.

Integrated Neighbourhood Teams (INTs)

- Harlow South INT business case approved for a 6mth pilot - INT coordinator to support with discharge planning – ensuring all community partners are aware of admissions and discharges real time and community led actions are followed through to prevent re-admission. Working closely with Transfer of care hub.
- LB&C PCN care home hub evaluation underway and looking positive.
- To date, 189 patients have been discussed holistically, at 36 proactive care MDTs, led by the INTs.
- DELPHI data platform live and data to robustly evaluate the proactive care model is being scheduled.

Winter plans

- This year, PCN plans need to demonstrate the approach of working differently, (including with system partners) and how outcomes can be measured.
- Priority 1 - plans include - Using Enhanced Access minutes on Saturdays to proactively support care homes to prevent admissions, focus on isolated elderly, a winter proactive care visiting programme with a winter checklist of preventative care. 48 hours post discharge reviews of patients.
- Priority 2 – plans include - Extra care home ward round per week to improve confidence with more frequent medical input, aiming to reduce unnecessary ambulance calls. Target patient cohorts ie, children and frailty groups. Increase the amount of same day appointments available for patients. Proactive use and promote the CCC and utilising community capacity.

Personalised Care Collaborative

Social prescribers, Health & Well-Being Coaches, and Care coordinators across WE meet every 6 weeks. Focus this month – carers. Very informative presentation from Essex Well Being Service, promoting their Carers noticeboard. Presentation from TEC Transformation, Essex County Council, promoting the technology to support patients at home, which teams can refer patients into free of charge, once they have completed the referral training.

East & North Herts Place - Primary Care Update – November 2024

Key Information:

12 PCNs – 6 Localities
47 practices
6 INT (2 Vanguard Sites identified)
Patient list - 624,692
Weighted - 585,182.61

Primary Care Access Recovery

GPIP: in total 21 out of 47 practices in ENH will have taken part in General Practice Improvement Programme.

Support Level Framework (SLF) Visits: (21%) 10 SLF plans completed overall. The place team have identified a further 15 practices for the team to work with and support offer to the end of March 2025, to date 3 visits have been booked, all other practices outstanding have been contacted and discussions for dates taking place.

Capacity and Access Improvement Plans 24/25: To date (41.6%) 5 PCN CDs have signed off "Better Digital Telephony", (16.6%) 2 "Simpler Online requests" & (25%) 3 "Faster Care Navigation, Assessment and response". Team are working with the remaining PCNs and areas to ensure they are able to access the associated funding offer.

Modern General Practice: To date all (100%) 47 practices have submitted their plans and claims for the 2nd year of transition funding. Majority of ENH practices are focusing on development of their triage models. (30%) 14 Practices have adopted Total Triage model, whilst others a hybrid triage model to test it with lower risk, minimising sudden impact to staff and patients.

Winter Plans 24/25

All Winter additional capacity plans have been received. The ENH place team are working with PCNs to gain assurance that each plan will provide additional, accessible capacity for primary care in line with the ICB priorities.

Winter plan – key projects:

- SVV & Icknield PCNs to run additional Care home rounds with winter funding.
- Hitchin & Whitwell are increasing the number of reviews of patients with LTCs to continue this often-overlooked area in winter.
- Stevenage South are utilising funds to increase their same day access offer over winter utilising their tried and tested SDA hub model.
- Stevenage North as well as continuing SDA Hub, they are providing additional Care coordinator staff to provide enhanced support and a point of contact for vulnerable patients and care home residents.
- H&R PCN utilising paramedic role to deliver additional capacity and frailty work, also looking at contact within 72 hours discharge.

Health Inequalities

Asylum Seekers: There are currently 7 Asylum Seekers Hotels supported by ENH Practices/PCNs who currently care for 1,145 residents.

Veterans: 22/47 (47%) of ENH practices are now Veteran-Friendly accredited and all PCNs (12/12) have at least one practice accredited.

Workforce (PCN/Locality recruitment/Retention)

Workforce plans – 75% of PCNs have returned their workforce plans, projecting recruitment for the remainder of the financial year.
2 PCNs are projecting overspend, but this is dependent on plans coming to fruition.
H&R PCN have agreed to conduct a PCN ARRS workforce review meeting with the place team and workforce team.
CYP Mental Health ARRS roles with HPFT ending due to finance constraints, Ware & Rurals and Icknield affected.

Vaccinations

Flu: 135,000 vaccinations delivered = **42% uptake** - Later start this year (Oct 3rd)

COVID: 80,000 vaccinations delivered = **45% uptake** (75% of ENH care homes have had Covid/Flu vaccination visits).

RSV: 8,500 vaccinations administered to those 75+ or pregnant.

HCT running weekend children's clinics and working with system to encourage uptake of all vaccinations in Traveller and Homeless cohorts. “Off the Grid” team visiting food banks and events organised in deprived areas.
Planning for Spring 25 programme for Covid is underway.

Integrated Neighbourhood Teams (INTs) and Proactive Care

ENH Health and Care Partnership Frailty Conference 13th November 24

System partners meeting to discuss collaborative working in proactive care for Frail patients. Teams will work in locality groups and address the following high impact interventions from an INT perspective:

- Community Falls
- Falls Response
- Outpatient Parenteral Antibiotic Therapy (OPAT)
- Polypharmacy
- Advanced Care Plans
- Frailty Same Day Emergency Care

The Primary Care place team will assist on the day with facilitation.

East & North Herts Place - Primary Care Update – November 2024

HWE Celebrating Primary Care Achievement Awards 6th November 2024

7 categories relevant to General Practice, ENH had 10 entries from practices/PCNs that made it to the finals, with 5 winning overall

Practice/PCN	Award Title
Stockwell Lodge - LVH PCN	Excellence in Supporting Staff Health and Wellbeing
Stevenage South PCN Patient Participation Group	Excellence in Patient Engagement
Hitchin & Whitwell PCN	Excellence in Integration and Collaboration
Hitchin & Whitwell PCN	The HWE Primary Care Network of the Year 2024
Much Hadham Health Centre - SVV PCN	The HWE Primary Care General Practice of the Year 2024

Others that entered and were runners up:

- Hoddesdon and Broxbourne PCN Social Prescribing Link Workers
- Ware & Rurals Social Prescribing Team
- Broxbourne Alliance PCN personalised care team
- Warden Lodge Medical Practice
- Hatfield PCN

Examples of Good Practice and Anything Else to Share

Broxbourne Alliance PCN: **Broxbourne Community Event** 17th Oct 2024: took place at the Laura Trott Leisure Centre in Cheshunt (12:30 to 14:30), organised by Broxbourne Alliance PCN and the Council. Local community groups and charities showcased what support services are available to the community. A video has been produced by the ICB jointly to promote the event and will be available to the public and system partners soon.

Stevenage North PCN: **Care Home Education Programme** – Clinical Team including a GP, ECP, Frailty lead nurse and Care Co-Ordinator work together to help care homes to better manage their patients to avoid unnecessary A&E attendances and 111 calls out of hours. They review previous cases and reflect on what could have been done differently to proactively manage the patients and/or deal with their acute conditions in house. They review with them their internal protocols to reduce the default – call 999/111 - reaction unless absolutely necessary.

Hatfield PCN: **Active Practice Charter Status** - As the first PCN to receive this, they have pledged to reduce sedentary behaviour and increase physical activity to benefit the health of their patients and staff. Working with Herts Sport & Physical Activity Partnership (HSP) via a programme of work delivered in partnership with HCC Public Health, they clearly demonstrate movement as the best medicine. They were recently presented with a Community Champion Award – For Outstanding Service to Community Health and Wellbeing, from High Sheriff of Hertfordshire.

Peartree Group Practice: - **Patient Education Talks:** Working collaboratively with ENHT and healthcare charities to run patient talks on self-managing and caring for others with long term conditions. The first talks are: Parkinson's Disease (October) with Parkinson's nurse speaker and support from Parkinson's UK; Diabetes (November tbc) and Dementia (December tbc) with plans to run further talks next year.

South West Herts Place Primary Care Update

November 2024

Key Information: 17 PCNs
49 practices
4 Locality Areas
689,499 Raw Population
639,336.11 Weighted

Pharmacy First: 118 Community Pharmacies are signed up in SWH to deliver 7 clinical pathways.

Sep 24 data show that SWH Pharmacy First referrals have increased since the same month of 2023: Sep 23, 7 referrals per 10,000 population & Sep 24, 18 per 10,000 pop.
Pharmacy-related referrals from 111 have also increased : Aug 23 - 334 referrals & 582 in Aug 24. (Sep data N/A as of 13/11/24)

Same Day Access
A minor illness winter service is being piloted in Hertsmere, the first time this has been available for their patients. It will be evaluated in terms of impact on low acuity A&E attendances and in hours 111 calls.

Primary Care Access & Modern General Practice

- **Practices Visit programme undertaken per locality** – 3 in Hertsmere, 6 visits completed in Dacorum with 3 more booked, 8 completed in St Albans & Harpenden & 2 more booked, In Watford 10 completed & 1 tbc. Positive feedback and agreement to repeat supportive visits regularly.
- **SLF Visits:** A total of 20 SLF visits completed to date, each attended by senior GP, PM and Place team member, excluding those in national programme. Remaining visits continue to be arranged
- **Modern General Practice:** 23 practices using a total triage model. A small number of practices (approx. 5) expressed total triage is not appropriate for their practice, however, they are implementing other ways to increase access and meet demand, develop multi-disciplinary staff workforce and improve care navigation. Primary Care Managers are working closely with practices to support movement towards MGP.
- **Transition Funding**: All 49 applications have been received, and all bar 2 approved and paid.
- **GPIP:** The national GPIP programme has been taken up by 22 practices and 4 currently undertaking the PLS course. Feedback at practice visits have been positive where changes have been made.
- **Quality & Contract Visits Pilot** to commence in September, 5 practices have volunteered in SWH – 2 visits & 3 desk top reviews.

St Albans IUCH

• Total number of patients seen YTD (April'24 – 30th September inclusive): 10,949.
  - NHS 111 directly booked: 3,095.
  - GP directly booked: 7,601.
  - Pharmacy directly booked: 131.
  - Hemel UTC redirection: 4

•Validated utilisation so far in 2024/25 is 82%
•99.2% are discharged within 2 hours
•99.8% of patients are discharged within 4 hours
• Injury remains low as a proportion of cases 8.2%

Vaccinations Flu and covid boosters are currently being offered until 20 Dec 2024. This is for 6 months to under 65 at risk and those aged 65 plus, residents of older adult care homes and health & social care workers. Covid uptake to date in South and West Herts is 49% for all cohorts up to the 12th November, compared to 47.6% in the whole ICB. Flu uptake as of 10th November is at 68% for those aged 65+ in South and West Herts, compared to 67% in the whole ICB.
RSV is being offered by practices to 75–79-year-olds and by HCT to pregnant women at 28 weeks.

Wound Care Management Workstream

Audit completed .
Audit findings to be presented at Care Closed to Home Meetings and shared with providers (CLCH)
Task & Finish Place Based Groups to be set up and TORS agreed.

Primary Care Awards Runners Up from SWH
Excellence in Supporting Staff Health and Wellbeing: Sheetal Shah from Schopwick Surgery in Hertsmere and Midway Movers @ Midway Surgery in St Albans
Excellence in Patient Engagement: Attenborough PCN
Excellence in Innovation and Transformation: Attenborough PCN Complex Care Service and The Lodge Health Partnership Senior Clinical Assistant Team
Excellence in Integration and Collaboration: The Lodge Health Partnership Frailty Team and Dacorum Healthcare Providers Ltd Asylum Seekers Team
HWE Primary Care Network (PCN) of the Year 2024: Abbey Health PCN

Hertfordshire and West Essex Integrated Care System

South West Herts Place Primary Care Update - Continued

Best Practice

Primary Care Awards 2024

In Hertsmere, Herts Health and Jyoti Bhojani from Hertsmere Borough Council were joint **winners** of the **Excellence in Innovation and Transformation** award. The Hertsmere Cancer Screening Initiative has sought to combat health inequalities in cancer screening uptake and diagnosis by doing the below:

- identifying and contacting eligible patients who had not responded to cancer screening invites, with a focus on cervical and breast screening
- contacting black and mixed ethnicity men over 45, and those at risk of prostate cancer, encouraging early PSA testing, and discussion around risk
- running the Hertsmere Against Cancer campaign which seeks to raise awareness of the signs and symptoms of cancer through community engagement events.

In Watford, Attenborough Surgery / PCN was the **winner** of the **Excellence in Training and Development** Award. Some of the highlights of their extensive teaching and development work include:

- Undergraduate teaching via the University of Cambridge since 2017
- Postgraduate teaching via 5x GP trainers. Most GP registrars stay on post CCT.
- Attenborough's unique “Complex Care Team” affords additional development and leadership opportunities – the work of this team was recently showcased at the RCGP Annual Conference in October
- Extensive research work, including involvement in the Oxford University Toucan Trial (featured on the BBC)

In addition to this win, Attenborough also came runner up in “**Excellence in Patient Engagement**” and in “**Excellence in Innovation and Transformation**” for their Complex Care Service.

Also in Watford, the Blue Cross Dental Care Team were **winners** of **The HWE Primary Care Dental Practice of the Year 2024** award. They were commended for the work experience opportunities they provide to young students, and their aims to launch the “Blue Cross Campaign for Dental and Medical Work Experience” to encourage other practices to uptake work experience offers.

St Albans & Harpenden Locality Based District Nurse

- General practice had no meaningful relationship with the district nursing team, so meetings with CLCH took place to discuss the ideas of having a district nurse allocated to a locality to improve communications and patient care. With the aim being to Improve referrals into urgent care response team and therefore avoiding admissions for patients.
- Success of the project will be made by analysing admissions data. This will support care closer to home, a CLCH project.

South West Herts Place Primary Care Update - Continued

Integrated Neighbourhood teams

All 4 Localities have agreed on their INTs and are at various stages of development.

Dacorum Pro-active Care Model: identified patient cohort as moderately frail over 65 who have had 2+ admissions to hospital and more than 10 hospital bed days. Segmentation modelling and risk stratification complete. GP searches finalised with clinical sign-off and available in EMIS. All practices in both Beta and Delta PCN are running the searches and going through patient lists to provide feedback on 21/03/24. MDT / workforce and employment model being developed, estates being scoped, and discussions being held with WHTHT re Jubilee Wing at Hemel Hempstead Hospital.
Initial proposal approved by Macmillan Board; next step is to develop a formal business proposal for Dec'24.

Hertsmere Complex Mental Health INT - identified non-responders to annual LD and SMI health check, living in the 3 most deprived electoral wards of Hertsmere. To be reviewed by an MDT to increase uptake of health checks for individuals identified and to provide holistic support to these individuals from relevant agencies. Currently doing Data Protection Impact Assessment. Are going to start a frailty cohort for a further INT, initially with care home patients.

Watford/Three Rivers Top 300 Frailty INT project: Key Stakeholders are engaged and contributing to the INT via the working group. Initial Patient Reviews have begun at Vine House Practice, to serve as a pilot for the INT work. Findings from Patient Reviews will be shared at the next working group in December.

St Albans/Harpenden Frailty Project To identify patients within St Albans & Harpenden Locality that are high users of the GP appointments/Primary Care , high attenders of ED & usage of hospital bed days. 20-30 patients per practice have been identified. To begin with a pilot will identify 5 patients per PCN and deliver a preventative and personalised care approach for these patients and measure outcomes. This will then be rolled out to all practices within the locality.

All SWH INTs focused on frailty are working towards the following outcomes:
1. 25% reduction in emergency admissions for people 65 over with frailty (ICB measure)
2. Decrease the rate of admissions for people living with frailty.
3. Improve patient / carer experience
4. Improve provider satisfaction
5. Reduce cost of care

Hypertension in Dental and Optometry Practices - PILOT

HWE ICB were successful in their bid for funding to support Hypertension case-finding in both Dental and Optometry practices

- All equipment and patient materials delivered to all 14 sites.
- Site training now competed facilitated by ICB Training Hub.
- High level activity data combined for both dental and optom sites (12 out of the 14 sites live for this period)
- Next report due from all sites 22/11. Data reporting due to NHSE National CVD team bi-monthly (but collected monthly for ICB intel).
- As of 22/10 all 14 sites live offering BP checks to eligible patients. Sites linked with local Pharmacies for self-referral onto 7-day BP monitoring.
- Evaluation element locally established working in partnership with Hertfordshire University. Local data to feed into national evaluation facilitated by Health Innovation Southwest.

Metric name	Count for this reporting period September> 10th October 24'
Number of blood pressure (BP) checks offered	120
number of BP checks delivered	67
Total number of people referred onwards	18
Number of people referred to community pharmacy	12
Number of people referred to locally agreed urgent care service or 999	0
Number of people directly referred to GP (e.g for low BP, irregular heartbeat, other clinical reasoning)	6

Questions

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 Transformation Committee meeting held in Public				**Meeting Date:**	**28/11/2024**	
Report Title:	**Primary Care – System Access Improvement Plan**				**Agenda Item:**	**09**	
Report Author(s):	Updates incorporated from various leads across Primary Care Avni Shah, Director Primary Care Transformation						
Report Presented by:	Andrew Tarry, Head of Primary Care Contracting						
Report Signed off by:	Avni Shah, Director Primary Care Transformation						
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						
Key questions for the ICB Board / Committee:	Board is asked to discuss the content and how we ensure we through this and wider channels information on progress is shared with the population we serve.						
Report History:	Discussions at Primary Care Transformation group; Primary Care Commissioning Committee and NHSE oversight meeting						
Executive Summary:	Following the publication of the Delivery plan for recovering access to primary care in May 2023, integrated care Primary Care Boards (ICBs) were required to develop system-level access improvement plans for primary care. In July 2023, NHSE published a briefing note to support the development by ICBs of their system-level access improvement plans. This referenced "checklists", published June 2023, which detailed expected actions for both ICBs and PCNs to achieve primary care access recovery. These "checklists" were updated by NHSE September 2023. The purpose of this report is to provide Primary Care Board with a 24/25						

<table>
<tr><td></td><td>year-end overview of the NHSE Primary Care Recovery Plan (PCARP) and the commitments to patients therein, and provide assurance to Primary Care Board that, through the development and implementation of HWE ICB's "System-level Access Improvement Plan". We will deliver on these commitments for the people of HWE by: -
Tackling the 8 am rush - make it easier and quicker for patients to get the help they need from Primary Care
Enabling "Continuity of Care"
Reducing Bureaucracy
The report will describe work already undertaken, work to be progressed, and the methodology for monitoring and assuring delivery.</td></tr>
<tr><td>Recommendations:</td><td>The Hertfordshire and west Essex Primary Care Transformation Group is asked to:
DISCUSS this report that describes the key components of the HWE System-level Access Improvement Plan and outlines how the ICB intends to deliver its key actions and priorities.
APPROVE the System Level Access Improvement Plan for Primary Care with a 24/25 final year report to come to the HWE Primary Care Transformation Committee in May 2025 updating on plan outcomes.</td></tr>
<tr><td>Potential Conflicts of Interest:</td><td><table>
<tr><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>N/A as decisions on where funding is approved is with Primary Care Commissioning Committee which manages the conflict of interest with independent clinicians from primary care professionals as appropriate.</td></tr>
<tr><td colspan="2">Implications / Impact:</td></tr>
<tr><td>Patient Safety:</td><td>Yes, this is key to when considering improvement in access in primary Care.</td></tr>
<tr><td>Risk: Link to Risk Register</td><td>Link to Risk Register the Primary Care Risk Register outlines the key keys associated with Primary Care Access.</td></tr>
<tr><td>Financial Implications:</td><td>National funding through Advanced telephony, Transition funding to support.
Improvement in general practice and national funding through prioritisation of improvement in access PCN DES and GMS contract for 2024/25.</td></tr>
</table>

Impact Assessments: *(Completed and attached)*	***Equality Impact Assessment:***	Yes, and approved – the Primary Care Strategic Delivery Plan has EIA completed overall.
	Quality Impact Assessment:	Yes, and approved– the Primary Care Strategic Delivery Plan has EIA completed overall.
	Data Protection Impact Assessment:	N/A

NHSE Primary Care Recovery Plan
Hertfordshire and west Essex "System-level Access Improvement Plan"

1. Introduction

This report provides Primary Care Board with an overview of the NHSE Primary Care Recovery Plan (PCARP) and provide assurance to Primary Care Primary Care Board that, through the development and implementation of HWE ICB's "System-level Access Improvement Plan", we will deliver the objectives and outcomes we agreed in our ICB wide Primary Care Strategic Delivery plan approved in July 2023. It describes the current general practice access position in HWE, the improvements we intend to make but also reflects on some of the plans in relation to dental, optometry and community pharmacy.

2. Background

General Practice, like many parts of the NHS, is under tremendous pressure – nationally one in five people report they did not get through or get a reply when they last attempted to contact their practice. 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 also provides valuable insights on the preferences of people waiting for and choosing appointments: - *People waiting for an appointment with their GP prioritise different things. Some need to be seen straightaway while others are happy to get an appointment in a week's time. Some people – often, but certainly not always, patients with more chronic long-term conditions – need or want continuity of care, while others are happy to be seen by any appropriate clinician, as long as they can be seen quickly. Equally, for some patients it is important to be seen face to face while others want faster, more convenient ways of accessing treatment and there is emerging evidence of a growing appetite (even before COVID-19) for patients to access care digitally.*

The NHSE "Delivery Plan for Recovering Access to Primary Care" (NHSE May 2023) has two central ambitions:

- 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.
- 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 (e.g., community pharmacy or self-referral services).

The Recovery Plan seeks to support recovery by focusing on four areas:
I. Empower patients to manage their own health including using the NHS App, self-referral pathways and through more services offered from community pharmacy.
II. 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. The 2023/24 revised GMS contract requires practices to assess patient requests on the day.

III. 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.

IV. 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.

3. Our Primary Care Strategic Delivery Plan

The HWEICB Primary Care Strategic Delivery Plan was approved by the ICBs Board on 28 July 2023 and sets out how we want to develop GP, community pharmacy, dentistry, and ophthalmology services across Hertfordshire and west Essex to benefit patients and communities over the next three years.

These objectives will be supported by several key areas of work such as empowering and educating patients, improved use of buildings used to deliver services, developing the primary care workforce, better use of data, information and digital technology and ensuring good value contracts and locally funded projects. It is believed that focusing time and resource in these areas will have the greatest impact to support the delivery of a primary care service which meets people's needs into the future.

The full plan can be viewed here: Primary Care Strategic Delivery Plan 2023-2026 – Hertfordshire and West Essex NHS ICB

4. System Access Improvement Plan

The May PCB update outlined the national requirements under the Capacity and Access Guidance for 2023/24, including the Capacity and Access Improvement Payment (30% of the overall payment) which is linked to PCN agreement and delivery of an improvement plan, to be assessed at year-end.

It was also noted that in July 2023 NHSE published a briefing note to support the development by ICBs of their system-level access improvement plans. This referenced a "checklist", published June 2023, which detailed expected actions for both ICBs and PCNs to achieve primary care access recovery.

