NHS HWE ICB Primary Care Board meeting held in Public

Thursday 24th April 2025 @ 09:30

MS Teams

Hertfordshire and West Essex Integrated Care Board

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

09:30	Welcome, apologies and housekeeping	Verbal	Chair
	Declarations of interest incl. Register of Committee Members		
	Minutes and actions from previous meeting		
09:45	Questions from public	For discussion	Chair
09:50	Hypertension Deep Dive	For discussion	Simon Hey/Emily Perry/Dr Rachel Alexander
10:20	Primary Care Transformation– Directorate Report and HCP highlight reports	For discussion	Avni Shah
10:40	HWE Progress on General Practice Workforce and priorities for 2025/26 across Primary Care	For discussion	Sarah Dixon
11:00	Winter 24/25	For discussion	Phillip Sweeney/Penny Thomas
	Evaluation of the additional Primary Care Network funding		
	Vaccination evaluation 24/25 and plans for 25/26		
11:15	Risk Register	For information	Trudi Mount/Andrew Tarry
11:25	Reflections and feedback from the meeting	For information	Chair
11:30	Close of meeting		Chair

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐			
	Primary Care Transformation				**Meeting Date:**	**24 April 2025**	
Report Title:	**Committee Register of Interests**				**Agenda Item:**	**1.1**	
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 compliance with the HWE Standards of Business Conduct and Conflicts of Interest Policy and the ICBs statutory duties. ▪ All members, and those in attendance must declare any actual or potential (previously known as direct or perceived) 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. ▪ The ICB has just commenced the annual Conflicts of Interest refresh for financial year 2025/26, with the requirement for colleagues to complete a new declaration of interest form (see attached template) and return to hweicbwe.declarations@nhs.net by no later than 31 May 2025. ▪ At the point of drafting this report, the status of committee members/regular attendees declarations for 2025/26 have been noted as follows: (i) 2025/26 declaration received and processed (white background),						

<table>
<tr><td></td><td colspan="4">(ii) 2025/26 declaration received but currently being processed, the entry on the register is as per 2024/25 declaration (green background),

(iii) 2025/26 not received (deadline 31 May 2025), the entry on the register is as per 2024/25 declaration (yellow background).</td></tr>
<tr><td>Recommendations:</td><td colspan="4">The Committee is asked to:
▪ If your new fully completed 2025/26 submission has not been returned, please complete and return the declaration of interest form included with this paper (see attached),
▪ 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 should be countersigned by their Line Manager or lead, and then forwarded to hweicbwe.declarations@nhs.net for logging.</td></tr>
<tr><td rowspan="4">Potential Conflicts of Interest:</td><td>Indirect</td><td>☐</td><td>Non-Financial Professional</td><td>☐</td></tr>
<tr><td>Financial</td><td>☐</td><td>Non-Financial Personal</td><td>☐</td></tr>
<tr><td colspan="3">None identified</td><td>☒</td></tr>
<tr><td colspan="4">N/A</td></tr>
<tr><td colspan="5">Implications / Impact:</td></tr>
<tr><td>Patient Safety:</td><td colspan="4">N/A</td></tr>
<tr><td>Risk:</td><td colspan="4">N/A</td></tr>
<tr><td>Financial Implications:</td><td colspan="4">N/A</td></tr>
<tr><td rowspan="3">Impact Assessments:</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>

Key:	White background indicates 2025/26 delcaration received
	2024/25 declaration - awaiting 2025/26 declaration
	2024/25 declaration - processing 2025/26 declaration
	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

Hertfordshire and West Essex ICB
Register of Interests 2025-26

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
			Speciality Doctor Paediatric Allergy - Lister Hospital, Stevenage.		√	-	√	-	2015 approx	Ongoing	Declare interest at meetings where relevant
			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
			Previous Director of Optimise Health Limited until June 2024, which has developed hypertension software application (called OptBP) that is being used in GP practices. I continue to work with Optimise Health part time and hold shares in the company.	√	-	-	√	-	2014 approx	Ongoing	Declare interest at meetings where relevant

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			PML NHS ultrasound service hosted at the Maltings Surgery	√	-	-	√	-	2019	Ongoing	Declare interest at meetings where relevant
			Maltings Surgery of which I am a partner is a hub for contraceptive implant and coil insertion	√					Nov-22	Ongoing	Declare interest at meetings where relevant
			Hosting HertsOne GP Federation Primary Care ADHD service	√					Feb-22	Ongoing	Declare interest at meetings where relevant
			Spouse, Board Trustee CIMPSA (Chartered Institute of the Management of Sport and Physical Activity)	-	-		-	√	Jan-22	Ongoing	Declare interest at meetings where relevant
			Private allergy specialist	√					Apr-24	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
			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	

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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, Rainbow 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
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)	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	

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			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	
			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	Nil								
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 Transformation Committee	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	-	-	-	-	-	-	-	-

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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		
			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	-	-	-	-	-	-	-	-

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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 Committee GP/PCN CD Lead ENH Place	Clinical Director, PCN hoddesdon and broxbourne	√					2019	Current	
			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, Primary Care for the ICB - Primary Medical services	GP Executive 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	
			CD Stevenage North PCN	√					2022	Continuing	
			Director North Stevenage PCN Ltd	√	-	-	√	-	2024	Continuing	
			GP 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	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	

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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 Transformation Committee	Nil								
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

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			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
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	Nil								
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	None
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 30 January 2025**			
Time:	**09:30 – 11.45am**			
Venue:	**The Forum, Conference Room 2/MS Teams**			

MINUTES

Name	Title	Organisation
Members present:		
Prag Moodley (PM) **(Meeting Chair)**	Partner Member (Primary Medical Services)	Herts and West Essex ICB
Avni Shah	Director of Primary Care Transformation	Herts and West Essex ICB
Leighton Colegrave (LC)	Citizen Representative, East & North Herts	Herts and West Essex ICB
Sarah Dixon (SD)	Primary Care Workforce Clinical Lead	Herts and West Essex ICB
Trevor Fernandes (TF)	Partner Member (Primary Medical Services)	Herts and West Essex ICB
Leanne Fishwick (LF)	Representative Community Provider	Central London Community Healthcare Trust
Jayna Gadawala (JG) Via MS Teams	Primary Care Workforce Clinical 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 Clinical Lead – CCIO	Herts and West Essex ICB
Marianne Hiley (MH)	Citizen Representative, South & West Herts	Herts and West Essex ICB

Alison Jackson (AJ)	HCP Care Closer to Home, GP Lead	Herts and West Essex ICB
Ian Perry (IP) Via MS Teams	Partner Member (Primary Medical Services)	Herts and West Essex ICB
Melanie Powell (MP)	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
Anurita Rohilla (AR) Via MS Teams	Chief Pharmacist	Herts and West Essex ICB
Babatunde Sokoya (BS)	Community Pharmacy PCN Engagement Lead	Herts and West Essex ICB
Michelle Campbell (MC)	Head of Primary Care Contracting	Herts and West Essex ICB
Philip Sweeney (PS)	Head of Primary Care Transformation and Integration – West Essex	Herts and West Essex ICB
Andrew Tarry (AT) Via MS Teams	Head of Primary Care Contracting	Herts and West Essex ICB
In attendance:		
Melanie Bedoya (MB) Via MS Teams	Frailty & End of Life Programme Manager	Herts and West Essex ICB
Amanda Burfot (AB) Via MS Teams	Senior Primary Care Manager for Transformation, Integration and Delivery – South & West Herts	Herts and West Essex ICB
Calisir Cagdas (CC) Via MS Teams	Stort Valley Care Home Lead	Local Medical Council (LMC)
Rosie Connolly (RC)	System Quality Director	Herts and West Essex ICB
Clint Foreman (CF) Via MS Teams	Assistant Secretary	Local Dental Committee (LDC)
Sam Glover (SG) Via MS Teams	CEO	Healthwatch, Essex
Faisal Khan (FS) Via MS Teams	Manager – Care Home Hub – Loughton Buckhurst Hill/Chigwell	PCN
Iram Khan (IK)	Corporate Governance Manager	Herts and West Essex ICB
Elizabeth Kendrick (EK) Via MS Teams	Strategic Programme Clinical lead for Urgent and Emergency Care and Clinical Lead – Care Closer to Home	Herts and West Essex ICB
Lakhvinder Larh (LL) Via MS Teams	PCN Clinical Director – Loughton, Buckhurst Hill/Chigwell	PCN
Nisha Mistry (NM) Via MS Teams	Pharmaceutical Advisor	Herts and West Essex ICB
Clair Moring (CM)	Strategic Clinical Lead - Frailty,	Herts and West Essex ICB
Helen Musson (HM) Via MS Teams	Chief Officer	Hertfordshire Local Pharmaceutical Committee
Emily Perry (EP)	Primary Care Manager – Strategy and Transformation	Herts and West Essex ICB

Annette Pullen (Minutes)	EA to Director of Primary Care Transformation	Herts and West Essex ICB
Josephine Smit (JS)	Senior Primary Care Manager for Transformation, Integration and Delivery – West Essex	Herts and West Essex ICB
Emma Spofforth (ES)	LOC Representative Essex	Local Optical Committee (LOC)
Jessica Steele (JSt) Via MS Teams	Primary Care Manager - West Essex	Herts and West Essex ICB
Neil Tester (NT) Via MS Teams	Chair	Healthwatch Hertfordshire
Nicky Williams (NW) Via MS Teams	Co-Chief Executive	Local Medical Committee (LMC)
Sam Williamson (SW)	Associate Medical Director	Herts and West Essex ICB
Liam Wilson (LW)	Assistant Director – Quality Improvement and Patient Safety	Herts and West Essex ICB

PCTC/43/25	**Welcome, apologies and housekeeping**
43.1	Prag Moodley (PM) 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.
43.2	Apologies for absence had been received from: • Elliott Howard-Jones – Representative Community Provider • Kevin Barrett – HCP Care Closer to Home GP Lead • David Tideswell - HCP Care Closer to Home GP Lead - WE • Raja Vaiyapuri - Medical Director/Deputy Chief Executive -Essex LMC • Steve Claydon – Independent ICB Clinical Advisor for Dental The meeting was declared quorate.
PCTC/44/25	**Declarations of interest**
44.1	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/45/25	**Minutes from the previous meeting**
45.1	The minutes were approved.
45.2	**The minutes of the last meeting held on 28 November 2024 were approved**
PCTC/46/25	**Action tracker**
46.1	No open actions

46.2	**The Primary Care Transformation Committee noted there were no open actions**
PCTC/47/25	**Questions from the Public**
47.1	No questions received
PCTC/48/25	**Case studies Primary Care support into Care Homes**
48.1	Emily Perry (EP) introduced the Deep Dive (see pages 24-85 of the document pack) which focuses on current provision of Primary Care into Care Home residents, outlines the challenges and opportunities and providing examples of case studies. Nisha Mistry (NM) outlined an approach to prescribing and medicines management in Care Homes giving example of case study of polypharmacy and working in partnership with the practice and the home to manage the patient in the holistic way. Lakhvinder Larh (LL) shared slides outlining Care Home Hub, pilot delivered as a PCN and evaluation. • Pilot commenced May 2024. • Centralising multidisciplinary team providing dedicated carte for six care homes. Team consists of GP, Pharmacist, Paramedic and Care Co-ordinator. • Model ensures dedicated team of permanent staff, providing consistency with improved relationships to residents and staff. • Proactive care as teams able to respond quicker. • Approach simplifies communications/co-ordination with system partners. • Data provides detail to indicate significant potential savings. • Positive feedback, sharing vision with several stakeholders. • Infrastructure accessing records, diagnostics and referrals proved challenging. • System partners strong support although due to operational pressures, PCN predominantly taking lead and initiative forward.
48.2	Questions and comments were invited: • AS clarified purpose of deep dive is to focus from a Primary Care provision whilst it needs to be acknowledged that range of system health and care partners who have input into care homes. Purpose is to share the learning, opportunities of integrating with partners to deliver the care in the most cost-effective way and how we are continuously improving outcomes. • The meeting was not to discuss the costing model of the PCN Care home hub but to understand the costings to deliver the outcome using existing primary care resources and some non -recurrent additional funds in primary care to deliver the wrap around • Team happy to work collaboratively, sharing achievements, open to further discussions, feedback with a view to agreeing to visits. • PCN noted that recurrent funds were required to show the continuous impact on outcomes and reduction in non-elective admissions. • All members agreed valuable pilot and important to share the detailed case studies and other examples across PCN/localities and wider.

	• SD shared date of next protected learning time webinar which will focus on Carers. This will be on 4 February via Teams. Would encourage attendance as expect informative session. AS concluded, overall progress on care homes falls under ICB programme of work on Frailty and each Health and Care Partnership currently working to develop their plans on frailty which will include initiatives/projects on care homes.
48.3	**The Primary Care Transformation Committee noted the Report**
PCTC/49/25	**Directorate Highlight Report including Place Integrated Reports**
	Avni Shah (AS) introduced highlight report (pages 86-115 of the document pack) A great amount of work underway since the last meeting and the paper highlights some of the key areas of progress to note including: • Update on winter and uptake on vaccinations. • Update on Digital and primary care workforce. • Progress update on primary care projects in community pharmacy, dental and optometrists. • Place updates from each are including good new story to share and progress on key areas of priorities.
49.2	Questions and comments were invited: LC requested clarity around whether GP roles within ARRS were affecting none GP roles e.g. social prescribing. • SD confirmed there should be no impact. There may be some misunderstanding when recruiting, therefore we will ensure all Practices are aware of some of the issues to improve understanding within this area. BS commented if low uptake on vaccinations may be due to commencing month later than previous years. • AS responded graphs/data reflect this although in comparison to other areas in East of England, we previously were top of list, now in the middle. The Chair shared feedback from NHSE, CEO complimenting Primary Care for efforts on continued engagement, stating webinars proving helpful.
49.3	**The Primary Care Transformation Committee noted the Report**
49.4	**West Essex place update** Philip Sweeney (SW) introduced slide (page 117 of pack) highlighting key areas: • Harlow surgery received award relating to best practice around work with local Care Home. • Local hospital PAH implemented an Electronic Patient Record system – Alex Health. A working group set up to alleviate any teething issues affecting Primary Care.

	• In depth progress on health checks particularly weight management together with wellbeing service referrals which indicates good trajectory on improvement from last year.
49.5	Questions and comments were invited: • SW suggested across all three place reports for consideration to be given to incorporate any key actions around delivery of hypertension work and any other areas of priorities under Medium Term Financial Plan.
49.6	**The Primary Care Transformation Committee noted the Report**
49.7	**East & North Herts place update** Cathy Galione (CG) introduced slides (pages 118-120 of pack) outlining key areas: • Working collaboratively with health Care Partnerships (HCP) with assurance report on locality delivery to be provided at next HCP Board next week. • Multidisciplinary team reporting clinical templates are being developed to support the data recording required for the delivery of the Integrated neighbourhood teams and measuring the impact this is having on outcomes set out including reduction in non-elective admissions • Recruitment of an Associate Medical Director of Primary care currently underway which will be a post hosted at East & North Herts Trust. • Case Study 'Hatfield PCN and active practice charter' highlighted (slide 120 provides full detail). • Procurement for the Enhanced health in care homes for care homes in East and North Health and care Partnership has completed and aim is provider to start contract 1 April.
49.8	Questions and comments were invited: • TF asked if there was potential for ICB to commission Accrux to support community pharmacy. • AS responded Accrux is funded from community pharmacy and not ICB which is commissioned for General Practice.
49.9	**South West Herts place update** Amanda Burfot (AB) introduced slides (pages 121-127 of pack) outlining key areas: • Key focus working with Carers this month with practices and PCNs promoting health checks to carers as outlined in the Enhanced Commissioning Framework for 24/25. • Expect to go live with W:ISH Pilot which is a Wellness Interactive Support Hub. This is an online public facing digital platform to provide patients with education, tools and information around local activities to assist them in managing their own

	health and well-being. Update to be provided at next meeting on progress including funding. • Progress on delivery of Integrated Neighbourhood Teams (INT) outlined as per slide 122.
49.10	Questions and comments were invited: MH shared below for consideration: • Expressed concern relating to discharge process at weekend. • Encouraged patient groups representation at GP Practice meetings • Felt PCN aggregated data does not reflect variation which exists within Practices. HM commented as below: • Complimented South West Herts on pharmacy first inclusion. • Requested consistent inclusion all communications, all areas to avoid creating extra demand. AS summarised as below: • Welcome positive feedback relating to continued pharmacy integration. • Continued building on consistency in all areas, with Clinical Leads involvement together with Locality Leads/teams. • As part of commissioning services, communications to be shared at appropriate stage of work.
49.11	**Action:** Reports to incorporate key highlighting any actions on work being delivered around hypertension to align with priority areas as part of system.
49.12	**Action:** Reports to incorporate consistent headings including general practice vaccination, integration around neighbourhood teams to evidence alignment to medium term financial plan. Include process to share with localities and primary care via the bulletin together with stakeholders.
49.13	**The Primary Care Transformation Committee noted the Report**
PCTC/50/24	**Primary Care Patient Safety Strategy**
50.1	Liam Wilson (LW) presented this item (see pages 128- 136 of the document pack) highlighting the following: • Shared headlines within slides. • Strategy published September 2024, which was co designed with frontline staff, building on wider patient strategy launched in July 2019, bespoke to Primary Care. • Identifies from report published in 2023. • Focus on three points around developing a supporting culture and sharing learning across systems as highlighted on slide 132. • Key points around the impacts of patient safety in primary care outlined as per slide 133.

	• Drawing together best practice with testing and piloting. • Delivery time iterative. • Key point is it is not contractual requirement on Primary Care Providers/Integrated Care Boards. • Piloting within limited number of practice and will share 1 pilot case at meeting in July.
50.2	Questions and comments were invited: • Request from members to extend a virtual Patient Safety training day set for March. • Confirmed training is around wider framework and not Primary Care specific, GP's very welcome. • Sessions are limited to twenty per session although will explore possibilities of further dates.
50.3	**The Primary Care Transformation Committee noted the Report**
PCTC/51/24	**For Information only – information pack provided separately (pages 1-32)**
51.2	**Healthwatch reports (pages 3-24)**
51.3	**The Primary Care Transformation Committee noted the Healthwatch update**
PCTC/52/24	**Minutes from subgroups**
52.1	• Primary Workforce Implementation Group (pages 25-29) • Primary Care Digital – to be shared next meeting
52.2	**The Primary Care Transformation Committee noted the sub-group minutes**
PCTC/53/24	**Reflections and feedback from the meeting**
53.1	• Reassurance significant transformation taking place with good collaborative working.
The meeting closed at 11.45am	

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Herts and West Essex Integrated Care Board PRIMARY CARE TRANSFORMATION GROUP Action Tracker Last updated on 3 April 2025

Public	Action Tracker Ref No	Date of Meeting	Subject	Action	Responsible Lead	Deadline Date	Comments and Updates	Status
PCTC/49/25	49.11	30/01/2025	Directorate Highlight Report	Reports to incorporate key highlighting any actions on work being delivered around hypertension to align with priority areas as part of system.	Place teams	24/04/2025	03.04 Place teams are updating reports to incorporate the suggestions made for PCTC in April Annette emailed team 27 Mar - any updates	Closed
PCTC/49/25	49.12	30/01/2025	Directorate Highlight Report	Reports to incorporate consistent headings including general practice vaccination, integration around neighbourhood teams to evidence alignment to medium term financial plan. Include process to share with localities and primary care via the bulletin together with stakeholders.	Place teams	24/04/2025	03.04 Place teams are updating reports to incorporate the suggestions made for PCTC in April Annette emailed team 27 Mar - any updates	Closed

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

Key:	White background indicates 2025/26 delcaration received
	2024/25 declaration - awaiting 2025/26 declaration
	2024/25 declaration - processing 2025/26 declaration
	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

Hertfordshire and West Essex ICB
Register of Interests 2025-26

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
			Speciality Doctor Paediatric Allergy - Lister Hospital, Stevenage.		√	-	√	-	2015 approx	Ongoing	Declare interest at meetings where relevant
			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
			Previous Director of Optimise Health Limited until June 2024, which has developed hypertension software application (called OptBP) that is being used in GP practices. I continue to work with Optimise Health part time and hold shares in the company.	√	-	-	√	-	2014 approx	Ongoing	Declare interest at meetings where relevant

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			PML NHS ultrasound service hosted at the Maltings Surgery	√	-	-	√	-	2019	Ongoing	Declare interest at meetings where relevant
			Maltings Surgery of which I am a partner is a hub for contraceptive implant and coil insertion	√					Nov-22	Ongoing	Declare interest at meetings where relevant
			Hosting HertsOne GP Federation Primary Care ADHD service	√					Feb-22	Ongoing	Declare interest at meetings where relevant
			Spouse, Board Trustee CIMPSA (Chartered Institute of the Management of Sport and Physical Activity)	-	-		-	√	Jan-22	Ongoing	Declare interest at meetings where relevant
			Private allergy specialist	√					Apr-24	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
			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	

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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, Rainbow 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
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)	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	

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			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	
			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	Nil								
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 Transformation Committee	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	-	-	-	-	-	-	-	-

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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		
			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	-	-	-	-	-	-	-	-

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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 Committee GP/PCN CD Lead ENH Place	Clinical Director, PCN hoddesdon and broxbourne	√					2019	Current	
			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, Primary Care for the ICB - Primary Medical services	GP Executive 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	
			CD Stevenage North PCN	√					2022	Continuing	
			Director North Stevenage PCN Ltd	√	-	-	√	-	2024	Continuing	
			GP 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	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	

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	
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 Transformation Committee	Nil								
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

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	
			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
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	Nil								
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	None
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

Meeting:	*Meeting in public*	☐	*Meeting in private (confidential)*		☒		
	Primary Care Transformation			**Meeting Date:**	**24 April 2025**		
Report Title:	**Committee Register of Interests**			**Agenda Item:**	**2**		
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 compliance with the HWE Standards of Business Conduct and Conflicts of Interest Policy and the ICBs statutory duties. ▪ All members, and those in attendance must declare any actual or potential (previously known as direct or perceived) 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. ▪ The ICB has just commenced the annual Conflicts of Interest refresh for financial year 2025/26, with the requirement for colleagues to complete a new declaration of interest form (see attached template) and return to hweicbwe.declarations@nhs.net by no later than 31 May 2025. ▪ At the point of drafting this report, the status of committee members/regular attendees declarations for 2025/26 have been noted as follows: (i) 2025/26 declaration received and processed (white background),						

<table>
<tr><td></td><td colspan="4">(ii) 2025/26 declaration received but currently being processed, the entry on the register is as per 2024/25 declaration (green background),

(iii) 2025/26 not received (deadline 31 May 2025), the entry on the register is as per 2024/25 declaration (yellow background).</td></tr>
<tr><td>Recommendations:</td><td colspan="4">The Committee is asked to:
▪ If your new fully completed 2025/26 submission has not been returned, please complete and return the declaration of interest form included with this paper (see attached),
▪ 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 should be countersigned by their Line Manager or lead, and then forwarded to hweicbwe.declarations@nhs.net for logging.</td></tr>
<tr><td rowspan="4">Potential Conflicts of Interest:</td><td>Indirect</td><td>☐</td><td>Non-Financial Professional</td><td>☐</td></tr>
<tr><td>Financial</td><td>☐</td><td>Non-Financial Personal</td><td>☐</td></tr>
<tr><td colspan="3">None identified</td><td>☒</td></tr>
<tr><td colspan="4">N/A</td></tr>
<tr><td colspan="5">Implications / Impact:</td></tr>
<tr><td>Patient Safety:</td><td colspan="4">N/A</td></tr>
<tr><td>Risk:</td><td colspan="4">N/A</td></tr>
<tr><td>Financial Implications:</td><td colspan="4">N/A</td></tr>
<tr><td rowspan="3">Impact Assessments:</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 Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐
	Primary Care Transformation Committee (Public)		**Meeting Date:**	**24 April 2024**
Report Title:	**Deep Dive – Hypertension**		**Agenda Item:**	**3**
Report Author(s):	Dr Corina Ciobanu, Clinical Lead for CVD and Respiratory, HWEICB Dr Sam Williamson, Associate Medical Director, HWEICB Dr Rachel Alexander, Associate Medical Director, HWEICB Simon Hey, Senior Commissioning Manager, HWEICB James Gleed, Associate Director Primary Care Strategy and Transformation, HWEICB Emily Perry, Primary Care Manager – Strategy and Transformation, HWEICB Susan Haigh, Deputy Head of Communications and Engagement, HWEICB Del Ford, Senior Head of Population Health Management Delivery, HWEIC Kevin Hallahan, Health Inequalities Lead, HWEICB Tom Neale-Peppiatt, Primary Care Workforce Programme Manager, HWEICB Mefino Ogedegbe, Community Pharmacy Clinical Lead, HWEICB Alpesh Patel, Pharmacist, Crescent Pharmacy Hertford and Community Pharmacy PCN Engagement Lead for HWE ICB			
Report Presented by:	Simon Hey, Senior Commissioning Manager, HWEICB Emily Perry, Primary Care Manager – Strategy and Transformation, HWEICB Dr Rachel Alexander, Associate Medical Director, HWEICB			
Report Signed off by:	James Gleed, Associate Director Primary Care Strategy and Transformation, HWEICB			
Purpose:	**Approval / Decision** ☐	**Assurance** ☒	**Discussion** ☒	**Information** ☒
Which Strategic Objectives are relevant to this report **[Please list]**	• Increase healthy life expectancy, and reduce inequality • Give every child the best start in life • Improve access to health and care services • Increase the numbers of citizens taking steps to improve their wellbeing • Achieve a balanced financial position annually			

Key questions for the ICB Board / Committee:	▪ Within the current constraints and relevant frameworks, what more (if anything) might be possible, taking advantage of system working and /or building on current provision, to enhance health outcomes. ▪ Would the Committee like to receive any further information related to any of the initiatives outlined within the paper?
Report History:	▪ A number of hypertension reports have been taken to various ICB forums to highlight the work that is taking place within this area.
Executive Summary:	Cardiovascular disease (CVD) and hypertension remains a National (The NHS Long Term Plan) and Regional priority – the importance of detection of hypertension is outlined within the ICBs Medium Term Plan, and the Primary Care Strategic Delivery Plan. CVD, which includes coronary heart disease, heart failure, stroke and vascular dementia, is a significant cause of disability and death. CVD is one of the main contributors to the gap in life expectancy, accounting for approximately 20% of the difference between the most and least deprived communities in England. It is largely preventable, and the NHS Long Term Plan identified it as the single area that can save the most lives. Hypertension is a key risk factor for CVD, with at least 50% of heart attacks (myocardial infarctions (MIs)) and strokes being associated with hypertension. Hypertension is usually asymptomatic, which highlights the importance of people having their blood pressure (BP) checked - the early detection of elevated blood pressure levels and disease is key to the prevention and management interventions with a preference for assessment before microvascular or macrovascular damage has occurred. The ICB is undertaking multiple initiatives to work to improve the detection and management of hypertension. Some of these are outlined below: • An evidence-based communications campaign was launched in 2024 across HWEICB, to raise awareness of the importance of detecting hypertension, and to encourage people to have a free blood pressure check. • To improve access to blood pressure (BP) checks the number, location, and variety of organisations offering BP checks in the community has increased. These include community pharmacists, dental practices, optometrists, and voluntary, community, faith and social settings. • Targeted GP practice visits - using practice level data, the ICB identified the GP practices with a high number of people who had an elevated BP reading but no diagnosis of hypertension, a low hypertension prevalence or both. In total 45 practices were identified as having significant opportunity. The 45 practices were sent a letter on 5th February 2025 highlighting this opportunity and a request to arrange a visit – all visits are expected to have been completed by end of May 2025. • The Enhanced Commissioning Framework (ECF) for 25/26 incentivises GP practices to increase hypertension detection. • During 2024/25 several courses were offered as part of the ICB Training Hub's core training offer relating to hypertension. For

<table>
<tr><td></td><td colspan="4">2025/26, the Primary Care Workforce Team is currently organising the training programme which will include hypertension training offers.
• The key next steps for the hypertension programme in 25/26 include:
○ The communications campaign for hypertension will continue across the ICS, and the communications team will work with region to develop a regional communications campaign.
○ Dental and optometry providers will continue to deliver BP checks in phase 2 of the pilot.
○ The ICB will continue to work with GP practices to increase case finding through reviewing patients identified as having a high BP reading and no diagnosis of hypertension.
○ The ECF 2025/26 indicator to incentivise GP practices to increase the prevalence of hypertension is in place.
○ Work with the regional team on the New Care Model for CVD.
○ Work with Hertfordshire County Council to increase the uptake of NHS Health Checks.</td></tr>
<tr><td>Recommendations:</td><td colspan="4">▪ The Committee are asked to note the work that is taking place across the ICB related to hypertension</td></tr>
<tr><td rowspan="4">Potential Conflicts of Interest:</td><td>Indirect</td><td>☐</td><td>Non-Financial Professional</td><td>☐</td></tr>
<tr><td>Financial</td><td>☐</td><td>Non-Financial Personal</td><td>☐</td></tr>
<tr><td colspan="3">None identified</td><td>☒</td></tr>
<tr><td colspan="4">N/A</td></tr>
<tr><td colspan="5">Implications / Impact:</td></tr>
<tr><td>Patient Safety:</td><td colspan="4">N/A</td></tr>
<tr><td>Risk: Link to Risk Register</td><td colspan="4">N/A</td></tr>
<tr><td>Financial Implications:</td><td colspan="4">N/A</td></tr>
<tr><td>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

Hypertension Deep Dive

ICB CVD LTC Team, ICB PHM Team and ICB Primary Care team

Primary Care Transformation Committee

Thursday 24 April 2025

Working together
for a healthier future

Hypertension Deep Dive

- Importance of detecting hypertension
- Strategic priorities (national, regional, and local)
- HWE ICB Approach
  - Current ICB data
  - Awareness raising and improving access to BP checks
  - Improving hypertension diagnosis, monitoring, and coding
  - Optimising management
- Next steps

Introduction

The importance of detecting hypertension

- CVD, which includes coronary heart disease, heart failure, stroke and vascular dementia, is a significant cause of disability and death. CVD is one of the main contributors to the gap in life expectancy, accounting for approximately 20% of the difference between the most and least deprived communities in England. It is largely preventable, and the NHS Long Term Plan identified it as the single area that can save the most lives.

- Hypertension is a key risk factor for CVD, with at least 50% of heart attacks (myocardial infarctions (MIs)) and strokes being associated with hypertension.

- Hypertension is usually asymptomatic, which highlights the importance of people having their blood pressure (BP) checked

- The early detection of elevated blood pressure levels and disease is key to the prevention and management interventions with a preference for assessment before microvascular or macrovascular damage has occurred

- Although the effect of a single indicator of high blood pressure is associated with higher disease risks, the assessment of blood pressure trajectories provides a valuable nuance in the understanding of the associations between blood pressure and hypertension-related outcomes, such as stroke.

- It is estimated that 50% of people with hypertension are currently undiagnosed.

Strategic Priority - National, Regional, & Local

CVD and hypertension remains a National (The NHS Long Term Plan) and Regional priority.

The Regional New Care Model for CVD focuses on increasing the prevalence and optimising management of hypertension.

ICB Medium Term Plan (2024-2026)

- Reduce inequality with a focus on outcomes for CVD and hypertension.

