Primary Care Commissioning Committee Part One

Tue 11 June 2024, 13:30 - 16:30

Agenda

13:30 - 13:30 0 min

Agenda

Debbie Bartlett

2024 06 11 Item 00 ICB Primary Care Committee Agenda Pt 1.pdf (1 pages)

13:30 - 13:30 0 min

1. Chair's Introduction and Report on any Chair's Action

Information *Debbie Bartlett*

13:30 - 13:30 0 min

2. Apologies for Absence

Information *Debbie Bartlett*

13:30 - 13:30 0 min

3. Declarations of Interest

Information *Debbie Bartlett*

2024 06 11 Item 03 Declarations of Interest.pdf (5 pages)

13:30 - 13:30 0 min

4. Review of Minutes and Action Log from the May 2024 meeting

Decision *Debbie Bartlett*

2024 05 07 Item 04 NWICB PCCC Minutes Part One.pdf (10 pages)

2024 06 11 Item 04 PCCC Action Log Part One.pdf (1 pages)

13:30 - 13:30 0 min

5. Forward Planner

Information *Sadie Parker*

2024 05 07 Item 05 NWICB PCCC Forward Planner 2024-2025 Part 1.pdf (2 pages)

13:30 - 13:30 0 min

6. Risk Register

Decision *Sadie Parker*

2024 06 11 Item 06 Monthly combined risk ratings.pdf (23 pages)

Webb, Sarah
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13:30 - 13:30 0 min

Service Development

13:30 - 13:30

7. Community Health and Wellbeing Workers – ARRS funding

0 min

Decision *Olga Tsirogianni*

- 2024 06 11 Item 07 Community Health and Wellbeing Workers - ARRS funding.pdf (5 pages)

13:30 - 13:30
0 min

8. Strategic Care Quality Commission Inspection Report

Information *Shepherd Ncube*

- 2024 06 11 Item 08 Strategic Care Quality Commission Inspection Report.pdf (8 pages)

13:30 - 13:30
0 min

9. Delivery Report

Information *Leiat Becker*

- 2024 06 11 Item 09 Delivery Report.pdf (3 pages)
- 2024 06 11 Item 09 Delivery Report info1.pdf (1 pages)
- 2024 06 11 Item 09 Delivery Report info2.pdf (1 pages)
- 2024 06 11 Item 09 Delivery Report info3.pdf (1 pages)
- 2024 06 11 Item 09 Highlight report for N&W - Workforce.pdf (1 pages)
- 2024 06 11 Item 09 Highlight report for NW - Dentistry.pdf (1 pages)
- 2024 06 11 Item 09 Highlight report for NW - GP.pdf (1 pages)
- 2024 06 11 Item 09 Highlight report for NW Pharmacy.pdf (1 pages)

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0 min

10. Complaints & Contacts

Information *Jon Punt*

- 2024 06 11 Item 10 Complaints & Contacts.pdf (7 pages)
- 2024 06 11 Item 10 Appendix 1 - GP contacts 2023-24.pdf (1 pages)
- 2024 06 11 Item 10 Appendix 2 - Dental and Pharmacy contacts 2023-24.pdf (1 pages)

13:30 - 13:30
0 min

Finance & Governance

13:30 - 13:30
0 min

11. Operational Delivery Reports• General Practice & Community Pharmacy• Dental

Information *Shepherd Ncube / William Lee*

- 2024 06 11 Item 11 Operational Delivery Group Report - General Practice.pdf (3 pages)
- 2024 06 11 Item 11 Operational Delivery Report - Dental.pdf (6 pages)

13:30 - 13:30
0 min

12. Pharmaceutical Services Regulation Committee Report General Opthalmic Services Quarter End Update Report

Information *Sharon Gardner*

- 2024 06 11 Item 12 PSRC Front Sheet.pdf (2 pages)
- 2024 06 11 Item 12 PSRC Report.pdf (4 pages)
- 2024 06 11 Item 12 GOS Front Sheet.pdf (2 pages)
- 2024 06 11 Item 12 GOS Q4.pdf (3 pages)

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0 min

13. Strategic Finance Report

Information *James Grainger*

2024 06 11 Item 13 Strategic Finance Report.pdf (8 pages)

13:30 - 13:30
0 min

14. Strategic Prescribing Report

Information *Michael Dennis*

2024 06 11 Item 14 Strategic Prescribing Report.pdf (8 pages)

13:30 - 13:30
0 min

15. Any Other Business • Delivery Plan for Recovering Access to Primary Care - Circulated to PCCC members for Information

Information *Debbie Bartlett*

2024 06 11 Item 15 PCARP - for information.pdf (23 pages)

Webb,Sarah
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NHS
Norfolk and Waveney
Integrated Care Board

Meeting of the Norfolk and Waveney ICB Primary Care Commissioning Committee
Tuesday 11 June 2024, 13:30 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. *For Noting*	Chair
4.		**Review of Minutes and Action Log from the May 2024 meeting** *For Approval*	Chair
5.		**Forward Planner** *For Noting*	SP
6.		**Risk Register** *For Approval*	SP
		Service Development	
7.	13:50	**Community Health and Wellbeing Workers – ARRS funding** *For Approval*	OT
8.	14:00	**Strategic Care Quality Commission Inspection Report** *For Noting*	SN
9.	14:10	**Delivery Report** *For Noting*	LB
10.	14:20	**Complaints & Contacts** *For Noting*	JP
		Finance & Governance	
11.	14:40	**Operational Delivery Reports** • **General Practice & Community Pharmacy** • **Dental** *For Noting*	SN/WL
12.	14:50	**Pharmaceutical Services Regulation Committee Report** **General Opthalmic Services Quarter End Update Report** *For Noting*	SG
13.	15:00	**Strategic Finance Report** *For Noting*	JG
14.	15:10	**Strategic Prescribing Report** *For Noting*	MD
15.	15:20	**Any Other Business** • **Delivery Plan for Recovering Access to Primary Care** - *Circulated to PCCC members for Information*	Chair

Date, time and venue of next meeting
Tuesday 10 September 2024 13:30 – 16:30 – ICB PCCC
To be held by videoconference and You Tube

Any queries or items for the next agenda please contact:
sarah.webb7@nhs.net

Questions are welcomed from members of the public.
Please send by email: nwicb.contactus@nhs.net
For a link to the meeting in real-time, please click here.
Glossary of Terms
https://improvinglivesnw.org.uk/about-us/website-glossary-of-terms/

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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	
Debbie Bartlett	Partner Member - Local Authority (Norfolk), Norfolk and Waveney ICB	Norfolk County Council		X		Direct	Interim 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.
		Diss Parish Fields			X	Direct	Patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
Dr Hilary Byrne	Partner Member - Primary Medical Services	Attleborough Surgeries	X				GP and partner Attleborough Surgeries	2001	Present	
		MPT Healthcare	X				Director MPT Healthcare	2020	Present	
		SNHIP PCN					Clinical Director SNHIP PCN	2023	Present	
		Norfolk Community Health Care					Husband is an employee of NCHC	2021	Present	
Steven Course	Executive 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
Patricia D'Orsi	Executive 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
Karen Watts	Director of Nursing and Quality, Norfolk and Waveney ICB	Norfolk and Norwich University Hospital				X	Son-in-law is a Locum Cardiology Consultant at NNUH with sessions at JPUH	Jun-23	Present	I declare this as an indirect interest. I always ensure the chair is aware and withdraw from the meeting if cardiology at the NNUH or JPUH is discussed in terms of benefiting the service
		Royal college of Nursing			X		Member of the RCN	1980	Present	I always ensure the chair is aware if any matters to this arise on the agenda
		Coltishall surgery			X		Patient at a Norfolk and Waveney GP Practice			To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
Hein van den Wildenberg	Non-Executive Member, Norfolk and Waveney ICB	Lakenham Surgery			X	Direct	Registered patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest

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		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	Executive 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 might have an interest
		Lakenham Practice				X	Wife is Nurse Prescriber who is currently undertaking occasional locum work at Lakenham Practice in Norwich	Aug-21	Present	Declare at any relevant meetings and remove myself from any significant discussions or decisions relating to the practice
Shepherd Ncube	Associate Director of Primary Care Commissioning	Nothing to Declare		N/A		N/A	N/A	N/A		N/A
Sadie Parker	Director of Primary Care, Norfolk and Waveney ICB	Active Norfolk Board					Represent N&W ICB as a member of the Active Norfolk Board	2019	Present	Declare interest as applicable at PCCC meetings and agree any action with PCCC chair, and the same for other relevant meetings
		St Stephensgate Medical Practice and One Norwich Practices Ltd					Friendship with Dr Jeanine Smirl who is a GP partner at St Stephensgate Medical Practice and Associate Medical Director of Primary Care	2023	Present	Declare interest as applicable. Ensure no conflicted items are discussed. Ensure line manager has oversight and approves all matters in relation to JS' conflicts
Oliver Loveless	Head of Primary Care Strategic Planning (on secondment until end of March 2024)	Cromer Group Practice			X	Indirect	Partner works for the ICB	Oct-22	Ongoing	Withdrawal from any discussions and decision making in which the Practice might have an interest
Sharon Gardner	Head of Primary Care Commissioning, Community Pharmacy and Optometry	Nothing to Declare	X			Direct	Complete self-employed Locum Work as a pharmacist for various pharmacy contractors for whom we are responsible for commissioning since April 2023	Apr-23	Ongoing	Complete self-employed Locum Work as a pharmacist for various pharmacy contractors for whom we are responsible for commissioning since April 2023
Fiona Theadom	Head of Primary Care Commissioning, Norfolk & Waveney ICB	Windmill Surgery			X	Direct	Registered patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
Local Medical Committee Attendees										
Mel Benfell	Norfolk & Waveney Local Medical Committee Joint Chief Executive	Norfolk & Waveney Integrated Care Board				X	Close friend is an employee N&W ICB	2015	Mar-24	
		Norfolk & Waveney Integrated Care Board				X	Close relative is an employee of N&W ICB	Dec-22	Mar-24	
		Windmill Surgery			X		Patient at a Norfolk and Waveney GP Practice		Mar-24	To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
Lisa Drewry	Executive Officer, Norfolk & Waveney LMC	Burnham Market			X	Direct	Registered patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
Ian Wilson	Executive Officer with Norfolk & Waveney Local Medical Committee	National Health Service England				Indirect	Father-in-Law is member of national NHSE Sounding Board	Ongoing		

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		Norfolk and Waveney Enterprise Services				Indirect	Brother – Senior employee (non-Board member) – Norfolk and Waveney Enterprise Services		Ongoing	
		Drayton & St Faiths Medical Practice			X	Direct	Registered patient at a Norfolk and Waveney GP Practice		Ongoing	Withdrawal from any discussions and decision making in which the Practice might have an interest
Joni Graham	Executive Officer Norfolk & Waveney Local Medical Council	Orchard Surgery			X	Direct	Registered patient at 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	Registered patient at 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										
Sarah Buchan	Practice Manager Speciality Advisor	Fakenham Medical Practice		X		Direct	CEO at Fakenham Medical Practice	2018	Ongoing	Withdrawal from any discussions and decision making in which the Practice might have an interest.
		NN1		X		Direct	Member of NN1	2019	Ongoing	Withdrawal from any discussions and decision making in which the PCN might have an interest.
		Cromer Group Practice		X		Direct	Registered patient at a Norfolk and Waveney GP Practice	2020	Ongoing	Withdrawal from any discussions and decision making in which the Practice might have an interest.
		NN PM Group		X		Direct	Chair of NN PM Group	2020	Ongoing	Withdrawal from any discussions and decision making in which the Group might have an interest.
Health and Wellbeing Board Attendees (Norfolk and Suffolk)										
Bill Borrett	Norfolk Health & Wellbeing Board Chair	North Elmham Surgery			X	Direct	Registered patient at a Norfolk and Waveney GP Practice		Ongoing	Withdrawal from any discussions and decision making in which the Practice
		Norfolk County Council	X			Direct	Elected Member of Norfolk County Council, Elmham and Mattishall Division		Ongoing	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	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	Low risk. If there is an issue it will be raised at the time.
James Reeder	Suffolk Health and Wellbeing Board	Suffolk County Council	X			Direct	Cabinet Member for Children and Young People's Services		Feb-24	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		Feb-24	
		East of England Government Association	X			Direct	East of England Government Association	Ongoing	Apr-24	
		James Paget University Hospital Trust	X			Direct	James Paget Healthcare NHS Foundation Trust Governors Council	Ongoing	Apr-24	
		Suffolk County Council	X			Direct	Suffolk Safeguarding Children Board	Ongoing	Apr-24	
		Norfolk and Suffolk NHS Foundation Trust	X			Direct	Norfolk and Suffolk Foundation Mental Health Trust – Governors Council	Ongoing	Apr-24	

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		Suffolk and North East Essex Integrated Care Partnership	X			Direct	Suffolk County Council representative for Suffolk and North East Essex Integrated Care Partnership	Ongoing	Apr-24	
		Suffolk Chamber of Commerce	X			Direct	Member of the Lowestoft and Waveney Chamber of Commerce board part of Suffolk Chamber of Commerce	Ongoing	Apr-24	
		High Street Surgery, Lowestoft			X	Direct	Patient at a Norfolk and Waveney GP Surgery	Ongoing	Apr-24	Withdrawal from any discussions and decision making in which the Practice might have an interest
		Northfields St Nicholas Primary Academy			X	Direct	Governor of Northfields St Nicholas Primary Academy part of the Reach2 Academy Trust.	Ongoing	Apr-24	Low risk. If there is an issue it will be raised at the time.
Healthwatch Attendees (Norfolk and Suffolk)										
Andrew Hayward	HealthWatch Norfolk Trustee	East Harling GP Practice			X	Direct	Registered patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
		HealthWatch Norfolk	X			Direct	Trustee and board member HeathWatch Norfolk	2020	Present	Will not take part in any discussion or decisions relating to the declared interests.
		East Harling Parish Council			X	Direct	Member, East Harling Parish Council	2020	Present	
		NHS England		X		Direct	GP appraiser, NHSE	2015	Present	
Sally Watson	Healthwatch Suffolk (Community & Engagement Manager)	Nothing to Declare		N/A			N/A	N/A		N/A
Other Primary Care Members										
Andrew Bell	Vice-Chairman Norfolk Local Dental Committee General Dental Practitioner in Norfolk and Waveney	Dental Practices	X			Direct	Partner within a group of Dental Practices within Norfolk and Waveney (John G Plummer and Associates)	Ongoing		Non-voting member - risks will be taken in accordance with COI Policy
		General Dental Practice Committee		X		Direct	Vice-Chair Norfolk LDC, General Dental Practice Committee (BDA) Representative for Norfolk	Ongoing		
		Bridge Road Surgery			X	Direct	Registered patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
Deborah Daplyn	Chair, Norfolk & Waveney Local Optical Committee Optical Contractor working within ICB boundaries	Integrated Care Board	X			Direct	Receipt of fees and honorarium for attendance at meetings with ICB and other interested parties	Apr-23	Onoing	Non-voting member - risks will be taken in accordance with COI Policy
		General Optical Services	X			Direct	Own a practice which works within primary care and receives money under a General Optical Services Contract	Apr-23	Ongoing	
		Sheringham Medical Practice			X	Direct	Registered patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
Tony Dean	Chief Officer, Norfolk Local Pharmaceutical Committee (now known as "Community Pharmacy Norfolk"	CO of the LPC		x		Direct	CO of the LPC- the statutory representative body for community pharmacy Contractors	2005	Present	Non-voting member - risks will be taken in accordance with COI Policy

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		Docking & Great Massingham Surgeries			X	Direct	Registered patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
Tania Farrow	Chief Officer of Community Pharmacy Suffolk representing Waveney contractors	Community Pharmacies		X		Direct	Local Representative body for Community Pharmacies involved in negotiation and support for local Community Pharmacy services	Nov-15	Mar-24	Non-voting member - risks will be taken in accordance with COI Policy
Lauren Seamons	Joint Chief Officer, Norfolk LPC (Community Pharmacy Norfolk)	Norfolk LPC	X			Direct	Employed by Norfolk LPC	Ongoing		Non-voting member - risks will be taken in accordance with COI Policy
		The Hollies, Downham Market			X	Direct	Registered patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
Jason Stokes	Secretary Norfolk Local Dental Committee (LDC)	National Health Service	X				I have an NHS GDS Contract	2007	Present	I would exclude myself from any discussions particular to my own GDS contract. I would exclude myself from any section of a meeting that ICB members
		British Dental Association		X			I am a member of the British Dental Association (BDA) Principal Executive Committee (PEC) – board of directors	2015	Present	This is unlikely to impact on working with the ICB. I would exclude myself from any section of a meeting that ICB members felt appropriate.
		Associate Dental Postgraduate		X			I am Associate Dental Postgraduate Dean for Early Years (Health Education England)	2022	Present	This is unlikely to impact on working with the ICB. I would exclude myself from any section of a meeting that ICB members felt appropriate.
		St Stephens Gate, Norwich			X	Direct	Registered patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
Nick Stolls	Dental Advisor PCCC	Landlord of Harleston Dental Practice	X				Landlord of Harleston Dental Practice	2001	Ongoing	Declare Conflict of Interest and withdraw from a meeting if discussions take place that might benefit Harleston Practice

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NHS
Norfolk and Waveney
Integrated Care Board

Norfolk and Waveney Extraordinary Primary Care Commissioning Committee

Part One

Minutes of the Meeting held on
Tuesday 7 May 2024
via video conferencing and YouTube

Voting Members - Attendees

Name	Initials	Position and Organisation
Debbie Bartlett	DB	Chair, Partner Member – Local Authority (Norfolk) Norfolk and Waveney ICB
Steven Course	SC	Executive Director of Finance, Norfolk and Waveney ICB
Patricia D'Orsi	PD'O	Executive Director of Nursing and Quality, Norfolk and Waveney ICB
Hein Van Den Wildenberg	HW	Non-Executive Member, Norfolk and Waveney ICB (deputy Chair)

In attendance

Name	Initials	Position and Organisation
Tim Ambler	TA	Blakeney Resident
Michael Archant	MA	Blakeney Resident
Duncan Baker	DBaker	Member of Parliament, North Norfolk
Steve Blatch	SBlatch	Head of Paid Service, North Norfolk District Council
Sarah Buchan	SB	Practice Manager Committee Attendee
Mark Burgis	MB	Executive Director of Patients and Communities, Norfolk and Waveney ICB
Shelley Cook	SCook	Executive Partner, Holt Medical Practice
Sheelin Cuthbert	SCu	Field Dalling Resident
Lisa Drewry	LD	Executive Officer, Norfolk and Waveney Local Medical Committee
Heather Farley	HF	Acting Associate Director – North Locality, Norfolk and Waveney ICB
Katie Franklin	KF	Business Manager, Holt Medical Practice
Chris Gadsby	CG	Chair, Field Dalling Parish Council
Sharon Gardner	SG	Head of Primary Care Commissioning Community Pharmacy and Optometry, Norfolk and Waveney ICB
James Grainger	JG	Head of Finance Primary Care and Corporate, Norfolk and Waveney ICB
Andrew Hayward	AH	Trustee of Healthwatch Norfolk
Victoria Holliday	VH	District Councillor and Chair, Cley Parish Council
Alexandra Hooper	AHo	Chair of Stiffkey Parish Council
William Lee	WL	Senior Primary Care Commissioning Manager – Dental, NHS Norfolk and Waveney ICB
Rob Metcalfe	RM	Chair of Morston Parish Council
Shepherd Ncube	SN	Associate Director of Delegated Commissioning, Norfolk and Waveney ICB
Sadie Parker	SP	Director of Primary Care, Norfolk and Waveney ICB
Lauren Seamons	LS	Joint Chief Officer, Community Pharmacy Norfolk
Jason Stokes	JS	Secretary, Norfolk Local Dental Committee (LDC)

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Nick Stolls	NS	Speciality Dental Advisor
Nigel Sutcliffe	NSu	Vice Chair, Blakeney Parish Council
Peter Taylor	PT	Assistant Director, Public Health Commissioning Norfolk County Council, Public Health
Fiona Theadom	FT	Head of Primary Care Commissioning, Norfolk and Waveney ICB
Rosemary Thew	RT	Chair of Blakeney Parish Council
Sarah Webb	SW	Primary Care Administrator, Minute Taker, Norfolk and Waveney ICB
Tim Winters	TW	Head of Data Insights, Norfolk and Waveney ICB

Apologies received

Name	Initials	Position and Organisation
Bill Borrett	BB	Chair of the ICP and Partner Member of the ICB
Deborah Daplyn	DD	Chair, Norfolk and Waveney Local Optical Committee Optical Contractor working within ICB boundaries
Tony Dean	TD	Joint Chief Officer, Community Pharmacy Norfolk
Michael Dennis	MD	Associate Director of Pharmacy and Medicines Optimisation (Chief Pharmacist) Norfolk and Waveney ICB

No	Item	Action owner
1.	**Chair's introduction** Chair welcomed attendees to the May 2024 Extraordinary Primary Care Commissioning Committee. Chair reminded those present that this was a meeting held in public and not a public meeting. Chair proposed to follow the same procedure and structure for the meeting as February 2024 for the Blakeney item. • Officers to present the paper. • Members of the Committee to check for clarifications. • Members of the public to ask questions. • Committee discussion and agreement to reach a decision.	**Chair**
	Matters Arising There were no matters arising.	
2.	**Apologies for absence**	**Chair**
	Noted above.	
3.	**Declarations of Interest** *For Noting*	**Chair**
	None received.	
4.	**Review of Minutes and Action Log from the March 2024 Committee** *For Approval*	**Chair**
	The minutes were agreed to be an accurate reflection of the March 2024 Committee and minutes would be sent to the Chair for signing. **ACTION: SW to send Chair signed minutes for safekeeping.**	**SW**

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	Action Log 0176 for June Committee 0177 Closed 0178 SN confirmed meeting taken place. Closed 0179 DB/HW to pick up offline. Closed 0180 FT discussed with Corporate Affairs team, agreed amendments approved. Closed 0181 Terms of Reference for Delivery Groups updated to reflect PH involvement. To agree how this will work. Closed 0182 SN confirmed completed. Closed 0183 PD'O confirmed that as part of the workstream that had focussed on discharge a subgroup had been set up which looked at prescribing which ensure that communication between primary care and secondary care and the patient is in the best state it can be. PDO confirmed this action can be closed.	
5.	**Forward Planner** *For Noting*	**SP**
	The planner was noted.	
6.	**Holt Medical Practice – Application to Close Blakeney Branch Surgery** Item format: • Presentation of report • Clarification questions from committee • Questions from members of the public • Committee discussion and decision	
	SP presented on the basis the papers had been read. The report followed on from the one received in February 2024, where there was an agreement to defer the decision on the Holt Medical Practice application in order for more public involvement to be undertaken. SP acknowledged the efforts and the amount of engagement through the whole process from local people living in local communities, their representatives, the practice, and other local stakeholders. The practice had updated their application following the ICB's public involvement period and there was a refreshed version of that application included in the appendices. SP confirmed the report content had been structured around the process that the ICB were obliged to follow and went in order as the sections appear in the NHS England policy guidance manual and then considered the ICB statutory duties to show how the ICB had tried to consider all the aspects required against information gathered. SP then went on to highlight the main issues in some detail from the report for the Committee's attention. DB invited members of the Committee for any specific clarification questions for SP or the officers first. HW thanked Chair and SP. HW commended on the very clear structured report and gave compliments to SP and colleagues. HW thought that by following process it made it clear to follow the storyline. HW acknowledged the engagement from all stakeholders. HW took the opportunity to highlight an item	

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	in the conclusion section where it said officers had concluded that there was likely to be minimal health impact on the closure of the Blakeney Surgery Branch. HW was aware that some of this had been covered in the introduction. HW pointed out that the emergency admission activity since March 2020 had been used and asked SP to elaborate on the various inputs that had underpinned the conclusions outlined in the report. SP thanked HW for his question. SP outlined in the health profile there were various slides towards the end which showed the use of services from the local community to Blakeney compared to the use which would be expected for the health profile of the population. Emergency admissions was one of the proxy indicators shown and it was seen that that the local population followed the trend seen anywhere else and there had not been any worsening of emergency or emergency admissions over and above anywhere else. The ICB analyst had worked through expected activity for that local population and compared to others such as the Melton Constable population with Holt, and the Kelling population with Holt, but also other geographically remote communities and the Norfolk and Norfolk and Waveney average. In most cases in the graphs, the health activity was lower than expected for this population which is why those conclusions had been reached. HW thanked SP for her response. PD'O wanted to make a couple of comments and would then ask a question. PD'O reflected on the detail and overview provided in the papers and reflected the practice was valued by patients and provided a very good standard of care, and any such request for a decision by the Committee would not be taken lightly and this came through in the papers. PD'O's second comment was around infection prevention control. For transparency, as the Executive Director of Nursing the infection prevention control team report directly to PD'O and they had undertaken their own independent assessment and returned with recommendations. This had not in any way been influenced by PD'O's role at the Committee and PD'O emphasised this point. PD'O asked a question. From March 2020 when services ceased due to COVID from that point until now had there been a large volume of individuals leaving the list and registering with other practices. PD'O recognised when a branch closed people would often move to other practices. By remaining at the practice this often meant that people were satisfied with their arrangement based on the quality of care they had received from the practice. PD'O welcomed SP's thoughts on this. SP confirmed over the period March 2020 to the present the ICB had not been made aware of any substantial changes to patient registrations. The practice had informed the ICB that during the engagement period there had been a move of around 50 patients to neighbouring practices. Those practices also had not raised any concerns that they had seen any kind of increased numbers. Practices would normally talk to the ICB if any issues arose around a sudden increase in patient registrations. PD'O thanked SP. PD'O had one last question on finances and wanted to be clear from the papers. The investment estimated to be required to refurbish the premises was £245,000 plus an increase in wages of £145,000, totalling	

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£390,000. PD'O asked that if the branch surgery continued would these figures be added together and SC confirmed this.

SP confirmed the staff wage increase would be recurrent regardless of the application and that this was the rise in pay to meet the national minimum wage from April 2024 and would affect all practices.

PD'O thanked SP for the clarification of the investment.

DB confirmed that with no further questions from Committee members there were 11 people who had requested to speak. DB would take residents first, local government colleagues and Duncan Baker MP to finalise.

Questions from members of public present (Appended to the minutes)

DB thanked members of the public for their questions.

SP confirmed a full response to questions would be published on the website alongside the papers in due course.

SP confirmed a few items for clarification.

Throughout the process the ICB had sought to ensure the practice continued to meet the reasonable needs of the whole practice population which it was required to do under its contract with the ICB. Having looked at the profile, the numbers of appointments, home visits, the ICB concluded the practice did continue to meet the reasonable needs of the practice population. Emergency admissions generally reflect unmet need, which is why this proxy indicator was used. There was no evidence health outcomes had been affected over the last 4 years, while there had been no clinical appointments provided in the Blakeney branch surgery. There had been comments today on the fact face to face appointments had not been provided in Blakeney since the surgery closed for the first Covid lockdown. From the data, the practice did appear to continue to meet the reasonable needs of its population. The practice had provided more home visits than other practices do and had arranged their services to undertake these and the level of access appeared to be consistent in terms of the number of appointments offered. There had not been any reduction in access with the loss of those face to face appointments in Blakeney. These had been re-provided by the other two surgeries.

The ICB recognised medicines were a concern for many people who had responded to the public involvement phase and the practice fully intend to ensure they continued to offer local medicines collection, but they would need the support of the local community to arrange that provision.

Finally, SP noted there were a few concerns raised about process. A legal review of our process was sought to ensure the ICB met their statutory duties and complied with national process set out in the NHS England policy and guidance manual. The ICB had sought to reflect best practice in the process, rather than only undertake the statutory minimum requirement around the process. The legal review was satisfied with the process the ICB had undertaken and advice was also taken from NHS England Regional team around our responsibility under the new Secretary of State call in powers which came into effect at the end of January 2024.

