

Primary Care Commissioning Committee

Tue 10 December 2024, 13:30 - 16:30

Agenda

13:30 - 13:30 **Agenda**

0 min

Hein van den Wildenberg

 2024 12 10 Item 00 ICB Primary Care Committee Agenda Pt 1.pdf (2 pages)

13:30 - 13:30 **1. Chair's Introduction and Report on any Chair's Action**

0 min

Information *Hein van den Wildenberg*

13:30 - 13:30 **2. Apologies for Absence**

0 min

Information *Hein van den Wildenberg*

13:30 - 13:30 **3. Declarations of Interest**

0 min

Information *Hein van den Wildenberg*

 2024 12 10 Item 03 Declarations of Interest.pdf (5 pages)

13:30 - 13:30 **4. Review of Minutes and Action Log from the September 2024 meeting**

0 min

Decision *Hein van den Wildenberg*

 2024 09 10 Item 04 NWICB PCCC Minutes Part One.pdf (11 pages)

 2024 12 10 Item 04 PCCC Action Log Part One.pdf (1 pages)

13:30 - 13:30 **5. Forward Planner**

0 min

Information *Sadie Parker*

 2024 12 10 Item 05 NWICB PCCC Forward Planner 2024-2025 Part 1.pdf (2 pages)

13:30 - 13:30 **6. Risk Register**

0 min

Decision *Sadie Parker*

 2024 12 10 Item 06 Monthly risk ratings.pdf (30 pages)

13:30 - 13:30 **Service Development**

0 min

13:30 - 13:30 **7. Toftwood Medical Centret**

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0 min

Decision *Sadie Parker*

The impact assessment will be on the public facing website

- 📄 2024 12 10 Item 07 Toftwood Medical Centre.pdf (31 pages)
- 📄 2024 12 10 Item 07 Toftwood Medical Centre consultation feedback - Final.pdf (21 pages)
- 📄 2024 12 10 Item 07 Toftwood Population Profile.pdf (28 pages)

13:30 - 13:30 8. Complaints & Contacts

0 min

Information *Jon Punt*

- 📄 2024 12 10 Item 08 Complaints and Contacts.pdf (6 pages)
- 📄 2024 12 10 Item 08 Appendix 1 - GP contacts.pdf (1 pages)
- 📄 2024 12 10 Item 08 Appendix 2 - Dental and Pharmacy contacts.pdf (1 pages)

13:30 - 13:30 9. National Patient Safety Strategy

0 min

Information *Karen Watts / Debbie Blake*

- 📄 2024 12 10 Item 09 Patient Safety Primary Care Strategy.pdf (12 pages)

13:30 - 13:30 10. Norwich Health Centre Procurement

0 min

Information *Sadie Parker*

- 📄 2024 12 10 Item 10 Norwich APMS contract procurement.pdf (4 pages)

13:30 - 13:30 Finance & Governance

0 min

13:30 - 13:30 11. Delivery Group Reports• General Practice & Community Pharmacy• Dental Services Report• Dental Development Group Report

0 min

Information *Shepherd Ncube / Fiona Theadom*

- 📄 2024 12 10 Item 11a GPCPDG Report.pdf (6 pages)
- 📄 2024 12 10 Item 11b Dental Services Delivery Group Report.pdf (6 pages)
- 📄 2024 12 10 Item 11c Dental Development Group Report.pdf (4 pages)

13:30 - 13:30 12. Delivery Report - Primary Care Access Recovery Plan

0 min

Information *Leiat Becker*

- 📄 2024 12 10 Item 12 Primary Care Access Recovery Plan Delivery Report.pdf (5 pages)
- 📄 2024 12 10 Item 12 GP appts and workforce.pdf (2 pages)

13:30 - 13:30 13. Strategic Finance Report

0 min

Information *James Grainger*

- 📄 2024 12 10 Item 13 M7 Primary Care Commissioning Committee Finance Report (2425 Update).pdf (8 pages)

13:30 - 13:30 14. Terms of Reference Review

0 min

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📄 2024 12 10 Item 14 PCCC Terms of Reference Review.pdf (4 pages)

13:30 - 13:30 15. Strategic Prescribing Report

0 min

Information

Michael Dennis

📄 2024 12 10 Item 15 Strategic Prescribing Report.pdf (6 pages)

13:30 - 13:30 16. Pharmaceutical Services Regulations Committee • Memorandum of Understanding and Terms of Reference For approval• Reports from the Pharmaceutical Services Regulations Committee For noting

0 min

Approval & Noting

Sharon Gardner

📄 2024 12 10 Item 16a Appendix 1 Final MOU PO Oct 24.pdf (12 pages)

📄 2024 12 10 Item 16a Appendix 2 Delegation Agreement Table.pdf (25 pages)

📄 2024 12 10 Item 16a Appendix 3 FINAL PSRC ToR - 2024-2025.pdf (5 pages)

📄 2024 12 10 Item 16a Appendix 4 Quality Mapping Swimlane diagram.pdf (6 pages)

📄 2024 12 10 Item 16a Appendix 5 - Pharmacy Optometry Structure 2024 no names.pdf (1 pages)

📄 2024 12 10 Item 16a Appendix 6 - Escalation of Comm Pharm Complaints.pdf (3 pages)

📄 2024 12 10 Item 16a HWE MoU and Terms of Reference.pdf (4 pages)

📄 2024 12 10 Item 16b Reports from the PSRC.pdf (5 pages)

📄 2024 12 10 Item 16b Reports from the PSRC Front Sheet.pdf (2 pages)

13:30 - 13:30 17. Optometry Report

0 min

Information

Sharon Gardner

📄 2024 12 10 Item 17 Optometry Report Front Page.pdf (2 pages)

📄 2024 12 10 Item 17 Optometry Report.pdf (3 pages)

13:30 - 13:30 18. Any Other Business

0 min

13:30 - 13:30 Policies Review (standing item), Primary Care Access Recovery Plan, Primary Care Vision and Principles

0 min

For information purposes only, these will not be presented.

📄 2024 12 10 Item 18a Policies Review.pdf (2 pages)

📄 2024 12 10 Item 18b Primary Care Access Recovery Plan Front Sheet.pdf (1 pages)

📄 2024 12 10 Item 18b Primary Care Access Recovery Plan.pdf (13 pages)

📄 2024 12 10 Item 18c Primary Care Vision and Principles Front Sheet.pdf (3 pages)

📄 2024 12 10 Item 18c Primary Care Vision and Principles.pdf (7 pages)

Meeting of the Norfolk and Waveney ICB Primary Care Commissioning Committee
Tuesday 12 December 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. <i>For Noting</i>	Chair
4.		Review of Minutes and Action Log from the September 2024 meeting <i>For Approval</i>	Chair
5.		Forward Planner <i>For Noting</i>	SP
6.		Risk Register <i>For Approval</i>	SP
Service Development			
7.	13:45	Toftwood Medical Centre (Norfolk HWB Board member DOI) <i>For Approval</i> Item format: <ul style="list-style-type: none"> • Presentation of report • Clarification questions from committee • Clarification questions from members of the public • Committee discussion and decision 	SP (DOI)
8.	14:25	Complaints & Contacts <i>For Noting</i>	JP
9.	14:35	National Patient Safety Strategy <i>For Noting</i>	KW/DB
10.	14:45	Norwich Health Centre Procurement (Practice Manager Specialty Advisor DOI) <i>For Noting</i>	SP (DOI)
Finance & Governance			
11.	14:50	Delivery Group Reports <ul style="list-style-type: none"> • General Practice & Community Pharmacy • Dental Services Report • Dental Development Group Report <i>For Noting</i>	SN/FT
12.	15:00	Delivery Report - Primary Care Access Recovery Plan <i>For Noting</i>	LB
13.	15:05	Strategic Finance Report <i>For Noting</i>	JG
14.	15:10	Terms of Reference Review <i>For Noting</i>	SG
15.	15:15	Strategic Prescribing Report <i>For Noting</i>	MD
16.	15:20	Pharmaceutical Services Regulations Committee <ul style="list-style-type: none"> • Memorandum of Understanding and Terms of Reference <i>For approval</i> • Reports from the Pharmaceutical Services Regulations Committee <i>For noting</i> 	SG

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Item	Time	Agenda Item	Lead
17.	15.25	Optometry Report <i>For information</i>	SG
18.	15:30	Any Other Business	Chair
		Policies Review (standing item) <i>For Noting only – no presentation</i>	
		Primary Care Access Recovery Plan <i>For Information purposes only</i>	
		Primary Care Vision and Principles <i>For Information purposes only</i>	
Date, time and venue of next meeting Tuesday 11 March 2025 13:30 – 16:30 – ICB PCCC To be held by videoconference and You Tube			
Any queries or items for the next agenda please contact: nwicb.primarycarecommissioningcommittee@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	
Ian Wake	Partner Member - Local Authority (Norfolk), Norfolk and Waveney ICB	Norfolk County Council	N/A	N/A	N/A	N/A	N/A	Nov-24		N/A
Debbie Bartlett	Local Authority Partner Member on ICB	Norfolk County Council		X		Direct	Interim Executive Director Adult Social Services, Norfolk County Council	Jun-23	01/04/2025 Retired October 2024	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	Jun-23	01/04/2025 Retired October 2024	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		N/A		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	Professional Body - RCN Union	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	Coltishall surgery			X		Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared

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		Norfolk and Norwich University Hospital			X	Indirect	Son-in-law is a Cardiology Consultant at the NNUH with sessions at JPUH	Jun-23	Present	I inform the chair and will not take part in any discussion or decision that may benefit cardiology at the NNUH and JPUH
		Royal College of Nursing			X	Direct	Member of the Royal College of Nursing Union	1980	Present	Inform the chair and will not take part in any discussions or decisions relating to the RCN
Hein van den Wildenberg	Non-Executive Member, Norfolk and Waveney ICB	Lakenham Surgery			X		Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
		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. In the unlikely event that a risk arises I will discuss and agree any appropriate steps which need to be taken with the ICB Chair
		Broadland Housing Association	X			Direct	Non-Executive Director and Board member for Broadland Housing Association	2024	Present	Will excuse myself from any decisions relating to Broadland Housing Association
Norfolk and Waveney ICB Attendees										
Mark Burgis	Executive Director of Patients and Communities, Norfolk and Waveney ICB	Lakenham Practice	X			Indirect	Wife is Nurse Prescriber who is currently undertaking occasional locum work at Lakenham Practice in Norwich. Wife receives an income from the practice when undertaking locum shifts at the practice	Aug-21	Present	Declare at any relevant meetings and remove myself from any significant discussions or decisions relating to the practice
		Drayton Medical Practice			X		Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
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			X		Board member for Active Norfolk	2019	Present	Declare interest in meetings where relevant, agree any resulting action with the chair. Seek advice in advance where possible. COI training undertaken
		St Stephengate Practice			X		GP partner of St Stephengate Practice, Director of N2S	2023	Present	Declare interest in any meetings where relevant, ensure any potential for conflict is overseen by line manager to ensure robust decision-making. Agree any action with the chair of the meeting. Seek advice when unsure. Recuse myself from any situations likely to place myself or my friend in a compromised position. COI training undertaken.
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	ICS Community Pharmacy Clinical Lead	Humbleyard Medical Practice			X		Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared

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		Locum Work	X				Self-employed Locum Pharmacist in addition to my role in the ICB. Complete self-employed Locum Work as a pharmacist for various pharmacy contractors for whom we are responsible for commissioning since April 2023	Apr-23	Present	No information sharing of non-public workstreams during locum work and conflict to be raised at all relevant meetings where discussions/decision relate to the conflict declared. Also remove myself from any decision making around any locally commissioned services as and where relevant
		Royal Pharmaceutical Society Great Britain		X			Royal Pharmaceutical Society Great Britain. Member of the RPSGB which is over and above that of my	*01/07/2000	Present	Low/negatable risk. If there is an issue it will be raised at the time
Sarah Johnson	Senior Primary Care Commissioning Manager - Dental	Sheringham Medical Practice			X		Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
Fiona Theadom	Head of Primary Care Commissioning, Norfolk & Waveney ICB	Nothing to Declare	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Local Medical Committee Attendees										
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		
		Norfolk and Waveney Enterprise Services				Indirect	Brother – Senior employee (non-Board member) – Norfolk and Waveney Enterprise Services	Ongoing		
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		CEO at Fakenham Medical Practice. Employed by practice	Feb-18	Present	Withdrawal from any discussions and decision making in which the Practice might have an interest.
		NN1 Ltd			X		Member of NN1 Ltd. Employed by practice member of NN1 Ltd	Apr-23	Present	Withdrawal from any discussions and decision making in which the PCN might have an interest.
		NN PM group			X		Chair of NN PM group. Employed by member practice	Mar-20	Present	To not relay any information discussed about these practices at the PCCC.
		Humbleyard Medical Practice			X		Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
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. If there is an issue it will be raised at the time..
		Norfolk County Council	X			Direct	Cabinet Member for Adult Social Care and Public Health	Ongoing		

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		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		
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		
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	Ongoing	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
		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	
Lauren Seamons	Deputy 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	

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		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 to PCCC	Nothing to Declare					N/A		N/A

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Norfolk and Waveney Extraordinary Primary Care Commissioning Committee

Part One

**Minutes of the Meeting held on
Tuesday 10 September 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
Rashmi Balakrishnan	RB	Primary Care Reporting Finance Manager, Norfolk and Waveney ICB (deputising for Steven Course)
Karen Watts	KW	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
Leiat Becker	LB	Senior Primary Care Delivery Manager, NHS Norfolk and Waveney ICB
Andrew Bell	AB	Norfolk Local Dental Committee
Bill Borrett	BB	Chair of the Integrated Care Partnership and Partner Member of the ICB
Sarah Buchan	SB	Practice Manager Committee Attendee
Michael Dennis	MD	Associate Director of Pharmacy and Medicines Optimisation (Chief Pharmacist) Norfolk and Waveney ICB
Lisa Drewry	LD	Executive Officer, Norfolk and Waveney Local Medical Committee Executive Officer, Norfolk and Waveney Local Medical Committee
Sharon Gardner	SG	Head of Primary Care Commissioning Community Pharmacy and Optometry, Norfolk and Waveney ICB
Joni Graham	JGr	Executive Officer (Estates, Digital, Pharmacy & Prescribing), Norfolk and Waveney Local Medical Committee
Andrew Hayward	AH	Trustee of Healthwatch Norfolk
Anne Heath	AHe	Associate Director of Digital, Norfolk and Waveney ICB
Cath McWalter	CMcW	Senior Primary Care Estates Manager, Norfolk and Waveney ICB
Shepherd Ncube	SN	Associate Director of Delegated Commissioning, Norfolk and Waveney ICB
Sadie Parker	SP	Director of Primary Care, Norfolk and Waveney ICB
Lorna Perrott	LP	Place Transformation and Delivery Manager (North), Norfolk and Waveney ICB
Keri Robinson	KR	Primary Care Workforce Lead, Norfolk and Waveney ICB

Amanda Sear	AS	Senior Manager, Primary Care, Norfolk and Waveney ICB
Lauren Seamons	LS	Joint Chief Officer, Community Pharmacy Norfolk
Jason Stokes	JS	Secretary, Norfolk Local Dental Committee (LDC)
Nick Stolls	NS	Specialty Dental Advisor
Fiona Theadom	FT	Head of Primary Care Commissioning, Norfolk and Waveney ICB
Sarah Webb	SW	Primary Care Administrator, Minute Taker, Norfolk and Waveney ICB
Ian Wilson	IW	Executive Officer, Norfolk and Waveney Local Medical Committee

Apologies received

Name	Initials	Position and Organisation
Mark Burgis	MB	Executive Director of Patients and Communities, Norfolk and Waveney ICB
Steven Course	SC	Executive Director of Finance, Norfolk and Waveney ICB
Tony Dean	TD	Joint Chief Officer, Community Pharmacy Norfolk
James Grainger	JG	Head of Finance Primary Care and Corporate, Norfolk and Waveney ICB
Peter Taylor	PT	Assistant Director, Public Health Commissioning Norfolk County Council, Public Health

No	Item	Action owner
1.	Chair's introduction Chair welcomed attendees to the September Committee.	Chair
	Matters Arising There were no matters arising.	
2.	Apologies for absence	Chair
	Noted above.	
3.	Declarations of Interest <i>For Noting</i>	Chair
	None received.	
4.	Review of Minutes and Action Log from the June 2024 Committee <i>For Approval</i>	Chair
	The minutes were agreed to be an accurate reflection of the June 2024 Committee and minutes would be sent to the Chair for signing. ACTION: SW to send Chair signed minutes for safekeeping. Action Log Actions 0185 Closed 0186 Closed 0187 Closed 0188 Closed - JP confirmed he was attending a Practice manager Conference the LMC organised on 25 September 2024, JP will deliver the session then, and took an action to speak to LD about any further enquiries post meeting. 0189 – leave open	SW

5.	<p>Forward Planner <i>For Noting</i></p>	SP
	<p>Strategic Primary Care Resilience Report – a report would feature in P2. This item is scheduled to be presented in Part 1 at March 2025 Committee.</p> <p>The forward planner was noted.</p>	
6.	<p>Risk Register <i>For Approval</i></p>	SP
	<p>SP presented the risk register for approval.</p> <p>SP outlined the changes to the way risks were managed within the ICB. A new strategic risk for primary care had been created which related to the joint forward plan ambition for primary care and this was the new risk for approval today.</p> <p>3 other risks would be seen by the Board on an operational risk register and the other proposal was that risks scoring under 12 would be managed at operational level with teams rather than at Committee.</p> <p>The only risk that impacted primary care was the Learning Disability health checks which scored 9 on our risk register and this would therefore be monitored through the delivery group only in future.</p> <p>SP requested:</p> <ul style="list-style-type: none"> • approval of the new strategic risk • to note the three risks which would be reported to the Board through the Operational Risk Register • to note the removal of the Learning Disability Health check risk from the Committee Register – this would continue to be monitored by the team and SN would remain responsible for that • to approve the proposed changes to the target dates for the three risks highlighted in red. <p>DB reflected that focus would not be lost on the risks and in some sense this focus would strengthen the link to the joint forward plan.</p> <p>HW confirmed that he had focussed on the new strategic risk and this read well and highlighted some specificity for some of the providers, common themes across primary care and that the score of 20 was right.</p> <p>KW questioned the risks scoring below 12 as within her own directorate 12 and below was monitored at team level unless there was a specific reason and KW thought needed to be some consistency across the ICB.</p> <p>SP would confirm with the Corporate Team whether this scoring was under 12 or 12 and below.</p> <p>ACTION: SP would confirm with the Corporate Team whether this scoring was under 12 or 12 and below.</p> <p>DB noted the comments and the need to follow a consistent approach. DB went on to note that 3 risks would be reported to Board and recognised the learning disability risk would likely be managed by staff and noted the updated target</p>	

	dates. DB asked if Committee members were happy to approve and agree the recommendations and Committee approved these.	
7.	Developing our Strategic Framework: Primary Care Vision and Principles <i>For Approval</i>	AS/LP
	<p>AS presented the Developing our Strategic Framework: Primary Care Vision and Principles for approval.</p> <p>AS asked for feedback from primary care colleagues that were in attendance.</p> <p>AH requested an offline discussion with AS around the reference made to principles and ‘recognising when there may be trade-offs’. AH understood that there would be trade-offs but had concerns that patient relationships and continuity of care were listed and these were 2 items that should not be traded for something else.</p> <p>AS agreed that this was a helpful challenge, and will meet with AH to discuss in more detail. AS noted that not all change will be welcomed by everyone and that this may be reflected in perceptions around patient experience, for instance the move to “modern general practice”. Some changes might not be ideal and it is not an indication of compromise in any area but continuity of care is beneficial.</p> <p>AH thought that the emphasis should be on continuity of care and to remember the whole basis of primary care and general practice was long term relationships not transactional.</p> <p>BB was pleased to see the report and had concerns about the guiding principle of prevention and the patient being the centre of the pathway but BB did not see this in the document.</p> <p>KW thanked AS for the document and agreed with BB and AH comments and that she would like to see the principle that the populations should expect to receive a quality safe service that takes into account their patient experience and first and foremost what we are doing this for – the local population.</p> <p>HW thanked AS for the document and acknowledged the level of engagement that colleagues had undertaken. One comment was around the language used being for the primary care providers rather than the patient population or the resident and the need to recognise this. With regard to the slide with the enablers on it HW asked if one or two more enablers around funding and contracting could be added as they were highly influential on what we can do and to acknowledge these with a footnote outlining that it was less within our gift.</p> <p>SP thanked members for their comments and accepted AH offer of help and confirmed that the document had been shared with the Healthwatch already and would appreciate a further discussion on this. SP fully supported the other comments around prevention and the enablers.</p> <p>SN reacted to AH comment and the balance of access and continuity as one of those issues that we have to work with.</p>	

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	<p>DB had a sense that this document was positioned to a more professional audience rather than an external audience and may not resonate with patients and asked if there was a way of aligning these two things.</p> <p>SP confirmed that this was one of the comments that came through Healthwatch. It was part of the first step in the development of the overall strategic framework and agreed it was not aimed at a patient audience at this stage.</p> <p>SP confirmed next steps would be to talk to ICS partners and if PCCC were supportive today with the additional comments and continued development towards the overall strategic framework for primary care committed to in the joint forward plan.</p> <p>DB reflected that this was a first step towards a long-term vision and there were some refinements required to this document and asked for some introductory words to set out that this was the first stage. DB agreed that there was a further discussion to be had with Healthwatch and the ICB.</p> <p>DB asked if Committee members were happy to accept the recommendations.</p> <p>BB stated it was a document for the public and a roadmap within primary care and supported DB's comment around an introduction about what it is for and how it would be used when people received it.</p> <p>SP agreed that this would be accommodated.</p> <p>DB confirmed that Committee accepted these proposals</p>	
8.	<p>Primary Care Workforce Strategy 2024 - 2027 & Primary Care Workforce Delivery Plan 2024 – 2025 <i>For Approval</i></p>	KR
	<p>KR presented the Primary Care Workforce Strategy 2024 - 2027 & Primary Care Workforce Delivery Plan 2024 – 2025 to Committee for approval.</p> <p>KR outlined the purposes of the documents for Committee's attention.</p> <p>KW thanked KR for the excellent piece of worked and mentioned historically there had been evening sessions for access to consultants for CPD (continuing professional development), these helped support retention as it allowed open access to consultants to hold educational sessions and whether this still happened or was considered. Additionally, this supported clinicians to keep CPD updated and allowed networking with acute care colleagues attending.</p> <p>KR was unsure about access to consultants but there had been an inclusion of non-clinical CPD and development for those management areas for practice managers and equivalent roles.</p> <p>SP agreed that KW raised a good point and confirmed SP and JRo had held discussions on this, however there was currently no capacity or funding to take this forward, but there were some informal arrangements from time to time within individual localities. SP confirmed the development of an interface programme was underway now that the vacancy had been recruited to and it may develop out of that, however it was at an early stage of consideration.</p>	

	<p>LD agreed it was a good report and highlighted that in terms of recruitment and retention, general practice was extremely vulnerable as there were limited funds with financial pressures, and this impacted getting the right staff into the right roles and general practices were losing highly experienced clinicians and back-office staff. LD reflected on the time it took to recruit, retrain and have the right skill mix.</p> <p>SB reflected on a North Norfolk Practice Managers meeting she had attended and there was an update on some consultant training sessions. SB requested that these were recorded to enable them to be played back to clinicians and managers at a time that suited the practice. Specific patients were discussed and if these could be removed from the discussions then these could be recorded and there would be a wider reach. SB reflected on LD comments about back-office staff and losing the corporate knowledge as some of these staff were now retiring or going to work in a commercial organisation as the pay and hours were much better. It was these roles where there was a struggle to recruit, and SB did not see these mentioned within the update.</p> <p>BB highlighted one point under reform, where it showed to grow the number and proportion of NHS staff working in primary care to enable more preventable and proactive care by 73% by 2036/37. The document talked about building broader teams with more flexible skills and BB was interested to know how that would sit with the way primary care was delivered and whether this was across networks or particular practices.</p> <p>Action: KR took this away to feedback to JR.</p> <p>LS confirmed the pharmacy strategy workforce plan would be developed in the medicines optimisation team and LS wanted to highlight that training and development opportunities were being planned in PCN areas rather than across the piece. The multidisciplinary training opportunities that really enabled pharmacists and the GP colleagues to develop their relationships locally and to understand each other's pressures, skills and increase signposting. LS asked if it could be acknowledged there could be some real opportunities if some of the training opportunities were linked up as it would be helpful in terms of relationships, interoperability, and integration.</p> <p>HW agreed that this was an excellent point and hoped it resonated with MD from medicines optimisation. MD noted that there was a workstream in place with the Deputy Medical Director who leads on multi professional training and would ensure it was widely circulated.</p> <p>HW reflected on the importance of back-office staff and checked that Committee were happy to support the recommendation for the workforce strategy and the operational delivery plan.</p> <p>Committee approved the plan.</p>	KR
9.	<p>Winter Pharmacy Bank Holiday Commissioning <i>For Approval</i></p>	SG
<p>Webb, Sarah 04/12/2024 09:53:32</p>	<p>SG presented the Winter Pharmacy Bank Holiday Commissioning paper to Committee for approval.</p> <p>SG set out some key highlights within the report for Committee's attention.</p>	

	<p>SG also asked for noting the intention to pursue finance approval to ensure Bank Holiday Commissioning of pharmacies was on a recurrent basis.</p> <p>AH asked that when people attend the Walk In Centre on a Bank Holiday if they could have available a stock of medication to prescribe and supply immediately instead of patients having to find a pharmacy that was open. AH also asked if there were end of life care drugs available at those times.</p> <p>SG was unsure in terms of the Walk In Centre and their contract. In respect of out of hours, if pharmacies were not open then a supply could be made from the out of hours provider IC24. SG confirmed work was being addressed with the Walk In Centre particular in terms of Pharmacy First and referrals out from there into Community Pharmacy. SG confirmed a new palliative care scheme on 2 year cycle had been commissioned for 23 pharmacies to hold palliative care stock and SG reviewed the palliative care pharmacies that had applied to be open.</p> <p>RB asked SG if she had requested non recurrent funding as she thought it had been approved in the Triple Lock.</p> <p>SG confirmed that £30,000 had been approved in Triple Lock and SG sought a future financial source to continue on a recurrent basis and if the funding was found that it would be brought back to PCCC or DG for approval. SG was aware that additional funding would also have to be taken through the Triple Lock process again as this would be classified as new funding.</p> <p>BB had looked at the recommendations and acknowledged the aspirations of the ICB to provide coverage on Bank Holidays and agreed with these.</p> <p>DB suggested amending the recommendation to support the provision of out of hours pharmacies on a recurring basis and this should be part of the winter plan. DB thought it was worth mentioning to encourage the public to ensure they were stocked up with medicines as the Bank Holidays approached.</p> <p>SG agreed. The Pharmacy First message would be used to reinforce the message and was part of the communication strategy.</p> <p>DB confirmed that with the slight amendment Committee approved the recommendations.</p>	
<p>10.</p>	<p>Pharmaceutical Needs Assessment <i>For Noting</i></p>	<p>SG</p>
	<p>SG presented the Pharmaceutical Needs Assessment paper for noting and set out some key highlights for Committees attention.</p> <p>BB confirmed this assessment was presented at the Health and Wellbeing Board and looked forward to receiving the new ones coming forward.</p> <p>DB thought the profile of the pharmacist had significantly increased within the ICB and within the system and reflected on the new commissioning responsibilities and the refreshed pharmaceutical needs assessment.</p> <p>DB confirmed the paper was noted.</p>	
<p>11.</p>	<p>GP Patient Survey Results 2024 <i>For Approval</i></p>	<p>SN</p>
	<p>SN presented the GP Patient Survey Results 2024 for approval.</p>	

	<p>DB reflected on the importance of this and asked SN to provide the Committee with an overall briefing.</p> <p>DB suggested setting up a separate briefing for this for Committee members.</p> <p>SN then went through the survey in some detail for Committees attention.</p> <p>DB thanked SN for highlighting some key areas and asked for reflections and questions. DB re-emphasised the point on hosting a further session in the future.</p> <p>KW was pleased to note the achievement was slightly higher than the national position and that there was more work to do in terms of the number of participants that had engaged to obtain richer data. On a positive note, there were some really good areas which had busted some myths and KW thought there needed to be more aspiration for the figures in particular dentistry and asked whether the ICB going to do and the same for inequalities.</p> <p>IW had a couple of reflections. The results reflected on societal change where the public had become more demanding over the last 5-10 years and the different dynamics within the younger and older populations. IW agreed that it was right to highlight the areas where the system may be missing some patients such as learning disabilities and schools.</p> <p>BB congratulated everyone on Norfolk's performance and recognised how hard people had worked. BB agreed on the comment around the age dynamic and to look at approaching different parts of the population in different ways and BB was interested in the age breakdown on respondents and asked if there was a way in connecting with the issue of the LD Health check and if there was a specific piece of quality research that was part of the LD Health Checks.</p> <p>HW echoed congratulations and that it would be good to bring this back as DB suggested. HW reflected on some of the slides around the ease of contacting for PCN and the variation of results.</p> <p>IW commented it was noticeable that if you correlated new builds across the PCN that patients may be struggling with ease of access there was a huge correlation between house building and influx of patients but not the corresponding expansion of general practice.</p> <p>DB asked if SN could set up a future meeting for some of these areas to be address and also to provide a further update at a future Committee and turn some of the outputs into actions.</p> <p>ACTION: SN to set up a further meeting for some of these areas to be addressed and also to provide a further update at a future Committee and turn some of the outputs into actions.</p> <p>The report was approved.</p>	
12	<p>General Practice Collective Action <i>For Noting</i></p>	SP
	<p>SP presented the GP Practice Collection Action to Committee for noting.</p>	

	There were no questions and DB thanked SP for the paper and the report was duly noted.	
13.	<p>Delivery Group Reports</p> <ul style="list-style-type: none"> • General Practice & Community Pharmacy • Dental Services Report • Dental Development Group Report <p><i>For Noting</i></p>	SN/FT
	<p>SN presented the General Practice & Community Pharmacy report to Committee for noting and highlighted the items that had been approved.</p> <p>DB confirmed Committee had noted the report.</p> <p>FT presented the Dental Service Report and the Dental Development Group report to Committee for noting and highlighted some of the decisions made within these groups.</p> <p>DB reflected on the detailed work that had taken place within the groups and thanked the people contributing towards this.</p> <p>DB confirmed Committee noted the report.</p>	
14.	<p>Delivery Report – Primary Care Access Recovery Plan</p> <p><i>For Noting</i></p>	LB/SP
	<p>SP presented the Delivery Report – Primary Care Access Recovery Plan to Committee for noting.</p> <p>HW asked if there was a possibility to discuss this in more detail at a further Committee.</p> <p>ACTION: to discuss in more detail at a future Committee.</p> <p>DB and HW thanked SP for the report and the information contained within.</p>	
15.	<p>Pharmaceutical Services Regulation Committee Report</p> <p>Optometry Services – contractual changes and other matters</p> <p><i>For Noting</i></p>	SG
	<p>SG presented the PSRC paper as duly noted and there were no questions asked on this item.</p> <p>AH asked in regard to the Pharmacy First figures if there was a difference between people who self-refer straight direct to the pharmacist. SG confirmed the figures break it down in terms of referrals from general practice and patients attending pharmacies. The difference was that if a patient was referred from general practice into the service and this did not meet the gateway criteria for treatment for one of the seven clinical conditions, the pharmacy convert that referral into a minor illness referral and would be paid for that consultation with the patient.</p> <p>SG confirmed the PSRC decisions would be heard in Part 2 along with the additional information on contract provision for Optometry.</p> <p>DB asked if there was anything further that SG wanted to highlight and SG confirmed it was for noting.</p> <p>Committee duly noted the paper.</p>	
16.	<p>Strategic Prescribing Report</p> <p><i>For Noting</i></p>	MD

	<p>MD presented the Strategic Prescribing Report to Committee for noting.</p> <p>DB thanked MD for the report and noted the information on the carbon footprint.</p> <p>KW acknowledged the huge amount of work that the Medicines Optimisation team does in terms of financial savings and effectiveness of medication and what was managed in terms of the market and drug shortages and that this work could not be underestimated.</p> <p>DB confirmed the report was duly noted.</p>	
17.	<p>Strategic Estates Report <i>For Noting</i></p>	CMcW
	<p>CMcW presented the Strategic Estates Report to Committee for noting and highlighted the publication of the revised Premises Costs Directions and an update on the Wave 4B Programme.</p> <p>DB thanked CMcW and opened up for questions.</p> <p>BB asked about the new hospitals programme and if this would affect the new model of care and if there would be a report from the Estates team about that.</p> <p>CMcW confirmed that colleagues had been engaged with the teams that were involved at the QEH and JPUH in terms of impacts on estate. The Estates Team would include an update in the next iteration of the report to Committee.</p> <p>BB asked about the increase in housing targets and whether any modelling had been completed to understand the potential impact on healthcare estate. CMcW confirmed that the Estates Team was working with planning authorities to understand the impact as they remodelled their local plans.</p> <p>DB thanked CMcW for the update and the report was duly noted.</p>	
18.	<p>Strategic Finance Report <i>For Noting</i></p>	RB
	<p>RB presented the Strategic Finance Report to Committee for noting and went through the report in some detail for Committees attention.</p> <p>DB asked about the efficiencies and what steps were to be taken around meeting these.</p> <p>RB confirmed there was a fortnightly prescribing efficiency meeting with the Medicines Optimisation team. There were a few risks within the NICE guidelines that meant there may be cost pressures there and this was the reason for the forecasted overspend.</p> <p>DB confirmed the report was duly noted.</p>	
19.	<p>Strategic Digital Report <i>For Noting</i></p>	AHe
	<p>AHe presented the Strategic Digital Report for noting and went through the report for Committee's attention.</p> <p>DB confirmed there were regular updates on the Integrated Care Partnership around digital across the system and that it might be helpful to have a particular focus on primary care and perhaps the interface with primary care.</p>	

	<p>BB reflected on progress to date and asked if people were recording information in a timely way and were they all using it and if there was enough training and support for the digital infrastructure. Was there a need to focus on behaviour in order to change or encourage people to work in a different way. BB also requested acronyms be laid out in full in the future.</p> <p>AHe confirmed not everyone was using it and there was work to be done. The change in the last 18 months to 2 years was where the practices were more open to the transformation and adopting the technology. AHe confirmed there were training packages available and a training site with online learning for every digital user and this had grown and developed well. The interface with the clinical systems team happened regularly and AHe confirmed she meets with the digital transformation leads to ensure they have to resources to work with their colleagues and PCNs. The practice digital leads met on a 6-weekly basis. In terms of the clinicians in the wider organisation the shared care record team meets with them.</p> <p>BB was encouraged by this response.</p> <p>AHe confirmed she had agreed for one of her staff members to do a talk in East Harling to talk to residents who may need some help with the NHS app and what apps are and with their mobile phones to make best use of the NHS app.</p> <p>The report was duly noted.</p>	
20.	Any Other Business	Chair
	<p>Questions from the Public</p> <p>There being no further business or questions from the public, the meeting then closed at 15:35</p>	

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 & Waveney IBC Primary Care Commissioning Committee - Part One Action Log
10 December 2024

No	Meeting date added	Agenda Item	Owner	Action Required	Action Undertaken / Progress	Due date	Status	Date Closed
0189	11-Jun-24	13	SN/LB	Strategic Finance Report - for the next delivery report - to show the actual activity and outcomes gained re interest in diabetes	SN advised limited progress has been made with this, this is partly to do with staffing gaps in the team and delays in data flows from the national team Report to be taken to Delivery Group for Q4	10/09/2024 10/12/2024		18-Nov-24
0190	10-Sep-24	4	SW	SW to send Chair signed minutes for safekeeping	SW sent these across	10-Dec-24		11-Sep-24
0191	10-Sep-24	6	SP	Risk Register - SP to confirmed with the corporate team the scoring.	15 or more = Board Operational Risk Register (EMT/PCCC) 12 or more = Operational Risk Register (PCCC) Suggest to close	10-Dec-24		
0192	10-Sep-24	8	KR	Primary Care Workforce Strategy 2024 - 2027 & Primary Care Workforce Delivery Plan 2024 – 2025 - item under reform - KR to feedback to JRo	JRo feedback The 73% is a national target that has been set. In terms of building flexible skills this intelligence is coming from the training needs analysis which both PCN's and practice complete. The education plan is then built from this data. Practices and PCN's are taking up all CPD offers across the system. Workforce recruitment tools look at skill mix, population health management, succession planning which practices and PCN's are also now using as part of their planning technique. Suggest to close	10-Dec-24		
0193	10-Sep-24	11	SN	GP Patient Survey Results 2024 - SN to set up a further meeting for some of these areas to be address and also to provide a further update at a future Committee and turn some of the outputs into actions.	Attendees were invited to confirm their interest in a follow up meeting by email, outlining any specific areas of interest for further discussion. There were 4 responses. SN and DE plan to schedule a meeting in the New Year Suggest to close	10-Dec-24		
0194	10-Sep-24	11	LB/SP	Delivery Report – Primary Care Access Recovery Plan - to discuss in more detail at a future Committee.	Delivery report on the agenda for noting at the Committee. Work underway with BI team to develop suite of indicators. Suggest to move to forward plan - close	10-Dec-24		

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

Item	7 May 2024 (EPCCC)	11 June 2024	10 September 2024	20 Nov 2024 (EPCCC)	10 December 2024	11 March 2025	Lead officer	Notes
Risk Register		Y	Y		Y	Y	SP/FT	All risks scored 12 or more 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	Moved to May 2025 to allow a report on CQC activity for a full year
Delivery Report		Y	Y		Y	Y	AS/OL	A focus on long term dental plan – for December. Moved to March 2025 to align with annual reporting on LTDP.
General Practice & Community Pharmacy Delivery Group Report Dental Services Delivery Group Report		Y	Y		Y	Y	SN/SG	Noting/ assurance
Dental Development Group Report		Y	Y		Y	Y	FT	Noting/ assurance
Contract Assurance Framework		Y			Y	Y	SN	Elements of this are reported regularly to Delivery Groups
Delivery Plan for Recovering Access to Primary Care		Y			Y	Y	AS	Moved to December PCARP – for noting (will be submitted to ICB Board November 2024)
Complaints and Contacts		Y			Y		JP	
Primary Care Resilience (Strategic Report)			Y			Y	SN/OL/FT/SG	
Terms of Reference Review					Y	Y	FT	Either December or March – not both – frequency of meetings and roles and responsibilities
Primary Care & Workforce Recruitment and Retention		Y	Y			Y	JRo	June for approval – deferred until Sept (EMT sign off)

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Programme (strategic report)								March '25 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	FT	Removed in September in DSDG in August. Moved to March 2025 to align with annual reporting.
Norwich Health Centre Procurement				Y	Y		EB/SP	EPCCC in November 2024 for this item only stood down.
Developing our strategic framework: Primary Care Vision and Principles			Y				AS	Added as new item September 2024
Policies Review					Y	Y	Nikki Bartrum	Added as new standing item December 2024 (as requested by Audit Committee)

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	
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	
Care Homes Quality Assurance	SN	CQC inspections – care homes – quality assurance (closed action log 0187)
TJA Report	LB	Submitted to October Delivery Groups, will form part of Delivery Group report.

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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	12	12	12	12	12	12			
PC6	Learning Disability Annual Physical Health Checks	09	09	09	09	09	09	09	09	09			
PC9	Hypnotics and anxiolytics prescribing	12	12	12	12	12	12	12	12	12			
PC 14 BORR11 Inphase 00000023	The resilience of general practice	16	16	16	16	16	16	16	16	16			
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 BORR09 Inphase 00000025	Dental Services Resilience	20	20	20	20	20	20	20	20	20			
PC19 BORR08 Inphase 00000029	Secondary care dental services (Oral Surgery and Maxillo Facial Services, Orthodontic Services)			16	16	16	16	20	20	20			
BAF02 Inphase 00000032	Primary Care Resilience and Transformation					20	20	20	20	20			
PC20	The resilience of Community Pharmacy							16	16	16			

PC6 – to be heard at GPCPDG only

BORR08/09 DSDG

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Ref 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			Risk team	
Mark Burgis		Primary Care Committee Commissioning (PCCC)		Jayde Robinson			Primary Care Workforce	
Risk programme board		Date Risk Identified		Target Delivery Date			Date risk last reviewed	
Primary Care Committee Commissioning (PCCC)		01/06/20		31/03/25			20/11/24	
Risk type		Workforce & people						
Risk Scores								
Unmitigated			Mitigated			Target		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	3	4	12	2	4	8
Risk appetite:		TBC			Risk tolerated:		TBC	
Controls								
<ul style="list-style-type: none"> • 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. • Primary Care Equality, Diversity and Inclusion Fellow recruited. • Wide range of initiatives in place to support GP retention. • Advanced Practice Forum established. • Primary Care Workforce Strategy 2024-2027 • Communication Engagement strategies updated to reflect PCN development updates and post pandemic environment. • Workforce data to measure trajectory levels against actual recruitment. • AI software mapping and reports provided for vacancy levels for primary care. • Succession planning led 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 								
Assurances on controls								
<ul style="list-style-type: none"> • Internal: Reporting to Primary Care Commissioning Committee (PCCC). • Reporting: ICS Norfolk & Waveney People Board. • External: NHSEI returns monthly as part of the NHSE Primary Care Oversight Board KPI's and quarterly assurance meetings. 								

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.
- Extension of national training hub contract has only been renewed for a further year (up to 31st March 2026) rather than the 2-year extension expected.
- GPN lead position and GPN Mentor not filled to support Primary Care Workforce development.

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Actions			
Date opened	Action	BRAG	Target completion
October 2024	<p>Latest NHSE workforce data illustrates the following:</p> <ul style="list-style-type: none"> -4.5% decline in Nursing workforce roles across N&W during the period of July 24 vs July 23. 432 WTE are in place across the system. 1.6% growth in GP workforce roles (excluding training GPs) during the same period. 521 WTE are in place across the system. 8.4% growth in GP Trainees across N&W during the same period. 135 FTE are in place across the system. <p>As of 1st October 2024, the following positions currently advertised for recruitment within general practice, linked to this risk (PC01) are:</p> <ul style="list-style-type: none"> 2 x Advance Nurse Practitioners 5 x Practice Nurse 11 x Salaried GP's 1 x GP Partner <p>The decline in nursing numbers across the system is of real concern, particularly in "general practice" nursing roles. Led by the ICB Chief Nurse, a General Practice Nurse forum is being established support the voice of primary care nursing. We are actively seeking to recruit a GPN Lead to support us in the development of GPN workforce programmes.</p>		November 2024
November 2024	<p>Latest NHSE workforce data illustrates the following:</p> <ul style="list-style-type: none"> 2.1% decline in Nursing workforce roles across N&W during the period of September 24 vs September 23. 438 WTE are in place across the system. 0.4% growth in GP workforce roles (excluding training GPs) during the same period. 525 WTE are in place across the system. 20.4% growth in GP Trainees across N&W during the same period. 167 FTE are in place across the system. <p>As of 21st November 2024, the following positions currently advertised for recruitment within general practice, linked to this risk (PC01) are:</p> <ul style="list-style-type: none"> 6 x Practice Nurse 9 x Salaried GPs 1 x GP Partner <p>Led by the ICB Chief Nurse, a General Practice Nurse forum is being established to support the voice of primary care nursing. We are actively seeking to recruit a GPN Lead to support us in the development of GPN workforce programmes and working with NHSE to develop some localised initiatives.</p>		January 2025

Visual Risk Score Tracker – 2024/25												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	12	12	12	12	12	12	12	12	12			
Change	→	→	→	→	→	→	→	→	→			

Created by Sarah
04/12/2024 09:53:32

PC9								
Risk Title	Hypnotics and anxiolytics prescribing							
Risk Description	High prescribing rate of hypnotics and anxiolytics in primary care – improved to 4 th nationally on volume per 1,000 patients. These medications have negative side effects on patients and should not routinely be used long term.							
Risk Owner	Responsible Committee	Operational Lead			Risk team			
Dr Frankie Swords	Primary Care Commissioning Committee (PCCC)	Michael Dennis						
Risk programme board	Date Risk Identified	Target Delivery Date			Date risk last reviewed			
PCCC	30/9/2020	31/12/2024			21/11/2024			
Risk type	Pick one from: Transformational / environmental / political / reputational / financial / quality & patient safety / corporate / workforce & people / health inequalities							
Risk Scores								
Unmitigated			Mitigated			Target		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	4	3	12	3	3	9
Risk appetite:					Risk tolerated:		9	
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.								
Assurances on controls								
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 90 th percentile are highlighted on the GPCPDG report. Outlier practices are offered support.								

Webb, Sarah
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Actions			
Date opened	Action	BRAG	Target completion
June 2024	March 24 data 97 th percentile nationally – outliers are being focussed on through targeted PQS audits. Extend target to September.		30/9/2024
July 2024	April 24 data 96 th percentile, 5 th nationally – our linear trajectory is decreasing faster than other national outliers – see trend chart.		30/9/2024
Aug 2024	May data 97 th percentile, 4 th nationally		30/9/2024
Sept 2024	June data 96 th percentile, 4 th nationally		31/12/2024
Oct 2024	July data 96 th percentile, 4 th nationally		31/12/2024
Nov 2024	August data 95 th percentile, 7 th nationally		31/12/2024

Visual Risk Score Tracker – 2024/25												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	12	12	12	12	12	12	12	12	12			
Change	→	→	→	→	→	→	→	→	→			

Webb, Sarah
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BORR11 (Inphase ref 00000023)

Risk Title	The resilience of general practice							
Risk Description Please include any collaboration and partnership aspects of the risk.	<ul style="list-style-type: none"> 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. The BMA campaign is live and there are 10 ways general practice can participate in collection action. The participation of individual practices is a choice for them. The initial national GP contract price uplift does not cover the required increase in meeting the minimum wage, however global sum has since been further uplifted. The LMC has written to practices to cease un-commissioned work. 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			Risk team		
Mark Burgis	Primary Care		Sadie Parker			Patient & Communities		
Risk programme board	Date Risk Identified		Target Delivery Date			Date risk last reviewed		
	01/09/2020		31/03/2026			December 2024		
Risk type	Transformational / financial / quality & patient safety / health inequalities							
Risk Scores								
Unmitigated			Mitigated			Target		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	4	20	4	4	16	3	4	12
Risk appetite:			Risk tolerated:					
Controls								
<ul style="list-style-type: none"> 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 provided additional capacity but has not grown in this contract year. GPs have been added to the scheme with limited criteria. 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 LMC General Practice Alert System sitreps 								
Assurances on controls								
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.
- Vacancies and newly appointed staff within primary care commissioning, workforce, quality, and locality teams impacts the level of support which can be provided to practices.
- 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.
- Reporting process for inappropriate transfers of workload from community and secondary care providers to general practice not fully utilised by practices, leading to under-reporting of issues. Alternative approaches being considered with the LMC.
- 50% overall response rate (less than 30% in one area) to LMC General Practice Alert System, meaning full picture is not available. System remains anonymous.
- 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.

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Actions			
Date opened	Action	BRAG	Target completion
August 2024	<ul style="list-style-type: none"> 1 remaining vacancy out to external advert. Most roles will have commenced during September. There is continued risk from the long-term absence of the head of strategic planning post, with some part time resource internally until the end of September. An application is being made to extend this through the triple lock process. NHSE has confirmed a further uplift to the global sum. While this is welcome it will not impact the ongoing collective action. Internal EPRR structure in place around collective action. As yet no significant impact has been felt, but this is expected to grow as practices agree what action they will take heading into the autumn. MGUS specification is in the final stages of discussion with the LMC, funding approval has been received through the triple lock process with governance now in progress. Interface work programme and System Group Terms of Reference due to be reviewed in September and October. Trusts have been reminded of need to undertake further self-assessments in September and NHSE is expected to write to systems in early September. 	B	30/11/24
September 2024	<ul style="list-style-type: none"> Commissioning team fully recruited, final post starting in October. Awaiting triple lock decision on cover for absent head of strategic planning role. Global sum uplifts now made to practices, ARRS has been adjusted to include GPs. Continuing to monitor impact of collective action. Providers reporting referrals being made by letter rather than form. Guidance has been issued to practices about good quality referrals, following feedback from providers. MGUS LES should be offered to practices through a contract variation in October. Movement of primary care workforce transformation team into the primary care directorate from 1 October. <p>Steady progress with interface task and finish groups. All programme governance is being reviewed and a workshop was held in September to review the Terms of Reference with all system partners.</p>		31.12.24
October 2024	<ul style="list-style-type: none"> ARRS uplifts have only been applied from 1 October, which is a national decision. This will mean staff may not have pay backdated, unlike those employed directly by practices. All three acute providers have now undertaken the national self-assessment tool for the nationally prioritised interface areas. These are being analysed before being presented to the system interface group. The roll out of pathology test requesting for non-medics is progressing with over 60 practices signed up for the first phase. While not one of the national interface requirements, this was a priority for our practices. 		31.12.24
December 2024	<ul style="list-style-type: none"> PCARP update report went to ICB Board in November. Concerns about general practice resilience and position of national funding informing collection action noted by LMC. Work on new HSP specification ongoing and submitted to triple lock process. Roll out of pathology requesting progressing slowly, as per interface work. ICB Board has requested a plan and trajectory for this, which has been requested from JPUH and NNUH, QEH is already in place. 		28.2.25

Viewed by Sarah
09/11/2024 09:33:32

	<ul style="list-style-type: none"> Delays to standard contract gap analysis by providers following prioritisation of national self-assessment tool. Work programme in development for system interface group to ensure this is built in for 2025. 		
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Visual Risk Score Tracker – 2024/25												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	16	16	16	16	16	16	16	16	16			
Change	→	→	→	→	→	→	→	→	→			

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Ref PC16

Risk Title	Severe Mental Illness (SMI) Annual Physical Health Checks							
Risk Description	<ol style="list-style-type: none"> The ICB is at risk of failing to meet its commissioning commitment to meet the needs of its SMI population which leads to a clinical risk that patients with SMI will experience significant health inequalities and a 15-20% higher mortality when compared to their peers. There is also a performance risk identified with regards to delivering the national target of the Norfolk and Waveney system delivering 75% of SMI health checks for 2024-25. 							
Risk Owner	Responsible Committee	Operational Lead			Risk team			
Sadie Parker	Primary Care Commissioning Committee	Shepherd Ncube			Primary Care Commissioning Team			
Risk programme board	Date Risk Identified		Target Delivery Date		Date risk last reviewed			
Primary Care Commissioning Committee	10/05/2022		31/03/2025		02/12/2024			
Risk type	Transformational / environmental / political / reputational / financial / quality & patient safety / corporate / workforce & people / health inequalities							
Risk Scores								
Unmitigated			Mitigated			Target		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	3	3	12	2	2	8
Risk appetite:					Risk tolerated:			
Controls								
<ul style="list-style-type: none"> 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 								
Assurances on controls								
<p>Internal: Primary Care Commissioning Committee, quarterly steering group, Commissioning and Performance Committee, and the Community Transformation Programme risk register</p> <p>External: NHSE Checkpoint and Assurance Framework, Health Overview and Scrutiny Committee, Reports to NHSE/I.</p>								
Gaps in controls or assurances								
<ul style="list-style-type: none"> 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 resilience, specifically gaps in recruitment and staff retention, remains an ongoing challenge to SMI performance. The national target has been uplifted to 75% for 2024/25 and there is limited confidence in meeting this in the 2024/25 year. A recovery trajectory has been compiled to try and drive uptake and impact of these checks. 								

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Actions			
Date opened	Action	BRAG	Target completion
October 2024	<p>Q1 24/25 was published on 12th September 2024, showing that N&W ICB had delivered SMI Health Checks to 60% of the eligible population. This meets the minimum requirement of the SMI LTP, though the full requirement target for ICBs is 75%. This is the first data reported since the changes implemented on 1st April 2024 and includes the following changes:</p> <ul style="list-style-type: none"> - Now extracted directly from primary care systems via General Practice Extraction Service (GPES). - The GPES extract only include checks delivered to those with a diagnosis of schizophrenia, bipolar and other psychosis (MH_COD) and does not include those without such a diagnosis but who have been prescribed lithium. - This new data extract does not include NSFT SMI HCs (prior to Q1 24/25 the data did include this). <p>Detailed review of Q1 24/25 delivery data will be undertaken at a practice/ PCN level now that the national reporting is available. The SMI Health Check Outreach service has been extended for a further 12 months, giving a new end date of 31/03/26. Primary Care Commissioning managers are liaising with Together UK to ensure targeted support is offered to practices across N&W ICB.</p>		November 2024
November 2024	<p>Currently waiting for Q2 24/25 data to be shared by NHSE. Further updates will follow once national reporting has been received and reviewed.</p>		December 2024

Visual Risk Score Tracker – 2024/25												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	12	12	12	12	12	12	12	12	12			
Change	→	→	→	→	→	→	→	→	→			

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Ref 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			Risk team	
Mark Burgis		Primary Care Committee Commissioning (PCCC)		Jayde Robinson			Primary Care Workforce	
Risk programme board		Date Risk Identified		Target Delivery Date			Date risk last reviewed	
Primary Care Committee Commissioning (PCCC)		01/06/20		31/03/25			20/11/24	
Risk type		Workforce & people						
Risk Scores								
Unmitigated			Mitigated			Target		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	3	4	12	2	4	8
Risk appetite:		TBC			Risk tolerated:		TBC	
Controls								
<ul style="list-style-type: none"> • 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. • Primary Care Equality, Diversity and Inclusion Fellow recruited. • Wide range of initiatives in place to support GP retention. • Advanced Practice Forum established. • Primary Care Workforce Strategy 2024-2027 • Communication Engagement strategies updated to reflect PCN development updates and post pandemic environment. • Workforce data to measure trajectory levels against actual recruitment. • AI software mapping and reports provided for vacancy levels for primary care. • Succession planning led 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 								
Assurances on controls								
<ul style="list-style-type: none"> • Internal: Reporting to Primary Care Commissioning Committee (PCCC). • Reporting: ICS Norfolk & Waveney People Board. • External: NHSEI returns monthly as part of the NHSE Primary Care Oversight Board KPI's and quarterly assurance meetings. 								

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.
- Extension of national training hub contract has only been renewed for a further year (up to 31st March 2026) rather than the 2-year extension expected.
- GPN lead position and GPN Mentor not filled to support Primary Care Workforce development.

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Actions			
Date opened	Action	BRAG	Target completion
October 2024	<p>Latest NHSE workforce data illustrates the following:</p> <ul style="list-style-type: none"> 2.6% growth in Direct Patient Care workforce roles across N&W during the period of July 24 vs July 23 (641 WTE). 1.4% growth in non-clinical roles (1752 WTE) <p>As of August 2024, the current Additional Roles Reimbursement Scheme (ARRS) levels, Norfolk and Waveney utilised 90% of the ARRS financial sum, however not all PCN's have submitted their claims yet.</p> <p>As of July 24, we have a total of 583 WTE being claimed through the ARRS portal system by PCN's. However, the National Workforce Reporting tool is showing 510 FTE being reported in July 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.</p> <p>As of 1st October 2024, the following positions currently advertised for recruitment within general practice, linked to this risk (PC17) are:</p> <ul style="list-style-type: none"> 7 x Direct Patient Care Roles (Practice employed) 8 x non-clinical roles (Practice employed) 4 x Additional Roles Reimbursement, Direct Patient Care (Primary Care Networks) 		November 2024
November 2024	<p>Latest NHSE workforce data illustrates the following:</p> <ul style="list-style-type: none"> 2.9% growth in Direct Patient Care workforce roles across N&W during the period of September 23 vs September 24 (649 WTE). 2.5% growth in non-clinical roles (1768 WTE) <p>As of September 2024, the current Additional Roles Reimbursement Scheme (ARRS) levels, Norfolk and Waveney utilised 94% of the ARRS financial sum, however not all PCN's have submitted their claims yet.</p> <p>As of September 24, we have a total of 523 WTE being claimed through the ARRS portal system by PCN's. However, the National Workforce Reporting tool is showing 353 FTE being reported in September 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.</p> <p>As of 21st November 2024, the following positions currently advertised for recruitment within general practice, linked to this risk (PC17) are:</p> <ul style="list-style-type: none"> 5 x Direct Patient Care Roles (Practice employed) 8 x non-clinical roles (Practice employed) 2 x Additional Roles Reimbursement, Direct Patient Care (Primary Care Networks) <p>All PCN's have submitted their recruitment intentions as part of workforce planning for the remaining 24/25 period.</p> <p>Anecdotal information from practices suggest receptionist roles are challenging to recruit and retain.</p>		January 2025

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Visual Risk Score Tracker – 2024/25

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

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BORR09								
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 1 st 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			Risk team			
Mark Burgis	Primary Care	Sadie Parker			Patients & Communities			
Risk programme board	Date Risk Identified	Target Delivery Date			Date risk last reviewed			
	01/04/2024	31/03/2026			28/11/2024			
Risk type	Transformational / political / reputational / financial / quality & patient safety / workforce & people / health inequalities							
Risk Scores								
Unmitigated			Mitigated			Target		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	4	20	5	4	20	4	3	12
Risk appetite:						Risk tolerated:		
Controls								
<ul style="list-style-type: none"> 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 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 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 primary care commissioning team to ensure workforce retention programmes and training support is linked to the Dental Delivery Plans Clinical Dental Advisor role recruited for ICB in 2024 to replace NHS England roles 								
Assurances on controls								
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								
<ul style="list-style-type: none"> 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

Actions			
Date opened	Action	BRAG	Target completion
September 24	<p>Emergency contract agreed for 12 months, subject to all regulatory, CQC registration and quality controls being in place, to replace services offered by provider in administration.</p> <p>Two other providers have advised the ICB they intend to terminate their contracts March 2025 – primary care team is working with each provider to try and retain NHS services.</p> <p>Contract termination (highlighted above) effective end of August.</p> <p>Clinical Advisor – Dental appointed subject to recruitment checks.</p> <p>Year-end process completed; clawback monies being recovered.</p> <p>Local providers invited to expand their capacity for new patients either through sessional payments or extension of UDA contract. Deadline for submissions is 30 August. Aim is to reduce health inequalities in line with Long Term Plan.</p> <p>All 23 Golden Hellos offered for 2024/2025 (national and local programmes).</p>	B	Complete
October 24	<p>Mid-year review process underway to focus on practices delivering <30% of activity in September. Providers required to submit action plans to the NHSBSA by 14/11/24 for ICB review. To discuss with individual providers with opportunity to renegotiate contracts underperforming year on year for reinvestment.</p> <p>Access improvement plan assessment of Expressions of Interest underway, outcome delayed due to lack of capacity within ICB due to competing priorities.</p> <p>Expressions of Interest invited for Shared Care Pathway</p> <p>National workforce data update received and being analysed by ICB.</p>	A	31/01/2025
November/ December 2024	<p>Initial phase of applications agreed under the Access Improvement scheme for new patients, individual providers being informed. Agreed investment of £1.5m for 2024/2025. Next phase and priorities for investment to be agreed.</p> <p>Service specification and guide for Child Focused Dental Practices finalised for ICB to invite Expressions of Interest to be approved subject to meeting criteria for participation. Evaluation methodology being finalised.</p>	A	31/01/2025

Visual Risk Score Tracker – 2024/25												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	20	20	20	20	20	20	20	20	20			
Change	→	→	→	→	→	→	→	→	→			

BORR08

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 1 st 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			Risk team		
Mark Burgis	Primary Care		Sadie Parker			Patients & Communities		
Risk programme board	Date Risk Identified		Target Delivery Date			Date risk last reviewed		
TBC	01/02/2024		31/03/2027			28/11/2024		
Risk type	Transformational / quality & patient safety / workforce & people / health inequalities							
Risk Scores								
Unmitigated			Mitigated			Target		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	4	20	4	4	16	3	4	12
Risk appetite:					Risk tolerated:			
Controls								
<ul style="list-style-type: none"> 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 and Senior Clinical Fellows for 2024/2025 for strategic development, transformation and commissioning purposes 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 Clinical Advisor for Dentistry recruited to ICB from October 2024 								
Assurances on controls								
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								
<ul style="list-style-type: none"> 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. 								