- Three key indicators to measure progress:
  - To increase the hypertension Quality Outcomes Framework (QOF) prevalence across HWE by 2% by March 2026.
  - Increase the percentage of patients with GP recorded hypertension in whom the last BP reading was within target range to 80%.
  - To increase the age standardised prevalence of hypertension in the most deprived 20% of the ICB population from 17.6% to 19% by March 2026.

Primary Care Strategic Delivery Plan (2023-2026)

- Continued focus on prevention and health inequalities - helping people to stay well for longer, and notes the importance that all providers, including community pharmacy and the VCFSE sector, play in supporting delivery of blood pressure monitoring.

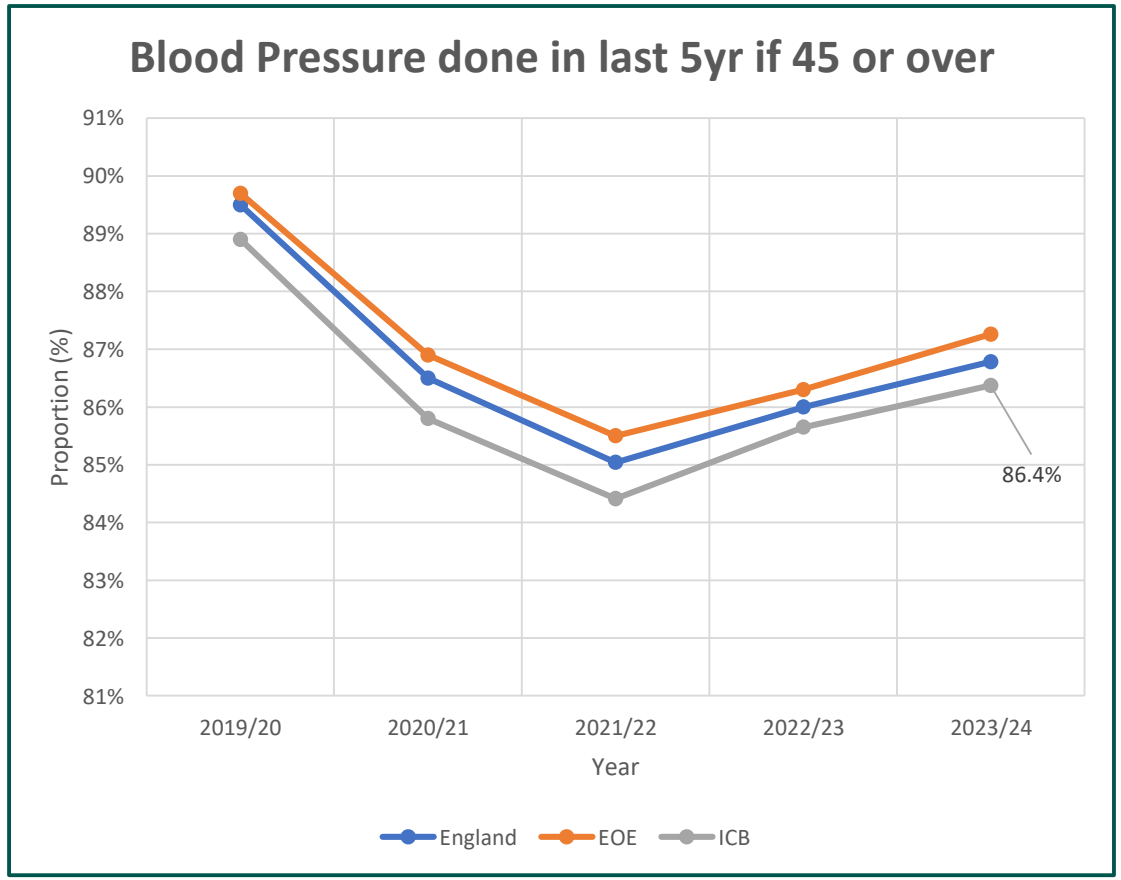
Herts & West Essex ICB Approach

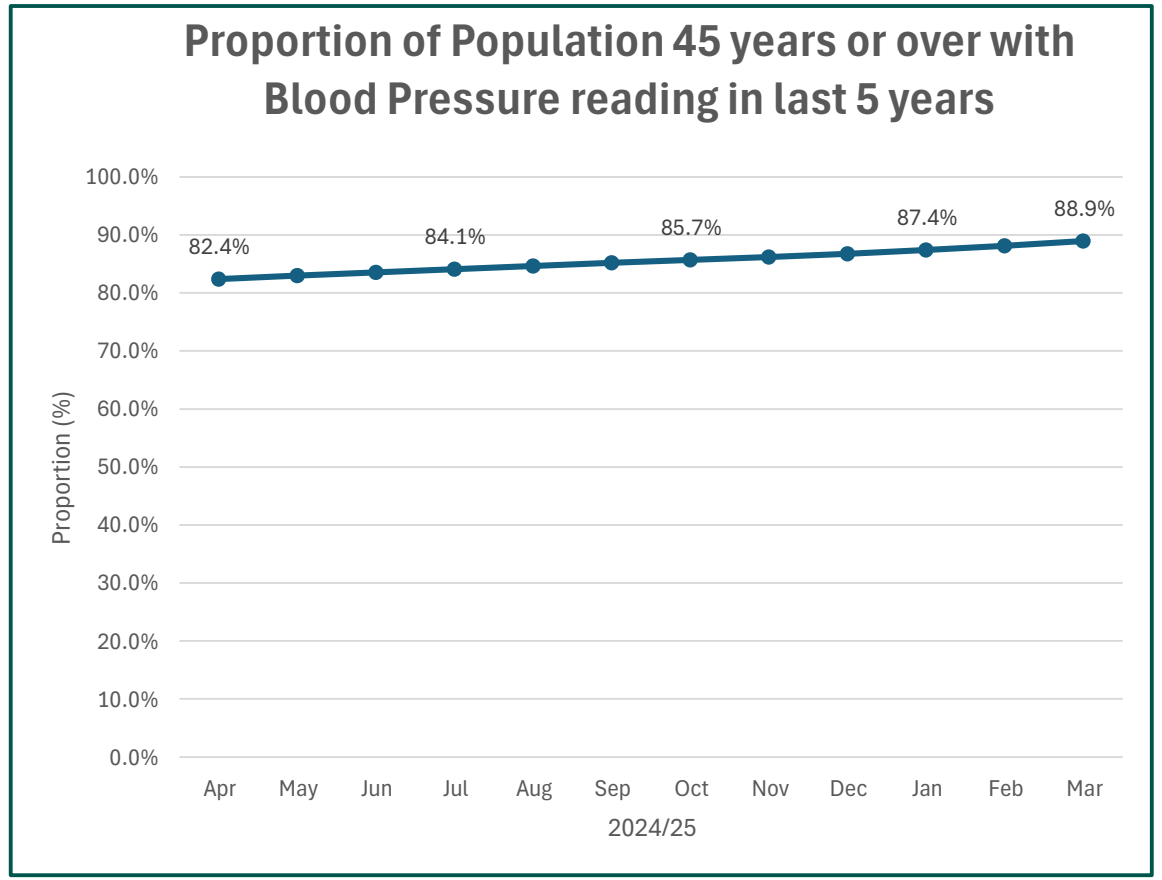
- **Awareness raising and improving access to BP checks**
  - Communications campaign
  - Access to BP checks
    - Community pharmacies
    - Dental and optometry pilot
    - Community and acute providers
    - Voluntary, community, faith and social enterprise organisations

- **Improving hypertension diagnosis, monitoring and coding**
  - Primary care hypertension insights pack
  - Targeted practice visits
  - Enhanced commissioning framework
  - Data cleansing and coding of people with raised BP reading and no diagnosis of hypertension

- **Optimising management – treat people with hypertension to target**
  - Community Pharmacy Pathfinder project
  - Quality Outcome Framework
  - Regional prescribing guidance on hypertension management

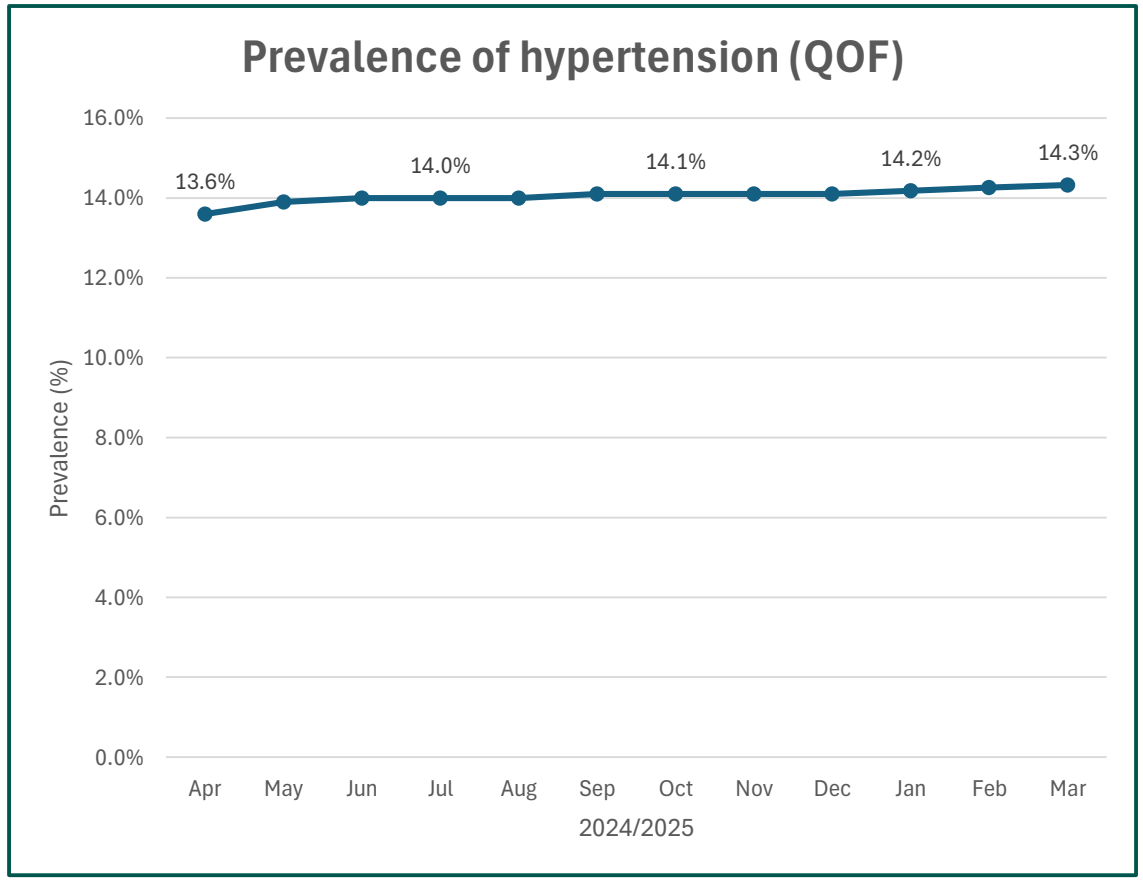
HWE ICB Current Data: Blood Pressure Checks

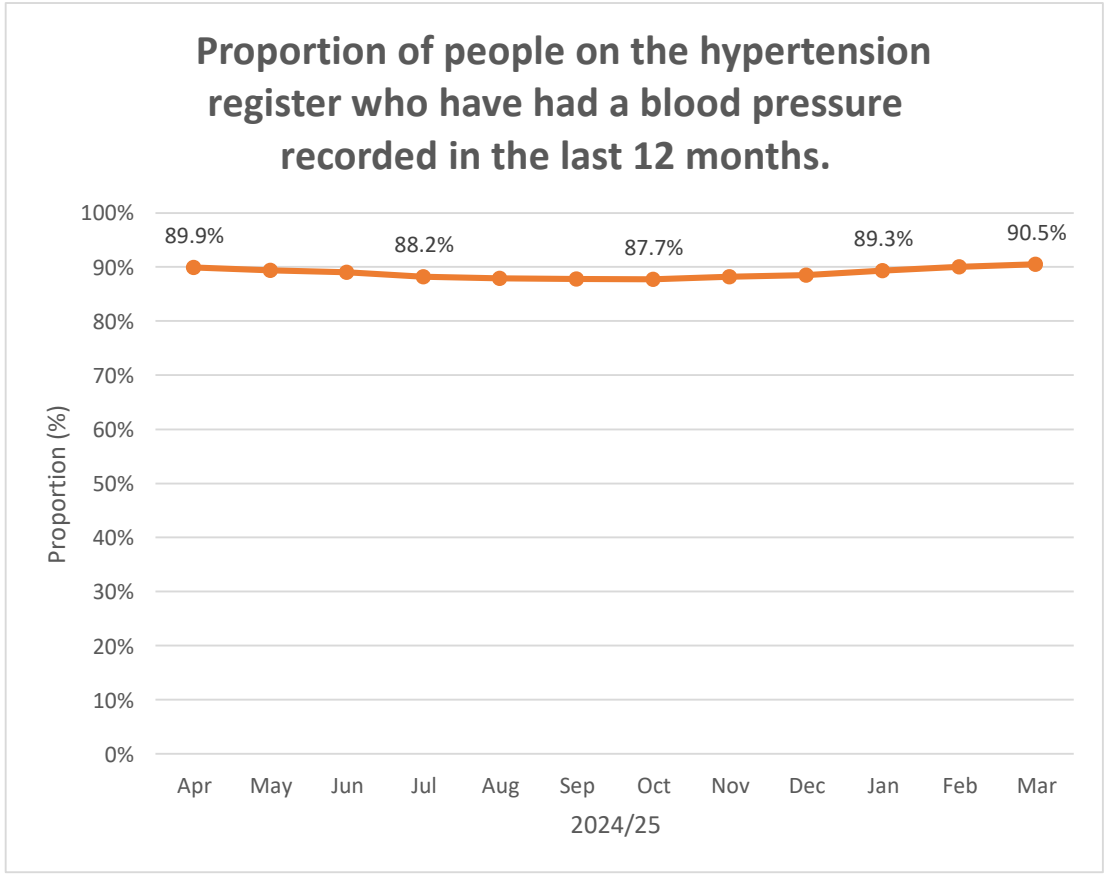




Source: Health Analytics – Mid Term Plan Dashboard

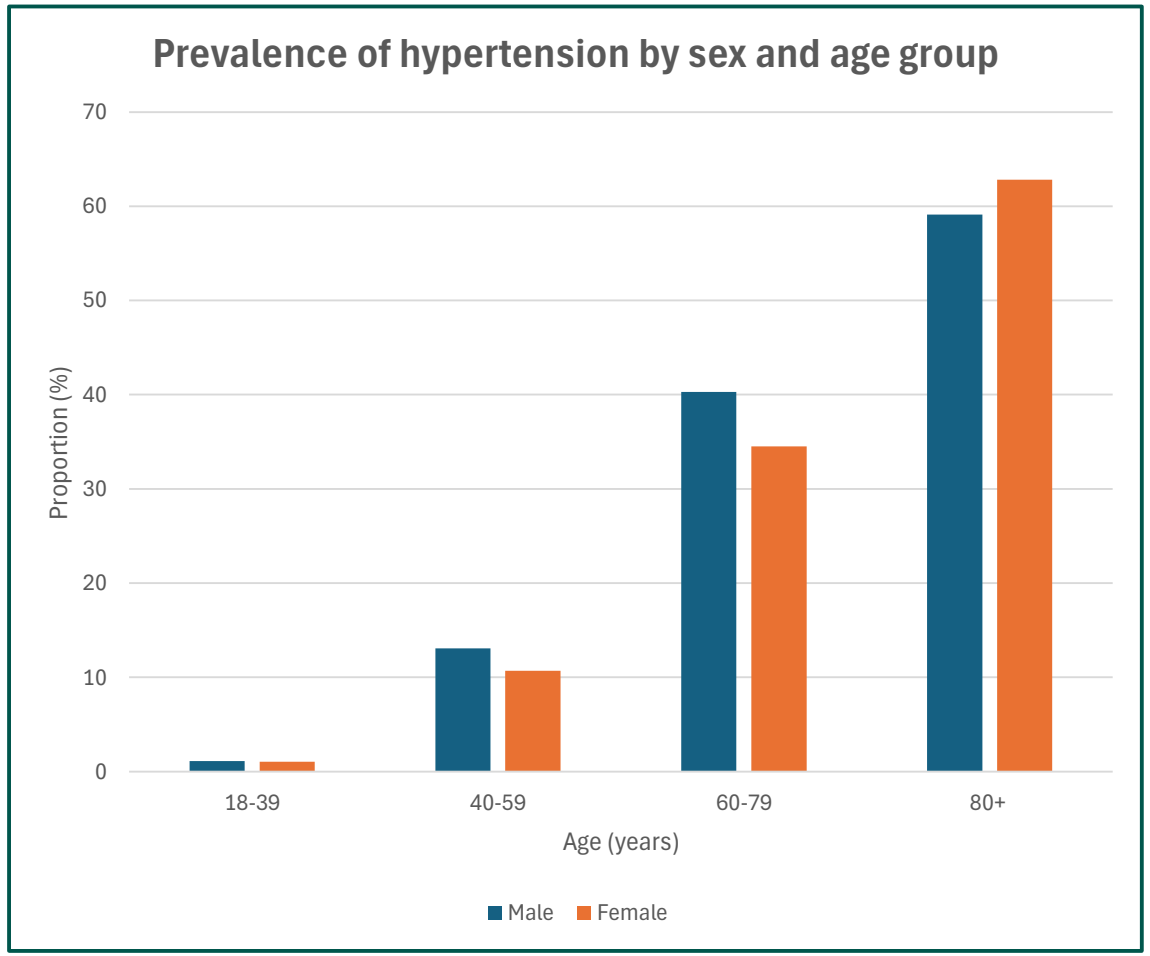
HWE ICB Prevalence of Hypertension

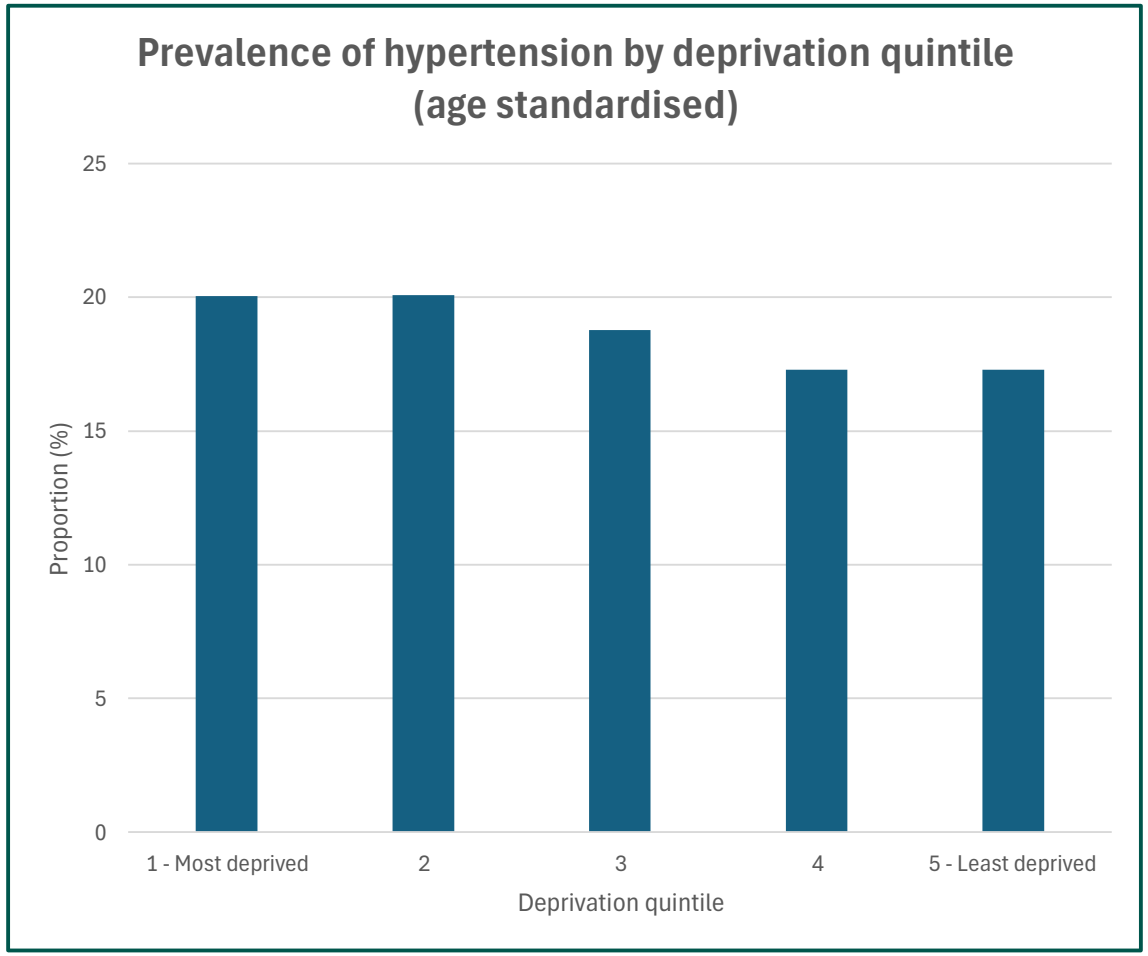




Source: Health Analytics – Mid Term Plan Dashboard

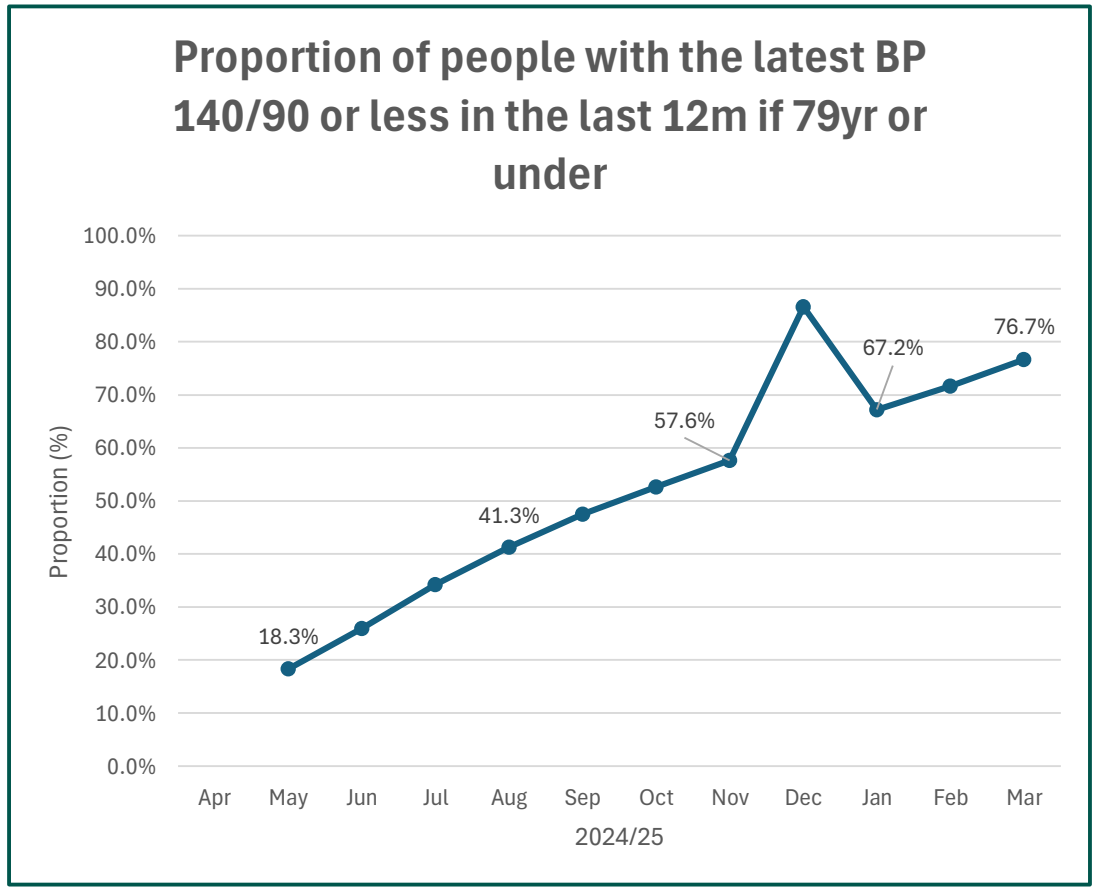
HWE ICB Hypertension Prevalence by Sex, Age, and Deprivation

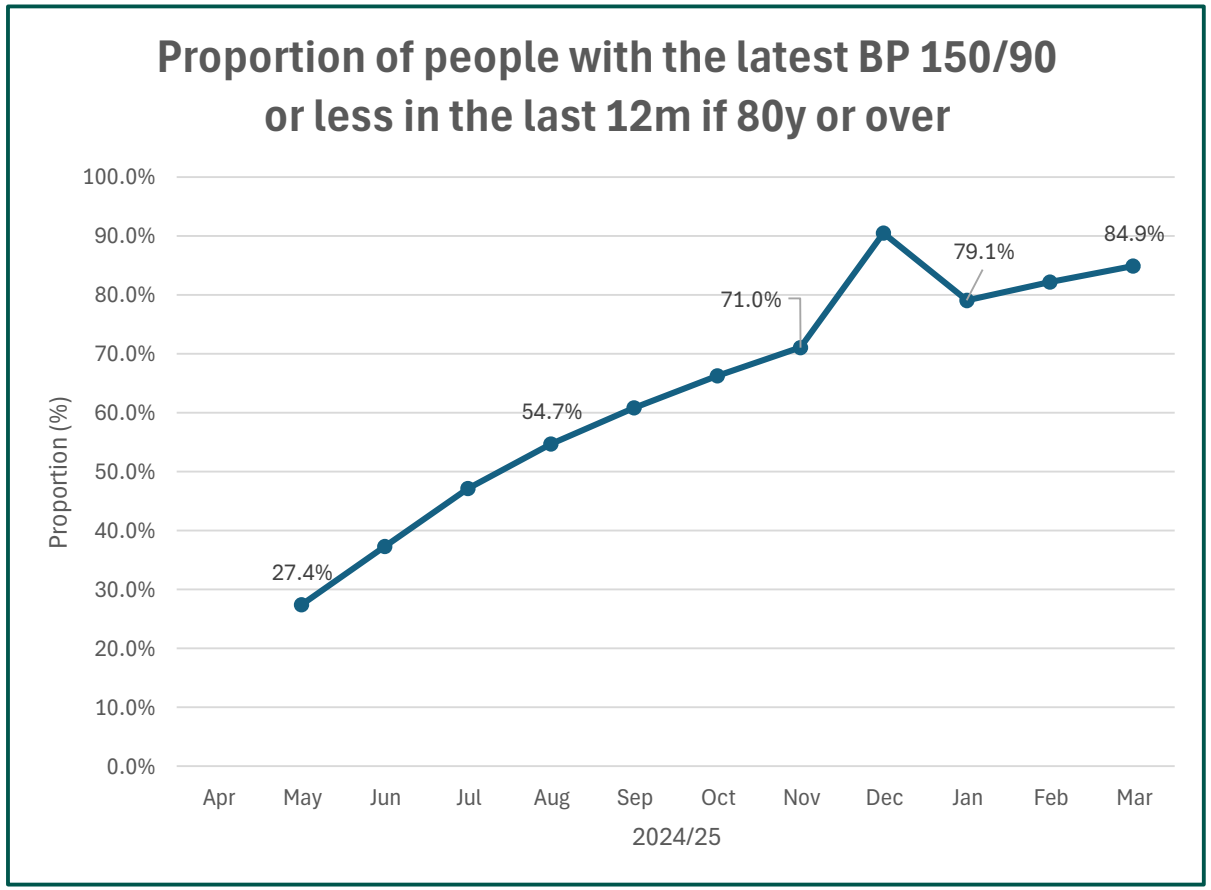




Source: CVD Prevent, September 2024

HWE ICB Treatment to target





Source: Ardens manager *(December 2024 – data point anomaly due to change in the metric).*

Awareness raising and improving access to BP checks

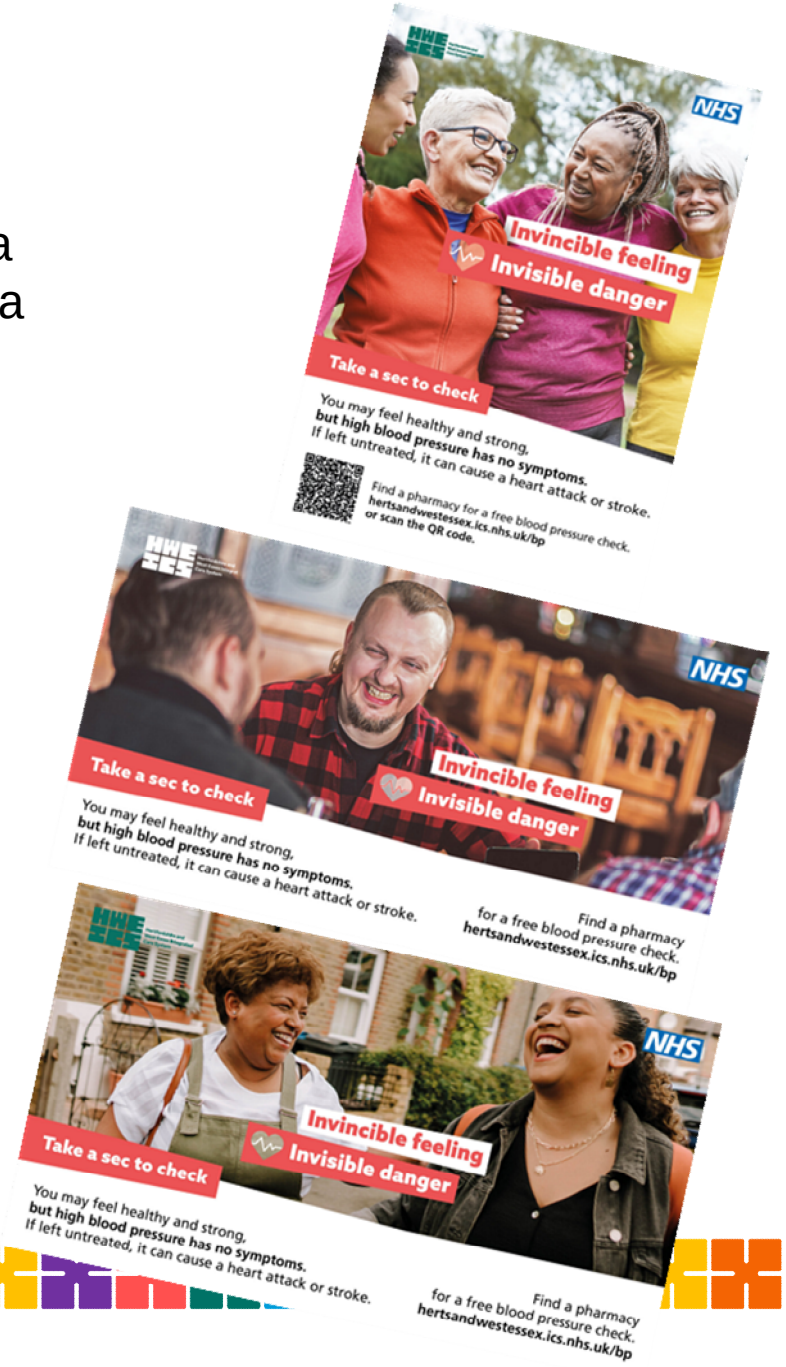
- Communications campaign
- Access to BP checks
  - Community pharmacies
  - Dental and optometry pilot
  - Community and acute providers
  - Voluntary, community, faith and social enterprise organisations

Communications Campaign

Evidence based communications campaign was launched in 2024, to raise awareness of the importance of hypertension, and encourage people to have a free BP check. The HWE ICS communication campaign has been adopted as a template by the East of England region.

