

Meeting of the Norfolk and Waveney ICB Primary Care Commissioning Committee
Tuesday 10 January 2023, 13:30 – 15:00/15:30 **Part 1**
Meeting to be held via video conferencing and You Tube

Item	Time	Agenda Item	Lead
1.	13:30	Chair's introduction and report on any Chair's action	Chair
2.		Apologies for absence	Chair
3.		Declarations of Interest To declare any interests specific to agenda items. Declarations made by members of the Primary Care Committee are listed in the ICB's Register of Interests. <i>For noting</i>	Chair
4. Pg 5		Review of Minutes and Action Log from the December 2022 meeting <i>For approval</i>	Chair
5. Pg 16		Forward Planner <i>For Noting</i>	SP
6. Pg 17	13:35	Risk Register <i>For Noting</i>	SP
Service Development			
7. Pg 34	13:45	Learning Disability Health Checks <i>For Noting</i>	SN
8. Pg 38	13:55	SMI Health Checks <i>For Noting</i>	JD
9. Pg 42	14:05	Workforce and Training Update <i>For Noting</i>	JR
10. Pg 50	14:15	Primary Care Networks Direct Enhanced Service <i>For Noting</i>	SH
11. Pg 56	14:25	CQC Reports <ul style="list-style-type: none"> • Wensum Valley Medical Practice <i>For Noting</i>	SN
Finance & Governance			
12. Pg 63	14:35	Terms of Reference Review <i>For Approval</i>	AB
13. Pg 79	14:50	Prescribing Report <ul style="list-style-type: none"> • Community Pharmacy Strategy <i>For Noting</i>	MD
14. Pg 132	15:00	Finance Report <i>For Noting</i>	JG
Any Other Business			
15.	15:10	Questions from the Public	Chair
<p align="center">Date, time and venue of next meeting Tuesday 14 February 2023, 13:30 – 16:30 – ICB PCCC To be held by videoconference and You Tube</p>			
<p align="center">Any queries or items for the next agenda please contact: sarah.webb7@nhs.net</p>			
<p align="center">Questions are welcomed from the public. Please send by email: nwicb.contactus@nhs.net For a link to the meeting in real-time Please email: nwicb.communications@nhs.net Glossary of Terms https://improvinglivesnw.org.uk/about-us/website-glossary-of-terms/</p>			

**NHS Norfolk and Waveney Integrated Care Board (ICB)
Register of Interests**

Declared interests of the Primary Care Commissioning Committee

Name	Role	Declared Interest- (Name of the organisation and nature of business)	Type of Interest			Is the interest direct or indirect?	Nature of Interest	Date of Interest		Action taken to mitigate risk
			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests			From	To	
James Bullion	Partner Member - Local Authority (Norfolk), Norfolk and Waveney ICB	Norfolk County Council	X			Direct	Executive Director Adult Social Services, Norfolk County Council	Ongoing		In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		Skills for Care	X			Direct	Trustee of Skills for Care	Ongoing		Member prepared to leave any meeting where training and development provision might be likely awarded or recommended to be provided by skills for care
Dr Hilary Byrne	Partner Member - Primary Medical Services	Attleborough Surgeries	X			Direct	GP Partner at Attleborough Surgeries	2001	Present	To be raised at all meetings to discuss prescribing or similar subject. Risk to be discussed on an individual basis. Individual to be prepared to leave the meeting if necessary.
		MPT Healthcare Ltd	X			Direct	Director of MPT Healthcare Ltd	2020	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		Norfolk Community Health and Care Trust (NCH&C)				Indirect	Spouse is employee of NCH&C (Improvement Manager)	2021	Present	
Steven Course	Director of Finance, Norfolk and Waveney ICB	March Physiotherapy Clinic Limited				Indirect	Wife is a Physiotherapist for March Physiotherapy Clinic Limited	2015	Present	Will not have an active role in any decision or discussion relating to activity, delivery of services or future provision of services in regards March Physiotherapy Clinic Limited
Tricia D'Orsi	Director of Nursing, Norfolk and Waveney ICB	Royal College of Nursing		X		Direct	Member of Royal College of Nursing	Ongoing		Inform Chair and will not take part in any discussions or decisions relating to RCN
Hein van den Wildenberg	Non-Executive Member, Norfolk and Waveney ICB	Lakenham Surgery			X	Direct	Member of a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
		College of West Anglia			X	Direct	Governor at College of West Anglia (Note: the College hosts the School of Nursing, in partnership with QEHKL and borough council)	2021	Present	Low risk. If there is an issue it will be raised at the time.
Norfolk and Waveney ICB Attendees										
Mark Burgis	Director of Patients and Communities, Norfolk and Waveney ICB	Drayton Medical Practice			X	Direct	Member of a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice

	Waveney ICB	Castle Partnership				Indirect	Partner is a practice nurse at Castle Partnership	Ongoing	might have an interest
Shepherd Ncube	Head of Delegated Commissioning	Nothing to Declare			N/A	N/A	N/A	N/A	N/A
Sadie Parker	Associate Director of Primary Care, Norfolk and Waveney ICB	Active Norfolk			X	Direct	Represent N&WCCG as a member of the Active Norfolk Board	2019 Ongoing	Low risk. If there is an issue it will be raised at the time
NHS England and NHS Improvement Attendee									
Fiona Theadom	Contracts Manager, NHS England and NHS Improvement	Nothing to Declare			N/A		N/A	N/A	N/A
Local Medical Committee Attendees									
Mel Benfell	Norfolk & Waveney Local Medical Committee Executive Officer	N&W ICB				Indirect	Personal friend of an employee of the ICB	2015 Present	Will not take part in any discussion or decisions relating to the declared interests.
		N&W ICB				Indirect	Close relative is an employee of N&W ICB	2022 Present	Will not take part in any discussion or decisions relating to the declared interests
		Windmill Surgery				Indirect	Member of a Norfolk and Waveney GP Practice	Ongoing	Withdrawal from any discussions and decision making in which the Practice might have an interest
Naomi Woodhouse	Norfolk & Waveney Local Medical Committee Joint Chief Executive	Long Stratton Medical Practice			X	Direct	Member of a Norfolk and Waveney GP Practice	Ongoing	Withdrawal from any discussions and decision making in which the Practice might have an interest
Practice Managers drawn from General Practice Attendees									
James Foster	Member Practice Representative	St. Stephens Gate Medical Practice	X			Direct	Partner at St. Stephens Gate Medical Practice	2019 Present	Will not take part in any discussion or decisions relating to the declared interests.
		One Norwich	X			Direct	Director, One Norwich Practices Ltd (GPPO/PCN)	2019 Present	
		N2S	X			Direct	Director, N2S, Provider of day surgery in a primary care setting	2014 Present	
Rosemary Moore	Member Practice Representative	Acle Surgery	X			Direct	Supporting the newly appointed practice manager at Acle Surgery	2022 2022	Withdrawal from any discussions and decision making in which the Practice might have an interest
		Norfolk and Norwich University Hospitals NHS FT (NNUHFT)			X	Direct	Chair of NNUHFT Patient Panel	2018 Present	
Health and Wellbeing Board Attendees (Norfolk and Suffolk)									
Bill Borrett	Norfolk Health & Wellbeing Board Chair	North Elmham Surgery			X	Direct	Member of a Norfolk and Waveney GP Practice	Ongoing	Withdrawal from any discussions and decision making in which the Practice might have an interest. Low risk. In attendance as a representative of the Local Authority. Chair will have overall responsibility for deciding whether I be excluded from any particular decision or discussion.
		Norfolk County Council	X			Direct	Elected Member of Norfolk County Council, Elmham and Mattishall Division	Ongoing	
		Norfolk County Council	X			Direct	Cabinet Member for Adult Social Care and Public Health	Ongoing	
		Norfolk County Council	X			Direct	Chair of Norfolk Health and Wellbeing Board	Ongoing	
		Breckland District Council	X			Direct	Elected Member of Breckland District Council, Upper Wensum Ward	Ongoing	
		Norfolk County Council	X			Direct	Chair of Governance and Audit Committee	Ongoing	
		Manor Farm	X			Direct	Farmer within Dereham patch	Ongoing	

James Reeder	Suffolk Health and Wellbeing Board	Suffolk County Council	X		Direct	Cabinet Member for Children and Young People's Services	Ongoing	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.	
		Suffolk County Council	X		Direct	Children's Services and Education Lead Members Network	Ongoing		
		East of England Government Association	X		Direct	East of England Government Association	Ongoing		
		Hight Street Surgery		X	Direct	Member of a Norfolk and Waveney GP Practice	Ongoing		
		James Paget University Hospital Trust	X		Direct	James Paget Healthcare NHS Foundation Trust Governors Council	Ongoing		
		Suffolk County Council	X		Direct	Suffolk Safeguarding Children Board	Ongoing		
		Norfolk and Suffolk NHS Foundation Trust	X		Direct	Norfolk and Suffolk Foundation Mental Health Trust – Governors Council	Ongoing		
		Suffolk and North East Essex Integrated Care Partnership	X		Direct	Suffolk County Council representative for Suffolk and North East Essex Integrated Care Partnership	Ongoing		
		Suffolk Chamber of Commerce	X		Direct	Member of the Lowestoft and Waveney Chamber of Commerce board part of Suffolk Chamber of Commerce	Ongoing		
Northfields St Nicholas Primary Academy		X	Direct	Governor of Northfields St Nicholas Primary Academy part of the Reach2 Academy Trust.	Ongoing	Low risk - individual is prepared to not take part in any discussions which may impact on the declared party			
Healthwatch Attendees (Norfolk and Suffolk)									
Andrew Hayward	HealthWatch Norfolk Trustee	East Harling GP Practice			X	Direct	Member of a Norfolk and Waveney GP Practice	Ongoing	Withdrawal from any discussions and decision making in which the Practice might have an interest Will not take part in any discussion or decisions relating to the declared interests.
		HealthWatch Norfolk	X			Direct	Trustee and board member HeathWatch Norfolk	2020 Present	
		East Harling Parish Council			X	Direct	Member, East Harling Parish Council	2020 Present	
		NHS England		X		Direct	GP appraiser, NHSE	2015 Present	
Sue Merton	HealthWatch Suffolk	Nothing to Declare		N/A			N/A	N/A	N/A

Norfolk and Waveney Primary Care Commissioning Committee

Part One

Minutes of the Meeting held on
Tuesday 13 December 2022
via video conferencing & YouTube

Voting Members - Attendees

Name	Initials	Position and Organisation
James Bullion	JB	Chair, Partner Member – Local Authority (Norfolk) Norfolk and Waveney ICB
Steven Course	SC	Director of Finance, Norfolk and Waveney ICB
Chris Turner	CT	Head of Nursing and Quality, Patient Safety Specialist, Norfolk and Waveney ICB, deputising for Tricia D’Orsi, Director of Nursing
Hein Van Den Wildenberg	HW	Non Executive Member, Norfolk and Waveney ICB

In attendance

Name	Initials	Position and Organisation
Jessica Adcock	JA	Head of Pharmacy and Medicines Optimisation (Deputy Chief Pharmacist) – deputising for Michael Dennis, Head of Medicines Optimisation, Norfolk & Waveney ICB
Mel Benfell	MBe	Joint Chief Executive Officer, Norfolk & Waveney Local Medical Committee (LMC)
Mark Burgis	MB	Director of Patients and Communities, Norfolk & Waveney ICB
Cllr Bill Borrett	BB	Chair of the ICP and Partner Member of the ICB
James Foster	JF	Practice Manager Committee Attendee
Carl Gosling	CG	Senior Delegated Commissioning Manager Primary Care, Norfolk & Waveney ICB
James Grainger	JG	Senior Finance Manager – Primary Care, Norfolk & Waveney ICB
Sarah Harvey	SH	Head of Primary and Community Strategic Planning, Norfolk and Waveney ICB
Andrew Hayward	AH	Trustee of Healthwatch Norfolk
Rosemary Moore	RM	Practice Manager Committee Attendee
Shepherd Ncube	SN	Head of Delegated Commissioning, Norfolk and Waveney ICB
Sadie Parker	SP	Associate Director of Primary Care, Norfolk and Waveney ICB
Cllr James Reeder	JR	Cabinet Member for Children and Young People’s Services, Suffolk County Council
Fiona Theadom	FT	Deputy Head of Delegated Primary Care Commissioning
Sarah Webb	SW	Primary Care Administrator (minute taker) Norfolk & Waveney ICB

Apologies

Name	Initials	Position and Organisation
Dr Hilary Byrne	HB	ICB Board Partner Member – Providers of Primary Medical Services, Norfolk & Waveney ICB
Michael Dennis	MD	Head of Medicines Optimisation, Norfolk and Waveney ICB
Patricia D’Orsi	PDO	Director of Nursing, Norfolk and Waveney ICB
Sue Merton	SM	Healthwatch Suffolk

No	Item	Action owner
1	Chair’s introduction	Chair
	Chair welcomed everyone to the meeting. JB welcomed SH to the Committee and SH introduced herself to the Committee as the Head of Primary and Community Strategic Planning (on secondment).	
2	Apologies for absence	Chair
	Noted above.	
3.	Declarations of Interest <i>For Noting</i>	Chair
	JR declared he was a registered patient at High Street, Lowestoft	
4.	Review of Minutes and Action Log from the November 2022 Committee <i>For Approval</i>	Chair
	It should have been noted that James Grainger was deputising for Steven Course. Otherwise, there being no further amendments, the minutes were agreed to be an accurate reflection of the November 2022 Committee. ACTION: SW to send to JB for signing Action Log Action 120 FT advised this was being taken forward by the contracts team within the ICB who initially negotiated the contract for blood collections with the NNUH. FT felt a conclusion would be reached. Discussions were still ongoing around workforce and capacity.	SW
5.	Forward Planner <i>For Noting</i>	SP
	SP updated on two items. Review of Terms of Reference – new timeline attached to fit in with wider review of ICB Committees – will be heard in January 2023. Enhanced Access – no new information to report and would be brought in due course when there would be a fuller update.	
6.	Director of Patients and Communities report <i>For Noting</i>	MB
	MB took the report as read and highlighted the following: <ul style="list-style-type: none"> The excellent progress made for both the booster programme and flu uptake across the region. Latest figures indicated a 70% uptake on the booster programme which put N&W in first position regionally and around sixth or seventh nationally. MB acknowledged the significant 	

work undertaken by colleagues across N&W to support the booster programme.

- The increased appointment activity across primary care and general practice. MB referenced the stats in the report and highlighted the significant increase in appointments given when compared to previous years. The figures demonstrated the equivalent of well over half of the total population of Norfolk and Waveney accessing general practice during October 2022.
- MB added that HealthWatch had very helpfully provided a report on people's views on general practice. It was pleasing to note that that, in the main, patient views were positive, but it also highlighted areas where improvements could be made and work will be undertaken with general practice to improve in these areas. One area highlighted by patients was delays in answering telephones; this had been recognised and work will be completed to support practices understanding the very real pressures currently being experienced.
- Concerns regarding the increased number of missed appointments and Did Not Attend (DNAs) between September and October, which was in excess of 30,000. The Comms and Engagement team will be providing messaging to support practices and patients, to ensure that every available appointment is utilised.
- More examples of how primary care and general practice resilience had been tested recently; a combination of growing demand, increased workload pressures and workforce shortages. It was noted there had been an increase in abusive behaviour which MB acknowledged was linked (in part) to patient frustrations, however abusive behaviour would not be tolerated and the ICB team would be working with Communications around messages to support patients and practices.
- A piece of work was underway to ease urgent and emergency care demand across the system and some funding had been allocated to support winter pressures focussing on discharge. A process to allocate the funding was ongoing now and it would be presented to the Health and Wellbeing Board for sign off. MB added that it was widely recognised that primary care was an integral part of the urgent and emergency care system and completed upwards of 80% of urgent activity. The ICB and wider system were exploring what more can be done to support primary care and overall system resilience, and updates regarding this would be provided to the Committee over the coming months.

MB offered to take questions.

JB felt it would be helpful to have sight of the funded schemes in relation to winter pressures once these decisions had been made.

AH thanked MB for reading the Heathwatch report. AH had highlighted before that he felt poor communication was often behind some of the issues and the explanation to patients of what the various new professions do and what the meaning of triage was. AH referenced an appraisal he had undertaken with a GP which had been challenging. AH also referenced respiratory hubs and

<p>asked if these had been considered locally? MB agreed that this had been considered. MB felt patient expectations have changed over the years. MB went on to say that in respect of the respiratory hubs, that the ICB were looking to roll these out quite quickly and MB would update at the next meeting on this.</p> <p>JB thanked AH and MB.</p> <p>JR was keen to highlight and support views on bullying and was in agreement that this must not be tolerated and wanted to know how Committee could help practices.</p> <p>MBe reiterated AH comments and referenced the comments the LMC fed back around the resilience of general practice and reflected the morale of GP's and their practices. MBe felt the identified risks and causes of that remained on the agenda until there was a tangible solution, as MBe felt there would be a significant migration of staff.</p> <p>JB agreed with MBe that this would stay on the agenda as it was a core issue.</p> <p>JF referenced aggressive behaviours, and the most damaging form was psychological bullying and wanted to ensure that the perspective was widened to recognise this. JF highlighted that there one seventh of the amount of direct winter pressure support this winter than last and recognised that discharge was important but recognised this was a limited pot.</p> <p>MB thanked JR and JF. MB recognised it was not just about the shouting and hurling abuse that was very vocal. In terms of funding, this was something that had been escalated to NHS England and beyond and a recognised risk.</p> <p>BB referenced the winter pressures money and asked if this was a local, regional or national position and MB referred to technical guidance around what the funding can and cannot be used for. There had been work done on the guidance as there had been a heavy bias to supporting discharge and MB noted that it had been nationally set.</p> <p>SP followed up on BB question. Last year, the national NHS England team awarded each STP (as we were then) with an amount of money ringfenced for general practice. For Norfolk and Waveney this was around £4.5m however this year no specific funding had been received. There had been a recycling of funding that was due to the system for the primary care network impact and investment fund of around £700,000 which was already mapped into the PCNs which would not have been received this early and would not have necessarily been repurposed. It was a small percentage of what had been received before and currently we do not expect to receive any general practice funding as had been received last winter.</p> <p>JG was in agreement with SP on the non-recurrent funding and it was unfortunate it had not returned this year to enable this to be distributed out.</p> <p>JB acknowledged the report was for noting and that there should be an action around the communications for primary care and asked MB to take this as an action point.</p> <p>ACTION: Further comms to be produced for patients in support of primary care. – MB</p>	<p>MB</p>
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7.	Learning Disability Health Checks <i>For Noting</i>	SN
	<p>SN took the paper as read.</p> <p>SN focussed on performance, performance as an ICS and a piece of work the BI team had done on the rates of declines.</p> <p>SN highlighted attention to the improvement of the quality of annual health checks and referenced a meeting from mid and south Essex ICS.</p> <p>Risks continue to be monitored to ensure they are managed for associated pressures.</p> <p>SN referenced work done on the report's appendix and identifying those individuals not seen. The BI team had identified activity by practice but are not able to identify individuals that have not had health checks. SN felt it was positive that more people had been seen than before. The data covered an 18-month period and SN wanted to draw attention to the patterns in Q4 as SN felt this confirmed how the system had been organised in completing the annual healthchecks and SN referenced numbers completed and declined and explained the data in each quarter in depth for Committee's information.</p> <p>JB thanked SN for the report and the explanation around the declines.</p> <p>MBe reported that most practices would not report a decline at the first decline or first lack of contact and would continue to try and deliver the healthcheck within the financial year. MBe felt that practices would only record a decline at the very last opportunity hence the proportion of declines being recorded towards the end of the year in most cases.</p> <p>JR thanked SN for the report and felt the figures speak for themselves and reflected upon the increase and the patients now registered. JR asked why a patient would decline and what the main reasons were for patients declining healthchecks.</p> <p>SN observed that there are different segments in the population not attending checks particularly those with mild learning disabilities and those in employment and those holding responsibilities in the community. Adjustments would be needed around that group of people. It had been noted that there were declines in younger people aged 14 and 15 and SN was interested in exploring this further.</p> <p>The communication with people with LD seemed to be one of the big factors and this was reflected in the survey undertaken by Open Doors. Families and people with LD had been contacted on how they would like to be communicated with and they indicated they preferred to be spoken to rather than receive letters and SN wondered whether reasonable adjustments were not always undertaken to communicate with patients.</p> <p>JR reflected on his experience of children in care and those with foster carers and felt that healthchecks were not where they should be and that was because of the difficulty of getting the children to a place where an assessment needed to be carried out and the distance they have to travel. JR asked if there was provision provided where the young or the person with LD is, and JR asked</p>	

	<p>whether they were expected to attend a particular clinical appointment and wanted to understand it that was one of the barriers.</p> <p>SN felt this was possible however he believed the region was fortunate in that the lead in the area was interested in children and young people and were connected with schools and doing some good work there. SN though this would benefit from testing and agreed to explore.</p> <p>JB was in agreement as he felt from his experience that some of this was to do with providers and enabling people to access primary care as well as being accessible themselves to primary care. JB suggested an action from the report for a deep dive into the declines to enable better and more descriptive information made available and investigate what the main causes were and how the Committee can promote this work in overcoming barriers.</p> <p>ACTION: SN to complete deep dive into declines and provide more context within his next update.</p> <p>JB thanked SN for his report.</p>	<p>SN</p>
<p>8.</p>	<p>SMI Health Checks <i>For Noting</i></p>	<p>JD</p>
	<p>JD took the paper as read.</p> <p>JD provided a focus on performance, the headlines and identification of risks for the winter months to Committee.</p> <p>JD drew attention to quarter 2 performance data to the Committee for their information and outlined work done with the Charity Together, providing an outline of this work to Committee.</p> <p>JD highlighted the potential risk of delivery during the winter season due to competing priorities and the potential for staff absence due to sickness and annual leave. JD had looked at performance through the previous years and noted that Q4 tended to see a dip during winter months and a catch up as practices moved through winter pressures. JD had reached out to all locality colleagues to put mitigation planning in place but expected to see an upward trend in performance in Q4 following on winter season.</p> <p>BB was keen to see some benchmarking such as featured in the LD healthchecks report and reflected the points on learning from others and that practices were keen to tick off as many metrics as possible in one visit. BB believed health checks were key to the prevention agenda and will be fundamental to the new long-term plan. BB reflected the positive change and asked if there could be some leverage into others. BB was not sure of what other health checks were undertaken in the system and it this would be a piece of work worth consideration.</p> <p>JD agreed to undertake a piece of work on benchmarking for the next report. In terms of the collaborative approach across annual health checks JD confirmed work had commenced and clinical leads from LD, SMI, diabetes and smoking cessation were looking at health checks as a whole and how to translate learning. JD reported that there was a meeting monthly, albeit in its infancy and JD agreed to draw on some of the work in the next report to provide Committee with some oversight.</p>	

	ACTION: JD to provide information on benchmarking within his next report and provide Committee with oversight of the learning from the annual health checks meeting (that look at SMI, LD, Diabetes etc.)	JD
9.	<p>CQC Reports</p> <ul style="list-style-type: none"> • High Street Surgery • Manor Farm Medical Centre • CQC Ratings across N&W Practices <p><i>For Noting</i></p>	SN
	<p>SN took the papers as read.</p> <p>Firstly, SN outlined the report on the two practices for Committee.</p> <p>JR stated it was encouraging to see a practice move from inadequate to good in one step. JR asked why High Street had remained RI since 2015, and whether the support they had been offered had not been sufficient. JR asked if the inspections had a negative impact rather than helping the system improve and asked how the ICB worked with the CQC. He was particularly concerned about how to attract staff to a practice with bad ratings.</p> <p>CT tried to answer the point around variation between practices and that the approach taken was similar from the quality team and others in the ICB. Some practices accept and work with the ICB teams and others prefer to lead the improvements internally or by bringing in independent support.</p> <p>BB reflected on the last point and asked whether some case studies where there had been a dramatic turn around and what that means would be useful.</p> <p>CT agreed and highlighted the monthly bite size CQC sessions to focus on the key trends CQC identify at their inspections and there was a suite of tools and documents that can be shared with practices. CT would consider this with SN.</p> <p>AH acknowledged most practices were good or outstanding and felt that the CQC were a regulator and commentated where regulations were broken and it could be argued this was not necessarily an indicator of clinical standards, and in some incidents individual clinicians were doing a good job but the CQC provided a low rating as the contractor was not meeting regulations which he believed were often managerial and not clinical. AH wondered if there was a pattern in terms of staff to patient ratios.</p> <p>BB reflected on other indicators, for example prescribing levels and telephony and wondered if there was use of other indicators in the system that had not been previously mapped to give a picture beyond the sort of pure regulation of the CQC.</p> <p>SN felt that the next report would also allow those conversations. Just to draw a distinction between the two practices as the conversation was not comparing the like for like.</p> <p>Manor Farm was in special measures and High Street was rated requires improvement and the interventions for requires improvement would not be the same as a practice in special measures.</p> <p>CQC Ratings across N&W Practices</p>	COI – JR, paper for noting so no action taken

	<p>This report provided Committee with the overview of CQC activity and the ratings for practices across the system.</p> <p>SN provided an update on the inspection activity over the last 7 years however SN felt the focus should be on activity from 2016 – 2018, note the reduction in the following years and note the activity is now starting to rise again as the system settles into a new normal routine.</p> <p>JB thanked SN for his update and reflected on the CQC inspection activity. He wondered if there were some good and outstanding ratings that have not been discovered yet and reflected that the programme of practice visits and quality assurance may help anticipate that and put the support in early.</p> <p>SN confirmed that CQC colleagues really cared about practice improvements and how we could encourage practices to proactively reach out to have conversations.</p> <p>JB asked MB about the relationship with the ICB and CQC being strategic and regulatory, noting there would be no intention to interfere with regulatory tasks but wanting to have a regional and local relationship, so that their knowledge about how we improve gets transferred to us.</p> <p>MB responded by noting there were both formal and informal networks in place with CQC colleagues, which were helpful at a strategic and local level. Colleagues were building on this as an early conversation is better than an assessment and regulations.</p> <p>MBe reiterated MB comments and said that the LMC also had a relationship with the CQC and meet with both the CQC and the ICB regularly.</p> <p>JB thanked SN for his report.</p>	
<p>10.</p>	<p>Prescribing Report <i>For Noting</i></p>	<p>JA</p>
	<p>JA provided a few highlights on the prescribing team focus to Committee and offered to take questions.</p> <p>JR was fascinated to note the reduction of 500 tons of carbon from the greener inhalers and asked how that was possible. JA confirmed work had been done with practices when they had reviewed patients for their inhaler treatment and practices had a list of preferred greener options to replace devices that do not contain aerosols. This was an outcome of the work that had been done across practices.</p> <p>HW referred to table 9 and the outlier practices and asked if JA was satisfied with the traction she was getting from the practices. JA met with the regional antimicrobial pharmacist last month at the antimicrobial stewardship working group where a discussion was had as to why improvement was not happening in these places. There was an agreement to look at the highest prescribing practices in the top 4 PCNs to identify trends in those practices and use learning to work with other practices.</p> <p>AH reflected on discussions being held about the lowering of clinical thresholds for antibiotic prescribing in reaction to Strep A concerns, which may make a difference to future statistics. Secondly, he asked about the supply situation locally, as he had seen assurances nationally that there was no shortage, but</p>	

	<p>rather it was the distribution that was the problem and asked if there were any problems locally.</p> <p>JA confirmed that the situation was being monitored daily and work was being done with community pharmacy leads and hospital trust pharmacies and there was a local supply issue. As per national guidance we have asked that our GP practices communicate with their local pharmacies regularly to establish what is available, and to work together to provide the most appropriate antibiotic available at the time. We have agreement with the trusts that if the supply worsens, we have a process in place to divert patients to hospital stock.</p> <p>AH asked if the situation is the formulation has to be dispensed as prescribed, and JA confirmed this. There had been no national short stock protocol issued, which effectively could relieve pressure on the practices who were prescribing and allowed the pharmacist to prescribe what is available at the time. JA reflected on a conversation she had with colleagues around educating patients and parents to help administer drugs to children.</p> <p>BB reported that this issue was raised at the Integrated Care Partnership where they looked at the joint pharmaceutical needs assessment. The overall assessment was that the range of pharmaceutical premises was suitable, but there was anecdotal evidence provided to Committee to say there were challenges. These were not always shortages of medicines but often workforce shortages, leading to an inability to process prescriptions or pharmacies were shut due to staffing. BB reported it had been highlighted at system level.</p> <p>JB thanked JA for her updated and there was acknowledgement that more work needed to be done in terms of pharmacy commissioning.</p> <p>Committee noted progress on this report.</p>	
<p>11.</p>	<p>Finance Report <i>For Noting</i></p>	<p>JG</p>
	<p>JG provided an update for Committee for noting.</p> <p>Reporting the 4th month of the ICB accounts (month 7 of the financial year) and a forecast of 9 months for the ICB as reporting was done in arrears.</p> <p>The position at M7 for primary care and prescribing budgets were £2.2m favourable to budget for the ICB, which represented Q2-Q4 of this financial year. Position included an efficiency target of just over £7.3m built into the budget. This formed part of the full year efficiency requirement of £8.4m. These efficiencies were not phased in a linear fashion and would build up over the year. Through continued monitoring of the efficiency projects, forecast at M7 to deliver on plan. There was potentially some slippage forecast from M8 onwards. The risk around DOAC switching had now reduced and the major area of slippage was within the low-risk cost effective switching project.</p> <p>Financial summary showed that GP prescribing was £0.3m adverse to plan as at M7. With the figures being 2 months in arrears, this showed the April to August estimates cumulatively were marginally undervalued. Efficiency savings had materialised in this period which allowed the forecast to be delivered and efficiency expectations were already within the budget. Of the £7.3m requirement for the 9 months we have received 5 months of actual achievement, and this to date had over delivered. The budget phasing of these efficiencies would increase rapidly from this point onwards, and the delivery</p>	