An interim update was provided in January-24, then a 23/24 full year update in May 24. The following represent the key interim 24/25 updates since the previous iteration of the plan. These are summarised under the four main sections the Delivery Plan.

I. Empowering Patients

Prospective Patient Record Access – A significant majority of practices are now fully enabled to allow patients to have prospective patient record access.
Almost 720,000 patients across HWE have access to their records, which represents over 84% of patients who have online access (51% of patients have online access). 60% of practices have 90%+ of patients with online access + records access enabled; Over 83%% of practices with 80%+ of patients with online access.

From a configuration perspective, all practices are configured appropriately for prospective records access, with all bar 5 practices having this as the default for new NHS app users.

Focused support for practices on a 1:1 basis to progress before putting in any contractual levers – there are only 9 practices which have yet to ensure at least 50% of patients with prospective record access.

Further support planned for those that yet to achieve 90% of patients enabled and/or over 10% of opt outs applied.

NHS App usage – 62% of HWE eligible population (13 and over) have an NHS App account. HWE logins in October 2024 were 1,501,859, representing an 88% increase compared to October 2023. Over 121,000 repeat prescriptions ordered in October 2024 compared to just over 75,000 in October 2023.

Working in partnership with primary care Digital Leads and delivery partners to work with practices where uptake and benefits not seen using the dashboard and patient feedback Ongoing monitoring and collation of lived experience and feedback from practices and patients on the impact this is having whether that is efficiency in the practice and patient experience. Communications are to be shared as wide as possible including with local councillors having met with them across Hertfordshire and Essex.

Practice Websites – A website audit commenced in January 2024 using national tool based on Guidance. 115 practices out of 128 practices now assessed (the remaining 13 are all remodelling their websites so were excluded from the audit).

Most sites performed well in the assessment – planning how we follow up with those where areas for improvement were identified. Several practices already developing websites in line with access plans – they have been given access to the assessment tool to ensure alignment with that. As audits are completed outcomes of the audit will be fed back to the practice to continuously improve. There are plans in place to re-assess the 20 lowest performing sites in Q4 of 2024/25.

Self-referrals - Key planned next steps:

- From the data analysis available from NHS England the ICB will work with service providers, where the greatest variance exists against the highest performing ICB in region, for example; District Nursing and crisis response intermediate care service.

- Consistent definition and approach on self-referral for re-referrals to be agreed following the mapping completed so that we mitigate the risks but also clarity on how data is collated. This needs to be embedded across all contracts to allow consistency.
- Identify dedicated internal project support to improve the position.

- Continue with work across the 3 PLACE areas to continue to encourage information to be placed on GP websites and the promotion of Self-Referral on their homepage.

- Continue to work with our patient representative groups & VCFSE to help raise awareness of available services & pathways. The issue of accessibility particularly for those who are digitally disadvantaged is a recurring theme.

Community Pharmacy

Pharmacy First - Continued work on Pharmacy First service with target approach via the newly appointed Community Pharmacy PCN Engagement Leads from September 2024. Community Pharmacy PCN Clinical Leadership Role appointed and are engaging with PCN/locality leadership to develop relationships and ways of collaborative working. Approximately 97% of community pharmacies across HWE ICB have opted in to provide the national Pharmacy First service as of 6 November 2024.

HWE continues to have the highest percentage of ICB GP practices referring patients to Pharmacy First across East of England (increased from 45% in May 2024 to 78% in June 2024) according to national Pharmacy First report.

There were a total 11,472 consultations including clinical pathways, urgent medication supply and minor illness referrals within HWE in July 2024.

Blood pressure check service - Integration developments with the Hypertension case finding work with practices with low prevalence and integrating where appropriate with local pharmacies to work together to empower patients, improve access and improve diagnosis.

Pharmacy Contraception service - There were a total of 76% community pharmacies within HWE that registered to provide the national pharmacy contraception service on 3 November 2024. HWE ICB have developed local oral contraceptive formulary recommendations, aimed at community pharmacists, following the commissioning of the Pharmacy Contraception Service (PCS).

II. Implementing Modern General Practice

Highlights for 23/24

PCN Access Improvement Plans - Place teams engaged throughout 23/24 with PCNs to review progress with Access Improvement Plans & required support. GPAD data was reviewed and shared with PCNs to support PCN Access Improvement Plan achievement. This data does show different interpretation & implementation by practices, with considerable variances between practices. A targeted dashboard was developed, sharing key data with PCNs to highlight where practices are outliers.

The vast majority of PCNs/practices have been able to demonstrate access improvements through the year to merit award of the full funding at the discretion of the ICB (Local Capacity & Access Improvement Payment).

Best practice/examples are shared with key highlights including:

- Much focus on implementing modern general practice model, including triage &

- prioritisation approaches;
- enhanced care navigation capability contributing to improved signposting & appropriate
- utilisation of ARRS roles;
- increased collaborative approach to service provision;
- patient surveys & engagement as part of managing transition to new access models;
- greater use of enhanced telephony capacity & digital/online accessibility for patients.

ARRS Workforce Plans – Total HWE ARRS budget spend at year-end of c87% - almost £30m, with c740 ARRS roles in place by March-24. Some PCNs were enabled to exceed individual PCN budget, which is possible due to other PCNs underspending. Place teams engaged with PCNs to understand PCN 'credible plans to stay within budget going forward into 24/25.

Implementing Modern General Practice/Transition Cover – 95% of practices were granted Transition Cover funding (c£1m) to support with implementation of the Modern General Practice Model. There will be a review of approach for 24/25 budget allocation to provide further support for practices, including a renewed focus on the importance of patient engagement as part of changing practice approaches to appointment systems.

Encouragement of practices to participate in the National GP Improvement Programme - 30 practices participated through 23/24 in the programme, plus 4 PCNs are also participating in the PCN support scheme. Plan for Support level framework implementation – initial priority practices were identified and the Primary Care Team worked jointly with NHSE PC Transformation Team to pilot the approach, helping to develop ICB team capability. It is planned to accelerate implementation through the early part of 24/25 to provide practices with the opportunity to consider key access improvement development areas.

24/25 Update

Focus for the remainder of 24/25 is to make a full assessment of progress in implementing MGP. Much progress has been made by practices, but it is not necessarily a straightforward yes/no answer for many – some aspects may have been adopted, others still to progress.

Using key information sources, including Transition Cover applications, CAIP declarations, but also nationally sourced data including Online Consultation rates, 111 calls in-hours, Telephony data when available.

For this interim 24/25 update, key headlines are provided per place team on Transition Cover utilisation, MGP progress, GPIP engagement & local SLF approach. Expectation that all practice swill be supported via Transition Cover funding

Local Capacity and Access Improvement Payment (CAIP) 24/25
Paid to PCNs in 2024/25 based on the PCN's progress in implementing the Modern General Practice Access (MGPA) model and specifically in delivering against three priority domains. This approach continues the work commenced in 23/24 Access Improvement Plans. National approach for 24/25 is simplified and based on PCN declaration. PCNs have until 31st March 2025 to make their self-declaration.

Summary of submissions to November 24:

1. Better digital telephony - Digital telephony solution implemented, national data extraction; use of telephony data to support capacity/demand service planning and quality improvement – 22 of 35 PCNs claimed.
2. Simpler online requests - Online consultation (OC) is available for patients to make administrative and clinical requests at least during core hours – 16 of 35 PCNs claimed.
3. Faster care navigation, assessment, and response - Consistent approach to care navigation and triage across access channels – 20 of 35 PCNs claimed.

Online Consultation usage
National OCVC (Online Consultation/Video Consultation) data shows clinical & admin Online Consultation submissions per practice. HWE for Sept-24 shows a rate of 92 submissions per 1,000 patients, second highest rate in England.

Considerable variance across practices, although is to be expected, given some practices have implemented a digital led triage model, so high volumes expected. 19 practices show use of over 200 submissions per 1,000 patients; 30 practices show of less than 10 submissions per 1,000 patients.

This will be a key element in reviewing MGP implementation & Local CAIP submissions leading into year-end.

111 call volumes in GP hours
HWE have been monitoring this data for some time and have included in wider Primary Care data access dashboard. NHSE have additionally just published this data for the period April-Sept 24, *To support the implementation of Modern General Practice Access, the plan commits NHS England to sharing data on the number of calls to 111 in core hours with primary care network (PCN) clinical directors, to support quality improvement, so practices only divert to NHS 111 in exceptional circumstances.*

This data shows HWE with a lower call rate than the national average; ranked the 15th best of 42 ICBs. Whilst the national data methodology differs from that used by HWE, however the outcomes are broadly similar in that the same practices are identified with higher call rates. Further targeted work is planned to triangulate 111 call outliers to corroborate aspects of implementing the MGP model.

Cloud based telephony implementation
All practices now have Cloud Based Telephony of some level.
National Team working to on benefits report to show impact on access and practice capacity
National collection of telephony data due from October 2024 on CBT usage – ICB will look to use this information to aid us to work with practices on maximising benefits
Looking at options for improving services at the circa 25 practices who are on the lowest level of CBT
Correlating Patient Survey results against CBT position to understand if benefits being recognised and areas for improvement.

Same Day Access Hub developments
WE - UTC in Harlow live from November-23 and mobilisation successful. Providers working very well together daily to manage demand and revise approaches and workforce accordingly. Waiting times very low and patient satisfaction good. IUATC dashboard produced outlining attendances, demand over the week, waiting times, frequent users. Detailed analysis of S1 data commenced to inform workforce modelling.

LB&C PCN enhanced/same day access hub – flexible to support with demand e.g. OPEL 3 and 4 practices.

SWH - St Albans IUCH appt only ANP led service-initiated in Nov 22 - 98% seen & treated within 2 hours.

ENH - Stevenage North & Stevenage South PCNs detailed case study and evaluation report to be presented under separate agenda items at this committee meeting today.

The Herford & Rurals (H&R) PCN Minor Illness Hub service unfortunately had to be scaled back from October 2024 in view of other PCN operational pressures and priorities and has now been paused. H&R PCN is spread over a relatively large geographical area, and therefore some patients are reluctant to travel to the hub site location which has resulted in an inequity spend vs usage for each GP practice. Discussions are ongoing of how this could be resolved within the PCN delivery model for their patient population served.

III. Build Capacity

Highlights are provided in respect of the continued expansion and retention commitments in the Long-Term Workforce Plan (LTWP).

In the year to June 2024 there has been a steady increase in the total primary care workforce, with a 2.4% (80 FTE) rise over the 12-month period (not including ARRS roles) ARRS staff in post has risen by 72 FTE between January 2024 and September 2024. To c746 FTE, albeit has decreased marginally since the start of the financial year, owing to the lack of increases to the ARRS funding.

New GP Educator Pathway - There has been significant interest and enthusiasm for the new, locally administered, interactive, and supportive model of GP Educator Training. This initiative is a collaborative effort involving the HWE TH Training & Expansion Lead, HWE Quality Lead, and GP School HWE Associate Deans, aimed at developing, expanding, and streamlining the programme. Support is provided from the initial expression of interest by new aspirants, through pre-course preparation, addressing any issues faced by aspirant educators or practice/PCN-based Learning Organisations (LOs), and facilitating the path to Educator approval. The aim is to continue, expand, and further develop support for New Educators and New LOs as they transition into active training.

IV. Cut Bureaucracy

The 3 main HWE Acute Trusts completed the national self-assessment tool providing a baseline of where each Trust is against all the required areas highlighted in recovery plan: Onward referrals; Fit notes; Discharge summaries; Call and recall; Clear points of contact.

There are examples of good practice across all trusts and within the trusts in particular specialties. However, there are inconsistencies which will be picked up as actions in discussion with the individual trusts.

The system access policy which includes consultant to consultant referrals has recently been agreed across all partners and being implemented. Secondly teams are considering what elements of this baseline survey can be considered in discussion with community providers.

Online Registrations – Register with a GP
From October 2024 it is a contractual requirement that practices use the national 'Register with a GP' service to allow patients to register with a practice via a standardised online form. To date 117 of our 125 practices have enrolled with this service.

Key benefits include:

- Enhanced patient experience: the service is integrated with 'Find a GP,' and the NHS App allowing patients to easily find practices within their catchment area. This significantly reduces unnecessary traffic from patients unsure of where to go, creating a seamless patient experience.
- Verified patient information: patients are verified during sign-in using NHS login, enhancing security and trust in the registration process.
- Efficient NHS number matching: with a 90% success rate in matching patient information to Personal Demographics Service (PDS) records, we save time and avoid data duplication.

V. Dental Recovery Plan

On 7 February 2024, NHSE published their joint plan with the Department of Health and Social Care on the recovery and reform of NHS Dentistry. The plan builds on the dental contract reforms announced in July 2022 and is designed to improve access to NHS dental care and supporting the return to pre-pandemic levels of activity.

Key Measures include:

1) Increase access and delivery of activity:
   a) New Patient Premium/Tariff will be introduced for patients who have been unable to access care in the past 2 years; Scheme is planned to run for 13 months – 1st March 24 – 31st March 25 additional payments on top of the current treatment Bands 1 (£15), 2 and 3 (£50).

      There is no additional funding to support this initiative so the additional UDA credits that relate to new patients are deducted from the contracted activity; resulting in a quicker delivery of contracted activity than previous years. This has an unintended consequence of reducing access as there is less capacity within those contracts who routinely achieve the 96-102% contract thresholds.

      The mid-year performance data for 2024/25 reports that contract delivery at this point has increased by 7.32% compared to mid-year in 23/24 and 9.55% compared to mid-year 22/23

   b) Increase of the minimum UDA value from £23 to £28 – this will take effect from 1 April 2024 and will be applied nationally.
   c)
      In HWE, most UDA rates are set at a more favourable rate but there were 9 practices whose rate was below the minimum £28. Contractors were given an option of additional funding to increase their UDA rate or a reduction of the annual contracted

activity but retain the contract value. Most contractors opted for the additional funding option which was implemented with immediate effect.

d) Offer of a "Golden Hello" Dental Recruitment Incentive Scheme (DRIS) – funding for up to 240 posts across England where recruitment is challenging on the proviso that the dentist commits to stay in post for a full 3 years.

   Across EoE there is a requirement to attract 41 new dentists to the region – this has been allocated out to ICBs based on current dental access and workforce rates and as HWE is in the top for both categories (alongside MSE), our 'allocation' is for 3 WTE posts; following an EoI process where 11 applications were submitted, only 1 application met the eligibility criteria and the practice has been successful in its recruitment process.

e) Ambition to introduce Dental Vans to support rural and/or under-served areas and to support hard-to-reach communities

2) In addition, a range of government-delivered public health initiatives to improve the oral health of children

Key priorities and next steps for 24/25

These are summarised and follow the key NHS delivery actions for 2024/25.
The ICB supportive approach will continue through 24/25. Full assessment of MGP implementation utilising resources available, including Transition Cover applications, Local CAIP self-declarations, Online Consultation rates, 111 calls in-hours, Telephony data when available.

5. Recommendations

The Hertfordshire and west Essex Primary Care Transformation Group is asked to:

DISCUSS this report that describes the key components of the HWE System-level Access Improvement Plan and outlines how the ICB intends to deliver its key actions and priorities.

APPROVE the System Level Access Improvement Plan for Primary Care with a 24/25 final year report to come to the HWE Primary Care Transformation Committee in May 2025 updating on plan outcomes.

Hertfordshire and
West Essex Integrated
Care System

Hertfordshire and west Essex

System Access Improvement Plan 2024/25

Update report – Nov24

Working together
for a healthier future

Hertfordshire and West Essex Integrated Care Board
Primary Care Strategic Delivery Plan

The HWEICB Primary Care Strategic Delivery Plan was approved by the ICBs Board on 28 July 2023 and sets out how we want to develop GP, community pharmacy, dentistry, and ophthalmology services across Hertfordshire and west Essex to benefit patients and communities over the next three years.

The key objectives outlined in the plan are:

- **Prevention and Health Inequalities -** a continued focus on preventing ill health and helping people to stay well for longer
- **Improved access for urgent same day health needs –** creating same day access options to support patients with urgent health needs, across all providers – not just general practice/primary care whilst also supporting patients to access planned/routine access into primary and community as appropriate
- **Joined up local teams of health and care professionals -** the creation of team of teams through Integrated Neighbourhood Teams (INTs) where health and care professionals work together across organisations to meet patients' medical, social, and psychological needs in a more joined up way

These objectives will be supported by several key areas of work such as: empowering and educating patients, improved use of buildings used to deliver services, developing the primary care workforce, better use of data, information and digital technology and ensuring good value contracts and locally funded projects. It is believed that focusing time and resource in these areas will have the greatest impact to support the delivery of a primary care service which meets peoples needs into the future.

The full plan can be viewed here: Primary Care Strategic Delivery Plan 2023-2026 – Hertfordshire and West Essex NHS ICB

NHS England Delivery Plan for Recovering Primary Care Access

- The Delivery Plan was published on 9th May 2023 outlining the core ambitions to support improving access and sustainability of general practice, underpinned by several supporting programmes either financial, training or transformational
- Checklist for both ICBs, practices and PCNs published on 19th May 2023 summarising the support offer with required actions and timelines
- The delivery plan covers 4 key areas:

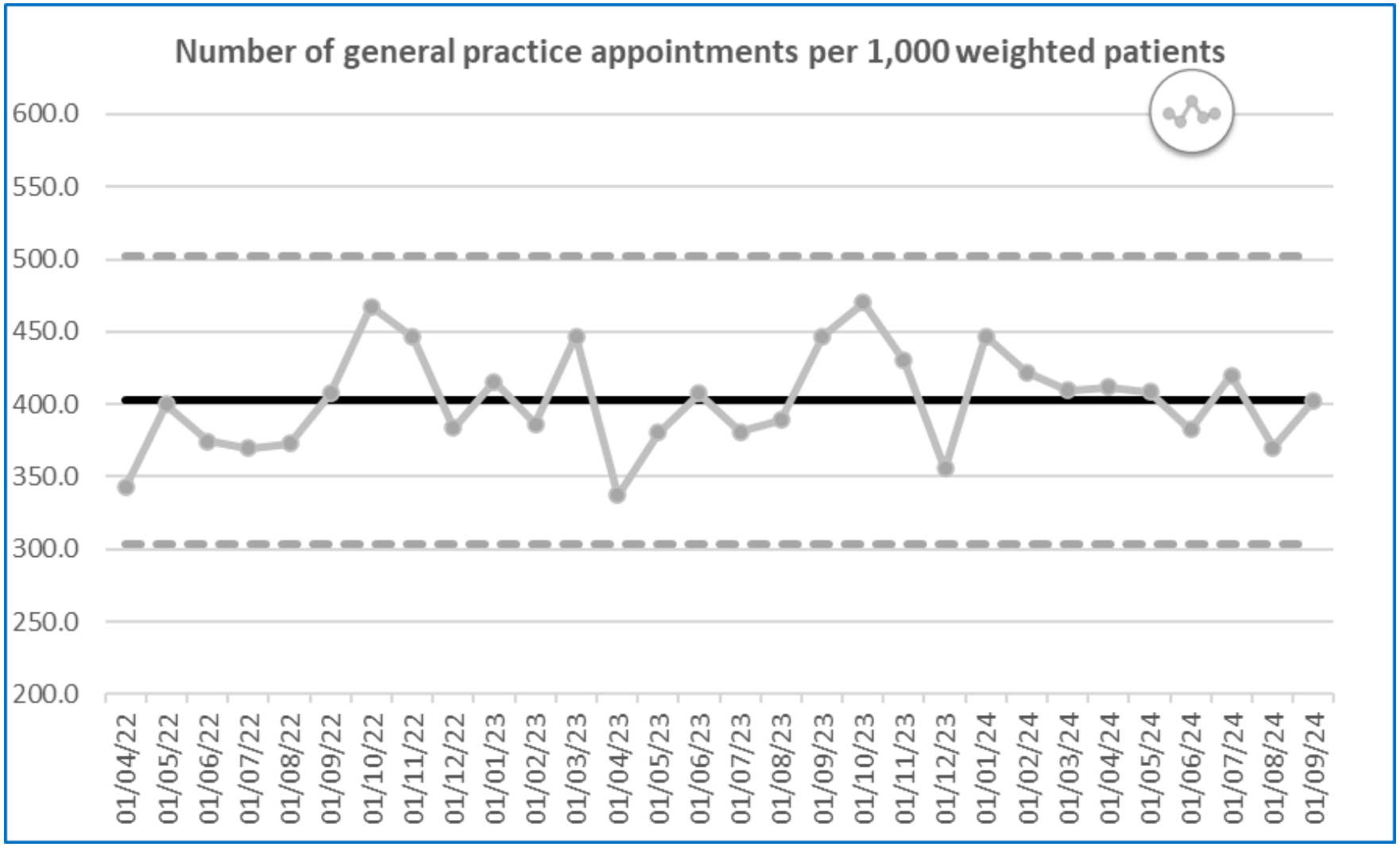
1	**Empower patients**	• Improving NHS App functionality	• Increasing self-referral pathways	• Expanding community pharmacy	
2	**Implement new Modern General Practice Access approach**	• Roll-out of digital telephony	• Easier digital access to help tackle 8am rush	• Care navigation and continuity	• Rapid assessment and response
3	**Build capacity**	• Growing multi-disciplinary teams	• Expand GP specialty training	• Retention and return of experienced GPs	• Priority of primary care in new housing developments
4	**Cut bureaucracy**	• Improving the primary-secondary care interface	• Building on the 'Bureaucracy Busting Concordat'	• Streamlining IIF indicators and freeing up resources	

Primary Care – GP appointment activity

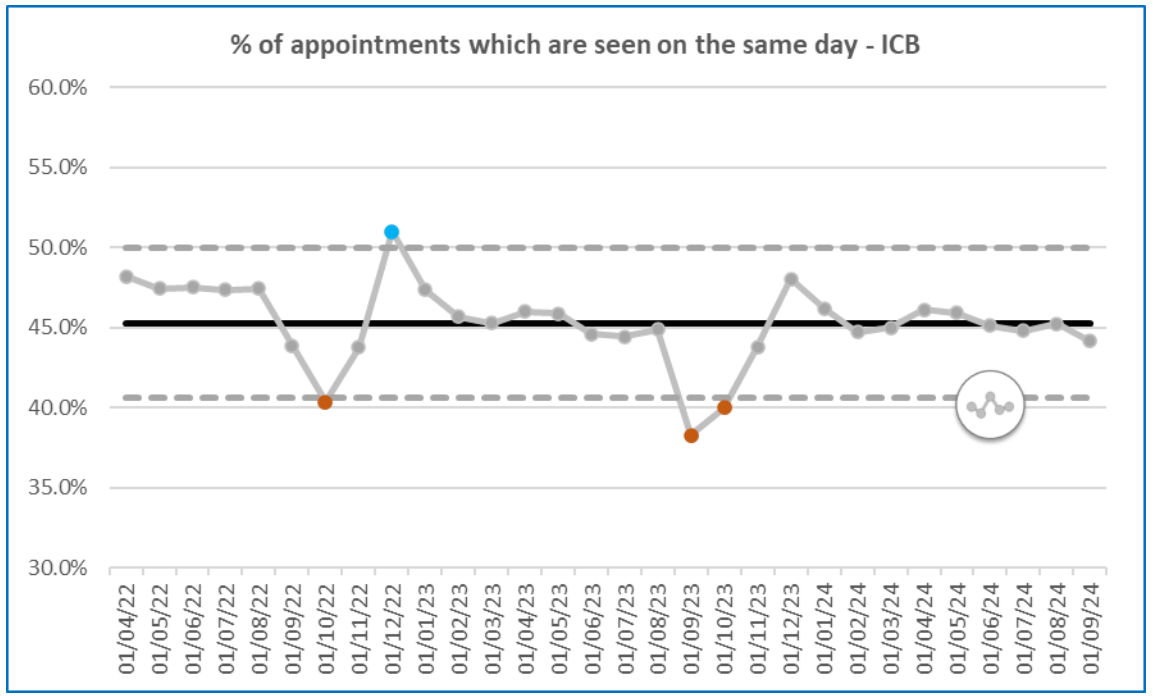
Update based on latest data (year 24/25 to Sept24)