The campaign included:

- Social media advertising; including targeting groups that experience inequalities such as those from Black African/ Caribbean background.
- Leaflet drops – particularly in areas of deprivation
- Advertising on buses and in bus shelters
- Events and engagements at football clubs
- GP practice waiting rooms
- Hospital waiting room screens
- Library TV screens in West Essex
- Council eNewsletters
- Media coverage (including to tie in with awareness events, such as the BHF's Heart Month)



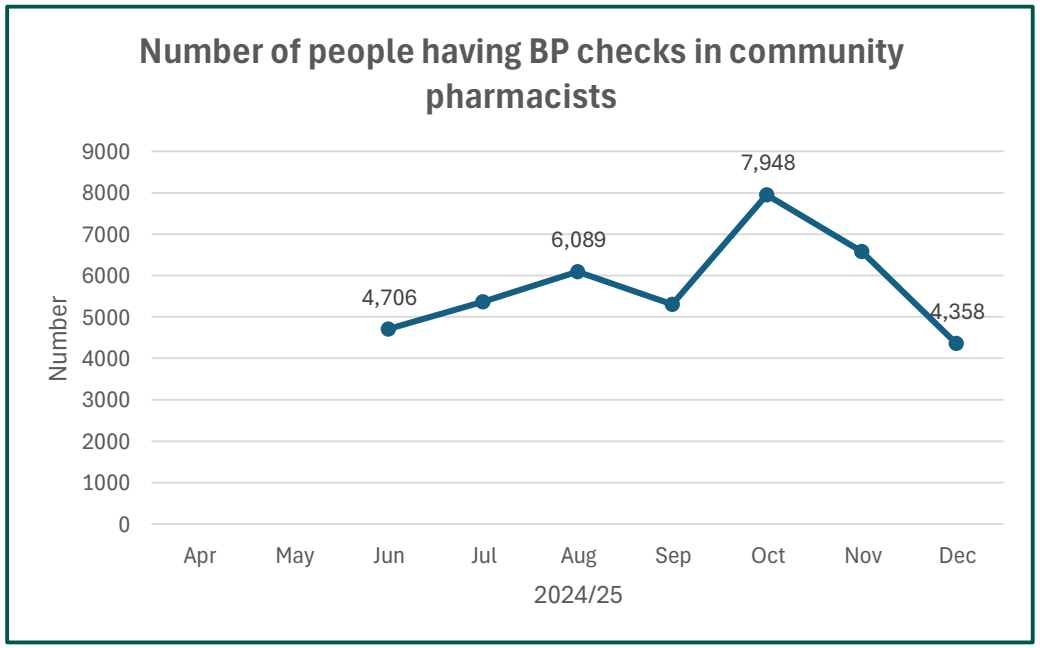
Improving access to BP checks

To improve access to BP checks to support the communications campaign, the number, location, and variety of organisations offering BP checks in the community has increased. These include community pharmacists, dental practices, optometrists, and voluntary, community, faith and social settings.

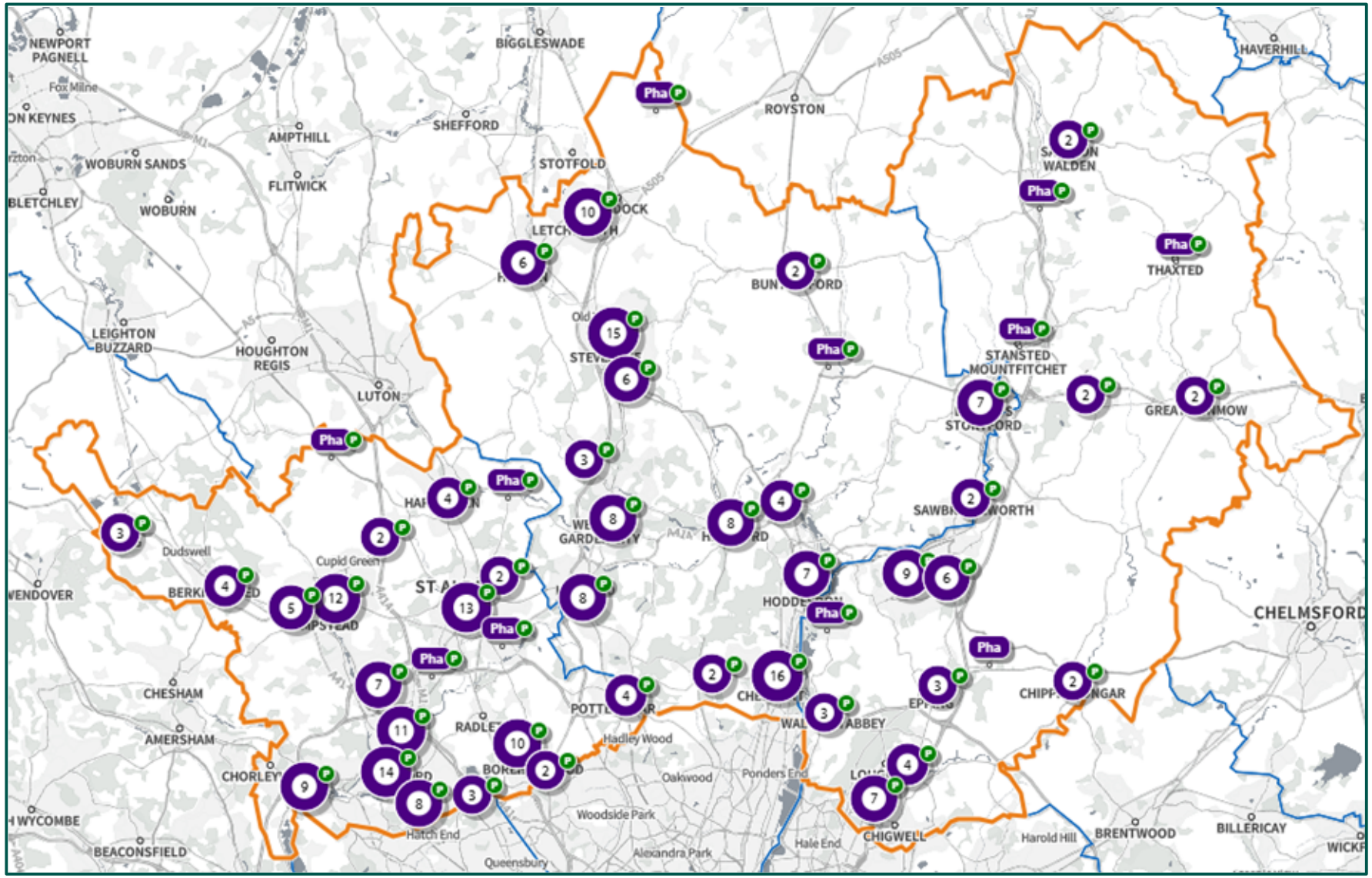
Community Pharmacists

The NHS community pharmacist BP check service supports the identification of people with undiagnosed hypertension, targeting people 40 years and older.

- There has been an increasing trend in the number of BP checks
- 75% of community pharmacies claim for BP checks
- 35% of community pharmacies claimed for providing ambulatory BP monitoring in November 2024
- The fees have been restructured to better support the intended outcome:
  - fee for a clinic check consultation will reduce from £15 to £10
  - fee for an ambulatory blood pressure monitoring (ABPM) consultation will increase from £45 to £50.85.



Location of community pharmacists offering BP checks



Over 230 pharmacies are offering BP checks.

VCFSE sector delivering blood pressure checks

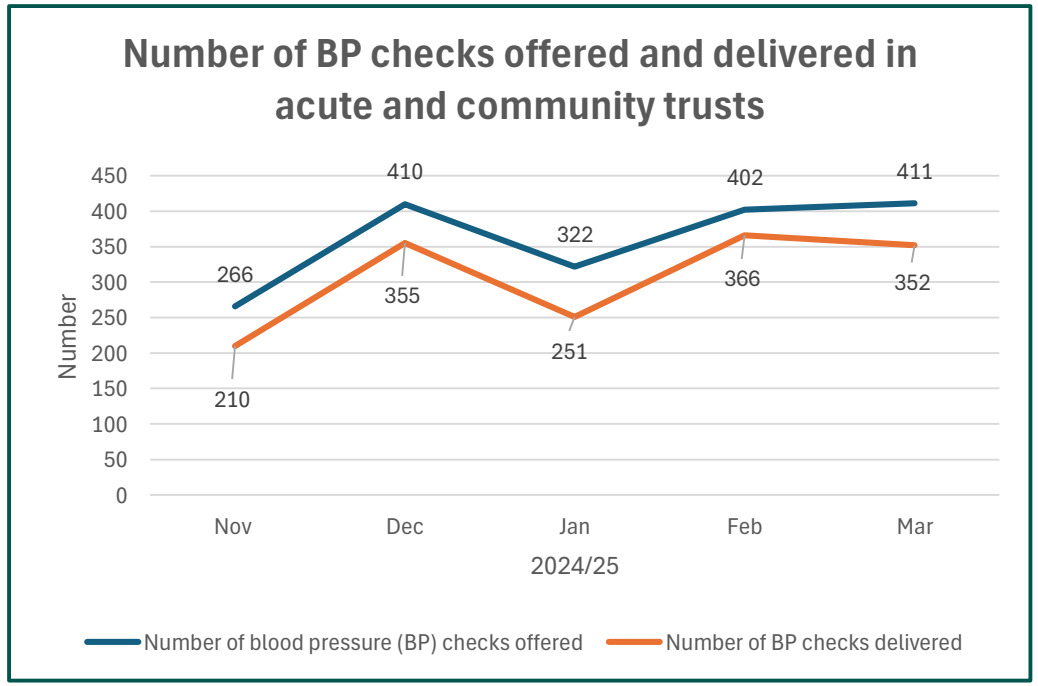
- The ICB CVD team and the ICB Inequalities team have worked with a wide variety of VCFSE sector organisations to increase access to BP checks.

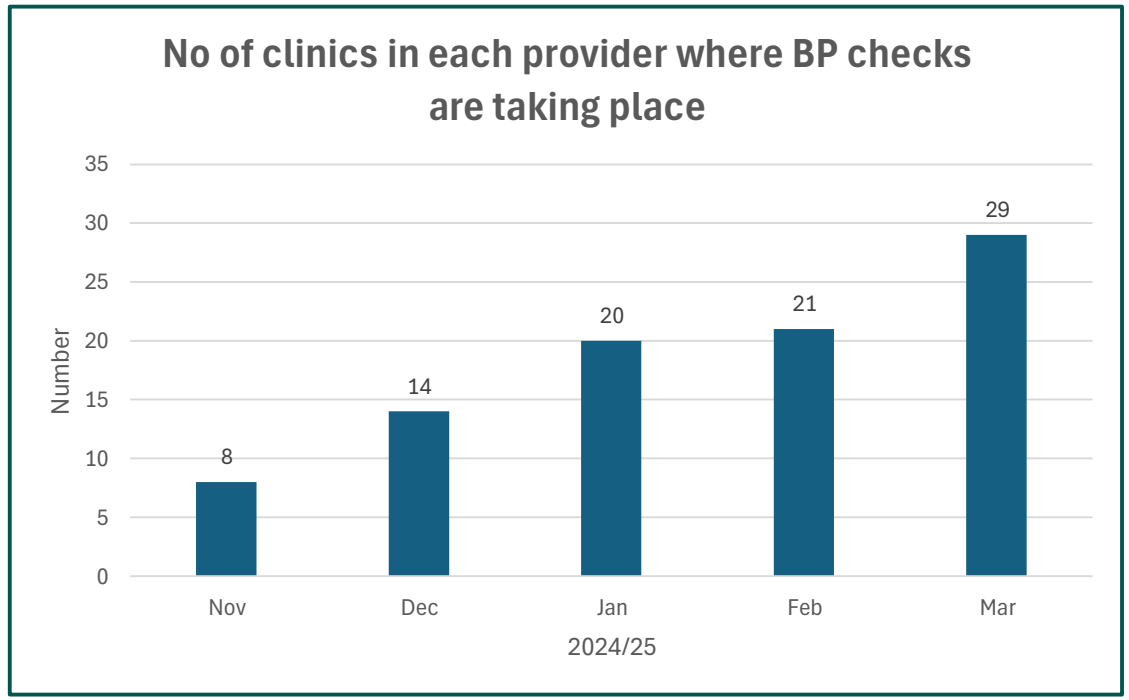
- The teams have provided BP monitors and training to different organisations. Organisations include:
  - One Vision Watford - onevision.org.uk - who support the local residents in Watford and work with all faiths and non-faiths, ethnic groups, and communities of interest on equal terms.
  - Healthy Hub (South Hill Centre)
  - DENS Nightshelter (The Elms)
  - Liberty Tearooms
  - Nigerian Church at Grovehill APG
  - Deeper Life Bible – Warners End
  - Dacorum Borough Council
  - Sunnyside Rural Trust
  - Mencap at the Roundhouse (Hemel Hempstead)
  - 4 deaf clubs across Hertfordshire
  - Community Development Action Hertfordshire - https://www.cdaherts.org.uk/

- ‘The Living Well Course’, a free course designed by a team of certified Lifestyle Medicine doctors has been offered to VCFSE based groups. Training programme consists of 4 online sessions and an in-person training day, taking place in April across Herts and West Essex and will help people improve their health and reduce their risk of lifelong problems.

Acute and Community Trusts

- All the community and acute trusts in HWE are offering BP checks in various settings and clinics.
- Each trust has identified clinical champions who have been working with the ICB and leading on the project within their trust.
- Staff are utilising Make Every Contact Count (MECC) approach.
- West Herts Hospital Trust have established a mechanism to include BP readings in outpatient clinic letters to aid coding in primary care.





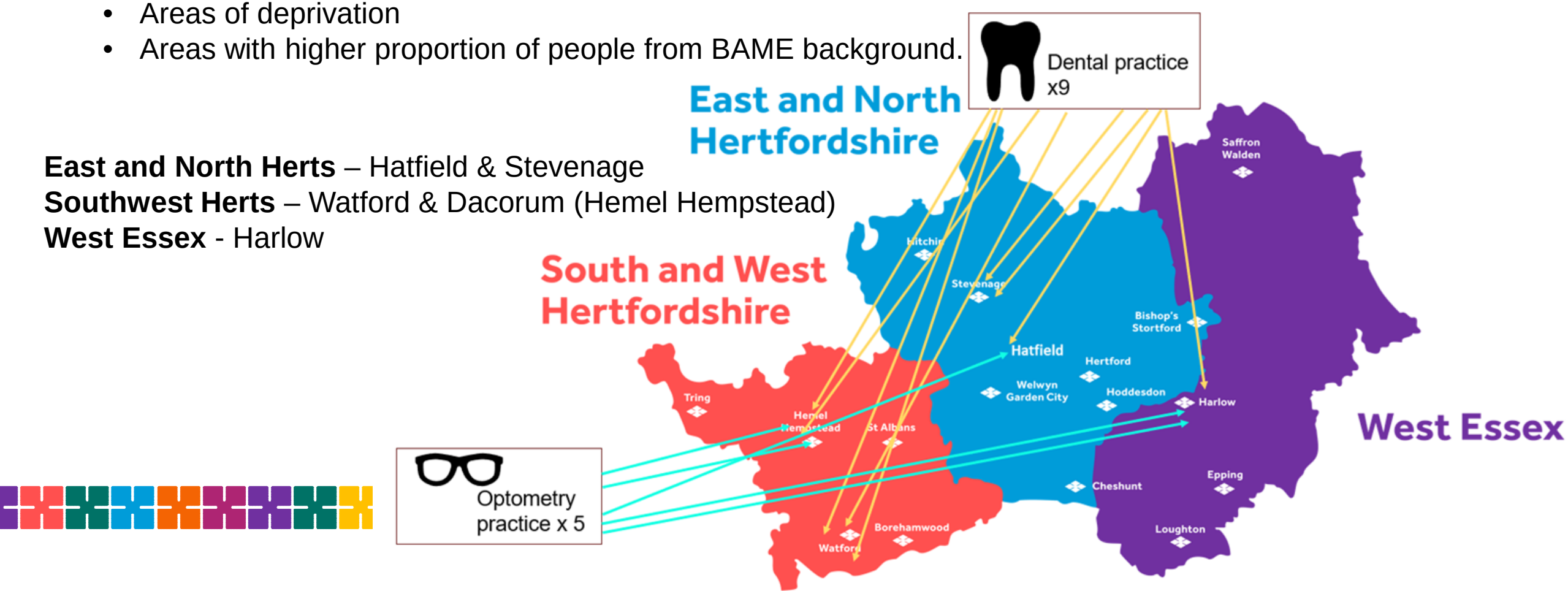
BP checks in dental and optometry practices

- In 2024, Hertfordshire and West Essex ICB submitted a bid to NHSE for funding to establish locally commissioned hypertension case finding pilots in dental and optometry services.
- The Hertfordshire and West Essex ICB was one of two ICBs in England to submit successful bids for both dentistry and optometry.
- Funding: £50K for dental practices and £60K for optometry practices.
- The funding is available for:
    - Purchase of equipment
    - Incentive payments
    - Staff training
    - Evaluation.

Dental and Optometry Practices

- 9 Dental practices and 5 optometry practices.
- Criteria for choosing practices:
  - Aim for 2-3 practices in each Place
  - Low prevalence of hypertension
  - Low BP check coverage
  - Areas of deprivation
  - Areas with higher proportion of people from BAME background.

East and North Herts – Hatfield & Stevenage
Southwest Herts – Watford & Dacorum (Hemel Hempstead)
West Essex - Harlow



Our approach

- Worked closely with a wide range of stakeholders, including the Regional team and across the ICS.

- Healthwatch undertook an engagement project with people with lived experience, to inform final specification and SOP for the service.

- Each participating dental practice/optometrist would receive:
  - A small number of digital blood pressure monitors for use in clinic.
  - Training for staff, via ICB Training Hub in how to consent patients, take blood pressures, what action to take based on reading, and offering lifestyle advice (MECC principles)
  - Set up payments of £440 (for parity with pharmacy offer)
  - Incentive payment of £15 for each check completed (for parity with pharmacy offer)
  - Provider is required to report activity by completing and providing a minimum data set monthly (as per signed MOU)

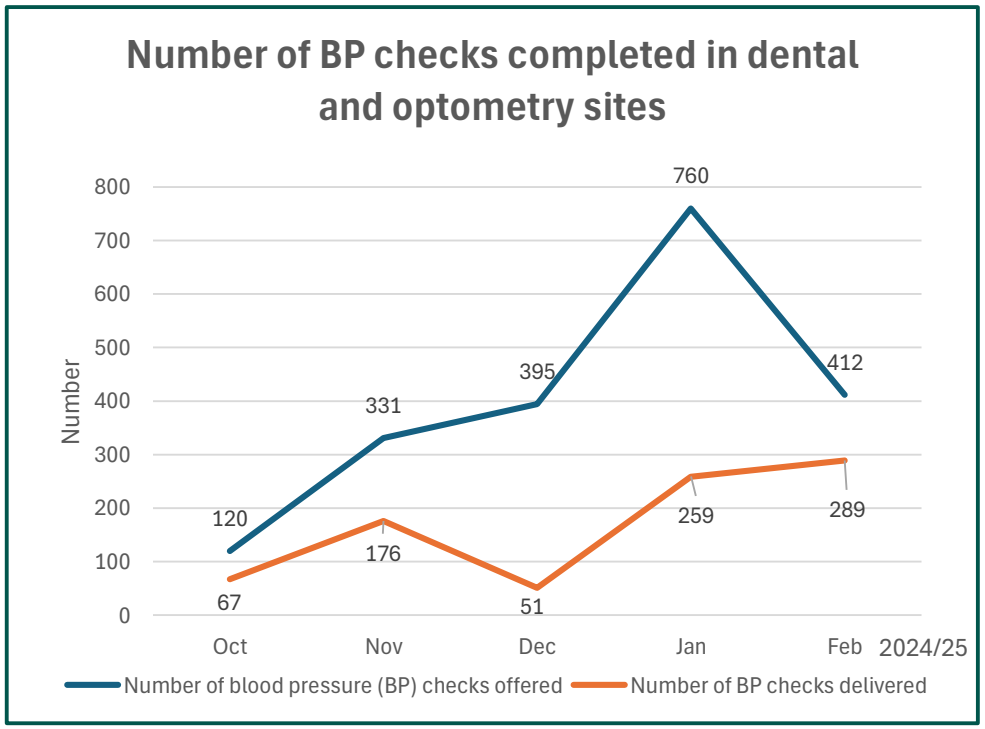
- Clear inclusion and exclusion criteria, and clinical pathway.

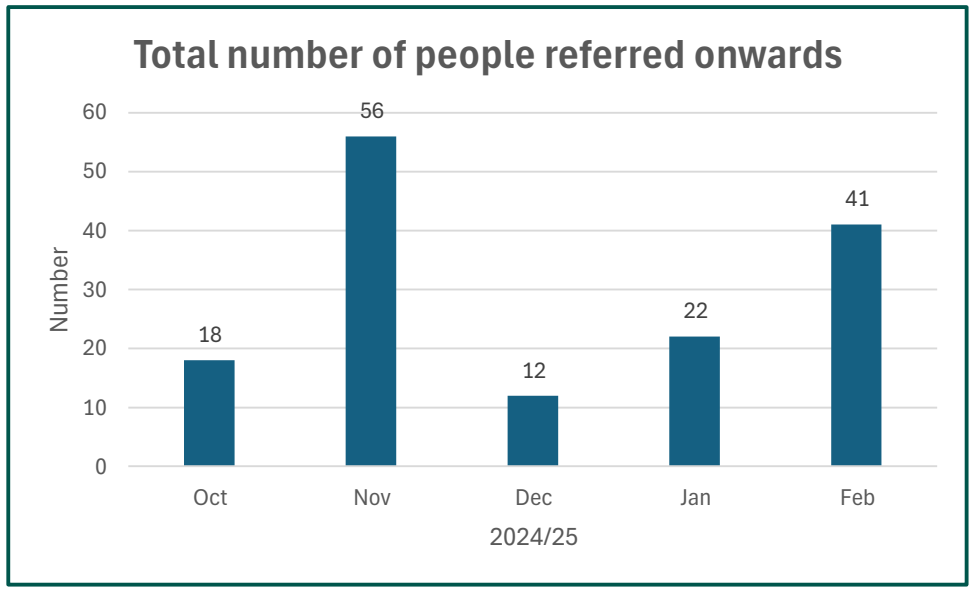
- Practices started offering BP checks in October 2024.

- Monthly meetings with the providers; an opportunity to share successes and challenges.

- Evaluation of the programme: University of Hertfordshire is completing a local evaluation, and the ICB are submitting data for the NHSE evaluation.

Number of BP checks by dental and optometry practices





- Since the launch, 41.7% of people offered a BP check accepted, and 70.1% of people accepted in February ‘25.
- 10.8% of people who receive a BP check require an onward referral.

Phase 2 of the pilot – 25/26:

- 10 dental and optometry providers have been confirmed for phase 2 of the pilot for 2025/26.
- Phase 2 will run from 1 April – 31 August 2025.
- The ICB plan to host a local “community of practice” meeting with our appointed providers in late April 2025, to offer the opportunity to share best practice, good news stories, ideas on how uptake can be increased.
- Practices that are part of this will be set targets based on their previous uptake.

Improving hypertension diagnosis, monitoring and coding

- Hypertension insight packs
  - Developed for PCNs and practices to use to identify areas for improvement. Contains data on prevalence of hypertension, number of people with raised latest BP reading and not coded as hypertension, and treatment to target.
- Targeted practice visits
- Enhanced Commissioning Framework (ECF)

Hypertension Detection And Treatment To Targets in General Practice

- Work with HWE ICS practices started in 2023/2024 when we visited (and re-visited after 6 months) top 11 GP practices with the lowest prevalence for hypertension and the highest index of deprivation in the ICS.
- 60% of the GP practices improved their hypertension detection rates by working with their clinical pharmacist in the community, voluntary groups and patient groups; learning from the visits was shared at the Locality/PCN meetings
- **November 2024**: the ICB cardiovascular and Population Health Management teams reviewed local data and identified that there were a high number of patients who had submitted an elevated home, ambulatory or 24-hour BP reading but were not diagnosed with hypertension
- The team summarised the findings and, between **December 24 to the end of January 25**,presented the key messages and the data to clinical and non-clinical meetings across the 3 places in the ICS, emphasising the significant variation in performance across our patch, the work needed to be done, and the support offered by the ICB to move closer to targets.

Hypertension Detection – Key Messages Delivered to General Practice

- Only half of the estimated number of people with hypertension in HWE ICS have a recorded diagnosis (53.1%). Rates for blood pressure checks for those over 45 are lower than nationally and have not yet recovered to pre-pandemic levels
- There are no significant inequalities in the prevalence of HT. Those in most deprived areas are more likely to be diagnosed with HT at a younger age. Those from black and ethnic backgrounds and deprived groups have lower rates of annual BP checks and are therefore less likely to achieve BP targets.
- HT detection is a requirement under GMS contract (detect/diagnose/treat/prevent) and HT recording is a data quality requirement in all GP contracts: GMS, QOF, ECF.
- There are medicolegal implications of failure to diagnose and treat adequately with documented legal cases of patients who had suffered catastrophic ischaemic events as they weren't timely diagnosed and treated despite high blood pressures being documented in their records
- CQC – uses disease prevalence as a quality indicator when assessing practice's performance
- Poor prevalence rates affect GP surgeries' income and help exists from HWE ICB and Ardens with HT detection, including the published PHM PCN Hypertension packs

Example of Data Presented to Practices: Prevalence and number of patients on hypertension register by GP practice (SWH)

GP Practice	HTN Register Prevalence (% of total registered population)	Number of people on Hypertension Register
Vine House Health Centre	18.4%	1985
Grove Hill Medical Centre	17.4%	896
Parkwood Surgery	16.8%	3027
Parkfield Medical Centre	16.5%	2114
Schopwick Surgery	16.3%	2443
Little Bushey Surgery	16.2%	1029
Archway Surgery	16.1%	432
Consulting Rooms	16.1%	1074
Rothschild House Surgery	16.0%	6957
New Road Surgery	15.9%	2243
The Colne Practice	15.8%	1633
Gossoms End Surgery	15.7%	507
Midway Surgery	15.5%	2110
Highview Medical Centre	15.4%	1553
Annandale Medical Centre	15.4%	1188
Haverfield Surgery	15.0%	562
Suthergrey House Medical Centre	14.9%	1328
Everest House Surgery	14.7%	2161
Village Surgery	14.5%	2263
Sheepcot Medical Centre	14.4%	1561
Fairbrook Medical Centre	14.3%	2042
Abbotswood Medical Centre	14.2%	691
Lincoln House Surgery	14.2%	3262
Lodge Surgery	14.1%	2817
Chorleywood Health Centre	14.1%	1042

GP Practice	HTN Register Prevalence (% of total registered population)	Number of people on Hypertension Register
The Red House	14.0%	2647
Fernville Surgery	13.9%	2471
Bennetts End Surgery	13.8%	2110
Harvey Group Practice	13.8%	1997
Gade Surgery	13.6%	1664
Summerfield Health Centre	13.5%	1394
Grange Street Surgery	13.5%	1430
Kings Langley Surgery	13.3%	2052
Manor View Practice	13.2%	6281
Attenborough Surgery	13.2%	4346
South Oxhey Surgery	13.0%	537
Garston Medical Centre	12.9%	1624
The Manor Street Surgery	12.5%	1549
Bridgewater Surgeries	12.4%	4363
The Grove Medical Centre	12.3%	1598
Watford Health Centre	11.8%	2299
Elms Medical Practice	11.6%	1982
Parkbury House Surgery	11.2%	2512
Davenport House Surgery	10.6%	1354
Maltings Surgery	10.3%	1898
Woodhall Farm Medical Ctr	10.3%	341
Verulam Medical Group	9.7%	704
The Elms Surgery	9.3%	830
Hatfield Road Surgery	9.0%	470

Additional Support for GP Practices Presented at Place Meetings

1.Engaging with community pharmacies:

- What they offer: GP practices can refer any patient over 18 for a BP or an ABPM check at a community pharmacy that has registered to provide the advanced hypertension case finding service.
- Participating practices can be found here: Find a pharmacy that offers free blood pressure checks - NHS
- The specification for the service, including the recommended care pathway is here:

NHS England » NHS Community Pharmacy Blood Pressure Check Service

- **2.Raising patient's awareness:**

High blood pressure - Herts and West Essex ICS

3.Clinical Fellow: Dr Nisha Santhirarajah – to work with selected practices to support them using Ardens to improve data quality, risk detection, management plans

GP Practice Visits February – March 2025

- Using practice level data, we identified the GP practices with a high number of people who had an elevated BP reading but no diagnosis of hypertension, a low hypertension prevalence or both. In total 45 practices were identified as having significant opportunity.
- The 45 practices were sent a letter on 5th February 2025 highlighting this opportunity and a request to arrange a visit.
- The agenda for the meeting with the GP Practice's teams included, but was not limited to the following:
  - *Review main areas for improvement with personalised data for their practice*
  - *Discuss current systems in place in practices to aid with hypertension detection*
    - *how are practices coding and actioning BP readings from hospital outpatient letters*
    - *how are practices coding and actioning BP readings sent in from patients*
  - *Identify current barriers for those practices to be able to discuss solutions*
  - *Guidance on how to extract this data from Ardens Manager*

GP Practice Visits February – April 25 - Summary on 7th April 2025

	South and West Herts	East and North Herts	West Essex
Practice Visits Planned	18	18	9
Practice Visits Done	9	2	0
Practice Visits Booked To Be Done	5	7	4
Practice Visits Declined or No Response (data will be rerun for these in June 25 and the practices will be contacted if no improvement noted)	4	9	5

GP Practice Visits: Impact

- The CVD and PHM teams have reviewed the data following these visits to assess the impact on diagnosis and if there are changes to the number of people who have potentially undiagnosed hypertension

The findings demonstrate that:

- The case finding searches are an effective way to identify undiagnosed hypertension.
- Following the visits, **80%** of the practices were able to significantly increase the number of people included on the register and reduce the number of people who had a high BP reading but were not diagnosed with hypertension.
- Presenting at locality meetings, sending targeted letters, and offering practice visits has significantly increased hypertension diagnosis.
- Scaling this across the whole ICB would potentially result in an additional 13,000 diagnoses (even accounting for only 80% engagement). If 80% of these people are subsequently treated to target, this would result in **105 fewer heart attacks, 157 fewer strokes and 105 fewer deaths over the next five years**

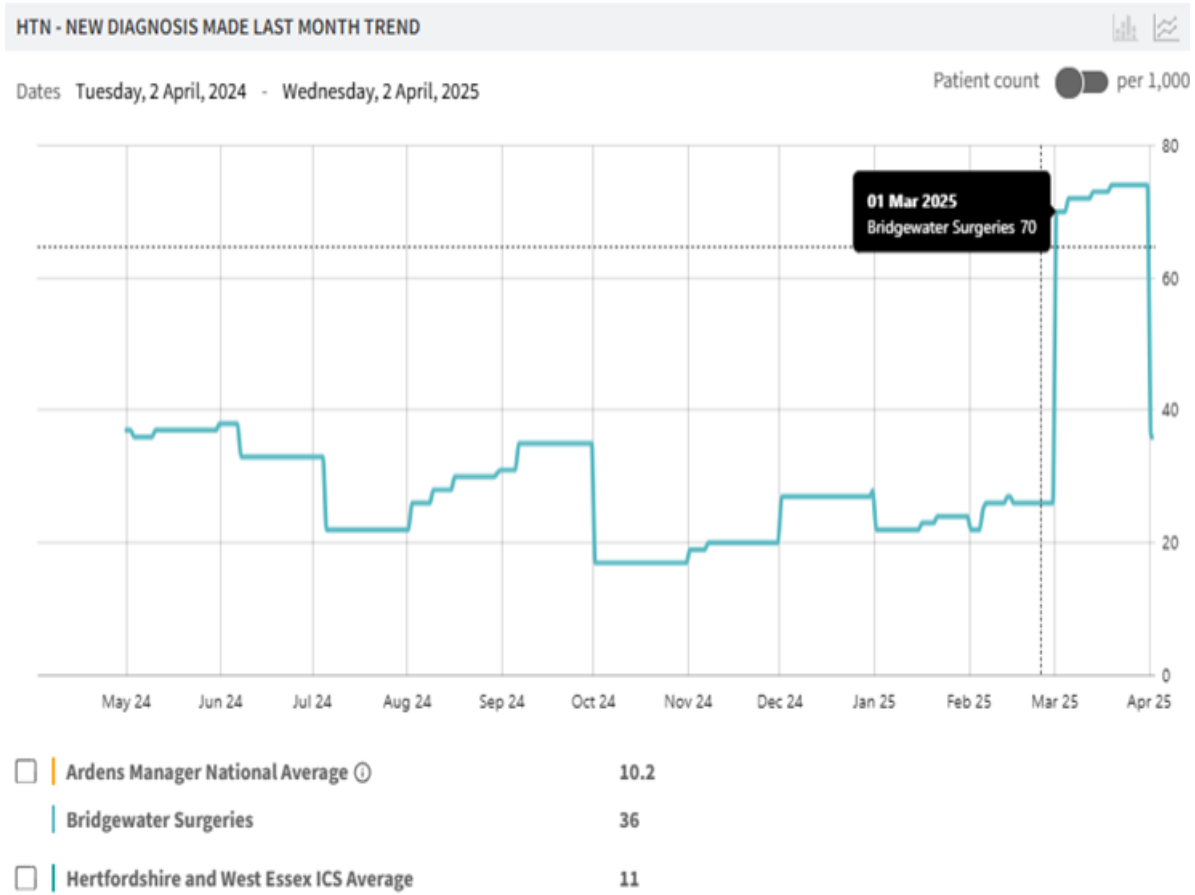
GP Practice Visits – Example 1

Bridgewater surgeries (SWH)

Bridgewater Surgeries is a large practice in SWH with a registered population of 35,681 (March ’25) and a hypertension prevalence of 12.0% (March ’24).