	<p>would need to match that. There were also prior year benefits within GP Prescribing. There were prior year benefit and other positive variances within delegated primary care that has crystallised worth £1.6m year to date.</p> <p>Detailed finance analysis showed the key drivers behind the prescribing spend on plan however there were still some key areas of risk around Continuous Glucose Monitoring and SGLT2. There was a high degree of uncertainty over the financial implications of these factors. Additional EPACT figures for DOACS, CGM and SGLT2 had been received and year on year increases can be seen in these areas and they all showed large year on year increases at M7.</p> <p>System development fund showed as on plan and is closely scrutinised both locally and nationally through the financial returns to NHSE.</p> <p>Delegated Co-Commissioning showed an underspend which was predominantly due to the way in which PMS GMS budgets were ring fenced to delegated primary care and prior year credits from 2021/22 most specifically around the accruals for QOF.</p> <p>GP and Other Prescribing showed detailed variances with prescribing leading to the overall 9 month adverse forecast of £0.7m. This had moved significantly from M6 to M07 as some of the prescribing cost pressures materialised.</p> <p>It still needs to be reported that there was a large degree of uncertainty and risk within prescribing. The finance and medicines management teams work closely together to monitor the EPACT data for the key areas of risk DOACS, Continuous Glucose Monitoring and SGLT2. Year on year comparison shows these areas grew considerably more than the growth built into budgets.</p> <p>There was still also a high degree of pressure coming from No Cheaper Stock Obtainable (NCSO) items. Some high increases in prices will begin to materialise in M8 onwards and stabilise M9 to M10.</p> <p>JB thanked JG for his report and recognised the pressures.</p>	
12.	Any Other Business Questions from the Public	Chair
	There being no other business or questions from the public the Committee finished at 14:55	

Name:	Signature:	Date:
Signed on behalf of NHS Norfolk and Waveney Integrated Care System		

Code
RED Overdue
AMBER Update due for next Committee
GREEN Update given
BLUE Action Closed



Norfolk & Waveney IBC Primary Care Commissioning Committee - Part One
 Action Log 10 January 2023

No	Meeting date added	Agenda Item	Owner	Action Required	Action Undertaken / Progress	Due date	Status	Date Closed
0120	13-Sep-22	5	FT	Enhanced Access - SC requested he could be fully sighted on the financial risk	(Nov 2022) 13.12.22 FT advised this was with the contracts team to take forward.	13-Dec-22	Blue	14-Dec-22
0122	11-Oct-22	6	CT	Risk Register - GP resilience - Primary Care Multi Professional Forum scheduled for 2 November 2022	Forum rescheduled to February 2023. Added to forward planner	14-Mar-23	Blue	14-Dec-22
0125	13-Dec-22	4	SW	SW to amend minutes and send signed copy to Chair	SW sent signed copy of minutes to Chair	10-Jan-23	Blue	13-Dec-22
0126	13-Dec-22	6	MB	Director of Patient and Communities Report - MB to action further communications to be produced for patients in support of primary care.		14-Feb-23	Yellow	
0127	13-Dec-22	7	SN	SN to complete deep dive into declines and provide more context within his next Learning Disabilities Health Checks update.	Underway, propose to bring to February meeting	14-Feb-23	Yellow	
0128	13-Dec-22	8	JD	JD to provide information on benchmarking within his next Severe Mental Illness health checks report and provide Committee with oversight of the learning from the annual health checks meeting (that look at SMI, LD, Diabetes etc.)	Benchmarking included in the report.	10-Jan-23	Yellow	

Norfolk and Waveney ICB – Primary Care Committee – 2022/23 PART ONE

Proposed date:		July 12th	August 9th	September 13th	October 11th	November 8th	December 13th	Jan 10th	Feb 14th	March 14th			
Standing items:	Risk Register	Y		Y		Y		Y		Y			
	Monthly Finance Report	Y	Y	Y	Y	Y	Y	Y	Y	Y			
	Estates Quarterly		Y			Y			Y				
	Digital Quarterly		Y			Y			Y				
	Prescribing Report	Y	Y	Y	Y	Y	Y	Y	Y	Y			
	Workforce and Training			Y	Y				Y				
	PCN DES			Y					Y				
	CQC Inspections Report	Y	Y	Y	Y	Y	Y	Y	Y	Y			
	Director of Patients and Communities report		Y		Y		Y		Y				
Spotlight items:	Annual or Bi Annual Report on Delegation	TBC											
	Terms of Reference Review	Y					Y	Y					
	Learning Disability /Autism Health checks	Y	Y	Y	Y	Y	Y	Y	Y	Y			
	PCCC Self Assessment										Y		
	Severe Mental Illness Health checks	Y	Y	Y	Y	Y	Y	Y	Y	Y			
	Enhanced Access			Y			Y			Y			
	Restoring Diabetes Care								Y				
	GP resilience - Primary Care Multi Professional Forum (CT)									Y			
Items noted without a date:													

Notes:													
01.08.22 - GP Patient Survey results report to September committee				Y									
05.09.22 Workforce and Training deferred to October committee													
05.09.2022 No CQC inspections published since the last committee													
13.09.2022 Following the death of Her Majesty the Queen, the public session of the primary care committee was cancelled in line with national mourning guidance received. A small number of time critical items were heard by voting members. 1) Branch closures advice note. 2) Additional roles and PCN DES appendix and PCN development funding focussed. 3) Enhanced access.													
11.10.22 workforce plans going to part 2 meeting													
11.10.22 SMI - No changes to update from previous month													
08.11.22 SMI will be a verbal update													
06.12.2022 Revised timeline for TORs review - now due in New Year to align with NHSE transition and other committees													
06.12.2022 Enhanced access paper, no new information to report													

Ref	Risk description	Month risk rating											
		1	2	3	4	5	6	7	8	9	10	11	12
PC1	General Practice – Workforce (GPs and nurses)				12	12	12	12	12	12	12		
PC6	Learning Disability Annual Physical Health Checks				12	12	12	12	12	12	12		
PC9	Hypnotics and anxiolytics prescribing				16	16	16	16	12	12	12		
PC10	Gabapentinoids prescribing in primary care				9	9	9	9	9	12	12		
PC 14 BAF16	The resilience of general practice				12	12	16	16	16	16	16		
PC15	Wave 4B Primary Care Hubs – loss of capital funding				8	8	8	8	8	8	8		
PC16	Severe Mental Illness (SMI) Annual Physical Health Checks				12	12	12	12	12	12	12		
PC17	General Practice – Allied Health Professionals Workforce including PCN Additional Roles				12	12	12	12	12	12	12		

**NHS Norfolk and Waveney ICB – Primary Care Commissioning
Committee Assurance Framework**

PC1									
Risk Title		General Practice – Workforce (GPs and Nurses)							
Risk Description		Lack of general practice GPs and Nurse workforce due to vacancies and impending staff retirements. The impact on the service delivery to patients.							
Risk Owner		Responsible Committee		Operational Lead		Date Risk Identified		Target Delivery Date	
Sadie Parker		Primary Care Committee Commissioning (PCCC)		Jayde Robinson		01.06.2020		31.03.2025	
Risk Scores									
Unmitigated			Mitigated			Tolerated			
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total	
4	4	16	3	4	12	2	4	8	
Controls					Assurances on controls				
<ul style="list-style-type: none"> Workforce plans in place at system level. Primary Care Workforce Transformation team expanded to support workforce development working within ICS workforce team. Training hub supported by clinical leadership with two clinical roles recruited to support Placement and Quality of Learning Organisations and Educators. Primary Care Networks (PCNs) supported to develop and implement workforce trajectories in support of the Additional Roles Recruitment Scheme (ARRS) to provide a multi-disciplinary approach to patient care National workforce reporting service - Practices report monthly, PCNs report quarterly, contractual requirement as part of General Medical Services (GMS) and PCN Directed Enhanced Services (DES). Wide range of initiatives in place to support GP retention Advanced Practice Forum established 					<p>Internal: Reporting to Primary Care Commissioning Committee (PCCC) and the People Board. Training Hub and Workforce Implementation Group meets two-monthly Workforce Strategy (in development for approval by end Q2)</p> <p>External: NHSEI returns monthly as part of the General Practice Transformation implementation and assurance meetings with Health Education England (HEE) and NHSE/I</p>				
Gaps in controls or assurances									
<ul style="list-style-type: none"> Lack of national or regional plans to increase GPs and Nurses in training ICS level working required to support Nurse recruitment and retention throughout their career pathway from Trainee Nurse Associates to senior level roles. General Practice workforce plans need to be refreshed and updated at local level Understanding general practice resilience as work refocuses from pandemic response towards business as usual may lead to higher numbers of the workforce leaving/retiring during 2022 and 2023. Cost of Living crisis impact on workforce yet to be fully understood. Ability to attract new workforce to Norfolk and Waveney and can be mitigated by system level action Awaiting the Expansion Lead to start during 2023 to support Quality Lead roles 									
Updates on actions and progress									
Date	Action						RAG	Target completion	

September 2022	<p>To support retention: Wide range of initiatives in place. Continue to increase Schwartz Rounds participation and to develop system wide round with the ICS workforce team. Outline CPD plan for 2022-23 submitted; further engagement sought within Norfolk and Waveney to finalise by September. Education Plan submitted to HEE.</p> <p>To increase placement capacity, continue to increase the number of Learning Organisations and educators through active engagement by Quality Leads. The Deep End Project launched on 29/7/2022: aims to support GP practices within the most deprived communities, reduce health inequalities and support 12 sites to become learning organisations. Evaluation of project to be undertaken.</p> <p>Quality leads to link in with ICB workforce team regarding placement expansion work across the system</p> <p>To develop system level approach to Nurse recruitment and retention.</p> <p>To continue to expand the newly established Advanced Practice forum</p>		March 2023
October 2022	<p>Learning Organisations and educators through active engagement has increased uptake across the system. Since March a 2% increase has been seen including a 6% increase for Tier 3 placements. Plans are being developed to further support GPST placements for August 2023, as currently there are more students' placements available than learning organisations across N&W. It has been recognised that an incentive and support programme should be put in place as result.</p> <p>Plans have been submitted to EOE for GP Fellowships and GPN Fellowships as part of our recruitment plans, which we are awaiting approval on.</p> <p>16 Training Nurse Associates are currently enrolled for the programme and 15 have expressed an interest. It is anticipated this will increase given the introduction of the TNA role which can be claimed under ARRS.</p> <p>A review of all the workforce retention and training packages, health & wellbeing is now underway which will be driven by placement capacity, demand through appointment activity and Core20plus requirements. An updated position on each PCN workforce vacancy levels, retirement and retention challenges will be part of this localised approach for succession planning.</p>		December 2022
December 2022	<p>Latest HEE workforce data illustrates the following:</p> <ul style="list-style-type: none"> • 2.6% growth in Nursing workforce roles across N&W during the period of Oct 21 vs Oct 22. 445 FTE are in place across the system. • 0.4% decline in GP workforce roles (excluding training GPs) during the same period. 519 FTE are in place across the system. A contributing factor in the decline is the loss of GP Partners (18 FTE during this period). • 8.1% growth in GP Trainees across N&W during the same period. 128 FTE are in place across the system. <p>New programmes are being scoped to attract "First 5 GPs" local offer and also to enhance the national model of "New to GP partnership scheme" with a local context.</p> <p>International Nurse recruitment pilot programme has now been launched to support recruitment in areas of deprivation. Several practices have expressed support in this area.</p> <p>PCN Learning organisation programme launched to attract GP practices to become a training practice by August 2023 and Tier 3</p>		August 2023

	educators. 34 practices across N&W are not currently receiving student placements, which is not sufficient to meet the future demand. A total of 118 students will need to be found placements during 2023 and 2024.		
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Visual Risk Score Tracker (ICB July 2022 onwards)												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score				12	12	12	12	12	12	12		
change				→	→	→	→	→	→	→		

	PC6							
Risk Title	Learning Disability Annual Physical Health Checks							
Risk Description	<p>The ICB is at risk of failing to meet its commitment to improve health and wellbeing for people with a learning disability if the quality and uptake of the annual physical health checks are not completed in line with the NHS national guidance.</p> <p>Access to an annual physical health check is intended to help reduce this risk, however, there are variable rates of uptake across Norfolk & Waveney GP practices. The ICB will not be able to fully meet its commitment to transform the lives of people with Learning Disabilities.</p> <p>National delivery targets to improve the uptake and quality of annual health checks for people aged 14 and over with a learning disability have been set for commissioners. All GP practices in Norfolk and Waveney have voluntarily signed up to the national Directed Enhanced Service (DES) which does not set a target for achievement, but requires practices to identify all registered patients, aged 14 years and over, with a learning disability, with the aim of reducing their health inequalities. The contract specification requires the practice to 'invite patients on the health check learning disabilities register for an annual health check.' Practices may resign from the DES at any time by giving not less than 1 months' notice.</p>							
ICB priority								
Risk Owner	Responsible Committee		Operational Lead		Date Risk Identified		Target Delivery Date	
Sadie Parker	Primary Care Commissioning Committee		Shepherd Ncube		01.07.2022		31.03.2023	
Risk Scores								
Unmitigated			Mitigated			Tolerated		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	3	4	12	2	3	6
Controls					Assurances on controls			
<ul style="list-style-type: none"> Plan in place to increase uptake of LD health checks across practices All practices signed up to the LD DES (bar 1 - UEA as they feel their student population does not meet the criteria) Regular monitoring by Norfolk Health Overview and Scrutiny Committee CQC inspections usually include review of LD health checks performance Transformation funding secured for a small peripatetic team, this will help support practices that are behind their trajectory. Peripatetic team and GP with a special interest are now in post and their first pilot area to improve LD health checks was in the Norwich PCN, moving on to South Norfolk in 2022/23. Regular assurance reports to NHSE/I & PCCC 					<p>Internal: Primary Care Commissioning Committee</p> <p>External: NHSE Checkpoint and Assurance Framework, Health Overview and Scrutiny Committee Reports to NHSE/I</p>			
Gaps in controls or assurances								
LDAHCs are now being undertaken face to face.								
Updates on actions and progress								
Date	Action					RAG	Target completion	
Oct 2022	Good progress has been made against our Q2 delivery targets-25% by end of September). Norfolk and Waveney completed more checks than any						01/11/2022	

	<p>other system in the east of England region. NHS England has released validated uptake data to August 2022. Norfolk and Waveney have reported an increase in activity to 25.1%, has already met its target for Q2 and remains on track to meets its yearend commitment.</p> <p>This learning disabilities service line benefited from the additional resources funded from the winter resilience money last year and without additional funding this year the number of checks completed will drop. Discussion to manage delivery risk are planned to take place later this week.</p>		
Jan 2023	An internal bid has been made to fund increased clinical capacity, otherwise no significant changes to report since risk was last reviewed at PCCC in November 2022. Full update included in separate paper.		

Visual Risk Score Tracker

ICB 2022/23 (months July 2022 – March 2023)

Month	04	05	06	07	08	09	10	11	12
Score	12	12	12	12	12	12	12		
Change	→	→	→	→	→	→	→		

PC9								
Risk Title	Hypnotics and anxiolytics prescribing							
Risk Description	High prescribing rate of hypnotics and anxiolytics in primary care - 3rd nationally on volume per 1,000 patients. These medications have negative side effects on patients and should not routinely be used long term.							
ICB priority								
Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date				
Dr Frankie Swords	Primary Care Commissioning Committee (PCCC)	Michael Dennis	28.07.2020	31.3.2023				
Risk Scores								
Unmitigated			Mitigated			Tolerated		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	4	3	12	3	3	9
Controls				Assurances on controls				
Practices have been encouraged to review their use of hypnotics/anxiolytics however not all practices have taken decisive action to reduce this. This years' Prescribing Quality Scheme (PQS) incentivises work to reduce prescribing.				Internal: Review Open Prescribing data each month, report progress to PCCC. Identify practices with the highest prescribing rates. External: NHS England				
Gaps in controls or assurances								
The Prescribing Team are moving back to Quality Innovation Productivity and Prevention (QIPP) delivery and Business As Usual (BAU) alongside ongoing Covid vaccination work. The CSU team joined the ICB team on 1 st July 2022 and we are seeking to recruit to vacancies.								
Updates on actions and progress								
Date	Action						RAG	Target completion
Jun 2022	March 22 data = ADQ/1000 patients = 399.991 98 th percentile (a longer month 31 days vs 28) We are now working on a longer-term project around deprescribing with NSFT, this will aim to change the prescribing culture within the organisation and reduce the use of all sedatives by clearer prescribing guidelines. Rate per day = 12.903							30.11.2022
Jul 2022	April 22 data = ADQ/1000 patients = 371.297 98 th percentile (30 days in this month vs 31 last month). Rate per day = 12.377							30.11.2022
Aug 2022	May 22 data = ADQ/1000 patients = 383.362 98 th percentile (31 days this month) Rate per day = 12.367							30.11.2022
Sep 2022	June 22 data = ADQ/1000 patients = 373.690 98 th percentile (30 days this month) Rate per day = 12.456, overall trend is downwards and at a rate greater than national average.							30.11.2022
Nov 2022	August 22 data = ADQ/1000 patients = 374.950 98 th percentile (31 days this month) Rate per day = 12.095, overall trend continues to be downwards and at a greater rate than national average (see below chart)							31.3.2023

Dec 2022	Sept 22 data = ADQ/1000 patients = 369.229 97 th percentile (30 days this month) Rate per day = 12.31, overall trend continues to be downwards and at a greater rate than national average (see below chart)		
Jan 2023	Oct 22 data = ADQ/1000 patients = 359.179 98 th percentile (31 days this month) Rate per day = 11.59, overall trend continues to be downwards and still at a greater rate than national average (see chart below)		

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	16	16	16	16	16	12	12	12	12	12		
change	→	→	→	→	→	↓	→	→	→	→		

PC10												
Risk Title		Gabapentinoids prescribing in primary care										
Risk Description		High prescribing of gabapentinoids in primary care - 28 th nationally on volume per 1,000 patients. These medications have negative side effects on patients, their use should be regularly reviewed and they should be used in caution with opioids/hypnotics.										
Risk Owner		Responsible Committee			Operational Lead		Date Risk Identified		Target Delivery Date			
Dr Frankie Swords		Primary Care Commissioning Committee (PCCC)			Michael Dennis		28.07.2020		31.03.2023			
Risk Scores												
Unmitigated			Mitigated			Tolerated						
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total				
4	3	12	3	3	9	2	3	6				
Controls						Assurances on controls						
Practices have been encouraged to review their use of gabapentinoids however not all practices have taken decisive action to reduce this. Outlier practices are encouraged to audit their use of all DFM's						Internal: Review Open Prescribing data each month, report progress to PCCC. Identify practices with the highest prescribing rates. External: NHS England						
Gaps in controls or assurances												
The CSU team have been in-housed by the ICB and vacancies that they have been carrying will be advertised to improve team resilience. Practice engagement is occasionally an issue.												
Updates on actions and progress												
Date	Action							RAG	Target completion			
Nov 2022	August ePact data shows only minor change in national ranked position at 73 rd percentile. If this remains below 75 th percentile for a further couple of months then we should consider retiring this risk								31.12.22			
Dec 2022	September ePact data, this ICB is now 29 th and at 73 rd percentile								31.1.23			
Jan 2023	October ePact data, ICB remains at this position, consideration should be given to retiring it from the risk register as it is likely we will be able to reduce the risk score								28.2.23			
Visual Risk Score Tracker												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	9	9	9	9	9	9	9	9	9	9		
change	→	→	→	→	→	→	→	→	→	→		

PC 14 BAF16								
Risk Title		The resilience of general practice						
Risk Description		There is a risk to the resilience of general practice due to several factors including the ongoing Covid-19 pandemic, workforce pressures and increasing workload. There is also evidence of increasing poor behaviour from patients towards practice staff. Individual practices could see their ability to deliver care to patients impacted through lack of capacity and the infrastructure to provide safe and responsive services will be compromised. This will have a wider impact as neighbouring practices and other health services take on additional workload which in turn affects their resilience. This may lead to delays in accessing care, increased clinical harm because of delays in accessing services, failure to deliver the recovery of services adversely affected, and poor outcomes for patients due to pressured general practice services.						
Risk Owner		Responsible Committee		Operational Lead		Date Risk Identified	Target Delivery Date	
Mark Burgis		Primary Care		Sadie Parker		01/09/2020	31/03/2023	
Risk Scores								
Unmitigated			Mitigated			Tolerated		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	4	20	4	4	16	3	4	12
Controls					Assurances on controls			
<ul style="list-style-type: none"> Locality teams and strategic primary care teams prioritised around supporting the resilience of general practice, dedicated resource to support the Covid vaccination programme. All practices have been supported to review business continuity plans PCN ARRS (additional roles reimbursement scheme) funding has increased again in 2022/23 Primary care workforce and training team working closely with locality teams to identify clinical and volunteer workforce and to ensure training available to support practices and PCNs in setting up and maintaining services Resilience funding process has been completed earlier this year (Q2) to provide practices with more opportunity to bid and respond 					<p>Internal: Executive Management Team, Senior Management Team, workforce steering group, primary care strategic planning meetings</p> <p>External: Primary Care Commissioning Committee, NHS England via delegation agreement, Health Education England, Norfolk and Waveney Local Medical Committee</p>			
Gaps in controls or assurances								
<ul style="list-style-type: none"> Practice visit programme, CQC inspections focused on where there is a significant risk or concern Unplanned risk associated with outbreaks or positive cases Impact of ambulance delays diverting practice teams from routine and urgent care to respond to emergencies Continued reports of poor patient behaviour across practices, decrease in patient satisfaction with general practice through GP patient survey, consistent with national position 								
Updates on actions and progress								
Date	Action					RAG	Target completion	
01.09.22	This risk (resilience impact due to Covid-19 pandemic) has been combined with risk PC13 (general practice resilience) following agreement at the primary care commissioning committee in July.						30.11.22	

	<p>Resilience funding process has been completed with practices invoicing where funding has been awarded.</p> <p>It is expected there will be national funding for general practice for winter – discussions are taking place to determine how to invest this funding for best impact.</p> <p>There has been an unplanned influx of asylum seekers into our system in August and September, with several local hotels being procured as contingency accommodation. This is having an impact on practices local to the hotels, as well as on wider health and care partners. Work is underway to support both an immediate response and a longer-term system approach to the needs of asylum seekers.</p> <p>There are currently four practices rated as inadequate by the CQC, requiring increased support and development from multiple teams in the ICB, as well as the increased work and focus for the teams in the practices to respond. Training and learning are being shared with all practices on an ongoing basis.</p>		
31.10.22	<p>Winter funding letter for general practice now published, winter fund being created from funding already allocated to PCNs, but available to draw down sooner. Workforce team is working with localities and PCNs to finalise ARRS forecasts. Currently investigating if any underspends can be identified for investing in practices through the winter, subject to discussion with LMC. A further practice has been rated as inadequate by the CQC, ICB teams are supporting.</p>		30.11.22
29.12.22	<p>No change in risk score. Practices reporting increasing pressures, compounded by sickness and workforce challenges in the context of the system being in a level 2 critical incident. Rising costs for practices also impacting ability to increase capacity. Comms campaign underway with further planning to raise awareness and understanding of clinical triage and the varied roles in general practice. Agreement with LMC for local discretionary support for practices to enable clinicians in practices to clinically prioritise services for patients on the balance of risk – this will focus on QOF and IIF. Further measures being considered for discussion with the LMC in the New Year.</p>		31.1.23

Visual Risk Score Tracker												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score						16	16	16	16	16		
change				→	→	↑	→	→	→	→		

PC15												
Risk Title		Wave 4B Primary Care Hubs – loss of capital funding										
Risk Description		<p>There is a risk that there could be a loss of £25m capital funding if the Wave 4b Primary Care Hubs are not operational by March 2024. The Programme Business Case was revised and resubmitted June 2022, following NHSE feedback, reducing the programme from 5 schemes to 4.</p> <p>Programme Business Case was approved September 2022, Full Business Cases to be approved by Spring 2023.</p>										
Risk Owner		Responsible Committee			Operational Lead		Date Risk Identified		Target Delivery Date			
Sadie Parker		Primary Care Commissioning Committee (PCCC)			Paul Higham		31.03.2021		31.03.2024			
Risk Scores												
Unmitigated			Mitigated			Tolerated						
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total	
4	4	16	2	4	8	2	2	4				
Controls						Assurances on controls						
<p>The Wave 4b Primary Care Hub Programme is managed by the Wave 4b Programme Board which includes representatives from the ICB, NHSE, NHSPS, NorLife and the LMC.</p> <p>Below this:</p> <ol style="list-style-type: none"> NHSPS have teams in place to develop the FBCs for 2 of the 4 schemes. NorLife (existing landlord) are developing the FBC for 1 scheme. PHP (existing landlord) are developing the FBC for 1 scheme. <p>All schemes report into the programme board for ICB oversight.</p>						<p>INTERNAL: Wave 4B Programme Board, Primary Care Estates Team, PCN Teams, PCCC, ICB EMT.</p> <p>EXTERNAL: NHSE/I, LMC, Provider Trusts, Third Party developers (tbd), County, City and District Councils</p>						
Gaps in controls or assurances												
Programme plan monitored by Programme Board. Feedback awaited from NHSE around approval process which could put the delivery of the programme at risk.												
Updates on actions and progress												
Date		Action							RAG	Target completion		
October 2022		Approvals for Programme Business Case in September were confirmed by NHSE Groups and by DHSC Joint Investment Sub Committee – with some conditions. Work required in October to determine funding flow for two new build premises.							Blue	31.10.22		
December 2022		Discussions continue with NHSE in terms of funding arrangements for the two new build premises – next meeting 17.01.23. Business case for Thetford scheme expected for submission January 2023.							Yellow	28.02.23		
Score	1	2	3	4	5	6	7	8	9	10	11	12
change				8	8	8	8	8	8	8		
				→	→	→	→	→	→	→		

PC16								
Risk Title		Severe Mental Illness (SMI) Annual Physical Health Checks						
Risk Description		<ol style="list-style-type: none"> The ICB is at risk of failing to meet its commissioning commitment to meet the needs of its SMI population which leads to a clinical risk that patients with SMI will experience significant health inequalities and a 15-20% higher mortality when compared to their peers. There is also a performance risk identified with regards to delivering the national target of the Norfolk and Waveney system delivering 60% of SMI health checks. Out of a total of 9,463 patients, 3,398 checks were done or 35.9% (according to Q4 2021-22 data). Access to a SMI annual health check is recommended to reduce this risk, however there are variable rates of patient uptake across GP practices. 						
Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date				
Sadie Parker	Primary Care Commissioning Committee	Shepherd Ncube	10/05/2022	31.03.2023				
Risk Scores								
Unmitigated			Mitigated			Tolerated		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	3	4	12	2	3	6
Controls					Assurances on controls			
<ul style="list-style-type: none"> Plan in place to increase uptake of SMI checks across N&W reviewed by PCCC and MH boards. A 2-year improvement trajectory has been agreed with NHS England. Monthly steering group has been established with input from Mental Health and Locality colleagues. All practices signed up to the SMI LCS; letter to be sent to practices highlighting end of year position and plan for improvement by June 2022. Funding from Mental health for additional clinical capacity has been secured to trial a small clinical team to provide checks across a PCN. The resource is expected to start from Quarter 3. This will help support practices that are behind their trajectory. Regular assurance reports to NHSE/I & PCCC 					<p>Internal: Primary Care Commissioning Committee, monthly steering group</p> <p>External: NHSE Checkpoint and Assurance Framework, Health Overview and Scrutiny Committee Reports to NHSE/I.</p>			
Gaps in controls or assurances								
<ul style="list-style-type: none"> Planned additional resources are not expected to have an impact until Quarter 3 (22-23). 								
Updates on actions and progress								
Date	Action					RAG	Target completion	
October 2022	<ul style="list-style-type: none"> Positive improvements in uptake have been observed in Q2. We have completed approximately 350 checks more in Q2 than the previous quarter. Good progress is being made in our Norwich pilot, Swaffham and Downham Pilot. The plan is for a dedicated staff to deliver SMI checks (similar approach delivering the LD annual checks) 						31.12.2022	

	<ul style="list-style-type: none"> Steady progress is being made both with actions and with data on delivery that is coming through. Link to QOF usually sees an increase in Q4 NSFT leadership post has now been agreed and advert to go out this week. This post will bring internal leadership across the 7 Assistant Practitioner posts who were funded to provide the SMI PHC across NSFT community teams System connection and development within the system i.e. to support the introduction of GPES collection (moving from ICB submission to NHSE direction extraction of data from Primary Care system ONLY) 		
December 2022	<ul style="list-style-type: none"> Q2 data shows ongoing progress in terms of checks delivered. Both pilots in Norwich and Swaffham and Downham Pilots have experienced delays due to staffing vacancy and recruitment challenges which are impacting their ability to launch this concept. Further to request from PCCC to share learning from LD annual health check project to improve uptake in SMI, under discussion. 		31/01/2023

Visual Risk Score Tracker												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score				12	12	12	12	12	12	12		
change				→	→	→	→	→	→	→		