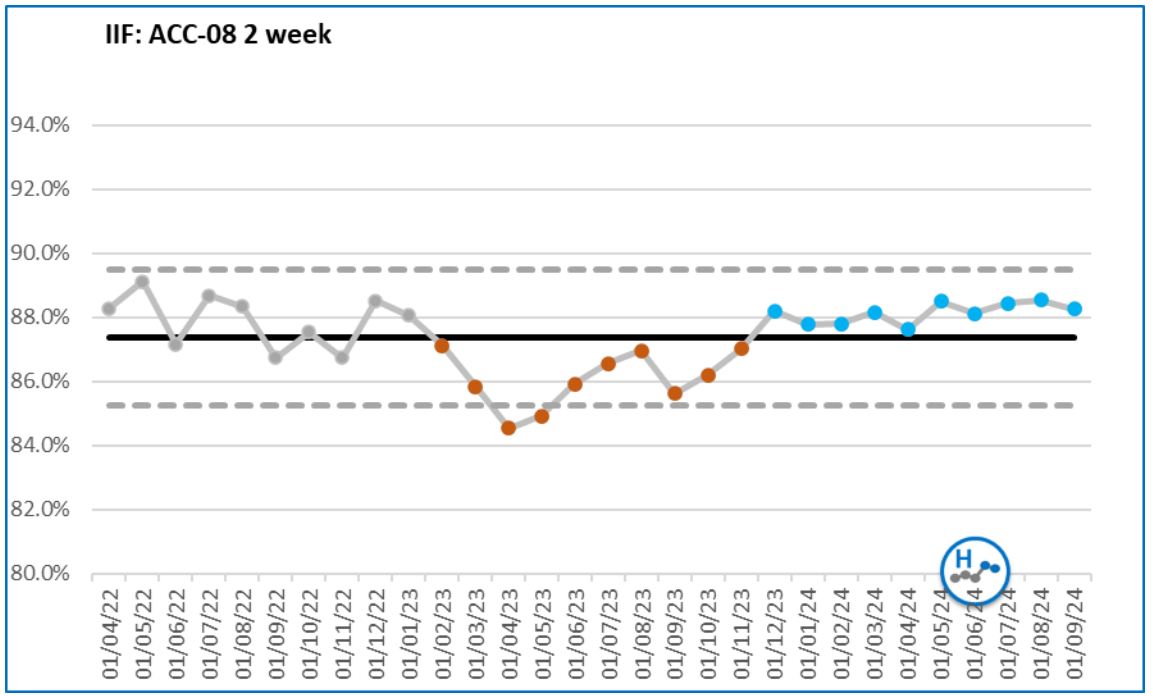
- Total Practice appointments in 2024/25 year to date show more consistency month to month than in previous years. Noting that it is the Winter period with associated Flu & Covid vacc programmes that show an upturn in activity
- Year to date appointments per 1,000 population represents an over 10% increase vs pre-Covid (2019/20) & 39% increase vs Covid impacted period (2020/21)
- Year to date appointments are 6.5% up on the previous year
- Over 88% of appointments were within 14 days (for appointments where patients would normally want the first available appointment)
- On average 67% of appointments were face to face; 25% were telephone based
- Home visits have been steadily rising and are comparable to where they were pre-Covid.
- Online consultation rates have increased throughout 24/25, up to 90 per 1,000 population, per month. HWE has the second highest online consultation rate in England.
- Collaborative PCN work means an increasing number of appointments are offered vis PCN (or wider) hubs. Due to some of the data complexities not all this data is part of the national GP appointment dataset. Over the year these additional appointment, not included in the above data, were at least 250,000, but could be easily be more than double this level.

Primary Care – GP appointments

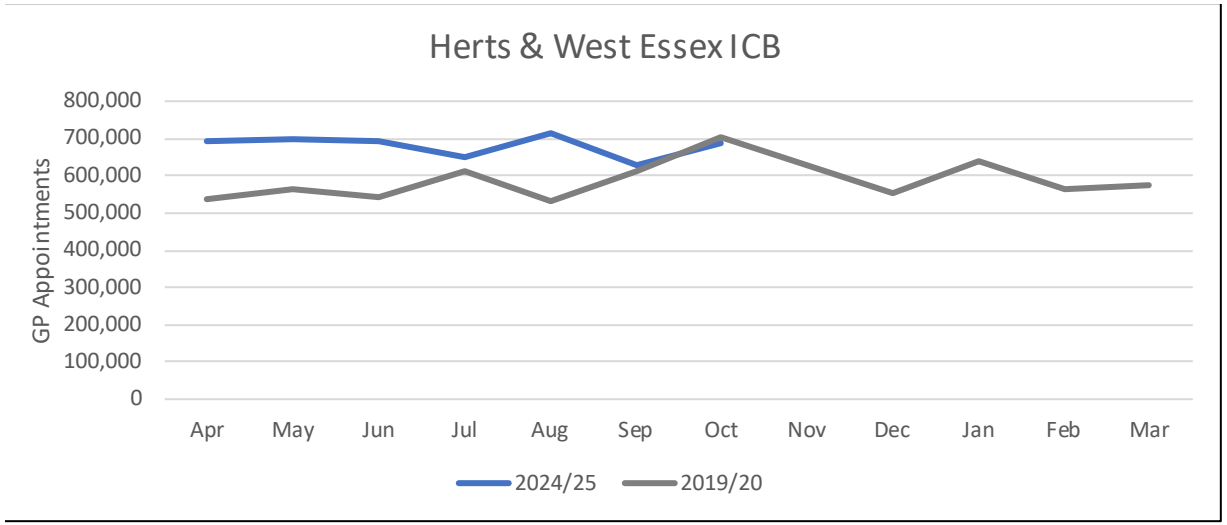


Primary Care – GP appointments – same day/within 2 weeks

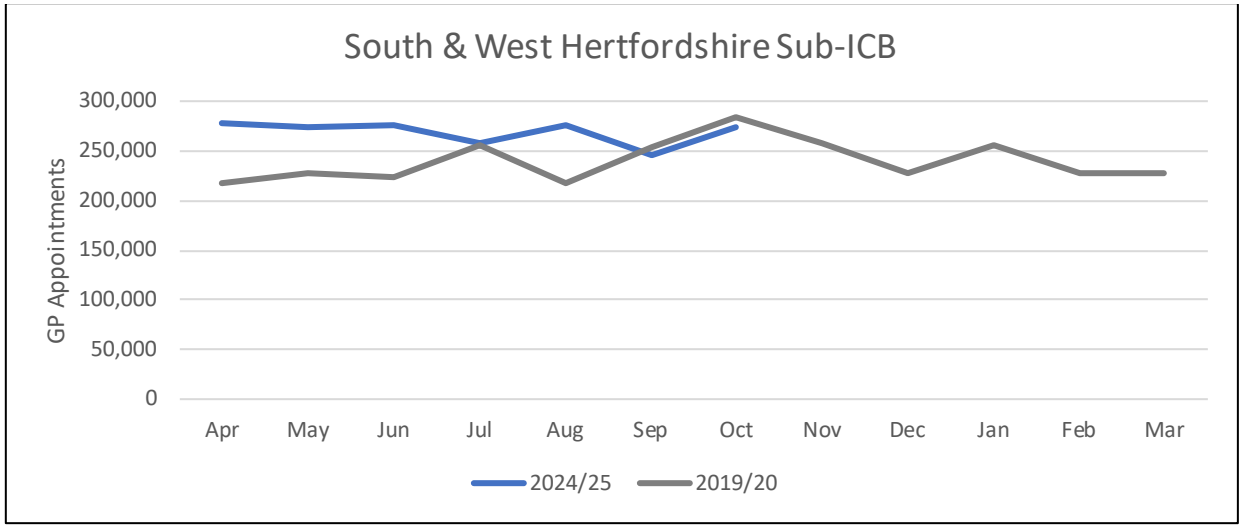




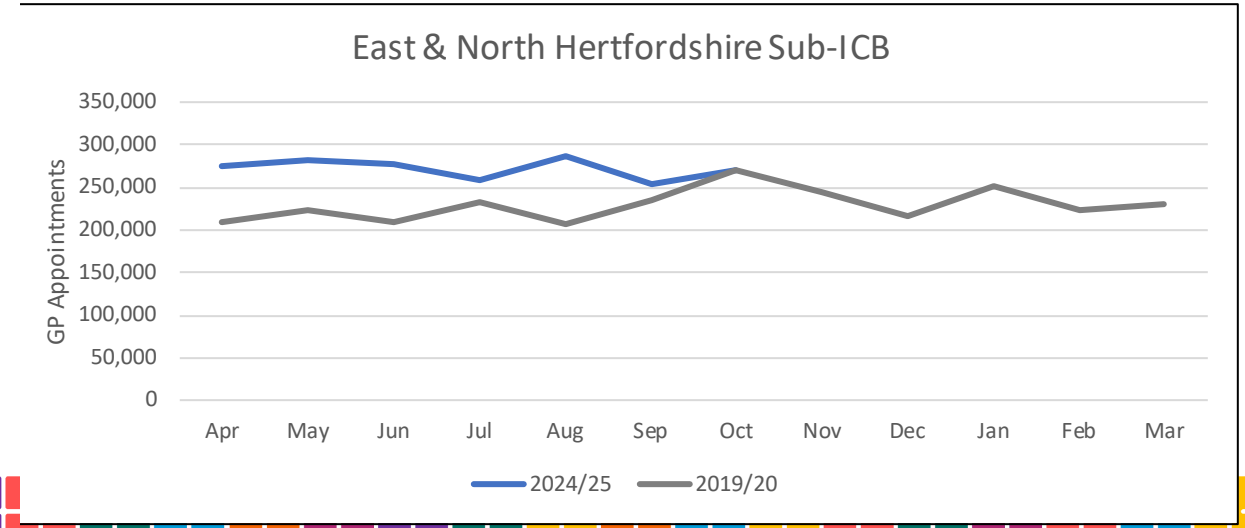
GP Appointments – 2019/20 & 2024/25, Year on Year Increases



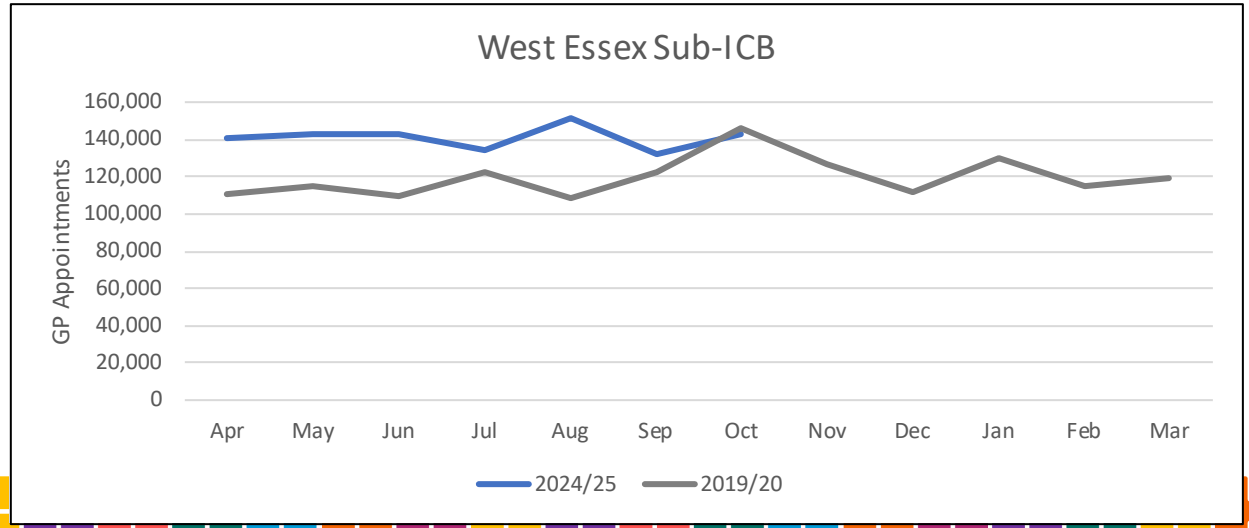
Month on Month	+29.4%	+23.4%	+28.3%	+6.5%	+34.3%	+3.2%	-2.2%					



Month on Month	+27.8%	+20.1%	+23.4%	+1.3%	+26.7%	-2.8%	-3.8%					

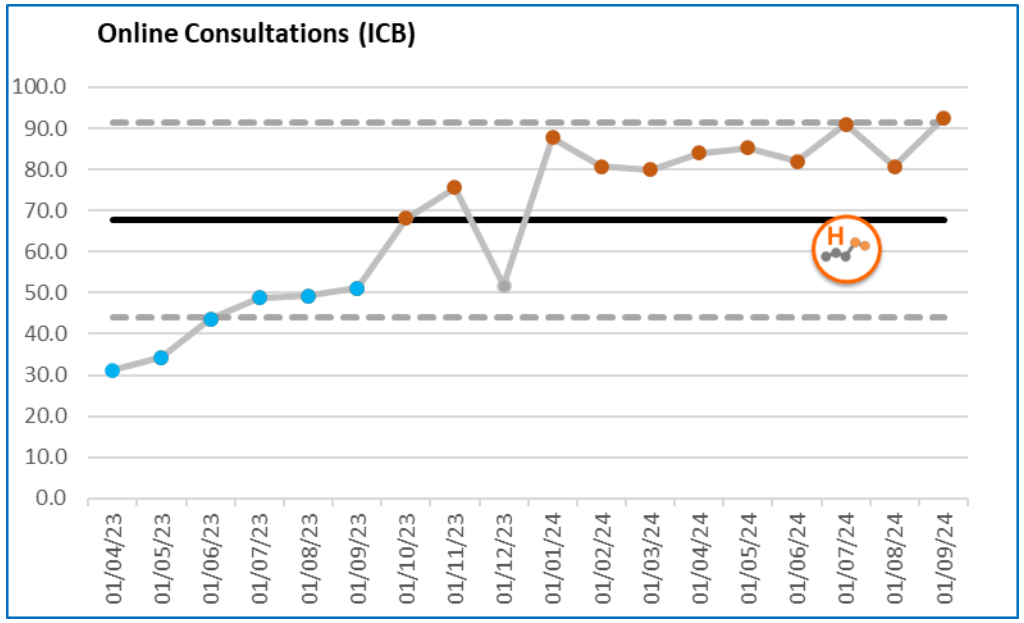


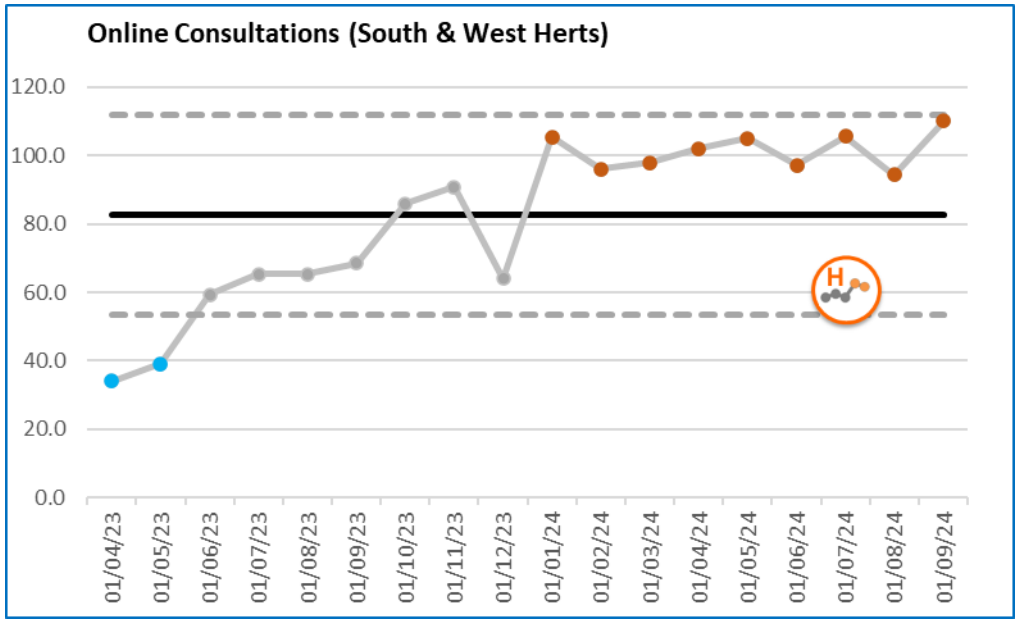
Month on Month	+31.8%	+26.6%	+32.7%	+10.3%	+39.8%	+7.5%						

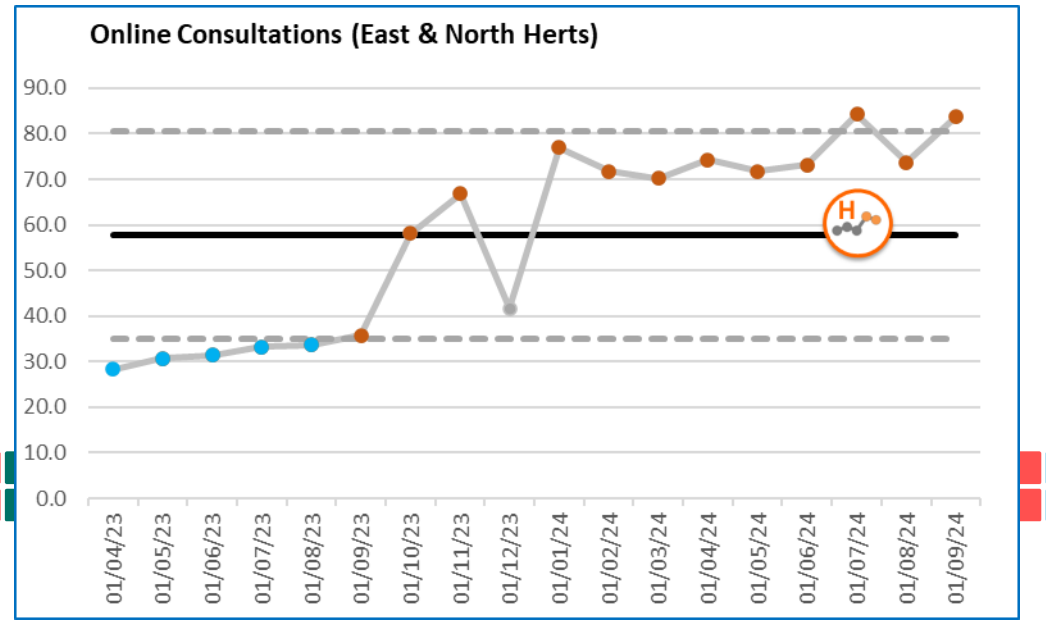


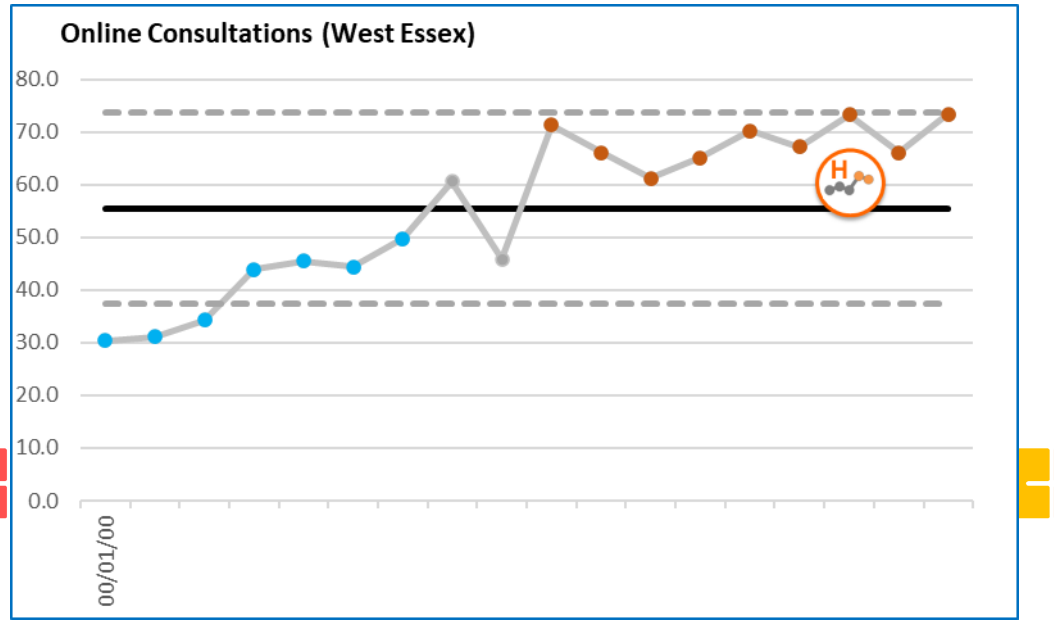
Month on Month	+27.7%	+23.9%	+30.1%	+10%	+39.4%	+7.5%	-2.6%					

Online Consultations (rate per 1,000 registered population)









Empowering Patients – Digital

Prospective Patient Record Access

- A significant majority of practices are now fully enabled to allow patients to have prospective patient record access
- Almost 720,000 patients across HWE have access to their records, which represents over 84% of patients who have online access (51% of patients have online access)

- 96% of practices have prospective records access as the default for new NHS app users
- 60% of practices have 90%+ of patients with online access + records access enabled; Over 83%% of practices with 80%+ of patients with online access

- Focused support for practices on a 1:1 basis to progress before putting in any contractual levers – there are only 9 practices which have yet to ensure at least 50% of patients with prospective record access

Empowering Patients – Digital

NHS App – Key actions and progress against them

We will work with practices and system partners to optimise their interfaces with the NHS App so that any options for automation/integration are applied.