The practice was identified as it had a lower than expected prevalence and a high proportion of the registered population on the case finder search.

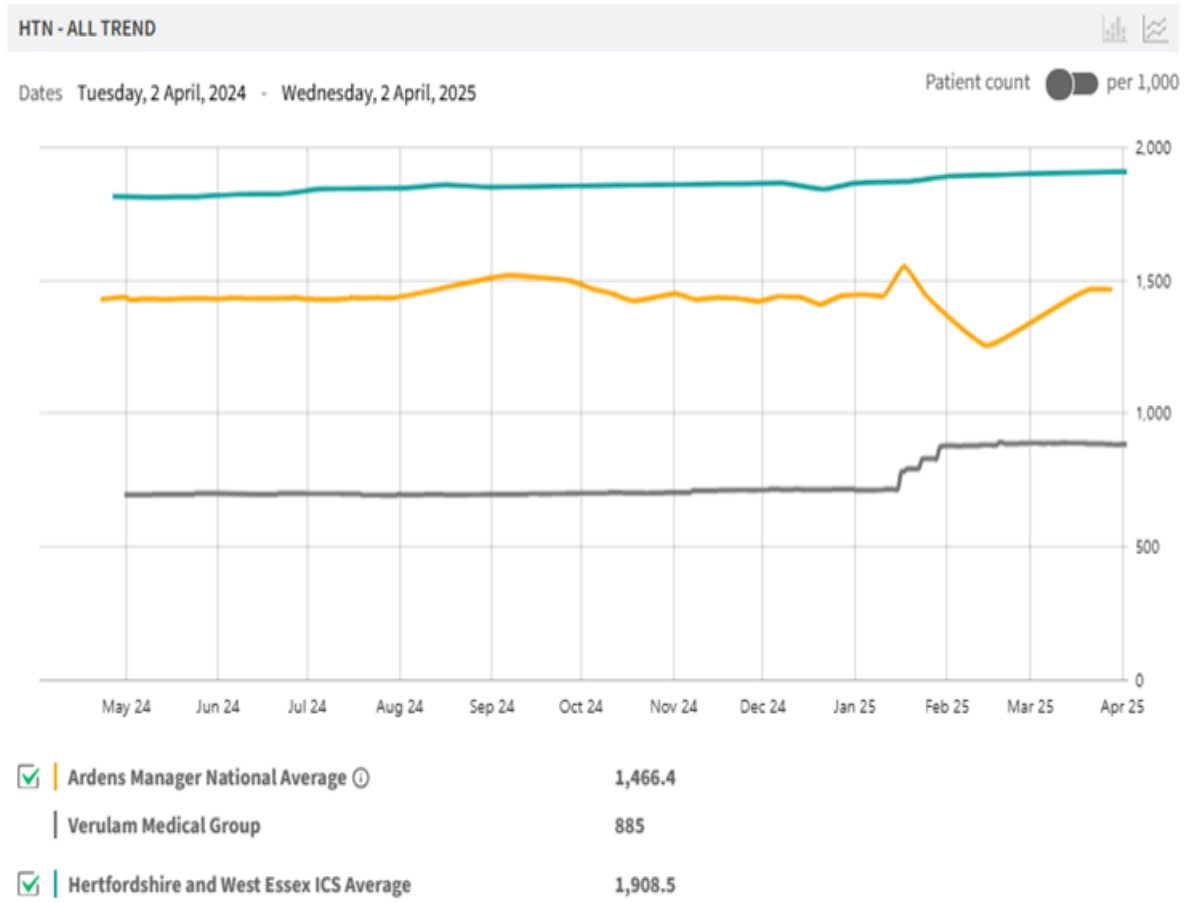
- The practice visit took place on 18th February 2025 and the practice has subsequently increased the number of people on the hypertension register by an additional **137 patients** (compared with 31st January 2025) representing an increase of 0.7% in the prevalence.



GP Practice Visits – Example 2

Verulam Medical Group is a small practice in SWH with a registered population of 7,273 (March ’25) and a hypertension prevalence of 15.0% (March ’24). The practice was identified as it had a lower than expected prevalence and a high proportion of the registered population on the case finder search.

The practice visit took place on 13th February 2025. The data show that the practice began addressing the low prevalence prior to the practice visit, following presentations at locality meetings during January. There has been an increase in the number of people diagnosed with hypertension. Between 31st December ’24 and 1st April 2025, the practice has increased the number of people on the hypertension register by an additional **169** patients representing an increase of 2.7% in the prevalence



GP Practice Visits – Example 3

Vine House Health Centre

Vine House Health Centre is a medium sized practice in SWH with a registered population of 10,694 (March ’25) and a hypertension prevalence of 18.0% (March ’24). This practice had the highest prevalence for hypertension in SWH Place.

The practice was identified as it had a high proportion of patients on the case finding searches.

The practice visit took place on 18th February 2025 and the practice has subsequently increased the number of people on the hypertension register by an additional **122 patients** (compared with 31st January 2025) representing an increase of 1.8% in the prevalence

GP Practice Visits – Key Messages Post - Visits

- We recognise the significant time and effort that the teams in our GP Surgeries are putting into this important piece of work. Additional clinics for diagnosing and monitoring hypertension have been put in place in many surgeries in our system. Admin staff have been trained to adopt new protocols that include frequently running case finder searches and flagging patients needing review due to their high blood pressure readings.
- Practices have requested better integration of the IT systems and streamlining of Ardens data so that Ardens Manager (used by the ICB to extract data) is in sync with EMIS/S1 Ardens to facilitate easy detection of patients that require prompt follow up.
- Increase patient's awareness of the importance of hypertension detection and treatment as many practices are reporting that patients do not attend invitations for monitoring blood pressure. Support from patient's groups and voluntary organisations needs to improve so that hypertension treatment targets are achieved.
- Sharing experience on improved hypertension detection across PCNs and Neighbourhood Teams needs to be planned and so that struggling practices can learn from colleagues so addressing variability.

Hypertension Detection in General Practice – Next Steps

- Complete all planned practice visits by the end of May 2025.
- Re-run of data by June 2025 and approach practices that have not shown improvements.
- Aim to embed a systematic process within every visited practice to continually review case finding searches and diagnose hypertension as this will further increase the prevalence.
- On going work with all practices and continuous monitoring of data as there is opportunity to further increase prevalence using the case finding searches, with a high number of patients still identified as having a high BP reading and no diagnosis of hypertension.
- **ECF 2025/2026** (local incentive scheme) change of indicator to incentivise and reward GP practices for improving hypertension detection: (21 ECF point). This change has been based on the data from previous year showing that practices who opted to work on hypertension prevalence have increased it by 0.89% compared to 0.47% in practices who didn't.

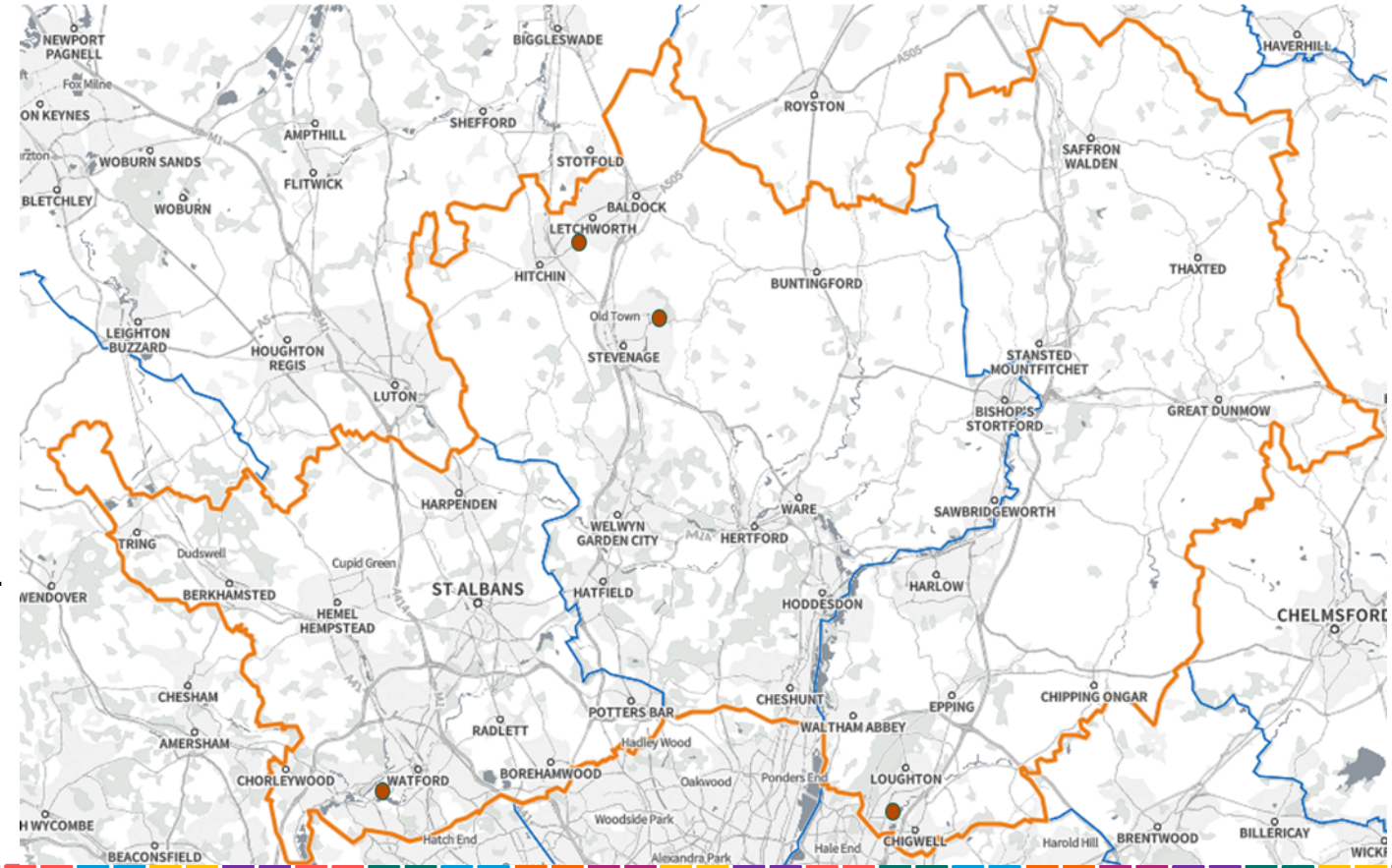
ECF-DD01. The percentage change in hypertension prevalence from baseline (March 2023 QOF prevalence). Where the prevalence is 18% or more the practice will need to maintain the prevalence between the start and end of the year. Where the prevalence is 15-18%, practices will receive full points if prevalence is 18% or more by the end of the year.

Optimising management – treat people with hypertension to target

- Community Pharmacy Pathfinder project
- Quality Outcome Framework
- Regional prescribing guidance on hypertension management

Community Pharmacy Pathfinder programme

- National programme for community pharmacists with independent prescribers, there are three clinical models including a hypertension model.
- Five practices in HWE ICB have signed up to the programme, with four practices delivering the hypertension clinical model.
- The clinical model includes initiating treatment for non-complex patients with hypertension and dose adjustment for previously diagnosed non-complex patients.
- All practices are assigned a GP practice.
- The programme is newly launched, and the ICB are monitoring its impact.
- There has been a total of 759 consultations undertaken by participating community pharmacies from 30 September 2024 to 25 March 2025 for the pathfinder programme in HWE. The majority of consultations & prescribing undertaken from the community pharmacy independent prescribing pathfinder sites has been for minor ailments (as we initially started with this model then rolled out to the others). According to the data, there has been five consultations so far for the hypertension clinical model.



Quality Outcome Framework

- National incentive programme for primary care.
- Two metrics for age-specific target to treatment:
  - Patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less
  - Patients aged 80 years and over with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less
- ICB monitors the achievement of these targets, and supports practices to increase achievement during targeted practice visits.
- A large number of QOF points are being re-purposed in 25/26 towards cardiovascular disease to help achieve the national ambition of reducing premature mortality from heart disease or stroke; the allocated points and upper thresholds for both of the hypertension management indicators are increasing for 25/26.

Regional prescribing guidance on hypertension management

- The regional CVD team have developed prescribing guidelines for rapid optimisation of hypertension management.
- The ICB CVD LTC and Prescribing and Medicines Optimisation Teams are reviewing the guidelines, and will take the guidelines through appropriate governance routes as required.

NHS Health Checks

- Local authorities are responsible for making provision to offer an NHS Health Check to eligible individuals aged 40-74 years once every five years.
- The Health Check programme aims to prevent heart disease, stroke, type 2 diabetes and kidney disease, and raise awareness of dementia both across the population and within high risk and vulnerable groups.
- The NHS Health Check measures 7 key indicators, one of these being blood pressure.
- In Hertfordshire, of the 23,525 health checks delivered in 2023-2024, there were almost 500 people identified with hypertension, all of whom were offered lifestyle advice and referred to their GP for further investigation and clinical support.
- In West Essex, 5,867 health checks were completed April 2024 - March 2025

Training

- During 2024/25 several courses were offered as part of the ICB Training Hubs core training offer relating to Hypertension. These courses were commissioned to support the hypertension asks within the ECF, but were also commissioned due to intelligence acquired as part of our Training Needs Analysis.

- The courses commissioned during the 24/25 financial year include: Essentials of Hypertension; Hypertension Masterclass; Long Term Conditions (10 Min Review); Long Term Conditions for HCAs and Understanding Preventable Diseases for HCAs. 22 staff attended these courses, with the majority staff group being HCAs (14) and Nurses (5), with the remainder being care navigation, pharmacy and phlebotomy staff.

- For 2025/26, the Primary Care Workforce Team is currently organising the training programme for the primary care workforce. The team are currently booking places on the following courses: Essential of Hypertension; Advanced Management of Cardiovascular Disease and Long-Term Conditions for HCAs (covering cardio/hypertension). The team are also looking to commission some ECG training for both HCAs and clinical staff to support an increase in demand for this course option in 2024/25. Budget dependent, the ICB will also consider individual requests for Hypertension related training as a priority for area of approval for the 25/26 financial year.

- The ICB Primary Care Training Hub facilitated a short (1.5 hour) training session to each of the participating dental and optometry practices who were part of the BP check pilot. The Hub supported the recruitment of the trainers, and training material was provided by the ICB CVD LTC Team – the trainers (a number of GPNs from HWE practices / PCNs who had previously worked as GPN PCN education team leads), then delivered these training sessions to optometry and dental sites.

Next steps

Work will continue to achieve the MTP priority (reduce inequality with a focus on outcomes for CVD and hypertension) and the three key indicators.

- The communications campaign for hypertension will continue across the ICS, and the communications team will work with region to develop a regional communications campaign.
- Dental and optometry providers will continue to deliver BP checks in phase 2 of the pilot.
- Continue to work with GP practices to increase case finding through reviewing patients identified as having a high BP reading and no diagnosis of hypertension.
- The ECF 2025/26 indicator to incentivise GP practices to increase the prevalence of hypertension.
- To work with the regional team on the New Care Model for CVD.
- To work with Hertfordshire County Council to increase the uptake of NHS Health Checks

Appendix – Case Studies

Blood pressure checks across primary care

Improving access and making every contact count

Invincible feeling

Invisible danger

GENERAL PRACTICE

Offering blood pressure checks as part of routine appointments with practice staff. Some self-service machines available.

PHARMACY

Around **200** pharmacies across Hertfordshire and west Essex offering an average of **5,000** blood pressure checks each month.

DENTAL PRACTICES

9 NHS dental practices taking part in pilot programme. So far, **333** blood pressure checks carried out with **72** patients signposted on for further support with their high reading.

OPTICIANS

5 opticians taking part in pilot programme. So far, **220** blood pressure checks carried out with **36** patients signposted on for further support with their high reading.

“Patients are interested in having it done and admit they may not have found the time to do it otherwise.”

Dr Sonal Patel – Principal Dentist
Broadwater Dental Practice
Stevenage

Invincible feeling

Invisible danger

> As Optometrists we ask about a patient's family history, and symptoms they may be experiencing, as well as examine blood vessels at the back of the eye...

Invincible feeling

Invisible danger

> “...this puts us in an excellent position to advise a patient to have a blood pressure check.”

Neha Patel – Optometrist, Specsavers Harlow

Invincible feeling

Invisible danger

“Offering this service in an opticians allows people to check an important aspect of their health in a setting they already visit, making preventative care more convenient.”

Selina Holmes – Optometrist, Specsavers Hemel Hempstead

Invincible feeling

Invisible danger

“Men, in particular, are reluctant to visit their GP and get their blood pressure checked, so the introduction of free, NHS-backed blood pressure checks is an incredibly welcome addition to the many NHS services we can offer.”

Amit Patel – Pharmacist
Letchworth Pharmacy

Invincible feeling

Invisible danger

Blood pressure checks at Crescent Pharmacy, Hertford

Situation/Setting

- *Crescent Pharmacy in Hertford, alongside many other pharmacies across Hertfordshire and West Essex offer walk in blood pressure checks to patients as part of the NHS pharmacy advanced service.*
- *Some pharmacies, including Crescent Pharmacy, also offer Ambulatory Blood Pressure Monitoring(ABPM) as part of this service.*

Actions/Activity

- *Walk in blood pressure checks, in line with the advanced service specification, are available every day, however the team at Crescent Pharmacy aim to increase promotion of these on a couple of days each month – this includes having team members either out the front or inside of the pharmacy sharing promotional materials, as well as using social media to promote the service – an example Facebook post can be found to the right of this text.*
- *The pharmacy ensure that results are shared with the patient, as well as the relevant GP practice via PharmOutcomes. In addition to this, the pharmacist ensures that, where there may be a particular concern, an email is also sent to the GP practice to highlight this, supporting the patient and joint working between the pharmacy and GP practice.*

Learning

- *The pharmacist at Crescent Pharmacy is one of the ICBs PCN Pharmacy Integration Leads and is working with pharmacies in Hertford to encourage and support offering of the ABPM (24 hours BP service) where needed. Work is also taking place to ensure processes and steps are in place to engage with patients to encourage uptake of the blood pressure check service, as well as engaging with the local surgeries by making contact and not solely relying on the automatic messages from the IT systems.*

Impact – patient case studies

- *A female patient attended the pharmacy for some advice regarding a single bloodshot eye. After a private consultation with the patient, the pharmacist learnt that the patient was on no medication which was unusual for an eighty-two-year-old. From here, the pharmacist checked the patient's blood pressure as a part of the hypertension case finding service and found that her blood pressure was extremely high. On learning this, the pharmacist referred the patient to the local GP practice and called them ahead of her visit and emailed them with the patient's information. A week later the patient came back to the pharmacy and thanked them for the intervention and advised that she was prescribed some medication by the GP; the pharmacist later consulted with the patient and gave her some advice – as part of this the patient explained that she had been under a lot of stress recently as her husband had been diagnosed with early-stage dementia. After learning this, the pharmacy signposted the patient and provided them with organisations that could help. The patient later gave the pharmacy chocolates and a thank you card that read:* ***'Thank You so much for taking the time to help me. You and your staff's caring nature really made me feel welcome and I can't be more grateful.'***
- *A further example of tests offered via the hypertension case finding service that Crescent Pharmacy have provided includes two patients who had come in asking to have their blood pressure checked - the initial check recorded that their blood pressure was high. Instead of immediately referring the patients to the GP, the pharmacist instead provided them with the ABPM 24hr blood pressure monitor and told them to come back the day after so the pharmacy could review their blood pressure throughout the previous day. In both instances, the pharmacy was able to see from the 24hr readings that their blood pressure readings were fine and there was no need to refer them further. This saved the patients having to be referred on and removed any unnecessary burden on the GP practice.*
- *The above case studies highlight the importance of the service and how treating patients in a holistic manner is key, ensuring any abnormal results are followed up – this also notes the duty of care pharmacists have to the patient. The importance of integrated working between healthcare providers is important in providing a quality service. Community pharmacy sees a large volume of people every day, this is a great opportunity to make life changing interventions for the betterment of the patient.*

Hertfordshire and West Essex Integrated Care System

Blood pressure patient stories

The ICB website features several patient stories that outline the importance of getting your blood pressure checked, these can be found here: [Blood pressure patient stories - Herts and West Essex ICS] – please see a couple of these stories featured below:

> In the summer of 2021, while feeling totally fit and well, I suffered a stroke as a result of high blood pressure. I had never even considered that I may need to get my blood pressure checked. Fortunately I made an excellent recovery. It is important to get blood pressure checked as a preventative measure. medication can so easily prevent a catastrophic stroke.
>
> **Anne, from Tewin in Hertfordshire**

> "My blood pressure was measured at an event last summer and was slightly high. I started to get headaches during the winter and put two and two together and had it checked again. It had gone up into the range where it needed treatment. My advice would be – just find out if you have high blood pressure and deal with it, through improving your lifestyle changes and if necessary taking drugs. You might, like me, find you actually have slightly more time because you feel more energetic."
>
> **Dr Mark Lim, Associate Medical Director, Hertfordshire and West Essex ICB**

Discussion / Questions?

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐
	NHS HWE ICB Primary Care Transformation Committee meeting held in Public		**Meeting Date:**	**24th April 2025**
Report Title:	**Primary Care Transformation– Directorate Report and HCP highlight reports**		**Agenda Item:**	**4**
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 Cathy Galione, Head of Primary Care – ENH Melani Powell, Head of Primary Care – SWH Philip Sweeney, Head of Primary Care WE			
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. Launch of the Enhanced Commissioning Framework for 25/26 b. 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.			

Hertfordshire and West Essex Integrated Care System

NHS
Hertfordshire and West Essex
Integrated Care Board

Recommendations:	Committee 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		

Hertfordshire and West Essex Integrated Care System

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Primary Care Transformation– Directorate Report April 2025

Avni Shah, Director of Primary Care Transformation

Contribution from a number of leads across the directorate

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Launch of the Enhanced Commissioning Framework 2025/26

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The approach 25/26

The Enhanced Commissioning Framework (ECF) is a local funding scheme for general practice that delivers enhanced services to patients and delivers evidence based best practice.

The ECF is an important resource for improving disease detection and proactive management of people living with long term physical and mental health conditions. It delivers enhanced care, beyond national contracts and supports both the national ambition of shifts in care from acute to community and reactive to proactive, as well as local priorities outlined in the Medium-Term Financial Plan

The ECF was produced in October 2022, following an extensive review all various local enhanced/commissioned services across the previous CCG to:

- Ensure that care is in line with strategic priorities
- Ensure the specification reflects and complements wider transformation work
- Reduces Variation and drives good practice/outcomes and performance.
- Ensure that funding allocation reflects the work that practices are required with reviews identified of areas year on year.

The scheme outlines the impact it has had but acknowledges with the lack of the triangulation of the data we have not always been able to quantify all the measurable outcomes but have been able to quantify increases in prevalence through case finding and quantify the number who have had reviews completed; advance care plans, 8 care processes as an example which would all support to the delivery of the outcomes.

Integrating prescribing indicators as part of the clinical/disease pathway has been a positive rather than having a prescribing incentive scheme separate.

The approach 25/26

ECF continues to have three main sections:

A. Compliance and Engagement

First part (A.1) confirms the wider compliance and engagement requirements to support the development and integration of primary medical care.

Second part (A.2) of this section is **Pharmacy and Medicines Optimisation** which has 4 components including:

- Compliance and Engagement
- Clinical transformation – Reducing Overprescribing
- Transactional – Anticoagulation
- Shared care and specialist guided prescribing as agreed within the ICB

B. Proactive care and enhanced reviews for long term conditions: This section focusses on ICB wide agreed clinical priorities and sets out enhanced interventions and improved outcomes in several disease specific areas based on the local needs of the population and the reduction of health inequalities working in partnership with system partners through PCN networks, locality delivery/transformation groups etc.

Transactional Services: This section sets out a package of enhanced services that are to be provided either from individual practices or where practices share this resource to deliver through PCN/locality to manage capacity and demand but also the maintain the skills in some cases. This includes provision of ECGs, wound care management, spirometry, ear syringing, ring pessary etc. It is proposed to review all the remainder of the areas under treatment room in the 6 months of 25/26 to inform future commissioning models.

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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 March/April 2025

v2

Key Information:

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

Best Practice

High St Epping – Sig improvement in online consultation usage (Anima). 50%+ patients were signed up in Jan (at SLF visit). Usage zero in Oct 2024 to 800+ clinical consults in Dec and currently 900+/month.

Vaccinations

- **COVID** uptake 24/25 - 44.8% patients (46.4% in HWE compared to 48.1% in the East of England).
- **RSV** uptake for ages 75 to 80 is 51.5% in WE compared to 58.9 in HWE and 60.8 in EoE. (offered in a phased approach)
- **Flu** uptake 24/25 in WE is 74.7% (All eligible 65+)
- **MMR** uptake 23/24 for WE 78.9%
- **COVID** Spring Booster start 1 April '25 (aged 75+, those with a weakened immune system & residents of older people care homes)

Primary care access recovery and modern general practice

- MGP assurance completed, including follow-up visits with practices.
- Further practices adopting clinical triage as part of their daily management of patient demand, with several using the total triage model – now in place across one PCN, Harlow South. New GP contract likely to drive full online consultation delivery across all practices in working hours by October 2025.
- All transition support fund bids received and being used to further implement/maximise use of Cloud Based Telephony (5 practices), expanding use of Online consultation tools (4), further work within the practice to make triage process more consistent (9) and miscellaneous improvement work (3)
- Considering options for practices support during 25/26 in line with any national funding available.
- GP ARRS roles in place in Harlow North, Harlow South, South Uttlesford, LB&C and Epping Forest North PCNs. Newly qualified GPs are predominately working in individual practices to support on the day demand or in LB&C PCN hub supporting on the day demand, enhanced access and supervision of other ARRS roles.

Wound Care Quality Improvement Project - HWE

- Work to develop an integrated pathway across acute, community and general practice underway, with HWE oversight group and 3 place groups operating.
- Commissioning model with GP practices agreed in ECF 2526, funding aligned to workload (item of service basis) alleviating practice concerns.
- HWE wide Community contract in drafted as part of HWE community contract review process – to be agreed by end May 25

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 remains 3rd of 5 in Essex, with 26 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 now 4th for referrals and quits in Essex for January.
- **Health checks –** EWS offer outreach support to 6 GP practices. Delivery on track as 66% of target completed to January, holding position 4th highest of 5 in Essex.
- **LD AHC –** Ardens data shows practices have completed nearly 80% of their LD reviews and action plans.
- **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

- Continued collecting good practice examples via SLF, website reviews, direct feedback, and regular 1:1 practice manager meetings
- North and South Uttlesford INTs put carers into their INT plans for 2024/25 to reduce non-elective admissions and North's outcomes were presented in the February online Time To Learn event
- The plan for Quarter 4 implemented for Harlow North practices to maximise ECF delivery and support improvement in identification of carers, as a contribution to their overall INT plan.
- ECF achievement significantly improved in year across all PCNs. Identification of carers' status for frail elderly target met, blood pressure target met, depression assessments close to 40% lower target met, some good examples of communication needs and reasonable adjustment by individual practices.

Integrated Neighbourhood Teams (INTs)

- Harlow South INT care coordinator recruited, to support with discharge planning from Princess Alexandra Hospital, and prevention of re-admission. Ensuring proactive support and follow through on discharge action, with GP practice and wider INT members.
- Harlow enhanced proactive care project underway, to accelerate proactive care support to patients risk stratified as most at risk of admission in next 6 months (PHM search). Support provided by a dedicated community matron, employed via EPUT, working with practices and wider INT colleagues. Phase one (April to Oct) Harlow South, Phase 2 (Oct to April) Harlow North.
- LB&C PCN care home hub evaluation complete and funding secured for remainder of project. Considering options for longer term.
- To date, 238 patients have been discussed holistically, at 40 proactive care MDTs, led by the INTs.
- Majority of WE practices signed DELPHI data sharing agreement to enable primary care data flow.

