NHS HWE ICB Primary Care Board meeting held in Public

Thursday 30 January 2025

Conference Room 2

The Forum

Hemel Hempstead, HP1 1DN

09:30 - 11:30

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

Agenda

09:30	1. Welcome, apologies and housekeeping		Chair
09:30	2. Declarations of Interest		Chair
09:35	3. Minutes of the last meeting held on 28 November 2024	Approval	Chair
09:35	4. Action Tracker - no open actions		Chair
09:45	5. Questions from Public		Chair
09:50	6. Case studies Primary Care support into Care Homes	Discussion	James Gleed / Emily Perry
10:30	7. Directorate Highlight Report including Place Integrated Reports	Discussion	Avni Shah
10:50-11am	Comfort break		
11:00	8. Primary Care Patient Safety Strategy	Discussion	Liam Wilson
11:15	9. Reflections and feedback		Chair
	10. Closing of meeting		
	For information only		
	11. Update on Healthwatch reports	Information	Emily Perry
	12. Minutes from subgroups	Information	Chair

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☐	*Meeting in private (confidential)*			☒	
	HWE ICB Primary Care Transformation Committee			**Meeting Date:**	**30 January 2025**		
Report Title:	**Register of Interests**			**Agenda Item:**	**02**		
Report Author(s):	Gay Alford, IG and Governance Officer Jas Dosanjh, Governance Manager – Conflicts and Policies						
Report Presented by:	Simone Surgenor, Deputy Chief of Staff - Governance and Policies						
Report Signed off by:	Michael Watson, Chief of Staff						
Purpose:	**Approval / Decision**	☐	**Assurance**	☐	**Discussion**	☒	**Information** ☒
Which Strategic Objectives are relevant to this report:	▪ Relevance to all five ICB Strategic Objectives						
Key questions for the ICB Board / Committee:	▪ Please see the 'Recommendations' section						
Report History:	▪ The full ICB Declarations of Interest Register is routinely reported to the Audit & Risk Committee in line with the Committee Workplan and Terms of Reference						
Executive Summary:	▪ The Board Sub-Committees' Register of Interests are maintained in line with the HWE Standards of Business Conduct Policy (incorporating Conflicts of Interest). ▪ All members, and those in attendance must declare any actual or potential conflicts of interest which will be recorded in the minutes. Where a conflict is identified, at the Chair's discretion, the person may be asked to leave the meeting while a particular topic is being discussed.						
Recommendations:	The Committee is asked to: ▪ Note the returned declarations and whether these reflect the current membership/regular attendees for this Committee, ▪ Review any potential conflicts of interest that need to be managed at the meeting in accordance with the agenda, ▪ Remind members and regular attendees that - whenever an individual's role, responsibility or circumstances change in a way that						

	affects the individual's interests (e.g., where an individual takes on a new role outside the ICB or enters into a new business or relationship), a further declaration should be made to reflect the change in circumstances as soon as possible, and in any event within 28 days. The revised declaration will countersigned by their Line Manager or lead, and then forwarded to hweicbwe.declarations@nhs.net for logging.			
Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***	☐
	Financial	☐	***Non-Financial Personal***	☐
	None identified			☒
	N/A			
Implications / Impact:				
Patient Safety:	N/A			
Risk:	N/A			
Financial Implications:	N/A			
Impact Assessments:	***Equality Impact Assessment:***		N/A	
	Quality Impact Assessment:		N/A	
	Data Protection Impact Assessment:		N/A	

Key:	White background indicates 2024/25 delcaration received
	Awaiting 2024/25 declaration form / queries
	Full Grey Line indicates staff no longer employed by ICB - declaration to remain on the register for 1 year
	Part grey line indicates the interest has ended.

Hertfordshire and West Essex Integrated Care System

HWE ICB Primary Care Transformation Committee
Register of Interests

NHS Hertfordshire and West Essex Integrated Care Board

Name:		Current position(s) held in the ICB	Declared Interest (Name of the organisation and nature of business)	Type of Interest					Date of Interest		Action taken to mitigate risk
Surname	Forename			Financial Interest	Non-Financial Professional Interest	Non-Financial Personal Interest	Direct interest	Indirect interest	From	To	
Aneja	Dr Amik	Harlow North Clinical Lead ICB Primary Care Transformation Committee GP/PCN CD Lead WE Place	Substantia Capital Limited 12792673 ABC Living Limited - not set up yet - project name Keyworker accommodation.	√				√	Oct-23	Ongoing	Declare interest at meetings where relevant
			Director of Harley Fitzrovia Health (11169375) Private Practice- General Practice and Specialist Outpatients Private/NHS services/Fertility services/Diagnostics	√					Sep-23	Ongoing	Declare interest at meetings where relevant
			Director of Premier GP Limited (15113256)	√					Sep-23	Ongoing	Declare interest at meetings where relevant
			Old Harlow Health Centre	√					May-09	Ongoing	Declare interest at meetings where relevant
			Harlow North Primary Care Network Clinical Director	√					Apr-21	Ongoing	Declare interest at meetings where relevant
			Shareholder/Board member/CSO Medivys and Rubrahealth Ltd - Healtech AI companies	√					Apr-24	Ongoing	
Campbell	Michelle	Head of Primary Care contracts Regualr Attendee ICB Primary Care Transformation Committee	Nil	-	-	-	-	-	-	-	-
Carlton-Conway	Dr Daniel	Clinical Lead Planned care Clinical Lead Primary Care Prescribing	Partner- The Maltings Surgery - NHS GP surgery	√	-	-	√	-	2008	Ongoing	Declare interest at meetings where relevant
			The Maltings surgery is member of Abbey Health Primary Care Network	√	-	-	√	-	Jul 2019	Ongoing	Declare interest at meetings where relevant
			Member - The Hertfordshire Clinic LLP (not currently trading)	√	-	-	√	-	Jan 2014	Ended Feb-22	
			Speciality Doctor Paediatric Allergy - Lister Hospital, Stevenage.		√	-	√	-	2015 approx	Ongoing	Declare interest at meetings where relevant

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			Maltings surgery is a member of St Albans and Harpenden G Federation, STAHFED Ltd, although I believe the federation is no longer active.	√	-	-	√	-	2016 approx	Ongoing	Declare interest at meetings where relevant
			I am director of Optimise Health Limited, which has developed a hypertension software application (called OptBP) that is being used in GP practices	√	-	-	√	-	2014 approx	Ongoing	Declare interest at meetings where relevant
			PML NHS ultrasound service hosted at the Maltings Surgery	√	-	-	√	-	2019	Ended Jun-22	Declare interest at meetings where relevant
			Maltings Surgery is a Hertfordshire wide hub for Long Acting Reversible Contraception (LARC)	√					2022	Ongoing	Declare interest at meetings where relevant
			Hosting HertsOne GP Federation Primary Care ADHD service	√					Feb 2022	Ongoing	Declare interest at meetings where relevant
			Spouse, Board Trustee CIMPSA (Chartered Institute of the Management of Sport and Physical Activity)	-	-		-	√	Jan 2022	Ongoing	Declare interest at meetings where relevant
			Spouse, has previously worked with MyHealthSpecialist a medical technology company that may wish to work with health and care providers.	-	-		-	√	Sep 2021	Ongoing	N/A
			I previously received funding from ALK Abello which contributed to study MSc in allergy at Southampton Medical School (> 7 years ago).		√				2011 approx	2014 approx	N/A
			Private allergy specialist	√					Apr-14	Ongoing	Declare interest at meetings where relevant
Chastell	Alison	Regular Attendee ICB Primary Care Transformation Committee									
Ciobanu	Corina (Dr)	Primary Care Transformation - GP Regualr Attendee ICB Primary Care Transformation Committee	GP Partner at Haverfield Surgery	-	-	-	-	-	Aug-04	Ongoing	Declare interest at meetings where relevant
			Haverfield surgery s a shareholder in Dacorum Health Providers Limited (GP Federation) whom may be interested in bidding for services.	-	-	-	-	-	May-14	Ongoing	Declare interest at meetings where relevant
			Partner is the Chief Finance Officer for HWE ICB	-	-	-	-	√	Aug-10	Ongoing	Declare interest at meetings where relevant
Claydon	Steve	Dental Clinical Lead / Senior Clinical Dental Adviser ICB Primary Care Transformation Committee - Independent Clinical Advisor for Dental	Senior clinical dental adviser – NHS England Midlands and East of England regions.		√				26/01/2010	Ongoing	Declare interest at meetings where relevant

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			Local Dental Network Chair Northamptonshire and Leicester, Leicestershire & Rutland ICBs						22/10/2020	Ongoing	Declare interest at meetings where relevant
			Serving magistrate – Cambridgeshire			√			1995	Ongoing	Declare interest at meetings where relevant
			I have a condition requiring individually funded treatment.			√			1992	Ongoing	Declare interest at meetings where relevant
Clough	Tony	Essex Local Dental Committee (LDC) Secretary Regular Attendee ICB Primary Care Transformation Committee	2024/25 Declaration to be completed.								
Colegrave	Leighton	1. Citizen representative member of the HWEICB Primary Care Transformation Committee. 2. Patient member of the HWEICB Patient Engagement Forum.	Chair of Peartree PatientVoices, the PPG for Peartree Group Practice, Welwyn Garden City			√			2019	Ongoing	
			World Tamils Historical Society (WTHS - registered charity number 1170343) - planning committee (now complete) Also I ndirect Interest, as my close relative was general secretary of the WTHS for approx 8 years from 2015.			√		√	2019	Ended 2023	
			Close relative is an independent life sciences translation quality manager working from my address. The work comes from TransPerfect and is for companies such as Pfizer, IQVIA, AstraZeneca and others. It typically concerns worldwide clinical trials and medical reports.					√	Oct-24	Ongoing	
Das	Joy Jayati	Patient Volunteer ICB Regular Attendee ICB Primary Care Transformation Committee	Member of patient panel, central surgery, sawbridgeworth						8/9 years	Ongoing	
			Trustee, Rianbow Services Harlow						2019	Ended 02.10.2024	
Disney	Elizabeth	Director of Operations, HWE ICB	Close relative is employed by the ICB. Role sits in a different directorate, no line management overlap.	-	-	-	-	√	Jan-23	Ongoing	No involvement in recruitment process or decision to employ

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Dixon	Sarah (Dr)	Primary Care Workforce - GP ENH Regualr Attendee ICB Primary Care Transformation Committee	GP and Managing Partner at South Street Surgery	√					Sep 2001	Current	Declare at meetings when necessary
			Federation Director for Stort Valley Health Federation STORT VALLEY HEALTHCARE LIMITED Registered office address - C/O Parsonage Surgery Hertfordshire & Essex Community Hospital, Cavell Drive, Bishops Stortford, Hertfordshire, United Kingdom, CM23 5JH Company number 09489615 (Locality Federation)	√					Feb-20	Current	Declare at meetings when necessary
			GP Trainer West Essex Vocational Traininng Scheme and Princess Alexandra Hospital Foundation Programme	√					Mar 2012	Current	Declare at meetings when necessary
			GP Appraiser for NHS England - Midlands and East	√					Oct 2015	Current	Declare at meetings when necessary
			ICB Clinical Lead for Primary Care Workforce	√					Aug-24	Current	Declare at meetings when necessary
			Clinical Lead for Primary Care Workforce ENH Place						Aug-22	Ended Jul-24	Declare at meetings when necessary
			Clinical Lead for CYP ENH Place	√					Aug-22	Ended Jul-24	Declare at meetings when necessary
			Joint Locality Lead Stort Valley and Villages	√					Nov-22	Current	Declare at meetings when necessary
Eliad (Dr)	Rami	CYPM SWH Clinical Lead Watford & Three Rivers Locality Lead ICB Primary Care Transformation Committee GP/PCN CD Lead SWH Place	GP Partner Garston Medical Centre, Watford	√	-	-		-	1989	Ongoing	Declared
			Director Garston Properties Ltd (owns the surgery premises and receives rent from the ICB via the Practice)	√					2020	Ongoing	Declared
			LMC Member	√	-	-	√	-	1995	Ongoing	Declared
			My close relative is the Practice Manager at Garston Medical Centre	-	-		-	√	2017	Ongoing	Declared
			Close relative is a GP Partner at Garston Medical Centre					√	Feb-23	Ongoing	Declared
			Director of Eliad & Gozzard Healthcare Ltd	√	-	-		-	2012	Ongoing	Declared
Fernandes	Trevor (Dr)	GP Locality Lead - Dacorum Partner Member, Primary Medical Services	Salaried GP at Parkwood Surgery, Hemel Hempstead GP Trainer, GP Appraiser, Joint Injections	-	-	-	√	-	2020	Ended Aug-2024	
			Registered with GP in Hertfordshire			√			1990	To date	
			My spouse works at: Michael Sobell Hospice, Northwood,Middlesex Fonthill Nursing Home, St Albans, Herts St Elizabeth's Centre, Perry Green, Herts	-	-		-	√	Various	To date	
			NHS Complaints Reviewer Birmingham and Solihill ICB Mid and South Essex ICB	√					Dec-22	To date	
			Outpatient at Royal Marsden Hospital London			√			Jan-23	To date	
			GP appraiser East of England (previously included in salaried GP post as paid to practice)	√					2005	To date	

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			GP locum Herts/Beds/Bucks	√					Aug-24	To date	
			Attend educational meetings - Spire hospital Harpenden, OSD Healthcare			√			Jan-23	To date	
			Community Medical Examiner employed by WHTHT.	√					Feb-22	To date	
Foreman	Clint	Secretary Essex LDC	2024/25 declaration of interest to be completed.								
Gadawala	Jayna (Dr)	South West Herts GP Clinical Lead Primary Care workforce development	I am a GP Partner, Highview Medical Centre, Potters Bar	√	-	-	√	-	2017	Continuing	Declare conflict
Galione	Cathy	Head of Primary Care Transformation, Integration, Development & Delivery – East & North Hertfordshire place Regualr Attendee ICB Primary Care	Nil								
Gleed	James	Associate Director Primary Care Strategy & Transformation, HWE ICB Regualr Attendee ICB Primary Care Transformation Committee	Spouse is employed by local healthcare provider ENHT as Compliance and Sustainability Manager, Estates and Facilities	-	-	√	-	√	Oct-21	Ongoing	We have very different portfolios which are not expected to overlap or create a conflict of interest. I would substitute my involvement with a colleague in any programmes of work or decision-making should a conflict of interest materialise.
Glover	Sam	Non-voting member of the Primary Care Board Regular Attendee of HWE ICB Primary Care Transformation Committee Volunteer member of the HWE ICB's Patient Engagement Forum	As CEO of Healthwatch Essex we present information to the board and challenge where we feel user voice is not being represented					√	Jun-05	Current	
Halksworth	Rachel	AD for Primary Care Contracting	Nil	-	-	-	-	-	-	-	-
Harvey	Bryan	Chairman Essex LDC Regular Attendee ICB Primary Care Transformation Committee	I am a senior Dento-Legal adviser for the Dental Defence Union and give advice to Together dental regarding complaint handling and ethical issues. I have no paid interest within that corporate but I do work as an associate on alternative Saturdays and occasional days treating children. I believe therefore I have no interest to declare.								
Hazeldene	Dr Rachel	CCIO Primary Care	GP Retainer at John Tasker House Surgery, Dunmow		√				Dec-20	Ongoing	To be declared at relevant meetings.
Hiley	Marianne	ICB Primary Care Transformation Committee– patient representative for South and West Herts	One of 3 lead members of Gade practice PPG			√			2022		

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			Patient Representative on Virtual Hospital Programme Team at West Herts Hospital (Watford)			√			2021		
Howard -Jones	Elliott	Role of CEO at Hertfordshire Community NHS Trust Partner Member - Community Provider Representative SRO - East & North Herts HCP	Nil			-	-	-	-		
Joyce	Rachel (Dr)	Medical Director	Married to an NHS consultant who works for East and North Herts Trust.	-	-	-	-	√	Jun-01	Current	To be logged on ICB DoI registers and declared if relevant in meetings/ work
			From 2018 I was a Director for Ranine Ltd - a company that provides private medical services by one consultant (spouse as above) to local independent hospitals. From 1st April 2022, I resigned my role as Director and now act as secretary who also holds shares in the company. The company does not however provide, or intend to provide, services to the NHS, social care, or NHS patients.	√	-	-	-	-	2018	Current	To be logged on ICB DoI registers and declared if relevant in meetings/ work
			Director of Castellan Homes Ltd, a family company for which I am a director.	√					2024	Current	It does not have and has never had a contract with the health or social sector - operating completely out of that environment.
Karia	Parul (Dr)	Chief Clinical Information Officer for Primary Care HWE ICB	Medical Director Beds and Herts LMC	-	√	-	√	-	May-21	Continuing	To be declared at relevant meetings.
			Salaried GP New Road surgery (Baldwins Lane surgery)		√				Apr-22	Continuing	
			Board Trustee/Director for Watford Sheltered Worksjop Ltd. This is a charity that provides employment, work and life skills to adults with disabilities.			√			Nov-23	Continuing	
Khan	Iram	Corporate Governance Manager - Board & Committees	Nil	-	-	-	-	-	-	-	-
Khan	Roshina	Head of Primary Care Transformation and Integration Regualr Attendee ICB Primary Care Transformation Committee	Nil								
Marovitch	Joanna	Chair VCSFE Alliance VCFSE Allinace board member Regular Attendee ICB Primary Care Transformation Committee	CEO of Hertfordshire Mind Network	√					2021	Current	
Mayson	Dr Robert	Locality Lead GP salaried role ICB Primary Care Transformation	Clinical Director, PCN hoddesdon and broxbourne	√					2019	Current	

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		ICB Primary Care Transformation Committee GP/PCN CD Lead ENH Place	Locality Lead GP - 1 session a week supporting various boards and groupsin meetings representing general practice interests.	√					Oct-22	Current	
			GP Partner - Hailey View surgery	√					2011	Current	
			GP Chair of ENH CD Alliance, Need to support my CD colleagues in their role						2020	Current	
Moodley	Pragasen	Partner Member for the ICB - Primary Medical services	Partner at Stanmore Medical Group 5 Stanmore Road, Stevenage, SG1 3QA	√	-	-	√	-	2004	Continuing	Verbal declarations to be made at the beginning of any meeting
			Director of AVM Medical. Suite 3 Middlesex House, Rutherford Close, Stevenage, Hertfordshire, United Kingdom, SG1 2EF. Company number 10507387 I use this company to carry out private medicals and nursing home ward rounds	√	-	-	√	-	2016	Continuing	
			Director North Stevenage PCN	√	-	-	√	-	2022	Continuing	
			Partner at Larksfield Medical Practice	√	-	-	√	-	2018	Continuing	
			Partner is a GP at King George Medical Practice	-	-	√	-	√	2016	Continuing	
Mount	Trudi	Head of Primary Care Digital Regular Attendee ICB Primary Care Transformation Committee	Nil	-	-	-	-	-	-	-	-
Musson	Helen	Training Hub Primary Care Workforce Project Manager, HWE ICB (Part Time 0.3 WTE) End date 05.08.2024 Regular Attendee ICB Primary Care Transformation Committee	Chief Officer, Community Pharmacy Hertfordshire.	√	√				Apr-14	Ongoing	
Perry	Dr Ian	Partner Member, Primary Medical Services	GP Partner in Maynard Court Surgery	√	-	-		-	2013	To date	Verbal declaration to be made at the beginning of any meeting
			Epping Forest North PCN GP Partner	√					2019	To date	
			Stellar Healthcare Shareholder		-	-		-	2014	To date	
Pullen	Annette	EA to Director of Primary Care Transformation	Close relative works in Grovehill Medical Centre, Hemel Hempstead as receptionist	-	-	-	-	√	-	Current	-
			Close relative works as Medical Secretary in Paediatrics at WHHT					√		Current	
Raja	Dr Vaiyapuri	Deputy Chief Executive, North & South Local Medical Committees (LMC) Regular Attendee ICB Primary Care	Nil								