- 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 clarity for responsibility following restructure
- 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

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Actions			
Date opened	Action	BRAG	Target completion
May 24	<ul style="list-style-type: none"> 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 <p>Medical Needs pathway under development by ICB</p>		30/09/2024
Aug 24	<ul style="list-style-type: none"> Paper presented to EMT relating to the emerging risk with NNUH as lead provider for both JPUH and NNUH patients for secondary care orthodontic services following JPUH notice to terminate. Paper to be presented to ICB Performance and Commissioning Committee in September. Shared Care Pathway approved for mobilisation. Trauma pilot in primary care ceases end September 2024. Discussions under review to consider if to extend pending review of pilot. If not extended, more patients will be seen in secondary care including Emergency Departments. 	B	Complete
Sep 24	<ul style="list-style-type: none"> Regional ICB agreement to extend the Trauma pilot to end March 2025, subject to ICB governance arrangements, to enable evidence based informed discussion to take place re future of the service and links to urgent treatment pathway and OOH services 	B	Complete
Oct/Nov/ Dec 24	<ul style="list-style-type: none"> Trauma pathway pilot in primary care extended to 31/3/24 for regional collaboration to continue to agree commissioning intentions from April 2025 (subject to ICB governance processes). Paper presented to Performance & Commissioning Committee (P&C) 17/10/24 re orthodontics at JPUH and NNUH. Further discussion at P&C Committee in January 2025. Lack of capacity within ICB to monitor contracts and complete EIA/CQRA remains a risk A meeting is being scheduled with Matt Dooley, ICB Executive Director of Commissioning and Performance to discuss support for assurance for the monitoring of secondary care dental contracts. 	R	31/03/2025

Visual Risk Score Tracker – 2024/25												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score			NEW	16	16	16	16	16	16			
Change				→	→	→	→	→	→			

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BAF02 Inphase 0000032

Risk Title	Primary Care Resilience and Transformation
Risk Description	<p>Under the Joint Forward Plan we have committed to integrating primary care services to deliver improved access (including digital tools and remote monitoring offers, etc.) to a wider range of services from multi-professional teams, focused on preventing illness and improving outcomes for our population within their communities.</p> <p>Our high-level outputs include:</p> <ul style="list-style-type: none"> • Developing a vision for providing accessible enhanced primary care services • Improving patient outcomes and experience • Stabilise dental services and setting a strategic direction for the next five years <p>Primary Care Services are the responsibility of the Integrated Care Board, including the recruitment and retention of healthcare professionals.</p> <p>There are particular risks to the resilience of general practice, access to NHS dentistry treatment and Level 2 dental services which are reflected in the risk scores.</p> <p>The community pharmacy and optometry landscape is less defined at the time of writing, but workforce and funding challenges are evident across community pharmacy which represent a risk, but could potentially be supported through greater integration and collaborative working with other primary care providers.</p> <p>Limitations of national contracts, collective action by General Practice, independent contractors 'handing back' NHS contracts, workload pressures, recruitment and retention and interface challenges are, together, impacting on access to high quality, sustainable primary medical, community pharmacy and dentistry services together with Level 2 dental services for our population.</p> <p>This may lead to delays in accessing care, unavailability of care (particularly dentistry), 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, and fragile services.</p> <p>As the cornerstone of healthcare, primary care resilience risks system ability to deliver against key workstreams, including the overall aim of moving towards a more population-based proactive community model of care which addresses prevention, health inequalities and improves outcomes. Reduced access in primary care may also impact on the resilience of other system providers.</p>

Risk Owner	Responsible Committee	Operational Lead	Risk team
Mark Burgis	Primary Care Commissioning	Sadie Parker	Patient & Communities
Risk programme board	Date Risk Identified	Target Delivery Date	Date risk last reviewed
	31 August 2024	31 March 2027	2 December 2024

Risk type Transformational/ workforce & people / health inequalities

Risk Scores

Unmitigated			Mitigated			Target		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	4	20	5	4	20	3	4	12

Risk appetite:		Risk tolerated:	
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Controls

- ICB organisational change programme has seen a reduction in vacancies within the Primary Care Commissioning and Strategic teams.
- Operational readiness work is seeking to align the Primary Care Team with colleagues from Workforce, Estates, Digital, Place, Quality, Planned Care and Finance, etc. to support joined up primary care; including access to sustainable dentistry and general practice services.
- An overarching strategic vision and principles for primary care are being finalised to support the development long-term plans for general practice and community pharmacy during 2024/25, followed by optometry.
- A long-term dental plan has been published, with delivery monitored through PCCC.
- Performance/quality management and reporting in place.
- Clinical expertise provided by Clinical and Care Professional and Clinical Fellow roles across primary care.
- Ring-fenced budgets and commissioning targeted to simultaneously support population need and resilience.
- Primary Care Access Recovery Plan delivery reported regularly to ICB Board and NHS assurance meetings.
- System Interface Group and matrix working in place to support national requirements for self-assessment.
- Local LMC General Practice Alert System established which informs improvement and support work monitored through the PCCC.
- Strong relationships in place with local representative committees across all primary care services

Assurances on controls

Internal: ICB Executive Management Team, Primary Care Commissioning Committee, Dental Services and General Practice & Community Pharmacy Delivery Groups, Workforce Steering Group, Primary Care Strategic Planning Meetings, Primary Care Team

External: NHS England via delegation agreement and assurance framework, Health Education England, Norfolk and Waveney Local Dentistry and Medical Committees, Health Overview and Scrutiny Committee meetings, Regional and Local Professional Network and Managed Clinical Networks, Healthwatch Norfolk/Suffolk, NHS Business Services Authority. Primary Care Commissioning Committee meetings held in public.

Gaps in controls or assurances

- Lack of in-depth knowledge about the resilience and stability of **all** primary care services across Norfolk and Waveney.
- Lack of awareness and understanding across the system about the impact struggling primary care services will have in the longer term on other system partners and services.
- Unknowns associated with the ongoing collective action associated with the BMA's 'Save General Practice' campaign in respect of pressure on primary medical care and other system partners and impact on access to healthcare for our population.
- Significant capacity gaps in ICB teams remain following restructure and reliance on wider teams (eg Quality and Workforce) to address the issues – there is a reduction in vacancies in the primary care team but building knowledge and relationships will take time, with operational readiness work in progress.
- ICB's financial position is impacting on our ability to support resilience and transformation in primary care leading to temporary and more expensive solutions being put in place, particularly across dental and primary medical contractors.
- Primary care dashboard/ delivery report remains in development, leading to a lack of integrated performance oversight.
- Lack of access to NHS dentistry services is an area of quality and safeguarding concern - this impacts 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.
- CQC activity is currently focused on private dental practice, rather than NHS practices.
- General practice visit programme has been tested but not launched due to vacancies impacting capacity, CQC inspections focused on where there is a significant risk or concern.
- Data to capture inappropriate transfers of workload and general practice pressures is incomplete - planning resources may be less effective if based on an incomplete picture.
- Workforce and capacity shortages across general practice, community pharmacy and dental practices,

together with the ongoing drug shortages, are having an impact on access to robust and effective primary care provision.

- Resilience policy in development but impacted by team capacity, which will link into any bids for section 96 support for general practice.
- Five-year Primary Care Strategy has expired, new strategic framework/long term plans in development for integrated neighbourhood working, general practice and community pharmacy, however capacity and long term absence is affecting progress.

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Actions			
Date opened	Action	BRAG	Target completion
September 2024	<p>Dental</p> <ul style="list-style-type: none"> ICB clinical advisor has commenced. Expressions of interest received from existing providers to increase access with a focus on health inequalities. New senior primary care commissioning manager has taken up post. SNEE ICB has begun recruiting to the regional team for supporting development of specialist secondary care dental services <p>Medical</p> <ul style="list-style-type: none"> Workshop held to review Terms of Reference and project infrastructure for system interface group. Close monitoring of BMA collective action ongoing. MGUS disease monitoring LES fully approved and being offered to practices. Draft primary care vision and principles approved in principle, final amends being circulated to voting members. <p>Community Pharmacy</p> <ul style="list-style-type: none"> National discussion about potential collective action for community pharmacy. New risk for community pharmacy developed for approval. Commissioning officer in the team remains vacant. 		31.12.24
October 2024	<p>The primary care workforce team has moved into the primary care directorate and is responsible for general practice, dentistry and optometry. 49 programmes are actively being delivered. Community pharmacy workforce development sits within the medical directorate.</p> <p>Primary care vision and principles has been shared with primary care commissioning committee members for final approval. Work is now starting to develop an overall strategic framework for primary care</p> <p>Dental</p> <ul style="list-style-type: none"> Expressions of interest to provide additional capacity targeting health inequalities reviewed and in the process of being confirmed with providers so capacity can come on stream this financial year. Mid-year review process underway. National workforce data received with analysis underway. A reduction in workforce is noted, and the staff groups collected are limited. <p>Medical</p> <ul style="list-style-type: none"> Close monitoring of the impact of GP collective action continues, feeding into regional monitoring. The team has started planning for a programme of work to develop a long-term plan for general practice. The ICB is currently out to consultation on a proposal to close the Toftwood Medical practice in Dereham and transfer patients to neighbouring practices. Public drop in sessions and a public 		31.12.24

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	<p>meeting are due to take place in November, with the final decision at Primary Care Commissioning Committee in December.</p> <p>Community Pharmacy</p> <ul style="list-style-type: none"> Materials being developed to support general practice in referring to Pharmacy First. Relaunch of Pharmacy First coming on line in early November. NWICB performance on Pharmacy First is strong when compared to regional colleagues however there is more opportunity to increase referrals 		
November/ December 2024	<p>Dental</p> <ul style="list-style-type: none"> Continuing to work on priority areas set out in Long Term Plan with a focus on health inequalities. Significant ongoing political interest, which impacts on capacity of the team. Clinical advisor has commenced in role and is already making an impact in the work we do and the support to the team. <p>Medical</p> <ul style="list-style-type: none"> Ongoing close monitoring of GP collective action. Referring by letter rather than form is increasing across practices, as reported by providers. Lack of winter resilience funding for general practice is causing concern with practices already reporting increased activity. At the same time, EDs are reporting a significant increase in minors activity. Vision and principles document has been approved, and a PCARP report has been noted by the ICB Board at its meeting in November. <p>Community pharmacy</p> <ul style="list-style-type: none"> Pharmacy First activity continues to grow, however there remains much potential and referrals from general practice and NHS111 are relatively low. The likelihood of collection action by community pharmacy is increasing, following support to a national ballot by The National Pharmacy Association. Potential impact being modelled. 		28.02.25

Visual Risk Score Tracker – 2024/25												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score					20	20	20	20	20			
Change					NEW	➡	➡	➡	➡			

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NEW PC20

<p>Risk Title</p>	<p>The resilience of Community Pharmacy</p>
<p>Risk Description</p>	<p>The resilience of Community pharmacy is at risk due to several factors listed below, including workforce pressures which is covered in a separate report. The risk could ultimately lead to an increase in the number of permanent closures of pharmacies within our ICB which would reduce the accessibility of pharmacy services to our population. It could also lead to reduction to core service provision only. The rurality of Norfolk and Waveney does mean that this risk is significantly projected due to geographical distance between existing providers.</p>
<p>Risk Factors</p>	<ul style="list-style-type: none"> • The financial viability of Pharmacies was highlighted in a Pharmacy pressures survey published by Community Pharmacy England (CPE) in August 2024. • The current Community Pharmacy Contractual Framework remains in negotiation with the Department of Health; therefore the future of Pharmacy funding and the commissioning landscape remains uncertain. • Medicines supply shortages are not only causing additional workload but, in many cases, medicines are having to be dispensed at loss with the prices being above that of the drug tariff price, again leading to financial uncertainty. Almost 64% of contractors surveyed say they are operating at a loss. • The rurality of Norfolk and Waveney does mean that this risk is significantly projected due to geographical distance between existing providers. • Pharmacy workforce shortages leading to unplanned pharmacy closures highlighted in a Healthwatch report released 26th September 2024. The main reason for these closures were reported as staff shortages which could include all members but likely to encompass mainly the availability of a responsible pharmacist.
<p>Risk Consequences</p>	<ul style="list-style-type: none"> • It is reported that nationally 7 pharmacies a week are closing permanently due to funding and profitability pressures. There is an indication that 1-in 6 may close within the next year. It is not yet known how this will affect Norfolk and Waveney. • Permanent closures will impact accessibility to pharmaceutical and dispensing services particularly where only one pharmacy contract exists in a rural location. It also has a significant impact on neighbouring pharmacies which have often not had time to plan effectively for the increase in patient services activity. • Lack of pharmacy services will negatively impact the delivery of the Joint Forward Plan, which aims to deliver more care in the community and supports the use of community pharmacy for clinical services to support the wider system resilience. • This will have a wider impact as neighbouring pharmacies and other health service partners take on additional workload which in turn affects their resilience. • Any local lack of pharmacy services will impact our ability to deliver the primary care access recovery plan (PCARP) which empowers pharmacies to deliver more clinical services and to support the resilience of General Practice. • Closure of pharmacies could also put pressure on out of hours services such as NHS111 and A&E during late nights and weekends as lack of accessibility will drive the patients to seek healthcare in different settings. • The pressures on community pharmacy means they may have to restrict their services to core contractual provision, such as reducing extended opening hours, ceasing free delivery services, and ceasing additional support such as dossette boxes, other than for those patients covered by the Disability Discrimination Act. Also locally commissioned services could be at risk of being stopped including for example the provision of emergency contraception. This in turn could cause an

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	increase in workload for our general practice providers who are already themselves facing resilience challenges.							
Risk Owner	Responsible Committee			Operational Lead	Date Risk Identified	Target Delivery Date		
Mark Burgis	Primary Care			Sharon Gardner	01/09/2024	01/09/2027		
Risk Scores								
Unmitigated			Mitigated			Tolerated		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	5	20	4	4	16	3	4	12
Controls					Assurances on controls			
<ul style="list-style-type: none"> Quality assurance processes Primary care engagement Removing additional pressures Promoting integration between primary care providers Ensuring new funding through Pharmacy First is being maximised. Integration funding Development of the operational delivery groups to include community pharmacy. MoU in place with HWE ICB for the delivery of contractual services on the behalf of the East of England. Ability through this team to monitor contractual activity including closures but also market entry applications. Strong engagement with the Local Pharmaceutical Committee Engagement with the Locality teams and the Local Medical Committee Establishment of Head of Pharmacy Workforce role within the ICB reporting into the Chief Pharmacist 					<p>Internal: Executive Management team, general practice and community pharmacy delivery group, primary care commissioning committee</p> <p>External: NHS England via delegation agreement and assurance framework, community Pharmacy Norfolk and Suffolk (LPC), Health Overview and Scrutiny Committee meetings</p>			
Gaps in controls or assurances								
<ul style="list-style-type: none"> Contractor visit programme, Support visits currently focused on where there is a significant risk or concern, and a full programme is to be implemented. Pharmacy strategy and long-term plan in development, along with wider primary care strategic framework Pharmacy dashboard/ delivery report remains in development, leading to a lack of integrated performance oversight. Additional assurances to those already in place, to be requested from the HWE contracting team to ensure that any recommendations made are presented to PCCC to consider the implementation of any the recommended actions e.g. internal audit. One band 5 vacancy remains on the pharmacy and optometry team which impacts capacity and ability to support and push forward developments and long-term plans. Risk Register- development of a risk report presented routinely to the GPCPDG will help support risk assurance. The first report is to be presented at the October GPCPDG. Development of a robust operational risk register is in place, although a quality risk register is maintained by the quality team in line with feedback from the primary care team. 								

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Updates on actions and progress			
Date	Action	RAG	Target completion
September 2024	<ul style="list-style-type: none"> National Pharmacy Association (NPA) announced a ballot of its members on potential work to rule action. Number of pharmacies eligible to vote unknown. A work to rule outcome may mean that our out-of-hours services would be impacted as pharmacies would only look to deliver their core 40-hour contracts which generally are based within the week Monday-Friday. Awaiting outcome but already considering what system impact could be and how it may be mitigated. Internal ICB Pharmacy team band 7 vacancy filled and band 5 vacancy in progress with trac advertisement. Work to develop a vision and set of principles for our primary care strategic framework is progressing well, with wide engagement across primary care. Healthwatch release a report on the impact of temporary closures of pharmacies. Norfolk and Waveney reported as the ICB with the highest number of hours lost per pharmacy of 17.48 hours. Document to be reviewed and risk report to be amended with updates if required. 		31/12/24
October 2024	<ul style="list-style-type: none"> No update on the NPA ballot but it is expected a decision on the outcome will be before Christmas. This will be recommended action so the risk to the system remains unknown. It is to be noted Independent Pharmacy Association (IPA) announced that had they been consulted they would have advised against a ballot whilst the new pharmacy contract is being negotiated. ONE permanent Pharmacy closure occurred in October. ONE reduction in supplementary hours removing hours post 18:30 was submitted in October. ONE increase in supplementary hours adding hours into a Saturday to increase accessibility submitted October. Considering pharmacies are already reducing their supplementary hours and in advance of the potential ballot results a review of the late night and weekend accessibility to be started to assess the 'want vs the need' ICB Pharmacy team band 5 vacancy out for advert with interviews planned for 14th November 2024, currently have 19 applications. Vacancy for ICB quality pharmacist role, interviews conducted 29th October but likely to be a gap until early February which may reduce ICB capacity for support Community Pharmacy England release a 3rd report in the series concentrating on staff morale and wellbeing the key findings were <ol style="list-style-type: none"> Community pharmacies are facing widespread workforce shortages and problems recruiting, and staff wellbeing is one of pharmacy owners' biggest worries. 		31/12/24

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	<p>2) Staff shortages are impacting patient care and leading to increased pressure on pharmacy teams.</p> <p>3) Some community pharmacies are being forced to close temporarily because of staffing shortages.</p> <p>4) Pharmacy teams are struggling to cope with staffing and other pressures, as well as abuse from some patients.</p> <p>The current risk rating remains the same for this month. However, it is to be noted that the outcome of the NPA ballot could significantly impact the risk.</p>		
November 2024	<ul style="list-style-type: none"> Band 5 vacancy in the Pharmacy and Optometry Commissioning team has been interviewed and offered on 28.11.2024. Pending acceptance. ICB Quality Pharmacist role has been accepted, gap likely to remain until early March. NPA ballot confirmed Pharmacy Owners are in favour of collective action, however a confirmed date for action has not been made. A full risk assessment on the impact of a reduction in supplementary hours has been completed by the Pharmacy and Optometry Team and shared with colleagues in NW ICB. However, due to the lack of available information we cannot plan for any reduction in service provision as a result of collective action. ONE permanent Pharmacy closure occurred in November. THREE increases to supplementary hours to increase accessibility. ONE new pharmacy has opened in Norfolk in November. <p>The current risk rating remains the same for this month. However, it is to be noted that any action as a result of the NPA ballot would significantly impact the risk.</p>		31.1.25

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

Appendices

Pharmacy workforce pressure survey funding and profitability report

https://cpe.org.uk/wp-content/uploads/2024/08/Pharmacy-Pressures-Survey-2024-Funding-and-Profitability-Report_compressed.pdf

[Pharmacy Pressures Survey 2024: Funding and Profitability Report \(cpe.org.uk\)](https://cpe.org.uk)

Pharmacy workforce pressure survey Medicines Supply report

<https://cpe.org.uk/wp-content/uploads/2024/05/Pressures-Survey-2024-Medicines-Supply-Report-Final.pdf>

[Pharmacy Pressures Survey 2024: Funding and Profitability Report \(cpe.org.uk\)](https://cpe.org.uk)

Healthwatch Report- Pharmacy temporary Closure report

<https://www.healthwatch.co.uk/news/2024-09-26/temporary-closures-add-crisis-community-pharmacies>

[Temporary closures add to crisis in community pharmacies \(healthwatch.co.uk\)](https://www.healthwatch.co.uk)

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Agenda item: 07

Subject:	Proposal to Close Toftwood Medical Centre
Presented by:	Sadie Parker, Director – Primary Care
Prepared by:	Sadie Parker, Director – Primary Care
Submitted to:	Primary Care Commissioning Committee
Date:	10 December 2024

Purpose of paper:

This paper is to seek approval for a recommendation on a proposal to close Toftwood Medical Centre, following a period of public consultation undertaken by the ICB.

The Health and Wellbeing Board representative for Norfolk has a conflict of interest for this item. The chair has agreed he should remain present in the meeting but not participate in the discussion.

1. Introduction

The purpose of this paper is to seek approval for a recommendation on a proposal to close Toftwood Medical Centre, following a period of public consultation undertaken by the ICB.

In considering this paper, the Committee is invited to be mindful of the Board Assurance Framework (BAF) risk on the resilience of general practice, and our Joint Forward Plan commitments.

The ICB would like to acknowledge the efforts put into the process by both the Dereham practices (including the Toftwood Medical Centre) and the local community and stakeholders.

2 Background

The Elmham Partnership was awarded the APMS (Alternative Provider of Medical Services) contract to run Toftwood Medical Centre in May 2018, it was previously run

by the Coastal Villages Partnership. An APMS contract was first let in early 2016; previously this was a GMS contract (General Medical Services).

The APMS contract was procured by NHS England before the local NHS became responsible for commissioning services. This was the contract of choice used by NHS England when a commissioning gap or contract handback happened. APMS contracts are time limited (a contract length of over five years must be approved by NHS England) and can be held by any company satisfying the tender requirements. GMS contracts can only be held by GP partnerships, or certain companies limited by shares (where at least one share in the company is legally and beneficially owned by a qualifying general medical practitioner, and any other share or shares in the company that are legally and beneficially owned by a medical practitioner are owned by a qualifying general medical practitioner) and are held in perpetuity. Most of the 105 practices in Norfolk and Waveney are GMS with seven being APMS and therefore time-limited.

The current provider has worked hard to steadily improve primary medical services for patients. There are currently 4,099 registered patients (accurate as at 1 October 2024). It is a small practice in an expanding market town with good local and national transport links. There are no current performance concerns about the provider.

The annual contract value is £586,424 for 2024/25 with a price per Carr-hill weighted patient of £140.00 (weighted list size of 4188.74 at 1 January 2024) – this price per patient is broadly in line with other APMS contracts in Norfolk and Waveney. The average GMS price per weighted patient for 2024/25 is £107.16 (inclusive of out of hours deduction), which would give a total contract value on the same weighted list of £448,865. The APMS contract is time-limited which does not support sustainability or resilience of the practice or the workforce.

GPs from the Elmham Partnership work at the Toftwood Medical Centre and the management of the two practices is also shared. There is a dedicated team of clinical and non-clinical staff employed at the Toftwood Medical Centre.

3. Public consultation

The ICB proposed that the best way to continue to provide general practice services to patients registered with the Toftwood Medical Centre, in suitable facilities and in a more cost-effective way, would be to close Toftwood Medical Centre and to move people's registration to one of Orchard Surgery or Theatre Royal Surgery on 1 April 2025.

This change of registration would be undertaken automatically with no action required by anyone currently registered with the Toftwood Medical Centre. Once they had been moved to one of the two surgeries, people would have the right to choose to register with a different practice if they preferred, as long as they lived within that practice's catchment area.

We proposed to do this because we believed it was the best way to ensure people were cared for in appropriate facilities and in a cost-effective way, while ensuring

none of the people currently registered with the Toftwood Medical Centre were left without GP practice registration.

We embarked on a period of public consultation on 10th October, concluding on 21st November - the [Consultation Document](#) is available via the link and the Consultation Outcome Report can be seen appended to this report. We are grateful to local people and local stakeholders for their participation in the process and the feedback has enabled us to update our Equality Impact Assessment (appended) and to further consider our proposal.

4. Consideration of the proposal and the consultation response

When considering the proposal, the ICB must have regard to its statutory duties, any processes set out in the NHS England Primary Medical Services Policy and Guidance Manual (PGM) and any relevant ICB policies or guidance.

In doing so, the ICB should consider how future arrangements will meet the reasonable needs of patients, as defined in the GMS contract.

Clauses 8.15.13 and 8.15.14 of the NHSE Policy Guidance Manual (NHSE PGM) set out the considerations in assessing applications from practices to close a branch surgery. In the absence of a specific section of the NHSE PGM on main surgeries, this section has been used to structure this report.

- *financial viability;*
- *registered list size and patient demographics;*
- *condition, accessibility and compliance to required standards of the premises;*
- *accessibility of the main surgery premises including transport implications;*
- *the Commissioner's strategic plans for the area;*
- *other primary health care provision within the locality (including other providers and their current list provision, accessibility, dispensaries and rural issues);*
- *dispensing implications (if a dispensing practice);*
- *whether the contractor is currently in receipt of premises costs for the relevant premises;*
- *other payment amendments;*
- *possible co-location of services;*
- *rurality issues;*
- *patient feedback;*
- *any impact on groups protected by the Equality Act 2010 (for further detail see chapter 4 (General duties of NHS England));*
- *the impact on health and health inequalities; and*
- *any other relevant duties under Part 2 of the NHS Act (for further detail see chapter 4 (General duties of NHS England)).*

Chapter 4 of the PGM set out the general duties of NHS England and these are attached in Appendix A. Many of these duties are similar to the ICB's statutory duties, which are listed in Appendix B.

4.1 Financial viability

The Toftwood practice has been provided through an APMS (Alternative Provider of Medical Services) contract, originally let by NHS England, since 2016. This is a time-limited contract and the current price per patient is £140. The equivalent GMS (General Medical Services) price is £107.16 (inclusive of out-of-hours deduction), with GMS contracts being in perpetuity.

In addition to this, GP practices receive rent and rates reimbursement, funding for digital equipment and licences, Quality and Outcomes Framework payments and locally commissioned/ enhanced services payments.

The British Medical Association has called on GP practices to participate in GP collective action, following a vote of all members. The Saving General Practice campaign was launched in the summer following several years of below inflationary uplifts to national contracts. The recent budget announcement increasing employers' national insurance contributions is also causing great concern. It is not yet known if there will be any increase to general practice funding nationally to mitigate the rises.

The ICB understands it is becoming increasingly challenging for all our practices to meet their financial commitments within the national funding provided, and that practices are looking very carefully about how they provide their services within their contractual requirements. This is why the ICB has added a risk on the resilience of general practice to its Board Assurance Framework and monitors it closely through the ICB Board and the Primary Care Commissioning Committee.

4.2 Registered list size and patient demographics

The average list size of a GP practice in Norfolk and Waveney as at 1 October 2024, compared to Toftwood Medical Centre and other comparators is as follows:

Mean list size	10,467
Median list size	8,851
Smallest list size	1,917
Largest list size	30,685
Toftwood Medical Centre	4,099

The viability of a practice is likely to be affected by economies of scale, and it is more difficult to cover unplanned absences from a small team. The ICB has received five applications from practices for section 96 funding over the last 12 months, due to their resilience and requiring support for turnaround plans. Section 96 funding is emergency funding which can be provided to practices to support delivery of specific actions to improve resilience and sustainability when a practice is in crisis. The NHSE Policy and Guidance Manual sets out the conditions and expectations attached to this funding.

Within the ICB the smallest area health activity data and registered population data is available is at lower super output area (LSOA). Registered population data from

NHS Digital highlights the majority of patients registered with Toftwood Medical Centre are from the four LSOAs in south Dereham (see the health profile appended to this paper). These account for about 75% of the registered population at Toftwood Medical Centre. Four other LSOAs to the north of Dereham account for another 20% of the registered population.

Looking at the communities where about 75% of Toftwood Medical Centre patients live, about 7,600 people reside in these communities of which almost 3,000 are registered with Toftwood Medical Centre. The rest of the residents are mostly registered with Orchard Surgery and Theatre Royal Surgery.

Census information for this part of the Toftwood community indicates that the population is about the same as the Norfolk average, is in slightly better health and provides a similar amount of unpaid care.

The general practice profile for Toftwood Medical Centre shows the population is similar to the Norfolk and Waveney ICB average, which is older than England, and as a whole the population experiences lower levels of deprivation. Patient satisfaction is about average and there is a higher prevalence of long standing health conditions compared to the England average.

Local people raised concerns that, by closing Toftwood Medical Centre, demand would increase on other services, and access to care would become more difficult. Local people were also worried about the impact on vulnerable people, such as the frail elderly and those with disabilities. We have updated our Equality Impact Assessment following the public consultation to include the feedback we have received, and we have considered this in our recommendations.

Provisional analysis indicates that for the age/sex distribution of the Toftwood population and given the Norfolk and Waveney average, Toftwood Medical Centre has fewer patients in the frailty segment but more patients in the dominant major chronic condition segment. For other segments Toftwood is about as expected for the age and sex distribution. Provisional analysis also indicates that for the age and sex distribution of the Toftwood population, healthcare activity is generally lower than expected given the Norfolk and Waveney average. This is also the case for other practices in Dereham apart from community services activity. The number of patients at Toftwood with polypharmacy and multi-morbidity are about as expected.

We can use relative change in emergency admissions as one proxy measure to help understand how unmet health need in Toftwood has changed over time compared to other practices in Dereham. We use this because other measures, like GP appointments and community services, might be constrained by supply. The table below shows the rate of emergency admissions in bold, compared to the other Dereham practices and the Elmham Surgery (which currently provides the service at Toftwood Medical Centre). All of these rates are below the Norfolk and Waveney average, note these data are from April 2024.

Area	Average emergency admissions per month	Registered Population April 2024	Crude Rate (not standardised for age and sex)
	12	1,200	1.0
	10	1,000	1.0
	8	800	1.0
	6	600	1.0
	4	400	1.0
	2	200	1.0

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Toftwood	27	4,045	6.7
Elmham Surgery	62	9,691	6.4
Theatre Royal	69	9,000	7.6
Orchard	82	11,100	7.4
Norfolk and Waveney	8,533	1,094,600	7.8

4.3 Condition, accessibility and compliance to required standards of the premises

The ICB's infection prevention and control nursing team has undertaken an inspection of the Toftwood Medical Centre premises and have confirmed the level of updating required to ensure current standards are met – there is a significant amount of revision required to ensure compliance. Members of the Committee arranged site visits to Toftwood Medical Centre, Orchard and Theatre Royal Surgeries, and were able to speak with staff, GPs and managers about the challenges faced and the emerging plans for the transition, should the proposal be approved.

The larger premises at Orchard and Theatre Royal Surgeries provide better facilities for patients, the ability to provide a larger range of services and the modern general practice access model. All consulting rooms are on the ground floor. If the Toftwood site was required for longer term use then the property would benefit from significant investment to improve the clinical rooms and general functionality of the building. The building is too small for the size of the registered list and does not lend itself to deliver modern general practice services where a range of clinicians deliver services.

One of the consulting rooms is upstairs, in what was formerly office space. There is no lift in the building and this makes things challenging for the practice operationally. The width of the stairs is narrow which limits to single file access. Practice staff have to ensure patients with mobility issues are not booked into that consulting room meaning staff having to swap rooms during the day to accommodate patient needs, which is not the most efficient use of resources.

Building costs have increased significantly over recent years. Our primary care estates team have provided us with cost estimates to fully refurbish the Toftwood Medical Centre based on a national tool which is widely used by the NHS. Investment of up to £760k excluding VAT would be required to fully refurbish the surgery to bring it up to the required standards, but this would not address the size of the building.

There have been attempts to identify an alternative site for the practice over many years, dating back to the former South Norfolk CCG (clinical commissioning group – the commissioning organisations in place across the country prior to ICBs) and the expiry of the previous lease in 2010. The five CCGs covering Norfolk and Waveney merged to form Norfolk and Waveney CCG in 2020, and the newly created primary care estates team worked with the South Norfolk locality team to seek to resolve the

premises issues with the support of NHS Property Services. In 2021 a preliminary business case to relocate Toftwood Medical Centre to an interim modular building on a new site was approved by NHS England. Unfortunately in 2022 the site became unavailable. Attempts at identifying alternative sites have not been successful with sites either proving unsuitable or becoming unavailable.

In 2022, the ICB was working with the existing landlord to add a temporary extension to the current building in order to prolong the life of the practice while the ICB continued to seek an alternative site. (There had previously been a portakabin on site, however this had rotted through, was no longer safe to use and had to be removed.) The preliminary business case was approved by NHS England and a capital grant was approved. Unfortunately, it was not possible to agree a lease with the landlord and as such the funding for the extension (a grant from NHS England) had to be invested into other areas before it was lost.

Rebuilding the premises on the same footprint, which is too small by modern standards, is estimated to cost in the region of £1.5m excluding VAT, but rebuilding a surgery which met current standards is estimated to cost £2.753m excluding VAT.

The MP for Dereham, George Freeman offered to facilitate meetings between the ICB, the landlord, and local councillors to try to find a solution to the lease issues which have prevented us from securing services in the current premises. The ICB attended two meetings in November where the issues preventing the lease being agreed were discussed. As a result, the ICB provided various documents and our suggested proposal for the priority backlog maintenance work required. Unfortunately, while some progress was made it was not possible to make sufficient progress in negotiations to the extent ICB officers can be confident in securing services in the building past 31 March 2025. We are grateful to George Freeman, MP for facilitating the meetings.

4.4 Accessibility of the main surgery premises including transport implications. Rurality issues.

The ICB's proposal set out the potential transport times for people by either public transport or car. This was done using NHS Digital data and can be seen in the Health Profile appended to this report.

At the present time, looking at the communities where about 75% of Toftwood Medical Centre patients live, about 7,600 people are resident in these communities of which almost 3,000 are registered with Toftwood Medical Centre. The rest of the residents are mostly registered with Orchard Surgery and Theatre Royal Surgery.

Journey time statistics to general practice by public transport indicates that for all the LSOAs around Dereham the proportion of the population able to access general practice within 30 minutes by public transport or walking is in the upper quintile and 100% for most LSOAs. Travel time by public transport for the communities with the most Toftwood patients appears to be consistent between morning and afternoon.

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Both Orchard and Theatre Royal Surgeries are accessible by car in around 10 minutes.

During the consultation, some people raised concerns about the level of traffic congestion in Dereham which could cause delays for people accessing appointments. If the proposal is approved, we will work with both surgeries to look at how we can mitigate this risk, for example by trying to offer planned appointments outside of peak travel times, or in the enhanced access service hosted by all surgeries in the Mid Norfolk Primary Care Network (PCN - PCNs are groups of practices that have come together to share staff and offer certain services at scale, such as enhanced health in care homes, enhanced access appointments and social prescribing). Where clinically appropriate, and in line with the national Delivery Plan for Recovering Access to Primary Care, appointments may also be offered digitally or remotely by telephone.

We also heard concerns during the consultation about the ability of the frail elderly or people with disabilities being able to access the surgeries in Dereham. We have updated our Equality Impact Assessment accordingly, and have also been discussing with the local practices what actions we could take to support people if the Toftwood Medical Centre closed. At the time of writing the report, Orchard Surgery has reported they currently have 536 Toftwood residents aged over 65 registered with them, and Theatre Royal Surgery has reported they have 396.

There is a regular bus service running through Toftwood, which stops near to both surgeries, however this may not be suitable for everyone. There is also a community care scheme in Dereham which is jointly subsidised by the Town and Breckland Councils. Those Toftwood residents who are unable to make an essential journey by public or private transport are able to contact the coordinator to see if they can help. Journeys within Dereham, including Toftwood, are charged at £1.80.

We have begun discussions with Toftwood Medical Centre, Orchard and Theatre Royal Surgeries about ensuring people can be supported, if the proposal is approved. We have discussed the support available for individual people through the PCN social prescribing service, care coordinators and health and wellbeing coaches. We have also discussed the potential for an open session at Orchard and Theatre Royal Surgeries for patients to visit at quieter times, to see the surgery before any automatic transfer takes place.

4.5 The Commissioner's strategic plans for the area

The ICB's [Joint Forward Plan](#) ambition for general practice is to support the development of integrated neighbourhood working between primary care networks and other local providers. The ICB's ambition is also to support the provision of services, traditionally provided in hospitals, to be provided closer to communities (sometimes referred to as a left-shift). These form part of a wider ambition to improve the resilience of primary care.

The national guidance – the [Delivery Plan for Recovering Access to Primary Care](#), refreshed on 9 April, requires ICBs to work with practices to continue to implement the national plan. The key areas are set out below:

- Empowering patients
 - Encourage use of the NHS App among patients for ordering prescriptions, booking appointments and viewing medical records
 - Encouraging the uptake in Community Pharmacy of Pharmacy First services for patients
 - Supporting self-referrals
- Implementing Modern General Practice Access
 - Encouraging the use of digital telephony and the use of digital tools to support service provision, triage and streaming into the right service
 - Supporting practices to transform their service models, using data
- Build capacity
 - Workforce programmes, such as recruitment and retention initiatives and training
- Cut bureaucracy
 - Enabling online registration
 - Improving interface issues where care has been inappropriately transferred to general practice from other providers

Officers believe the ICB’s proposal is in line with the strategic plans set out in this section.

4.6 Other primary health care provision within the locality (including other providers and their current list provision, accessibility, dispensaries and rural issues)

Toftwood Medical Centre is part of a wider primary care network (Mid Norfolk PCN), including the following practices:

- Mattishall and Lenwade Surgeries
- Elmham Surgery
- Theatre Royal Surgery
- Orchard Surgery
- Shipdham Surgery

Discussions took place with all local surgeries and with the PCN leadership prior to the consultation launch. Ongoing discussions have been taking place with Toftwood Medical Centre, Orchard and Theatre Royal Surgeries to support the consultation and to share feedback and any concerns.

The practice boundaries of both Orchard and Theatre Royal surgeries encompass the Toftwood Medical Centre boundary and between them they have just over half of the residents of Toftwood registered between them. Their list sizes are currently as follows:

Orchard Surgery	11,058
Theatre Royal Surgery	9,029

Both surgeries have significantly more space than the Toftwood Medical Centre. Orchard Surgery was already assessed as having sufficient space for growth, and

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the landlord is currently refurbishing and remodelling the internal space to create three more consulting rooms. This would provide Orchard Surgery with the physical capacity to take on a share of the Toftwood Medical Centre patients, while also providing further capacity for the expected housing growth around Dereham in the coming years.

Theatre Royal Surgery has more limited physical capacity, however is currently in early talks with the ICB to further extend its building through a modular extension, which would provide it with sufficient space to accommodate the additional Toftwood patients. It is unlikely this would be in place by 1 April 2025, as such the practice is considering the contingency plans it could put in place if the proposal is approved.

One of the concerns raised in the consultation was about the planned housing growth in Dereham and the ability of local services to be able to absorb the additional patients. Patients of Orchard and Theatre Royal Surgeries were also concerned about the impact on their services from having additional patients from Toftwood. We believe there is capacity in the coming years to do this in the existing premises, however the ICB will be joining the Dereham Action Planning Group so it can consider the longer-term development plans (5-10 years) for primary health care provision in Dereham. The ICB will also provide support to the Dereham practices around recruitment and workforce.

Both Orchard and Theatre Royal Surgeries have agreed to take on the additional Toftwood patients between them with support from the ICB, should the proposal be approved. They have been working up their plans for how they would manage the transition and support the change. They have been supported by their PCN manager in this, and the PCN roles, such as social prescribing, care coordinators and health and wellbeing coaches, are also being considered to support patients with a transition.

4.7 Dispensing implications (if a dispensing practice)

There would be no change to dispensing controlled locations through this application, and those patients who have their medicines dispensed would be able to continue to be dispensed to, or to choose to take their prescriptions to a pharmacy as they can now. The Toftwood Pharmacy has confirmed it is not affected by the ICB's proposal and remains committed to providing pharmaceutical services to the Toftwood community.

As well as over the counter advice and services, and the dispensing of medicines, the Toftwood Pharmacy provides Pharmacy First services. These include seven common conditions and means patients can seek support directly without having to contact their GP practice. The GP practice can also refer patients to the pharmacy following clinical triage. The seven conditions are as follows and we expect this to grow further in the coming years:

- impetigo (aged 1 year and over)
- infected insect bites (aged 1 year and over)
- earache (aged 1 to 17 years)

- sore throat (aged 5 years and over)
- sinusitis (aged 12 years and over)
- urinary tract infections (UTIs) (women aged 16 to 64 years)
- shingles (aged 18 years and over)

4.8 Whether the contractor is currently in receipt of premises costs for the relevant premises

The practice currently receives £27,600 per annum in rent payments from the ICB, which are forwarded to the landlord. This would cease should the surgery be closed.

The practice also receives reimbursement for its business and water rates, and these payments would also cease.

4.9 Other payment amendments

The ICB is not aware of any other payment amendments being required.

4.10 Possible co-location of services

The current building is too small by modern standards to accommodate the current practice list size or to co-locate services.

4.11 Patient feedback

The ICB undertook a period of public consultation to gain feedback about the proposal to close Toftwood Medical Centre. The report can be seen appended to this paper.

The key themes provided in the feedback are listed below. While the mitigations are set out throughout the report in various sections, they are summarised here too for ease.

- Access or quality of care at Toftwood Medical Centre.
All three practices are rated Good by the Care Quality Commission.
- Access or quality of care at Orchard and/ or Theatre Royal Surgeries.
Both Orchard and Theatre Royal Surgeries have been working on their plans to incorporate Toftwood patients should the proposal be approved. They have confirmed they can do this without compromising their contractual requirements. The ICB would work closely with both practices to support the transition.
- Capacity of Orchard and/ or Theatre Royal Surgeries to take on new patients.
There is sufficient physical capacity in the Orchard Surgery building and a

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further three consultation rooms are in the process of being created. Theatre Royal Surgery is working with the ICB to plan an extension to its building and is working on contingency plans until this is in place. Both practices are developing their workforce and recruitment plans, and staff from Toftwood Medical Centre may also be TUPE'd.

- *Population growth in and around Dereham
Orchard Surgery has sufficient physical capacity to take on Toftwood patients and continue to take on more patients in the short to medium term, as housing growth takes place. In addition they have recently added three new consultation rooms to further increase capacity. Theatre Royal Surgery is working with the ICB in planning a modular extension to the premises to enable it to continue to expand. The ICB has agreed to join the Dereham Action Planning Group to consider health care provision in the town in the longer term.*
- *Patient experience and health outcomes
The ICB would work with Toftwood Medical Centre, Orchard and Theatre Royal Surgery throughout the mobilisation and transition period, to support workforce recruitment and any TUPE arrangements and the identification of those individuals likely to be most impacted by the change.*
- *Equality Impact
An EIA was developed and included in the Consultation Document, which has been updated further to the public consultation feedback. The aim is to identify those patients likely to be most affected by the change and offer appropriate support, eg from the social prescribing service or care coordinators. Patients have access to enhanced access appointments at quieter times, and both surgeries are considering holding open mornings for patients to familiarise themselves with the new surgeries.*
- *Transport, travel and traffic
Around half of Toftwood residents are registered with Orchard and Theatre Royal Surgeries. There are good public transport links in place through Toftwood to Dereham with bus stops being nearby both surgeries. For those unable to make essential journeys by public or private transport, there is a community car scheme in place with journeys costing £1.80. There is free parking at Orchard Surgery and nearby to Theatre Royal Surgery, albeit Breckland Council is currently consulting on introducing charges, with no decision yet made.*
- *Trust, transparency and the consultation process
The ICB has listened carefully to all feedback through the consultation and has reconsidered all options. These have informed the report and recommendations.*
- *Alternative options
The ICB has set out the rationale for its proposal in the Consultation document. Alternative options have previously been explored over many years, dating back to the former South Norfolk CCG. Recent discussions*

have made insufficient progress to reassure officers a suitable lease can be agreed. The ICB is committed to working with the Dereham Action Planning Group to consider longer term plans for Dereham. The option to expand Toftwood Medical Centre was explored in 2022/23 but failed to make progress. Recent discussions have made insufficient progress to reassure officers a suitable lease can be agreed.

The feedback from the consultation document was reviewed and used to update the draft Equality Impact Assessment. This is appended to this report.

5. The ICB's duties

Appendix A to the paper sets out the NHS England (NHSE) duties which apply to the consideration of applications from practices to close a branch surgery. Many of these duties are replicated for ICBs and the ICB's general duties are listed in Appendix B and set out in brackets in each sub-section below.

Duties are grouped into four distinct groups:

- Duties which must be fulfilled
- The 'regard to' duties
- The 'view to' duties
- The 'promote' duties

These are listed below along with an explanation of how the ICB has fulfilled NHSE's and its own duties through consideration of the proposal to close Toftwood Medical Centre and the recent public consultation period.

5.1 Equality and health inequalities duties (section 149 - Equality Act 2010 Public Sector Equality Duty ('PSED') and section 14Z35 – ICB duties as to reducing inequalities in access and outcomes)

The ICB has undertaken impact assessments to support its decision-making process. This has included developing a health profile for the local population, enabling us to analyse health and care need to contribute to the impact assessments.

An equality impact assessment (EIA) was undertaken, which was reviewed by our quality team and health inequalities leads. This can be seen in the appendices and sought to assess any impact on safety, effectiveness, caring, responsive and well-led domains, as well as considering staff experience and the local economy. This highlighted the issues with infection prevention and control, the issues around the size and configuration of the clinical rooms and the potential impact on registered patients, older and vulnerable people and staff if the surgery was closed.

The EIA identified a number of actions for the ICB and the practices in assessing the practice's registered patient population. These include ensuring staff are aware and trained as appropriate in areas such as those covered by the NHS Accessible Information Standard.

The EIA highlighted, that for the following protected characteristics, there was not thought to be a disproportionate impact if the Toftwood Medical Centre closed:

- Race and culture
- Religion and beliefs
- Marriage and civil partnership
- Sexual orientation
- Gender re-assignment
- Pregnancy and maternity
- Sex

A revised EIA and QIA were drafted following the consultation and this was done on the new ICB template, which looks different to the one originally published with the consultation document. The following protected characteristics have been reviewed in the EIA and actions considered:

- Age

A site closure in Toftwood may impact both the older and younger population without the ability to drive to another site and those with mobility issues not having very local access to a surgery. It was noted that pharmaceutical services were not impacted by this proposal.

Transport links in and around Toftwood and to the other Dereham practices are good. There is a community car scheme in operation which may be suitable for some people.

Older patients may not be digitally aware or enabled.

Potential actions would be as follows:

The three practices will work together with the ICB on mobilizing the transition. This would include ensuring patients understand the different types of appointment on offer and taking reasonable preferences into consideration for appointment times, eg in enhanced access appointments at quieter times. All surgeries are considering how they can provide an open morning for patients to familiarise themselves with the new surgeries. Patients who are most likely to be affected by the change will be identified as part of the transition and offered support from care coordinators or community connectors. Patients who are clinically housebound would continue to be able to request home visits.

- Disability

Those with a physical/learning disability or who are neurodivergent who are registered with Toftwood Medical Centre may struggle with a change in location both in terms of distance / travel and a busier environment to navigate. Access to medicines in Toftwood and a pharmacist would be unaffected.

Potential actions would be as follows:

ICB to confirm with Orchard and Theatre Royal Surgeries that all staff are fully trained and aware of how to manage the needs of individual patients with disabilities (physical or other) regardless of which surgery site(s) an individual patient uses. Patient registers should be updated to reflect individual needs and those of their carers where appropriate and agreed with the patient. Patients who are clinically housebound would continue to be able to request home visits.

Ongoing compliance with NHS Accessible Information Standard is a requirement and to ensure any reasonable adjustments are made.

All practices to continue to ensure literature is available in other formats such as Easy Read for any registered patient who will benefit from it.

All practices to continue to offer flexible appointment times for individual patients, for example, those with special educational needs or learning disabilities when waiting areas and surgery premises are quieter.

All surgeries are considering how they can provide an open morning for patients to familiarise themselves with the new surgeries. Patients who are most likely to be affected by the change will be identified as part of the transition and offered support from care coordinators or community connectors.

- Pregnancy and maternity

Pregnant people and new parents may have difficulty travelling to premises some distance from their home, however it should be noted that community midwifery services are already only provided from the Dereham Hospital site. Feedback from the ICB patient/public involvement did not identify any additional impact for reasons of pregnancy and maternity.

Potential actions would be as follows:

All practices have baby changing facilities and private areas for breast feeding. Consider contacting individuals to agree mitigating actions such as local transport, volunteer car schemes, timing of appointments etc.

- Carers

Carers may be impacted by their ability to support people to attend the Dereham practices.

Potential actions would be as follows:

The practices should identify and engage with individual carers who are potentially impacted by a possible closure of Toftwood Medical Centre and understand the impact for them, e.g. making appointments for convenient times. Ensuring carers have sufficient information to enable them to access appropriate voluntary sector services. Patients who are clinically housebound would continue to be able to request home visits.

5.2 The involvement duty (and section 14Z45 - Public involvement and consultation by ICBs)

Following a discussion with the Norfolk County Council Health Overview and Scrutiny Committee chair and officers, the ICB has undertaken a public consultation exercise. This included attendance at a public meeting, two local drop-in sessions and the opportunity for local people to provide feedback to the ICB via a survey. The content of this feedback is considered and discussed earlier in the report and the public consultation report can be found appended to this report.

The ICB has been invited to attend the Norfolk Health Overview and Scrutiny Committee (NHOSC) on 7 December. Members of the public are also able to attend and to speak at this meeting.

5.3 Duty to act fairly and reasonably

The ICB has sought to be as fair and reasonable as possible, prioritising a significant amount of resource and time over many years in trying to find a solution to the issues affecting the ongoing provision of services in Toftwood Medical Centre, before reaching the point of consulting on our proposal. We have since spent time listening to local people considering their feedback and exploring the suggested potential alternative options for the future of Toftwood Medical Centre. The ICB understands the feedback from local people has to be balanced against the ongoing challenges set out in the consultation document, which led to the proposal to close Toftwood Medical Centre.

Unfortunately, while it was possible to make some progress with discussions to resolve the issues with the premises through the two facilitated meetings, it was not possible to resolve them within the time we had available. We have also not managed to identify a provider of services on 1 April 2025.

If the Toftwood Medical Centre closed, it is the view of officers that there are reasonable alternative options with Orchard and Theatre Royal Surgeries, which are around 1.5 miles from the Toftwood Medical Centre and are served by good public transport links and accessible by car in around 10 minutes. There is a community car scheme, which may be suitable for those individuals who are unable to make essential journeys by public or private transport.

There is free parking and disabled parking available on site at Orchard Surgery and next to Theatre Royal Surgery. Breckland Council is consulting on proposals to introduce charges for parking, however no decision has yet been made.

5.4 Duty to obtain advice (and section 14Z38 – ICB duty to obtain appropriate advice)

Duty to exercise functions effectively (and section 14Z33 – ICB duty as to effectiveness, efficiency)

The ICB has sought advice from its business intelligence team, who linked in with and used public health information in developing the health profile of the community local to Toftwood Medical Centre, and comparing it to other communities served by Dereham practices and against the Norfolk and Waveney average.

The ICB has been working closely with Toftwood Medical Centre, Orchard and Theatre Royal Surgeries during this period, as well as the PCN, to ensure any concerns are taken into consideration. Both Orchard and Theatre Royal Surgeries are willing to take on Toftwood patients and have been planning accordingly.

NHS England regional colleagues have been notified and have provided support and advice to the ICB in appropriately managing the process. NHSE regional colleagues have provided advice in respect of the Secretary of State for Health and Care notification provisions, and Norfolk HOSC has also been kept updated, albeit the meeting takes place after this report was written. A verbal update will be provided to the Primary Care Commissioning Committee.

Our estates team and our infection prevention and control nursing team have provided advice in their areas of expertise. The ICB's director of corporate governance and the Communications and Engagement team have been fully involved in overseeing the work, and the ICB's executive team have been kept briefed.

The draft equality impact assessment has been reviewed and commented on by the ICB's internal multi-disciplinary panel, and the revised version following the public consultation, has also been submitted.

5.5 Duty not to prefer one type of provider

The ICB, in delivering its functions, is not aware this duty has been impacted by the consultation or this process.

5.6 The 'regard to' duties

- **Desirability of allowing others to act with autonomy and avoid imposing unnecessary burdens upon them** (note this NHSE duty was revoked under the Health and Care Act 2022 but remains in the PGM, as such we have considered it against guidance and the wider consideration of issues)
- **The need to promote education and training for those working in the health service**
- **The likely impact of commissioning decisions on healthcare delivered close to the border of Wales or Scotland** (this duty is not applicable here)

Toftwood Medical Centre is provided by an independent contractor commissioned to provide primary medical services to its whole registered population. The contract expires on 31 March 2025 and there are issues with the premises which have been set out earlier in this report and in the consultation document. The ICB proposal aims to provide the best quality services to the registered population, while

recognising the changing model of general practice provision and its future challenges, such as the resilience of service provision more generally.

5.7 The 'view to' duties

- **To act with a view to delivering services in a way that promotes the NHS Constitution**
- **To act with a view to securing continuous improvement in the quality of services in health and public health services (and section 14Z34 – ICB duty as to improvement in quality of services)**
- **To act with a view to enabling patients to make choices about their care (and section 14Z37 – ICB duty as to patient choice)**
- **To act with a view to securing integration where this would improve health services (and section 14Z42 – ICB duty to promote integration)**

The ICB's proposal and the population health profile have been reviewed against the NHS Constitution and its principles, the NHS aims, patient and public rights and NHS pledges, patient and public responsibilities, staff rights and NHS pledges and staff responsibilities.

Officers believe the proposal does not intend to operate contrary to the NHS Constitution, or the other view to duties and the ICB's functions are not believed to be impacted.

The consultation is clear that, should the proposal be approved, patient registrations would be transferred automatically to one of the other two practices (this would be done by the national Primary Care Support England (PCSE) organisation) so that no individual would be left without GP registration. Following this, patients have the right to change their registration to another practice covering where they live, if they prefer.

5.8 The 'promote' duties

- **Awareness of the NHS Constitution (and section 14Z32 – ICB duty to promote NHS Constitution)**
- **Involvement of patients and carers in decisions about their own care**
- **Innovation in the health service (and section 14Z39 – ICB duty to promote innovation)**
- **Research and the use of research on matters relevant to the health service (and section 14Z40 – ICB duty in respect of research)**

The ICB's proposal has been considered against the NHS Constitution and its principles, the NHS aims, patient and public rights and NHS pledges, patient and public responsibilities, staff rights and NHS pledges and staff responsibilities.

ICB officers believe the proposal does not intend to operate contrary to the NHS Constitution, or the other 'promote' duties and the ICB's functions are not believed to be impacted.

The Toftwood Medical Centre has a patient participation group (PPG) and regularly discusses service provision and proposed improvements. The PPG has attended a

meeting of the Theatre Royal Surgery PPG. The Orchard Surgery PPG did not have a meeting scheduled during the consultation.

The Orchard Surgery already participates in the ICB's research programme and plans to become a training practice again in future, following the loss of their GP trainer. The Theatre Royal Surgery is a training practice.

5.9 Considering the wider impact of decisions (and section 14Z43 – ICB duty to have regard to wider effect of decisions (the triple aim))

Section 244 - Requirement to consult with the local authority about service change in certain circumstances. (Regulation 23)1

ICB officers have written to or engaged with neighbouring practices, the PCN clinical director and PCN manager, Local Medical Committee, Local Pharmaceutical Committee, Norfolk County Council, Breckland District Council, Dereham Town Council, Norfolk Primary Care and Healthwatch Norfolk, to understand the potential for impact on the services they provide to patients of the Toftwood Medical Centre, should the surgery close.