- July – January 2024 - Developed public facing communications campaign – ICB have attended several patient engagement events to publicise the NHS App across the ICB area as well as PPG meetings and internal ICB meetings. Posters publicising NHS App being provided to all Community Pharmacies and Dentist practices for display.
- Usage Dashboard now in place – available to place teams to use in access conversations. Working on monthly update figures for NHS App to be sent to individual practices.
- January 2024 – December 2024 – Working in partnership with primary care Digital Leads and delivery partners to work with practices where uptake and benefits not seen using the dashboard and patient feedback
- January 2024 – June 2025 – Ongoing monitoring and collation of lived experience and feedback from practices and patients on the impact this is having whether that is efficiency in the practice and patient experience
- Communications are to be shared as wide as possible including with local councillors having met with them across Hertfordshire and Essex.

NHS App - Impact

62% of HWE eligible population (13 and over) have an NHS App account

HWE logins in October2024 were 1,501,859 compared to 798,869 logins in October 2023

Over 121,000 repeat prescriptions ordered in October 2024 compared to just over 75,000 in October 2023

Over 90,000 visits to acute information pages in October 2024 for HWE

100% of practices in HWE have patients with the NHS App enabled. 100% have repeat prescriptions enabled.

NHS App Dashboard - Logins (per 1,000 population)

HERTFORDSHIRE & WEST ESSEX ICS

Data source: NHS App Tableau Analytics Dashboard as of Jun 2024

Place All

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2022	680	494	483	428	436	358	363	316	335	360	275	235
2023	273	251	284	277	296	276	284	306	404	495	388	389
2024	485	490	527	572	591	564						
2023 compared to 2022	-60%	-49%	-41%	-35%	-32%	-23%	-22%	-3%	20%	37%	41%	66%
2024 compared to 2023	78%	95%	85%	107%	100%	104%	-	-	-	-	-	-

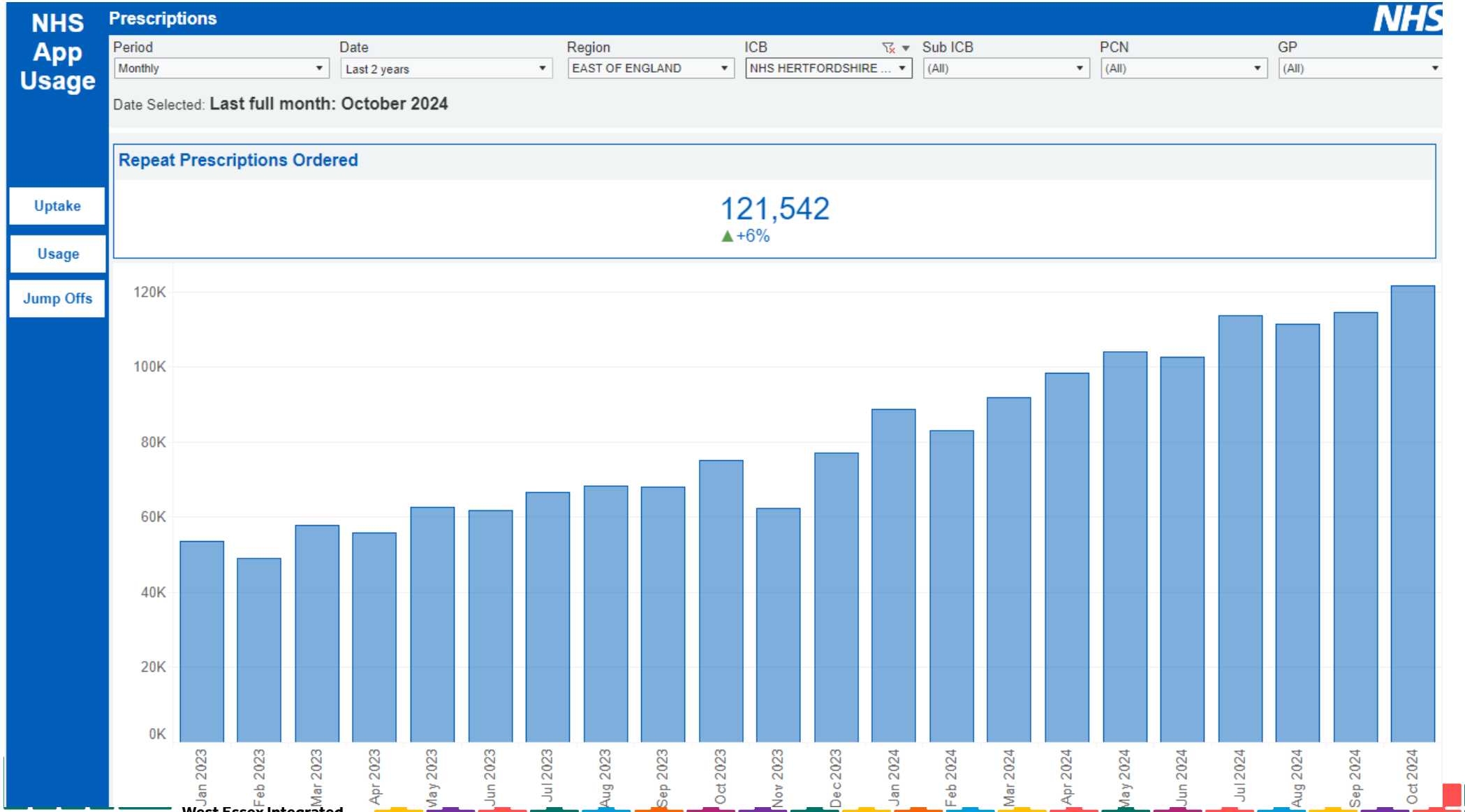
Jun-24

Number of patients registered for NHS App (over 13 years old)	% Eligible Patients Registered for NHS App	Logins per 1000 patients	No of Appts booked per 1000 patients	No of Appts cancelled per 1000 patients	No of repeat meds ordered per 1000 patients	No of records viewed per 1000 patients	No of SCRs viewed per 1000 patients	No of DCRs viewed per 1000 patients
4182	51%	554	0	0	53	266	224	258
7710	67%	505	0	1	24	302	302	301
6337	61%	400	0	0	42	256	255	195
4877	59%	336	0	1	32	148	148	93
5276	51%	366	0	0	40	219	219	211
6804	55%	478	1	0	56	240	0	230
10486	68%	396	0	0	37	244	243	223
4412	49%	441	5	1	50	295	295	293
7012	67%	359	1	0	33	228	215	222
11476	72%	511	1	0	76	311	308	307
8684	62%	485	0	2	49	343	338	334
2980	67%	280	4	1	56	133	129	130
9309	68%	491	4	3	41	344	333	340
10078	67%	828	9	2	57	286	284	284

Monitoring of usage and uptake via dashboards

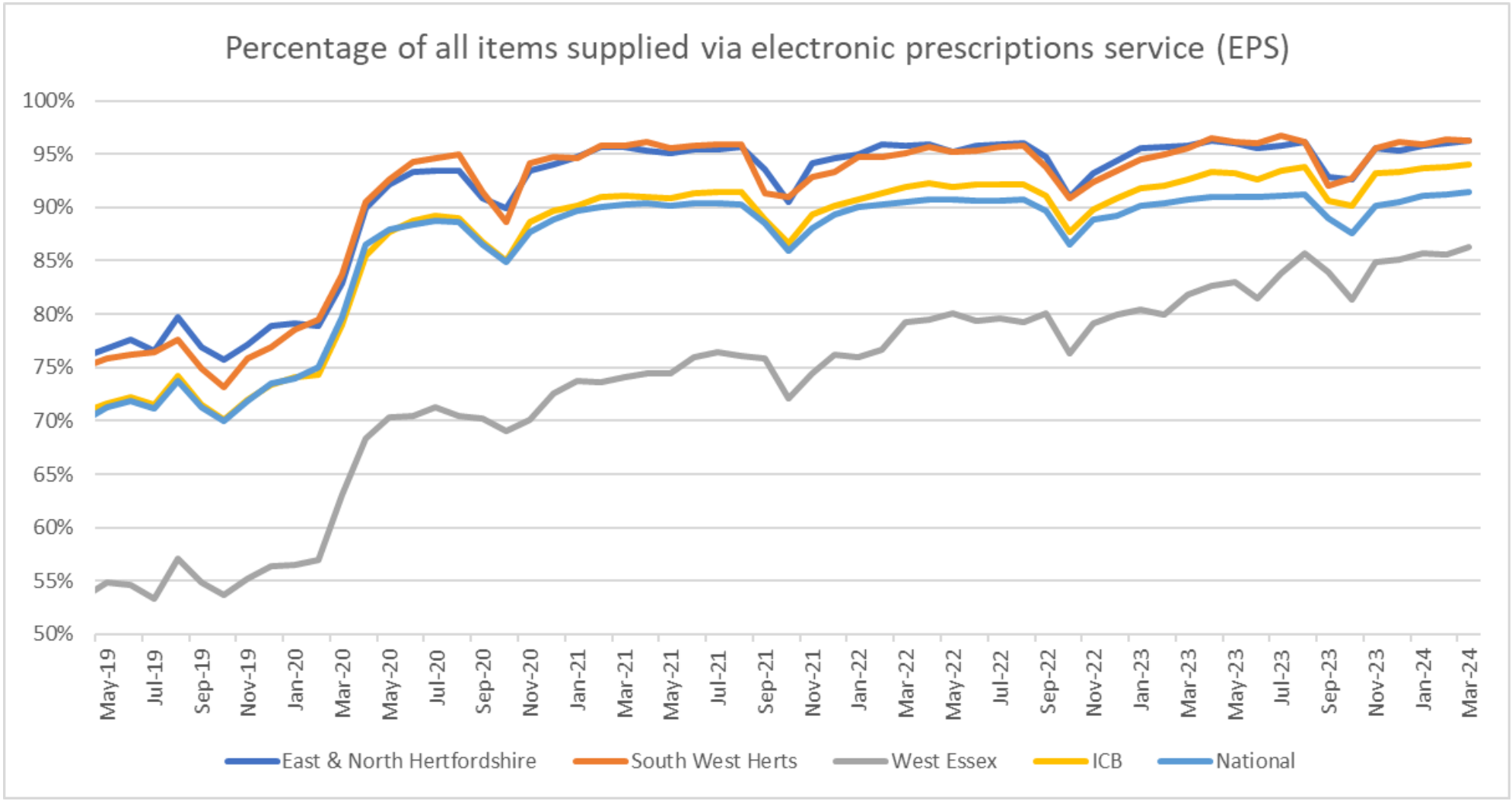
Hertfordshire and West Essex Integrated Care System

Repeat Prescribing usage in NHS App



West Essex Integrated Care System

Empowering Patients – Digital – Electronic Prescription Service



EPS allows a practice to send a prescription electronically to a pharmacy for a patient to collect the medication.

Whilst focus is on the NHS APP for patients to repeat medication teams are also looking at improvements in EPS across HWE and how this improves access and also improves efficiency within the practice.

In addition working with PMOT on repeat dispensing and how we reduce wastage.

Practice Websites

- Started Website Audit in January 2024 as per ‘Delivery Plan for Recovering Access to Primary Care’)
- Assessed using national tool based on guidance
- 115 practices out of 128 practices now assessed (the remaining 13 are all remodelling their websites so were excluded from the audit)

- Locality Teams have access to results to inform access conversations.

- All practices informed of results

- Several practices already developing websites in line with access plans – they have been given access to the assessment tool to ensure alignment with that. As audits are completed outcomes of the audit will be fed back to the practice to continuously improve.

- Most sites performed well in the assessment – planning how we follow up with those where areas for improvement were identified.

- Plans in place to re-assess the 20 lowest performing sites in Q4 of 2024/25

Empowering Patients – Self Referrals

NHSE definition –

Self-referral means people referring themselves directly into community or other health services where this is clinically appropriate to do so. The person will identify or be signposted to local services related to their condition/situation and will proactively refer themselves into the service.

This can include self-referral for re-referrals where a person is already known to a service from a prior assessment and can self-refer directly back into that same service.

Recognised that often the "signposting" is offered by the GP

Whilst HWE are making some progress against the metric collated, through mapping of the pathways and having a better understanding of what is being counted there are potential risks/barriers which have been highlighted working with the partners including :

- Financial, additional cost for an increase in referrals and additional triage services, where block contract may need increase in contractual activity/cost.
- Possible increase in waiting time in existing pathways.
- Capacity to see additional referrals
- Patient/carers - will require good engagement and communication to ensure uptake.
- Digital uptake – allowing for referrals to be made and tracked.
- Equality of access may be an issue for some of our localities (areas of deprivation) and patients i.e., disability and will need to consider as part of the roll out of new and existing pathways.

Empowering Patients – Self Referrals

Planned next steps

- From the data analysis available from NHS England the ICB will work with service providers, where the greatest variance exists against the highest performing ICB in region, for example; District Nursing and crisis response intermediate care service.
- Consistent definition and approach on self-referral for re-referrals to be agreed following the mapping completed so that we mitigate the risks but also clarity on how data is collated. This needs to be embedded across all contracts to allow consistency.
- Identify dedicated internal project support to improve the position.
- Continue with work across the 3 PLACE areas to continue to encourage information to be placed on GP websites and the promotion of Self Referral on their homepage.
- Continue to work with our patient representative groups & VCFSE to help raise awareness of available services & pathways. The issue of accessibility particularly for those who are digitally disadvantaged is a recurring theme.

Empowering Patients – Community Pharmacy

Pharmacy First service

- Continued work on Pharmacy First service with target approach via the newly appointed Community Pharmacy PCN Engagement Leads from September 2024.
- Approximately 97% of community pharmacies across HWE ICB have opted in to provide the national Pharmacy First service as of 6 November 2024.
- Hertfordshire and West Essex continues to have the highest percentage of ICB GP practices referring patients to Pharmacy First across East of England (increased from 45% in May 2024 to 78% in June 2024) according to national Pharmacy First report.
- There were a total 11472 consultations including clinical pathways, urgent medication supply and minor illness referrals within HWE in July 2024.

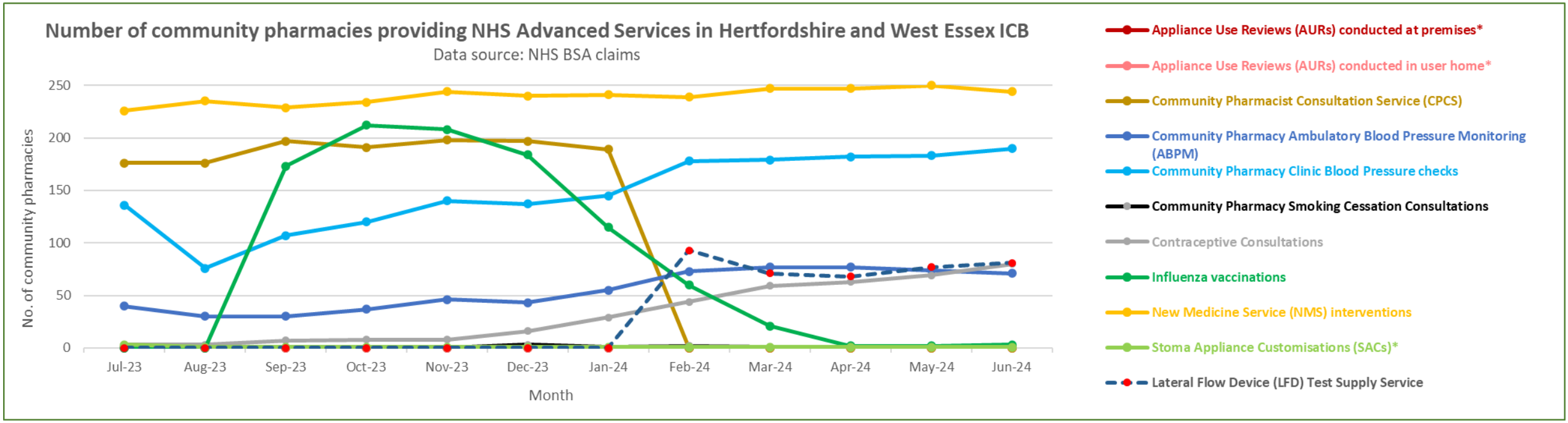
Blood pressure check service

- Integration developments with the Hypertension case finding work with practices with low prevalence and integrating where appropriate with local pharmacies to work together to empower patients, improve access and improve diagnosis.

Pharmacy Contraception service

- There were a total of 76% community pharmacies within HWE that registered to provide the national pharmacy contraception service on 3 November 2024.
- HWE ICB have developed local oral contraceptive formulary recommendations, aimed at community pharmacists, following the commissioning of the Pharmacy Contraception Service (PCS) - Oral contraceptive formulary recommendations

Current Variation of Advanced Services across community pharmacies



- Variation is across all providers whether that is primary care providers or others. The Primary Care Strategic Delivery Plan aims to reduce this variation and ensure right patient is seen by the right professional in timely way.
- Good working relationships between practices and community pharmacies generally facilitates increased uptake
- Ongoing pharmacy closures, reduced core hours of community pharmacies, increased pressures on CP workforce
- Some elements of Pharmacist First are dependent on referrals from other healthcare settings
- Community pharmacies can choose to register to provide NHS advanced services optionally and these are not essential services

Implement New Modern General Practice

Implementing MGP

Response to the twin challenges of rising volume and increasing complexity of need

- **Optimising contact channels**; offering patient choice of access channel (telephone, online and in person)
- **Structured information gathering** at the point of patient contact (regardless of contact channel) to understand what is being asked of the service.
- **Using one care navigation (and workflow) process** across all access channels to assess and prioritise need safely and fairly, and to efficiently get patients to the right healthcare professional or service, in the appropriate time frame. Move away from a ‘first come first served approach’.
- **better allocating existing capacity to need,** making full use of a multi-professional primary care team, community services and ‘self access’ options where appropriate
- **building capability in general practice teams to work together** and to access, understand and use data, digital tools and shared knowledge to lead, plan, implement, improve and sustain change.

PCN Access Improvement Plans – monitoring & support during 23/24

- Place teams have engaged throughout the year with PCNs to review progress with Access Improvement Plans & required support
- GPAD data was reviewed and shared with PCNs to support PCN Access Improvement Plan achievement
- Data does show different interpretation & implementation by practices There are considerable variances between practices
- Targeted Dashboard sharing key data with PCNs & to highlight where practices are outliers
- Continued encouragement for practices to promote & report FFT responses

ARRS Workforce Plans

- PCN ARRS budget spend of c87% - almost £30m. c740 ARRS roles in place by March-24
- Some PCNs were enabled to exceed individual PCN budget, which is possible due to other PCNs underspending
- Place teams engaged with PCNs to understand PCN 'credible plans to stay within budget going forward into 24/25
- Recruitment & Retention challenges exacerbated by competing with London Weighting & Locum use

Implementing Modern General Practice/Transition Cover

- 95% of practices were granted Transition Cover funding to support with implementation of Modern General Practice Model
- Review of approach for 24/25 budget allocation to provide further support for practices

General Practice Improvement Programme (GPIP) & Support Level Framework (SLF)

- 30 practices & 4 PCNs participated in this nationally supported facilitated programme, enabling them to focus on key development areas to improve access
- Roll-out of SLF facilitated sessions for practices at increased pace

PCN Access Improvement Plans 23/24 – year end assessment

- The vast majority of PCNs/practices have been able to demonstrate access improvements through the year to merit award of the full funding at the discretion of the ICB (Local Capacity & Access Improvement Payment)

Best practice/examples shared on the following slides, key highlights include:

- Much focus on implementing modern general practice model, including triage & prioritisation approaches;
- enhanced care navigation capability contributing to improved signposting & appropriate utilisation of ARRS roles;
- increased collaborative approach to service provision;
- patient surveys & engagement as part of managing transition to new access models;
- greater use of enhanced telephony capacity & digital/online accessibility for patients.

- ICB supportive approach will continue through 24/25, albeit reflecting the 'lighter-touch' national direction – based on Clinical Directors' declaration of PCN/practice status
- A few areas key likely of focus include – maximising the increased functionality of new cloud-based telephony systems; maximising online consultation availability & use, recognising this remains an area of considerable variance; renewed focus on the importance of patient engagement as part of changing practices approaches to appointment systems

Progress in implementing MGP 24/25

- Focus for the remainder of 24/25 is to make a full assessment of progress in implementing MGP
- Much progress has been made by practices, but it isn't necessarily a straightforward yes/no answer for many – some aspects may have been adopted, others still to progress
- Using key information sources, including Transition Cover applications, CAIP declarations, but also nationally sourced data including Online Consultation rates, 111 calls in-hours, Telephony data when available.
- For this interim 24/25 update, key headlines are provided per place team on Transition Cover utilisation, MGP progress, GPIP engagement & local SLF approach

Local Capacity and Access Improvement Payment (CAIP) 24/25

Paid to PCNs in 2024/25 based on the PCN's progress in implementing the Modern General Practice Access (MGPA) model and specifically in delivering against three priority domains. This approach continues the work commenced in 23/24 Access Improvement Plans. National approach for 24/25 is simplified and based on PCN declaration. PCNs have until 31st March 2024 to make their self-declaration

Better digital telephony - Digital telephony solution implemented, including call back functionality; each practice has agreed to comply with national data extraction; telephony data is routinely used to support capacity/demand service planning and quality improvement discussions

Simpler online requests - Online consultation (OC) is available for patients to make administrative and clinical requests at least during core hours.

Faster care navigation, assessment, and response - Consistent approach to care navigation and triage so there is parity between online, face to face and telephone access including collection of structured information for walk-in and telephone requests. Approach includes asking patients their preference to wait for a preferred clinician if appropriate, for continuity

Local Capacity and Access Improvement Payment (CAIP) 24/25

PCNs self-declarations received as at 11th November 2024.
Remaining declaration form part of ongoing Place Team engagement/support with PCNs.

The 'Simpler online request' aspect is proving challenging with the request for practices to move to offering OC throughout core hours as many practices open OC for specific hours and/or have a cap to manage workload.

	PCNs	Faster care navigation, assessment, and response	Better digital telephony	Simpler online requests
ENH	12	3	5	2
SWH	17	13	13	10
WE	6	4	4	4
	35	**20**	**22**	**16**

Modern General Practice 2024/25 – South and West summary

PCN	Summary
South and West overall	100% (49) practices have submitted **Transition Funding** applications for both 23/24 and 24/25. There are 2 practices outstanding but approved in principle. All practices in South and West will have claimed 24/25 transition funding to support them towards MGP. Currently, 53% of practices are **implementing Modern General Practice** based on total triage OR medical Online Consultations open all day. All practices are / have demonstrated using this funding to move towards MGP. To support this, all practices have CBT in place and most have full functionalities i.e. call-back service In addition, the below categories have been chosen by practice, the ones in bold are the areas with the highest priorities: **Online consultation, Consistent Triage, Admin/Support, Clinical Workforce, I.T/Digital, Patient/ PPG Engagement, Training/Development** CBT, Estates/Facilities, Equipment 23 practices using a **total triage** model. A small number of practices (approx. 5) expressed total triage is not appropriate for their practice, however, they are implementing other ways to increase access and meet demand, develop multi-disciplinary staff workforce and improve care navigation. Primary Care Managers are working closely with practices to support movement towards MGP. The national **GPIP programme** has been taken up by 22 practices and 4 currently undertaking the PLS course. Feedback at practice visits have been positive where changes have been made. A total of 20 **SLF visits** have been completed to date, each attended by senior GP, PM and Place team member, excluding those in national programme. Remaining visits continue to be arranged. 26 practices are **veteran-friendly** practices. Central Watford PCN practices all accredited. **Capacity and Access Improvement Plans 24/25**: To date 13 PCN CDs (76%) have signed off "Better Digital Telephony", 10 (59%) "Simpler Online requests" & 13 (76%) "Faster Care Navigation, Assessment and response".