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	DB thanked SP and then moved to other members of the Committee. PD'O thanked SP for the response to the summary of points passionately raised today and asked for clarification on one point raised with regard to the legal review. One of the themes raised by local people was the removal of face to face consultations in Blakeney had not been consulted on. PD'O thought that was a very important point of clarification with regard to the process followed by the ICB because it was one of the principles to listen to people and asked SP had this been fully considered. SP confirmed this was considered. The practice removed face to face appointments in Blakeney at the onset of first COVID lockdown. Up until the week beforehand they provided face to face appointments. The temporary decision not to restart face to face appointments was based on the infection prevention and control issues highlighted. SP reiterated the infection prevention control team inspected the branch surgery. We had discussed the temporary decision with the legal adviser, and it was confirmed it remained a temporary decision but would be concluded in the decision around the future of the branch surgery. DB asked for any other questions, reflections from members of the Committee and there were none. DB highlighted the importance of the decision for the Committee. In reaching their decision, the Committee would need to abide by the criteria provided and set out in Section 3 and 4 of the paper. DB asked SP to confirm the process had been followed and considered in some detail and the conclusion set out in section C weighs those together and comes to that view. SP confirmed legal advice had been sought on this and this had been confirmed. DB then referred to Section 6 and the conclusions, notwithstanding this was a hugely difficult decision. DB went to members of the Committee to ask then on the basis of that conclusion whether they accepted the conclusion and therefore whether they agreed the recommendation set out in Section 7 and asked for members to confirm. DB confirmed a decision had been reached and asked SP to summarise for the record what the planned mitigations were. SP confirmed the practice wanted to continue to provide a medicines collection service in the Blakeney area and this would be on a similar basis to what was in place now, subject to them being able to agree a suitable location. A number of locations had been approached and none were happy to progress discussions until a final decision had been reached. Once a decision was reached the practice would be able to reach out to those locations, and consider any others, and work through the logistical preparations for putting this in place. A maximum six-month mobilisation period had been suggested to enable this to happen and if the practice were able to work through the logistical arrangements more quickly, then the service would move over but this would not be an open ended arrangement. DB outlined the recommendation had been agreed and asked for absolute clarity for an ongoing evaluation and to review the impact. Whilst it is not in the paper, DB asked the ICB to formalise this with an evaluation done on the	

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	impact in due course. DB reflected on the pressures of primary care and the pressures on the health service, particularly in remote areas and DB noted it was an important piece of work and requested that a recommendation be considered around public transport. The ICB was not responsible for public transport however issues of accessibility to public services were relevant to health and social care. DB was aware HF and MB were in attendance and asked if this could be considered at Place Board. MB agreed that he would work on this with colleagues. DB then went to DBaker. DBaker asked for clarification on the Committee vote and how the system worked and if there were individual votes on the recommendation as he only saw one hand raised. DB confirmed there were four voting members on the Committee. DB as Chair, the Executive Director of Nursing, The Executive Director of Finance at the ICB and HW who was Vice Chair of the Committee. DB confirmed they all supported the recommendation and it had been agreed. DBaker asked for confirmation it was a unanimous decision and DB confirmed this. DB apologised that she was unable to hold any further discussion on this and the decision was not taken lightly. DB reflected on the work and background information undertaken to arrive at this point and this demonstrated the seriousness with which the decision was taken. DB recognised local people would be disappointed. DB further reflected on the issues raised locally and the questions asked had significantly contributed to the mitigation and the further work that would take place. DB confirmed guests were welcome to stay for the final item as this was also a highly important area.	
7.	**The Norfolk and Waveney Long Term Dental Plan** *For Approval*	**FT**
	FT set out the Norfolk and Waveney Long Term Dental Plan to Committee for approval. FT started off by thanking colleagues in the dental profession who had provided invaluable support, advice and guidance over the past year as the plans had developed and the support from system partners, particularly the local authorities and colleagues in the ICB and the East of England. FT confirmed the ICB wanted to continue working collaboratively as this would be critical to deliver plans successfully. FT wanted to thank the public and patients for their engagement with the survey earlier in the year which had generated many responses. There was widespread support for the ICB LTDP priorities for the next 2 years. FT then went on to outline some further points in detail for Committee's attention. DB thanked FT and acknowledged the impact of the short-term plan and the difference this had made. DB acknowledged the long term plan would make a	

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sustainable difference and recognised the emphasis on children and young people from a preventative sense which was really welcome.

DB opened to questions and comments from members of the Committee first.

HW was encouraged by the response rate and that the report had been developed with various stakeholders. HW supported the plan as presented and asked for one tweak to be made in the next steps, as the proposal was to report to Committee annually. HW asked for this to be done quarterly as this would allow this item to be more strategic. HW had one question on the urgent treatment pilot service as the feedback in the pie chart gave some concern. HW was aware this was reviewed and asked when FT hoped to report back on this.

FT responded by saying there was an intention to carry out a review with all the providers, IC24 and NHS111 and colleagues in our urgent and emergency care team about the concerns raised. 1800 appointments were provided a month and there were a small number of DNAs however there were concerns as to whether the messaging and managing of patient expectations was right. This service was set up very quickly and it was time for a review to see where improvements could be made. FT anticipated this would be brought back to Committee in September and be heard at the Delivery Group before then.

HW thanked FT for her response.

PD'O confirmed she was supportive of the long-term plan in view of the state of dental access across Norfolk and Waveney. PD'O had a couple of points to clarify her understanding better. With regard to acute activity under 4 year olds were presenting to have extractions which was a concern. PD'O recognised the commitment from the ICB and assumed it would be well supported by colleagues in public health to ensure we had maximum impact into education to enable the ICB to drive improvement forward for children.

PD'Os second question was the review of the UDA rate and if this was nationally driven - was there an opportunity to do something locally.

FT thanked PD'O for her questions. In respect of the first question there was a task and finish group led by colleagues in Norfolk County Council public health team to look at children's oral health education and prevention and the ICB sit on that group. Their PH team also sit on our task and finish group to look at the establishment of child focused dental practices. Work was also being done with Suffolk County Council for Waveney oral health education.

In terms of the second question the UDA rate review value the ICB arrived at was £30 and was higher than the recommendation from the national team of £28. The ICB agreed it some months ago and the UDA rate uplift came into effect on 1 April 2024. The ICB were in the early stages of the development of a framework which would look at how the ICB could consider ad hoc requests for UDA rate reviews. FT advised the ICB can commission flexibly when commissioning other services to help support practices.

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NS introduced himself as Dental Advisor to the Committee and recognised the huge amount of work the ICB had to do. It was no surprise there were a number of areas to be worked on at the moment and one area NS suggested needed to be looked at in the future was the residents in care homes and nursing homes. There was a small number of responses in the survey from these kinds

	of environments. NS felt the priorities were right and it was important to ensure vulnerable people were not lost sight of. The other area NS suggested was undergraduate dental training and there had been some discussion around the possibility of training undergraduates in the area. NS thought the support from dental colleagues in the county was greater than many other areas and it was important to harness this. JS also recognised the effort and hard work to deliver the plan. JS agreed NS raised an important point around care homes. The point JS wanted to raise was on Page 12 of the long term plan and the reference to the utilisation of clinical leadership fellows and Level 2 service provision. In his role in NHS England's Workforce, Training and Education directorate, JS referred to getting people to work in places such as Norfolk and Waveney where there is no dental school and where the practice was not close to a large major urban area, as people need to feel supported and there had to be a professional infrastructure in place. Recently the level 2 pilots for periodontics and endodontics which were key areas where young professionals wanted to develop their skills had finished. JS appreciated that it was difficult for a single ICB to work towards this if not backed up by other colleagues in the region, but this was needed. DB confirmed Norfolk County Council agreed to lobby for a dental school in Norfolk. DB was keen to understand what level of improvements were being made to access NHS dentistry and thought it would be helpful to have some idea of what the ambition was and to track the progress towards this. FT confirmed there had been a discussion on this and it was felt too soon to set ourselves targets when services were still so fragile, but as part of the review next year it was the intention to consider setting targets. ICBs nationally had been asked to restore UDA activity to 2019/2020 levels as a national target. FT referred to the use of flexible commissioning which made the restoration of UDA activity more challenging to measure. Measuring the number of new patients being treated or being seen was, however, straightforward and this would be monitored over the next year. FT took the opportunity to respond to NS question on care homes. One of the advantages of working closely with other ICBs in the region was where there were pilots ongoing in other ICB areas. One of these was around care homes and the ICB could look at their scheme and see whether it would work for us or need adaption. Norfolk and Waveney was a more rural county and had a significantly larger number of care homes. One thing the ICB was being asked to do later in the year was screening in special educational needs schools. The long term plan did not include significant workforce detail as this was included within the Primary Care Workforce Plan. A substantial amount of work has been done by the primary care workforce team working with NHS England and colleagues to look at how the ICB could encourage dentists and dental care professionals to live and work in Norfolk and Waveney. PD'O was interested in NS thoughts on care homes and SEND education. PD'O asked not to forget the adult person with disabilities who would require reasonable adjustments and to ensure the ICB commissioned the best services it could. DB passed on her thanks and the appreciation to FT and the team. The Committee confirmed this had been approved.	

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8.	**Any Other Business**	**Chair**
	Questions from the Public There being no further business or questions from the public, the meeting then closed at 15:20	

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

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

Norfolk and Waveney Integrated Care Board

Norfolk & Waveney IBC Primary Care Commissioning Committee - Part One Action Log
11 June 2024

No	Meeting date added	Agenda Item	Owner	Action Required	Action Undertaken / Progress	Due date	Status	Date Closed
0176	13-Feb-24	11	JG	Finance report - JG to provide an update on the LCS activity in respect of diabetes and SMI at a future Committee	Included in this month's report - propose to close.	11-Jun-24		
0178	07-May-24	4	SW	SW to send Chair signed minutes for safekeeping	SW sent these across	11-Jun-24		08-May-24

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Norfolk and Waveney Integrated Care Board

Norfolk and Waveney Primary Care Commissioning Committee Forward Plan – 2024/2025

Item	7 May 2024 (EPCCC)	11 June 2024	13 September 2024	10 December 2024	11 March 2025	Lead officer	Notes
Risk Register		Y	Y	Y	Y	SP/FT	All risks to be considered following ICB Governance Audit recommendations
Strategic Finance Report		Y	Y	Y	Y	JG	
Strategic Estates Report			Y		Y	PH	Noting/ assurance
Strategic Digital Report			Y		Y	AH	Noting/ assurance
Strategic Prescribing Report		Y	Y	Y	Y	MD	
Strategic CQC Inspections Report		Y		Y		CG	
Delivery Report		Y	Y	Y	Y	AS/ OL	
General Practice & Community Pharmacy Delivery Group Report		Y	Y	Y	Y	SN/SG	Noting/ assurance
Dental Delivery Group Report		Y	Y	Y	Y	WL	Noting/ assurance
Contract Assurance Framework		Y	Y	Y	Y	SN	
Delivery Plan for Recovering Access to Primary Care		Y			Y	OL/SN	
Complaints and Contacts		Y		Y		JP	
Primary Care Resilience (Strategic Report)			Y		Y	SN/OL/FT/SG	
Terms of Reference Review					Y	FT	
Primary Care & Workforce Recruitment and Retention Programme (strategic report)		Y			Y	JRo	June for approval – deferred until Sept (EMT sign off) March update for noting
Optometry Services – contractual changes and other matters			Y		Y	SG	Noting/ assurance
Pharmaceutical Needs Assessment		Y	Y			SG	Deferred due to Pre-Election Period
Reports from the Pharmaceutical Services Regulations Committee		Y	Y	Y	Y	SG	Noting/ assurance
Long Term Dental Plan	Y		Y	Y	Y	FT	Noting September an update on the Urgent Treatment Service

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SEE BELOW

Proposed item (no date assigned)	**Lead officer**	**Notes**
Deep Dive Ophthalmology	SG	SG to confirm
Dental year-end report	FT	
Deep Dive Community Pharmacy	SG	SG to confirm
Population Health Strategy	SM	
Health Inequalities Strategy	SA	
Primary Care Principles and Vision	AS	
Framework for Integrated Working	AS	To include community services review
Long Term Plan for Community Pharmacy	SG/AS	
Long Term Plan for General Practice	AS	

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2024 - 2025

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									
PC6	Learning Disability Annual Physical Health Checks	09	09	09									
PC9	Hypnotics and anxiolytics prescribing	12	12	12									
PC 14 BAF16	The resilience of general practice	16	16	16									
PC16	Severe Mental Illness (SMI) Annual Physical Health Checks	12	12	12									
PC17	General Practice – Allied Health Professionals Workforce including PCN Additional Roles	12	12	12									
PC18 BAF18	Dental Services Resilience	20	20	20									
PC19	Secondary care dental services (Oral Surgery and Maxillo Facial Services, Orthodontic Services)	X	X	16									

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2023 - 2024

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	12	12	12	12	12
PC6	Learning Disability Annual Physical Health Checks	12	9	9	9	9	9	9	9	9	9	9	9
PC9	Hypnotics and anxiolytics prescribing	12	12	12	12	12	12	12	12	12	12	12	12
PC 14 BAF16	The resilience of general practice	16	16	16	16	16	16	16	16	16	PCCC	PCCC	PCCC
PC15	Wave 4B Primary Care Hubs – loss of capital funding	8	8	8	8	6	6	6	6	6	6	6	4
PC16	Severe Mental Illness (SMI) Annual Physical Health Checks	12	12	12	12	12	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	12	12	12	12	12
PC18 BAF18	Dental Services Resilience	12	12	20	20	20	20	20	20	20	PCCC	PCCC	PCCC

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2022 2023

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	12	12
PC6	Learning Disability Annual Physical Health Checks				12	12	12	12	12	12	12	12	12
PC9	Hypnotics and anxiolytics prescribing				16	16	16	16	12	12	12	12	12
PC10	Gabapentinoids prescribing in primary care				9	9	9	9	9	9	9	9	6
PC 14 BAF16	The resilience of general practice				12	12	16	16	16	16	16	16	16
PC15	Wave 4B Primary Care Hubs – loss of capital funding				8	8	8	8	8	8	8	8	8
PC16	Severe Mental Illness (SMI) Annual Physical Health Checks				12	12	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	12	12
PC18	Transition and delegation of Primary Care Services (Dentistry, Optometry and Community Pharmacy)								16	16	16	16	12

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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**
• Workforce team recruited in ICB structure. • Primary Care Workforce Transformation Team supported by Clinical Fellowships and Secondments • Primary Care Networks (PCNs) supported to develop and implement workforce trajectories in support of the Additional Roles Recruitment Scheme (ARRS). • PCN ARRS Workforce – online portal for 2024/25 for PCNs to update and draw national funding down 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). • Primary Care Health & Wellbeing Fellow recruited. • Wide range of initiatives in place to support GP retention • Advanced Practice Forum established • Workforce and Communication Engagement strategies updated to reflect PCN development updates and post pandemic environment. • Workforce data to measure trajectory levels against actual recruitment. • Succession planning lead recruitment to support practice and PCN with demand vs capacity requirements. • Training Needs Analysis completed for 24/25. • Coastal and Rural project to support geographical areas facing greater challenges in recruitment, e.g. West and East	**Internal:** Reporting to Primary Care Commissioning Committee (PCCC). Reporting to the Norfolk & Waveney People Board. **External**: NHSEI returns monthly as part of the NHSE Primary Care Oversight Board KPI's and quarterly assurance meetings.

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Gaps in controls or assurances
• 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. • Understanding general practice resilience as work challenges increase may lead to higher numbers of the workforce leaving/retiring during 2024 and 2025 • 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. • Impact of financial controls on ability to utilise SDF funding for workforce recruitment and retention schemes

Updates on actions and progress

Date	Action	RAG	Target completion
May 2024	Latest NHSE workforce data illustrates the following: • -1% decline in Nursing workforce roles across N&W during the period of March 24 vs March 23. 439 WTE are in place across the system. • 2.4% growth in GP workforce roles (excluding training GPs) during the same period. 523 WTE are in place across the system. • 4.8% growth in GP Trainees across N&W during the same period. 141 FTE are in place across the system. As of 21st May 2024, positions currently advertised for recruitment within general practice show: • 10 x Advance Nurse Practitioners • 4 x Nursing positions • 15 x Salaried GP's positions • 1 x GP Partnerships A Norfolk and Waveney Primary Care Workforce Business Intelligence Dashboard, which includes ARRS, has been produced. This provides an overview of recruitment intentions, turnover levels, WTE in post by practice and Primary Care Networks. An overview of the results is reported below: • North Norfolk and West Norfolk have the highest % of GP's per 1000 patients and Nurses across Norfolk and Waveney • Great Yarmouth and Waveney has the highest proportion of Male GPs across the system • South Norfolk and Great Yarmouth has the highest proportion of GPs aged 60 years plus across the system • South Norfolk and West Norfolk has the highest proportion of Nurses aged 60 years plus across the system To understand the reason behind the high leaver rates for Nursing Professionals, a GPN Legacy Nurse Mentor role has been advertised to support Primary Care Network colleagues. It is important to note that over 34% of our nursing professionals are over the age of 55.	Amber	September 2024

Visual Risk Score Tracker

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

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	PC6
Risk Title	Learning Disability (LD) Annual Physical Health Checks
Risk Description	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 by NHSE. ICB is at risk of not meeting the national target (75% uptake) set by NHS England designed to tackle health inequalities associated with this population group. All practices in Norfolk and Waveney have signed up to deliver the LD Health Checks (apart from UEA Medical Centre), but there are significant challenges in relation to workforce and resources. Last year (2023/4), the ICB via practices has successfully delivered up to 74% of LD Health Checks. There is a risk for the 26% remaining without checks being done.
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	31.03.2025

Risk Scores								
Unmitigated			**Mitigated**			**Tolerated**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	3	3	9	2	3	6

Controls	Assurances on controls
• LD Health Checks (HC) is one of the national priorities for general practices and one of only two IIF Indicators for 24/25. • All practices signed up to the LD HC DES apart from UEA as the practice covers university student population and the numbers have been assessed as low. If checks are required alternative arrangements will be made by the ICB. • CQC inspections usually include review of LD health checks performance • The Health Improvement Team for Learning Disabilities supports practices with training around delivering high quality LD Health Checks, as well as increasing take up and promoting the service to LD patients. • Regular assurance reports to NHSE/I & PCCC • N&W ICB LD Health Check Working Group meets monthly to review performance and implement projects which increase quality and delivery.	**Internal:** Primary Care Commissioning Committee, Learning Disabilities & Autism Programme Board **External**: NHSE Checkpoint and Assurance Framework, Health Overview and Scrutiny Committee Reports to NHSE/I

Gaps in controls or assurances

- Lack of verified data on LD Health Check delivery. This is something which N&W ICB BI team are working on as a key priority using the new Primary Care Data Warehouse.
- No consistent method of gathering service user feedback on experience of LD Health Check delivery, though patients can access their practice's Friends & Family Test.

Updates on actions and progress

Date	Action	RAG	Target completion

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January 2024	Additional capacity to accelerate the delivery of LD HCs has been agreed by the ICB Executive Management Team (EMT). Hosting arrangements for the additional clinical resource have been agreed with NNUH and Fens and Brecks PCN. Additional LD HCs expected to be completed in January – end of March 2024. With the additional resources the ICB expects to see increased activity in Q4 to meet the national target of 75%.		31/03/24
March 2024	Good progress has been made with accelerating the uptake and quality of checks in January 2024. February 2024 data is yet to be published and our year end landing position remain unchanged with the ICB expecting to meet the national target as planned. Additional clinical capacity has been made available to practices via Norfolk and Norwich University Hospital and Fens and Brecks PCN to build clinical capacity within Primary Care. N&W learning disability registers have increased due to national coding errors, and these are in the processed of being resolved. However, this may not be fully resolved in time before year end, and this will negatively impact our performance by 2-4%. Practices will be supported with manual adjustments to manage cashflow. Draft delivery plans for next year have been submitted to NHSE for approval and these will be shared once agreed.		31/03/24
June 2024	ICB CQRS local data (for payment purposes to practices) shows an achievement of 74%. A total of 5,525 LD Health checks have been carried out in 23/24 – an increase of 500 checks compared to the same period in 2022/23. This is the highest percentage achieved by Norfolk & Waveney practices in the last three years, and the greatest number of LD patients receiving their annual health checks. Please note NHSE national figures for 2023/24 are yet to be published and unfortunately not all the activity will be captured in the national figures. Q1 2024/25 data for April is yet to be published. Awaiting confirmation from NHSE on the draft delivery plans for 2024/25 while also finalising a plan for the year. Additional clinical capacity continues in Q1 24/25 to support practices with hard-to-reach patients who didn't have an LD HC in 23/24. Targeted work is being provided in 24/25 to address the low take up of LD HCs for the 14-17 year olds and to support Practices experiencing significant resilience challenges.		31/03/25

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

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PC9				
Risk Title	Hypnotics and anxiolytics prescribing			
Risk Description	High prescribing rate of hypnotics and anxiolytics in primary care – improved to 4th 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	30.09.2024

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. The 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
This workstream is supported by the prescribing quality scheme but practices need to have capacity to deliver. NICE have also issued patient decision aids on stopping them. Practices that are above 90th percentile are highlighted on the GPCPDG report. Outlier practices are offered support.

Updates on actions and progress			
Date	**Action**	**RAG**	**Target completion**
Nov 2023	Aug 23 data 97th percentile 5th nationally		31 3 24
Jan 2024	Oct 23 data 97th percentile 4th nationally		31 3 24
Mar 2024	Dec 23 data 97th percentile 4th nationally		30 9 24
Jun 2024	March 24 data 97th percentile, 4th nationally– outliers are being focussed on through targeted PQS audits. Extend target to September.		30 9 24

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

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PC14 (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 workforce pressures and increasing workload (including workload associated with secondary care interface issues). • There is also evidence of increasing poor behaviour from patients towards practice staff, leading to retention and recruitment issues. • There is an increasing risk of industrial action following the BMA referendum where the GP contract and associated uplift was rejected. • The national GP contract price uplift does not cover the required increase in meeting the minimum wage. • The LMC has written to practices to cease uncommissioned work associated with MGUS monitoring and Advice and Guidance. Further communications are likely. • 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 service partners 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	31/03/2026

Risk Scores

Unmitigated			Mitigated			**Tolerated** (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	4	20	4	4	16	3	4	12

Controls	Assurances on controls
• Locality teams and strategic primary care teams structured around supporting the resilience of general practice.~~—~~All practices have previously been supported to review business continuity plans. • PCN ARRS (additional roles reimbursement scheme) funding has ~~increased again in 2023/24~~ has provided additional capacity but has not grown in this contract year. • Primary care workforce and training team working closely with locality teams to ensure training available to support practices and PCNs in setting up and maintaining services. • System interface group with representation from primary, community and secondary care system partners established. • Standard contract requirements on interface – gap analysis and action plans, including monitoring being reviewed by contracts team. New national requirement for providers to self-assess using national toolkit 6-monthly • Commencement of LMC General Practice Alert System sitreps	**Internal:** Executive Management Team, workforce steering group, primary care strategic planning meetings, establishment of new general practice and community pharmacy delivery group, Primary Care Commissioning Committee, risk is on the Board Assurance Framework **External**: NHS England via delegation agreement and assurance framework, Health Education England, Norfolk and Waveney Local Medical Committee, Health Overview and Scrutiny Committee meetings

Gaps in controls or assurances
• Practice visit programme, CQC inspections focused on where there is a significant risk or concern. • Significant number of vacancies within primary care commissioning, workforce, quality, and locality teams impacts the level of support which can be provided to practices. Organisational change is impacting on support available due to vacancy controls.

- Continued reports of poor patient behaviour across practices, decrease in patient satisfaction with general practice through GP patient survey, consistent with national position.
- Progress on interface action planning process across Trusts impacted by ongoing pressures and national strike action.
- Reporting process for inappropriate transfers of workload from community and secondary care providers to general practice not ~~yet~~ fully utilised by practices, leading to under-reporting of issues. Alternative approaches being considered with the LMC.
- 50% overall response rate to LMC General Practice Alert System, meaning full picture is not available.
- Workforce and capacity shortages across community pharmacy and dental practices, and ongoing drug shortages, are having an impact on general practice and the rest of the system.
- Pressure on and unavailability of primary care budgets due to the ICB's financial position impacting on our ability to support resilience and transformation in general practice.
- Resilience policy in development, which will link into any bids for section 96 support.
- Five-year Primary Care Strategy has expired, new strategic framework in development.
- Primary care dashboard/ delivery report remains in development, leading to a lack of integrated performance oversight.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
Jan 2024	• £750k further winter funding for general practice was released in January, along with a further investment of £750k in ARI (acute respiratory infection) hubs. This funding remains available for investment during quarter 4. • A significant number of practices have reported challenges with the annual health checks requirement for people with a learning disability and have requested additional support. Appropriate support has been agreed with respective practices. • The LMC has launched their General Practice Alert System, designed to monitor the resilience of general practice in a similar way to the Opel system. Anonymous sitreps are being provided to the primary care team. • Work remains underway to improve the issues caused at the interface between primary and secondary care. A new reporting form is proposed for implementation to automate the process and reduce administrative burden for all providers, LMC and the ICB. QEH has launched ICE requesting for pathology and radiology and a working group has been set up at the NNUH to seek to progress the project there, including colleagues from JPUH. A plan will be developed for 2024/25 and agreed through the interface group. The additional Interface task and finish groups continue and are reported against monthly in terms of progress. The primary care and locality teams continue to work with individual practices at resilience risk to support them to stabilise.		31.03.24
February 2024	• Good progress has been made with the practice visiting programme and, the first practice visit to Magdalen in Norwich was successfully completed in January 2024. Plans are underway for the next visit, which will take place in West Norfolk and dates are currently being discussed. There were no resilience concerns identified or reported at Magdalen practice during the visit. The practice benefits from stable partnership arrangements, stable workforce, and experienced practice manager.		31.3.24

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	• An additional £357k resilience funding has been made available to practices. As a result, practices have submitted request for extra clinics including but not limited to enhancing support for learning disability annual health checks and asthma clinics. • Despite the changes in contractual arrangements in Norwich recently, the ICB continues to work with the new medical service provider to ensure continuity of service provision for patients. A proposal to change the current network arrangements has been received from Norwich practices, the ICB is working closely with PCN leadership to understand the proposal and the risk associated with the changes. • In February 38 practices requested and received Transition Cover Funding totalling £305,089 spread across the practices. Transition Cover Funding is available to support practices in moving into delivering via the Modern General Practice Access Model and N&W ICB are encouraging all practices to access this support. • The other 67 practices have been individually contacted with information on how to access the funding and how much is available to them. Practices must request this funding by the 11th of March to allow for payment before the end of March. • N&W ICB had 8 practices sign up to the final cohort of the GP Intermediate Support Programme run nationally – bringing our total practices who have engaged in the current phase of the GP improvement programme to 23 to date. • LD HC support to practices to improve the uptake and the quality of the annual LD HC continues with specific support with complex cases. • The GP contract letter was published on 28 February which is detailed on the March agenda. The financial settlement will be challenging for practices and we may well see further resilience issues as a result.		
April 2024	• New interface monitoring tool released nationally, with expectation Trusts will review their baseline for submission in late April, and monitor progress six-monthly. • GP contract uplift has caused resilience concern among practices, with national BMA vote overwhelmingly in favour of rejecting the contract. Next steps are awaited but some form of industrial action is expected. In the meantime, the LMC has written to practices advising them to cease provided MGUS monitoring, due to it being uncommissioned. • Joint Forward Plan ambition for primary care updated. Work has commenced on developing our engagement approach to inform how we develop our vision and principles for primary care, and then our long-term strategic framework for general practice to underpin our approach to supporting development in future and to guide investment in primary care. • Locally commissioned services (x3) have been refreshed for 2024/25, however due to delays in confirmation of funding, this has delayed implementation in general practice and potentially affected patient services by leaving a service gap. • One further application for section 96 funding has been received from a practice. • Two branch surgery closure applications are being considered by the Committee.		30.4.24

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May 2024	• All provider trusts completed the new interface monitoring tool and this was submitted to NHS England. National data appears to be in line with our local reporting. • The new ICB interface manager role is currently being advertised internally. This role will provide additional capacity into the system to develop the work programme and coordinate work across the system. • The BMA is going out to ballot for industrial action with a closing date of 29 July. We are modelling the potential impact of this on the system. It is thought interface areas (nationally thought to make up 20% of practice workload) will form part of the action. • 8 vacancies in the primary care commissioning team are currently being internally advertised as part of the ICB's restructure process. This will bring in valuable additional capacity to the team. • The issue of private referrals to Trusts has now been agreed and the Trusts' joint access policy updated. Trusts are working through the implementation of this policy update, noting this has been raised as an issue by the LMC for some years, due to the associated workload for GPs in having to pass on the referrals. • ICE ordering of tests for non-medical staff has been implemented in QEH and has been agreed in principle in JPUH and NNUH, which are now working through an implementation plan. Funding the additional capacity required is a particular issue to work through. The LMC has provided significant support to the task and finish group in this area.		31.8.24

Visual Risk Score Tracker – 2024/25

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	16	16	16									
Change	➔	➔	➔									

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PC16	
Risk Title	Severe Mental Illness (SMI) Annual Physical Health Checks
Risk Description	1. 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. 2. There is also a **performance risk** identified with regards to delivering the national target of the Norfolk and Waveney system delivering 75%of SMI health checks for 2024-25.