Not all organisations responded, however those that did have had their views incorporated into the consultation response document. A meeting with an executive director and portfolio holder at Breckland District Council is due to take place in early December, after this report is submitted.

In making a decision about the exercise of its functions, an ICB must have regard to all likely effects of the decision in relation to:

- the health and well-being of the people of England;
- the quality of services provided to individuals by the NHS or in pursuance of arrangements made by the NHS in connection with the prevention, diagnosis or treatment of illness, as part of the health service in England;
- efficiency and sustainability in relation to the use of resources by relevant bodies for the purposes of the health service in England.

In assessing any wider impact the service change may have on existing services, we have reviewed the health profile of the community local to Toftwood Medical Centre, we have reviewed the CQC ratings of both Theatre Royal and Orchard Surgeries and the GP Patient Survey results. The primary care commissioning team has also been working with the Place team and the PCN on support access improvements in line with the national Delivery Plan for Recovering Access to Primary Care.

Both Orchard and Theatre Royal Surgeries have been considering their mobilisation plans, should the ICB's proposal be approved. If the decision is made to approve the closure, the ICB will work directly with the practices to support the mobilisation plans, including ensuring appropriate resources are assigned to supporting the most vulnerable people registered with the Toftwood Medical Centre, to ongoing communication with local people and to finalise TUPE arrangements and undertake any necessary further recruitment. Both practices have agreed to take on the additional patients from Toftwood, should the proposal be approved.

We have no reason to believe the quality of services will be impacted by the closure of Toftwood Medical Centre, from the data provided in the health profile – both Orchard and Theatre Royal Surgeries have confirmed they can continue to meet their contractual requirements while taking on additional patients. They have been planning in the event the proposal is approved, and the ICB would also be providing support and oversight. Orchard and Theatre Royal Surgeries are around 1.5 miles from Toftwood Medical Centre and around half of people living in Toftwood are already registered with them. There is a good bus service through Toftwood into Dereham, it takes around 10 minutes in the car and there is also a community car scheme which may be suitable for those people who are unable to make essential journeys by public or private transport.

There may be an adverse impact on a minority of individuals in line with our Equality Impact Assessment, however we would seek to mitigate this through the individual support we would seek to offer to support the transition. We accept it may be less convenient to travel to one of the Orchard or Theatre Royal Surgeries should Toftwood Medical Centre close.

As well as an early briefing provided to the Norfolk Health Overview and Scrutiny Committee (NHOSC) chair and lead officer, the ICB will also attend NHOSC on 7 December 2024 to discuss the ICB's consultation, the outcomes and recommendations.

5.10 Section 14Z44 – ICB Duty to have regard to Climate Change

Each ICB must, in the exercise of its functions, have regard to the need to contribute towards compliance with the UK net zero emissions target, and other air quality and species abundance targets under that Act.

Concerns have been raised during the public involvement phase about the potential for further increasing traffic congestion through the closure of the Toftwood Medical Centre. The ICB has agreed to join the Dereham Action Planning Group, and has discussed the potential for offering appointments at quieter times, or by remote methods where clinically suitable. There is also a regular bus service running through Toftwood to Dereham.

It should be noted the Toftwood Medical Centre building itself will have a carbon footprint, and is in need of modernisation. The Orchard Surgery is a modern building which is currently being further refurbished. Operating out of fewer buildings could reduce carbon emissions.

While the effect of patient travel is one of the 'plus' areas currently out of scope of the NHS guidance, it is estimated to form 5% of all NHS emissions. For primary care, the largest proportion of emissions is for medicines and chemicals, followed by metered dose inhalers and business services. Our medicines optimisation team works closely with practices and incentivises switches to more cost effective medicines and the switch to 'green' inhalers is a key part of our work as an ICB.

The NHS guidance planned interventions for primary care include:

- Replacing primary care estate with new builds where appropriate
- Upgrading existing buildings
- Optimising building usage
- On-site generation of renewable energy and heat
- National electricity decarbonisation
- Research, innovation and off-setting

In addition to these actions, with the introduction of the modern general practice access model and the developments since the Covid pandemic, patients have the option of contacting the practice online or by telephone, and appointments can also be offered remotely when clinically appropriate. Pharmacy First services are being rolled out in line with national guidance and are available from the Toftwood pharmacy.

6. Options for committee to consider

1. To approve the proposal to close Toftwood Medical Centre, when the contract expires on 31 March 2025, and to transfer registered patients to both Orchard and Theatre Royal Surgeries.
2. To defer a decision on the proposal to enable the ICB to take more time to attempt to seek an alternative short term provider, and to continue to negotiate with the landlord.

7. Conclusions

ICB officers have carefully reviewed the consultation feedback, the impact assessments, other relevant information set out in this report, and the health profile of the community local to Toftwood Medical Centre, against the ICB's legal obligations under national guidance and its statutory duties. Officers have also spent time exploring with various providers the possibility of providing services from 1 April 2025 under a new contract and to resolve the longstanding premises issues following attendance at two facilitated meetings with the landlord. Unfortunately we have not made the progress we would need to be able to recommend a deferral of a decision (option 2).

ICB officers have concluded there is likely to be minimal health impact for the majority of people in closing the Toftwood Medical Centre. A minority of people may be affected by the change of practice, particularly in the short-term, for example the frail elderly and those with disabilities, and they will be identified and offered support through the transition; all patients will be able to access a new patient check appointment with their new practice, and we will work together with Toftwood Medical Centre, Orchard and Theatre Royal Surgeries to target those who may be most affected. The ICB will work closely with all three practices to plan the mobilisation of the transfer and the transition, including the transfer of and recruitment of staff, as appropriate.

It is accepted accessing primary medical services may become less convenient for patients registered with the Toftwood Medical Centre, however this should be balanced against the ability for the ICB to continue to commission high quality,

resilient and sustainable services in suitable premises for its entire patient population and for the staff that work there. Both Orchard and Theatre Royal Surgeries are located around 1.5 miles away from the Toftwood Medical Centre, there are good public transport links and they are easily reachable by car. A local community car scheme is in operation, which may be suitable for those who are unable to make essential journeys by public or private transport. There is currently free parking, including disabled parking, at the Orchard Surgery, and nearby to the Theatre Royal Surgery. Breckland Council is currently consulting on whether to introduced parking charges however a final decision has not yet been made.

The ICB has been invited to join the Dereham Action Planning Group and this will enable us to consider the longer term healthcare provision for the growing population of Dereham and Toftwood. In the meantime, there will be sufficient physical capacity within the two surgeries with the current and planned expansion, to both expand to include the Toftwood Medical Centre patients, and to accommodate growth in the short to medium term.

The practices and the PCN are continuing to develop their offer of remote appointments and digital access through the implementation of the national modern general practice model and how this can benefit patients living across their patient areas.

8. Recommendation to Committee and next steps:

PCCC members are invited to approve a recommendation to close the Toftwood Medical Centre when the contract expires on 31 March 2025.

If this recommendation is approved, the ICB will continue to work closely with the Toftwood Medical Centre, Orchard and Theatre Royal Surgeries and the PCN leadership, with a focus on mobilising transition plans, including workforce and recruitment plans. Patients will be informed about the decision, and in due course patients will be informed about their new GP surgery, with their registration being moved automatically. PCSE will ensure families in the same house are registered with the same surgery, and they will use postcode data to identify the most suitable surgery.

Health and wellbeing support will also be made available to staff affected. ICB officers will work with and support the practices to engage with the actions identified as part of the Equality Impact Assessment. The ICB communications and engagement team will support all three practices in their communications with patients.

While not required due to the lack of lease for the Toftwood Medical Centre premises, the ICB will provide reasonable notice to the landlord and will continue to reimburse rental payments accordingly. Sufficient time will be provided to the provider and the ICB Digital team to enable the building to be cleared of practice and ICB-owned assets, before it is handed back.

The ICB will support the transition by continuing to facilitate meetings with the three practices until the point of transition, and with the two practices post transition for a period of 12 months, to monitor the impact of the change and any required actions accordingly.

Key Risks	
Clinical and Quality:	Primary care resilience has a significant impact on service provision to patients across all parts of the system. The ICB's proposal will indirectly support the resilience and sustainability of Orchard and Theatre Royal Surgeries in future, while maintaining the quality of services for the whole population. Infection and prevention control issues have been identified at the Toftwood Medical Centre, as well as priority backlog maintenance works which could have enabled the surgery to continue until an alternative site was found.
Finance and Performance:	The ICB has no concerns about the performance of Toftwood Medical Centre and patient feedback about their experience of using their services is generally good. There would be a small saving in rent and rates reimbursement should the Toftwood Medical Centre closure be approved, and the GMS capitation fee will provide better value for the NHS than the current APMS capitation fee.
Impact Assessment (environmental and equalities):	The ICB has undertaken an EIA and a health profile has been developed. Concern about further traffic congestion was raised in the public involvement period. The NHS aim for delivering a net zero greener NHS was published in 2020 setting out aims over which the NHS has direct control and those it can influence. The ICB's EIA takes into consideration health inequalities and provides mitigating actions. Toftwood is served by a regular bus service which stops nearby to both Orchard and Theatre Royal Surgeries. Community transport options are available to those people who are unable to make essential journeys by private or public transport and costs £1.80.
Reputation:	There is significant local, political and media interest in the ICB's proposal.
Legal:	Formal delegation agreement with NHSE, delegation assurance framework, NHSE Primary Medical Services Policy Guidance Manual, Advice Note 3: Branch Closures
Information Governance:	Not identified

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Resource Required:	Primary care, quality, finance, comms teams, noting the capacity issues being experienced.
Reference document(s):	Formal delegation agreement with NHSE, delegation assurance framework, NHSE Policy Guidance Manual, Advice Note 3: Branch Closures, primary care assurance framework
NHS Constitution:	None identified, consideration set out in the report
Conflicts of Interest:	None identified
Reference to relevant risk on the Board Assurance Framework	The resilience of general practice

Governance

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

Extract from the NHS England Primary Medical Services Policy and Guidance Manual – chapter 4 (correct and the time of writing this report)

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Summary of duties covered by this chapter:

Equality and Health Inequalities duties

a) Equality Act 2010

- 1.1.1** The Equality Act 2010 prohibits unlawful discrimination in the provision of services on the grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. These are the "protected characteristics".
- 1.1.2** As well as these prohibitions against unlawful discrimination, the Equality Act 2010 requires commissioners to have "due regard" to the need to:
 - 1.1.2.1** eliminate discrimination that is unlawful under the Equality Act;
 - 1.1.2.2** advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it; and
 - 1.1.2.3** foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

This can require NHS England to take positive steps to reduce inequalities

- 1.1.3** The duty is known as the public sector equality duty or PSED (see section 149 of the Equality Act 2010). The Equality Act 2010 also imposes (through Regulations made under the Act) particular inequality related duties on commissioners. Failure to comply with these specific duties will be unlawful.

b) NHS Act 2006 (as amended by the Health and Social Care Act 2012)

- 1.1.4** Under the NHS Act 2006 (as amended by the Health and Social Care Act 2012) commissioners also have a duty to have regard to the need to:-
 - 1.1.4.1** reduce inequalities between patients with respect to their ability to access health services; and
 - 1.1.4.2** reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services
 - 1.1.4.3** (in respect of NHS England, see section 13G of the NHS Act 2006; and, in respect of CCG/ICB, see section 14T of the NHS Act 2006)

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Other non-equality and health inequalities related duties

The "Regard Duties"

1.1.5 In addition to the above, there are other obligations on commissioners to "have regard" to particular factors. These are set out in the NHS Act 2006 (as amended by the Health and Social Care Act 2012). The other "Regard Duties" are:

1.1.5.1 the duty to have regard to the desirability of allowing others in the healthcare system to act with autonomy and avoid imposing unnecessary burdens upon them, so far as this is consistent with the interests of the health service (in respect of NHS England, see section 13F of the NHS Act 2006)

1.1.5.2 the duty to have regard to the need to promote education and training of those working within (or intending to work within) the health service (in respect of NHS England, see section 13M of the NHS Act 2006; and, in respect of CCG/ICBs, see section 14Z of the NHS Act 2006)

1.1.5.3 the duty to have regard to the likely impact of commissioning decisions on healthcare delivered in areas of Wales or Scotland close to the border with England (in respect of NHS England, see section 13O of the NHS Act 2006)

The "View To Duties"

1.1.6 The "View To Duties" are:

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- 1.1.6.1** the duty to act with a view to delivering services in a way that promotes the NHS constitution (in respect of NHS England, see section 13C(1)(a) of the NHS Act 2006; and, in respect of CCG/ICBs, see section 14P of the NHS Act 2006)
- 1.1.6.2** the duty to act with a view to securing continuous improvement in the quality of services in health and public health services (in respect of NHS England, see section 13E of the NHS Act 2006; and, in respect of CCGs, see section 14R of the NHS Act 2006)
- 1.1.6.3** the duty to act with a view to enabling patients to make choices about their care (in respect of NHS England, see section 13I of the NHS Act 2006; and, in respect of CCG/ICBCCGs/ICBs, see section 14R of the NHS Act 2006)
- 1.1.6.4** the duty to act with a view to securing integration, including between health and other public services that impact on health, where this would improve health services (in respect of NHS England, see section 13N of the NHS Act 2006; and, in respect of CCG/ICBCCGs/ICBs, see section 14Z1 of the NHS Act 2006)

The "Promote Duties"

- 1.1.7** The "Promote Duties" are:

- 1.1.7.1 the duty to promote awareness of the NHS Constitution among patients, staff and members of the public (in respect of NHS England, see section 13C(1)(b) of the NHS Act 2006; and, in respect of CCG/ICBCCGs/ICBs, see section 14P(1)(b) of the NHS Act 2006)
- 1.1.7.2 the duty to promote the involvement of patients and carers in decisions about their own care (in respect of NHS England, see section 13H of the NHS Act 2006; and, in respect of CCG/ICB, see section 14U of the NHS Act 2006)
- 1.1.7.3 the duty to promote innovation in the health service (in respect of NHS England, see section 13K of the NHS Act 2006; and, in respect of CCG/ICBCCGs/ICBs, see section 14X of the NHS Act 2006)
- 1.1.7.4 the duty to promote research and the use of research on matters relevant to the health service (in respect of NHS England, see section 13L of the NHS Act 2006; and, in respect of CCG/ICBCCGs/ICBs, see section 14Y of the NHS Act 2006)

The "Involvement Duty"

1.1.8 Commissioners have a duty to make arrangements to secure that service users and potential service users are involved in:

- 1.1.8.1 the planning of commissioning arrangements by commissioners;
- 1.1.8.2 the commissioners' development and consideration of proposals for changes to commissioning arrangements, if the implementation of the proposals would impact on the range of health services available to service users or the manner in which they are delivered; and
- 1.1.8.3 the commissioners' decisions affecting the operation of commissioning arrangements, if those decisions would have such an impact.

(in respect of NHS England, see section 13Q of the NHS Act 2006; in respect of CCG/ICBCCGs/ICBs, see section 14Z2 of the NHS Act 2006)

Duty to act fairly & reasonably

1.1.9 Commissioners have a duty to act fairly and reasonably when making its decisions. These duties come from case law that applies to all public bodies.

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Duty to obtain advice

1.1.10 Commissioners have a duty to "obtain appropriate advice" from persons with a broad range of professional expertise (in respect of NHS England, see section 13J of the NHS Act 2006; and, in respect of CCG/ICBCCGs/ICBs, see section 14W of the NHS Act 2006)

Duty to exercise functions effectively

1.1.11 Commissioners have a duty to exercise their functions effectively, efficiently and economically (in respect of NHS England, see section 13D of the NHS Act 2006; and, in respect of CCG/ICBCCGs/ICBs, see section 14Q of the NHS Act 2006)

Duty not to prefer one type of provider

1.1.12 Commissioners must not try to vary the proportion of services delivered by providers according to whether the provider is in the public or private sector, or some other aspect of their status.

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Appendix B

Key general duties of an ICB arising from the National Health Service Act 2006

- Section 14Z32 - Duty to promote NHS Constitution
- Section 14Z33 - Duty as to effectiveness, efficiency
- Section 14Z34 - Duty as to improvement in quality of services
- Section 14Z35 - Duties as to reducing inequalities in access and outcomes
- Section 14Z37 - Duty as to patient choice
- Section 14Z38 - Duty to obtain appropriate advice
- Section 14Z39 - Duty to promote innovation
- Section 14Z40 - Duty in respect of research
- Section 14Z42 - Duty to promote integration
- Section 14Z43 - Duty to have regard to wider effect of decisions (the triple aim)
- Section 14Z44 – Duty to have regard to Climate Change
- Section 149 - Equality Act 2010 Public Sector Equality Duty ('PSED')
- Section 14Z45 - Public involvement and consultation by ICBs
- Section 244 - Requirement to consult with the local authority about service change in certain circumstances. (Regulation 23)1

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Toftwood Medical Centre consultation report

This report summarises the feedback from a public consultation undertaken by NHS Norfolk and Waveney Integrated Care Board (ICB) around how general practice services are provided to people registered with Toftwood Medical Centre in the future.

We would like to thank every person, group and organisation who took the time to share their thoughts, feedback and ideas.

Background

Toftwood Medical Centre is a GP practice located in Toftwood, south of Dereham, serving approximately 4,000 registered patients. The ICB's contract with Toftwood Medical Centre for providing general practice services is due to expire on 31 March 2025. With the contract coming to an end, the ICB reviewed the service and developed a proposal for how to provide general practice services in future to patients registered with Toftwood Medical Centre.

When we are considering making changes to services, we want to understand how people's care and wellbeing may be impacted. We know that changing how services are provided affects people's lives and we take these decisions seriously, so we carried out a consultation to find out what people thought about the proposal. The consultation opened on 10 October 2024 and closed on 21 November 2024.

The consultation document, which sets out further background and information, can be found on the ICB's website, alongside our draft Equality Impact Assessment: <https://improvinglivesnw.org.uk/toftwood-medical-centre-consultation/>.

An Easy Read version of the consultation document and survey was available, and translated versions in different languages and large print copies were available upon request.

We asked people to:

- Tell us what they thought of the changes being proposed.
- Help us understand what the impact would be on people currently registered with Toftwood Medical Centre, Orchard Surgery and Theatre Royal Surgery.
- Share their thoughts about any other options we might not have considered that would help us meet our objective of finding the best way to provide general practice services for people registered with Toftwood Medical Centre.

Stakeholders

We engaged with a wide range of stakeholders, including:

- Patients and the carers of patients registered with Toftwood Medical Centre, Orchard Surgery and Theatre Royal Surgery.
- Staff working at Toftwood Medical Centre, Theatre Royal Surgery and Orchard Surgery.
- Norfolk County Council's Health Overview and Scrutiny Committee.
- Local elected representatives, including the MP, county and district councillors.
- Local statutory and voluntary organisations.
- Norfolk and Waveney Local Representative Committees.

Engagement activities

People could share their views by:

- Completing our online survey.
- Completing a paper copy of the survey. These were available at Toftwood Medical Centre, Theatre Royal Surgery and Orchard Surgery, as well as the engagement events and by calling the ICB. These could be returned to the surgeries or posted to the ICB.
- Two informal face-to-face feedback sessions, one held at Toftwood Medical Centre in the afternoon on 22 October and one held at Toftwood Methodist Church in the morning on 5 November.
- One public meeting held at Dereham Memorial Hall in the evening of 13 November.
- People could also write a letter, email or call the ICB.

We ensured events were held at a variety of locations and at different times of the day to ensure people had as much chance as possible to attend if they wished to share their views that way.

The events were promoted via the ICB website, social media, via the local media and in the consultation document.

Respondent information

In total there were 1,984 written responses to the consultation. In addition, people gave feedback at the drop-in sessions and the public meeting. Here is a breakdown of the people that responded in writing:

Responding as:		
I am registered with Toftwood Medical Centre.	1,068	55.25%
I am supporting someone who is registered with Toftwood Medical Centre to respond.	177	9.16%
I am registered with Orchard Surgery.	132	6.83%

I am supporting someone who is registered with Orchard Surgery to respond.	22	1.14%
I am registered with Theatre Royal Surgery.	678	35.08%
I am supporting someone who is registered with Theatre Royal Surgery to respond.	53	2.74%
I work at Toftwood Medical Centre.	5	0.26%
I work at Orchard Surgery.	5	0.26%
I work at Theatre Royal Surgery.	6	0.31%
I am responding on behalf of a local organisation (please state)	10	0.52%
Total		100%

Demographic questions

We asked a number of demographic questions to make sure that the consultation was representative of the community we serve and the people that use our services. These were not mandatory and people could choose not to share this information.

Age	Under 16	16-24	25-34	35-44	45-54	55-64	65-74	75+
Number of people	8	50	189	222	298	394	400	302
Percentage	0.4%	2.7%	10.1%	11.9%	16.0%	21.1%	21.5%	16.2%

	Number of people	Percentage
Male	617	32.3%
Female	1,265	66.2%
Prefer not to say	29	1.5%

The majority of respondents told us they were white British (1,361 people / 69%), followed by British (333 people / 17%), white (57 people / 3%) and English (45 people / 2%).

The vast majority of respondents told us their first language was English (1,804 people / 91%), followed by Portuguese (11 people / 1%), Polish (3 people / 0.2%) and Romanian (3 people / 0.2%).

Do you have a disability?	Number of people	Percentage
Yes	550	29.2%
No	1,220	64.7%
Prefer not to say	115	6.1%

Format

Of the 1,984 written responses received, the majority (1,835 or 92.5%) were responses to the online survey.

How we received the responses:		
Online survey	1,835	92.5%
Paper survey	143	7.2%
Email	6	0.3%
Total	1,984	100%

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Themes

Every response was carefully read by a member of the ICB and was categorised based on the key themes, the points raised and the information included. Many responses raised multiple points and therefore have numerous tags attached to them.

We asked two open questions about the proposal. Sometimes people made the same point or a very similar point in response to question one and question two of the survey. The column titled 'Numbers of times mentioned' provides the combined number of times a point was made in response to both question one and question two of the survey.

All quotes included have been lifted verbatim directly from responses provided.

Theme	Points raised	Number of times mentioned	Quotes
Access or quality of care at Toftwood Medical Centre	<ul style="list-style-type: none"> The quality of care at Toftwood is excellent. Staff are friendly, professional and caring. Patients can usually secure an appointment when they need one. 	339	<ul style="list-style-type: none"> "I love the personal and happy service I get from Toftwood surgery and have been very happy with everything they have done." "Toftwood has a genuine community GP feel." "The Toftwood practice is amazing, they are patient and understanding of my own needs and of those of my children." "Staff are brilliant and never had such a good doctors surgery!" "We are so lucky to be able to ring up on the day and 9 times out of 10 we are able to get an appointment."
Access or quality of care at Orchard Surgery and / or Theatre Royal Surgery	<ul style="list-style-type: none"> Some Toftwood patients were previously registered at Orchard Surgery or Theatre Royal Surgery and felt the quality of care was poor. 	74	<ul style="list-style-type: none"> "I was previously registered at Orchard Surgery and whilst I am sure staff did their best, Orchard Surgery staff are overwhelmed and cannot cope with the patients they have got now."

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			<ul style="list-style-type: none"> • “I moved to Toftwood from Theatre Royal because you could never get an appointment there, and trying to speak to a medical professional was impossible.”
	<ul style="list-style-type: none"> • Friends, relatives or neighbours report the quality of care at Orchard Surgery or Theatre Royal Surgery to be poor. • Friends, relatives, or neighbours registered at Orchard Surgery or Theatre Royal Surgery report they cannot get an appointment. 	166	<ul style="list-style-type: none"> • “I haven't heard good reviews from orchard surgery, I know a few people who have had a really difficult time there and this will make me anxious as to what service I will receive.” • “It only takes a quick jaunt onto social media to find people that are complaining that it is too difficult to get an appointment as the practices are too busy.”
Capacity of Orchard Surgery and / or Theatre Royal Surgery to take on new patients	<ul style="list-style-type: none"> • People highlighted concerns around the capacity of Orchard Surgery or Theatre Royal Surgery to take on Toftwood patients. 	1,207	<ul style="list-style-type: none"> • “Both Orchard and Theatre street surgeries are at capacity and this will cause inevitable issues with appointments.” • “...both practices have full capacity already and I understand from friends who attend both these surgeries that being able to get an appointment to see a doctor is already extremely difficult – so this is going to make this situation much worse.” • “Theatre Royal surgery in particular has inadequate consultation space and very limited room for expansion.”
Population growth in and around Dereham	<ul style="list-style-type: none"> • Concerns around the impact that local housing developments will have on general practice services, particularly if Toftwood were to close. • There needs to be a long-term plan for ensuring that 	653	<ul style="list-style-type: none"> • “Toftwood is an area that is expanding at an alarming rate with no plans to improve the infrastructure around it.” • “The town has significantly increased in population over the last 30 years but the healthcare provision has not. If anything there needs to be additional services added to deal with this rather than combining existing services.”

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	Dereham has the infrastructure and services in place to support the growing population.		<ul style="list-style-type: none"> “Thousands of new houses are being built around the area, but no new infrastructure is ever built, no schools, no new medical centres.”
Patient experience and health outcomes	<ul style="list-style-type: none"> The proposal would negatively impact people’s physical and mental health and care. The proposal would make it harder for people to access services. Concerns around moving to a different or larger practice for those who are neurodivergent or those who have mental health conditions. Concerns the proposal could cause additional pressure on emergency departments and walk-in centre. 	1,454	<ul style="list-style-type: none"> “The health of the patients will be negatively impacted as the longer waiting times, limited appointments and services will mean some people cannot get treatment they need.” “This could also mean that if symptoms are not seen and diagnosed early because of the wait it could have a serious impact on people's health.” “Patients who have ongoing/lifelong medical conditions that require several appointments weekly/monthly will also be penalised, as it is hard enough to get an appointment now let alone if this proposal goes ahead.” “I suffer with anxiety and I am comfortable with my current doctor and all staff at Toftwood Medical Practice and feel in safe hands there.” “My whole family are SEN myself and 2 children are autistic and ADHD having the smaller practice is more beneficial to us than the larger ones.” “I am autistic and attending a smaller doctors surgery is far easier than a larger one and the thought of changing at all gives me a lot of anxiety.” “...would invariably have to go to Norfolk and Norwich A&E and wait for 4 or 5 hours to get treatment. Not a great way to spend my day and a massive waste of a valuable NHS Resource.”
	<ul style="list-style-type: none"> Impact on existing Orchard Surgery / Theatre Royal Surgery patients 	425	<ul style="list-style-type: none"> “A bad idea. I am a patient with Orchard and struggle to get an appointment as it is without half another surgery in there too.”

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			<ul style="list-style-type: none"> • “As a patient of Theatre Royal Surgery my concern are how can a doctors that is struggling at the present patient numbers cope with 2 thousand more.”
Equality impact	<ul style="list-style-type: none"> • Concerns about the impact on older people. 	282	<ul style="list-style-type: none"> • “The population of patients in Toftwood is high, many are elderly vulnerable and in need of a local service.” • “Dad has always been able to see the same doctor at Toftwood and this is helpful as he has dementia.” • “They have a large population of elderly and housebound that struggle to travel, or require home visits, alongside covering multiple care homes...” • “...the Toftwood medical centre serves many elderly patients including my grandmother, who is nearly blind and cannot walk well. she will not be able to get to the doctors in Dereham as it's too far for her.” • “It would make it very difficult if I needed to visit the doctor as I rely on my daughter and she is not always available.” • “Now with limited mobility and increasing health issues it is most worrying that we will need to travel by bus or taxi into town for a consultation.”
	<ul style="list-style-type: none"> • Concerns about the impact on people with disabilities or people who have reduced mobility. 	127	<ul style="list-style-type: none"> • “I am a disabled war veteran and when I am unwell with one of my more serious problems I am unable to travel on public transport or walk very far.” • “I cannot take public transport safely alone and am ... housebound so I feel like individuals like me have not been considered.” • “I am disabled & need to be fully hoisted. With some of my ailments I require a home visit - I am very concerned that I would have to wait longer for a home visit by the doctor.”

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			<ul style="list-style-type: none"> • “As a parent of 3 special needs children I don't want to worry about future medical appointments or lack of them...”
	<ul style="list-style-type: none"> • Concerns about the impact on children, young people and families. 	117	<ul style="list-style-type: none"> • “...would have a significant impact on my family, as a family who doesn't drive getting to other practices is challenging esp with a sick child.” • “Closing this practice would mean struggling to get an appointment for myself or my baby daughter.” • “...it's only around the corner for my family which also gives me the advantage to pop in before school run and book if needed to.” • “I and my family are registered with one of the surgeries in town and it is extremely hard to get appointments now, let alone with an extra couple of thousand patients from Toftwood being added!” • “I live and work in Toftwood, my sons school is in Toftwood, I don't drive. If I'm at work or if he's at school we can just nip out and return back with in a few minutes.” • “My children being autistic would not cope well with these changes!”
	<ul style="list-style-type: none"> • Concerns from people who work. 	17	<ul style="list-style-type: none"> • “As someone who works for a living I cannot get an appointment now without taking time off work. Now you want to move my surgery so it is even more inconvenient.” • “I work from home and so having the local surgery means I can get to appointments during working hours.” • “...it would affect not only my self, but also my wife as we work long hours on different shifts and this move would make having an appointment difficult”

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			<ul style="list-style-type: none"> • “I live and work in Toftwood, certainly wouldn't be able to have an appointment and then get to work on time.”
	<ul style="list-style-type: none"> • Concerns about the impact on people on low incomes and the increase in the cost of living. 	39	<ul style="list-style-type: none"> • “The ever diminishing money in ours and everyone's household would mean finding means to pay for public transport into town.” • “I work and live in Toftwood, certainly can't get to an appointment and back to work, without losing pay.” • “Having to travel to another surgery would be timely and costly, in a time of ever increasing costs.”
Transport, travel and traffic	<ul style="list-style-type: none"> • Concerns about the distance people will have to travel, especially when feeling unwell. • Concerns about traffic congestion and the impact on the environment. 	497	<ul style="list-style-type: none"> • “I have to carry a 5kg oxygen tank and this increased travel would not only cause physical stress but considerable mental fatigue in planning my trip to appointments.” • “My parents are elderly with compromised immune systems, so putting them on public transport when unwell is opening them up to increased risk when compared to the current surgery which is walking distance.” • “It would have an impact on elderly patients who may need to get a taxi, which is costly with the current cost of living.” • “For those who do drive, they are now getting cars out and joining an ever busier trip into Dereham and achieving exactly the opposite in becoming environmentally friendly, by using cars where they would have walked to Toftwood Centre...”
	<ul style="list-style-type: none"> • Concerns about the cost, availability, reliability and accessibility of public transport. 	112	<ul style="list-style-type: none"> • “You suggested that current patients could easily bus into town but busses are FREQUENTLY CANCELLED at short notice meaning missed/wasted appts.” • “Although there is public transport, the journey and following walk there + back, with buses maybe every 1/2

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	<ul style="list-style-type: none"> Concerns included the distance between the bus stop in the town and both surgeries. 		<p>hr when you are unwell, infirm or aged is a very daunting thought.</p> <ul style="list-style-type: none"> “...sometimes the buses are already full by the time they get to the bottom of Middlemarch Road, especially on a Friday, market day. There have been a few times when I have had to stand all the way to the marketplace, because at my age, I cannot climb the stairs.” “...not everyone can access or afford public transport to get the other side of town.” “If Toftwood medical centre closed down I then wouldn't be able to get to an alternative location as I don't get on buses due to anxiety.”
	<ul style="list-style-type: none"> Concerns around the availability and cost of local car parking at Orchard Surgery and / or Theatre Royal Surgery. 	137	<ul style="list-style-type: none"> “Orchard Surgery again has limited parking and you often have to wait for a space.” “Neither of the two Dereham surgeries have adequate parking, with Theatre having none available to the public.” “Driving would not be an option, especially as Breckland Council plan to introduce parking charges at all car parks. I would effectively be charged to see a GP.”
Trust, transparency and the consultation process	<ul style="list-style-type: none"> Concerns that a decision has already been made. More engagement is needed or the engagement is too late. Questions and further information needed regarding the proposals to form an opinion. 	89	<ul style="list-style-type: none"> “On reading through the proposals, it feels as though the decision has already been taken to close down Toftwood Medical Centre. I'd like to think that this is not the case and that the views of all the residents will be taken into account...” “This survey will probably be conducted to satisfy a standard procedure!!” “Consultation at such a late stage doesn't give any room to arrange other options, so it would appear we won't have a choice.”

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			<ul style="list-style-type: none"> • “No details on expansion of Orchard or Theatre surgeries i.e. How many doctors / nurses / staff will be taken on to deal with extra patients.”
Alternative options	<ul style="list-style-type: none"> • Keep Toftwood open. 	584	<ul style="list-style-type: none"> • “Keep it open - some provision is surely better than none.”
	<ul style="list-style-type: none"> • Keep Toftwood open and invest in it. 	124	<ul style="list-style-type: none"> • “Investment in Toftwood centre to ensure a fit for purpose practice, even if it is on the small side.”
	<ul style="list-style-type: none"> • Keep Toftwood open and expand or extend it. 	311	<ul style="list-style-type: none"> • “Extending the surgery seems to have been dismissed, there is plenty of room at the rear to extend; alternatively adding a second floor to the existing surgery may be an option.” • “...add a extension or a mobile unit, do a refurbishment of the building with space saving furniture...”
	<ul style="list-style-type: none"> • Build a new practice. 	326	<ul style="list-style-type: none"> • “Build a new surgery near a bus stop or within walking distance in Dereham or Toftwood.” • “Keep the old surgery open while you build a new surgery.” • “...build a fit for purpose sustainable surgery in Toftwood. One that can grow with the ever increasing population.”
	<ul style="list-style-type: none"> • Relocate Toftwood to alternative premises or use an empty building. 	389	<ul style="list-style-type: none"> • “Given the number of empty business properties in the Dereham area it would surely be possible to find somewhere suitable that could accommodate the service...” • “Would it not be possible to find or build warehouse type accommodation on one of the estates within the Toftwood area ... which could be built or adapted for surgery use?”
	<ul style="list-style-type: none"> • Use the Dereham Hospital site, potentially for a health hub. 	126	<ul style="list-style-type: none"> • “Dereham Hospital is underused. Again, good car parking available. It has many areas that are not used at the moment.”

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			<ul style="list-style-type: none"> • “Why not follow Costessey’s lead in merging all three surgeries into one big medical centre at Dereham Hospital where the NHS has a lot of unused space which is cost ineffective. There's also plenty of room for expansion, car parking facilities, there is already a Toftwood to Dereham bus service serving the hospital.”
	<ul style="list-style-type: none"> • Relocate to the Fred Nicholson school site. 	89	<ul style="list-style-type: none"> • “The Fred Nicholson School is moving to Swaffham, maybe part of that site could be considered, it would make a good medical centre with ample parking.” • “It is central to Toftwood and on a bus route, so would ease the difficulty faced by the many patients who would find it very difficult to travel into Dereham to access the surgeries there.”
	<ul style="list-style-type: none"> • Relocate to the old Jewson’s site / Westfield Road. 	66	<ul style="list-style-type: none"> • “Westfield Road Toftwood has a vacant site for a new building. This has been empty for sometime, and would be perfect for a centre for people living in Toftwood.” • “The land on Westfield Road were Jewson was could have been a good place...”
	<ul style="list-style-type: none"> • Use the old dentist building to increase capacity. 	28	<ul style="list-style-type: none"> • “As I understand the dentist bungalow is now empty it is on the same site and could be used to good effect.” • “...take over the former dentist surgery - as it is adjacent to the pharmacy, there is a very good case for doing this and integrating all three buildings.”
	<ul style="list-style-type: none"> • Review Toftwood’s patient catchment area or criteria. 	50	<ul style="list-style-type: none"> • “...move those who live closest to Dereham and the option for voluntary change by anyone else.” • “Perhaps stop accepting new people if you are already aware its too small for the amount of people in Toftwood.” • “Have a smaller stricter catchment area, or a certain. Demographic... over 60's, diabetics, long term illnesses etc”

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			<ul style="list-style-type: none"> • “Stretch the catchment boundaries of Swanton Morley surgery, or those of North Elmham.”
	<ul style="list-style-type: none"> • Allow patients to be transferred to other surgeries, not just Orchard Surgery and Theatre Royal Surgery. 	32	<ul style="list-style-type: none"> • “Transferring registration to Swanton Morely or North Elmham so to keep continuity of health professionals.” • “Perhaps consider giving people the option of which surgery to go to such as the neighbouring villages for those who can access transport and are happy to travel 10-15 minutes again if there's capacity at the surgery for further patients.”

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There were also a range of other ideas put forward by individuals or a small number of people.

- Find alternative / additional funding to keep Toftwood Medical Centre open, this could include fundraising or crowd sourcing, working with the council to secure section 106 funding / community infrastructure levy funding, renting out space to local groups to raise income for the practice or asking people from Toftwood to pay more council tax.
- Increase the capacity of Toftwood Medical Centre by opening in the evenings and at weekends so that they could care for more patients and it would be a more efficient use of resources.
- The NHS could buy the building outright or make a compulsory purchase order.
- Work with the landlady to agree a new lease.
- Get a court order to force a temporary lease extension.
- Make house builders and developers pay more towards to costs of new infrastructure, like a new GP practice for Toftwood.
- Keep the building open, but provide a more limited range of services from Toftwood which do not require a GP to deliver.
- Introduce appointments at all three surgeries that you can book online in advance to make better use of resources and improve patient experience – on the day appointments could be held in one location.

The following suggestions were made for if the proposal to close the practice were to go ahead:

- Do not close Toftwood until you have either built a new practice or are ready to move to an alternative premises.

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|--|--|---|
| <p>Webb, Sarah
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|--|--|---|

<p>Positive and neutral responses</p>	<ul style="list-style-type: none"> The vast majority of the responses were negative or raised concerns about the proposal, but there were a few responses which were positive or neutral regarding the proposal. 	<p>24 positive 41 neutral</p>	<ul style="list-style-type: none"> “...as a former practice manager, I understand the pressures and feel that it will be in the best interests of everyone to make the move.” “I understand perfectly why the Toftwood Surgery could close and I think what you are proposing transferring patients to Orchard or Theatre Street surgeries would be better for me.” “Yes good idea to close down it is not fit for purpose...” “I think it will be okay if the other surgeries are supported to provide the care for the new patients.”
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Feedback from groups, organisations and businesses

We received some responses from people who told us they were responding on behalf of a group, organisation or business. The organisations cited were:

- Healthwatch Norfolk
- Orchard Surgery Patient Participation Group (PPG)
- Specsavers Hearcare East Dereham
- Shipham Manor Care Home

Healthwatch Norfolk raised concerns about the consultation process and the survey design. They also urged the ICB to pause or halt the consultation and to try to find a way to extend the current contract for a period of time, engage with the landlady to discuss what could be done to improve and develop the current building, hold a wider discussion about the future of primary care in the Dereham area, generate a Dereham area plan, and then conduct any further consultation required.

Orchard Surgery PPG raised concerns about the capacity of the surgery to take on additional patients and the impact this would have on the care that existing Orchard Surgery patients would receive. They also noted concerns about the surgery's capacity to take on more patients as new housing developments are built.

Specsavers Hearcare East Dereham noted their concern that if it were to become harder to get an appointment with a GP then it could put additional pressure on other NHS services, such as such as NHS 111, pharmacies, primary care providers and emergency departments.

Shipham Manor Care Home commended the care provided by Toftwood Medical Centre and said that having the practice so close to the care home had saved residents.

Feedback from staff

We received 16 responses from staff who work at the three practices impacted by the proposal. Their feedback was broadly in line with that of other people who responded to the consultation. They highlighted that the staff at Toftwood Medical Centre care about their patients and they provide good quality services. They raised concerns that some Toftwood patients, for example older people, might struggle to get into the town, as well as concerns about the capacity of other practices to take on more patients. They suggested further work is done to investigate alternative sites in Toftwood to relocate the practice to.

Events

141 people attended the public meeting held in the evening. We also held two drop-in sessions during the day. The feedback received at the in-person events was largely similar to the feedback received via the survey, however there were some additional points and some points that came through more strongly at the events:

- There were quite a lot of concerns raised and comments made about the consultation itself and the process at the in-person events, as well as requests for additional information about the proposal and how it was developed.
- It was commented that the draft EqIA should have a greater focus on the potential impact on people and that it was too focused on the potential impact on services.
- There were a range of questions and comments about the past and current discussions between the ICB and the landlady.
- The potential impact of the ICB's proposal on the resilience of general practice was questioned.
- The need for a long-term plan for general practice and primary care provision for Dereham and the surrounding area was raised in light of planned housing developments.
- There were some questions about the potential impact of the proposal on the pharmacy, as well as questions about the services that the pharmacy does and could provide.
- There were questions about patient choice and how it would be decided which patients would go to which surgery if the proposal were to go ahead.

Petition

In addition, we also received a petition signed by 792 people. The petition was titled: 'Petition to stop the closure of Toftwood Medical Centre' and included the following wording: "This petition to stop the closure of Toftwood Medical Centre, was started in response to NHS Norfolk and Waveney's current consultation which started on 10th October 2024, after it reviewed the services provided by Toftwood Medical Centre."

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Appendix A – Survey questions

Q1. What do you think of our proposal to close Toftwood Medical Centre and transfer the people registered there to another practice in Dereham? How would this proposal affect you if it went ahead? Please write in the box below:

Q2. Are there any other options that we have not considered that would help us to achieve our objective of finding the best way to provide general practice services for people registered with Toftwood Medical Centre? If yes, please tell us about these by writing in the box below:

Q3. Please place a tick against the descriptions that apply to you:	
I am registered with Toftwood Medical Centre.	
I am supporting someone who is registered with Toftwood Medical Centre to respond.	
I am registered with Orchard Surgery.	
I am supporting someone who is registered with Orchard Surgery to respond.	
I am registered with Theatre Royal Surgery.	
I am supporting someone who is registered with Theatre Royal Surgery to respond.	
I work at Toftwood Medical Centre.	
I work at Orchard Surgery.	
I work at Theatre Royal Surgery.	
I am responding on behalf of a local organisation (please state)	
Other (please state)	

About you

NHS Norfolk and Waveney ICB wants to make sure that services are open and accessible and that our consultations are representative of the community we serve and the people that use our services. Please help us measure how far we are achieving this by answering the following questions.

Please note: You do not have to give us this information, but it will help us if you do. We will keep this information confidential and not use it for any other purpose.

How old are you?

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2. Are you ...? (Please tick one box only)

Male Female Prefer not to say

Prefer to self-describe.

3. How would you describe your ethnicity? For example white British / black British

4. What is your first language?

5. Would you describe yourself as having a sensory disability (affecting your sight or hearing), physical disability, learning difficulty or long-term illness? Please tick one box only.

Yes No Prefer not to say

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Toftwood Medical Centre population summary compared to other practices in the area, the rest of Norfolk and Waveney and England

- Defining the communities
- Access and travel times to GP practice
- Publicly available information from census
 - Age, general health and disability
 - Households, accommodation and access
- Health and care activity information
- Educational achievement and school health need index

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Summary 1 – access, census summary, school age population

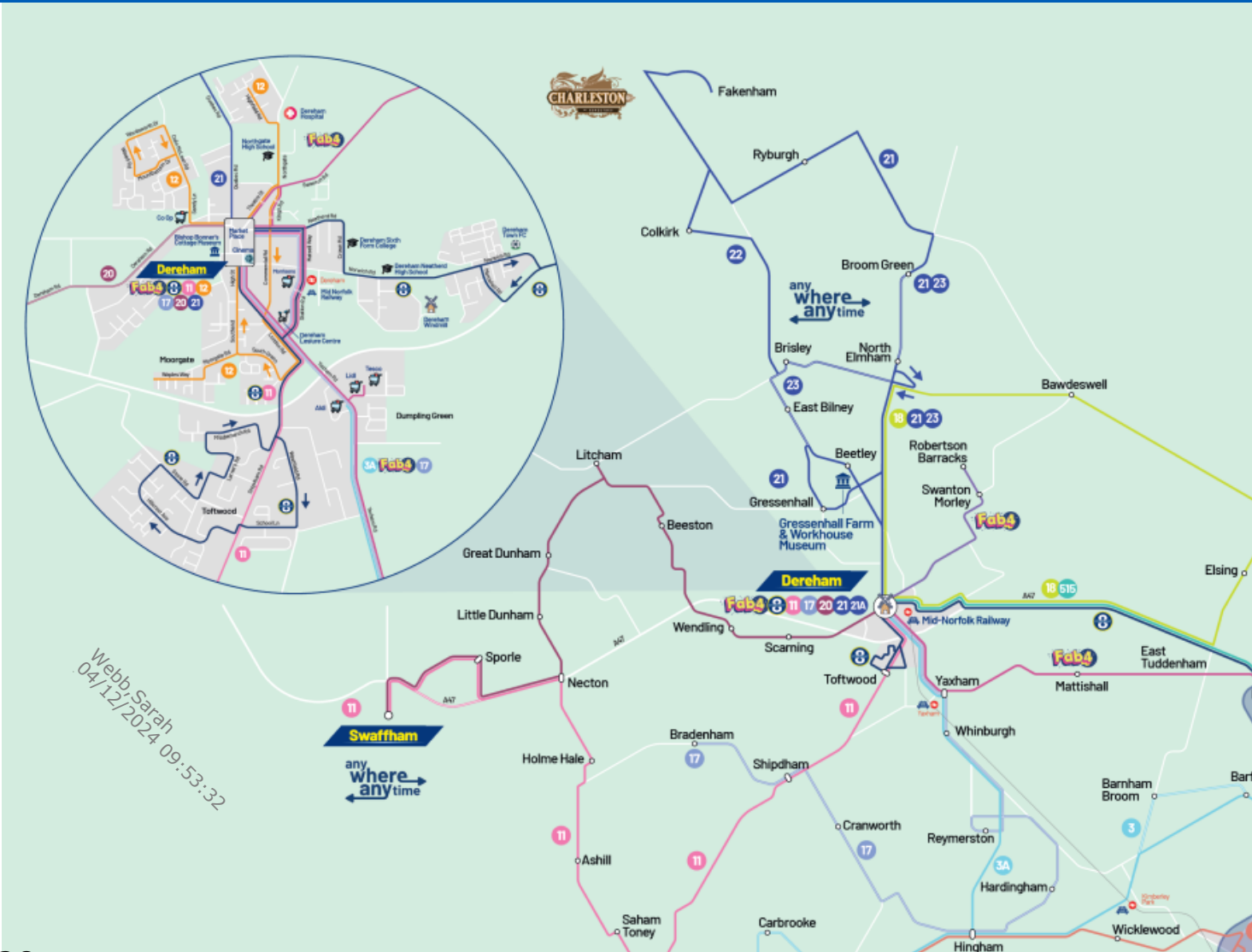
- Registered population data from NHS Digital highlights that the majority of patients registered with Toftwood Medical Centre are from the four communities that make up the Toftwood area of south Dereham. These account for about 75% of the registered population. Four other communities to the north of Dereham account for another 20%.
- Similar numbers of patients from the same communities registered at Toftwood Medical Centre are registered with Orchard Surgery and Theatre Royal Surgery. This shows that residents can and do use the different surgeries in Dereham. The catchment areas of Orchard Surgery and Theatre Royal surgery contain the catchment area of Toftwood Medical Centre
- DfT transport statistics indicate that almost 100% of the population within the Toftwood area (and elsewhere in Dereham) can access a GP practice within 30 minutes by walking or public transport.
- SHAPE travel time statistics show that many practices are accessible by car and travelling from Toftwood to neighbouring surgeries in Dereham indicates that it is about 30 minutes to walk from Toftwood to Theatre Royal and about 20 minutes to walk from Toftwood to Orchard Surgery
- Census information shows that the Toftwood community is:
 - Census information indicates that the population in the Toftwood area is about the same as the Norfolk average, is in slightly better health and provides a similar amount of unpaid care.
 - There are fewer one person households than the Norfolk average, the proportion owning their own property is higher, more have access to a car or van. However, households are more likely to be deprived in one dimension
- 2022/23 school achievement data indicates that primary school achievement is about average compared to Norfolk and England
- The experimental 2019 school health needs index indicates that for Toftwood Junior School, compared to the Norfolk average, the need based on the communities where school pupils are from is about average overall, although there are some indicators of higher need.
- Overall summary: access is generally good, other outcomes are generally average

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Summary 2 – health needs, workforce and health care activity

- The general practice profile for Toftwood shows that Toftwood Medical Centre is similar to the ICB average but older than England, and as a whole the population experiences lower levels of deprivation. Older population is more likely to have one or more long term conditions compared to the England average.
 - Given the age and sex distribution of the Toftwood population has fewer patients in the frailty segment but more patients in the dominant major chronic condition segment given the Norfolk and Waveney average. For other segments Toftwood is about as expected for the age and sex distribution.
 - Healthcare activity is generally lower than expected given the Norfolk and Waveney average. This is also the case for other practices in Dereham apart from community activity. Numbers of patients at Toftwood with polypharmacy and multi-morbidity are about as expected
 - Links to general practice profiles for Toftwood Medical Centre, Orchard Surgery and Theatre Royal Surgery are in the further information
- Emergency admissions for areas served by Toftwood have not yet returned to levels seen four years ago in March 2019. This might imply that unmet need has not changed appreciably over time. However, there does appear to have been an increase through 2023. Toftwood crude emergency admission rates are lower than the Norfolk and Waveney average and lower than Orchard Surgery and Theatre Royal Surgery.
- GP secondary care usage per 1,000 weighted population shows about average GP referrals and A&E attendances but higher than average A&E High Intensity Users, lower than average emergency admissions and lower than average Mental Health referrals
- The Elmham GP workforce is generally younger than the Norfolk and Waveney and England average. However, the nursing workforce is older. The Toftwood Medical Centre workforce is younger. For Elmham and Toftwood practices there are higher than average number of nurse FTE per 100,000 patients than England.
- National General Practice profiles indicate Toftwood population has about average levels of patient satisfaction, average smoking prevalence, higher obesity, higher prevalence of long-standing health conditions, good cancer screening coverage and uptake. Secondary prevention and management of patients with long term conditions is generally good. However, there are some opportunities e.g. heart failure review, atrial fibrillation treatment.
- The overall summary is that the Toftwood Medical Practice is generally in line with the England average with slightly higher prevalence of long-standing health conditions.

Bus routes into and around Dereham



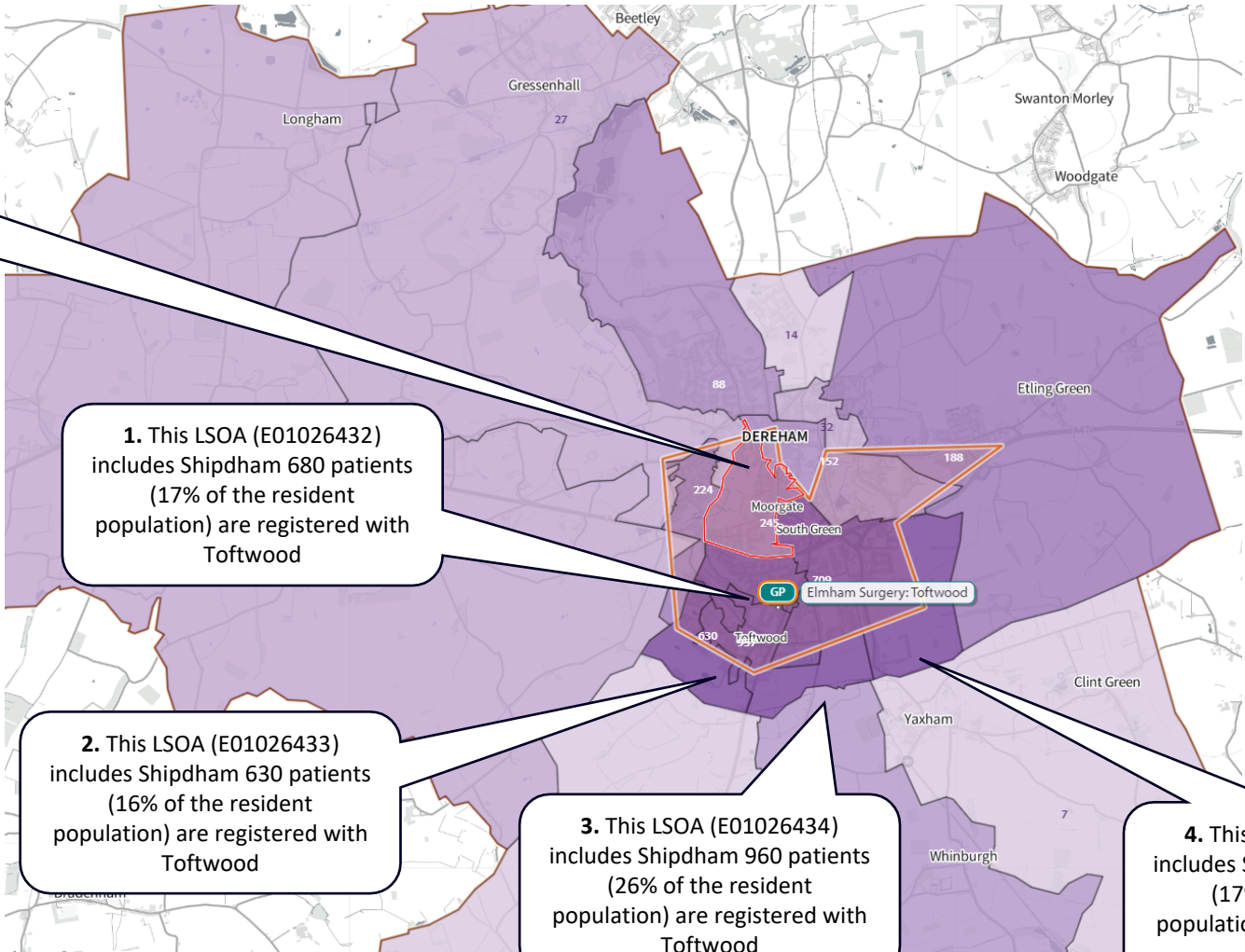
- Bus services mostly provided by Konect



https://images-konectbus.passenger-website.com/2024-03/LargeMap_Jan2024.pdf

Within the ICB the smallest area that health activity data and registered population data is available is at lower super output area (LSOA). Registered population data from NHS Digital highlights that the majority of patients registered with Elmham Surgery: Toftwood are from the four LSOAs in south Dereham centre. These account for about 75% of the registered population. Four other LSOAs to the north of Dereham account for another 20%.