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Randhawa	Professor Gurch	Non Executive member, NHS HWE ICB Chair - ICB Strategy Committee Vice Chair - ICB Strategic Finance & Commissioning Committee	Professor of Diversity in Public Health & Director. Institute for Health Research University of Bedfordshire. Honorary Academic Contract, UK Health Security Honorary Academic Contract, Office for Health Improvement & Disparities Expert Advisor, NICE Centre for Guidelines, UK Facilitator, faculty of Public Health accredited Practioner Program, UK Faculty of Public Health Non-Executive Director, Forestry England. Adjunct Professor, Ton Due Thang University, Vietnam, Trustee, Race Equality Foundation, UK National Member, National Black and Minority Ethnic Transplant Alliance, UK Member, British Medical Association Ethics Committee, UK Deputy Lieutenant, Bedfordshire Patron of the Bedfordshire Rural Communities Charity Ambassador, Keech Hospice Care Volunteer, Luton Sikh Soup Kitchen Junior Cricket Coach, Harpenden Cricket club							Current	All interests declared with all parties.
			Patient, Davenport House surgery, Harpenden							Current	To be declared as appropriate.
			Extended family member employed by Harpenden Health PCN							Current	To be declared as appropriate.
Roberts	Steven	Vice-Chair, Hertfordshire Local Optical Committee	2024/25 Declaration of interest to be completed.								
Rohilla	Anurita	Chief Pharmacist, HWE ICB ICB Primary Care Transformation Committee - Chief Pharmacist AD for Primary Care Strategy and Planning	NICE Medicines and Prescribing Associate	-	√	-	√	-	2013	Present	Verbal declaration to be made at the beginning of any meeting
			Health Foundation member of the Q Community	-	√	-	√	-	2015	Present	
			Enterprise Advisor	-	√	-	√	-	2017	Present	
			Attend some events sponsored by pharmaceutical companies	-	√	-	√	-	-	Present	
			Family member is founder and CEO of the registered charity National Multifaith Youth Centre	-		-		√	2024	Present	
Shah	Avni	Director of Primary Care HWE ICS	Spouse works for a Pharmaceutical Industry – Scope, who distribute a number of eye products across the UK.					√	Nov-20	Current	As Director of Primary Care I am not directly involved in the local decision making process of new drugs hence managing conflict
			Spouse provides supervision and support via CPPE to foundation year community pharmacist who required support. This is commissioned through HEE and covered London and South East Area					√	Apr-23	Current	This is commissioned directly from HEE to CPPE hence NO involvement in commissioning and contracting of this

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Sweeney	Philip	Head of Primary Care Transformation, West Essex Regualr Attendee ICB Primary Care Transformation Committee	Nil								
Tarry	Andrew	Head of Primary Care Contracts Regualr Attendee ICB Primary Care Transformation Committee	Nil	-	-	-	-	-	-	-	-
Tatton	Peter	Hertfordshire Local Dental Committee Secretary	2024/25 Declaration of interest to be completed.								
Tester	Neil	Chair, Healthwatch Hertfordshire	Chair (trustee and company director, unremunerated), Healthwatch Hertfordshire Ltd (charity no: 1158089).			√			Nov-21	Present	
			Company director (unremunerated), Healthwatch Hertfordshire Trading Ltd			√			Jan-24	Present	
Tideswell	David	Clinical Lead for Care Closer to Home West Essex HCP	GP Partner in John Tasker House Surgery, Great Dunmow, CM6 1BH	√	-	-		-	2003	Continuing	Awareness of any conflict; no involvement with related commissioning decisions.
			JohnTasker House Surgery is a member of Uttlesford Health	√	-	-		-	2014	Continuing	
			Director or DJT Medical Limited		√	-		-	Jun-22	Continuing	
Williams	Dr Nicky	Beds & Herts LMC Ltd Co-CEO Regular Attendee ICB Primary Care Transformation Committee	Co-CEO, Beds & Herts Local Medical Committee Ltd, The Shires, Astonbury Farm, Astonbury Lane, Stevenage SG2 7EG		√				2018	Current	

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 28 November 2024**			
Time:	**09:30 – 12 noon**			
Venue:	**The Forum, Conference Room 2/MS Teams**			

MINUTES

Name	Title	Organisation
Members present:		
Trevor Fernandes (TF) **(Meeting Chair)**	Partner Member (Primary Medical Services)	Herts and West Essex ICB
Michelle Campbell (MC)	Head of Primary Care Contracting	Herts and West Essex ICB
Leighton Colegrave (LC)	Citizen Representative, East & North Herts	Herts and West Essex ICB
Jayna Gadawala (JG) Via MS Teams	Primary Care Workforce Lead	Herts and West Essex ICB
Cathy Galione (CG)	Head of Primary Care Transformation, Integration, Development & Delivery – East & North Herts	Herts and West Essex ICB
James Gleed (JG)	Associate Director Primary Care Strategy and Transformation	Herts and West Essex ICB
Rachel Halksworth (RH) Via MS Teams	Assistant Director – Primary Care Contracting	Herts and West Essex ICB
Rachel Hazeldene (Rha) Via MS Teams	Primary Care Digital Lead - CCIO	Herts and West Essex ICB
Marianne Hiley (MH)	Citizen Representative, South & West Herts	Herts and West Essex ICB
Alison Jackson (AJ)	Clinical Director	Broxbourne Alliance PCN
Rachel Joyce (RJ) Via MS Teams	Medical Director	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

Trudi Mount (TM) Via MS Teams	Head of Primary Care Digital	Herts and West Essex ICB
Ian Perry (IP) Via MS Teams	Partner member (Primary Medical Services)	Herts and West Essex ICB
Avni Shah (AS)	Director of Primary Care Transformation	Herts and West Essex ICB
Andrew Tarry (AT)	Head of Primary Care Commissioning	Herts and West Essex ICB
Philip Sweeney (PS)	Head of Primary Care Transformation – West Essex	Herts and West Essex ICB
In attendance:		
Leah Adams (LA)	Acting Clinical Director	Special Dental Service Herts Community Trust (HCT)
Alice Baldock (AB) Via MS Teams	Medical Director	Bedfordshire & Herts Local Medical Committee
Mark Beyeler	Communications and Engagement Officer	Herts and West Essex ICB
Sarah Brierly (SB) Via MS Teams	Director of Strategy Representing Howard Elliot-Jones	Herts Community Trust (HCT)
Jane Bunker (JB) Via MS Teams	Chair	Hertfordshire Local Optical Committee
Matt Charles (MCh) Via MS Teams	Chief Operating Officer/PCN Manager	Stevenage Healthcare/Stevenage South PCN
Kolade Daodu (KK) Via MS Teams	GP Partner and Trainer Clinical Director Health Inequalities Group Chair	Shephall Health Centre Stevenage South PCN East & North Health and Care Partnership
Sam Glover (SG) Via MS Teams	CEO	Healthwatch Herts
Chloe Gunstone (CG) Via MS Teams	Senior Research Manager	Healthwatch Herts
Iram Khan (IK)	Corporate Governance Manager	Herts and West Essex ICB
Julia Lisk (JK) Via MS Teams	Primary Care Manager	Herts and West Essex ICB
Louise Manders (LM) Via MS Teams	Head of Programme Communication and Engagement	Herts and West Essex ICB
Robert Murray (RM) Via MS Teams	Project Manager	Herts County Council
Helen Musson (HM) Via MS Teams	Chief Officer	Hertfordshire Local Pharmaceutical Committee
Mefino Ogedegbe (MO)	Community Pharmacy Lead	Herts and West Essex ICB
Emily Perry (EP)	Primary Care Manager – Strategy and Transformation	Herts and West Essex ICB
Steve Roberts (SR) Via MS Teams	Vice Chair	Hertfordshire Local Optical Committee
Karen Samuel-Smith (KSs) Via MS Teams	Chief Officer	Essex Local Pharmaceutical Committee

Emma Spofforth (ES) Via MS Teams	LOC representative	Essex Local Optical Committee (LOC)
Valia Savido (VS) Via MS Teams	Research and Evaluation Specialist in the Behaviour Change Unit – Public Health	Herts County Council (HCC)
Peter Tatton (PT) Via MS Teams	Secretary	Hertfordshire Local Dental Committee
Penny Thomas (PT) Via MS Teams	Senior Primary Care Manager Transformation, Integration, Development & Delivery – East & North Hertfordshire	Herts and West Essex ICB
Sam Williamson (SW) Via MS Teams	Associate Medical Director	Herts and West Essex ICB

PCTC/29/24	**Welcome, apologies and housekeeping**
29.1	Trevor Fernandes (TF) welcomed all to the meeting. He confirmed that this was not a public meeting but a meeting being held in public (members of the public were welcome to attend but were not permitted to participate). Questions from the public were welcomed in advance and there were instructions on the website explaining how to submit these.
29.2	Apologies for absence had been received from: • Prag Moodley • Anurita Rohilla • Raja Vaiyapuri The meeting was declared quorate.
PCTC/30/24	**Declarations of interest**
30.1	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/31/24	**Minutes from the previous meeting**
31.1	The minutes were approved.
31.2	**The minutes of the last meeting held on 25 July 2024 were agreed as an accurate**
PCTC/32/24	**Action tracker**
32.1	Updates received closing all actions.
32.2	**The Primary Care Transformation Committee noted the updates to the action tracker and that all actions were completed**
PCTC/33/24	**Questions from the Public**
33.1	• There was one question received following deadline which will be shared.

PCTC/34/24	**COVID-19 booster vaccine uptake in the immunosuppressed population**
34.1	Penny Thomas (PT) introduced the project (see pages 26-67 of the document pack) and highlighted the following: • Project set up couple years ago exploring poor uptake of COVID vaccination in immunosuppressed cohort of patients. • Commissioned HCC to undertake work which was funded NHSE EoE region. Penny introduced Valia Savvidou (VS) from Public Health to provide a summary of the findings from the pilot: • Immunosuppressed individuals are at considerable risk of severe Covid 19, therefore crucial encouraged to receive vaccine. • Approach to project was behavioural science to identity and address barriers. • Outlined process to shortlist two interventions to deliver. Valia introduced Robert Murray (RM) the Project Manager who added further updates within slides. • Estimated costs savings should the intervention be rolled out on a national scale outlined. • Intervention one costs minimal as current NHS test/texting system within Primary Care Practices could be used. • Intervention two higher costs due to manpower involvement.
34.2	Questions and comments were invited: • Suggestion age group should be extended slightly to tackle vulnerable groups over seventy-five. • Response outlined cohort above 75 not included as more challenging to find specifics. • Should pilot be rolled out, would widen portion of population. • Cost savings small if extrapolated nationally. • Signposting for vaccines important to include Pharmacy. • AS updated the committee members the recent enhanced service which was launched by EoE was to use the learning from this to increase the vaccination uptake for this winter.
34.3	**The Primary Care Transformation Committee noted the Report**
PCTC/35/24	**HWEICB Primary Care Strategic Delivery Plan 2023 – 2026 Progress Against Year One Priorities & Deep Dive**
	James Gleed (JG), Emily Perry (EP) Mefino Ogedegbe (MO), Michelle Campbell (MC), Leah Adams (LA), Alison Jackson (AJ), & Cathy Galione (CG) introduced their respective sections of the report (See pages 68-138 of the document pack)

35.1	**Enabling** **Community Pharmacy PCN Leads: MO (page 90)** Mefino provided overview referring to slide 90 of pack: • Outlined situation prior to intervention. • Highlighted lack of understanding within PCNs/General Practice. • Collaborating with community pharmacies building secure relationships. • Leads recruited within each PCN to support task of integration. • Positive feedback from Pharmacy representatives, feeling more informed and engaged. • Stakeholders reported increased joint working with better communication.
35.2	Questions and comments were invited: • Conscious the immediate pressures within pharmacies, causing strain. • Continued priority connection with community pharmacies vital. • LMC/LPC working together to support how community pharmacy can be integrated with general practice • Ongoing work with the newly appointed Community Pharmacy Clinical Leads in their development. • Open discussions with PCNs encouraging continued collaboration and support. • Primary care Workforce team encouraged further support in development for clinical leaders for community pharmacy and explore opportunities for other primary care contractor groups including dental and optometry.
35.3	**The Primary Care Transformation Committee noted the Report**
35.4 35.5	**Access** **HCT Hertfordshire Special Care Dental Service - Nurse Led Anxiety Management Pathway: MC/LA (page 88)** Leah Adams (LA) introduced slide 88 of pack highlighting key areas: • Hertfordshire Special Dental Service is a service consultant and specialist service for adults and children with special needs. • Nurse Led Anxiety Management Pathway (AMP). • Case study outlined to add context to service. • Management of patient explained in slide. • Utilising pathway to enable successful treatment of patients. • Feedback from patient positive. • Prevention offered around good oral health. Michelle Campbell (MC) provided an overview on community dental and how this case studies supports the transformation work underway in community dental area. The findings of this service are shared across the region and work is underway with the expansion of

	the community dental service as the whole service across HWE will be reviewed over the 12 months to propose future commissioning models.
35.6	Questions and comments were invited: • Currently working with younger children promoting all health, highlighting services available. • Visiting children's centres to target five and under. • Prevention identified early.
35.7	**The Primary Care Transformation Committee noted the Report**
35.8	**<u>Stevenage Same Day Access PCN Hubs: CG (page 89)</u>** Cathy Galione (CG) introduced Matt Charles (MC) and Kolade Daodu (KD), joining today for this item Slide 89 shared outlining key areas: • One of the three geographical priority areas identified in the primary care strategy and ICB Urgent and Emergency Care Strategy. • High levels of increasing demand within the place system area. • Stevenage PCNs considerable experience leading acute respiratory hubs during pandemic. Matt Charles added: • Positive feedback patients welcome closer to home care same day. • Patient surveys highlighting impact wider system, very positive. • Learning continuing, tweaking to provide consistent approach as service developed. • Various Health care professionals covering good skill mix to support range of conditions. • Mix system partners supporting access. • Enables capacity to work on preventative care. • Continued working with Stevenage North, joining up care. • Aligns with key priorities of ICB. • Population growth within Stevenage affects mismatch creating additional pressure within area.
35.9	**<u>Stevenage Same Day Access Evaluation Access Hub Evaluation: (pages 95-138)</u>** Cathy Galione (CG) introduced report outlining key areas: • Report sets out clearly recommendations, next steps, further discussion points.

	• Acknowledge latest development of Urgent Treatment Centre (UTC) at Lister Hospital site following introduction of same day access hubs through health and Care Partnership. • East and North Herts in final stages of evaluation report relating to the introduction of UTC. • Evaluation report to be presented at Health and Care Partnership Transformation Committee later today. • Further meetings in place discussing with PCNs/localities Phase 2. • Learning from Harlow model introduced in West Essex • Welcome views and discussion next steps to enable paper to be presented at Commissioning Committee in few weeks, to secure commitment.
35.10	Questions and comments were invited: • Suggestion improve integration around Stevenage Pharmacy First as referrals appear low. • Consider learning from Watford/UTC utilising enhanced access directly, explore possibilities within other areas. • Collaborate with Community Pharmacy PCN Leads to enable integration within areas. Infrastructure in place on high street and in locality – needs to be utilised as part of enhanced service. Not across entire ICB. High street optical practices in position to integrate, with some funding commissioned and utilised. Urge conversations with LOC to commission pathways which would add significant difference to patients. • Integrated decision from all partners key to establish clear guidelines as opal reporting suggests no notable change on pressures. • Opportunity to move forward following key meetings to establish commitment, next steps. • Essential not to lose focus on impact to General Practice and entire system. • Communication important with patients, essential continue educations patients to use most suitable service which will take time. • Assurance offered will continue to work collaboratively. • Analysis in place with data highlighting services uptake. • Filtering of patients to correct service in place via triage system. • Essential to retain continuity of care. • Recognise potential opportunities to work with pharmacies and Optometrists. • Further work on pathways to understand types of patients and most effective way to move forward within localities.
35.11	**Proactive Management** **Lower Lea Valley Community working together at Broxbourne volunteers fair (video): AJ (page 91)**

	• Alison Jackson (AJ) introduced video showcasing event held bringing together voluntary sector health services, social care, patients to support volunteers within community. • Extremely successful, with excellent outcomes. • Building momentum, connections with volunteer sector/NHS care services. • Sign posting carers to information to support with families. • Raising awareness across all organisations.
35.12	Questions and comments were invited: Positive feedback, with excellent partnership working using targeted approach
35.13	**The Primary Care Transformation Committee noted the Report**
PCTC/36/24	**Directorate Report**
36.1	Avni Shah (AS) presented this item (see pages 139-167 of the document pack) highlighting the following: • Capacity in winter • Workforce engagement University of Hertfordshire • Launch of digital skills support webpage. • Community pharmacy projects. • Hypertension pilot picking up pace. • Update on the Vaccination uptake.
36.2	Questions and comments were invited: • Discussion around pharmacy education/training within workforce. • Currently issue with remit as funding and resource sits with NHSE. • AS will keep LPC informed of any progress/decisions.
36.3	**The Primary Care Transformation Committee noted the Report**
PCTC/37/24	**Primary Care - System Access Improvement Plan**
37.1	Andrew Tarry (AT) presented this item (see pages of the document pack 168-252) highlighting the following: • Update on report published May 2023. • 4 key areas outlined as per report. • Detailed report provides in depth detail.
37.2	Questions and comments invited**:** <u>CG provided update on key development within East & North Herts:</u> • Useful resources shared following LMC meeting and webinar from Confed relating to interface improvement programme.

	• The consult-to-consult referrals in comparison to previous years appears higher. • ENH actively seeking Associate Director to host within Trust position to work on interface between Primary and Secondary Care. <u>PS provided update on West Essex:</u> • Interface works collaboratively with various providers. • Local acute recently changed clinical system following 16-month transformation. • Once all electronic systems in place, expect to see Patient benefits, reducing bureaucracy ensuring patient requests are dealt with more efficiently to meet needs without communication issues. AS concluded progress is being made including work on access to Dental. Continued work to embed models of care including cloud-based telephony. How we continue working collaboratively with pharmacies, community partners, neighbourhoods.
37.3	**The Primary Care Transformation Committee noted the Report**
PCTC/38/24	**Primary Care Risk Register**
38.1	Andrew Tarry (AT) presented this item (see pages 253-261) of the document pack highlighting the following: • Reviewed risk versus issue. • Monitoring issues log to build understanding. • Revised to ensure rationale clear on scores.
38.2	Questions and comments invited: • HM highlighted risk within Community Pharmacies being unable to deliver as currently not financially viable. • A collective action with National Pharmacy Association ongoing. • Pharmacies unable to deliver outside of services commissioned. • Consider including this on register. AS confirmed, unable to register risks with national contracts. Currently limited information relating to access to local pharmacies, although available to discuss further
38.3	**The Primary Care Transformation Committee noted the latest iteration of the risk register**
PCTC/39/24	**For Information only**
39.1	**I**nformation pack provided separately (pages 1-64)
39.2	**The Primary Care Transformation Committee noted the report**

PCTC/40/24	**Evaluation of Community Pharmacy Project**
40.1	Report pages 3-55 provided by Mefino Ogedegbe (MO)
40.2	**The Primary Care Transformation Committee noted the report**
PCTC/41/24	**Minutes from subgroups**
41.1	• Primary care digital (pages 56-60) • Primary care Workforce Implementation Group (pages 61-64)
41.2	**The Primary Care Transformation Committee noted the sub-group minutes**
PCTC/42/24	**Reflections and feedback from the meeting**
42.1	• Continued challenges within Primary Care. • Case studies useful. • Integration, communication key to continue through particularly challenging times.
The meeting closed at 12.05pm	

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐			
	NHS HWE ICB Primary Care Board - meeting held in Public				**Meeting Date:**	**30/01/2025**	
Report Title:	Case Studies: Primary Care Support into Care Homes				**Agenda Item:**	**6**	
Report Author(s):	This paper has had input from a number of leads from across the ICB and wider system.						
Report Presented by:	Emily Perry, Primary Care Manager – Strategy and Transformation, Hertfordshire and West Essex Integrated Care Board James Gleed, Associate Director Primary Care Strategy and Transformation, Hertfordshire and West Essex ICB Sarah Crotty, Senior Pharmacist (innovation, integration, finance and specialities), Hertfordshire and West Essex Integrated Care Board Dr Lakhvinder Larh, Loughton, Buckhurst Hill and Chigwell PCN Clinical Director Plus other section leads as required.						
Report Signed off by:	James Gleed, Associate Director Primary Care Strategy and Transformation, Hertfordshire and West Essex ICB Avni Shah, Director of Primary Care Strategy and Transformation, Hertfordshire and West Essex Integrated Care Board						
Purpose:	**Approval / Decision**	☐	**Assurance**	☐	**Discussion**	☒	**Information** ☒
Which Strategic Objectives are relevant to this report	• Increase healthy life expectancy, and reduce inequality • 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:	▪ Has the committee identified any opportunities for further service development and integration? ▪ Do committee members wish to see further quality markers and health outcomes data for care homes residents in any future reports ▪ Does the committee want any further information related to updates provided?						