Risk Owner	**Responsible Committee**	**Operational Lead**	**Date Risk Identified**	**Target Delivery Date**
Sadie Parker	Primary Care Commissioning Committee	Shepherd Ncube	10/05/2022	31.03.2025

Risk Scores								
Unmitigated			**Mitigated**			**Tolerated**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	3	12	4	3	12	4	2	8

Controls	**Assurances on controls**
• Plan in place to increase uptake of SMI checks across N&W and regularly reviewed by PCCC and MH boards. • A 2-year improvement trajectory has been agreed with NHS England taking into account the revised national target • Quarterly steering group has been established with input from Mental Health and Locality colleagues to review performance, risk and to discuss any challenges or service improvements . • All practices signed up to the SMI LCS with no gaps in provision identified • Regular assurance reports to NHSE/I & PCCC	**Internal:** Primary Care Commissioning Committee, monthly steering group and Mental Health Commissioning Board **External**: NHSE Checkpoint and Assurance Framework, Health Overview and Scrutiny Committee Reports to NHSE/I.

Gaps in controls or assurances

- From April 2024; migration to GPES extract will have an impact on register size and overall performance; Q1 performance reports will give an indication as to what this impact looks like.
- General Practice resiliency specifically gaps in recruitment and staff retention remains an ongoing challenge to SMI performance.
- The national target has been uplifted to 75% and there is limited confidence in meeting this in the current year. A recovery trajectory has been compiled to try and drive uptake of these checks.
-

Updates on actions and progress			
Date	**Action**	**RAG**	**Target completion**
January 2024	• Q3 SMI performance figures are yet to be published by NHS England. There are no changes to report since our update in November. • NHSE have released national guidance around reporting and delivery of SMI Health checks.		March 204

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	• Internal discussions within the ICB to review performance considering the new guidance against national standards are underway. • The SMI working group is working on a proposal to increase uptake of health checks, however this will require additional resource in terms of staffing.		
March 2024	• Q3 SMI performance figures have been published by NHSE. • For a register size of 9,139 patients with SMI, N&W as a combined system carried out 4,988 checks or 54.3% in Quarter 3 of 23/24. This was the highest performance seen in 23-24. • The ICB teams have reviewed the new national changes to reporting via GPES from 24/25. • A trajectory for improvement is also currently being worked on to address these changes. • The risk to performance remains current workload pressures in General practice as well as financial restrictions to recruit additional resources.		April 2024
June 2024	• 2023/4 Q4 SMI performance figures have been published by NHSE. The ICB has achieved its highest achievement (68%) for SMI health checks across all six health checks- against a national target, which will be increased in 2024/25 to 70%. • N&W practices carried out 5,815 out of a possible 9,117 = 63.8% • NSFT carried out 444 out of a possible 3,286 = 13.5% • Combined, 6,259 out of a possible 9,117 = 68.7% • The ICB teams have reviewed the new national changes to reporting via GPES from 2024-25. • The risk to performance remains relatively high due to workload pressures in general practice and workforce challenges. • Month 1 performance figures for 2024/5 are yet to be published. • For 24/25; the SMI stakeholder group will focus on the missing checks required to achieve full compliance. We will also review the upcoming change to register/performance sizes based on GPES extract and share the findings with GP colleagues to ensure everyone understands their impact. • We will also continue to work with Mental Health colleagues to ensure communication and support is provided where required.		August 2024

Visual Risk Score Tracker

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Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	**12**	**12**	**12**									
change	➔	➔	➔									

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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	31.03.2025

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
• Workforce team recruited in ICB structure. • Primary Care Workforce Transformation Team supported by Clinical Fellowships and Secondments • Primary Care Networks (PCNs) supported to develop and implement workforce trajectories in support of the Additional Roles Recruitment Scheme (ARRS). • PCN ARRS Workforce – online portal for 2024/25 for PCNs to update and draw national funding down 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). • Primary Care Health & Wellbeing Fellow recruited. • Wide range of initiatives in place to support GP retention • Advanced Practice Forum established • Workforce and Communication Engagement strategies updated to reflect PCN development updates and post pandemic environment. • Workforce data to measure trajectory levels against actual recruitment. • Succession planning lead recruitment to support practice and PCN with demand vs capacity requirements. • Training Needs Analysis completed for 24/25. • Coastal and Rural project to support geographical areas facing greater challenges in recruitment, e.g. West and East	**Internal:** Reporting to Primary Care Commissioning Committee (PCCC). Reporting to the Norfolk & Waveney People Board. **External**: NHSEI returns monthly as part of the NHSE Primary Care Oversight Board KPI's and quarterly assurance meetings.

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Gaps in controls or assurances

- Recruitment of mental health practitioners, community pharmacists and technicians remain challenging. Similar roles recruited into PCNs from community pharmacy.
- Understanding general practice resilience as work challenges increase may lead to higher numbers of the workforce leaving/retiring during 2024 and 2025.
- 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.
- Data quality discrepancies against ARRS reporting on the national reporting service is reflective across the system which is impacting trajectory targets.
- Pressure of system financial controls is impacting the amount of SDF funding available for investment in workforce recruitment and retention schemes.

Updates on actions and progress

Date	Action	RAG	Target completion
April 2024	Latest NHSE workforce data illustrates the following: • 3.5% growth in Direct Patient Care workforce roles across N&W during the period of February 24 vs February 23 (633 WTE). • 0.5% growth in non-clinical roles (1743 WTE) As of February 2024, the current Additional Roles Reimbursement Scheme (ARRS) levels, Norfolk and Waveney is forecast to utilised 95%. As part on the GP Contract for 24/25 a 2% of budget increase for ARRS is expected. As of February 24 we have a total of 624.5 WTE being claimed through the ARRS portal system by PCN's. However, the National Workforce Reporting tool is showing 521 being reported in February 24. To support the data quality discrepancies, we are working with each PCN to ensure they are reporting their ARRS staff accurately and we are making significant progress. It is also important to note that many PCN's have 3rd party contracting arrangements in place, in which they are not required to report these staff members through the National Workforce Reporting tool. As of 19th April 2024, positions currently advertised for recruitment within general practice show: • 4 x Direct Patient Care roles (Practice employed) • 5 x Non-clinical roles (Practice employed) • 1 x Additonal Roles Reimbursement (Primary Care Networks) A Norfolk and Waveney Primary Care Workforce Business Intelligence Dashboard, which includes ARRS, has been produced. This provides an overview of recruitment intentions, turnover levels, WTE in post by practice and Primary Care Networks. An overview of the results is reported below for 23/24: • Direct Patient Care roles joiner rate 71% • Direct Patient Care roles leaver rate 25.2% • Non-clinical role joiner rate 10.5% • Non-clinical roles leaver rate 31.4% To understand the reason behind the high levers within Primary Care Networks, a dedicated programme will be put in place during 24/25 to understand why in particular Health and Wellbeing, Social Prescribers and General Practice Assistants have a higher % of leavers rates.		June 2024

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	In addition, it's important to note and 31.4% of our non-clinical roles are aged over 55 years.		
May 2024	Latest NHSE workforce data illustrates the following: • 4.9% growth in Direct Patient Care workforce roles across N&W during the period of March 24 vs March 23 (647 WTE). • 1% growth in non-clinical roles (1753 WTE) As of March 2024, the current Additional Roles Reimbursement Scheme (ARRS) levels, Norfolk and Waveney utilised 93% of the ARRS financial sum. As part of the GP Contract for 24/25 a 2% of budget increase for ARRS is expected. As of March 24 we have a total of 654.5 WTE being claimed through the ARRS portal system by PCN's. However, the National Workforce Reporting tool is showing 521 being reported in March 24. To support the data quality discrepancies, we are working with each PCN to ensure they are reporting their ARRS staff accurately and we are making significant progress. It is also important to note that many PCN's have 3rd party contracting arrangements in place, in which they are not required to report these staff members through the National Workforce Reporting tool. As of 21st May 2024, positions currently advertised for recruitment within general practice show: • 21 x Direct Patient Care roles (Practice employed) • 11 x non-clinical roles (Practice employed) • 1 x Additonal Roles Reimbursement (Primary Care Networks) A Norfolk and Waveney Primary Care Workforce Business Intelligence Dashboard, which includes ARRS, has been produced. This provides an overview of recruitment intentions, turnover levels, WTE in post by practice and Primary Care Networks. An overview of the results is reported below: • South Norfolk and Great Yarmouth and Waveney has the highest % of Direct Patient Care and Non-Clinical roles per 1000 patients across Norfolk and Waveney • Norwich has the lowest proportion of Direct Patient Care roles per 1000 patients across the system • West Norfolk has the lowest proportion of non-clinical roles per 1000 patients across the system.		September 2024

Visual Risk Score Tracker

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	12	12	12									
change	➔	➔	➔									

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PC18 (BAF18)

Risk Title	**Resilience of NHS General Dental Services in Norfolk and Waveney**
Risk Description	Primary Care Services became the responsibility of the Integrated Care Board from 1st April 2023, the risk is the unknown resilience, stability and quality of dental services, and critical challenges relating to the recruitment and retention of dentists and dental care professionals and the limitations of the national dental contract, leading to a poor patient experience for our local population with a lack of access to NHS general dental services and Level 2 dental services.

Risk Owner	**Responsible Committee**	**Operational Lead**	**Date Risk Identified**	**Target Delivery Date**
Mark Burgis	Primary Care	Sadie Parker	01/04/2023	31/03/2026

Risk Scores

Unmitigated			**Mitigated**			**Tolerated** (Target in 36 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	**4**	**20**	**5**	**4**	**20**	**4**	**3**	**12**

Controls	**Assurances on controls**
• ICB primary care team recruited and in place working alongside newly recruited Quality Dental Nurse in Quality team and Finance colleagues, and Planned Care Team (for secondary care dental services) • Ring fenced dental budget for investment • Active engagement with dental contractors, LDC and Local Professional Network (and Managed Clinical Networks), regular dental newsletter in place • Dental Development Group established to engage with key stakeholders to agree short term plan by Sept 2023 • Dental Services Delivery Group established reporting to PCCC • Dental Strategy and local workforce plan to be in place by May 2024 • NHS England Long Term Workforce plan published June 2023 • NHS Business Services Authority performance/quality management reporting and quality framework in place with regular meetings established with the ICB. Access to eDen dental data management reports and dashboard for ICB staff. • Clinical expertise provided by NHSE through the LPN, MCN and Senior Clinical Fellow roles during 2024/2025 for strategic development, transformation and commissioning purposes • Dental Data Review being updated to inform commissioning plans • Primary care workforce and training team working closely with delegated commissioning team to ensure workforce retention programmes and training support is linked to the Dental Delivery Plans • Clinical Dental Advisor role to be recruited for ICB in 2024 to replace NHS England roles	**Internal:** EMT, Primary Care Commissioning Committee, Dental Services Delivery Group **External:** NHS England, Norfolk and Waveney LDC, regional Local Professional Network and Managed Clinical Networks, Healthwatch Norfolk/Suffolk, NHS Business Services Authority

Gaps in controls or assurances

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- The level of the unmet need for general dental services and the associated financial consequence of this once addressed (if possible) given the transfer for funds was based on 2022-23 current expenditure which are below budget required to meet population need
- Concern around the financial consequences due to dental contracts currently being returned or removed from providers, resulting in temporary and more expensive contracts with reduced activity and higher UDA (Unit of Dental Activity).
- Lack of access to NHS dentistry services is an area of quality concern. This impacts on some of our most vulnerable patient groups.
- Significant workforce shortfalls across general dental services, Level 2 services and secondary care dental services and a lack of comprehensive workforce data to support planning
- Lack of in depth knowledge about the resilience and stability of all dental services across Norfolk and Waveney: primary, community and secondary care services

Updates on actions and progress			
Date opened	**Action / Update**	**BRAG**	**Target completion**
March 2024	ICB Engagement survey closed 21 February 2024 with over 2000 responses to be analysed for the Long Term Dental Plan to be finalised for approval. NHS England Dental Recovery Plan 2024/2025 published 7 February 2024 ([Faster, simpler and fairer: our plan to recover and reform NHS dentistry - GOV.UK (www.gov.uk)]) and the ICB is working to mobilise the individual elements of the Plan as details are released and adapt ICB plans accordingly: • New patient premium to encourage dentists to see individuals who've not seen a dentist for more than two years, effective from 1 March 2024 • UDA uplift to £28 minimum. This is superceded by the ICB's agreed plan to uplift to £30 minimum UDA rate from 1 April 2024 • Mobilisation of a mobile dental van to improve access and oral health prevention schemes. • Golden Hello to retain dentists working in NHS services for 3 years. This is addition to the ICB initiative. 14 dentists have benefited from the ICB's workforce schemes to date. An early review of the Urgent Treatment Services pilot is underway to see if any learning can be applied to improve services going forward. The total patient appointments offered since November 2023 is 5339, and only 8 Did Not Attends. The average number of appointments offered per month to date is 1779.		30/04/2024
April 2024	Actions to implement the Dental Recovery Plan, the UDA uplift and new patient premium, are complete. Discussions underway with NHS England region, Cambridgeshire & Peterborough and Suffolk & North East Essex ICBs to mobilise a dental van across the 3 ICB areas.		30/6/2024
May 2024	Both the Long Term Dental Plan and the Dental Workforce Plan approved by Committee 7 May 2024 to help improve resilience and stability of NHS dental services and improve access. Risk raised with Dental Services Delivery Group about the risks associated with managing secondary care dental services contracts and lack of resources to monitor and support. The risk has been		30/6/2024

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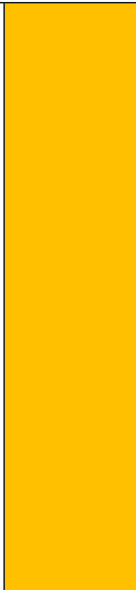
	escalated to Primary Care Commissioning Committee for review in June 2024. ICB Clinical Advisor recruitment underway to support ICB with clinical advice and to work with East of England Regional Chief Dental Officers, Managed Clinical Networks and Clinical Fellows. Review of the Urgent Treatment service pilot is still underway and will report back to Dental Services Delivery Group in July 2024. Feedback from patient survey, providers, UEC, NHS 111 and IC24 will all inform the evaluation. The review is receiving clinical input from the Managed Clinical Network Chairs (General Dental Practice/UEC) Level 2 endodontics and periodontics pilot in East of England ceased 31 March 2024 increasing possibility of secondary care referrals or lack of access to these services for patients. Options are being explored as an interim measure – development of plans is built into the Long Term Dental Plan for 2025/2026. Task and Finish Group to look at mobilising Child Focused Dental Practices established. Work has commenced on Year End reconciliation for 2023/2024.		

Visual Risk Score Tracker – 2023/24

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	16	16	20	20	20	20	20	20	20	20	20	20
Change	→	→	↑	→	→	→	→	→	→	→	→	→

2024/2025

Month	1	2	3									
Score	20	20	20									
Change	→	→	→									

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NEW PC19

Risk Title	**Secondary care dental services (Oral Surgery and Maxillo Facial Services, Orthodontic Services)**
Risk Description	Primary Care Services, and secondary care dental services, became the responsibility of the Integrated Care Board from 1st April 2023, the risk is the unknown resilience, stability and quality of secondary care dental services, and critical challenges relating to the recruitment and retention of professionals and waiting lists, and resources within the ICB Primary care team to implement the recommendations from the East of England NHSE report lack of resources to monitor and manage 3 secondary care contracts

Risk Owner	**Responsible Committee**	**Operational Lead**	**Date Risk Identified**	**Target Delivery Date**
Mark Burgis	Primary Care	Sadie Parker	01/02/2024	31/03/2027

Risk Scores

Unmitigated			**Mitigated**			**Tolerated** (Target in 36 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	**4**	**20**	**4**	**4**	**16**	**3**	**4**	**12**

Controls	**Assurances on controls**
• ICB primary care team recruited and in place working alongside newly recruited Quality Dental Nurse in Quality team and Finance colleagues to manage primary and community care contracts • Ring fenced dental budget for investment • Active engagement with dental contractors, secondary care, LDC and Local Professional Network (and Managed Clinical Networks), regular dental newsletter in place • Dental Development Group established to engage with key stakeholders to input to commissioning plans • Dental Services Delivery Group established reporting to PCCC • Dental Long Term Plan and local primary care Workforce Plan agreed 7 May 2024 sets out ambitions for primary care, Level 2 and secondary care service collaboration • NHS England Long Term Workforce plan published June 2023 • Clinical expertise provided by NHSE through the Regional Chief Dental Officers and Managed Clinical Networks extended for 2024/2025 • NHSE Recommendations for secondary care services in East of England 2024 published • Suffolk and North East Essex ICB (SNEE) lead in region for East of England secondary care work programme under MOU with ICBs. • Monthly OMFS meetings in place all ICBs in region	**Internal:** EMT, Primary Care Commissioning Committee, Dental Services Delivery Group **External:** NHS England, Norfolk and Waveney LDC, regional Local Professional Network and Managed Clinical Networks, Healthwatch Norfolk/Suffolk, NHS Business Services Authority

Gaps in controls or assurances

- The level of the unmet need for general dental services and consequent impact on secondary care service referrals and waiting lists for oral surgery and orthodontic services is unknown
- The financial consequence given the transfer for funds was based on 2022-23 current expenditure which are below budget required to meet population need
- Lack of access to NHS dentistry services is an area of quality concern resulting in higher numbers of referrals into secondary dental care, urgent and emergency and planned care with waiting lists.

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- Significant workforce shortfalls across general dental services, Level 2 services and secondary care dental services and a lack of comprehensive workforce data to support planning, training and education of whole dental workforce
- Lack of knowledge about the resilience and stability of existing secondary care dental services
- Lack of ICB resources to manage and monitor secondary care contracts and the impact for primary and community care referral pathways
- Lack of understanding and management of waiting lists in secondary care by commissioners
- Unable to implement the NHSE East of England recommendations for collaborative working between secondary care providers to support patient care and management of waiting lists across Trusts
- Lack of support for workforce plans and succession planning, understanding of impact for primary and community dental services
- Lack of ICB resources to implement the East of England recommendations for secondary care dental services
- Lower priority in operating theatres for GA extractions led by Community Dental Services
- Inappropriate referrals for cancer treatment in secondary dental care
- Primary care/secondary care interface could be improved

Updates on actions and progress

Date opened	Action / Update	BRAG	Target completion
May 2024	• Suffolk and North East Essex ICB (SNEE) lead for East of England (EoE) ICBs in relation to secondary care matters that rely on collaboration and wider impact across EoE and for escalation., MOU agreed by Primary Care Directors. • Proposals to prepare an ICB business case to establish a provider collaborative discussed but no resources to take forward in ICB. • To draw up an Equality Impact Assessment and Clinical Quality Risk Assessment with support from Quality team • Medical Needs pathway under development by ICB		30/9/2024

Visual Risk Score Tracker – 2024/25

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score			16									
Change												

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NHS
Norfolk and Waveney
Integrated Care Board

Agenda item: 07

Subject:	Community Health and Wellbeing Workers – ARRS Funding
Presented by:	Dr Olga Tsirogianni, Head of Integrations and Partnerships
Prepared by:	Jenni Lotarius, Primary Care Development Manager
Submitted to:	Primary Care Commissioning Committee
Date:	11 June 2024

Introduction

The 2024/25 GP Contract gives PCNs more staffing flexibility by allowing the recruitment of other direct patient care, non-nurse and non-doctor MDT roles, if agreed with the ICB.

This paper seeks approval for the principle of allowing PCNs to recruit the role of Community Health and Wellbeing Workers (CHWWs) as part of the Additional Roles Reimbursement Scheme (ARRS).

Background

The Community Health and Wellbeing Worker (CHWW) concept originated in the favelas of Brazil.

Their success of improving health outcomes and addressing the wider determinants to reduce hospitalisation has resulted in the trialling of the model of care in England as well as elsewhere in the world.

CHWWs in Norfolk and Waveney were piloted in Watton as part of the Breckland PCN. These roles were introduced in January 2023 targeting an area where 55.8% of residents are deprived in at least one or more dimension. The CHWWS are employed by Breckland Council but are fully integrated as part of a multi-disciplinary team clinically supervised by one of the GP Partners. The CHWWs have been proactively knocking on resident households at least once a month offering holistic support to anyone in the household.

The service implemented in Watton references a trial referenced in the Fuller Stock Take in Westminster dated 2021 to now. The key themes that emerged from the Westminster implementation were:

- Identification of unmet need
- Reduction in General Practice inappropriate workload and DNAs
- Supporting the residents with the wider determinants of health
- Improved trust and connectiveness between the residents and public services
- Real time support

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- Deeper understanding of the community

Comparing statistics from the two areas, Watton CHWW's working as a pair took 2.2 occasions to engage with a household member whereas the Westminster team required 3.6 occasions. Engagement with households in Watton has been effective and as of 31/7/23 91 (52%) households have asked for support compared to 40% in Westminster over 12 months.

Interventions with residents have included, but not limited, support to book the right type of appointment and learn how to use Footfall, provision of information re issues like immunisation/NHS health checks, blood pressure monitoring, informing and offering to book an appointment for any screening/prevention appointment (NHS health checks, breast screening, smear test, vaccination for adults and children), welfare calls. From a social perspective the CHWWs have been able to support this group with food vouchers, referrals to the Department of Working Pensions (DWP), Household Support Fund, Housing referrals and Adult Social Care referrals.

In Year 2 of the project the practice has started experimenting with a number of different use cases such as increasing the vaccination rate across the practice and supporting the High Intensity Users of the practice. The practice considers them now an indispensable resource and they have helped the practice to increase engagement with a difficult to reach group of patients while improving their health outcomes and reducing unnecessary activity.

Reducing health inequalities is a key theme in the NHS long-term plan where there is a 19-year gap in healthy life expectancy across England. "Prior to Covid – 19 health inequalities were estimated to cost the NHS an extra 4.8 billion a year" (All our health, 2022). Health inequalities are thought to be complex but are associated with a variety of health-related behaviour's such as smoking, diet, access to services, social deprivation, access to work, education levels, social networks and control that people feel they have over their own lives. Core20plus5 is a national NHS England approach to reduce health inequalities at both national and system level. CHWW roles are designed and are proven to help support deprived and/or difficult to engage communities to drive down these inequalities while reducing demand for General Practice.

CHWWs have a similar impact on communities compared with Social Prescribing Link Workers, Care Coordinators and Health and Wellbeing Coaches that are funded by the ARRS scheme. These roles focus on improving health outcomes for those with multi-morbidity, particularly those in social deprivation or where English is not their first language.

The table below shows the key differences between CHWWs and Social Prescribers (SP) roles:

CHWW's	**Social Prescribing**
Areas of universal offer – face to face, knocking on doors proactively. No stigma.	Referral Based.
Project evolves in line with the need of the Practice and area.	Based within NHS Framework.
Supports residents with any need ranging from health, social, environmental and particularly based on the need of the individual and household.	Based on non-clinical need.
Practice can give the team jobs, targets, small projects or allocated tasks as part of safeguarding or other concerns for the patients.	SP is often a standalone service, commissioned and agreed with a service agreement.

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CHWWs get involved in safeguarding and have been able to put in interventions that have improved situations.	Do not get involved in safeguarding.
Work across the Primary Care Network, with individual practices on improving patients health outcomes.	Works within an allocated PCN.

CHWWs have shown to help primary care resilience and develop closer links with the local population as well as the broader Health and Social Care system and a diverse range of partners in their communities including the voluntary sector and patient groups to benefit patients.

CHWWs would align to direct patient care roles that are non-medical. Although there is no set job description for these workers, they would work across Primary Care Networks fulfilling health inequalities and supporting the PCNs. Under the Network Contract DES these roles would help to improve patient care, meet the needs of patients, collaborate with non-GP providers and provide non-clinical guidance and support.

Additonal Roles Reimbursement Scheme (ARRS) request

These CHWW roles are to be funded through the ARRS scheme under a third-party organisation agreement.

Where the Additional Role is provided by a third-party organisation under a contract of service:

a) the PCN must ensure that the specification of the service incorporates the requirements set out in Annex B within the Network Contract DES specification;

b) any obligation in section 4.7.1 and Annex B of the PCN should be read as an obligation that the PCN must procure that the third-party organisation carries out that obligation.

Employers recruiting staff under the ARRS scheme will determine the terms and conditions such as salary and consideration of Agenda for Change if offered by the PCN. A fair approach must be given to remuneration so that is relative to existing staff working within or across the PCN.

As there are no minimum job requirements set for non-clinical roles set out within the Network Contract DES specification (Annex B), the commissioner must have assurances that these roles will:

a) Co-ordinate, organise and deploy shared resources to support and improve resilience and care delivery at both PCN and practice level.

b) Improve health outcomes for its patients through effective population health management and reducing health inequalities.

c) Target resource and efforts in the most effective way to meet patient need, which includes delivering proactive care.

d) Collaborate with non-GP providers to provide better care, as part of an integrated neighbourhood team (INT).

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The commissioner also must agree the band maxima for the non-clinical role, we are suggesting it should align to Agenda for Change band 3 salary with a maximum reimbursement of £29,649 per role.

Risks and impact

As outlined above CHWWs would support the most deprived areas of communities in a proactive way to reduce health inequalities. A study in the UK that mirrored the impact of a study in Brazil demonstrates positive uptakes of national screening programmes, increased immunisations and NHS Health Checks. Data in the article published by BMC Health Services Research, 2023 states that "Likelihood of immunisation uptake specifically was 47% higher and cancer screening and NHS Health checks was 82% higher. The average number of GP consultations per household decreased by 7.4%".

The CHWW role would be funded by individual PCN ARRS budgets and therefore would be dependent on funds already committed. It is also worth noting that ARRS funding is paid to PCNs in arrears.

Recommendation

PCCC members are invited to approve the following:

- Agree that the Community Health and Wellbeing Workers can be claimed under the ARRS, subject to:
    - Network Contract DES minimum requirements have been satisfied.
    - Third party agreements are in place and can be evidenced.
    - Primary Care Networks are not exceeding their maximum reimbursement sum allocation budget.
- Agree the band maxima for Community Health and Wellbeing Workers is set at £29,649 (Band 3, AfC).

Key Risks	
Clinical and Quality:	CHWWs can support improvements in clinical care and quality through their role, and by freeing up clinical time.
Finance and Performance:	The role would be funded through the ARRS allocation to a PCN, there is no financial pressure for the ICB.
Impact Assessment (environmental and equalities):	These workers specifically target health inequalities.
Reputation:	None identified
Legal:	None identified
Information Governance:	Agreements are in place.
Resource Required:	None identified.
Reference document(s):	PCN ARRS
NHS Constitution:	None identified

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Conflicts of Interest:	Arrangements are in place to manage conflicts of interest.
Reference to relevant risk on the Board Assurance Framework	The resilience of general practice.

Governance

Process/Committee approval with date(s) (as appropriate)	PCCC Committee for approval

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Agenda item: 08

Subject:	Delegated Primary Care Commissioning - CQC Ratings Position Report
Presented by:	Shepherd Ncube – Associate Director Primary Care Commissioning
Prepared by:	Carl Gosling – Senior Lead Commissioning Manager, Primary Care William Lee – Senior Primary Care Commissioning Manager, Dental
Submitted to:	Norfolk and Waveney ICB Primary Care Commissioning Committee
Date:	11 June 2024

Purpose of paper:

To update the Committee on the Care Quality Commission (CQC) inspection activities for primary care medical and dental services within the Norfolk and Waveney Integrated Care Board (ICB).