Modern General Practice 2024/25 – East & North Hertfordshire place summary

PCN	Summary
East & North Hertfordshire place overall	All Practices have engaged well; working collaboratively within their PCNs and across Localities to share learning for improvement initiatives and to implement Modern General Practice across place. 30% of practices have now implemented a total triage model with many others taking a 'hybrid' model approach. Nearly all Practices have adopted some form of clinical and or admin triage processes as part of their service model delivery in order to better manage their daily demand and capacity. **The national GPIP programme** – to date, 45 % of practices have taken part in General Practice Improvement Programme, with one PCN having completed at the outset. A considerable amount of work has been undertaken to share the learning across place to encourage uptake, this was recognised by NHSE regional colleagues who attended a place-based Practice Manager's meeting. **SLF visits –** to date, 21% of Practices have had a visit completed. The place team are currently engaged with a further 15 practices identified with an offer to visit; at the time of writing this report 3 visits are confirmed with all others to be completed by the end of March 2025. **Transition Support Funding** has now been claimed by all 47 Practices in 2024/25, as part of their 2-year plans. The main themes across Practices are: • *A focus on continuous development and improvement of hybrid triage models.* • *Working towards a consistent approach regardless of method of patient contact to the practice* • *Improvement on overall Patient Engagement.* • *Increasing use of Digital interventions; ie. Online consultation tools and NHS APP.* • *Other improvement work covering targeted training for both clinical and administrative practice staff.*

Modern General Practice 2024/25 – West Essex summary

PCN	Summary
West Essex overall	• Clear improvements in collaborative working across PCNs by practices have been maintained • More practices adopting clinical triage as part of their daily management of patient demand, with several using the total triage model. • Current online consultation data (September 2024) shows the majority of practices are using online triage for admin and clinical requests at a rate per 100 patients that indicates it is embedded in their BAU. • Transition Support Funding claimed by 23/29 practices in 2024/25 (20 approved - see below), with the expectation all 29 will claim this year (27 of the 29 West Essex practices received funding in 2023/24). The main themes of the plans have been: ○ Further support in implementing and maximising use of Cloud Based Telephony (5 practices) ○ Expanding use of Online consultation tools (4) ○ Further work within the practice to make triage process more consistent (8) ○ Miscellaneous improvement work (3) • The national GPIP programme has involved 8 practices and one PCN • A schedule of 18 SLF visits completed during summer 2024, each by senior GP and Place team member, excluding those in national programme, and one practice declined. Two final visits being arranged – one delayed because of CQC, other with a new GP partner/practice manager team. • 19/29 are now veteran-friendly practices

Advanced Telephony

- All practices now have Cloud Based Telephony of some level
- National Team working to on benefits report to show impact on access and practice capacity
- National collection of telephony data due from October 2024 on CBT usage – ICB will look to use this information to aid us to work with practices on maximising benefits
- Looking at options for improving services at the circa 25 practices who are on the lowest level of CBT
- Correlating Patient Survey results against CBT position to understand if benefits being recognised and areas for improvement

Patient Feedback from National report produces in 2023 on CBT (based on national CBT pilot)
32.8% improvement on getting through to the practice with comments "A more simple, easy to use system", " since the change in the system it has been a more pleasant experience", "I now use the call back option rather that wait in the queue"
25% improvement on not getting an engaged tone
76.2% responded that wait to speak to someone at the practice has improved with comments "much faster pickup", "the recently upgraded phone system was very quickly answered.“

From the patient comments two main features of the upgraded phone system can be identified as having a positive impact and these are the call back feature and queue position notification. In addition, there are a number or references indicating that the telephone access has improved. Detailed below is a sample of responses received:
"I notice it had IMPROVED as you are now able to request call back & hold your place in the queue – saves time & cost of a long phone call"
"Getting through to the surgery on the phone has improved a lot"
"Much, much improved than before. Its easier to speak to someone now"
"The new system is so much easier. The option for a call back is much better"
"Easier than expected and pleased to know my queue number so I can ring back later if I so choose“

**** To note responses are collated responses from the National Pilot report from across 4 regions in England***

Demand and Capacity

Benefits and challenges with OPEL reporting in general practice

Benefits	Challenges
Provides a daily report on pressure in general practice (4 categories). Previously only anecdotal feedback on an adhoc basis.	The ICB do not have sufficient support options if a practice reports OPEL 3 or 4
Status in general practice can be shared with wider system partners so pressure across the whole system can be recognised and managed, sometimes on a daily basis	Have not been able to mobilise mutual aid to date as often the technology and infrastructure is not available
Provides an opportunity to consider support to practices who are regularly reporting OPEL 3 or 4 (albeit long term options)	Interpretation of OPEL status varies – what one practice may deem OPEL 2, another may deem OPEL 3
Measures pressure over time to inform commissioning decisions	No metrics to standardise the interpretation/ reporting
	Practices operate and deliver care differently eg. level of appointments offered, workforce, balance on the day/planned appointments

As a result of these challenges, we have reviewed and refined the current OPEL reporting descriptions, practice actions and ICB actions and added examples of each OPEL stage with the aim of introducing measurable/metrics to minimise variation in reporting and maximise support

The purpose is still about how this informs the system on the demands on general practice as part of the system

Further work is underway to explore system to support in primary care to effectively measure demand and how capacity can be shaped as part of the individual practice and PCN.

Online Consultation data

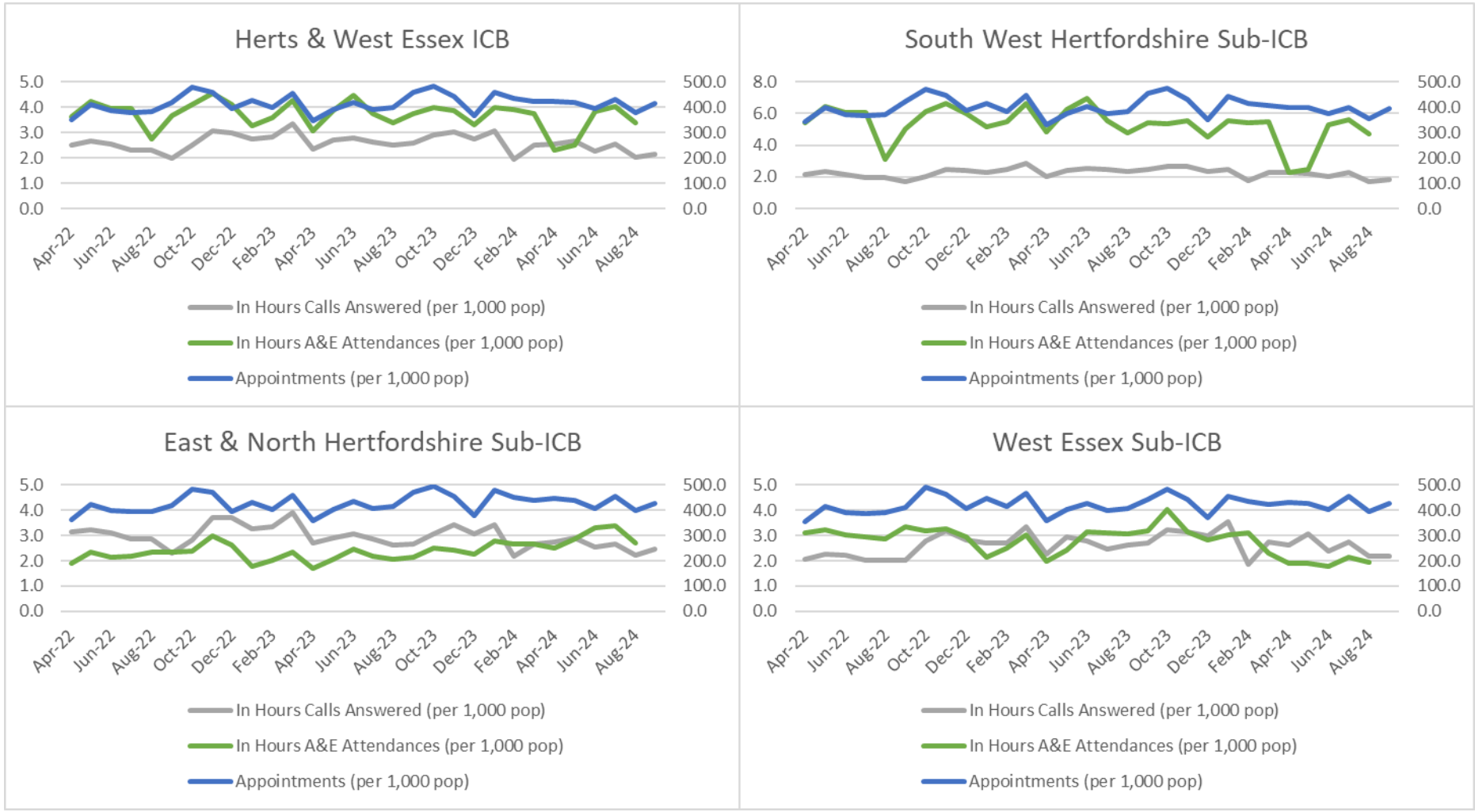
- National OCVC data shows clinical & admin Online Consultation submissions per practice.
- HWE for Sept-24 shows 92 submissions per 1,000 patients, second highest rate in England
- Considerable variance across practices, although is to be expected to some extent, given some practices have implemented a digital led triage model, so high volumes expected
- 19 practices show use of over 200 submissions per 1,000 patients, per month
- 30 practices show of less than 10 submissions per 1,000 patients, per month
- This will be a key element in reviewing MGP implementation & Local CAIP submissions leading into year-end

111 calls in GP core hours

- HWE have been monitoring this data for some time and have included in wider Primary Care data access dashboard
- NHSE have additionally just published this data for the period April-Sept 24
- *To support the implementation of Modern General Practice Access, the plan commits NHS England to sharing data on the number of calls to 111 in core hours with primary care network (PCN) clinical directors, to support quality improvement, so practices only divert to NHS 111 in exceptional circumstances.*
- This data shows HWE with a lower call rate than the national average; ranked the 15th best of 42 ICBs
- Whilst the national data methodology differs from that used by HWE, however the outcomes are broadly similar in that the same practices are identified with higher call rates.
- Further targeted work is planned to triangulate 111 call outliers to corroborate aspects of implementing the MGP model.

Primary Care Access Dashboard to support monitoring and impact – early stage

GP Appointments & 111 Calls & Minor A&E by ICB/Place (VB11Z – No significant treatment)



Same Day Access Hubs – latest developments

WE

- UTC in Harlow live from 1st November 2023 and mobilisation successful. Providers working very well together on a daily basis to manage demand and revise approaches and workforce accordingly. Waiting times very low and patient satisfaction good. IUATC dashboard produced outlining attendances, demand over the week, waiting times, frequent users. Detailed analysis of S1 data commenced to inform workforce modelling

- LB&C PCN enhanced/same day access hub – flexible to support with demand e.g. OPEL 3 and 4 practices

SWH

- St Albans IUCH appt only ANP led service-initiated in Nov 22 - 98% seen & treated within 2 hours.

ENH

- A detailed case study and evaluation report of the same day access hubs in Stevenage North & Stevenage South PCNs are both to be presented under separate agenda items at this committee meeting today.

- The Herford & Rurals (H&R) PCN Minor Illness Hub service unfortunately had to be scaled back from October 2024 in view of other PCN operational pressures and priorities and has now been paused. H&R PCN is spread over a relatively large geographical area, and therefore some patients are reluctant to travel to the hub site location which has resulted in an inequity spend vs usage for each GP practice. Discussions are ongoing of how this could be resolved within the PCN delivery model for their patient population served.

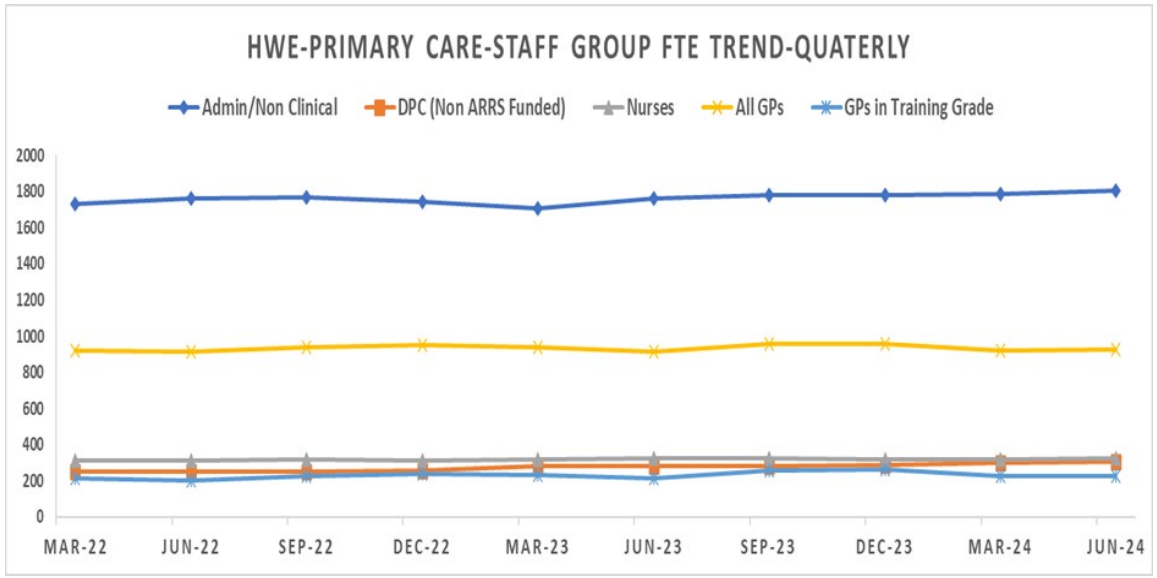
Building Capacity – Developing Primary Care Workforce

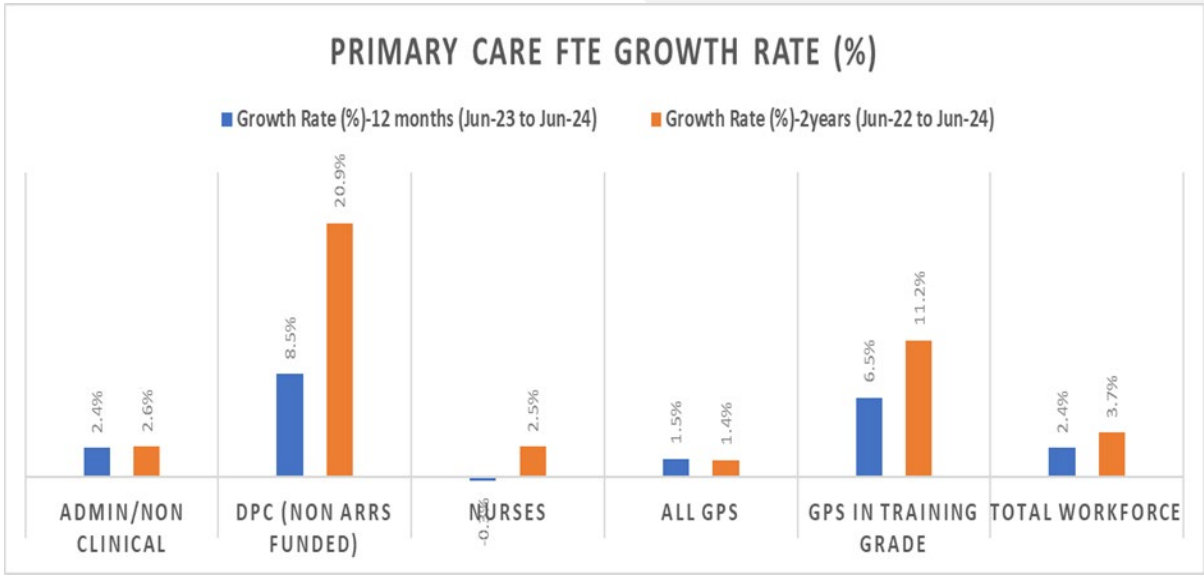
Overview

- Analysis shows that between June 2023 and June 2024, there has been a steady increase in the total primary care workforce, with a 2.4% (80 FTE) rise over the 12-month period. This does not include ARRS staff.
- The ratio of GPs to nurses in each PCN varies considerably. However, many GP practices are facing significant challenges in recruiting and retaining staff. There are also various workforce models involving different types of staff.
- The age profile of key staff in primary care poses a risk regarding future attrition.
- Anecdotal evidence suggests that vacancy rates are a concern across primary care. However, data on vacancy rates and turnover is not collected, meaning we lack a complete picture and cannot track changes over time. The Training Hub, along with system workforce planning colleagues, is investigating methods to capture this type of intelligence to better inform planning.
- The Training Hub continues to support practices with staff recruitment and is currently working with Primary Care Careers to ensure practices and networks have the appropriate resource to quickly advertise and recruit staff.

Primary Care FTE Growth Rate (%) By Staff Group

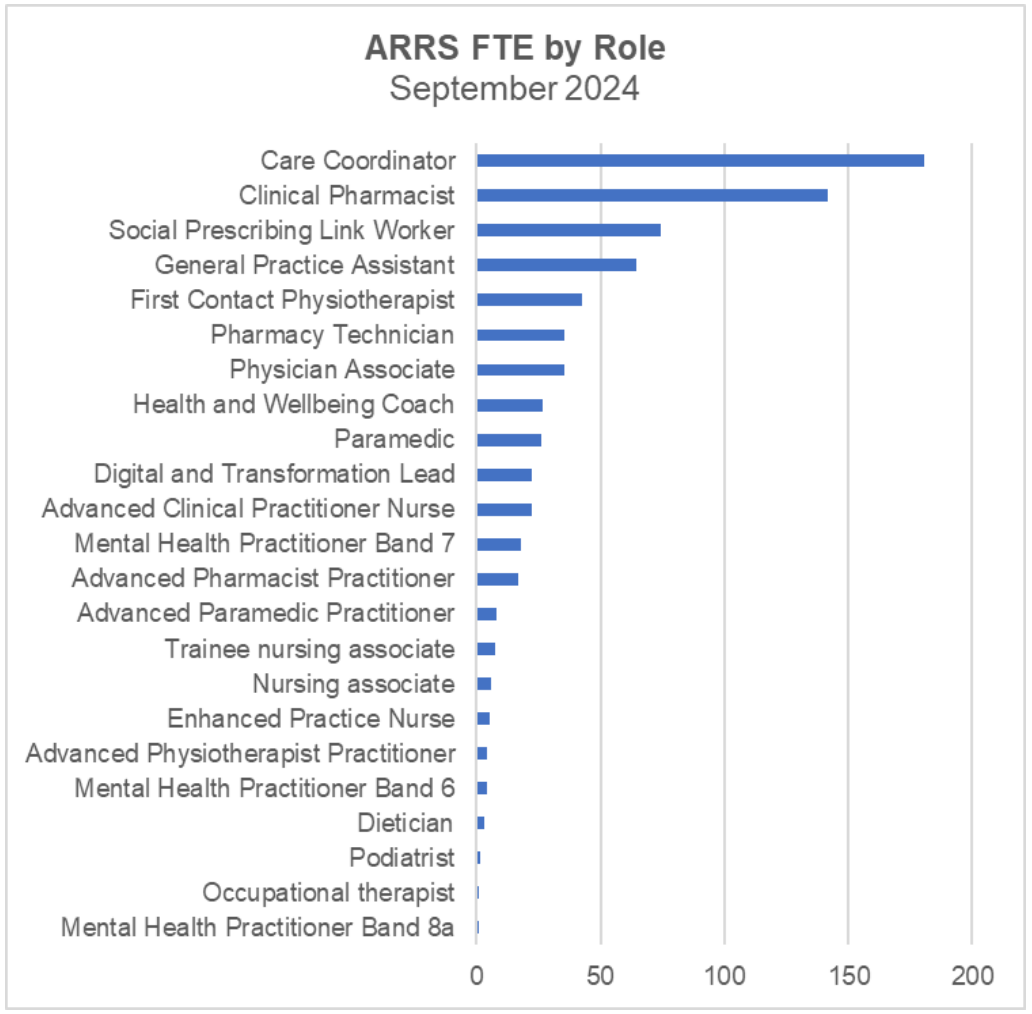
- Analysis shows a steady growth in the total primary care workforce:
  - A 3.7% (119 WTE) rise over the 2-year period from June 2022 to June 2024.
  - A 2.4% (80 WTE) rise over the 12-month period from June 2023 to June 2024.
- Over the 12 months from June 2023 to June 2024, there was a 1.54% (14 FTE) increase in all GPs and a 6.54% (14 FTE) increase in GPs in training grades.



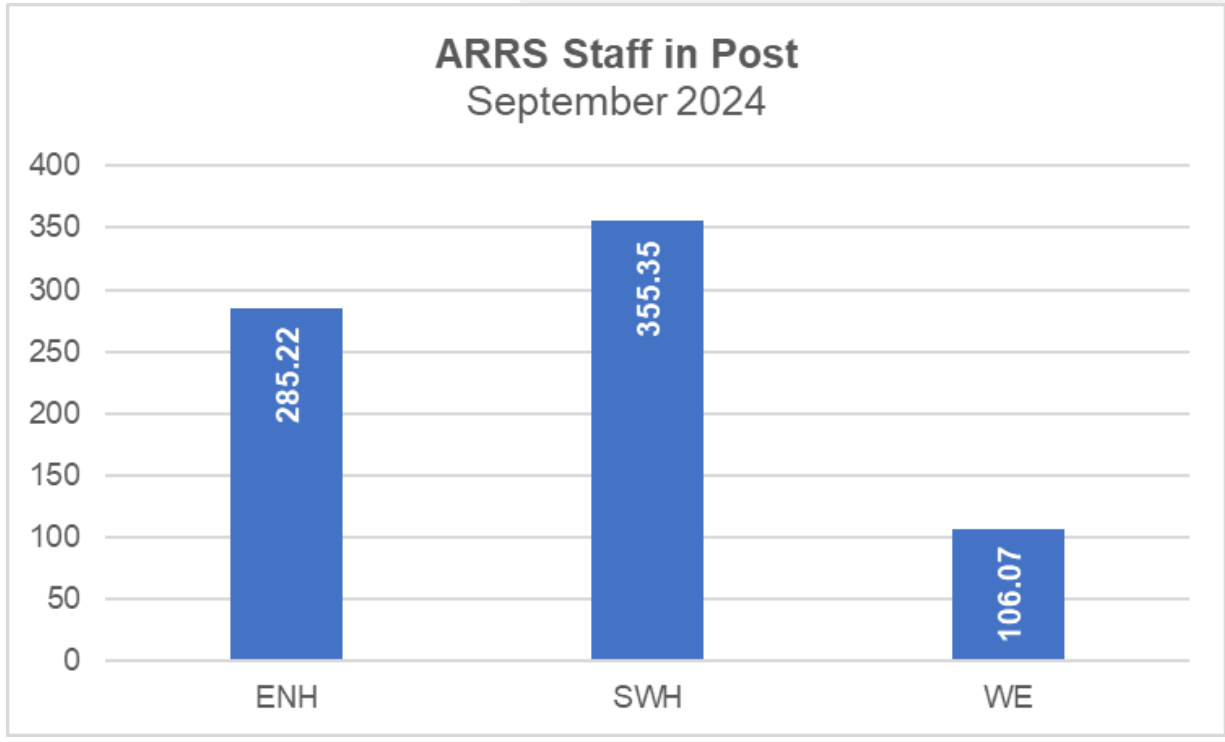


Hertfordshire and West Essex Integrated Care System

PCN Additional Roles Scheme (ARRS)



- ARRS staff in post has risen by 72 FTE between January 2024 and September 2024.
- FTE has decreased marginally since the start of the financial year, owing to the lack of increases to the ARRS global sum funding.