Report History:	▪ N/A
Executive Summary:	This paper is being taken to Primary Care Transformation Committee for discussion and responds to comments from committee members that the committee would like to review service provision in the round rather than through a series of separate instances. Whilst the population of care homes is small in comparison to the wider population (depending on the definition and measure of nursing or residential care homes there are c11,000 beds across the Herts and West Essex), the cohort of people who reside in care homes often have a high level of care needs, and account for a high proportion of emergency admissions. Demographic changes in Hertfordshire and West Essex mean that our older population will be growing rapidly over the coming 15 years or so, and it is this section of the population that are the most intensive users of health and care services. The importance of ensuring appropriate support for care home patients falls across a number of ICB and system wide plans and priorities. In addition, it is important that patients are discharged from acute hospital beds as soon as their health and care needs allow which has in recent years increased the complexity and turnover of people in community-based beds. This in turn has impacted on healthcare requirements in the out-of-hospital setting and the associated healthcare providers; it is important to ensure that the service model and level of resource being invested remains proportionate as the landscape continues to evolve. This paper outlines a summary of the work taking place to support care homes across Hertfordshire and West Essex from a primary care point of view. The paper has had input from various leads from across the ICB and the wider system and covers the following; • Background and information on growth of care home bed numbers • Primary care offer to care homes - including pharmacy, dental and eye care services, • Digital updates • Information on Discharge to Assess (DTA) • Updates from Place teams, information on the Enhanced Health in Care Homes (EHCH) Service in East & North Hertfordshire place • Case study and evaluation of the Loughton, Buckhurst Hill and Chigwell Care Home Hub Pilot.

<table>
<tr><td></td><td>Primary care provides a variety of services to care home residents, which are outlined in further detail within the paper, however these include;
General practice support care home residents via the GMS contract, as well as the national DES and locally offered DES Plus contract –this includes providing weekly ward rounds to see patients that have been clinically prioritised, carrying out Structured Medication Reviews and ensuring established protocols are in place for information sharing between the PCN, care home and system partners - further details of the general practice offer to care homes are outlined within this paper
Community pharmacies provide and deliver medicines to residents and under the Community Pharmacy Advanced Service Specification 2024-25 can also undertake flu vaccines within care homes.
The General Ophthalmic Additional Services Contract provides mobile services to patients who cannot attend Ophthalmic Services premises
Domiciliary Dental treatment in care homes across HWE is provided by both the Hertfordshire Special Care Dental Service (HSCDS) and the Essex Community Dental Service (CDS) provider. As part of the HSCDS offer, a dental domiciliary screening pilot is currently being delivered across a number of care homes.
This paper, in bringing together the various aspects of primary care service provision that exist within the care home environment, highlights the degree of connectivity and potentially enables opportunities for greater integration and innovation to be identified. It also provides a platform upon which to consider future patient needs, service models and resourcing.</td></tr>
<tr><td>Recommendations:</td><td>To note the totality of primary care service provision to care homes and support the work at place level that is under way and to receive further updates on those projects and pilots in due course.</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>
<tr><td colspan="4">N/A</td></tr>
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Implications / Impact:		
Patient Safety:	*N/A*	
Risk: *Link to Risk Register*	*N/A*	
Financial Implications:	*N/A*	
Patient or public engagement or consultation:	*N/A*	
Impact Assessments: *(Completed and attached)Please detail key impacts the Board/Committee should note:*	***Equality Impact Assessment:***	N/A
	Quality Impact Assessment:	N/A
	Data Protection Impact Assessment:	N/A

Hertfordshire and West Essex Integrated Care System

Primary Care support into Care Homes in Hertfordshire and West Essex

Primary Care Transformation Committee in Public

30 January 2025

Working together
for a healthier future

Introduction and background

- This paper has come to the Primary Care Transformation Committee to look at the current provision from primary care to residents in care homes and to understanding the connections between service provision, ensuring resourcing is adequate and appropriate and to discuss any improvements that can be made.

- **One in seven people, aged 85 or over, permanently live in a care home**. Older residents have high levels of healthcare need, largely determined by chronic, progressive disease and resulting in multiple disabilities. Over the last 10 years the dependency of residents living in care homes is also reported to have increased.

- Demographic changes in Hertfordshire and West Essex mean that our **older population will be growing rapidly over the coming 15 years or so,** and it is this section of the population that are the most intensive user of health and care services

- Depending on the definition & measure of Nursing or Residential Care Homes **there are c11,000 beds across the Herts and West Essex (HWE) area** - this represents a c9% growth just in the last 16 months (Oct-23 – Jan-25)

  - In terms of type of beds across HWE, there is a c50/50 split between Nursing Homes (those with qualified nursing care) vs Residential Homes

  - Almost 90% of beds in HWE support older people or those with physical disability; 7.7% are for Learning Disability patients; 2.3% for those with Mental Health conditions & 0.3% being Rehab or Neuro support

- National evidence suggests that **many care home residents do not have their needs adequately assessed and addressed**. **NHSE advocate that people living in care homes should expect the same level of support as those people living in their own homes.**

Supporting strategies

- **The ICB Medium Term Plan notes the importance of** expanding frailty support to shift from reactive acute care to preventive, anticipatory and community-based care.

- As part of the **Enhanced Commissioning Framework** (ECF) for 2024/25 **each GP practice is asked for have a lead** (clinical or non-clinical) for **frailty, including care homes.**

- **The HWEICB Primary Care Strategic Delivery Plan** notes the importance, under prevention and health inequalities, of ensuring high quality oral health care and attention for all those living in care homes or requiring care in other domiciliary settings - information on the dental domiciliary screening pilot for care home residents in Hertfordshire case study can be found later in this paper.

- The ICB has created a **care homes dashboard** that is shared internally and with practices and PCNs and outlines information such as A&E admissions and attendance from care homes across HWE.

Primary Care offer to Care Homes

- Whilst some needs of care home residents will be met through the care home provider, it is recognised that this patient population will also need input from medical, nursing, pharmaceutical and other services

- Primary Care services support care homes and their residents as follows:

    - **Community pharmacies** provide and deliver medicines to residents and under the Community Pharmacy Advanced Service Specification 2024-25, community pharmacies can also undertake flu vaccines within care homes.

    - The **ICB care home pharmacy team** works with care homes to raise the standards of care - *further information about this work can be found later in the paper.*

    - The General **Ophthalmic** Additional Services Contract provides mobile services to patients who cannot attend Ophthalmic Services premises – this can include residential homes. There are 28 General Ophthalmic Additional Services Contracts in Hertfordshire and West Essex.

    - Domiciliary **Dental** treatment in care homes is an “additional service” and not required under the national core dental contract and therefore requires separate commissioning to general dental provision (GDP). Across Hertfordshire and West Essex, the only local offer to care homes currently in relation to dental is from the domiciliary service provided by both the Hertfordshire Special Care Dental Service (HSCDS) and the Essex Community Dental Service (CDS) providers across the ICB. As part of the HSCDS offer to care homes, they are currently delivering a dental domiciliary screening pilot across a number of care homes in Hertfordshire, commissioned by the ICB and led by Hertfordshire Community NHS Trust – *further information about this can be found in the case study further down in this paper.*

The General Practice offer to Care Homes includes;

- **Core *General Medical Services* (GMS) contract**
- **National *Directed Enhanced Services* (DES) contract**
- **locally offered *DES plus contract***

• National Directed Enhanced Services (DES) contract;

- **All care homes** are aligned to a PCN/GP Practice **and will have a named clinical lead (who is responsible for overseeing implementation of the PCN DES requirements**), this does not need to be a GP but a suitably experienced clinician.
- **All care homes** should have a **weekly ward round** to see patients that have been clinically prioritised, they should be supported by the care home **Multi-Disciplinary Team (MDT)** as required.
- Carry out **Structured Medication Reviews** (SMR).
- There should be **established protocols** between the PCN, care home and system partners for information sharing, shared care planning, use of shared care records and clear clinical governance.

• Additional locally offered DES plus contract;

- The GP practice aligned to the care home will ensure **a named GP who holds responsibility for provision of medical advice.**
- PCN/Practice **will deliver to each resident a completed personalised care and support plan (PCSP**) covering the principles of the Comprehensive Geriatric Assessment (CGA), including the structured medication review.
- The PCN should ensure **that any resident who is newly admitted** into the care homes **will have a new or amended personalised care and support plan in place within 7 days** and completed within 28 days.
- All care homes will have a **weekly ward round**; this ward round should take the form of a face to face or virtual 'board round' of the residents in the care home and **should include any resident who has been triaged as needing to be seen by General Practice and will include any new residents.**
- **Ensure that the care home has a bypass phone number** and that urgent matters are responded to **within 30 minutes** of the Care Home staff contacting the coordinator.

Hertfordshire and
West Essex Integrated
Care System

Pharmacy, Dental and Ophthalmic Services

Working together
for a healthier future

HWE ICB Care Home Pharmacy Medicines Optimisation Team (PMOT) – key areas of focus

The ICB care home pharmacy team works with the highest risk homes to raise the standards of care – focusing on the following areas:

1. Safeguarding: If medication is involved, the team work with ICB Nursing/Quality & Local Authority teams. Learning from medicines incidents is shared via training and newsletters.

2. Queries – dedicated email for any professional staff (e.g from care homes, GP practices, the ICB etc) to answer queries relating to care home medication & processes – this might include queries related to regulations, risks, or general questions.

3. Falls reduction through medication adjustments and personalising the medicines regimen.

4. Training Care Home staff. 2024-25 - seven training webinars (available to playback) for care home staff, very well watched. Facilitated by Hertfordshire Care Providers Association (HCPA), West Essex care homes also attend.
Training PCN staff. Pharmacists & technicians support & train PCN staff;
If there is no PCN pharmacist & if a need is identified, we work with practices to undertake meds reviews.
Proxy ordering support homes to move to a more electronic ordering process – this is led by HBLICT with the Pharmacy team supporting

5. System & Process Audits. The PMOT Care Home team aim to visit every home in the ICB over 2 years. This work raises standards by highlighting good & bad practice. Support offered may improve CQC ratings and feed into level of support the local authority need to provide to the care home. If information is flagged that needs to be shared with GP practice/ ICB Quality team this will be shared by the PMOT after the visit.
Note: CQC inspections - care homes must evidence work with external stakeholders to enhance patient care.

6. Deprescribing saved **£200k** on drugs being stopped and **£150K** on admission avoidance; total **£350K** in 24-25 so far
Reducing waste **we are trialling new ways to optimise savings in 24-25.**

To consider: how can medicines waste management in care homes be improved, through working with GP practices, the care home and community pharmacies – e.g ensuring that prescriptions align with amount of medication needed per month.

Medicines Optimisation challenges

- HWE have over double the care home beds that would be expected for our population of 1.6M
- Over the last decade care home residents have become increasingly frail and their medication to treat multiple conditions has become more complex
- Considering stopping medicines is important as every medication has the potential to cause harm
- We come across many cases where medication A causes a side effect which is treated by medication B, which leads on to using medication C etc

Case Study:

- An elderly resident was diagnosed with high blood pressure (hypertension) for which **amlodipine** was given
- A known side effect of amlodipine is oedema (leg swelling), when this occurred the doctor prescribed a diuretic, **furosemide**.
- The diuretic caused the elderly lady to have urinary incontinence for which the lady was given **oxybutynin**
- The oxybutynin is known to have side effects which make falls more likely and she started to fall regularly
- Our ICB pharmacist assessed the lady, along with a PCN prescribing colleague. He was able to change the BP medicine, and stop the rest. The result over 6 months, no falls, BP controlled, oedema and incontinence no longer an issue.

Feedback from care homes across HWE about the ICB Care Home Pharmacy Medicines Optimisation Team:

Hertfordshire and West Essex Integrated Care System

Eye care services in care homes

- General Ophthalmic Additional Services Contract provides mobile services to patients who cannot attend Ophthalmic Services premises – this can include residential homes. There are 28 General Ophthalmic Additional Services Contracts in HWE.

- Whilst the ICB doesn't hold activity or comprehensive patient experience data, there is no information or evidence to suggest that this level of provision isn't adequately meeting patient need.

Dental: Information for commissioners on dental domiciliary screening pilot for care home residents in Hertfordshire in 2023/24.

Situation/Setting

- In 2023, it was identified that the Dental Domiciliary Contract had capacity within its baseline and it was agreed to repurpose a proportion of the contract value to support a dental screening pilot in a small number of care home residents.
- There was a concern that many care home residents were not accessing a dental check-up due to concerns from families and carers about the financial cost incurred or worries that a visit from a dentist might upset a vulnerable individual.
- There was also evident lack of understanding of how much can be achieved when an experienced special care dentist and dental nurse engage with a resident who has dementia and who may be demonstrating care resistant behaviour.
- Further there was lack of awareness generally by care home staff and families of the urgent importance of good oral hygiene for frail patients (and especially those with neurological conditions and dementia) to prevent conditions such as sepsis and/or aspiration pneumonia and to screen for oral cancers.

Action

- Commissioners agreed to trial a screening programme across 3 care homes. This would allow a special care dentist and dental nurse to attend a care home and ensure that all residents had been seen for dental screening. It would allow them to screen for oral cancer/dental disease and apply fluoride varnish on teeth, as well as prescribe prescription strength fluoride toothpaste as required There was also a strong focus on using a train the trainer approach within each care home to educate staff and promote better understanding of the importance of oral health for frail patients as well as establish improved delivery of oral hygiene skills

For 2023/24 - 3 care homes were visited and 103 patients were seen.

- The dental team used a similar approach to information gathered in school screening programmes with a template agreed with commissioners

Outcome/ Impact

- 67 % of residents were identified as having poor oral health and required intervention to improve hygiene.
- One patient was identified as having potential oral cancer and was fast tracked for urgent ongoing care.
- There was limited need for ongoing dental treatment with only 5 needing referral for further dental treatment.
- Oral health training using a train the trainer approach was implemented in all care homes.
- At care home request videos were created which demonstrated training and which could be used for ongoing training purposes.
- Care homes reported they were very pleased with the screening approach and were keen to engage again if further screenings were planned.

Learning

- Highlighted general poor oral health and need for oral hygiene instruction and prevention
- Production of train the trainer teaching packs provided to enable ongoing oral health and prevention support.
- Screening model used reduced need for administrative paperwork and enabled a universal approach where no payment claims were required. Enabling a more efficient and effective service.
- Further care homes across the county have been booked in for 2024/25 with one each booked in Broxbourne, Three Rivers, Welwyn, Hatfield, Dacorum, St Albans, Watford, Stevenage, East Herts, Hertsmere and an additional home in Hemel Hempstead.
- A similar approach has been used in each of the 11 care homes and data is currently being collected.

Longer-term aim following further evaluation of this pilot, will be to commission an integrated pathway between SCDS/CDS and GDPs to support care home residents. Learning from other ICB pilots will also be considered to ensure an optimum commissioning model.

Hertfordshire and
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Care System

Digital

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Digital and care homes

- Many care homes do not use electronic systems, and where they are used they do not interface with General Practice systems.

- Key is ensuring General Practice clinicians can securely access their own clinical systems to inform visits – this is usually via a laptop

- Encourage Care Homes and Practices to implement Proxy Access to allow homes to order medication on behalf of patients - reducing work on both sides around repeat medication.

- Most care homes have an nhs.net email address.

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Discharge to Assess (DTA) beds

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HWE ICB Discharge to Assess (DTA) Beds

- A short-term funded service which comprises of a portfolio of residential and nursing care including dementia care home beds to support patients following discharge from hospital. Generally, for up to 28 days stay during which time the wrap around service assist to get the person in their forever home following assessments.

- The “multi-agency wraparound service” work closely with health and social care professionals such as social workers, physios, occupational therapists, GPs and mental health professionals and community service providers to support people to improve their wellbeing following hospital stay while they are in the DTA beds and enabling independence.

- DTA is a targeted service striving to enable people to return to their own homes, whenever it is possible. Therefore, there are eligibility criteria and people are assessed as part of their discharge from hospital to make sure this service is suitable for them. There is also homecare DTA, for those that are going to their own home rather than a care home.

- As pressures in acute trusts increase, the need to move patients into the intermediate wrap-around care in care homes in a timely manner is crucial. However, this is having an impact on primary care capacity to carry out their routine work within general practice due to the additional workload.

- Primary care teams have been working collaboratively with county council colleagues over the last year and meet regularly to engage GP practices to help support the ongoing care of those that are placed in these DTA beds.

- In response to this, a new service specification was co-produced with the ICB and council colleagues last year with additional funding.

- With an ageing population the need for these beds and similar schemes is expected to increase, and a consideration of new models of care need to be explored going forwards with the system partners.

- A reduction in bed capacity numbers is planned as part of the recovery from COVID 19 pandemic over a 4 year period and is currently on track to meet this target with a Homefirst Model. The numbers of beds commissioned increase during peak winter periods and reduce during the summer months.

- In Hertfordshire (South and West Herts & East and North Herts place) we currently have a block winter contract capped at **86 DTA beds** to the end of March 2025 with an option to use some already identified framework spot purchase beds when the block beds are full or often for personal needs ie: diversity or equality needs.

- In west Essex, there are currently **27** commissioned DTA beds. 22 in St Margaret's Hospital via the complex bed pilot and 5 via the Recovery to Home bed service. Further beds are then spot purchased from eligible care homes when the demand arises.

Hertfordshire and West Essex Integrated Care System

South and West Herts (SWH) Place update

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SWH Place Care Homes – January 2025

PCN	Number of Care Homes	Number of Residents	Number of DTA Beds Summer (Apr – Sept)	Number of DTA Beds Winter (Oct/Nov-Mar)
Alliance	6	130	8	13
Alpha	7	209	0	0
Dacorum Beta	11	427	5	5
Delta	7	358	6	4
Potters Bar	11	312	0	0
Herts Five	12	688	14	6
Abbey Health	6	160	0	0
Alban	11	360	6	3
Harpenden	7	230	0	2
Halo	7	269	5	7
Attenborough	6	306	0	4
Central Watford	7	222	6	0
Manor View & Pathfinder	8	362	0	0
North Watford	6	117	0	0
Rickmansworth & Chorleywood	8	189	0	0
Grand Union	4	265	0	0
Bridgewater	6	294	14	12
TOTAL	**130**	**4898**	**64**	**56**

The table below shows the number of care homes and residents in the last 3 years. There has been an increase of 139 residents in the last year but an overall decrease in the number of homes – after closures, openings and change in status (some were changed to Supported Living residences).

Year	Number of care Homes	Number of Residents
January 2025	130	4898
January 2024	133	4759
January 2023	137	4771

The following homes will open this year:
- **Meadowhill Care Home** in Borehamwood, 75 beds in *~opening April 25 (Home to be aligned)*
- **Northwood Nursing Home** in Watford *~opening June 25 (Home allocated to a Practice/PCN)*
- **Furzewood Lodge** in Watford *~opening April 25 (referred to Contracts for formal allocation process)*

South West Herts – Care Home Conveyance project

- Supporting the achievement of 25% frailty admissions reduction
- Reports into SWH Frailty and EoL and SWH Systems Resilience Group (SRG)
- Collaborative working – partners include – EEAST, WHTHT, CLCH, HCC, HCPA
- A task and finish group with three key areas of focus
- Each area of focus will have a specific task associated to it to support reduction in conveyances
- Designed to support long term but also support ahead of winter this year.