Executive summary:

The objective of the report is to provide an overview of the current position in relation to CQC inspections conducted in the past ten years.

Where relevant, information in this report is broken down by locality (and PCN) along with themes from CQC inspections.

The Primary Care Commissioning Team is responsible for the contract management of regulated activity. The Team works closely with the ICS Locality Teams, Quality Team and Medicines Management Team, alongside Practices in preparation for CQC inspections and to support with action plans if required.

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General Practice

The table below shows a comparison of CQC ratings for practices in each locality, how each of them has been rated, and how many Practices are within each locality.

N&W ICB CQC Ratings split by ICB Primary Care Localities				
ICB Locality	Inadequate	Requires Improvement	Good	Outstanding
North Norfolk	0	0	17	2
South Norfolk	0	2	20	2
West Norfolk	0	1	20	0
GY&W	0	2	15	2
Norwich	0	4	18	0
Total	0	9	90	6

Common themes as to why GP Practices have been rated as Requires Improvement following a CQC inspection include:

- The practice did not always ensure the safe management and safe prescribing of medicines.
- Clinical concerns about management of long-term conditions including misdiagnosis of diabetes. There was a high number of patients with a potential missed diagnosis of diabetes as the clinical coding system was not effective.
- Performance data was below local and national averages for a range of indicators and National targets.
- Systems and processes for managing risks, issues and performance required further improvement.
- A lack of clinical oversight and ineffective safety netting across systems and processes to support safe care.
- Challenges in recruitment and retaining staff. High use of external staff.
- Meds Management: Prescribing for hypnotic and psychotropic medicines was high.
- The practice systems and processes for the appropriate and safe use of medicines, including medicines optimisation review, embedding, and sustaining.
- Lack of effective governance systems in place as some systems and processes failed to ensure risks were fully reviewed, documented, and monitored to drive safe and effective services.
- Prescribing for hypnotic medications was above local and national averages.
- National patient survey data remained below local and national averages.
- New systems put in place to address concerns around the Well-led domain need time to be established and embedded.
- Lack of effective process and systems to provide safe care for patients and staff.

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- Concerns about management of long-term conditions, care and treatment of patients being delivered in line with current legislation, standards, and evidence-based guidance.
- New ways of working which had been newly implemented, needed to be further embedded to ensure they were safe, effective, and sustained.
- Services did not always meet the patients' needs with challenges with access and staffing.
- Backlog of reviewing, filing, and coding information from patient correspondence.
- Clinical documentation was not always clear to help with follow up care.
- Significant concerns about leadership
- Practice has been rated as requires improvement from various inspections in the past 10 years.

In terms of inspection dates, the table below illustrates this from 2015-2024.

N&W ICB CQC Inspection Date (by year)										
ICB Locality	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
North		4	5	6	1	0	0	2	0	1
South		2	3	5	2	1	1	1	4	5
West		2	6	5	0	4	1	1	0	2
GYW		3	0	3	3	3	3	4	0	0
Norwich	1	4	2	4	3	1	1	1	5	0
Total	1	15	16	23	9	9	6	9	9	8

N&W System Observations:

In reviewing the above across the localities taking into account all 4 CQC domains, the following has been recognized:

- Out of 105 Practices within the system, 90 have achieved a rating of Good; a system performance position of 85.7% which is positive.
- 6 practices have achieved a ranking of Outstanding, 9 Requiring Improvement and 0 being rated Inadequate.
- Due to COVID- the frequency of CQC inspections declined, compared to 2018 and 2017, where the system experienced circa 20 inspections per year.
- So far there have been 8 inspections in 2024 and we expect the number of inspections to increase.

The following table demonstrated the PCN overview:

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N&W ICB CQC Rating Split by ICB Primary Care PCNs				
North Norfolk	NN1	NN2	NN3	NN4
	3 Good	5 Good	4 Good	1 Outstanding 5 Good
South Norfolk	Breckland	Ketts Oak	Mid Norfolk	SNHiP
	4 Good	4 Good 1 RI	6 Good	2 Outstanding 6 Good 1 RI
West Norfolk	Coastal	Fens & Brecks	Kings Lynn	Swaffham & Downham Market
	1 Outstanding 3 Good 1 RI	6 Good	4 Good	7 Good
GY&W	Gorleston	GY & Northern Villages	Lowestoft	SWAN
	2 Good	1 Outstanding 4 Good	5 Good 2 RI	1 Outstanding 4 Good
Norwich	Central	East	West	North
	5 Good	7 Good 1 RI	3 Good 3 RI	3 Good

Locality & PCN Observations:

With reference to the Improvement and Support Register for clarity:

- Inadequate: No Practices have been rated this classification
- Requires Improvement: High Street Surgery, Alexandra & Crestview MP, Thorpewood Medical Group, Taverham Surgery, Bacon Road Medical Centre, Wensum Valley Medical Practice, Heacham Group Practice, Chet Valley Medical Practice and Humbleyard Surgery.
- Outstanding: The Park Surgery, Sole Bay Medical Practice, Ludham & Stalham Surgery, Wells Medical Practice, Harleston Medical Practice and Heathgate Medical Practice, The Humbleyard Surgery.
- All GP Practices rated as Requires Improvement have an CQC action plan in place to address the concerns raised by the CQC in the arears identified as needing attention which are reviewed on a Monthly basis in order to provide assurance to the ICB and CQC that improvements are being made.
- 42 practices have been inspected over the last 5 years (since 2019).
- 8 practices have been inspected so far in 2024.

Dental

In the UK, all dental practices are inspected by the Care Quality Commission (CQC) to ensure they meet national standards of quality and safety. The CQC assesses dental practices based on several key criteria. Here's an overview of the inspection process which is similar to that for general practice and other healthcare services.

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Registration:

All dental practices must register with the CQC to provide either or both private and NHS dental services. Registration involves meeting certain legal requirements and standards set out in the Health and Social Care Act 2008.

Inspection Framework:

Inspections are carried out under the CQC's inspection framework, which focuses on five key questions about the services provided:

- Are they safe? Ensuring patients are protected from abuse and avoidable harm.
- Are they effective? Assessing if care, treatment, and support achieve good outcomes and promote a good quality of life.
- Are they caring? Evaluating if staff involve and treat people with compassion, kindness, dignity, and respect.
- Are they responsive to people's needs? Ensuring services are organized to meet patients' needs.
- Are they well-led? Assessing if the leadership, management, and governance ensure high-quality care that is based on individual needs, encourages learning and innovation, and promotes an open and fair culture.

Inspection Process:

1. Preparation: Before the inspection, the CQC gathers information about the dental practice from various sources, including previous inspection reports, information from patients, and notifications from the practice.

2. Site Visit: Inspections typically include an on-site visit, where inspectors observe care, talk to staff and patients, review records, and check facilities.

3. Interview and Observation: Inspectors may interview the dental practice staff and observe interactions with patients to assess the quality of care and compliance with standards.

Rating and Reporting:

Dental services are reviewed against 4 quality metrics (safe, effective, well-led & caring). If a provider does not meet the required standards, a regulation notice is served, and the CQC reports the findings as not meeting requirements. For dental services, no overall final score is given. The findings are published in a report, which includes details of what the practice is doing well and areas where it needs to improve. This report is made publicly available on the CQC's website.

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Follow-Up and Enforcement:

If a dental practice does not meet the required standards, the CQC can take enforcement action. This can range from requiring the practice to make improvements within a certain timeframe to suspending or cancelling the practice's registration if there are serious concerns.

Ongoing Monitoring:

The CQC continuously monitors practices through various means, including feedback from patients, information from other regulatory bodies, and periodic reviews. Practices may also be required to submit regular updates on their performance and any improvements made.

Collaboration with Norfolk and Waveney ICB

The ICB works closely with the CQC to enhance the quality of dental practices in their region. This collaboration involves several key activities aimed at continuous improvement and maintaining high standards between CQC inspections.

Regular Quality Meetings:

The quality team from the Norfolk and Waveney ICB meets regularly with CQC inspectors to share concerns and focus on quality improvement. These meetings facilitate the exchange of information and ensure that both the ICB and the CQC are aligned in their efforts to support dental practices.

Pre-Inspection Support and Toolkit:

The ICB has recently launched a toolkit designed to assist dental practices in preparing for CQC inspections. This proactive approach includes risk assessments and support to address any areas of concern identified from previous inspections or whistleblowing reports. Each visit is followed up with a report and action plan as agreed and discussed with the providers.

Risk Assessment and Monitoring:

The ICB conducts thorough risk assessments for every practice based on CQC reports, ICAT (Integrated Care Analysis Tool) reports, Healthwatch feedback, IC24/111 (NHS 111 service) data, and patient complaints. They monitor trends from former CQC reports and use data from the BSA (Business Services Authority) and Compass to gain a comprehensive understanding of each practice's performance.

Current Performance

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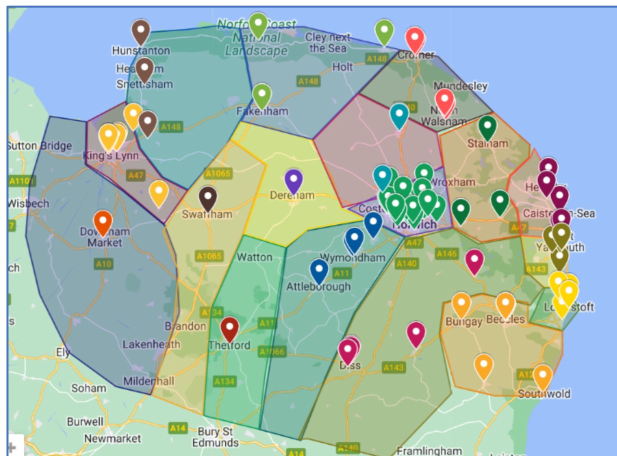
In a recent meeting with the CQC, it was highlighted that specific performance numbers for the inspection of dental practices in the Norfolk and Waveney area were available.

However, the CQC operates under a model where approximately 10% of dental practices are inspected annually. Each CQC inspector covers a large geographic area, and inspections are generally planned according to this 10% model. Nevertheless, if any concerns are raised, whether through complaints, whistleblowing, or other sources, this would prompt an inspection outside of the regular schedule, ensuring that potential issues are addressed promptly.



NHS Dental Practices within Norfolk & Waveney and Breakdown

West Norfolk	13
South Norfolk	8
Suffolk	11
East Norfolk	13
Norwich/North Norfolk	48

<u>Continuous Quality Improvement:</u>

In between CQC inspections, the ICB plays a critical role in maintaining and improving quality standards. They provide ongoing support to practices, helping them address issues before they escalate and ensuring they are always prepared for the next CQC inspection.

Through these efforts, the Norfolk and Waveney ICB and the CQC work together to ensure dental practices deliver safe, effective, and high-quality care to patients. This collaborative approach helps identify potential issues early, supports continuous improvement, and ultimately enhances patient safety and satisfaction.

Recommendation to the Committee:

Committee members are requested to review the report and share their observations and feedback.

Key Risks	
Clinical and Quality:	The Group will be monitoring quality improvement, raise concerns with CQC and incorporate into our existing monitoring framework.
Finance and Performance:	N/A
Reputation:	Healthwatch Norfolk and Healthwatch Suffolk, Local Professional Network and the Local Dental Committee are all represented on the Group
Legal:	Terms of Reference Policy Guidance Manual

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	Dental Policy Handbook
Information Governance:	N/A
Resource Required:	Primary Care Commissioning Team Primary Care Quality Team
Reference document(s):	Primary Medical Services Regulations general dental services contracts, regulations and Dental Policy Handbook
NHS Constitution:	N/A
Conflicts of Interest:	None noted
Reference to relevant risk on the Board Assurance Framework	BAF PC18 – Dental Resilience

Governance

Process/Committee approval with date(s) (as appropriate)	PCCCommittee for information.

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NHS
Norfolk and Waveney
Integrated Care Board

Agenda item: 09

Subject:	Delivery Report
Presented by:	Leiat Becker, Senior Primary Care Delivery Manager
Prepared by:	Sadie Parker, Director of Primary Care Leiat Becker, Senior Primary Care Delivery Manager
Submitted to:	Primary Care Commissioning Committee
Date:	11 June 2024

Summary of Paper

This year's Operational Planning Guidance contained several areas for primary care, across three of the four contractor groups. The ICB has been working with NHS England to finalise metrics for each of these requirements, and the specific metrics can be seen in Appendix 1 covering the following areas:

- Pharmacy First consultations – please note these metrics are yet to be developed due to the delay in receiving any data on uptake from NHSE.
- Appointments in general practice – this is a count of the total numbers of appointments. We have grown last year's figures by our expected population growth and adapted them to the number of working days in the month. We have also taken into account the anticipated impact of Pharmacy First.
- Appointments seen in two weeks – the national target for this is 80%. Given the ongoing pressures on general practice, we have mirrored our outturn for last year while we understand the constraints on practices, monitor the impact of potential industrial action and continue to improve the coding of appointments.
- Number of unique patients (adults and children measured separately) seen by NHS dentistry – this is a key area for development for the ICB as we seek to improve access.
- Units of dental activity (UDAs) delivered – there is an expectation for systems to return to pre-pandemic levels of activity. With the introduction of more flexible commissioning approaches (ie sessional payments), it may be challenging to deliver UDAs, and a focus on new patients may support with this.

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- Severe mental illness – our SMI health checks LCS maintains the focus on this area. The new target is 75%, which we believe will be challenging in the current climate and as such have opted for more conservative uptake which builds on previous levels of achievement.

- Learning disability health checks – we continue to prioritise this area as an ICB, and practices undertook the most health checks they have ever done in 2023/24. The target remains 75%.

We would like to propose a quarterly report to Committee updating on progress against these metrics, supported by the highlight reports on the wider programmes of work in the primary care team. These can also be seen in draft work in progress form in the appendices.

Recommendation

- Note the metrics in the appendix.
- Note the intention to bring a quarterly report to committee updating on progress, accompanied by the highlight reports appended to this report.

Key Risks	
Clinical and Quality:	Good oversight of data in the national priority areas will support the ICB in focusing its efforts to support providers which are struggling.
Finance and Performance:	Regular delivery reporting is in line with the internal audit requirements and will form part of the committee report to Board.
Impact Assessment (environmental and equalities):	Good oversight of data will support the ICB in developing plans to support the reduction in health inequalities.
Reputation:	Operational planning guidance requirements
Legal:	None identified
Information Governance:	None identified
Resource Required:	Primary Care team
Reference document(s):	Operational Planning Guidance
NHS Constitution:	N/A
Conflicts of Interest:	None identified

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Reference to relevant risk on the Board Assurance Framework	The resilience of primary care

Governance

Process/Committee approval with date(s) (as appropriate)	N/A

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Pharmacy First Consultations				Feb-24
NHS NORFOLK AND WAVENEY INTEGRATED CARE BOARD	E.D.19	Count	Appointments in General Practice and Primary Care Networks	1,584
	E.D.19	Hypertension	Number of patien	1897
	E.D.19		Number of Clinic Blood Pressure checks	1849
	E.D.19		Number of Ambulatory Blood Pressure Monitoring (ABPM)	57
	E.D.19	Oral contraception		6

Appointments in General Practice				Feb-24	Plan Basis	Apr 2024-Mar 2025	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
NHS NORFOLK AND WAVENEY INTEGRATED CARE BOARD	E.D.19	Count	Appointments in General Practice and Primary Care Networks	621,579	in period activ	7E+06	579,887	589,703	534,247	604,095	543,728	605,004	732,917	601,428	541,919	624,657	550,941	589,242

Appointments seen within two weeks				Jan-24	Plan Basis	Apr 2024-Mar 2025	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
NHS NORFOLK AND WAVENEY INTEGRATED CARE BOARD	E.D.21	Numerator	Appointments seen within two weeks	625,886	in period activ	3E+06	283,674	287,873	260,264	297,506	262,533	269,227	304,651	274,034	259,078	316,072	286,156	355,467
	E.D.21	Denominator	Total number of appointments	772,086	in period activ	4E+06	364,620	364,627	327,993	368,471	324,910	336,572	384,893	344,485	318,745	389,903	348,678	448,379
	E.D.21	Percentage	Percentage of appointments seen within two weeks	81.06	in period activ	79.97	77.8	78.95	79.35	80.74	80.8	79.99	79.15	79.55	81.28	81.06	82.07	79.28

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Units of dental activity delivered				Quarter 3 2023/24	Plan Basis	Apr 2024-Mar 2025	Quarter 1 2024/25	Quarter 2 2024/25	Quarter 3 2024/25	Quarter 4 2024/25
NHS NORFOLK AND WAVENEY INTEGRATED CARE BOARD	E.D.24	Numerator	Units of dental activity delivered	234,609	in period activity	938,436	234,609	234,609	234,609	234,609
	E.D.24	Denominator	Units of dental activity contracted	370,868	in period activity	1,471,698	366,470	378,104	366,470	360,653
	E.D.24	Percentage	Units of dental activity delivered	63	in period activity	63.77	64.02	62.05	64.02	65.05

Severe mental Illness				Sep-23	Plan Basis	Apr 2024-Mar 2025 Average	Quarter 1 2024/25	Quarter 2 2024/25	Quarter 3 2024/25	Quarter 4 2024/25
NHS NORFOLK AND WAVENEY INTEGRATED CARE BOARD	E.H.13	Numerator	People with severe mental illness receiving a full annual physical health check and follow up interventions	3,901	12-month rolling	4591.75	4,453	4,546	4,638	4,730
	E.H.13	Denominator	Number of people on the General Practice SMI registers'	7,837	12-month rolling	7884	7884	7884	7884	7884
	E.H.13	Percentage	Percentage of people with severe mental illness receiving a full annual physical health check	49.78	12-month rolling	58.24	56.48	57.66	58.83	59.99

Learning disability registers and annual health checks delivered by GPs				Quarter 2 2023/24	Plan Basis	Apr 2024-Mar 2025	Quarter 1 2024/25	Quarter 2 2024/25
NHS NORFOLK AND WAVENEY INTEGRATED CARE BOARD	E.K.3	Numerator	Number of AHCs carried out for persons aged 14 years or over on the QOF Learning Disability Register in the period	1,758	in period ac	5,454	1,091	1,091
	E.K.3	Denominator	Population on the GPs Learning Disability Register	7,271	in period ac	7,271	7,271	7,271
	E.K.3	Percentage	%	**24%**	in period ac	75.01	15	15

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Number of unique patients seen by an NHS dentist - adult				Quarter 4 2023/24	Plan Basis	Apr 2024-Mar 2025 **Average**	Quarter 1 2024/25	Quarter 2 2024/25	Quarter 3 2024/25	Quarter 4 2024/25
NHS NORFOLK AND WAVENEY INTEGRATED CARE BOARD	E.D.22	Numerato	Number of unique patients seen by an NHS dentist - adult	307,131	24 month rolling	309831	307,131	308,667	310,211	313,314
	E.D.22	Denomin	Resident population registered with any GP	913,560	24 month rolling	913560	913,560	913,560	913,560	913,560
	E.D.22	Percentage	Percentage of resident population seen by an NHS dentist - adult	33.62	24 month rolling	33.91	33.62	33.79	33.96	34.3

Number of unique patients seen by an NHS dentist - child				Quarter 4 2023/24	Plan Basis	Apr 2024-Mar 2025 **Average**	Quarter 1 2024/25	Quarter 2 2024/25	Quarter 3 2024/25	Quarter 4 2024/25
NHS NORFOLK AND WAVENEY INTEGRATED CARE BOARD	E.D.23	Numerato	Number of unique patients seen by an NHS dentist - child	91,928	12 month rolling	93435	91,928	92,388	93,774	95,650
	E.D.23	Denomin	Resident population registered with any GP	188,185	12 month rolling	188185	188,185	188,185	188,185	188,185
	E.D.23	Percentage	Percentage of resident population seen by an NHS dentist - child	48.85	12 month rolling	49.65	48.85	49.09	49.83	50.83

Webb,Sarah
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Summary of Primary Care Access Improvement Plan
Lead : Jayde Robinson

Overall programme RAG Rating

Correct as of 04/06/2024 | Approved

Workforce

GP Retention
32 ST3 Incentives , 17 GP partnerships, 19 NTP GP Fellowships

Pharmacy Retention
PTPT, DPP Incentive, Pharmacy Integration Leads

Dental Retention
Foundation Practice Incentive, Foundation Supervisor Incentive, Tier 2 Visa Sponsorship, Foundation Student Retention Incentive, Golden Hello Incentive

Previous activity for last quarter:

Workforce more generally - impact of SDF on what we can deliver based on set KPI's set within the Training Hub Contract, lack of workforce funding for the newly delegated contractor groups and PCN Additional Roles, lack of dental school in EoE and limited funding for Clinical Professional Development for specific roles.

Planned activity for the next quarter:

- Optometry Workforce Retention Programmes
- Volunteer to Career
- Generalist Enhanced School
- Coastal and Rural Communities
- Business Intelligence workforce profiling for Dental and Optometry
- Artificial intelligence software mapping for vacancies

Milestone:	Delivery Date:	RAG:

Risks/Issues

- Workforce team continue to bid for funding and pilots to support other contractor groups. Dental underspend identified for non-recurrent workforce initiatives. Workforce team in place, albeit fixed term posts. Coastal and rural programme pilot.
- Aging Workforce demographics – significant impact for general practice GP's, Nursing and Non-Clinical Roles, pharmacy technicians within community pharmacy.
- No dedicated funding stream for workforce retention and clinical professional education for Optometry, Community Pharmacy or Dental.
- No contractual requirements within existing ICS Training Hub Contract to the deliver the wider POD workforce, training, and education requirements.
- Negligible ARRS funding uplift will not help increase workforce growth across the system in line with the Long-Term Workforce Plan. Reduction in university placements across the EoE for nursing professionals.
- No EoE Dental School

Webb Sarah
05/06/2024 10:26:46

Summary of Primary Care Access Improvement Plan

Lead : Fiona Theadom

Overall programme RAG Rating

Correct as of 04/06/2024 | Approved

Dental

Delivery the ICB Primary Care Workforce plan 2024/2025

Build resilience and stability in N&W across all NHS dental services

Utilise flexible commissioning to increase access for new patients through additional sessions (focus on health inequalities and children and young people)

Increase number of urgent treatment appointments (currently 1800 per month)

Mobilise a dental van for vulnerable patients in rural and coastal areas through sessional payments (national Dental Recovery Plan)

Provide access for patients with medical needs via sessional payments to local dental providers

Deliver all elements of the national Dental Access Recovery Plan for 2024/2025 including workforce incentive schemes

Previous activity for last quarter:

- Year-End and Force Majeure Guidance: Finalised the YE and FM guidance (approved in April and May 2024) outlining our local approach to managing dental contracts at year-end. This includes handling exceptional circumstances and breach notices and aligns with the Financial Year End Policy on Repayment Plans (approved March 12, 2024).
- Urgent Treatment- mobilised UT pilot in October 2023, with 23 providers across N&W. The averages since the pilot was launched are below.
  - 1779 Appointments Offered per month.
  - 61 Patients Accepted for further stabilization per month.
  - 3 DNAs per month, an average of 0.20%.
- UDA uplift implemented 1/4/2024
- Task & Finish Group established for mobilisation of Child Focused Dental Practices

Planned activity for the next quarter:

- Invite offers from local providers for expansion of capacity to improve access
- Complete review of Urgent Treatment Service, present report to DSDG
- Agree Out of Hours commissioning plans (contract expiry 31/12/24)
- Secure contract for mobilisation of dental van (national Dental Recovery Plan)
- Commission medical needs pathway by end Sept 2024
- With our long-term plan and workforce plan both finalised on May 7th, now focusing on planning and implementing our priorities. Agree how to translate these plans into actionable projects that will drive our commissioning intentions and long-term plan towards achieving our goals.
- Complete Year End process for 2023/2024
- Workforce plans begin to be implemented

Milestone:	Delivery Date:	RAG:
Year end	Sept 2024	
UTS review	August 2024	
OOH	Sept 2024	

Risks/Issues

- Continued shift from NHS to private work and the resultant contract hand backs, financial uplift 24/25 not known, poor CQC results, UDA contract is not liked by dentist may limit our ability to commission additional capacity with them, flexible commissioning may impact our UDA activity target.
- Time for dental workforce plan to take effect
- Financial investment constraints (ICB and NHSE Triple Lock)

Webb Sarah 05/06/2024 10:26:46

Summary of Primary Care Access Improvement Plan
Lead : Shepherd Ncube

Overall programme RAG Rating

Correct as of 04/06/2024 | Approved

GP

Deliver on the system level plan to support primary care networks and practices with maintaining and improving current levels of access to general practice. Continue to work collaboratively with PCNs and practices on their access improvement plans

Enabling practices and networks to move towards modern general practice, this will include promoting the use of digital tools and bolstering our focus on enhancing the patient experience.

In 2022/23, the level of access to primary care was significantly high, with vast majority of appointments held face to face and within two weeks, ensuring high patient care. However, looking ahead to 2024/25, our focus will shift towards enhancing data quality and utilising insights to strengthen our grip on delivery.

Previous activity for last quarter:

- Finalising LCS for 24/25.
- CQC support meeting for practices on the improvement register.
- LD health checks finalising end of year data which looks like our highest to date
- Submitted a LD health check plan to NHSE for 24/25

Planned activity for the next quarter:

- Review and action gaps in LCS sign ups.
- One practice procurement is delayed due to Pre-Election Period until 5th July.
- Initial planning for the next practice procurements
- Completing POCT pilot project
- Identify GP practices for GPIP and supporting sign up.
- Building an informed view of GP appointment activity for 23/24 using current data

Milestone:	Delivery Date:	RAG:

Risks/Issues

- Poor CQC results, practice resilience, industrial action, slow progress against interface issues, contract financial uplift 2024/25
- Ongoing support to GP practices, system interface group with workplan in development, developing new resilience policy.
- There is a risk of practices not signing up to Locally Commissioned Services and therefore gaps in patient service provision.

Webb Sarah
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Summary of Primary Care Access Improvement Plan
Lead : Sharon Gardner

Overall programme RAG Rating

Correct as of 04/06/2024 | Approved

Pharmacy

172 community pharmacies out of 174 across Norfolk and Waveney signed up to for the new national Pharmacy First scheme which launched at the end of January enabling pharmacies to treat seven common conditions without the need in most cases for referral to a GP. All pharmacies signed up to the pharmacy first also have the capacity to support minor ailment referrals through the pharmacy first process, although in this case an electronic referral is required rather than a simple signpost such as with the 7 common conditions.

3365 consultations were completed in February and March with 799 of those patients offered just self care advice and not prescribed antibiotics.

Currently, 56 pharmacies signed up to deliver the hypertension service and 82 pharmacies signed up to deliver the contraception service so further engagement work across the pharmacy sector is required.

Community Pharmacy engagement role funding released in May 2024. This isto support the regional implementation of the pharmacy elements of the Primary Care Access Recovery Plan (PCARP) requirements, including implementing the Pharmacy First Service and expanding the Blood Pressure Checks Service and Pharmacy Contraception Service.

Previous activity for last quarter:

- Pharmacy first awareness across the whole system for all partners.
- Pharmacy first engagement with key stakeholders such as the LPC, Clinical Directors, PCN Leads and Practice representatives where possible.
- Pharmacy First CPD collaborative event post launch to gain feedback and insights from both pharmacy and General Practice.

Planned activity for the next quarter:

- Develop Pharmacy First long term strategy following feedback from CPD event to support the further development of the service and support patient access.
- Develop training materials to support referrals from general practice into community pharmacy.
- Review and update the Pharmacy First communication strategy to support patient education and to manage patient expectations of the service.
- Work with existing PCN community pharmacy leads and implement new funding to support the PCARP agenda.

Milestone:	Delivery Date:	RAG:

Webb Sarah
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Risks/Issues

- Poor CQC results, practice resilience, industrial action, slow progress against interface issues, contract financial uplift 24/25.
- Ongoing support to GP practices, system interface group with workplan in development, developing new resilience policy.
- There is a risk of practices not signing up to Locally Commissioned Services so there will be a gap in care.