Hertfordshire and West Essex Integrated Care System

Primary Care- Staff Group distribution per 10,000 Patients

- The Direct Patient Care (DPC) roles presented in this table are practice employed (PCN ARRS roles are not included)
- According to the BMA, a single full-time GP is now responsible for an average of 2,295 patients. This is 357 more than in September 2015 (BMA)
- The table shows that min of 5.7 GP FTE is responsible for 10,000 patients, which suggests that in HWE there is a slightly higher ratio of GP to patients.

Jun-24											
HWE PCNs	**TOTAL_PATIENTS**	**TOTAL_GP_FTE**	**TOTAL_GP_TRN_GR_FTE**	**TOTAL_NURSES_FTE**	**TOTAL_DPC_FTE**	**TOTAL_ADMIN_FTE**	**ALL GP FTE per 10K patients**	**Nurses FTE per 10K patients**	**DPC FTE per 10K patients**	**Admin FTE per 10K patients**
ABBEY HEALTH PCN	28356	14.02	1.71	5.28	3.05	25.13	4.94	1.86	1.08	8.86
ALBAN HEALTHCARE PCN	46683	32.61	8.00	8.29	11.82	56.38	6.99	1.78	2.53	12.08
ALLIANCE PCN	27623	9.99	0.00	2.76	2.64	25.79	3.62	1.00	0.96	9.34
ALPHA PCN	58914	32.15	7.15	9.32	9.96	66.88	5.46	1.58	1.69	11.35
ATTENBOROUGH PCN	32685	13.94	2.13	2.32	2.24	39.62	4.27	0.71	0.69	12.12
BRIDGEWATER PCN	35113	23.23	9.07	4.71	17.09	37.85	6.62	1.34	4.87	10.78
BROXBOURNE ALLIANCE PCN	45056	27.24	9.28	9.59	2.94	52.30	6.04	2.13	0.65	11.61
CENTRAL WATFORD PCN	37371	13.49	0.00	3.13	15.49	34.36	3.61	0.84	4.15	9.19
DACORUM BETA PCN	50681	24.48	3.09	7.03	9.10	53.26	4.83	1.39	1.80	10.51
DELTA PCN	52452	28.13	2.67	9.48	4.28	60.80	5.36	1.81	0.82	11.59
EPPING FOREST NORTH PCN	67544	43.49	17.71	14.97	18.04	74.79	6.44	2.22	2.67	11.07
GRAND UNION PCN	26527	14.39	3.52	2.24	9.37	23.69	5.43	0.84	3.53	8.93
HALO PCN	34524	26.95	8.53	9.17	3.61	48.13	7.81	2.66	1.05	13.94
HARLOW NORTH PCN	63589	27.48	7.89	15.29	14.27	68.49	4.32	2.41	2.24	10.77
HARLOW SOUTH PCN	42912	25.99	11.09	7.14	11.27	50.00	6.06	1.66	2.63	11.65
HARPENDEN HEALTH PCN	45327	30.87	7.47	6.85	2.88	48.96	6.81	1.51	0.64	10.80
HATFIELD PCN	53883	37.21	8.32	8.64	12.43	60.58	6.91	1.60	2.31	11.24
HERTFORD AND RURALS PCN	68158	37.05	5.12	14.03	10.31	70.96	5.44	2.06	1.51	10.41
HERTS FIVE PCN	67539	31.96	2.67	10.65	10.16	68.12	4.73	1.58	1.50	10.09
HITCHIN AND WHITWELL PCN	47695	32.04	5.12	10.24	7.13	61.37	6.72	2.15	1.50	12.87
HODDESDON and BROXBOURNE PCN	42042	26.15	4.59	11.51	1.69	50.18	6.22	2.74	0.40	11.94
ICKNIELD PCN	59011	33.00	8.53	11.13	3.43	51.22	5.59	1.89	0.58	8.68
LEA VALLEY HEALTH PCN	34556	12.89	2.77	8.16	7.73	42.11	3.73	2.36	2.24	12.19
LOUGHTON BUCKHURST HILL and CHIGWELL PCN	62269	38.75	12.48	11.05	3.12	62.31	6.22	1.78	0.50	10.01
MVPS PCN	51203	27.25	1.07	9.84	13.63	55.25	5.32	1.92	2.66	10.79
NORTH UTTLESFORD PCN	42382	23.15	5.33	11.68	17.44	53.86	5.46	2.76	4.11	12.71
NORTH WATFORD PCN	26548	10.83	2.13	4.36	3.40	29.45	4.08	1.64	1.28	11.09
POTTERS BAR PCN	30629	25.99	9.17	4.05	6.03	31.27	8.49	1.32	1.97	10.21
RICKMANSWORTH and CHORLEYWOOD PCN	29969	14.81	3.63	5.44	4.68	31.75	4.94	1.82	1.56	10.59
SOUTH UTTLESFORD PCN	47910	26.64	6.29	9.03	19.87	59.93	5.56	1.89	4.15	12.51
STEVENAGE NORTH PCN	50740	19.72	4.69	12.79	5.92	40.16	3.89	2.52	1.17	7.91
STEVENAGE SOUTH PCN	66020	33.94	13.44	13.92	11.55	58.13	5.14	2.11	1.75	8.80
STORT VALLEY and VILLAGES PCN	69569	42.55	18.35	13.81	12.89	78.44	6.12	1.99	1.85	11.28
Unaligned	14713	11.85	4.27	4.97	4.33	22.43	8.05	3.38	2.95	15.24
WARE AND RURALS PCN	36264	21.20	4.27	10.53	3.94	33.33	5.85	2.90	1.09	9.19
WELWYN GARDEN CITY A PCN	59785	30.23	6.19	11.00	8.07	64.59	5.06	1.84	1.35	10.80
Grand Total	**1656242**	**925.66**	**227.73**	**314.41**	**305.81**	**1791.86**	**5.59**	**1.90**	**1.85**	**10.82**

Celebrating Primary Care Achievement Awards 2024

- One the 6th November 2024, the second annual 'Celebrating Primary Care Achievements' awards were held, showcasing a wealth of different NHS primary care service across HWE. 65 nominations were received, highlighting projects, teams and individuals across nine categories.

- Dr Jane Halpin, Chief Executive of HWE ICB, praised the nominees and all those who work in primary care: *"I want to say a huge thank you to every member of the primary care workforce, without whom we would not be providing high-quality primary care services for our population. The increasing need for health services in our communities means it has been an extremely challenging year, and each member of the workforce has stepped up to the challenge and shown what it takes to truly work together as a team".*

- The categories and the winners were as follows:
    - Excellence in Supporting Staff Health and Wellbeing: Stockwell Lodge Medical Centre Management Team (Cheshunt)
    - Excellence in Training and Development: Attenborough Surgery (Bushey)
    - Excellence in Patient Engagement: Stevenage South PCN Patient Participation Group
    - Excellence in Integration and Collaboration: Loughton, Buckhurst Hill and Chigwell PCN - Centralised Care Home Hub and Hitchin & Whitwell PCN Carers' Cafe Team
    - Leaders in Innovation: Hertsmere Cancer Screening Initiative
    - Ophthalmic Service of the Year: Hertford Optometry
    - Dental Practice of the Year: Watford Blue Cross Dental Care Team
    - General Practice of the Year: Much Hadham Health Centre
    - Primary Care Network of the Year: Hitchin & Whitwell PCN

GP Educator & Learning Organisation Expansion

- **New GP Educator Pathway**
  - There has been significant interest and enthusiasm for the new, locally administered, interactive, and supportive model of GP Educator Training. This initiative is a collaborative effort involving the HWE TH Training & Expansion Lead, HWE Quality Lead, and GP School HWE Associate Deans, aimed at developing, expanding, and streamlining the programme. Support is provided from the initial expression of interest by new aspirants, through pre-course preparation, addressing any issues faced by aspirant educators or practice/PCN-based Learning Organisations (LOs), and facilitating the path to Educator approval. The aim is to continue, expand, and further develop support for New Educators and New LOs as they transition into active training.
  - Since April 2024, the following new GP Educators have been approved through the pathway:
    - Tier 2a (OOH Supervisors, providing supervision to GP trainees in out of hours settings): 4
    - Tier 2b (Associate Trainers, providing supervision to ST2 GP trainees and foundation doctors) = 10
    - Tier 3 (GP Trainers, providing clinical and educational supervision to all GP trainees and foundation doctors) = 86
  - Aspiring Educator Training dates delivered/planned as per below:
    - 13th and 14 March 2024 = 35 attendees
    - 4th and 11th July 2024 = 31 attendees
    - 13th & 14th November 2024 = 28 planned attendees
- **GP Trainee Exam Support**
  - Over the past 24 months, the Training Hub has improved trainee exam support and trainer support in Central Hertfordshire (CH) and West Essex (WE). Key outcomes include:
    - Central Hertfordshire: AKT pass rates increased from 42% to 66%, and SCA pass rates from 53% to 82%.
    - West Essex: Focused on RCA/SCA exams, with ongoing data collection.
  - These improvements have enhanced workforce capacity and morale and aim to support more trainees to pass exams first time and reduce extensions. Additional support measures for trainers in CH and WE are being implemented, including workshops and events.

Retention Initiatives for Primary Care Staff

- **Fellowships (Enhanced & Mid-Career Programmes))**
  - **Enhanced Fellowship:** One-year specialist placements for GPs within five years post-CCT; final cohort due to conclude this financial year. Broad provider engagement across specialist areas; ongoing placements despite funding constraints.
  - **Mid-Career Fellowship:** One-year placements to develop clinical, management, and leadership skills for mid-career GPs. 5 fellows (2 in frailty, 2 in dermatology and 1 in public health. Programme aims to bridge the primary/secondary care gap.
  - **AHP & Nursing Fellowships:** Specialist roles in Lifestyle Medicine, Cardiology, and Women's Health; supports recruitment/retention for experienced AHPs, Pharmacists, and Nurses. 3 fellows (2 pharmacists and 1 GPN). Provides clinicians with career/portfolio opportunities across different sectors.
- **New to Practice Programme 24/25**
  - Redesigned programme to provide a range of support to newly qualified GPs. 19 GPs enrolled and will have access to online webinars, business fundamentals, peer support and mentoring. Programme supports transition to general practice with the aim of reducing attrition.
- **First 5 & Wise 5 GP Networks**
  - Peer support networks for GPs in their first five-year post-qualification, and the latter stages of their career, respectively. Dedicated GP Clinical Leads supporting 1:1 career conversations and signposting to available initiatives. First 5 network = 159 members; Wise 5 network = 60 active members.
- **Supporting Mentors Scheme**
  - Programme provides recently qualified GPs with experienced, trained mentors to help provide career guidance and personal development support. 7 mentors currently trained; 19 new GPs joined as mentees in 2024/25.

Primary Care Training Programme & Development

- All Primary Care staff can apply to the HWE Training Hub for funding towards their continued professional development following their annual appraisal/1:1s with their line managers.

- Since the start of the financial year (April 2024 to October 2024), a total of **680 course places have been commissioned** across various programmes. These include CPD courses for Allied Health Professionals (AHP) and Nursing staff, as well as GP career grant funding to support portfolio development. The distribution of these places by staff role is as follows:
    - **Nursing Staff:** 267 (39%)
    - **Administrative Staff:** 183 (27%)
    - **Direct Patient Care:** 206 (30%)
    - **General Practitioners:** 24 (4%)

- The training and development initiatives have been strategically reviewed and aligned with ICB priorities, local enhanced services, and local commissioning frameworks such as the Enhanced Care Framework (ECF). This ensures that the training needs of the primary care workforce are continuously assessed and matched with commissioning decisions, promoting an appropriate skill mix to support the delivery of high-quality care.

- **Advanced Practitioner role** – Those interested in undertaking the ACP course apply via the Training Hub and complete a Pre-Application Questionnaire. Following this, applicants will have an interview with a clinician at the Training Hub. Additionally, AP forums are held monthly. Focus for 25/26 is enrolment via the apprenticeship levy to maximise supervision funding available to practices.

PHARMACY KEY WORKSTREAMS

Undergraduate pharmacy clinical placements
Increase capacity & quality of placements across all pharmacy sectors.
This is to support the new General Pharmaceutical Council's Initial Education & Training standards for pharmacists, which were introduced in 2021. Implementation is expected to transform the education and training of pharmacists, so they are able to play a much greater role in providing clinical care to patients and the public from their first day on the register, including through prescribing medicines. In preparation, undergraduate training requires a greater focus on core practical skills development, supported by a significant increase in clinical placement exposure.
HWE ICB (in conjunction with University of Herts) ran a successful training event for potential placement providers in March 2023. This work continues with the development of 'champion roles'.

Develop system wide pharmacy recruitment & retention plan
(1) Map the gaps against the operation programme of work for each sector (including intra-professional collaboration & safe staffing levels), & develop a process at regular time periods to update, particularly at the point that supports winter planning;
(2) develop a system-wide recruitment and retention programme across all sectors.

Independent prescribing
Maximise the value of independent prescribers (including through commissioning) in all sectors in preparation for 2025/26, when all new pharmacist graduates will be Independent Prescribers. The aim is to facilitate the implementation of innovative pharmacy practices and service delivery models.

Staff wellbeing & experience
Implement strategies to promote job satisfaction, work-life balance, & a positive work environment

Cross sector working
Increase number of rotational & hybrid roles working across secondary care, community pharmacy and PCNs. Workstream to include facilitation, e.g. governance, access to IT hardware & systems.

Career pathway for pharmacy workforce
To establish a training pathway for the pharmacy workforce in primary care to support retention & role development. To include salary progression, peer support networks, mentorship, interprofessional education

Specialist roles
Increase number of advanced specialist, advanced generalist, & consultant roles for pharmacy workforce

University of Hertfordshire Medical School

The Primary Care Workforce team have been involved in the external stakeholder groups to learn more about the whole process of the medical school approval process. The University is working with St George's Medical School to develop their curriculum and are developing a Primary Care faculty.

The University is looking at international recruitment as their first intake of students to start in 2026 but the long term plan is to be a medical school for local people and with a focus on widening participation as with their other courses.

To ensure a comprehensive implementation plan is in place an internal validation event is planned for the Bachelor of Medicine, Bachelor of Surgery (MBBS) programme at the University, scheduled for 11 December 2024. The University has asked the ICB to affirm a commitment to providing clinical placements for the medical students from the Medical School.

The University is preparing to submit a full application to the GMC in January 2025.

Next Steps

Implication of the NHS Long Term Plan and Primary Care Strategic Plan on how we support the whole primary care workforce

Further build on workforce planning/attraction/recruitment and retention

- **Retention and Recruitment of AHP and Nursing Staff**
  - Nurses retiring and challenges to recruit – explore innovative ways of supporting to retain staff
  - Increase the number of apprenticeships
  - Increase the number of student placements
  - Increase the number of mentors
- **Embedding New Roles in Practices and PCNs**
  - Support for AHPs / ARRs including new roles such as General Practice Assistants (GPA)
  - Competency Frameworks
  - Continue the development of embedding PCN Training Teams in PCNs
- **Support to Develop Learning Organisations**
  - Increase numbers of learners
  - Increase trainers
  - Develop Culture of Learning
- **Training for non-clinical staff**
  - Increase training opportunities
  - Recruitment to non-clinical teams

Cut Bureaucracy

South and West Hertfordshire:

West Hertfordshire Teaching Hospitals Trust Primary & Secondary Care Interface meeting

Structure

- Monthly meetings with clear Terms of Reference and regularly reviewed
- Chair – Trust Deputy Medical Director, Co-chair is GP & ICB Clinical Lead
- Core Membership

Group Membership
Deputy Medical Director WHTHT
ICB Clinical Lead for Planned Care and Diagnostics
Director of Integrated Care WHTHT
Primary Care Locality GP Clinical Leads Two Leads agreed, when not available a deputy will be nominated to attend
HCP Care Closer to Home GP
WHTHT Director of Performance
Long Term Conditions and Prevention GP Lead - ICS
LMC representative
Head of Primary Care at Place
SWHHCP Development Director
Chief Strategy & Collaboration Officer, WHTHT
Senior Primary Care Manager - Transformation, Integration and Delivery
Assistant Director, Planned Care
Lead Pharmacist, HWE ICB
ICB Digital Clinical Lead (GP CCIOs)

Purpose of the Interface Group

- **Ensuring the patient is the centre of everything**
- **Work together** to identify and resolve any issues that arise between the Trust and primary care services that affect the effective integration of patient care services. The focus is the resolution of any issues that may hamper day to day clinical interaction
- Contribute to the maintenance of **strong working relationships and open communication** between WHTHT Consultants and local GPs.
- Focus on **resolution of issues** that may hamper day to day clinical interaction, keeping the patient in the centre
- To resolve **concerns and queries** before they become formal clinical concerns or complaints
- The forum will focus on **influencing and shaping practical issues** to improve local clinical pathways
- **New** and or **proposed changes to pathways** by primary or secondary care are discussed to ensure impact on other partners will be identified and a way forward agreed before any change is implemented
- To **share learning** and other **key developments** with colleagues across primary and secondary care

What's working well

- Consistent he patient at the centre of everything we do in the purpose please
- Built on **good working relationships** and wanting to do the right thing
- **Excellent Senior Trust engagement** and buy in (Deputy Medical Director, Director of Integrated Care, Director of Performance) *noting* the key here is that they are **decision makers** and can implement things quickly
- Representation from all 4 Localities (Clinical Leads)
- **Summary of key messages** from the meeting to be now shared as a regular item at **Locality Delivery Boards** (Dacorum, Watford & Three Rivers, Hertsmere and Dacorum)
- **Action Tracker** actively managed by Director of Integrated Care
- **Consensus document for Primary/secondary care interface working -** agreed and implemented

What's working well - continued

- **Deep Dives** (these are key, every 2 months, rotating through clinical specialties. Gathers feedback widely from Primary care and Secondary care clinicians on how interface for those specialties can be improved and future pathways that can be developed). **Cardiology, Dermatology, Neurology** and **Frailty** so far.
- Supporting and refining implementation of **new services/pathways** (e.g. move to online blood test booking system
- **Feedback to primary care** to complete the loop (work in progress, but will be happening)
- Noting this is **not** a Contract or Performance Group

Achievements

- Agreement of the Primary and Secondary Care Consensus document through Clinician-to-Clinician collaboration
- Process embedded within both Primary and Secondary Care to identify any clinical interfaces issues (informing the agenda as appropriate)
- Identification of which pathway(s) may need to be reviewed/amended or implemented. Build a work programme by specialty area.
- Developed best practice ‘Advice and Guidance’ Guidelines for Primary and Secondary Care
- Standardisation of DOAC Prescribing & Patient reconciled treatment education, (OTC Medication) delivering significant financial benefits for the system and were all worked through by our group.
- Testing and then roll out of iRefer has been highlighted by LMC colleagues as far smoother than in other areas as we kept a line through the group

Achievements - continued

Key areas reviewed - either via pathway amendment/or producing comms/socialising this through webinars/locality forums include:

Giant Cell Arthritis Pathway-
Discharge Summary and Outpatient letters
DEXA scans
Familial Hypercholesterolaemia (FH)
RACP/Heart Failure

Barriers

- Mainly **communication** reaching all areas of the Trust and Primary Care to have a standardised approach – this remains an *ongoing project* and we continue communicating and reminding clinicians of their respective obligations

Next Steps

- Continue to work on communication routes
- Embed and communicate learning from quick wins
- Liaison with other Acute Trusts to join existing Interface Groups (e.g. Royal Free Hospital) – Primary Care Team Leads

East & North Hertfordshire NHS Trust
Primary & Secondary Care Interface meeting

and

Primary & Community Services (Hertfordshire Community Trust) Interface group

East & North Hertfordshire NHS Trust - Primary & Secondary Care Interface meeting

Structure and format

- The interface group reviewed the Terms of reference in January 2024 which were subsequently updated & agreed. Meetings are held every 3 months for duration of 90 mins.
- The meetings are currently co-chaired by Primary Care Partner member and Consultant and Clinical lead from Trust.. Group membership consists of Primary care GP's, Consultants, LMC Representative, Senior Trust & ICB primary care management. With speakers/presenters joining on an ad hoc basis depending on topics being covered on the agenda. A dedicated action tracker is used for recording & updating of any agreed actions.

Key Focus areas

- Any day to day operational issues which may impact on day to day clinical interactions from a primary or secondary perspective
- Relationship building; improve communication, to facilitate discussions around patient pathway issues to improve outcomes
- Aim of reducing bureaucracy – reducing workload between primary & secondary care
- Improvement of local clinical patient pathways and discuss any proposed changes
- Sharing of learning and any key developments from a primary or secondary perspective

Key Achievements

- Code of conduct consensus document agreed and signed off in early 2024
- A second update of the Primary & Secondary care Assessment tool was ratified and signed off in September 2024
- Open discussions around operational issues with solutions provided and or agreed timelines for update and resolution
- Action tracker holds task holders to account in providing updates with timelines
- Identifying dates/times to schedule meetings however progress has been made to forward plan more recently

Challenges

- Availability of key attendees can be challenging (often due to clinical commitments)
- Attendance variable (often due to clinical commitments)

Next Steps

- Continue the good work that is already progressing.
- Review clinical leadership of group in view of recent clinical lead appointments and attendance from core membership across both Trust, Primary care and the ICB
- How we can learn from other interface groups and share how issues have been resolved.

East & North Hertfordshire NHS Trust - Primary & Community Services Interface meeting

Structure and format

- This operational focused interface group was established in autumn 2023 in response to matters raised from the Clinical Leadership meetings and to improve relationships between partners; agreeing and implementing actions to reduce bureaucracy at place.
- Group membership consists of Primary care GP's, , Senior Community Trust management & ICB primary care management. With other colleagues joining on an ad hoc basis depending on topics being covered on the agenda.
- Administration of this meeting is now shared between Trust GP Liaison Officer and Primary Care Administration team member
- Meetings are held bi-monthly and operational matters discussed ad hoc in between. The chairing of this meeting is shared by primary and community leads
- A dedicated action tracker is used for recording & updating of any agreed actions of which are shared back to the clinical leadership meeting at place.