One LSOA in Dereham is a core20 LSOA (E01026425) and about 245 patients from this LSOA are registered with Toftwood Surgery (6% of surgery total)

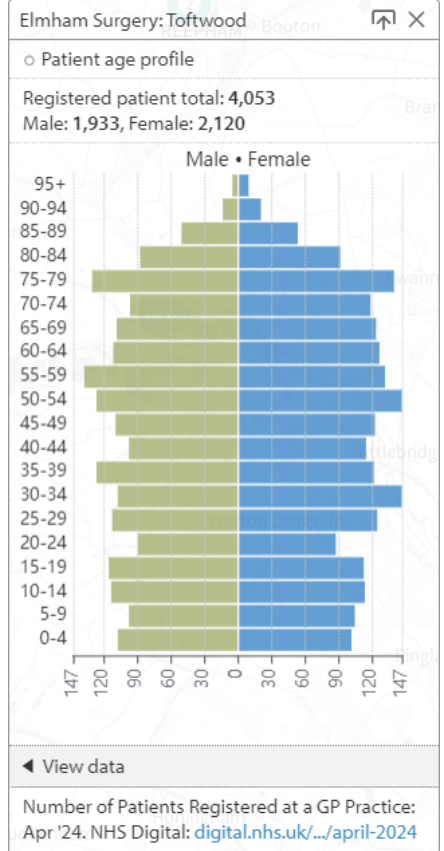


1. This LSOA (E01026432) includes Shipdham 680 patients (17% of the resident population) are registered with Toftwood

2. This LSOA (E01026433) includes Shipdham 630 patients (16% of the resident population) are registered with Toftwood

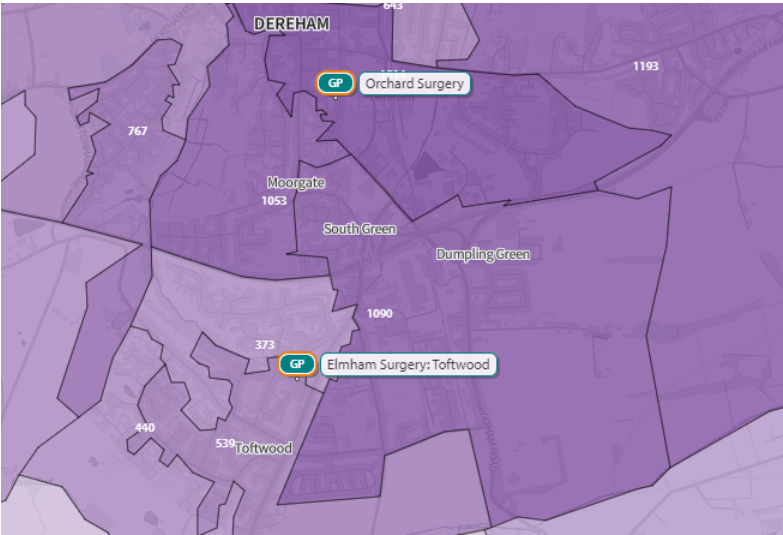
3. This LSOA (E01026434) includes Shipdham 960 patients (26% of the resident population) are registered with Toftwood

4. This LSOA (E01026427) includes Shipdham 710 patients (17% of the resident population) are registered with Toftwood

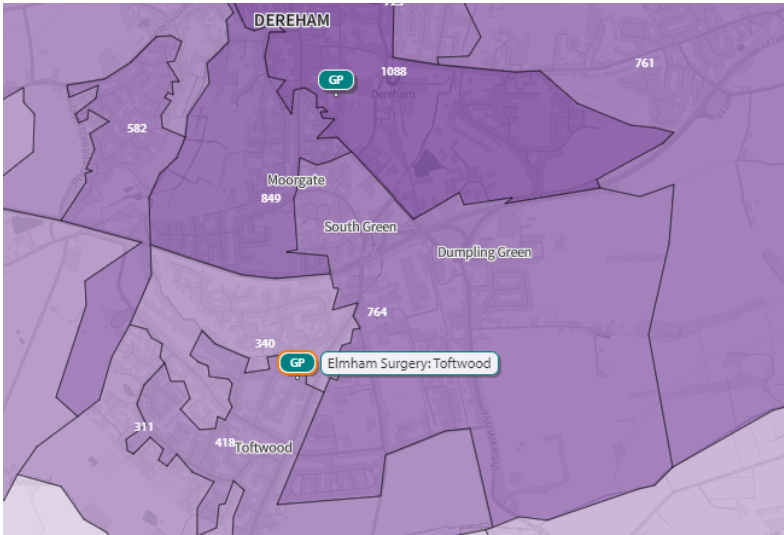
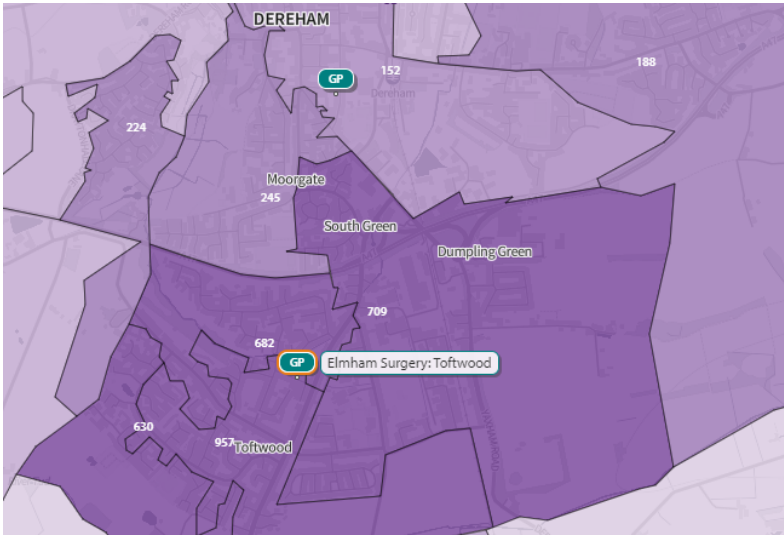


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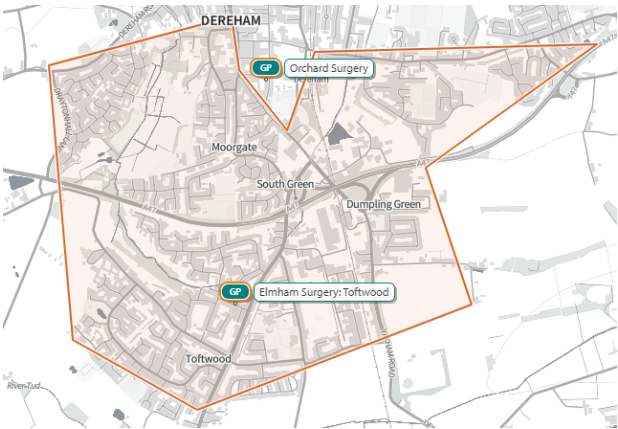
These maps compare registered patients from Toftwood, Orchard and Theatre Royal practices. Similar numbers of patients from the same communities are registered at the three practices. This shows that residents can and do use the different surgeries in Dereham.



Orchard Surgery registered patients

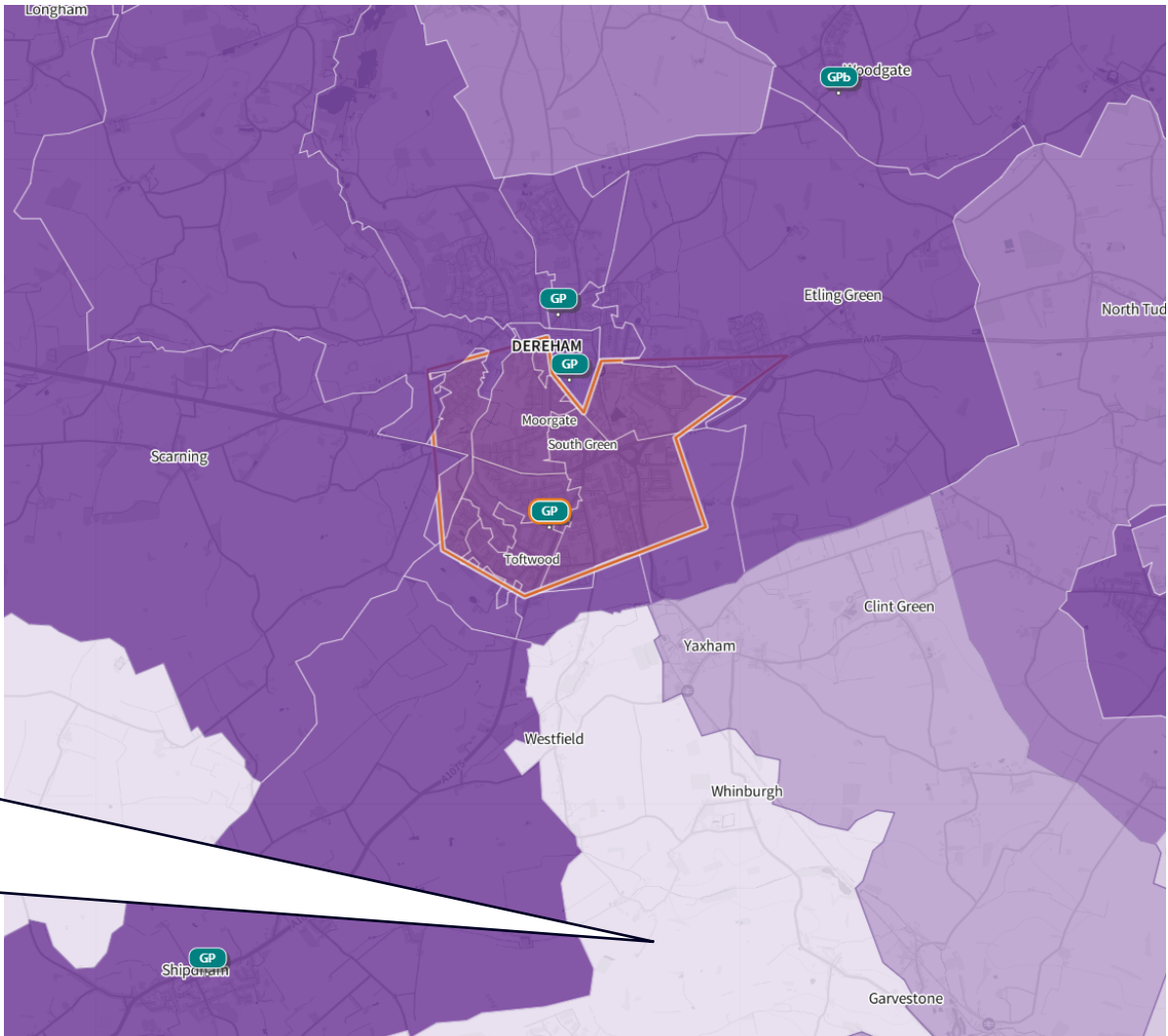


Theatre Royal Surgery registered patients



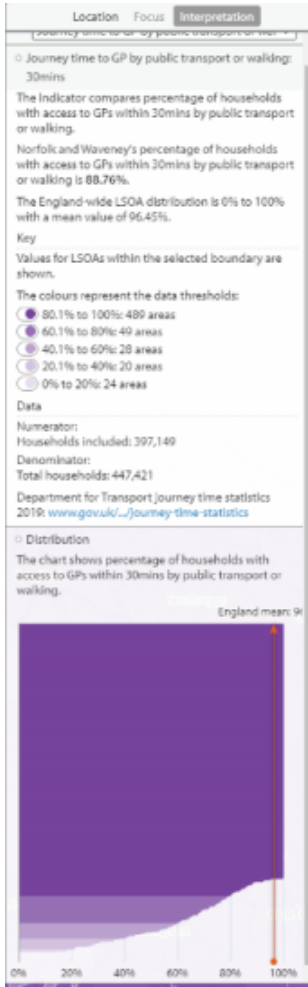
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For the LSOAs journey time statistics to general practice by public transport indicates that for all the LSOAs around Dereham the proportion of the population able to access general practice within 30 minutes by public transport or walking is in the upper quintile and 100% for most LSOAs



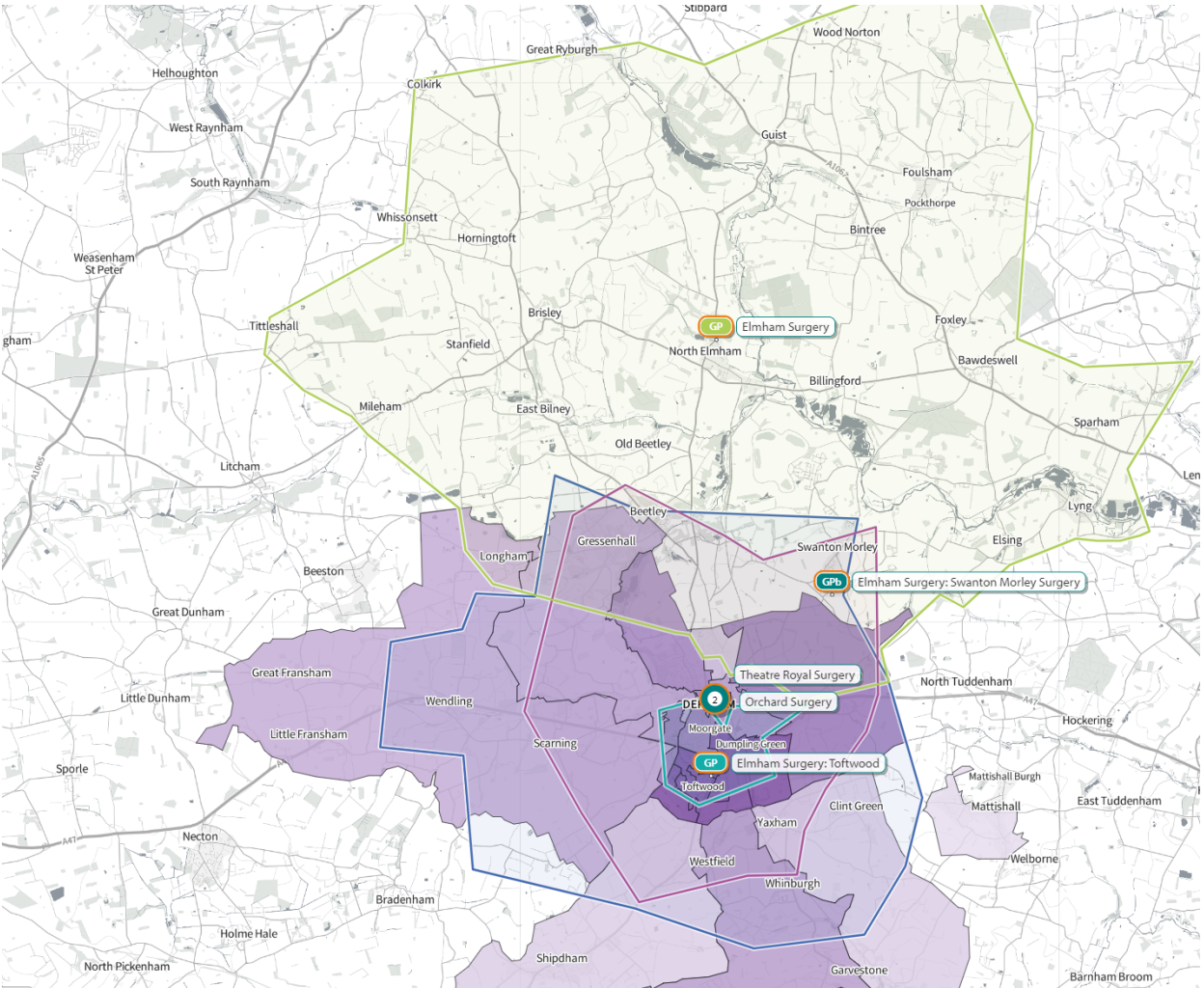
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Less than 20% of the population can access general practice by public transport in under 30 minutes This LSOA (E01026485) includes Whinburgh. 53 patients (1.3% of the resident population) are registered with Toftwood



<https://app.shapeatlas.net/place/E54000022#10/52.6551/0.9714/rh-0,rdr-t>

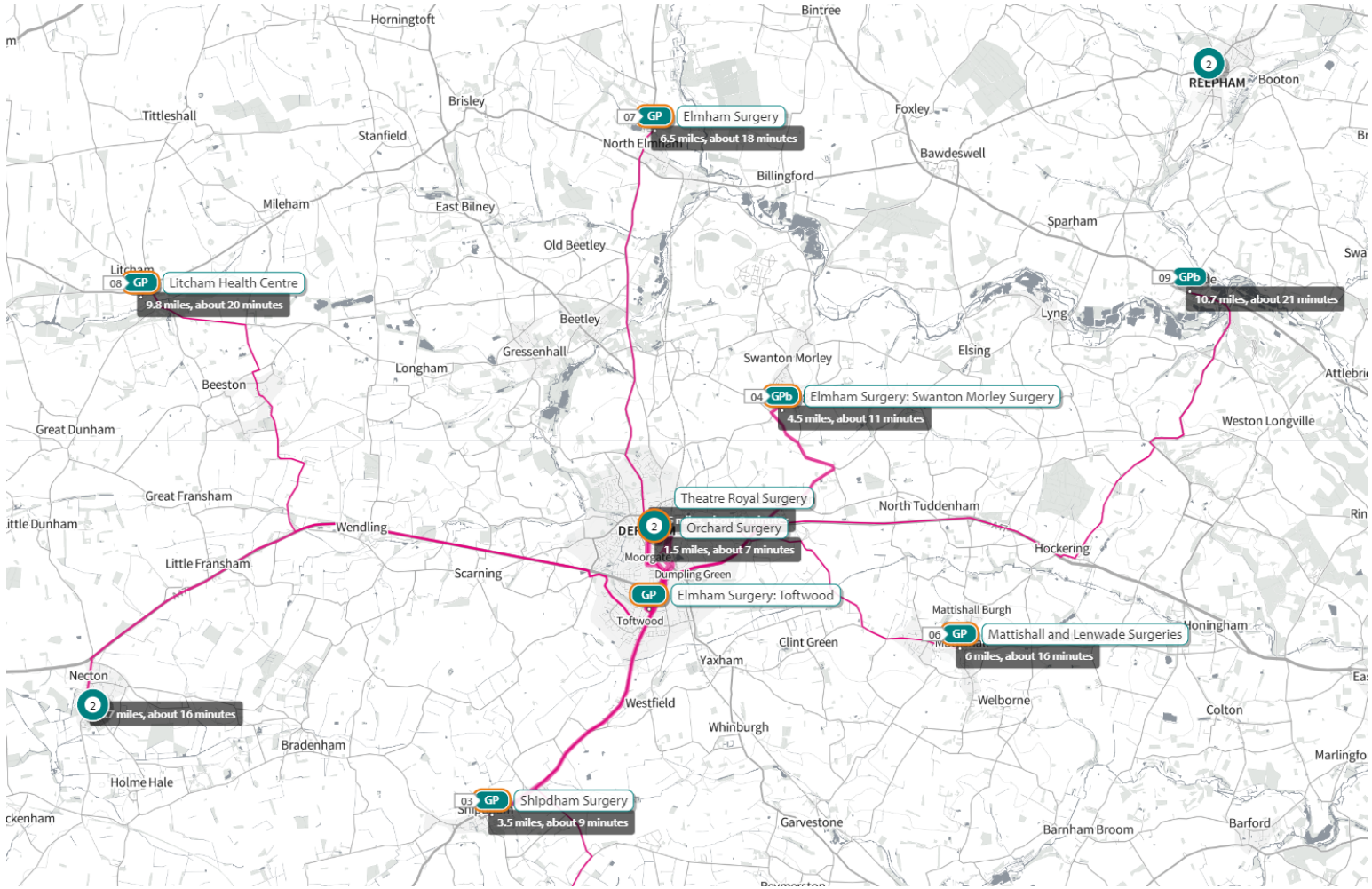
This map shows the catchment areas for Elmham Surgery: Toftwood together with the catchment areas for Elmham Surgery (and the Swanton Morley branch), Orchard Surgery and Theatre Royal Surgery. This indicates that all of the communities where Toftwood patients reside are at least in part covered by another GP catchment area.



- Practice submitted inner catchment area
 - As: All individual, overlaid All merged
 - Elmham Surgery
 - Elmham Surgery: Toftwood
 - Orchard Surgery
 - Theatre Royal Surgery
- NHS Digital: June '24: digital.nhs.uk

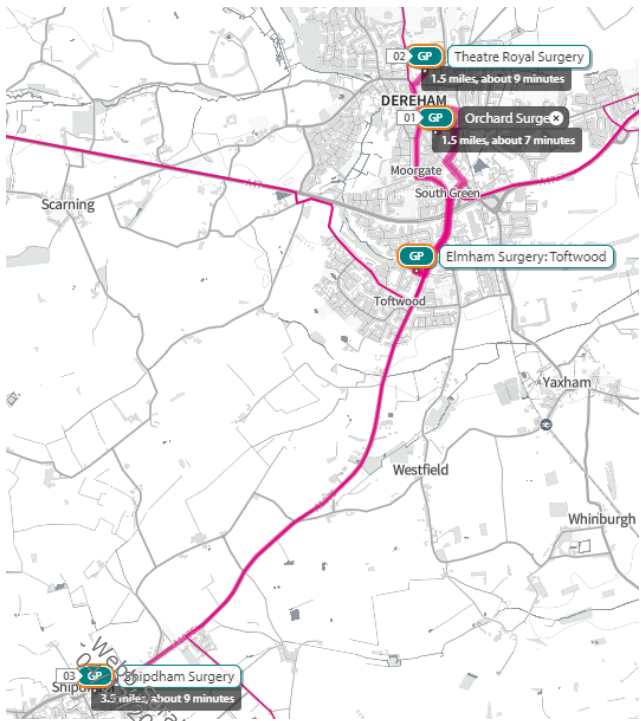
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Travel times by car from Elmham Surgery: Toftwood to other locations. There are many surgeries accessible by car.

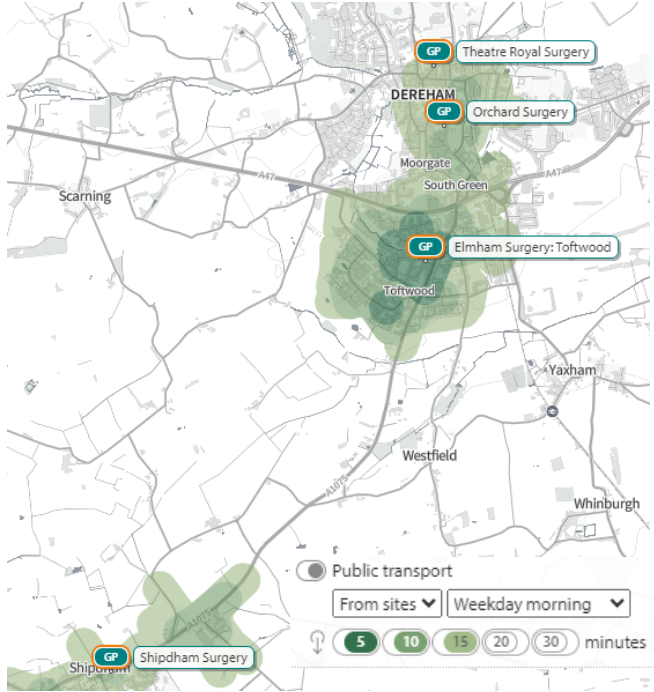


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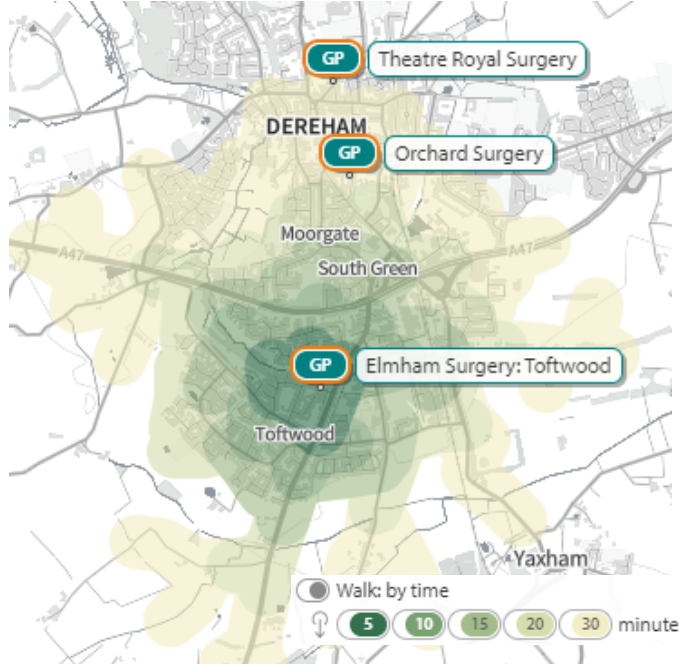
Travelling from Toftwood to neighbouring surgeries indicates that it is about 30 minutes to walk from Toftwood to Theatre Royal and about 20 minutes to walk from Toftwood to Orchard Surgery



Drive time



By public transport



Walking time

This maps highlights the public transport travel times to Toftwood surgery. Travel time for the communities with the most Toftwood patients appears to be consistent between morning and afternoon with a number of communities being able to access Toftwood within 10 minutes and most within 45 minutes

Info Layers Access Indicators

ICB: Norfolk and Waveney

Travel times and distance Population

Sites

Single site

Elmham Surgery: Toftwood, Dereham

Sites by category

GP practice, branch practice

Selected sites

5 visible

All sites

5 visible

Travel type

By distance radius

Walk: by time

Walk: by distance

Cycle

Car: by distance

Car: by time

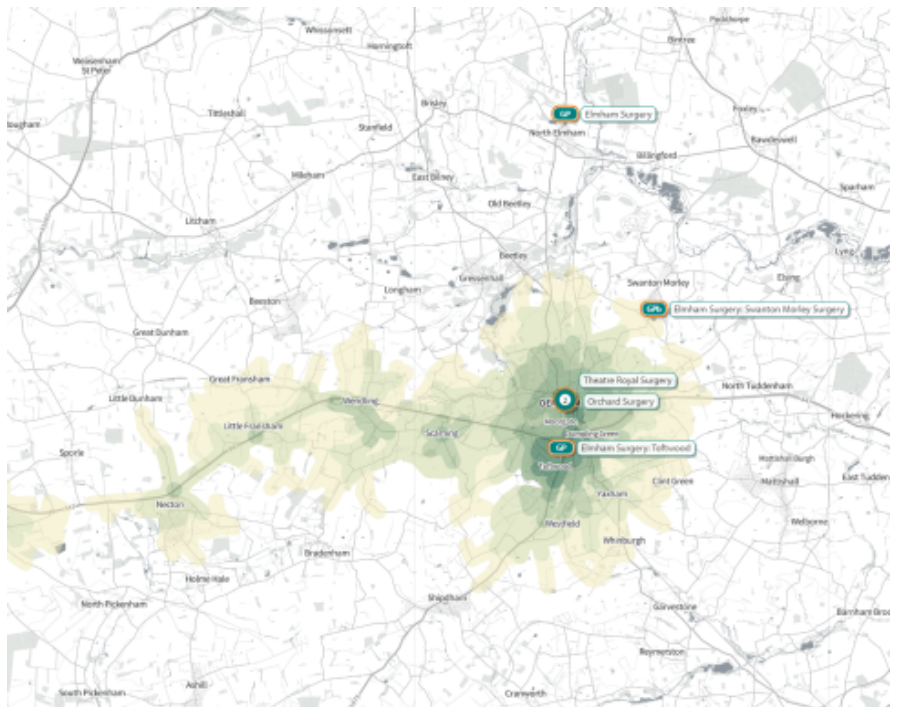
Rush hour

Public transport

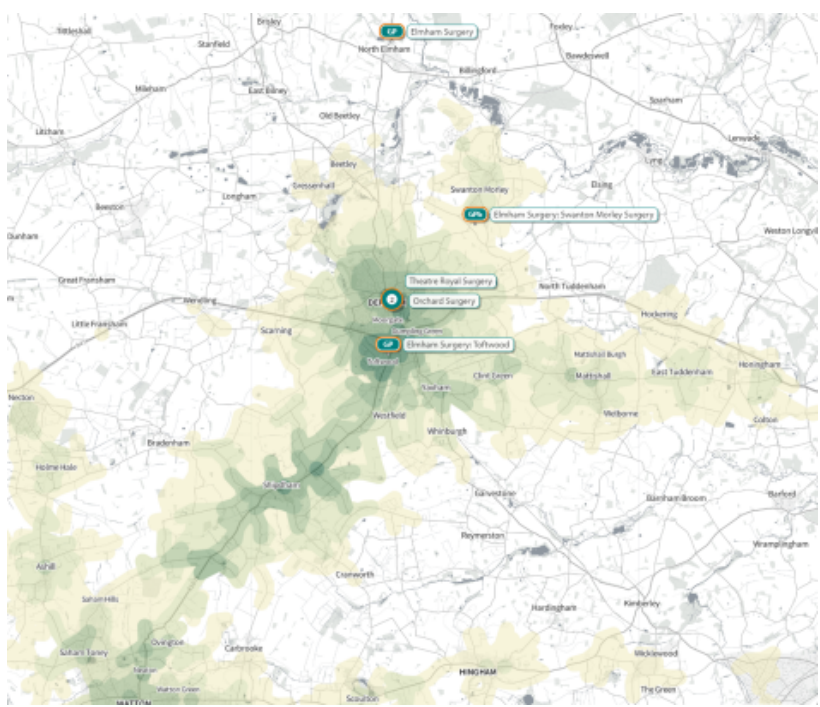
To sites Weekday morning

10 20 30 45 60 minutes

Targomo



Weekday Morning



Weekday Afternoon

Info Layers Access Indicators

ICB: Norfolk and Waveney

Travel times and distance Population

Sites

Single site

Elmham Surgery: Toftwood, Dereham

Sites by category

GP practice, branch practice

Selected sites

5 visible

All sites

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Travel type

By distance radius

Walk: by time

Walk: by distance

Cycle

Car: by distance

Car: by time

Rush hour

Public transport

To sites Weekday afternoon

10 20 30 45 60 minutes

Targomo

Webb, Sarah
04/12/2024 09:53:32

<https://app.shapeatlas.net/place/E54000022#10/52.6551/0.9714/rh-0,rdr-t>

If we include just Elmham Surgery and Elmham Swanton Morley most of Dereham and Toftwood can access the two branch surgeries within 45 minutes.

Info Layers Access Indicators

ICB: Norfolk and Waveney

Travel times and distance Population

Sites

Single site

Elmham Surgery, East Dereham

Sites by category

GP practice, branch practice

Selected sites

2 visible

All sites

2 visible

Travel type

By distance radius

Walk: by time

Walk: by distance

Cycle

Car: by distance

Car: by time

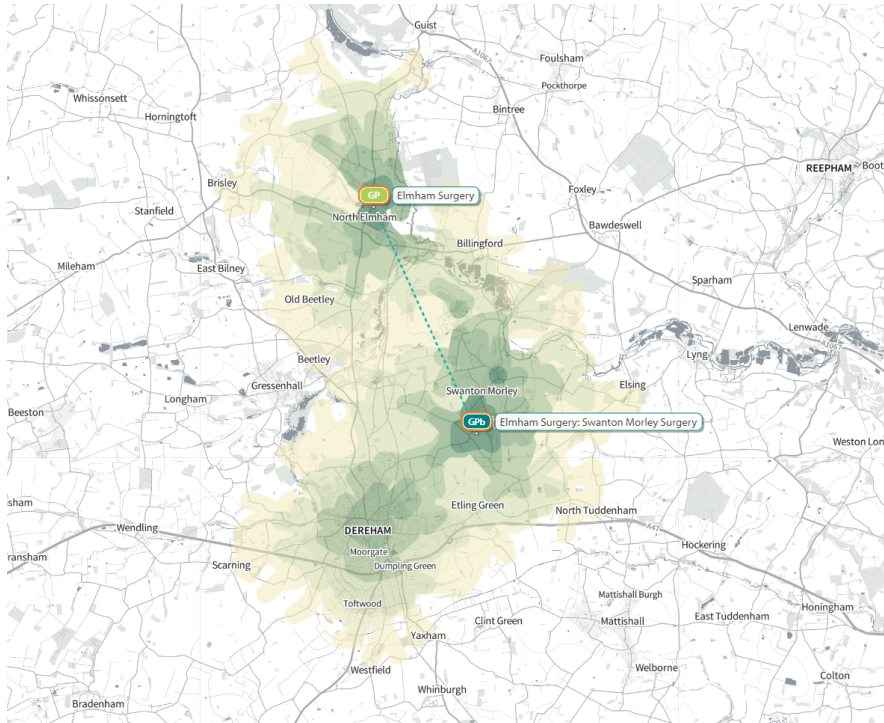
Rush hour

Public transport

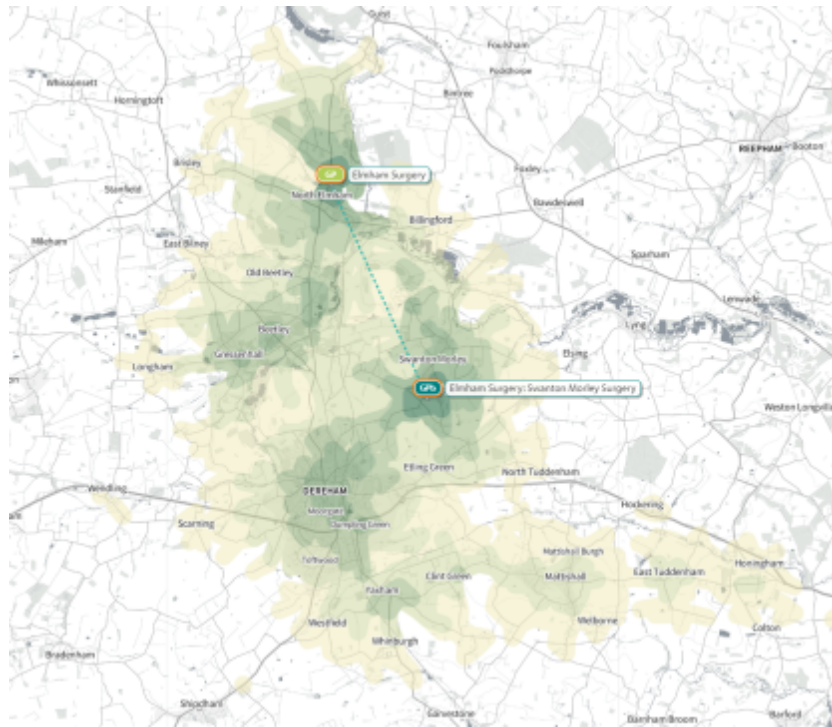
To sites Weekday morning

10 20 30 45 60 minutes

Targomo



Weekday Morning



Weekday Afternoon

Info Layers Access Indicators

ICB: Norfolk and Waveney

Travel times and distance Population

Sites

Single site

Elmham Surgery, East Dereham

Sites by category

GP practice, branch practice

Selected sites

2 visible

All sites

2 visible

Travel type

By distance radius

Walk: by time

Walk: by distance

Cycle

Car: by distance

Car: by time

Rush hour

Public transport

To sites Weekday afternoon

10 20 30 45 60 minutes

Targomo

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<https://app.shapeatlas.net/place/E54000022#10/52.6551/0.9714/rh-0,rdr-t>

This map shows the travel time to Toftwood Surgery by car. Most places can access Toftwood Surgery within 15 minutes

Info Layers Access Indicators

ICB: Norfolk and Waveney

Travel times and distance Population

Sites

Single site
 Elmham Surgery: Toftwood, Dereham

Sites by category
 GP practice, branch practice

Selected sites
 3 visible

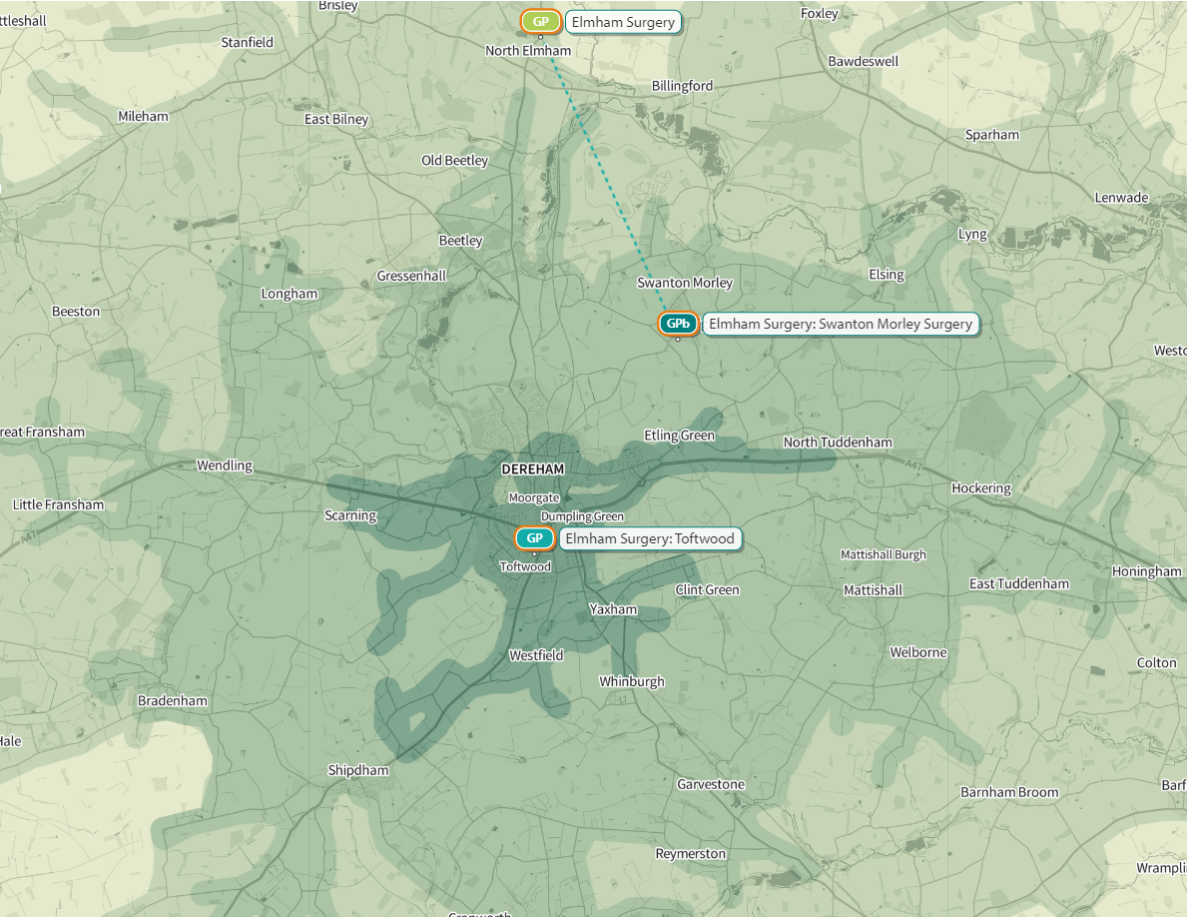
All sites
 3 visible

Travel type

By distance radius
 Walk: by time
 Walk: by distance
 Cycle
 Car: by distance
 Car: by time Rush hour
 Public transport

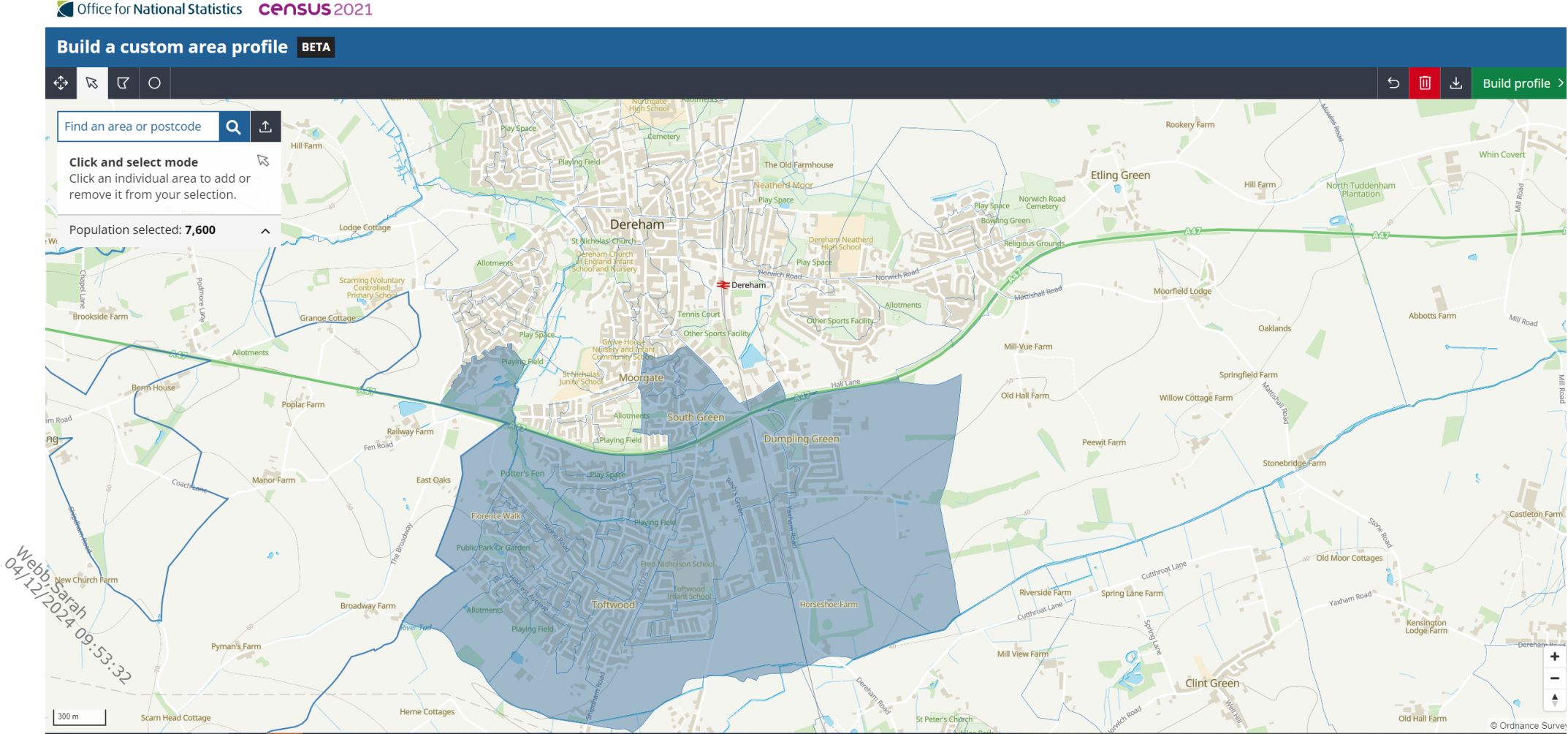
5 10 15 20 30 minutes

Targomo



Webb, Sarah
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Looking at the communities where about 75% of Toftwood patients live. About 7,600 people are resident in these communities of which almost 3,000 are registered with Toftwood. The rest of the residents are mostly registered with Orchard Surgery and Theatre Royal Surgery.



<https://www.ons.gov.uk/visualisations/customprofiles/>

Census information for this part of the Toftwood community indicates that the population is about the same as the Norfolk average, is in slightly better health and provides a similar amount of unpaid care.

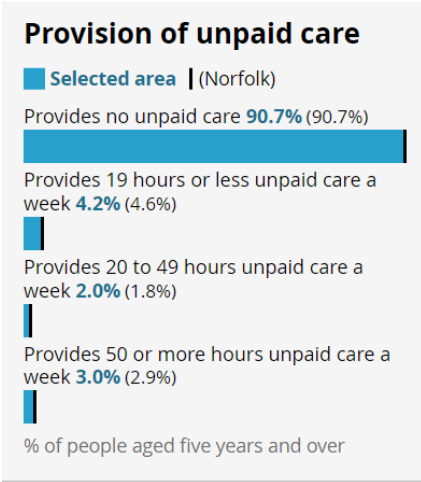
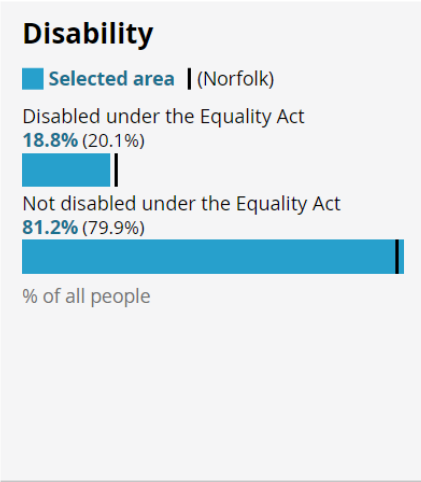
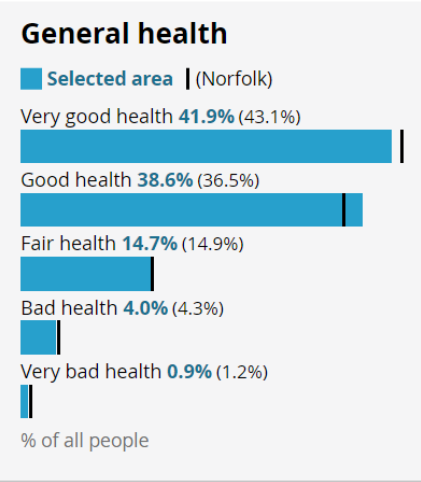
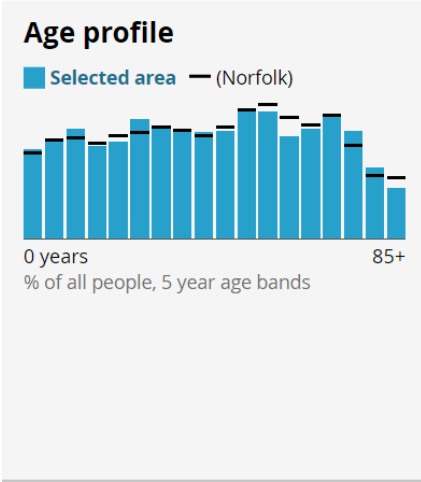
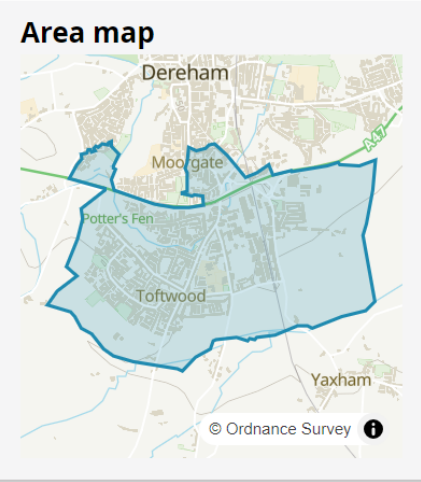
Compared to Norfolk:

Age profile is about the same as the the Norfolk average (apart from a higher % in the 75-79 age band)

Proportion in bad health or very bad health is **lower** (4.9% vs. 5.5%) – *however, this is not standardised for age or sex*

Proportion disabled under equality act is **lower** (18.8% vs 20.1%) - *however, this is not standardised for age or sex*

Provision of unpaid care is similar (9.3% vs 9.3%)



Source: Office for National Statistics - Census 2021

Census information for the Toftwood community; household, accommodation and access to a car

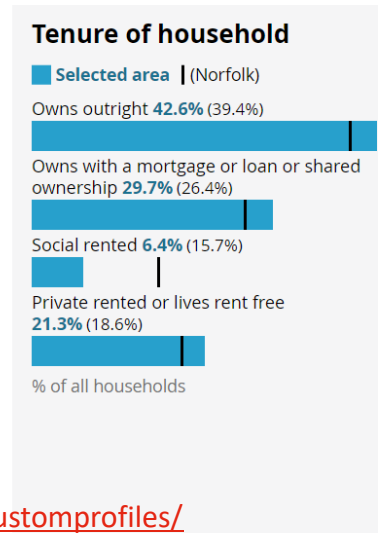
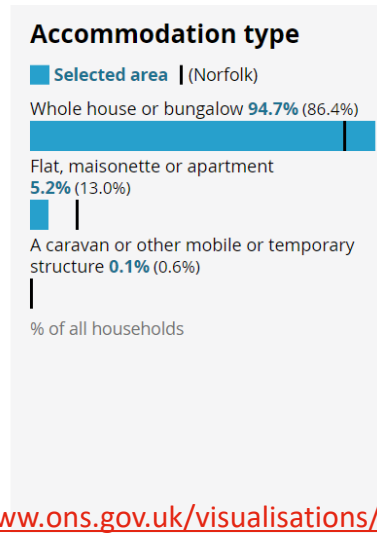
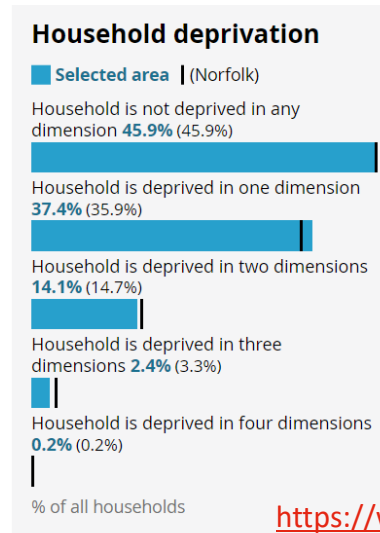
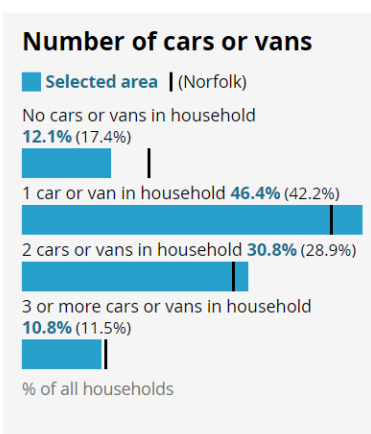
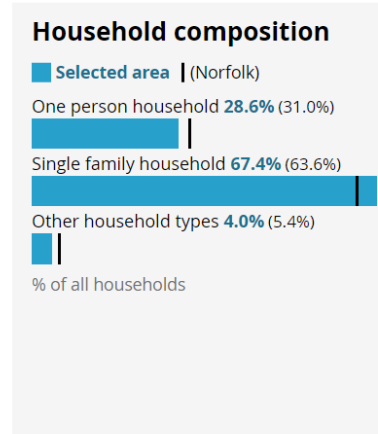
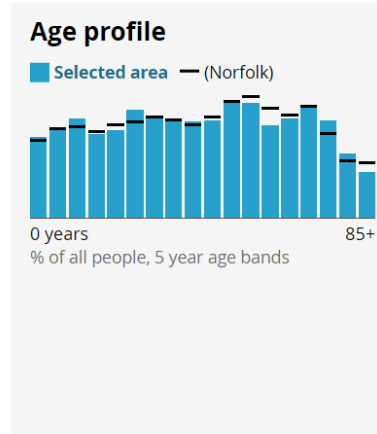
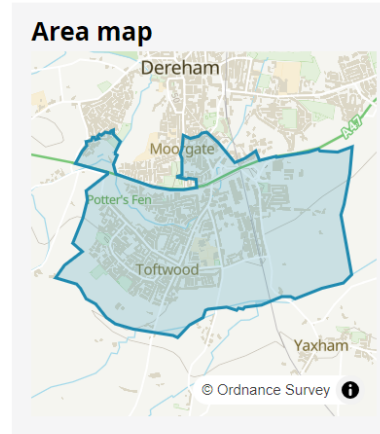
Compared to Norfolk:

Household composition indicates that the area has **fewer** one person households than the Norfolk average (28.6% vs 31%)

Proportion of households experiencing deprivation in any dimension is the same (54.1% vs. 54.1%) but **more likely** to be deprived in one dimension (37.4% vs. 35.9%)

Proportion owning their property is **higher** (72.3% vs 65.8%) but the number in private rented accommodation is higher (21.3% vs 18.6%)

Proportion of households with access to a car or van is **higher** (87.9% vs 82.6%)



<https://www.ons.gov.uk/visualisations/customprofiles/>

Source: Office for National Statistics - Census 2021

Census information for the Dereham Toftwood ward: age profile and general health

Compared to Norfolk:

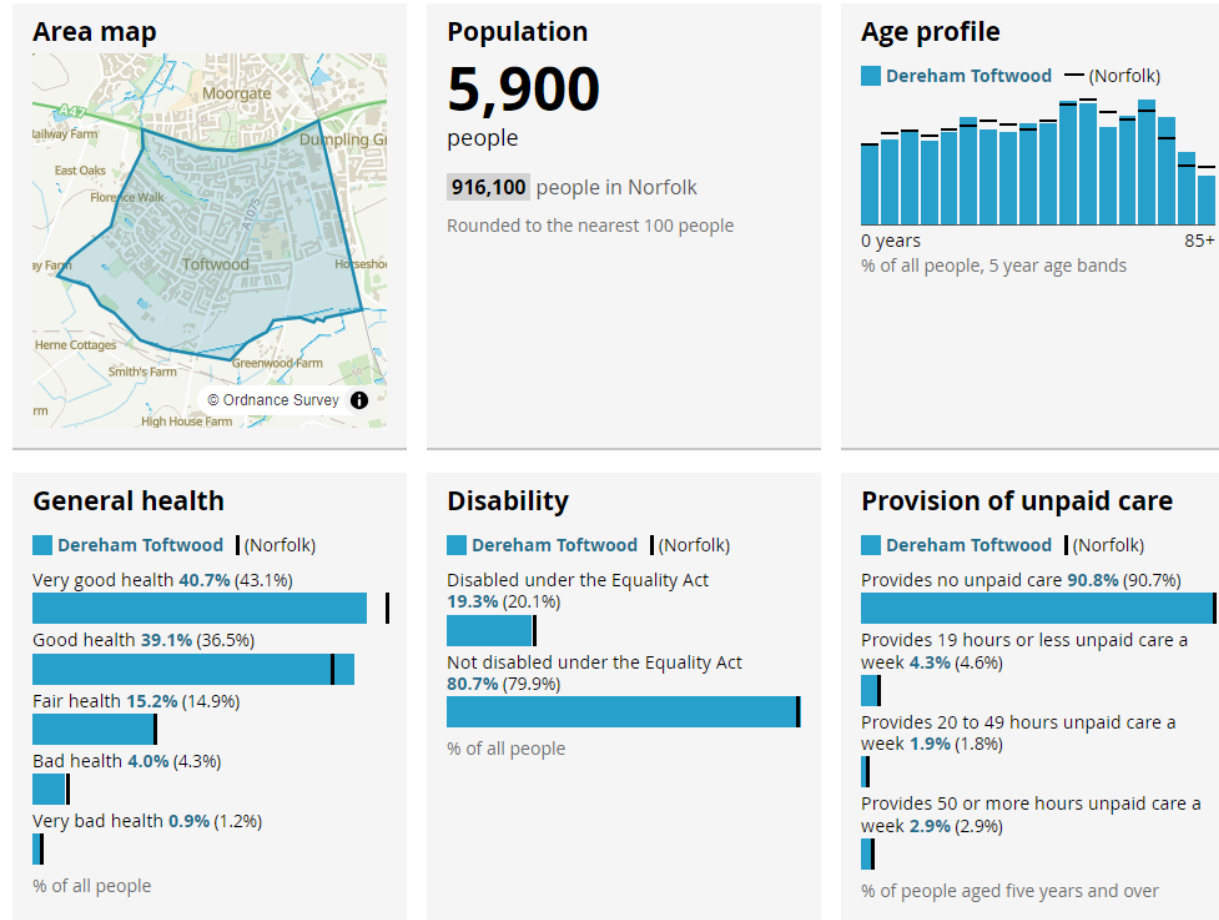
Age profile is slightly older than the Norfolk average

Proportion in bad health or very bad health is **lower** (4.9% vs. 5.5%) but less people are in very good health – *however, this is not standardised for age or sex*

Proportion disabled under equality act is **lower** (19.3% vs 20.1%) - *however, this is not standardised for age or sex*

Provision of unpaid care is similar (9.2% vs 9.3%)

Dereham Toftwood



Source: Office for National Statistics - Census 2021

Census information for the Dereham Toftwood ward; household, accommodation and access to a car

Compared to Norfolk:

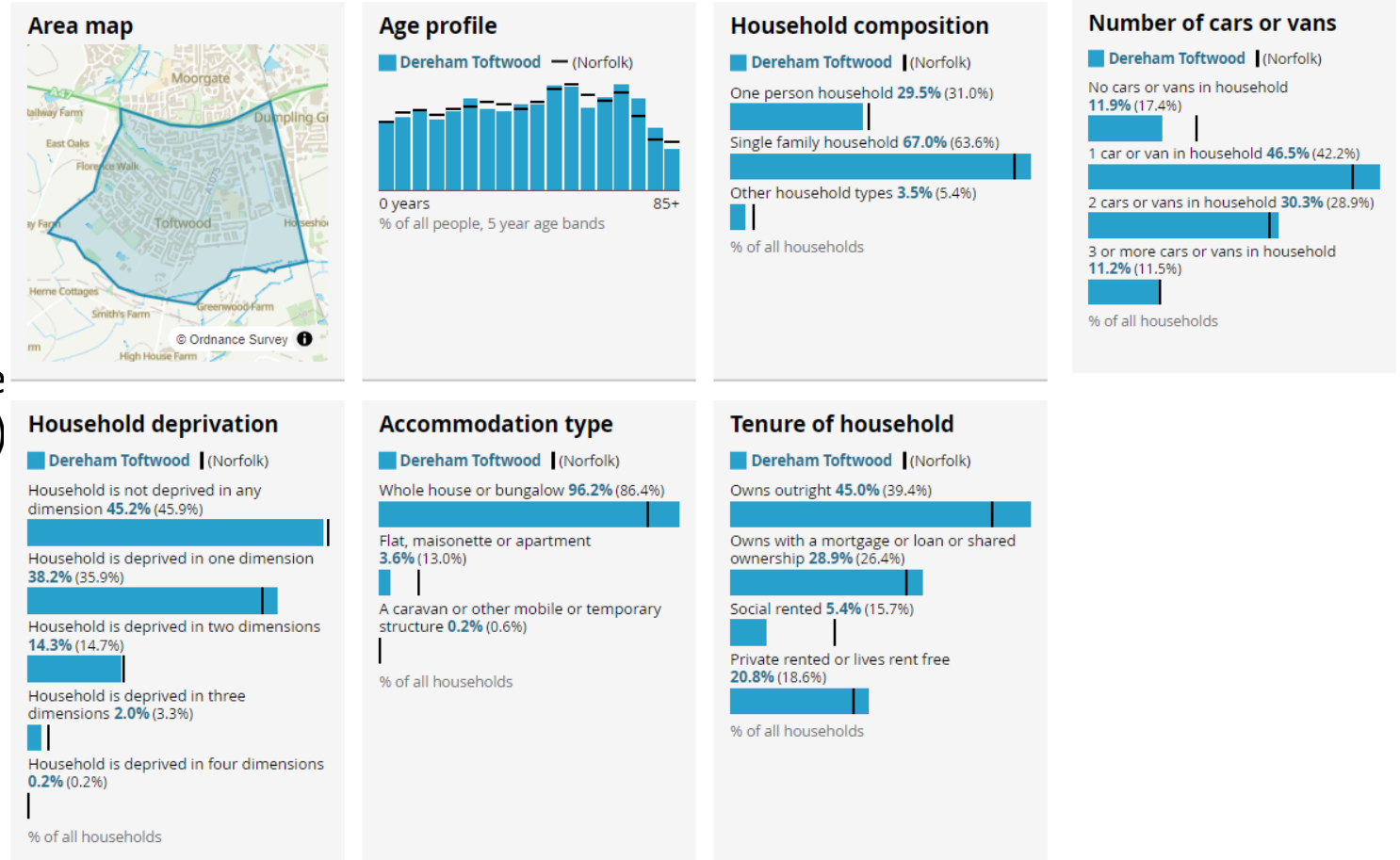
Household composition indicates that the area has **fewer** one person households than the Norfolk average (29.5% vs 31%)

Proportion of households experiencing deprivation in any dimension is about the same (54.7% vs. 54.1%) but **more likely** to be deprived in one dimension (38.2% vs. 35.9%)

Proportion owning their property is higher (73.9% vs 65.8%) but the number in private rented accommodation is higher (21.3% vs 18.6%)

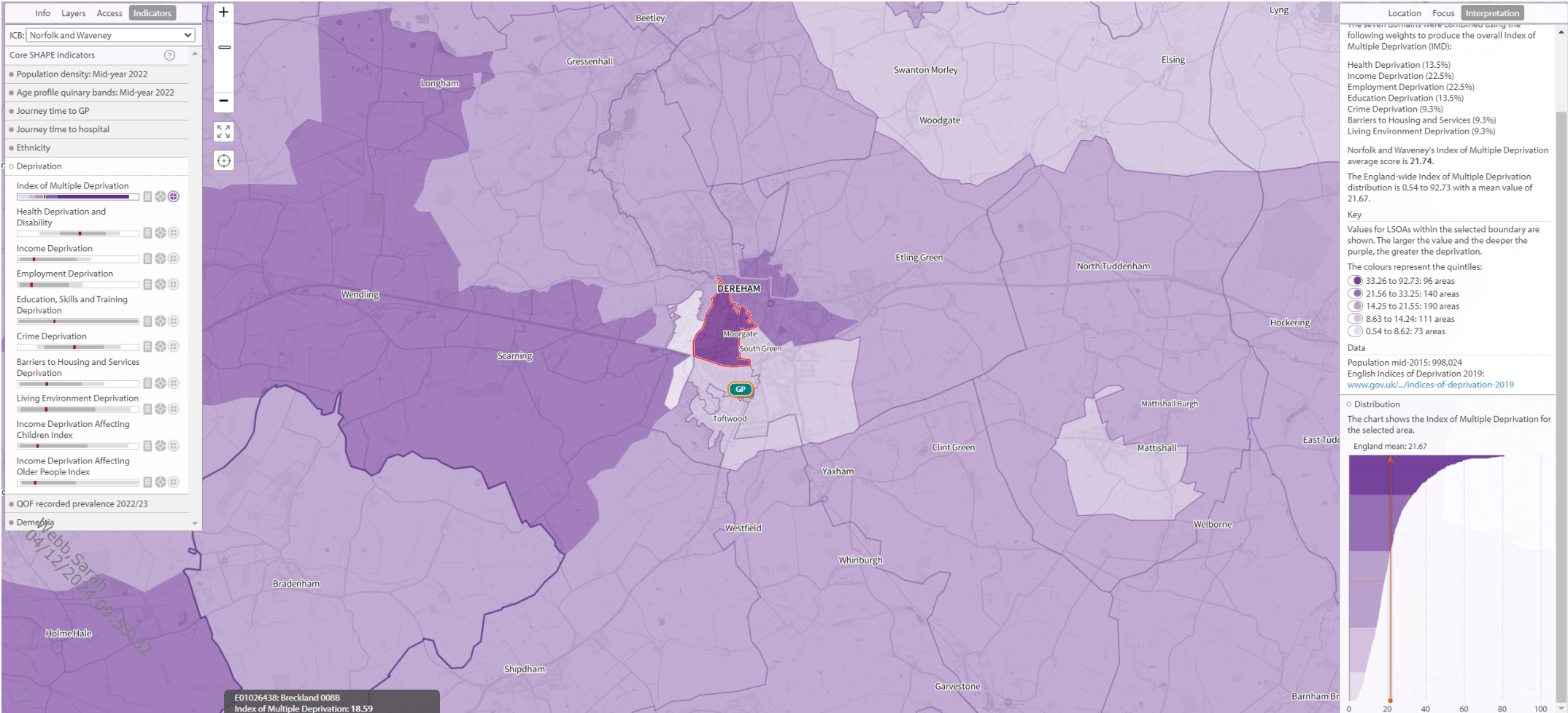
Proportion of households with access to a car or van is higher (88.1% vs 82.6%)

Dereham Toftwood



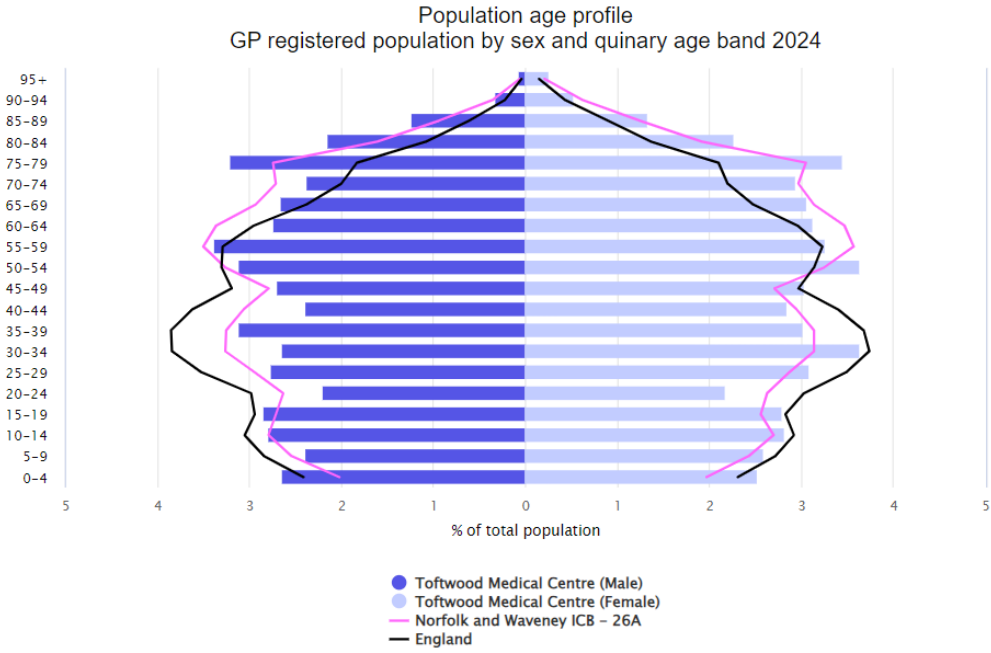
Source: Office for National Statistics - Census 2021

The majority of the communities served by Toftwood Surgery are less deprived than average. Apart from the community in the core20 LSOA (E01026425) highlighted in the map below.