NHS
Norfolk and Waveney
Integrated Care Board

Agenda item: 10

Subject:	Primary Care Complaints, Enquiries and MP Queries – 2023-24
Presented by:	Jon Punt, Patient Experience Senior Manager
Prepared by:	Jon Punt, Patient Experience Senior Manager and Charlene Roberts, Patient Experience Senior Officer
Submitted to:	Primary Care Commissioning Committee
Date:	11 June 2024

Introduction

The purpose of this paper is to provide an update in relation to the contacts received from patients and members of the public in relation to primary care services during the entirety 2023/24.

Executive Summary

NHS Norfolk and Waveney Integrated Care Board (the ICB) recognises complaints and concerns as a vital form of feedback to help improve the service the organisation and local providers offer. The ICB aims to ensure all people making contact with the ICB feel listened to, have their concerns considered thoroughly and that any response is delivered in a personalised way.

This report provides an overview of complaints and enquiries specifically around primary care received by the ICB during 2023/24. It also details themes arising from those concerns raised.

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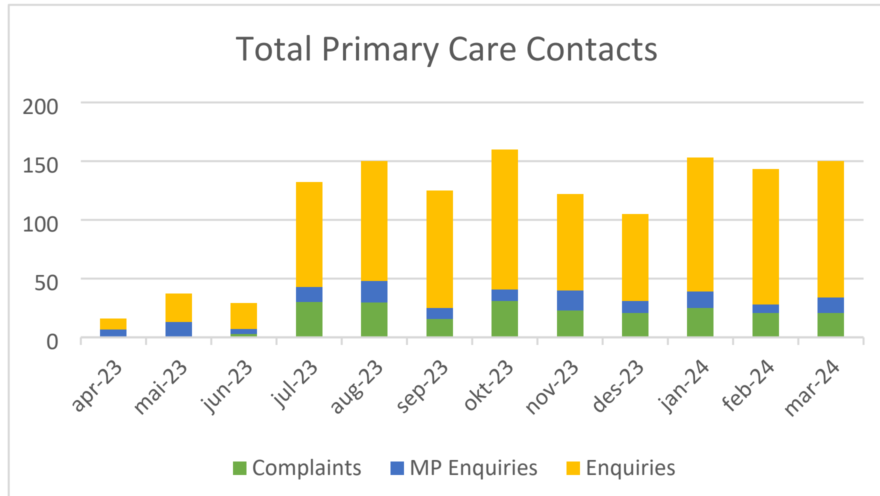
Volumes of contact

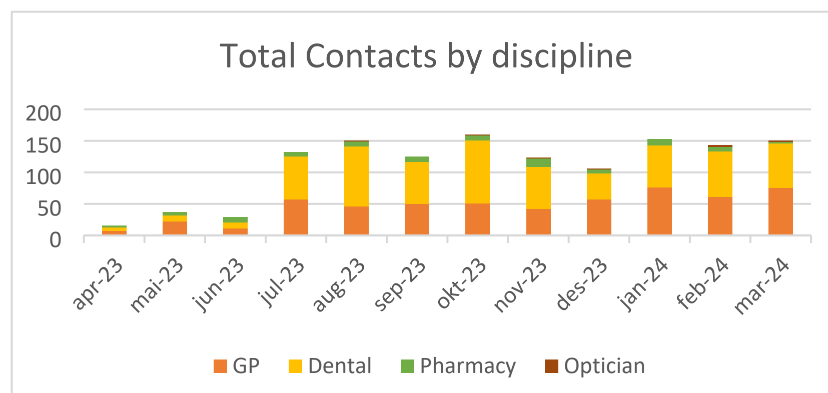
The ICB's Complaints and Enquiries team have received 1322 contacts regarding primary care during the 2023-24. The breakdown of how this was split across formal complaints, enquiries from MPs and informal concerns/enquiries can be seen below.



In total the team received 221 formal complaints, 135 MP enquiries and 966 informal enquiries/concerns. Where possible the Complaints and Enquiries Team will do everything possible to try and resolve an informal enquiry, to avoid the escalation into a formal complaint.

The full delegation of handling complaints and concerns regarding primary care from NHS England to ICBs occurred in shadow form on 1 April 2023, and then fully on 1 July 2023. Therefore, the number of contacts increased dramatically from 1 July 2023 and was more than the initial indicative numbers NHS England advised the ICB could be expected. It should be noted that NHS England provided no numbers around how many informal contacts/concerns the ICB may receive (only formal complaint numbers) and did not transfer over any resource in order to handle these additional cases.

As might be expected, the largest proportion of contacts received related to General Practice and Dentistry. The breakdown of contacts across each discipline can be found below:



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In Appendix 1 and 2, the specific numbers of contacts received about each primary care provider can also be found.

A breakdown of the type of contacts received across each primary care discipline can be found below:

Dental

674 contacts were received regarding dental services across the year, the vast majority of these being received post delegation of primary care complaints from July 2023. The number of contacts has remained consistent since that time, although it is worth noting a pronounced spike of enquiries in October (100), with many of these seeking urgent access to emergency dental care.

Access to Treatment

The overwhelming majority of contacts (560) received were from patients struggling to access dental services. This was 83 percent of all contacts received relating to dentistry.

The largest proportion of these contacts were from patients looking to access routine NHS dental treatment, who had tried various NHS dental practices with no success. There were also smaller pockets of patients who had struggled to gain access to emergency treatment via NHS 111, with many of these stating they had been provided with incorrect telephone numbers for providers who would only offer private appointments.

Other patients contacted the ICB when their dental practice had decided to cease their NHS contract, they were dissatisfied with how this was managed and the notice given in some cases.

Care and treatment

13 formal complaints and 67 informal enquiries related to the care and treatment patients had been offered by their dental practice. These were all shared or signposted to the practice, investigated and a response issued, with a review from an independent clinician if appropriate.

Lessons learned

A number of patients flagged difficulties accessing services via NHS 111 for dental emergencies. As a result of this, IC24 issued refreshed communication to their call handling staff, advising of the ICB's urgent treatment service providers, so patients could be better signposted to these when seeking emergency treatment.

General Practice

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555 contacts were received regarding general practice across the year, with a marked increase across Q4, 212 contacts were received during this period, a 41 percent increase on Q3.

Care and Treatment

The largest proportion of contacts received were in relation to the care and treatment provided by a patient's GP practice.

There was an overall theme of people being dissatisfied with the general care and treatment they had received, including queries to a diagnosis given, the level of care not being appropriate, care being affected by what was deemed as inappropriate referral pathways, or feelings of a lack of support from the general practice.

Communication presents highly as an underlying theme. The cause of a communication breakdown is not always evident due to differing recollections or lack of evidence but some of the contacts received detail that they have also been dissatisfied with staff attitudes and they were not considered as always being helpful or kind in their approach. Inadequate or confusing information also played a part in the dissatisfaction experienced.

Accessing appointments

The second largest number of contacts received concerned the difficulties experienced in accessing a GP appointment.

Themes included the lack of available appointments, the inability to access an appointment on the same day and having to wait a considerable amount of time in the future to attend an appointment.

General frustrations with the appointment booking system also featured, as well as the process of booking an appointment after detailing their health concern to a Care Navigator. Following on from this, many contacts expressed their dissatisfaction with not having secured an appointment with a GP, but rather another member of the practice clinical or nursing team.

How to make a complaint

A number of general enquiries were received about how to raise a complaint about their GP practice, as patients faced difficulties in locating contact information or just did not know who to send their concerns or complaints to. As an ICB, we are aware that some practices do not have access to specialised teams to support them, therefore we are aware to signpost as appropriate, offering to forward their concerns onto the practice on the patient's behalf, or indeed take the lead in overseeing the management of their formal complaint.

To support general practice, the ICB also offered a complaints handling session for practice managers just prior to the delegation of primary care complaints in July 2023.

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Prescribing

Many contacts received were in relation changes to a prescription, including the stopping of medication, refusal to issue medication, incorrect prescriptions being provided and changes to a particular medication being prescribed following instruction by the ICB.

Habitual and aggressive enquirers

It should be noted the ICB continues to receive contacts from patients who present as aggressive or persistent in their representations. These patients can often take a scattergun approach in who they contact, which can cause confusion across the healthcare system. In some instances, patients may contact the ICB, their GP practice, advocacy services, Healthwatch, the press and their local MP.

Often the presenting issue is one of expectation not meeting the reality of the services general practice is able to offer. This results in a disproportionate amount of time being spent on these cases, which can often involve the Patient Experience team, practice staff and ICB officers/senior managers. The numbers of these cases are relatively low, but time spent resolving the issues is extremely high.

Lessons learned

Based on feedback the ICB received, and through liaison with GP practices, there were a number of key areas, some of which are outlined below

- Improved access to same day appointments for patients
- Extra caution being taken when issuing prescriptions for patients with allergies
- Reflection and amendments made to language used towards patients when communicating with them around non-attendance for GP appointments
- Improved systems for escalation for care navigators when triaging appointment requests
- Action plan created for improved clinical note taking
- Customer service training provided for reception staff

Optometry

Only a very small number of contacts (9) were received in relation to optometry, therefore it has not been possible to conduct any meaningful analysis in relation to this discipline.

Pharmacy

87 contacts were received across 2023-24, with a spike in contacts during the latter part of 2023 and very early 2024. This may have been due to the impact of some branch closures and patient feedback related to this.

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Prescription issues/errors

Over a quarter of the contacts received related to issues around a person's prescription, typically around a perceived/established error in the prescribing, missed items or a shortage of the desired medication.

Customer service issues

39 percent of queries related to service issues at a person's pharmacy, consisting of alleged poor staff attitude, long waits to obtain prescriptions or other customer service problems encountered.

Pharmacy closures

A small number of contacts related to the closure of pharmacies, either permanently, or at times when they should have been contracted to open, which the ICB escalated as appropriate.

Lessons learned

Some individual cases identified errors in prescribing, which allowed for opportunities to improve systems to avoid issues in the future.

In addition to this, the ICB worked with local partners around some pharmacy branch closures, to try and assist to improve capacity with affected providers, but also to better advise local patients of alternative options, such as online pharmacies or those offering a delivery service. In turn this should help to alleviate pressure on the affected providers who continue to operate.

Development work

The ICB's Patient Experience Team delivered a complaints handling session to practice managers across Norfolk and Waveney. This helped establish some relationships with those who attended and has assisted with the swift resolution of some enquiries. In addition, individual GP practice managers have also reached out to the team to gain advice or assistance when it comes to complaint handling.

The team has also met with representatives from the Local Pharmaceutical Committee and Local Dental Committee to discuss complaints handling and how best learning can be identified, while also offering support to providers.

Recommendation

Members are invited to note the contents of this report.

Webb,Sarah
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Key Risks	
Clinical and Quality:	Themes from contacts and complaints can inform improvements in patient care
Finance and Performance:	N/A
Impact Assessment (environmental and equalities):	N/A
Reputation:	Good complaints management processes can preserve the reputation of provider and commissioner
Legal:	It is a national requirement to have an NHS-compliant complaints process
Information Governance:	None identified
Resource Required:	Complaints team
Reference document(s):	NHS Complaints process
NHS Constitution:	N/A
Conflicts of Interest:	None identified
Reference to relevant risk on the Board Assurance Framework	N/A

Governance

Process/Committee approval with date(s) (as appropriate)	N/A

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GP Practice contacts / enquiries to ICB - 2023-24

Total contacts (includes formal complaints, MP enquiries and informal concerns/queries)

Norwich Locality	111
Old Catton Medical Practice	12
St Stephens Gate	11
Trinity and Bowthorpe Medical Practice	10
Oak Street Medical Practice	8
East Norwich Medical Practice	8
One Norwich Practices	8
Magdalen Medical Practice	6
Lionwood Medical Practice	5
Beechcroft and Old Palace Surgeries	5
Roundwell Medical Centre	5
Wensum Valley Medical Practice	5
Castle Partnership	4
UEA Medical Centre	4
Lawson Road Surgery	3
Lakenham Surgery	3
Prospect Medical Practice	3
Thorpewood Medical Group	2
West Pottergate Medical Centre	2
Bacon Road Medical Centre	2
Taverham Surgery	2
Woodcock Road Surgery	2
Hellesdon Medical Practice	1

South Norfolk Locality	132
Humbleyard Practice	32
East Harling and Kenninghall Medical Practice	18
Watton Medical Practice	15
Mattishall and Lenwade Surgeries	12
Harleston Medical Practice	8
Attleborough Surgeries	8
Long Stratton Medical Partnership	4
Elmham Surgery	4
Grove Surgery	4
Parish Fields Practice	4
Old Mill and Millgates Medical Practice	3
School Lane Surgery	3
Heathgate Medical Practice	3
Orchard Surgery	3
Wymondham Medical Partnership	3
Windmill Surgery	3
Chet Valley Medical Practice	2
Theatre Royal Surgery	2
Hingham Surgery	1
Shipdham Surgery	1

Great Yarmouth and Waveney Locality	87
Beccles Medical Centre	15
Millwood Partnership	10
High Street Surgery	10
East Norfolk Medical Practice	8
The Beaches Medical Centre	8
Rosedale Surgery	6
Alexandra & Crestview Surgeries	6
Bungay Medical Practice	6
Bridge Road Surgery	5
Coastal Villages Surgeries	3
Andaman Surgery	3
Kirkley Mill Surgery	2
The Park Surgery	2
Victoria Road Surgery	2
Sole Bay Health Centre	1

North Norfolk Locality	64
Holt Medical Practice	23
Drayton Medical Practice	8
Acle Medical Partnership	4
Wells Health Centre	4
Birchwood Medical Practice	4
Stalham Staithe Surgery	3
Reepham and Aylsham Medical Practice	3
Ludham and Stalham Green Surgeries	2
Mundesley Medical Centre	2
Sheringham Medical Practice	2
Cromer Group Practice	2
Blofield Surgery	1
Brundall Medical Partnership	1
Aldborough Surgery	1
Fakenham Medical Practice	1
Coltishall Medical Practice	1
Hoveton and Wroxham Medical Centre	1
The Market Surgery, Aylsham	1

West Norfolk Locality	86
Vida Healthcare	20
Southgates and The Woottons Surgeries	11
Heacham Group Practice	11
St James Medical Practice	9
Watlington Medical Centre	6
Campingland Surgery	6
Howdale Group Practice	4
Bridge St Surgery, Downham Market	3
Upwell Health Centre	2
Manor Farm Medical Centre	2
St Clements Surgery	2
Great Massingham and Docking Surgeries	2
St Johns Surgery	2
Feltwell Surgery	2
Litcham Health Centre	2
Grimston Medical Centre	1
Plowright Medical Centre	1

Dental and Pharmacy contacts / enquiries to ICB - 2023-24

Total contacts (includes formal complaints, MP enquiries and informal concerns/queries)

Dental	
Taverham Dental Practice	20
John G Plummers	5
Together Dental, Great Yarmouth	4
Orford Hill Dental Practice	4
Smile Dental Care Norwich	3
Grange Dental Surgery	3
Prince of Wales Road Dental Practice	3
Together Dental, Norwich	3
Carlton Lodge Dental Practice	2
Together Dental, Sheringham	2
Marham Dental Surgery	2
Dental Design Studio, Kings Lynn	2
All Saints Green Dental Clinic	2
Dental Design Studio Lowestoft	1
West Earlham Dental Health Practice	1
Golden Triangle Dental Practce	1
MyDentist, Kings Lynn	1
Brundall Dental Practice	1
Night Dental	1
Witard Dental Health Centre	1
Beechcroft Dental Practice	1
Bupa Dental	1
Colosseum Dental, Kings Lynn	1
Enslin Limited, Cromer	1
MyDentist, Norwich	1
MyDentist, Thetford	1
St Cuthberts Dental Care	1

Pharmacy	
Total Health Pharmacy, Watton	7
Well Pharmacy, Mundesley	5
Well Pharmacy, Brundall	5
Well Pharmacy, Coltishall	4
Well Pharmacy, North Walsham	2
Haydens Chemist, Lowestoft	2
Well Pharmacy, Norwich	2
Asda Pharmacy, Hellesdon	2
Well Pharmacy, Long Stratton	2
Boots, Watton	2
Well Pharmacy, Poringland	1
Well Pharmacy, Kings Lynn	1
Tesco Pharmacy, Thetford	1
Well Pharmacy, Wymondham	1
Well Pharmacy, Acle	1
Wellbeing Pharmacy, Wroxham	1
Wellbeing Pharmacy, Norwich	1
West End Street Pharmacy	1
Boots, Sheringham	1
Hado Pharmacy, Diss	1
Jhoots, Sheringham	1
Lloyds Pharmacy, North Wootton	1
Lloyds Pharmacy, Norwich	1
Morrisons Pharmacy, Riverside Norwich	1
Roundwell Pharmacy	1
Taverham Pharmacy	1
Total Care Pharmacy, Norwich	1
Well Pharmacy Lowestoft	1
Willows Pharmacy, Aylsham	1
Boots, Anglia Square Norwich	1

Webb,Sarah
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NHS
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Integrated Care Board

Agenda item: 11

Subject:	**General Practice & Community Pharmacy Delivery Group Report**
Presented by:	**Sadie Parker, Director of Primary Care**
Prepared by:	**Sadie Parker, Director of Primary Care**
Submitted to:	**Primary Care Commissioning Committee**
Date:	**11 June 2024**

Purpose of paper:

To provide the Board with a report of the General Practice & Community Pharmacy Operational Delivery Group meetings held on 26 March 2024 and 14 May 2024

Group:	General Practice & Community Pharmacy Operational Delivery Group
Chair:	Sadie Parker, Director of Primary Care
Meetings since the previous update:	26 March 2024 and 14 May 2024
Overall objectives of the GPODG:	The purpose of the Delivery Group is to provide a framework for effective decision making in relation to certain contractual matters for general practice under delegated authority from the ICB's Primary Care Commissioning Committee.
Main purpose of meeting:	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 Primary Care Committee on the exercise of the ICB's delegated primary care commissioning functions and any resources received for investment in primary care.
BAF and any significant risks relevant / aligned to this Group:	• The resilience of general practice. The increasing risk to services associated with potential industrial action was noted.

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Key items for assurance/noting:	**26 March 2024** The group noted three practices had been inspected by the CQC and received reports rating them as good overall. For Mattishall and Lenwade Surgeries, it was noted they had moved from being rated as inadequate to good, which reflected on their determination and hard work to improve following a previous inspection. **14 May 2024** • The group noted the new terms of reference and the expansion of the group to include community pharmacy commissioning. • The joint work with Suffolk and North East Essex ICB to progress a project on collaborative community pharmacy integration was noted. • The operational risk register was discussed. Following a recent audit of ICB risk management, it had been agreed that PCCC would in future review all risks, rather than just the BAF risks. • The finance report was noted, alongside the challenging financial position for the ICB going into the new financial year.
Items for escalation to Committee:	• There were no items for escalation.
Items requiring approval:	**26 March 2024** The group approved a proposal to continue to procure clinical waste contracts on a regional basis, alongside other ICBs. **14 May 2024** • An updated advice note for practices applying to close their branch surgery was reviewed and approved. • A new internal Contract Assurance Framework document, developed to support teams working with primary care in monitoring and supporting contract delivery was approved. This was one of the previous audit recommendations covering delegated commissioning.
Confirmation that the meeting was quorate:	Yes. Attendance at the meeting is set out below: **26 March 2024** **Voting members** Sadie Parker, Director of Primary Care, NWICB (chair) Shepherd Ncube, Associate Director, Primary Care Commissioning, NWICB,

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	James Grainger, Head of Finance, Primary Care & Corporate/Reporting, NWICB Sarah Taylor, Senior Nurse for Patient safety Primary care, Senior Nurse for NCHC and small contracts NWICB (deputising for KW) **14 May 2024** **Voting members** Sadie Parker, Director of Primary Care, NWICB, (chair), James Grainger, Head of Finance Primary Care and Corporate Reporting, NWICB, Shepherd Ncube, Associate Director, Primary Care Commissioning, NWICB, Karen Watts, Director of Nursing and Quality, NWICB

Key Risks	
Clinical and Quality:	The group monitors progress in developing our dashboard and our overall monitoring framework
Finance and Performance:	Finance and BI are part of the group, performance will be monitored in detail with a dashboard in development.
Impact Assessment (environmental and equalities):	There is a focus on the delivery of LD and SMI health checks.
Reputation:	Healthwatch Norfolk and Suffolk and the Local Medical Committee are part of the group.
Legal:	Terms of reference, primary medical services contracts, premises directions and policy guidance manual
Information Governance:	No risks identified.
Resource Required:	Primary care commissioning, locality, quality, finance, BI, medicines management teams
Reference document(s):	Primary medical services regulations, statement of financial entitlements, premises directions and policy guidance manual, delegation agreement with NHS England
NHS Constitution:	No risks identified.
Conflicts of Interest:	Arrangements are in place to manage conflicts of interest

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NHS
Norfolk and Waveney
Integrated Care Board

Agenda item: 11

Subject:	Dental Services Operational Delivery Group report
Presented by:	William Lee, Senior Primary Care Commissioning Manager – Dental
Prepared by:	William Lee, Senior Primary Care Commissioning Manager – Dental
Submitted to:	Primary Care Commissioning Committee
Date:	11 June 2024

Purpose of paper:

To provide the Committee with a report of the meetings of the Dental Services Delivery Group ("DSDG") held on 9th April 2024 and 14th May 2024.

Group:	Dental Services Delivery Group
Chair	9th April 2024: Mark Burgis, Executive Director of Patients & Communities, Norfolk and Waveney ICB 14th May 2024: Sadie Parker, Director of Primary Care, Norfolk and Waveney ICB
Meetings since previous update	9th April 2024 14th May 2024
Overall objectives of DSODG	The purpose of the meeting is to provide a framework for effective decision making in relation to certain contractual matters for dental services under delegated authority from the ICB's Primary Care Commissioning Committee ("PCCC")
Main purpose of the meeting	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 improve access and transform services by providing oversight and assurance to PCCC on the exercise of the ICB's delegated primary care commissioning functions and any resources available for investment in primary, community and secondary dental care
BAF and significant risks relevant / aligned to this Group	At this stage, the risk register is monitored by PCCC however work is being undertaken to agree how operational and strategic risks can be monitored across DSODG and PCCC respectively. The BAF risk has been updated to include workforce matters.

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	A second risk has been raised in relation to Secondary Care dental services which was considered by DSDG in May and has been escalated to Committee at this meeting for discussion.
Key items for assurance / noting	**9th April 2024:** The following papers were discussed by DSDG: • paper for approval pertaining to dental year end contracting policy. The paper set out a summary of the overall approach of the ICB's dental commissioning team on managing contractual arrangements at Year-End and a local approach to manage exceptional circumstances and breach notices. Following discussions, the paper was approved, however with an amendment to include the rewording of rebasing contracts and to include a framework for breach notices. • a report for approval relating to setting up an Individual Funding Request (IFR) process within Dental. The group outlined support for the process and the paper but requested further information, specifically on the role of each panel member, specific clinical examples, and discussion with ICB existing IFR team to potentially incorporate. Agreed to bring back to April DSDG for further discussion and approval. • a paper for approval relating to an ad-hoc UDA uplift request and the incorporation of 3000 additional UDAs which the practice have received on a non-recurrent basis for the past five years. The Group discussed the request in two parts, approving the request for 3000 additional UDAs on a non-recurrent basis at the current UDA rate for one year and then to review. Regarding the UDA uplift, the Group requested a criteria framework for exceptional requests to be brought to next meeting for approval before any further ad-hoc uplifts were agreed upon. • a paper for approval which aimed to provide oversight of the Minor Oral Surgery contracts and secure approval to financially uplift the rates to align with regional ICBs. The importance of maintaining these vital services was highlighted

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	during the discussion and approval was given to financially uplift the rates to align with regional ICBs. **14th May 2024** • The Group was informed that a decision to extend a PDS+ Contract was taken outside the meeting due to a short timeframe and to ensure continuity of care for patients. The PDS+ Contract has been extended for 12 months. • The Group discussed for approval a new Secondary Care risk and agreed to escalate the risk to PCCC and to conduct a CQRA and EIA and to build this into all future risks • The Individual Funding Request paper was discussed, following feedback at the previous DSDG. The paper was provisionally agreed following amendment, however for final approval, clarify was requested on the appeals process and geographic limit on the requests. Agreed the paper would be amended and distributed via email for final sign off in June. • The Group discussed a paper for approval which outlined the criteria for exemptional requests, alongside an example practice who had requested a UDA uplift. The paper was discussed in two parts. Approval was granted for future requests to be assessed under the outlined Framework in the paper. The Group then reviewed the UDA uplift request against the newly approved framework and determined they met the criteria, the request for the uplift was approved, subject to funding approval. • A Force Majeure request for approval was presented and discussed, it outlined a provider who was seeking the carry forward of 2530.42 UDAs into the 2024/25 financial year, in addition to their normal contractual target due to unforeseen illness within their workforce. The paper was approved. • A paper was presented for approval which outlined one provider at two locations had requested a one-off increase of Units of Orthodontic Activity (UOA) with a corresponding

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	temporary reduction of Units of Dental Activity (UDA) for the financial year 2024/2025. The change was approved but with a mid-year review to determine future service planning. • The Engagement and Survey report results were discussed for noting purposes, with a thank you to all those who participated.
Items for escalation to Committee	9th April 2024: There were no items requiring escalation to PCCC. 14th May 2024: The Secondary Care Risk was agreed for escalation to PCCC.
Items requiring DSODG approval	9th April: • Dental Year End Policy. • Change from 3000 Non-Recurrent UDAs to recurrent basis • MOS Rates uplift to align with regional ICBs. 14th May: • IFR paper was provisionally agreed as outlined above. • Criteria for exceptional requests alongside example practice requesting UDA uplift. • Force Majeure individual request • UDA to UOA conversion paper was approved, with agreement to review mid-year.
Confirmation that the meeting was quorate	9th April: Yes. Attendance at the meeting is set out below: Voting Members: Mark Burgis (Chair). Executive Director of Patients & Communities, Norfolk and Waveney ICB Sadie Parker. Director of Primary Care, Norfolk and Waveney ICB Fiona Theadom. Head of Primary Care Commissioning, Norfolk and Waveney ICB (deputizing for Shepherd Ncube, Associate Director – Primary Care Commissioning) Stuart White, Finance Manager – Primary Care & Corporate/Reporting, Norfolk and Waveney ICB (deputising for James Grainger, Head of Finance – Primary Care & Corporate/Reporting) Karen Watts, Director of Nursing and Quality, Norfolk & Waveney ICB In attendance:

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	Andrew Bell, Vice-Chair, Norfolk Local Dental Committee Rachel Hayes, Senior Commissioning Officer, Norfolk & Waveney ICB Matthew Lewis, Primary Care Finance Officer, Norfolk & Waveney ICB Tom Norfolk, Chief Regional Dental Officer, East of England Nick Stolls, Dental Advisor to PCCC and DSDG Jason Stokes, NHS England/Norfolk LDC Secretary Ben Oakenfold, Primary Care Commissioning Support Officer – Dental, Norfolk and Waveney ICB Rashmi Purkayastha, Commissioning Manager (Dental), Norfolk and Waveney ICB Louise Wilson, Quality Improvement Dental Nurse, Norfolk and Waveney ICB 14th May 2024: Yes. Attendance at the meeting is set out below: <u>Voting Members:</u> Sadie Parker (Chair) Director of Primary Care, Norfolk and Waveney ICB Shepherd Ncube, Associate Director – Primary Care Commissioning James Grainger, Head of Finance – Primary Care & Corporate/Reporting, Norfolk and Waveney ICB Karen Watts, Director of Nursing and Quality, Norfolk & Waveney ICB <u>In attendance:</u> Fiona Theadom. Head of Primary Care Commissioning, Norfolk and Waveney ICB Ben Oakenfold, Primary Care Commissioning Support Officer – Dental, Norfolk and Waveney ICB Rashmi Purkayastha, Commissioning Manager (Dental), Norfolk and Waveney ICB Louise Wilson, Quality Improvement Dental Nurse, Norfolk and Waveney ICB Rachel Hayes, Senior Commissioning Officer, Norfolk & Waveney ICB Matthew Lewis, Primary Care Finance Officer, Norfolk & Waveney ICB Tom Norfolk, Chief Regional Dental Officer, East of England Jayde Robinson, Head of Primary Care Workforce Transformation, Norfolk and Waveney ICB Nick Stolls, Dental Advisor to PCCC and DSDG

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	Alex Stewart, Chief Executive, Healthwatch. Andrew Bell, Vice-Chair, Norfolk Local Dental Committee

Recommendation to the Committee:

To note the report for assurance purposes

Key Risks	
Clinical and Quality:	The Group will be monitoring quality improvement and development of a performance dashboard and overall assurance framework
Finance and Performance:	Finance is part of the membership, performance and spend against the dental budget will be monitored in detail and reported to the Committee
Impact Assessment (environmental and equalities):	Each proposal will be accompanied by an inequalities impact assessment to inform the Group's decision making
Reputation:	Healthwatch Norfolk and Healthwatch Suffolk, Local Professional Network and the Local Dental Committee are all represented on the Group
Legal:	Terms of reference, general dental services contracts, regulations and Dental Policy Handbook
Information Governance:	N/A
Resource Required:	Primary Care Commissioning Team
Reference document(s):	general dental services contracts, regulations and Dental Policy Handbook
NHS Constitution:	N/A
Conflicts of Interest:	Arrangements are in place to manage conflicts of interest
Reference to relevant risk on the Board Assurance Framework	N/A

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Norfolk and Waveney
Integrated Care Board

Agenda item: 12

Subject:	**Pharmaceutical Services Regulation Committee (PSRC) – Decisions Made 01 January 2024 to 29 March 2024**
Presented by:	**Sharon Gardner, Head of Primary Care Commissioning, Pharmacy and Optometry**
Prepared by:	**Sharon Gardner, Head of Primary Care Commissioning, Pharmacy and Optometry in conjunction with ICB contracting team hosted by Herts and West Essex ICB**
Submitted to:	**Primary Care Commissioning Committee Part 1**
Date:	**11 June 2024**

Summary of Paper

The attached paper contains the final quarter (Q4) report from the Pharmaceutical Services Regulation Committee (PSRC) relating to the market entry and fitness decisions made at the monthly PSRC meetings between 1st January 2024 to 30th March 2024 in relation to Norfolk and Waveney matters.