Primary: Secondary interface

- HCP interface group finalising agreed primary care: secondary care interface policy, with all parties in agreement, expected in April.
- Alex Health implementation – support ongoing to work through issues. Patient portal live for dermatology outpatients, rest to follow throughout the year.
- HSL, new phlebotomy/pathology provider commenced and early operational changes positive. Proactive engagement with practices. Development areas put forward.

Sport England Harlow Place based Partnership

FIND YOUR ACTIVE

HARLOW

"Providing inclusive opportunities that inspire and empower residents to thrive and live active healthy lives in safe, supportive environments."

Asset Mapping in Harlow - supports physical activity

- Multiple green & Blue space (town Park & River Stort)
- Significant cycle network and walking routes active travel
- Multi sports areas, paddling pool
- Huge pride within the community and good networks
- Band stand – music & culture and Community spaces (libraries)

Restricts physical activity

- Lack of maintenance / safety of spaces
- Financial barriers to bikes and sports clubs
- Crime rates high and overall safety

Continue to consider, 'What we can do together to influence the system?' Continue to share 'What is missing / what could we scale and replicate locally? To support people to increase physical activity and decrease inactivity

C£300k secured for dev't phase 24/25:

- System Leadership Programme to develop partnership across Active Essex, Harlow council, NHS, Vol sector, Gilston Town Dev't, MIND, Children & Families etc
- Test and Learn projects – Pedal Power, Active Navigator, vol sector community projects
- Regular system leaders working group, regular stakeholder group (over 100 small orgs across Harlow), and networking events to progress shared initiatives and generate system of change/culture
- Submission of Sport England bid for further funding 25/26 to 27/28. Main themes - Leadership, Learning and Workforce, Children/young people/Families, Accessible & Inclusive Environments, Active Environments, Communities, Health and Wellbeing. Including Active Practice development and alignment with ICB prevention workstream.

https://www.activeessex.org/place-partnership-expansion/

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

Key Information:

12 PCNs – 6 Localities/INT's
47 practices
Patient list – 631,645
Weighted – 593,802

Primary Care Access & Modern General Practice

GPIP: The last phase of the programme has now been completed (March 25) by the 9 ENH practices who took part. The improvement areas included: Reductions in Monday 8am Rush, Duty GP list, volume of unnecessary GP appointments. Training non-clinical staff to help with signposting. ANPs carrying out more minor illness functions using their time effectively, website updates, patient communications improvements. Updating back-office processes, addressing frequent attenders, team development and prescribing processes. Better utilisation of Online Consultations,

Support Level Framework (SLF) Visits: (%) revisits booked for Symonds Green and Whitwell Surgery; Stanmore and Peartree to follow.

Capacity and Access Improvement Plans 24/25: All PCNs have signed off most of the 3 areas of the CAIP plans. Team are looking at collating and providing additional assurance to NHSE by 4th April deadline for ICB.

Modern General Practice (MGP): Team have completed follow up conversations with all of the practices to understand how they have progressed against the Transition plans funding paid earlier in the year.

Integrated Neighbourhood Teams (INTs) and Proactive Care

Our Integrated Neighbourhood Locality reporting via the HCP board has enabled a real focus on key areas for progress in implementation of the holistic case management and proactive care for this target Frail Cohort of patients.

In March it was reported that the count of people added to the INT proactive care caseload in last 6 months has increased to 121 up from 40 in January (a threefold increase). This reflects the establishment of more Frailty MDTs and the wider use of an interactive approach to Proactive case management by more INTs. Monitoring at PCN level delivery will be used to target support and ensure blockers are identified and where possible removed.

It is recognised at place that our ability to deliver at scale is dependent upon repurposing existing workforce from across several system partners to work together in a new more coordinated manner. To support this work there is a stakeholder event planned for 16 April to work through the current proactive pathway and discuss any barriers to delivery at place level.

In addition to this the GP Locality leads are holding INT localised events to accelerate understanding of delivery at PCN level with stakeholder partners, some are re purposing the Protected Time to Learn (PTL) events to ensure all general practice staff can attend these events, the place team are supporting with this work and intend for all INT's to have held their events by June 2025 which is when the next round of INT assurance reports are due to be received by HCP Board.

Workforce (PCN/Locality recruitment/Retention)

Herford & Rurals PCN: CYP Changes – The existing CYP Social Prescriber left their role and is now covered by Hertfordshire Mind via their young people's group, called SPARK. **ARRS year-end position** – some PCNs managed to recruit and utilise their budgets further available towards end of year. Proactive conversations are taking place around the year ahead focussing on those challenged with recruitment.

Vaccinations

The Autumn/Winter COVID vaccination campaign closed on 31st January. The uptake in ENH place was as follows:

- Adults aged 65+ = 63.7%
- At Risk = 56.1%
- Care Homes = 75.4%

The Spring/Summer COVID vaccination campaign commences on 1st April.

ECF – see attached slide for focus on Frailty and EoLC.

Monthly ECF Data Packs – these slides are produced by the PC Team and shared with all Practices, PCN Managers and PCN CDs. They have been well-received and have aided discussions with outlier practices.

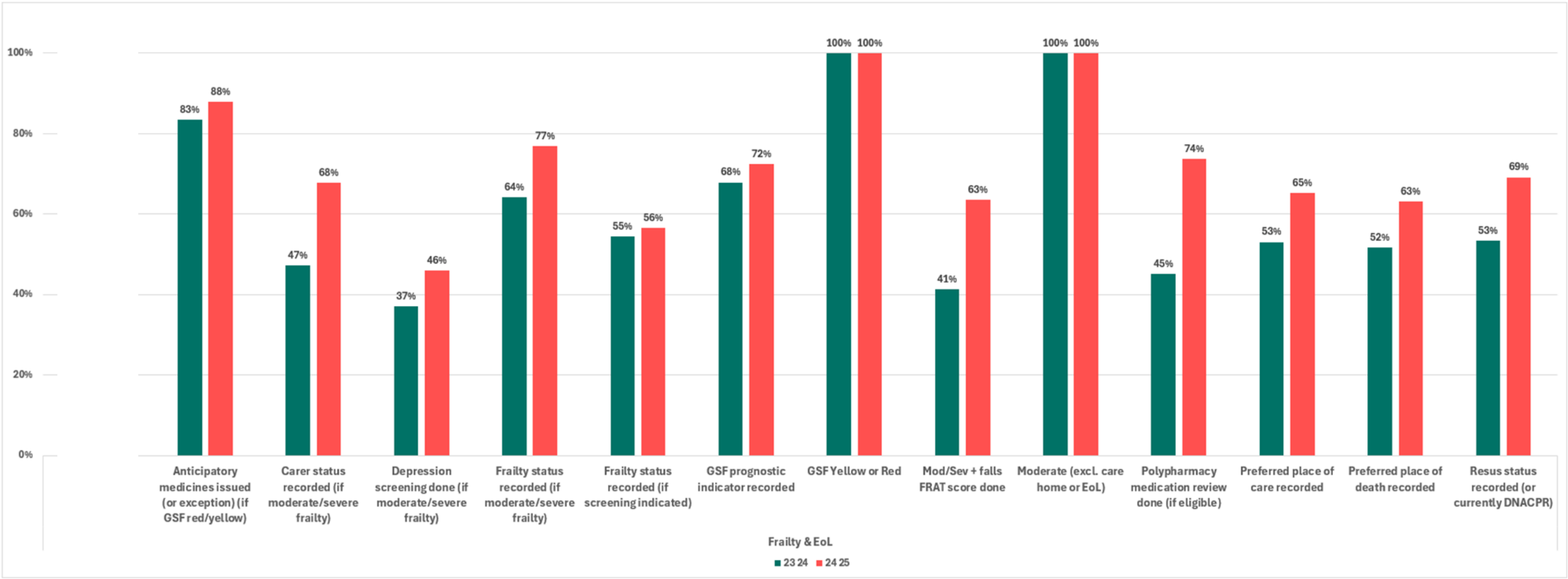
Highlighted areas of good practice/impact;
LVH PCN – Deputy Clinical Director has set up a group with the Practice Managers, they meet monthly and review their ECF and share good practices for improvements. This has been reflected in their end of year improved results.
Broxbourne Alliance PCN - Health and Wellbeing team established who carry out Carers assessments, include SPLWs and signpost to local services for health and wellbeing improvements. Increased numbers of assessments completed.
South Street Surgery (SVH PCN) – Have set up a dedicated data team within the practice to review and ensure practice coding is correct before and after appointments and track ECF and QOF performance.

Health Inequalities

Stort Valley PCN - Healthy Eating and Equipment: Air fryer cooking sessions provided for at-risk residents via local food bank referrals. Six 4-week courses provided. Final project report being prepared as project ends.
Hertford & Rurals PCN + Active in the Community CIC: Tai chi programme for frail individuals now at the mid-point. Progress report will be submitted end of March and patient surveys are ongoing.
Collaboration with 4 PCNS in Stevenage/North Herts + North Herts District Council, Stevenage Borough Council, Stevenage FC Community Foundation, Letchworth Heritage, Public Health nursing. Healthy eating cookalong webinar series Jan/Feb 2025

ECF – Financial Year Comparison 23/24 and 24/25 (Frailty and End of Life)

East and North Herts Place



Overall all areas of Frailty and End of Life areas have improved. Most improvement shown in Carers status being recorded, Polypharmacy medication reviews and resus status.

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

Examples of Good Practice

New Carers Café – Collaboration between Broxbourne Alliance PCN, Lea Valley Health PCN and Carers in Herts

-Launched in February 2025.
-Well attended already
-Offers carers a space to come and discuss concerns and get support & advice about local services on offer to them
-The PCNs also utilise this time to carry out carers assessments.

Stockwell Lodge Medical Centre (Lower Lea Valley PCN)

The GP Practice had a reconfiguration of existing estate to include 3 new Clinical rooms in their Annex building, which will be utilised to accommodate PCN ARRS staff and also increase their training space for trainees at SLMC.

The newly improved annex building was opened by Mayor Sherrie McDaid on 24 January 2025. The photo shows this event and includes Dr Navina Sullivan of SLMC and Dr Pearl Onyekuru Clinical Director for Lea Valley Health PCN

North Herts and Stevenage Localities

North Herts hosted a Community Cookalong for patients in both localities.
Targeting families in economic difficulties to encourage healthier eating
- 6 1-hour webinars on Thursdays from February to April (breaks for holidays)
- 250 people signed up to attend. Varied attendance across sessions.
- Feedback was positive from patients and presenters.
- Discussions to be had before end of April around how to proceed and what happens next given the enthusiasm for the sessions.
- Looking at funding opportunities across system partners via Prevention Improvement Plans (PIP).

Hertford and Rurals PCN & Ware and Rurals PCN – Tai Chi Classes:

A collaboration between the two PCNs saw a selected group of patients offered the chance to undertake a series of Tai Chi classes. The referrals focused on patients with long term health conditions, back problems, low mobility, loneliness, stress, anxiety, risk of falls and more.

Two sites were offered to patients, included a rural site in Tewin, that allowed older patients to access these services who had previously sited travel issues as a barrier to improving their health outcomes.

Patients were asked to complete a questionnaire before/after the classes, with improvement seen in most patients.
The organisers are hoping to replicate this in other areas of Hertfordshire.

South West Herts Place Primary Care Update

April 2025

Key Information: 17 PCNs
49 practices
4 Neighbourhood Areas
692,596 Raw Population
644,608.571 Weighted

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

Jan 25 data show that SWH Pharmacy First referrals have decreased significantly since the same month 2024 (Jan 24, 9.3 referrals per 10,000 population & Jan 25, 4.9 per 10,000 pop).

However, Pharmacy-related referrals from 111 have increased : Jan 24 - 378 referrals & 579 in Jan 25. (Feb data not yet available)

Primary Care Access & Modern General Practice

Practices Visit programme undertaken per locality –

- 8 practices in **Hertsmere**
- 10 visits completed in **Dacorum**
- 8 completed in **St Albans & Harpenden** (further visits tbc)
- 13 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:** 3 SWH Practices continue to progress on the PLS course, following Parkwood Surgery's decision to withdraw. Feedback at practice visits have been positive where changes have been made.

- **Modern General Practice:** Practices are asked to have online consultations open for admin requests, medication queries and non-urgent appointment requests during core hours, starting from October 2025.

Vaccinations

Flu vaccinations are currently being offered until 31 March 2025, whereas **covid** vaccinations for Spring will start again on April 1st. This is for those aged 6 months to under 75 with a weakened immune system and all aged 75 plus, and residents of older adult care homes.
Flu uptake as of 26th January (final data set) is at 76% for those aged 65+ in South and West Herts (SWH), compared to 74% in the whole ICB. Those at risk 6 months - 64 yrs are at 43.5% in SWH compared to 40.6% in the ICB.
RSV is still being offered by practices to 75–79-year-olds – uptake is now 63% in SWH and 59% in the ICB. HCT continue to offer to pregnant women at 28 weeks, along with any other vaccinations needed.

DNA Reduction Project

- Work is progressing with the rollout of the DNA work to other interested Practices
- Bridgewater, Lincoln House and Bennetts End have progressed on this project with meetings with the Patient Reps leading on this work
- This work has now also been shared with colleagues in East and North Herts to offer to their practices

- **W:ISH** will be rolled out in SWH to 4 selected PCN's, one from each Locality to 10-12 patients. With a focus on pathways for diabetes and obesity; heart disease; lung disease and older people in the first instance. Plan to commence September
- Meeting went well with the NHSE senior leadership team to review the potential of rolling this out further via the NHS App
- Sir Steven Powis, Claire Fuller, Sarah Price plan to visit pilot PCN'S end of May/ beginning of June
- Funding discussions continuing.

Validated Total number of patients seen YTD (April'24 – Feb'25): 20,547

- NHS : 4,641
- GP directly booked: 15,439 111 directly booked (up 13% on the same period last year)
- Pharmacy directly booked: 286
- Hemel UTC redirection: 4

- Validated average weekday utilisation (April'24 to Feb'25): 95%
- Validated average weekend utilisation (April'24 to Feb'25): 66%
- 96.2% seen within 30 mins
- 99.6% are discharged within 2 hours
- 99.98% of patients are discharged within 4 hours
- 79.4% of cases are minor illness related
- 20.6% is minor injury related

Same Day Access

A **Minor Illness Winter Service** has been evaluated and showed a positive impact in terms of reductions in low acuity in hours A&E attendances – this is now below the rest of southwest Hertfordshire. There has been a decrease in activity to Barnet General Hospital (UTC & ED) since October 2024, and a decline in activity from October 2024 onwards compared to the same months in the previous year.
The Service is delivering a good service which offers good value for money. It is supporting in managing and mitigating urgent on day demand, without negatively impacting other areas of the health and care system.
Unfortunately, funding is not available to continue with pilot. Future funding is dependent on a wider review of all urgent treatment centre (UTC) care provision across S&W Herts.

Integrated Neighbourhood Teams

- **Dacorum Pro-active Care Model:** Pilot planned to commence May/June 2025 with a view to expand across neighbourhoods if successful.
- Funding stream - third workshop to be held- Social Finance McMillan and WHTHT.
- Implementation plan template has been initiated. To be completed beginning of April
- Estates have confirmed usage of Jubilee Wing for Project. Rooms to be decided.

Hertsmere Complex Mental Health INT - non-responders to annual LD and SMI health check, living in the 3 most deprived electoral wards of Hertsmere have been reviewed by an MDT to increase uptake of health checks for individuals identified and to provide holistic support to these individuals from relevant agencies. The next step is to extend this to all areas of Hertsmere.

Hertsmere Frailty INT – Hertsmere is beginning this work, and the 3 nominated practices have sent CLCH their 5 referrals. They will be visiting the care homes, looking at the RESPECT form, liaising with the relevant practice and carrying out a holistic assessment. Onward referrals will be carried out by CLCH where possible.

Watford/Three Rivers Top 300 Frailty INT project: Following the initial pilot patient reviews, roll-out to the other Practices/PCNs in the neighbourhood has been paused on the direction of the Clinical Lead, due to a lack of funding/resources to support GPs with the additional workload. It is hoped that rollout can continue once there is further update on resources. In the meantime, a meeting is being arranged with EoL and Palliative Care system partners, to explore opportunities for the INT to further develop in this area.

St Albans/Harpenden Frailty Project: In total, 108 patients were included in the INT – much higher than initially thought as received further updates/data and reporting.

- All patients had a visit or call with a clinician and social prescriber for a full Frailty Assessment; MDT discussions included where required.
- Patients were kept informed of MDT decision/outcomes; the issues with the identified cohort were reported early on.
- Medications reviewed with patients through MDT's. Signposting patients to further support in the community including voluntary groups.
- Project brought the ARRS team together in a way that may not been possible before
- INT has enabled patients to be supported with different opportunities which they may have had if not identified through this process.

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

- Attenborough Surgery/PCN currently run a specialist Complex Care Pathway/Service for their high needs patients.
- To the right is an excerpt from a presentation given at the RCGP annual conference in Liverpool late last year which demonstrates some of the benefits of this service.
- The ICB are now in talks with Attenborough to look at how the excellent work they are doing could be incorporated into a dedicated INT project, to further benefit the HCP as well as learn from their experiences.

Hertfordshire and West Essex Integrated Care System

Abstract

Attenborough's PCN complex care service is the first of its kind in Hertfordshire to provide a bespoke service for patients with complex needs.

Objectives

- Offer continuity to frequent flyer patients to understand their needs better.
- Reduce pressure on GPs.
- Upskill allied health professionals in the PCN by providing further training.
- Ultimately reduce the number GP of appointments required for complex patients.

Method

- An EMIS search was carried out looking at all patients on the PCN list size that had consulted the practice 15 times or more over a 3-month period.
- A code was added onto their clinical record stating they were under the PCN complex care team.
- A complex care protocol was created for both clinicians & admin staff to instruct how patients on the complex care register should be managed. Training offered to both clinical & admin staff.
- Monthly MDT's have been held on the first Thursday of each month with full access to the clinical record with cases discussions of patients on the register.

Impact

- Improved continuity for patients on the complex care register. Reduction in unnecessary GP appointments freeing up GP time. Improved wellbeing for reception staff when call handling.
- Positive impact on clinical staff in the PCN.

Introduction

Primary care accounts for approximately 90% of all NHS contacts with 365 million appointments provided in 2023[1]. An ageing population & a cost of living crisis exacerbated by the covid pandemic has resulted in an increased complexity of GP consultations[2].Coupled with years of underinvestment and issues with GP recruitment have lowered GP moral and work satisfaction rates[3].

The formation of a PCN complex care team provided a novel way of working to deal with complex & challenging patients to provide better continuity of care. By doing so the team could also reduce the strain that high intensity users have on the GP's & admin staff within our PCN thereby improving wellbeing but still offering appropriate patient centred care.

Results

Figure 2.

GP contacts in 3 of our most complex high intensity users, reduced by 85% since the implementation of the complex care team (Fig 2).

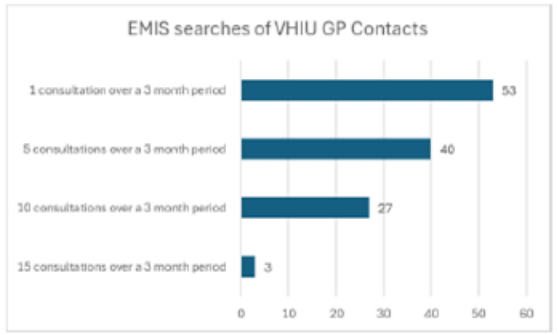


Figure 3.

The number of complex care patients having 15 or more consultations with a GP, in a 3-month period reduced from 79 to 3, showing a 96% reduction in GP contacts. We also ran searches at 10 , 5 & 1 GP consultation. This showed a reduction in consolations as per Fig 3.

Figure 4.

- 85% of GP's strongly agreed that the complex care team had improved frequent patient contact and provided significantly improved continuity of care for their patients (Fig 4).

Questions

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	x☐	*Meeting in private (confidential)*				
	Primary Care Transformation Committee			**Meeting Date:**	**24 April 2025**		
Report Title:	HWE Progress on General Practice Workforce and priorities for 2025/26 across Primary Care			**Agenda Item:**	**5**		
Report Author(s):	Dr Sarah Dixon, Primary Care Workforce GP Lead Joyce Sweeney, Head of Primary Care Workforce Tom Neale-Peppiatt, Primary Care Workforce Programme Manager						
Report Presented by:	Dr Sarah Dixon, Primary Care Workforce GP Lead						
Report Signed off by:	Avni Shah, Director of Primary Care Transformation						
Purpose:	**Approval / Decision**		**Assurance**	☐	**Discussion**	x ☐	**Information**	**x**
Which Strategic Objectives are relevant to this report **[Please list]**	▪ Improve access to health and care services ▪ 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:	The committee is asked to: ▪ Discuss the contents of this report.						
Report History:	Not applicable						
Executive Summary:	This report details the education and training workstreams developed by the Primary Care Workforce team to address Primary Care workforce priorities for 2025/26. Aligned with local and regional workforce strategies, the report outlines initiatives focused on building a sustainable workforce through targeted training programmes to ensure that the Primary Care workforce is trained and has the necessary skills to support the patients they serve effectively, and staff retention programmes such as fellowship programmes which support the 25% reduction target in emergency admissions for frail patients, supporting the increase in student nurse placement to support the ageing GPN workforce crisis.						

<table>
<tr><td>Recommendations:</td><td colspan="4">The committee acknowledges the report which details the Primary Care Workforce training priorities in 2025/26</td></tr>
<tr><td rowspan="4">Potential Conflicts of Interest:</td><td>Indirect</td><td>☐</td><td>Non-Financial Professional</td><td>☐</td></tr>
<tr><td>Financial</td><td>☐</td><td>Non-Financial Personal</td><td>☐</td></tr>
<tr><td colspan="3">None identified</td><td>☒</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td colspan="5">Implications / Impact:</td></tr>
<tr><td>Patient Safety:</td><td colspan="4">Staff training and education is a key competent to ensure that staff have the right skills, knowledge, values and behaviour to ensure that patient safety is maintained.</td></tr>
<tr><td>Risk: Link to Risk Register</td><td colspan="4">No new risks identified through this report which are not already on the directorate risk register</td></tr>
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<tr><td colspan="2">Quality Impact Assessment:</td><td colspan="2">N/A</td></tr>
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Hertfordshire and West Essex Integrated Care System

HWE Progress on General Practice Workforce and priorities for 2025/26 across Primary Care

Dr Sarah Dixon
Joyce Sweeney
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24th April 2024

Working together
for a healthier future

Primary Care Workforce Team: Priorities and Purpose

- Developing programmes and supporting the delivery of workforce priorities
    - Integrated Care Board (ICB) Priorities
    - Regional Priorities
    - National Priorities
- Identifying and addressing local priorities
- Collaborating with stakeholders (Higher Education Institutions (HEI), Local Medical Committee, Practices (LMC), Pharmacy, Optometry, Dental (POD), Primary Care Networks (PCN), Health Care Partnerships (HCP), Trusts)
- Leading and facilitating forums
- Developing and delivering training and support programmes
- Developing the future workforce – create new and innovative ways of working more closely with secondary and community care and Pharmacy, Optometry, and Dental
- Reviewing workforce data and supporting Primary Care Networks (PCNs) with challenges around workforce and training

Workforce education

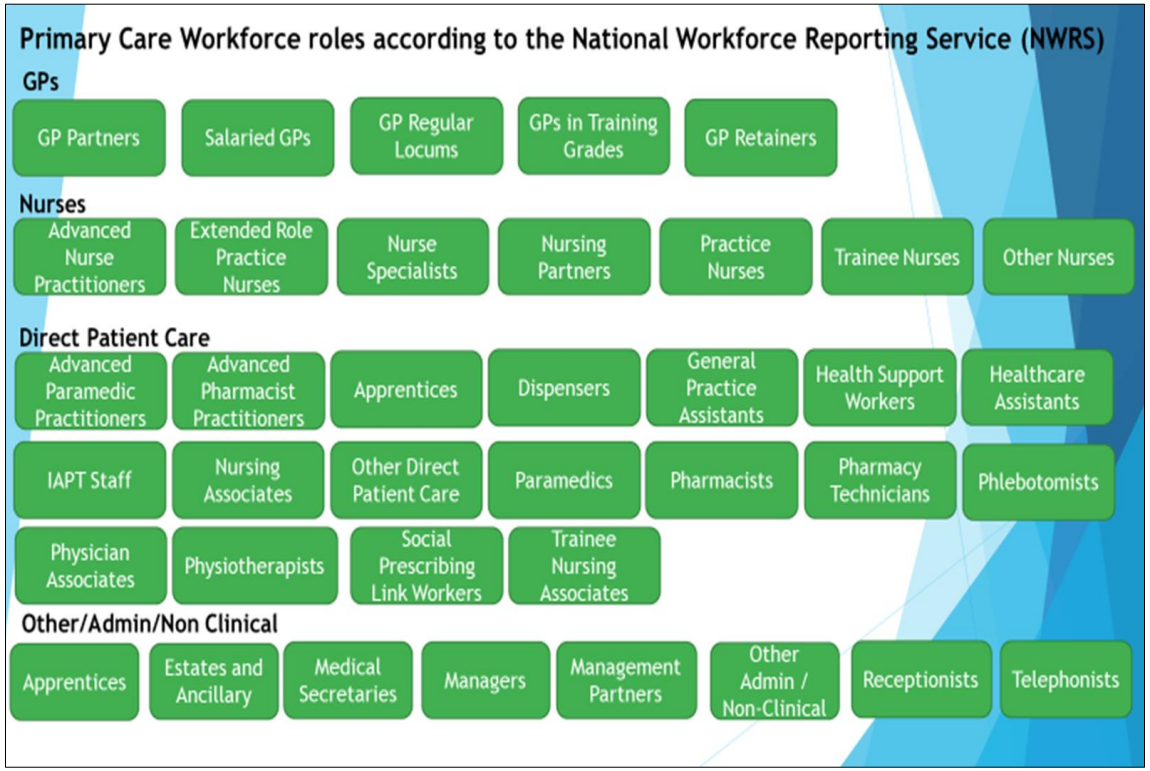
Professional Support and Development

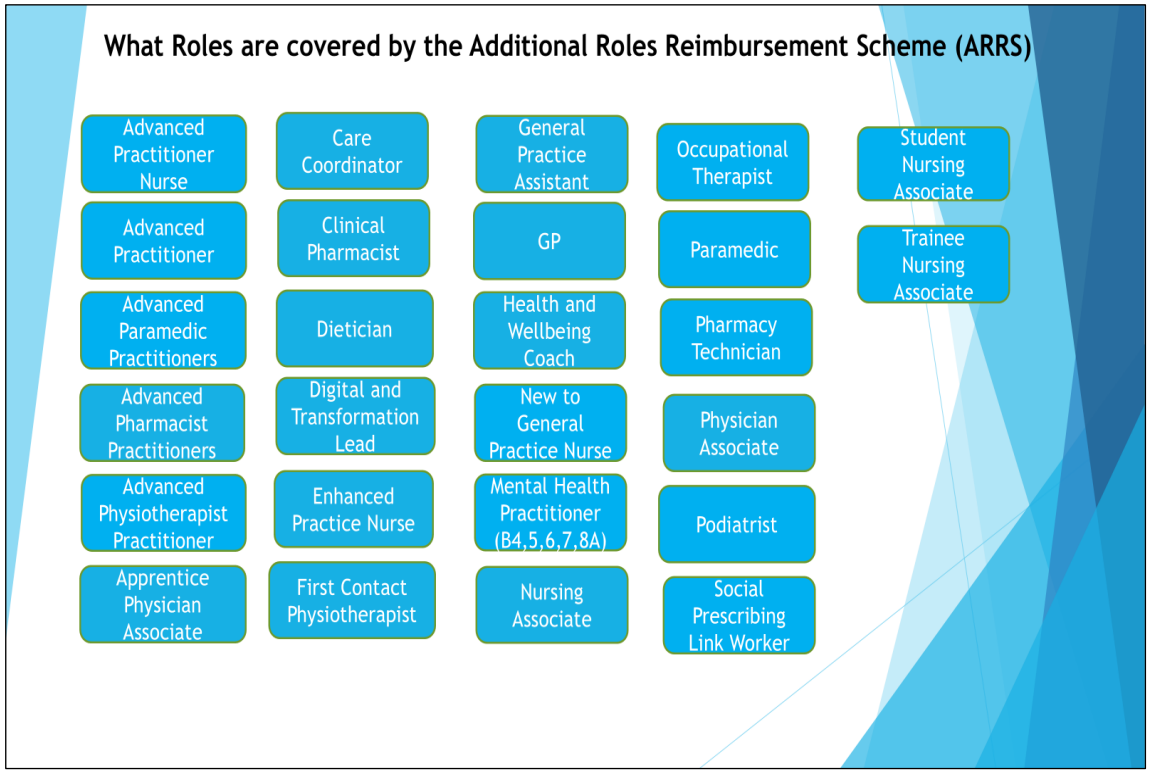
Workforce Sustainability and Planning

Future Workforce training and teaching

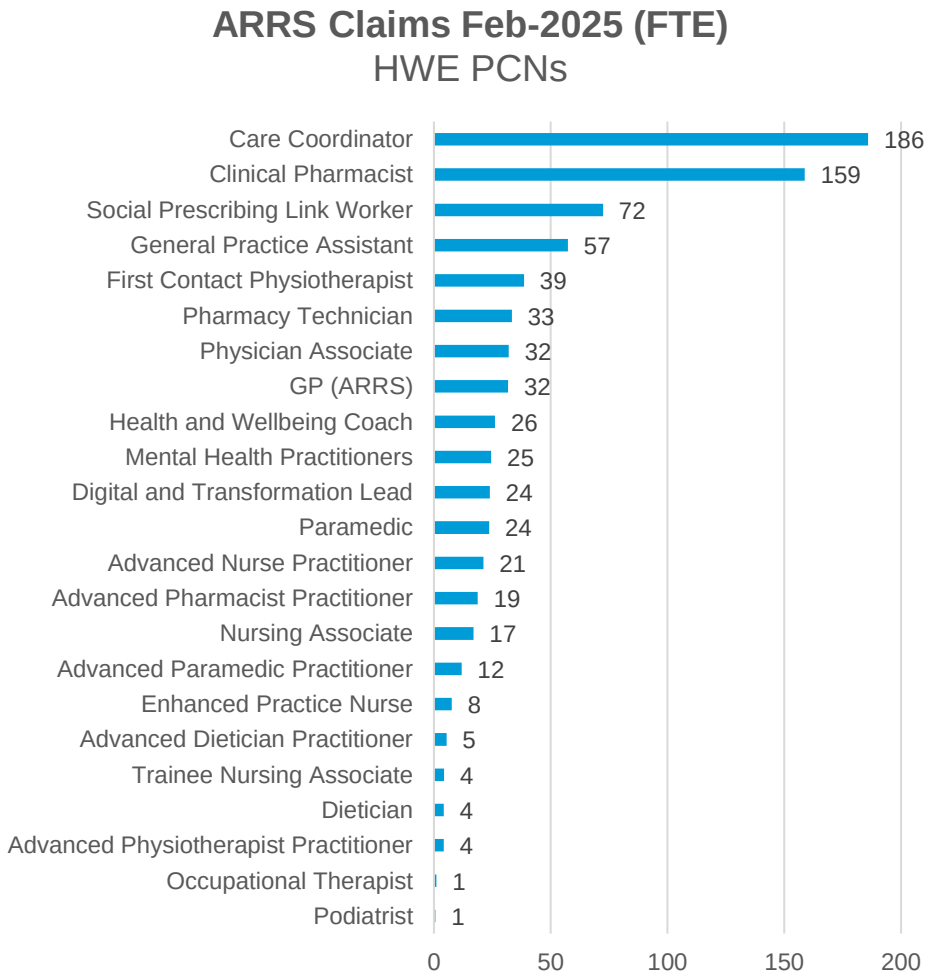
Hertfordshire and West Essex Integrated Care System