South West Herts – Care Home Conveyance project

Focus		Task	Latest actions/updates
Reactive Response	**Hospital Admission Avoidance Response Car (HAARC)**	• Understand which homes are successfully using the HAARC service as a first port of call and to prevent admission. • Correlate use of HAARC to attendance data per home – compare HAARC usage with attendance data with the hypothesis that those homes who use HAARC less will have higher attendance. • Engage with Homes with lowest HAARC utilisation to increase usage. • Monitor usage activity and attendance from those homes.	• Tableau dashboard now produced, showing utilisation rates and conveyances rates • Further exploring data to add in DTA beds, ED attends and NEL admissions for one complete data set • Agreed to work with primary care to support education of care homes regarding utilisation of HAARC as first port of call instead of 999
	Urgent Community Response (**UCR**)	• Understand how many UCR referrals are for residents in care homes – data to show which homes are being supported by UCR. • Support better understanding and use of UCR – linking to HAARC service – to support more residents being able to remain at home and avoid ED attendance. • Link in HAARC and Virtual Hospital to increase VH use for care home residents.	• Data in showing low use of UCR from care homes • Agreed that HAARC should remain as first port of call to avoid confusing homes • HAARC to establish a link in with UCR CCC to support decision making for patients • Agreed to increase knowledge of VH in both homes and HAARC to support decision making for VH. VH to be accessed via UCR Care Coordination Centre (CCC).
FALLS		• Rapidly receive evaluation from lifting cushion project – correlate to attendance data. Understand how lifting cushion project has supported reduction in 999 or attendance. • Rapidly scope existing reactive and proactive support for fallers in care home – understand which homes utilise these and correlate to attendance data. • Coordinate the response for SWH to support the delivery of the falls work	• HCPA leading on fall prevention and pathway work • Agreed that this T&F group will not take on any additional actions but will support coordination of falls work for South West Herts for care homes • HCPA to bring any requests for support to the meeting
MDT Proactive		• To work with one specific care home in order to support both proactive and reactive prevention of admission. • From available data, develop a top 5 list of highest attendances to identify one specific care home in South West Herts to work with. • A Multi-Disciplinary Team (MDT) will be convened to work with the home management team to support proactive initiatives that will support their residents to stay healthy and to support their workforce in managing deteriorating patients.	• Data has been compiled and a home to work with (The Chase in Watford) - has been identified • A visit has taken place with the primary care surgery responsible for that home (Bridgewater Surgeries) and the care home concerned, both have agreed to be part of the pilot. • Initial scoping meeting has identified several areas of support. • Next step to pull together MDT and also ensure home will follow falls pathway. • This pilot will become the blueprint for the future support of SWH care homes.

Hertfordshire and
West Essex Integrated
Care System

East & North Herts (ENH) Place update

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ENH Place Care Homes – January 2025

PCN	Number of Care Homes	Number of Residents	Number of DTA Beds Summer (Apr - Sept 24)	Number of DTA Beds Winter (Oct/Nov 24 - March 25)
Broxbourne Alliance	3	65		
Hatfield	15	471	0	**
Hertford & Rurals	15	605	13	14
Hitchin & Whitwell	11	385		
Hoddesdon & Broxbourne	6	176		
Icknield	10	457		
Lea Valley Health	7	156	0	5
Stevenage North	8	369		
Stevenage South	8	456	6	8
Stort Valley & Villages	8	377		
Ware & Rurals	7	353		
WGC	10	381		
Total	**108**	**4251**	**19**	**27**
** 3 New DTA beds in Hatfield wef Nov 24 not covered				
There are SPOT beds which can be used when needed, outside of these Block beds commissioned.				

The table below shows the numbers of care home and resident numbers since Oct 2023.

Bed types in Homes Jan 25	Numbers of homes
Nursing	26
Residential	81
Nursing/residentail	8
TOTAL	**115**

Opening/ Closures Care Homes	Numbers
2023 Closures	6
2023 Open	4
2024 Open	2
2025 known Opening	1

Year	Number of Care Homes	Number of residents
Oct-23	102	3758
Oct-24	106	4345
Jan-25	115	4527

Hot Spots for ENH Care homes and numbers:

5 PCNs out of 12 have 10 or more Care Homes in their boundary, so proportionately higher than others:

PCN	Number of Care Homes	Number of Residents
Hatfield	15	471
Hertford & Rurals	15	605
Hitchin & Whitwell	11	385
Icknield	10	457
WGC	10	381

Overview of ENH place PCN/GP Practice work linked to Care Homes

Current projects and examples of good practice	
Locally designed GP Practice Leaflet to support residents and their families and carers who are new to residing in a Care Home	A GP practice in North Herts locality has produced a leaflet to share with new care home residents and their families and carers. This leaflet explains what they can expect from the GP practice, who to contact and when. There is also useful information and advice about approaching Advance Care Planning, wills, LPAs, POA etc.
Additional weekly ward rounds	A GP practice in Lower Lea Valley locality has increased their weekly ward round on accepting to support 5 new Discharge To Assess (D2A) Beds. This change in delivery model has meant more efficient working within the GP Practice and with the Care Home as it has reduced the need for ad hoc calls and requests for additional care home visits.
Nurse Educator service	The Isabel Hospice Nurse Educator service delivers specialist End of Life, Palliative Care, and Advance Care Planning across all care homes. A bespoke specialist intervention, all sessions are tailored to specific training gaps/ needs of the staff.
Current Enhanced Health in Care Homes (EHCH) service (ends 31.03.25)	Current EHCH locally commissioned service, offers additional support to care home residents. There are currently 4 incumbent providers who cover all the care homes in ENH are 2 GP Practices, Community and Hospice providers. See slides covering new EHCH services from 1 April 2025.
Dementia service pilot 'Sunflower Unit'	This was a pilot led by Hertfordshire County Council colleagues working with local system partners including General Practice which stood up a specialist dementia unit within a Care home in Hatfield PCN area. The unit had a maximum of 26 beds for people with Dementia so that they could be cared for in the community and outside of the acute hospital setting with a wraparound service and support before their onward placements to their chosen place of care. The GP provision was provided by a GP Practice from a neighbouring PCN within the same locality in view of capacity issues within the closest GP Practice within Hatfield PCN. An evaluation was undertaken and the learning shared for any future pilot proposals, the service was stood down due to lack of non-recurrent funding at the present time.
Care Home Education Programme	The clinical team in Stevenage North PCN (Stanmore Medical Group) which includes a GP, Emergency Care Practitioner, Frailty Lead Nurse and Care Coordinator are working together with their care homes teams to help educate them to better manage their patients. The aim is to avoid unnecessary A&E attendances and 111 calls. They review Care Plans along with their internal protocols to reduce the default 'Call 999/111' reaction unless necessary.

Hertfordshire and West Essex Integrated Care System

Enhanced Health in Care Homes (EHCH) Service in East & North Hertfordshire place

Primary Care Transformation Committee – January 2025

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Enhanced Health in Care Homes

- In March 2020, NHSE released a framework for **Enhanced Health in Care Homes (EHCH),** taken from Vanguard findings. **Followed by an updated version in November 2023, both versions of the framework identify seven core elements, including**:

1. **Enhanced primary care support**
2. **Multi-disciplinary team (MDT)** support including coordinated health & Social Care
3. **High quality** palliative and end-of-life care, Mental health, and dementia care
4. Falls **prevention**, Reablement, and rehabilitation including strength and balance.
5. **Joined-up commissioning and collaboration between health and social care.**
6. Workforce **development.**
7. **Data, IT and technology**.

Overview of new EHCH service specification

Provider	The East & North Hertfordshire (ENH) place primary medical care provider will work collaboratively with ENH place local system partners to deliver the service
Workforce	Assurance of ability to deliver services with a sustainable workforce to ensure continuity of care (eg cover staff absences and any vacancies, if required)
Access	The ENH place primary medical care provider will have a named Contact linked to the service provision for each care home.
Mobilisation	Capacity to mobilise service across ENH place within stated timescales
Inequalities	Commitment to address inequalities as part of the wider priorities and ensure best practice in the care homes
Engagement	Working with care home staff, residents and family/carers and ENH place local system partners

Population covered;

- This service specification covers all care homes (residential and nursing), as registered by the Care Quality Commission (CQC), registered with East and North Practices, and covered under the PCN DES/DES plus by general practice.
- These also include non-weight bearing and Discharge to Assess beds (D2A) as well as Learning Disability adult care homes.

Any acceptance and exclusion criteria and thresholds

- Short break services and neurological specialist care home services will be excluded from this contract.
- Older people placed in Flexi care schemes –independent living schemes, supported housing and Learning Disability supported living will be excluded from this contract.
- People who do not reside in a care home within East and North Hertfordshire Place will be excluded.

East & North Hertfordshire

PCN	No. of Care Homes / Beds
Broxbourne Alliance	4 / 123
Hatfield	13 / 393
Hertford & Rurals	6 / 235
Hitchin & Whitwell	16 / 517
Hoddesdon & Broxbourne	6 / 176
Icknield	10 / 412
Lea Valley	5 / 94
Stevenage North	8 / 317
Stevenage South	8 / 456
Stort Valley & Villages	8 / 362
Ware & Rurals	9 / 412
Welwyn Garden City	9 / 269

EHCH Practitioner April 2025 Service Specification

Key Aims & Outcomes

- Facilitating self-management and promoting personal health planning for frail elderly and residents with LTCs
- Working to improve outcomes for frail elderly, residents with Long Term Medical Conditions (LTC) and End of Life Care
- Reducing demand for secondary care services by using services closer to home, admission avoidance services, and implementing new pathways
- Working collaboratively with the integrated primary and community services including MDT working
- Improvement in quality of life for individuals living in care homes including liaising with families and carers
- Supporting people to maintain their independence.
- Residents to die in their preferred place of death (PPD).
- Working with care homes to identify best practice as well as identifying the need for development and supporting training
- Increase and improve implementation of advanced care plans.

High level Care Pathway

New resident reviews to be completed within 7 days of admission, including falls risk status, tissue viability, hydration and nutrition. (not an exhaustive list)

Every resident discharged from secondary care to receive a review of their care and support plan including medication review and RESPECT plan including TEP within 7 days.

Every new resident to have a completed RESPECT, ACP, TEP (including PPC and PPD) and dementia care, plan within 28 days of arrival to the care home.

Every resident to have an up-to-date RESPECT plan and TEP where appropriate, including signposting for a structured medication review by general practice, regular 6 monthly reviews to take place if not seen within that time or plans not updated within that timeframe.

Residents to die in their preferred place of death (PPD).

Care home data

- **The number of patients that this service will benefit is approximately 3,766**; this will vary depending on occupancy rates across the 102 homes.
- All care homes aligned to PCNs and receive the national specification of PCN DES and local component of DES plus including weekly ward rounds, personalised plan when newly admitted/post hospital episode; named co-ordinator to support MDTs etc
- In addition robust sno-med recorded activity via primary care on patients in care homes with ACP, having had DNAR discussions and flagged using PHM approach to NHS 111 system to support continuity of care and access to summary care record and shared record via GP connect.
- **The current rate of non-elective admissions** – trend line is 0.3 per 1000. Clinical audits at local trusts indicating approximately 50% of admissions can be avoided which is similar to audits from other areas.
- Aim of this pilot model is to test how this **enhanced proactive management** support can support the delivery of outcomes with the proposed target set up to 20% reduction of non-elective admissions from care homes across ENH which is approx. 36 per month, 360 per annum.

Learning and interventions

EHCH Service Provider to review admissions data as part of the MDT on a quarterly basis with system partners and registered practice
• Audit 20% of the admissions and discuss whether the resident's admission could have been avoided. • Highlight themes and areas arising from weekly MDTs held and organised by the PCN/Practice as per the DES/DES plus. Including actions taken and followed through of learning / improvements, support and training offered to care home staff to empower them to provide confident care and contribute towards the Care Closer to Home programme aim of reducing avoidable admissions by 25%. • These findings will be presented on a regular basis at local primary care meetings and frailty boards to ensure learning is embedded across ENH Health Care Partnership (HCP) and linked to the Care Closer to Home Programme. *A template will be provided.*

Timeline of process to enable delivery of the new service from 1 April 2025

November 2023 –
New EHCH framework guidance issued

January 2024 –
Change in procurement laws

Review and development of EHCH service
(in line with new framework)

Development of the Business Case and New model of care with a view for EHCH to go live 1st April 2025

Providers sighted on the earlier draft scope of EHCH service specification
(opportunity to input)

First Market Engagement Event – March 2024

Providers sighted on quality expectations and ICB seeking to understand the market and what the potential contract could look like

April to September 2024
Incorporating the feedback in March, Further development of the business case, specification and model of commissioning outlined

ICB Governance

Embedding of this as part of the emerging Health and Care Partnership delivery plan

Agreement to align learning from this into the ICB wide development of the Care Closer to Home model

October 2024
Market Engagement Event – launch the procurement via MSP

Providers informed of the:

- new EHCH service spec,
- approach to procurement process with timelines/upcoming key dates ;
- contract length-2 year pilot with potential to extend for one more year
- Annual financial envelope £822k
- Lead provider contract

Hertfordshire and
West Essex Integrated
Care System

West Essex Place update:

Loughton, Buckhurst Hill and Chigwell Care Home Hub Pilot – Case Study and Evaluation

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Care home data in West Essex

PCN	Number of Care Homes	Number of Residents	Number of DTA Beds
Buckhurst Hill, Loughton and Chigwell	10	631	14
Epping Forest North	13	647	12
Harlow North	5	185	10
Harlow South	2	178	12
North Uttlesford	7	280	16
South Uttlesford	12	488	6

The national Enhanced Health in Care Homes (EHCH) service is delivered to all care homes in West Essex by various providers including practices and PCNs.

Loughton Buckhurst Hill and Chigwell Care Home Hub Pilot

Situation/Setting

- Provision of support to care homes in Loughton Buckhurst Hill and Chigwell (LBC) is provided by social care, Essex Partnership University Trust (EPUT), St Clare Hospice and General Practice. The General Practice element of care was provided by individual practices that patients within the care homes were registered with, meaning that each care home was assigned 2-3 practices and many practices covered multiple homes. Both practices and care homes reported difficulties with this model.

- The aim of the centralised care home hub is to provide a integrated neighbourhood team approach across LBC. This has meant putting in place a lead GP working across 6 care homes, totalling 218 beds, with a dedicated team supporting this including a pharmacist, paramedic and a care co-ordinator. These roles work alongside the existing community resource within social care and EPUT enabling fewer hand offs and more seamless care for patients.

- The set up and mobilisation of this service took huge time, effort and commitment from the INT who established a dedicated project team to this workstream. Not only did this require working with all participating practices but also required working very closely with wider stakeholders who form part of patient care in the care home setting.

Action

The INT had to work in a timely and structured way to mobilise the project. As well as weekly core project team meetings, monthly project groups were established with stakeholders to work through several areas to allow for successful mobilisation. These meetings covered: -

-GP and Additional Roles Reimbursement Scheme Recruitment
-Clinical governance and referral pathways
-IT infrastructure
-Communication networks - including all system partners, care homes and community pharmacies
-Quality assurance and data analysis

Participation from community matrons and care home managers was crucial to the success of these meetings, where operational processes were discussed and agreed, and any concerns talked through.

Alongside this the team worked with the Integrated Care Board in the run up to the go live date to ensure clear KPI's were set out to allow for clear evaluation of the service following its pilot period.

Impact

- The project is still in its early phase. Three months' worth of KPI data has been reviewed with many being met. October will see a focus on all End-of-Life KPI's with training being arranged by the community provider for the care home hub and PCN as a whole. We are working with end-of-life commissioners, EPUT and St Clare Hospice to deliver this.

- The wider system target of reduction in readmissions requires more time in order to see the impact the service has throughout the year. However, the first 3 months' worth of data looks promising showing that the average number of admissions from these homes appears to have fallen since the establishment of the service when compared to last year. Targets continue to be monitored monthly and further outcome data will be shared in the 6 month evaluation.

- Qualitative feedback to date has been extremely positive from care home managers, GP's, community staff and families. This feedback is being captured to inform our midway evaluation of the pilot. Key themes coming out of feedback so far highlight – better response to urgent/on the day requests, better follow ups for patients recently discharged from hospital to home, reduced hospital admissions, prescriptions arriving in a timely way (care home not having to chase), reduced complaints from patients and relatives, patients and carers being pleased with the service because there is always someone there (who will respond to care home requests).

Learning / what hasn't worked

Estates:-
Having the use of Buckhurst Way Clinic as a centralised space whereby the care home hub team can be based has made a big difference within LBC PCN both for the staff within the PCN aligned to the care home hub and for the local community staff involved. This has also been useful for regular stakeholder meetings that they have been able to hold in a hybrid manner.

Recruitment and workforce:-
Release of funding took longer than expected which in turn delayed recruitment of staffing. This meant the initial start date moved from early April to early May. However, through the PCN, Primary Care Transformation Team and Training Hub working together (the GP employed is part of the GP fellowship scheme) this was worked through, and recruitment was successful albeit 1 month later than originally planned. Plans on workforce to cover the hub also evolved after it became clear that the paramedic involved was invaluable to the hub. Therefore, workforce plans were reviewed and adapted accordingly.

Systems and IT:-
Delayed access to ICE for the Care Home Hub was flagged as an issue and a risk when the service was first initiated. This risk was due to more handoffs than necessary having to take place as pathology requests were having to go via individual practices rather than directly through the hub. LBC PCN have worked with the ICB's digital team and PAH pathology team to resolve this issue to get Buckhurst Way Clinic access to ICE. This was not straight forward taking a lot of time and effort but has made a big difference to day to day running of the service. There was also an issue with capturing data from one GP practice due to it being on a different system to the other practices. Again, the PCN worked through this and have now successfully set this up.

Mobilisation:-
When the service was established in May the initial month saw the team being faced with many reactive requests from the care homes at the same time as implementation of new operational processes that all system partners were getting used to. The team and wider stakeholders worked well together through this settling in period and are now at a stage whereby they are carrying out their proactive as well as reactive work within the homes in a structured way.

Improved Better Care Fund (iBCF) Outcomes Evaluation Template for Loughton, Buckhurst Hill and Chigwell Care Home Hub

iBCF Evaluation - November 2024

Scheme Name	Loughton, Buckhurst Hill and Chigwell Care Home Hub
Scheme Lead:	Jessica Steele
Lead Provider	Dr Lak Larh, LBC PCN CD
Length of contract	1 year (May 24-April 25)
Scheme Value (total and funded value)	Total - £386,600 Funded - £95,932
Scheme Funding Source:	Better Care Fund
Scheme start and end date:	1st May 2024 – 30th April 2025
Date for next evaluation:	30th April 2025

Description of Scheme: Loughton, Buckhurst Hill and Chigwell Care Home Hub

Exec summary or introduction of the purpose of this evaluation

- The Loughton, Buckhurst Hill and Chigwell (LBC) Integrated Neighbourhood Team (INT) centralised Care Home Hub was established in early May 2024. The intention of the hub is to enhance the provision of consistent quality care for their care home residents. This has been seen as a proof-of-concept model as it is a very new way of working and has pushed LBC INT forwards in their development of collaborative working across all system partners.
- The aim is that by improving the continuity of care that this will lead to reduction in admissions, enabling more sustainable discharge and therefore will also support with reduction in readmission rates for patients, ensuring they receive the right treatment at the right time in a proactive manner. Alongside this the team expect to see a reduction in duplication for all system partners as services become more joined up in their care benefiting both patients and workforce.
- The aim of the centralised care home hub is to provide a Primary Care Network (PCN) approach with LBC PCN putting in place a lead GP working across 6 care homes, totalling 218 beds, with a dedicated team supporting this including a pharmacist, paramedic, advanced nurse practitioner and a care co-ordinator. These roles work alongside the existing community resource within social care and EPUT enabling fewer hand offs and more seamless care for patients.
- As the service has been running since the beginning of May the purpose of this paper is to provide a 6month evaluation

Delivery Model:	
Workforce (Staffing levels):	**Workforce** Key Staff:- / WTE GP 1 ANP 1 Phmaraicst 1 Paramedic 1 GP administrator 1
Planned Capacity (e.g. care hours/beds etc)	Monday – Friday 9-6 214 care home beds
Interdependencies (other schemes or funding impacting on the scheme):	Scheme currently funded partially by PCN (£291,208) and partially by BCF (£95,392). Without BCF funding the PCN will need to find another source of funding to continue with this service.