Further IMD mapping from here: <https://www.arcgis.com/apps/mapviewer/index.html?layers=85c8b350c1a4442eacefc1bbe1b03205>

The general practice profile for Toftwood shows that the population is similar to the ICB average but older than England, and as a whole the population experiences lower levels of deprivation. Patient satisfaction is about average and there is a higher prevalence of long standing health conditions compared to the England average.



Registered Persons

Toftwood Medical Centre	3,895
Norfolk and Waveney ICB - 26A	10,364 (average)
ENGLAND	9,803 (average)

Y05291 - Toftwood Medical Centre

QOF achievement 613.6 (out of 635)

Life expectancy (Male) 81.5 years

Life expectancy (Female) 86.0 years

% having a positive experience of their practice 73.2%

Deprivation

Third less deprived decile

More deprived Less deprived

Ethnicity Estimate

1.4% mixed, 1.8% other non-white ethnic groups

CQC Rating

Overall: Good

Inadequate Outstanding

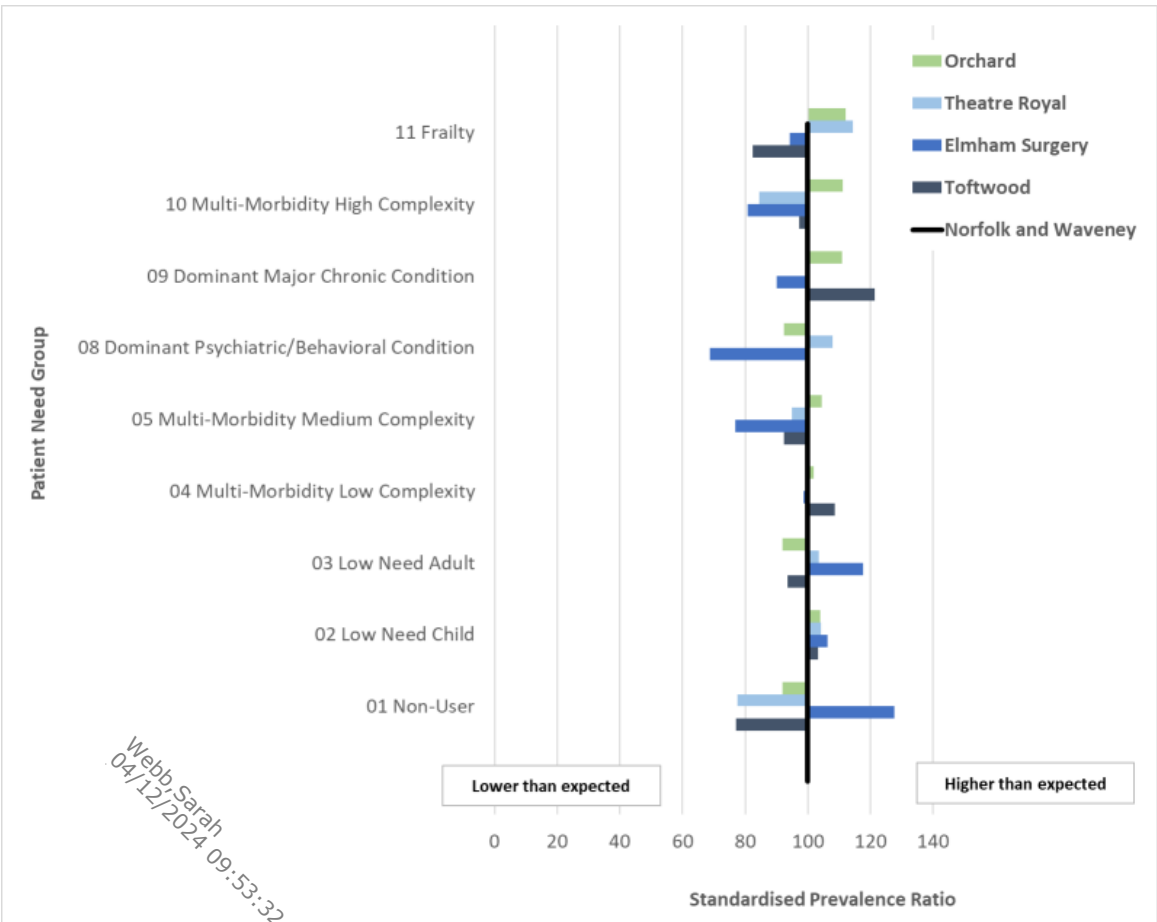
Source: <https://www.cqc.org.uk/location/1-6256707018>

Report published: 14 July 2020

- About average levels of patient satisfaction
- High prevalence of long-standing health condition and MSK (older population)
- Average prevalence of active smokers but many former smokers
- Higher numbers of cancer cases
- Generally good cancer screening coverage and uptake
- Higher obesity prevalence (QOF)
- Higher than average hypertension prevalence (QOF)
- Lower depression incidence but higher prevalence (QOF)
- Average prevalence of COPD but higher Asthma prevalence (QOF)
- Average prevalence of Diabetes (QOF)

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Provisional analysis indicates that for the age/sex distribution of the Toftwood population and given the Norfolk and Waveney average, Toftwood has fewer patients in the frailty segment but more patients in the dominant major chronic condition segment. For other segments Toftwood is about as expected for the age and sex distribution.



The Patient Need Groups methodology allows segmentation and stratification of the population, using available diagnosis markers and predictive models from the Johns Hopkins ACG system. This allows us to segment the population into groups with similar levels of need.

There are eleven mutually exclusive population segments applicable to all age groups that enable a whole person approach to understanding health needs across the life course.

The segmentation approach is useful for:

- Helping to understand a populations health needs and analysing use of services
- Supporting the development of services and programmes
- Targeted interventions for specific conditions, comorbidities and frailty
- Identifying suitable groups for initiatives like virtual wards

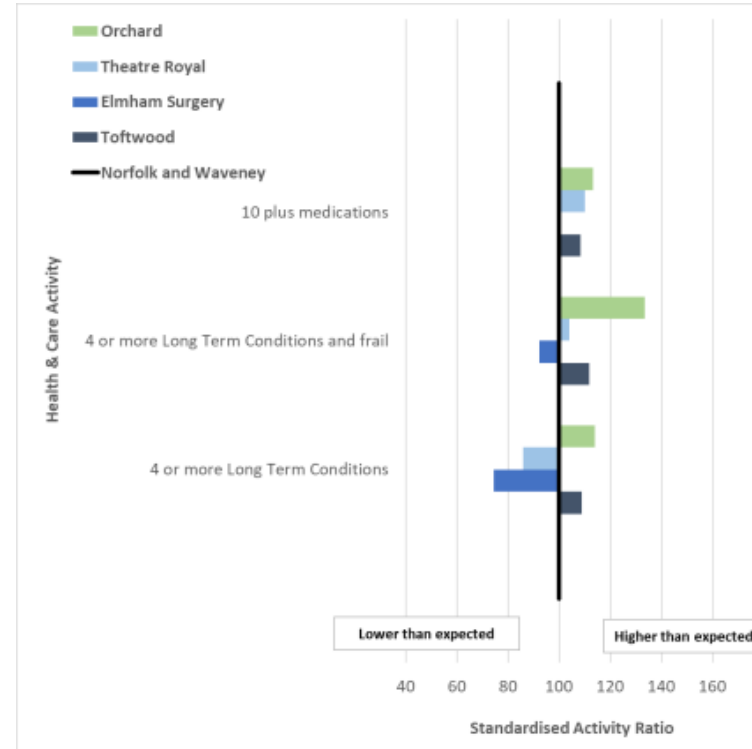
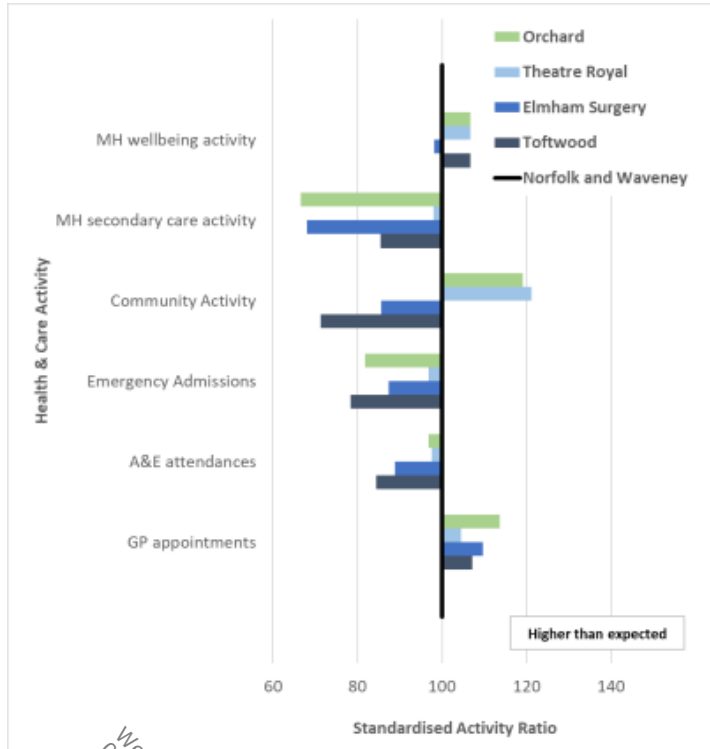
The groups are:

Frailty	11 Frailty	Adults aged 65 and older with evidence of 2 or more frailty concepts
High Complexity; Multi-Morbidity	10 Multi-Morbidity, High Complexity	Multi-morbidity with <i>high complexity</i> (major and unstable chronic conditions)
Dominant Chronic	09 Dominant Major Chronic Condition	<i>Somatic condition with high impact on health, without treatment the condition is progressive and unstable over time</i>
	08 Dominant Psychiatric/Behavioral Condition	<i>Psychiatric condition with high impact on health, without treatment the condition is progressive and unstable over time</i>
Pregnancy	07 Pregnancy, High Complexity	Pregnancy with or without delivery among women with high morbidity burden
	06 Pregnancy, Low Complexity	Pregnancy with or without delivery among women with low morbidity burden
Moderate Needs	05 Multi-Morbidity, Medium Complexity	Multi-morbidity with <i>moderate complexity</i> conditions
	04 Multi-Morbidity, Low Complexity	Multi-morbidity with <i>low complexity</i> conditions
Healthy	03 Low Need Adult	Adults aged 18 and older with acute morbidity and no more than one low complexity condition
	02 Low Need Child	Children aged 0 to 17 with acute morbidity and no more than one low complexity condition
	01 Non-User	Individuals who have <i>no diagnosis</i>

For more information about the Johns Hopkins ACG system and the Patient Need Group Segmentation see the webinar recordings here <https://www.hopkinsacg.org/acg-uk-webinar-recordings/> and more generally here <https://www.hopkinsacg.org/>

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Provisional analysis indicates that for the age and sex distribution of the Toftwood population, healthcare activity is generally lower than expected given the Norfolk and Waveney average. This is also the case for other practices in Dereham apart from community activity. Numbers of patients at Toftwood with polypharmacy and multi-morbidity are about as expected



Exp = Expected counts for each community and health care activity type are calculated for each age band and sex by multiplying the population in the age band by the Norfolk and Waveney average for the age band. The expected counts are then summed for all age bands to give a single expected count for each community and each health care activity type.

Obs = Observed values for each community and health care activity type

$$\text{Standardised Activity Ratio} = \text{Obs} / \text{Exp} \times 100$$

A Standardised Activity Ratio **greater than 100** implies we observe **more** health and care activity than we expected for the age and sex distribution of the community.

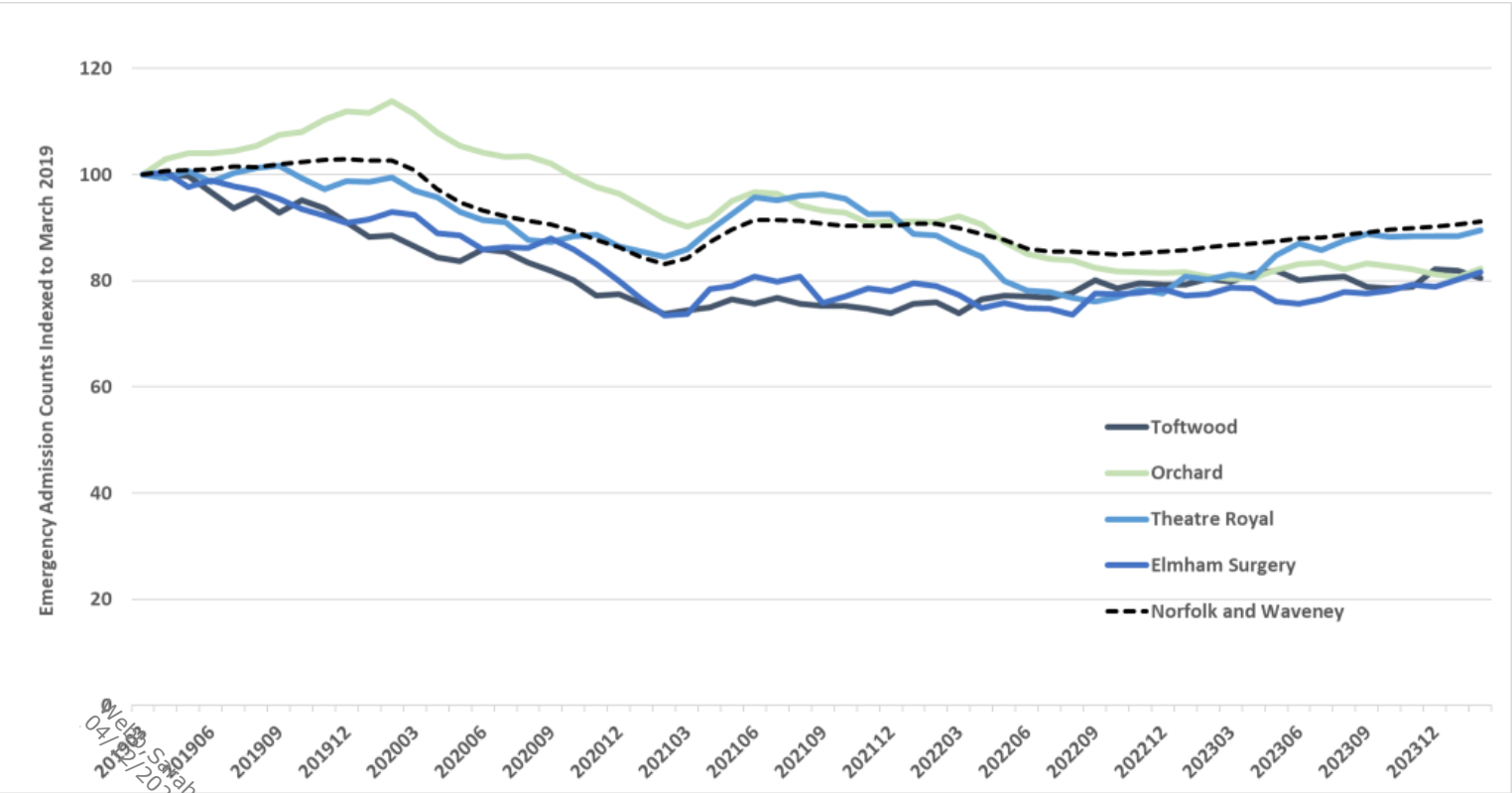
A Standardised Activity Ratio **lower than 100** implies we observe **less** health and care activity than we expected for the age and sex distribution of the community.

Insight & Analytics, BI analysis of pseudonymised national data sets held in Data Hub for 2023.

Given the age and sex of the population of Toftwood practice and the Norfolk and Waveney average, Toftwood practice:

- Has about expected numbers of patients with 10 or more medications
- Has about expected numbers of patients with four or more long term conditions
- Generally, uses less Health and Care activity than we would expect

We can use relative change in emergency admissions as one proxy measure to help understand how unmet health need in Toftwood has changed over time compared to other practices in Dereham. Other measures like GP appointments and community services might be constrained by supply.



Areas served by Toftwood Practice have not returned to levels seen four years ago in March 2019. This might imply that unmet need has not changed appreciably over time. However, there does appear to have been an increase through 2023.

Toftwood crude emergency admission rates are lower than the Norfolk and Waveney average

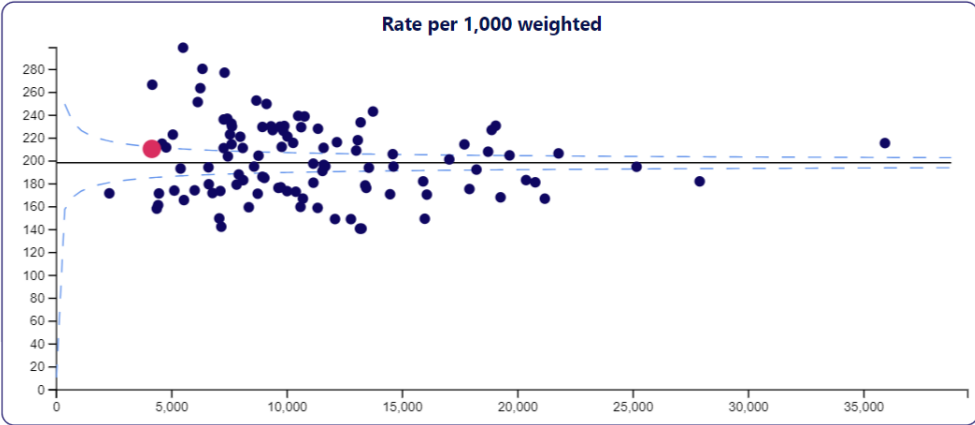
Area	Average emergency admissions per month	Registered Population April 2024	Crude Rate (not standardised for age and sex)
Toftwood	27	4,045	6.7
Elmham Surgery	62	9,691	6.4
Theatre Royal	69	9,000	7.6
Orchard	82	11,100	7.4
Norfolk and Waveney	8,533	1,094,600	7.8

This uses a 12 month moving average for patients registered with Toftwood, those registered with other practices in Dereham and all patients in Norfolk and Waveney. This helps remove seasonality.

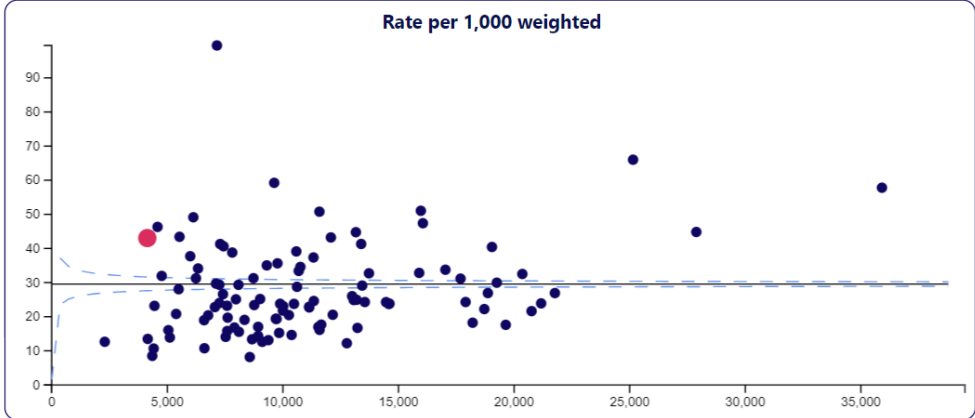
There is more variation over time for those practices with fewer average monthly admissions.

Toftwood Medical Centre: GP secondary care usage per 1,000 weighted population shows about average GP referrals and A&E attendances but higher than average A&E High Intensity Users, lower than average emergency admissions and lower than average Mental Health referrals

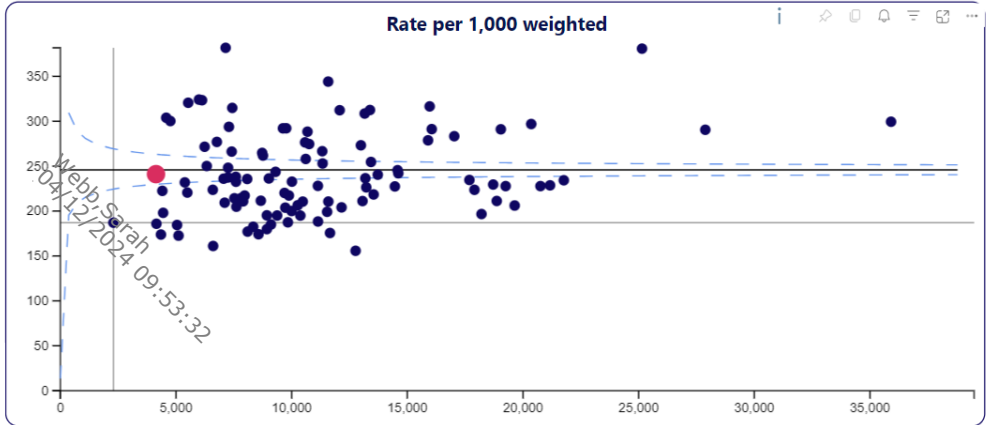
GP Referrals



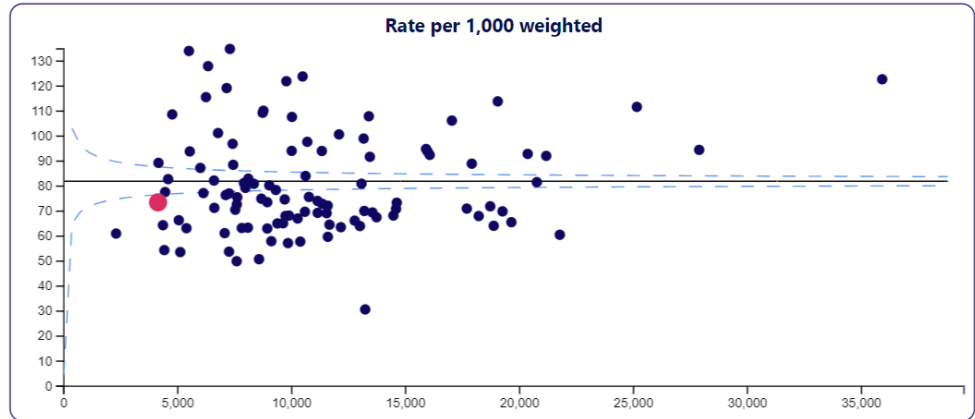
A&E High Intensity Users (five+ attendances in last 12 months)



A&E attendances

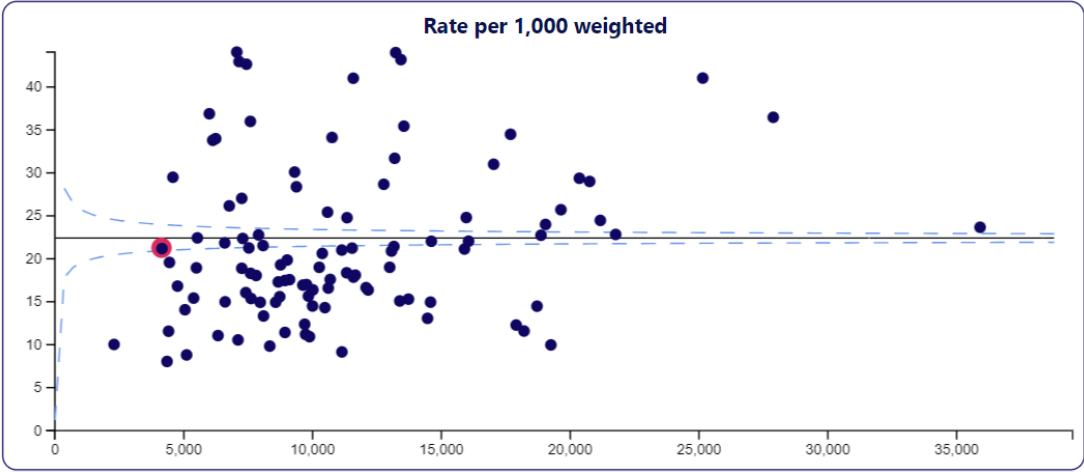


Emergency admissions



Toftwood Medical Centre: mental health referrals

Mental Health Referrals



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2022/23 achievement indicates that primary school achievement in Toftwood is about the same as the Norfolk average

School 2022/23 achievement	Pupils at end of Key Stage 2	% of pupils meeting standard	% achieving at higher standard	Average score in reading	Average Score in Maths
Dereham, Toftwood Community Junior School	81	56%	5%	106	104
Norfolk	9,642	52%	4%	104	103
England - state-funded schools	673,069	60%	8%	105	104
England - all schools	676,101	60%	8%	105	104

National data: <https://www.compare-school-performance.service.gov.uk/schools-by-type?step=default&table=schools®ion=926&geographic=la&for=primary&orderby=ESTABLISHMENTNAME&orderdir=asc>

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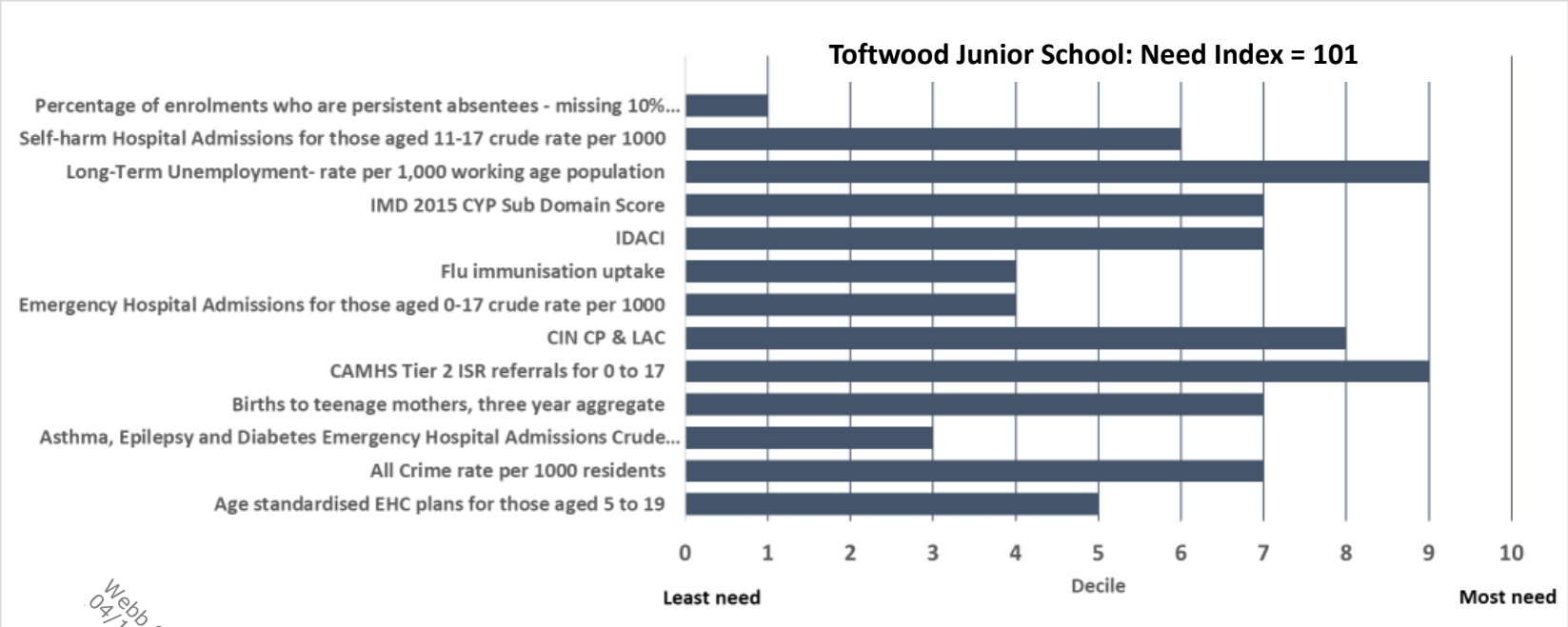
The experimental 2019 Norfolk School Health Needs Index based on the communities where pupils who attend a school are from was about average compared to Norfolk in 2019. Although there are some indicators in the index that indicated a higher level of need for certain outcomes.

The school health need index is currently being updated by public health

2019 School Health Need Index prior to the pandemic and release of the Index of Multiple Deprivation 2019

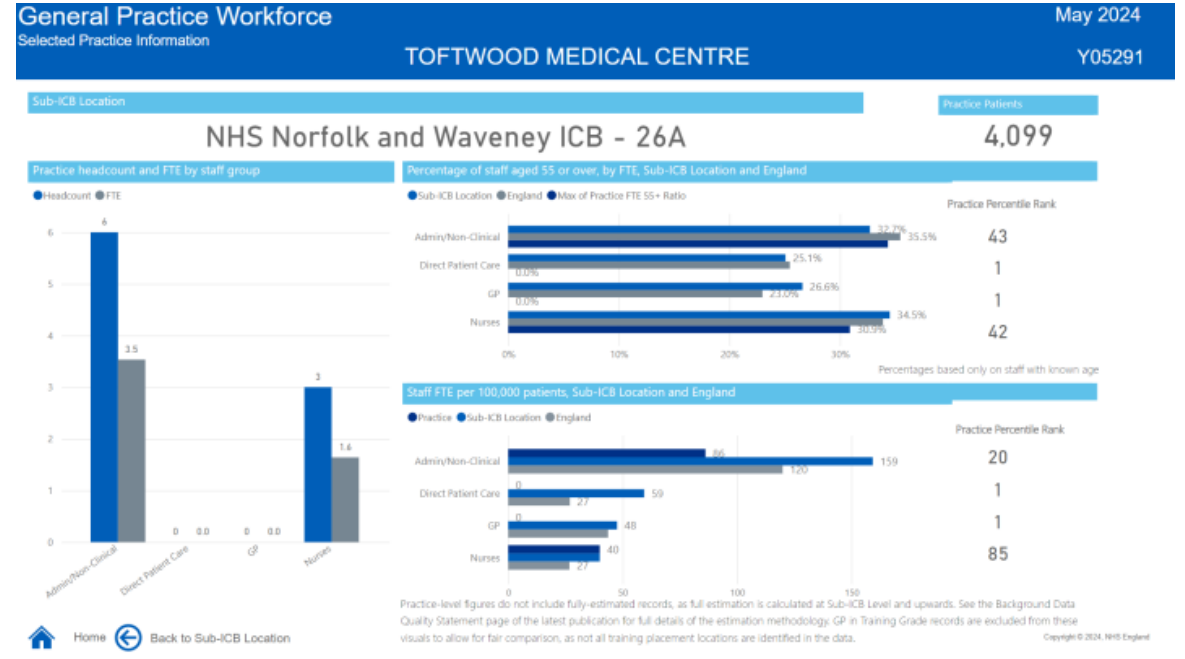
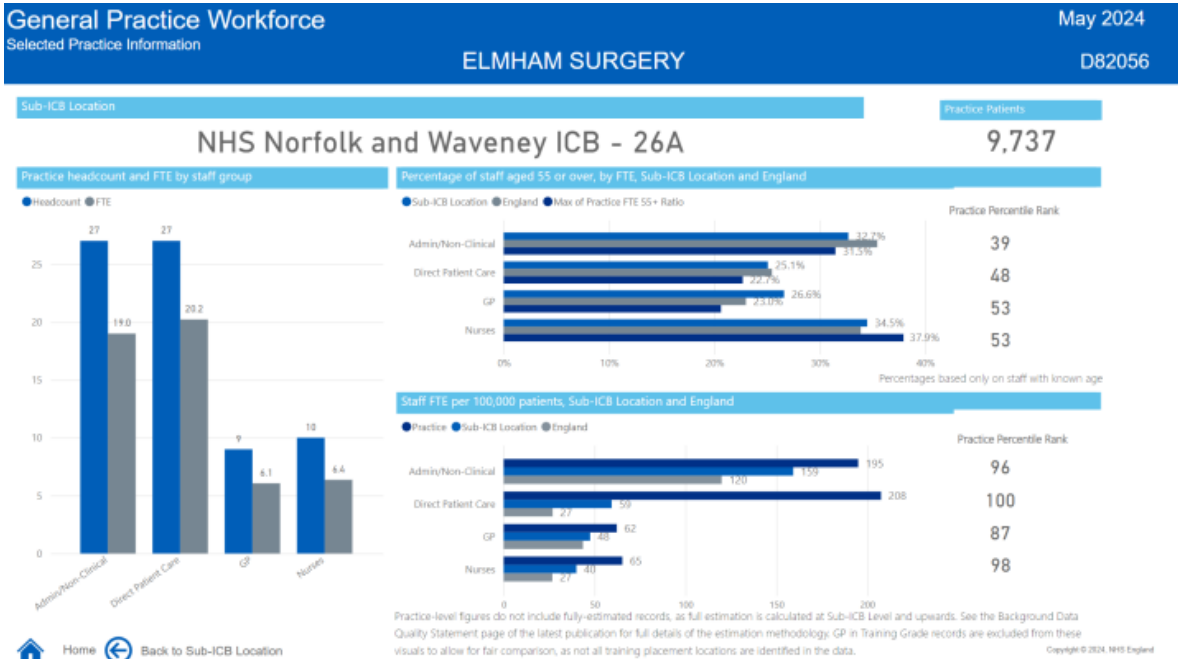
The indicators in the charts have been used to create the Need Index score

An index score < 100 = need lower than average
 An index score > 100 = need higher than average



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GP care for patients at Toftwood Medical Centre is provided by Elmham Surgery. The Elmham GP workforce is generally younger than the Norfolk and Waveney and England average. However, the nursing workforce is older. The Toftwood Medical Centre workforce is younger. For both practices there are higher than average number of nurse FTE per 100,000 patients than England.



Much higher FTE workforce per 100,000 registered population at the Elmham Surgery compared to Norfolk and Waveney and England. Combining both workforce and populations indicates that workforce FTE per 100,000 is higher than the England average apart from for GPs where it is the same.

Staff Group	Elmham + Toftwood	Norfolk and Waveney	England
Admin	163	159	120
DPC	146	59	27
GP	44	48	44
Nurses	58	40	27

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Agenda item: 08

Subject:	Primary Care Complaints, Enquiries and MP Queries – Q1 and Q2, 2024-25
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:	10 December 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 Quarters 1 and 2 of the financial year 2024/25.

Executive Summary

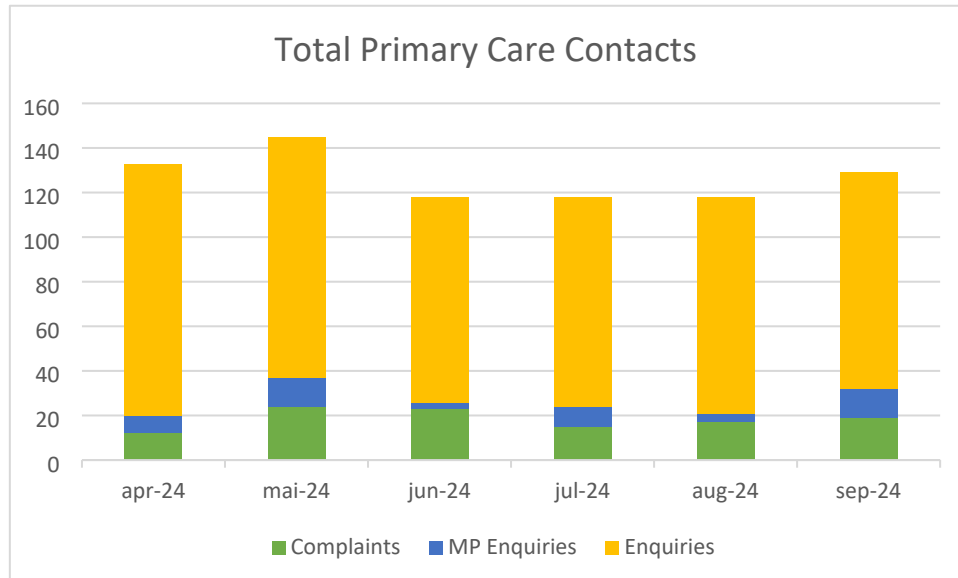
NHS Norfolk and Waveney Integrated Care Board (the ICB) recognises complaints and concerns as a vital form of feedback to help improve the service the organisation and local providers offer. The ICB aims to ensure all people making contact with the ICB feel listened to, have their concerns considered 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 so far in 2024/25, including themes and trends.

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Volumes of contact

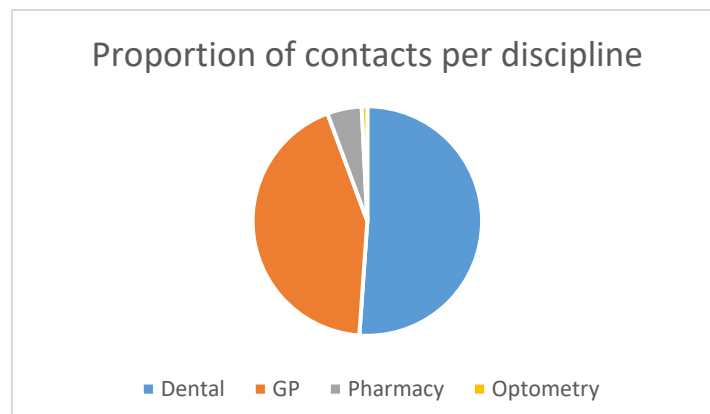
The ICB's Complaints and Enquiries team have received 761 contacts regarding primary care during the reporting period. The breakdown of how this was split across formal complaints, enquiries from MPs and informal concerns/enquiries can be seen below.



In total the team received 110 formal complaints, 50 MP enquiries and 601 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, it is difficult to compare the number of contacts based on the same reporting period last year. However, if a direct comparison to Q2 for 2023-24 and 2024-25 is made, there has been 10.3% reduction in contacts year on year (407 to 365).

The breakdown of contacts across each discipline can be found below. Just over half relate to concerns about dental services (389 contacts in total).



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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

389 contacts were received regarding dental services during the reporting period. It should be noted that when comparing quarter 2 of 2023-24 (which is when the delegation of primary care complaints and concerns to ICBs occurred) and quarter 2 of 2024-25, there has been a significant reduction in contacts this year, from 230 in 2023/24 to 175 in 2024/25. This is a reduction of 23.9 percent, which seems mainly to have been driven by the ICB's short term plan being implemented, meaning patients are experiencing better access to urgent dental care, following the Urgent Treatment Service being implemented in October 2023.

Contacts consisted of 42 formal complaints, 26 queries from Members of Parliament and 321 informal concerns/queries.

The general themes noted around dental contacts can be found below:

Access to Treatment

The majority of contacts (293) received were from patients struggling to access dental services. This was 75 percent of all contacts received relating to dentistry.

Given the improvements noted in access to urgent care, the vast majority of these patients were seeking access to routine dentistry or registration with a dental practice. The ICB have developed a comprehensive response to deal with these queries, however typically there are no NHS practices taking on patients within Norfolk and Waveney and therefore enquirers have come back with challenges. Some patients have asserted their legal right to be able to access dental care locally.

Other patients have presented with very specific sets of circumstances where it has been necessary to source treatment for them, which have included those in a cancer treatment pathway or with chronic dental issues that need further assessment.

Care and treatment

11 formal complaints, two MP queries and 46 informal enquiries related to the care and treatment patients had been offered by their dental practice.

Having analysed these contacts for any themes, there were several patients unhappy with the root canal treatment they had received, while others noted they had been charged more than once for NHS banded treatment.

Lessons learned

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Patients continued to highlight that sometimes it can be difficult to get through to urgent treatment service providers on a day-to-day basis, once they have been signposted to do so by NHS 111. They have also flagged being provided with incorrect telephone numbers.

This has been picked up with NHS 111, so they can provide the correct information but also set expectations around the finite capacity in the system.

General Practice

334 contacts were received regarding general practice during the reporting period, this number was down on the peaks in contacts received across Q4 in 2023/24.

Care and Treatment

51.1 percent (171) of contacts received were in relation to the care and treatment provided by a patient's GP practice.

Several patients cited dissatisfaction with care received from individual practitioners and wanted to highlight this to the ICB. Other cases highlighted errors made over thyroid levels, a lack of communication from practice and accessibility in relation to diabetes care, referrals not being made in a timely way and the attitude of clinicians in telephone and video consultations.

Two particular cases highlighted issues around pathways for transgender patients looking to access particular hormone therapies, which primary care had been left to manage while the patients were waiting to be seen by a gender identity clinic.

Access

Contacts regarding access to appointments continues to present prominently. As well as registered patients experiencing difficulties, a particular case involved a visitor to Norfolk not being able to access services after developing back pain. Other enquiries included patients expressing concerns at appointment systems on practice websites getting shut down when they reach capacity, patients being unable to see preferred GP and a lack of specific services available at local surgeries.

Prescribing

22 contacts received were in relation to GPs prescribing, where concerns ranged from medications being removed from repeat prescriptions to changes being made to the prescribing duration. There were a number of enquiries received concerning difficulties accessing diabetes items such as lancets and test strips.

Staff attitude

Several contacts raised concerns about the attitude of staff in general practice. These included issues with prescription management and approach of the practice manager towards issues raised, reception staff not handling manners to an empathetic manner and the dismissive nature of clinicians during consultations.

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Often these complaints can be difficult to progress as there can be differing accounts of events.

Lessons learned

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

- A practice are in the process of working with community service providers to improve communication for patients. This was as a result of a poor experience a patient received regarding end-of-life care.
- Specific training has been offered to practice staff around medical certificate of cause of death processes.
- Electronic prescribing process reminders have been issued to staff to avoid patient frustration after issues experienced.
- Vaccination programme information has been communicated to all practices as a result of poor experiences for specific cohorts of patients in being sent to incorrect agencies.

Optometry

Only a very small number of contacts (6) were received in relation to optometry.

Pharmacy

37 contacts were received during the reporting period, with a particularly high proportion of these being formal complaints (29.7 percent, compared to 14.4 percent across all primary care contacts).

Customer Service Issues

27 percent of queries related to service issues at a person's pharmacy, comprising of allegations of poor staff attitude, long waits to obtain prescriptions and impromptu branch closures without warning.

Shortages in medicines

While it was acknowledged as a national issue in many cases, drug shortages experienced by Norfolk and Waveney patients was highlighted on many occasions, typically for certain types of illnesses and conditions.

Development work

The ICB's Patient Experience Team is liaising directly with the Local Medical Committee, with a view to offering a place-based support package for complaints handling, initially across general practice. This is likely to be delivered in Quarter 4 of 2024/25 and if successful can be considered for roll out across other disciplines.

Recommendation

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Members are invited to note the contents of this report.

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 - Q1 and Q2 2024-25

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

Norwich Locality	53
Lakenham Surgery	5
Thorpewood Medical Group	5
St Stephens Gate	4
Castle Partnership	4
East Norwich Medical Practice	3
Lawson Road Surgery	3
Bacon Road Medical Centre	3
Woodcock Road Surgery	3
Hellesdon Medical Practice	3
Old Catton Medical Practice	2
Trinity and Bowthorpe Medical Practice	2
Weat Earlham Health Centre	2
Lionwood Medical Practice	2
Beechcroft and Old Palace Surgeries	2
Roundwell Medical Centre	2
Wensum Valley Medical Practice	2
West Pottergate Medical Centre	2
Taverham Surgery	2
Oak Street Medical Practice	1
Magdalen Medical Practice	1

North Norfolk Locality	33
Fakenham Medical Practice	8
Birchwood Medical Practice	5
Holt Medical Practice	4
Mundesley Medical Centre	3
Hoveton and Wroxham Medical Centre	3
Drayton Medical Practice	2
Stalham Staithe Surgery	2
Wells Health Centre	1
Ludham and Stalham Green Surgeries	1
Burnham Surgery	1
Paston Surgery	1
Coltishall Medical Practice	1
The Market Surgery, Aylsham	1

South Norfolk Locality	73
East Harling and Kenninghall Medical Practice	13
Humbleyard Practice	12
Watton Medical Practice	8
Attleborough Surgeries	8
Harleston Medical Practice	4
Long Stratton Medical Partnership	4
Parish Fields Practice	4
Grove Surgery	3
Heathgate Medical Practice	3
Elmham Surgery	2
Church Hill Surgery	2
School Lane Surgery	2
Shipdham Surgery	2
Mattishall and Lenwade Surgeries	1
Orchard Surgery	1
Wymondham Medical Partnership	1
Windmill Surgery	1
Chet Valley Medical Practice	1
Theatre Royal Surgery	1
Hingham Surgery	1

West Norfolk Locality	52
Vida Healthcare	11
Plowright Medical Centre	6
Heacham Group Practice	5
St James Medical Practice	4
Watlington Medical Centre	4
Bridge St Surgery, Downham Market	4
Southgates and The Woottons Surgeries	3
Manor Farm Medical Centre	3
Howdale Group Practice	2
Upwell Health Centre	2
Great Massingham and Docking Surgeries	2
Feltwell Surgery	2
Campingland Surgery	1
The Hollies Surgery	1
Litcham Health Centre	1
Boughton Surgery	1

Great Yarmouth and Waveney Locality	34
Beccles Medical Centre	7
Millwood Partnership	5
East Norfolk Medical Practice	4
Cutlers Hill Surgery	4
The Beaches Medical Centre	3
Bungay Medical Practice	2
Bridge Road Surgery	2
Kirkley Mill Surgery	2
The Park Surgery	2
High Street Surgery	1
Fleggburgh Surgery	1
Andaman Surgery	1

Dental and Pharmacy contacts / enquiries to ICB - Q1 and Q2 2024-25

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

Dental	
The Compass Clinic	7
Taverham Dental Practice	5
All Saints Green Dental Clinic	5
MyDentist, Norwich	4
Hunstanton Dental Practice	3
Prince of Wales Road Dental Practice	2
Smile Care United Limited	2
Smile Dental Care, Kings Lynn	2
Plummers, Wymondham	2
Together Dental, Norwich Earlham Road	2
Plummers, Bradwell	2
Together Dental, Downham Market	1
Acle Dental Surgery	1
Smile Dental Care Kings Lynn	1
Grange Dental Surgery	1
Palace Plain Orthodontic Practice	1
Southwold Dental Practice	1
Dental Design Studio Lowestoft	1
John Holmes Dental Practice	1
Loddon Dental Practice	1
Castle and Costa	1
MyDentist, Kings Lynn	1
Beech House Dental Surgery	1
Beechcroft Dental Practice	1
Aylsham Dental Practice	1
MyDentist, Aylsham	1
MyDentist, Gorleston	1
Treetops Dental Practice	1
UEA Dental Practice	1
West Earlham Dental Health Practice	1

Pharmacy	
Boots, Great Yarmouth	4
Haydens Chemist, Lowestoft	4
High Street Pharmacy	3
Greyfriars Pharmacy	1
St Stephens Gate Pharmacy	1
Watlington Health Pharmacy	1
Alan Stockley and Co	1
Well Pharmacy, Poringland	1
Boots, Sheringham	1

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Improving lives **together**

Norfolk and Waveney Integrated Care System

Primary Care Patient Safety Strategy- October 2024.

By Debbie Blake, Senior Lead Nurse for Quality.

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Introduction

- The [NHS Patient Safety Strategy \(2019\)](#), the first national strategy for improving patient safety, applies to all sectors. However, it was recognised that it needed more specific interpretation for primary care. This Primary care patient safety strategy describes the national and local commitments to improve patient safety in primary care, supporting all areas in this sector to fully implement the NHS Patient Safety Strategy.
- Primary care delivers 90% of NHS interactions, face to face, by phone or online. The overwhelming majority of these are safe, but with between 20,000 and 30,000 incidents of avoidable significant harm identified in general practice in England per year, there is opportunity to continue to improve the safety of care in primary care.
- Less than 1% of the 2.2 million incidents recorded nationally each year are from primary care, despite this being where most patient interactions take place.

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Patient Safety Themes in General Practice- Avery et al., BMJ, 2020.

Patient safety themes in general practice - Avery et al., BMJ, 2020



Diagnosis (61%)

- Wrong diagnosis—original diagnosis is found to be incorrect because the true cause is discovered later.
- Delayed diagnosis (non-cancer)—diagnosis could have been made earlier if care was evidence-based.
- Delayed cancer diagnosis



Medication (26%)

- No drug treatment given
- Insufficient drug treatment given
- Prescribing errors
- Monitoring errors
- Adverse drug reaction
- Medication not commenced in a timely manner
- Vaccine administration



Referral (11%)

- Delayed referral
- Referral not performed when indicated



Other (2%)

- Patient communication not sent from secondary to primary care
- Incorrect test ordered

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Patient Safety Primary Care Strategy

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



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Safety Culture.

- A positive safety culture is defined as one where the environment is collaboratively crafted, created and nurtured so that everybody (individual staff, teams, patients, service users, families and carers) can flourish to ensure brilliant, safe care.
- There are two myths that can undermine a safety culture within all settings, including primary care:
 - perfection myth: if we try hard enough, we will not make any errors
 - punishment myth: if we punish people when they make errors, they will not make them again
- The ambition is to promote a culture of safety event recording in primary care, together with an improved learning response. This is encouraged by moving to a just culture that focuses on the role of systems, not individuals, when things go wrong, a systems approach to solutions, compassionate leadership, and engagement with staff, patients and families following a patient safety incident.

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Safety Systems.

- Following COVID-19 from October 2021, new digital and online services requirements guidance was implemented for GP practices to provide increased choice and flexibility for patients in how they access care, and to also provide benefits to practices in managing and prioritising their workload.
- The aim is for primary care to have information systems that automatically flag patient safety issues such as missed patient referral follow-ups, safeguarding, diagnoses and medication issues, and accredited IT tools that support reliable referral and follow-up. Plus, IT to consistently support clinical decisions in primary care, by digitally embedding differential diagnosis decision guidance and safety netting advice.
- Digital systems to help improve communication and support the patient's journey between the different areas of primary care, and between primary care and secondary care, mental health, ambulance, community care, social care and the voluntary, community and social enterprise (VCSE) sectors. We know that patient safety events are more likely to occur at these points of change
- Tools such as the [VCSE inclusion health audit tool](#) and [inclusion health tool for primary care networks](#) can help primary care organisations to understand how effectively they are engaging with their service users and community partners. The [SPOTLIGHT tool](#) and the [health inequalities dashboard](#) can also be used to build an inclusion health data profile.

Insight

- Patient safety insight is about improving the understanding of safety across the whole system by drawing intelligence from multiple sources of patient safety information. Central to learning from safety events in primary care are the new Learning From Patient Safety Events (LFPSE) system and the Patient Safety Incident Response Framework (PSIRF).
- Local recording of patient safety events via LFPSE enables local learning, sharing of learning and of the incident response. At a national level, recording will identify new or under-recognised patient safety issues in primary care and act to prevent future harm to patients via alerts.
- The PSIRF was launched in acute, ambulance, mental health and community healthcare providers in 2022, most of our local organisations transitioned in September 2023. It sets out the approach for responding to patient safety events (or incidents) for the purpose of learning and improving patient safety. This approach is flexible and adapts as organisations learn and improve, so they explore patient safety incidents relevant to their context and the populations they serve.

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The PSIRF Principles.

- **Compassion:** engaging meaningfully with those affected by patient safety events (including staff and patients), through answering questions, and addressing concerns, and involving those affected in any learning response.
- **Systems-thinking:** understanding how a safety event happened and not who to blame. This includes exploring work conditions and processes.
- **Proportionality:** focusing effort where there's the greatest potential for learning and improvement. This avoids bureaucracy that drains time and deflects resources away from improvement activity.
- **Supportive leadership:** Leaders engage and empower, asking questions to understand rather than to judge. Leaders enable improvement and collaboration by creating a psychologically safe workplace that encourages honest conversation.

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Involvement.

- Patient safety involves everyone in all aspects of healthcare: patients, service users, families, carers, staff and students. The NHS Patient Safety Strategy emphasises the important role of patients, service users, their families and carers, and other lay people in providing safer care via the [Framework for involving patients in patient safety](#).
- Patient Safety Partners. General practice has had patient involvement via patient participation groups (PPGs) for several decades, and as a contractual requirement since 2015.
- Patient Safety Specialists are nominated staff who lead safety improvement. There are around 800 PSSs embedded in acute, ambulance, mental health, community healthcare providers, ICBs, and a few primary care providers.
- Staff and students to complete the free online [NHS patient safety syllabus training](#) levels 1 and 2, introduced in 2022, and where possible to have protected training time to do so.

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Improvement.