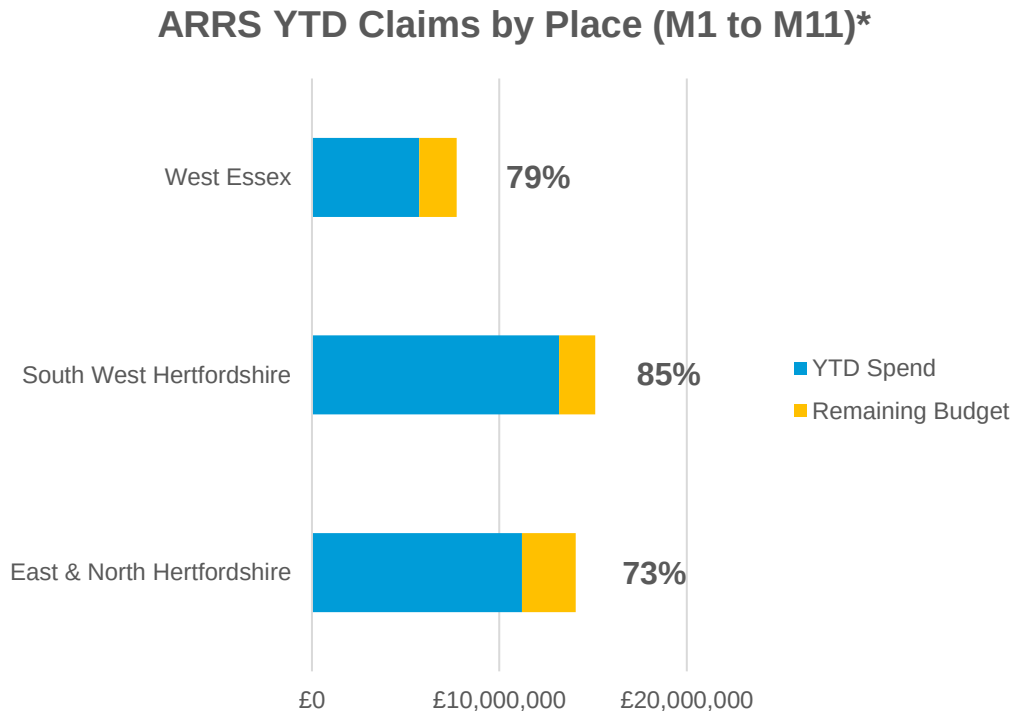
The General Practice Workforce





PCN & Additional Roles Reimbursement Scheme (ARRS) Workforce



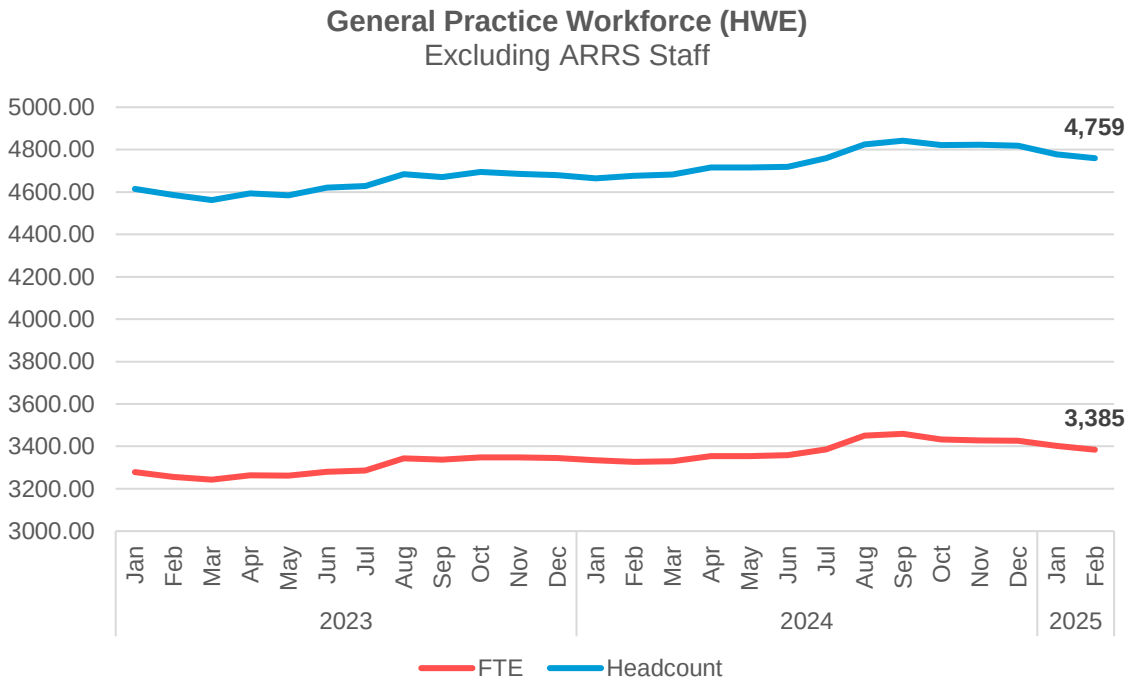


*includes additional GP funding made available during 24/25

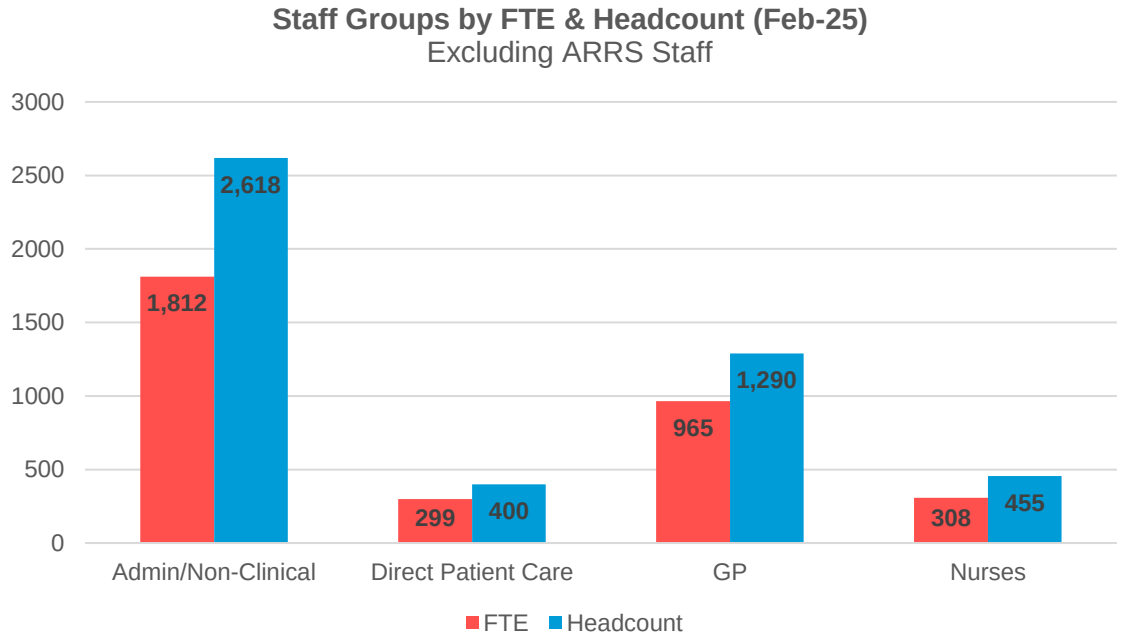
PCN & ARRS Workforce

- **Care Coordinators** now represent the highest number of ARRS claims, with widespread utilisation across practices and PCNs.
- **Clinical Pharmacists** remain the second most claimed ARRS role. They are essential to the delivery of **Structured Medication Reviews (SMRs)** and play a key role in supporting the **frailty agenda**.
- **General Practice Assistants (GPAs)**, while a relatively new addition to the workforce, have quickly gained popularity.
- **Advanced Practice roles** are on the rise, supported by the development of an **Advanced Practice Forum** aimed at ongoing professional development and peer learning.
- **GP Roles under ARRS**: GPs are now included within the overall ARRS budget. Some PCNs are opting to replace other roles with GPs. Since October, over **1,500 GPs** have been recruited via the scheme nationally, exceeding the government's target. However, this equates to just **851.3 FTE GPs**, highlighting a gap between headcount and working hours.
- **Nursing Roles** have been newly introduced into the ARRS. Although uptake was low last year, this may change in light of this year's **Directed Enhanced Service (DES)** specification, which includes GPN roles.
- **Integrated Neighbourhood Teams**: ARRS roles offer strong potential to support and integrate within these teams.
- **Workforce Expansion**: Ongoing discussions with PCN leads are focused on supporting and accelerating the **recruitment of ARRS roles**.

General Practice Workforce Data



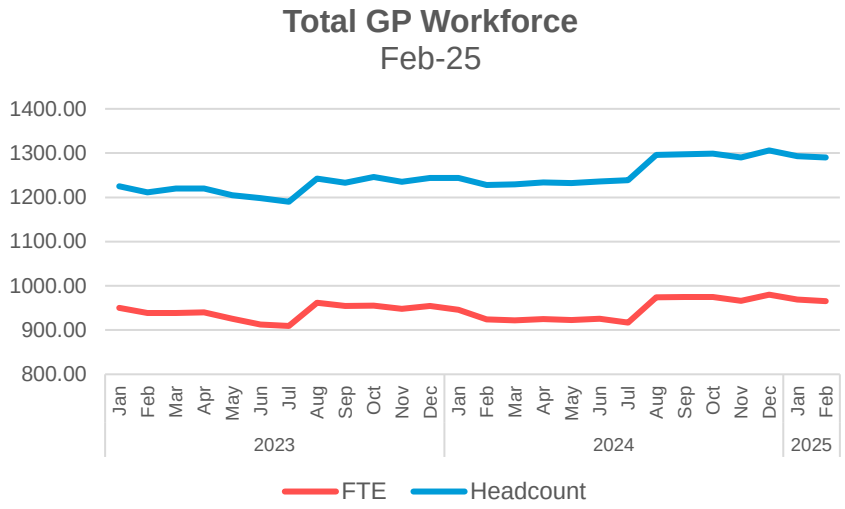
Staff Group	Feb-24 (FTE)	Feb-25(FTE)	Variance (+/-)
Qualified GPs	689	707	▲ 18
GP Trainees	235	258	▲ 23
Nurses*	317	314	▼ 3
DPC (Non-ARRS)	298	299	▲ 1
Admin & Non-Clinical	1787	1811	▲ 24
Total	**3,326**	**3,389**	**▲63**

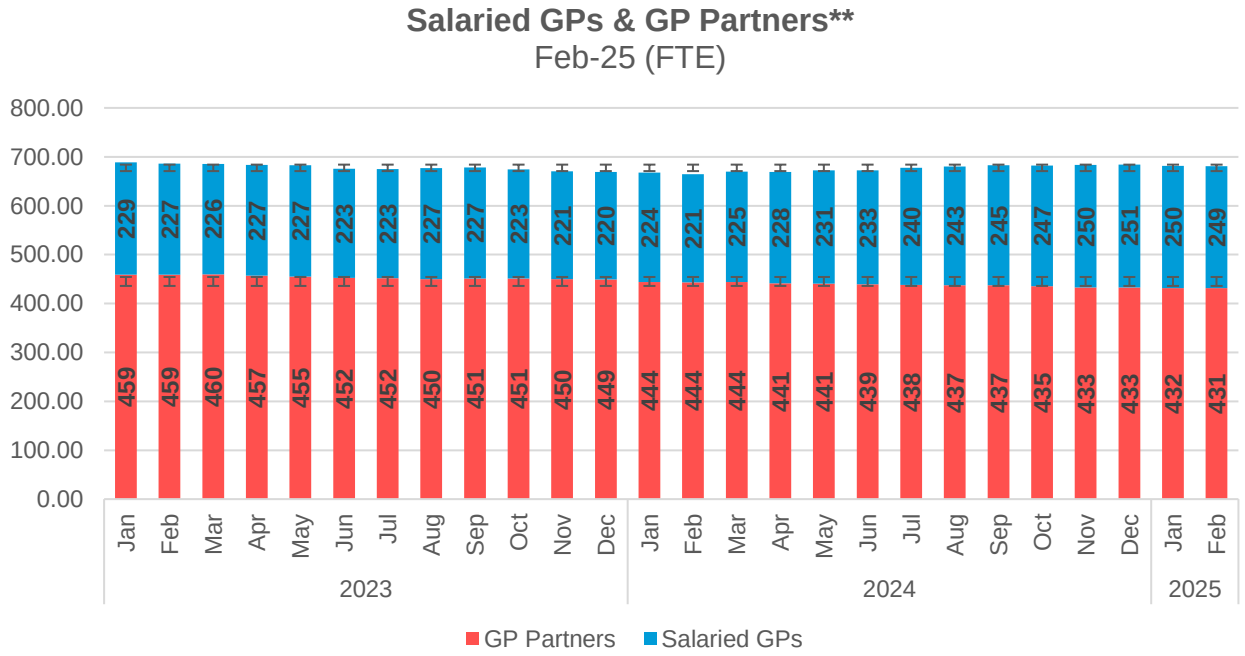


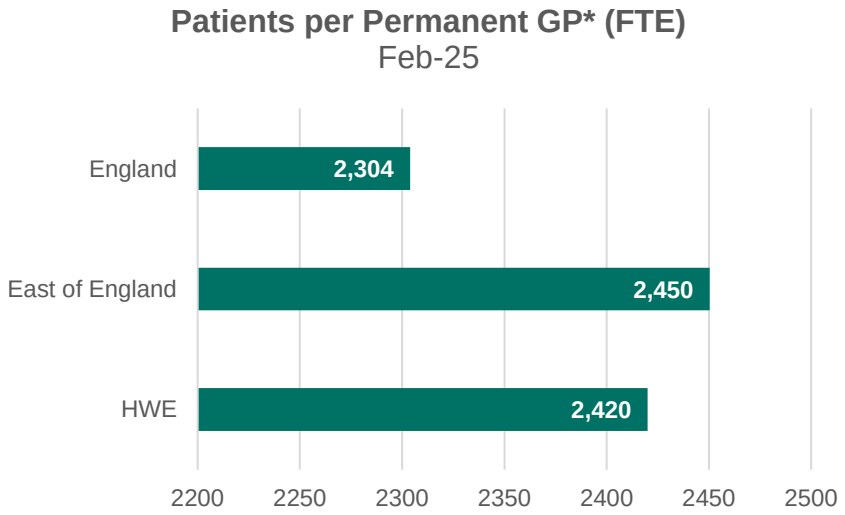
DPC = Direct Patient Care
FTE = Full Time Equivalent
GP = General Practitioner
ARRS = Additional Roles Reimbursement Scheme

**does not include nurses employed via the Additional Roles Reimbursement Scheme (ARRS). Although the data table shows a decrease, there has been a net increase if both GP and PCN datasets are combined.*

GP Workforce Data





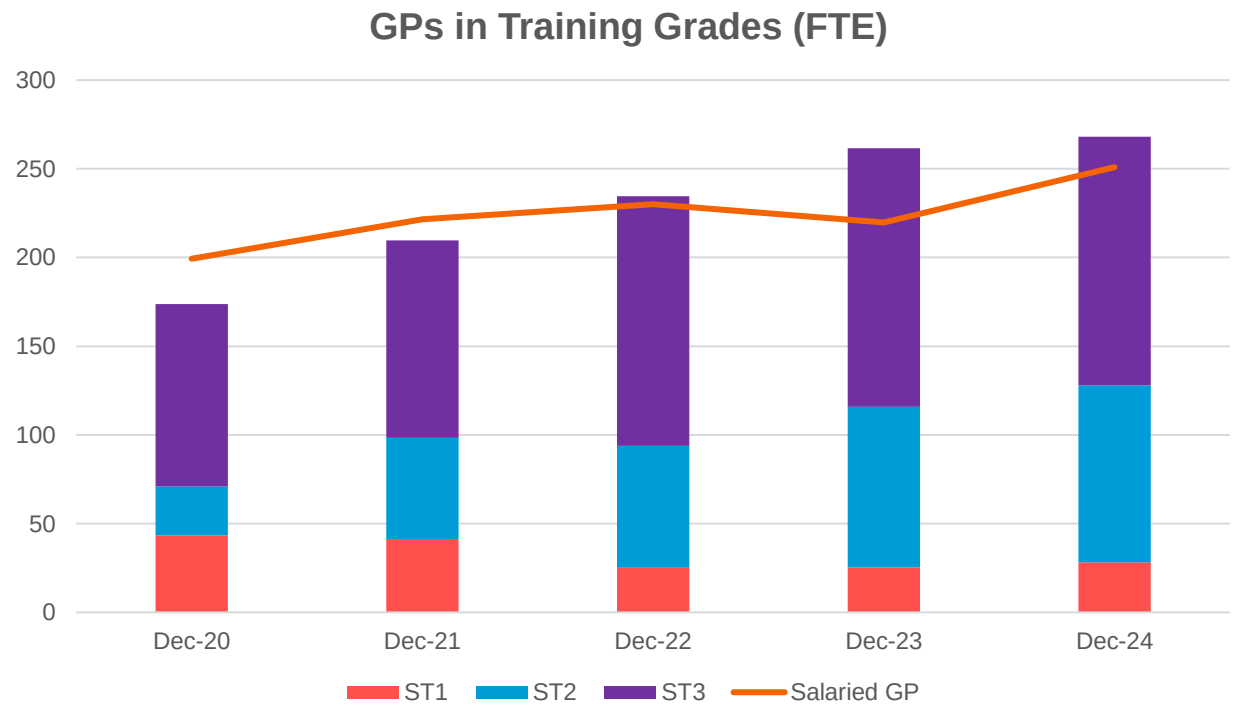


*excludes GP trainees and locum GPs
**excludes GP Retainers, Locums & Trainees

- The number of GP Partners has decreased by 28 FTE between Jan-23 and Feb-25.
- During the same period, 20 FTE Salaried GPs have taken up core (non-ARRS funded) roles in HWE.
- Not shown in the above, but an additional 32 FTE GPs are working in Salaried ARRS funded positions. Therefore, the permanent GP workforce has risen by 24 FTE during the two years.
- Despite the population increasing by 36,775 since Feb-23, the number of patients per Permanent GP has increased by 71 patients.

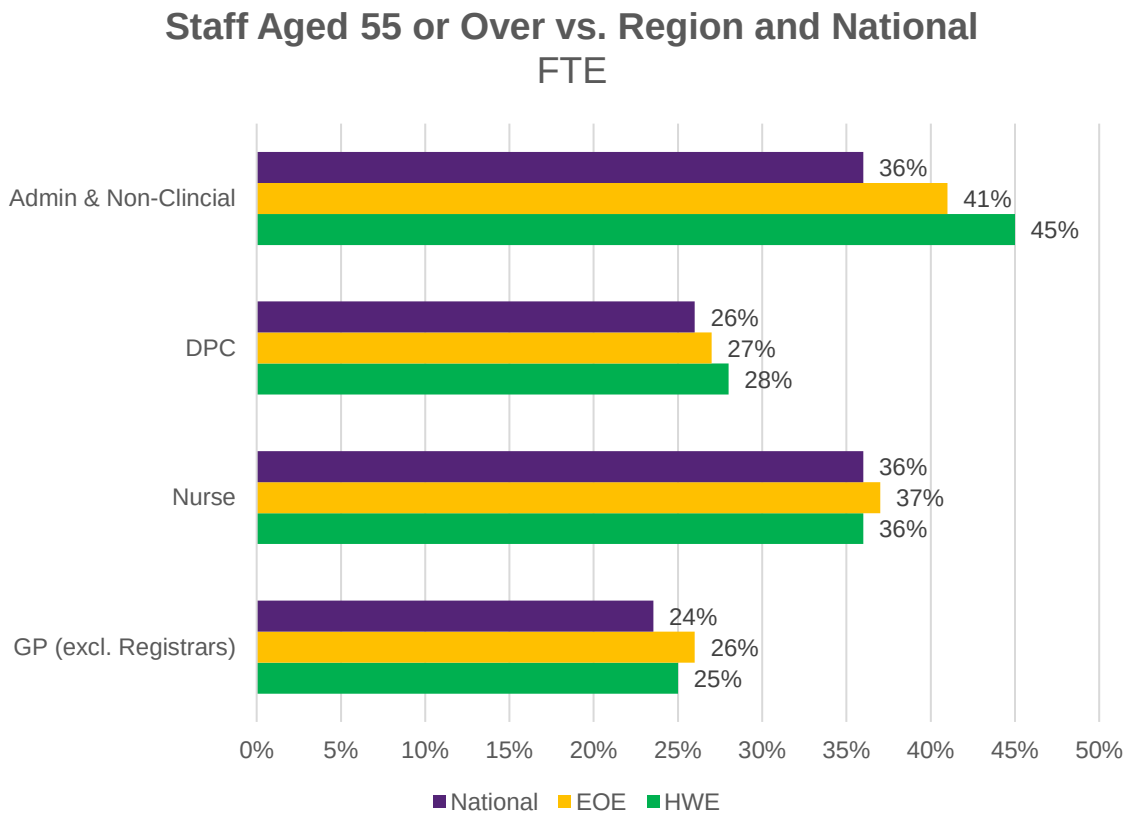
GPs in Training Grades

- **Overall Growth in GP Trainees**: The total number of GPs in training (ST1, ST2, ST3) has steadily increased, with ST2 and ST3 showing the most significant growth.
- **Largest Increase in ST3 Cohort**: ST3 trainees, representing the final stage before becoming fully qualified GPs, consistently made up the largest proportion, rising from **102.83 (Dec 2020)** to **140.16 (Dec 2024)**.
- The increasing number of ST3 trainees suggests a **direct impact on the growth of salaried GPs**, as most ST3 graduates transition into salaried roles. The peak in ST3 numbers in Dec 2023 (145.71) is followed by a rise in salaried GPs in Dec 2024 (250.92), suggesting a **time lag between training completion and workforce entry**.
- **The GP Educator and Expansion Clinical Lead** has developed programmes of support with each of the Training Programmes in HWE to ensure trainees are supported to pass exams and educators are provided with additional support.



ST1 = Specialist Training Year 1
ST2 = Specialist Training Year 2
ST3 = Specialist Training Year 3

General Practice Age Profile



ENH	<30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65>	Unknown
Admin/Non-Clinical	118	58	67	73	78	118	165	178	119	17
Direct Patient Care	11	24	15	16	10	13	16	16	3	1
GP	9	67	106	64	69	70	33	30	18	0
Nurses	4	14	15	25	20	39	31	34	17	4

SWH	<30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65>	Unknown
Admin/Non-Clinical	121	69	81	82	73	131	198	198	145	3
Direct Patient Care	28	17	23	15	13	15	25	9	17	0
GP	38	102	114	93	75	53	44	26	13	2
Nurses	3	8	14	17	26	29	25	25	8	3

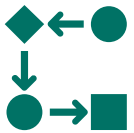
WE	<30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65>	Unknown
Admin/Non-Clinical	56	37	41	39	41	70	95	81	62	7
Direct Patient Care	7	9	15	16	11	13	11	18	11	2
GP	15	51	56	33	38	27	26	7	13	0
Nurses	3	7	12	10	21	6	4	22	12	1

- The age profile of the workforce in HWE has not changed significantly over the last four years.
- The proportion of DPC (non-ARRS) and Admin & Clinical staff aged 55 or over remains high compared to regional and national averages.
- GPs aged 55 or over is comparatively low compared to neighbouring systems (exceeding 30% aged 55+)

GP Retention Scheme

Eligibility
Open to GPs considering leaving or who have left general practice.

Support
Provides financial assistance to both GP and employing practice.



Duration & Review
GPs can remain on the scheme for five years. Local application and review process in place.

32 GPs are currently on the scheme in HWE

7 new GPs have been approved using a new application process implemented locally

6 GPs are due to complete the scheme or no longer meet the scheme requirements

New approval process for existing and new GP retainers was implemented in Q4 2024/25.

2024/25 to 2025/26: Building on our Success

Strategic Alignment – attendance at various committee meetings	Protected Time to Learn (8 events a year omitting Aug, Dec, Jan, Feb)	New to Practice Programme (Monthly forums)	Fellowship Programmes (Annual)	Future Leaders -New to Partnership (LMC) (Monthly forum)	Compassionate Appraisals (project)	Conferences/Careers Fairs (Annual)
GP Retainers Programme (Quarterly)	ARRS Forum (Quarterly)	Primary Care Educational Webinars Lunch Time/Evening (Monthly)	Quality – Educators/Learning Organisations (Monthly panels)	Multi Professional Educational Forum (Quarterly)	Supporting Head of Community Resilience - Carers delivery plan (Monthly meetings)	Workforce Implementation Group meetings (Quarterly)
Clinical Leads meetings (Monthly)	PCN Workforce planning support (Monthly, Working with Place Leads to support ARRS workforce plans)	Supporting Oliver McGowan training roll out (BAU – promotion)	Expansion of Clinical Pharmacist Student placements (Programme)	Supporting Mpharm placements (Programme)	Supporting Designated Pharmacist prescribing opportunities (Programme)	GP Mentorship (Programme)

- **Protected Time to Learn:** Following the end of the PCN Training Teams pilot in September 2024, we've been working with PCNs and practices to continue essential training through PTL days. This approach supports alignment with wider initiatives, improves access, and helps overcome staffing challenges by enabling broader attendance.
- **Designated Prescribing Practitioners (DPPs)** are supporting Independent Prescribing (IP) training for community pharmacists in HWE, with 7 DPPs currently in place. We aim to grow DPP capacity and IP enrolments to upskill the pharmacy workforce and enhance local healthcare delivery.
- **Fellowship Programmes**
  - 2 Frailty Fellows- supporting the 25% reduction target in emergency admissions for frail patients
  - 2 dermatology Fellows supporting an area of high referral rates

2024/25 to 2025/26: Building on our Success

GPN/Students – working with Universities to support growth of student placements in general practice (BAU)	General practice as a first destination career – supporting the health academy with promotion to schools and colleges (BAU)	Advanced Practice initiatives i.e. apprenticeships, e-portfolio supported route, recruitment drive (Programmes)	Advanced Practice Forum (Quarterly)	Clinical Supervision sessions (Monthly)	Apprenticeships (Programme)
Supporting GPs, Nurses, AHPs and Pharmacists through structured career development opportunities	Primary Care Awards (Annual)	Expanding Educator programme – aspiring educator training (2 per year)	GP Exam and Trainer support Programme	Wise 5/First 5 Forums (Monthly)	Research Forum (Quarterly)
Annual Review of Competence Progression Panels (ARCP) (Programme)	Clinical Pharmacist Forum (Monthly)	Future Leaders Forum (Quarterly)	ARRS GP Forum (Quarterly)	CPD Prospectus (Annual/BAU)	Website (BAU)

General Practice Nurse (GPN)/Students

- Supporting the ageing GPN workforce crisis and promoting practice nursing as a career pathway
- Apprenticeships
- GPN apprenticeships increase retention and allow Practices to ‘grow their own workforce’

Priorities 25/26

Supporting Local Enhanced Commissioning Framework / Operational Plan / National & Regional plans

Primary Care workforce planning and development

Career development opportunities:

- Provide Primary Care Staff training opportunities that support the new commissioning processes i.e. electrocardiogram (ECG), Wound Care, Leg Ulcers, frailty, heart failure, chronic obstructive pulmonary (COPD), diabetes, learning disabilities
- Improve Leadership – bespoke courses and forums
- Educational Webinars – clinical and nonclinical staff
- Protected Time to Learn Events – increased training access
- Evaluation and Impact – ensure effectiveness and impact of training programmes. Is it making a difference?
- Developing roles in priority areas – working with Primary and Secondary care to help alleviate pressures on existing staff, bringing health and care organisations together to have joint roles that can navigate between primary and secondary care
- Collaborating with other teams to share training opportunities i.e. hospices
- Scoping of opportunities of integrating community pharmacy, dental and optometry where appropriate into the priorities of primary care workforce planning and development
- Strategic support to workforce planning at practice/PCN level with opportunity aligned to new estates, service delivery etc

Training Opportunities

Educational webinars

Leadership

Protected Time to Learn

Evaluation and Impact

Hertfordshire and West Essex Integrated Care System

2. Building a Sustainable Workforce: Retain

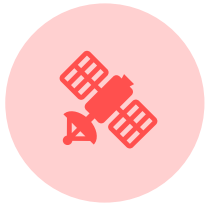
Growing the Primary Care Workforce

Medical Student Placements (New Hertfordshire Medical School)

Student Nurse Placements

Apprenticeships

Community Designated Prescribing Pharmacists



Continue to support embedding New Roles: expansion of roles including ARRs GPs and GPNs

Use data to identify workforce gaps and trends

Support the enhancement of integrated care: exploring rotational and hybrid roles, expanding cross sector career pathways across secondary and community

Hertfordshire and West Essex Integrated Care System

3. Reform

Improving data accuracy

Have a deep understanding of the Primary Care workforce and focus on using data to inform and drive improvement. This will include working closely with PCNs and practices to create a clear understanding of accurate data reporting and using data as a tool to design a workforce that supports patient requirements.

Improve Awareness in Primary Care: Provide opportunities for teams to contribute to educational webinars to improve awareness of initiatives within Primary Care ie supporting Primary Care to better identify carers and improve carers' health

Collaboration

Working closely with community pharmacy, optometry, and dental to understand their support requirements from the Primary Care Workforce team

Develop innovative programmes of work

Design and implement new innovative strategies that help to aid staff retention and engagement.