PSRC is hosted and chaired by NHS Hertfordshire and West Essex Integrated Care Board (HWE ICB) working on behalf of the 6 ICBs in the East of England.

Recommendation

Note the decisions made at the PSRC meetings between 01 January 2024 to 29 March 2024

Key Risks	
Clinical and Quality:	The ICB is responsible for ensuring quality and performance in relation to the provision of community pharmacy services in Norfolk and Waveney and to escalate concerns, where appropriate, to PSRC for consideration.
Finance and Performance:	National funding formula for community pharmacy provision
Impact Assessment (environmental and equalities):	The Pharmaceutical Needs Assessment (PNA) is agreed by Health and Wellbeing Boards on a five year cycle. Significant changes in provision in the

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	interim may need to be reviewed and changes to the PNA considered.
Reputation:	Failure to adhere to the regulations can have reputational issues for the ICBs.
Legal:	Pharmaceutical Services Regulations
Information Governance:	N/A
Resource Required:	Primary Care and Quality teams
Reference document(s):	Pharmacy Manual, Pharmaceutical Services Regulations
NHS Constitution:	N/A
Conflicts of Interest:	None identified
Reference to relevant risk on the Board Assurance Framework	The resilience of primary care

Governance

Process/Committee approval with date(s) (as appropriate)	N/A

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To be completed by Meeting Secretary
Agenda item: 12
Paper No:

Meeting/Committee:	**Primary Care Commissioning Committee**
Venue:	**Teams Meeting**
Date:	**11 June 2024**

Title of Report	**Pharmaceutical Services Regulation Committee (PSRC) – Decisions Made (January 2024 to March 2024)**	
Presented by	**Sharon Gardner, Head of Primary Care Commissioning Pharmacy and Optometry**	
Author	**Katie Donohue, Commissioning Support Officer** **Reviewed/Updated by: Jackie Bidgood, Senior Contract Manager, Pharmacy and Optometry**	
Commercially Sensitive	No	
Status	For:	Information
Finance Lead sign off (if required)	Name: NA	Date: NA
Conflict of Interest	None known.	
Governance and reporting – at which other meeting has this paper already been discussed (or not applicable)	This paper has not been discussed at other meetings however all decisions reported in this paper were made at the PSRC meetings held between 01 January 2024 to 29 March 2024.	Outcome of Discussion: All decisions made at the PSRC meetings are made in line with the Pharmaceutical Services Regulations 2013 (as amended)
ICS Engagement (Describe engagement and co-creation with ICS colleagues)	PSRC is hosted and chaired by NHS Hertfordshire and West Essex Integrated Care Board (HWE ICB) working on behalf of the 6 ICBs in the East of England. All ICBs are invited to attend. The meetings are governed by Terms of Reference (TOR) as set out in the Pharmacy Manual and have been ratified by PSRC. TOR have been shared with ICBs.	

Executive Summary:

Following the delegation of pharmaceutical services by NHS England to Integrated Care Boards (ICBs) with effect from 1 April 2023, the six ICBs in the East of England have formed a Pharmaceutical Services Regulations Committee (PSRC) under section 65Z5 of the National Health Service Act 2006 (hereafter referred to as the 2006 Act).

By virtue of NHS England's Pharmacy Manual this Committee is responsible for making decisions required by the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013, as amended (hereafter referred to as the 2013 regulations). For the avoidance of doubt, this includes use of the fitness powers set out in the 2006 Act and the 2013 regulations. The PSRC is hosted by Hertfordshire and West Essex (HWE) ICB on behalf of the six ICBs.

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The PSRC is required to apply the regulatory tests as set out in the 2013 regulations to grant or refuse market entry applications and make decisions on fitness matters. PSRC meetings are held in two parts, the first to consider market entry applications and the second to consider and review fitness and matters of concern. ICBs are invited to Part 2 where there is an issue / concern that is relevant to their ICB, noting the sensitivities and confidential aspects of some discussions.

The Committee is required for certain applications to consider the information published in the Health and Wellbeing Boards (HWB) Pharmaceutical Needs assessment (PNA). Each Health and Wellbeing Board is required to publish a PNA every three years.

The following are the market entry and fitness decisions made at the monthly PSRC meetings between 01 January 2024 to 29 March 2024.:

Market Entry - Decisions made (within scheduled PSRC meetings):

Application	Health and Wellbeing Board	Decision
Application for inclusion in a pharmaceutical list: consolidation onto an existing site Laffak Limited t/a Allied Pharmacy. Site 1 Remaining Site – 7 Church Street, Attleborough, Norfolk, NR17 2AH. Site 2 Closing Site– Guilt Cross Club, Queens Square, Attleborough, Norfolk, NR17 2AF	Norfolk	Granted
Application for inclusion in a pharmaceutical list: routine application offering to secure unforeseen benefits Cox Mountain Ltd - University of East Anglia, Norwich Research Park, Earlham Road, Norwich, NR4 7TJ.	Norfolk	Granted
Application for inclusion in a pharmaceutical list: routine application offering to secure unforeseen benefits Loyal Pharmacy Ltd	Norfolk	Refused
Application for inclusion in a pharmaceutical list: routine application offering to secure unforeseen benefits Blofield Surgery Healthcare Ltd	Norfolk	Refused
Application for inclusion in a pharmaceutical list: routine application offering to secure unforeseen benefits Blofield Surgery Healthcare Ltd	Norfolk	Refused
Request for a planned temporary suspension of services Birchwood WA Ltd t/a North Walsham Pharmacy	Norfolk	Granted

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Market Entry - Decisions made (outside scheduled PSRC meetings):

None

Market Entry Applications under Appeal

The following applications were sent to NHS Resolution, appealing the decisions made by PSRC:

Application	HWB Area	Commissioner Decision	NHS Resolution Decision	Appeal Ref.

Fitness Decisions (within scheduled PSRC meetings):

Fitness Notifications / Concerns	Health and Wellbeing Board	Decision
Blofield Surgery Healthcare Ltd New inclusion pending Unforeseen Benefits application	Norfolk	The Committee agreed that Blofield Surgery Healthcare Ltd is a fit and proper person to be included on the Norfolk HWB pharmaceutical list pending their unforeseen benefits application.
Gorleston Pharma Ltd New Inclusion Pending Change of Ownership	Norfolk	The Committee agreed that Gorleston Pharma Ltd is a fit and proper person to be included on the Norfolk HWB pharmaceutical list pending a successful change of ownership application.
OMAzuike Ltd New Inclusion Pending Change of Ownership	Norfolk	The Committee agreed that OMAzuike Ltd is a fit and proper person to be included on the Norfolk HWB pharmaceutical list pending a successful change of ownership application.

Fitness Decisions (outside scheduled PSRC meetings):

Due to the throughput at PSRC, it was necessary to schedule an additional PSRC. The additional meeting was scheduled for Wednesday 6 March 2024 however there were no cases heard relating to N&W ICB.

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Fitness Decisions under Appeal:

It is to be noted that fitness appeals do not go to NHS Resolution, instead they are heard by the First Tier Tribunal.

Application	HWB Area	Commissioner Decision	First Tier Tribunal	Appeal Ref.
None				

Recommendation(s):

Note the decisions made at the PSRC meetings between January 2024 to March 2024.

Next Steps:

- Reporting will occur on a quarterly basis.
- Members and colleagues in ICBs are welcome to attend any future PSRC meetings should they wish to learn more about the regulatory processes that are followed.

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Norfolk and Waveney
Integrated Care Board

Agenda item: 12

Subject:	**General Ophthalmic Services (GOS) Contracting – Quarter End Update Report (Q4)**
Presented by:	**Sharon Gardner, Head of Primary Care Commissioning, Pharmacy and Optometry**
Prepared by:	**Sharon Gardner, Head of Primary Care Commissioning, Pharmacy and Optometry in conjunction with ICB contracting team hosted by Herts and West Essex ICB**
Submitted to:	**Primary Care Commissioning Committee**
Date:	**11 June 2024**

Summary of Paper

The attached paper contains the final quarter (Q4) report which provides an update on GOS contracting arrangements and sets out the current GOS contracting position for Norfolk and Waveney ICB.

Recommendation

- Note the content of the report and that reports will continue to be produced quarterly.
- Note that any contractual issues requiring escalation (outside the remit of GOS contracting), will be sent to the relevant ICB Committee for decision as appropriate.

Key Risks	
Clinical and Quality:	The contracting aspect of NHS sight tests is the only element managed by the ICB contracting team. All other eye health services are commissioned by individual ICBs (excluding specialised services) or retained by NHS England at this stage
Finance and Performance:	N/A
Impact Assessment (environmental and equalities):	It should be noted that NHS sight tests are only available to certain people such as those over 60, children and people with diabetes or at risk of glaucoma

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Reputation:	Failure to adhere to the regulations can have reputational issues for the ICBs. NHSE also assures the ICB on its delivery against the Delegation Agreement
Legal:	GOS regulations
Information Governance:	N/A
Resource Required:	Primary Care and ICB contracting team
Reference document(s):	N/A
NHS Constitution:	N/A
Conflicts of Interest:	None identified
Reference to relevant risk on the Board Assurance Framework	The resilience of primary care

Governance

Process/Committee approval with date(s) (as appropriate)	N/A

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To be completed by Meeting Secretary
Agenda item: 12
Paper No:

Meeting/Committee:	**Primary Care Commissioning Committee**
Venue:	**Teams Meeting**
Date:	**11 June 2024**

Title of Report	**General Ophthalmic Services (GOS) Contracting – Quarter End Update Report (Q4)**	
Presented by	**Sharon Gardner, Head of Primary Care Commissioning Pharmacy and Optometry**	
Author	**Jackie Bidgood, Senior Contract Manager, Pharmacy and Optometry**	
Commercially Sensitive	No	
Status	For:	Information
Finance Lead sign off (if required)	Name: NA	Date: NA
Conflict of Interest	None known.	
Governance and reporting – at which other meeting has this paper already been discussed (or not applicable)	This paper has not been discussed at other meetings however an update report on GOS contracting was requested by ICBs following delegation on 1 April 2023.	Outcome of Discussion: NA
ICS Engagement (Describe engagement and co-creation with ICS colleagues)	The Pharmacy and Optometry Team is employed and hosted by NHS Hertfordshire and West Essex Integrated Care Board (HWE ICB) but works on behalf of the 6 ICBs in the East of England. This is a standard report requested by ICBs following delegation.	

Executive Summary:

Following the delegation of General Ophthalmic Services (GOS) by NHS England to Integrated Care Boards (ICBs) on 1 April 2023, the Pharmacy and Optometry Contracting Team (P&O Team), manage the GOS contracting function on behalf of the six ICBs in the East of England.

GOS contracting is in summary, the provision of NHS sight tests to eligible patients either from a fixed premises (mandatory services contract) or from a patient's usual place of residence or at a Day Centre (additional services contract). The contracting aspect of NHS sight tests is the only element managed by the contracting team.

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All other eye health services are commissioned by individual ICBs (excluding specialised services) or retained by NHS England at this stage (this may be subject to change). This includes:

- Regional Eye Health Network Board (nb. ICBs are members of this Board) and the leadership for regional transformation programmes from this Board.
- Diabetic Eye Screening.

The purpose of this report is to provide an update on GOS contracting arrangements and set out the current GOS contracting position for the ICB.

This is the second report produced for ICBs and is reflective of the Quarter 4 (Q4) position. General principles of GOS contracting and background information was provided in the Q3 report.

GOS Contracting Overview

An overview of the number of contractors for mandatory and additional services are set out below. ICBs should note that the numbers detailed in this paper will be subject to change as new applications are made and contracts are terminated by contractors. ICBs should therefore expect to see different numbers at Q1 2024/25.

Table 1

Mandatory	Additional
87	7

Contract Re-issue (Mandatory Contractors only)

In December 2021, NHS England East of England commenced a GP and optometry contract re-issue project. The purpose of this project was to ensure that all contractors had an up to date 2018 mandatory contract in place. The P&O Team continue the project as part of business as usual.

The information below sets out the position for the ICB:

Table 2

Number of Mandatory contracts	Number of contracts issued	Number of contracts still to be issued
77	54	23

*This figure is different to the 87 mentioned in Table 1. Table 1 includes contracts issued to new contractors since the start of the re-issue project.

New Model Contract and Contract Variation (CV) for 2023

In September 2023, NHS England (national) issued a revised national model GOS contract and model contract variation for both mandatory and additional services.

- Mandatory services contractors - Those contractors who had a 2018 contract were sent the 2023 variation. Those that didn't have a 2018 contract in place were sent the 2023 contract.
- Additional services contractors – prior to September 2023, additional services contractors were working on a 2013 contract. Additional services contractors were not included in the contract re-issue project and the P&O Team have inherited through multiple re-organisations and staff changes, gaps in records. It is anticipated that there will be contractors who we do not have an electronic contract in place. Where this is the case, the P&O Team will issue a September 2023 additional services contract rather than the variation.

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The table below shows there are 4 mandatory contracts still to be issued where we do not have a contract on file for the contractor. They have not responded as part of the contract re-issue project. 53 variations have been issued to contractors who have a 2018 contract, and this variation will bring them in line with the 2023 contract.

Table 3

Mandatory Contracts	
Contract	**Contract Variations**
4	53
Additional Contracts	
Contract	**Contact Variations**
2	4

*(*There are a number of additional contracts that are held by other ICB teams, but the contractor performs NHS services in your ICB)*

There is a risk that due to work pressures and capacity issues a "baseline" position for mandatory and additional contract holders will not be reached. To mitigate this risk and with agreement of all ICBs in the East of England, HWE ICB have engaged AGEM CSU to support with the GOS contract re-issue project and administrative processes for the contract variations administration until June 2024. There may be an opportunity to extend this arrangement if required and this will be assessed nearer the time.

Recommendation(s) and Next Steps:

The Committee are to:

- Note the content of this report.
- Note that any contractual issues requiring escalation (outside the remit of GOS contracting), will be sent to the relevant ICB Committee for decision as appropriate.
- Note that reporting will occur on a quarterly basis.

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2023/24 Primary Care Commissioning Committee

Finance Report Norfolk & Waveney ICB

March 2024

Primary Care Commissioning Committee 11th June 2024

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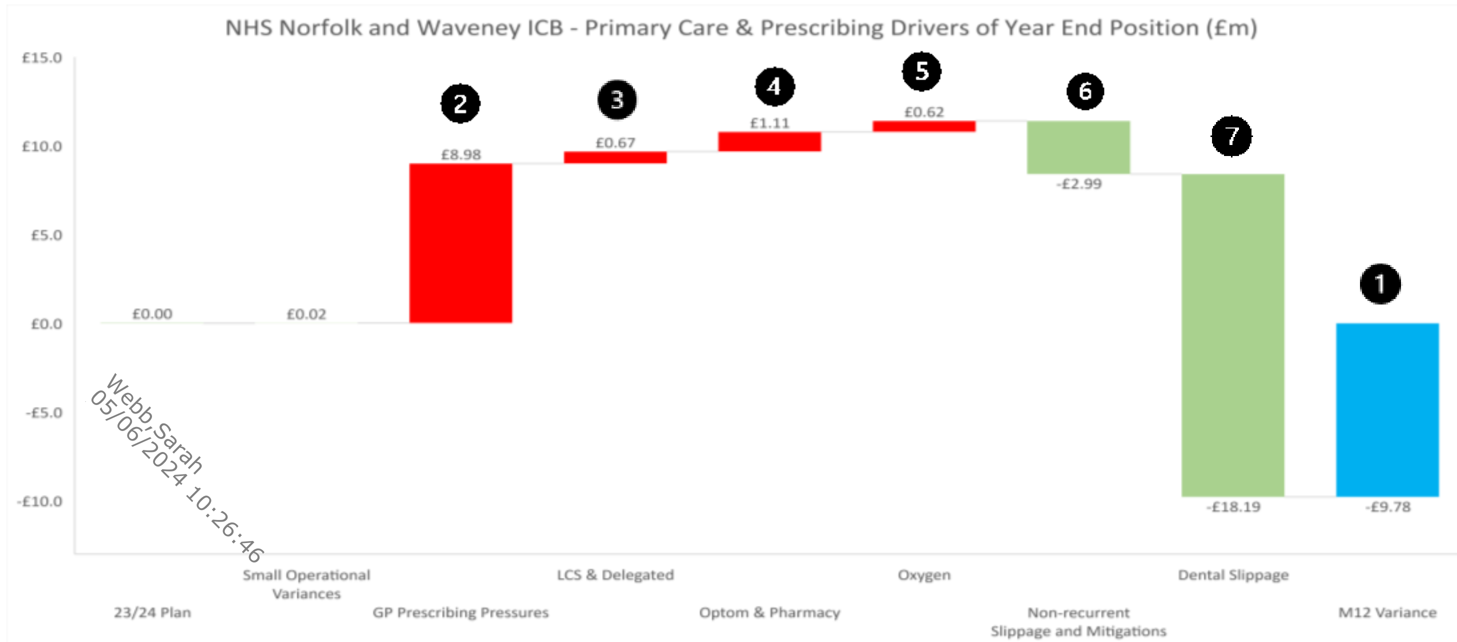
1.0 Executive summary – Reporting

Reported Financial Position: As at March 2024 (M12), the Primary Care & Prescribing reported position is £9.8m surplus

	Annual Budget	Budget	Actual	Variance	Forecast	FOT Variance
	£m	£m	£m	£m	£m	£m
Reported	556	556	546	(10)	546	(10)

Variances:
Whilst under plan ❶, there are key operational variances which have been incurred in the following sub directorates:



The GP & Prescribing position is a £9.8m surplus noting the following variances.

- Prescribing pressures including a reduction in Edoxoban rebates ❷
- LCS & Delegated pressures including complex dressings and dispensing fees ❸
- National pressures around Pharmacy advanced services and Optom home visits. ❹
- Home Oxygen patient electricity costs ❺
- N/R Slippage from PY including SDF. ❻
- Dental claw back from underactivity on contracts ❼

Managing In-Year Risks:

- **Efficiencies**

The Executive Management Team conducted a 'Closing the Gap' event in July to identify efficiencies to eliminate the previously flagged £17m unidentified efficiency target. This exercise provided a pipeline ideas of £6.1m within Prescribing and Primary Care. Of this, £7.3m was advanced enough to be included in the directorate positions (i.e. an over delivery of £1.2m). The total delivery across all area's was £17.8m (i.e. an over delivery of £0.8m)

NHSE National Half 2 Reset Exercise:

- **Dental underspend**

The position has been adjusted to reflect the expected under activity of NHS dental contracts. This is net of additional investments committed to by the ICB Executive Team for workforce initiatives, children's oral health pathway and emergency pathway.

2. Primary Care and Prescribing reporting M12

Sub-Directorate (£m)		Full Year Variance (underspend) / overspend	Variance – significant items
GP Prescribing Budget	£192	£8.66 4.5%	The adverse variance of £8.7m is due to the year on year increase in SGLT 2 £3.4m, Continuous Glucose Monitoring £1.3m, Increase in Respiratory Drugs £0.9m, Increase in inhalers £0.7m, Increase in Oral nutrition £0.7m and Increase in stoma and continence care £0.9m.
Other Prescribing costs Budget	£18	£0.94 5.2%	The adverse variance of £0.9m is due to budget reduced in Central Drugs and Oxygen due to unidentified efficiencies £0.5m and increased electricity cost pressures in oxygen mitigated partly by improvements in dressings costs.
Delegated Primary Care Budget	£221	£(4.04) -1.8%	The favourable variance of £4m is offset against £4.7m adverse variance in LES as budget is reported In Delegated and spend is reported separately in LES due to NHSE directives offset by increased dispensing fees within delegated co-commisioning and rent reviews.
Local Enhanced Services(LES) Budget	£9	£4.71 49.6%	The variance is due to the budget being reported in the Delegated Primary Care line and also increases in activity in complex dressings
Other Primary Care Budget	£16	£(2.97) -18.9%	£3m favourable variance is made up of £0.7m underspend in surge capacity funding and balance in non-recurrent prior year benefit
Dental Budget	£66	£(18.19) -27.4%	£18m favourable variance is in historic underperformance which is partly offset by funding for workforce incentives, childrens oral health pathway, emergency dental pathway and rate reviews.
Optom Budget	£10	£0.78 7.7%	There have been increased home visits, NHS funded sight test and NHS funded glasses which is driving the adverse variance in this area.
Pharmacy Budget	£22	£0.33 1.5%	The FOT adverse variance is due to advanced services £0.9m mitigated by reductions in the quality Payment scheme £0.6m
Total	**£556**	**£(9.78)**	

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* Sodium-glucose co-transporter-2 (SGLT2) inhibitors = type of oral medication used to treat type 2 diabetes in adults

3. ICB Financial Position M12

Directorate (£m)	Full Year Variance (underspend) / overspend	Variance – significant items
Acute Budget £1,227	£27.92 2.3%	£28m adverse variance largely due to £7.9m unidentified efficiencies, £10.7m System Support to QEH and £5.3m ERF over performance at JPUH. Additional pressures across Independent Sector Providers (capacity above plan) and High Cost Drugs (increased activity from glucose monitoring devices).
Community and Better Care Fund (BCF) Budget £219	£4.80 2.2%	£4.8m adverse variance due to £4.3m unidentified efficiencies and £2.0m Surge Funding to ECCH. Less £1.5m favourable variance from reduced Q1 activity within long term conditions, underperformance on ICES and minor contract slippage.
Continuing Healthcare Budget £128	£28.79 22.5%	Adverse full year variance resulting from growth (volume) and cost increases. Mostly adults - £20m, of which key drivers are: FT (all volume) £8m, LD £4m (cost of packages and level of complexity) and MH £2.7m. Other variances: Childrens backdated care packages & volume £2.5m and £2.6m in assessment & support - VAT invoice accrual, Liaison Gainshare and agency costs.
Mental Health Budget £255	£(1.19) -0.5%	£1.2m favourable variance due to over achievement on year to date efficiencies and other non recurrent slippage.
Prescribing Budget £210	£9.60 4.6%	£9.3m GP Prescribing overspend due to national cost pressures (linked to stock), continuous glucose monitoring devices and SGLT2 and efficiency slippage. Home Oxygen Service increased spend due to patients electricity costing £0.622m.
Primary Care Budget £345	£(19.38) -5.6%	Optometry and Pharmacy national pressures of £1.1m, LCS Complex dressing pressure £0.7m offset by prior year release and resilience releases and slippage in SDF (£3.0m). Plus dental contract hand backs, dental staff slippage and performance adjustment (£18.2m)
Other - Combined areas Budget £70	£(50.21) -71.7%	Benefits of non-recurrent opportunities including contract negotiations and prior year releases totalling -£18m. ERF over performance of -£14m and system support allocations -£7m. Plus other benefits across in-year allocation slippage, bad debt, vacancy factor and provision release.
Running Costs Budget £23	£(0.00) 0.0%	Spend on plan
Total £2,477	**£0.33**	

* Sodium-glucose co-transporter-2 (SGLT2) inhibitors = type of oral medication used to treat type 2 diabetes in adults

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4.0 Prescribing Efficiencies M12

Prescribing Efficiencies Top 10 by value Budget (£000's)		Actual (£000's)	Var (£000's) (Fav) Adv	Variance – significant items
OptimiseRx Budget	£1,800	£1,973	£(173) -9.6%	Significant increases in the take up of practices using OptimiseRx in the prescribing leading to overperformance
Continuation of 22/23 Schemes Budget	£1,740	£1,132	£608 34.9%	Underperformance in Low risk cost effective switches 22/23
Transformation and expansion of Prescription Ordering Direct (POD) Budget	£1,506	£321	£1,185 78.7%	Restructure resulting in reduced savings
DOAC edoxaban rebate and overall costs Budget	£1,000	£831	£169 16.9%	Introduction of reduced Apixaban costs had an impact on performance and changes to the rebate in early 23/24
Lower cost greener inhalers (Luforbec switch) Budget	£750	£594	£156 20.8%	Slower uptake than expected
Opioid Costs (supported by PQS/rebates) Budget	£500	£284	£216 43.2%	Lower than expected uptake from practices, some patients harder to remove prescriptions. Delays in elective surgery impacting also.
Blood glucose testing strips (PQS and switch) Budget	£450	£597	£(147) -32.7%	Easy incentive for practices to achieve, so good uptake and hence overperformance
Dressings Budget	£300	£300	£0 0.0%	Change in routing from FP10 to NHS Supplies helped achieve target
Sitagliptin windfall and switch Budget	£250	£226	£24 9.6%	Sitagliptin in short supply and affected performance.
Novarapid vs Trurapi Budget	£200	£98	£102 51.0%	Not as high an uptake from practices as planned
All other Schemes Budget	£730	£1,193	£(463) -63.4%	Overperformance in Low risk cost effective switches 23/24
Sub-Total	**£9,226**	**£7,549**	**£1,677**	
Unidentified Savings converted to identified Sitigliptin and Apixiban Budget	£1,885	£2,070	£(185.00) -9.8%	Windfall savings sitagliptin and apixaban
Grand Total	**£11,111**	**£9,619**	**£1,492**	

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5.0 LCS Activity Tracker

Norfolk and Waveney ICB Locally Commissioned Services Activity Tracker

Locally Commissioned Service	Full Year Activity Budget (£)	Full Year Claimed (£)	Utilisation %	Comment
Care Homes	341,391	292,941	86%	
Diabetes	299,474	453,844	152%	Over performance on the Key Care Processes and Treatment Targets elements of Diabeties linked to QOF acheivement pushing utilisation up
Eating Disorders	341,233	258,764	76%	
Inclusion Health	531,672	381,441	72%	
Mental Health SMI Health Checks	363,930	287,436	79%	Reduced level of utilisation linked to GP & Other staff resource required to carry out checks. Utilisation is improving potentially again linked to QOF performance going from fixed to variable payouts.
Phlebotomy	5,022,548	5,266,215	105%	
Proactive Healthcare	4,180,233	4,053,417	97%	
PSA	264,485	332,442	126%	Over performances by some practices
Shared Care	1,277,634	1,333,647	104%	
Spirometry	294,080	388,552	132%	Some practices signed up for scheme after the budget was set
Treatment Room	1,476,631	2,265,993	153%	Injections, Minor injuries and Post Op Wound care based on activity hence overperformance
Warfarin	807,584	716,881	89%	
Provision for over performance	725,404	-		Utilisation of provision held for over performance in M12
	15,926,299	**16,031,571**	**101%**	

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- The above shows the take up of claims for Locally Commissioned Services for 23/24
- The above is a mixture of block and activity-based schemes up until first 6 months of 23/24 only

Appendix A – Detailed Financial Position

Norfolk and Waveney ICB Service Line	Description	N&W ICB Annual Budget	N&W ICB Position at Month 12 £000s Budget	Actual	Variance	N&W ICB Forecast £000s Forecast	FOT Variance
Prescribing	Central Drugs	5,099	5,099	5,695	595	5,695	595
	Gp Prescribing	192,349	192,349	201,012	8,664	201,012	8,664
	Medicines Management - Clinical	3,763	3,763	3,484	(279)	3,484	(279)
	Other Prescribing	5,911	5,911	5,914	3	5,914	3
	Oxygen	1,991	1,991	2,614	623	2,614	623
	Prescribing Incentives	1,246	1,246	1,240	(5)	1,240	(5)
Prescribing Total		**210,359**	**210,359**	**219,960**	**9,602**	**219,960**	**9,602**
Primary Care	Gp Forward View	2,153	2,153	1,517	(636)	1,517	(636)
	Local Enhanced Services	9,499	9,499	14,209	4,710	14,209	4,710
	Other Primary Care	4,015	4,015	1,657	(2,357)	1,657	(2,357)
	PMS to GMS Transition	0	0	0	0	0	0
	Primary Care Delegated Co-Commissioning	221,008	221,008	216,972	(4,036)	216,972	(4,036)
	Primary Care IT	9,550	9,550	9,569	19	9,569	19
	DOP Delegated pay	769	769	563	(206)	563	(206)
	Ophthalmology Services	10,156	10,156	10,935	779	10,935	779
	Community Pharmacy	22,350	22,350	22,679	329	22,679	329
	Community Dental	3,363	3,363	3,247	(117)	3,247	(117)
	Primary Dental Services	47,921	47,921	30,054	(17,866)	30,054	(17,866)
	Secondary (Acute) Dental	14,381	14,381	14,381	0	14,381	0
Primary Care Total		**345,164**	**345,164**	**325,783**	**(19,381)**	**325,783**	**(19,381)**
Prescribing & Primary Care Total		**555,523**	**555,523**	**545,743**	**(9,779)**	**545,743**	**(9,779)**

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NHS
Norfolk and Waveney
Integrated Care Board

Agenda item: 14

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:	**11 June 2024**

Purpose of paper:

For information and discussion of strategic approach to medicines optimisation

Executive Summary:

Our strategic priorities are highlighted and discussion on implementation is welcomed.