Intended Impact / Aims and Objectives

What were we hoping to deliver, why and when?

The Loughton, Buckhurst Hill and Chigwell (LBC) Integrated Neighbourhood Team (INT) centralised Care Home Hub was established in early May 2024. The intention of the hub is to enhance the provision of consistent quality care for their care home residents. This is seen as a proof-of-concept model as it is a very new way of working and has pushed LBC INT forwards in their development of collaborative working across all system partners.

The business case for the proposed service was worked on between both PCN leads and ICB leads, and the proposal was approved in November 2023 via the Better Care Fund Board for a 1-year pilot with them covering the gap between the PCN's current care home funding streams and the proposed cost of the whole service. The training hub also supported the PCN on this project via the GP fellowship scheme.

LBC Care Home Hub was established at the beginning of May 2024. The aim is that by improving the continuity of care that this will lead to reduction in A&E attendances and hospital admissions, enabling more sustainable discharge and therefore will also support with reduction in readmission rates for patients, ensuring they receive the right treatment at the right time in a proactive manner.

Key Milestones LBC Care Home Hub	Target Date	Update
LBC care home hub business case approved at intermediate care board	Nov-23	Agreement for LBC to pilot a care home hub whereby 3 practices covering 6 homes have a centralised team
KPI's developed and agreed	Jan-24	All KPI's have been entered on to SystmOne ready for information capture
Internal and external recruitment complete	Jan-24	All recruitment completed including GP via training hub
Go live date	8/5/24	Care home hub live – weekly team meeting and monthly steering group with all system partners established
Monthly monitoring meetings established	Ongoing	Series of monthly meetings arranged to look at KPI's and issues – next meeting 25th July
Review of KPI's in monthly meetings	25/7/24 – ongoing beyond this in monthly meetings	Proactive work to meet KPI's has begun. End of Life KPI to be the focus for August now that they have established processes for other KPI's (i.e. SMR's, personalised care and support plans). Collation of qualitative data to begin.

KPI Activity Performance to Date - Baseline

Baseline reminder:-

For the baseline of this project, we used Loughton Surgeries A&E attendance figures over a year period (Nov22-Nov23) for their care home beds. This equated to 107 A&E attendances over 80 care home beds. This worked out as a rate of 1.3 attendances per bed per year. When applied to the total of 214 beds within the pilot this meant 286 attendances over a year period (See table below).

We also used the Loughton Surgery NEL admission hospital bed day figures over the same year period (Nov22-Nov23) for their care home beds. This equated to 1049 NEL bed days over 80 beds. When applied to the total of 214 beds within the pilot this meant 2806 bed days over a year period for their care home patients.

Loughton Surgery 80 care home bed activity Nov22-Nov23	**Activity per bed based on 80 beds supported by Loughton Surgery**	**Activity per bed over 214 care home beds in pilot**	**Monthly baseline**
Total A&E Attendances: 107	1.3375	286.23	24
Total Hospital admission days	13.1125	2806.08	234

Split equally across 12 months this meant **our baseline was 24 A&E attendances per month and 234 NEL bed days per month**. The aim was to reduce these figures by 10%.

A comparison to how we are performing in relation to this baseline can be seen on the next slide.

KPI Activity Performance to Date - Actuals

Actual Activity/Performance to Date:-

We have to date received 5 months' worth of A&E attendance data and NEL bed day data from the care home hub spanning June24-October24.

The total A&E attendances for this 5-month period has been 39 meaning the average monthly attendance is currently 8 vs the 24 in our baseline data. This means the **total percentage reduction in attendances currently stands at 67% equating to 80 fewer attendances across these 5 months**. This is 57% more than our planned target reduction rate of 10%.

The total NEL bed days for this 5-month period is 204 meaning the average monthly bed days is 41 vs the 234 in our baseline data. This means **the total percentage in reduction for NEL bed days currently stands at 83% equating to 965 fewer bed days**.

A&E attendance Data from Care Homes June24-October 24

	June	July	August	September	October	Total
23/24 baseline A&E attendance data	24	24	24	24	24	119
Pilot A&E attendance figures	4	4	5	15	11	39
Difference	20	20	19	9	13	80
Percentage reduction in A&E attendances	-83%	-83%	-79%	-37%	-54%	-67%

NEL Admission Days Data from Care Homes June24-October 24

	June	July	August	September	October	Total
23/24 baseline NEL bed days	234	234	234	234	234	1,169
Pilot NEL bed day	41	41	41	41	41	204
Difference	193	193	193	193	193	965
Percentage reduction in NEL bed days	-83%	-83%	-83%	-83%	-83%	-83%

KPI Activity Performance to Date - Projections

Projections:-

A&E Attendances

If current performance of a 67% reduction in A&E attendances were to be extrapolated over a year, the projections for reduction in activity could be as great as 191 fewer A&E attendances. See table below:-

A&E attendnace activity saving projections

	June	July	August	September	October	November	December	January	February	March	April	May	Total
23/24 baseline A&E attendance data	24	24	24	24	24	24	24	24	24	24	24	24	286
Pilot A&E attendance figures	4	4	5	15	11	8	8	8	8	8	8	8	95
Difference / reductiion	20	20	19	9	13	16	16	16	16	16	16	16	191
Percentage reduction in A&E attendances	-83%	-83%	-79%	-37%	-54%	-66%	-66%	-66%	-66%	-66%	-66%	-66%	-67%

NEL Bed Days

If current performance of an 83% reduction in NEL bed days were to be extrapolated over a year, the projection for reduction in activity could be as great as 2316 bed days. See table below:-

NEL admission activity saving projections

	June	July	August	September	October	November	December	January	February	March	April	May	Total
23/24 baseline NEL hospital admission day	234	234	234	234	234	234	234	234	234	234	234	234	2,806
Pilot NEL bed day figures	41	41	41	41	41	41	41	41	41	41	41	41	490
Difference / reductiion	193	193	193	193	193	193	193	193	193	193	193	193	2,316
Percentage reduction in A&E attendances	-83%	-83%	-83%	-83%	-83%	-83%	-83%	-83%	-83%	-83%	-83%	-83%	-83%

Financial Impact – Actuals and Projections

Actuals:-

The table below shows the actual savings made from the 80 fewer attendances over the first 5 months of the service. This amounts to a £16,480 saving.
The table also shows the actual savings made from 965 fewer bed days over the first 5 months of the service. This amounts to a £337,750 saving.
If we add ambulance conveyances and return journeys to this, the **actual savings to date work out to be £385,718**

LBC Care Home Hub Activity Reduction to Date	**Activitty reduction**	Costs	**Savings to date**
Total A&E Attendances	80	206	£16,480
Total ambulance conveyances to PAH	80	276	£22,080
Total return ambulance journeys to care home	64	147	£9,408
Total hospital admission days	965	350	£337,750
Total potential savings			**£385,718**

Projections:-

The 10% cost saving outlined in the original business case showed a projected saving of £115,372. If we were to apply our 67% reduction in A&E attendances and 83% reduction in NEL bed days to our proposed cost saving **the projected saving for the year could amount to £930,129 which is £814,747 greater than expected**. The table below shows our original cost saving proposal of 10% vs what this will look like if we continue along our current trajectory.

Care Home Hub Potential 1 Year Projected Savings	Activity	Costs*	Annual cost	Baseline saving target - based on 10% reduction of attendances over 214 care home beds	**Projected savings - based on current achievement of 67% reduction of A&E attendances and 83% reduction of NEL bed days over 214 care home beds**
Total A&E Attendances (based on Loughton Surgery extrapolated data, see slide 7)	286	£206.00	£58,963	£5,896	£39,505
Total ambulance conveyances to PAH	286	£276.00	£78,999	£7,900	£52,930
Total return ambulance journeys to care home	229	£147.00	£33,659	£3,366	£22,551
Total hospital admission days	2806	£350.00	£982,100	£98,210	£815,143
Total potential savings			£1,153,721	£115,372	**£930,129**

**See appendix 1 for costing sources used for baseline and current projections*

Financial Impact

Current cost of service:-

The PCN utilise the following resources from within their PCN to support this project: -
-Additional Roles Reimbursement posts (pharmacist, paramedic, GP administrator and ANP)
-Direct Enhanced Service (DES) funding relating to care home delivery
-Local Enhanced Service care home support funding
-Discharge to Assess funding

The table below highlights the shortfall in funding of £95,392 that BCF funding is supporting to enable this project to take place over the course of a year (see appendix 2 for original breakdown of costs).

Total Cost of service	**£386,600**
Current funding sourced by PCN and Training Hub	£291.208
Funding shortfall / funding required	£95,392

If the service were to continue as it currently is, the projected savings of £930,129 as per slide 9 would show how the investment has allowed for savings over and above the £95,392 cost of the service. If we are to simply achieve the 10% reduction of attendances and admissions this would equate to £115,372 which would still cover the current cost of the service that is being provided via the BCF.

KPI Performance to Date

The table below demonstrates how the PCN are performing to date against their other KPI's. Data is being collected via the care home hub and the GP systems of those practices partaking. All KPI's have been entered on practice systems to ensure data capture is as easy as possible.

We can see that KPI's relating to personalised support plans are meeting their target of ensuring 100% of care home residents have these in place on admission to the home.

In 5 months, 164/ 214 SMRs have been completed, which equates to 77% and demonstrates the PCN are on track to achieve this target.

The PCN are keen to progress with the EOL KPI, however identified their staff and the care home staff needed more support and training around Advance Care Planning and did reach out to the wider INT in June 2024. Unfortunately, due to matters outside of the Care Home Hub's control the training has not taken place yet and we are in the process of organising the necessary support needed working with EPUT and St Clare Hospice.

KPI's - Care Home Hub Data Collection

	Information required	May	June	July	August	Setpember	October	November	Comments
•100% care home patients to receive a standardised good quality personalised care and support plan based on the principles and domains of a Comprehensive Geriatric Assessment within 7 working days of admission using a MDT approach	Number of patients receiving a good quality personalised care and support plan based on the principles and domains of a Comprehensive Geriatric Assessment within 7 working days of admission using a MDT approach		9/9	11/11	10/10	6/6	5/5		
•100% plans to be reviewed by the MDT within 2 days of patient being admitted to home following a hospital attendance	Number of patients reviewed by the MDT within 2 days of patient being admitted to home		4/4	4/4	5/5	3/3	10/10		
•100% of consenting residents receive their influenza vaccination	Number of consenting residents receiving their influenza vaccination		n/a	n/a	n/a	n/a	1st visit	2nd visit	
•100% care home patients to receive a SMR	Number of care home patients receiving a SMR		27	46	39	19	33		Discussing denominators with PCN
•100% of EOL care patients to have comprehensive PEACE / ReSpect Advance Care Planning including:- DNAR, PPC, PPD, Anticipatory medications recorded. *	Number of EOL care patients to have comprehensive PEACE / ReSpect Advance Care Planning including:- DNAR, PPC, PPD, Anticipatory medications recorded.		2	3	0	1	0		Discussing denominators with PCN
• 10% reduction in A&E attendances at 12months	Number of A&E attendances by care home		4	4	5	15	11		
•Weekly MDT "home round" for each care home prioritising residents based on need	Number of weekly MDT "home rounds" for each care home prioritising residents based on need		Yes	Yes	Yes	Yes	Yes		Dates shared with ICB

Quality Narrative /Feedback

Qualitative feedback to date has been extremely positive from care home managers, GP's, community staff and families. This has been captured and detailed examples of feedback received can be seen over the next 2 slides.

Key themes from feedback so far highlight:-

- *Better response to urgent / on the day requests*
- *Better follow ups for patients recently discharged from hospital to home*
- *Reduced hospital admissions*
- *Prescriptions arriving in a timely way (care home not having to chase)*
- *Reduced complaints from patients and relatives*
- *Patients and carers being pleased with the service because there is always someone there (who will respond to care home requests).*

The team continue to work closely with all system partners including EPUT, East of England Ambulance Service, care homes and local acute hospitals to reduce conveyances and admissions to hospital from care homes. We hope to see that by continuing to improve the continuity of care that this will lead to reducing further admissions, enabling more sustainable discharge, and therefore supporting with reduction in readmission rates for patients. Alongside this we hope to continue to see a reduction in duplication for all system partners as we become more joined up in our care.

Alongside the positive feedback received to date the Care Home Hub Pilot recently won joint first in the Integration and Collaboration category at the ICB Primary Care Achievement Awards. Details of the service along with the other winners of the night are being shared on the ICB intranet alongside contact details so people can contact the team to understand more about how the service is working.

Quality Feedback from Care Homes and Residents

“We’ve seen reduced hospital admissions. Excellent responsiveness and communication, especially from admin team who are lovely, someone is always present and helpful. Concerns are always addressed during the week”.

“When we have requested emergency home visits the hub have responded well and visited the same day”.

“Improved on the day service, always follow up by telephone call, follow ups on discharge from hospital, noticed reduced hospital admission. Prescriptions arrive on time with the right medication, makes it easier for us (at the care home) as we don't have to chase pharmacies all the time. Reduced complaints from patients and their relatives”.

“Having access to care for residents so they receive timely medical advice or medical attention. When we email, the doctors come out the same day - before this wasn't possible. Thank you for adding proxy ordering, does make it a lot easier to order and all in sync. Less medication errors because of this”.

“Paramedic service is brilliant, she comes in straight away and always so polite. prescriptions come on time and helps us save time dealing with med errors”.

“Having face to face appointments seeing the doctor regularly preventing people from getting worse. Patients are very happy”.

“Happy that now there's a face and a name to talk to about issues or concerns. We know that we can contact Nathan, for example, and he will reassure us that someone will deal with a concern. If someone deteriorates, they are quick to physically come and review. very helpful compared to before dealing with prescription clerks who weren't always available or responsive. Patients and carers love the service because there is always someone there”.

Quality Feedback from GP Practices

"Happy with overall service of the care home hub, admin staff are all aware of where to send information and how to easily contact the hub. Has saved time for clinicians as there's no need to allocate time and resources for a weekly ward round anymore. As a result, the practice have now gained back 16-18 appointments a week, gained a doctor back on site one half-day a week, significantly reducing pressure on the practice clinicians. Care homes appreciate the service, with many wanting to move some patients to LHC from other practices to receive the benefit of the care home hub. No concerns/issues reported back to the practice".

"Care home hub has been significantly helpful in reducing workload for clinicians at the practice, as well as standardising the care across practices in the PCN. Seeing positive feedback from care homes who are pleased with the service, especially with the increased consistency in the GPs/clinicians they're seeing and improved responsiveness in care. Big improvement from previous system where an allocated nurse and pharmacist would attend a ward round. On average, the hub has saved the practice at least an hour a day of clinician time. As a result, the practice is now able to offer more appointments. Good feedback from both care homes and patients. Would be more helpful if the hub went beyond the 1-year pilot into a long-term arrangement".

"Very happy with how the service has saved practice time and resources as well as providing a more proactive approach through more frequent ward rounds. Clinicians are happy about freeing up clinical time from ward rounds and repeat prescriptions etc, has created other opportunities to use practice time e.g. more appointments for the practice. Positive feedback from patients and care homes. Better continuity of care and consistency because the clinicians are familiar with patients. No issues or concerns at present".

Reflections / Lessons learnt :

Has the scheme achieved it's intended outcomes?

As per the performance section above we can see that the scheme is currently showing achievement beyond the proposed mid-range of 10% reduction in A&E attendances. We can also see the KPI's relating to personalised care plans have been met and work towards Structured Medication Reviews and End of Life KPI's are underway. We can also see the positive impact it has had on patient care via the qualitative feedback from staff on the ground in the community.

What has been the learning?

Estates:-Having the use of Buckhurst Way Clinic as a centralised space whereby the care home hub team can be based has made a big difference within LBC PCN both for the staff within the PCN aligned to the care home hub but also for the local community staff involved, as they know they are able to attend the clinic to discuss any cases. It has also been useful for regular stakeholder meetings that they have been able to hold in a hybrid manner.

Mobilisation:-When the service was established in May the initial month saw the team being faced with many reactive requests from the care homes at the same time as implementation of new operational processes that all system partners were getting used to. The team and wider stakeholders worked well together through this settling in period and are now at a stage whereby they are carrying out their proactive as well as reactive work within the homes allowing them to work to the KPI's agreed in the initial set up of the service.

Systems and IT:-Delayed access to ICE for the Care Home Hub was flagged as an issue and a risk when the service was first initiated. This risk was due to more handoffs than necessary having to take place as pathology requests were having to go via individual practices rather than directly through the hub. LBC PCN have worked with HBLICT, the ICB and PAH pathology team to resolve this issue to get Buckhurst Way Clinic access to ICE. This has made a massive difference to day to day running of the service.

Process evaluation:

Risks / Issues / Mitigations

Description of Risk or Issue	Mitigation to date or support required
Recruitment of GP due to delay in funding	Despite receiving confirmation of funding in November, release of funding was an issue which in turn delayed recruitment of staffing. This meant the initial start date moved from early April to May. However, through the PCN, Primary Care Transformation Team and Training Hub working together (the GP employed is part of the GP fellowship scheme) this was worked through, and recruitment was successful albeit 1 month later than originally planned.
LBC Care Home Hub delayed access to ICE was an issue and a risk. This was a risk due to more handoffs than necessary having to take place as pathology requests had to go via individual practices rather than directly through the hub. LBC PCN worked with the HBLICT and the PAH pathology team to get Buckhurst Way Clinic access to ICE. They had been ready to test from March 24. PAH IG passed relevant information on to PAH contracting team for an SLA to be drawn up but this took time to complete. This is created a big issue for the hub and practices as it created a large amount of extra admin for both and increased clinical risk due to more handoffs.	Issue resolved – senior team involvement resulted in a contract being drawn up between LBC PCN and PAH to allow Buckhurst Way access to ICE. This was then actioned immediately.
Data capture for KPI's for Loughton Health Centre was proving hard due to them being on EMIS. Care coordinator in LBC worked this through with them. ICB asked for PCN to let them know if they were struggling to resolve.	Issue resolved – care coordinator worked with Loughton Health Centre to resolve issue. Data now being captured.

Exit/Sustainability Plan

[please outline the plans for contract end, e.g. will you be seeking BAU funding within your organisation, external funding source or will the scheme stop and if so, what is the impact/risk on system and service/staff etc?]

LBC PCN are funded to provide this service up until 31st April. Following this 6-month evaluation, if the Board agree that the scheme is able to continue for a further 6months we would then be looking to seek funding to allow for continuation of the service beyond May 2025. We would like to understand if there are any potential funding sources available either via the ICB or externally to enable this to happen and to understand governance routes we would need to work through.

If this service were to stop, the risk on the system would quickly become evident in day-to-day operational processes between the care home, GP practices and community team. We can see from the qualitative feedback to date the positive impact this has had on care homes and practices alike allowing for continuity of care for patients and a consistent accessible service.

Risk to staff employed would mainly fall on the GP employed to oversee the care home hub as well as the ARRS staff employed to work as part of the care home hub.

Recommendations:

Based on the findings what is the recommendation, e.g., should the scheme stop to allow reinvestment elsewhere, should the scheme continue or continue with some changes/areas of development?

Following recommendations, the conclusion should include the author and SRO's own recommendation supported with evidence.

- Based on the 6month evaluation findings we would recommend that the scheme continue for a further 6 months as per the original business case.
- We would welcome feedback from the board with regards to how delivery to date would influence the way we choose to move forwards beyond the pilot period of a year. If reduction in A&E attendances and admissions for care home residents continues along the same trajectory as the first 6 months of the pilot, we would be extremely keen for the service to continue beyond this date. Some potential options moving forwards could be:-
    - Continue as is with the practices and care homes involved enabling us to continue to gather impact data.
    - Expand the care home hub offer to more practices across LBC PCN if there is the appetite following sharing of the 6month evaluation with practices not currently participating in the PCN.
    - Expand the care home hub to include out of hours care - this could mean working up until 10pm alongside weekend working.
    - Expand the care home hub pilot model to other PCN areas across West Essex. This would require commitment from those PCN's to utilise their PCN ARRS staff to support the care home hub as this is the model upon which the hub is based.

iBCF board's decision:

Decision: *approved to be extended for a further 6 months by Intermediate Care Board pending approval of funding*

Date of the decision: *TBC*

Questions?