HWE Training Hub – Training Opportunities

Training Hub website: https://www.hwetrainginghub.org.uk/

Training Hub email address: hwetraininghub@nhs.net

CPD training including locally designed opportunities

Primary Care Webinar Library

Webinars and Support Forums

Hertfordshire and West Essex Integrated Care System

Questions

Hertfordshire and West Essex Integrated Care System

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐				
	ICB Primary Care Transformation Committee (Public)				**Meeting Date:**	**24/04/2025**		
Report Title:	**Winter 24/25** **1. Evaluation of the additional Primary Care Network funding** **2. Vaccination evaluation 24/25 and plans for 25/26**				**Agenda Item:**	**6**		
Report Author(s):	Philip Sweeney, Head of Primary Care Transformation, West Essex place ICB Penny Thomas, Senior Primary Care Transformation Manager Julia Lisk, Primary Care Manager Marius van der Lith, Senior BI Analyst							
Report Presented by:	Philip Sweeney, Head of Primary Care Transformation, West Essex place ICB Penny Thomas, Senior Primary Care Transformation Manager							
Report Signed off by:	Avni Shah, Director of Primary Care Transformation							
Purpose:	**Approval / Decision**	☐	**Assurance**	☐	**Discussion**	X	**Information**	X
Which Strategic Objectives are relevant to this report **[Please list]**	▪ Improve access to Health and Care Services. ▪ Increase healthy life expectancy, and reduce inequality. ▪ Increase the numbers of citizens taking steps to improve their wellbeing. ▪ Give every child the best start in life.							
Key questions for the ICB Board / Committee:	▪ Committee to discuss the paper and plans for vaccination for this year and how we can enhance our uptake for vaccination across all groups as key intervention to prevent non-elective admissions.							
Report History:	▪ Winter planning for 2025/26 was presented on 2nd September 2024 at Primary care Commissioning Committee							

Executive Summary:	**Winter funding for General Practice** The ICB agreed for additional funding for Primary Care Networks for the winter months from primary care budget, defined as November to February, of 24/25. This has been in place over the last 3 years. For 2025/26 in line with the national priorities for winter, the PCNs were to develop plans to focus on the 2 main ICS priorities. 1. Prevention, frail population, those living with multiple long-term conditions or at end of life. 2. Community Urgent and Emergency Care. Based on each bespoke plan PCN's baseline metrics were agreed. The aim was to show improvement on that baseline over the winter months and where appropriate for comparisons to be drawn from the previous years. During the evaluation, two issue became apparent. The first was data being returned from Princess Alexandra Hospital Trust as incorrect and couldn't be used. Secondly practices/PCN's have continued to evolve with the implementation of Modern General Practice since last winter and improvements such as introducing total triage would also impact on the data returns. This has therefore proved difficult to compare impact from last year because variables have changed. From the data presented - On average same day appointments, across HWE, increased by 4.3% from the previous winter. - No statistically significant impact was seen on in hours Acute Trust activity across any of the metrics, for SWH or ENH hospitals (PAH data not available). **Vaccinations** Each year NHS England publish the latest guidance on winter vaccinations. They outline when each programme starts and ends, eligibility criteria, recommended vaccines and reimbursement. Aim is to deliver a 100% offer to eligible groups and ensure they have robust plans in place to identify and address health inequalities for all underserved groups, and it is expected progress will be made on reducing unwarranted variation and improving uptake. Nationally 24/25 data shows low uptake numbers in particular cohorts (health and social care workers, clinical risk groups, children aged 2 and 3 years old, and pregnant women) and therefore firm plans are needed to improve uptake rates in 2025 to 2026. HWE ICB has reviewed the data compared to the others in the East of England region and identified learning and opportunities to improve uptake for 25/26.

<table>
<tr><td>Recommendations:</td><td colspan="4">To work with all Health Care Partners to seek suggestions on Primary Care focuses for Winter 25/26 including how we can enhance our approach to vaccination which is one of the key interventions to reduce non elective admissions.</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">Vaccinations come with funding for the delivery of them. As there are several providers that can deliver them conflicts particularly for General Practice and pharmacies may exist.</td></tr>
<tr><td colspan="5">Implications / Impact:</td></tr>
<tr><td>Patient Safety:</td><td colspan="4">Yes, by not creating additional appointments in the busy winter months patient safety is a factor to consider.</td></tr>
<tr><td>Risk: Link to Risk Register</td><td colspan="4">PC2 Risk – Refers to the high-level pressures in General Practice; If additional capacity is not created over the winter period, then this could impact the ability to provide patient care and cause sub-optimal patient experience.</td></tr>
<tr><td>Financial Implications:</td><td colspan="4">By not creating appropriate winter capacity for General Practice patients' may seek low level healthcare from other providers which could cost more</td></tr>
<tr><td rowspan="3">Impact Assessments:
(Completed and attached)</td><td colspan="2">Equality Impact Assessment:</td><td colspan="2">Not applicable however the winter money is commissioned across all primary care networks and funding on weighted population to meet the needs of the population. Similarly for vaccination, there is a huge emphasis on identifying vulnerable groups of population and commissioning outreach services where appropriate for hard to reach for the vaccination programme.</td></tr>
<tr><td colspan="2">Quality Impact Assessment:</td><td colspan="2">N/A</td></tr>
<tr><td colspan="2">Data Protection Impact Assessment:</td><td colspan="2">N/A</td></tr>
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ITEM 1

General Practice Winter funding 24/25

Evaluation paper April 2025

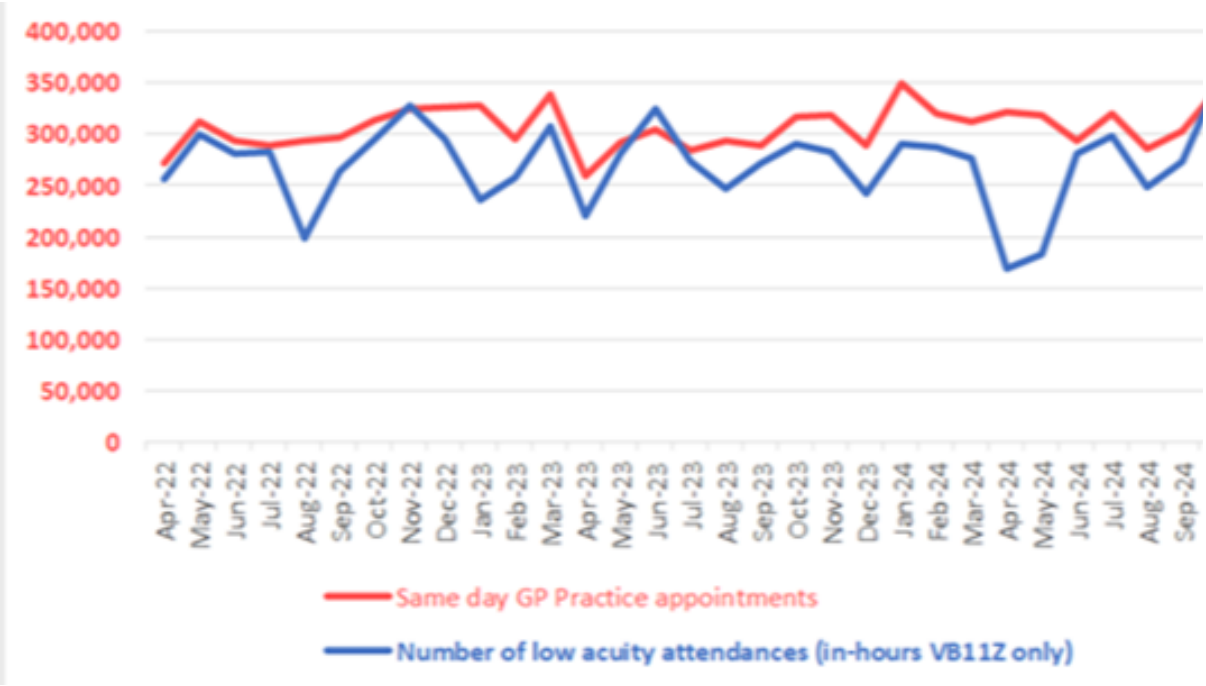
Introduction

It is widely accepted that during the winter periods the demand and management of healthcare service increases and becomes more difficult, due to multiple factors; colder weather, sessional illness and increased staff sickness. In recognition for this the Integrated Care Board (ICB) approved additional funding, in winter 2024/2025, to General Practices services to provide additional capacity in their practice to support the Integrated Care System (ICS). This evaluation investigates the impact and analysis of these actions and how they effected other parts of the Integrate Care System. Throughout the report the Winter period is defined as the 1st of November 2024 until 28th February 2025.

Background

The ICB has been commissioning additional capacity to support winter pressures since 21/22 recognising the pressure on general practice following the COVID pandemic and consistently high levels of demand during the winter months. In 22/23 there was additional national funding for additional appointments via re-purposed 'Investment and Impact Fund' (IIF) and funding for acute respiratory hubs. For 23/24 funding was only provided via the ICB which has been replicated for 24/25.

The emphasis for winter planning in 23/24 was about system working and responsibilities for each part of the system to work together to deliver operational resilience. It reflects the publication of the delivery plan for recovering Urgent and Emergency Care (UEC) services along with the Primary Care Recovery Plan, Elective Recovery Plan and the broader strategic and operational plans and priorities for the NHS. The ICB approach for 2024/25 was to build on the learning from previous years, which showed additional appointments in general practice did not impact the number of low acuity activity seen in secondary care. This graph from the last few years demonstrates the point well, increasing GP same day capacity at any time of the year generally just makes the low acuity demand in secondary care follow suit. The average yearly same day appointments offered compared to all appointments is around the 40% mark with clear increases in the winter months to around 46%.



Whilst reviewing in year data and planning for winter 24/25, it was identified in the ICB Urgent and Emergency Care (UEC) strategy and Primary Care Strategic Delivery Plan, one of the deprived areas lacking immediate access to urgent same day minor illness care within the ICS was Hertsmere. A previous business case for a minor illness hub had not been approved due to lack of funding. Following discussion at Southwest Hertfordshire (SWH) Health and Care Partnership (HCP) and Primary Care Transformation Committee, a proposal was approved to use part of the primary care winter monies to support with additional capacity in Hertsmere, with a view to also give an opportunity to evaluate proof of concept and see the impact of reduction of minor illness activity at local trusts. The funds for this were taken from the SWH allocation before Primary Care Networks (PCN's) received the remaining share, (£1.10 per weighted population). Please note the PCN minor illness hub was for a 6 month period which is only just completing its term, analysis of this service is therefore not included in this report but general reference will be made.

For the past 4 years the assumption has been by creating additional same-day access appointments this would help with the increasing demand over the winter months. However, with the strategic direction of working collaboratively as system partners and the steer to reducing admissions by 25% the approach this year will be different. PCNs were asked to develop plans for funding use in line with the priorities set out below,

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 inpatient episodes. Key areas are 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 50% of EA capacity can be utilised for these)

Priority 2: Community Urgent and Emergency Care

Improve access to urgent and emergency care appointments which will give protection to our emergency departments for those people that need access to the specialist urgent and emergency response of our acute hospitals. (an example of creating capacity in a local UTC)

Each place team had bespoke discussions with their locality clinical leads and PCN Clinical Directors to explore the best opportunities for their individual areas. The aim was simply to create additionality but recognising that each PCN is different with in terms of population health, workforce, and geographical challenges. Therefore, if a particular area had struggles with phone answering than by allowing an increase to administrative care navigators would in theory aid in resolving this and patients' could then be correctly directed. Other ideas that had been tabled during the discussions, but are not exhaustive, were.

1. Increasing the number of care home ward rounds each week.
2. Additional admin staff to allow clinical staff to see patients.
3. Collaborate with local MIU's/UTC's to assist with additional capacity.
4. More appointments in Extended Access.
5. More same-day access appointments throughout the day.
6. An entire PCN approach or at local practice level.

PCN's were required to set an initial baseline on the activity they would be trying to enhance, they needed to articulate what the predicted impact of their plan will be and how this would be measured, appendix 1 shows the baseline headings and data given to the PCN's). This would then allow an in-depth analysis post winter 24/25 to measure success, the ICB Primary Care team would help support this element. Appendix 2 shows an example return required from the PCN.

It was also identified from the previous 4 years that there are certain months of winter where demand is of its highest. This has resulted in condensing this year's funding period over a 4-

month period and not 6 months as in previous years. Winter for 24/25 funding was used during November'24, December'24, January'25, and February'25.

The offer to General practice, by the ICB, was created after debriefs and knowledge collection from previous years. By working with PCN's using data collection and their own local intelligence, plans could be more tailored to their needs and not a one size fits all approach. This allowed PCN's to take greater ownership of the plans and really work through how they could make impact to the healthcare system.

The ICB Business Intelligences (BI) teams were enlisted in supporting the data analysis to see if the following two key questions could be answered.

1. To determine whether the additional winter 24/25 funding provided to Primary Care Networks achieve the purpose for which it was intended.

2. To determine which actions taken by PCN's had greatest impact on the Integrated Care System.

PCN's had the choice to focus on a single metric or multiples, this table shows how many PCN's focused on which areas.

Locality	Monthly Average of Same Day Appointments	Monthly Average of In Hour A&E Attendances	Monthly Average of In Hours 111 Calls	All monthly A&E attendances	Monthly Non-Elective admissions
ENH	10	1	2	2	4
SWH	9	3	9	3	6
WE	3	1	1	3	6
TOTALS	22	5	12	8	16

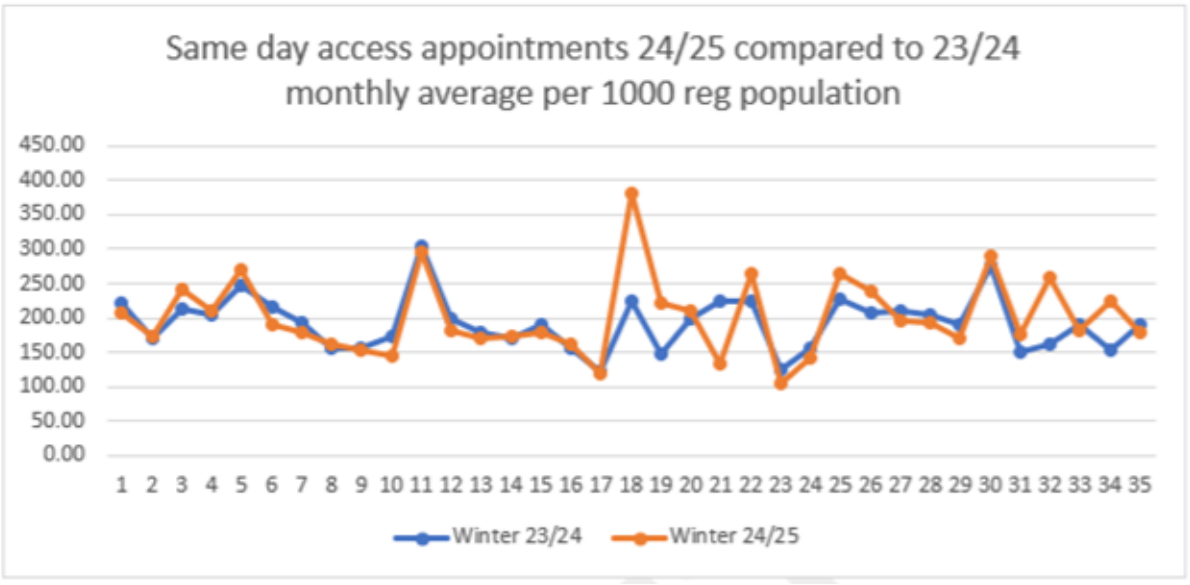
What the evaluation/analysis showed

(Please acknowledge that some logical assumptions must be made in relation to the report, mathematically answers are not completely accurate, due to year-on-year variations.)

For this analysis A+E and non-elective admission data from Princess Alexandra Hospital Trust has not been available which has resulted in gaps in analysis for PCN's using this secondary care provider.

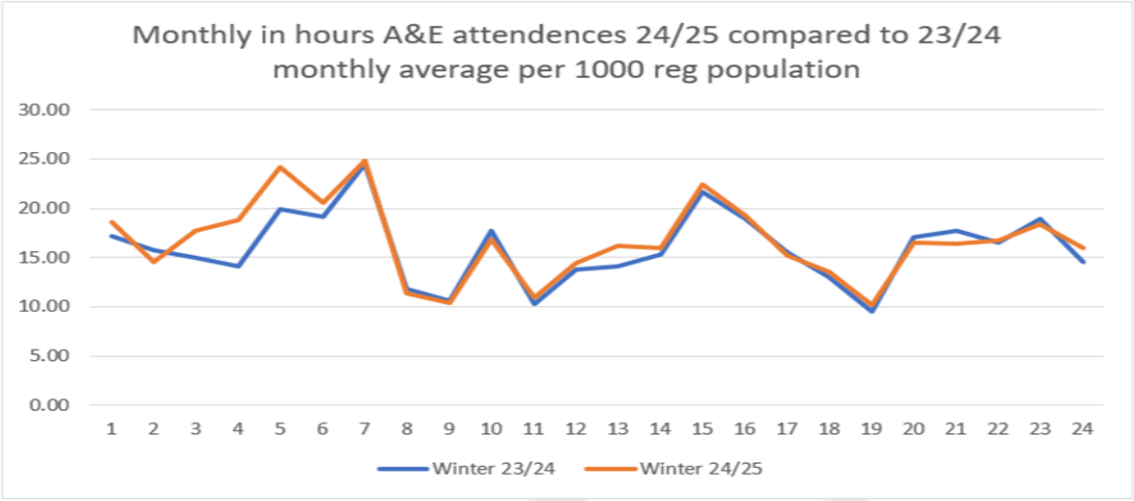
The following summary is split into each of the above table heading showing graphs and narrative produced by the Bi team. PCN's have been given random numbers from 1 to 35.

Monthly average same day appointments compared to last winter 23/24 analysis:



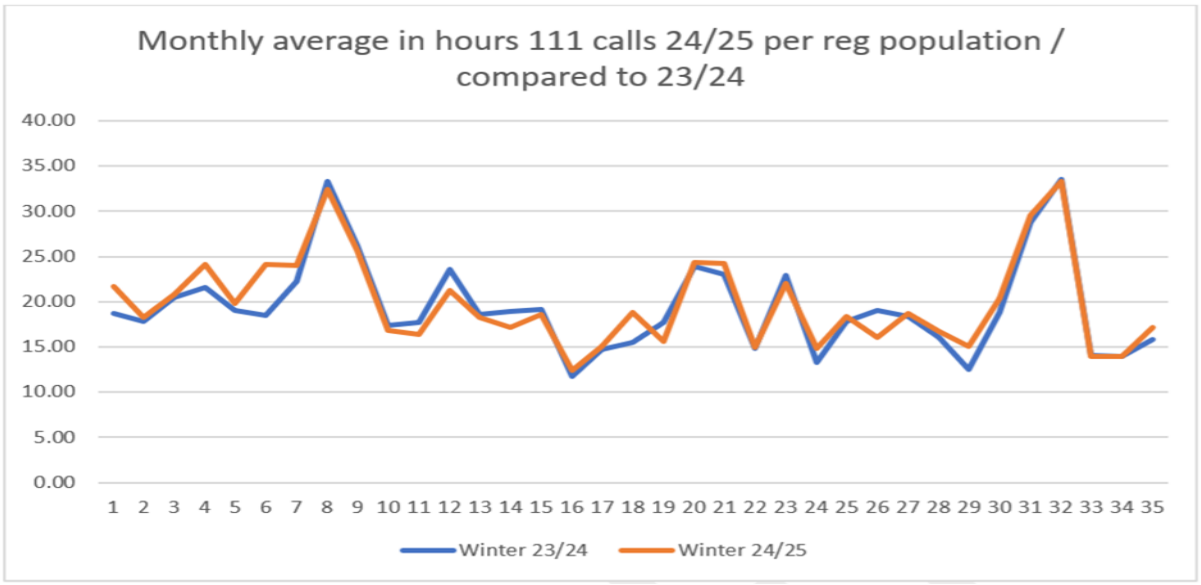
With regarding GP access appointment data, the average Same Day GP appointment rate showed 17 PCN delivering more than previous years and 18 PCN's delivering less. As an ICB collective 4.37% more appointments were delivered than previous years. Although the slight increase is positive it does not equate to a statistically significant difference and is therefore like due to chance (random variation). The graph does show some PCN's, 8 in total, that could be classed as statistically significant increases from the previous winter. However, in across these 8 PCN's other factors are likely to have influenced, such as moving to total triage systems., coding appointment data more consistently and workforce model changes. We are unable to conclude that any statistically significant difference was solely because of winter funding.

Monthly average in hour A&E attendances 24/25 per 1000 reg population compared to last winter 23/24 analysis:



With regards to in-hour A&E attendances, the average rate was marginally more in Winter 24/25 than from the previous year. As an ICB this was an average increase of 4.3% for the 24 PCN's that data was available for (and note that we are unable to analyse data for ENH and WE PCN's who's data would have come from PAH due to quality issues). No individual PCN had any increase or decrease that would be classed as statistically significant and therefore any variance from the previous year were likely due to chance (random variation).

Monthly average in hour 111calls 24/25 per 1000 reg population compared to last winter 23/24 analysis:



In relation to 111 calls, the average 111 calls rate was greater in Winter 24/25 than in winter 23/24 for 21 out of the 35 PCNs. As a system this equated to a 1.76% increase overall. This does not equate to a statistically significant increase. However, 2 PCN's that were higher this year than last year and could be thought of as statistically significant (at 6%) had focused their efforts on other metrics which had no statically significant increases which may explain this.

The aim of the above data, with analysis, was to answer the initial two questions of:

1. To determine whether the additional winter 24/25 funding provided to Primary Care Networks achieve the purpose for which it was intended.

2. To determine which actions taken by PCN's had greatest impact on the Integrated Care System.

For the first question this is where some mathematical evidence and assumptions need to be brought together. The aim was not necessarily to reduce activity in other parts of the system but to ensure the increased pressures commonly seen, across all parts of healthcare, during the Winter period is equally owned. Although a 4.3% increase in same day access

appointments is not statistically significant, mathematically, patient demand increases year on year and these additional appointments would have surely (an assumption) stopped a percentage of patients attending other healthcare settings for their needs. The question that still can't be answered is what would happen if this additional general practice Winter funding stopped, would statistically significant spikes be seen in A&E attendances and NEL admissions?

For the second question PCN's plans were reviewed against the metrics they had chosen to baseline themselves against. However, each PCN that had any significant differences across their metrics and also developed in other ways such as total triage systems, different ways of working, Care Home hubs and more accurate data recording so it has not been possible to attribute any of the positive results to solely the funding provided.

Winter 25/26 conclusions

Whilst difficult to draw conclusions on whether this has an impact on reducing A&E attendances, the capacity is utilised as the demand outweighs the capacity across the system. It was early to also draw any conclusions on the capacity commissioned nationally via community pharmacy on the implementation of Pharmacy First Scheme for a number of minor illness conditions.

Population behaviour due to demographics, cultures, ethnicity, age, disabilities and social status can all influence decisions when accessing healthcare.

ITEM 2

Hertfordshire and West Essex Vaccinations

Evaluation paper April 2025

1. Introduction

Each year NHS England publish the latest guidance on vaccinations to be completed for the financial year. They outline when each programme starts and ends, eligibility criteria, recommended vaccines and reimbursement.

Each year providers are expected to deliver a 100% offer to eligible groups and ensure they have robust plans in place to identify and address health inequalities for all underserved groups, and it is expected progress will be made on reducing unwarranted variation and improving uptake.

Nationally 24/25 data shows low uptake numbers in particular cohorts (health and social care workers, clinical risk groups, children aged 2 and 3 years old, and pregnant women) and therefore firm plans are needed to improve uptake rates in 2025 to 2026.

HWE ICB has reviewed the data compared to the others in the East of England region and identified learning and opportunities to improve uptake for 25/26.

2. Background

In response to the Covid pandemic in 2020, a national programme for vaccination was established and rolled out at pace during 2021. The programme was a huge success as it was able to draw resource and workforce from across system partners to mobilise quickly and efficiently. The Covid vaccination programme was scaled down during 2022/23 with staff and resources being pulled back to their original posts etc. leaving the management of the programme within primary care directorate to be picked up as a portfolio across a few members of the primary care place team and incorporated within their day-to-day work as locality managers.

Each year the NHS prepares for the unpredictability of flu. For most healthy people, flu is an unpleasant but usually self-limiting disease with recovery generally within a week.

However, there is a particular risk of severe illness from catching flu for:

- older people
- the very young
- pregnant women

- those with underlying disease, such as chronic respiratory or cardiac disease
- those who are immunosuppressed.

The development of the programme has seen the reduction of centralised sites such as mass vaccination centres and hospital hubs with a focus of long-term solution through primary care. This delivery has continued through PCNs but has expanded through roll out within community pharmacies.

As a result of this shift there are now 33 PCNs (out of 35) and 200+ Community Pharmacies (235 individual contractors to operationally manage) taking part in the programme (flu and covid or just flu) across the three places. This has given patients a vast array of choice on were to obtain their vaccines.

3. Brief evaluation of the 24/25 program

Although having multiple contractors delivering vaccines benefits patients and access opportunities the amount of administrative burden has tripled over the last 2 years as whilst NHS England is the commissioner for vaccination programme, the operationalisation of the programme includes:

- onboarding contractors as each season contractors have to sign up (twice per year)
- weekly vaccine allocation, (note recent consultation for flu vaccination to mirror covid vaccination which will be if progressed put huge pressure on the teams)
- mutual aid with the short expiry of the vaccination
- managing stock as a system to avoid wastage
- general enquiries on type of vaccine, availability, location, specific queries from vulnerable patients including those with allergic reaction, pregnancy etc and complaints
- role in wider vaccination uptake including flu and the introduction of RSV in 2024
- broader support for primary care teams on infection prevention and vaccinations when outbreaks occur (GP and POD - over 800 contractors across HWE), ensuring staff trained on FFP3
- follow up on mpox, DTP and MMR vaccination uptake in specific areas/localities/PCNs
- overarching governance responsibility of the vaccination programme
- ongoing reporting into region and cascade of information plus follow through with contractors in relation to supply etc

In addition, Herts Community Trust are also commissioned by NHSE to:

- deliver the vaccination programme for vulnerable patients in particular residents in care homes and housebound patients registered with the PCNs who have opted out of the programme.
- deliver targeted vaccination to support health inequalities including communities such as travellers, migrant and specific BAME groups learning from previous years.

Although there is a seasonal ask for Covid, the work to support the programme covers the whole year, with a concentration twice a year for three-month periods.

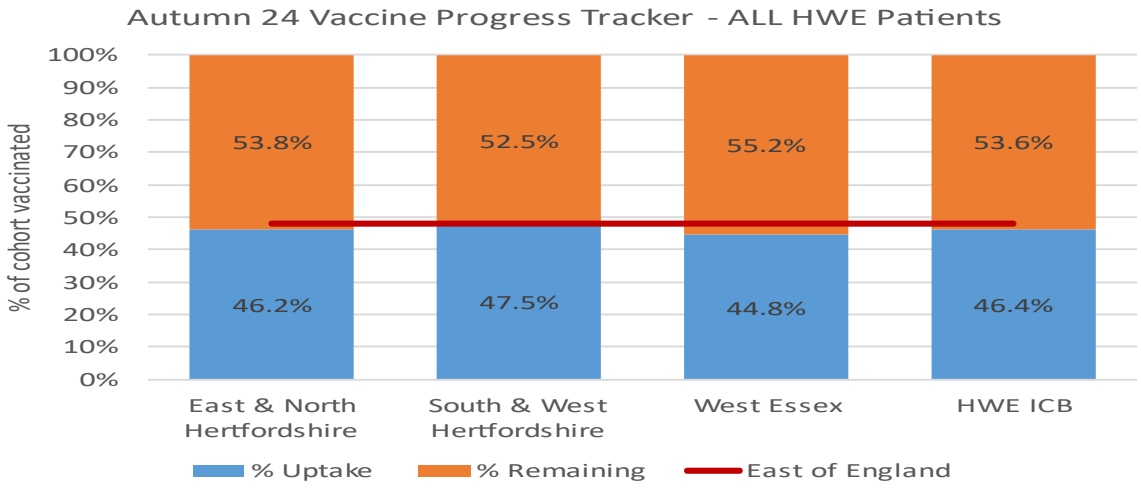
The main issues related to the 24/25 program have been identified as;

- National communications limited.
- The National Booking Service closes before the end of the campaign.
- For covid, vaccinations still need to be entered onto Pinnacle, whereas flu vaccinations are entered into the practice clinical system (EMIS, SystmOne) which is inefficient.
- Spikevax (previously Moderna covid-19 vaccine), as it has a short shelf life and risk to wastage is higher.
- Some ICBs have a small, dedicated vaccine team managing the yearly programmes, whereas HWE ICB absorb this across the Primary care team.

It is worth mentioning that the National Institute for Health and other sources have widely accepted the term of 'Vaccination fatigue', people's inertia or inaction towards vaccine information or instruction due to perceived burden and burnout. This has become a national issue with some sources reporting that up to 20% of people decline vaccines for this reason.

COVID-19 Vaccination

The covid vaccination patient data for HWE compared to the rest of the East of England is as follows.



46.4% of total HWE patients have received their Autumn 24 vaccination. Past data are not reliable; however, uptake seems to be decreasing every year.

We have reached out to neighbouring ICB's with slightly higher uptake to try and learn lessons. Norfolk and Waveney ICB have the highest uptake across all eligibility groups, however after conversations around their approach the most likely reason for increased uptake is the population demographic differences. HWE in comparison have a higher multi-cultural inhabitant which can present barriers for choosing not to be vaccinated.

FLU Vaccinations

In both adult eligibility groups (accept Pregnant women) flu vaccine uptake has reduced from previous years.

	Over 65s		At-risk under 65s		Pregnant women	
	Week 3 23/24	Week 3 24/25	Week 3 23/24	Week 3 24/25	Week 3 23/24	Week 3 24/25
MSE	75.5	72.7	37.7	34.7	27.0	27.4
BLMK	76.8	74.0	39.5	37.5	30.7	35.4
SNEE	80.9	78.5	44.4	42.8	32.2	34.8
HWE	77.5	75.2	41.6	40.7	32.2	34.0
N&W	81.2	78.7	46.5	45.2	36.8	38.5
C&P	79.6	77.2	43.2	42.3	34.9	38.2
Total EoE	**78.7**	**76.1**	**42.0**	**40.4**	**32.0**	**34.3**
Number EoE	**1.05m**	**1.05m**	**422,000**	**422,000**	**22,000**	**21,000**
Total England	**77.4**	**74.4**	**40.8**	**39.5**	**31.5**	**34.5**

Uptake for the young children have stayed stable from previous years and the East of England, as a total, have the highest flu vaccine uptake in school age children in the country.

	At-risk 6 months to 2 years (EoE population c. 2000)		2 and 3 year olds	
	Week 3 23/24	Week 3 24/25	Week 3 23/24	Week 3 24/25
MSE	4.0	7.0	40.5	41.5
BLMK	9.9	12.3	43.9	42.7
SNEE	10.9	8.4	48.9	52.3
HWE	13.5	15.2	48.3	46.5
N&W	13.5	17.4	53.3	55.4
C&P	12.5	14.2	48.9	51.6
Total EoE	**10.8**	**12.3**	**46.7**	**47.5**

Despite the general decrease in both Covid and Flu vaccination uptake, which was a national trend. Some positive work and improvements were seen in the 24/25 program;

- Good engagement and support from partners including Public Health
- Wide geographical coverage from PCNs and community pharmacies
- Support from HCT with housebound and care home residents where PCNs had opted out
- Communications support from within ICB
- Continuous improvement to the Federated Data Platform with easy access for all sites
- Functionality on National Booking Service for patients to book Covid and Flu at the same time
- Wastage was less due to stock allocation algorithm working well and exceptions process
- Vaccine types in latest campaign caused little confusion and errors with data capture
- Site contract sign up from September '24 to March '26
- A&I funding was used for communication activity such as delivering leaflets about the benefits of vaccinations to food banks and day centres, with the aim of reaching homeless groups and Gypsy and Roma Travellers but not limited to this group

Potential impact of vaccination uptake and NEL admissions

Further analysis underway via BI with triangulation of primary care data on patients vaccinated and NEL. (this includes in relation to the RSV vaccine that was introduced in the last 12 months)
Initial analysis from a snap shot of practices who have shared data on ICB data platform indicated a reduction in the respiratory-related NELs rate for those adults with asthma who had been vaccinated against flu.

4. 2025/2026 plans

On the 13 February 2025, NHS England sent the national Flu immunisation programme letter to all Integrated Care Boards.