PC17									
Risk Title		General Practice – Allied Health Professionals Workforce including PCN Additional Roles							
Risk Description		Lack of general practice (GP) Additional Roles (ARRS) and Direct Patient Care roles in the workforce due to vacancies and recruitment and retention challenges. The impact on the service delivery to patients.							
Risk Owner		Responsible Committee			Operational Lead		Date Risk Identified		Target Delivery Date
Sadie Parker		Primary Care Committee (PCC)			Jayde Robinson		30.06.2022		31.03.2024
Risk Scores									
Unmitigated			Mitigated			Tolerated			
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total	
4	4	16	3	4	12	2	4	8	
Controls					Assurances on controls				
<ul style="list-style-type: none"> Workforce team recruited in ICB structure. Training hub supported by clinical leadership via 5 Ambassador roles. Primary Care Networks (PCNs) supported to develop and implement workforce trajectories in support of the Additional Roles Recruitment Scheme (ARRS). PCN ARRS Workforce Templates – online portal for 2022/23 for PCNs to update to NHSE to inform Training Hub spending. National workforce reporting service - Practices report monthly, PCNs report quarterly, contractual requirement as part of General Medical Services (GMS) and PCN Directed Enhanced Services (DES). New ICS Social Prescribing Lead recruited 					<p>Internal: Reporting to Primary Care Commissioning Committee (PCC). Training Hub and Workforce Implementation Group meets two-monthly</p> <p>External: NHSEI returns monthly as part of the General Practice Transformation implementation and quarterly assurance meetings with Health Education England (HEE) and NHSE</p>				
Gaps in controls or assurances									
<ul style="list-style-type: none"> Workforce strategy requires review and refresh to reflect PCN development updates and post pandemic environment Recruitment of community pharmacists and technicians remains challenging. Similar roles recruited into PCNs from community pharmacy System approach for paramedic rotational roles agreed approach subject to national and regional review. Understanding general practice resilience as work challenges increase may lead to higher numbers of the workforce leaving/retiring during 2022 and 2023 Ability to attract new workforce to Norfolk and Waveney and may be mitigated by system level action Some geographical areas facing greater challenges in recruitment, e.g. West and East Challenges of recruitment, retention and integration can only be addressed if PCNs and commissioning bodies can understand the huge values the additional roles can bring. 									
Updates on actions and progress									
Date	Action						RAG	Target completion	

Sept 2022	<p>The new Ambassadors to build upon early work in acting as a point of contact to support new staff working in primary care, creating peer support groups for questions, dissemination of key information and understanding training and development needs. Physicians Associate careers fair planned August.</p> <p>Clinical Pharmacy Ambassadors developing an online forum for pharmacy professionals within primary care to highlight development opportunities as well creating a space for networking and peer support. A support pack has been developed for pharmacy professionals new to primary care to communicate key information which will be useful to them in their new roles. Work has also been done around providing guidance on clinical supervision for pharmacy professionals recruited through ARRS.</p> <p>The Newly Qualified Pharmacist (NQPh) pathway is established in community pharmacy and the NHS managed sector. N&W hoping to pilot a developmental role [band 6 to band 7 AFC] model to introduce a NQPh - GP pathway to attract a pipeline of newly qualified ARRS pharmacists into general practice to compliment or reduce recruitment from other pharmacy sectors.</p> <p>Discussions ongoing with HEI about nursing placements. The aim is to map placements and to share information on the quality of the learning environments. Slow engagement from HEIs. restructures.</p>		November 2022
October 22	<p>Additional Roles across Norfolk Waveney has seen an increase to 404.958 WTE during the month of September 2022, which is utilising 77% of the budget. The notifiable increase has been shown across all clinical and non-clinical roles.</p> <p>During October, each PCN submitted their intended recruitment plans, based on the introduction of three key roles:</p> <ul style="list-style-type: none"> • Training Nurse Associate • General Practice Assistant and • Digital & Transformation Lead <p>These submissions now suggests that N&W will increase to 507.91 WTE by March 23. It is anticipated that N&W will fully utilise the £19 million ARRS budget allocated, subject to recruitment.</p> <p>A review of all the workforce retention and training packages, health & wellbeing is now underway which will be driven by placement capacity, demand through appointment activity and Core20plus requirements.</p>		December 22
Dec 22	<p>Latest HEE workforce data illustrates the following:</p> <ul style="list-style-type: none"> • 7.3% growth in Direct Patient Care workforce roles across N&W during the period of Oct 21 vs Oct 22. 589 FTE are in place across the system. <p>Additional Roles across Norfolk Waveney has seen an increase to 462.9 WTE during the month of November 2022, which is utilising 86% of the budget. The notifiable increase has been shown across all clinical and non-clinical roles.</p> <p>The clinical ambassador roles are now working directly with ARRS staff and PCN's to understand recruitment, mentoring and training support needs. Succession planning through student placements,</p>		August 23

	<p>recruitment drives and exploring joint roles between general practice, community pharmacy and acute providers.</p> <p>An updated position on each PCN workforce vacancy levels, retirement and retention challenges will be part of this localised approach for succession planning.</p>		
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Visual Risk Score Tracker (ICB July 2022 onwards)												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score				12	12	12	12	12	12	12		
change				→	→	→	→	→	→	→		

Agenda item: 07

Subject:	Learning Disability Annual Health Checks progress update
Presented by:	Shepherd Ncube, Associate Director- Primary Care Commissioning,
Prepared by:	Thomas Araya, Senior Contracts Manager- Primary Care
Submitted to:	ICB Primary Care Commissioning Committee
Date:	January 2023

Purpose of paper:

To update the Committee on progress made to improve the uptake of learning disability annual health checks (AHC) across Norfolk and Waveney for 2022/23. The report is based on data taken from the national Central Quality Reporting System (CQRS) data.

1. Background

- National delivery targets to improve the uptake and quality of annual health checks for people aged 14 and over with a learning disability have been set for commissioners. All GP practices in Norfolk and Waveney have voluntarily signed up to the national Directed Enhanced Service (DES) which does not set a target for achievement, but requires practices to identify all registered patients, aged 14 years and over, with a learning disability, with the aim of reducing their health inequalities. The contract specification requires the practice to 'invite patients on the health check learning disabilities register for an annual health check.' Practices may resign from the DES at any time by giving not less than 1 months' notice.
- NHS England has shared uptake data from the Central Quality Reporting System (CQRS) showing delivery of learning disability health checks from April-Oct 2022.

2. Learning disability AHC activity to-date

Steady progress continues to be made month on month; we have seen slightly over 6% increase in activity from our reporting last month. Significant improvements have been observed compared to the same period last year-11% increase in activity has been reported this year so far.

April to November 2022

Learning disability health check uptake up to November 2022				
Locality	Register	Completed	Declined	%
GYW	1803	934	31	52.0%
North Norfolk	1201	437	43	36%
Norwich	1,496	667	17	45%
South Norfolk	1,453	603	8	40%
West Norfolk	982	411	13	43%
Norfolk & Waveney	6,935	3052	112	44%

- Norfolk and Waveney have reported 44% uptake via the national CQRS portal. This is an increase of 524 checks year on year against uptake end of November 2021/22.
- Please refer to appendix 1 for a rolling total of health checks over the past year.

3. Next steps

- Continue with delivery meetings with localities every 2 weeks.
- Bid for additional funding has been submitted and a decision is yet to be made.
- Practices with low uptake have been identified and contact is being made to offer support if this is required. Several practices have reported significant challenges and have indicated the need for additional clinical support.
- Validated data will continue to be shared with PCNs and practices to enable situational analysis at a local level.
- Continue to report monthly progress via PCCC

Recommendation to the Board:

Board members are invited to note the update, progress and current challenges. Further progress reports will be brought to future meetings in line with the forward plan

Key Risks	
Clinical and Quality:	Annual health checks are a proactive and evidence-based way of supporting people with a learning disability with new and existing health care requirements.
Finance and Performance:	Annual health checks for people with a learning disability are to be undertaken as per the specification within the national Directed Enhanced Service (DES) for GPs, the Quality Outcome Framework (QOF) and the Investment and Impact Fund (IIF).
Impact Assessment (environmental and equalities):	N/A
Reputation:	Health inequalities
Legal:	N/A
Information Governance:	N/A
Resource Required:	Business Intelligence team Children's and Young Peoples' team Delegated Commissioning team Locality teams Quality in Care team
Reference document(s):	The NHS Long Term Plan
NHS Constitution:	<ol style="list-style-type: none"> 1. The NHS provides a comprehensive service, available to all 3. The NHS aspires to the highest standards of excellence and professionalism 4. The patient will be at the heart of everything the NHS does 5. The NHS works across organisational boundaries 7. The NHS is accountable to the public, communities and patients that it serves
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	PC6

Governance

Process/Board approval with date(s) (as appropriate)	
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Appendix 1

Detailed activity breakdown of annual health checks year-on-year

Actual HCs completed in month	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Great Yarmouth and Waveney	34	53	73	78	77	99	107	113	124	106	125	189	66	135	106	148	141	92	134	112
North Norfolk	11	18	41	29	32	88	80	92	69	67	100	252	37	28	46	26	64	97	72	67
Norwich	30	38	95	88	80	115	78	71	84	89	103	142	21	63	84	82	99	121	85	112
South Norfolk	57	28	25	38	36	29	86	80	51	97	175	202	54	42	70	109	74	141	71	42
West Norfolk	10	24	11	28	33	32	55	58	62	61	133	168	79	54	56	43	15	24	71	69
Norfolk And Waveney	142	161	245	261	258	363	406	414	390	420	636	953	257	322	362	408	393	475	433	402

Actual HCs declined in month	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Great Yarmouth and Waveney	0	0	1	1	1	1	0	6	1	19	18	86	1	1	9	3	6	5	1	5
North Norfolk	1	0	0	0	0	0	4	4	8	4	8	29	2	1	2	3	0	3	10	22
Norwich	0	1	2	1	1	1	1	5	3	5	11	13	0	4	0	1	2	4	2	5
South Norfolk	1	0	1	2	1	1	3	1	3	6	7	20	1	0	0	3	1	1	1	1
West Norfolk	0	0	0	0	0	0	0	2	0	4	7	42	0	2	2	6	0	0	1	3
Norfolk And Waveney	2	1	4	4	3	3	8	18	15	38	51	190	4	8	13	16	9	13	15	36

With HC - Declined HAP	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Great Yarmouth and Waveney	1	2	1	2	2	1	5	4	1	3	3	1	1	1	9	3	6	5	1	5
North Norfolk	0	1	0	0	1	0	0	0	1	3	0	11	2	1	2	3	0	4	9	22
Norwich	2	1	3	4	2	1	0	0	5	11	1	3	0	4	0	1	2	4	2	5
South Norfolk	1	0	0	0	1	0	1	0	0	0	1	1	1	0	1	4	1	1	1	1
West Norfolk	0	0	0	1	0	2	1	1	0	1	0	1	0	2	2	6	0	0	1	3
Norfolk And Waveney	4	4	4	7	6	4	7	5	7	18	5	17	4	8	14	17	9	14	14	36

Agenda item: 08

Subject:	SMI Health Checks- Monthly Update
Presented by:	Shepherd Ncube, Associate Director of Delegated Commissioning, Primary Care
Prepared by:	Julian Dias, Deputy Senior Delegated Commissioning Paper
Submitted to:	Primary Care Commissioning Committee
Date:	January 2023

Purpose of paper:

To update the PCCC on plans and progress to-date to around patients with Severe Mental Illness (SMI) for January 2023.

1. Background

NHS England (NHSE) set out the ambition for annual physical health checks for those living with an SMI in the NHS Long Term Plan. The national metric for CCG performance is set by NHSE, and was previously given as a percentage of the SMI population, given in table 1:

Table 1: SMI PHC ambition for Norfolk and Waveney	2021/22	2022/23	2023/24
NHSE set minimum number of people with SMI receiving APHC	5,184	5,939	6,695

% of the SMI population (based on 21/22 Q4 QOF register size (9,134) (note QOF register size varies each quarter)	57%	65%	73%
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Note: QOF is the Quality and Outcomes Framework, which is a voluntary framework that incentivises practices to deliver care according to nationally negotiated indicators.

2. Activity to-date

Quarter 3 data has yet to be published. As a reminder, the Q2 performance position for SMI annual checks released and vetted by the BI Team is set out below for information.

In summary for all 6 core SMI checks:

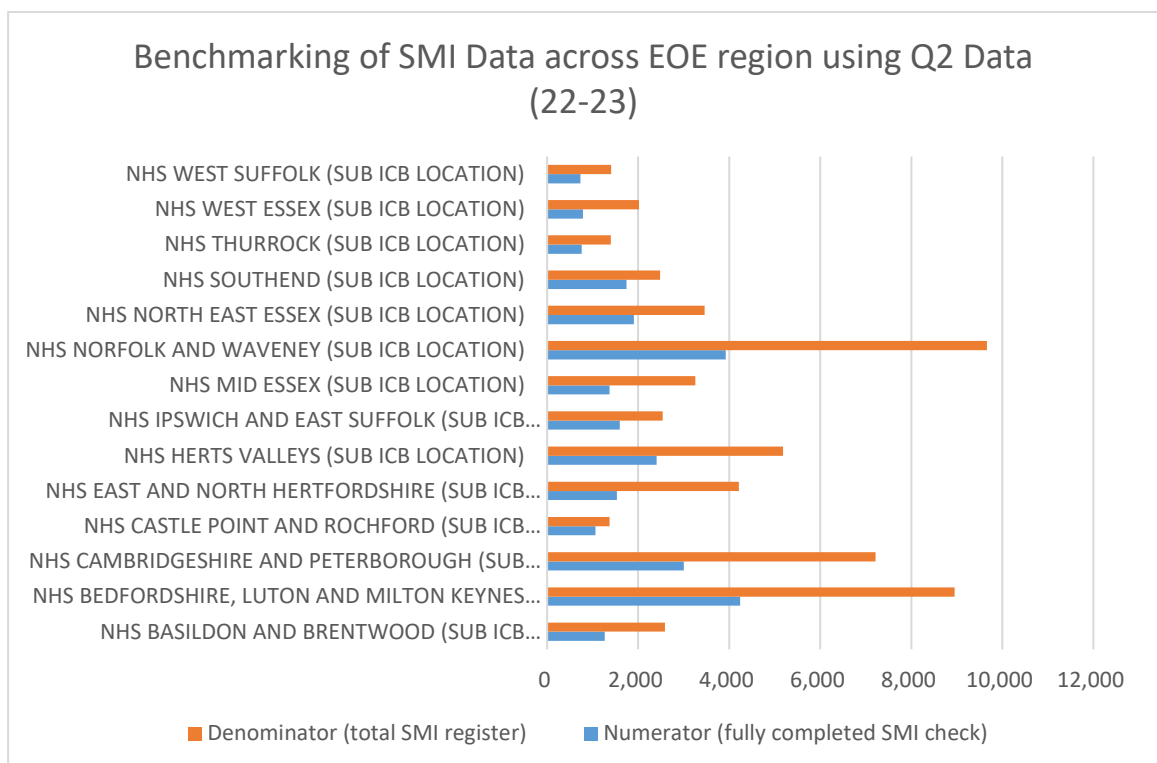
- N&W carried out 3,624 from a possible 9,664 = **37.5% (283 checks more than Q1)**
- NSFT carried out 300 from a possible 3,314 = **9.1% (53 more than Q1)**
- Combined 3,924 from a possible 9,664 = **40.6% (336 more than Q1)**

2. Progress Plans Update since December 2022 report:

- We have experienced delays in launching our 2 pilots in the Norwich and West localities.
- For Norwich; there have been issues with recruiting the extra clinical staff needed to provide additional capacity to support SMI health checks.
- For the West, there have been delays in recruiting new PCN staff to be responsible for launching this pilot.
- There are ongoing support meetings in place to ensure the projects still proceed but there is a risk of delays in performance improvements while these challenges are worked through.

3. Benchmarking Performance Data:

- At the last Primary Care Commissioning Committee meeting, benchmarking of performance data was requested to see how the N&W ICB performs comparatively against other ICBs in the East of England region.
- The below graph utilises Q2 data for this year (while we await Q3 to be published) and displays completed checks (Numerator) versus total register size (Denominator):



- N&W ICB has the largest patient cohort size (9,664) and carried out the 2nd largest number of SMI checks during Q2 (3,924).
- This was second only to BLMK ICB; who carried out 315 more checks than us; but have 710 patients less on their SMI register.

- Our ambition is to carry out offering these vital checks for our patients and to preserve this activity during the winter months; however, we acknowledge the pressure currently being faced across the system which may impact this.

4. Recommendation to the Board:

PCCC members are invited to note the update, progress and current challenges. Further progress reports will be brought to future meetings in line with the forward plan

Key Risks	
Clinical and Quality:	Improving the care and treatment of people with a serious mental illness is one of the top clinical priorities in the NHS Long term plan. The clinical risk is that if the annual health checks are not completed, the risk of premature death for this population group remains high.
Finance and Performance:	<ul style="list-style-type: none"> • Risk to delivery of service due to potential disruption caused by winter pressures. • Long term clinical additional resources will be required to be able to make significant and sustainable improvements with the uptake and quality of checks.
Impact Assessment (environmental and equalities):	N/A
Reputation:	ICB is at risk of failing to meet its commissioning responsibility in line with NHS Constitution and the national drive to address health inequalities within systems.
Legal:	N/A
Information Governance:	N/A
Resource Required:	Business Intelligence team Delegated Commissioning team Locality teams Quality in Care team NSFT Mental Health Commissioning team
Reference document(s):	The NHS Long Term Plan
NHS Constitution:	<ol style="list-style-type: none"> 1. The NHS provides a comprehensive service, available to all 3. The NHS aspires to the highest standards of excellence and professionalism

	<ul style="list-style-type: none"> 4. The patient will be at the heart of everything the NHS does 5. The NHS works across organisational boundaries 7. The NHS is accountable to the public, communities and patients that it serves
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	PC16

Governance

Process/Committee approval with date(s) (as appropriate)	
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Agenda item: 09

Subject:	Workforce and Training Update
Presented by:	Jayde Robinson, Head of Primary Care Workforce Transformation
Prepared by:	Keri Robinson, PC Transformation Manager - Workforce Planning and Governance
Submitted to:	ICB Board
Date:	10/01/2023

Purpose of paper:

To provide Primary Care Commissioning Committee members with an update on the Primary Care Workforce Team (formerly called the Training Hub) and changes to our governance arrangements.

This report also sets out the work of the Primary Care Workforce Team and our plan for the remainder of this financial year.

Executive Summary:

The Norfolk and Waveney Primary Care Workforce (PCW) team has gone through broad changes since our last update to the Committee, we have changed our name from Training Hub to the Primary Care Workforce Team, we have stood down the Training Hub Workforce Implementation Group, and we have welcomed a new head of Workforce Transformation and a new Training Hub manager.

This paper also provides an update on delivery of our Workforce and Training Projects and Programmes since our last update.

Report

1. Name change

To better incorporate our collaborative working under the Integrated Care Board Workforce Team and encompass our wider work around Retention and Recruitment we have moved away from our previous name 'The Norfolk and Waveney Training Hub' toward our new name the 'Primary Care Workforce Team'.

2. Team update

Recruitment of core team members is almost complete following successful recruitment to the below roles. The team has a broad mix of skills, experience, and clinical roles across primary and secondary care.

The following team members have been recruited since our last update:

- Jayde Robinson, Head of Primary Care Workforce Transformation
- Ben Chandler, Training Hub Manager – Workforce Development
- Cat McCormack, Quality Administrator

The team is led by our new Head of Workforce Transformation which sets the conditions for us to deliver the Primary Care Workforce Strategy and the Communications and Engagement Strategy for 2022-25.

3. Governance

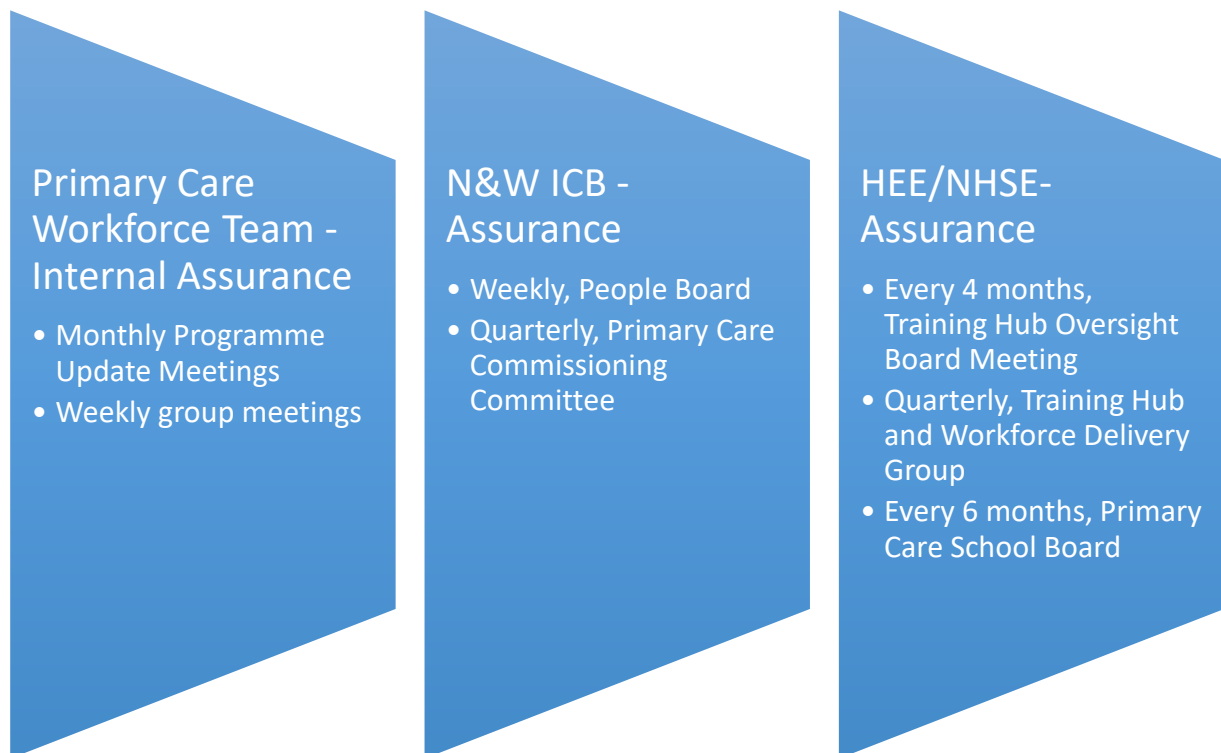
Health Education England (HEE) and NHS England (NHSE) oversee Training Hub Progress through a Training Hub Oversight Board meeting held three times a year. The first of these meetings was held 19 August 2022 and the next Oversight Board meeting will be held Thursday 12 January 2023 and will be attended by representatives from the Workforce team, ICB Primary Care Team, HEE and NHSE. Prior to this meeting the extensive Primary Care Workforce Delivery Plan has been revised and submitted including updates on all key Performance areas:

- Workforce planning
- Supporting development of educational programmes
- Support equality, diversity and inclusion
- Expanding and managing innovative and high-quality learning environment
- Increasing capacity and capability of educators
- Embedding new roles as part of the ARRS supporting retention
- Sustainability
- Communication and stakeholder management
- Development of systems
- NHSE/I GP Retention Schemes
- Placement Data
- Advanced Practice

The Norfolk & Waveney Workforce Steering Group (formerly known as the Training Workforce Implementation Group (TWIG)) has now been stood down. All Primary Care Workforce and training updates including sign off of activities will be conducted through the Primary Care Commissioning Committee – Part One, as part of our new governance arrangements. In addition, the Head of Primary Care Workforce Transformation will be in attendance at the People Board to ensure Primary Care is also represented at this level.

The changes in the governance process will enable utilisation of existing networks established to ensure the Primary Care Workforce Team are more visible during

these discussions. These are through Practice Managers meetings, Clinical Directors', PCN discussions as well as the Strategic Primary Care networks through the ICB.



4. Finance

We are working within our financial budget limits with no concerns to be raised; the finance update will be presented in Item 4 by Rashmi Balakrishnan.

5. Primary Care Workforce Programme updates

Retention Schemes

Schwartz Rounds: for Clinical and Non-Clinical Primary Care staff were launched/relaunched in May 2022, the pandemic gave us the opportunity to pause, reflect and reconsider our model of delivery and project plans for rollout. To create parity and meet the needs of staff working within the Primary Care landscape; we launched to the 108 practices across Norfolk and Waveney with monthly virtual Rounds, 123 people booked on between May and November and we have seen the Schwartz ripple effect in action with attendance growing at each Round. We have already released the dates and topics for the virtual Rounds for 2023 and have 19 people booked on already, we are in discussion with our Steering Group and facilitators to scope the possibility of undertaking a hybrid approach to Rounds and add a face-to-face Round into each locality in addition once a year. Since May 2022 the Steering Group has grown from 4 members to 10 and we are currently in the process of increasing our facilitators with 5 people booked onto their training with the Point of Care Foundation in the new year to improve resilience. Staff who have

attended the Rounds have left comments evidencing a positive impact thus far, e.g. “thought provoking”, “powerful”, “transformational” and “feeling connected”.

We are supporting the ICB Rounds and have begun promoting them to ensure Primary Care have a voice in the wider Rounds.’

Mentoring Scheme: Consideration of a cohort of trainee mentors to take place in 2023.

General Practice Assistant Programme: 30 places were provided by Health Education England this year. 17 places were filled in April 2022, and the final 13 places were allocated to commence in December 2022.

We are currently awaiting further direction from Health Education England regarding a further cohort to take place in 2023.

There has been a significant increase in interest in the GPA Programme since the inclusion of the (Trainee) General Practice Assistant role to the Additional Roles Reimbursement Scheme.

GP Careers Plus: The GP careers plus programme has seen an increase in membership, and now has 61 members, with a further 11 GPs currently in the process of joining. A further 12 GPs are known to be working as locums in the area and will be invited to join the programme if they wish.

The programme has recently been reviewed to ensure it meets the current needs of its members and the region, and local GP members were invited to engage with sharing opinions and information, fostering a better understanding. These opinions were gathered through surveys and discussion meetings in Autumn 2022. Key themes were identified supporting a better understanding of need, and plans are being developed to enhance the programme over 2023. A proposal to enact changes to the existing programme will be put forward for approval in the spring PCCC following engagement with our system partners, including the LMC. Feedback from this process of GP engagement was excellent with GPs reporting that they felt listened to, felt valued, considered that this was an example of policies were being built from the bottom up, and that the ICB was responsive to their needs.

Flexible Staff Pool: The digital flexible staff pool provided by Lantum has experienced growth in quarter 4 of 2022, with 78/105 practices signed up and 48 clinicians approved to work. There are geographical differences in take up and activity across N&W, and work continues to improve outcomes in rural areas where the activity is shown to be lesser. Lantum is working hard to close gaps and improve outcomes and will be visiting the Norfolk and Waveney area in January 2023 to run a GP CPD day and engage with practices. The framework for Flexible Staff Pools from 2021-2022 was not able to be extended and a new framework and guidance for the 2022-2023 funding has now been published. A procurement exercise will take place through Jan/Feb 2023 with the aim of securing the best contract moving forward. The current provision has been extended until February 2023 to allow for this process to take place without interruption to the existing provision of service for practices, and to prevent any impact on staff or patients.

Newly Qualified and First 5 GPs: Following feedback from a number of First 5 GPs and a First 5 GP lead, we are reviewing the local support available for this cohort with the intention to propose a package of support in the future, funded from the GP Retention Budget. This work will align directly with the ICS KPI of making Norfolk and Waveney the best place to work, encouraging more general practitioners to stay in, or move to Norfolk earlier in their careers therefore positively impacting the age demographic within Norfolk and Waveney.

First 5 Events: We are planning two events in 2023, in collaboration with the RCGP, which will be specifically for ST3, newly qualified and First 5 GPs with the aim of showcasing the Norfolk and Waveney area as a great place to work and live and gather information on the work portfolio new GPs will be looking to achieve. The information gained through this event will support regional planning and resilience and the event will provide a springboard to talk about the programmes of support available to new GPs. This plan directly aligns with the ICS KPIs. These events will take place in March and August 2023. Funding for these events has been provided from the GP retention and recruitment budget.

Fellowships

GP Fellowships: There are 31 active GP Fellowships at present, 20 of which have commenced and are either in their first or second year, 11 are currently awaiting to start or have paused their Fellowship for any reason. We have a further seven fellowships in development. To date, 9 GP Fellowships have been completed. All current fellowships have been offered. All fellows have been offered mentorship with over 65% of them taking up the offer.

Nurse Fellowships: We have 1 Nurse fellowship ongoing with 2 further Nurse fellowships in development alongside two Physician Associate fellowships in development.

Apprenticeships

Nursing: As of January 2023, there are 33 Nursing Apprentices in Primary Care within Norfolk and Waveney, consisting of 26 Trainee Nursing Associates and 7 Nursing Degree Apprentices. Further communications are due to be shared to promote the September 2023 Nursing Apprentice Programmes.

Pharmacy: There are currently 26 Pre-Registered Trainee Pharmacy Technicians across Norfolk and Waveney with 4 new PTPTs having started in September 22. A new HEE PTPT Programme manager has started in post and we are working closely to develop the programme looking forward to the Sept 23 cohorts.

Non-clinical: Administration and Management apprenticeships continue to be promoted by the Hub. Level 3 and 5 Management Apprenticeships are currently being advertised to take place in February and March 2023, with the cohort mixed with those from Norfolk and Waveney Primary Care and Mind.

New Workforce Retention Schemes

Two programmes are now being scoped by the Head of Primary Care Workforce Transformation, which have been specifically designed to mitigate PCCC risk PC01 with GP and Nurse recruitment.

These include International Nurse Recruitment Pilot and the GP Partnership Model. The October 22 data from Health Education England indicates that the “GP Partners” have reduced by 15 FTE in the last 12 months. However, nursing staff have increased by 19 FTE in the last 12 months.

6. Additional Roles Reimbursement Scheme (ARRS)

Planning Update

Norfolk and Waveney PCNs submitted their ARRS workforce plans for 2022-23 at the end of October 2022, those plans projected an overspend of almost £1m, therefore there will be no underspend to distribute this year.