- Enable patient safety improvements in primary care, focussed on the 3 patient safety themes, supporting teams to co-develop change with patients and families that prevents harm.
- Review patient safety themes for improvement in community pharmacy, optometry services and dental services and then to develop and test novel approaches.
- Identify medical conditions and patient groups that are more at risk of harm. Once identified co-design treatment options that provide optimal care pathways.
- General practices to deliver continuity of care and systems in place to ensure both this and that patients who visit their GP practice multiple times with unresolved symptoms are identified and prioritised.

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What is the value of General Practice adopting a PSIRF approach?

- PSIRF can support appraisal and revalidation.
- PSIRF can support CQC inspections.
- PSIRF promotes a proactive and positive culture of safety based on openness and honesty.
- Working collectively under PSIRF can reduce duplication of effort through agreeing shared improvement goals and increase engagement in improvement activity.
- PSIRF's focus on improvement can shift culture away from blame and bureaucracy, enable generation of meaningful insight, improve staff well-being and patient experience and provide timely and accurate learning about systems and processes.
- The PSIRF approach improves the culture of recording and sharing, enables shared learning and improvement across practice boundaries and provides access to skills and resource to support systems thinking and compassionate engagement.

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Thank you.

[NHS England » Primary care patient safety strategy](#)

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Agenda item: 10

Subject:	Norwich APMS contract procurement
Presented by:	Sadie Parker, Director of Primary Care
Prepared by:	Stuart White, Senior Primary Care Commissioning manager Sadie Parker, Director of Primary Care Emma Bugg, Associate Director of Norwich PCN Development
Submitted to:	Primary Care Commissioning Committee
Date:	10 December 2024

Purpose of paper:

This paper is for consideration and ratification by the Committee.

It should be noted that Sarah Buchan, Practice Manager Speciality Advisor may be conflicted for this item and should therefore refrain from participating in the discussion.

Executive Summary:

To ratify:

- The abandonment of the current procurement of the APMS contract in Norwich, covering the Walk-in-Centre, registered practice and Vulnerable Adults Service on the grounds of affordability.
- The extension of the current services beyond 31st March 2025 for a period of 12 months.

Introduction and background

The Norwich APMS contract currently includes three parts, the Walk in Centre, Health Centre with a registered patient list and Vulnerable Adult Service Inclusion Health Hub. The Walk in Centre (WIC) was opened in the late 2000's as part of a national policy initiative whereby each Primary Care Trust at the time was required to commission one. It is the only such centre remaining in Norfolk and Waveney and is

situated in the centre of Norwich, co-located with the Norwich Health Centre. The Inclusion Health Hub is situated in Westwick Street.

The GP-led health centre policy was designed to introduce competition and improve access and quality of services. While often seen as part of the UEC system, the walk-in centre provides primary medical services on a walk-in basis, as such it is duplicating the provision of primary medical services during core hours in neighbouring practices, and also to some degree the GP out of hours service. Data shows the majority of activity is primary care-related (otherwise patients are redirected, eg to an emergency department) and that most attendances are from people already registered with a Norfolk and Waveney practice (including the co-located practice).

A public consultation was undertaken in January 2023 to seek views on closing the walk in centre and re-providing services in a different way. There was a significant response to the consultation, including campaigning by current MPs, with the ICB at the time agreeing to continue to commission services on the same basis as previously.

Following the winding up of One Norwich Practices Limited, a caretaker provider, Norfolk Primary Care CIC., was secured to cover the three services under a short-term APMS contract between December 2023 and 31 March 2025. A full procurement process was then initiated to identify a new provider to start from 1st April 2025 for a period of three years.

Decision

For the reasons outlined below, a decision has been made by Committee voting members, following a recommendation from the ICB's Executive Team, to abandon the current procurement process. This paper is here today for formal ratification by the Committee of that decision.

The decision to abandon the procurement had to be taken ahead of this meeting due to commercial factors and time pressures within the procurement process, which meant that bidders needed to be made aware of the decision before the formal meeting date. The ICB was also required to act urgently to ensure it has a pathway in place to secure continued, quality patient services.

A) Financial

Following a significant adverse variance to the financial plan in August 2024 the Norfolk and Waveney ICS has been placed under the Investigation and Intervention programme by the NHS East of England regional team. This programme (I&I level 4) includes the intervention of Deloitte consulting; they are looking at, amongst other things, areas of 'discretionary' spend. With this in mind, it is prudent for the ICB to undertake a review of this service in view of the financial budget now available to the ICB for this service, and to re-procure the services as quickly as possible through ICB governance processes as part of a broader review of the services we are commissioning and buying.

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Every area of spend in the ICB has been subject to efficiency targets on a fair share basis. Outside of the prescribing budget there are efficiencies within primary care which remain as unidentified. The primary care commissioning budget currently has circa £900k of unidentified efficiencies, we must therefore justify areas of 'discretionary' spend if we are unable to meet our share of efficiencies.

B) APMS review

The ICB is currently reviewing or planning a review of all of its APMS contracts as part of our sustainable commissioning process.

The opportunity to review the Norwich Health Centre APMS contract alongside the others, especially if there are opportunities to achieve economies of scale, would seem wise.

C) Legislative compliance

The ICB has sought legal advice in relation to this decision. Whilst this advice is legally privileged and confidential to the ICB, the ICB is satisfied that abandoning the current procurement process will enable it to procure any future services required (as determined through the ICB's review and governance processes) in a manner which complies with the public procurement regime.

What will happen to current services?

To allow the ICB to fully review the services and the ICB's future commissioning requirement, the current service will be extended beyond March 2025 for a fixed period of 12 months. During this time, a commissioning review will be undertaken of the current services and the finances now available for commissioning. Further detail on this will be set out on this process shortly.

Recommendation to the Committee:

Members are invited to discuss the contents of this report and ratify the following:

- The abandonment of the current procurement of the APMS contract in Norwich, covering the Walk-in-Centre, registered practice and Vulnerable Adults Service on the grounds of affordability.
- The extension of the current services beyond 31st March 2025 for a period of 12 months.

Key Risks

Clinical and Quality:

There are no quality issues with the current provision.

Finance and Performance:

There are no current performance issues, and the finance is currently included in this year's budget

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	plan, however the ICB's financial position has deteriorated since triple lock approval and there remains £900k of unidentified efficiencies in the primary care budget.
Impact Assessment (environmental and equalities):	The aim of this work should be to ensure future commissioned services reduce health inequalities.
Reputation:	The ICB will maintain services through an extension of current arrangements.
Legal:	Legal procurement advice has been sought in relation to these proposals.
Information Governance:	N/A
Resource Required:	ICB staff.
Reference document(s):	Procurement legislation, primary medical services regulations
NHS Constitution:	N/A
Conflicts of Interest:	Arrangements are in place to manage actual or potential conflicts of interest in line with our obligations under procurement rules. All project group members are required to complete a declaration of interest and action will be determined and reported as appropriate.
Reference to relevant risk on the Board Assurance Framework	Resilience of general practice.

Governance

Process/Committee approval with date(s) (as appropriate)	
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Agenda item: 11a

Subject:	General Practice & Community Pharmacy Delivery Group Report
Presented by:	Shepherd Ncube, Associate Director of Primary Care Commissioning
Prepared by:	Sharon Gardner-Head of Primary care Commissioning-Community Pharmacy and Optometry Shepherd Ncube, Associate Director of Primary Care Commissioning Sadie Parker, Director of Primary Care
Submitted to:	Primary Care Commissioning Committee
Meeting Date:	10 December 2024

Purpose of paper:

To provide the Board with a report of the General Practice & Community Pharmacy Delivery Group meetings held on 8th October 2024 and 13th November 2024

Group:	General Practice & Community Pharmacy Delivery Group
Chair:	Sharon Gardner Head of Primary Care Commissioning Pharmacy and Optometry for October 2024, Mark Burgis, Executive Director of Patients and Communities for November 2024
Meetings since the previous update:	8 th October 2024 and 13 th November 2024
Overall objectives of the GPCPDG:	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

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	received for investment in primary care.
BAF and any significant risks relevant / aligned to this Group:	<ul style="list-style-type: none"> • The resilience of general practice. The increasing risk to services associated with potential collective action was noted. • The resilience of community pharmacy. The increasing risk of financial viability of contractors and the risk to service with potential collective action was noted.
Key items for assurance/noting:	<p><u>8 October 2024</u></p> <p>The Operational Risk Register was presented to the group for discussion and approval by voting members. A new risk relating to the resilience of community pharmacy was introduced to the committee. It was agreed this would be reported in line with the general practice risk and was welcomed by the committee.</p> <p>The Patient Safety Incident Reporting Framework was presented for discussion and to share information with general practice colleagues in preparation for its upcoming mandatory implementation. The group supported this approach; however, as the meeting was not quorate, full approval will be sought from voting members outside the meeting.</p> <p>A detailed paper on the Magdalen Medical Practice Boundary Change was presented, and the impact of the changes was discussed. The group approved the request, but further approval will be required outside the meeting due to quorum issue.</p> <p>CQC Reports: Four Care Quality Commission inspections were shared with the group, all receiving an overall rating of "Good".</p> <p>Learning Disability Annual Health Check Update: A strong start has been reported in Q1 of this year.</p> <p>Locally Commissioned Services (LCS): An initial paper was shared to introduce the proposed direction for local commissioned services. The Local Medical Committee provided extensive feedback on the proposed transition to Local Enhanced Services (LES). It was agreed that further discussions will take place, and a paper will be brought back to the group for approval to recommission the LCSs due to expire this year.</p>

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	<p>Contract Monitoring Report – Dispensing Services Quality Scheme (DSQS) Report 2023/2024: A paper was presented for the first time updating on the number of dispensing practices that had completed the DSQS. A positive response from the practices was noted. The importance of the link with the medicine’s optimisation team in their quality work was highlighted.</p> <p>Prescribing Report: The focus was on quality indicators. Positive progress was noted in antibiotic prescribing, while efforts continue to influence prescribing behaviours for strong painkillers.</p> <p>Finance Update: Budget overperformance was reported, partly driven by unidentified efficiencies and the prescribing service line. A forecasted overspend of £5.2 million above the allocated budget is expected by the year-end.</p> <p><u>13 November 2024</u></p> <p>The group reviewed the progress made so far on the first step of the Strategic Framework for Primary Care, namely the development of a vision and a set of principles for primary care. This would go to PCCC for approval.</p> <p>Pharmacy workforce and recruitment and retention plan: A paper was presented by the newly appointed pharmacy workforce lead and presented data relating to community pharmacy workforce. An outline workplan in relation to attraction, recruitment, retention and reform was also introduced.</p> <p>The group reviewed the latest finance report and the ongoing challenges in meeting our challenging financial plans.</p>
<p>Items for escalation to Committee:</p>	<p>There were no items for escalation at either meeting.</p>
<p>Items requiring approval:</p>	<p><u>8 October 2024</u></p> <p>The group reviewed, noted, and approved the update report on the Operational Risk Register.</p> <p>The Patient Safety Incident Reporting Framework (item 11) and the proposed approach were discussed, supported, and approved by the group.</p>

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	<p>The proposed changes to the Magdalen Medical Practice Boundary (item 12) were reviewed, discussed, and approved. The group recommended that commissioners monitor and review the impact of these changes in six months.</p> <p>The outcome of the TIAA Audit Report for dentistry, pharmacy and optometry was reviewed, discussed, and approved. The committee congratulated the primary care team on the achievement of a 'reasonable' rating in the audit.</p> <p><u>13 November 2024</u></p> <p>The group reviewed the Operational Risk Register, noting the updated actions. No significant changes to report since the last meeting.</p> <p>A progress update report was shared and presented at the meeting, highlighting good progress since the previous report in delivering mental health and learning disability annual health checks. Over 60% of our Primary Care Networks achieved an uptake rate exceeding 60%. The group acknowledged the collaborative efforts with voluntary sector organisations and commended the progress achieved to date.</p> <p>The Finance report was presented and an overspend of £4.5m by the end of this financial year driven by efficiency services was predicted.</p> <p>A process to manage Section 96 applications was shared, discussed and approved by the group.</p> <p>The group approved a proposal to recommission the six Local Enhanced Services due to expire on 31 March 2025. These would be reviewed through the usual process of engagement with clinical advisors and the LMC. The ICB would also move to commission services as a local enhanced service (through a contract variation to the GMS contract) in future. For any interested PCNs, the ICB would support piloting at scale commissioning this year.</p>
<p>Confirmation that the meeting was quorate:</p>	<p>The October meeting was not quorate, therefore the items for approval were followed up with voting members outside of the meeting. Attendance at the meeting is set out below:</p>

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	<p><u>8 October 2024</u></p> <p>Voting members Sharon Gardner Head of Primary Care Commissioning Pharmacy and Optometry, NWICB – Chair (deputising for SN) Fiona Theadom Head of Primary Care Commissioning (Dental and Medical), NWICB Rashmi Balakrishnan, Primary Care Finance Manager, NWICB (deputising for JG) Karen Watts, Director of Nursing and Quality NWICB</p> <p><u>13 November 2024</u></p> <p>Voting members Mark Burgis, Executive Director of Patients and Communities, NWICB Shepherd Ncube, Associate Director, Primary Care Commissioning, NWICB Sadie Parker, Director of Primary Care, NWICB Marie McDermott- Snr Lead Nurse NWICB - deputising for Karen Watts, Director of Nursing and Quality. NWICB Sarah Elliott, Primary Care Finance Manager, NWICB - deputising for James Grainger</p>
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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.

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Conflicts of Interest:	Arrangements are in place to manage conflicts of interest
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Agenda item: 11b

Subject:	Dental Services Delivery Group report
Presented by:	Fiona Theadom, Head of Primary Care Commissioning (Dental and GP)
Prepared by:	Sarah Johnson, Senior Primary Care Commissioning Manager – Dental
Submitted to:	Primary Care Commissioning Committee
Date:	10 December 2024

Purpose of paper:

To provide the Committee with a report of the meetings of the Dental Services Delivery Group (“DSDG”) held on 8th October 2024 & 13th November 2024.

Group:	Dental Services Delivery Group
Chair	8 th October 2024: Fiona Theadom, Head of Primary Care Commissioning (Dental and General Practice), Norfolk and Waveney ICB 13 th November 2024: Mark Burgis, Executive Director of Patients & Communities, Norfolk and Waveney ICB
Meetings since previous update	8 th October 2024 13 th November 2024
Overall objectives of DSDG	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	13th November 2024: Risk Register – Update given to the group on 2 risks:

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	<ul style="list-style-type: none"> • Special Care Dental Services – It was highlighted that Special Care Dental Services are currently five staff members down and experiencing significant workforce issues. • Secondary Care Dental Services – A risk was highlighted in relation to a lack of resources within the ICB to monitor secondary care dental services or build relationships and this includes for the trauma pathway. It was suggested that this risk be raised with the Executive Director of Commissioning and Performance.
<p>Key items for assurance / noting</p>	<p>8th October 2024:</p> <p>The following papers were discussed by DSDG:</p> <ul style="list-style-type: none"> • Dental Finance Report – Current position was discussed with the group and confirmation that the mid-year position was still awaited from BSA – Discussion in relation to ensuring that budget is spent by year-end was had and confirmation given that all options are being considered. • Quality and Risk Report – An update was provided to the group in relation to 2 dental practices purchased by Damira (Wells and Holt) and the subsequent support provided to Damira from ICB teams. An overview of the collaborative approach was also provided. Some challenges were highlighted by members of the Group, and it was agreed these would be fed back to the team. • TIAA Audit Report (Pharmacy and Dental) - The TIAA Audit Report for pharmacy, optometry and dentistry was presented for noting and approval. The basis of the report was confirmed to the Group and the report gone through it in some detail for members attention. The corresponding action log was also shared. <ul style="list-style-type: none"> • Repayment plan for year end clawback • Request for an uplift in contract • Trauma Pathway • Year End Clawback Repayment Extension <p>13th November 2024:</p> <ul style="list-style-type: none"> • Dental Finance Report

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	<ul style="list-style-type: none"> • End of Year Report • Workforce Update • Items for Escalation to PCCC • Conversion UDAs to UOAs (Conflict of Interest noted)
<p>Items for escalation to Committee</p>	<p>8th October 2024: There were no items requiring escalation to PCCC.</p> <p>13th November 2024: There were no items requiring escalation to PCCC.</p>
<p>Items requiring DSDG approval</p>	<p>8th October 2024: This meeting did not meet quoracy and therefore any approvals agreed at the meeting were circulated to voting members outside of the meeting to ratify the approvals.</p> <ul style="list-style-type: none"> • Out of Hours Provision – Request for approval to extend the current Out of Hours Provision for a further 3 months for Lowestoft and Norwich and agree a short-term contract for provision in Kings Lynn. This was agreed with the next steps going through the ICB Prioritisation process. • Dental Provider – Request for approval to implement a repayment plan for the 23/24 debt to run concurrently with the 22/23 repayment plan until Feb 2026. This was agreed. • Dental Provider – Request to uplift the UDA rate for this contract to £35.00 within the existing contract value to support emergency transfer of patient care and in recognition of short-term contract. This was agreed. • Trauma Pathway – Request to extend the current arrangements in line with other ICBs in the region. This was agreed. • Year End Repayment Extension – Request to extend the debt repayment for a Dental Practice over 10 months. This was agreed subject to additional information about dentist recruitment being gathered. <p>13th November 2024:</p> <ul style="list-style-type: none"> • Conversion UDAs to UOAs – A request for approval was presented to the group for the conversion of UDAs to UOAs for a local provider. Whilst this was agreed in the short-term it was felt that a full Orthodontic Needs Assessment was required to be undertaken to establish whether this was the right decision for the long-term.

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Confirmation that the meeting was quorate

8th October 2024:

No, approval was sought from Voting Members after the meeting for decisions. Attendance at the meeting is set out below:

Voting Members:

Fiona Theadom. Head of Primary Care Commissioning (Dental and General Practice), Norfolk and Waveney ICB (nominated Chair for this meeting and deputising for SN)
Sharon Gardner. Head of Primary Care Commissioning (Pharmacy and Optometry). Norfolk and Waveney ICB.
Karen Watts. Director of Nursing and Quality. Norfolk and Waveney ICB.
Sarah Elliott. Finance Manager. Norfolk and Waveney ICB (Deputizing for James Grainger)

In attendance:

Andrew Bell, Vice-Chair, Norfolk Local Dental Committee
Jordan Bingley, Primary care Workforce Lead, Norfolk and Waveney ICB
Bridget Chisholm, Healthwatch Norfolk
Rachel Hayes, Senior Commissioning Officer, Norfolk and Waveney ICB
Ben Oakenfold, Primary Care Commissioning Support Officer – Dental, Norfolk and Waveney ICB
Tom Norfolk, Chief Regional Dental Officer, East of England
Jayde Robinson, Head of Primary Care Workforce Transformation, Norfolk and Waveney ICB
Jason Stokes, NHS England/LDC Secretary
Nick Stolls, Dental Advisor to PCCC and DSDG
Sarah Webb, Commissioning Support Officer – Dental, Norfolk and Waveney ICB

13th November 2024:

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

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	<p>Shepherd Ncube, Associate Director – Primary Care Commissioning</p> <p>Marie McDermott, Senior Nurse for POD Services, Small Contracts and Specialist Commissioning (deputising for Karen Watts)</p> <p>James Grainger, Head of Finance – Primary Care and Corporate Reporting, Norfolk and Waveney ICB</p> <p><u>In attendance:</u></p> <p>Fiona Theadom. Head of Primary Care Commissioning, Norfolk and Waveney ICB</p> <p>Sarah Johnson, Senior Primary Care Commissioning Manager, Dental, Norfolk and Waveney ICB</p> <p>Rashmi Purkayastha, Commissioning Manager (Dental), Norfolk and Waveney ICB</p> <p>Rachel Hayes, Senior Commissioning Officer, Norfolk and Waveney ICB</p> <p>Ben Oakenfold, Primary Care Commissioning Support Officer - Dental, Norfolk and Waveney ICB</p> <p>Sarah Elliott. Finance Manager. Norfolk and Waveney ICB (Deputizing for James Grainger)</p> <p>Louise Wilson, Quality Improvement Dental Nurse, Norfolk and Waveney ICB</p> <p>Tom Norfolk, Chief Regional Dental Officer, East of England</p> <p>Nick Stolls, Dental Advisor to PCCC and DSDG</p> <p>Alex Stewart, Chief Executive, Healthwatch.</p> <p>Andrew Bell, Vice-Chair, Norfolk Local Dental Committee</p> <p>Ben Chandler, Senior Workforce Transformation Manager - Rural and Coastal, Norfolk and Waveney ICB</p> <p>Sally Weston Price, Consultant in Dental Public Health</p>
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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

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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 equalities impact assessment to inform the Group's decision making. Papers to DSDG seek to identify potential impact on equalities and mitigating actions required. Action will be taken to draw up Equality Impact Assessments and Clinical Quality Risk Assessments for new projects and proposals.
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	The resilience of primary care

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Agenda item: 11c

Subject:	Dental Development Group report
Presented by:	Fiona Theadom, Head of Primary Care Commissioning (Dental and GP)
Prepared by:	Sarah Johnson, Senior Primary Care Commissioning Manager – Dental
Submitted to:	Primary Care Commissioning Committee
Date:	10 December 2024

Purpose of paper:

To provide the Committee with a report of the meetings of the Dental Development Group (“DDG”) held on 22nd October 2024 and 20th November 2024.

Group:	Dental Development Group
Chair	<p>22nd October 2024: Sadie Parker, Director of Primary Care, Norfolk, and Waveney ICB</p> <p>20th November 2024: Sadie Parker, Director of Primary Care, Norfolk, and Waveney ICB</p>
Purpose of the Group	<p>The purpose of the group is to:</p> <ol style="list-style-type: none"> 1. provide a ‘safe space’ for key stakeholders across the Norfolk and Waveney system to come together to discuss and drive delivery of the systems dental ambitions. 2. share information, soft intelligence and agree actions as how to best work together to keep the dental transformation and support for Norfolk and Waveney (N&W) 3. work together to agree a 3 – 5-year strategy by March 2024 4. enable a joined-up approach to solution finding and decision making, ensuring that we utilise all aspects of our system in the initial scoping of decisions and outcomes for N&W. 5. To inform decision making by the ICB from 1 April 2023

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	<p>Engagement planning in the co-production of services going forward including those from secondary care, community care, urgent and emergency care and Patients.</p> <p>Terms of Reference are in place however there is no formal quoracy for the meeting.</p>
<p>Meetings</p>	<p>22nd October 2024</p> <p>20th November 2024</p>
<p>Key items for assurance / noting</p>	<p>22nd October 2024:</p> <p>The following items were discussed by DDG:</p> <ul style="list-style-type: none"> • Workforce - A presentation was given setting out Workforce updates including a decline in the workforce data. This data is to be analysed further with business intelligence to identify any trends. Results of a Training Needs Analysis highlighted the demand for upskilling training and complaints resolution handling. Confirmation was given that 5 practices have expressed interest in becoming a foundation training practice and all national Golden Hello incentives have been fully utilised, with local Golden Hello Incentives receiving positive uptake too. Further projects are in the pipeline. • Special Care Dental Services – This presentation was postponed due to technical issues. <p>20th November 2024:</p> <p>The following items were discussed by DDG:</p> <ul style="list-style-type: none"> • Child Focussed Dental Practices – A progress update was provided including evaluation planning, onboarding practices, expressions of interest, coverage and selection, and urgent care for children. • 111 Directory of services – Discussion in regards to the number of dental practices who are listed on the 111 directory of services who are unable to accept NHS patients and the

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	<p>challenges this is causing in terms of frustration and escalating behaviours. Agreement that options for only practices accepting urgent treatment service referrals being listed on the DoS, along with consistent wording being provided for 111 call handlers should be explored with a view to implementing this as soon as possible.</p> <ul style="list-style-type: none"> • Orthodontics Update – Update provided to the group explaining approval having been obtained by other ICBs for 10-year contracts, but that workforce planning was required. • Special Care Dental Services – the recorded presentation was circulated to the group outside of the meeting due to further technical issues.
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Recommendation to the Committee:

To note the report for assurance purposes

Key Risks	
Clinical and Quality:	The Group contributes to the development of ICB plans and projects aimed at ensuring and improving the quality of NHS dental care in Norfolk and Waveney. The Group’s membership includes a wide range of clinicians to inform ICB plans from a clinical perspective.
Finance and Performance:	Finance is part of the membership to consider if schemes offer value for money opportunities and to keep informed about potential developments
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

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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	The resilience of NHS primary care dental services The resilience of secondary care dental services

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Agenda item: 12

Subject:	General Practice Delivery Report
Presented by:	Leiat Becker, Senior Primary Care Delivery Manager
Prepared by:	Leiat Becker, Senior Primary Care Delivery Manager
Submitted to:	Primary Care Commissioning Committee
Date:	10 December 2024

Purpose of paper:

To note the update provided on appointments recorded in GP Appointment Data (GPAD) during the first six months of 2023/24 and provide feedback to inform future reports or request further information to support assurance.

Executive Summary:

The delivery report looks at appointment activity recorded in GPAD during the first six months of 2024/25, in particular delivery on the proportion of appointments recorded within two weeks between booking against NHS targets.

Report

The information below shows appointment activity recorded in GPAD for the first six months of 2024/25 compared with the same time in 2023/24.

One of the objectives set by NHSE for Primary Care in 2024/25 is to “Continue to improve the experience of access to primary care, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within 2 weeks and those who contact their practice urgently are assessed the same or next day according to clinical need¹.”

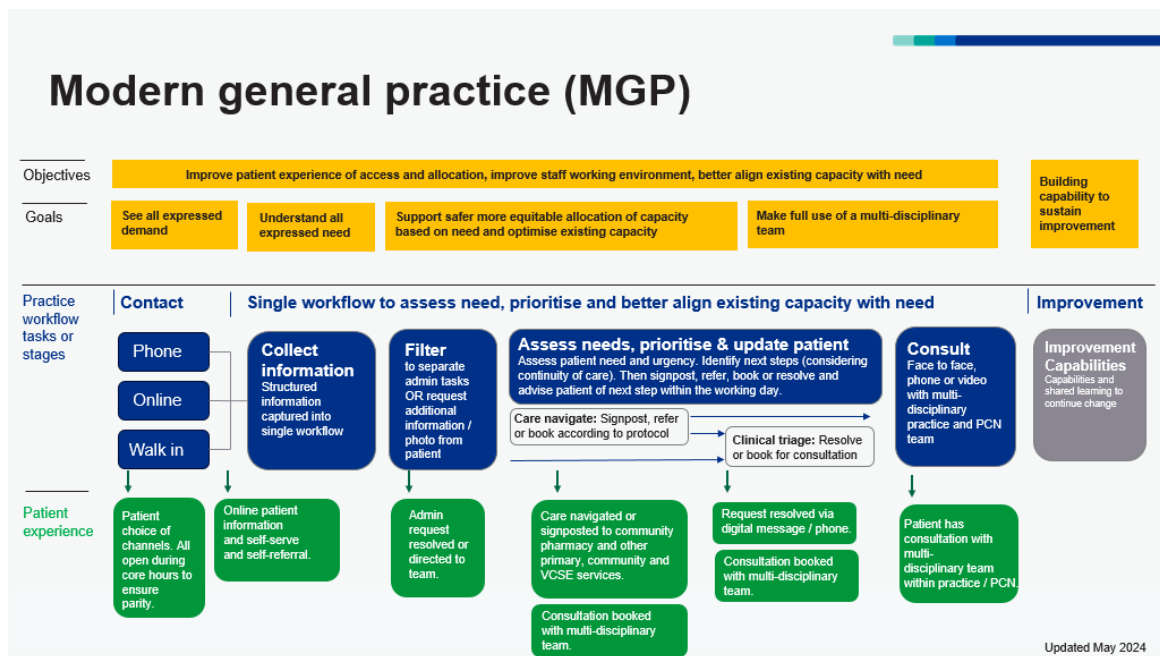
¹ [2024/25 priorities and operational planning guidance](#)

GPAD is data collected from general practice appointment systems across the NHS, and includes:

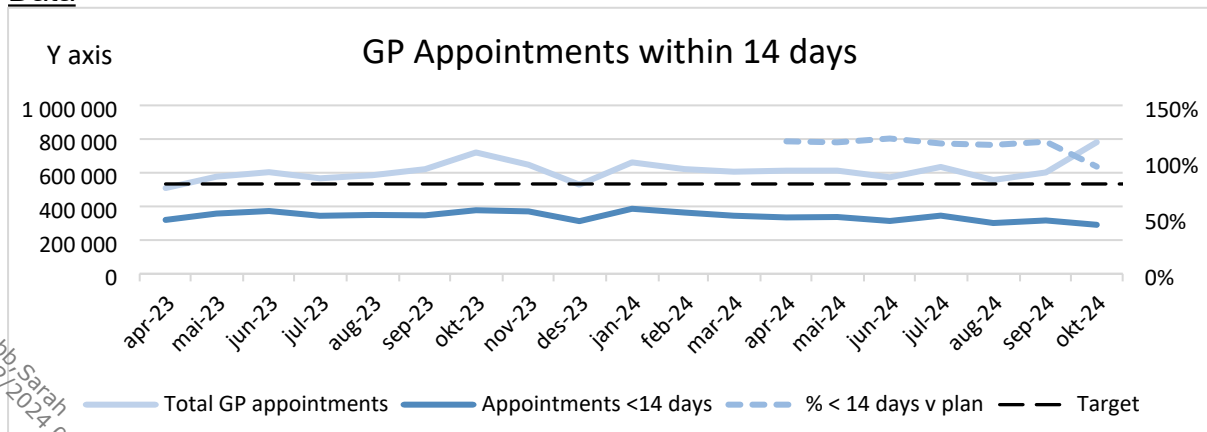
- The number of appointments delivered.
- The healthcare professional involved.
- The mode of delivery, such as face-to-face or telephone
- The time between the booking and appointment

As with most data, it is reliant on coding which in this instance is undertaken at practice level.

GPAD is intended to support both the accuracy, and collective understanding, of general practice appointment data to usefully inform the development of sustainable and resilient models for general practice, aligned to the overarching objective of better matching capacity with need, as shown in the Modern General Practice visual below.



Data



Graph 1: Total of planned & actual number of GP Appointments (including those seen within 14 days) April 2023 – March 2025

Graph 1 above shows the NHS Target as 80% of appointments within two weeks.

- On the y axis is the number of appointments
- Light blue, solid line is total appointments for the month.
- Dark blue, solid line is appointments seen within 14 days.
- On the secondary Y axis (on the right of the chart) is the percentage
- Black dashed line is the target of 80% (to see 80% of people within 14 days)
- Blue dashed line is the percentage of appointments seen with 14 days compared to what was planned.

According to the graph, from April 2024 to September 2024, we were working at over 100% of what we had planned to see within 14 days. In October 2024, we saw a dip to below 100% (95%). Even though we need to take into consideration the seasonal variation inline with the vaccine programme, we are still seeing increase in GP appointments.

According to Graph 1 above, GP appointments have largely remained steady other than seasonal increases (vaccination campaigns) or dips in activity (Christmas etc). N&W practices have reported a gradual decrease though in appointments booked within 14 days since the February 2024. Further analysis into this is planned in order to identify any trends or key areas that need support.

Appointments seen in two weeks.

- There have been 511,036 (65.39%) in October 2024. In October 2023 there were 492,138 (68.31%) this is an extra 18 thousand appointments overall in Norfolk and Waveney ICB.
- Great Yarmouth total 112,043 (66.91%)
- North Norfolk 79,934 (63.52%)
- Norwich 106,897 (65.19%)
- South Norfolk 109,686 (64.78%)
- West Norfolk 102,476 (66.18%)

The average for East of England is 85% and we are sitting at 68.31%.

While practices in N&W have a lower % of appointments within 14 days, this is most likely linked to the fact that N&W have a higher number of face-to-face appointments compared to the England average.

Moving to an increase in appointments being booked within 14 days will most likely happen as practices move to delivering more appointment remotely, increasing the ways patients can book appointments and reviewing patient triaging models.

Primary Care Commissioning team are working with the Clinical Systems Team to support General Practice in implementing the four key functionalities for the NHS App which GPs are contractually required to provide; the ability for patients to request repeat prescriptions, access their prospective health record, book directly online for regular routine appointments that do not require prior assessment and to receive secure messages from their GP Practice. Increased focus is now on GPs to ensure that they start providing patients with the ability to book routine appointments (such as cervical screening & phlebotomy) via the NHS App. There is significant

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variation across practices in N&W, with many practices not offering any appointments via the NHS App. Supporting practices to include more routine appointments on the NHS App should increase access, free up capacity for those contacting the practice via phone, and therefore have an effect on the appointments booked within 14 days. We are also aware that NHSE will start sending reminders to patients via the NHS App to encourage them to book their cervical screening on the app from Spring 2025².

Next steps

- Further review NHS APP data to identify practice sign up and activity in line with NHS England’s future plan to send out reminders for cervical screening and phlebotomy appointments via the App.
- Investigate if there is any correlation with practices/PCNs who have undertaken the GPIIP programme and those who have seen an increase in their percentage or who are achieving a higher percentage.
- Explore if there is any correlation with practices who are disproportionately funded under the car hill formula because of their IMD and who are achieving a low %
- Continue to develop our data base to explore and identify our strengths and weaknesses.

Recommendation to the Board:

Note the report and provide a steer on any items for inclusion in future updates or areas within this report which require further detail or analysis to support assurance against delivery.

Key Risks	
Clinical and Quality:	Review and triangulation of data will support the ICB identify and work with providers and communities to improve outcomes
Finance and Performance:	Delivery reports form part of our internal audit processes
Impact Assessment (environmental and equalities):	Collective, in-depth, understanding of data will support planning to
Reputation:	Operational planning guidance requirements
Legal:	None identified
Information Governance:	¹ NHS England » NHS ‘ping and book’ screening to help save thousands of women’s lives
Resource Required:	Primary Care and Business Intelligence teams
Reference document(s):	Operational Planning Guidance

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NHS Constitution:	N/A
Conflicts of Interest:	None identified
Reference to relevant risk on the Board Assurance Framework	The combined BAF for resilience and transformation of primary care is 20

Governance

Process/Committee approval with date(s) (as appropriate)	N/A
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Practices with Booking to Appointment under 14 days sorted by Place

Month Year Place	July 2024		August 2024		September 2024	
	Appts	%	Appts	%	Appts	%
Great Yarmouth and Waveney	102,948	75.74%	91,428	75.10%	95,912	73.29%
North Norfolk	77,576	72.28%	67,174	70.67%	69,542	66.89%
Norwich	97,187	72.00%	82,815	71.76%	90,453	71.99%
South Norfolk	99,509	73.40%	86,755	72.73%	91,370	72.37%
West Norfolk	90,613	75.15%	79,212	75.17%	85,842	74.60%

Practices with Booking to Appointment under 14 days

Month Year PCN	July 2024		August 2024		September 2024	
	Appts	%	Appts	%	Appts	%
Breckland Surgeries PCN	19,071	83.70%	16,181	79.85%	16,034	76.77%
Central Norwich PCN	21,611	65.99%	18,656	66.04%	21,107	68.76%
Fens & Brecks PCN	19,017	78.09%	16,919	77.16%	17,661	74.23%
Gorleston PCN	17,247	77.20%	15,917	76.99%	16,230	73.74%
Great Yarmouth & Northern Villages PCN	28,756	78.72%	26,033	78.13%	26,355	75.27%
Ketts Oak PCN	23,541	66.38%	20,188	65.81%	21,378	65.68%
Kings Lynn PCN	29,397	66.78%	25,024	67.03%	28,992	69.02%
Lowestoft PCN	30,319	72.94%	26,234	71.27%	28,255	71.14%
Mid Norfolk PCN	19,429	71.56%	17,950	73.22%	19,809	76.79%
North Norfolk 1 PCN	19,247	76.81%	17,047	75.84%	17,338	72.18%
North Norfolk 2 PCN	16,766	65.73%	13,736	61.47%	14,774	59.76%

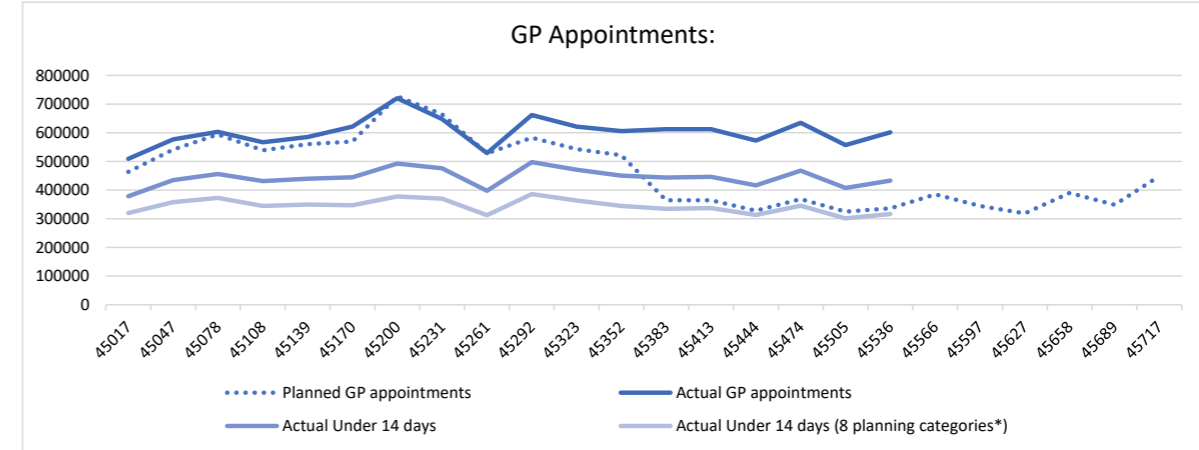
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ICS Level		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Appointments in General Practice	Planned GP appointments	463,247	540,941	593,941	538,662	560,449	569,374	727,009	664,364	528,167	582,624	542,769	521,262
	Actual GP appointments	509,078	576,664	603,428	566,831	585,417	621,195	720,454	647,506	529,072	661,513	621,569	606,104
	Actual Under 14 days	378,440	434,650	456,479	431,416	439,728	444,485	492,138	475,611	397,414	497,580	470,746	450,346
	Actual Under 14 days (8 planning categories*)	319,842	357,477	372,719	344,365	349,366	346,981	377,346	370,414	312,495	386,043	363,548	344,717

ICS Level		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Appointments in General Practice	Planned number of General Practice appointments	364,620	364,627	327,993	368,471	324,910	336,572	384,893	344,485	318,745	389,903	348,678	448,379
	Actual number of General Practice appointments	612,444	612,601	572,887	634,392	556,870	601,807						
	Actual Under 14 days	443,932	446,298	416,496	467,833	407,384	433,119						
	Planned Under 14 days	283,674	287,873	260,264	297,506	262,533	269,227	304,651	274,034	259,078	316,072	286,156	355,467
	Actual Under 14 days (8 planning categories*)	334,631	337,101	313,563	345,303	301,349	316,700						

Denominator: Number of appointments delivered by the general practice under eight national appointment categories

- General Consultation Acute
- General Consultation Routine
- Unplanned Clinical Activity
- Clinical Triage
- Walk-in
- Home Visit
- Care Home Visit
- Care Related Encounter but does not fit into any other category.





Improving lives **together**

Norfolk and Waveney Integrated Care System

2024/25 Primary Care Commissioning Committee Finance Report Norfolk & Waveney ICB

December 2024

Primary Care Commissioning Committee 12th December 2024

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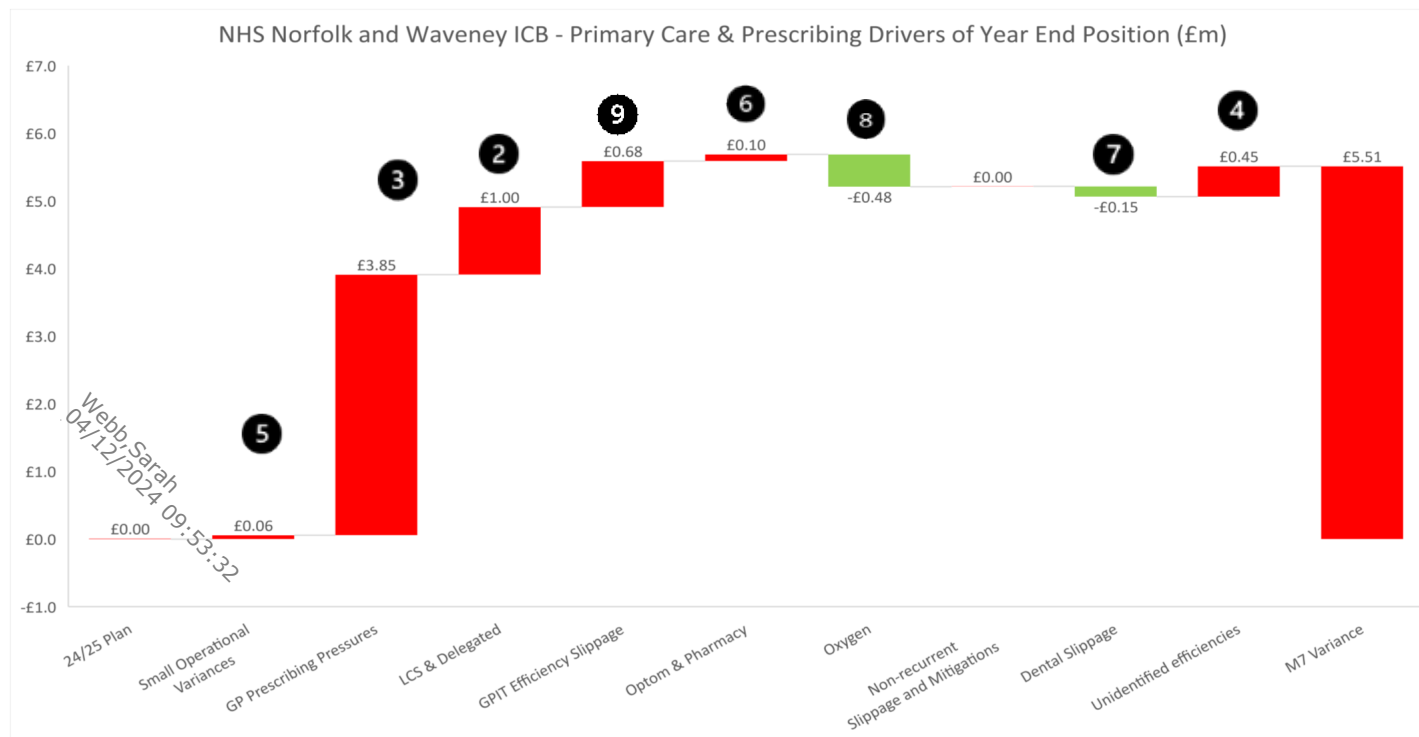
1.0 Executive summary – Reporting

Reported Financial Position: As of October 2024 (M7), the Primary Care & Prescribing reported position is £5.5 m overspent.

	Annual Budget	Budget	Actual	Variance	Forecast	FOT Variance
	£m	£m	£m	£m	£m	£m
Reported	580.9	334.9	335.8	0.8	586.4	5.5

Variations:

The key operational variations are shown below: ①



The GP & Prescribing position is a £5.5m overspend noting the following variances.

- This balance includes both cost and accrued income for the Additional Role Reimbursement Scheme (£1m) due to NHSE retaining 20% of the fair share allocation for this scheme until later in the year. The Locally Commissioned Services are £0.3m overspent due to PY Complex Dressings costs being higher than anticipated and in year pressures for the same area. The remaining £0.7m relates to Delegated Rent costs due to higher revaluations of GP estate. ②
- Unidentified Efficiencies in GP Prescribing is the reason for the overspend. The original stretch target was circa £4m which has been reducing due to DOAC switch benefits. ③
- Unidentified Efficiencies in Primary Care has led to overspend. ④
- Small operational variance in other primary care. ⑤
- Increased Optom activity visits and eye tests. ⑥
- Dental contract hand back and activity change ⑦
- Backdated Home Oxygen VAT reclaim (4 years due to change in VAT rules) ⑧
- MLL Data line increased costs, and delay in efficiencies in GPIT contract moving to new provider. ⑨

Managing In-Year Risks:

Efficiencies

The 24/25 plan required an ambitious efficiency target in order to balance the financial position at both ICB and ICS level which led to an Efficiency target of 6.25%. Whilst many schemes are still being worked, this gap is shown in ICB finance and also declared in the Financial Risk register.

2. Primary Care and Prescribing reporting M7

Sub-Directorate (£m)	Full Year Variance (underspend) / overspend	Variance – significant items
GP Prescribing Budget £202	£3.86 1.9%	The adverse variance of £3.86m is due to Unidentified Efficiencies £4.2m mitigated by Prior Year benefit crystallised and over delivery of identified efficiencies eg Apixaban
Other Prescribing costs Budget £19	£(0.43) -2.3%	Back dated VAT reclaim on Home Oxygen contract
Delegated Primary Care Budget £233	£0.70 0.3%	Additional Roles Reimbursement Scheme(AARRS) Forecast Outturn is shown as per NHSE Guidelines £1m and allocation to follow in Month 11. Balance £0.7m cost pressure is due to rent reviews.
Local Enhanced Services(LES) Budget £12	£0.30 2.5%	Prior Year actuals came in higher than estimate in Treatment Rooms (Complex Dressings) and Phlebotomy and also some in year adverse variance for the same areas
Other Primary Care Budget £14	£0.68 5.0%	Cost Pressures due to termination of MLL contract and deferral of GPIT contract efficiency beyond 24/25
Dental Budget £67	£(0.15) -0.2%	Slight underspend
Optom Budget £11	£0.10 0.9%	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 £23	£(0.00) 0.0%	Reported on Plan
Unidentified efficiencies Budget £0	£0.45 -100.0%	Efficiencies still being worked on
Total	£581	£5.51

3. ICB Financial Position M7

Directorate Full Year Budget (£m)	M07 Full year Variance (underspend) / overspend	Variance – significant items
Acute Budget £1,311	£14.11 1.1%	Unidentified Efficiency = £5m adverse Balance is due to an increase in Independent Sector Provider activity where additional ERF funding is included within 'Other' below.
Spec Comm Budget £195	£0.00 0.0%	On plan
Community and Better Care Fund (BCF) Budget £263	£3.85 1.5%	Unidentified Efficiency = £2.6m adverse Balance operational overspend
Continuing Healthcare Budget £164	£0.46 0.3%	Overspend in Agency nurses
Mental Health MHIS Budget £199	£(0.59) -0.3%	Underspend due to recruitment slippage.
Mental Health Non MHIS Budget £80	£0.00 0.0%	On plan
Prescribing Budget £220	£3.43 1.6%	Unidentified Efficiency = £4.2m adverse Mitigated in part by increased 23/24 DOAC income than estimate-prior year benefits and overperformance in indentified efficiencies
Primary Care Budget £361	£3.08 0.9%	Unidentified Efficiency = £0.4m adverse Overspend in Community Ophthalmology (£0.2m) and rent and rate review (£0.7m). NHSE approach to for ARRS (offsetting variance of £1m in 'Other') and £0.7m MLL contract.
Other - Combined areas Budget £23	£(0.51) -2.2%	Identified efficiencies over achievement , offset by increased property costs and bad debt
Planning Budget -£61	£(23.06) 37.6%	Planning / contractual negotiation benefits (£4.0m) and Prior Year benefits crystalised (£2m), Extra ERF for ISP (£8.7m) & offsetting ARRS credit (£1m)
Running Costs Budget £18	£(0.77) -4.4%	favourable provision release for reorganisation costs and over achievement of vacancy factor
Total £2,774	£0.00	

4.0 Prescribing Efficiencies M7

Prescribing Efficiencies Top 10 by value Budget (£000's)		Actual (£000's)	Var (£000's) Fav (Adv)	Variance – significant items
OptimiseRx			£249	
Budget	£2,400	£2,649	10.4%	Increased savings than plan as more surgeries use Optimise Rx
DT Windfall(Apixaban savings)			£400	
Budget	£2,310	£2,710	17.3%	Increased savings than plan as more patients prescribed Apixaban.
BOC VAT Rebate			£348	
Budget	£867	£1,215	40.1%	Increased savings than plan due to additional VAT recovery due
Low Risk, cost effective switching programme			£0	
Budget	£600	£600	0.0%	On Plan.
New Rebate opportunities			£(250)	
Budget	£600	£350	-41.7%	Savings lower than expected
Rivaroxaban windfall			£965	
Budget	£600	£1,565	160.8%	Increased savings than plan as more patients patients prescribed Rivoraxaban
Low Priority Prescribing			£353	
Budget	£500	£853	70.6%	Increased savings than plan
Fostair Rebates			£108	
Budget	£475	£583	22.7%	Increased savings than plan
Greener/lower cost inhalers (supported by PQS/rebates) - 5%			£(57)	
Budget	£394	£337	-14.5%	Marginally under plan
Opioid costs (supported by PQS/rebates) - 10%			£(143)	
Budget	£360	£217	-39.7%	Under plan mainly due to elective surgery waiting times
Other Efficiencies			£(164)	
Budget	£1,630	£1,466	-10.1%	On Plan.
Sub-Total	£10,736	£12,545	£1,973	
Unidentified Savings			£(4,223.00)	
Budget	£4,223	£0	-100.0%	Gap still being worked out
Grand Total	£14,959	£12,545	£(2,414)	Net under delivery against plan

5.0 LES Activity Tracker

Norfolk and Waveney ICB Locally Commissioned Services Activity Tracker

Locally Commissioned Service
Care Homes
Diabetes
Eating Disorders
Inclusion Health
Mental Health SMI Health Checks
Phlebotomy
Proactive Healthcare
PSA
Shared Care
Spirometry
Treatment Room
Warfarin

Qtr 1 Budget (£)	Qtr 1 Claimed (£)	Utilisation %
90,462	79,476	88%
178,669	176,472	99%
87,313	50,091	57%
164,826	96,879	59%
117,166	61,002	52%
1,294,017	1,480,520	114%
1,045,058	1,039,809	99%
85,396	113,122	132%
346,131	352,090	102%
148,190	109,703	74%
577,188	534,040	93%
252,714	172,509	68%
	-	
4,387,131	4,265,714	97%

Comment

19 practices still to claim
 6 practices did not claim in Qtr 1
 11 practices did not claim in Qtr 1
 12 practices did not claim in Qtr 1
 14 practices claimed more than 30% above their Qtr 1 budget
 32 practices claimed more than 30% above their Qtr 1 budget
 1 practice did not claim in Qtr 1
 All practices have claimed, mainly under budget.
 Qtr 1 window closed 31 Jul (14th Aug for some schemes as problems with Ardens searches)

Locally Commissioned Service
Care Homes
Diabetes
Eating Disorders
Inclusion Health
Mental Health SMI Health Checks
Phlebotomy
Proactive Healthcare
PSA
Shared Care
Spirometry
Treatment Room
Warfarin

Qtr 2 Budget (£)	Qtr 2 Claimed (£)	Utilisation %
85,998	75,275	88%
93,530	157,972	169%
56,947	43,456	76%
99,262	90,208	91%
55,136	70,273	127%
1,045,058	1,476,096	141%
1,289,025	1,039,809	81%
74,272	100,188	135%
346,131	351,531	102%
78,026	97,096	124%
535,836	537,352	100%
153,855	130,962	85%
	-	
3,913,076	4,170,218	107%

Comment

- Quarter 1 window closed on the 31st July (14th Aug for some schemes as problems with Ardens searches). Claims all processed for payment in August for all schemes.
- Quarter 2 window closed on the 31st October and the finance team are still assessing any underclaims

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Appendix A – Detailed Financial Position

Norfolk and Waveney ICB	
Service Line	Description
Prescribing	Central Drugs
	Gp Prescribing
	Medicines Management - Clinical
	Other Prescribing
	Oxygen
	Prescribing Incentives
Prescribing Total	
Primary Care	Gp Forward View
	Local Enhanced Services
	Other Primary Care
	PMS to GMS Transition
	Primary Care Delegated Co-Commissioning
	Primary Care IT
	DOP Delegated pay
	Ophthalmology Services
	Community Pharmacy
	Community Dental
	Primary Dental Services
	Secondary (Acute) Dental
	Unidentified efficiencies
ARRS allocation due	
Primary Care Total	
Prescribing & Primary Care Total	

N&W ICB Annual Budget	N&W ICB Position at Month 7 £000s			N&W ICB Forecast £000s	
	Budget	Actual	Variance	Forecast	FOT Variance
5,690,725	3,319,589	3,302,150	(17,439)	5,690,689	(36)
201,533,123	117,447,580	118,904,582	1,457,002	205,394,614	3,861,491
3,801,729	2,155,348	2,151,838	(3,510)	3,792,651	(9,078)
5,943,898	3,467,275	3,426,764	(40,511)	6,000,880	56,982
1,810,788	1,056,286	707,440	(348,846)	1,332,071	(478,717)
1,291,118	753,151	753,151	0	1,291,118	0
220,071,381	128,199,229	129,245,925	1,046,696	223,502,023	3,430,642
1,901,713	877,471	877,478	7	1,901,720	7
12,184,733	7,230,263	7,410,033	179,770	12,483,815	299,082
3,985,458	2,077,941	2,013,527	(64,414)	3,989,378	3,920
233,231,382	132,979,196	132,709,508	(269,688)	234,930,573	1,699,191
7,858,702	3,969,625	4,101,681	132,055	8,539,185	680,483
541,638	292,259	252,050	(40,209)	528,898	(12,739)
11,230,489	6,551,119	6,610,512	59,393	11,330,489	100,000
23,498,198	14,010,445	14,010,444	(1)	23,498,196	(1)
3,470,928	2,024,708	2,024,707	(1)	3,470,927	(1)
48,560,007	28,324,337	27,841,137	(483,200)	48,422,340	(137,667)
14,845,014	8,659,594	8,659,594	0	14,845,014	0
(449,712)	(262,332)	0	262,332	0	449,712
				(1,000,000)	(1,000,000)
360,858,550	206,734,626	206,510,671	(223,956)	362,940,535	2,081,987
580,929,931	334,933,855	335,756,596	822,740	586,442,558	5,512,629

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Agenda item: 14

Subject:	Primary Care Commissioning Committee – Terms of Reference
Presented by:	Fiona Theadom, Head of Primary Care Commissioning (Dental and GP)
Prepared by:	Fiona Theadom, Head of Primary Care Commissioning (Dental and GP)
Submitted to:	Primary Care Commissioning Committee
Date:	10 December 2024

Purpose of paper:

To inform the Primary Care Commissioning Committee of proposed changes to meeting schedules in 2025/2026 and to clarify roles and responsibilities.

Executive Summary:

In March 2024, the Board approved amendments to the Primary Care Commissioning Committee’s (PCCC) Terms of Reference and those of the General Practice and Community Pharmacy Delivery Group and Dental Services Delivery Group (“Delivery Groups”).

The meeting schedule for PCCC was adjusted to quarterly meetings with a focus on responsibility for primary care strategy and quality matters and oversight of the ICB’s responsibilities under the Delegation Agreement with NHS England. Delivery Group meetings have been held in the months when PCCC does not meet.

This paper sets out proposed changes to the schedule of meetings from April 2025 for PCCC and the Delivery Groups. It also clarifies the understanding of the responsibilities of Voting Members and their nominated deputies to ensure decisions can be made.

No amendments to the Terms of Reference are required to be approved by the Board to enact these changes.

Report

In March 2024, the Board approved amendments to the Primary Care Commissioning Committee’s (PCCC) Terms of Reference and those of the General

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Practice and Community Pharmacy Delivery Group and Dental Services Delivery Group (“Delivery Groups”).

PCCC is responsible to the Board for ensuring that the ICB’s responsibilities for primary care commissioning functions are discharged in accordance with section 13Z of the NHS Act and in line with the Delegation Agreement with NHS England, including oversight of primary care quality matters. The Committee is also responsible for delivery and oversight of the primary care strategic framework.

In April 2025, PCCC meetings were adjusted to meet quarterly with the intention of allowing PCCC to take a more strategic role and oversight of the ICB’s primary care functions supported by delegating its authority for operational matters to the Delivery Groups meeting in the months PCCC does not meet.

Proposed Amendment to meeting schedule

The ICB has recently reviewed the operational effectiveness of this arrangement and is proposing changes to the meeting schedule from April 2025 that will mean that PCCC and Delivery Group meetings will alternate months, thereby increasing the number of PCCC meetings to six per year. Each Delivery Group will also meet six times per year. This may result in PCCC considering some operational items where decisions are required to be made to ensure timely decision making.

Proposed Training Sessions for members

Voting members of both PCCC and each of the Delivery Groups are asked to nominate named deputies who have the authority to make decisions on behalf of the Voting Member and in line with the ICB’s Delegated Financial Limits. The effectiveness of this structure and how decisions are being made together with attendance has been reviewed over the past eight months particularly in relation to Delivery Groups.

The deputising Voting Member can make decisions on behalf of the Voting Member to enable effective and timely decision making. To raise awareness and understanding of the roles and responsibilities of those attending, the ICB is planning to run briefing sessions for all PCCC and Delivery Group members.

Due to the increasing complexity of managing potential or perceived conflicts of interest, the sessions will also raise awareness about how these can be managed.

Forward Planning

Updated ICB governance processes around project management oversight, prioritisation of work programmes and investment have been established this year across the ICB. The Primary Care team is embedding them within the directorate processes. Not only will this strengthen governance, project management planning will help the directorate to manage its limited resources, it will also support robust forward planning of agendas for PCCC and Delivery Groups. Increasingly strategic reports linked to the Board Assurance Framework risk to primary care resilience and

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transformation will cover all primary care services in a single report, thereby reducing the need for multiple reports on the same subject area.