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Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐
	NHS HWE ICB Primary Care Transformation Committee meeting held in Public		**Meeting Date:**	**30/01/25**
Report Title:	**Primary Care Transformation– Directorate Report**		**Agenda Item:**	**07**
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. Update on winter and uptake on vaccinations b. Update on Digital and primary care workforce c. Progress update on primary care projects in community pharmacy, dental and optometrists d. Place updates from each are including good new story to share and progress on key areas of work
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 discussion on the agenda and to give a flavour of the forward look of some of the key areas of focus.
Recommendations:	The Board is asked to ▪ Note and discuss the key contents of the report

Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***	☐
	Financial	☐	***Non-Financial Personal***	☐
	None identified			
Implications / Impact:				
Patient Safety:	*Areas of progress which will impact on improving patient outcomes and patient safety.*			
Risk: *Link to Risk Register*	*No new risks identified through this report which are not already on the directorate risk register*			
Financial Implications:	*Not applicable*			
Impact Assessments: *(Completed and attached)*	***Equality Impact Assessment:***		N/A	
	Quality Impact Assessment:		N/A	
	Data Protection Impact Assessment:		N/A	

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Primary Care Transformation– Directorate Report January 2025

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)

PCN returns indicate a variation of utilisation of that resource for this winter including;

- 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)

PCN returns indicate a variation of utilisation of that resource for this winter including;

- 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.

Evaluation of winter will be discussed at future meetings

Baseline/metrics
Non-elective admissions – Zero LOS; looking at admissions from Care homes
A&E attendances including in hours attendances at UTC
Same day access appointments
Re-admissions rates within 30 days
In hour 111 calls including disposition to pharmacy/GPs
Pharmacy 1st referrals
Care Co-ordination Centre referrals – utilisation rates of urgent response services in the community including Emergency Practitioner car; acute in hours visiting; Rapid intervention service car
Patient feedback / surveys/complaints Vaccination rates across priority groups

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Update Vaccination Programme

Penny Thomas, Senior Transformation Manager

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Vaccination Update

(Updated 14th Jan 2025)

RSV uptake is 47% in those aged 75–79 in Herts and west Essex ICB, as of 10th Jan 2025. This vaccine is being offered in a phased approach. Hertfordshire Community Trust are offering the vaccine from 28 weeks of pregnancy.

Covid - 46% of total HWE patients have received their Autumn 24 vaccination, please note this is provisional data. Those aged 65+ have an uptake of 61%, those clinically at risk 24% and care home residents 73.5%. All care home residents have been offered a vaccine, some may have moved or declined.

A spring booster has been recommended by the JCVI for April 2025. This will be aimed at the same cohorts as last Spring, meaning those aged 75+, those with a weakened immune system and residents of older people care homes.

Vaccination Update (2)

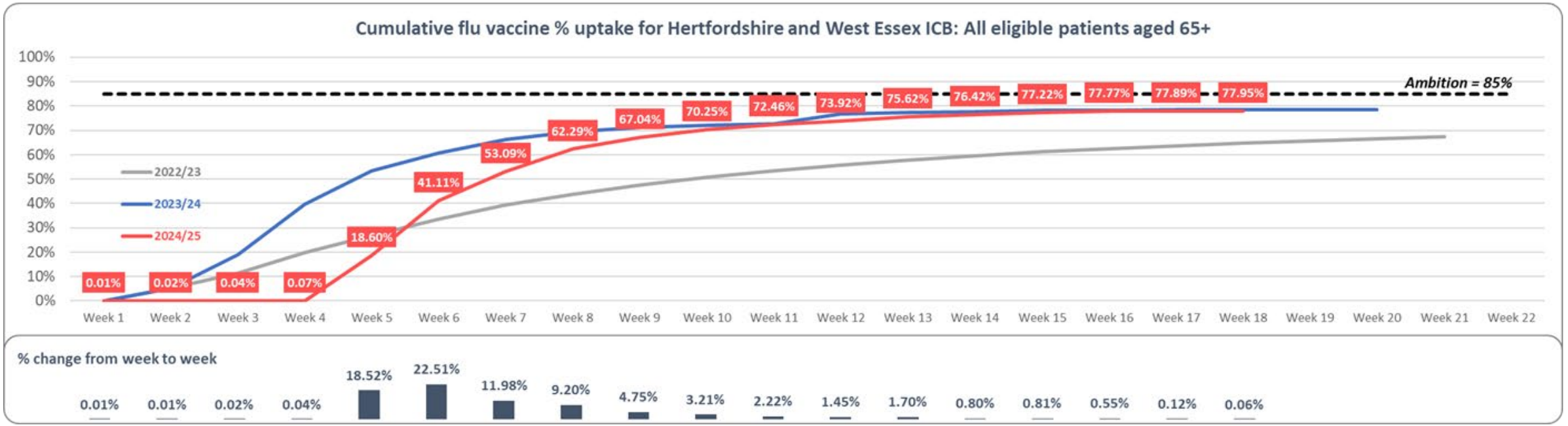
Flu – patients aged 65+ have an uptake of 78%, close to the uptake at the same time last year. Clinically at-risk patients aged 6 months to 64 years have an uptake of 40%, lower than the same week last year's uptake of 45% in this group – note that the flu campaign started a month later this year. Patients with severe learning disabilities have an uptake of 62.6%. See charts below for more information.

During the Autumn/Winter campaign 24/25, a Local Enhanced Service was implemented to fund GP practices to conduct extra vaccination reviews with any patients that had outstanding respiratory vaccinations and encourage further uptake. This has resulted in at least 41,200 extra winter vaccinations for patients at risk due to their health or their age group.

Measles – there have been no outbreaks in recent months, and the task and finish group has ended.

We have an ICB **Mpox** pathway, which covers the post-exposure vaccination of contacts in HWE in response to an Mpox case or outbreak.

Herts & West Essex Flu
All eligible patients aged 65+



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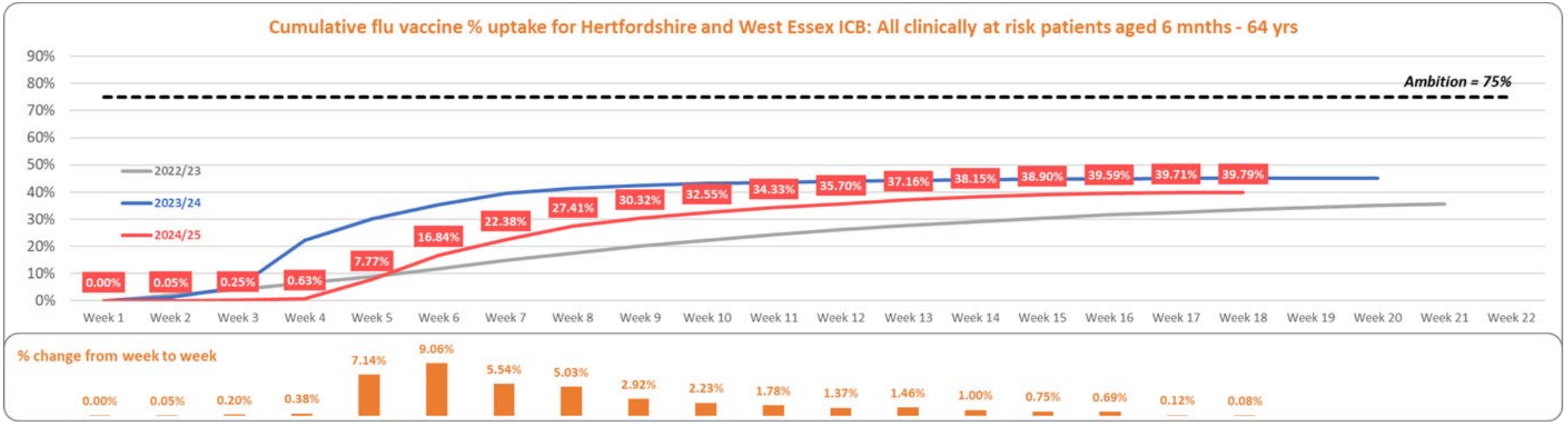
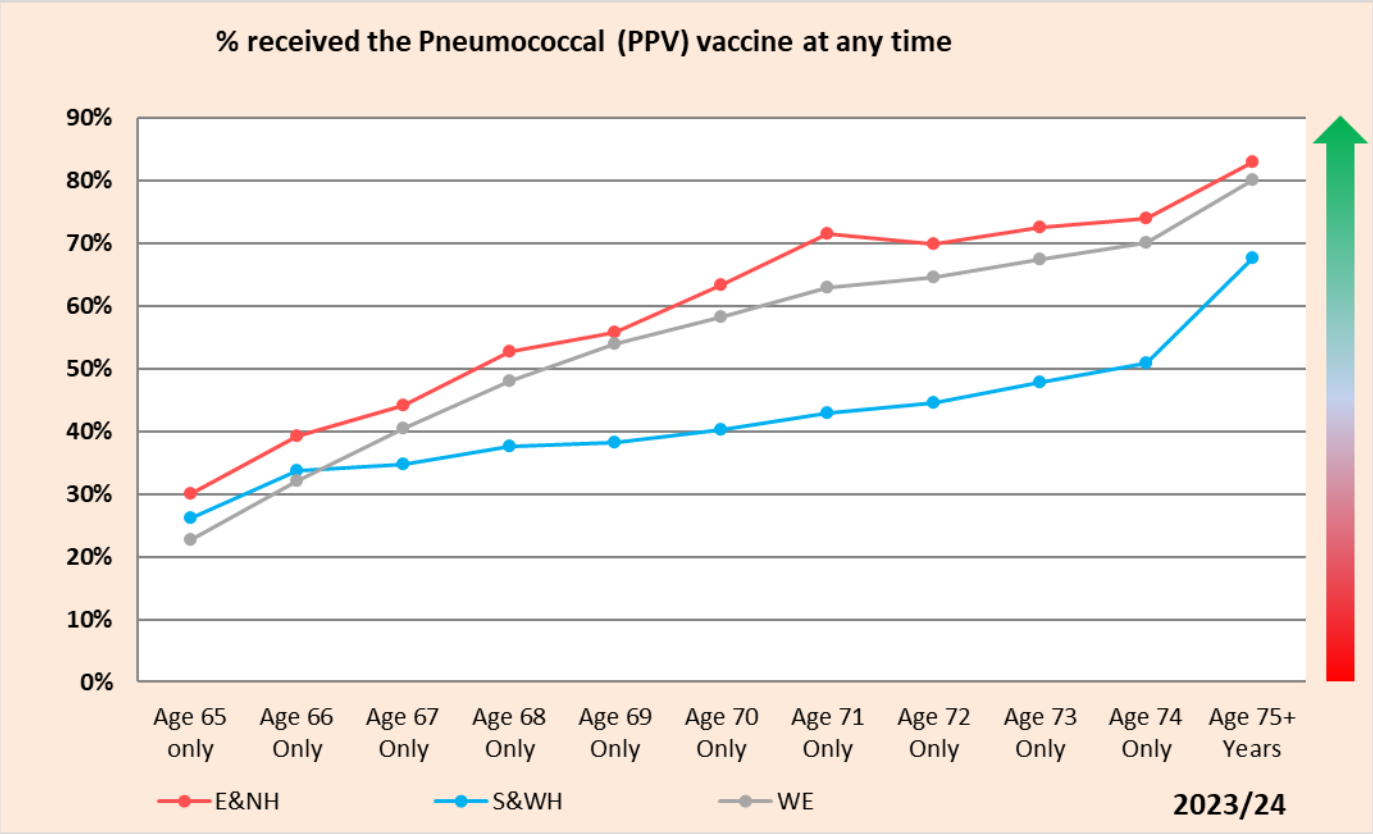
Data as at 7th January 2025

Herts & West Essex Flu
All clinically at-risk patients aged 6 months – 64 years



Hertfordshire and West Essex Integrated Care System

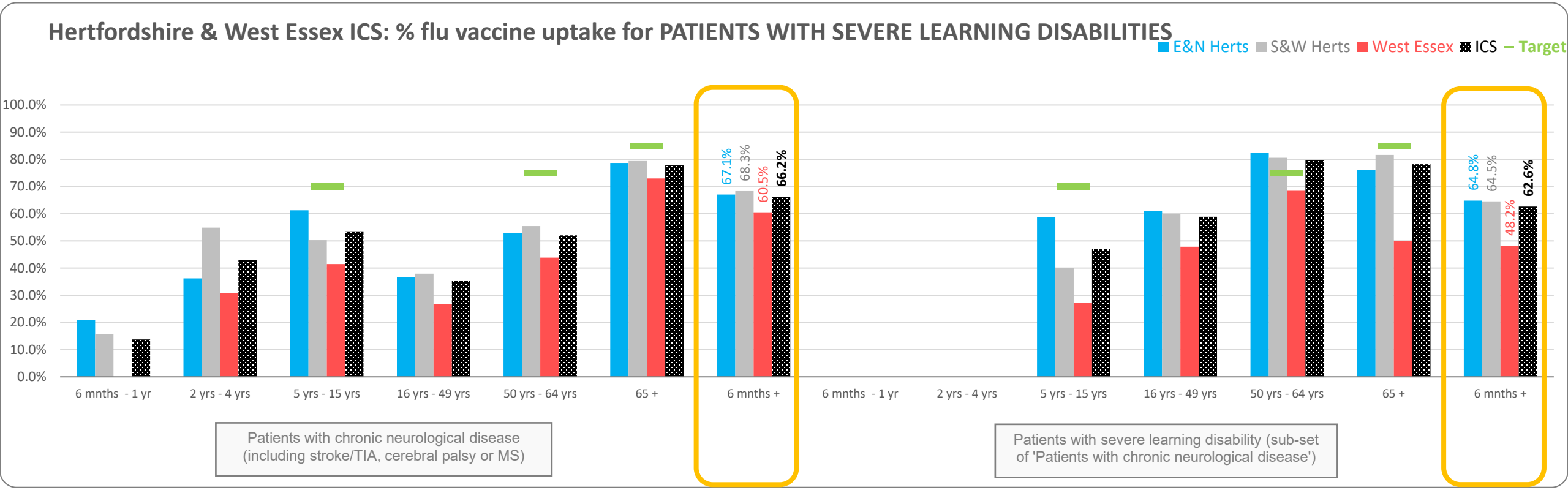
Data as at 7th January 2025



Pneumococcal vaccine (PPV) uptake varies by age group; ranging from 20-30% in those aged 65 years, to 68-82% in those aged 75+.

People become eligible when they are 65 years old (unless they have a health condition which makes them eligible).

Herts & West Essex Flu
Patients with severe learning disabilities



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Update on Primary Care Workforce

Joyce Sweeney, Head of Primary Care Workforce

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Update since last meeting

Hertfordshire University – Medical School

The Primary Care workforce Team is working with the University to promote future student placements in primary care and have supported with interviews for key roles.

To- date twenty practices across HWE have expressed an interest in taking on medical students. This demonstrates a strong level of support from general practice for medical student education.

Primary Care Multi-Professsional Conference 2025

Planning is underway for a Primary Care muilti-professional conference. The conference aims to provide a comprehensive educational experience for primary care colleagues, advance best practice in primary care and foster collaboration among primary care professionals including Pharmacy, Optometry, Dentists (POD).

The conference is for all Primary Care staff clinical and non clinical.

At present we are currently exploring dates, venue options, speakers and developing a diverse range of workshops.

Leg Ulcer Training – Registered Nurses/Health Care Assistants

The Primary Care Workforce team in collaboration with Hertfordshire Community Trust have developed leg ulcer training for all registered nurses and health care assistants across East and North Hertfordshire.

A recent scoping exercise has identified a need for training for 12 nurses and 11 Health Care Assistants. The training will commence in January 2025.

A further scoping exercise is taking place to identify leg ulcer training requirements in West Essex and South West Herts.

Successful Living Well Training Day – 30+ Attendees

A full day of training around Lifestyle Medicine and encouraging people to develop their own Living Well courses was delivered in November 2024 was a resounding success. 30+ people from across the ICS, from many different disciplines joined and will be taking forward the learning to their practices and PCN. The aim is for the course to have a significant impact on the health and well being of the attendees and their patients.

Trainer and Trainee Support to Vocational Trainee Scheme (VTS) Scheme – Increased Pass Rate

This scheme developed by the Primary Care Expansion Lead together with the local GP Training Programme Directors has provided additional support to GP registrars to get through their exams and has also enabled support for trainers who we want to support and retain to train our future workforce.

Since the implementation of these meetings, there has been a rise in the AKT (Applied Knowledge Test) and SCA (Simulated Consultation Assessment) pass rate among trainees.

The AKT exam pass rate was 65.75% from January to summer 2024 (the end of the 23/24 academic year) as opposed to 42% in 2023 (the start of the 23/24 academic year), an increase in the pass rate of 56.5% (against the 20% nominal target).

The SCA (Simulated Consultation Assessment) exam pass rate was 81.5% from January to summer 2024 as opposed to 53% in 2023, an increase in the pass rate of 54% (against the 20% nominal target).

This positive trend suggests that the ongoing support and professional development opportunities provided through these meetings are contributing to improved trainee performance. Furthermore, these meetings have had a significant impact on trainer morale.

Carers Training Session – 4 February 2025

Planning is underway for increasing the identification of carers. A training session about carers will be taking place on 4 February 2025, at the Protected Time to Learn event for General Practices. The training will be via MS Teams and is for both clinical and non clinical staff and will cover a few different areas related to carers ie speakers from Carers in Herts, carer and carers champion and presentation on support available for carers.

Protected Time to Learn Events 2025

In 2024, we successfully implemented 'Protected Time to Learn Events' which provide dedicated time for staff to engage in professional development activities. These events prove valuable in creating opportunities for professional learning and development, improve team working, quality of care provided to patients and their quality of experience.

The proposal for 2025 is to continue to support the continuation of PTL events in 25/26 from 1 April 25 to 31 March 26 including the commissioning of Herts Urgent Care to cover the events. The key elements of the proposal is that the events frequency (8 sessions over the financial year, on a rotating day each month with the exception of August, December, January and February) and session time (1:30 pm to 5:30 pm) remain the same as previous years.

PCN ARRS Workforce Plans Meetings

The Primary Care Place Teams and Workforce Team are working in collaboration in setting up meetings to meet with PCNs to support the utilizing of their Advanced Roles Reimbursement Scheme (ARRS) funding for workforce development. The aim is to understand their current spending patterns and identify where support is needed. Discussions focus on ARRS spending, workforce planning, and identify any challenges they are facing. By collaboratively working with PCNs we can effectively support PCNs in building a strong sustainable workforce to meet the evolving needs of their communities.

GP ARRS - Recruitment

- A total of 16.6 (WTE) GPs have been recruited through the PCNs via the ARRS, the majority of which have been recruited in South West Herts.

- Recruitment to GP roles via the ARRS has been lower than expected nationally; however, local intelligence suggests that the maximum reimbursement rate for GP role is significantly below the sessional average paid in HWE, leading to poor uptake. There is also concern from some PCNs that the scheme will be withdrawn, leading to future employment liability and cost.

Hertfordshire and West Essex Integrated Care System

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Update on Primary Care Strategic Delivery plan

Emily/James

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Update on Assura Grants Programme

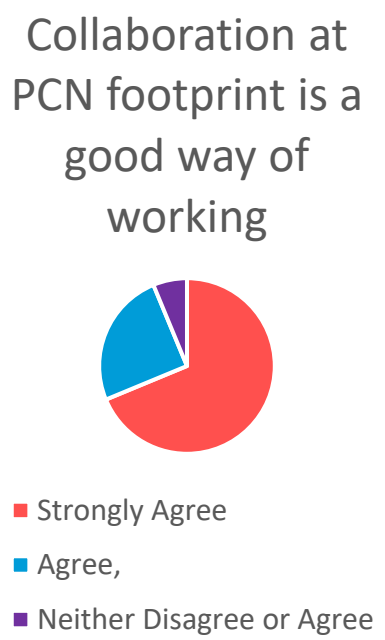
- Assura PLC (via The Assura Community Fund) and Hertfordshire and West Essex Integrated Care Board are providing funding and working in partnership with VCSE partners, Primary Care Networks, and Integrated Neighbourhood Teams, to support a grants programme to reduce health inequalities, help prevent poor health, and improve opportunities for better lives in Hertfordshire and West Essex. A total of 30 applications were received and all applications are aligned with one or more of the ICB/ICS priorities.