We explored with NHSE the possibility of bidding for underspend from other areas, but this is not possible. All PCNs have been advised to proceed to work within their financial allocation. We are continuing to monitor ARRS fund usage against plans and have the process in place to trigger an underspend process should any be identified.

462.96 FTE ARRS roles have been introduced into Primary Care across the system since April to November 22.

Baseline Update

The Committee is asked to note an agreed change to the roles within the baseline for Great Yarmouth and Northern Villages PCN, the baseline was set at 9.51 Whole Time Equivalent (WTE) in 2019. As per the GP contract extract below this change was agreed by Sadie Parker on Mon 28 November 2022.

“7.2.4. With the agreement of the commissioner, which will not be unreasonably withheld, a PCN will be able to substitute between clinical pharmacists, first contact physiotherapists, physician associates and paramedics within the PCN baseline. Where agreement to a substitution has taken place, the PCN will not be subject to an equivalent WTE reduction in workforce funding under the Network Contract DES Additional Roles Reimbursement Scheme.”

Baseline set 2019		New Baseline position agreed November 2022	
Role	WTE	Role	WTE
Clinical Pharmacist	0.51	Clinical Pharmacist	0.51
Paramedic	5	Paramedic	6
Physician Associate	4	Physician Associate	3

First Contact Physiotherapist	0	First Contact Physiotherapist	0
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7. Newsletter changes

Following feedback taken into consideration from Primary Care staff regarding our weekly newsletter that is issued every Friday containing funded training and workforce updates that staff can access, we have made a series of improvements to increase engagement and subscribers such as:

- Respecting the time of the reader we have capped the size of the issue at 4 pages maximum per week.
- Limited the length of items to a maximum of 1 paragraph and a few bullet points
- Following a similar and successful layout to the ICS issued GP Bulletin we have added a Red, Amber and Green system e.g. Red for urgent updates within the same or following week, Amber for updates within that month, and Green for general awareness.

On top of this as well as our general subscriber pool we also distribute our newsletter via email to all of the Norfolk and Waveney Practice Managers and known GP locums in the area, all of our updates are linked to our Education and Workforce Information Repository located on our Microsoft Teams channel that all Primary Care staff are members of.

8. Strategy update

Our last paper sought preliminary approval of the Primary Care Workforce Strategy and Communications and Engagement Strategy, subject to the outcome of engagement with primary care. Approval was granted in October 2022 subject to engagement with primary care.

As part of this engagement process undertaken in Q3, there were several areas identified to be included within the Primary Care Workforce Strategy. These were: Volunteering, Equality Diversity and Inclusion, Bullying, Health & Wellbeing and Research. The strategy is being updated in Q4 to reflect these changes and will be presented back to the Committee for final approval in May 2023. This timeline will also reflect the transfer of responsibilities for the other primary care services (dental, pharmaceutical and optometry). Community Pharmacy workforce plan will form part of the ICS People Plan.

Overall, the strategy and its components have been well received amongst stakeholders, with a particular focus on a place-based approach. A review of the existing operational programmes has commenced, to ensure they maximise the ICS primary care workforce strategy.

9. Community Pharmacy

Community Pharmacy PCN Leads: Additional HEE funding has been received for ICBs to appoint and develop Community Pharmacy PCN Leads this year. Norfolk & Waveney PCNs have agreed match funding allowing us to recruit 4 posts instead of two. These posts will be in GYW, Kings Lynn and two across Norwich. The JD, role requirements and training programme are currently under development with the recruitment aiming to commence in late Jan 23.

Recommendation to the Board:

To note the updates.

Key Risks	
Clinical and Quality:	Function of the workforce and training function supports the delivery of clinical service
Finance and Performance:	Delivery of function within agreed budget
Impact Assessment (environmental and equalities):	None
Reputation:	Delivery of Primary Care Workforce function ensures successful achievement of HEE and NHSEI objectives and development of primary care workforce
Legal:	None
Information Governance:	None
Resource Required:	N/A
Reference document(s):	N/A
NHS Constitution:	N/A
Conflicts of Interest:	None Identified
Reference to relevant risk on the Board Assurance Framework	PC1, PC17, PC14/GBAF06 – resilience of general practice

Governance

Process/Committee approval with date(s) (as appropriate)	Audit Committee for information.
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Agenda item: 10

Subject:	Primary Care Network Contract Direct Enhanced Service
Presented by:	Sarah Harvey, Head of Primary and Community Care Strategic Planning
Prepared by:	Sarah Harvey, Head of Primary and Community Care Strategic Planning
Submitted to:	Primary Care Commissioning Committee
Date:	10 January 2023

Purpose of paper:

The purpose of this paper is to provide an overview of the current status of the Primary Care Network Contract Direct Enhanced Service (PCN DES) and its component parts.

Executive Summary:

The PCN DES has been in existence since 2019, although progress was delayed due to the pandemic, focus has been realigned to support reducing inequalities. Key components of the DES are also vital to supporting delivery of the Long-Term Plan and recommendations laid out by the Fuller Report (May 2022).

This paper recaps on the key components of the PCN DES with a specific highlight on PCN Transformation, ARRS roles and System Resilience.

Report

1. Background

Across Norfolk and Waveney, our 17 PCNs build on years of collaborative working between GP practices and community partners to improve care delivery for patients. We understand that in order to deliver more sustainable and personalised care, General Practice, through PCNs, will be the driver for developing integrated care delivery.

PCNs formed in 2019/20, during what is recognised as the Foundation Year, where PCNs were predominantly focused on organisation set-up. The years following, PCNs were required to develop their maturity as well as delivering against the DES

service specifications. Some of the timescales for delivery and assurance shifted as a result of the pandemic, but as part of the Phase 3 recovery plan NHS England have looked to PCNs in response to some of the new emerging intel on widening inequalities.

2. The PCN DES Structure – An Overview

The PCN DES has multiple components to it:

A. Service Specification Delivery including:

- Enhanced Health in Care Homes
- Early Cancer Diagnosis
- Structured medication reviews and medicines optimisation

As part of re-phasing plans post recovery:

- Implementation of digitally enabled personalised care and support planning for care home residents by 31 March 2024
- An extension to December 2022 for implementation of the **anticipatory care specification**
- New Early Cancer Diagnosis service requirements
- Enhanced Access from October 2022

The Network Contract Directed Enhanced Service (DES) will be updated annually until at least 2023/24.

B. The [Investment and Impact Fund](#) – For 2022/23, three new indicators focused on Direct Oral Anticoagulants (DOAC) prescribing and FIT testing for cancer referrals will be introduced.

C. PCN Transformation – PCN development funding ceased in 2020/21. However, in order to support the continuing development and maturity of PCNs, the ICB has ring fenced £400,000 (non-recurrent) for 2022/23 PCN Transformation.

[Additional Role Reimbursement Scheme \(ARRS\)](#) – Through the DES funding bigger teams of health professionals that will work across PCNs, as part of community teams, providing tailored care for patients and will allow GPs to focus more on patients with complex needs.

3. Progress Updates

3.1. PCN Transformation

As previously noted, PCN development funding ceased in 2020/21. However, in order to support the continuing development and maturity of PCNs, the ICB has ring fenced non-recurrent funding, £400,000 for 2022/23.

Building on previous year's PCN Development planning process, PCNs were invited to bid against the funding pot (now referred to as PCN Transformation) with ideas to support developing quality and leadership within their network.

Bids were expected to address a shared problem or a development need, at the same time encouraging collaboration between all partners of the PCN.

All bids were expected to be in the region of £20,000 per PCN (or per neighbourhood for Norwich).

A summary of the bids approved at the Primary and Community Care Delivery Group in November is included in the appendix.

PCNs with successful bids have received written confirmation to confirm this. For bids that have not yet been approved, meetings have taken place with locality colleagues to explore the suitability of the bid and how further development could ensure approval.

A progress update of the approved bids will be provided to PCCC in March 2023 with on-going monitoring through the Primary and Community Care Delivery Group.

3.2. ARRS Roles

Oversight of the ARRS (additional roles reimbursement scheme) programme continues to be managed through the Primary Care Workforce Steering Group and governed through PCCC.

The uptake of ARRS roles has increased in the last four months from 356.1 WTE in July 2022 to 462.9 WTE in November 2022. The table below shows the increase in each profession.

<i>Role</i>	WTE Jul 2022	WTE Nov 2022
<i>Advanced Practitioner</i>	5.4	9.4
<i>Care co-ordinator</i>	86.2	124.1
<i>Clinical Pharmacist</i>	51.2	59.4
<i>Dietician</i>	1	1
<i>Digital/ Transformation Lead</i>	-	3
<i>Health and Wellbeing Coach</i>	24	30
<i>MHP B6</i>	2.4	3.8
<i>MHP B7</i>	9.3	12.5
<i>MHP B8a</i>	2.0	3
<i>Nurse associate</i>	6.0	9.1
<i>Occupational Therapist</i>	2.0	1
<i>Paramedic</i>	15.7	17.1
<i>Pharmacy technician</i>	42.8	43
<i>Physician associate</i>	12.3	13.9
<i>First Contact Physiotherapist</i>	37.5	41.6
<i>Social Prescribing Link Worker</i>	58.4	69.6
<i>Trainee Nurse associate</i>	-	4.8

Grand Total	356.1	469.2
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Based on November 2022 finance data, it is anticipated that there will be significant unclaimed funding at year end.

As outlined within section 7.5 of the Network Contract DES, where a PCN forecasts that they will not utilise their total ARRS funding allocation, other PCNs can submit bids to access additional funding.

The Primary Care workforce team will manage the bidding process, with associated governance, that will be enacted to ensure maximum usage of the fund by the end of the financial year. Bids will be measured against the criteria as set out in [section 7.5.8](#) of the Network Contract DES.

A progress update of the approved bids will be provided to PCCC.

3.3. System Resilience

The Norfolk and Waveney system has been in a level 2 critical incident for many weeks and the level of pressure continues to be seen throughout service providers. As part of the ICB response to supporting General Practice throughout winter, details of the Quality Support and Stability Payment (QSSP), previously approved by PCCC, and application process was communicated in writing to all practices at the end of December 2022.

The aim of the QSSP is to provide practices with the flexibility over winter to manage their capacity to target patients most at risk of complications and / or admissions. The QSSP is available to all practices and PCNs and aims to provide financial stability should practices and PCNs not meet established targets for QOF and IIF as a result of using their clinical judgement to clinically prioritise their services in response to the critical incident.

This approach does not take away practices' responsibility to care for their patients in line with their primary medical services contract requirements, as well as GMC and NICE guidelines, however it will enable delivery, through the utilisation of clinical judgement to assess the clinical needs of their patients and through a making every contact count approach.

Each practice wishing to be provided with the QSSP is required to submit a simple plan for ICB agreement, explaining how they will prioritise care, including identifying any patient cohorts they will actively target through appropriate risk stratification. The plan should also include how practices will recover services into 2023/24 for patients who have been deemed to be at lower risk.

Recommendation to the Primary Care Commissioning Committee:

PCCC is asked to note the update. Updates are provided to PCCC every four months with the next update due to be provided in May 2023.

Key Risks	
Clinical and Quality:	There is a risk that there is a widening gap between PCNs in terms of their development and ability to work collaboratively to deliver at scale. There is a risk related to other providers' ability to engage and participate at PCN level. There is a risk that PCNs will de-stabilise other providers by procuring staff in ARRS roles.
Finance and Performance:	Consideration may need to be given to PCNs at the lower performing end of the metrics detailed in IIF and service specification metrics - this information needs to be triangulated with other performance metrics such as QOF, prescribing, and any local resilience issues the ICB may be aware of.
Impact Assessment (environmental and equalities):	N/A
Reputation:	There may be an external stakeholder reputational impact if a PCN is unable to engage and participate in collaborative forum.
Legal:	N/A
Information Governance:	N/A
Resource Required:	N/A
Reference document(s):	N/A
NHS Constitution:	N/A
Conflicts of Interest:	GP practice colleagues - PCN members and Clinical Directors
Reference to relevant risk on the Board Assurance Framework	N/A

Governance

Process/Committee approval with date(s) (as appropriate)	
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Appendix:

PCN transformation funding

A summary of the bids approved at the Primary and Community Care Delivery Group in November is included below:

- Great Yarmouth and Waveney
 - Gorleston and Great Yarmouth & Northern Villages – Organisational development for core PCN members
 - South Waveney – PCN Development
- North Norfolk
 - NN1, 2 and 3 – PCN Management and Training
 - NN4 – Accelerated paramedic transformation
- Norwich
 - Development of PCN Governance
- South
 - Breckland Surgeries and Ketts Oak – Development of PCN Governance
 - Mid Norfolk – Development of Estates Strategy
 - South Norfolk HIP – Staff development and retention programme
- West Norfolk
 - Swaffham and Downham – Population Health Management approach to managing Diabetes

Agenda item: 11

Subject:	Briefing - Recent Care Quality Commission (CQC) inspection Wensum Valley Medical Practice
Presented by:	Shepherd Ncube – Associate Director of Primary Care Commissioning
Prepared by:	Gemma Claridge– Delegated Commissioning Manager – Primary Care
Submitted to:	NHS Norfolk and Waveney ICB Primary Care Commissioning Committee
Date:	Tuesday 10th January 2023

Purpose of paper:

For Information - To provide an update to PCCC members on the Care Quality Commission inspection of the following practice who recently had a CQC inspection report published:

- Wensum Valley Medical Practice

Executive Summary:

PCCC members will be regularly updated with Care Quality Commission (CQC) inspection reports where the GP Practice has been rated or previously rated as Requires Improvement or Inadequate.

The CQC inspects against five key areas as follows:

Safe
Effective
Caring
Responsive
Well Led

The following practice was inspected, and the report findings are summarised below:

GP Practice	Locality	Date of Inspection/ Re-inspection	Previous Rating/Year	New Overall Rating
Wensum Valley Medical Practice 12,639 actual list size 1/10/2022	Norwich	3 rd November 2022	Inadequate	Requires Improvement

Report

Background

The Care Quality Commission (CQC) is the independent regulator of health and social care in England, this includes GP practices.

The CQC inspection is based on five key questions asked of all services being inspected. These are:

- **Is it safe?** Are you protected from abuse and avoidable harm?
 - **Is it effective?** Does your care, treatment and support achieve good results and help you maintain your quality of life, and is it based on the best available evidence?
 - **Is it caring?** Do staff involve you and treat you with compassion, kindness, dignity and respect?
 - **Is it responsive?** Are services organised so that they can meet your needs?
 - **Is it well-led?** Does the leadership of the organisation make sure that it's providing high-quality care that's based around your needs? And does it encourage learning and innovation and promote an open and fair culture?

The inspection and evidence obtained by the CQC against the five above questions will lead to an individual and an overall rating, which is either, **outstanding, good, requires improvement or inadequate.**

If practices fall short of the standards the CQC has the power to fine a practice, enforce an action plan or where there are very serious findings immediately close a practice.

Wensum Valley Medical Practice Norwich Locality – Inspected: 3 November 2022					
Overall rating: Requires Improvement					
	Are services safe?	Are services effective?	Are services caring?	Are services responsive to people's needs?	Are services well-led?
Rating	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement

Following the CQC's previous comprehensive inspection carried out and announced at the practice on 1 March 2022. The practice was rated as inadequate overall and placed into special measures. As a result of the concerns identified, CQC issued the

practice with a warning notice relating to a breach of regulation requiring them to achieve compliance with the regulation by 15 June 2022. CQC undertook a focused review on 27 June 2022 to check that the practice had addressed the issues in the warning notice and found they had met the legal requirements.

The CQC carried out an announced inspection at Wensum Valley Medical Practice on 3 November 2022.

Overall, the practice was rated as **Requires Improvement**.

The ratings for each key question were:

- Safe - requires improvement.
- Effective - requires improvement.
- Caring - good.
- Responsive - good.
- Well-led - requires improvement

Throughout the pandemic CQC has continued to regulate and respond to risk. However, taking into account the circumstances arising as a result of the pandemic, and in order to reduce risk, the CQC have conducted their inspections differently.

This inspection was carried out in a way which enabled the CQC to spend a minimum amount of time on site. This was with consent from the provider and in line with data protection and information governance requirements.

This included:

- Conducting staff interviews using video conferencing
- Completing clinical searches on the practice's patient records system and discussing findings with the provider
- Reviewing patient records to identify issues and clarify actions taken by the provider
- Requesting evidence from the provider
- A short site visit.
- Staff questionnaires

CQC findings

The CQC based their judgement of the quality of care at this service on a combination of:

- What they found when they inspected
- Information from ongoing monitoring of data about services and
- Information from the provider, patients, the public and other organisations.

The CQC has rated this practice as Requires Improvement overall.

CQC found that:

- The practice and leaders had been fully engaged with the external support provided by the Integrated Care Board (ICB). They were working to a clear action plan and had made improvements. These improvements had been newly established and required further time to be fully implemented, embedded and monitored to ensure improvements would be sustained.
- The clinical oversight had been improved and the leaders had greater awareness of their responsibilities in driving and monitoring the improvements needed. They had developed a new management structure which needed to be embedded and gain experience to ensure safe and effective services were delivered.
- The governance framework had been strengthened to identify and manage gaps or actions required that had been identified through risk assessments.
- There continued to be evidence of low morale at the practice and evidence of a closed culture at times, although some staff told us this had started to improve. Although the practice had made improvements, these had not been wholly implemented, or had sufficient time to demonstrate effectiveness. There were gaps across practice systems to support safe, effective and well-led services.
- The practice was reliant on external support staff to address all the issues and implement changes. The practice was in the process of recruiting new staff.

CQC found two breaches of regulations. The provider must:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed to meet the fundamental standards of care and treatment.

In addition, the provider should:

- Support all clinical staff to attain level 3 safeguarding children training.
- Continue to encourage uptake of cervical cancer screening appointments.
- Continue to engage with patients to gain feedback to deliver appropriate services to the population.
- Review and improve complaint response letters to patients and or relatives including contact details of where they may escalate their complaint if needed.

The CQC are taking this service out of special measures. This recognises the significant improvements that have been made to the quality of care provided by this

service.

Background to Wensum Valley Medical Practice

Wensum Valley Medical Centre West Earlham Health Centre is situated in a purpose-built health centre, also known as West Earlham Health Centre, in the West Earlham area of Norwich, Norfolk.

The practice has two branch sites at:

Adelaide Street Health Centre and Bates Green Health Centre.

The provider is registered with CQC to deliver the Regulated Activities; diagnostic and screening procedures, family planning, maternity and midwifery services and treatment of disease, disorder or injury.

The practice is situated within the Norfolk and Waveney Clinical Commissioning Group (CCG) and delivers General Medical Services (GMS) to a patient population of about 12,650. This is part of a contract held with NHS England. The practice is part of a wider network of GP practices (One Norwich Practices).

Information published by Public Health England shows that deprivation within the practice population group is in the second lowest decile (two of 10). The lower the decile, the more deprived the practice population is relative to others.

According to the latest available data, the ethnic make-up of the practice area is 91% White, 4% Asian, 2% mixed, 2% Black, and 1% Other.

The practice has a partnership of three GPs. In addition to the GP partners there are four salaried GPs and two long term locum GPs employed at the practice. The clinical team includes four nurses and there are three Advanced Nurse

Practitioners within the nursing team. There are two Practice Managers. The practice is supported by a team of staff who cover reception, administration, secretarial and patient care co-ordination roles.

Due to the enhanced infection prevention and control measures put in place since the pandemic and in line with the national guidance, most GP appointments were telephone consultations however if the GP needs to see a patient face-to-face then the patient is offered an appointment with a clinician suited to their needs.

The main practice site at West Earlham Health Centre is open between 8am and 6pm Monday to Friday. Patients can

also be seen at the practice branch sites at Adelaide Street (open on Mondays, Tuesdays, Wednesdays and Fridays) and Bates Green Health Centres (only open on Tuesdays and Thursdays) which are open between 9am and 5pm.

Patients can access appointments on evenings and Saturdays at two local practices through the Primary Care Network. In addition, when the practice is closed patients are directed to the GP out of hours service which is accessed through the NHS 111 service.

Download full report

[Download full inspection report for Wensum Valley Medical Practice West Earlham Health Centre - PDF - \(opens in new window\)](#)

Download evidence table

[Download evidence table for Wensum Valley Medical Practice West Earlham Health Centre - PDF - \(opens in new window\)](#)

Following the inspection and the new CQC rating of Requires Improvement the ICB's Primary Care, Norwich Locality, Quality and Medicines Optimisation teams continue to work closely to support the practice to develop an action plan to address the required improvements and provide advice and guidance to support the work going forward.

Fortnightly meetings are currently in place between the practice, CQC and ICB support team to review progress to ensure that the areas highlighted by the CQC are addressed. From January 2023 it has been agreed that these will move to monthly meetings.

Key Risks	
Clinical and Quality:	The concerns identified by the CQC which lead to a poor rating may put patients at risk
Finance and Performance:	Practice income could be affected as they invest in implementing identified improvements.
Impact Assessment (environmental and equalities):	Improving the health of the population
Reputation:	A poor rating may affect the practice's reputation
Legal:	GMS Contractual Obligations
Information Governance:	N/A
Resource Required:	This forms part of the delegated commissioning team's portfolio
Reference document(s):	CQC inspection framework and published reports
NHS Constitution:	N/A
Conflicts of Interest:	GP practice members may be conflicted

Reference to relevant risk on the Governing Body Assurance Framework	CQC inspections form part of a wider risk on the resilience of general practice.
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GOVERNANCE

Process/Board approval with date(s) (as appropriate)	A regular report on CQC inspections is brought to PCCC for noting, along with reports as practice inspections are published.
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Agenda item: 12

Subject:	Terms of Reference for Primary Care Commissioning Committee (April 2023)
Presented by:	Amanda Brown, Head of Corporate Governance
Prepared by:	Amanda Brown, Head of Corporate Governance and Fiona Theadom, Deputy Head of Primary Care Commissioning
Submitted to:	Primary Care Commissioning Committee
Date:	10 January 2023

Purpose of paper:

To seek agreement for the amended Terms of Reference for the Primary Care Commissioning Committee and Scheme of Delegation to take effect from 1 April 2023.

Subject to agreement, final approval will be sought from the ICB's Board in February 2023.

Executive Summary:

In line with legislation, on 1 July 2022 all ICBs assumed delegated responsibility for primary medical services (previously delegated to all CCGs). A Delegation Agreement between NHS England (NHSE) and Norfolk and Waveney ICB is in place.

From 1 April 2023, ICBs will also assume responsibility for pharmaceutical, general ophthalmic and dental services under the terms of a Delegation Agreement with NHSE.

With the transfer of responsibilities for primary dental, pharmaceutical and optometry services, the ICB has been reviewing at how the governance arrangements and decision making will operate for primary care commissioning and contracting from that date.

The ICB already has a Primary Care Commissioning Committee in place which reports to the ICB Board and is responsible for all general practice commissioning and contracting decisions and related matters. It is our intention is to expand the responsibilities for this Committee to include all four primary care services.

As this expansion of responsibilities will increase the workload for the Committee, the ICB has also been thinking about how we can streamline the decision making process and make it effective. We propose to establish two Delivery Groups, one for primary medical services and one for dental services who will have delegated authority as outlined in the paper attached for making operational decisions. The Committee will retain its assurance and oversight responsibilities and will receive regular reports from each of the Delivery Groups. The interim Scheme of Delegation will be reviewed in September 2023 to ensure it is fit for purpose.

Report

Introduction

With the transfer of responsibilities for primary dental, pharmaceutical and optometry services, the ICB has been reviewing at how the governance arrangements and decision making will operate for primary care commissioning and contracting from that date.

The ICB already has a Primary Care Commissioning Committee in place which reports to the ICB Board and is responsible for all general practice commissioning and contracting decisions and related matters. It is our intention is to expand the responsibilities for this Committee to include all four primary care services.

Attached (as Appendix A) are the draft Terms of Reference (one clean copy and one tracked version) which will take effect from April 2023.

As this expansion of responsibilities will increase the workload for the Committee, the ICB has also been thinking about how we can streamline the decision making process and make it effective. We propose to establish two Delivery Groups, one for primary medical services and one for dental services who will have delegated authority as outlined in the paper attached for making operational decisions. The Committee will retain its assurance and oversight responsibilities and will receive regular reports from each of the Delivery Groups.

It is proposed that the interim Scheme of Delegation is reviewed in September 2023 to ensure it is fit for purpose.

The Pharmaceutical Services Regulations Committee is mandated by NHS England to make decisions on all pharmaceutical matters in line with NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 and NHS England's Pharmacy Manual. It will report to the Committee on a regular basis in line with the Memorandum of Understanding with Hertfordshire and West Essex ICB who will be hosting the Pharmacy and Optometry team.

Optometry matters will be raised directly with the ICB's Primary Care Commissioning Committee for a decision or information as required.

Stakeholder engagement

The ICB has engaged with the Local Representative Committees for Medical, Dental Optometry and Pharmacy, also the Chair of the regional Local Dental Professional Network for their feedback. Responses were requested by 6 January and due to the short turnaround for replies over the Christmas and New Year period, their feedback will be shared prior to or at the meeting on 10 January 2023.

Next steps

If agreed, the Primary Care Commissioning team and Corporate Governance teams will work together to agree membership of each of the Delivery Groups and the extended Committee membership by 1 April 2023 with a draft meeting schedule agreed.

Each Delivery Group will be asked to agree a forward work plan for 2023/24 to be agreed by PCCC.

For information, the ICB is also in the process of establishing arrangements to oversee transformation and strategic development of primary care and the Primary Care Commissioning Committee will receive regular reports from any relevant Groups, e.g. Dental Taskforce, workforce matters, community pharmacy strategy and transformation.

Recommendation to the Committee:

To agree the amended Terms of Reference and Scheme of Delegation for approval by the Board at an exceptional meeting in February 2023.

Key Risks	
Clinical and Quality:	Amendments to the Terms of Reference are required to ensure the Committee continues to have oversight and assurance of quality matters across primary care
Finance and Performance:	Amendments to the Terms of Reference will provide PCCC with oversight of the delegated funds for primary care services
Impact Assessment (environmental and equalities):	N/A
Reputation:	The ICB has a responsibility to ensure governance arrangements for oversight and assurance of primary care commissioning is in place
Legal:	Delegation Agreement with NHS England for primary medical services, Delegation Agreement with NHS England for pharmaceutical, dental and optometry services
Information Governance:	N/A
Resource Required:	Primary Care Commissioning, Corporate Governance

Reference document(s):	Delegation Agreement with NHS England for primary medical services, Delegation Agreement with NHS England for pharmaceutical, dental and optometry services
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	N/A

Governance

Process/Committee approval with date(s) (as appropriate)	
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APPENDIX F

Norfolk and Waveney Integrated Care Board Primary Care Commissioning Committee Terms of Reference

1 Constitution

- 1.1 The Primary Care Commissioning Committee (the Committee) is established by the Norfolk and Waveney Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution.
- 1.2 These Terms of Reference (ToR), which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.
- 1.3 The Committee is a non-executive committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

2 Authority

- 2.1 The Committee is authorised by the Board to:
 - Investigate any activity within its terms of reference.
 - Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these terms of reference.
 - Create a Primary Medical Services Delivery Group and a Dental Services Delivery Group that will undertake specific agreed tasks and decision making as set out in the Scheme of Reservation and delegation as delegated to the appropriate director. The Committee shall determine the membership and terms of reference of these groups in accordance with the ICB's constitution, standing orders and Scheme of Reservation and Delegation (SoRD).
- 2.2 For the avoidance of doubt, the Committee will comply with the ICB Standing Orders, Standing Financial Instructions and the SoRD.

3 Purpose

- 3.1 To contribute to the overall delivery of the ICB's objectives to create opportunities for the benefit of local residents, to support Health and Wellbeing, to bring care closer to home and to improve and transform services by providing oversight and assurance to the ICB Board on the exercise of the ICB's delegated primary care commissioning functions and any resources received for investment in primary care.
- 3.2 The duties of the Committee will be driven by the ICB's objectives and the associated risks. An annual programme of business will be agreed before the start of the financial year, however this will be flexible to new and emerging priorities and risks.
- 3.3 The Committee has no executive powers, other than those delegated in the SoRD and

specified in these terms of reference.

4 Membership and attendance

Membership

- 4.1 The Committee members shall be appointed by the Board in accordance with the ICB Constitution.
- 4.2 The Board will appoint no fewer than 4 members of the Committee based on their specific knowledge, skills and experience.
- 4.3 The members of the Committee who will attend Part 1 and Part 2 meetings are:
 - A Local Authority Partner Member from the ICB Board (Chair)
 - Non-Executive Director (Deputy Chair)
 - Director of Nursing or their nominated deputy
 - Director of Finance or their nominated deputy
- 4.4 Where a member of the Committee is unable to attend a meeting, a suitable deputy may be agreed with the Committee Chair. The nominated deputy will count in the quorum for the meeting and be able to cast a vote if required.

Chair and Vice Chair

- 4.5 The Chair of the ICB will appoint a Chair of the Committee who has the specific knowledge, skills and experience making them suitable to chair the Committee.
- 4.6 Committee members may appoint a Vice Chair from amongst the members.
- 4.7 In the absence of the Chair, or Vice Chair, the remaining members present shall elect one of their number to Chair the meeting.
- 4.8 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these Terms of Reference.