It should be noted that the nature of primary care commissioning and contracting regularly means unplanned decisions need to be made quickly and the agendas will need to be able to accommodate these.

Recommendation to the Committee:

To approve the recommended changes to the meeting schedule for PCCC and the Delivery Groups from April 2025 and to note the clarification on the roles and responsibilities of Voting Members.

Key Risks	
Clinical and Quality:	Effective management of PCCC and Delivery Group meetings will ensure matters relating to quality and clinical matters can be addressed in the proper manner
Finance and Performance:	Effective management of PCCC and Delivery Group meetings will ensure financial matters are reported and where appropriate, issues addressed in the proper manner
Impact Assessment (environmental and equalities):	N/A
Reputation:	Effective management of PCCC and Delivery Group meetings will ensure efficient decision making and management of risk relating to primary care matters are handled appropriately and ICB's reputation is maintained
Legal:	Not applicable
Information Governance:	Not applicable
Resource Required:	Primary Care directorate, PCCC and Delivery Group members and attendees
Reference document(s):	Delegation Agreement with NHS England
NHS Constitution:	N/A
Conflicts of Interest:	None identified
Reference to relevant risk on the Board Assurance Framework	N/A

Governance

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Process/Committee approval with date(s) (as appropriate)	
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Agenda item: 15

Subject:	Medicines Optimisation 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:	10 December 2024

Purpose of paper:

For information and discussion of strategic approach to medicines optimisation and to highlight some successes and challenges of implementing activity across a system

Executive Summary:

Our strategic priorities are highlighted and discussion on implementation is welcomed. This time I will focus on implementation of the green agenda with respect to medicines and the important work to reduce the risks associated with valproate prescribing

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 have now formed our medicines optimisation pillars and will be developing our pillar focus and strategy. Key work from our pillars is highlighted below.
- 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

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- Best value biologics in line with NHSE commissioning recommendations
- Improving valproate safety – see below
- Switching IV antibiotics to oral (hospital in-patients)

In addition to the above we also have an ICS zero carbon delivery group and we, the medicines teamwork with partners to monitor the carbon footprint of key medicines and have helped develop long term plans to reduce this. The [NHS long term plan](#) (page 120) sets out the milestones for improvement. carbon footprint alternatives where clinically appropriate and reducing inhaler waste and recycling schemes where they exist.

2. MO Pillar highlight report – Quality and Safety

Within the past 12 months there has been two Patient Safety Alerts relating to teratogenic medicines; valproate and topiramate. Both alerts were as a result of evidence highlighting the known possible risks of physical birth defects and neurodevelopmental delays to the mother’s unborn child if taken during pregnancy. Both alerts stipulate females of childbearing potential should only be prescribed these drugs if a Pregnancy Prevention Programme (PPP) is adhered to. Valproate referrals to secondary care are now live.

A valproate prescribing guidance document was produced and formulary status of valproate was reviewed to align to the changes in the alert. This policy is currently under review to reflect the requirements of the topiramate alert and also a second valproate alert relating to males. In October GP surgeries were tasked with auditing female topiramate patients so we can understand how many patients may require referral to secondary care. This data collection and analysis is ongoing.

NHS System Oversight Framework (SOF) Antimicrobial Prescribing Metrics for 2024-25 remained the same as 2023-24. The antibiotic volumes target is 0.871 or less antibacterial items per STAR-PU. The national target for percentage of broad-spectrum antibiotic prescriptions as a total of overall antimicrobial prescriptions is at or below 10%. Norfolk and Waveney ICBs overall antimicrobial prescribing is at a consistent level above the second volume target of 0.965 with a value of 1.041 antibacterial items per STAR-PU in the 12 months to September 2024. Norfolk and Waveney ICB are now following a downward trajectory for broad spectrum prescribing remaining below the national target of no more than 10% of all antibiotics at 9.83% in the 12 months to September 2024.

NHS England introduced a new antimicrobial metric in September 2023, reducing amoxicillin 500mg three times a day from a 7-day to a 5-day duration. This will deliver a 29% reduction in Defined Daily Doses (DDD). The NHS England target is 75% of all prescriptions prescribing amoxicillin 500mg caps should be for a 5-day duration. The current achievement for Norfolk and Waveney in September 2024 is 56.98% (22.82% increase since the target was introduced in October

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2023). The Medicines Optimisation team are working with our outlier practices to drive improvement in Antimicrobial Stewardship

3. MO Pillar highlight report – Clinical Experience and Delivery

The prescribing of unlicensed medicines has reduced significantly across the Norfolk and Waveney footprint over the last 12 months. The prescribing of licensed alternatives promotes better patient safety, outcomes, and value. The medicines optimisation team's work has resulted in a significantly improved benchmark within East of England, due to a reduction in the total number of items prescribed (35%) and the overall prescribing spend (15%).

The team continues to engage and work with healthcare professionals aligned with GP Practices and Primary Care Networks teams, especially those with costs above the average weighted cost of a prescription. Currently, a handful of GP practices in West Norfolk are no longer using Optimise Rx, an integrated patient care system that promotes the delivery of value-based prescribing. This issue was highlighted at the recent medicines optimisation programme board meeting chaired by Dr Frankie Swords and there is now a plan in place to work with primary care leads.

A recent evaluation of the Appliance Management service showed an improved 1% reduction in growth, when benchmarked against GP Practices across Norfolk & Waveney not aligned to service and the England average. The financial recovery board has approved an extension of the service, with a funding of £60k.

4. MO Pillar highlight report – Interface and Formulary

The pillar work collaboratively with ICB colleagues, N&W system partners and neighbouring Associate Commissioners. I&F continue to develop guidance and pathways with the Acute Trusts, aiming for a do it once approach across the system. There is a focus on achieving best value from the use of medicines, including excluded from tariff High-Cost Drugs.

NHS England - National medicines optimisation opportunities 2024/25, opportunity 6, Using best value biologic medicines has been a priority. N&W use of ranibizumab biosimilar has been consistently above the England average for the past 15 months and released substantial system savings during 2023/24 with further savings made in 2024/25. Ustekinumab biosimilars became available on 1st Sept 2024. New patient initiations, existing patient review and active switching is already underway for clinically appropriate patients, with system savings expected to be at least 50% of current spend. These two biosimilar switches are the largest proportion of the £2.2m identified deliverable efficiencies for N&W in 2024/25.

Netformulary is built and managed in collaboration with our system partners. I&F team are currently working with NSFT colleagues to populate Mental Health

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Chapter 4; ensuring all previously agreed TAG decisions are clearly documented. Net formulary and Knowledge NoW continue to be a valuable resource to Health Care professionals.

A localised System One formulary has been built and embedded in a few GP practice systems. After a successful pilot, this will be offered to all GP practices across N&W. Supplying a System One formulary and managing prescribing support software, OptimiseRx, supports adherence to the local formulary, cost effective prescribing and improves the safety of prescribing. Our local platform has contributed to £153k efficiency savings to date for 2024/25.

5. MO Pillar highlight report – Population Health and Data

The team now has access to detailed data through the data team which has been used to support other pillars work and to identify the patient numbers likely to be in each cohort for the expected NICE TA for Tirzepatide for weight loss, anticipated Jan 2025. This has been shared with commissioning.

There have been a number of meetings with secondary care contracts teams regarding HCL (Hybrid Closed Loop) to explain the finances with NHS E providing 25% of average funding for new pump patients. This has changed from 25% of differential funding. The remainder, from the ICB, is made up of the CGM (Continuous Glucose Monitoring) component.

Data has been shared with finance and will be updated monthly. There is now agreement that the CGM monies will be transferred to trusts which will enable savings to be made on the procurement of the systems according to the prices agreed by NHS supply chain.

Data to support the PQS has been updated to provide practices with information on their distance from target.

The Flu and Covid vaccinations are going well. N&W have administered the most Covid vaccines in the East of England with two thirds of patients getting this co-administered with flu vaccines.

We have signed a further 3 rebates. The Q1 total income from rebates was £1,251,058.

6. MO Pillar highlight report – Workforce and Projects

6.1 Workforce

Community Pharmacy Workforce Data - Key findings include growth in pharmacist headcount since 2021 but a reduction in FTE. There has also been an 11% decrease in pharmacy technicians, alongside changing of employment status from permanent to locum pharmacists. Legislative changes are supporting role expansion for pharmacy technicians, who can now perform more clinical

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services, such as vaccinations and certain health checks, potentially enhancing career attractiveness. Workforce challenges continue to impact on pharmacy workforce wellbeing, and access for patients to services due to temporary closures.

Foundation Trainee Placements 2025/26 – changes to the training requirements for this year include the need for Trainee Pharmacists to complete prescribing competencies. 19 placements are currently listed on the national ORIEL selection tool, and the final numbers for inclusion within Norfolk and Waveney in 25/26 should be known shortly.

Pre-registration Pharmacy Technicians – 6 out of 15 available commissioned places have been allocated funding for salary support to train a student. The six students are either in Year 1 or Year 2 of their course. A national scheme has recently run for community pharmacy to train pharmacy technicians, but it is unknown whether any places have been allocated within Norfolk and Waveney.

Pharmacy Careers – two events have been attended by the team to highlight available careers options in Pharmacy.

6.2 Projects

Repeat Prescribing and Support – the RPS / RCGP Repeat Prescribing Toolkit has now been launched. The team are working to amend the audit which is intended to be completed as a multi-disciplinary audit to identify issues and improvement actions in repeat prescribing systems.

The team are also working in practices to identify interventions to improve repeat medication safety and costs. A number of practices have expressed interest in the use of electronic Repeat Dispensing and plans are in place to support this work in the new year.

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

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Impact Assessment (environmental and equalities):	Not applicable
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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Memorandum of Understanding (MOU) for the Hosting Arrangement of Community Pharmacy and Optometry

Section one: MOU terms and conditions

1. Purpose of the MOU

From 1st April 2023, NHS England delegated responsibility for the contractual management of community Pharmacy and Optometry (P&O) to Integrated Care Boards (ICBs). As part of this transition, the teams that were responsible for this area of work also transferred to ICBs. As a relatively small team, the ICBs across the East of England agreed that, rather than assign part of individuals time to each ICB, the team would continue to work as one, hosted by one ICB. Hertfordshire and West Essex ICB (HWE ICB) agreed to host the team that fulfils this function, and this MOU sets out how the responsibilities are split between the host ICB, the other ICBs and the interdependent functions that have been retained by NHS England and how they will work together to provide an effective hosted contract management function.

2. Legal Basis of this MOU

It is acknowledged that this MoU is not a legally binding agreement, and it does not change the statutory roles and responsibilities or functions of either Party. NHS England will continue to exercise its statutory powers where necessary to address organisational issues and support system delivery in line with the principles set out in this document. The accountabilities of individual NHS organisations also remain unchanged.

3. Parties to the MOU

The following organisations are party to this agreement and will confirm its application through appropriate internal governance mechanisms:

- NHS Herts and West Essex (HWE) Integrated Care Board (ICB) – the host
- NHS Bedfordshire, Luton and Milton Keynes (BLMK) ICB
- NHS Cambridgeshire and Peterborough (C&P) ICB
- NHS Mid and South Essex (MSE) ICB
- NHS Norfolk and Waveney (N&W) ICB
- NHS Suffolk and North East Essex (SNEE) ICB

NHS England, whilst not a party to this MOU remain a key partner through their retained responsibilities as set out in section 7.

Signatures for each party can be found at Appendix 1 to this document.

4. Core principles

This MOU has been drafted around the following core principles:

- The national Delegation Agreement is the primary agreement and the primary point of definition of the responsibilities of organisations in relation to this function. This MOU sets out how the ICBs in the East of England will fulfil the responsibilities and is not designed to replace the requirements set out in the national Delegation Agreement.
- Whilst HWE ICB is hosting the P&O Contracting Team, all ICBs signing up to this agreement have equal responsibility for ensuring the effective commissioning of P&O services which meets the needs of their local population.

5. Responsibilities of the host ICB

HWE ICB as host ICB will be responsible for the employment and day to day management of the P&O Contracting Team. HWE will ensure a single point of entry to the P&O Contracting Team, and provide management oversight to enable planning, prioritisation and communication.

More details on the responsibilities of the P&O Contracting Team are included within the Standard Operating Procedure (SOP).

6. Responsibilities of each ICB

This MOU supports the national requirements as set out in the Delegation Agreement and each ICB will be responsible for compliance with the requirements as set out in it. Each ICB will identify a lead to work with the P&O Contracting Team to act as point of contact for local issues and represent the ICB at key meetings. In addition, the specific points below are noted:

a. Financial management

Each ICB will receive their agreed delegated funds direct from NHSE and will retain financial responsibility for the management, monitoring and payment process relating to these. This includes compliance with their ICB's financial requirements, processes and systems and audit requirements. HWE ICB is not responsible for any overspends or cost pressures relating to these services.

b. Oversight

Each ICB will ensure that there is adequate oversight and monitoring of the commissioning and contracting of the performance of P&O contracts through their local Primary Care Commissioning Committee or relevant ICB Assurance Committees. Where contractual issues are identified by individual ICBs, this will be raised with the P&O Contracting Team for addressing through contractual routes. ICBs will be informed of any outcome.

c. Commissioning, transformation, and innovation

Each ICB is responsible for the commissioning of and transformation and innovation relating to local pharmacy and optometry. Where services are locally commissioned in addition to the core specification, the monitoring of performance and payment in relation to this will be the responsibility of the local ICB.

d. Controlled drugs

The current arrangement for controlled drugs continues to apply in line with the policy and procedure of the individual ICB and responsibilities set out by the Controlled Drugs Accountable Officer / Function. The ICB will continue to link with the regional Controlled Drugs Accountable Officer on matters of assurance. Contractual issues arising out of controlled drugs issues will be managed by the P&O team via the Pharmaceutical Services Regulation Committee (PSRC).

e. Data Protection and Information Governance

Data Protection and Information Governance will be the responsibility of each ICB and will provide information and advice to the P&O function as required in relation

to their data and processes. HWE ICB is not responsible for specialist advice to the team in relation to these matters.

f. Quality

The responsibilities around quality stays 'as is', with the P&O Contracting Team signposting of contractors as required to the ICB nominated contact who can signpost onwards to the relevant team e.g. safeguarding team, complaints team, quality team etc.

g. Locally Commissioned Services

Locally Commissioned Services are the responsibility of each ICB. Liaison with the relevant local professional committee will sit with the respective ICB. The P&O Contracting Team will work with the ICB to share any relevant intelligence on contractors from which new services will be commissioned.

h. Commissioning responsibilities in relation to Fitness matters

On occasion Fitness decisions may be appealed to the First-Tier Tribunal (FTT). The relevant ICB will be the named respondent on the case. The named ICB will have financial and legal responsibility in cases that are subject to appeal at FTT and will be required to attend meetings. The named ICB will be the decision maker as FTT sits outside the remit of PSRC. The process will be supported by a member of the P&O Contracting Team.

7. Responsibilities that are retained by NHS England

Directly supporting the delivery of the P&O function are a number of (reserved) functions retained by NHSE East region and third-party suppliers as set out in the National Delegation Agreement. This includes the Professional Standards Team and Counter fraud, provision of these services by NHSE will continue.

8. Governance and decision making

The formal governance of matters relating to pharmaceutical services contracting will be through the Pharmaceutical Services Regulations Committee (PSRC) which will have delegated powers from a relevant committee (through the Terms of Reference) of each of the six ICB Boards (equivalent to the Primary Care Commissioning Committee). The P&O Contracting Team will provide standard quarterly reports to the local PCCC or equivalent on decisions made at PSRC. The P&O Contracting Team will provide updates as necessary to respective systems as issues arise.

The P&O Contracting Team will produce a standard quarterly report to the local PCCC or equivalent on General Optometry Services (GOS) matters. The P&O Contracting Team will provide updates as necessary to respective systems as issues arise.

9. Risk management and risk sharing

a. Risk Management

Each ICB will maintain a risk register. The P&O Contracting Team will maintain a log of contract issues such as those arising from CPAF visits. This will be shared annually with ICB leads and formally with the PCCC or equivalent within each ICB. This may be a nil return for some ICBs as number of visits are limited. It will be each ICBs responsibility to include P&O risk and issues in their directorate risk

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register presented to the equivalent of the Primary Care Commissioning Committee. The P&O Contracting Team will be responsible for escalating or recommending contractual action to PSRC.

Corporate risks such as team resilience, would be recorded as part of the HWE Primary Care Risk Register and shared with all ICBs to include in their risk registers as necessary.

b. Staffing resource risk sharing

HWE ICB will seek to maintain the current level of staff resource to undertake the P&O Contracting Function. Where there is a cost pressure arising such as reliance on agency staff to cover vacancy or absence, HWE will take steps to mitigate this. Any additional costs arising will be shared equally between the six ICBs. Wherever possible, this will be agreed in advance. If there is a significant underspend against the budget e.g., due to prolonged, unfilled vacancies this will be shared equally by the six ICBs.

c. Financial Risk

Each ICB will receive their agreed delegated funds direct from NHSE and will retain financial responsibility for the management, monitoring and payment process relating to these. This includes compliance with their ICB's financial requirements, processes and systems and audit requirements. HWE ICB is not responsible for any overspends or cost pressures relating to these services.

10. Data sharing

A data sharing agreement is in place across the ICBs covered by this MOU and NHS England as a key partner to enable relevant information to be shared. From April 2023 there will be a national data sharing agreement for POD which will be subject to review when available to enable data to flow from hosted function to individual ICBs. Responsibility for the safe sharing of this information sits with HWE as host ICB.

11. Agreement and updating of the SOP

The MOU stands on its own in terms of the agreement to host the P&O Contracting Team by HWE ICB on behalf of the other parties. However, following transition and the embedding of working arrangements, the SOP will continue to be refined. This MOU should therefore be read in conjunction with the latest version of the SOP. Changes will be agreed by ICB nominated leads. As a minimum the SOP should be reviewed **six-monthly** to ensure that it is reflective of current working practices.

12. Termination of this agreement

This MOU took effect on the commencement date (1st April 2023) and shall continue in force until the date that the parties jointly determine that this MOU shall terminate.

The ICB Parties, acting collectively or individually, may terminate this MOU for convenience at any time by giving the other Parties not less than twelve months' notice in writing. The Parties shall comply with clause consequences of termination of this MOU.

The termination of this MoU for any reason shall be without prejudice to any rights or obligations which shall have accrued or become due between the Parties prior to the date of termination. Nor shall it affect the coming into force or the continuation in force of any provision of this MOU which is expressly or by implication intended to come into or continue

in force on or after such termination.

On termination of this MOU howsoever arising:

- the Parties shall provide all reasonable assistance to each other to ensure an orderly handover of the management services of the contracts undertaken by the P&O Contracting Team under the terms of this MOU;
- the Parties shall use reasonable endeavors to ensure that the handover is carried out with the minimum inconvenience and disruption to the Commissioner Parties and the service users; and
- each Party shall comply with any additional obligations on such Party relating to termination of this MOU as are agreed by the Parties.

On termination of this MOU, each Party shall immediately return to the other Parties (as relevant), all confidential information of the Parties in its possession, which was obtained pursuant to this MOU.

In the event the hosting arrangement is dissolved, the resource will be reallocated in accordance with the new arrangements in line with TUPE or other relevant policy.

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Section two: Standard Operating Procedures (SOP)

1. The purpose of the SOP

The SOP sets out the way that the hosted team will work and interact with the other ICBs to ensure effective commissioning and contracting of services in line with the national contract and the local requirements of ICBs. This element will be reviewed and updated on a regular basis to reflect changes to business processes as the changes are embedded.

2. The duties of the P&O Contracting Team

The P&O Contracting Team will continue to undertake the same duties performed within NHSE. In addition, the P&O Contracting Team will from 01.08.2023 manage the “fitness” function on behalf of all ICBs. This function was previously undertaken by the Performance Standards Team at NHS England. The duties of the P&O team in relation to Fitness matters are embedded in Appendix 2 along with other duties within the remit of the P&O Contracting Team. In summary they include:

Pharmacy

- Market Entry and application of the pharmaceutical regulations (noting that these services are not procured)
- Management of Fitness function in relation to pharmaceutical contractors.
- Administration and governance at PSRC
- Rota changes including bank holiday opening. The P&O team will manage an expression of interest process and commission services on Easter Sunday and Christmas Day for those ICBs that indicate they wish for the P&O team to do on their behalf. (It is recognised that ICBs may wish to make their own arrangements). Where the P&O Team commission services, a list of commissioned pharmacies and their opening hours will be provided, two weeks in advance of the day services are commissioned.

Optometry

- Management of General Ophthalmic Services (GOS) contracting
- Issuing of NHS Contracts and national amendments e.g. contract variations
- Coordination and oversight of post payment verification
- Coordination of common approach to contracting (linking with other contracting teams, NHSBSA, PCSE)

The P&O Contracting Team is fully integrated with staff members undertaking roles relating to both contractor groups. This single operating model and one team approach has facilitated economies of scale that will continue under the hosting arrangement with HWE ICB.

Under a hosted arrangement, the P&O Contracting Team have transferred to HWE ICB. The resource that transferred was detailed in the original MOU at Appendix 5. An updated structure chart is provided with this MOU. (*Appendix 5*).

The P&O Contracting Team will not undertake any new duties without explicit agreement between all six parties and due consideration given to the resourcing impact.

The current and established contact routes between contractors and their local representative committees (i.e. LPC, LOC) regarding contracting issues will remain in place

and are not altered by the delegation. ICBs may set their own forums for discussion with their local representative committees. Contractors are responsible for notifying the representative committee on contractual issues if they wish. National contracts are negotiated by the Community Pharmacy England and the national NHS England team and the Department of Health and Social Care (DHSC). They are responsible for engaging with representative committees. Local service developments are the responsibility of each ICB.

Clinical Advisors

Clinical Advisors (CA) for pharmacy and optometry have transferred from the medical directorate at NHS England. The CA and independent representatives are:

Pharmacy	Optometry
Emma Murray	Rupal Lovell-Patel
Jane Newman	
Bhavesh Patel	
David Standerwick	
Paul Duell	
Mike Barbour	
Carolyn Larsen (Independent)	
Adrian Thrower (Independent)	

The CA and independent representative are required for clinical expertise and advice on regulatory matters, support on the clinical aspects of the fitness function, managing concerns, clinical complaints and to support the PSRC function.

The funding associated with the engagement of CA and the independent representative has been transferred from NHS England however any additional cost associated with the engagement of CAs will be agreed in advance and shared equally across all ICBs.

The CAs will be pastorally line managed by Director of Primary Care Transformation at HWE ICB.

CA are a resource for PSRC. Work will be allocated / coordinated by the P&O Contracting Team to support the fitness and PSRC function only. The process of allocation takes into account capacity of CAs and any conflicts of interests they may have.

3. Line management, HR and OD

HWE ICB will be responsible for line management of the team as the employer and HWE HR policies will apply.

a. Host policies

The P&O Contracting Team will work to HWE ICB employment policies and procedures and HWE ICB will ensure that the team receives an effective induction, including to the other five ICBs. The other ICBs will ensure that there is effective material to facilitate the induction of new staff, and that new members of the team are introduced to their key contacts across the systems.

b. Recruitment

HWE ICB will be responsible for the recruitment to vacancies with input from

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partner ICB where the post to be replaced has a named interface role. Where there is a change that requires either a reduction or increase in resources, this will be agreed with the parties of the MOU and the cost or benefit will be shared equally.

c. Access to training and development

HWE ICB will ensure that all staff in the P&O Contracting Team and all CAs and independent representatives receive an effective induction and all applicable mandatory training. Colleagues should be able to access other training as per organisational policy.

The cost of training (PCC training sessions and training from other providers) required to enable the P&O Contracting Team and CA / independent representatives to effectively manage and deliver their core functions will be shared equally between the parties of the MOU.

Regulatory expertise is required at PSRC. This is currently funded by HWE ICB however funding from 1 April 2024 will need to be agreed in advance and shared equally between the ICBs.

At the start of each financial year the ICBs will agree funding for the PCC CIC Advisor at meetings and additional resource for training from PCC CIC to P&O team and Advisors in the form of credits for drawdown. This will be monitored in year to ensure usage.

d. Employment terms

The P&O Contracting Team will be employed in line with other ICB staff including CoSoP/TUPE for staff transfers (subject to a national decision). No reductions in the team will be made without express agreement of all six ICB parties.

The CA / independent representatives will be “contracted for services” and paid on an hourly rate following submission of an invoice for the services required. The CAs will accrue holiday but are not subject to CoSoP/TUPE, redundancy payments and are not included in the ICB “head count.”

4. The handling of queries and feedback

a. Freedom of Information (FOI) and Subject Access requests (SAR)

Regional FOI requests will continue to be coordinated by NHS England. Each ICB remains responsible for FOI and SAR requests about their contracts. FOI and SAR requests received by HWE pertaining to the other ICBs will be directed to apply to the relevant team within each ICB. The P&O Contracting Team will work with each ICB FOI team to provide information if available and will work to agreed timetables as set out in the request from the ICB. (Once a process is agreed with IG leads, this will be added to the MOU as an Appendix).

b. MP letters

MP letters will come to the relevant ICB and the ICB complaints team work collaboratively with P&O Contracting Team to provide a response. Signing off the responses will be the role of the ICB in line with their internal policy.

c. Complaints

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Complaints will be the responsibility of each ICB who will coordinate how the complaint is managed, response from the contractor and associated administration. The P&O Contracting Team will work with each ICB complaints team to provide information on contractual matters if applicable and will work to agreed timetables as set out in the request from the ICB in supporting the drafting of the response (where the complaint relates to contracting matters). The ICB complaints team will be responsible for finalising and issuing any complaint letters and liaising with the patient.

On occasion, a complaint made to an ICB may need to be escalated to a pharmacy CA. A process has been drafted and is included as part of appendices.

PALS - will be the responsibility of each ICB. The P&O team will work with each ICB PALS team to provide any relevant contractual information if required and to provide advice but will not be responsible for liaising directly with patients, providing full patient response, and/or managing the PALS function.

d. Incidents and serious incidents

Contractors are responsible for logging and investigation of incidents. Each ICB will be responsible for managing incidents, serious incidents, issues, and concerns as raised by the Contractor in line with ICB policies and processes.

The P&O Contracting Team will undertake any contractual action arising from the incident. Where the P&O Contracting Team become aware of an incident it will encourage the contractor to report the incident appropriately using Learning From Patient Safety Events (LFPSE). Incidents related to Controlled Drugs will be reported to the Controlled Drugs Accountable Officer/Team at NHS England. The P&O Contracting Team will report any incidents to the relevant ICB when made aware.

e. Data Security Breaches

- i) By Contractors - Data Security Breaches should be reported by the contractor within 24-48 hours (working week). Where the P&O Contracting Team are aware of the breach, the Team will follow up with the contractor to ensure reporting.
- ii) By P&O Contracting Team – will follow HWE local policy and inform the relevant ICB IG lead.
- iii) ICB IG lead will be responsible for working with the P&O Contracting Team to manage any incidents reported.

f. Safeguarding

Safeguarding issues will be the responsibility of safeguarding leads at each ICB for safeguarding concerns to be dealt with as part of ICB safeguarding policy and procedures. The P&O Contracting Team will not manage the safeguarding function or safeguarding concerns.

g. Freedom to Speak Up and Whistleblowing

Each ICB will be responsible for managing any whistleblowing concerns via their Freedom to Speak Up (F2SU) Guardians. The P&O Contracting Team will direct any whistleblowers to the relevant ICB. As part of any whistleblowing/F2SU issue, the relevant ICB will need to seek contracting advice from the P&O Contracting Team where appropriate.

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5. Assurance function support

a. New contractors

Market Entry is managed by the P&O Contracting Team in collaboration with PCSE. PCSE will notify the P&O Contracting Team when there is an application for a contractor to open, close or a contractual change and the first referral process starts. First referrals require a response to a number of set questions. PCSE undertakes a review of information the applicant provides, and P&O Contracting Team undertake a further review and approves.

Checklist for each application and information that is required is completed. Information sent by PCSE to Interested Parties (45 days). 14-day consultation period.

Committee reports then drafted by P&O Contracting Team. Change of Ownership do not go to PSRC and can be determined under delegated authority. Other reports presented at PSRC where decisions are made on applications. Decision letters issued by PCSE. Memos reflecting any changes also issued by PCSE.

Notifications for Changes of Superintendent and Change of Directors and applications for inclusion onto the pharmaceutical list are included in the Fitness function and now managed by the P&O Contracting Team. See SOP in appendix 2 for further detail.

All ICBs are invited to attend PSRC. Only one representative from each ICB should attend. The meeting is divided in two parts:

- Part 1: Market Entry. All ICBs invited to attend.
- Part 2: Fitness and Managing Concerns. Due to the sensitive and confidential nature of some issues, only those ICBs in which the matter relates will be invited to attend.

The Pharmacy Manual sets out the process in detail ([NHS England » Pharmacy Manual](#)) and Terms of Reference are in place and are reviewed annually.

b. Existing contractors

Existing pharmaceutical contractors are maintained on a database which forms our Pharmaceutical List. This is a list of contractors broken down by Health and Wellbeing Board. It includes contractor code, full address, contact details including shared NHS mail addresses. A consolidated version of the Pharmaceutical List is available on NHS Futures and the NHSBSA website.

It also contains details of which advanced services contractors are registered to provide and other contractual information.

The Dispensing Doctors List is also maintained by the P&O Contracting Team. This is a list of all dispensing doctors across the region, broken down by Health and Wellbeing Board. It includes contractor code, full address (of main surgery and any branch surgeries), contact details including telephone numbers and NHS mail addresses.

A database of GOS contractors with a mandatory and/or additional services contract is maintained by the P&O Contracting Team. It includes contractor code,

contract type, full address and contact details.

Historically Quality in Optometry (QiO) has not been actioned in the East of England. This remains the case since delegation as the P&O team is not resourced to manage this workstream. It is however recognised that it needs to be addressed and considered moving forward.

c. Quality issues and links to ICB quality teams

Appendix 4 sets out the quality arrangements which will continue to follow this process.

6. Governance

a. PSRC

Each ICB has set out its governance and leadership arrangements in a constitution formally approved by NHS England. Each ICB scheme of delegation and reservation will be required to set out decision making responsibilities for the PSRC which are nationally mandated.

HWE ICB will coordinate and host the PSRC. This means that the secretariat, chairing responsibilities, agenda setting, management of the committee to agreed Terms of Reference as set out in the Pharmacy Manual (see Appendix 3) and involvement of lead representatives from each ICB.

HWE ICB will host the resources required to deliver the PSRC and deliver the agreed actions, decisions, proposals formed at the PSRC on behalf of the six ICBs. The constitution of the PSRC will ensure that proposals and decision making covering the six ICBs in East of England is effectively enabled. Each of the six ICBs will nominate a lead, senior representative for the PSRC.

Financial Implications

1. Legal representation* - On occasion a decision made at PSRC may necessitate legal representation at for example, a First Tier Tribunal or at NHS Resolution. Legal costs will need to be met by the relevant ICB and the relevant ICB will need to engage/lead from an ICB perspective, with support where appropriate from a member of the P&O Contracting Team.
2. Occupational Health (OH) Assessments – OH assessments are not generally commissioned for pharmacy or optometry contractors. Responsibility for ensuring the wellbeing of staff members sits with the independent contractor. There may be occasion however where a sole trader, superintendent pharmacist requires OH. The cost of OH services will need to be met by the relevant ICB.

*legal costs relating to historic cases may be met by NHS England.

b. Optometry governance / committee

All administrative processes relating to the issue of GOS contracts are managed by NHSBSA to ensure a standard, national approach to contract administration. The administrative processes are aligned with the Eye Health Policy Handbook. A “tracker” is sent and reviewed by the P&O Contracting Team to enable oversight.

Contract terminations, not instigated by the contractor, are managed by the P&O Contracting Team. Any decision to terminate a contract would be made at the

relevant ICB PCCC or equivalent Committee.

Individual ICBs are the “decision maker” on GOS contracting and therefore any contractual issue and/or fitness matter that falls outside “business as usual” will be facilitated by the P&O team but require a decision through the ICB PCCC (or equivalent). For example, if it is recommended that a contractor applying for a GOS contract is refused e.g not suitable for a GOS contract, the decision will need to go through governance at the relevant ICB.

7. Reporting

PSRC will provide standard quarterly reports to the local PCCC or equivalent on decisions made at PSRC. The P&O Contracting Team will provide updates as necessary to respective systems as issues arise.

The P&O contracting team will produce a standard quarterly report to the local PCCC or equivalent on General Optometry Services (GOS) matters. The P&O Contracting Team will provide updates as necessary to respective systems as issues arise.

Where HWE ICB audit programme includes primary care commissioning and specifically pharmacy and optometry contracting, the findings and/or outputs from the audit report (or appropriate aspects of the report) will be shared with respective ICBs.

The P&O contracting team will support ICBs in completion of submissions for the NHS England Primary Care Assurance Framework ([NHS England » Primary care commissioning assurance framework](#)) using an agreed template. Returns to NHS England are expected to be made by each ICB in April of each financial year.

Appendix 1

Signatures for and on behalf of the parties to this Memorandum of Understanding
(Attached with MOU)

Appendix 2

P&O Contracting and Fitness Function [taken from the Delegation Agreement]
(Attached with MOU)

Appendix 3

PSRC Terms of Reference [to be updated in line with changes to Pharmacy Manual]
(Attached with MOU)

Appendix 4

Quality Mapping Swim Lane Diagram
(Attached with MOU)

Appendix 5

Pharmacy Optometry Staff Structure – Updated August 2024
(Attached with MOU)

Appendix 6

Use of Clinical Advisor in exceptional circumstances when complaints require escalation.

Extracts from Delegation Agreement

Schedule 2C: Primary Ophthalmic Services

1. Introduction

Function	Current Role/Responsibilities
1.1 This Part 1 of Schedule 2C (<i>Primary Ophthalmic Services</i>) sets out general provisions regarding the carrying out of the Delegated Functions, being, in summary:	
1.1.1 Decisions in relation to the management of Primary Ophthalmic Services;	<p><i>P&O band 7s provide oversight: review and approve the spreadsheet. Band 3-6 colleagues support the NHSBSA to do administration e.g. new optician/ relocate/ new partners etc. Provide a spreadsheet for oversight on a weekly basis. Interface with Finance prior to issuing a new contract to obtain a code.</i></p> <p><i>Site visits – some conducted by NHSBSA and some by a clinical adviser (CA); If opticians act fraudulently and there is a need to terminate the contract, this action resides with P&O team. There are no market entry regs as long as individual practitioners pass checks for inclusion on the performers list.</i></p>
1.1.2 Undertaking reviews of Primary Ophthalmic Services in the Area;	<ul style="list-style-type: none"> <i>CA undertakes. e.g. BSA do Post Payment Verification (PPV) checks – opticians do as many sight tests as they want and get paid for sight tests. BSA do post payment verification. e.g. seeing patients too frequently or claiming for patients who do not qualify as eligible for NHS sight tests. CA will assess if recalling too frequently or not from clinical perspective i.e. there might be a clinical reason for more regular checks. No one in P&O team is clinical.</i> <i>Counter fraud work with BSA e.g. do notes review. Under professional standards, if meet requirement for counter fraud, (individual named practitioner), Medical Directorate triage; fact find, investigate etc. Clinical advisers paid by MD. Professional standards must have clinical adviser to undertake reviews – employed on sessional basis</i>
1.1.3 Management of the Delegated Funds in the Area;	<ul style="list-style-type: none"> <i>P&O/ finance – interface into system. The P&O finance resource will be delegated to the host system.</i>

Appendix 2

Function	Current Role/Responsibilities
1.1.4 Co-ordinating a common approach to the commissioning of Primary Ophthalmic Services with other commissioners in the Area where appropriate;	<ul style="list-style-type: none"> <i>P&O contract not commission. E.g. looking at new services for homeless patients – working with Transformation team to commission a service. Transformation team retained function of NHSE but will continue to work with P&O.</i>
1.1.5 Such other ancillary activities that are necessary in order to exercise the Delegated Functions.	

Part 2: General Obligations

2.1 The ICB is responsible for managing the provision of Primary Ophthalmic Services.	
2.2 When carrying out Delegated Functions in respect of Primary Ophthalmic Services, the ICB must comply with all Mandated Guidance issued by NHS England.	
2.3 The role of the ICB includes identifying and seeking to address any unmet needs which may be met through the delivery of Primary Ophthalmic Services. <i>i.e. System approach</i>	
2.4 In respect of integrated working, the ICB must:	
2.4.1 take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Eye Health Networks, Local Authorities, Healthwatch, acute and community providers, Local Optical Committees, and other stakeholders;	
2.4.2 work with NHS England and other ICBs to co-ordinate a common approach to the commissioning of Primary Ophthalmic Services generally; and	
2.4.3 work with NHS England to coordinate the exercise of their respective performance management functions.	
2.5 In relation to the Delegated Functions, the ICB agrees to perform the following general obligations:	
2.5.1 to manage the Primary Ophthalmic Services Contracts on behalf of NHS England and perform all of NHS England's obligations under each of the Primary Ophthalmic Services Contracts in	<ul style="list-style-type: none"> <i>800 contracts with various contracts – novation of contracts and regional contracts e.g. Translation and Interpretation</i>

Appendix 2

<p>accordance with the terms of the Primary Care Contracts as if it were named in the contract in place of NHS England;</p>	
<p>2.5.2 working with other organisations, including the NHS Business Services Authority and NHS England as appropriate, actively manage the performance of the Primary Ophthalmic Services Provider in order to secure the needs of people who use the services, improve the quality of services and improve efficiency in the provision of the services including by taking timely action to enforce contractual breaches, serve notices or provide discretionary support;</p>	<ul style="list-style-type: none"> • <i>NHSBSA is a mandated contractual arrangement in Schedule 6 of the delegation agreement.</i>
<p>2.5.3 ensure that it obtains value for money on behalf of NHS England and avoids making any double payments under any Primary Ophthalmic Services Contracts;</p>	<ul style="list-style-type: none"> • <i>NHSBSA – admin: PPV, correct errors. P&O is the decision maker about what is actioned.</i>
<p>2.5.4 notify NHS England immediately (or in any event within two (2) Operational Days) of any breach by the ICB of its obligations to perform any of NHS England’s obligations under the Primary Ophthalmic Services Contracts;</p>	<ul style="list-style-type: none"> • <i>ICB or P&O team to escalated depending on where breach initiates.</i>
<p>2.5.5 undertake any investigations relating (among other things) to whistleblowing claims, infection control and patient complaints;</p>	<ul style="list-style-type: none"> • <i>Safeguarding and IPC is undertaken by the Nursing Directorate - more work required. Adhoc requests / scenario specific issues may require input from P&O /Medical E.g. during covid it came to light there were opticians were claiming at pre-Covid levels. There was a concern that IPC standards and cleaning between appts weren’t being adhered to – this was a one-off scenario and clinical adviser x1 plus P&O team x1 undertook effort to complete a number of visits following a national request.</i>

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Appendix 2

<p>2.5.6 keep a record of all of the Primary Ophthalmic Services Contracts that the ICB manages on behalf of NHS England setting out the following details in relation to each Primary Ophthalmic Services Contract:</p> <p>2.5.6.1 name of the Primary Ophthalmic Services Provider;</p> <p>2.5.6.2 any practice or trading name by which the Primary Ophthalmic Services Provider is known (if different to the name recorded under paragraph Error! Reference source not found.);</p> <p>2.5.6.3 location of provision of services; and</p> <p>2.5.6.4 amounts payable under the Primary Ophthalmic Services Contract (if a contract sum is payable) or amount payable in respect of each patient (if there is no contract sum).</p>	<ul style="list-style-type: none"> • <i>Hosted so all with host system. P&O have list of contractors but not 2.5.6.4 which comes from finance. Contract re-issue project underway (Optometry only) to ensure when contracts transfer, documentation is up to date.</i> • <i>Transitions with finance</i>
<p>2.6 Without prejudice to clause 9 (<i>Finance</i>) or paragraph Error! Reference source not found. above, the ICB must actively manage each of the relevant Primary Ophthalmic Services Contracts including by:</p>	
<p>2.6.1 managing the relevant Primary Ophthalmic Services Contract, including in respect of quality standards, incentives, observance of service specifications, and monitoring of activity and finance;</p>	<ul style="list-style-type: none"> • <i>P&O, finance, NHSBSA</i>
<p>2.6.2 assessing quality and outcomes (including clinical effectiveness, patient experience and patient safety);</p>	<ul style="list-style-type: none"> • <i>NHSBSA undertakes PPV, complaints.</i> • <i>MD undertakes concerns management (named practitioners only)</i>
<p>2.6.3 managing variations to the relevant Primary Ophthalmic Services Contract or services in accordance with national policy, service user needs and clinical developments;</p>	<ul style="list-style-type: none"> • <i>NHSBSA and P&O</i>
<p>2.6.4 agreeing information and reporting requirements and managing information breaches (which will include use of the NHS Digital Data Security and Protection Toolkit);</p>	<ul style="list-style-type: none"> • <i>The return goes to NHSBSA – a primary care activity report (PCAR) – and P&O verify the list.</i>
<p>2.6.5 conducting review meetings and undertaking contract management including the issuing of contract queries and agreeing any remedial action plan or related contract management processes;</p>	<ul style="list-style-type: none"> • <i>a very low requirement for P&O</i>
<p>2.6.6 complying with and implementing any relevant Mandated Guidance issued from time to time.</p>	

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2.7 This paragraph is without prejudice to clause 10 (Information, Planning and Reporting) or any other provision in this Agreement. The ICB must provide NHS England with:	
2.7.1 such information relating to individual providers of Primary Ophthalmic Services in the Area as NHS England may reasonably request, to ensure that NHS England is able to continue to gather national data regarding the commissioning or performances of providers of Primary Ophthalmic Services;	<ul style="list-style-type: none"> • <i>P&O and NHSBSA</i>
2.7.2 such data/data sets as required by NHS England to ensure population of any national dashboards;	<ul style="list-style-type: none"> • <i>NHSBSA</i>
2.7.3 any other data/data sets as required by NHS England; and	
2.7.4 the ICB shall procure that providers accurately record and report information so as to allow NHS England and other agencies to discharge their functions.	
Part 2: Specific Obligations	
3 Introduction	
3.1 This Part 2 of Schedule 2C (<i>Primary Ophthalmic Services</i>) sets out further provision regarding the carrying out of each of the Delegated Functions.	
4 Primary Ophthalmic Services Contract Management	
in each case acknowledging that the NHS Business Services Authority provides end-to-end support services in relation to these functions, as referred to in Schedule 6. The ICB accordingly agrees to co-operate with the NHS Business Services Authority in the delivery of these functions.	
4.1 The ICB must:	
4.1.1 comply with all current and future relevant national Mandated Guidance regarding General Ophthalmic Contract reviews and any other contract reviews;	<ul style="list-style-type: none"> • <i>contracting change or GOS to P&O e.g. contract variation</i>
4.1.2 take on the responsibility for existing services provided pursuant to a Primary Ophthalmic Services Contract, and for commissioning new services;	
4.1.3 assume the responsibility for the award of new Primary Ophthalmic Services Contracts; and	
4.1.4 monitor contract performance with a view to achieving assurance and improvement in the delivery of services in the context of the ICB, develop standard and agree structure	
5. Transparency and freedom of information	

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5.1 The ICB must:	
5.1.1 Respond to requests for information from members and the public and the media, including requests made pursuant to the FOIA, whose subject-matter relates to the performance of the Delegated Functions in the ICB's Area;	<ul style="list-style-type: none"> • <i>P&O team</i>
5.1.2 Provide information and assistance as required to support NHS England in the preparation of responses to parliamentary questions in connection with the Delegated Functions.	<ul style="list-style-type: none"> • <i>P&O (utilise comms teams)</i>
6. Maintaining the Performers List	
6.1 On receiving a notice from a practitioner (who is party to a Primary Ophthalmic Services Contract) of an amendment to information recorded about them in the Performers List, pursuant to regulation 9(1) of the National Health Service (Performers Lists) (England) Regulations 2013, the ICB must support NHS England's amendment of the performers list as soon as possible after receiving the notice using the Primary Care Support services provided by NHS England, insofar as that amendment relates to a change in contractor details.	<ul style="list-style-type: none"> • <i>PCSE manage the performers list. MD has an interface with PCSE. Performers are advised to make any voluntary changes directly to PCSE, MD is notified of the change. MD can make changes to the Performers List arising out of concerns management e.g. compulsory removals.</i>
7. Finance	
7.1 Further requirements in respect of finance will be specified in Mandated Guidance.	
8. Workforce	
8.1 The arrangements for the provision and maintenance of sufficient and appropriately qualified, trained and experienced Staff in order for the ICB to fulfil its responsibilities for each of the Delegated Functions ("the Staffing Model"), will be communicated formally to the ICB by NHS England following recommendations made by the National Moderation Panel. Further requirements in respect of workforce will be specified in Mandated Guidance.	
8.2 The ICB is not permitted to vary the Staffing Model agreed with NHS England as part of its application for delegation of the said functions	

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<p>however a variation can be applied for by the ICB and considered by the National Moderation Panel at any time.</p>	
<p>9. Integrating optometry into communities at Primary Care Network level</p>	
<p>9.1 The ICB must exercise the Delegated Functions with a view to achieving greater integration of optometrists into the Integrated Care System at the Primary Care Network level.</p>	
<p>10. Complaints</p>	
<p>10.1 The ICB will handle complaints made in respect of primary ophthalmic services in accordance with the Complaints Regulations.</p>	<ul style="list-style-type: none"> • <i>MD involved when there are complaints about named practitioners and assigns CA when required. Main complaints about P&O relate to translation services issues – particularly for deaf patients. Generally there are 3-4 per annum linked to a specific optical chain.</i>
<p>11. Commissioning ancillary support services</p>	
<p>11.1 The arrangements for the provision of ancillary services to Primary Ophthalmic Services Providers are described in Schedule 7 (Local Terms).</p>	

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Schedule 2D: Delegated Functions – Pharmaceutical Services

The provisions of this Schedule 2D form part of this Agreement only where indicated in the Particulars.

1. In this Schedule, the following additional definitions shall apply:

Advanced Services	has the meaning given to that term by the Pharmaceutical Regulations
Conditions of Inclusion	means those conditions set out at Part 9 of the Pharmaceutical Regulations
Delegated Pharmaceutical Functions	the functions set out at paragraph 2 of this Schedule
Designated Commissioner	has the meaning given to that term at paragraph Error! Reference source not found. of this Schedule
Dispensing Doctor	has the meaning given to that term by the Pharmaceutical Regulations
Dispensing Doctor Decisions	means decisions made under Part 8 of the Pharmaceutical Regulations
Dispensing Doctor Lists	has the meaning given to that term by the Pharmaceutical Regulations
Drug Tariff	has the meaning given to that term by the Pharmaceutical Regulations
Electronic Prescription Service	has the meaning given to that term by the Pharmaceutical Regulations
Enhanced Services	has the meaning given to that term by the Pharmaceutical Regulations
Essential Services	is to be construed in accordance with paragraph 3 of Schedule 4 to the Pharmaceutical Regulations
Fitness to Practise Functions	has the meaning given to that term at paragraph Error! Reference source not found. of this Schedule
Locally Commissioned Services	means services which are not Essential Services, Advanced Services, Enhanced Services or services commissioned under an LPS Scheme
LPS Chemist	has the meaning give to that term by the Pharmaceutical Regulations
LPS Scheme	has the meaning given to that term by Paragraph 1(2) of Schedule 12 to the NHS Act
NHS Chemist	has the meaning given to that term by the Pharmaceutical Regulations
Pharmaceutical Lists	has the meaning given to that term at paragraph 2.1.1. of this Schedule and any reference to a Pharmaceutical List should be construed accordingly
Pharmaceutical Regulations	means the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 and reference to a Regulation refers to a provision of the Pharmaceutical Regulations, unless otherwise stated
Rurality Decisions	means decisions made under Part 7 of the Pharmaceutical Regulations

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Terms of Service	means the terms upon which, by virtue of the Pharmaceutical Regulations, a person undertakes to provide Pharmaceutical Services
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Function	Current Role/Responsibilities
Delegated Pharmaceutical Functions	
2. Except in so far as they fall within the scope of the Reserved Functions, and subject to paragraphs Error! Reference source not found. , Error! Reference source not found. , 4 and 5, the ICB agrees to perform the following functions of NHS England in respect of the Area (the “Delegated Pharmaceutical Functions”), in all cases in accordance with relevant Law, Mandated Guidance and other Guidance:	
<p>2.1.1 preparing, maintaining and submitting for publication by NHS England lists of persons, other than medical practitioners or dental practitioners, who have undertaken to provide pharmaceutical services from premises situated within the Area¹, specifically:</p> <p>2.1.1.1 lists of persons who have undertaken to provide pharmaceutical services in particular by way of the provision of drugs;</p> <p>2.1.1.2 lists of persons who have undertaken to provide pharmaceutical services only by way of the provision of appliances; and</p> <p>2.1.1.3 lists of persons participating in the Electronic Prescription Service² collectively referred to in this Schedule as the “Pharmaceutical Lists”. In doing so, it is sufficient for the lists</p>	<ul style="list-style-type: none"> • <i>P&O hold/manage Pharmaceutical List. This is a list of contractors e.g. Boots – want to change hours, change location. If new application not on Pharmaceutical List, an application process is required and this is managed by medical directorate i.e. fit and proper person etc. Once fit and proper, apply to P&O re need in market, gaps etc and added to Pharmaceutical List.</i> <p><i>e.g. provider of stomas – same process as 2.1.1</i></p>

¹ Including (without limitation) updates to those lists following any removal under regulation 115 of the Pharmaceutical Regulations

² Regulation 10 of the Pharmaceutical Regulations

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Function	Current Role/Responsibilities
referred to at paragraphs 2.1.1.1 and 2.1.1.2 to include a marker showing which persons are also participating in the Electronic Prescription Service, rather than preparing a separate list for the purposes of paragraph 2.1.1.3.	
2.1.2 managing and determining applications by persons for inclusion in a Pharmaceutical List ³ ;	<ul style="list-style-type: none"> • <i>P&O incl fitness to practice i.e. pharmacist, new pharmacy = PSRC</i>
2.1.3 managing and determining applications by persons included in a Pharmaceutical List;	<ul style="list-style-type: none"> • <i>PSRC</i>
2.1.4 responsibilities for financial resources related to the Delegated Pharmaceutical Functions as described in Mandated Guidance issued by NHS England;	<ul style="list-style-type: none"> • <i>finance to finance.</i>
<p>2.1.5 overseeing the compliance of those included in the Pharmaceutical Lists with:</p> <p>2.1.5.1 their Terms of Service and identifying and investigating breaches, including possible breaches, of those terms;</p> <p>2.1.5.2 relevant Conditions of Inclusion;</p> <p>2.1.5.3 requirements of the Community Pharmacy Contractual Framework.</p> <p>2.1.5.4 Management of the Dispensing Services Quality Scheme for those dispensing practices who wish to participate</p>	<ul style="list-style-type: none"> • <i>P&O manages terms of service which includes many aspects e.g. breaches etc, e.g. not complying with opening hours. This is business as usual.</i> • <i>If there is an issue with a clinician, e.g. performance issue with individual and not advised the P&O team, this constitutes a breach of contract.</i> • <i>GPHC related to individual performer.</i> • <i>P&O team / PSRC. GPHC also undertake visits to pharmacy – can place sanctions on pharmacies.</i> • <i>This is a national framework – falls to P&O, community pharmacy clinical leads or national team (NHSE). E.g. introduce new advanced services = national, implementation and monitoring of adv service = CPCL, pharmacy quality scheme = national, pilots = Transformation team (NHSE)</i> • <i>P&O team manage DSQS process.</i>

³ Schedule 2 of the Pharmaceutical Regulations

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Function	Current Role/Responsibilities
2.1.6 exercising powers in respect of Performance Related Sanctions and Market Exit ⁴ ;	<ul style="list-style-type: none"> • <i>P&O cover this although when a pharmacy is to be closed, P&O are involved to ensure the required notice period.</i>
2.1.7 exercising all other rights, and complying with all other obligations, of NHS England in respect of the Terms of Service and Conditions of Inclusion of those included in the Pharmaceutical Lists;	<ul style="list-style-type: none"> • <i>P&O)</i>
2.1.8 communicating to those included in the Pharmaceutical Lists any announcement made by NHS England modifying Terms of Service of any person included in the Pharmaceutical Lists as a consequence of a disease being, or in anticipation of a disease being imminently: 2.1.8.1 pandemic; and 2.1.8.2 a serious risk or potentially a serious risk to human health ⁵ ;	<ul style="list-style-type: none"> • <i>P&O (section 7a services retained function)</i> • <i>P&O</i>
2.1.9 communicating to those included in the Pharmaceutical Lists any other matters which NHS England may require the ICB to communicate from time to time;	<ul style="list-style-type: none"> • <i>P&O</i>
2.1.10 performing functions in respect of the disqualification of practitioners, and related measures concerning a practitioners inclusion in the Pharmaceutical Lists, set out in Chapter 6 of Part 7 to the NHS Act and the provisions of the Pharmaceutical Regulations made under that Chapter (“the Fitness to Practise Functions”);	<ul style="list-style-type: none"> • <i>P&O</i>
2.1.11 performing functions in respect of enforcement, reviews and appeals relating to the Fitness to Practise Functions ⁶ ;	<ul style="list-style-type: none"> • <i>P&O and GPHC</i>

⁴ Part 10 of the Pharmaceutical Regulations

⁵ Regulation 11(3) of the Pharmaceutical Regulations

⁶ Part 11 of the Pharmaceutical Regulations

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Function	Current Role/Responsibilities
2.1.12 making LPS Schemes ⁷ , subject to the requirements of paragraph 5;	<ul style="list-style-type: none"> • <i>East of England does not have any LPS Schemes. If it did, it would be P&O</i>
2.1.13 overseeing the compliance of those who are party to Local Pharmaceutical Services Contracts with the terms of those contracts and identifying and investigating breaches, including possible breaches, of the terms of those contracts;	<ul style="list-style-type: none"> • <i>P&O</i>
2.1.14 exercising all rights, and complying with all obligations, of NHS England under Local Pharmaceutical Services Contracts;	<ul style="list-style-type: none"> • <i>P&O</i>
2.1.15 determining LPS matters ⁸ in respect of LPS Schemes;	<ul style="list-style-type: none"> • <i>P&O</i>
2.1.16 determining Rurality Decisions and other rurality matters ⁹ ;	<ul style="list-style-type: none"> • <i>P&O</i>
2.1.17 determining Dispensing Doctor Decisions ¹⁰ ;	<ul style="list-style-type: none"> • <i>P&O</i>
2.1.18 preparing and maintaining Dispensing Doctor Lists ¹¹ ;	<ul style="list-style-type: none"> • <i>P&O</i>
2.1.19 making arrangements for the provision of adequate pharmaceutical service delivery across the ICB area;	<ul style="list-style-type: none"> • <i>local authority with input from P&O</i>
2.1.20 making arrangements for the delivery of Essential Services, Advanced Services and Enhanced Services;	<ul style="list-style-type: none"> • <i>P&O, ICBs, CPCL, NHSE national</i>
2.1.21 supporting implementation and delivery of all elements of the Community Pharmacy Contractual Framework;	<ul style="list-style-type: none"> • <i>P&O, ICBs, CPCL and national NHSE</i>
2.1.22 consulting with patients, the public and other stakeholders to the extent required by the duty of public involvement and consultation under section 14Z45 of the NHS Act;	<ul style="list-style-type: none"> • <i>new services liaison</i>

⁷ Section 134 NHS Act and Part 13 of the Pharmaceutical Regulations.