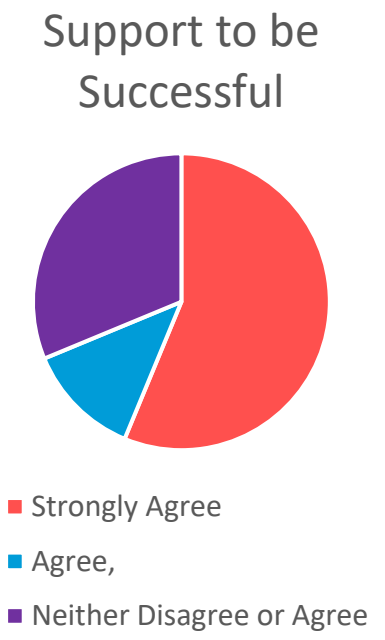
- Further to an update previously provided to the Primary Care Transformation Committee board in July 2024 a light update was requested from grant recipients in the interim between end of grant request that will be managed by Cheshire Community Foundation in April 2025, for this phase 1 of the Assura Plc and Primary Care work.

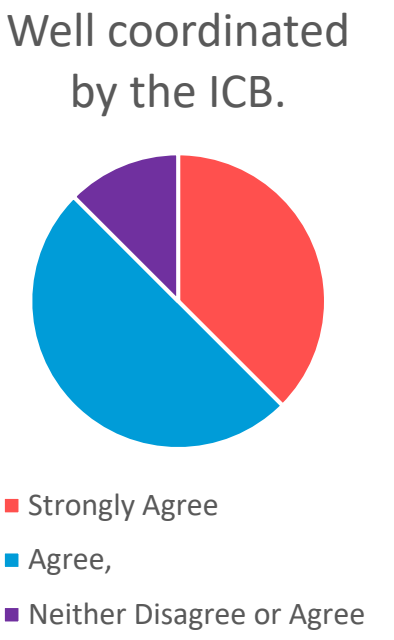
- 16 / 30 Projects responded to a questionnaire sent out.

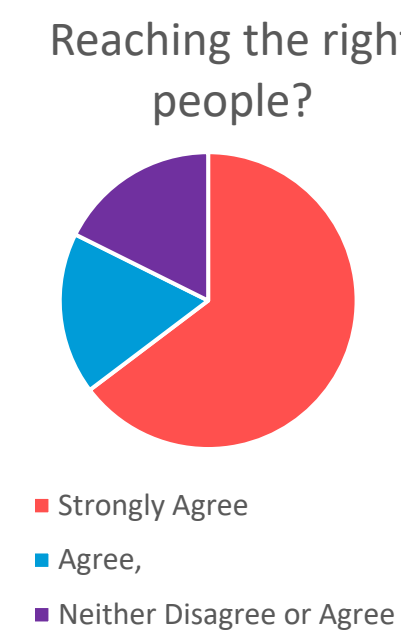
- Projects are working at pace to deliver their outcomes and it is reported that these projects alone have **reached 2050+ beneficiaries already.**

- Respondents where asked the following questions in relation to this work:









Hertfordshire and West Essex Integrated Care System

Update on Assura Grants Programme continued:

Inclusion Health Groups being reached via the projects are outlined below:

Unpaid Family Carers	Gypsy, Roma and Traveler Community	Children and Young people with mental health concerns	Those with and at risk of dementia
Those living with unhealthy weight	Those at risk of social isolation	Digitally excluded	Homeless

We are already able to highlight some learning that can be shared – below are some key success stories to date:

- **Supporting carers**: Thanks to referrals from the carers café, carer now has regular weekly respite to allow him a break. The care coordinators have synchronised all his and his wife's prescriptions, saving multiple pharmacy trips. At the café, he was found to have high blood pressure and this is now being well managed. His wife has "sundowning" but conversely it is hard for her to be ready for early appointments – the care coordinators have recorded reasonable adjustments and ensure that appointment timings are suitable. This gentleman comes every week and his absence was noted one Friday, so the care coordinators checked in with him. He had been at a funeral, but was genuinely pleased that the team had reached out, saying it was nice to feel cared for and not just be the one caring.

- **Nutrition projects**: Average age of those who attended projects focused on nutrition was 65 plus. Majority attending were women, 45% Asian, 55% White British. A person with Learning Disabilities supported to be independent cooking his own slow cooker meal.

- **Our Health Matters:** These two project sites have received positive feedback and have received funding from NHS England as part top up to continue the project until March 25, so that the trust that has been developed does not collapse in the most vulnerable communities that they have been engaging with, such as Gypsy, Roma and Traveller Communities in the Harlow area.

- One lady that used a weight loss program (Wellness Stride) lost nearly 20kgs in weight and inspired a lot of fellow participants in the process.

- Working closely with PCNs has allowed partners to start more conversations in other localities, both in Hertfordshire and neighbouring counties so this could launch a really successful series of partnerships for Voluntary Organisations.

Update on Assura Grants Programme continued:

Feedback from a local GP:

"I'm taking this opportunity to endorse how immensely valuable the grants given by Assura to conduct innovative prevention projects in our communities via PCNs.

It has been fascinating to observe how each PCN Clinical Director has focussed on the Assura projects to showcase what they are doing differently within their community.

Doctors feel closer to their community by being part of the projects and patients feel that their practices are taking a more proactive role in their care.

I very much hope that this is the beginning of far more involvement of primary care in the prevention agenda.

Long may similar projects continue.

Well done Assura."

Next steps:

- A process is in place to ensure updates and outcomes for each of the applications are being sought at the end of each project – it is proposed that a more in-depth update paper is brought to Primary Care Transformation Committee in July 2025.
- Assura Plc is in talks to agree year 3 partnership with potentially £75000 to be agreed in April 2025.

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Update on Primary Care Digital

Trudi Mount, Head of Primary Care Digital

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Primary Care Digital

- We are working with practices on usage of SMS to ensure messages are targeted, short and effective – HBL ICT are engaging directly with practices who are the highest users of SMS to understand if there are things they could do to reduce the SMS spend. This is not about stopping SMS messages – we understand that SMS is a vital tool for practices to communicate with their patients. This is about making sure messages are appropriate and effective. It is too soon to see if this work has had an impact on SMS usage but we monitor SMS usage monthly so will be looking at overall trends in the coming months to look at this.

- We are continuing to promote the NHS App, and in particular, how this fits into the newly announced Reforming Elective Care Programme. This will include working with partner organisations, such as acute trusts, to understand how they are using the NHS App and how we maximise engagement with patients who current patients at hospital. We are awaiting further information from national teams on how we progress this.

- Our key work areas for the coming year are continuing to promote and establish Modern General Practice (Online consultations, NHS App, websites and telephony); Digital Inclusion; Digital Workforce; Infrastructure; PHM and Risk Stratification; Automation and AI; Pharmacy, Dentistry and Optometry Integration. For Digital Inclusion this will be around promoting the area on the ICB website that links to local resources to help with those who have issues with digital access. For the workforce we are looking to see how we work more with the PCN Digital and Transformation Leads.

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Update on Community Pharmacy

Mefino Ogedegbe, Community Pharmacy Clinical Lead

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Community pharmacy update

Community Pharmacy PCN Engagement leads

- 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.
- A face-to-face induction programme meeting for the Leads was held on 17 October 2024, with presentations covering strategic ICB priorities, key functions, role, and expectations and how the Leads will be part of enhancing collaborative healthcare solutions.
- A list of the Leads, key responsibilities, contact details and areas they cover can be found here.

Community Pharmacy Independent prescribing pathfinder programme

- The NHS Community Pharmacy Independent Prescribing 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.
- The Pathfinder programme launched within HWE on 30 September 2024.
- There has been a total of 268 consultations undertaken by participating community pharmacies from 30 September 2024 to 13 January 2025.]
- Further information can be found on the Training hub website page: Independent Prescribing Independent Pathfinder Programme

Pharmacy First service

- Hertfordshire and West Essex had the highest percentage of ICB GP practices referring patients to Pharmacy First across East of England in August 2024 according to the national operational report.

Pharmacy Contraception Service

- There were a total of 76% community pharmacies within HWE that registered to provide the national pharmacy contraception service on 3rd 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.
- There has been an overall increase in the number of consultations for the Pharmacy contraception service in HWE with 592 consultations being undertaken in August 2024 according to the national NHSE operational report.

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Update on Hypertension Pilot in Dental and Optometrist Contractors

Simon Hey, Commissioning Manager

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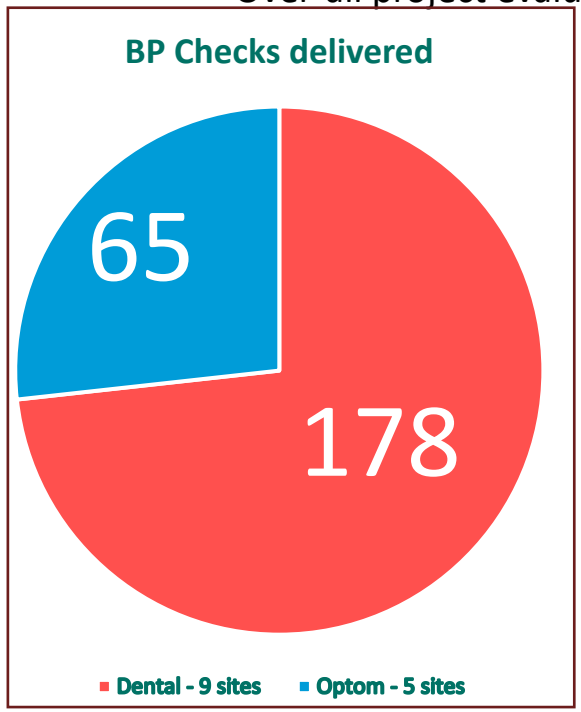
Hypertension detection update from practices, pilot in Dental and Optometry Practices - Simon Hey

- Training for all sites now completed, with training evaluation in progress
- All 14 practices now live as of October 24'
- MDS being received from practices as required
- Incentive payments claims being paid by ICB finance
- Over-all project evaluation data capture in progress – Herts Uni leading



73% uptake vs offered

30.5% onward referral

0% referral to urgent care

Data summary (Dental + Optom combined)

Metric name	Sept > Oct 24'	Oct > Nov 24'	Total count
Number of blood pressure (BP) checks offered	120	211	331
Number of BP checks delivered	67	176	243
Total number of people referred onwards	18	56	74
Number of people referred to community pharmacy	12	44	56
Number of people referred to home blood pressure monitoring	0	0	0
Number of people referred to locally agreed urgent care service	0	0	0
Number of people directly referred to GP	6	9	15

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Dental Update

Michelle Campbell, Head of Primary Care Contracting - Dental

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DENTAL UPDATE

- Current performance on Primary Dental Contracts (Dec 24) is at 67.87% which is an increase of 4.32% from same period the previous year
    - The New Patient Premium (NPP) scheme introduced as part of the dental recovery plan has increased contract performance due to additional Units of Dental Activity (UDAs) being credited from baseline annual contracted activity
    - 172 out of 203 contracts have NPP activity; 89,883 new patients have been seen across these contracts since 1 April 2024 (breakdown of adults/children not currently published)
- UDAs that have been returned to the ICB through contract handbacks (x2) or through reduction/rebasing of contracts are currently being redistributed through an expression of interest process to contractors in areas of low access/high need as outlined in the HWE Dental Access and Health review (Jan 24)
- Funding for over-performance is currently in the final stages ofc consideration with the aim to target contracts that are predicted to over-perform by year-end
- We continue to await national specification to support dental checks in residential special schools – anticipated end of January
- Discussions on the next steps of the Dental Contract Reform are underway with focus on urgent care and delivery of the government manifesto of 700k additional appointments; further guidance is due to be published over the next few months.

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Place Updates

Phillip Sweeney, Head of Primary Care – WE

Cathy Galione, Head of Primary Care – ENH

Amanda Burfot/Liz Cox, Senior Primary Care Manager SWH

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West Essex Place primary care update January 2025

v2

Key Information:

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

Best Practice

Nuffield Surgery, Harlow, received recognition for its work with local care home. Award presented by Princess Royal.

Vaccinations

COVID – provisional data available has uptake so far for west Essex (44.7%) noting that unpaid carers and household contacts of immunosuppressed are excluded this year.
North Uttlesford rate best in HWE, 64%
To Date 44,972 Covid vaccinations administered in WE
RSV – uptake across HWE for 75-79s is currently 44.4%, based on 27,116 out of an eligible cohort of 61,481 (no comparative data)
Flu – uptake 74% compared to HWE of 76%

Primary care access recovery and modern general practice

- MGP assurance by end January with small group of practices with concerns they are not demonstrating full compliance yet to be followed up with visits
- 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 (Nov. 24) shows majority of practices use online triage for admin and clinical requests; volumes suggest it is embedded as business as usual – ten practices have very high usage, indicating full online triage
- 28 transition support fund bids now 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 (9) and miscellaneous improvement work (3)
- National GPIP programme involved 8 practices and 1 PCN; initial schedule of 18 SLF visits complete – 1 additionally scheduled in January (only 1 practice declined SLF)..

Wound Care Quality Improvement Project - HWE

- Clinical audit complete and recommendations for developing integrated pathway across acute, community and general practice defined.
- Commissioning model 2526 - proposal for ECF Treatment Room basket developed to address practice and LMC concerns
- HWE oversight group and 3 place based groups established to take forward recommendations forward including post op pathway, prescribing, training etc.

Health Checks, prevention and long-term conditions

- **Weight management** – Pop up pilot improved referral rates to EWS – referrals increased by more than 100% from 78 in August, 177 September, then to 262 October. West Essex now up to 3rd of 5 in Essex, with 22 practices referring to EWS.
- **Smoking cessation** – Practices received training to deliver Vapes free of charge to patients as part of smoking cessation plan. Epping Forest council running swap to stop in their locality. WE third for referrals and quits in Essex in October.
- **Health checks –** EWS are offered outreach support to 6 GP practices. Delivery on track as 45% of target completed to October, holding as 4th highest of 5 in Essex.
- **LD AHC –** Ardens data shows 12 practices have completed 60% of their LD reviews and action plans. All practices have completed some reviews, 5 practices below 20% need to improve, but in Q4 expect more to be completed
- **SMI HC -** Ardens data shows all but one practice are over 50% compliant with SMI reviews, based on rolling 12 months' data (a further 2 practices did not sign up to SMI contract on Ardens).

Carers

- Identification of carers' champions at practice level via ECF and collecting of good practice examples via SLF, website reviews, direct feedback through the year, plus carers now included in regular 1:1 practice manager meetings
- Developed practice-facing version of this data pack and shared with practice carers champions and practice managers October 2024, informed by using Carers in Herts experience / good practice guide and carers' engagement events in August 2024.
- North and South Uttlesford incorporated carers in INT plans for 2024/25 to reduce non-elective admissions from target patient groups
- Shared N Uttlesford best practice carers' packs with S Uttlesford in November 2024
- Presentation of EWS carers dashboard and other carers-related services to Personalised Care Collaborative, November 2024
- Plan for Quarter 4 completed for practices to maximise ECF delivery and support improvement in identification of carers

Integrated Neighbourhood Teams (INTs)

- Harlow South INT care coordinator to support with discharge planning recruited and started early January – job is to ensure all community partners are aware of admissions and discharges in real time and community led actions are followed through to prevent re-admission.
- Review of Harlow South patients most at-risk of admission took place with EPUT – all patients known to community provider.
- LB&C PCN care home hub evaluation complete and outcomes are very positive so far.
- To date, 213 patients have been discussed holistically, at 38 proactive care MDTs, led by the INTs.
- DELPHI data platform live, widening to practices involvement from January, and data to robustly evaluate the proactive care model is being scheduled.

Primary: Secondary interface

- HCP interface group finalising agreed primary care: secondary care interface policy, with all parties in agreement
- Alex Health implementation in November 2024, followed by weekly working group to work through issues impacting on primary care, most notably discharge summary format and content, re-introduction of MESH to send summaries securely to practices' systems

East & North Herts Place - Primary Care Update – January 2025

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. Those that have completed the programme have found it very beneficial and it has made a big difference in the ways that they are working to improve access for patients.

Support Level Framework (SLF) Visits: (27%) 13 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, a further 2 visits to be carried out in the next few weeks. Discussions are still taking place to book some more.

Capacity and Access Improvement Plans 24/25: To date (58%)7 PCN CDs have signed off "Better Digital Telephony", (33%) 4 "Simpler Online requests" & (33%) 4 "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 (MGP): Team are carrying out discussions with practices and PCNs to establish how the MGP progress is taking place in each practice, how they have embedded MGP and improvements. Details will be collated at ICB level to report to NHSE in Feb 25.

Carer's update

- A further Carer's event held in ENH place in June 2024.
- Feedback collated from the event and shared at Practice Manager and PCN Manager forums with further cascade to practice staff.
- Named carer's champions for practices list updated and encouraged uptake where there were any gaps.
- Place teams continue to discuss carers support via ECF and carers survey results at practice visits to identify and share best practice and learning.
- Extended appointments have been offered to carers in many PCN's and close collaborative working with Carer's in Herts continues as does the take up of any dedicated carer training which is offered.
- There are now several carers/companionship/dementia café type initiatives which are running across the localities. These are well attended and supported with many partner organisations and the voluntary sector in attendance. Social prescribers are at the heart of these café.
- Stevenage North PCN offer daily direct access and weblink or phone appointments to carers. This PCN is also striving towards Daffodil standards accreditation.
- Discussions with PCNs/practices has led to some improved messages on websites for carers.

Workforce (PCN/Locality recruitment/Retention)

- All 12 PCNs have now returned their ARRS Workforce return for remainder of 24/25, and conversations concerning any projected overspend are taking place (3/12 PCNs are showing small overspends)
- 4 PCNs have recruited a GP under the ARRS Scheme, with a total of 9 different GPs are working in ENH place under the ARRS GP role.

Vaccinations

Flu and covid boosters are currently being offered until 31 March 2025 (flu) 31 Jan 2025 (covid). 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 46% for all cohorts up to the 14th January, compared to 46% in the whole ICB. Flu uptake as of 16th January is at 79% for those aged 65+ compared to 74% in the whole ICB. **RSV** is being offered by practices to 75–79-year-olds and by HCT to pregnant women at 28 weeks.

Integrated Neighbourhood Teams (INTs) and Proactive Care

MDT template in development and is being tested with N Herts and LLV Frailty nurses for clinical input; the next steps are to explore interoperability solutions and ensure correct coding as per INT implementation guide for reporting.
New assurance process to commence from February'25 with a focus on INT delivery, with a new locality reporting template agreed with our GP Locality Leads.
Mapping of resource requirements to support INT delivery is underway, proposal to be reviewed with GP Locality Leads. A proposal to be presented via Care Closer to Home steering group. Patient information leaflet on INT's in final stages of development and has been shared via GP Locality Leads for implementation. This leaflet to be reviewed and ratified by the Community Assembly group.