Attendees

- 4.9 Only members of the Committee have the right to attend Committee meetings. The following individuals, who are attendees and not members of the Committee, will be invited to attend Part 1 and Part 2 meetings subject to s.4.10:
 - ICB Board Partner Member – Providers of Primary Medical Services
 - Local Representative Committee members – Local Medical Committee, Local Dental Committee, Local Pharmacy Committee and Local Optical Committee
 - Director of Patients and Communities
 - Director of Primary Care
 - Two Practice Managers or representatives of the services, one drawn from general practice and one from dental services

The following attendees will be invited to attend Part 1 meetings only:

- Healthwatch Norfolk
- Healthwatch Suffolk
- Health and Wellbeing Board representative - Norfolk
- Health and Wellbeing Board representative – Suffolk

4.10 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

4.11 Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter including representatives from the Health and Wellbeing Boards, Secondary and Community Providers.

Attendance

4.12 Where an attendee of the Committee who is not a member of the Committee is unable to attend a meeting, a suitable alternative may be agreed with the Chair.

5 Meetings Quoracy and Decisions

5.1 The Committee will meet at least 4 times a year in public subject to the application of 5.4 below. The Committee will operate in accordance with the ICB's Standing Orders. The Secretary to the Committee will be responsible (or delegate where appropriate) for giving notice of meetings. This will be accompanied by an agenda and supporting papers and sent to each voting member and non-voting attendee at least 5 calendar days before the date of the meeting. When the Chair of the Committee deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as s/he/they shall specify. Additional meetings may take place as required in public or private as appropriate for the nature of the business to be transacted.

5.2 The Board, Chair or Chief Executive may ask the Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

5.3 In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

5.4 The Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

Quorum

5.4 For a meeting to be quorate a minimum of 3 Members of the Committee are required, including the Chair or Vice Chair of the Committee.

5.5 If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall

no longer count towards the quorum.

- 5.6 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken. If an urgent decision is required, the process set out at 5.10 and 5.11 may be followed.

Decision making and voting

- 5.7 Decisions will be taken in accordance with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.
- 5.8 Only members of the Committee or nominated deputy may vote. Each member is allowed one vote and a majority will be conclusive on any matter.
- 5.9 Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote or in their absence the Vice Chair.

Urgent Decisions

- 5.10 If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.
- 5.11 In the event that an urgent decision is required, if it is not possible for the Committee to meet virtually an urgent decision may be exercised by the Committee Chair and relevant lead director subject to every effort having been made to consult with as many members as possible in the given circumstances (minimum of one other member).
- 5.12 The exercise of such powers shall be reported to the next formal meeting of the Committee for formal ratification and noted in the minutes.

6 Responsibilities of the Committee

- 6.1 NHS England has delegated to the ICB authority to exercise the primary care commissioning and dental functions in accordance with section 13Z of the NHS Act and as set out in Schedule 2 of the Delegation Agreement as follows:

Schedule 2A: Primary medical services

- decisions in relation to the commissioning and management of Primary Medical Services;
- planning Primary Medical Services in the Area, including carrying out needs assessments;
- undertaking reviews of Primary Medical Services in respect of the Area;
- management of the Delegated Funds in the Area;
- co-ordinating a common approach to the commissioning and delivery of Primary Medical Services with other health and social care bodies in respect of the Area where appropriate; and
- such other ancillary activities that are necessary in order to exercise the Delegated Functions.

Schedule 2B: Primary dental services and prescribed dental services

- decisions in relation to the commissioning and management of Primary Dental Services; for clarity this includes primary care, community care/special care dental services and secondary care dental services;
- planning Primary Dental Services in the Area, including carrying out needs assessments;
- undertaking reviews of Primary Dental Services in the Area;
- management of the Delegated Funds in the Area;
- co-ordinating a common approach to the commissioning and delivery of Primary Dental Services with other health and social care bodies in respect of the Area where appropriate; and
- such other ancillary activities that are necessary in order to exercise the Delegated Functions.

Schedule 2C: Primary ophthalmic services

Ophthalmic services are hosted by Hertfordshire and West Essex Integrated Care Board (H&WE ICB) on behalf of the ICB. In accordance with the Memorandum of Understanding with HWE ICB and other ICBs in the East of England region H&WE ICB will report general optometry services matters to the Committee including information to support decision making as and when matters arise. The ICB remains responsible and accountable for the provision of this service.

- decisions in relation to the management of Primary Ophthalmic Services;
- undertaking reviews of Primary Ophthalmic Services in the Area;
- management of the Delegated Funds in the Area;
- co-ordinating a common approach to the commissioning of Primary Ophthalmic Services with other commissioners in the Area where appropriate; and
- such other ancillary activities that are necessary in order to exercise the Delegated Functions.

Schedule 2D: Pharmaceutical services and local pharmaceutical services

Pharmaceutical services are hosted by HWE ICB on behalf of the ICB.

NHS England has established local committees to be known as Pharmaceutical Services Regulations Committees (PSRC). NHS England has delegated decision making to each PSRC in relation to matters under the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 as amended.

H&WE ICB will coordinate and host the PSRC to agreed Terms of Reference as set out in the NHS England Pharmacy Manual (<https://www.england.nhs.uk/primary-care/pharmacy/pharmacy-manual/>).

In accordance with the Memorandum of Understanding with HWE ICB and other ICBs in the East of England region H&WE ICB will provide quarterly reports to the Committee on decisions made at the PSRC.

Applications and Notifications will be made by H&WE ICB on behalf of the ICB to the PSRC for determination.

The ICB remains responsible and accountable for the provision of this service.

6.2 Arrangements made under section 13Z do not affect the liability of NHS England for the exercise of any of its functions. However, the ICB acknowledges that in exercising its functions (including those delegated to it), it must comply with the statutory duties set out in Chapter A2 of the NHS Act and including:

- Management of conflicts of interest (section 14O);
- Duty to promote the NHS Constitution (section 14P);
- Duty to exercise its functions effectively, efficiently and economically (section 14Q);
- Duty as to improvement in quality of services (section 14R);
- Duty in relation to quality of primary care services (section 14S). The Committee has the remit for reviewing primary care quality. Due to the interface with other services, however, the Quality and Safety Committee will maintain oversight of issues which may require more system wide assurance and support.;
- Duties as to reducing inequalities (section 14T);
- Duty to promote the involvement of each patient (section 14U);
- Duty as to patient choice (section 14V);
- Duty as to promoting integration (section 14Z1);
- Public involvement and consultation (section 14Z2).

6.3 The functions of the Committee are undertaken in the context of a desire to promote increased quality, efficiency, productivity and value for money and to remove administrative barriers.

6.4 The role of the Committee shall be to carry out the functions relating to the commissioning of primary services under **the NHS Act** and detailed in the Delegation Agreement with NHS England.

6.5 In performing its role, and in particular when exercising its commissioning responsibilities, the Committee shall take account of:

- a) The recommendations of the executive management team, the relevant Delivery Group and other Board committees;

- b) The needs assessment and plan for primary care services in the areas covered by the ICB including the resilience of all primary care providers;
- c) The co-ordination of a common strategic and operational approach to the commissioning of primary care services generally including supporting developments in respect of integration with providers and local authority services including co-location of services;
- d) The management of the budget for commissioning of primary care services in the area covered by the ICB;
- e) In accordance with its duties to reduce inequalities, 14T, in the exercise of its functions, the Committee will have regard to the need to:
 - Reduce inequalities between patients with respect to their ability to access health services, and
 - reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services

7 Behaviours and Conduct

ICB values

- 7.1 Members will be expected to conduct business in line with the ICB values, objectives and follow the seven principles of public life (the Nolan Principles), comply with the standards set out in the Professional Standards Authority guidance.
- 7.2 Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy and Conflicts of Interest Policy.

Equality and diversity

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

Conflicts of Interest

- 7.4 Members and those attending a meeting of the Committee will be required to declare any relevant interests to the ICB in accordance with the ICB's Conflicts of Interest Policy.
- 7.5 A register of Committee members' interests and those of staff and representatives from other organisations who regularly attend Committee meetings will be produced for each meeting. Committee members will be required to declare interests relevant to agenda items as soon as they are aware of an actual or potential conflict so that the Committee Chair can decide on the necessary action to manage the interest in accordance with the Conflicts of Interest Policy.

Confidentiality

- 7.6 Issues discussed at Committee meetings held in private, including any papers, should

be treated as confidential and may not be shared outside of the meeting unless advised otherwise by the Chair.

8 Accountability and reporting

- 8.1 The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.
- 8.2 The Chair of the Committee, if not a member of the ICB Board, may be invited to attend Board meetings at the request of the Chair of the ICB.
- 8.3 The Chair of the Committee will be accountable to the Chair of the ICB for the conduct of the Committee.
- 8.4 The minutes of the meetings, including any virtual meetings, shall be formally recorded by the secretary. A report of the Committee's work will be submitted to the Board following each meeting.
- 8.5 The Committee Chair shall draw to the attention of the Board any issues that require disclosure to the Board or require action.

9 Secretariat and Administration

- 9.1 The Committee shall be supported with a secretariat function which will include ensuring that:
 - The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Committee Chair with the support of the relevant executive lead.
 - Attendance of those invited to each meeting is monitored, highlighting to the Chair those that do not meet the minimum requirements.
 - Good quality minutes are taken in accordance with the Standing Orders and agreed with the Chair and that a record of matters arising, action points and issues to be carried forward are kept.
 - The Chair is supported to prepare and deliver reports to the Board.
 - The Committee is updated on pertinent issues/ areas of interest/ policy developments.
 - Action points are taken forward between meetings and progress against those actions is monitored.

10 Review

- 10.1 The Committee will review its effectiveness annually.
- 10.2 These terms of reference will be reviewed annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the ICB Board for approval.

Date of approval:

PRIMARY CARE COMMISSIONING COMMITTEE

Scheme of Delegation (Interim) for Dental Services and Primary Medical Services

This Scheme of Delegation will be reviewed in September 2023 to determine its effectiveness and fitness for purpose.

Purpose

The Primary Care Commissioning Committee (“PCCC”) have agreed the establishment of a Primary Medical Services Delivery Group and a Dental Services Delivery Group that will undertake specific agreed tasks and decision making as set out in the Scheme of Reservation and delegation as delegated to the appropriate director. The Committee shall determine the membership and terms of reference of these groups in accordance with the ICB’s constitution, standing orders and Scheme of Reservation and Delegation (SoRD).

The purpose of the Delivery Groups is to provide a framework for effective decision making in relation to certain contractual matters for general practice and dental services under delegated authority from the ICB’s Primary Care Commissioning Committee. The Scheme of Delegation also allows for certain decisions to be made by an appropriate member of the Primary Care Commissioning Team.

The Scheme of Delegation does not remove the ICB’s obligations for engagement and consultation with patients and key stakeholders under 13Z of the Act. Decision making of each Delivery Group will be informed by appropriate and proportionate engagement and consultation with patients and communities and will also be evidence based making effective use of all available data and business intelligence as necessary.

Membership

The members of each Delivery Group will be agreed by the Primary Care Commissioning Committee.

The Chair of PCCC will appoint a Chair of each Delivery Group who has the specific knowledge, skills and experience making them suitable to chair the Group.

The voting members for each Delivery Group will be:

- Chair (*note: needs to be at Director level to approve under Finance Scheme of Delegation*)
- Director – Primary Care
- Head of Primary Care Commissioning
- Finance – Head of Finance
- ICB’s Quality team representative

The following attendees may be invited to attend each of the Delivery Groups as described below:

General Practice Delivery Group	Dental Services Delivery Group
<ul style="list-style-type: none">• Deputy Head of Primary Care Commissioning	<ul style="list-style-type: none">• Deputy Head of Primary Care Commissioning
<ul style="list-style-type: none">• Head of Primary and Community Care Strategic Planning	<ul style="list-style-type: none">• Head of Primary and Community Care Strategic Planning
<ul style="list-style-type: none">• Senior Primary Care Commissioning Manager (General Practice)	<ul style="list-style-type: none">• Senior Primary Care Commissioning Manager (Dental)
<ul style="list-style-type: none">• Representative of the Local Medical Committee	<ul style="list-style-type: none">• Representative of the Local Dental Committee
<ul style="list-style-type: none">• Patient representative (Healthwatch?)	<ul style="list-style-type: none">• Patient representative (Healthwatch?)
<ul style="list-style-type: none">• Independent member? – link to PCCC?	<ul style="list-style-type: none">• Independent member? – link to PCCC?
<ul style="list-style-type: none">• Representative of general practice, e.g. practice manager	<ul style="list-style-type: none">• Representative of Local Dental Professional Network
<ul style="list-style-type: none">• Medicines Optimisation team representative	<ul style="list-style-type: none">• Dental Public Health Consultant
<ul style="list-style-type: none">• Representative from the ICB’s BI team	<ul style="list-style-type: none">• Representative from Business Services Authority?

The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters. Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter

Where an attendee of the Group who is not a member of the Group is unable to attend a meeting, a suitable alternative may be agreed with the Chair

Quoracy of Group meetings and decisions

Each Delivery Group will meet at least 4 times a year or more often to meet business needs. Each Groups will operate in accordance with the ICB’s Standing Orders. The Secretary to each Group will be responsible (or delegate where appropriate) for giving notice of meetings. This will be accompanied by an agenda and supporting papers and sent to each voting member and non-voting attendee at least 5 calendar days before the date of the meeting. When the Chair of the Group deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as s/he/they shall specify. Additional meetings may take place as required as appropriate for the nature of the business to be transacted.

In accordance with the Standing Orders, the Group may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

For a meeting to be quorate a minimum of three (3) Members of the Group are required

If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken. If an urgent decision is required, the process set out below may be followed.

Decision making and voting

Decisions will be taken in accordance with the Standing Orders. The Group will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

Only members of the Group or nominated deputy may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

Where there is a split vote, with no clear majority, the Chair of the Group will hold the casting vote or in their absence the Vice Chair.

Urgent Decisions

If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

In the event that an urgent decision is required, if it is not possible for the Group to meet virtually an urgent decision may be exercised by the Chair and relevant lead director subject to every effort having been made to consult with as many members as possible in the given circumstances (minimum of one other member).

The exercise of such powers shall be reported to the next meeting of the Group for formal ratification and noted in the minutes.

General Responsibilities of the Delivery Groups

There will be two Delivery Groups directly reporting to PCCC:

- General Practice Operational Delivery Group
- Dental Services Operational Delivery Group

The Primary Care Commissioning Committee will provide assurance and oversight of all decisions made by the Delivery Groups of the Committee. Each Group will prepare an integrated assurance report that details the work of the Group. Frequency will be determined annually by PCCC and set out in the work plan of the PCCC. As a minimum, the integrated assurance report will include:

- Activities and decisions made by each Group since the last meeting
- Changes/updates to national policy/strategy
- Quality and Safety – emergent issues and thematic review and response
- Risk and finance assessment
- Forward plan
- Recommendations to PCCC (where required)

In addition to the two Delivery Groups acting as sub-groups of PCCC, the ICB may form other groups for primary care matters as required reporting to the [People and Communities Board] or to PCCC. For example, a Dental Taskforce to focus on dental transformation and strategy, or a community pharmacy strategy group. If established, each group will prepare a report to PCCC four times per year.

Phased introduction to Scheme of Delegation

It is envisaged that some decisions may be made by an appropriate member of the Primary Care Commissioning Team in the future, as described below, however initially the Primary Care Commissioning team will make a recommendation to the appropriate Delivery Group in a phased introduction to the Scheme of Delegation. This approach will be reviewed in September 2023 alongside review of the Scheme of Delegation with the intention of moving decision making for specified contractual matters to the Primary Care Commissioning Team. Individual roles within the Primary Care Commissioning Team empowered to make decisions will be set out in detail and agreed with the PCCC in advance.

APPENDIX A – Primary Care Commissioning Committee Scheme of Delegation

PRIMARY AND COMMUNITY CARE DENTAL SERVICES (For clarity, this includes Primary Dental Services commissioned under GDS or PDS contracts, special care dental services (community dental) and Level 2 specialist dental services, Out of Hours services and any other dental services commissioned by the ICB)	Primary Care Commissioning Team (in line with Finance delegated budget authority) from September 2023	Dental Services Delivery Group	Primary Care Commissioning Committee	Financial impact, risk or cost pressure
Change to hours of service delivery				
Sub-contracting				
Relocations				
Request to convert from PDS(+) (<i>time limited contract</i>) to GDS (<i>only if providing mandatory services</i>) (<i>changing to in perpetuity, the value of contract is likely to exceed £1m</i>)				
Managing Disputes – Informal Process				
Managing Disputes – (Local Dispute Resolution)				
Claims for Financial support (ex contract funding)				
Permanent re-basing by reducing contract value				
Incorporations/Dis-incorporation				
Force Majeure				
Contract Sanctions				
Contract Termination (initiated by provider)				
Contract Termination (initiated by ICB)				
Remedial notices				
Breach notices				
Managing Disputes – Informal Process				
Managing Disputes – (Local Dispute Resolution)				
Commission service intentions (<£100k)				
Commission service intentions (<£1m)				
Contract Award (<£1m over lifetime of contract)				
Commission service intentions (>£1m)				
Contract Award (>£1m over lifetime of contract)				
SECONDARY CARE DENTAL	Primary Care Commissioning Team (in line with ICB Finance delegated budget authority) from September 2023	Dental Services Delivery Group	Primary Care Commissioning Committee	Financial risk or cost pressure
Commission intentions (<£100k)				
Commission intentions (<£1m)				
Contract Award (<£1m over life time of contract)				

Commission intentions (>£1m)				
Contract Award (>£1m over life time of contract)				

PRIMARY MEDICAL SERVICES (For clarity, this includes general practice services commissioned under GMS, PMS and APMS contracts and Locally Commissioned Services)	Primary Care Commissioning Team (in line with ICB Finance delegated budget authority) from September 2023	Primary Medical Services Delivery Group	Primary Care Commissioning Committee	Financial impact, risk or cost pressure
Change to hours of service delivery (temporary)				
Changes to services (contractual) e.g. branch site closures, opening hours, services				
Local Enhanced Services				
Sub-contracting arrangements				
Practice relocation (<i>note: responsibility for dispensing relocation/changes is PSRC</i>)				
Managing Disputes – Informal Process				
Managing Disputes – (Local Dispute Resolution)				
Claims for Financial Support				
Practice Merger				
Incorporations/Dis-incorporation				
PCN DES contractual changes				
Force Majeure				
Contract Sanctions				
Contract Termination (initiated by provider)				
Contract Termination (initiated by ICB)				
Remedial notices				
Breach notices				
Change of practice boundary (increasing)				
Change of practice boundary (decreasing)				
Commission intentions (<£100k)				
Commission intentions (<£1m)				
Contract Award (<£1m over life time of contract)				
Commission intentions (>£1m)				
Contract Award (>£1m over life time of contract)				

Agenda item: 13

Subject:	Prescribing team report
Presented by:	Michael Dennis, Associate Director of Pharmacy and Medicines Optimisation
Prepared by:	Michael Dennis, Associate Director of Pharmacy and Medicines Optimisation
Submitted to:	Primary Care Commissioning Committee
Date:	January 2023

Purpose of paper:

Information

Executive Summary:

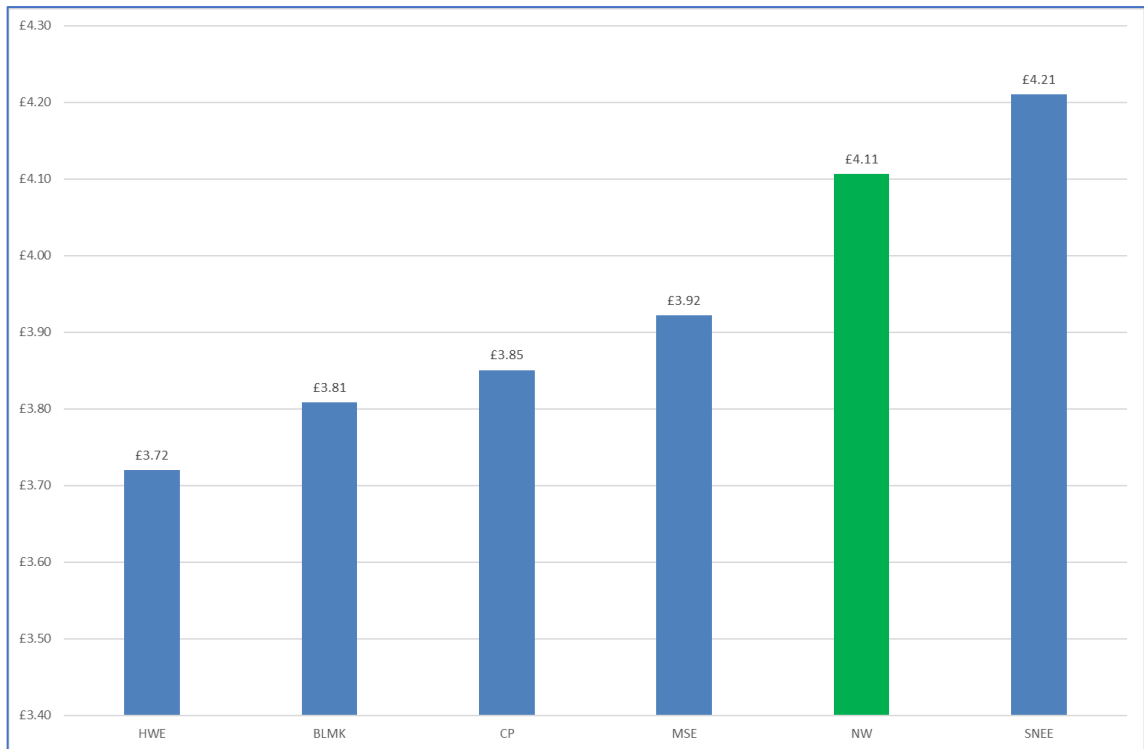
Progress on quality and spend indicators are outlined and some of our current projects are highlighted.

1. Prescribing team focus areas

- 1.1 The prescribing team are working up ideas for next year's prescribing quality scheme and potentially an additional switch scheme.
- 1.2 The prescribing quality scheme has facilitated some improvement in indicators (see below). The team continue to meet practices to facilitate implementation.

2. System Prescribing Performance

- 2.1 Net ingredient cost (NIC) per AstroPU (an attempt to normalise practice demographics) below is a proxy measure of relative cost-effectiveness. However, this does not take account of deprivation which is a key driver of prescribing spend. In the new ICB configurations Norfolk and Waveney have moved from 3rd out of 6 to 2nd out of 6, on investigation the biggest contributor was high costs of flu vaccines in October. The available deprivations score can be accessed [here](#) (registration required).



2.4 An explanation on retained margin (Category M) is below.

The community pharmacy sector will receive £2.592bn per year from 2019/20 to 2023/24. Of the annual sum, £800m is to be delivered as retained buying margin i.e., the profit pharmacies can earn on dispensing drugs through cost effective purchasing.

The £800m retained margin element is a target that the Department of Health and Social Care (DHSC) aim to deliver by adjusting the reimbursement prices of drugs in Category M of the Drug Tariff.

Where the delivery rate of margin to community pharmacy will be under or over deliver on the £800m target, the DHSC will re-calibrate Category M Drug Tariff prices to bring the margin delivery rate back on track. This is the CAT-M reimbursement adjustments.

NCSO (no cheaper stock obtainable)

NCSO is a price concession agreed by the Department of Health when a product cannot be sourced at the drug tariff price. The impact of price concessions continues.

There is a continued impact of price concessions since when they are no longer subject to the price concession, they tend to go back into the drug tariff at an increased price. The table below shows the impact year to date, and projected for the following 2 months.

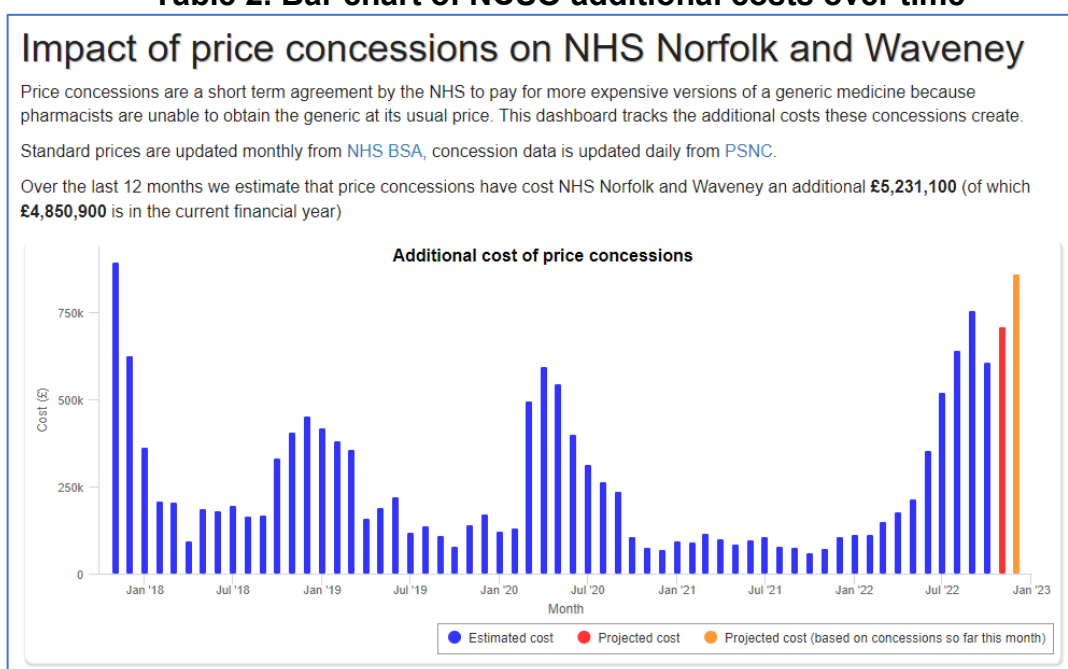
Table 1. Cost Pressure Report December 2022, October data

	YTD April-Oct	Projected Nov*	Projected Dec
NCSO and other price concessions	£3,494,574	£730,231	£937,443
Back into DT at increased prices	£540,185	£194,161	£223,756
Increase in cat M from Q3	£48,752	£48,752	£48,750
Total	£4,083,511	£973,144	£,209,949

* Projected figures are estimated but are based on price concessions announced

** based on price concessions announced to date, some are agreed after month end.

Table 2. Bar chart of NCSO additional costs over time



Some drugs have grown in costs due to an increase in the number of indications for their use e.g., SGLT 2's. This is expected to continue since whereas they had previously only been used in patients with diabetes they are now also used in patients with cardiovascular and renal disease. Freestyle Libre 2 costs are increasing significantly due to the implementation of NICE guidance.

3 Dependence forming medicines (DFMs)

3.1 As previously reported the ICB has made marked improvements to its position as a national outlier on its use of high dose opiates in chronic pain. Our high use of hypnotics (and anxiolytics) is also improving but remains a concern.

3.2 The national indicators for DFMs for October 2022 are below. This was out of the 134 organisations on OpenPrescribing with position 1 being the highest (usually worst). Since April there are only 106 organisations listed due to further mergers of ICBs.

- High dose opiates – a small decrease in use to 84th (82nd previously (out of 106 organisations) 21st percentile (previously 22nd) on [high dose opiate items as percentage of regular opiates](#)
 - Gabapentinoids – remained at 29th, 73rd percentile on [defined daily doses of gabapentin and pregabalin](#)
 - Hypnotics and anxiolytics – reverted back to 3rd nationally (98th percentile (previously 4th nationally 97th percentile) [volume per 1000 patients](#) – the trend (below) is however an improving one (yellow dotted line is Norfolk and Waveney performance and trend respectively)
- The second chart compares Norfolk and Waveney performance with national percentiles (NW is the red line and national average is the blue line)

Table 4. Anxiolytics and hypnotics volume trend over time by top prescribing ICBs nationally

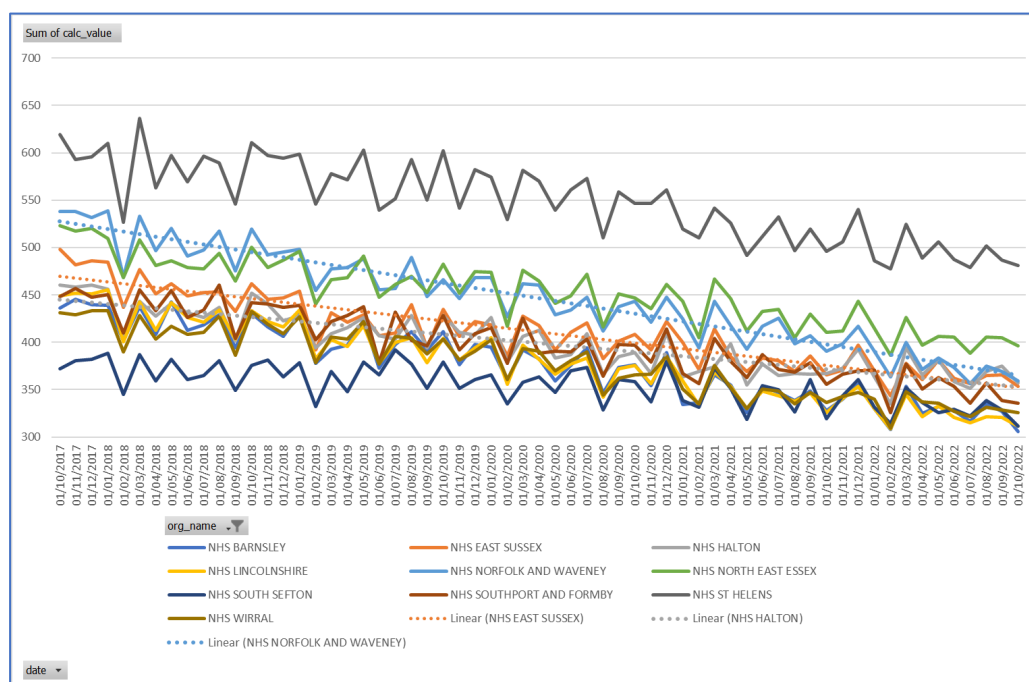
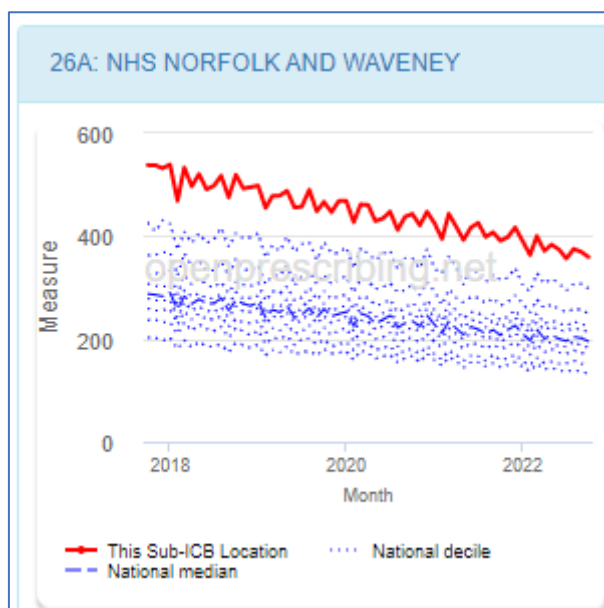


Table 5. Anxiolytics and hypnotics volume trend over time (red line is Norfolk and Waveney and darker blue line is national average)



3.3 We continue to work with the Academic and Health Science Network (AHSN) and Leicester University. Regional finance colleagues are funding additional workshops that we will be delivering in January/February 2023, and a bespoke 10-minute cognitive behavioural therapy /acceptance and commitment therapy training package for prescribers.