1. Prescribing team focus areas.

1.1 The prescribing team is focused on supporting the prescribing quality scheme and an additional switch scheme which is in the final stages of development.

1.2 The prescribing quality scheme has facilitated some improvement in indicators (see below). The team continue to meet practices to facilitate implementation.

1.3 We will shortly be forming our four medicines optimisation pillars and producing workplans following the final structure announcement.

1.4 We have a number of strategic priorities within the medicines workstream. Some of these are mandated by NHS England who have asked the ICB to pick 5 from a national list of medicines optimisation opportunities here.

1.5 Our five are.

- Addressing problematic polypharmacy
- Addressing low priority prescribing
- Best value biologics in line with NHSE commissioning recommendations

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- Improving valproate safety
- Switching IV antibiotics to oral (hospital in-patients)

Addressing problematic polypharmacy, which is normally experienced as a high medicine burden due to guideline prescribing to a number of long term conditions can be a source of unplanned emergency admissions to hospital.

Approximately 1 in 7 emergency hospital admissions are linked to adverse reactions to medicines and 1 in 20 are medicines related and potentially preventable.

Appropriate use of structured medication reviews by clinical pharmacists within general practice, if targeted can help reduce these adverse reactions by monitoring performance of the medicines and discussing stopping any that are high risk and appropriate for deprescribing.

1.6 The national overprescribing review was published in 2021 here and this looks to explore the causes, consequences and the culture of prescribing.

1.7 Often it is more appropriate to use social prescribing when medicines are, in reality unlikely to tackle the underlying social problems of some patients. Diet and lifestyle changes, whilst not easy, should remain a first line option for some patients when considering increasing blood pressure medication for example or the use of antiobesity drugs.

1.8 The CPPE have now produced an introduction to the issue of overprescribing here. Prescqipp will be launching a series of webinars on social prescribing in September. Prescqipp have also discussed deprescribing through the Practice Plus programme intended to support clinical pharmacists in general practice.

2. ICB Performance on polypharmacy indicators

2.1 Table 1 below shows that the ICB is broadly average on the overall polypharmacy indicator of unique medicines per patient in all ages. The second part of the chart shows that the number of medicines is going up nationally and locally but we are behind the national trend now.

2.2 There is a need to upskill our pharmacy workforce to provide high-quality targeted SMR's with a focus on reduce harm, and sometimes achieving this through agreed and safe deprescribing.

2.3 Stopping a medicine should become almost as common as starting a medicine. Sometimes there is a need for social prescribing rather than medicine prescribing. Evidence in deprived boroughs e.g. Tower Hamlets

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suggest that social prescribing is effective in reducing unnecessary medicine burden.

2.4 All pharmacy teams are advised to attend the regular Practice Plus workshops provided by PrescQipp

For example

Introducing Practice Plus

PrescQIPP Practice Plus is a professional network developed to connect PCN and practice pharmacists and pharmacy technicians with each other and to the wider NHS. Led by experienced clinical practice pharmacists, this network will support your development and enable the sharing of good practice as well as support with problem solving.

Next meeting: 13.00 – 14.00, 11th June 2024

A practical SMR Masterclass with Lelly Oboh and the PrescQIPP team

Join Lelly Oboh, Consultant pharmacist for Older People, Katie Smith, our Director of Clinical Quality and Sajida Khatri our Director of Medicines Optimisation along with others from the PrescQIPP team for a masterclass on how to deliver quality structured medication reviews (SMRs) to meet the PCN requirements of the network contract DES.

The webinar will highlight the range of PrescQIPP resources available to you and Lelly's expert advice and recommendations to do an evidence-based and comprehensive review of a patient's medication.

2.5 There are also tools provided by PrescQipp to help clinicians prepare for more complex medication reviews e.g. the Impact tool (registration required)

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Using IMPACT for a medication review

Webinar

On 12th October 1-2pm, Katie Smith, Director of Clinical Quality at PrescQIPP and Lelly Oboh, Consultant Pharmacist (Care of older people) demonstrated how to utilise IMPACT when doing a medication review.

Lelly has considerable experience of optimising medicines use in frail older people within general practice and community-based multidisciplinary teams and will use case studies to highlight how IMPACT supports her routinely in practice.

Watch the webinar

2.6 We have asked the data hub team to turn some of the available sources of information around polypharmacy and the data on SMR's into a potential dashboard for benchmarking and discussion with PCN's, practices and pharmacy teams within primary care.

2.7 At the moment these data sources aren't linked and aren't very user friendly.

2.8 We welcome comments and discussion around benchmarking, upskilling and improving the quality of SMR's and how to improve the confidence of individual prescribers to deliver safe and appropriate deprescribing in problematic polypharmacy.

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Table 1: Polypharmacy indicator – number of unique medicines per patient, March 24, all ages.

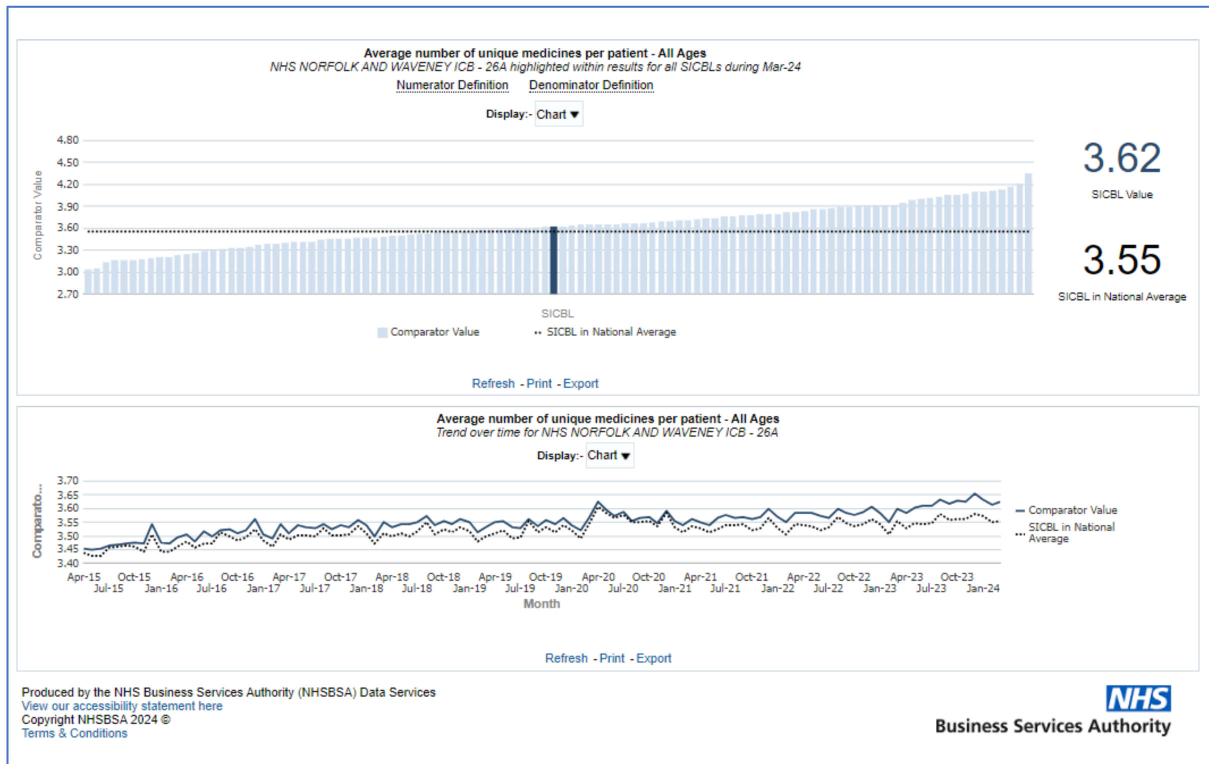

Table 2: Polypharmacy indicator – number of unique medicines per patient, March 24, aged over 75 years by PCN data

Average number of unique medicines per patient - Aged 75 and over

SWAFFHAM & DOWNHAM MARKET PCN highlighted within results for NHS NORFOLK AND WAVENEY ICB - 26A during Mar-24

Numerator Definition Total number of unique medicines prescribed for patients from BNF chapters 1 to 4 & 6 to 10

Denominator Definition Total number of patients prescribed one or more medicines from BNF chapters 1 to 4 & 6 to 10

Source: ePACT2

PCN	Numerator	Denominator	Comparator Value	PCN In Reporting SICBL Average	PCN In National Average
SWAFFHAM & DOWNHAM MARKET PCN	34,230	6,465	5.29	4.87	5.05
FENS & BRECKS PCN	23,072	4,445	5.19	4.87	5.05
KINGS LYNN PCN	36,989	7,212	5.13	4.87	5.05
BRECKLAND SURGERIES PCN	19,269	3,779	5.10	4.87	5.05
MID NORFOLK PCN	28,918	5,741	5.04	4.87	5.05
WEST NORFOLK COASTAL PCN	20,852	4,146	5.03	4.87	5.05
NORTH NORFOLK 4 PCN	32,589	6,613	4.93	4.87	5.05
GREAT YARMOUTH & NORTHERN VILLAGES PCN	27,030	5,488	4.93	4.87	5.05
SOUTH NORFOLK HIP PCN	48,363	9,890	4.89	4.87	5.05
NORTH NORFOLK 2 PCN	28,336	5,918	4.79	4.87	5.05
NORTH NORFOLK 3 PCN	26,823	5,626	4.77	4.87	5.05
SOUTH WAVENEY PCN	34,026	7,218	4.71	4.87	5.05
NORTH NORFOLK 1 PCN	29,522	6,279	4.70	4.87	5.05
GORLESTON PCN	19,328	4,112	4.70	4.87	5.05
KETTS OAK PCN	29,238	6,290	4.65	4.87	5.05
NORWICH PCN	71,324	15,690	4.55	4.87	5.05
LOWESTOFT PCN	33,598	7,505	4.48	4.87	5.05

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Table 3: Polypharmacy indicator – number of unique medicines per patient, March 24, aged over 75 years by PCN bar chart

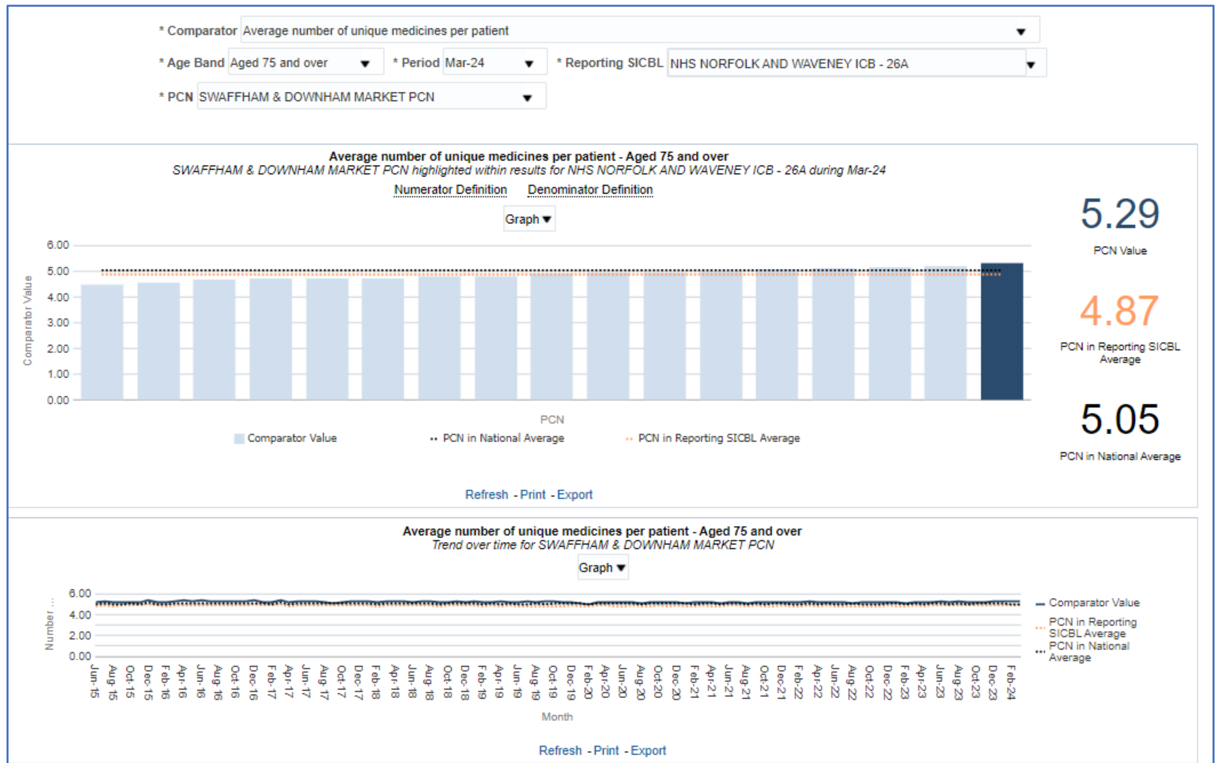

Table 4: NHS pathways screenshot showing modules to support practices with tailored SMR's

National medicines optimisation opportunities 2024/25

This is a supplementary support tool to be utilised in conjunction with your core clinical software.

NHS Great Yarmouth And Waveney CCG ↓

SMR Case Load | Priority SMRs | All SMR Pathways | Care Home

STOMP | Polypharmacy | High Risk Drugs | Medication Related Indicators | RADAR Alerts | **Frailty**

Recent Admissions | Dependency | Deprescribing | Antimicrobials | Carbon Optimisation | Pincer

	Prescribing Pathway	Prevalence	Alerts	Patient Engagement	Rating	
	Severe Frailty	1,868 0.8%	25 / 1 78 / 5	0.0% 0/1,868	-	View

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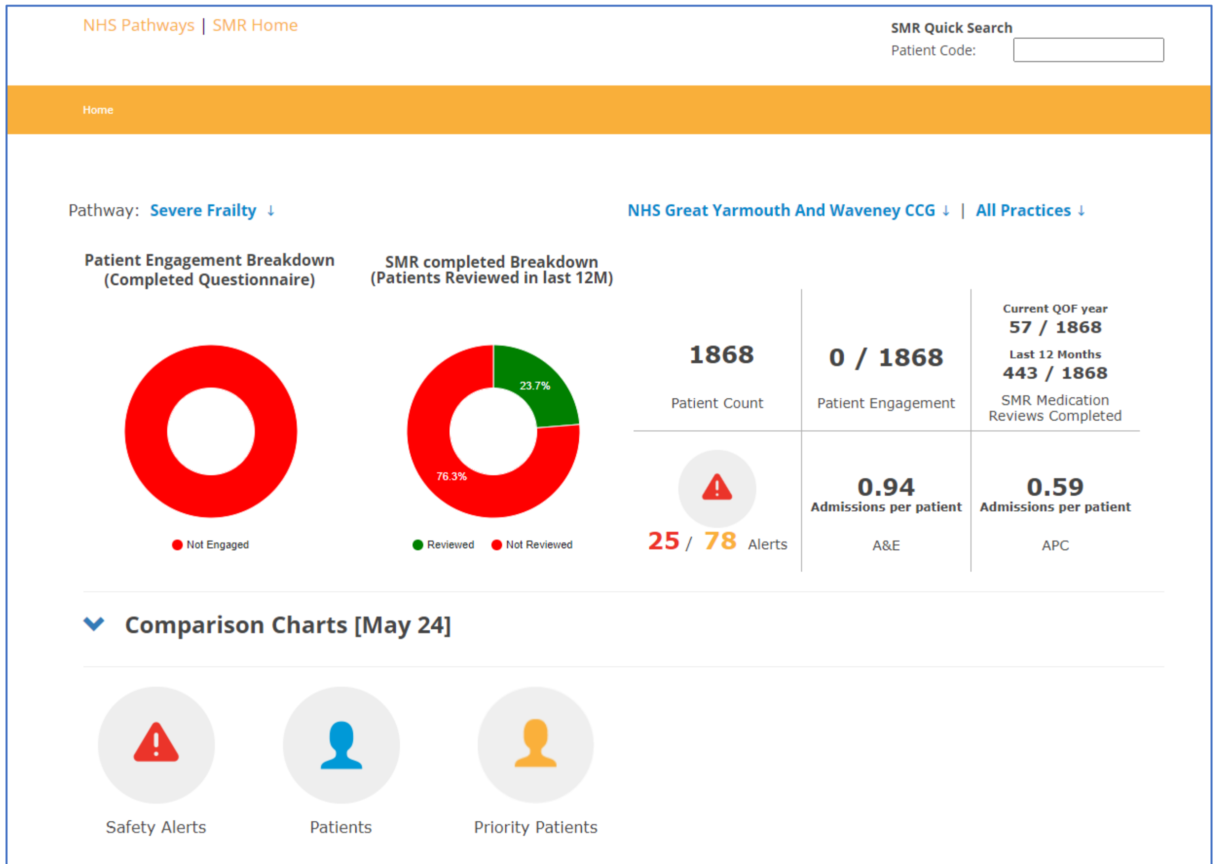
Table 5: NHS pathways screenshot showing how to access patient details for review



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Recommendation to 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 identified
Reputation:	ICB practices remain outliers for some quality indicators and selective medication reviews may help address these
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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NHS
Norfolk and Waveney
Integrated Care Board

Agenda item: 15

Subject:	Primary care access recovery plan and improving the issues across the primary-secondary care interface
Presented by:	Mark Burgis, Executive Director of Patients and Communities Sadie Parker, Director of Primary Care
Prepared by:	Sadie Parker, Director of Primary Care Amanda Sear, Senior Manager, Primary Care
Submitted to:	Norfolk and Waveney ICB Board
Date:	22 May 2024

1. Introduction

The purpose of this paper is to provide an update on progress of the system capacity and access recovery plan in response to the Delivery Plan for Recovering Access to Primary Care; and, as part of this, the work on-going to support improvements across the primary-secondary care interface.

An overview of Pharmacy First, launched on 31st January 2024 is also included. Pharmacy First is a national scheme designed to make pharmacies the first port of call for many patients who need healthcare advice and potentially treatment for several common health conditions without needing a GP appointment and is a key pillar of plans for recovering access to primary care.

2. Background

This paper seeks to set out progress made since the paper presented to the Board in November 2023.

Primary care access recovery plan

The expected outcomes for 2023/24 included:

1. We will continue to develop our interface programme of work and review all opportunities within the ‘General practice and secondary care: Working better together’ report.
2. We aspire to increase the number of sign-ups to the NHS App, and we will support practices to deliver promotional events for their patients.
3. We aim to support 34 practices to update their telephony systems to a cloud-based system to help them to better manage their call demand, so patients get a better experience of contacting the practice.

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4. We want to support as many practices as possible to transition to the modern general practice access model by the end of 2024/25 maximising the use of the transition funding provided to ICBs.
5. We seek to develop a culture of improvement and want to work with practices and PCNs to harness the power of technology and the tools available to support this.

Please see the following progress updates on each of the expected outcomes for 2023/24 listed above.

We will continue to develop our interface programme of work and review all opportunities within the 'General practice and secondary care: Working better together' report.

The ICS' Clinical Interface Group, chaired by the ICB Executive Medical Director has continued to meet, with positive engagement from system partners. The group has a wider remit than that set out in the Delivery Plan guidance, recognising that when the interface between primary and secondary care works well, the patient experience is far more positive.

Recruitment is underway to recruit to a dedicated interface post within the ICB primary care team to support the co-ordination of our work across the system. The role will work with clinicians and managers across ICS partners to develop, implement and monitor processes which support good, organised care and enables clinicians to deliver the changes needed in a way they recognise and value.

- In 2023, 53/105 practices reported at least one issue. 625 issues were reported in total.
- In 2024 as of 24th April 37/105 practices have reported at least one issue. 269 issues have been reported to date.
- In 2023, the numbers of issues reported by individual practices ranged from 1 to 109.
- In 2024, as of 24th April, the numbers of issues reported to date by individual practices ranged from 1 to 51.
- 9/105 practices have reported over 20 issues in 2023.
- 52/105 practices have never reported an issue.

Key themes to date include:

- Ensuring appropriate health professionals working in the community, can request laboratory tests via the WebICE system (for example for wound swabs, urine cultures, nutrition monitoring bloods) and similarly to receive their own results directly, to reduce clinical risk and prevent duplication of work in practices.

  The Queen Elizabeth Hospital has implemented this system. The Norfolk and Norwich and James Paget Hospitals have formed a working group to progress this work and development of a roll-out plan is underway.

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- Ensuring appropriate health professionals working in the community, can

request other diagnostic tests via the WebICE system after appropriate training in line with Ionising Radiation (Medical Exposure) Regulations (for example first contact physiotherapists being able to request plain X-rays) and similarly to receive their own results directly, again reducing time, errors and additional work for practices.

The Queen Elizabeth Hospital has implemented this system. The Norfolk and Norwich and James Paget Hospitals are committed to implementing this for those working in the community. The LMC has been particularly helpful in the development of this approach.

- Enabling private consultants to refer patients directly into Trusts, rather than requesting the GP makes that onward referral to hospitals.

  The Trusts review their Access Policies annually and this is expected to be included in the next update. While agreed in principle by all Trusts, there are technical issues with enabling private consultants to refer electronically.

- Trusts offering complete care e.g. making onward referrals as appropriate, sending urgent prescriptions directly to patients rather than asking them to seek these from primary care, arranging their own follow up phlebotomy, and checking and acting on results as well as other necessary follow up care instead of asking the patient's GP to act on or arrange these.

  All Trusts are committed to enabling their teams to undertake complete care. Trust self-assessments suggest this is not a systemic issue, but that one-off incidents continue to occur, and therefore this remains one of the key themes being reported through our reporting process. There are technical issues with Trust clinical systems which prevent electronic prescribing to a community pharmacy.

- Trusts issuing fit notes for the full duration of absence as opposed to passing these requests back to GPs.

  This is now one of the lowest reported themes from practices, with several months having seen no reported issues. This is well understood in Trust specialties, however one-off incidents continue to occur. There are technical issues associated with the Trust clinical systems, which prevent electronic fit notes in being issued.

- Improving communication, such as timely discharge letters which appropriately and clearly signal any actions or important information for general practice

  This has been one of the lowest reported themes from practices, with several months having seen no reports. This is well understood in Trust specialties.

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During February and March there appears to have been an increase in communication issues highlighted, including missed and delays with information reaching general practice. 17 issues were logged in February overall - and 6 as of 13 March. Work to understand and resolve issues flagged is ongoing.

- Developing and implementing a process for reviewing and agreeing new pathways of care, to ensure there are no unintended consequences on general practice.

This process is now well-established, and time is spent understanding any concerns the LMC has and how they can be addressed before pathways and referral forms are finalised. Where we cannot agree to a particular requested change, the rationale is provided to the LMC.

All providers have undertaken the contractually required self-assessed gap analysis and developed an action plan for improving the effectiveness of their interface working arrangements, in line with the NHS standard contract annual requirements. This process is overseen by the ICB's contracting and procurement team. Recognising contractual issues are likely to be significantly under-reported, the ICB has also been using data collected from the reporting process to support the Trusts with their action planning.

The *General practice and secondary care: Working better together* report outlines potential quick win actions for systems to implement to improve the working across the primary-secondary care interface. Good progress continues to be made with implementing the suggested actions (see Appendix A).

A new mandatory Self-Assessment Tool was introduced by the national team and had its first deadline at the end of April 2024. An update was given at the April Provider meeting, demonstrating a positive response from the acutes. They all provided a clear and thorough assessment responding to the 4 priority headings: Onward Referrals, Discharge, Call/Recall and Clear Points of Contact. Future actions were identified and acknowledged, with a collaborative supportive format agreed. This will be repeated six monthly so that NHS England can monitor progress nationally, and the following update will be in October 2024.

Challenges

Progress continues to be made in the high priority areas for improving the working across the primary-secondary care interface, however a challenging winter and the impact of strikes affected the capacity of NHS provider organisations to respond as quickly as they might have liked.

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Progress with implementing some of the key initiatives, such as ICE requesting and enabling private referrals, has been slow. Nationally, it is reported that interface issues make up approximately 20% of practice workload with an already over-stretched workforce, and while our local practices anecdotally report the same, we do not have the local data to evidence this. Under-reporting of issues from general practice is likely to be masking capacity issues.

Reporting patterns and referral behaviours, however, may change in light of the British Medical Association's General Practitioners Committee England being in dispute with NHS England in relation to the 2024/25 General Medical Services contract for general practice. The BMA has written to ICBs asking them to include a new risk on their Board Assurance Framework. This has been included in our general practice resilience risk reporting. We will be monitoring any potential impact associated with the dispute across the primary – secondary care interface, and other areas closely as the situation develops.

We aspire to increase the number of sign-ups to the NHS App, and we will support practices to deliver promotional events for their patients.

Many NHS App promotion events have been held since last July, dozens of NHS App Ambassadors have been signed up, and an NHS App toolkit developed for practices to use. Half a million Norfolk & Waveney residents are registered for the NHS App, which is just over 51% of the population with a range of practice sign up from 41% to 69%. Over the last 3 months, new sign ups to the NHS app in Norfolk & Waveney have been 49,000, 49,500 and 51,000 patients consecutively, which demonstrates that the numbers are growing regularly. We can also see that there are 600,000 log ins to the NHS App monthly, with 75,000 repeat prescriptions are ordered and over 300,000 patient record views.

We aim to support 34 practices to update their telephony systems to a cloud-based system to help them to better manage their call demand, so patients get a better experience of contacting the practice.

The Digital Team had implemented a pilot programme of cloud-based telephony (CBT) support before the national scheme was introduced. This included 38 practices with an operational date of the end of October 2024. Through the national scheme, a further 50 practices have been funded for Cloud Based Telephony systems over two phases. Of these, 36 practices are live with their new systems and 14 are in flight, with all installations due to be completed by the end of October 2024. The remaining 17 practices have CBT in other forms or with providers not on the national framework. This is for a variety of reasons, including contracts terms already agreed. The Digital Team continues to support these practices to ensure that their systems are compatible with national reporting requirements.