Health Inequalities

Stevenage South PCN- Assura Funding update -Hertfordshire Mind Network are working collectively with GPs from Stevenage South PCN who hold clinics to help increase the support for vulnerable people by referring onto relevant agencies/voluntary sector where applicable. This cohort can include patients who may have been trafficked and suffered with PTSD. Since starting the groups, Hertfordshire Mind Network have had a lot of attendees who have disclosed they have experienced varying types of abuse. This has led to numerous referrals to HPFT then onwards to the 1-1 service within Flourish for further support and intervention. The team will look to co-produce some 'lived experience' case studies, where it is appropriate, from this important initiative.
Hertford and Rurals PCN – Dementia Hub – The PCN have been running a biweekly dementia hub event in St Andrews Centre in Hertford. The event allows group activates for patients and their carers to get together and discuss their illness or have a break from caring responsibilities. The event also allows the Social Prescribers (SP) time to undertake some informal care and check in with patients they haven't seen for a couple of weeks and assess how

Examples of Good Practice

North Herts & Stevenage Community Cookalong

4 PCNs are working together with system partners to set up a few webinars, encouraging people to attend and cook together while they watch the webinar. Currently the working group are pulling together a list of recipes. The idea will be that easy recipes and everyday ingredients will be shared upfront, then people can cookalong at the same time. The webinars will be hosted by Stevenage football club foundation and recorded. The programme is for 6 weeks starting 26th Feb until Easter Holiday. Food parcels will be available for those that cannot afford the ingredients. This will be piloted to see how it works and whether it is popular, which will help with changing families' habits with food and how to eat healthy foods at a lower cost.

Hatfield PCN – Community Pharmacy

A pilot is being launched with Hatfield pharmacies and GP surgeries regarding improved digital communication (via AccuRx) to inform pharmacies of when Senior Medication Reviews have been conducted within the surgery and there is a request to stop the supply of medication. This supports the 25% reduction of frailty non-elective admissions – deprescribing including reduction in anticholinergic medicines. If successful, the pilot will be extended to Welwyn Garden City Pharmacies.

Stevenage North PCN – Christmas Event at the Dementia Café

The PCN together with Everyone Active are still successfully running the Dementia Café, utilising Assura Funding. The cafe continues to be very popular, and the Christmas party was a great success. In addition, children from a local Primary School came to visit the Café to have a fun after playing board games with those in attendance.

Some photos from the event;

Case study name: Hatfield PCN and Active Practice Charter

Situation/Setting

The Active Practice Charter is a fun and easy way to make some simple but impactful changes in the workplace that will demonstrate to patients and staff that physical activity can have a significant impact on the health of everyone connected to a practice

Hatfield PCN made a pledge to reduce sedentary behaviour and increase physical activity to benefit the health of their patients and staff which they have clearly demonstrated their ambition for movement as the best medicine.

Hatfield PCN were recently presented with a Community Champion Award – For Outstanding Service to Community Health and Wellbeing, from High Sheriff of Hertfordshire, Annie Brewster, who presented this to Hatfield at their protected time in October.

Actions/Activity

- ***PCN project coordinator and PCN business manager recognised how important being healthy is and highlighted that " sitting is the new smoking" and this needed to be addressed. This began with the staff in practice and then filtered to the patients.***
- ***By working with local leisure centres and signing up and taking part in GP referral schemes beginning with Hatfield Walk. This is led by the social prescribing teams at the practices within the PCN. Sign up by patients is very popular and there are so really good results. A treadmill has been provided for the staff area at one of the practices to encourage those who wish to use it throughout the day. A step challenge was also put into place this really encouraged staff to move around more during breaks.***

Impact

- ***Hatfield are the first PCN to achieve active practice status in Hertfordshire***
- ***There are exercise plans available online which are part of Active Connections programme that Herts Sport and Physical Activity Partnership are leading, funded by HCC Public Health. which have all different types of exercise and activities which can suit all fitness levels, one of the lead GP's has discussed this with the staff to see how the activities can be fitted to their wants and needs.***

Learning

There has been a significant improvement in health, wellbeing and fitness levels of the staff. With boosted staff morale and activity awareness.

Link to article:
https://sportinherts.org.uk/hatfield-pcn-achieve-active-practice-status-n688

Link to interactive map showing Active Practices:
RCGP Active Practice Charter map - Google My Maps

South West Herts Place Primary Care Update

January 2025

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.

Dec 24 data show that SWH Pharmacy First referrals have increased slightly since the same month of 2023: Dec 23, 7.8 referrals per 10,000 population & Dec 24, 8.3 per 10,000 pop. December 2024 numbers are however lower than November 2024, so this will be monitored. Pharmacy-related referrals from 111 have also increased : Nov 23 - 377 referrals & 624 in Nov 24. (Dec data N/A as of 19/1/25)

Same Day Access
A **Minor Illness Winter Service** is being piloted in **Hertsmere**, the first time this has been available for their patients. This is now fully up and running and operates from different practices in the patch, rotating daily; offering slots to be used by all practices. It will be evaluated in terms of impact on low acuity A&E attendances and in hours 111 calls. More detail on the Minor Illness Winter Service Slide.

Primary Care Access & Modern General Practice

Practices Visit programme undertaken per locality –

- 4 practice in **Hertsmere** with 4 more planned in January.
- 8 visits completed in **Dacorum** with 2 more booked.
- 8 completed in **St Albans & Harpenden** (further visits tbc)
- 12 completed in **Watford & Three Rivers.** Positive feedback and agreement to repeat supportive visits regularly.
- *Practices have particularly appreciated the inclusion of a colleague from the Quality team during Practice visits, who has provided valuable insight and support in preparation for future CQC visits.*

- **GPIP:** 4 SWH Practices continue to progress on the PLS course. Feedback at practice visits have been positive where changes have been made.

- **Modern General Practice:** Assurance process currently in place by end of January 25. This will identify that Practices are demonstrating their progression to Modern General Practice. Any Practices where concerns have been highlighted, will be targeted via a Practice visit.

St Albans IUCH
Validated Total number of patients seen YTD (April'24 – 31st November inclusive): 14,795

- NHS 111 directly booked: 3,780
- GP directly booked: 10,676
- Pharmacy directly booked: 185.
- Hemel UTC redirection: 4

•Validated utilisation for November Mon- Fri 98%
•99.5% are discharged within 2 hours
•99.9% of patients are discharged within 4 hours

Vaccinations Flu and covid boosters are currently being offered until 31 March 2025 (flu) 31 Jan 2025 (covid). 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 47% for all cohorts up to the 14th January, compared to 46% in the whole ICB. Flu uptake as of 5th January is at 75% for those aged 65+ in South and West Herts, compared to 74% 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 Quality Improvement Project - HWE
•Clinical audit complete and recommendations for developing integrated pathway across acute, community and general practice defined.
•Commissioning model 2526 - proposal for ECF Treatment Room basket developed to address practice and LMC concerns
•HWE oversight group and 3 place-based groups established to take forward recommendations forward including post op pathway, prescribing, training etc.

Carers update
The SWH primary care team is presenting the Carers Information pack for practices at Locality Forum meetings across the patch in January and February. We have adapted this practice-based pack to be relevant for Hertfordshire. We will encourage inclusion of carers in practice events (including inviting Carers in Herts as well as the carers themselves); and inclusion of carers information on practice websites. This will be covered at face-to-face visits and at Locality Forum meetings.
We are approaching practices that have fewer than 2% of their practice list identified as carers; and will also review practices whose number of carers is lower than 10% of the practice registered population (since it should be at least 8%, according to ONS data).

Hertfordshire and West Essex Integrated Care System

South West Herts Place Primary Care Update - Continued

Integrated Neighbourhood teams

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 have run the searches for patient cohort. Estates meeting held to explore usage of Jubilee Wing at Hemel Hempstead Hospital. Within the next 4 weeks the Business Case is to be presented at the following Committee's: ICAG, WHTHT & HCP. Social Finance, Macmillan and West Herts Trust are co-designing a place-based outcomes-based fund. This fund will be used to develop a Proactive Care Pilot.

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.

Hertsmere Frailty INT, initially with frail care home patients – to ensure that they have an Advanced Care Plan.

Watford/Three Rivers Top 300 Frailty INT project: Key Stakeholders are engaged and contributing to the INT via the working group. Some of the findings from the initial patient reviews at Vine House: From 20 initial tabletop reviews, 18 patients were invited for a GP review of which 16 accepted. 14 of which had Respect forms completed, 16 had polypharmacy reviews. Majority had at least 2 medications stopped and in one case a patient had 6 medications stopped. Very positive feedback from the GPs and the patients who appreciated the extended appointments. This work has highlighted some areas of improvement for referral pathways particularly for patients that may need services in future. This will form part of the INT work with partners moving forward. Findings will be taken through the next INT working group with a view to begin rolling this out to the other practices within the Locality.

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. 5 patients per PCN per practice have been identified. MDT sessions have taken place to decide on a preventative and personalised care approach for each patient. Next step to 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

Best Practice regarding Carers from Everest Surgery in Hemel

- Embracing the annual Carers Week earlier in June, Everest House Surgery hosted its first 'Coffee for Carers Event' which was well attended with around 20 patients in a carer's role coming to enjoy tea, coffee and cake.

- Carers were given the opportunity to informally meet and discuss issues with Susie Brown and Lynda Livsey-Randall from the Social Prescribing team and Jane Brown from Carers in Herts who gave an overview of services available to support them in their caring role.

- 100% of attendees said they would like this to become a regular event, and when asked what they found useful the overwhelming responses were:

Meeting other carers

Information exchange and learning about services I didn't know

Chatting with people that understand

Hertfordshire and West Essex Integrated Care System

Best Practice regarding Carers from Rothschild House Group

- **Dedicated admin hours** to process online 'carer registration' forms, patient carers are 'coded' appropriately to ensure staff give more flexibility for appointment times to fit around their caring role.
- **Carers 'in case of emergency' leaflets** are available at the patient services desk & patients are encouraged to collect the leaflet in their 'carers welcome' email.
- **Annual health checks for carers** ~ to include physical & mental health assessment. Referrals to the social prescriber, Carers in Herts, tasks are sent to GP's and Carers Champions following this telephone consultation. We offer these health checks with our Pharmacy technician face to face at our carers' coffee morning in a private room away from the public.
- Carers are invited for an **annual Flu vaccination** via text or sent a letter if they don't have a mobile.
- Quarterly **carers coffee mornings** are held in a location with convenient parking & disabled access. These events are well attended with an average of 30 carers, and we are building a sense of community for our patients. We vary the staff attending to give patients the opportunity to feel more connected to their surgery - putting a face to the name. We also give the opportunity for a carer to bring a friend for support or the person they care for if leaving them at home is not possible. Free refreshments are available, and we invite a guest speaker.
- At the coffee mornings we aim to do something for the **carers to light up their day**. Example of this is 'flowers for carers' & a 'Christmas raffle' The carers champion set up a cosmetic swap shop to raise money for the carers' flowers.
- Invitations to the coffee morning are sent via text & email as well as displayed on our waiting room screens and social media posts. These events are themed according to the time of year.
- Where possible a **carers champion is present at flu & covid clinics** to help identify patients that may not be currently registered as a carer ~ an opportunity to reach the more vulnerable patients & those with more challenging conditions.
- The carers champion has a **dedicated email** rhg.carers@nhs.net to provide direct contact/ support
- Upon registering as a carer, a '**Welcome email**' is sent to include information about registering with Carers in Herts followed by a telephone call.
- Where possible a **carers champion will call a newly registered carer** to reassure them that we have done all the necessary administration and to introduce ourselves.
- Carers champions are using their role within the surgery to communicate with a member of the team to **provide the right support**, an example of this is the medical secretaries arranging hospital transport for a carer's husband.
- We are with the **carers every step of the way** and offer the service to register them ourselves with Carers in Herts with their permission if they are unable to do this themselves online.

Best Practice regarding Carers – other practices

- **Bridgewater Surgeries** hold carers flu events annually, where they invite carers to have a flu jab and a carers health check. They are invited to come alone or bring the person they care for with them if this enables them to attend. They also hold carer coffee mornings throughout the year, again offering a carer health check and they invite guest speakers. At the last coffee morning, the police attended to talk about scams. Carers in Herts and the practice's social prescribers attend too.

- **Schopwick surgery** have previously held a patient healthy living event and invited Carers in Herts to have a stand. The Carers in Herts team spoke to many members of the public, plus were able to network with other organisations. Schopwick plan to do a similar event in 2025/26.

- **Highview** is one of the 5 SWH practices which have a gap between their unpaid carers and their expected 2% of their adult registered population list size. Their carers champion is actively seeking patients that may be carers, and carers that are children as part of their promotion work.

South West Herts Place Primary Care Update – Minor Illness Winter Service in Hertsmere

Summary

- A minor illness winter service is being piloted in Hertsmere, the first time this has been available for their patients.
- The clinics are rotated around the practices in Hertsmere and each practice has ring-fenced appointments it can book patients into. NHS 111 are also able to book into the service.
- In total the service has now seen 2,608 presentations between 21/10/24 and 3/1/25 inclusive.
- We plan to evaluate three areas: impact on patients, impact on UEC and the wider system, and the impact on primary care.
- In November we saw Hertsmere low acuity in-hours A&E activity rise at a much lower rate than the rest of south and west Hertfordshire. This brought Hertsmere activity (per 10,000 weighted population) in line with the rest of south and west Hertfordshire.
- In December that trend has continued, and Hertsmere activity (per 10,000 weighted population) is now ***lower*** than the rest of south and west Hertfordshire for the first time since summer of 2023.
- If we look at the year-on-year comparisons; we can see that south and west Herts (excluding Hertsmere) A&E activity increased by 30 per 10,000 weighted population compared to 23/24 and Hertsmere's increase by only 8.9 per 10,000 weighted population.

Evaluation

- We are in a strong position in terms of quantitative data to pull together for evaluation purposes, i.e. A&E activity and Pharmacy First utilisation.
- In addition to Royal Free London and West Herts Hospitals, for the evaluation we are also going to look at activity from Hertsmere to Edgeware and Finchley as that has traditionally been the third destination of choice for Hertsmere patients.
- We are also going to compare Hertsmere to Stevenage and Harlow; mainly to compare the deprivation and health inequalities angle; and the usage of NHS 111 to previous years.
- Will get qualitative feedback from locality clinicians and clinicians in the service.
- The provider of the service will undertake some patient surveys. They are already sending SMS messages to patients to get them to complete F&F feedback and share their experience of the service on NHS choices, so we will look at that.
- There is also the question of "where would the patients have otherwise gone". The group have recognised this is an important question, but something challenging to answer, but we will look at this.
- We will also look at productivity rates, not just of the service but how this service may or may not make the system more productive and reduce wastage.

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 Board				**Meeting Date:**	**30/01/2025**	
Report Title:	**Primary Care Patient Safety Strategy**				**Agenda Item:**	**08**	
Report Author(s):	Liam Wilson, Assistant Director Quality Improvement and Patient Safety, Hertfordshire and West Essex Integrated Care Board						
Report Presented by:	Liam Wilson, Assistant Director Quality Improvement and Patient Safety						
Report Signed off by:	Rosie Connolly, System Quality Director						
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:	▪ Are you satisfied with the information provided within this summary? ▪ Is Primary Care Transformation Committee satisfied to accept a progress report in July 2025? ▪ Any Feedback PCTC would like to give based on the information provided?						
Report History:	▪ N/A						
Executive Summary:	This strategy outlines the primary care implementation of the NHS Patient Safety Strategy and is for all areas of primary care. NHSE are suggesting implementing first in general practice to enable the successes and learning to be used in the rollout to community pharmacy, optometry, and dental services. The strategy was released in September 2024. The primary care patient safety strategy focuses on two core foundations: a patient safety culture and a patient safety system. Three strategic aims will support the development of both these foundations, these are Insight, Involvement, and Improvement. Within the strategy, the top three patient safety incidents have been identified within primary care are identified as: diagnosis, medication-related and delayed referrals.						

<table>
<tr><td></td><td colspan="4">Key messages from the national patient safety team are that we need to test and pilot the ideas encouraging discussion and exploration of the patient safety ambition.

The strategy has an iterative delivery timeframe and not a contractual requirement for primary care providers or integrated care boards at present.

There are local and national commitments to help embed this strategy within primary care. The HWE patient safety team are reviewing the local commitments with key internal ICB stakeholders and have arranged a meeting for January 2025. Following this meeting HWE ICB will liaise with all relevant stakeholders for example, Local Medical Committees and Primary Care Networks</td></tr>
<tr><td>Recommendations:</td><td colspan="4">Accept the approach of the implementation within HWE ICB of the Primary Care Patient Safety Strategy and agree with the planned next steps for implementation.</td></tr>
<tr><td rowspan="4">Potential Conflicts of Interest:</td><td>Indirect</td><td>☐</td><td>Non-Financial Professional</td><td>☐</td></tr>
<tr><td>Financial</td><td>☐</td><td>Non-Financial Personal</td><td>☐</td></tr>
<tr><td colspan="3">None identified</td><td>☒</td></tr>
<tr><td colspan="4">N/A</td></tr>
<tr><td colspan="5">Implications / Impact:</td></tr>
<tr><td>Patient Safety:</td><td colspan="4">The slides summarise the new strategy for patient safety within primary care. This is an opportunity for improving patient safety culture and safer systems within primary care.</td></tr>
<tr><td>Risk: Link to Risk Register</td><td colspan="4">N/A</td></tr>
<tr><td>Financial Implications:</td><td colspan="4">None at present.</td></tr>
<tr><td>Patient or public engagement or consultation:</td><td colspan="4">N/A</td></tr>
<tr><td rowspan="3">Impact Assessments:
(Completed and attached)
Please detail key impacts the Board/Committee should note:</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>

Hertfordshire and West Essex Integrated Care System

NHS England

Primary Care Patient Safety Strategy

30 January 2025

Primary Care Transformation Committee

Working together
for a healthier future

Headlines

- National strategy published 26th September 2024.
- Co-designed with NHS front-line primary care staff and lay patient safety partners.
- The strategy builds on the wider NHS Patient Safety Strategy and aims to develop a supportive environment within primary care where learning can be shared more widely to benefit patient and staff safety and wellbeing.
- Identifies three main patient safety incident types; *diagnosis, medication-related and delayed referral.*

<u>Three focus points:</u>

1. Developing a supportive, learning environment and just culture in primary care, with sharing across the system so that services can continually improve.
2. Ensuring that the safety and wellbeing of patients and staff is central, and that our approach to managing safety is systematic and based on safety science and system-level thinking.
3. Involving patients in the identification and co-design of primary care patient safety ambitions, opportunities and improvements.

The impact of patient safety in primary care

- 90% of all NHS patient interactions occur in primary care
- 97% of encounters in general practice are safe
- 0.7% of the 2.4 million patient safety incidents annually 'recorded' nationally relate to primary care, so there is probably an under-representation of incidents and therefore harm
- 21% of all new claims to NHS Resolution are from general practice (as reported in the Clinical Negligence Scheme for General Practice and the Existing Liabilities Scheme claims notified in 2023/24)
- Expenditure of £149 million for GP indemnity via NHS Resolution in 2023/34
- Avery et al., 2020 estimated there are between 19,800 and 32,200 incidents of avoidable significant harm in general practice in England per year (similar data for community pharmacy, optometry and dental services are currently unknown): 61% diagnosis; 26% medication; 11% referrals
- Every incident of significant harm has a personal cost to patients, service users, families, carers and staff.
- The financial cost of incident-related treatments, estimated at more than £100 million per year across the whole of primary care

Safety culture

Participate in staff surveys

Safety Systems

Complete the patient safety syllabus training

Insight

Register with the incident recording service (LFPSE) and trial the incident response framework (PSIRF)

Involvement

Identify staff patient safety leads and lay patient safety partners

Improvement

Review and test patient safety improvements in diagnosis, medication, referrals, optometry and dental services

Implementation

- The strategy is about setting the **ambition and vision**
- To encourage **discussion and exploration**
- **Not** about implementing everything on day one
- Provides **new ideas and opportunities** that can be shared
- Draws together **best practice**
- It is **not a contractual requirement** on primary care providers, or Integrated Care Boards
- **Most areas need testing and piloting**
- Delivery timeframe is **iterative**
- **Pilot approach for Patient Safety Incident Response Framework** (PSIRF) for a small number of General Practices supported by the Health Innovation Network

HWE Next Steps

- One practice have volunteered to be a pilot site for PSIRF implementation.
- Work is being planned with key ICB stakeholders on how we take forward and prioritise the local commitments identified within the Patient Safety Strategy for Primary Care, and build on existing good practice.
- We will report back on progress at July's Primary Care Transformation Committee.