4 Antibiotic Prescribing

4.1.0 NHS System Oversight Framework (SOF) Antimicrobial Prescribing Metrics for 2022-23 remain the same as 2021-22. The antibiotic volumes target is 0.871 or less antibacterial items per STAR-PU which aligns with the UK AMR National Action Plan ambition to reduce community antibiotic prescribing by 25% by 2024. The national target for percentage of broad-spectrum antibiotic prescriptions as a total of overall antimicrobial prescriptions is at or below 10%.

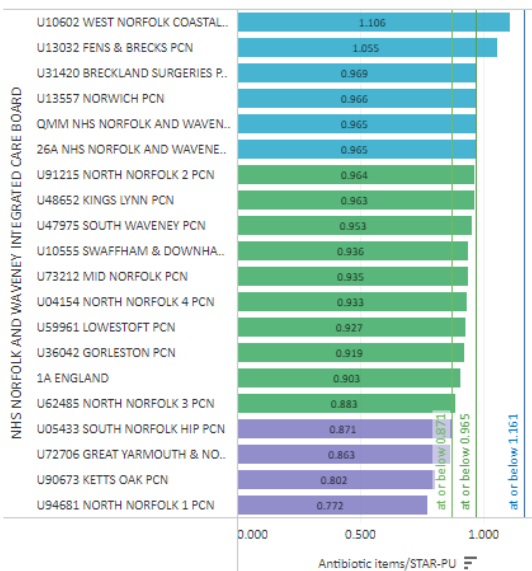
4.1.1 Antibiotic volumes, the bar chart on the left shows the volume of antibiotic prescribing by PCN. Norfolk and Waveney are still above the new volume target of 0.871 with a value of 0.965 antibacterial items per STAR-PU in the 12 months to October 2022.

4.2 Percentage of broad-spectrum antibiotics, the bar chart on the right shows the percentage by PCN. Norfolk and Waveney are currently above the national target of no more than 10% of all antibiotics at 10.41% in the 12 months to October 2022 (no change). Antibiotic performance will be seriously affected by the recent huge increase in demand due to national Strep A guidance.

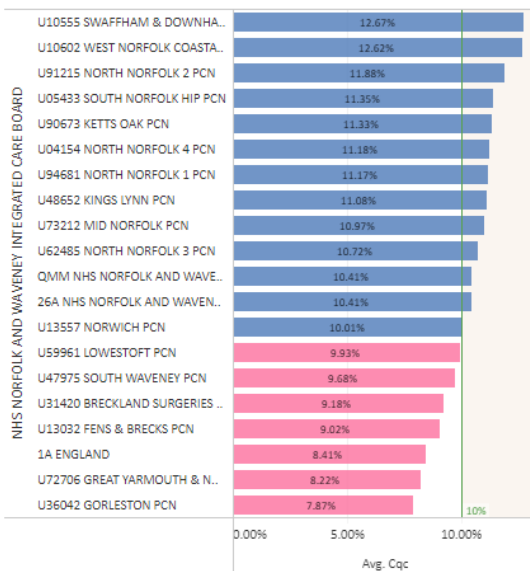
Table 6. PCN bar charts – Antimicrobial prescribing 12 months to end Oct 2022

Antimicrobial Stewardship data reporting against NHS AMR metrics 2022/23

PCN bar charts Antibacterial items/STAR-PU showing 12 months rolling data to Oct-22



PCN bar charts proportion of co-amoxiclav, cephalosporin & quinolone items showing 12 months rolling data to Oct-22



4.3 Our outlier practices (above 14%) that are driving the higher percentage of Broad-spectrum antibiotics in October data are shown in Table 7. The number of practices above this threshold has reduced significantly this month. The overall ICB percentage has remained static this month.

Table 7: Outlier Practices for prescribing Broad Spectrum Antibiotics

Row Labels	Sum of calc_value	Sum of percentile
LITCHAM HEALTH CENTRE	21.71%	99.78
MUNDESLEY MEDICAL CENTRE	18.50%	99.57
TOFTWOOD MEDICAL CENTRE	18.07%	99.49
BURNHAM SURGERY	16.33%	99.10
BLOFIELD SURGERY	14.20%	97.65
OLD CATTON MEDICAL PRACTICE	14.15%	97.59
WATLINGTON MEDICAL CENTRE	14.14%	97.55

Recommendation to Governing Body/ Committee:

The committee is asked to note this report

Key Risks	
Clinical and Quality:	Some key quality areas need focus and outlier performance needs addressing. Mitigated through the prescribing quality scheme
Finance and Performance:	Risks highlighted in report
Impact Assessment (environmental and equalities):	Not applicable
Reputation:	ICB practices remain outliers for hypnotics and anxiolytics as highlighted in the report
Legal:	Not applicable
Information Governance:	Not applicable
Resource Required:	Medicines management team support to practices
Reference document(s):	Not applicable
NHS Constitution:	N/A
Conflicts of Interest:	GP dispensing practices may be conflicted with competing financial interests associated with dispensing costs
Reference to relevant risk on the Governing Body Assurance Framework	Prescribing cost risk noted on register

GOVERNANCE

Process/Committee approval with date(s) (as appropriate)	Monthly report to PCCC
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East of England Partnership Strategy for Community Pharmacy

Rolling 5 years from December 2022









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East of England Partnership Strategy for Community Pharmacy

Vision	 <p>COMMUNITY PHARMACY IS INTEGRATED INTO PRIMARY AND COMMUNITY CARE WITH BETTER ACCESS AND IMPROVED OUTCOMES</p>		 <p>COMMUNITY PHARMACY SERVICES ARE PATIENT CENTRED AND THE FIRST POINT OF CALL FOR MANY PATIENTS</p>		 <p>COMMUNITY PHARMACY IS EMBEDDED IN PATHWAYS ACROSS THE WIDER HEALTH AND CARE SYSTEM</p>				
	 <p>COMMUNITY PHARMACY SUPPORTS SELF CARE AND IMPROVES POPULATION HEALTH</p>		 <p>COMMUNITY PROFESSIONALS AND WIDER TEAMS ARE VALUED AND RESPECTED</p>		 <p>COMMUNITY PHARMACY IS INTEGRAL TO REDUCING HEALTH INEQUALITIES</p>				
	Priorities	Increase health system integration and partnership		Optimise services and outcomes		Improve population health and address health inequalities		Develop the workforce for delivery	
		<p>Work in partnership with GP practices, Primary Care Networks. Local Authorities and other healthcare providers</p> <p>Develop integrated service models and whole system approaches to delivering services and reducing inequalities</p>		<p>Promote community pharmacy as a clinical provider</p> <p>Collaborate on pathway redesign</p> <p>Support extension of services to address unmet needs</p>		<p>Ensure services are consistently delivered, visible and actively promoted</p> <p>Consider innovative approaches to increase accessibility</p> <p>Develop greater understanding of the characteristics and needs of the local community</p>		<p>Optimise use of workforce skill mix within services</p> <p>Focus on the recruitment, retention and wellbeing of the community pharmacy workforce</p> <p>Develop an integrated workforce strategy for primary and community care</p>	
	Actions	IT and digital infrastructure and data services				Communication and engagement			
		Financial and contractual arrangements				Estates			
Enablers	IT and digital infrastructure and data services				Communication and engagement				
	Financial and contractual arrangements				Estates				

Foreword

The NHS Long Term Plan – a blueprint for the future of the NHS which provides the right care at the right time and in the right place – recognises that good health is about more than treating people when they fall ill. It presents a vision of health and care that is driven by prevention and tackling health inequalities. Central to delivering this is the creation of fully integrated community-based health care system. This includes community pharmacy playing an important and integrated role as recognised in the *Next steps for integrating primary care: Fuller Stocktake report*.

The East of England Partnership Strategy for Community Pharmacy outlines our strategic visions and goals to support and enable community pharmacy in the East of England to realise its full potential. Supporting integration and transformation, building on the strong foundations in place and to deliver on the vision of the NHS Long Term Plan. Playing a part in prevention of diseases, reducing health inequalities, helping to tackle obesity and high blood pressure, and providing enhanced public health care as part of a whole system approach. The Strategy represents the collaborative efforts of partners across the East of England including Local Pharmaceutical Committees, Local Authorities, Integrated Care Boards and Systems, and other key stakeholders. We would like to extend our thanks to all colleagues involved in the development of the document, whose contributions have been incorporated and without whom this would not have been possible.

Community pharmacy is and continues to demonstrate resilience, engagement and innovation in the services it provides to patients, communities and populations. This is evident in their ongoing contribution to the Covid-19 vaccination programme for example. To ensure that community pharmacy continue to build on this, health and care systems in the East of England collectively support a vision where:

1. Community pharmacy is an integral and integrated part of primary care, leading to improved outcomes for patients and facilitating better access
2. Community Pharmacy is part of integrated care pathways for primary care and urgent care
3. Community Pharmacy is the first point of contact for many patients
4. Community Pharmacy is integral to the delivery of self-care and avoiding ill health
5. Community Pharmacy is integral to addressing health inequalities
6. Community pharmacists are valued and respected as clinicians in their own right

Through the identified priorities, actions and enablers that underpin these six vision statements, our overall goal is to increase health system integration and partnership, optimise services, improve population health and reduce health inequalities, address workforce issues; all for the benefit of the patients, communities and population we are here to serve.

By realising the potential of community pharmacy and the expertise of the pharmacy teams within them, with the collaboration of partners across the East of England, we can be confident that community pharmacy will cement its position as a valued and essential component for healthcare delivery in primary care.

William Rial, Regional Chief Pharmacist

Introduction

This strategy has been developed to help give focus and direction for community pharmacy in the East of England over the next five years.

The strategy aims to facilitate collaboration across health, social, primary and community care teams in designing and delivering transformation programmes, reconfiguring services and redesigning pathways to deliver integrated community pharmacy services.

The creation of Integrated Care Boards (ICBs) in July 2022 and the delegation of the commissioning of community pharmacy to them in April 2023 now affords more opportunities. This strategy identifies a range of priorities and actions, which will be implemented at differing levels, such as neighbourhood, Integrated Care System (ICS) or region. By having an agreed regional strategy it will:

- Ensure a level of consistency in the implementation of national programmes and avoid unwarranted variation
- Identify and prioritise regional resources
- Maintain a focus on prevention and reducing health inequalities
- Enable regional and national support in areas such as workforce and infrastructure development, to avoid duplication of effort and maximise economies of scale
- Drive quality and oversight

This is a rolling strategy written at a point in time where structure, governance and commissioning responsibilities are still being defined and agreed for the ICBs and local partnerships. The intention is to regularly review and update to ensure it delivers improvements for patients, community pharmacy teams and wider stakeholders alike.

NHS England established 42 statutory ICBs on 1 July 2022 in line with its duty in the Health and Care Act 2022. This was as part of the Act's provisions for creating ICSs. ICSs are partnerships that bring together NHS organisations, local authorities and others to lead the delivery of NHS care and improvements for patients set out in the NHS Long Term Plan. See <https://www.england.nhs.uk/integratedcare/integrated-care-in-your-area/> for more information.

For the purpose of this strategy the term “system” has been used to reflect both the ICS and the ICB where the implications are across the ICS.

Vision

This strategy supports a vision where community pharmacy is a core part of health and care services, integrated into systems, and providing an essential contribution to system-wide health protection and improvement.



Community pharmacy is an integral part of primary and community care, leading to improved outcomes for patients and facilitating better access



Community pharmacy is embedded in pathways across the wider health and care system



Community pharmacy is a patient centred service that is the first point of contact for many patients



Community pharmacy is integral to the delivery of self-care, avoiding ill health and improving population health



Community pharmacy is integral to addressing health inequalities



Community pharmacy professionals and wider teams are valued and respected

Community pharmacy will support and strengthen wider health and care services by undertaking key roles in improving the use of medicines, treating common clinical conditions, managing long term conditions, and addressing health inequalities, population health and wellbeing.

To realise the potential of community pharmacy, development of the role and services needs to be underpinned by:

- Collaboration with partnership organisations to integrate strategies and services
- Increased public and health professional awareness of community pharmacy capabilities and services
- Sustainable workforce models which maximise the skill mix of community pharmacists, technicians and wider pharmacy teams
- Improved system and digital infrastructure with shared patient records
- Better use of data to inform decisions, monitor outcomes and improve services
- Good access to community pharmacies
- Investment and practical support in community pharmacy to realise full potential

Strategic context

This strategy is aligned with national and local policies and plans which aim to strengthen the role of community pharmacies as anchor institutions in local communities.

The [NHS Long Term Plan](#) (LTP) (Jan 2019) states that the NHS will focus on its aim to make the population fit for the future by:

- Enabling everyone to get the best start in life
- Helping communities to live well
- Helping people to age well

The plan commits to developing more joined-up and coordinated care across primary and community health services and a more proactive approach in the services provided. It supports expanded community multidisciplinary teams aligned with primary care networks (PCNs). It determines to make greater use of community pharmacists' skills and opportunities to engage patients; and identifies community pharmacies as being able to support urgent care and promote patient self-care and self-management as a key part of developing a fully integrated community-based health care system.

The LTP sets out a new service model offering patients more options, better support and joined-up care at the right time in the optimal care setting. It strengthens the focus on prevention and reducing health inequalities, and on improving care quality and outcomes. It also looks to address current workforce issues, support staff and to upgrade technology for digitally enabled care.

ICs and ICBs are central to the delivery of the LTP through enabling service integration to meet local needs, bringing together providers and commissioners of NHS services with local authorities and other local

partners, to make shared decisions on population health, service redesign and implementation.

The [Fuller Stocktake Report](#) (May 2022) describes a vision of integrating primary care, improving the access, experience and outcomes for communities, which centres around three essential offers:

- Streamlining access to care and advice for people who get ill but only use health services infrequently: providing them with much more choice about how they access care and ensuring care is always available in their community when they need it
- Providing a more proactive, personalised care with support from a multidisciplinary team of professionals to people with more complex needs, including, but not limited to, those with multiple long-term conditions
- Helping people to stay well for longer as part of a more ambitious and joined-up approach to prevention

Community pharmacies are contracted and commissioned in England under the national [Community Pharmacy Contractual Framework](#) (CPCF) (Jul 2019, updated September 2022). The CPCF is an agreement between the Department of Health and Social Care (DHSC), the Pharmaceutical Services Negotiating Committee (PSNC) and NHS England (NHSE) and describes the joint vision for pharmacy to be more integrated in the NHS, provide more clinical services, be the first port of call for healthy living support as well as minor illnesses and to support managing demand in general practice and urgent care settings.

The CPCF supports:

- Better utilisation of the clinical skills of the teams that work in pharmacies
- Doing more to protect public health
- Taking on an expanded role in urgent care
- Continuing to prioritise quality in community pharmacy and promoting medicines safety and optimisation

2022/23 is year four of the five-year framework. The agreement for the two remaining years ([Community Pharmacy Contractual Framework 5-year deal: year 4 \(2022 to 2023\) and year 5 \(2023 to 2024\)](#)) continues to support measured and incremental expansion in clinical service provision from community pharmacies, in line with the sector's ambitions, but recognising current capacity pressures.

Years 4 and 5 of the service development plan will introduce services that build on existing services, including:

- Expanding the Community Pharmacist Consultation Service to enable urgent and emergency care settings to refer patients to a community pharmacist for a consultation for minor illness or urgent medicine supply
- Expanding the New Medicines Service to include antidepressants to enable patients who are newly prescribed an antidepressant to receive extra support from their community pharmacist
- Introducing Tier 2 of the Pharmacy Contraception Service, enabling community pharmacists to also initiate oral

contraception, via a Patient Group Direction, and provide ongoing clinical checks and annual reviews

- The service specifications for the Blood Pressure Check Service and Smoking Cessation Service will be amended to allow delivery by pharmacy technicians, helping pharmacies to make best use of their skill-mix

The [Pharmacy Quality Scheme](#) (Sep 2021, updated Oct 2022) forms part of the CPCF. It rewards community pharmacies for delivering quality criteria in all three of the quality dimensions: clinical effectiveness, patient safety and patient experience.

Integrated Care Systems

ICSs have four key aims:

- Improving outcomes in population health and health care
- Tackling inequalities in outcomes, experience and access
- Enhancing productivity and value for money
- Helping the NHS to support broader social and economic development

The responsibility for community pharmacy commissioning is being delegated from NHSE to ICBs in April 2023 in the East of England. The CPCF will continue to be negotiated and set nationally, systems will have delegated responsibility for the commissioning and contracting locally.

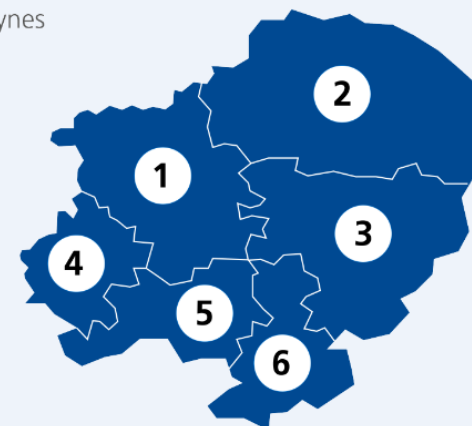
Giving ICBs responsibility for direct commissioning is a key enabler for integrating care and improving population health. It allows the flexibility to join up key pathways of care, leading to better outcomes and experiences for patients, and less bureaucracy and duplication for clinicians and other staff.

Systems vary in size and have differing priorities according to local needs, underpinned by developing structures and strategies. Each system has produced a summary (see Appendix A) of their current position and approach to community pharmacy. These reflect the differing approaches and need to ensure that this strategy is as flexible as possible to support system implementation.

The East of England has an estimated population of 7.1 million and as of April 2022 there were 1,144 community pharmacies (figures from NHSE – East of England).

There are six systems in the East of England.

1. Cambridgeshire and Peterborough
2. Norfolk and Waveney
3. Suffolk and North East Essex
4. Bedfordshire, Luton and Milton Keynes
5. Hertfordshire and West Essex
6. Mid and South Essex



ICS	Registered pharmacies
Cambridge and Peterborough	145
Norfolk and Waveney	178
Suffolk and North East Essex	170
Bedfordshire, Luton and Milton Keynes	158
Hertfordshire and West Essex	291
Mid and South Essex	212
East of England Total	1154

Views from service users

In Spring 2022 NHSE ran a patient and public survey throughout the East of England region to support development of this strategy. The survey 'Have your say in the future of community pharmacy' sought to identify views of need and priority areas from a patient / public perspective.

“Pharmacies are vital to communities and a very valuable [community] asset”

Clear themes emerged in the analysis of the survey results.

The role of community pharmacies has been especially valued during the pandemic, when the perception of reaching a GP was that it could present a challenge. However, there is a key theme indicating that pharmacies cannot and should not replace GPs. Rather, people wished for better communication and improved systems between the two.

There was strong agreement and support for :

- The pharmacy having good links with the doctor's surgery and working together to look after patients and their community
- Pharmacies taking a bigger role in patient healthcare by providing services to help their health and/or health conditions
- Pharmacies supporting vaccinations, pain management, routine blood tests and hypertension monitoring

The patients and public that responded to the survey expressed some concerns around understaffing, and areas identified for improvement included:

- Queues, long wait times and insufficient opening hours
- Communication and advertising of available services

It should be noted that the survey took place shortly following COVID-19 restrictions and social distancing had been in place.

Service users expressed that they see an ideal pharmacy as a perfect combination of **three S's** - **Staff** (including quality customer service), **Service/s** (including accessibility) and **Space** to give privacy.

- **Staff:** Many mentioned that on top of being friendly and helpful, pharmacy staff are providing or should provide excellent customer service and a personal touch taking the time to get to know their customers and community and often go above and beyond
- **Service:** Responders identified extended hours, specifically evenings and weekends, and an efficient, well-organised and well-staffed pharmacy as ideal
- **Space:** as commented on to a lesser degree than staff and service/s, but confidentiality and privacy is highly important when mentioned

An additional 'S', not directly stated but implied, is **Safety** – safe practice must underpin all community pharmacy services.

These findings have helped to shape the priorities and actions included in this strategy.

Views from pharmacy teams and healthcare professionals

In Spring 2022 a series of surveys and events sought the views of community pharmacy teams and other stakeholders involved in community pharmacy.

There were high levels of support for better integration of community pharmacy, primary, urgent and acute care, and for improving joint working across services to:

- Provide easier access to healthcare services for patients
- Ensure community pharmacy becomes the first point of call for minor ailments
- Manage long-term conditions with routine tests and enhanced monitoring
- Enable improved patient outcomes

The survey results have been summarised in four key areas – workforce, clinical services, digital and IT and pharmacy integration.

Workforce: community pharmacy teams feel there is a need for joined-up workforce planning that:

- Increases recognition of community pharmacy and community pharmacists to be valued and respected as clinicians
- Raises awareness about different roles in provision of healthcare services and the expertise of community pharmacy teams
- Increases workforce numbers, particularly accredited checking technician and pharmacist roles
- Enables workforce training and development time to be protected and funded
- Provides more opportunities to support flexible, portfolio working

Clinical services: community pharmacy teams identified that development and integration of services requires:

- Improved communication between services and ensuring close collaboration
- Ensuring adequate funding for community pharmacies
- Formal referral routes between community pharmacies and other healthcare services
- Improved referral processes, including potential for self-referral, into services

Digital and IT: community pharmacy teams agreed that a digitally enabled and improved system architecture is required to support:

- Integrated IT systems and/or single system use across pharmacies and GPs and wider services e.g. hospitals for discharge
- Shared healthcare records
- Improved referral tools and standardised data templates and data entry
- Increased application of digital solutions for example remote consultation capabilities, and electronic prescribing

Pharmacy integration: survey respondents highlighted that to be successful pharmacy integration will need to:

- Improve communication between services
- Have a clear roadmap and a shared vision
- Consider sustainability of programmes with adequate funding and incentivisation

Vision, priorities and actions

The six vision statements below were developed using the wider policy context and the views of the patients, public, and community pharmacy teams, as well as each system. Each system has identified priorities, potential actions and enablers to support the delivery of each vision statement. Below are the combined summaries which form the basis of this strategy.

The vision	Strategic priorities	Potential Actions	Enabled by
<p>1. Community pharmacy is an integral part of primary and community care, leading to improved outcomes for patients and facilitating better access</p>	<p>Align community pharmacy strategy with primary and community care strategy and system strategic priorities</p> <p>Embed community pharmacy into PCNs and integrated neighbourhood teams</p> <p>Raise the profile of community pharmacy across the system and gain insight and visibility of capacity, pressures and opportunities, gaps and variation</p>	<p>Include community pharmacy leads in all levels of system leadership, strategic planning and pathway design</p> <p>Develop the designated PCN Community Pharmacy Lead role</p> <p>Map current services for improved understanding of community pharmacy provision and incorporate into wider system resilience and capacity planning</p> <p>Develop integrated service delivery models</p> <p>Collaborate on optimised use of agreed pathways</p> <p>Monitor service delivery data to improve health outcomes and identify gaps in care</p>	<p>Funding for the PCN Community Pharmacy Lead role and community pharmacy participation in integration design and implementation activities</p> <p>Better communications platforms/services</p> <p>Improved interoperability of IT systems (including appropriate access to patient records)</p> <p>Shared data, insights and intelligence on current and planned provision, demand and capacity</p>

The vision

2. Community pharmacy is embedded in pathways across the wider health and care system

Strategic priorities

Establish community pharmacy as a core service element of the primary care system enabling patients to access care at the right time in the optimal setting

Provide better access to assessment, advice and medicines for patients requiring treatment for low acuity conditions

Increase reach of community pharmacy to promote self-care and preventative strategies for ill health

Potential Actions

Promote the expertise and knowledge of community pharmacy, including services offered to the public to encourage uptake and to other healthcare professionals to support referral

Further implementation and optimisation of currently commissioned services

Local commissioning of Patient Group Directives and independent prescriber-led services for the treatment of low acuity conditions in all community pharmacies

Review the range of services currently offered by community pharmacies and support extension of services to cover gaps

Enabled by

Community pharmacy involvement in health awareness campaigns

Peer network to share best practice, review learning and determine potential for local implementation

Better communications platforms/services

Improved interoperability of IT systems (including appropriate access to patient records)

Data sharing

Sufficiently funded pharmacy workforce (pharmacists and other staff)

The vision

3. Community pharmacy is a patient centred service that is the first point of contact for many patients

Strategic priorities

Improve public and patient awareness of community pharmacy expertise and services

Enable onward referral or signposting between community pharmacy and other healthcare teams such as general practice, NHS 111 or A&E

Improve service accessibility

Optimise the Community Pharmacist Consultation Service

Potential Actions

Promote community pharmacy as a clinical provider

Ensure services are consistently delivered, visible and actively advertised to patients/other healthcare providers

Review demand against current provision to identify accessibility issues and options to address inaccessibility

Consider innovative approaches to service provision to increase accessibility

Enabled by

Better communication platforms/services

Improved interoperability of IT systems (including appropriate access to patient records)

Funding for piloting and implementation of new service technologies and approaches

Sufficiently funded pharmacy workforce (pharmacists and other staff)

Contractual support for alternative service provision approaches

The vision	Strategic priorities	Potential Actions	Enabled by
<p>4. Community pharmacy is integral to the delivery of self-care, avoiding ill health and improving population health</p>	<p>Give people more control over their health and wellbeing</p> <p>Provide wider support for prevention and detection of ill health, to help people stay healthy and moderate demand on the NHS</p>	<p>Promote community pharmacies as 'healthy living' centres providing prevention support, advice and services</p> <p>Work with Local Authority public health teams and PCNs to develop greater understanding of the characteristics and needs of local populations</p> <p>Maximise delivery of existing clinical services including hypertension case finding, weight management and smoking cessation</p> <p>Consider extending currently commissioned services or implementing new services to address unmet needs</p>	<p>Better communications platforms/services</p> <p>Improved interoperability of IT systems (including appropriate access to patient records)</p> <p>Funding for piloting and implementation of new service technologies and approaches</p> <p>Sufficiently funded pharmacy workforce (pharmacists and other staff)</p>

The vision

5. Community pharmacy is integral to addressing health inequalities

Strategic priorities

Develop services to tackle local population health inequalities and address unwarranted variation

Maximise community pharmacy contribution to Core20PLUS¹

Potential Actions

Work in partnership with GP practices, PCNs, Local Authorities and other healthcare providers to develop whole system approaches to inequalities

Assess and understand local population health inequalities and unmet need

Enabled by

Availability and accessibility of population health data

¹ Core20PLUS5 is a national NHS England approach to support the reduction of health inequalities at both national and system level. The approach defines a target population cohort - the most deprived 20% of the population as identified by the Index of Multiple Deprivation – plus ICS-chosen population groups experiencing poorer-than-average health access and focuses on 5 clinical areas for accelerated improvement

The vision	Strategic priorities	Potential Actions	Enabled by
<p>6. Community pharmacy professionals and wider teams are valued and respected</p>	<p>Maximise the skills of community pharmacists, pharmacy technicians, wider pharmacy teams and associated healthcare professionals</p> <p>Address workforce shortages</p> <p>Create a structure that offers workforce development and opportunities</p>	<p>Review commissioning arrangements to actively encourage and optimise appropriate use of workforce/skill mix within services</p> <p>Develop a community pharmacy workforce strategy which is integrated into wider system workforce planning and resourcing</p> <p>Focus on recruitment, retention and wellbeing of the community pharmacy workforce</p> <p>Consider flexible, cross-sector workforce models including shared posts with GP practices and hospitals</p> <p>Reinforce positive image through public messaging, communications and engagement</p> <p>Embed the Quality Improvement approach to learn and expand best practice</p>	<p>Collaborative working with Health Education England (HEE), professional leads (including Local Pharmaceutical Committee) and higher education institutes</p> <p>Promotion of careers in Community Pharmacy</p> <p>Changes to pharmacy training and qualifications</p> <p>Increased community pharmacy placements for trainees</p> <p>Protected learning time</p> <p>Multidisciplinary training opportunities</p> <p>Pharmacy Integration Fund² investment</p> <p>Facilitation of independent prescriber training</p>

² [NHS England » Pharmacy Integration Programme](#)

Delivery of actions

The vision statements and the actions to deliver these have been grouped into four key pillars of work.