As well as valuable information on incoming calls to support management of demand and capacity, the new systems have call back functionality which means patients do not have to stay on the line paying for the call, the practice will ring back when the patient reaches the front of the queue.

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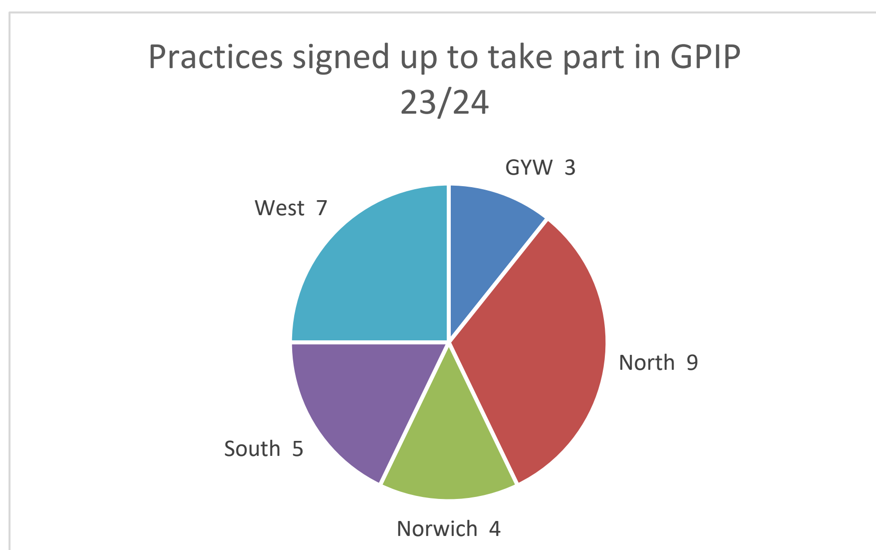
We want to support as many practices as possible to transition to the modern general practice access model by the end of 2024/25 maximising the use of the transition funding provided to ICBs.

The GP Improvement Programme and Care Navigation Training assists practices in moving towards the General Practice Access Model.

Throughout 2023/24 all practices have been working as part of their primary care network under PCN Capacity and Access Improvement Plans (CAIP), to move towards greater alignment with the Modern General Practice Access Model. Each of the PCNs have been working towards achieving the milestones they submitted in their CAIP at the start of 2023/24. The Primary Care Commissioning team have been coordinating the process of receiving the PCN plans, reviewing them, providing feedback and guidance and supporting PCN Leads with delivery. Through this process the team were able to identify practices which needed additional support or could benefit from the various training offers.

The team are now in the process of reviewing the end of year reports for 2023/24 and releasing the final 30% of payment for local Capacity and Access Improvement from the Investment and Impact Fund. Based on progress to date, it is expected that all PCNs will receive the full final payment.

The GP Improvement Programme (GPIP) provides a suite of training & support offers, ranging from online resources to in-person facilitated workshops. Across the East of England, Norfolk & Waveney ICB have the highest number of practices accessing GPIP as an ICB. As part of this, 28 practices have signed up to the GP Intermediate or Intensive Support Programme (see below for a breakdown by Locality). The programmes provide a hands-on package of support delivered over either 13 weeks (Intermediate) or 26 weeks (Intensive).



N&W ICB Practices Signed up to GPIP by Locality (2023/24)

Care Navigation training to February 2024: uptake across Norfolk and Waveney shown below:

- 68 practices have sent staff on a course (64.76% uptake from practices in N&W)
- Every PCN has sent at least one learner on a course.
- In total 123 learners attended a Care Navigation course over the past year (March 2023 - February 2024).
- Highest attendance was on the National Foundation Level courses (63 learners), followed by the local course (48 learners) and Advanced Level (12 learners).

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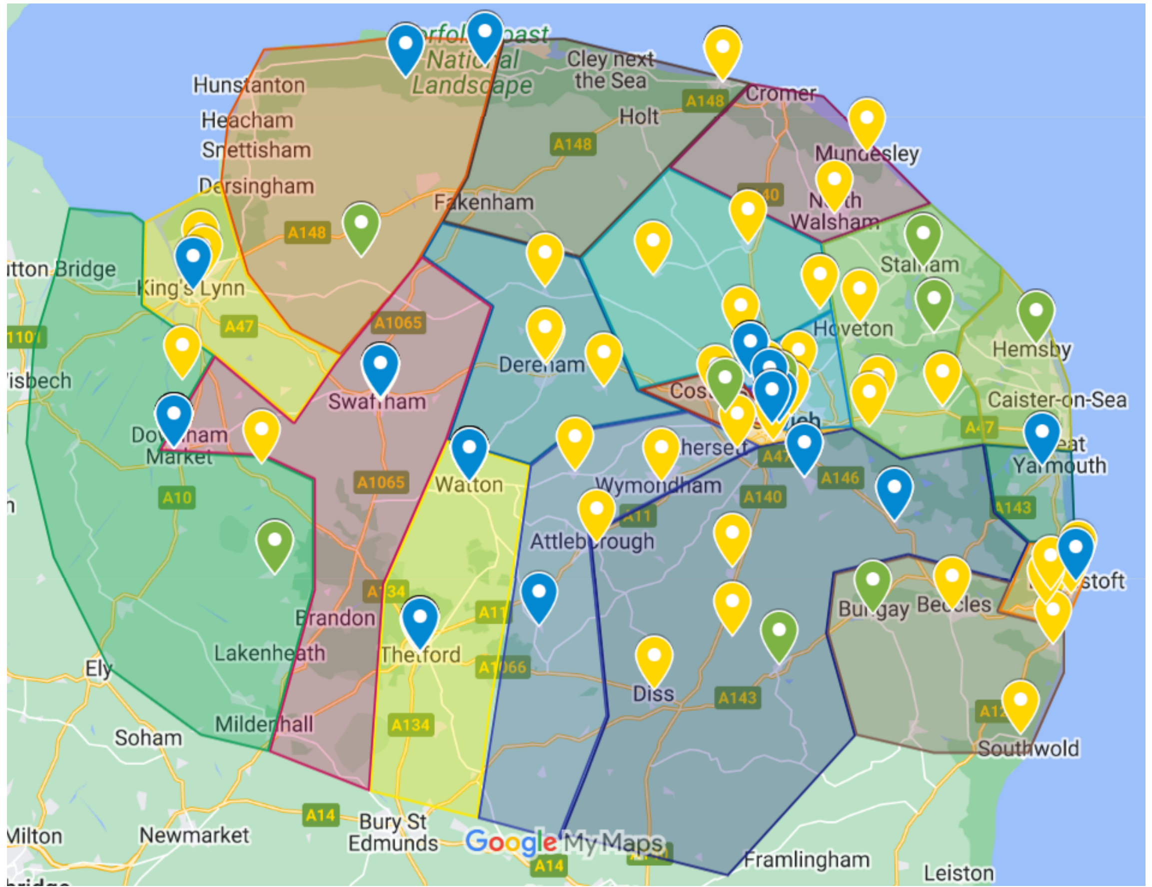

Key:
Green – Advance National Programme
Blue – Local Programme (via Training Hub)
Yellow – National Programme

Transition Cover Funding

Norfolk & Waveney ICB were allocated £860,000 in Transition Cover Funding for 2023/24 and were able to draw down 99% of this funding for practice support. £305,089 was released in response to 38 practice requests in February 2024. A further £547,158 was paid to 66 more practices by the end of March 2024.

Practices receiving the Transition Cover Funding have been asked to provide the following by the end June 2024:

- Completed Support Level Framework or Self-Assessment Form.
- Evidence to demonstrate their use of funding.

The Support Level Framework and Self-Assessment forms provide insight into where practice believe they are and where they are heading to across three key areas:

- Understanding demand and available capacity
- Patient experience
- Managing non-patient facing workload

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We seek to develop a culture of improvement and want to work with practices and PCNs to harness the power of technology and the tools available to support this.

Whilst the national Digital Pathways Framework launch has been delayed, this has not stopped progress in the use of digital tools and technology. Practices are supported through provision of an intranet site, giving access to resources and information about clinical system optimisation, best practice in messaging, the online consultation systems available and how to switch. Practices also have direct access to the Clinical Systems and Digital First Primary Care Support team for any queries they may have.

Practices have been provided with modern messaging tools, enabling direct messaging to patients via a floating toolbar, which also allows links to forms allowing patients to provide information directly.

Practices have access to a social media managed service that runs campaigns on their behalf, such as promotion of the NHS App and Pharmacy First schemes.

Two area wide forums are in place, DIGIT is a forum for anyone with an interest in IT and digital tools in primary care, and a separate, smaller forum is aimed at the PCN Digital Transformation Leads, giving them more detailed information on initiatives that can support primary care.

A small number of practices have adopted RPA – robotic process automation – of patient registrations and are saving around 15 minutes per registration. The ICB Digital Team has developed an automation for processing repeat prescriptions and this is also being made available to practices.

We are working on initiatives with Care Homes such as proxy access for online medication ordering and remote observations, to take tasks away from General Practice, and are rolling out the Shared Care Record to give clinicians in other settings access to information that they need without having to call the GP Practice.

New modern infrastructure is being implemented in all GP Practice premises which will bring fast fibre connectivity and wi-fi throughout the building, enabling the use of apps and giving patients the ability to use the internet to access services and information. Visiting clinicians from other services such as Mental Health, will be able to connect seamlessly using GovRoam.

Pharmacy First

Progress

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In May 2023 when the delivery plan for recovering access to primary care was launched an ambition was set to build on the clinical services provided within our community pharmacies to help support their integration within the NHS and to

make them the first port of call for many minor illnesses

This saw significant investment in:

- The launch of a new national Pharmacy First service enabling pharmacies to treat seven common conditions without the need in most cases for referral to a GP.

    - otitis media
    - sore throat
    - sinusitis
    - shingles
    - infected insect bites
    - impetigo
    - uncomplicated urinary tract infections in women

- Expansion of the already existing hypertension service which has already delivered over 930,000 blood pressure checks in just over a year. This has the potential to prevent over 1,350 cardiovascular events such as heart attacks and strokes. Savings of around £13 million would be seen from the reductions in these events across primary, secondary, and social care.

- Development of the oral contraception service to allow Community Pharmacist to not only continue treatment for patients but also to initiate treatment.

In all 3 cases it means that more people have the possibility of being seen outside of a GP setting for their triage and treatment, albeit Pharmacy First is a voluntary service for community pharmacy.

We currently have 168 community pharmacies out of 171 across Norfolk and Waveney signed up to provide the Pharmacy First service. All pharmacies signed up to the Pharmacy First service also have the capacity to support minor ailment referrals.

- To date we have had no patient concerns raised directly to the ICB regarding the service which points to a successful launch.

- Data shows that we have had activity on our ICB website landing page, which includes a *frequently asked questions* section.

- General practice engagement with the service overall has been good, but the ongoing impact of workforce challenges on pharmacy service provision in some area has caused some expected nervousness in making electronic referrals in preference to signposting.

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Challenges

- **Digital Integration** - The service, when introduced nationally at the end of January 2024, launched with unexpected, **limited** IT functionality. NHS England continues to work on this element of digital interface, and we

understand the rollout of this will be phased imminently across the four pharmacy IT platforms mandated as part of the service.

- **Absence of activity data –** ICB level data remains unavailable 3 months post launch. We are assured this data will be available in due course.

- **Lack of formal referrals –** most activity is currently driven through signposting or walk-ins. Increasing the use of electronic referral system by General Practice, particularly for pharmacies located in more rural locations, will be key to making the scheme viable for pharmacies in the longer term.

- **Lack of training –** training linked to the national launch was limited, particularly with general practice and NHS111 providers - a local engagement plan has been developed designed to fill some of the gaps. Clinical training was provided locally by the ICB for 120 pharmacists with a focus on upskilling knowledge for ENT (ears, nose and throat) and the use of otoscopes. Clinical mentoring is also being reviewed as part of our review of development and training needs.

Key next steps:

- Develop a toolkit/support package for our local practices to support with frequently asked questions.

- Work continues improving the functionality for referrals between General Practice and Pharmacy, this is critical to the future of the service. Although the current format is fully functional there is limited desire to use it due to it not being user friendly. If following research, a more user-friendly option is not available then a robust support package will need to be developed to ensure the uplift of electronic referrals using current functionality.

- Develop a training package and review the need for training sessions for our general practice teams on electronic referrals (current solution) to support the need for this approach going forward.

- Continue to monitor the risks of the service using the intelligence we receive within the ICB to ensure that patient safety is not impacted, and that support is provided in the areas where it is required. This will be done in conjunction with the ICB Pharmacy quality team.

- Deliver a post launch CPD (Continuing Professional Development) event for pharmacy contractors and general practice colleagues involved in the service to gain feedback and insights into opportunities for support post launch. The event is due to be completed in May 2024 and the invite to all relevant stakeholders has already gone out for parties to register their interest.

- Explore the need for a clinical mentorship programme to help support pharmacists within this new clinical field. This will also help to build and maintain current local relationships and to support our integration agenda.

- Develop a Pharmacy First communication plan and release patient directed communication to highlight the service locally, to encourage patients to think Pharmacy First. The timing of this will be key to ensure the public's confidence in the service remains high following positive experiences Our first directed

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communication was over the Easter period and focused on the Infected Insect Bite Clinical Pathway due to its seasonal occurrence at this time.

Once the Pharmacy First service has embedded, focus will switch to the hypertension and contraception services with the encouragement for sign up from our community pharmacies with initial numbers being low compared to that of the Pharmacy First service.

The Primary Care Workforce Team (PCWT) at Norfolk and Waveney ICB works alongside colleagues from community pharmacy to support the uptake of the Pre-Registration Trainee Pharmacy Technician Programme. The PCWT supports employers in accessing their government levy, regional funding allocation and supports candidates with their application to the course. With potential changes in supervision in pharmacy there will be more emphasis on technicians taking greater accountability for the operational running of the dispensary whilst the Pharmacist focusses on patient care and services. The role of a GPHC Registered Pharmacy Technician is essential to the future of the pharmacy workforce and the long-term aspirations of the workforce/recovery/access plan.

Conclusion

Whilst progress continues against implementing the ambitions outlined within the Delivery plan for recovering access to primary care, the resilience of general practice remains a significant issue and, without addressing this, delivery against some of the ambitions in our system capacity and access improvement plan will be limited.

New posts were introduced under the ICB organisational change programme designed to bring a greater focus across all system partners on the overall resilience of general practice and to improve the effectiveness of outputs from the System Interface Group. As the ICB transitions into the new operating model a positive impact is expected. The dispute, however, between the British Medical Association's General Practitioners Committee and NHS England has the potential to disrupt many of the workstreams sitting under the recovering access programme. The ICB will continue to monitor the national and local situation closely and work with providers to mitigate this wherever possible.

Recommendation

The ICB Board is asked to note the following:

- The progress, and challenges, against the ambitions of the *Delivery Plan for Recovering Access to Primary Care* and *General Practice and Secondary Care: Working better Together.*
- The focus on year two of the delivery plan against key targets will continue to follow the key themes of:
    - Empowering patients
    - Implementing modern general practice access

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- Building capacity
- Cutting bureaucracy

Further detail on delivery actions for 2024/25 can be found in Appendix C, with locally led workstreams for embedding Pharmacy First, improving interface, building our primary care workforce and supporting effective Primary Care Network plans for improving access under the PCN DES Contract. A further update will be brought to Board, in line with the national guidance requirements, later in the year.

Underpinning all workstreams will be an approach aimed at improving the resilience of primary care and addressing health inequalities.

Key Risks	
Clinical and Quality:	Quality and capacity in primary care can be impacted due to inefficient working arrangements across the primary-secondary care interface, causing resilience and workforce issues.
Finance and Performance:	Capacity of care can be impacted due to inefficient working arrangements across the primary- secondary care interface. Potential industrial action by general practice could impact on the performance of other healthcare partners. Failure to progress against the interface requirements of the plan will affect the ICB's and ICS assurance process.
Impact Assessment (environmental and equalities):	Reduced capacity could constrain the ability to target health inequalities.
Reputation:	Non-delivery of the ambitions outlined within the plan poses a significant system reputational risk due to the high profile of the plan nationally. Lack of perceived progress against primary secondary interface poses a reputational risk with practices.
Legal:	None identified
Information Governance:	System IG group established in response of challenges working across providers highlighted in previous report.
Resource Required:	Primary Care Workforce Transformation, Contracting and Procurement, Medical Directorate, Mental Health Directorate and Digital and Primary Care resource must be retained to support the delivery of this plan. Dedicated capacity within the ICB and secondary care providers is required to ensure timely progress with improving issues across the primary- secondary care interface. There is an ICB capacity risk relating to the

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	organisational change process and associated vacancy management processes.
Reference document(s):	Delivery Plan for Recovering Access to Primary Care General practice and secondary care: Working better together Delivery Plan for Recovering Access – Update published December 2023 https://www.england.nhs.uk/long-read/primary-care-access-recovery-plan-delivery-update/ Delivery Plan for Recovering Access – Update and Actions published April 2024 https://www.england.nhs.uk/publication/delivery-plan-for-recovering-access-to-primary-care-update-and-actions-for-2024-25/
NHS Constitution:	NHS Standard Contract
Conflicts of Interest:	GP and Trust partner members may be conflicted.
Reference to relevant risk on the Board Assurance Framework	Risk to resilience of primary care, on BAF and monitored through PCCC. Score of 16.

Governance

Process/Committee approval with date(s) (as appropriate)	N/A

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Appendix A

Progress against potential quick win actions for systems set out in *General practice and secondary care: Working better together* report

Recommended action	Progress
GPs giving trainee doctors regular 'show and tell' sessions on how to fill out discharge summaries in the most informative and accessible way.	**On-going** Providers have suggested they include information about the interface requirements within their junior doctor inductions and teaching sessions. This is currently in progress.
Provide clinicians with read-only access to health record systems across the interface.	**On-going** The Norfolk and Waveney Shared Care Record is being rolled out across the system, supporting this action.
Employ a Primary Care Liaison Officer to help in the resolution of queries between secondary care and general practice	**On-going** This has been highlighted to our providers for consideration. The Norfolk and Norwich Hospital has recruited a GP to be their Associate Medical Director supporting Primary Care Liaison. Other providers are developing local interface forums to resolution of queries between secondary care and general practice. ICB is recruiting to dedicated interface manager role.
Provide patients with a written update on where they are on the waiting list, asking if they still require or want treatment	**On-going** This recommendation has been shared with our providers. Providers already contact patients, either by phone or letter, when they have been waiting for extended periods to confirm they wish to remain on the waiting list. The ICB regularly provide practices with updates on waiting times per specialty and provider so that this information can be shared with patients at the time of referral.

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Standardise outpatient clinical letters where possible (placing particular emphasis on concise GP recommendations)	**On-going** There is work ongoing currently led by the ICB to review the content of clinic letters, including the requirement for clinic letters to be addressed directly to patients rather than referrers. This action is being considered alongside this work.

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Appendix B

A. Empower patients			
1	Enable patients in over 90% of practices to see their records and practice messages, book appointments and order repeat prescriptions using the NHS App by March 2024.	**Partially complete**	Half a million Norfolk & Waveney residents are registered for the NHS App. 75,000 repeat prescriptions are ordered via the NHS App by Norfolk & Waveney residents each month via the App and there are 308,000 record views.
2	Ensure integrated care boards (ICBs) expand self-referral pathways by September 2023, as set out in the 2023/24 Operational Planning Guidance.	**On track**	Self-referral pathways are in place across the services in the community and acute settings. At the end of March 2024 self-referrals made up 16% of all referrals for 23/24. For the community provided services it was 29% and for the acute based services it was 5%.
3	Expand pharmacy oral contraception (OC) and blood pressure (BP) services this year, to increase access and convenience for millions of patients, subject to consultation.	**Ongoing**	Launched December 2023, see paper for further detail for plans to monitor and expand.
4	Launch Pharmacy First so by the end of 2023 community pharmacies can supply prescription medicines for seven common conditions.	**Ongoing**	Launched January 2024, see paper for further detail on next steps and challenges.
5	Greater flexibility to release pharmacists' time for patient-facing services.	**On track**	Public consultations delivered and legislative changes, in preparation, the Primary Care Workforce Team are working alongside colleagues from community pharmacy to support the uptake of the Pre-Registration Trainee

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			Pharmacy Technician Programme
B. Implement Modern General Practice Access			
6	Support all practices on analogue lines to move to digital telephony, including call back functionality, if they sign-up by July 2023.	**Implementation nearing completion**	88 practices signed up and due to transition under two national phases and system pilot programme, 36 practices now live with the rest due to be completed by the end of October 2024. 17 remaining practices have their own CBT solution
7	Provide all practices with the digital tools and care navigation training for modern general practice access.	**Complete**	All practices have had access to funding to support procurement of digital tools. Further details of care navigation uptake can be found in the paper.
8	Deliver training and transformation support to all practices from May 2023 through National General Practice Improvement Programme.	**Complete**	All practices offered opportunity for support, further detail of take up can be found in the paper.
C. Build capacity			
9	Make available an extra £385 million in 2023/24 to deliver 26,000 more direct patient care staff employed and 50 million more appointments by March 2024 (versus 2019).	**Complete**	We have delivered both and exceeded staff roles within Direct Patient Care roles compared to 2019. DPC FTE across Norfolk and Waveney – total 1,118.39 FTE PCN Joiners rates 71% for DPC DPC ARRS increase by 39% since March 2019

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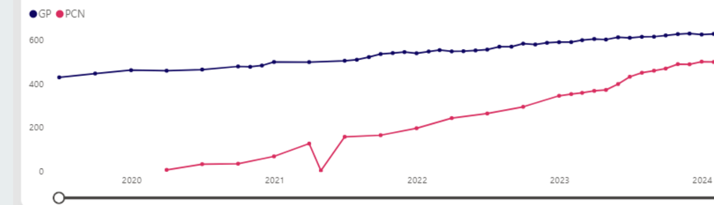
Primary Care - GP & PCN Workforce

Breakdown of both PCN and GP staff in post (FTE) as at the latest month submission, and over time.



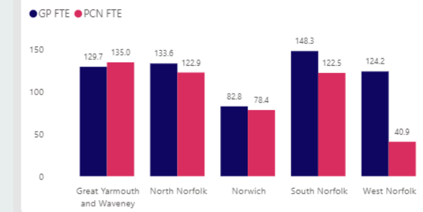
618.67 Latest GP FTE

499.72 Latest PCN FTE

Filters applied:

Staff Group: DPC

Place: Multiple selections



Staff Group	Latest GP FTE	Latest PCN FTE	PCN Leaver Rate	PCN Joiner Rate
DPC	**618.67**	**499.72**	**25.2%**	**71.0%**
Advanced Occupational Therapist Practitioner	0.00			
Advanced Paramedic Practitioner	15.85	1.79	0.0%	200.0%
Advanced Pharmacist Practitioner	9.49	6.52	92.2%	260.8%
Advanced Physiotherapist Practitioner	0.20	0.43	0.0%	200.0%
Advanced Podiatrist Practitioner	0.00			
Apprentice	0.00			
Apprentice - Health Care	0.00			
Apprentice - Other	4.53			
Apprentice - Pharmacist	1.00			
Total	**618.67**	**499.72**	**25.2%**	**71.0%**

10	Further expand GP specialty training	**Ongoing**	86% of N&W are now an approved training practice by NHSE 35% increase of Tier 3 Educators across the system during 23/24, this is an additional 35 Tier 3 GP's 5 PCN's piloting the PCN Learning Organisation Model 95% success rate of an 18-month GP Fellowships from CCT qualification within primary care. 19 new GP Fellowships within 23/24 and expected 21 new GP Fellowships within 24/24.
11	Change local authority planning guidance to raise the priority of primary care estates.	**On track**	Work underway with Department for Levelling Up, Housing and Communities. The National Planning Policy Framework (NPPF) requires local planning authorities to ensure that health and wellbeing, and the health infrastructure are considered at all levels of planning and decision making - In addition to the work being led nationally between DHSC and DLUHC, to raise the priority of healthcare infrastructure in planning guidance, locally the ICB are working closely with our local authority and planning colleagues.

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			- The ICB Estates team employs a Planning Liaison and Policy Lead who is responsible for influencing planning guidance, local plans, and responding to consultations. They ensure the impacts on healthcare and its estates infrastructure is highlighted throughout the planning and decision making processes and that mitigation is considered and prioritised. - A Planning in Health Protocol forms the basis for engagement between local planning authorities, the Norfolk and Waveney ICS, Health Providers and Public Health. The ICB estates team provides a single point of contact with planners to engage with the ICB and healthcare providers. - Discussions are taking place between the ICB and local authority colleagues to remove barriers preventing health accessing Community Infrastructure Levy (CIL) in Greater Norwich (Norwich, South Norfolk and Broadland) and King's Lynn & West Norfolk. - Our collaborative working with council and local planning authority colleagues has brought many positives. There are many instances where we have been successful in obtaining CIL and/or S106 capital contributions to help us expand our infrastructure. There are also several ongoing infrastructure initiatives the ICB, and local councils are working on together to provide new capacity in multi-tenanted sites/buildings, providing a range of services and facilities.
D. Cut bureaucracy			
12	Reduce time spent liaising with hospitals by improving the interface with primary care, especially the four areas highlighted by the Academy of Medical Royal Colleges report, in a public board update in Autumn.	**Ongoing**	Detailed update can be found in the paper.
13	Streamline the Investment and Impact Fund (IIF) from 36 to five	**Complete**	This has been completed and approach will continue in 2024/25. In 2024/25 the number of IIF indicators will be reduced further from 5 to

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	indicators – re-target £246 million – and protect 25% of Quality and Outcomes (QOF) clinical indicators.		2 (retaining the indicators on learning disability health checks and FIT/ testing), and the funding from the other 3 indicators (flu and access) will be redirected into the CAP.
14	Reduce unnecessary bureaucracy and administrative burdens placed upon General Practice to free up time for patients through the bureaucracy busting concordat.	**On track**	DHSC work ongoing with other government departments.

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Appendix C

NHS National Delivery Actions for 2024/25

A. Empower Patients		
1	Increase use of NHS App and other digital channels to enable more patients to access to their prospective medical records (including test results) and manage their repeat prescriptions.	Increase NHS App record views from 9.9m to 15m per month by March 2025. Increase NHS App repeat prescription numbers from 2.7m to 3.5m per month by March 2025.
2	Continue to expand Self-Referrals to appropriate services.	Increase number of self-referrals across appropriate pathways by a further 15,000 per month by March 2025.

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3	Expand uptake of Pharmacy First services.	Increase PF pathways consultations per month by at least 320,000 by March 2025 Increase oral contraception prescriptions coming directly from a Community Pharmacy by at least 25,800 by March 2025. Increase Community Pharmacy Blood Pressure check appointments by at least 71,000 per month by March 2025 as part of our ambition to deliver a further 2.5 million blood pressure checks in community pharmacy.
B. Implement Modern General Practice Access		
4	Complete implementation of better digital telephony.	Percentage of PCN practices meeting CAIP payment criteria (>90%).
5	Complete implementation of highly usable and accessible online journeys for patients.	Percentage of PCN practices meeting CAIP payment criteria (>90%).
6	Complete implementation of faster care navigation, assessment, and response.	Percentage of PCN practices meeting CAIP payment criteria (>90%).

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7	National transformation/improvement support for general practice and systems.	Programme milestones including sharing evidence, standards, best practice and support tools; which in turn enhance system-led targeted support to practices and PCNs.
C. Build capacity		
8	Continue with expansion and retention commitments in the Long Term Workforce Plan (LTWP).	As per the LTWP (https://www.england.nhs.uk/long-read/nhs-long-term-workforce-plan-2/).
D. Cut bureaucracy		
9	Make further progress on implementation of the four Primary Care Secondary Care Interface Arm recommendations.	Baseline in April 2024 using assessment tool and monitor ICB progress against implementation of AoMRC recommendations based on NHS Trust provider returns every 6/12.
10	Make online registration available in all practices.	More than 90% of practices using the on-line registration system by 31 December 2024.

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