JCVI has advised that the Spring cohort may be mirrored in Autumn 2025. Health and social care workers, 65–74-year-olds and adults in the ‘at risk’ cohort would be excluded from covid, where they have been included previously. This would mean a considerably smaller covid cohort than flu.

COVID

Based on a 55% assumed uptake (compared to 57% in 2024), we are expecting around **104,000** covid doses to be administered by HWE providers in Autumn/Winter 2025 (assuming Autumn/Winter cohorts are confirmed to be same as Spring).

FLU

For flu, uptake is also decreasing year on year, so we can expect a 27.5% uptake in 2025 for all from age 6 months plus, meaning we are expecting around **457,000** flu doses to be administered by HWE providers in Autumn/Winter 2025.

Respiratory Syncytial Virus

A common cause of coughs and colds. RSV infections usually get better by themselves, but can sometimes be serious for babies and older adults. The RSV vaccine was rolled out nationally last year and is recommended:

- for those turning 75 on after 1 September 2024
- during pregnancy (from 28 weeks)

During the first year (up to August 2025) there is also a catch up programme for those aged between 75 and 79. It is not a seasonal vaccination and is available all year round. Latest data for HWE shows uptake for 75-79 years olds at 59% when compared to a regional figure of 61% and the total rsv number is 53825 administered of which 12598 are maternal related.

Our general focus this year includes;

- National communication team has agreed to produce one region-wide set of good quality campaign assets, this will include a focus on myth busting. HWE communication team will support ensure this is disseminated far and wide with specific focus on patient cohort groups.
- Further engagement is needed from Acute partners in delivering occupational health programmes. Health & Social Care staff are not likely to be included for covid vaccines in 2025, and H&SC uptake is better for flu; however there needs to be better engagement with Acute Trusts in terms of them attending the Vaccination Cell.
- HWE, along with all other EoE ICBs have made requests for Access to National Booking Service to remain open until the end of the campaign, this was request last year but was not actioned, ultimately, it's a national decision.
- Where possible HWE will try to avoid Spikevax, as it has a short shelf life and risks higher financial and drug wastage.
- Video resources have been made available, created by diverse patient groups, that can be used to target our communication strategy.

- Our staff in the Primary Care team who have previously been involved in vaccination programs are continuing to lead on the 25/26 program as they are well versed in the complexities, barriers and processes involved.

5. Resources implications

The team that currently supports the vaccination programme is made up of colleagues from Primary Care teams supporting each other working across the system irrespective of which place their main role is in. The team is supported with communications lead managers and PMOT for medicine related enquiries from professionals/patients.

Like previous year, 2025/26 the ICB have been provided with programme management funding which will go towards the running costs allowance.

Depending on the future direction of delegation of vaccination and screening programme, and recent announcements, further discussions to be held as and when appropriate on the future commissioning and operational role for this function.

6. Recommendations and in progress

Main areas to focus on for the 25/26 vaccination program are;

1. Greater communication and engagement have started, with underserved cohorts of patient to help educate, myth bust and increase uptake.
2. The ICB communication teams are making resources, information, videos and posters widely available and promoted across all our system.
3. The ICB Primary Care team are working with our community providers to increase coverage.
4. The ICB Primary Care team are working with health inequality teams to target community events.
5. The ICB Primary Care team are exploring options on how to work with other teams to triangulated DNA reasons
6. For RSV – clear communication to the public and healthcare worker on the eligibility and delivery of this vaccine.

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐			
	Primary Care Transformation Committee (Public)				**Meeting Date:**	**24 April 2025**	
Report Title:	**Primary Care Risk Register**				**Agenda Item:**	**7**	
Report Author(s):	Andrew Tarry, Head of Primary Care Commissioning						
Report Presented by:	Andrew Tarry, Head of Primary Care Commissioning						
Report Signed off by:	Avni Shah, Director of Primary Care Transformation						
Purpose:	**Approval / Decision**	☐	**Assurance**	☐	**Discussion**	☒	**Information** ☒
Which Strategic Objectives are relevant to this report **[Please list]**	• Increase healthy life expectancy, and reduce inequality • Give every child the best start in life • Improve access to health and care services • Achieve a balanced financial position annually						
Key questions for the ICB Board / Committee:	The Committee is asked to note the content of paper						
Report History:	The risk register is a dynamic document and is presented to the respective primary care subgroups including Primary Care Commissioning Committee, Primary Care Workforce Group and Primary Care Digital Group and Primary Care Transformation Group for review, discussion and information.						
Executive Summary:	It is proposed that the following 2 risks have a reduction in risk rating: Risk 244 Access to Dental services - Risk rating proposed to reduce from 16 to 12, however will remain on Corporate Risk Register. Reduction in current risk score due to successful negotiation of rebasing of contracts and internal governance process for activity redistribution approvals in a timely manner Risk 687 POD Workforce - processes for monitoring and planning workforce requirements. Risk rating proposed to reduce - to align with risk 686, so reducing from score of 9 to 6. Initial risk rating is considered too high on reflection. A new risk is proposed regarding the potential lack of clarity in the process for GP practices to follow with regards to the management of the patients' electronic health record pertaining to adoptions. This may result in records not being available to all care settings and care professionals do not have all relevant health information when treating the child.						

	Key updates and rationale for risk scores have been provided on the remaining Primary Care risks. Updates have in particular focused on contractual updates for 25/26. The review and actions outlined will maintain the the number of Primary Care risks reported on the Corporate Risk Register as 2, albeit with the reduction in the Access to Dental services as highlighted.			
Recommendations:	The Committee is asked to • Note the proposed changes to the risks that have been reviewed • Note the update and progress made			
Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***	☐
	Financial	☐	***Non-Financial Personal***	☐
	None identified			☒
Implications / Impact:				
Patient Safety:	Patient safety issues are recognised in the appropriate risks			
Risk: *Link to Risk Register*	NA			
Financial Implications:	NA			
Impact Assessments: *(Completed and attached)*	***Equality Impact Assessment:***	NA		
	Quality Impact Assessment:	NA		
	Data Protection Impact Assessment:	NA		

1. Executive summary

It is proposed that the following 2 risks see a reduction in risk rating:
Risk 244 Access to Dental services - Risk rating proposed to reduce from 16 to 12, however will remain on Corporate Risk Register. Reduction in current risk score due to successful negotiation of rebasing of contracts and internal governance process for activity redistribution approvals in a timely manner
Risk 687 POD Workforce - processes for monitoring and planning workforce requirements Risk rating proposed to reduce - to align with risk 686, so reducing from score of 9 to 6. Initial risk rating is considered too high on reflection.

A new risk is proposed regarding the potential lack of clarity in the process for GP practices to follow with regards to the management of the patients' electronic health record pertaining to adoptions. This may result in records not being available to all care settings and care professionals do not have all relevant health information when treating the child.

Key updates and rationale for risk scores have been provided on the remaining Primary Care risks. Updates have in particular focused on contractual updates for 25/26.

2. Background

Historically each of the three CCGs in HWE developed and maintained a primary care risk register; risks meeting predetermined thresholds were reported to Board via the Corporate Risk Register. Each of the three individual risk registers were fully reviewed and archived as part of creating the new consolidated ICB Primary Care risk register across the three 'places'.

Following the Executive Team meeting in March-24, during which the Corporate Risk register was received, it became apparent that a further engagement with risk owners was paramount to ensure that the risks held on the corporate risk register are accurate.

In April-24 the Primary Care Team undertook a full review of the recorded risks with advice and expertise provided by the Information Governance and Risk Team. Many of the risks were long standing having been collated originally as part of initial consolidated Primary Care risk register, reflected the situation pre-delegation for POD contractual areas and pre-dated full adoption of the ICB operating model. Consequently, following the review, a number of risks were recommended for closure and these were agreed by the Committee in May-24.

Update to the Committee in Nov-24 noted further review of the Risk Register to refine the risks on the register, also to consider the 'issue' versus 'risk' position i.e. events that have occurred, rather than a potential risk that could occur. It was agreed to amend some of the previously recorded risks to issues, with these removed from the Risk Register itself, however, will continue to be monitored using a separate internal Primary Care issues log. The review and actions outlined reduced the number of Primary Care risks reported on the Corporate Risk Register from 6 to 2.

3. Issues

Key updates and rationale for risk scores have been provided on the remaining Primary Care risks. Updates have in particular focused on contractual updates for 25/26.

The review and actions outlined will maintain the number of Primary Care risks reported on the Corporate Risk Register as 2, albeit with the reduction in the Access to Dental services as highlighted.

4. Actions

General Practice Risks

Risk 320 Pressures in General Practice

Risk rating of 12 so remains on Corporate Risk Register. Current scoring remains valid. Despite positive step forward on national contract & significant increase in ECF resourcing, there remains a risk that practices may choose to not engage in the ECF scheme, resulting in impact on patient services delivered locally.

Update to controls:

- GMS Contract agreed by GPC; national 'Collective Action' dispute with NHSE is therefore resolved. However there may be an increased focus on local areas of non-funded work or where it is perceived that funding does not match work required or demand.
- There has been further development of ECF, including wound care treatment to be paid on item of service basis and increase in Treatment Room funding to recognise workload, especially on ECGs. Commitment to review activity during 25/26 with a view to considering commissioning approach for 26/27. Local PSA screening Enhanced Service being finalised.

Risk 324 Processes for monitoring quality and performance of contract

Current scoring remains valid.

Update to controls:

- National GP Dashboard launched to support identification of unwarranted practice variation.
- Operational Planning requirement to develop action plans to improve general practice contract oversight, commissioning and transformation and tackle unwarranted variation in by June-25. Further national guidance is awaited in this respect.

Risk 329 Forecasting or forward planning for changes and challenges in general practice workforce

Current scoring remains valid.

Update to controls:

- Work underway to improve the accuracy and data quality of National Workforce Reporting System. This will ensure data available is more trustworthy and can be acted on with more confidence.
- Additional flexibility to the ARRS for 25/26 creates an opportunity for PCNs to recruit the staff they need, including the removal of restrictions to nursing roles and salaried GP positions.
- Operational plan undertaken in March-25 will be used as a baseline to support workforce growth predictions for the financial year

Digital risks

New risk proposed

IF There is no clear process for GP practices to follow with regards to the management of the patients' electronic health record pertaining to adoptions
THEN The electronic health records for adopted children may be managed incorrectly
RESULTING IN Potential for clinical risk if records are not available to all care settings and care professionals do not have all relevant health information when treating the child; Information pertaining to the birth family not being redacted and is thus visible to the child via record access or other care professionals at point of care; Other care settings not informed of the adoption and records become 'confused'

Proposed initial risk rating of 6.
Initial controls:

- Meetings underway to ensure processes in place with all relevant stakeholders. Number of adoptions across HWE low in any given year so able to manage ad-hoc until processes in place.

No further updates on the 2 remaining Digital risks. Current risk scores considered to remain valid.

Pharmacy Optometry Dental (POD) Risks

Risk 244 Access to Dental services

Risk rating proposed to reduce from 16 to 12, however will remain on Corporate Risk Register

Reduction in current risk score due to successful negotiation of rebasing of contracts and internal governance process for activity redistribution approvals in a timely manner. Delivery of contracts has improved due to the implementation of elements of the national Dental Access Recovery Plan. Overall contract performance has exceeded pre-Covid levels in 24/25 - expected delivery to exceed 94%. by a contract hand-back and requests to reduce.

Update to Controls:

- National specification for commissioning of urgent appointments has been published to support delivery of ICB contribution of the 700,000 additional urgent appointments following the government manifesto. Paper to extend Enhanced Access Scheme is going through internal governance in April (PCCC).
- Further funding approved to support increase in dental nurse triage capacity in NHS111 to support increase in appointment utilisation

Risk 686 POD Workforce training & education opportunities

Current scoring remains valid
Update to controls:

- DPP has now been included in training plan from existing allocation.
- Community Pharmacy section on Training Hub website underway
- Representation of POD at Primary Care WIG Meeting membership (part two)

687 POD Workforce - processes for monitoring and planning workforce requirements

Risk rating proposed to reduce - to align with risk 686, so reducing from score of 9 to 6. Initial risk rating is considered too high on reflection.

5. Resource implications

Refinement of the Risk Register as proposed by this paper will mean that ongoing review of the live risks will be more focused, however will still require the relevant Primary Care Directorate members to commit to the process review.

6. Risks/Mitigation Measures

As noted above.

7. Recommendations

The Group is asked to:

Note the changes to the risk register and agree to the proposals to reduce the risk ratings as highlighted.

Receive the risk register at future meetings (in accordance with the Primary Care Transformation Group's Annual Cycle of Business) in order to satisfy itself that risks are being appropriately captured and rated and that relevant/proportionate mitigation and controls are in place.

8. Next Steps

Ongoing review and update of the risk register.

Ensure that all recent updates to the risk register are entered onto the Datix system.

Transition Risks

Primary Care Directorate Risks - GENERAL PRACTICE SPECIFIC															Assurance Mapping								
ID	Datix ID	Date Opened	Committee	Executive Owner	Revised Risk Lead	Risk Description	Rating (initial)	Rating (current)	Rating (Target)	Risk Movement	Rationale for current risk score	Controls	Gaps in controls	1st Line Operational functions enforcing required behaviours and working practices throughout the organisation's day-to-day activities	1st Line - Level of assurance	2nd Line Oversight functions undertaking scrutiny and monitoring of the governance framework to ensure that it operate in an efficient and effective manner	2nd Line - Level of assurance	3rd Line Functions providing independent and objective challenge and assurance with regards to the organisation's governance arrangements	3rd Line - Level of assurance	Gaps in assurance	Approval status
PC2	320	10/11/2021	Primary Care Board	Director of Primary Care Transformation	Heads of PC Transformation (WE/ENN/SWH)	**IF** pressures in general practice remain at the current high level... **THEN** there may be insufficient capacity for GP practices, primary care networks and federations to deliver against transformation of care priorities in a way that demonstrates tangible improvements for patients... **RESULTING IN** sub-optimal patient experience due to continued pressures across the system and especially in acute services.	20	12	8	No movement ↔	Current scoring remains valid. Despite positive step forward on national contract & significant increase in ECF resourcing, there remains a risk that practices may choose to not engage in ECF, resulting in impact on patient services delivered locally.	October 23 - Additional winter scheme to support continued demand in primary care through local funding. November 23 - Agreement to launch UTI pilot across HWE across community pharmacies ahead of national scheme which is due to start in February 24 - Launch of the integrated UTC at PAH and Stevenage PCN model to support priority localities as identified in UEC strategy. Risk of Hertsmere project which is planned for 2024. - ICB has responded to the publication of the Primary Care Access Recovery Plan and is communicating and supporting PCN's with implementation - ICB is supporting Practices and PCNs to participate in the GP Improvement Programme (GPIP) - in response to the ongoing IA the ICB is supporting PCN's with increasing capacity to support system wide approach. - the ICB has undertaken a period of engagement and has an approved Primary Care Strategy in place to support integration of primary care and to support general practice. - Primary Care Teams supporting PCNs in reviewing progress on Access Improvement Plans - Granted £1.074m Transition Cover funding to support implementation of Modern General Practice model - Plan for Roll out of Support Level Framework (SLF) to support practices in understanding their development needs Jan 2024: Additional funding provided to PCNs to support periods of junior doctor industrial action May 2024 - year 2 of PC Access Recovery Plan. Further support to implement CBT, implementation of moder General Practice April 2025 - GMS Contract agreed by GPC; national 'Collective Action' dispute with NHSE is therefore resolved. However may be an increased focus on areas of non-funded work or where it is perceived that funding does not match work required or demand. Further development of ECF, including wound care treatment to be paid on item of service basis and increase in Treatment Room funding to recognise workload, especially on ECGs. Commitment to review activity during 25/26 with a view to considering commissioning approach for 26/27. Local PSA screening Enhanced Svc being finalised.		• Primary Care Working Groups support the preparation and monitoring of plans with any risks or issues escalated. Risk registers monitor resilience in all practices. • Resilience panels receive applications for support • ICS population health management group. • Practices are compliant with national and regional guidance during the Covid 19 pandemic.	Reasonable	•Place based delivery boards have a strong primary care presence and monitor delivery against locality plans. • All overseen by the Primary Care Commissioning Committees and Primary Care Board and reported to ICB Boards as appropriate. •Primary Care updates and assurance papers to other ICB Committees and groups as appropriate. •Approval of expenditure above PCCC authorisation limit is escalated to another Committee or Board meeting. •-Audit and Assurance Committee receives internal audit reports and updates on	Reasonable	•CQC reporting shared with ICB. •NHSE/I remedial actions discussed with ICB •Internal audits of Primary Care Networks and Delegated Commissioning provide reasonable or substantial assurance.	Reasonable	ICB and HCP structures fully implemented and embedded	Approved by Committees meeting in common March 2022 Reviewed by PCB Sept22 Reviewed by PCB September 23
PC5	324	04/03/2022	Primary Care Commissioning Committee	Director of Primary Care Transformation	AD for Primary Care Contracting	**IF** there are not consistent and rigorous processes for monitoring quality and performance of contracts and investments... **THEN** there is potential for variable outcomes in improvements across the three geographical areas... **RESULTING IN** inequalities in the quality and performance of ICB primary care services and disparities in costs for the same services in different locations.	20	8	8	No movement ↔	Current scoring remains valid *Previous rationale:* *Review has concluded that there are now sufficiently consistent and rigorous processes for quality monitoring. This does not mean this removes the likelihood of variance across areas and practices, however the processes exist to flag these sufficiently & provide the opportunity to intervene.* *In light of this the risk rating has been amended to reduce to 8 (potential major impact, but unlikely to occur)*	1) Individual processes are in place for ICB, for example: -Inclusion of PC data in Quality and Performance reporting to ICB Board - PCCC meeting has independent input from an out of area GP. - PCCC membership has a non-GP majority. - Risk and information sharing meetings with all relevant teams, LMC, Nursing & Quality and CQC. - Support packages in place for all practices with an existing ratings of 'Inadequate' or 'Requires Improvement' - Quality visits to practices and Extended Access sites - Practice Manager meetings 2. Healthwatch action plan 3. Reporting to single ICB Primary Care Board, with non-GP majority membership. Single Primary Care Contracting Panel now in place May-24 - implementation of Quality/Contract Review visit pogramme as a supportive, consistent, improvement focussed process Resilience Tool April-25 - national GP Dashboard launched to support identification of unwarranted practice variation. Operational Planning requirement to develop action plans to improve general practice contract oversight, commissioning and transformation and tackle unwarranted variation in by June-25	Reviewing approach to joint Quality/Contracts visits. Propose using current WE risk dashboard format as a consistent ICB wide format. Assessment of PCNs needs further consideration - relationship between PCNs & member practices, supervision of PCN staff	Internal quality and performance monitoring processes in each place. Support to practices with 'inadequate' or 'requires improvement' rating. Support to practices with access challenges, e.g. staffing or premises.	Reasonable	Reports to PCB and Quality Group Assurance to PCCC Liaison with CQC and LMC	Reasonable	Liaison with CQC and LMC Internal audit opinions Updates to patient groups e.g. Patient Network Quality (PNQ) Monthly meetings with Healthwatch Presentations at Local Authority Overview and Scrutiny Groups	Reasonable	Extent of reporting of primary care quality and performance to Public Board - for discussion: terms of reference and work plans for ICB committees are being developed by the ICS. There is also discussion of Quality Groups at place at request of the ICS. Some practices reluctant to engage or nor highlighted as potential risks may be inspected by CQC, with further unknown risks emerging.	Reduced risk score from 12 to 8; agreed by PCTC Nov-24
PC10	329	04/03/2022	Primary Care Workforce	Director of Primary Care Transformation & Director of Workforce	Head of Primary Care Workforce	**IF** there were no forecasting or forward planning for changes and challenges in general practice workforce... **THEN** we would be unable to foresee changes in workforce and act proactively to address expected shortfalls in any profession... **RESULTING IN** threat to patient care as patients may not have access to a range of skilled professionals in primary care.	9	6	3	No movement ↔	Current scoring remains valid *With the controls we have in place and responsibility of contract holders for service delivery we would not expect to see this risk translate into an incident and given the provision of services across PCNs and wider health system would expect the impact to be moderate* *Previous rationale:* *Don't expect it to happen (score 2) and if it did the consequence would be moderate (score 3) with a significantly reduced service effectiveness and local media coverage likely*	1. Monitoring workforce trends by improving data accruacy and visability of data reporting 2. Taking novel approaches to recruitment and retention 3. Providing updates to PCNs including ARRS position 4. Primary Care Teams working with PCNs to submit forward ARRS workforce plans 5. PCN workforce teams connected to current /future issues in practices/PCNs 6. Plan with system partners to avoid destabilising the workforce Nov-23 Update - PCNs submitted updated Workforce plans by 31-Oct23. These plans are being reviewed by Primary Care Team. Balance to be struck between maximising utilisation of ARRS buget vs ensuring that PCNs move towards living within their means (ARRS budget) for 24/25 onwards - Budget for ARR scheme roles to be maintained from 24/25 onwards, however awaiting further clarity on the GMS contractual arrangements in this respect Jan 2024: New Primary Care Workforce Dashboard being developed PCN Training Teams estabilshed and meeting with TH NHSE Annual Operational Planning process includes workforce forecasting Training Hub working closely with ICS Workforce Team to share /optimise resources and avoid duplication Working with Primary Care to improve workfore data reporting Aug 2024 Update -National changes to ARRS scheme announced enabling newly qualified GPs to be recruited, prompting PCNs to review recruitment plans under ARRS against patinet needs for 2024-25 Nov 2024 - Engaging with PCNs. Primary Care Place leads and workforce team setting up meetings with PCNs to offer supportive conversations. Support tool template developed to support conversations April 2025 Update: - Work underway to improve the accuracy and data quality of National Workforce Reporting System. This will ensure data available is more trustworthy and can be acted on with more confidence. - Additional flexibility to the ARRS for 25/26 creates an opportunity for PCNs to recruit the staff they need, including the removal of restrictions to nursing roles and salaried GP positions. - Operational plan undertaken in March-25 will be used as a baseline to support workforce growth predictions for the financial year	1. Increasing numbers of GPs and GPNs taking retirement mean further plans necessary to address retention or recruitment. 2. Difficulties recruiting to some AHP roles due to competition for their skills. 3. PCNs have autonomy for ARRS recruitment plans and have identified finances (shortfall in salary cap and management overheads) and risk (liability for staff given uncertainty about future of PCNs) and perceived value of some non-GP roles as barriers	Quarterly Workforce Data Collection Annual Skill Mix Collection	Substantial	Update reports to PCTC ~~PCB~~ and PCCC Progress monitored in ICS Workforce Group	Substantial	Reports to NHSEI	Substantial	Workforce data anaylsed and submitted as part of assurance processes doesn't include vacancy rates (data unavailable)	

Transition Risks

Primary Care Directorate Risks - DIGITAL ALIGNED RISKS																		Assurance Mapping								
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New Risk - May 2024	682	16/05/2024	Primary Care Digital Group	Director of Primary Care Transformation	Head of Primary Care Digital	IF digital tools are not fit for purpose THEN practices may not adopt usage of them or be unable to provide functionality to fully support a Modern General Practice operating model RESULTING IN lack of opportunities to improve patient experience by offering choice of access method practices unable to work within workforce capacity inequality of services offered to patients across ICB practices practices unable to meet access requirements	12	9	4	No movement ↔	Risk is mainly a monitoring of current position and working through normal workstreams to minimise impact of any non-adoption. Not felt to be a significant risk	1.Ensure procurments involve wide stakeholder base to assess tools available 2. Learn from other areas on tools used and opportunities/issues they have encountered		Head of Primary Care Digital with organised networking meetings, creation of resource collateral to share		Formal Governance via PC Digital Group		PC & Digital Boards Reporting to NHSE as part of PCARP		Limited influence over national	May-24 - New risk to articulate overall digital risk to access agenda. Agreed by PC Transformation Committee. **Aug-24 - downgrading of risk rating from 12 to 9**
New Risk - May 2024	683	16/05/2024	Primary Care Digital Group	Director of Primary Care Transformation	Head of Primary Care Digital	IF digital tools are not adopted by practices THEN practices will not be able to move to a Modern General Practice operating model RESULTING IN lack of opportunities to improve patient experience by offering choice of access method practices unable to work within workforce capacity inequality of services offered to patients across ICB practices practices unable to meet access requirements	12	9	4	No movement ↔	Risk not viewed as significant and workstreams as part of BAU covering minimising risk. Felt possible that practices don't adopt tools - particularly given pressures in General Practice - which will impact the ability to transform and move to Modern General PRactice	1.Continuously monitor usage of digital tools via various data sets available 2. Support practices with training and access to best practice guidance` 3. Create networks for sharing e.g. Digital Innovation Group, PCN Digital Leads Group		Head of Primary Care Digital with organised networking meetings, creation of resource collateral to share		Formal Governance via PC Digital Group		PC & Digital Boards Reporting to NHSE as part of PCARP		Limited influence over national	May-24 - New risk to articulate overall digital risk to access agenda. Agreed by PC Transformation Committee. **Aug-24 - downgrading of risk rating from 12 to 9**
New Risk Jan 2025	737	04/02/2025	Primary Care Digital Group	Director of Primary Care Transformation	Head of Primary Care Digital	IF There is no clear process for GP practices to follow with regards to the management of the patients electronic health record pertaining to adoptions THEN The electronic health records for adopted children may be managed incorrectly RESULTING IN •Potential for clinical risk if records are not available to all care settings and care professionals do not have all relevant health information when treating the child •Information pertaining to the birth family not being redacted and is thus visible to the child via record access or other care professionals at point of care •Other care settings not informed of the adoption and records become 'confused'	6	6	1		Meetings underway to ensure processes in place with all relevant stakeholders. Number of adoptions across HWE low in any given year so able to manage ad-hoc until processes in place	Regular meetings with HCT, CHIS, GPs to manage and establish controls		Meetings with stakeholders								Awaiting approval review by PCTC April 25

Transition Risks

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	244	01/04/2023	Primary Care Commissioning Committee	AD Primary Care Contracting	Head of Primary Care Contracts	**IF** there is a lack of access to dental services **THEN** this will impact on patient's treatment and care **RESULTING IN** deterioration of oral health across the population patient's resulting to extreme measures to get out of pain (DIY dentistry) increase in referrals to secondary care dental services thus increase in waiting times	16	12	6	Reduction ↓	Reduction in current risk score due to successful negotiation of rebasing of contracts and internal governace process for activity redistribution approvals in a timely manner. Delivery of contracts has improved due to the implementation of elements of the national Dental Access Recovery Plan. Overall contract performance has exceeded pre-Covid levels in 24/25 - expected delivery to exceed 94%.	1. Enhanced Access Scheme commissioned for 6-months from December 2023 has been extended through to end of March 2025 1a. Further funding approved to support increase in dental nurse triage capacity in NHS111 to support increase in appointment utilisation 2. Phased implementation of pathway for anxious patients; commencing Autumn 2024 with a focus on children under 6 years of age 3. Increased funding to support demand within the SCDS for patients with special needs 4. Identification of persistent under-performers to start negotitions to rebase contracts and re-commission activity where it is needed most 5. Development of targeted Flexible Commissioning Programmes to support access for hard-to-reach groups, urgent access sessions and oral health improvement initiatives National specification for commissioning of urgent appointments has been published to support delivery of ICB contribution of the 700,000 additional urgent appointments following the government manifesto. Paper to extend Enhanced Access Scheme is going through internal governance in April (PCCC)	1. Providers unwilling to rebase their contract in 24/25 leading to significant under-delivery 2. Under-utilisation of enhanced access pilot due to lack of dental nurse capacity in NHS111 (HUC)	1. Regular monitoring of monthly contract performance and proactive meetings set with providers to discuss under-performance 2. Reviewed at weekly Dental Team meetings 3. Further development of dental activity and spend dashboard to support year-end forecasting and identification of potential under-spend/clawback		Reports to PC Contracting Panel, PCCC and PC Transformation Committee		Reports to ICB Board and NHSE/I		1. Unknown if funding will be available to support non-recurrent or recurrent commissioning schemes to increase access	Proposed to PCTC Aptil-25 to reduce risk score from 16 to 12
New risk - Jan-24	686	18/01/2024	Primary Care Workforce	Director of Primary Care Transformation	Head of Primary Care Workforce	**IF** there were insufficient further training and education opportunities available to Optometry, Dental and Community Pharmacy ... **THEN** there would be a failure to keep knowledge relevant and up to date. Capabilities will not be kept up to the same pace as others in the same profession. **RESULTING IN** a. Clincical and non-clinical staff potentially being unable to maintain and enhance their knowledge and skills needed to deliver primary care to patients. b. Practices would potentially fail their CQC Inspection c. Risk of mental health issues increasing across the workforce d. Delay to creation of new non-traditional roles e.Likely negative impact on staff recruitment and retention	6	6	3	No movement ↔	Still have not fully scoped gaps in training for all POD groups however, risk is perceived to be low due to professional obligations of registered professionals in terms of training *Previous rationale:* *Don't expect it to happen (score 2) and if it did the consequence woudl be moderate (score 3) with a significantly reduced service effectiveness and local media coverage likely*	Some ad-hoc training arranged by ICB for Community Pharmacy e.g. Pharmacy First and Hypertension pilot in Optometry and Dentistry Registered healthcare professionals required to meet professional standards, competencies and CPD requirements for clinical registration Statutory training is a legal requiremet Healthcare employees are expected to have a training and development plan agreed and supported by employer including statutory and mandatory training Training Hub met with LOC who confirmed that practitioners have a comprehensive training programme in place Planning the setting up of Primary Care Educators Forum - virtual quarterly forum to include POD April-25 Update: - DPP has now been included in training plan from existing allocation. - Community Pharmacy section on Training Hub website underway - Representation of POD at Primary Care WIG Meeting membership (part two)	ICB has not yet scoped training needs, provision and any gaps or developed a training and development plan /package for pharmacists Optometrists or Dentists. ICB has not received a defined delegated training and education budget for POD	Training Hub Team meetings Workforce Clinical Leads Meeting WIG		Reports to ~~PCB~~ PCTC and PCCC		CQC regulatory framework encompasses workforce training and development		Greater focus on primary medical services than POD in reporting to ICB sub-board committees reflecting long-standing commissioning and budgetary responsibilities	
New risk - Jan-24	687	18/01/2024	Primary Care Workforce	Director of Primary Care Transformation	Head of Primary Care Workforce	**IF** robust processes for monitoring and planning workforce requirements for Optometry, Dental and Community Pharmacy are not established... **THEN** we will be unable to identify required changes in workforce, acting proactively to address expected shortfalls or reactivley to mitigate unexpected gaps in any profession... **RESULTING IN** potential threat to patient care as patients may not have access to a range of skilled professionals in primary care.	9	6	3	Reduction ↓	Further development work required, however review of risk score confirms this as still appropriate at Likely/Moderate impact. Risk reduced to align with Risk 686. Initial risk rating is considered too high on reflection.	Community Pharmacy workforce audit undertaken by NHSE Independent contractors are responsible for ensuring a appropriately capatious and skilled workforce for safe and effective provision of contracted services	Local ICB processes still to be developed	Training Hub Team meetings Workforce Clinical Leads Meeting WIG		Reports to PCB and PCCC		Operational Plan with wokrforce forecasting submitted to NHSE			Proposed to PCTC Aptil-25 to reduce risk score from 9 to 6