The successful delivery of these four key pillars of work requires a number of enablers to be in place and challenges overcome, these include:

- Improved interoperability of IT systems and appropriate access to patient records
- Shared data, insights and intelligence
- Improved communication and engagement platforms and services
- Fit for the future facilities supporting operational efficiency and patient orientated service needs
- Appropriate funding and contractual arrangements – nationally and within systems

Pillar 1 Increase health system integration and partnership

Why is this important?

Partnership and shared ownership for improving local population health is at the core of the new way of working.

Whilst ICBs have been legislated as legal entities, it is important to recognise the limitations of what this legislation can realistically achieve. It is not possible to legislate for collaboration and co-ordination of local services; this requires changes to behaviours, attitudes and relationships among staff and leaders right across the system.

As ICBs take on commissioning of pharmacy they will need to take an integrated approach to working and co-ordinating with stakeholders including NHSE, LAs, Healthwatch, acute and community providers, professional representative groups, and contractor representatives.

What needs to change?

Community pharmacy integration must be embedded into system and primary care strategies going forwards. Support is needed for the development of strategic and operational community pharmacy leadership and this leadership must be formally recognised in the governance structure and process.

ICBs and ICSs are responsible for providing system leadership and bringing commissioners and providers together in new collaborative ways of working. Building a culture of collaboration and alignment of community pharmacy with PCNs, GPs and other primary care teams requires protected time and space in which to plan and problem solve together. **Cross service referrals and multi-disciplinary teams will**

need to be developed to provide agile service delivery teams and treatment pathways. This will need to be supported with the sharing of expertise and insights, and the pooling of data and information. Multi-disciplinary teams will combine learning, best practice and case studies in determining what 'good' may look like.

Central to enabling collaboration will be the recruitment of pharmacy roles to the ICB, funded by the Pharmacy Integration Fund for the first two years. These roles will work with system partners and key stakeholders to develop and support integration and transformation and are a dedicated resource to champion community pharmacy integration.

Another key enabler for ICBs is the appointment of a Community Pharmacist to the ICB Board, this person will also be a member of the Primary Care Commissioning and Assurance Committee thereby providing oversight, leadership and a different perspective on opportunities for integration and collaboration.

Actions to be delivered under this pillar

- Include community pharmacy leads in all levels of system leadership, strategic planning and pathway design
- Develop the designated PCN Community Pharmacy Lead role
- Map current services for improved understanding of community pharmacy provision and incorporate into wider system resilience and capacity planning
- Develop integrated service delivery models
- Work in partnership with GP practices, PCNs, Local Authorities and other healthcare providers to develop whole system approaches to inequalities

Pillar 2 Optimise services and outcomes

Why is this important?

Over recent years, community pharmacies have already developed and implemented a wide range of clinical and public health services which support integration and collaboration with other parts of the NHS.

Current community pharmacy services are largely a mix of Essential and Advanced services delivered as part of the CPCF. Please refer to Appendix B for more details.

What needs to Change?

Community pharmacy will continue and where necessary augment, existing services to ensure resilience and to deliver equitable access to services. Alongside this is the need to capture service outcomes to ensure continuous improvements in the quality of care, disease prevention and health inequalities.

Priority clinical areas in the LTP include:

Prevention
Smoking
Obesity
Alcohol
Antimicrobial resistance
Action on health inequalities
Hypertension

Better care for major health conditions
Cancer
Cardiovascular disease
Stroke care
Diabetes
Respiratory disease
Adult mental health services

In addition to the services within the pharmacy contract there are provisions for:

- Nationally commissioned services by NHSE to a national specification
- Locally commissioned services contracted via a number of different routes and by different commissioners, including Local Authorities, ICBs and NHSE local teams

ICBs may want to consider in their primary care strategies the opportunity to develop and commission innovative local services directly, either as a locally commissioned service or by making use of the Local Pharmaceutical Services regulations. There are good opportunities for collaboration and for reducing fragmentation of commissioning, for example in the wider rollout of oral contraception supply.

Local health partnerships, including PCNs and Integrated Neighbourhood Teams (INTs), will need to determine how community

pharmacy teams best contribute to preventing ill health, early detection of disease and population health management and improvement.

Taking a holistic view will be important, for example, embedding the principles of 'making every contact count' into more services with community pharmacies being able to refer directly to other neighbourhood services.

Actions to be delivered under this pillar

- Promote community pharmacy as a clinical provider
- Collaborate on optimised use of agreed pathways
- Monitor service delivery data to improve health outcomes and identify gaps in care
- Further implementation and optimisation of currently commissioned services
 - Maximise delivery of existing clinical services including hypertension case finding, weight management and smoking cessation
- Local commissioning of Patient Group Directives and independent prescriber-led services for the treatment of low acuity conditions in all community pharmacies
- Review the range of services currently offered by community pharmacies and support extension of services to cover gaps
- Consider extending currently commissioned services or implementing new services to address unmet needs

Pillar 3 Improve population health and address health inequalities

Why is this important?

Local health and care organisations and partnerships are increasingly focused on population health. It is not just about putting in standard services to a generic specification but combining local insights and data to ensure that service delivery is appropriate to local population needs.

The CPCF underlines the key role of community pharmacy as an agent of improved public health and prevention, embedded in local communities. For example, community pharmacy will play an increasingly important role in prevention, detection and screening, and case-management in primary care. Support can be targeted at communities with social and economic inequalities and poorer health outcomes and services designed to achieve improvements in population health.

Creating healthy communities

The Fuller report identifies the opportunity that integration of primary care presents to re-balance focus from treating people who have already become sick to helping people to stay well for longer. This aligns with the Core20PLUS5 programme addressing health inequalities with five clinical areas of focus requiring accelerated improvement:

- Chronic respiratory disease
- Early cancer diagnosis
- Hypertension case-finding
- Maternity

- Severe mental illness

This will not only have the greatest impact on the future sustainability of health and care services overall but can genuinely help to transform lives.

What needs to change?

When planning on how to address identified inequalities and developing preventative health and healthy lifestyle programmes, systems and PCNs need to consider the opportunities presented by community pharmacy. Community pharmacy services that target areas such as prevention of unplanned pregnancies and reduction from drug use harm (needle exchange, supervised consumption, provision of naloxone) can help provide appropriate provision in the right setting. Community pharmacies also offer unique geographical reach for addressing accessibility issues, as was seen in the successful approach to the COVID-19 vaccination programme which made the service more accessible and convenient for patients and therefore improved outcomes.

Actions to be delivered under this pillar

- Promote the expertise and knowledge of community pharmacy, including services offered to the public to encourage uptake and to other healthcare professionals to support referral
- Ensure services are consistently delivered, visible and actively advertised to patients/other healthcare providers
- Review demand against current provision to identify accessibility issues and options to address inaccessibility

- Consider innovative approaches to service provision to increase accessibility
- Promote community pharmacies as 'healthy living' centres providing prevention, support, advice and services
- Work with Local Authority public health teams and PCNs to develop greater understanding of the characteristics and needs of local populations
 - Assess and understand local population health inequalities and unmet need

Pillar 4 Develop the workforce for delivery

Why is this important?

It is recognised that a resilient and sustainable workforce plays a fundamental role in delivering the aims and goals of the strategy.

The LTP describes the ongoing training and development of multidisciplinary teams in primary and community hubs and making greater use of community pharmacists' skills and opportunities to engage patients.

NHSE and ICBs are working with Health Education England to further clinical education and development for pharmacists and pharmacy technicians. This collaboration is important to deliver the vision and actions and to avoid duplication of effort.

What needs to change?

Pharmacy workforce recruitment, retention and development will need to be a clear and ongoing focus. Each system is aiming to attract, retain, develop and equip a flexible and responsive workforce. Service models will be increasingly based on collaborative working across the primary healthcare system, bringing opportunities for new roles and new ways of working. A region-wide working group is providing the focus on workforce issues, and actions needed to support the required workforce transformation. The working group aims are to:

- Identify capacity and skills gaps and support staff in moving beyond traditional roles to meet changing needs
- Identify new workforce models that consider the roles of different pharmacy team members including pharmacy technicians,

prescribing pharmacists, multi-sector foundation pharmacists and opportunities for portfolio working across service teams

- Consider how development of digital and IT infrastructure will change the composition and skill requirement of the future workforce
- Identify how to reposition community pharmacy and its developing workforce models as a compelling service to work in
- Ensure commitment to supporting the emotional, mental and physical health and wellbeing of staff working in community pharmacy

A summary of development priorities is given at Appendix C.

Actions to be delivered under this pillar

- Review commissioning arrangements to actively encourage and optimise appropriate use of workforce/skill mix within services
- Develop a community pharmacy workforce strategy which is integrated into wider system workforce planning and resourcing
- Focus on recruitment, retention and wellbeing of the community pharmacy workforce
- Consider flexible, cross-sector workforce models including shared posts with GP practices and hospitals
- Reinforce positive image through public messaging, communications and engagement
- Embed the Quality Improvement approach to learn and expand best practice

Enablers

The Fuller Report (2022) identified that a consistent thread throughout successful case studies is that change was locally led and nationally enabled. Therefore, systems working together, and with NHSE, DHSC and PSNC, will be the most effective route to integration.

IT and digital infrastructure and data services

Key to enabling integrated care is the development of an information management and technology (IM&T) infrastructure that will:

- Increase system interoperability to provide shared care records and e-referral across service boundaries
- Enable community pharmacists and GPs to access the same system
- Support pharmacies to become digitally enabled
- Enable enhanced data and analytic capabilities around population health, service availability, capacity, demand and outcomes
- Improve access to services for patients and transform pharmacy processes including:
 - on-line appointment booking
 - remote access to health advice and guidance
 - video consultations
 - wearable technology to collect monitoring data (such as medicine use, lifestyle, blood pressure)
 - electronic prescribing and dispensing
 - automated stock control

- Transform communication and integration through remote, collaborative working and virtual networking between healthcare teams

During the COVID-19 pandemic digital technologies transformed the delivery of care in various services. There is opportunity now to build on this and use the potential of digital technologies to help address both long-term challenges and immediate pressures.

Care must be taken however, to ensure that health inequalities are not increased due to inability of population segments to access digital services.

The current picture in terms of community pharmacy digital capacity and effective use of data is complex. An understanding of the current baseline along with national priorities being embedded into the local digital strategy will be key to establishing next steps.

It may be more efficient for certain activities in this area to be coordinated at regional and national level for example:

- Standardisation of data items/definitions
- Production of data sharing agreements to overcome the problem of data-sharing liability
- Engagement with Information and Communications Technology (ICT) suppliers for value for money delivery

Communication and engagement

There is a need for greater patient and public awareness raising on what community pharmacy services offer in order to increase understanding and improve uptake.

At all levels, national, regional, system and place, more needs to be done to inform patients and empower them to seek the most appropriate care for their needs. Joint communication strategies to align approaches to patient communications, maximise effectiveness of available resources and make every contact count will be key. National campaigns should be underpinned by clear local signposting.

Financial and contractual arrangements

Delivering required service changes within the current funding envelope is a recognised challenge. For example, the CPCF has flat funding until 2024 which does not reflect increasing costs and inflationary pressures.

Contracting needs to reflect the requirements of a new integrated system. More responsive funding mechanisms may enable clinical interventions to be made within community pharmacies. This could include:

- Demonstration of the return on investment of locally commissioned pharmacy services
- Development of robust business cases to support appropriate and sustainable funding streams
- Moving away from non-recurrent short-term funding

It is recognised that some level of IT capital investment may be needed to achieve the level of infrastructure required and workforce development will also benefit from additional funding.

This investment will need to be provided at a national or system level through a combination of reprioritisation and efficiencies.

Estates and facilities

The infrastructure needs to meet the demands of an expanded community pharmacy role within an integrated primary and community care landscape:

- Fit for the future facilities supporting operational efficiency
- Dedicated patient orientated facilities for confidential consultation
- Increased evening and weekend use of facilities
- Accessibility for all

One challenge is that the expansion and / or improvement to estates provision within community pharmacies is not part of current contracting arrangements or funding models.

Future opportunities for community pharmacy

To inform this strategy a rapid scan of published literature was undertaken to identify key developments relating to community pharmacy. Please refer to Appendix D for a list of references.

Looking into the future, advances in medicine could radically change the way illness is managed. For example, drug treatment will be personalised to each individual ensuring the most effective treatment with the minimum risk of adverse effects.

At the same time the delivery of healthcare will need to evolve. The reasons for this are multifactorial and include the changing needs and expectations of the population and the ability of the public purse to fund services to meet those expectations.

Community pharmacy will have a key role in making patient care personalised, enabling patients to be involved in choices about their medicine treatment, deprescribing if appropriate and having direct referral to a range of other services.

The report by the Kings Fund - *A professional Vision for pharmacy practice in 2032*, sets out the possibilities for community pharmacy in the next 10 years envisioning an integrated multidisciplinary system enabled by IT and automation, supported by artificial intelligence. This technology supports safer medicines supply and releases clinical time within community pharmacy for one-to-one interaction, virtual or in-person, with patients.

Community pharmacy is already the easy access health hub within a community but additional clinical input can be used to enhance population health, for instance through early detection of illness and prevention of ill health.

The key themes identified in this strategy document: workforce; digital enablement; system integration; and development of clinical services; provide the steps to achieving the long term (5-year plus) vision.

The international horizon scanning indicated that throughout the world there are similar intentions to modernise the way pharmacy is delivered with a greater emphasis on clinical service delivery within integrated systems. With a few notable exceptions, such as Canada getting pharmacists to deliver long-term condition management and Estonia's digital integration of pharmacy, no country has made significant progress at scale. Most examples are small scale pilots or professional group's strategic intentions that require wider buy-in.

There has been progress where the health economies are well integrated and have a unified approach to care, so the recent formations of ICSs bode well for UK pharmacy development.

The Health Education England's initial training and education of pharmacists' reform programme culminates in 2026 with all newly registered pharmacists being able to independently prescribe medicines. This initiative will require all systems to have a strategic plan for how these new pharmacists, and already practising independent prescribers (PIPs), will support the systems prescribing priorities in a fully integrated way. Due to community pharmacy having access to the most deprived parts of the community there are opportunities to utilise pharmacists' independent prescribing qualifications to address health inequalities. Development of the existing workforce, to become independent prescribers, will require sufficient designated prescribing practitioners (DPPs) and designated medical practitioners (DMPs) to support the training programmes. Community pharmacy Scotland have funded community pharmacy DPPs to work with two pharmacists undergoing independent prescribing training.

There is currently a contractual obligation for all community pharmacies to complete the annual pharmacy workforce survey and this will provide an opportunity for each ICB to fully understand the complete local pharmacy workforce priorities and opportunities.

The successful scheme “walk in my shoes” has demonstrated the power of job shadowing to improve collaboration and integration between different practitioner groups. This model could be applied to improve patient care and reduce duplication of effort.

A number of proof of concept pilots are already underway to trial new ways of working to deliver improved services and outcomes for patients and service users. For NHSE East of England are piloting a scheme across the region to provide community pharmacies read and write access to consenting patients’ primary care records. The Community Pharmacy IT Integration Pilot (TPP Pilot) aims to:

- Enable community pharmacies and GP practices to send each other tasks via the system, and where permission is given, book appointments for patients in each other’s settings
- Improve integrated working between GP practice teams and community pharmacies by providing an audit trail of activity where patients have been referred from one setting to another
- Enable healthcare professionals to follow-up on tasks as required, and thereby create potential to improve patient care. Previously referrals would be sent via phone, e-mail or by asking patients to make appointments directly – with no way of primary care professionals following up on activity post-referral

The pilot will be implemented using SystmOne with up to 40 pharmacies being involved. The pilot is expected to commence in November 2022.

Next steps

To move from vision; to prioritisation; to action, systems need to develop local strategies, working pan regionally where it makes sense to “do once” or collaboration around a regional issue is needed.

Recognising that systems have differing priorities and timescales; it is recommended that systems:

- Work to understand the needs and priorities of the local population; and which and how priorities and actions identified in this strategy can be implemented to support local needs

This will be supported by reference to the area Pharmacy Needs Assessment (PNA), Joint Strategic Need Assessment (JSNA) products and the Joint Health and Wellbeing Strategy (JHWS)

- Make evidence-based decisions on service priorities focused on key issues and priorities
- Assess current status of digital infrastructure and system interoperability, and improvements required to support integration of community pharmacy
- Identify challenges for development and opportunities to address these challenges
- Develop detailed operational and implementation plans for short- and medium-term actions in line with the strategic priorities on the pathway to longer-term strategic changes
 - This will include revising commissioning arrangements, moving away from isolated commissioning to joint commissioning by local authorities and health organisations

- Implementation of new services, or of new models of delivery for existing services, will need to be done within capacity and capability constraints





A Regional Community Pharmacy Strategy Board, comprising of the six systems, NHSE and wider stakeholders, will remain in place to help coordinate actions delivered across the East of England, provide networking of good practice and support systems. The Board will also agree within six months of the publication of this strategy the measurable outcomes for each of the vision statements:

1. Community pharmacy is an integral part of primary and community care, leading to improved outcomes for patients and facilitating better access
2. Community pharmacy is embedded in pathways across the wider health and care system
3. Community pharmacy is a patient centred service that is the first point of contact for many patients
4. Community pharmacy is integral to the delivery of self-care, avoiding ill health and improving population health
5. Community pharmacy is integral to addressing health inequalities
6. Community pharmacy professionals and wider teams are valued and respected

This strategy will be refreshed and updated on a regular basis to align with national development and system plans.

Further information

For further information please contact:

  <p>Cambridgeshire & Peterborough Integrated Care Board</p> <p>Contact us - Cambridgeshire & Peterborough Integrated Care System (cpics.org.uk)</p>	  <p>Norfolk and Waveney Integrated Care Board</p> <p>Contact - Norfolk & Waveney Integrated Care System (ICS) (improvinglivesnw.org.uk)</p>
   <p>Suffolk and North East Essex Integrated Care Board</p> <p>Contact - Suffolk & North East Essex Integrated Care System (sneeics.org.uk)</p>	  <p>Bedfordshire, Luton and Milton Keynes Integrated Care Board</p> <p>Contact us - Bedfordshire, Luton and Milton Keynes Integrated Care Board (icb.nhs.uk)</p>
  <p>Hertfordshire and West Essex Integrated Care Board</p> <p>Contact us - Hertfordshire and West Essex Integrated Care System (hertsandwestessexics.org.uk)</p>	  <p>Mid and South Essex Integrated Care Board</p> <p>Contact - Mid and South Essex Integrated Care System (ourpeopleyourfuture.co.uk)</p>

There are two versions of the Strategy, one for the Profession and another patient facing strategy. These can be accessed via the NHS Futures Site ([FutureNHS Platform - FutureNHS Collaboration Platform](#)) and specifically the Pharmacy and Optometry (P&O) Workspace. If you have not accessed Futures before, you will need to register for the site. Also included on the site are other associated documents that were key in producing the strategy.

Appendix A – East of England integrated care systems

Systems vary in size and have differing priorities according to local needs, underpinned by developing structures and strategies. Each system has produced a summary of their current position and approach to community pharmacy. These reflect the differing approaches and need to ensure that this strategy is as flexible as possible to support system implementation.

Our integrated care system is committed to working together to improve the health and care of our local people throughout their lives. Our services will be designed to fit together around people and as such we recognise that community pharmacies represent the healthcare services that our people choose to use more frequently than any other.

As pharmacies are embedded in the heart of our communities, perfectly placed to address inequalities, we will jointly develop pharmaceutical services to help improve the lives of people in our communities.

Our healthy living pharmacies will help create an environment that is easily accessible giving our people the opportunities to be as healthy as they can be.

We will listen to our patients and develop local pharmacy services to meet the needs of both our population and the system through the commissioning of clinical services. We will enhance our programme of early intervention and detection of long-term conditions to help support improved outcomes.

Recognising that whilst prescribing is the most common intervention made in healthcare and yet can also cause significant harm, we will prioritise medicines safety through utilising the community pharmacy workforce expertise in medicines optimisation.

We will ensure that the full range of care professional and clinical leaders from diverse backgrounds are integrated into system decision making at all levels. As such community pharmacy leaders will be involved and invested in planning and delivery at system, place and neighbourhood level.

Our Plans for Community Pharmacy



Increase the use of the Discharge Medicines Service



Improve digital connectivity between providers through the local and national SystmOne pilot



Maximise the use of community pharmacy PGDs e.g. the insect bite service



Increase referrals via the Community Pharmacy Consultation Service



Supporting pharmacies to deliver self-care & self-management for both minor ailments & long-term conditions



Make best use of prevention services – vaccination services, hypertension case finding, smoking cessation, weight management etc.



Increase the number of prescriptions ordered via the electronic repeat dispensing service.



Expand the current oral contraceptive pilot



Support workforce to minimise unexpected closures

Norfolk & Waveney ICB benefits from long-standing and extremely positive relationships between system leadership and staff and the community pharmacies in our area and their representatives at the LPCs. This has led to the long-standing commissioning of pioneering services such as our local direct-access Urgent Medication Supply Service, the Medicines Support Service, and Palliative Care service.

This collaboration continues to develop as we moved to devolved commissioning. Alongside early integrated pharmacy and medicines optimisation (IPMO) work, which highlighted accelerating the uptake of community pharmacy services, our N&W Community Pharmacy Integration Group has been meeting bi-weekly for over 12 months. With a membership including our Deputy Head of Medicines Optimisation, GP Clinical Lead, LMC and LPC representatives and additional resource drawn from digital etc., this group has effectively led on developing pharmacy service integration to date.

A good example of the benefits of this group's work is the support they have provided to pharmacies and surgeries alike in terms of guidance on dealing with pressures, including how these partners can help each other. These N&W resources have now been incorporated into national guidance.

<https://norfolk.communitypharmacy.org.uk/pharmacy-contract-it/regulatory-matters/unauthorised-closure-of-pharmacies/pharmacy-surgery-pressure-guidance-and-resources-for-pharmacy-display/>

Recognising that our community pharmacies are, facing significant and challenging workforce shortages, we have been developing a pharmacy workforce plan, which is now well-advanced and is currently being

integrated into our wider workforce planning. It is unfortunately true, though, that the pharmacy workforce shortage has and is affecting the sector's ability to consistently engage with some developments, and has had an impact on service delivery, and perhaps confidence in some pharmacy services. Supporting pharmacies through this challenging time and seeking to maintain and improve working relationships between our pharmacies and surgeries/PCNs are fundamental to securing the foundations for future integration and development.

Building on the national picture, we recognise that integrating community pharmacy is and will increasingly be integral to the delivery of seamless high-quality patient care as set out in the Long Term Plan. It is therefore vital that across all levels of the ICS for Norfolk and Waveney that we include senior sector representatives in emerging structures, such as membership of the new Primary & Community Care Programme Board. As our network develops, we will seek to support further engagement and integration and Place and PCN level as appropriate.

It is recognised that plans for working with and developing community pharmacy services cannot and should not "stand alone", and so such plans will be intrinsically linked to our wider system strategies and planning.

Our Norfolk and Waveney landscape

Community Pharmacy in Norfolk and Waveney comprises 182 contractors, all of whom work largely independently of each other. We also have 105 GP practices and 17 Primary Care Networks (PCNs), all at different stages of maturity and development. Community Pharmacy

are involved in PCNs to varying degrees across the patch and the newly formed ICS offers opportunities to developing relationships across system, place and PCNs.

Norfolk and Waveney has a unique geography potentially impacting on recruitment and specifically attracting new workforce to the area. As depicted by the map below, Norfolk and Waveney is the furthest easterly point in the East of England region, with vast coast line and a mix of rural and urban landscape.

Pharmacy sectors have always collaborated well across the Suffolk and Northeast Essex (SNEE) ICS footprint, but this has been strengthened over recent years as the ICS structures continued to form. This will be key as the system prepares for the devolved commissioning of the community pharmacy contract and is being supported with increased capacity through the appointment of a Community Pharmacy Clinical Integration lead.

Successes

Recent initiatives include work on developing an Integrated Pharmacy and Medicines Optimisation (IPMO) Strategy and laying the foundations for the integration of nationally commissioned community pharmacy services into patient pathways. This has led to growing support for the use of community pharmacies as the experts in the management of minor ailments, as an accessible entry point for prevention and public health services and as a fundamental part of the primary care team.

The pandemic has demonstrated without doubt, the benefits that further development and integration of the community pharmacy network would deliver for our local population. The sector showed itself to be resilient, engaged, and innovative in the way that it rose to the challenge and the ICS has continued to work with the sector to build on this. This has led to involvement in innovative NHSEI service pilots such as the Oral Contraceptive Management Service, which is providing important insights as to how such a service could be commissioned nationally. A further pilot on IT integration through SystemOne is also being supported and community pharmacy continues to play an important role in the Covid Autumn Booster Campaign.

System partners are also clear that integration needs to happen, not only in terms of service development but also the enablers that underpin

true integration. SNEE has supported an initiative around the integration of community pharmacies with Primary Care Networks across the ICS and this will be developed further over coming years. Community pharmacy has been included in the Digital Strategy for the system so that the unique challenges the sector has around digital interoperability and data sharing can be addressed. The ICS has agreed and adopted a comprehensive pharmacy workforce strategy across all pharmacy sectors. This will ensure we have a sound foundation for optimising the role that pharmacists can play in all sectors in improving the health and wellbeing of our population. We are also starting to see the commissioning of locally funded community pharmacy services targeted to the support of patient need such as the Palliative Care Service.

There is also a recognition that community pharmacy should be involved at a strategic level and the ICB has welcomed community pharmacy representation as part of the ICP. As ICS strategies continue to develop, the contribution that community pharmacy can make to primary care can be fully recognised and this strategy will be used to feed into that wider strategic planning.

Bedfordshire, Luton and Milton Keynes (BLMK) Integrated Care System is committed to embedding integrated working and sees the transition of community pharmacies services to the ICB as a key enabler to support this.

In preparation for the transition a community pharmacist has been appointed to the ICB Board and the Primary Care Commissioning and Assurance Committee. The ICB has long standing, collaborative relationships with community pharmacies and has been able to build on this through funding and supporting community pharmacy representation at each of our four place-based boards representing our commitment to ensure the voice of the community pharmacy is at every level of the system.

BLMK will work with patients, voluntary sector, clinical networks, local authorities and community pharmacists to review and redesign clinical and social care pathways to address local health inequalities. We will do this by planning a targeted approach on the community pharmacy enhanced service programme to ensure the services offered will have the most impact and beneficial outcomes that supports our initiatives to “start well”, “live well” “age well” and “growth”.

BLMK was a national early implementer utilising our community pharmacists to successfully deliver the covid vaccination programme and this was and continues to be a catalyst for change and has enhanced relationships with our GP practices and Primary Care Networks which we will develop further.

Community pharmacies are at the centre of our communities and are one of the only primary care providers where a patient can directly access advice and support from a clinician. In BLMK we believe that access to health services is a system approach and we will commit to increasing the number of referrals to the Community Pharmacy Consultation Scheme. This is an opportunity to support GP contractors and Community Pharmacies. We will do this by aiming to transition 6%

of all appointments from General Practice to our community pharmacies over forthcoming years.

Fundamental to our strategy is digital programme to enable community pharmacists to have access to patients’ clinical records held on GP practice systems. This is an ambition that the ICB would like to pursue. It is in a strong position as all BLMK practices use SystmOne. To support this ambition the ICB has agreed to pilot this option and the learning from this will be further developed to see what is potentially feasible whilst ensuring that robust information governance is in place and patient consent.

The ICB is currently rolling out “Shiny Mind” app to our GP contractors this is a new national programme that provides training to clinical staff through a train the trainer model. The app is a wellbeing resource to promote self-management and self-efficacy utilising virtual prescribing at scale to chosen conditions, specific patient cohorts via a portal which uses content management system. This includes behaviour change nudges tailored by the clinician through communications with patients, supported by a messaging service. Evidence has shown that ‘positive behaviour nudges’ results in improved clinical outcomes e.g. population health. Research found that patients with diabetes sent personalised text messages had a positive outcome and saw HBA1C levels fall. Behavioural nudges have the potential to expand into wider public health programmes and the ICB is keen to explore the opportunities and aim to offer to our community pharmacies over the next 1-3 years.

Underpinning this the ICB will work in collaboration with Bedfordshire and Buckinghamshire Local Pharmaceutical Committees, whose role is to advise pharmacy contractors, to improve pharmaceutical services to our local population. This will include discussions on how we can support contractors, take forward our system plans ensuring the intended outcome is beneficial for contractors and the local community.

Successes

- Community pharmacies across Hertfordshire and West Essex (HWE) have been pivotal in embracing the COVID vaccination programme. An increased number of patients have been able to be vaccinated due to the longer opening hours of community pharmacies. In some cases, extra clinics have been set up on a Sunday to accommodate for patient demand. A number of pharmacies providing the vaccination service, are also situated in areas of inequality. This has vastly helped to meet the needs of the local population and in turn has helped increase accessibility to the vaccination service.
- Community pharmacies are central to their communities. They are recognised locally by the public and the wider system for their continued efforts and invaluable contributions, supporting throughout the pandemic in what has been a continuously changing and challenging environment.
- Pharmacists worked closely with voluntary organisations to ensure all patients including those most vulnerable had access to their medicines. Many pharmacies set up a home delivery service with the help of volunteers delivering medicines. Some pharmacists also tapped in to the support of St John's Ambulance volunteers and community nursing teams to help vaccinate patients. This brought about a more joined up working approach and helped alleviate pressures that pharmacists were faced with in their day to day job.
- Existing established pharmacy networks in west Essex have brought pharmacists together from all sectors. Cell network set ups across HWE by pharmacy leaders have enabled pharmacists to feel supported when faced with challenges. Conversations have focussed on providing solutions and the sharing of best practice.
- Some community pharmacies played an important role in supporting local GPs by vaccinating care home residents and ensuring the supply of medicines to care homes was still maintained during the pandemic.
- HWE ICB works closely with the Local Pharmaceutical committees (LPCs) for Hertfordshire and West Essex. Both LPCs are active members of various committees and provide input and community pharmacy leadership on numerous work streams. Working with the LPCs has made a tangible difference to the involvement of Community Pharmacists in existing and new enhanced services such as GP CPCS. All practices within HWE were trained on GP CPCS by the LPCs. GP practices were also provided with a number of reference resources to guide them. The LPCs continue to support pharmacies with this service. GP CPCS has been successful across HWE and the vast majority of GP practices are referring to pharmacies.
- Some Pharmacists will also be involved in the NMS anti-depressant pilot and the SystemOne pilot. These NHSE pilots are providing a great opportunity for pharmacists to work more closely and collaboratively with primary care.
- HWE ICB had funding approved by Health Education England (HEE) to pilot a lead Community Pharmacist in each PCN locally. Other PCNs within the East of England, will also have the opportunity to be involved in this pilot.