Next steps

- Continue the good work that is already progressing e.g. review and rationalising of referral processes by a GP working directly with the Community Trusts digital team.
- Review clinical leadership of group in view of recent clinical lead appointments and attendance from core membership across both Community Trust, Primary care and the ICB
- A review of the secondary interface assessment tool and how this can be utilised to drive improvement is underway

West Essex Primary & Secondary Care Interface meeting.

Structure

- Monthly meetings with clear Terms of Reference and regularly reviewed, since 2021

- Chair – Dr Mark Lim, Associate Medical Director and Consultant in Public Health

- Core Membership
  - West Essex HCP – Associate Medical Director, OD Director
  - EPUT
  - HCT
  - PAH
  - LMC
  - GP Digital Place lead / GP clinical lead
  - Quality
  - Contracting
  - Primary Care Place Team – Head of Primary Care Transformation

- PLEASE NOTE THIS MEETING IS SO MUCH MORE THAN PRIMARY AND SECONDARY CARE AND INCLUDES ALL HEALTHCARE PROVIDERS IN WEST ESSEX

Key updates for Primary Care, Secondary Care and Prescribing

- **Secondary Care**

- Avoid asking General Practice to organise specialist testing - The implementation of the new Electronic Health Record in November 2024 will further enhance this onward referral ability as clinicians will triage all internal referrals, accepting or responding with advice & guidance for the referring clinician & patient.

- If patients require a 'fit note (sick note)' then please provide one - EHR is now live expected to significantly improve this.

- Immediate prescribing is required from Outpatients, please prescribe accordingly -EHR is now live expected to significantly improve this.

- Please arrange onward referral without referring back to the GP, where appropriate - The implementation of the EHR in November will give clinicians & staff clearer visibility of test results, actions and follow-up requests required to enable better patient follow-up. In addition, the patient portal roll-out in 2025 will give patients better visibility through the NHS App.

- Ensure accurate, clear, and timely communication to Primary Care following patient contacts, using any agreed templates for this -EHR is now live expected to significantly improve this.

- When recommending ongoing prescribing from General Practice, please check locally agreed Prescribing Formulary first - EHR is now live expected to significantly improve this.

- Ensure any DNAs are not automatically discharged without clinical review – Numerous case studies have been reviewed and working through how to move this forward

- Ensure any discharge information is communicated to the patient and GP stating reasons why - EHR is now live expected to significantly improve this.

What's working well

- Core membership includes all WE healthcare providers. (not just primary care and acute trust)
- Working groups have been established to work through specific issues and provide progress updates.
- Case studies are presented at each meeting which cover issues and showcases good practice.
- A clear joint ethos of improving interfaces for the benefit of the patient and clinical care.
- Action Tracker actively managed by Director of Integrated Care
- It is always a face-to-face meeting to allow relationship building.

Barriers

- Princess Alexandra Hospital for the past 15months has been working on changing to a new clinical health system which has slowed some progress, but much needed to move forward.

Positives

- Princess Alexandra Hospital new clinical system is now live and with the new enhanced technology they will be able to deliver on many of the secondary care identified in PCARP.

Primary & Community Mental Health Services Interface meeting

Structure and format

- The group acts as a conduit to share updates, developments, learning and communications with colleagues. Dissemination of the discussion and information is cascaded to all clinical colleagues by those in attendance and minutes of the meetings which are held bi-monthly.

- The group contributes to existing and new patient pathways and the maintenance of strong working relationships and open communication between hospital consultants and local GPs, ensures the effectiveness of the systems, processes and behaviours in place for the interface between primary and secondary care.

- Discusses and brings issues that arise between the provider and primary care services that affect the effective integration of services surrounding the service user. The focus is the resolution of any issues that interfere with the seamless zipwire and joined up care for the service user. To problem solve with empathy and two-way facilitation – problem solving for each other in the practical and day to day tweaking of bad practice or faults in pathway

- There is no power to decision make at this meeting, but it is expected to provide clinical recommendations and a clinical view point on pathway implementation which will then be escalated to the relevant board and working groups

Next steps

- Continue the good work that is already progressing e.g. *working group quickly established in relation to Shared care information in support of ADHD and ASD operationally responding to requests for support.*

- A review of the secondary interface assessment tool and how this can be utilised to drive improvement is already underway.

Online Registrations – Register with a GP

From October 2024 it is a contractual requirement that practices use the national 'Register with a GP' service to allow patients to register with a practice via a standardised online form.

To date 117 of our 125 practices have enrolled with this service.

Benefits include

- Enhanced patient experience: the service is integrated with 'Find a GP,' and the NHS App allowing patients to easily find practices within their catchment area. This significantly reduces unnecessary traffic from patients unsure of where to go, creating a seamless patient experience.
- Verified patient information: patients are verified during sign-in using NHS login, enhancing security and trust in the registration process.
- Efficient NHS number matching: with a 90% success rate in matching patient information to Personal Demographics Service (PDS) records, we save time and avoid data duplication.

Dental Access Recovery Plan

Hertfordshire and
West Essex Integrated
Care System

Dental Recovery Plan - Overview

- On 7 February 2024, NHSE published their joint plan with the Department of Health and Social Care on the recovery and reform of NHS Dentistry[1] The plan builds on the dental contract reforms announced in July 2022 and is designed to improve access to NHS dental care and supporting the return to pre-pandemic levels of activity.

  Measures include:

  1. Increase access and delivery of activity:
     a) New Patient Premium/Tariff will be introduced for patients who have been unable to access care in the past 2 years; additional payments on top of the current treatment Bands 1 (£15), 2 and 3 (£50)
     b) Increase of the minimum UDA value from £23 to £28 – this will take effect from 1 April 2024 and will be applied nationally
     c) Offer of a "Golden Hello" – funding for up to 240 posts across England where recruitment is challenging on the proviso that the dentist commits to stay in post for a full 3 years
     d) Ambition to introduce Dental Vans to support rural and/or under-served areas and to support hard-to-reach communities
  2. In addition, a range of government-delivered public health initiatives to improve the oral health of children

[1] https://www.gov.uk/government/publications/our-plan-to-recover-and-reform-nhs-dentistry

New Patient Premium

- There is no formal registration system with a dental practice, as there is in General Practice. Patients who have no existing relationship with a dental practice are struggling to access care.

- The latest GP Survey (Jan – March 2023) suggested that nationally, patients with no relationship with a practice had a 30% success rate in accessing care, compared to 83% for those patients already known to a practice

    - In HWE, the position is slightly better than the national average with 36% success rate of getting an appointment for patients with no relationship with a practice and 88% for patients with an existing relationship.

- The definition of a 'new patient' is anyone who has:
    - Not received a Band 1, 2, or 3 course of treatment (excluding urgent care) from that Provider (e.g. the individual or business entity who holds the contract) in the previous 24 months, **and**
    - Not received a Band 1, 2, or 3 course of treatment (excluding urgent care) from that contract in the previous 24 months, **and**
    - Not received a Band 1, 2, or 3 course of treatment (excluding urgent care) from that clinician (a dentist or dental care professional) in the previous 24 months (this may be on contracts for different providers).

- The scheme is planned to run for 13 months – 1st March 24 – 31st March 25 and practice will receive an additional Unit of Dental Activity (UDA) credit equivalent to £15 for Band 1 treatment and £50 for Band 2 or 3 treatment on top of the UDAs they receive under their normal GDS Contract

- There is no additional funding to support this initiative so the additional UDA credits that relate to new patients are deducted from the contracted activity; resulting in a quicker delivery of contracted activity than previous years. This has an unintended consequence of reducing access as there is less capacity within those contracts who routinely achieve the 96-102% contract thresholds.

New Patient Premium – Impact Mid-Year 2024/25

- The mid-year performance data for 2024/25 reports that contract delivery at this point has increased by 7.32% compared to mid-year in 23/24 and 9.55% compared to mid-year 22/23

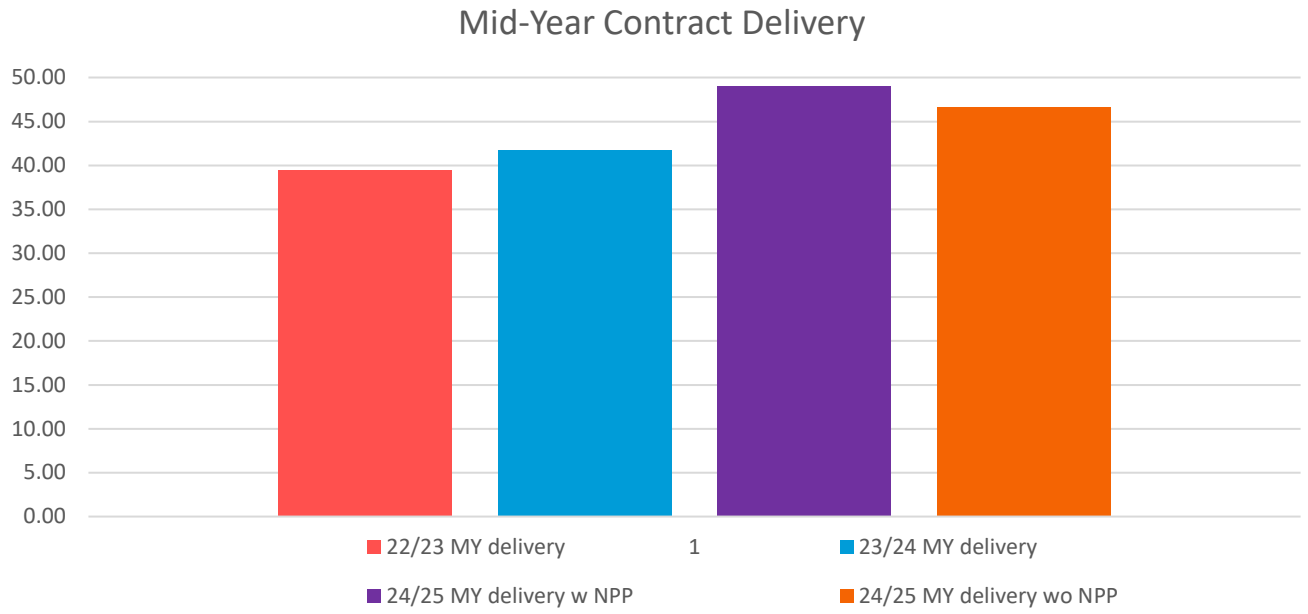


Table 1: comparison of UDA delivery at mid-year

- The number of UDAs delivered at mid-year, adjusted for NPP was 1,040,983 which is an increase of 50,861 if NPP had not been introduced

Increase to national UDA rate

- In 2022, as part of the national dental contract reform there was a commitment to introduce a minimum UDA rate for dental contracts of £23

- This was further increased in February 2024 to £28 to support recruitment and retention of workforce and to account for rising overhead costs and cost of living increases; however, it should be noted the increase does not go far enough to close the gap between income and expenditure.

- In HWE, the majority of UDA rates are set at a more favourable rate but there were 9 practices whose rate was below the minimum £28. These ranged from £25.33 per UDA to £27.58

    - Contractors were given an option of additional funding to increase their UDA rate or;
    - Reduction of the annual contracted activity but retain the contract value

- Most contractors opted for the additional funding option which was implemented with immediate effect.

Dental Recruitment Incentive Scheme

- The aim of the Dental Recruitment Incentive Scheme (DRIS) is to offer a financial incentive to attract dentists to commit to work in parts of the country that are struggling to attract workforce through the usual recruitment routes.

- The scheme is open to overseas dentists to widen the opportunity to attract dentists.

- A 'golden hello' bonus payment of £20,000 is offered per dentist subject to commitment to remain working in the same area for a minimum of 3 years. The payment of the incentive is therefore phased across the 3 years as follows:

	% Payment	Payment based on 1 WTE	
Year 1 (2024/25)	50%	£10,000	Paid on commencement into post and following receipt of a signed copy of the agreement (Annex D)
Year 2 (2025/26)	25%	£5,000	Payment made at beginning of second year in post.
Year 3 (2025/26	25%	£5,000	Payment made at beginning of third year in post.

- In addition to the commitment to remain in the same area, dentists are required to deliver a minimum number of UDAs and deliver the majority of their total working hours delivery NHS care. (Dentists can be recruited on a part-time basis and the incentive and required UDAs would be adjusted accordingly)

- Across EoE there is a requirement to attract 41 new dentists to the region – this has been allocated out to ICBs based on current dental access and workforce rates and as HWE is in the top for both categories (alongside MSE), our 'allocation' is for 3 WTE posts; following an EoI process where 11 applications were submitted, only 1 application met the eligibility criteria and the practice has been successful in it's recruitment process.

Next Steps for 24/25

- ICB supportive approach will continue through 24/25. Full assessment of MGP implementation utilising resources available, including Transition Cover applications, Local CAIP self-declarations, Online Consultation rates, 111 calls in-hours, Telephony data when available
- Digital focus – continued drive to increase NHS App usage; maximise prospective records access and promote online registration available in all practices
- Continue to expand & promote patient Self-Referral pathways
- Expand uptake of Pharmacy First services
- Further develop & implement new models at practice/PCN and place level
- Further progress on the implementation of the four Primary Care Secondary Care Interface Arm recommendations
- Continue with expansion and retention commitments in the Long-Term Workforce Plan (LTWP)
- Further refinement of metrics to measure impact of access improvements
- Show continuous improvement of LTC management – quarterly reporting of Enhanced Commissioning Framework – showing improvements such as increase in 8 care diabetes processes, Advance Care Planning whilst triangulating with prescribing and impact on NEL etc where possible

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 Transformation Committee meeting held in Public				**Meeting Date:**	**28/11/2024**		
Report Title:	**Primary Care Risk Register**				**Agenda Item:**	**10**		
Report Author(s):	Andrew Tarry, Head of Primary Care Commissioning							
Report Presented by:	Andrew Tarry, Head of Primary Care Commissioning							
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]**	• Increase healthy life expectancy, and reduce inequality • Give every child the best start in life • Improve access to health and care services • Achieve a balanced financial position annually							
Key questions for the ICB Board / Committee:	The Committee is asked to note the content of paper							
Report History:	The risk register is a dynamic document and is presented to the respective primary care subgroups including Primary Care Commissioning Committee, Primary Care Workforce Group and Primary Care Digital Group and Primary Care Transformation Group for review, discussion and information.							
Executive Summary:	Further review of the Risk Register has been ongoing to refine the risks on the register, also to consider the 'issue' versus 'risk' position i.e. events that have occurred, rather than a potential risk that could occur. Noting that this is assessment remains open to some interpretation, however it is proposed to amend some of the previously recorded risks to issues. In these cases the scenarios have been removed from the Risk Register itself, however, will continue to be monitored using a separate internal Primary Care issues log. It is proposed to reduce the risk score of Risk 324 Processes for monitoring quality and performance of contract. Review has concluded that there are now sufficiently consistent and rigorous processes for							

	quality monitoring. Proposal is to reduce the risk rating from 12 to 8 (potential major impact, but unlikely to occur) Key updates and rationale for risk scores have been provided on the remaining Primary Care risks. The review and actions outlined will reduce the number of Primary Care risks reported on the Corporate Risk Register from 6 to 2. Risk 320 Pressures in General Practice – rated at 12. Risk 244 Access to Dental services – rated at 15.			
Recommendations:	The Committee is asked to • Note the proposed changes to the risks that have been reviewed • Note the update and progress made			
Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***	☐
	Financial	☐	***Non-Financial Personal***	☐
	None identified			☒
Implications / Impact:				
Patient Safety:	Patient safety issues are recognised in the appropriate risks			
Risk: *Link to Risk Register*	NA			
Financial Implications:	NA			
Impact Assessments: *(Completed and attached)*	***Equality Impact Assessment:***	NA		
	Quality Impact Assessment:	NA		
	Data Protection Impact Assessment:	NA		

1. Executive summary

Further review of the Risk Register has been ongoing to refine the risks on the register, also to consider the 'issue' versus 'risk' position i.e. events that have occurred, rather than a potential risk that could occur. Noting that this is assessment remains open to some interpretation, however it is proposed to amend some of the previously recorded risks to issues. In these cases the scenarios have been removed from the Risk Register itself, however, will continue to be monitored using a separate internal Primary Care issues log.

It is proposed that the following 3 risks are reclassified as Issues, as these are scenarios that have already occurred:

Risk 681 General Practice contract deal 2024/25/Collective Action
Risk 684 new digital tools and systems deployed in Primary Care do not interoperate with existing systems.
Risk 685 POD Quality and the lack of NHSE aligned quality staff on assumption of delegated responsibility.

It is proposed to reduce the risk score of *Risk 324 Processes for monitoring quality and performance of contract*. Review has concluded that there are now sufficiently consistent and rigorous processes for quality monitoring. This does not mean this removes the likelihood of variance across areas and practices, however the processes exist to flag these sufficiently & provide the opportunity to intervene. Proposal is to reduce the risk rating from 12 to 8 (potential major impact, but unlikely to occur)

Key updates and rationale for risk scores have been provided on the remaining Primary Care risks.

The review and actions outlined will reduce the number of Primary Care risks reported on the Corporate Risk Register from 6 to 2.
Risk 320 Pressures in General Practice – rated at 12.
Risk 244 Access to Dental services – rated at 15.

2. Background

Historically each of the three CCGs in HWE developed and maintained a primary care risk register; risks meeting predetermined thresholds were reported to Board via the Corporate Risk Register.

Work commenced on a new consolidated risk register across HWE as part of preparations for the creation of the HWE ICB. Each of the three individual risk registers were fully reviewed and archived as part of creating the new consolidated ICB Primary Care risk register across the three 'places'.

Following the Executive Team meeting in March-24, during which the Corporate Risk register was received, it became apparent that a further engagement with risk owners was paramount to ensure that the risks held on the corporate risk register are accurate.

In April the Primary Care Team undertook a full review of the recorded risks with advice and expertise provided by the Information Governance and Risk Team. Many of the risks were long

standing having been collated originally as part of initial consolidated Primary Care risk register, reflected the situation pre-delegation for POD contractual areas and pre-dated full adoption of the ICB operating model. Consequently, following the review, a number of risks were recommended for closure and these were agreed by the Committee in May-24.

3. Issues

Further review of the Risk Register has been ongoing to refine the risks on the register, also to consider the 'issue' versus 'risk' position i.e. events that have occurred, rather than a potential risk that could occur. Noting that this is assessment remains open to some interpretation, however it has been agreed to amend some of the previously recorded risks to issues. In these cases the scenarios have been removed from the Risk Register itself, however, will continue to be monitored using a separate internal Primary Care issues log.

The review and actions outlined below will reduce the number of Primary Care risks reported on the Corporate Risk Register from 6 to 2.

4. Actions

General Practice Risks

Reclassified as an Issue

Risk 681 General Practice contract deal 2024/25/Collective Action
This scenario has clearly now occurred and Collective Action is ongoing. Further developments and impact are being actively monitored and is now updated in the Primary Care issues log.

Proposed reduction in risk score

Risk 324 Processes for monitoring quality and performance of contract
Review has concluded that there are now sufficiently consistent and rigorous processes for quality monitoring. This does not mean this removes the likelihood of variance across areas and practices, however the processes exist to flag these sufficiently & provide the opportunity to intervene.
In light of this it is proposed that the risk rating is amended to reduce to 8 (potential major impact, but unlikely to occur)

Key updates

Risk 320 Pressures in General Practice
Risk rating of 12 so remains on Corporate Risk Register
Review has concluded that current scoring remains valid. There are ongoing discussions with local LMCs regarding several workstreams perceived to be unfunded (potentially outside the scope of GMS contract or existing locally funded services). These include Wound Care & wider ECF Treatment Room services, PSA screening, ADHD Shared care.
The potential patient impact and mitigation steps are being considered.

Risk 329 Forecasting or forward planning for changes and challenges in general practice workforce
With the controls we have in place and responsibility of contract holders for service delivery we would not expect to see this risk translate into an incident and given the provision of services across PCNs and wider health system would expect the impact to be moderate
An update has been made to the Controls to reflect engagement with PCNs. Primary Care Place leads and workforce team setting up meetings with PCNs to offer supportive conversations; a support tool template has been developed to support conversations.

Digital risks

Reclassified as an Issue

Risk 684 new digital tools and systems deployed in Primary Care do not interoperate with existing systems.
Given new digital are now deployed this is now an issue, with the impact of any such occurrences being monitored and recorded on the Primary Care issues log.

No further updates on the 2 remaining Digital risks. Current risk scores considered to remain valid.

Pharmacy Optometry Dental (POD) Risks

Reclassified as an Issue

Risk 685 POD Quality and the lack of NHSE aligned quality staff on assumption of delegated responsibility.
This has now been transferred to the issues log, given delegated responsibility from April 23. Assurance processes for POD have been developed and implemented since the transfer of the delegated functions. Recent internal audit report identified only one medium management risk regarding dental visits;

Key updates

Risk 244 Access to Dental services
Risk rating of 15 so remains on Corporate Risk Register
There is no change to risk score since the previous update; access to NHS dentistry continues to be challenge which has been further impacted by a contract hand-back and requests to reduce contracted activity without the ability to recommission at pace due to internal governance and current budgetary position.
A new control measure has been included; the Enhanced Access Scheme has been extended for a further 4months to end of March following an evaluation of the pilot. Expecting national specification/guidance on commissioning urgent access but no timeline given.

686 POD Workforce training & education opportunities
There remains further work to fully scope the potential gaps in training for all POD groups however, the risk is perceived to be low due to professional obligations of registered professionals in terms of training.
A new control measure has been included; planning the setting up of Primary Care Educators Forum, as a virtual quarterly forum to include POD.

5. Resource implications

Refinement of the Risk Register as proposed by this paper will mean that ongoing review of the live risks will be more focused, however will still require the relevant Primary Care Directorate members to commit to the process review.

6. Risks/Mitigation Measures

As noted above.

7. Recommendations

The Group is asked to:

Note the changes to the risk register including the proposals to redefine those risks now highlighted as issues.

Receive the risk register at future meetings (in accordance with the Primary Care Transformation Group's Annual Cycle of Business) in order to satisfy itself that risks are being appropriately captured and rated and that relevant/proportionate mitigation and controls are in place.

8. Next Steps

Ongoing review and update of the risk register.

Ensure that all recent updates to the risk register are entered onto the Datix system.