- HWE ICB is proactively considering the part community pharmacy plays or could play in all pathways through its nationally commissioned services such as hypertension.
- HWE as part of the East of England prioritised the transfer of hospital discharge medicines information to community pharmacies. Acute Trusts have been involved since 2018 and this is now embedded as the Discharge Medicines Service.

Quotes from Community Pharmacists across HWE

Quadrant Pharmacy has been privileged to be part of the Covid-19 vaccination programme since January 2022, and our whole team is looking forward to supporting the Autumn booster programme for our local community.

The whole community pharmacy network has pulled together throughout the Covid pandemic, and the vaccination programme is one example of where we have worked with each other, and our local CCGs/ICB, to give integrated care to our population. We welcome the support we have had from the local NHS teams, and look forward to continuing collaborative working with our GPs and PCNs. Hopefully by expanding the community pharmacy network of vaccination hubs, we will be able to give a wider spread of local sites for vaccinations on all of our patients' doorsteps.

-Rachel Solanki

Superintendent Pharmacist, Quadrant Pharmacy & Chair, Community Pharmacy Hertfordshire.

Easter pharmacy has been working closely with the local PCN enabling the housebound patients to receive their Covid and Flu vaccinations promptly. We are starting to also work closely with local surgeries regarding monitoring of blood pressure. We provide advice and

assistance to local patients via GP CPCS with regards minor ailments ultimately saving GP appointments.

-Babatunde Sokoya

Easter Pharmacy, West Essex and committee member, community Pharmacy Essex

Challenges

Challenges outlined in the strategic priorities document include, digital interoperability, workforce and funding. Conflicting commissioning arrangements can inhibit collaboration. The key aim is to build trust across primary care providers. HWE ICB, has developed a number of actions and enablers to address these challenges as part of the Community Pharmacy East of England five-year strategy.

- CPCS has been successful in some areas but there is further progress to be made in other areas
- For both CPCS and hypertension service addressing the requirement for formal referral to be able to action, if that can be removed or amended then pharmacies will be able to provide a wider service.

The Mid and South Essex (MSE) Primary Care Strategy -will be updated for 2022/23 following receipt of the NHSE response to the Fuller Report and will drive integration of community pharmacy building on local successes to date.

Nationally commissioned Services

- **NHS 111-CPCS-** The majority of community pharmacies across MSE are signed up to provide this advanced service.
- **GP-CPCS-** In the first 6 months of 22/23 approximately 2,500 CPCS referrals were processed by community pharmacies across MSE, only 5% of which required urgent redirection to a GP. The local focus is on promoting the adoption and spread of CPCS referrals across a larger number of GP practices to more fully utilise the benefits this pharmacy service offers.
- **Discharge Medicines Service-** The ICB is working closely with MSE hospitals to overcome local implementation challenges in order to increase DMS referrals above current relatively low levels due to workforce and IT issues. Local community and mental health providers are also able to refer, including from Virtual Frailty wards. There remains significant scope to increase the local benefits.
- **Smoking Cessation Advanced Service-** 75 pharmacies across MSE are signed up to provide this service and will be linked with the Hospital Health Managers currently being recruited.

Locally commissioned services-

- **Sexual Health Services-** commissioner-local authorities
- **Smoking Cessation Services** -commissioner- local authorities-
- **Substance Misuse Service** -commissioner- local authorities

Integration of community pharmacy and GP practices through the framework and PCN DES contract: e.g. CPCS, hypertension case

finding; vaccinations; NMS; IIF- carbon inhalers and DOACs.

Innovation within MSE

- **Community Pharmacist PCN Leads** - during 2021/22 MSE funded protected time for 27 PCN leads to link with PCN clinical directors and develop local working relationships; and will be continued in 2022/23.
- **SystemOne pilots:** Chelmsford West PCN and one community pharmacist linked with a practice in Southeast Essex are taking part which provides read/write access to patient records, includes the pilot oral contraceptive service and is due to go live in September 2022.
- **New Medicines Service Pilot for antidepressants** - pharmacies in Aveley, South Ockendon and Purfleet PCN in Thurrock will be completing training in Sept and going live late Sept/Oct. This has been achieved through joint working with mental health, local authority and health taking a multiagency approach.
- **HPV-MSM and Monkeypox vaccination pilots** - 6 pharmacies are providing the HPV vaccinations, of which 2 are also providing Monkeypox vaccination.
- **Community Ear Health service- part of Audiology Pathway-** shortly to be piloted in three community pharmacies spread across MSE to support initial assessment for hearing loss which will include wax removal if necessary, using commercial technology.
- **Community Pharmacist Independent Prescribing-**there are a small number of IP community pharmacists currently providing private services, providing an opportunity to commission services to utilise this workforce in the NHS.
- Additional **Pharmacy First** initiatives are under consideration.

Appendix B – CPCF services as of 2022/23

Essential services - offered by all pharmacy contractors as part of the pharmacy contract
<p>Discharge Medicines Service Provide extra guidance around prescribed medicines to patients referred by NHS Trusts</p>
Dispensing Appliances
Dispensing Medicines and Electronic Prescription Service
<p>Disposal of unwanted medicines Accept back unwanted medicines from patients</p>
<p>Healthy Living Pharmacies Provision of a broad range of health promotion interventions. All pharmacies were required to become Level 1 HLP by April 2020</p>
<p>Public Health (Promotion of Healthy Lifestyles) Participate in up to six health campaigns at the request of NHS England and prescription-linked interventions on major areas of public health concern, such as encouraging smoking cessation</p>
<p>Repeat Dispensing and electronic Repeat Dispensing Dispense repeat dispensing prescriptions issued by a general practice; ensure that each repeat supply is required; and seek to ascertain that there is no reason why the patient should be referred back to their general practice</p>
<p>Signposting Help people who ask for assistance by directing them to the most appropriate source of care and support</p>
<p>Support for Self Care Help to manage minor ailments and common conditions, by the provision of advice and where appropriate, the sale of medicines, including dealing with referrals from NHS 111</p>

Advanced services – community pharmacies choose whether or not to provide these services
Appliance Use Review
Community Pharmacist Consultation Service
Flu Vaccination Service
Hepatitis C Testing Service
Hypertension case-finding Service (NHS Blood Pressure Check Service)
New Medicine Service
Pharmacy Contraception Services
Smoking Cessation Service
Stoma Appliance Customisation

Locally commissioned services and Patient Group Direction based services – community pharmacies choose whether or not to provide these services
<p>Interventions to reduce alcohol use Substance misuse support, supervised consumption and needle/syringe exchange service Support services for self-management of long-term conditions e.g. diabetes Weight management Pain management Early cancer detection Mental health support Women’s health services and sexual health including, chlamydia screening and treatment, menstrual health and menopause Infected insect bites NHS health checks Emergency supply Palliative care Collection and delivery services (non-funded - temporarily funded as a pandemic service)</p>

Appendix C Workforce development priorities identified by the East of England task and finish group

Strategic planning priorities	Population health need now and in the next five years	Skills and capability in the primary care workforce to meet the health needs	Ensuring that trained and competent healthcare professionals stay in the primary care workforce	Identify capacity and skills gaps and support staff in moving beyond traditional roles to meet changing needs
Consistent, high quality and integrated healthcare provision in primary care	Future workforce needs Vision for CP services and integration	Training and upskilling Improve uptake of HEE offer for existing workforce training e.g. IP for pharmacists	Workforce retention Wellbeing of the community pharmacy workforce (Maslow and safety factors)	Recruitment Attracting people into pharmacy – at all levels
	Describe how new skills will be utilised to improve local healthcare. Prioritise plans for deployment of pharmacist independent prescribers.	Reduce professional isolation, mechanism for periodic review and clinical supervision/mentoring	Promotion of pharmacy to other healthcare professions and the public feeling valued (belonging)	Skill mix needed to deliver clinical services efficiently
	Most appropriate clinician – working at top of license	System capacity to support new and developing workforce	Equality, Diversity and Inclusion	Vision of career progression
	Impact of technology, AI and robotics	Technician development programmes Foundation pharmacist programme support requirements	Improving working conditions and job satisfaction (purpose) Flexible & agile workforce able to work across sectors, portfolio working	
	Underpinned by	Designated Prescribing Practitioner (DPP) capacity	Protected time. Multidisciplinary learning environments	Transformation, innovation and contractual change
Develop a community pharmacy workforce strategy which is integrated into wider system workforce planning and resourcing				

Appendix D - Horizon Scan Review

The ambitions for community pharmacy within this strategy align with the recently published [A vision for pharmacy practice in England \(rpharms.com\), Jun 2022](#) commissioned to support the Royal Pharmaceutical Society working with The King's Fund, which aims to capture the key changes in the landscape from 2016 to inform the development of the vision of the future for pharmacy. References are made to key areas of development in the devolved nations and further afield within community pharmacy, and these include increasing focus on professional clinical services, including prescribing; increasing adoption of technology, particularly electronic health records and e-prescribing but also prescription dispensing machines and remote dispensing robots; contract reform in community pharmacy, and increasing the proportion of capitated and service-related payments as opposed to dispensing.

A review of the community pharmacy workforce 2021 and beyond (cpwdg-report-a-review-of-the-community-pharmacy-workforce-final.pdf (wordpress.com), June 2021) looks at the future direction of community pharmacy, how it can support the NHS and assesses how, with the requisite investment, the pharmacy workforce can meet these demands. Recommendations include a collaborative approach to ensure that community pharmacy is an attractive career choice for future pharmacists; development of frameworks and infrastructure, including services, to allow pharmacists and pharmacy technicians to use their clinical skills, a collaborative approach to ensure the updated Initial Education and Training standards [Standards for pharmacy education | General Pharmaceutical Council \(pharmacyregulation.org\)](#) are implemented in a way that meets the needs of colleagues, employers, the NHS and most importantly, patients.

As part of the HEE [three-year programme of education and training for post-registration community pharmacy professionals](#) and in preparation for 2026, when all pharmacists will be able to independently prescribe at registration, almost 3,000 funded training offers will be available from Autumn 2022 for current pharmacists eligible to undertake independent prescribing training [Independent Prescribing | Health Education England \(hee.nhs.uk\)](#). In addition to this, new 'pathfinder' sites will be launched across England from the beginning of 2023 which will include NHS-funded pharmacist prescribing services based in community pharmacies. The sites will be based in integrated care organisations and will become a "test bed" for a potential wider rollout of independent prescribing services through the community pharmacy contract in England [Pharmacist independent prescribing pilots will begin across England from 2023 - The Pharmaceutical Journal \(pharmaceutical-journal.com\)](#).

Community pharmacists in England will also be offered funded clinical skills training, expected to start in December 2022.

Key learnings, principles and priorities for transformation of the pharmacy profession are outlined in *The Future of Pharmacy in a Sustainable NHS: Key Principles for Transformation and Growth (Future of Pharmacy Policy Asks.pdf (rpharms.com), Jul 2020)* developed in response to the COVID-19 pandemic. It describes the need for Community pharmacy to be fully integrated into, and supported to deliver, NHS services as a valued and recognised NHS provider. Pharmacy teams must be fully integrated and utilised across primary and secondary care to support a seamless patient journey through mobilisation of the whole of the pharmacy workforce, ensuring clinical expertise is used across the system.

Pharmacy in Place. The Future for Community Pharmacy in Integrated Care Systems (SME v1 (bbi.uk.com), June 2021) provides a blueprint for

ICSs to develop Community Pharmacy in a way that takes account of the critical issues that have arisen for post pandemic, the shift in commissioning to ICSs, NHS LTP priorities and emergent and innovative technologies that are set to radically change the delivery of health care and population health management. The spheres of activity relevant to Community Pharmacy include:

- Restoring service delivery in primary care and community services
- Maximising diagnostic capacity
- Enhanced discharge arrangements
- Reducing pressure on A&E through the national NHS111 programme
- Increased capital to support urgent care
- Addressing health inequalities

The key areas for an ICS in the deployment of community pharmacy services will include:

- Extending the Community Pharmacist Consultation Service
- Personalised medicine and improving diagnostic pathways
- Developing pharmacogenomic services

Better integration and interoperability across healthcare settings requires digital health care solutions to enable community pharmacy to manage demand and meet patient needs.

A new pharmacy in Letchworth, Hertfordshire, has considerably invested in new technologies to improve efficiency and their dispensing robot frees up pharmacists' time. *Automation and services: 'Pharmacy of the 21st century' opens in Letchworth* ([Automation and services: 'Pharmacy of the 21st century' opens in Letchworth](#)|[Chemist+Druggist](#) ::

[C+D \(chemistanddruggist.co.uk\), February 2022](#)). After a patient requests their prescriptions electronically, the pharmacy dispenses it and sends the patient a text once it's ready. Patients can then collect their prescription from collection points which operate 24 hours a day.

A next generation patient medication record system that works with a centralised Hub and Spoke model and supports the pharmacists to manage their workload has unlocked potential for new services, providing a more service-led community pharmacy offering for patients. *How one team rolled out a bespoke dispensing model to 700 pharmacies* ([How one team rolled out a bespoke dispensing model to 700 pharmacies](#) :: [C+D \(chemistanddruggist.co.uk\), June 2021](#)). New handheld devices help staff in branches track and locate medicines and patients are updated via an SMS system.

Read and write access to a full and integrated electronic patient record will enable pharmacists to provide better advice to patients, the ability to improve medicines optimisation, make more informed clinical decisions and improve medication safety. A pharmacy explains how read-write medical record access and the ability to instant message doctors in surgery has derived huge benefits. ([The award-winning pharmacy with full read-write patient record access](#) :: [C+D \(chemistanddruggist.co.uk\), January 2020](#))

Patients and other health professionals will increasingly rely on the clinical knowledge and skills of community pharmacists who will deliver a wider range of clinical services as part of cross-sector, multi-professional teams, working to deliver joined-up, integrated patient care pathways.

A good example of this is provided by the team at Fferyllwyr Llyn Cyf explain how their innovative acute conditions service has demonstrated

that community pharmacies are ideally placed to offer high quality, timely healthcare to patients thereby reducing pressure on GP practices. Under the scheme, patients can walk in, phone for an appointment or be referred by their GP. They can be seen in a matter of minutes for a range of minor ailments including skin conditions, migraines or headaches, and urinary tract infections. *How one pharmacy team rolled out an acute conditions service.* ([How one pharmacy team rolled out an acute conditions service and bagged two C+D Awards in the process :: C+D \(chemistanddruggist.co.uk\), September 2021](#))

There also needs to be an increasing awareness of climate impact and delivering sustainable, greener services for example:

- Reduction of plastic packaging
- Re-usable devices
- Referral of patients to green initiatives such as walking and cycling outdoor activities
- Electric service vehicles

Agenda item: 14

Subject:	Spotlight on Primary Care expenditure
Presented by:	James Grainger, Head of Finance
Prepared by:	Emma Kriehn-Morris, Associate Director of Finance James Grainger, Head of Finance
Submitted to:	ICB Finance Committee
Date:	10th January 2023

Purpose of paper:

To present an update to the ICB Finance Committee on the financial, operational and efficiency performance within the Primary Care portfolio for November 2022.

Executive Summary:

Primary Care Financial Summary:

As at Month 8 (November), the 9 months forecast spend is £313.8m as against a plan of £312.2m leading to a total overspend of £1.6m for Primary Care and Prescribing in combination (excluding ARRS allocation due).

Details of the major areas of variance for Primary Care are reported in section 3.0 Detailed Variance Analysis.

The paper highlights the schemes currently identified and actions as a Prescribing Efficiencies Group that are being undertaken.

Co-working between finance and clinical Medicines Management colleagues continues and results are starting to be seen supporting governance, internal audit recommendations, project progression and efficiency delivery. Projects details and progress are shown within the report.

Report

Recommendation to the Board:

This report is presented for information only.

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Key Risks	
Clinical and Quality:	None
Finance and Performance:	Achievement of Financial plan
Impact Assessment (environmental and equalities):	None
Reputation:	The achievement of the plan impacts the ICB's reputation with NHSE/I
Legal:	None
Information Governance:	None
Resource Required:	None
Reference document(s):	NHSE/I guidance and communications
NHS Constitution:	None
Conflicts of Interest:	None
Reference to relevant risk on the Board Assurance Framework	Delivering Financial Plan

Governance

Process/Committee approval with date(s) (as appropriate)	
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Improving lives **together**

Norfolk and Waveney Integrated Care System

2022/23 Primary Care Commissioning Committee Finance Report Norfolk & Waveney ICB

November 2022

Primary Care Commissioning Committee 10th January 2023

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1.0 Executive Summary

- As the financial reporting for Primary Care and Prescribing is produced in arrears this report will relate to M8 (November-22) of the ICB accounts. Since the ICB (Integrated Care Board) was formed July 2022 the forecast included is for the ICB for 9 months from July-March 2023.
- The 2022-23 budgets for the ICB are from July – March 2023 and are based upon the final financial plans as submitted on the 20th June 2022
- The current efficiency requirement within the Primary Care and Prescribing directorate is £7.3m this is within the GP Prescribing sub-directorate and for the 9 months from July-March 2023. Efficiency target of £3.8m included in Forecast for remaining months from October –March.
- As at Month 8 (November), the 9 months forecast spend is £313.8m as against a plan of £312.2m leading to a total overspend of £1.6m for Primary Care and Prescribing in combination (excluding ARRS allocation due).
- Details of the major areas of variance for Primary Care are reported in section 3.0 Detailed Variance Analysis.

2.0 Financial Summary

Primary Care: Financial Summary	9 months ICB	Year to Date (November)			Forecast 9 Months (ICB)		Forecast at Month (October)		Comments on material Movement between October and November	Detailed Variance Analysis
	Budget	Budget	Actual	Variance (Fav)Adv	Actual	Variance (Fav) Adv	Actual	Movement (Fav) Adv		
	£m	£m	£ m	£m	£m	£m	£m	£m		
GP & Other Prescribing	143.2	79.9	80.5	0.6	144.3	1.1	142.9	1.4	The No Cheaper Stock Obtainable (NCSO) cost pressures and increase in Sodium glucose cotransporter 2 (SGLT2) prescriptions lead to an increase in FOT	3.1
Primary Care										
System Development Fund	3.2	2.0	2.0	0.0	3.1	(0.0)	0.3	2.9	£2.3m negative budget line recategorised under "other" directorate and corresponding negative forecast moved & and new allocation £0.48m received	3.2
Local Enhanced Services	12.4	7.1	7.1	0.0	12.4	0.0	12.4	0.0		
Other Primary Care	2.2	1.1	1.1	(0.1)	2.1	(0.1)	1.9	0.2		
Primary Care Delegated Co-Commissioning	147.2	83.0	81.0	(2.0)	147.8	0.6	144.4	3.4	ARRS allocation due shown below	3.3
Primary Care IT	4.2	2.0	2.0	(0.1)	4.1	(0.1)	4.2	(0.1)	Prior Year release	
Total Primary Care	169.1	95.2	93.1	(2.1)	169.5	0.5	163.2	6.4		
Total Directorate	312.2	175.1	173.6	(1.5)	313.8	1.6	306.1	7.8		
Variance as a % of Budget				-0.9%		0.5%		2.5%		
Retrospective ARRS allocation to be received	0.0	0.0	0.0	0.0	-3.5	-3.5	0.0	(3.5)		
Total Primary Care	312.2	175.1	173.6	-1.5	310.3	-1.9	306.1	4.2		

Variance Signage: (Favourable)/Adverse

The detailed explanations are provided in 3.0 Detailed variance analysis.

3.0 Detailed Variance Analysis

Primary Care: Detailed Variance Analysis	9 months Budget ICB	Year to Date (November)			9 Months Forecast (ICB)			Narrative
	Budget	Budget	Actual	Variance (Fav)Adv	Actual	Variance	Variance (Fav)Adv	
	£m	£m	£ m	£m	£m	£m	%	
3.1 GP and Other Prescribing	143.2	79.9	80.5	0.6	144.3	1.1	0.8%	<p>The GP Prescribing costs are reported nationally 2 months in arrears, hence actuals from July to September and estimates for October and November are considered in the Year to Date (YTD) position, and Forecast Outturn (FOT) considers July to September actuals and estimates from October to March.</p> <p>The YTD is overspent by £0.6m and FOT is overspent by £1.1m. This is driven by cost pressures of No Cheaper Stock Obtainable (NCSO) due to supply chain issues and increase in SGLT2 prescriptions mitigated by prior year benefits, increase in Oxygen Costs due to higher electricity costs £0.2m.</p> <p>An efficiency target of £(3.8)m is included in the FOT position for remaining months. It is assumed the efficiency savings are delivered as per revised plan. Analysis of the savings achieved to date validates this position.</p>
3.2 System Development Fund	3.2	2.0	2.0	0.0	3.1	(0.0)	-0.1%	£2.3m negative budget recategorised under "other" directorate and corresponding negative forecast moved & and new allocation £0.48m received
3.3 Primary Care Delegated Co- Commissioning	147.2	83.0	81.0	(2.0)	147.8	0.6	0.4%	The overspend here is due to ARRS allocation due.

4.0 System Development Fund

Primary Care: System Development Fund	9months Budget ICB	Year To Date(November)			9 months Forecast (ICB)	
	Budget	Budget	Actual	Variance (Fav) Adv	Actual	Variance (Fav) Adv
	£m	£m	£ m	£m	£m	£m
GP Retention	0.1	0.0	0.0	0.0	0.1	0.0
Training Hubs	0.2	0.1	0.1	0.0	0.2	0.0
Online Consultation	0.2	0.1	0.1	0.0	0.2	-0.0
Flexible Pool	0.1	0.1	0.1	0.0	0.1	-0.0
Infrastructure & Resilience	0.2	0.1	0.1	0.0	0.2	0.0
GP Fellowship	0.5	0.0	-0.0	(0.0)	0.5	-0.0
Improved Access	1.8	1.8	1.8	(0.0)	1.8	-0.0
Practice Resilience	0.1	0.1	0.1	(0.0)	0.1	-0.0
Transformational Support	0.3	0.0	0.0	0.0	0.3	0.0
Supporting Mentor	0.0	0.0	0.0	0.0	0.0	0.0
Nurse Fellows	0.1	0.0	0.0	0.0	0.1	0.0
Others	(0.5)	-0.3	-0.3	(0.0)	-0.5	0.0
	3.2	2.0	2.0	0.0	3.1	(0.0)
Variance as a % of Budget				0.1%		-0.1%

Variance Signage: (Favourable)/Adverse

- The above table details the schemes within the System Development Fund (SDF). The Year to Date and Forecast spend matches the plan in all areas bar some small immaterial differences.

5.0 Delegated Co Commissioning Analysis

Primary Care: Delegated Co Commissioning	9months Budget ICB £m	Year to Date (November)			9 Months Forecast (ICB)	
		Budget	Actual	Variance (Fav)Adv	Actual	Variance (Fav) Adv
		£m	£ m	£m	£m	£m
Contractual	94.0	52.2	52.6	0.3	94.8	0.8
QOF	11.9	6.6	6.6	0.0	11.9	0.0
Premises cost reimbursemen	11.1	6.2	6.5	0.3	11.4	0.3
Other - GP Services	10.7	6.2	6.0	(0.2)	10.5	(0.2)
Enhanced services	6.6	2.9	3.0	0.0	6.7	0.0
CCG Spend	0.3	0.2	0.2	(0.0)	0.3	(0.0)
PCN ARRS Staff	9.3	7.0	7.0	(0.0)	12.9	3.5
PMS to GMS	3.1	1.7	0.0	(1.7)	0.0	(3.1)
Prior Year	0.0	0.0	-0.7	(0.7)	-0.7	(0.7)
Total	147.2	83.0	81.0	(2.0)	147.8	0.6
<i>Variance as a % of Budget</i>				<i>-2.4%</i>		<i>0.4%</i>

Variance Signage: (Favourable)/Adverse

The above table details the category of expenditure within Delegated Co Commissioning

Areas of material forecast variances:

- **Contractual:** The major overspend is due to the Impact and Investment Fund (IIF), being funded to a level set by NHSE there is a prudent argument to increase this creating a cost pressure.
- **PMS to GMS:** Budgets held within Delegated PC as per NHSE guidance costs shown in Locally Commissioned Scheme.
- **PCN ARRS Staff:** This is due to Primary Care Networks (PCN's) using tranche 2 allocation which has not yet been received
- **Other GP Services:** This is due to underspend in Locum and Dispensing Fees.

6.0 GP And Other Prescribing

22/23 Primary Care: GP And Other Prescribing	9months Budget CCG	Year to Date(November)			9 months Forecast (ICB)		Forecast as at October		Comments on material Movement in Forecast Outturn (FOT) between October and November
	Budget	Budget	Actual	Variance (Fav)Adv	Actual	Variance (Fav)Adv	Actual	Movement in FOT (Fav)Adv	
	£m	£m	£ m	£m	£ m	£m	£ m	£m	
GP Prescribing Costs	134.7	75.4	77.2	1.8	137.3	2.7	134.7	2.6	The difference between between the September-22 actuals and estimate was £1.1m, this was driven by a £0.8m NCSO (No Cheaper Stock Obtainable) cost pressure and an increase in SGLT 2 drug costs in month . The result is a total of £2.6m increase in FOT between October and November mitigated by a prior year release of £-1.6m total.
Recharges to Local Authorities & NHS England	(3.9)	(2.1)	(2.5)	(0.5)	(3.8)	0.1	(3.9)	0.1	Lower Flu Rebates.
Rebates from pharmaceutical companies	(2.2)	(1.2)	(1.9)	(0.7)	(3.4)	(1.2)	(2.1)	(1.3)	An increase in Edoxaban Rebates.
GP Prescribing Subtotal	128.6	72.1	72.7	0.6	130.1	1.6	128.7	1.4	
Central Drugs	3.6	2.0	2.1	0.1	3.8	0.1	3.7	0.1	No Movement.
Dressings & wound care	4.4	2.4	2.4	(0.0)	4.3	(0.1)	4.4	(0.1)	Release of expense expected from localities.
Others (Medicine Management, Oxygen, incentives etc.)	6.6	3.3	3.3	(0.0)	6.1	(0.5)	6.1	(0.0)	No Movement.
Total Spend	143.2	79.9	80.5	0.6	144.3	1.1	142.9	1.4	
Variance as a % of Budget				0.8%		0.8%		1.0%	

9 months budget is the 9 months plan for 22/23
Variance Signage: (Favourable)/Adverse

The above table details the categories of expenditure within GP and Other Prescribing.

7.0 Financial risks

Risk	Mitigation
2022/23 outturn position deteriorates from the current forecast	There is robust management and oversight arrangements, detailed review of underlying position, via monthly review of actual expenditure compared to plan and specific mitigations agreed with budget managers.
New NICE Guidelines	Due to new NICE guidance which was published in March-22 there may be additional costs in the 2022/23 expenditure as a result of Continuous Glucose Monitoring (CGM) and prescribing of Sodium-glucose Cotransporter-2 (SGLT2) inhibitors. The potential mitigation is that these new drugs and therapies will not be suitable for all diabetic patients and will take time to roll out deferring the cost beyond 2022/23
Non delivery or under delivery of £1.026m Transformation Savings assumed in the financial position for Prescribing (Up to M3).	Practice Level Prescribing budgets, based on a scientific process to include deprivation, care home beds and list size has been calculated. Actual spend is being compared on a monthly basis to understand the outlying practices and take corrective steps. There is an oversight group also setup to monitor and take corrective action.
Increased number of prescriptions for anti depressants and pain killers due to the large Elective surgery waiting list.	Regular monitoring by Prescribing Team should identify the trend and take corrective steps.

7.0 Financial risks (Continued)

Risk	Mitigation
<p>Volatile prescribing costs, that can fluctuate and are exacerbated by the macro-economic climate, supply issues and interest rates. In addition the CAT M and NCSO (No Cheaper Stock Obtainable) costs are inherently volatile.</p>	<p>Robust management and oversight, through collaborative working between finance and medicines management to understand trends, variances and cost</p>
<p>Financially unstable practices</p>	<p>There are practices which are receiving resilience support from the ICB. The mitigation of this potential risk is to ensure continued surveillance. We are also in receipt of allocation from NHSE/I which can be paid to practices "at risk".</p>
<p>Additional costs due to existing estates costs, e.g. rent rate reviews, and new estates costs as a result of practice premises and expansion (e.g. additional revenue costs due to expansion of premises)</p>	<p>The ICB cannot mitigate existing establishment rates changes, but can look to be assured by close liaison with the District Valuer. Continued oversight so that estates growth is matched by annual increases in delegated budgets</p>
<p>Delegated financial position and the inability to control the spend within the ICB due to nationally mandated expenditure.</p>	<p>Negotiation with NHS England and Improvement and involvement in national allocation working groups. Look to cease or defer non mandated expenditure where possible.</p>