Transition Risks

Primary Care Directorate Risks - GENERAL PRACTICE SPECIFIC														Assurance Mapping							
ID	Datix ID	Date Opened	Committee	Executive Owner	Revised Risk Lead	Risk Description	Rating (initial)	Rating (current)	Rating (Target)	Risk Movement	Rationale for current risk score	Controls	Gaps in controls	1st Line Operational functions enforcing required behaviours and working practices throughout the organisation's day-to-day activities	1st Line - Level of assurance	2nd Line Oversight functions undertaking scrutiny and monitoring of the governance framework to ensure that it operate in an efficient and effective manner	2nd Line - Level of assurance	3rd Line Functions providing independent and objective challenge and assurance with regards to the organisation's governance arrangements	3rd Line - Level of assurance	Gaps in assurance	Approval status
PC2	320	10/11/2021	Primary Care Board	Director of Primary Care Transformation	Heads of PC Transformation (WE/ENH/SWH)	**IF** pressures in general practice remain at the current high level... **THEN** there may be insufficient capacity for GP practices, primary care networks and federations to deliver against transformation of care priorities in a way that demonstrates tangible improvements for patients... **RESULTING IN** sub-optimal patient experience due to continued pressures across the system and especially in acute services.	20	12	8	No movement ⇔	Review concluded that current scoring remains valid. Ongoing discussions with Beds & Herts LMC regarding several workstreams perceived to be unfunded - fall outside of scope of GMS contract or existing locally funded services - including Wound Care & wider ECF Treatment Room services, PSA screening, ADHD Shared care. Potential patient impact & mitigation steps being considered.	October 23 - Additional winter scheme to support continued demand in primary care through local funding. November 23 - Agreement to launch UTI pilot across HWE across community pharmacies ahead of national scheme which is due to start in February 24 - Launch of the integrated UTC at PAH and Stevenage PCN model to support priority localities as identified in UEC strategy. Risk of Hertsmere project which is planned for 2024. - ICB has responded to the publication of the Primary Care Access Recovery Plan and is communicating and supporting PCN's with implementation - ICB is supporting Practices and PCNs to partcipate in the GP Improvement Programme (GPIP) - in response to the ongoing IA the ICB is supporting PCN's with increasing capacity to support system wide approach. - the ICB has undertaken a period of engagement and has an approved Primary Care Strategy in place to support integration of primary care and to support general practice. - Primary Care Teams supporting PCNs in reviewing progress on Access Improvement Plans - Granted £1.074m Transition Cover funding to support implementation of Modern General Practice model - Plan for Roll out of Support Level Framework (SLF) to support practices in understanding their development needs Jan 2024: Additional funding provided to PCNs to support periods of junior doctor industrial action May 2024 - year 2 of PC Access Recovery Plan. Further support to implement CBT, implementation of moder General Practice		• Primary Care Working Groups support the preparation and monitoring of plans with any risks or issues escalated. Risk registers monitor resilience in all practices. • Resilience panels receive applications for support • ICS population health management group. • Practices are compliant with national and regional guidance during the Covid 19 pandemic.	Reasonable	•Place based delivery boards have a strong primary care presence and monitor delivery against locality plans. • All overseen by the Primary Care Commissioning Committees and Primary Care Board and reported to ICB Boards as appropriate. •Primary Care updates and assurance papers to other ICB Committees and groups as appropriate. •Approval of expenditure above PCCC authorisation limit is escalated to another	Reasonable	•EQC reporting shared with ICB. •NHSE/I remedial actions discussed with ICB •Internal audits of Primary Care Networks and Delegated Commissioning provide reasonable or substantial assurance.	Reasonable	ICB and HCP structures fully implemented and embedded	Approved by Committees meeting in common March 2022 Reviewed by PCB Sept22 Rviewed by PCB September 23
PC5	324	04/03/2022	Primary Care Commissioning Committee	Director of Primary Care Transformation	AD for Primary Care Contracting	**IF** there are not consistent and rigorous processes for monitoring quality and performance of contracts and investments... **THEN** there is potential for variable outcomes in improvements across the three geographical areas... **RESULTING IN** inequalities in the quality and performance of ICB primary care services and disparities in costs for the same services in different locations.	20	8	8	Reduction ↓	Review has concluded that there are now sufficiently consistent and rigorous processes for quality monitoring. This does not mean this removes the likelihood of variance across areas and practices, however the processes exist to flag these sufficiently & provide the opportunity to intervene. In light of this the risk rating has been amended to reduce to 8 (potential major impact, but unlikely to occur)	1) Individual processes are in place for ICB, for example: -Inclusion of PC data in Quality and Performance reporting to ICB Board - PCCC meeting has independent input from an out of area GP. - PCCC membership has a non-GP majority. - Risk and information sharing meetings with all relevant teams, LMC, Nursing & Quality and CQC. - Support packages in place for all practices with an existing ratings of 'Inadequate' or 'Requires Improvement' - Quality visits to practices and Extended Access sites - Practice Manager meetings 2. Healthwatch action plan 3. Reporting to single ICB Primary Care Board, with non-GP majority membership. Single Primary Care Contracting Panel now in place May-24 - implementation of Quality/Contract Review visit pogramme as a supportive, consistent, improvement focussed process Resilience Tool	Reviewing approach to joint Quality/Contracts visits. Propose using current WE risk dashboard format as a consistent ICB wide format. Assessment of PCNs needs further consideration - relationship between PCNs & member practices, supervision of PCN staff	Internal quality and performance monitoring processes in each place. Support to practices with 'inadequate' or 'requires improvement' rating. Support to practices with access challenges, e.g. staffing or premises.	Reasonable	Reports to PCB and Quality Group Assurance to PCCC Liaison with CQC and LMC	Reasonable	Liaison with CQC and LMC Internal audit opinions Updates to patient groups e.g. Patient Network Quality (PNQ) Monthly meetings with Healthwatch Presentations at Local Authority Overview and Scrutiny Groups	Reasonable	Extent of reporting of primary care quality and performance to Public Board - for discussion: terms of reference and work plans for ICB committees are being developed by the ICS. There is also discussion of Quality Groups at place at request of the ICS. Some practices reluctant to engage or nor highlighted as potential risks may be inspected by CQC, with further unknown risks emerging.	**Proposed to PCTC Nov-24 to reduce risk score from 12 to 8**
PC10	329	04/03/2022	Primary Care Workforce	Director of Primary Care Transformation & Director of Workforce	Head of Primary Care Workforce	**IF** there were no forecasting or forward planning for changes and challenges in general practice workforce... **THEN** we would be unable to foresee changes in workforce and act proactively to address expected shortfalls in any profession... **RESULTING IN** threat to patient care as patients may not have access to a range of skilled professionals in primary care.	9	6	3	No movement ⇔	With the controls we have in place and responsibility of contract holders for service delivery we would not expect to see this risk translate into an incident and given the provision of services across PCNs and wider health system would expect the impact to be moderate *Previous rationale:* *Don't expect it to happen (score 2) and if it did the consequence would be moderate (score 3) with a significantly reduced service effectiveness and local media coverage likely*	1. Monitoring workforce trends 2. Taking novel approaches to recruitment and retention 3. Providing updates to PCNs including ARRS position 4. Primary Care Teams working with PCNs to submit forward ARRS workforce plans 5. PCN workforce teams connected to current /future issues in practices/PCNs 6. Plan with system partners to avoid destabilising the workforce Nov-23 Update - PCNs submitted updated Workforce plans by 31-Oct23. These plans are being reviewed by Primary Care Team. Balance to be struck between maximising utilisation of ARRS buget vs ensuring that PCNs move towards living within their means (ARRS budget) for 24/25 onwards - Budget for ARR scheme roles to be maintained from 24/25 onwards, however awaiting further clarity on the GMS contractual arrangements in this respect Jan 2024: New Primary Care Workforce Dashboard being developed PCN Training Teams estabslished and meeting with TH NHSE Annual Operational Planning process includes workforce forecasting Training Hub working closely with ICS Workforce Team to share /optimise resources and avoid duplication Working with Primary Care to improve workfore data reporting Aug 2024 Update -National changes to ARRS scheme announced enabling newly qualified GPs to be recruited, prompting PCNs to review recruitment plans under ARRS against patinet needs for 2024-25 Nov 2024 - Engaging with PCNs. Primary Care Place leads and workforce team setting up meetings with PCNs to offer supportive conversations. Support tool template developed to support conversations	1. Increasing numbers of GPs and GPNs taking retirement mean further plans necessary to address retention or recruitment. 2. Difficulties recruiting to some AHP roles due to competition for their skills. 3. PCNs have autonomy for ARRS recruitment plans and have identified finances (shortfall in salary cap and management overheads) and risk (liability for staff given uncertainty about future of PCNs) and perceived value of some non-GP roles as barriers	Quarterly Workforce Data Collection Annual Skill Mix Collection	Substantial	Update reports to PCTC ~~PCB~~ and PCCC Progress monitored in ICS Workforce Group	Substantial	Reports to NHSEI	Substantial	Workforce data anaylsed and submitted as part of assurance processes doesn't include vacancy rates (data unavailable)	

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PC15	681	16/05/2024	Primary Care Board	Director of Primary Care Transformation	Heads of PC Transformation (WE/ENH/SWH)	**IF** the 24/25 GP Contract deal (& any subsequent DDRB uplift) provide a widely perceived insufficient uplift **THEN** general practice cost pressures will grow & resilience will be affected **RESULTING IN** potential reduction in general practice capacity & potential industrial action	16	16	12	No movement ⇔	Risk remains rated at 16 – Likely/Major. Collective Action largely commenced from 1st August onwards following BMA ballot outcome, although it remains far too early to assess the extent & impact of the potential action. There are 10 potential actions practices may choose to implement. Of greatest concern is that to Limit daily patient contacts per clinician to 25. Divert patients to local urgent care settings once daily maximum capacity has been reached. NHSE national projections suggest this could lead to an up to 30% reduction in GP appts, with resulting patient impact & alternative services such as 111 & UEC.	1. General Practice Resilience process to support vulnerable practices 2. Review of uplift of discretionary services commissioned in general practices, including ECF. 3. swift payments to reduce any cashflow issues, includes increase in QOF aspiration payments & PCN Access funding potentially to be paid monthly, rather than at year-end 4. Training Hub support for practices in the recruitment of ARRS and workforce in general practice 5. Guidance/support for new roles recruited through the increased flexibility of the ARRs scheme Aug-24 update BMA Collective Action ballot concluding iand was supported. 10potential actions identified by BMA Guidance. Primary Care to lead on response with EPRR support Co-ordination of approach via EoE IMT forum, meeting weekly National planning assumptions have been based on impact of between 10% to 30% reduction in GP appointments Particular concern regarding potential financial impact of withdrawal from meds optimisation measures & use of branded rather than generic meds National guidance & comms toolkit provided to ICBs. Guidance for practices provided reagrding continued GMS contractual compliance.	Is an emerging situation, not clear which practices are taking action & which specific actioner being followed. National Guidance is to use GMS contractual compliance clarification communication & review on a case by case basis, reacting to feedback (rather then undertaking a blanket assurance approach) feedback & soft intelligence being collated to inform this approach	Review by Primary Care SMT	Reasonable	Reports to PC Transformation Committee and PCCC	Reasonable	Reporting to and liaison with NHSE/I Regional Team	Reasonable	Recognising that there may be considerable variance between practices in their potential adoption of collective action measures Continued liaison with local LMCs to understand guidance and potential impact	Reviewed and approved by PCB March-24 **Aug24 update to PCCC**

Transition Risks

Primary Care Directorate Risks - DIGITAL ALIGNED RISKS															Assurance Mapping								
ID	Datix ID	Date Opened	Committee	Executive Owner	Revised Risk Lead	Risk Description	Rating (initial)	Rating (current)	Rating (Target)	Risk Movement	Rationale for current risk score	Controls	Gaps in controls	**1st Line** Operational functions enforcing required behaviours and working practices throughout the organisation's day-to-day activities	1st Line - Level of assur	**2nd Line** Oversight functions undertaking scrutiny and monitoring of the governance framework to ensure that it operate in an efficient and effective manner	2nd Line - Level of assu	**3rd Line** Functions providing independent and objective challenge and assurance with regards to the organisation's governance arrangements	3rd Line - Level of assurance	**Gaps in assurance**	**Approval status**
New Risk - May 2024	**682**	**16/05/2024**	**Primary Care Digital Group**	**Director of Primary Care Transformation**	**Head of Primary Care Digital**	IF digital tools are not fit for purpose THEN practices may not adopt usage of them or be unable to provide functionality to fully support a Modern General Practice operating model RESULTING IN lack of opportunities to improve patient experience by offering choice of access method practices unable to work within workforce capacity inequality of services offered to patients across ICB practices practices unable to meet access requirements	**12**	**8**	**4**	**Reduction ↓**	Risk is mainly a monitoring of current position and working through normal workstreams to minimise impact of any non-adoption. Not felt to be a significant risk	1.Ensure procurments involve wide stakeholder base to assess tools available 2. Learn from other areas on tools used and opportunities/issues they have encountered		Head of Primary Care Digital with organised networking meetings, creation of resource collateral to share		Formal Governance via PC Digital Group		PC & Digital Boards Reporting to NHSE as part of PCARP		Limited influence over national	May-24 - New risk to articulate overall digital risk to access agenda. Agreed by PC Transformation Committee. **Aug-24 - downgrading of risk rating from 12 to 9**
New Risk - May 2024	**683**	**16/05/2024**	**Primary Care Digital Group**	**Director of Primary Care Transform**	**Head of Primary Care Digital**	IF digital tools are not adopted by practices THEN practices will not be able to move to a Modern General Practice operating model RESULTING IN lack of opportunities to improve patient experience by offering choice of access method practices unable to work within workforce capacity inequality of services offered to patients across ICB practices practices unable to meet access requirements	**12**	**8**	**4**	**Reduction ↓**	Risk not viewed as significant and workstreams as part of BAU covering minimising risk. Felt possible that practices don't adopt tools - particularly given pressures in General Practice - which will impact the ability to transform and move to Modern General PRactice	1.Continuously monitor usage of digital tools via various data sets available 2. Support practices with training and access to best practice guidance` 3. Create networks for sharing e.g. Digital Innovation Group, PCN Digital Leads Group		Head of Primary Care Digital with organised networking meetings, creation of resource collateral to share		Formal Governance via PC Digital Group		PC & Digital Boards Reporting to NHSE as part of PCARP		Limited influence over national	May-24 - New risk to articulate overall digital risk to access agenda. Agreed by PC Transformation Committee. **Aug-24 - downgrading of risk rating from 12 to 9**

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New Risk - May 2024	**684**	**16/05/2024**	**Primary Care Digital Group**	**Director of Primary Care Transformation**	**Primary Care CCIO**	IF new digital tools and systems deployed in Primary Care do not interoperate with existing systems THEN 1.Systems may cause crashes of key core systems 2.Data having to be transposed between systems manually 3.Systems may not be used or be circumnavigated RESULTING IN 1.End users having to spend time rebooting computers takinn time away from patients 2.Data having to be entered multiple times increasing	**12**	**12**	**4**	No movement ↔	IF data is entered incorrectly into a patient record or into the wrong record then there is a chance of patient harm thorough delayed or inappropriate care hence felt to be a moderate impact	1. Making sure digital projects across the ICS consider impact on primary care and appropriate testing is done before deployment 2. Deployments are managed with appropriate communications, testing and training 3. Appropraite support and excaltion methods in place to maange issues if they arise	limited influence on ICB strategy or provider Digital strategies	Head of Primary Care Digital with GP IT delivery partners and clinical leads		Formal Governance via PC Digital Group		National/Regional network meetings and programme groups			May-24 - New risk relating to interoperability issues of primary care systems. Agreed by PC Transformation Committee.

Transition Risks

Primary Care Directorate Risks - POD RISKS															Assurance Mapping							
ID	Datix ID	Date Opened	Committee	Executive Owner	Risk Lead	Risk Description	Rating (initial)	Rating (current)	Rating (Target)	Risk Movement	Rationale for current risk score	Controls	Gaps in controls	1st Line Operational functions enforcing required behaviours and working practices throughout the organisation's day-to-day activities	1st Line - Level of assur	2nd Line Oversight functions undertaking scrutiny and monitoring of the governance framework to ensure that it operate in an efficient and effective manner	2nd Line - Level of assu	3rd Line Functions providing independent and objective challenge and assurance with regards to the organisation's governance arrangements	3rd Line - Level of assurance	Gaps in assurance	Approval status
	244	01/04/2023	Primary Care Commissioning Committee	AD Primary Care Contracting	Head of Primary Care Contracts	**IF** there is a lack of access to dental services **THEN** this will impact on patient's treatment and care **RESULTING IN** deterioration of oral health across the population patient's resulting to extreme measures to get out of pain (DIY dentistry) increase in referrals to secondary care dental services thus increase in waiting times	16	15	6	No movement ↔	No change to risk since last update - access to NHS dentistry continues to be challenge which has been further impacted by a contract handback and requests to reduce contracted activity without the ability to recommission at pace due to internal governance and current budgetary position. *Previous rationale:* *Access to NHS dentistry is reducing due to increases in contract handbacks, lack of appropriate funding, recruitment and retention challenges and increases in cost of overheads and increased complexity of dental need. Delivery of dental contracts is not yet up to pre-covid levels; however it is on an increased trajectory. (2023-24 delivery is at 90%; pre-covid was 93% and we expect to exceed that in 2024-25)*	1. Enhanced Access Scheme commissioned for 6-months from December 2023 has been extended through to end of November 2024 2. Phased implementation of pathway for anxious patients; commencing Autumn 2024 with a focus on children under 6 years of age 3. Increased funding to support demand within the SCDS for patients with special needs 4. Identification of persistent under-performers to start negotitions to rebase contracts and re-commission activity where it is needed most 5. Development of targeted Flexible Commissioning Programmes to support access for hard-to-reach groups, urgent access sessions and oral health improvement initiatives *Enhanced Access Scheme has been extended for a further 4months to end of March following an evaluation of the pilot. Expecting national specification/guidance on commissioning urgent access but no timeline given.*	1. Providers unwilling to rebase their contract in 24/25 leading to significant under-delivery 2. Under-utilisation of enhanced access pilot due to lack of dental nurse capacity in NHS111 (HUC)	1. Regular monitoring of monthly contract performance and proactive meetings set with providers to discuss under-performance 2. Reviewed at weekly Dental Team meetings 3. Further development of dental activity and spend dashboard to support year-end forecasting and identification of potential under-spend/clawback		Reports to PC Contracting Panel, PCCC and PC Transformation Committee		Reports to ICB Board and NHSE/I		1. Unknown if funding will be available to support non-recurrent or recurrent commissioning schemes to increase access	**Approved at PCCC Mar-23**
New risk - Jan-24	686	18/01/2024	Primary Care Workforce	Director of Primary Care Transformation	Head of Primary Care Workforce	**IF** there were insufficient further training and education opportunities available to Optometry, Dental and Community Pharmacy ... **THEN** there would be a failure to keep knowledge relevant and up to date. Capabilities will not be kept up to the same pace as others in the same profession. **RESULTING IN** a. Clincical and non-clinical staff potentially being unable to maintain and enhance their knowledge and skills needed to deliver primary care to patients. b. Practices would potentially fail their CQC Inspection c. Risk of mental health issues increasing across the workforce d. Delay to creation of new non-traditional roles e.Likely negative impact on staff recruitment and retention	6	6	3	No movement ↔	Stttill have not fully scoped gaps in training for all POD groups however, risk is perceived to be low due to professional obligations of registered professionals in terms of training *Previous rationale:* *Don't expect it to happen (score 2) and if it did the consequence woudl be moderate (score 3) with a significantly reduced service effectiveness and local media coverage likely*	Some ad-hoc training arranged by ICB for Community Pharmacy e.g. Pharmacy First and Hypertension pilot in Optometry and Dentistry Registered healthcare professionals required to meet professional standards, competencies and CPD requirements for clinical registration Statutory training is a legal requiremet Healthcare employees are expected to have a training and development plan agreed and supported by employer including statutory and mandatory training Training Hub met with LOC who confirmed that practitioners have a comprehensive training programme in place Planning the setting up of Primary Care Educators Forum - virtual quarterly forum to include POD	ICB has not yet scoped training needs, provision and any gaps or developed a training and development plan /package for pharmacists Optometrists or Dentists. ICB has not received a defined delegated training and education budget for POD	Training Hub Team meetings Workforce Clinical Leads Meeting WIG		Reports to ~~PCB~~ PCTC and PCCC		CQC regulatory framework encompasses workforce training and development		Greater focus on primary medical services than POD in reporting to ICB sub-board committees reflecting long-standing commissioning and budgetary responsibilities	
New risk - Jan-25	687	18/01/2024	Primary Care Workforce	Director of Primary Care Transformation	Head of Primary Care Workforce	**IF** robust processes for monitoring and planning workforce requirements for Optometry, Dental and Community Pharmacy are not established... **THEN** we will be unable to identify required changes in workforce, acting proactively to address expected shortfalls or reactivley to mitigate unexpected gaps in any profession... **RESULTING IN** potential threat to patient care as patients may not have access to a range of skilled professionals in primary care.	9	9	3	No movement ↔	Further development work required, however review of risk score confirms this as still appropriate at Likely/Moderate impact	Community Pharmacy workforce audit undertaken by NHSE Independent contractors are responsible for ensuring a appropriately capatious and skilled workforce for safe and effective provision of contracted services	Local ICB processes still to be developed	Training Hub Team meetings Workforce Clinical Leads Meeting WIG		Reports to PCB and PCCC		Operational Plan with wokrforce forecasting submitted to NHSE			

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New risk - Mar-23	685	20/02/2023	Primary Care Commissioning Committee	AD Primary Care Contracting	Head of Primary Care Contracts	**POD Delegation - Quality** **IF** as planned, there are no quality staff aligned to POD contracts at NHSE, quality review and input to these provider groups is extremely limited **THEN** likely to be unknown issues across providers particularly dentistry where there are high risk procedures, infection prevention and control risks etc; **RESULTING IN** limited knowledge of & scope to address potential patient safety issues leading to patient harm	15	12	10	Reduction ↓	Assurance processes for POD have been developed and implemented since the transfer of the delegated functions. Recent internal audit report identified one medium managent risk regarding dental visits; this has now been addressed as per the control identified	Nov-23 Update: Complaints function now delegated as of 1st July 2023. No Quality resource transferred with the POD functions. Pharmacy & Optometry and Dental Contracting teams work with available data to have oversight. P&O - the Team processes Fitness applications and concerns in line with the Regulations and compliance with Terms of Service in addition to the Market Entry Function, overseen by the Pharmaceutical Services Committee. Working in liaison with GPhC, NHSBSA, PCSE, local complaints teams, Regional Controlled Drugs Team and other stakeholders. This is in addition to regular monitoring through Community Pharmacy Assurance Framework, and the Pharmacy and Dispensing Quality Schemes. Dental - regular meetings are now in place with the Dental inspection team at CQC. The team work with NHSBSA to identify areas of investigation for quality reporting, link with the Managed Clinical Networks for specific workstreams. Remove the element of the risk relating to transfer of complaints Jan23 - now removed as noted above		ICB task and finish group are meeting weekly to update on progress and issues Meet regularly with NHSE and other ICBs in the Region to share issues and updates	Reasonable	Reports to PCB and PCCC	Reasonable	ICB Exec	Reasonable		**Approved at PCCC Mar-23**