⁸ Part 13 of the Pharmaceutical Regulations

⁹ Part 7 of the Pharmaceutical Regulations

¹⁰ Part 8 of the Pharmaceutical Regulations

¹¹ Regulation 46 of the Pharmaceutical Regulations

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Function	Current Role/Responsibilities
2.1.23 responding to Appeals to the Secretary of State and First Tier Tribunal in respect of the Delegated Pharmaceutical Functions ¹² ;	<ul style="list-style-type: none"> • <i>P&O</i>
2.1.24 responding to Claims in respect of the Delegated Pharmaceutical Functions; query	
2.1.25 recovering overpayments from NHS Chemists, LPS Chemists, Dispensing Doctors and Primary Medical Services Providers ¹³ ;	<ul style="list-style-type: none"> • <i>NHSBSA e.g. meds delivery service, pharmacy over claimed, to PSRC</i>
2.1.26 bringing any legal proceedings in respect of the Delegated Pharmaceutical Functions;	
2.1.27 making any notifications to, and consulting with, third parties in respect of the Delegated Pharmaceutical Functions;	<ul style="list-style-type: none"> • <i>P&O</i>
2.1.28 recognising one or more Local Pharmaceutical Committees which it considers are representative of Pharmaceutical Services Providers in the ICB's Area and liaising with and consulting such Local Pharmaceutical Committees as required by the Pharmaceutical Regulations;	<ul style="list-style-type: none"> • <i>P&O</i>
2.1.29 commissioning the provision of NHS Smartcards to Pharmaceutical Services Providers and their staff by registration authorities;	<ul style="list-style-type: none"> • <i>NHS digital</i>
2.1.30 making any payments due to NHS Chemists suspended from a Pharmaceutical List in accordance with the determination made by the Secretary of State in respect of such payments;	<ul style="list-style-type: none"> • <i>P&O/PSRC. Finance are informed when a suspension has occurred so that payments can be made.</i>
2.1.31 undertaking any investigations relating (among other things) to whistleblowing claims (relating to a superintendent pharmacist, a	<ul style="list-style-type: none"> • <i>Individual ICB responsible for whistleblowing. A CA could be engaged by HWE if it is an investigation into an organisation. P&O, or regulator or counter fraud – particularly if individual pharmacist (GPHC)</i>

¹² Schedule 3 of the Pharmaceutical Regulations

¹³ Regulation 94 of the Pharmaceutical Regulations

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Function	Current Role/Responsibilities
director or the operation of a pharmacy contractor), infection control and patient complaints.	
2.2 Where the Area comprises the areas of two or more Health and Wellbeing Boards in their entirety:	
<p>2.2.1 the Delegated Pharmaceutical Functions shall be exercised so as to maintain separately in respect of each Health and Wellbeing Board area:</p> <p>2.2.1.1 Pharmaceutical Lists in respect of premises in that Health and Wellbeing Board area;</p> <p>2.2.1.2 a list of LPS Chemists providing local pharmaceutical services at or from premises in that Health and Wellbeing Board area¹⁴; and</p> <p>2.2.1.3 a Dispensing Doctor List (together the “Relevant Lists”); and</p>	<ul style="list-style-type: none"> • P&O • P&O • P&O • P&O
2.2.2 the ICB shall comply with such Contractual Notices as NHS England may issue from time to time concerning the arrangements for the exercise of the Delegated Pharmaceutical Functions across two or more Health and Wellbeing Board areas.	<ul style="list-style-type: none"> • P&O
2.3 Where the Area comprises part of the area of a Health and Wellbeing Board (the “Relevant Health and Wellbeing Board”):	
<p>2.3.1 NHS England shall by Contractual Notice designate:</p> <p>2.3.1.1 the ICB;</p> <p>2.3.1.2 another ICB whose area comprises in part the area of the Relevant Health and Wellbeing Board; or</p> <p>2.3.1.3 NHS England;</p>	

¹⁴ Regulation 114 of the Pharmaceutical Regulations

Function	Current Role/Responsibilities
as the body responsible for maintaining as the body responsible for maintaining the Relevant Lists (as defined in paragraph Error! Reference source not found. of this Schedule 2D) in respect of the Relevant Health and Wellbeing Board (“the Designated Commissioner”);	
the ICB shall exercise the Delegated Pharmaceutical Functions in respect of that part of the Relevant Health and Wellbeing Board’s area that falls within the Area but in doing so shall liaise with any Designated Commissioner for the purposes of maintaining the accuracy of the Relevant Lists (as defined in paragraph Error! Reference source not found. of this Schedule 2D) in respect of the Relevant Health and Wellbeing Board; and	
2.3.2 the ICB shall comply with all Contractual Notices issued by NHS England for the purposes of determining responsibilities in the circumstances described in this paragraph 3.3.	
Prescribed support	
3. Notwithstanding the inclusion of the following within the Delegated Functions, the ICB shall discharge the functions set out at:	
3.1 Paragraph 3.1.1 (maintaining Pharmaceutical Lists)	<ul style="list-style-type: none"> • P&O
3.2 Paragraph 3.1.2 (managing applications for inclusion)	<ul style="list-style-type: none"> • P&O
3.3 Paragraph 3.1.3 (managing applications from those included in a list)	<ul style="list-style-type: none"> • P&O
3.4 Paragraph 3.1.5 (overseeing compliance with Terms of Service and Conditions of Inclusion)	<ul style="list-style-type: none"> • P&O
3.5 Paragraph 3.1.10 (Fitness to Practise)	<ul style="list-style-type: none"> • P&O
3.6 Paragraph 3.1.18 (maintaining and publishing Dispensing Doctors Lists)	<ul style="list-style-type: none"> • P&O
3.7 Paragraph 3.1.25 (recovery of overpayments)	<ul style="list-style-type: none"> • NHSBSA and P&O if specific requests needs to go to PSRC <p>with the assistance and support of the NHS Business Services Authority, Primary Care Support England or such other person as NHS England shall designate by Contractual Notice for these purposes from time to time and in accordance with the allocation of operational responsibilities described by NHS England in Mandated Guidance.</p>
LPS Schemes	

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Function	Current Role/Responsibilities
4. The ICB shall not without the prior written consent of NHS England make any new LPS Schemes.	
Barred Persons	
5. The ICB must ensure that persons barred from involvement in specific elements of the Delegated Functions are excluded from such involvement in accordance with the Pharmaceutical Regulations.	<ul style="list-style-type: none"> • P&O
Other Services	
6. The provisions of this schedule are without prejudice to the ability of the ICB to make arrangements for the provision of Locally Commissioned Services for the purposes of the NHS in accordance with its own commissioning functions and using its own financial resources.	<ul style="list-style-type: none"> • ICBs
Payments	
7. In exercising the Delegated Pharmaceutical Functions, the ICB must ensure that:	
7.1 all payments to which the Drug Tariff applies are made solely in accordance with the Drug Tariff; and	<ul style="list-style-type: none"> • Individual ICBs, P&O and finance
7.2 any other payments for services (including without limitation those relating to LPS Schemes and Enhanced Services) are made in accordance with recognised contractual mechanisms intended to apply to those services.	<ul style="list-style-type: none"> • Ad hoc = P&O / Individual ICBs e.g. Bank Holiday commissioning
Flu vaccinations	
8 The Parties acknowledge and agree that:	
8.1 responsibility for arranging any national scheme for flu vaccinations remains with NHS England as part of its Section 7A Functions; and Public Health,	
8.2 where any such national scheme is arranged by NHS England, the ICB is required to commission flu vaccines as Advanced Services. For the purposes of this Agreement, this forms part of the ICB's responsibilities under clause.	<ul style="list-style-type: none"> • Individual ICBs
Integration	
9 In respect of integrated working, the ICB must:	<ul style="list-style-type: none"> •

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Function	Current Role/Responsibilities
9.1.1 take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Authorities, Healthwatch, acute and community providers, professional representative groups, contractor representative groups and other stakeholders;	
9.1.2 work with NHS England and other ICBs to co-ordinate a common approach to the commissioning of Pharmaceutical Services generally; and	
9.1.3 work with NHS England to coordinate the exercise of their respective performance management functions.	
<i>Integrating pharmacy into communities at Primary Care Network level</i>	
10 The ICB must exercise the Delegated Functions with a view to achieving greater integration of community pharmacy into the Integrated Care System at the Primary Care Network level including participation in network governance arrangements.	
<i>Complaints</i>	
11 The ICB will handle complaints made in respect of Pharmaceutical Services and Local Pharmaceutical Services in accordance with the Complaints Regulations.	<ul style="list-style-type: none"> <i>Complaints responsibility of individual ICBs. P&O team to advise on contractual aspects relating to a complaint.</i>
<i>Commissioning ancillary support services</i>	
12 The arrangements for the provision of ancillary services to Pharmaceutical Services Providers are described in Schedule 7 (Local Terms).	
<i>Finance</i>	
12.1 Further requirements in respect of finance will be specified in Mandated Guidance.	
<i>Workforce</i>	
14.1 Further requirements in respect of workforce will be specified in Mandated Guidance.	

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SCHEDULE 1**Reserved Functions**

1.	Introduction
1.1	In accordance with clause Error! Reference source not found. of this Agreement, all functions of NHS England other than those defined as Delegated Functions are Reserved Functions.
1.2	This Error! Reference source not found. (Reserved Functions) sets out further provision regarding the carrying out of the Reserved Functions.
1.3	The ICB will work collaboratively with NHS England and will support and assist NHS England to carry out the Reserved Functions.
2.	Management of the national performers list – (Medical Directorate)
2.1	Subject to Paragraph 2.2, NHS England will continue to perform its functions under the National Health Service (Performers Lists) (England) Regulations 2013.
2.2	The ICB will carry out administrative tasks in respect of the Performers Lists as described at: <ul style="list-style-type: none"> 2.2.1 Paragraph 9 of Part 2, Schedule 2A; 2.2.2 Paragraph 9 of Part 2, Schedule 2B; and 2.2.3 Paragraph 6 of Part 2, Schedule 2C.
2.3	NHS England's functions in relation to the management of the national performers list include: <ul style="list-style-type: none"> 2.3.1 considering applications and decision-making in relation to inclusion on the national performers list, inclusion with conditions and refusals; 2.3.2 identifying, managing and supporting primary care performers where concerns arise; and 2.3.3 managing suspension, imposition of conditions and removal from the national performers list.
2.4	NHS England may hold local Performance Advisory Group ("PAG") meetings to consider all complaints or concerns that are reported to NHS England in relation to a named performer and NHS England will determine whether an initial investigation is to be carried out.

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<p>2.5 NHS England may notify the ICB of all relevant PAG meetings at least seven (7) days in advance of such meetings. NHS England may require a representative of the ICB to attend such meetings to discuss any performer concerns and/or quality issues that may impact on individual performer cases.</p>	
<p>2.6 The ICB must develop a mechanism to ensure that all complaints regarding any named performer are escalated to the Local NHS England Team for review. The ICB will comply with any Mandated Guidance issued by NHS England in relation to the escalation of complaints about a named performer.</p>	<ul style="list-style-type: none"> • <i>There is currently a process in place between MD and the complaints team. It is expected that this process will continue. (If this process needs to be broadened to incorporate existing complaints management within systems then a meeting to discuss would be necessary as will impact on resources if there are a greater number of complaints than current)</i>
<p>3. Management of the revalidation and appraisal process – (Medical Directorate)</p>	
<p>3.1 NHS England will continue to perform its functions under the Medical Profession (Responsible Officers) Regulations 2010 (as amended by the Medical Profession (Responsible Officers) (Amendment) Regulations 2013).</p>	
<p>3.2 All functions in relation to GP appraisal and revalidation will remain the responsibility of NHS England, including:</p> <p>3.2.1 the funding of GP appraisers;</p> <p>3.2.2 quality assurance of the GP appraisal process; and</p> <p>3.2.3 the responsible officer network</p>	
<p>3.3 Funding to support the GP appraisal is incorporated within the global sum payment to Primary Medical Services Provider.</p>	
<p>3.4 The ICB must not remove or restrict the payments made to Primary Medical Services Provider in respect of GP appraisal.</p>	
<p>3.5 Appraisal arrangements in respect of all other primary care practitioner groups shall also be Reserved Functions.</p>	
<p>4. Administration of payments and related performers list management activities – (National professional standards team)</p>	
<p>4.1 NHS England reserves its functions in relation to the administration of payments to individual performers and related performers list management activities under the National Health Service (Performers Lists) (England) Regulations 2013 and other relevant legislation.</p>	
<p>4.2 NHS England may continue to pay practitioners who are suspended from the national performers list in accordance with relevant determinations made by the Secretary of State.</p>	

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4.3	For the avoidance of doubt, the ICB is responsible for any ad hoc or discretionary payments to Primary Medical Services Providers (including those under section 96 of the NHS Act) in accordance with Error! Reference source not found. (Delegated Functions) Part 1 paragraphs Error! Reference source not found. and Error! Reference source not found. of this Agreement, including where such payments may be considered a consequence of actions taken under the National Health Service (Performers Lists) (England) Regulations 2013.
5.	Section 7A and Capital Expenditure Functions (Retained NHSE functions)
5.1	NHS England retains the Section 7A Functions and will be responsible for taking decisions in relation to the Section 7A Functions.
5.2	The ICB will provide certain management and/or administrative services to NHS England in relation to the Section 7A Functions.
5.3	NHS England retains the Capital Expenditure Functions and will be responsible for taking decisions in relation to the Capital Expenditure Functions.
5.4	The ICB will provide certain management and/or administrative services to NHS England in relation to the Capital Expenditure Functions.
6.	Such other ancillary activities that are necessary in order to exercise the Reserved Functions – (Medical Directorate)
6.1	NHS England will continue to comply with its obligations under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.
6.2	The ICB must assist NHS England’s controlled drug accountable officer (“CDAO”) to carry out its functions under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.
6.3	The ICB must nominate a relevant senior individual within the ICB (the “ICB CD Lead”) to liaise with and assist NHS England to carry out its functions under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.
6.4	The ICB CD Lead must, in relation to the Delegated Functions: <ul style="list-style-type: none">6.4.1 on request provide NHS England’s CDAO with all reasonable assistance in any investigation involving the Delegated Functions;6.4.2 report all complaints involving controlled drugs to NHS England’s CDAO;6.4.3 report all incidents or other concerns involving the safe use and management of controlled drugs to NHS England’s CDAO;6.4.4 analyse the controlled drug prescribing data available; and6.4.5 on request supply (or ensure organisations from whom the ICB commissions services involving the regular use of controlled drugs supply) periodic self–declaration and/or self-assessments to NHS England’s CDAO.

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7.	Reserved Functions – Primary Medical Services
7.1	The following functions and related activities shall continue to be exercised by NHS England (the “Reserved Primary Medical Services Functions”):
7.1.1	determining the outcomes expected from Primary Medical Services and the main characteristics of high quality services, taking into account national priorities for improving NHS outcomes and the Department of Health and Social Care mandate;
7.1.2	designing and delivering national transformation programmes in support of national priorities;
7.1.3	the negotiation and agreement of matters concerning General Medical Services contracts with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of primary medical services nationally;
7.1.4	the development of national standard Primary Medical Service contracts and national contract variations and guidance to ensure an equitable approach to applying nationally agreed changes to all Primary Medical Services providers;
7.1.5	the provision of commissioning and contracting policy and guidance to support ICBs to meet their delegated duties;
7.1.6	the provision of nationally contracted services delivering digital, logistical and support services for Primary Medical Services in England (including but not limited to):
7.1.6.1	Payments;
7.1.6.2	Pensions;
7.1.6.3	Patient Registration;
7.1.6.4	Medical Records;
7.1.6.5	Performer List;
7.1.6.6	Supplies;
7.1.6.7	Call and Recall for Cervical screening (CSAS); and
7.1.6.8	Pharmacy Market Management. (via P&O process)
7.2	The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.
8.	Reserved Functions – Primary Dental Services
8.1	The following functions and related activities shall continue to be exercised by NHS England (the “Reserved Primary Dental Services Functions”):

Appendix 2

- 8.1.1 determining the outcomes expected from Primary Dental Services and the main characteristics of high quality services, taking into account national priorities for improving NHS outcomes; designing and delivering national transformation programmes in line with any applicable commissioning policies and guidance;
- 8.1.2 the negotiation and agreement of matters concerning Dental Services Contracts with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of primary dental services nationally;
- 8.1.3 the development of national standard Dental Service Contracts and national contract variations and guidance to ensure an equitable approach to applying nationally agreed changes to all Primary Dental Services providers;
- 8.1.4 the provision of all dental commissioning and contracting policy and guidance to support ICBs to meet their delegated duties; and
- 8.1.5 the provision of nationally contracted services delivering digital, logistical and support services for Primary Dental Services in England (including but not limited to):
 - 8.1.5.1 Payments;
 - 8.1.5.2 Pensions;
 - 8.1.5.3 Performer List; and
 - 8.1.5.4 Market Management.

8.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

9. Reserved Functions – Primary Ophthalmic Services

- 9.1 The following functions and related activities shall continue to be exercised by NHS England (the “Reserved Ophthalmic Functions”):
 - 9.1.1 the Primary Ophthalmic Services Contracts policy and associated documentation;
 - 9.1.2 the negotiation and agreement of matters concerning Primary Ophthalmic Services with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of Ophthalmic Services nationally; and
 - 9.1.3 the provision of nationally contracted services delivering digital, logistical and support services for Primary Ophthalmic Services in England (including but not limited to):
 - 9.1.3.1 Payments;
 - 9.1.3.2 Performers List;

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Appendix 2

	<p>9.1.3.3 Market Management/Entry; and</p> <p>9.1.3.4 Contract management, assurance and post-payment verification.</p>	
<p>9.2</p>	<p>The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services</p>	
<p>10. Reserved Functions – Pharmaceutical Services and Local Pharmaceutical Services – Medical Directorate</p>		
	<p>10.1 The following functions and related activities shall continue to be exercised by NHS England (the “Reserved Pharmaceutical Functions”):</p> <p>10.1.1 publication of Pharmaceutical Lists; national (P&O manage from regional perspective)</p> <p>10.1.2 functions of NHS England as a determining authority in relation to pharmaceutical remuneration under Part 12 of the Pharmaceutical Regulations;</p> <p>10.1.3 functions in respect of lists of performers of pharmaceutical services and assistants, noting that as at the date of this Agreement regulations for the purposes of these functions have not been made¹⁵;</p> <p>10.1.4 the negotiation and agreement of matters concerning NHS pharmaceutical services with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of Pharmaceutical Services nationally;</p> <p>10.1.5 the provision of commissioning and contracting policy and guidance to support ICBs to meet their delegated duties; and</p>	<ul style="list-style-type: none"> • <i>We record a list of pre-reg trainees with their start date and end date and where they are/were training. The full cost of training is £18,440, paid monthly over 1 year.</i>

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¹⁵ Part 7, Chapter 4A of the NHS Act (not currently in force)

Appendix 2

10.1.6	administration of the pharmacist pre-registration training grant scheme.	
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Pharmaceutical Services Regulations Committee (PSRC)

Terms of Reference

Issue Date: September 2024

Date of next review: September 2025

1 Introduction

By virtue of the delegation agreements between NHS England and Integrated Care Boards (ICBs) and NHS England's Pharmacy Manual, each ICB is required to establish a Committee that is the equivalent of the former NHS England Pharmaceutical Services Regulations Committees (PSRCs).

Where such Committees are established and are properly constituted in line with the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013, as amended (the 2013 regulations), they are authorised by NHS England to undertake activities within the Terms of Reference set out in the Pharmacy Manual.

Via **Chapter 2 of the [Pharmacy Manual \(england.nhs.uk\)](https://www.nhs.uk/pharmacy-manual)** NHS England has delegated decision-making to each ICB in relation to the matters under the 2013 regulations that are listed in that chapter where the decision-maker is listed as "the committee".

Under section 65Z5 of the NHS Act 2006, the six ICBs in the East of England have formed a PSRC. The ICBs in the East of England are Hertfordshire and West Essex (HWE) ICB, Bedfordshire, Luton and Milton Keynes ICB, Cambridgeshire and Peterborough ICB, Mid and South Essex ICB, Suffolk and North East Essex ICB and Norfolk and Waveney ICB. The PSRC is hosted by Hertfordshire and West Essex ICB who will manage this function on behalf of the other ICBs across the East of England.

2 Membership

The membership of the PSRC is as follows:

- Director of Primary Care Transformation, HWE ICB (or their suitable, nominated deputy) who will chair the meeting.
- Assistant Director for Primary Care Contracting, HWE ICB (or their suitable, nominated deputy) who will chair the meeting in the absence of the Director of Primary Care Transformation and
- One or two independent (lay) advisors (or equivalent).

Due to the knowledge and understanding of the 2013 regulations that is required, PSRC independent members are considered to be "experts" and should receive an appropriate fee.

All members of the PSRC must have a good knowledge and understanding of the 2013 regulations to reduce the likelihood of a successful appeal against decisions made. It is

recognised that the ICB may occasionally not be able to appoint members to the PSRC who have the required level of knowledge and expertise. It is therefore essential that the PSRC is supported by officers or persons who have the relevant expertise. It is essential that members build up expertise in the 2013 regulations and therefore consistency of attendance is expected.

Meetings will be quorate if any two of the members are present, one of whom must be a HWE ICB officer. Each member of the PSRC has a vote and the Chair has the casting vote, if necessary. ICB representatives are non-voting observers.

The PSRC must ensure it has access to expert knowledge on the 2013 regulations and may obtain such legal or other independent professional advice as it considers necessary and may co-opt persons with relevant experience and expertise if required.

The PSRC may seek professional advice in relation to fitness matters, by local agreement, from a pharmacy advisor or a person who is a member of an NHS England professional standards group or performers lists decisions panel. For the avoidance of doubt, 'fitness matters' are defined as follows.

- Determining whether or not an applicant is a fit and proper person to be included in the relevant pharmaceutical list when applying to be included in it for the first time and determining whether or not an applicant remains a fit and proper person after the change of the Superintendent and/or directors on the relevant pharmaceutical list.
- Considering whether or not an applicant body corporate remains a fit and proper to be included in the relevant pharmaceutical list following the grant of an application for inclusion in that list, but before the body corporate is so included, where it notifies the commissioner that it has appointed a new superintendent.
- Review of conditions following the conditional inclusion of an applicant in a pharmaceutical list.
- Use of the fitness powers in connection with a person who is already included in a pharmaceutical list or lists as set out in the NHS Act 2006 and the Regulations 2013, to include removal, contingent removal, suspension and applying for a national disqualification. This could be as a result of a contractor notifying the commissioner of a fitness matter, the commissioner otherwise becoming aware of a fitness matter, or through contract management alongside, or instead of, use of the performance related sanctions.

The following persons may be co-opted to each committee, but will not have a vote:

- Pharmacy Contract Manager (or equivalent)
- Pharmacy Professional Adviser (or equivalent) (as required).

The PSRC may invite further ICB officers to attend committee meetings to discuss fitness matters. They will be sent copies of the papers in advance of each meeting, and these are shared in the strictest confidence. They must not be shared any wider unless it has been agreed to do so via the PSRC. For the avoidance of doubt, such officers will not have voting rights and will be in attendance for those matters relating to their specific ICB only.

ICB representatives will be invited to each meeting, only one ICB representative should attend each meeting. ICB representatives will be non-voting observers.

The following persons are ineligible to be voting or co-opted members of the PSRC, as specified in Regulation 82 and paragraph 26(1), Schedule 2 of the 2013 regulations, in relation to the determination of any application for inclusion in a pharmaceutical or dispensing doctor list.

- A person who is included in a pharmaceutical list or is an employee of such a person.
- A person who assists in the provision of pharmaceutical services under Chapter 1 or Part 7 of the NHS Act 2006.
- A person who is an LPS chemist, or a person who provides or assists in the provision of LPS.
- A person who is a provider of primary medical services.
- A person who is a member of a provider or primary medical service that is a partnership, or a shareholder in a provider of primary medical services that is a company limited by shares.
- A person who is employed or engaged by a primary medical services provider.
- A person who is employed or engaged by an alternative provider medical services contractor in any capacity relating to the provision of primary medical services.

In addition, no voting or co-opted member or other ICB officer may take part in a decision if, in the opinion of the remaining voting members, the circumstances set out in paragraph 26(2), Schedule 2 to the 2013 regulations apply (reasonable suspicion of bias).

Voting and co-opted members and other ICB officers must advise the Chair of any potential Conflict of Interest on receipt of the papers for a meeting. Discussion of those potential conflicts will take place at the beginning of each meeting and will be recorded. Where a conflict is perceived to exist in relation to a matter, the member with that conflict will leave the room/virtual meeting before discussion of that matter and will not return until the relevant decision has been made and the reasons for it have been recorded.

3 Meeting Arrangements

HWE ICB shall secure such administrative support as is reasonably necessary to carry out its functions.

The PSRC will meet every three weeks (or earlier if needed to discuss any urgent matters) where there is a need. Where a meeting is not required the PSRC will document this in line with local procedures. Meetings may be held virtually or face to face. Agendas and papers will be circulated electronically approximately one week before the meeting.

4 Reporting Arrangements

The PSRC will report quarterly to all ICB's Primary Care Commissioning Committee (or equivalent), in the East of England on the decisions taken and the outcome of any appeals on those decisions. It will also be required to report to NHS England in line with the assurance framework.

5 Responsibilities

The PSRC will be responsible for making those decisions set out in chapter 2 of the Pharmacy Manual where the decision-maker is listed as “the committee”. A list is provided at **Appendix 1**

The Pharmacy Contract Managers and Contracting Support Managers are responsible for ensuring that applications for inclusion in a pharmaceutical list are determined in line with the timescales set out in the 2013 regulations. As such they will escalate applications as and when required.

Health and Wellbeing Boards (HWB) are responsible for identifying current or future needs for, or improvements or better access to, a pharmaceutical service or pharmaceutical services in general via the Pharmaceutical Needs Assessment (PNA). There are twelve HWB covering the East of England. The PSRC is required to review the PNAs in its area and to record the actions taken to address identified needs, improvements or better access whether this is via the market entry process or through local commissioning processes.

6 Officer Level Decisions

Within the Pharmacy Manual, certain decisions may be made by ICB officers in the Contracting Team. Where that person is unavailable the manual allows the decision to be made by the PSRC.

The requirements of Regulation 62 and paragraph 26(1), Schedule 2 of the 2013 regulations apply to these officers. Before considering an application or making a decision that has been delegated to them, the officer must document that they are not barred by virtue of the relevant regulation or paragraph mentioned at the beginning of the paragraph.

Officers in the Contracting Team may not make a decision if the circumstances set out in paragraph 26(2), Schedule 2 to the 2013 regulations apply (reasonable suspicion of bias).

If, for whatever reason, an officer is unable to make a decision within the required timeframe (or at all), that decision shall be taken by the committee.

The officer will report to the PSRC on decisions taken and the outcome of any appeals on those decisions. The PSRC will be updated during regular meetings which are scheduled to take place in three weekly intervals.

6.1 Fitness Decisions

All fitness decisions will be made by the PSRC. The PSRC may nominate an ICB officer who has the appropriate clinical experience to make recommendations on whether the applicant is suitable to be included in the relevant pharmaceutical list on fitness grounds.

6.2 Other Decisions

HWE ICB are required to have an appropriately experienced officer in a role that is similar to the preceding NHS England pharmacy contracts managers. Where such person meets the requirements of the 2013 Regulations they are authorised by NHS England to make the decisions listed in Chapter 2 of the Pharmacy Manual marked as “officer”. For the purposes of the ICBs who have established this PSRC, this is the Pharmacy Contract Manager at HWE ICB (or equivalent).

Appendix 1



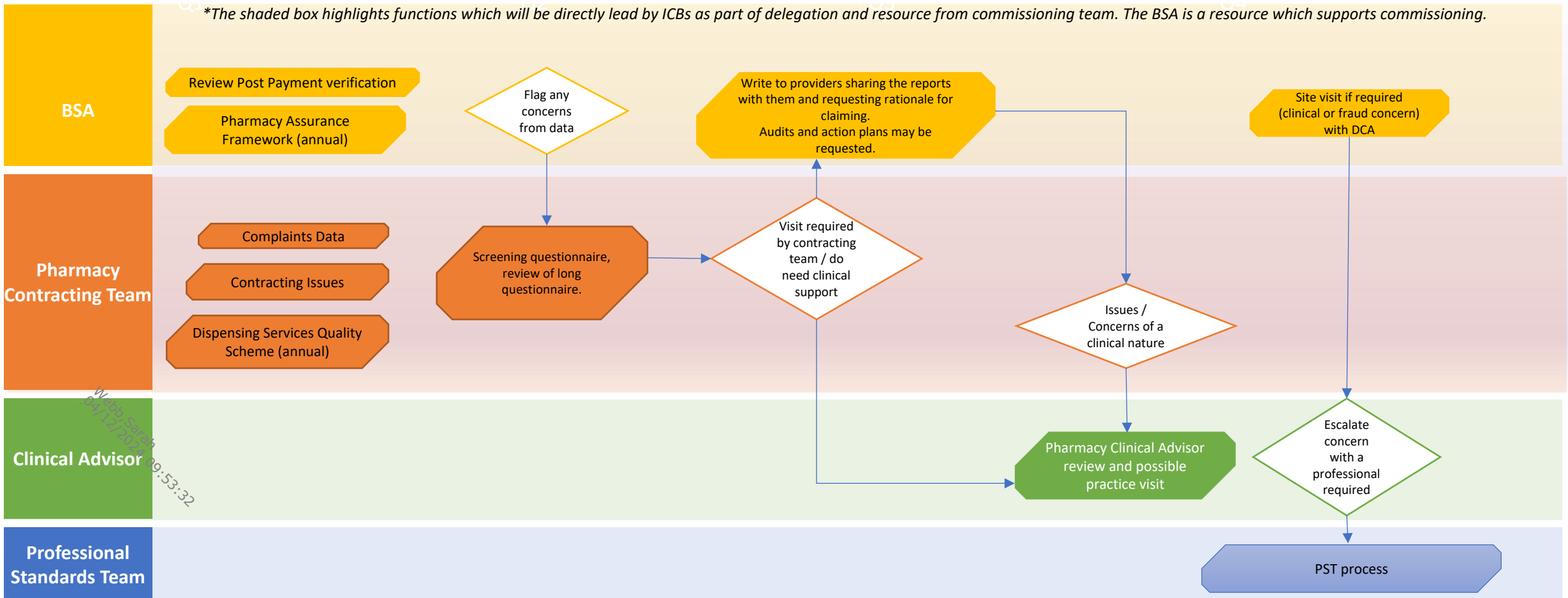
Appendix 1 -
Delegated Decision M

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Pharmacy Quality Review and Audits

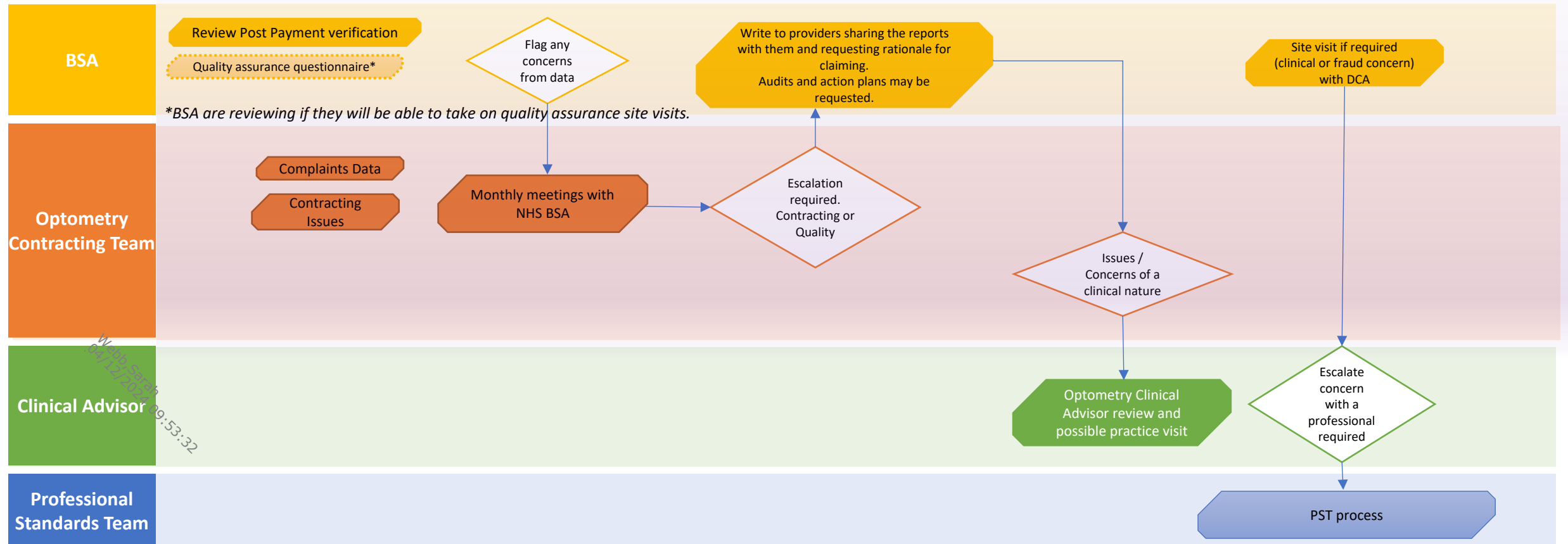
- Pharmacy quality in terms of contractual, clinical and professional are monitored by Contracting and BSA team, utilising the clinical advice and professional standards team review process where escalation is required.
- Direct Commissioning Nursing and Leadership Team sit on Professional Standards Team professional review process only.



Optometry Quality Review and Audits

- Optometry quality in terms of contractual, clinical and professional are monitored by contracting and BSA team, utilising the clinical advice and professional standards team review process where escalation is required.
- Direct Commissioning Nursing and Leadership Team sit on Professional Standards Team professional review process only.

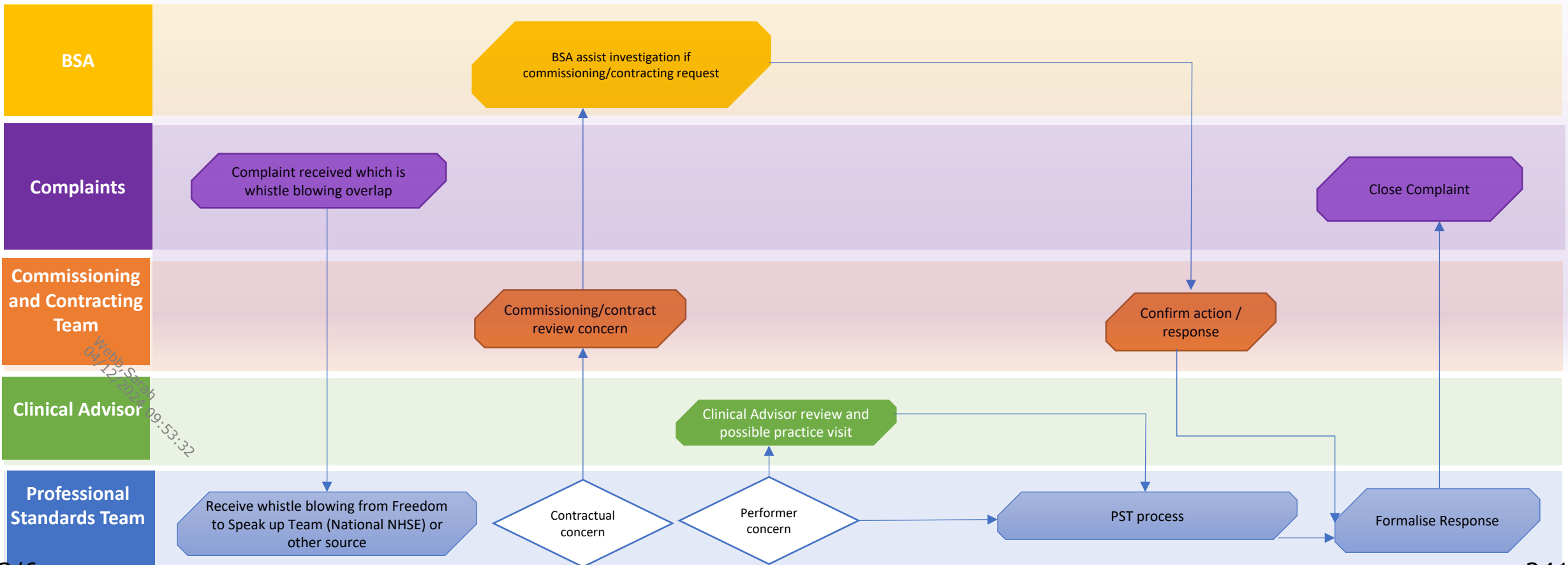
**The shaded box highlights functions which will be directly lead by ICBs as part of delegation and resource from commissioning team. The BSA is a resource which supports commissioning.*



Whistle Blowing

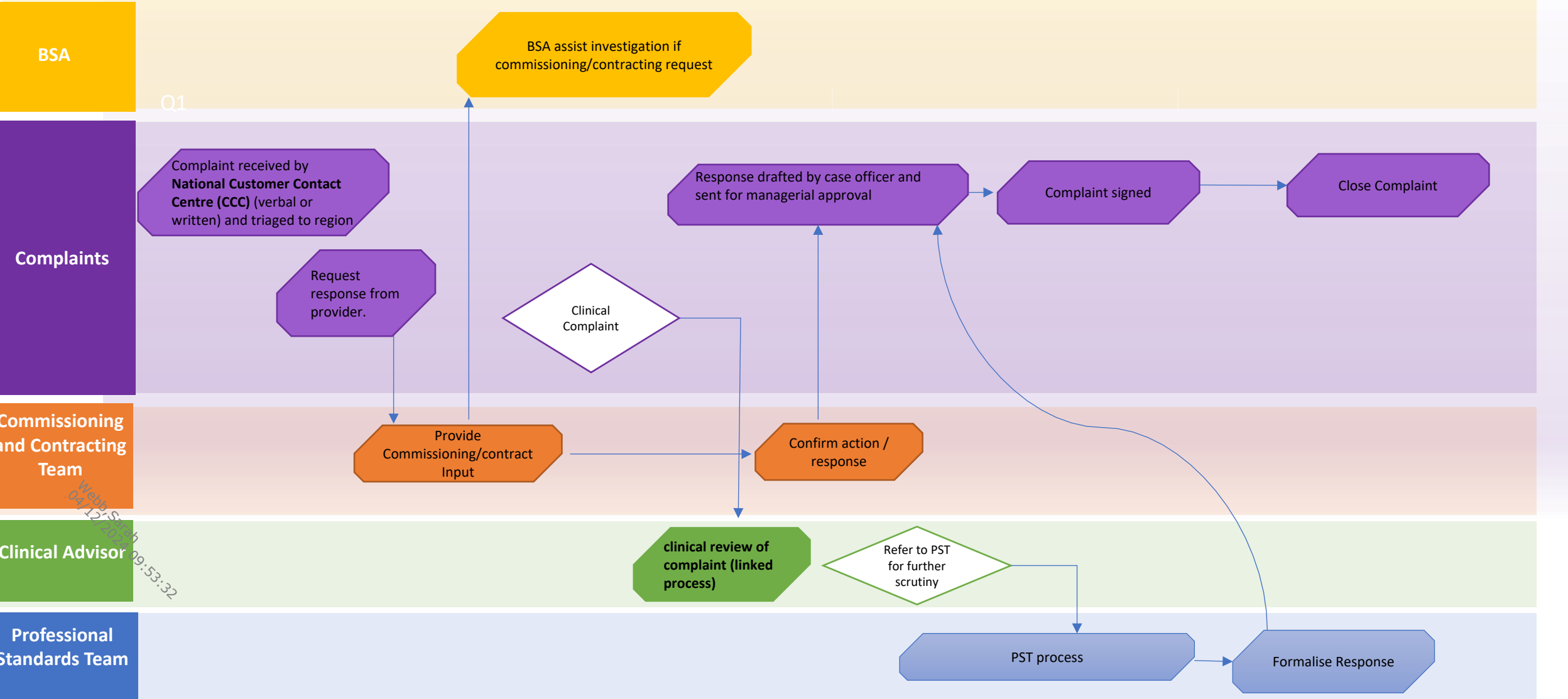
- National Freedom to Speak Up remains in place, Professional standards team who deals with these remain at region. Interface with POD Commissioning required and complaints.

**The shaded box highlights functions which will be directly lead by ICBs as part of delegation and resource from commissioning team. The BSA is a resource which supports commissioning. Complaints will be a delegated function with the workforce model TBC.*



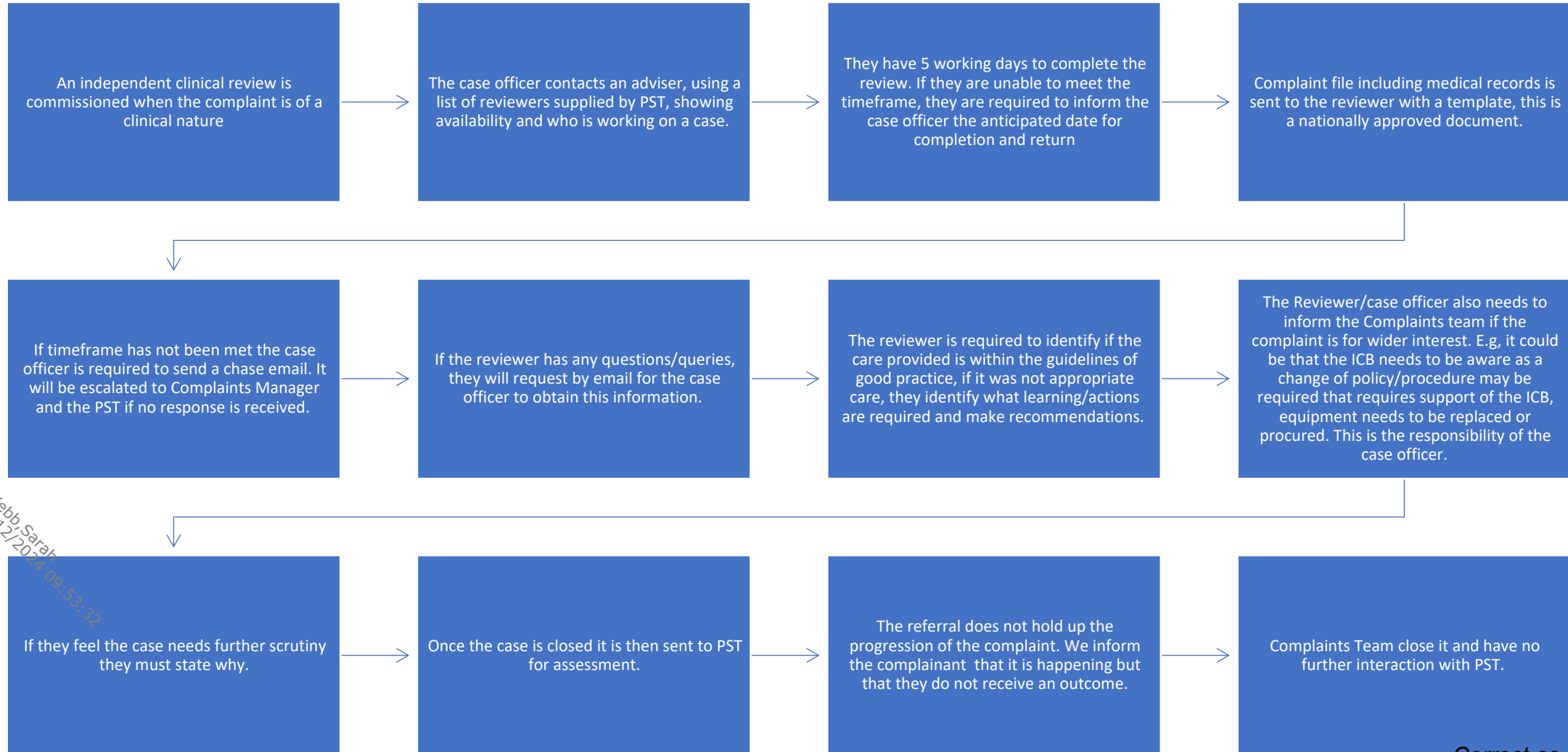
Complaints

*The shaded box highlights functions which will be directly lead by ICBs as part of delegation and resource from commissioning team. The BSA is a resource which supports commissioning. Complaints will be a delegated function with the workforce model TBC.



Complaints Process (Clinical review)

- Retained process for NHSE, led by Professional Standards Team. Interface required.

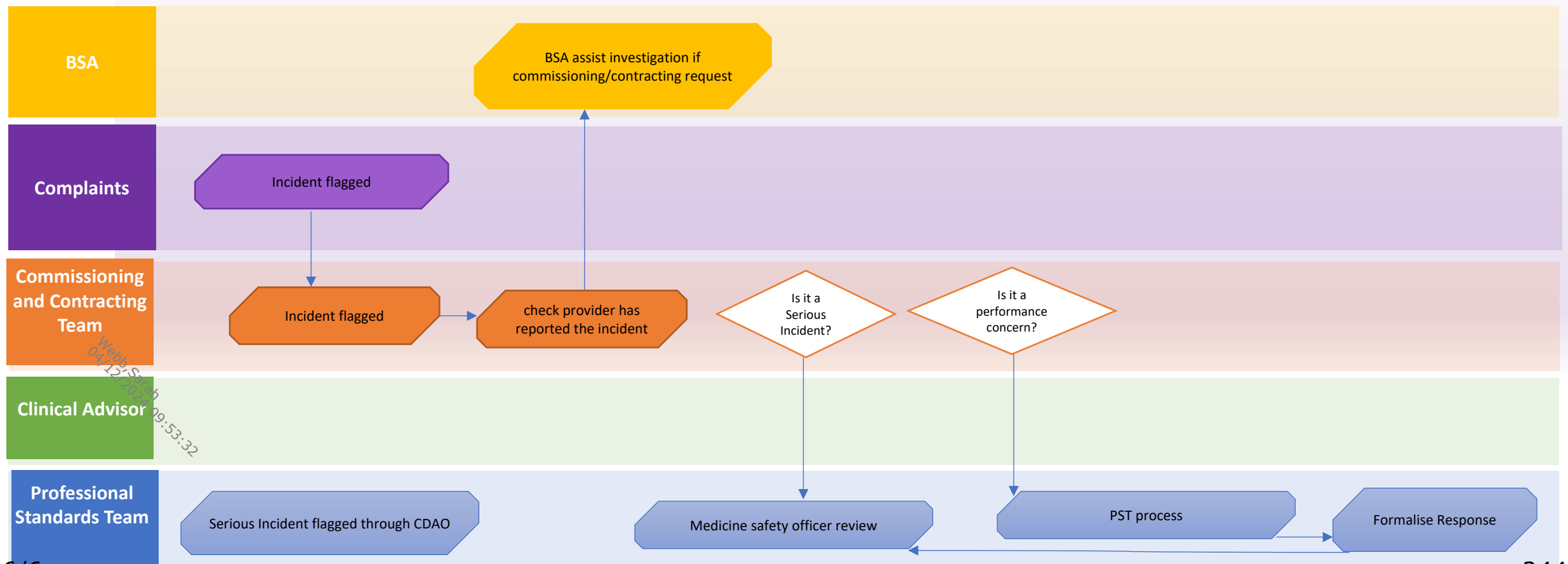


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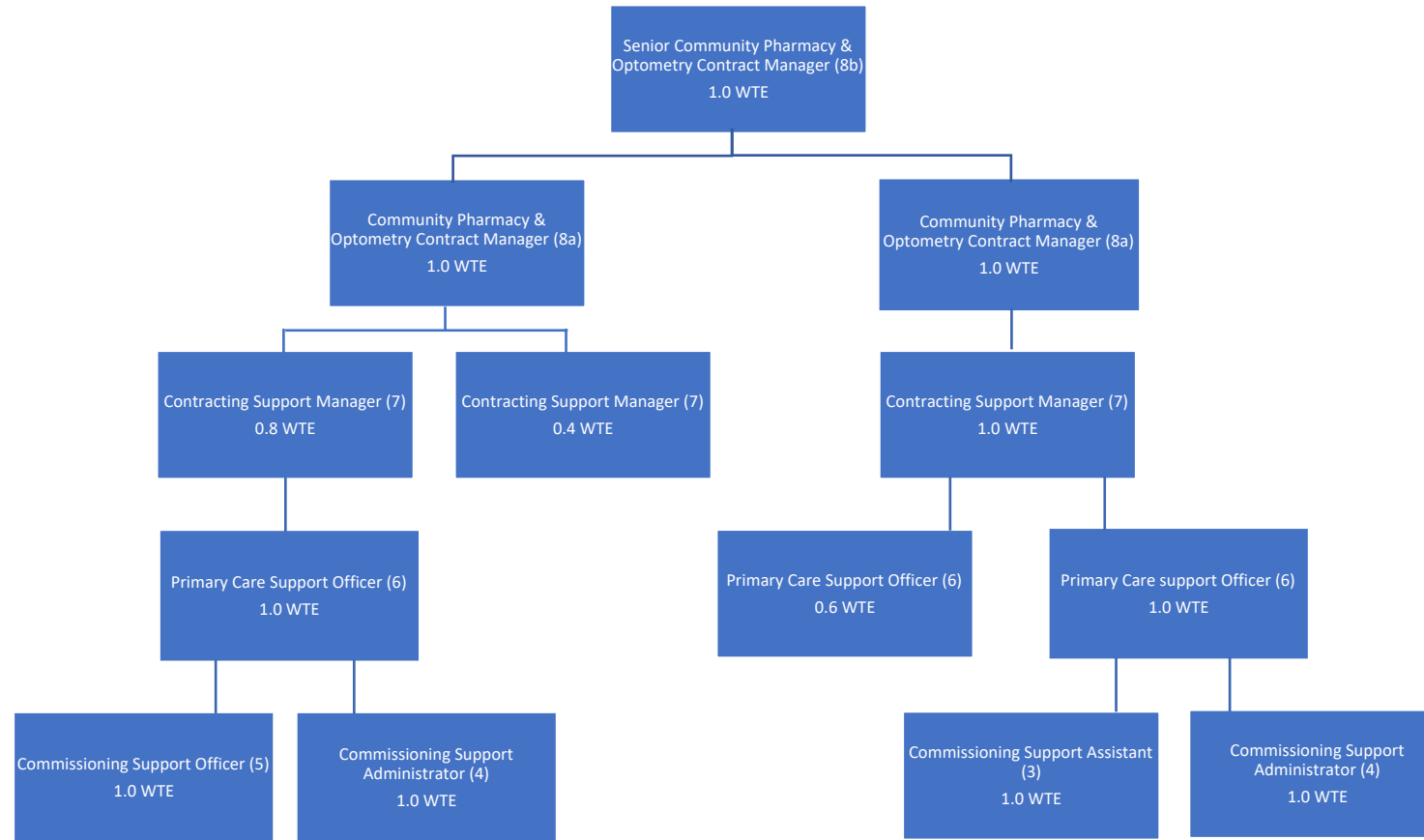
Serious Incident

There will be subtle differences in processes between POD functions. For example in Optometry, they would refer the SI to the GOC and some may notify NHS. Optometry does not have a set SI process in their contracts so difficult to state a definitive process. The clinician may be referred to the professional standards team as a concern if it progressed to going to a GOC investigation.

**The shaded box highlights functions which will be directly lead by ICBs as part of delegation and resource from commissioning team. The BSA is a resource which supports commissioning. Complaints will be a delegated function with the workforce model TBC.*



Pharmacy & Optometry Team August 2024



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Managing and Handling Community Pharmacy Complaints

Introduction and Background

The purpose of this paper is to set our arrangements for managing and handling community pharmacy complaints. It has been developed to support ICB Patient Experience Teams (or equivalent), the Pharmacy Contracting Team and Pharmacy Clinical Advisors (PCA). It is suggested that the principles and processes as set out in this paper (most are likely to already be in place) are adopted by all ICBs in East of England to ensure community pharmacy clinical complaints are managed consistently across the six ICBs in the East of England region.

On 1 April 2023, pharmaceutical services were delegated to individual ICBs. Due to the small size of the Pharmacy Contracting Team, it was not possible to assign staff to individual ICBs, instead the team transferred as one team and are employed and hosted by Herts and West Essex ICB. The team continues to provide the contracting function on behalf of all ICBs in the East of England. This includes providing advice and contracting knowledge for any pharmacy related complaints to Patient Experience Teams (or equivalent teams/colleagues) in the 6 ICBs.

The PCAs have also recently transferred from NHS England to HWE ICB. Whilst managed by HWE ICB, the PCAs work across all ICBs in East of England. It is therefore important that HWE ICB coordinate the use of PCAs in conjunction with Patient Experience Teams. It is recognised that the Pharmacy Contracting Team may be best placed to do this.

Please note, the term “Patient Experience Team” is used generically noting that some ICBs may use a different term e.g., Complaints Team, Quality Team or have individuals identified within their ICB that may manage this process.

General Principles

Patients should always be encouraged to complain directly to the contractor so issues and concerns can be dealt with at the most local level. If a patient does not want to complain to the contractor, the patient can then contact the relevant ICB as the commissioner of the service.

Any of the following from patients or their representatives

- queries / Patient Advice Liaison (PALs)
- complaints
- compliments
- Member of Parliament/local counsellor queries

must be sent to the patient experience team in the ICB that is relevant to the patient’s address and/or location of the service involved. It is the responsibility of individual ICBs to manage and respond to complaints.

For the East of England these are the contact emails for the teams:

ICB	Email contact
NHS Beds, Luton and Milton Keynes	blmkicb.contactus@nhs.net
NHS Cambridgeshire and Peterborough	cpicb.pet@nhs.net

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NHS Herts and West Essex	hweicbwe.patientfeedback@nhs.net
NHS Mid and South Essex	mseicb.complaints@nhs.net
NHS Norfolk and Waveney	nwicb.complaintsservice@nhs.net
NHS Suffolk and North East Essex	sneicb.complaints@nhs.net

ICB teams work from these shared mailboxes so any queries will be picked up as soon as possible. The requirements, in line with the NHS complaint regulations are to acknowledge a query/complaint within 3 working days – this will be done more quickly if it is possible.

If the Pharmacy Contracting Team receives any queries from patients/their representatives/MPs etc, they will be sign posted to the relevant ICB Patient Experience Team.

Complaints should then be handled by the relevant ICB in line with the NHS complaint regulations and local procedures. If the ICB requires input from the Pharmacy Contracting Team, the ICB Patient Experience Team should forward the complaint / relevant part of the complaint to the generic pharmacy inbox: hweicbhv.pharmacy@nhs.net . Please allow a reasonable timescale for queries to allow the team to make a considered response.

If ICB Patient Experience Teams are unsure of where to direct a pharmacy related complaint, the Pharmacy Contracting Team may be able to help, and the generic inbox should be used hweicb.pharmacy@nhs.net

Any complaint or concern that includes a controlled drug (of any schedule) must also be notified to the Controlled Drug Accountable Officer (CDAO) via the Controlled Drug (CD) reporting website (www.cdreporting.co.uk). The ICB Patient Experience Team should ensure that the pharmacy has made a report to the CD reporting website as part of the complaint management process. The pharmacy clinical advisor will be able to identify if any of the drugs are controlled drugs. The CDAO Team will re-direct to contracting team (or relevant other team) if following initial review, serious issues are identified in the handling or management of controlled drugs. If the case involves controlled drugs and the complaints team need to contact the CD team directly for advice the inbox is england.ea-cdao@nhs.net

Exceptions

The Pharmacy Contracting Team cannot investigate individual pharmacists or locums. That responsibility sits within the remit of the regulator, the General Pharmaceutical Council (GPhC). <https://pharmacyregulation.org/reporting-concerns/report-concern>. Sometimes/often the boundaries between GPhC and contracting overlap so it is useful for the Pharmacy Contracting Team to be informed of any GPhC referrals if known to individual ICBs.

Use of Pharmacy Clinical Advisors (PCA)

ICBs will on occasion, receive complaints that are very clinical in nature and may require an external review and support from a PCA. It is appreciated that this is a judgement call. It is very difficult to define what may or may not need clinical input and whether the pharmacy contractor has deviated from accepted practise. Examples could include when a complaint has a complex clinical aspect that the ICB is unable to manage locally, a serious complaint which would benefit from a second opinion or where an ICB has a potential conflict of interest.

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Where an ICB judges that a clinical review may be needed, an initial screening exercise will be undertaken by a PCA (this will need to be documented as set out below). The ICB Patient Experience Team will need to request a PCA by emailing hweicbhv.pharmacy@nhs.net who will identify a PCA for the ICB Patient Experience Team.

The ICB Patient Experience Team will need to complete the Complaints Clinical Review Template (Section 1) and send it to their allocated PCA. (Complaints Clinical Review Template is included at **Appendix 1**). The PCA will determine whether a full clinical complaint review is needed or whether it could be dealt with in another way e.g a conversation between a PCA and the ICB Patient Experience Team, re-direction elsewhere etc.

If the PCA advises that a full clinical review is not required, the ICB Patient Experience Team will need to act on the advice given by the PCA / implement next steps and manage the complaint including response to the patient in the usual way. The outcome of screening should be documented on the Complaints Clinical Review Template and sent to hweicb.pharmacy@nhs.net for audit purposes.

If the PCA determines that a full clinical review is required, they will conduct a full clinical review and document their findings using the Complaints Clinical Review Template and will return the template to the ICB Patient Experience Team. The ICB should have an internal process to ensure the information in the review is shared with any relevant teams within their ICB e.g community pharmacy leads, quality teams etc. The complaint should then be managed by the Patient Experience Team, responding to the patient in the usual way.

Prior to delegation, a Clinical Review of a complaint may have been presented at the Performance Advisory Group (PAG) or the Performers List Decision Panel (PLDP) at NHS England. Since 1 April 2023, the route for escalation of clinical complaints is via referral to the Pharmaceutical Services Regulation Committee (PSRC).

PSRC is hosted by HWE ICB and makes decisions on behalf of all ICBs across the East of England. If the PCA findings are that a referral to PSRC is needed, the ICB Patient Experience Team should contact the P&O contracting team via hweicbhv.pharmacy@nhs.net providing the Complaint Clinical Review Template.

The subject heading for the email should be "Clinical Complaint for PSRC." Process ends for Patient Experience Team here.

The Pharmacy Contacting Team will arrange for the case to be presented at the next PSRC which meets monthly. PSRC will decide on any next steps and the matter will be managed from this point on by PSRC in conjunction with the contracting team and PCAs if required.

Appendix 1 - Complaints Clinical Review Template



Draft - Complaint
Review Template.docx

Available on request.

Webb, Sarah
04/12/2024 09:53:32

Agenda item: 16a

Subject:	Review of the hosting arrangements with Herts and West Essex ICB to deliver pharmaceutical and ophthalmic contracting services on the behalf of Norfolk and Waveney ICB
Presented by:	Sharon Gardner- Head of Primary Care Commissioning Pharmacy and Optometry
Prepared by:	Sharon Gardner- Head of Primary Care Commissioning Pharmacy and Optometry
Submitted to:	Primary Care Commissioning Committee
Date:	10 December 2024

Purpose of paper:

To Inform and gain approval from the Primary Care Commissioning committee in relation to the updated Memorandum of understanding (MoU) with Herts and West Essex (HWE) ICB to host the Pharmaceutical and ophthalmic contracting function, on behalf of the 6 ICBs in the East of England. This includes the hosting of the governance function relating to pharmaceutical services contracting called the Pharmaceutical Services Regulations Committee (PSRC)
This also includes an update to the terms of reference (TOR) for the PSRC.

Executive Summary:

As of 1st April 2023, Norfolk and Waveney ICB became responsible for pharmaceutical, optometry and dental services (primary, community and secondary care) under a delegated agreement signed in March 2023 with NHS England (NHSE)

It was agreed as part of the delegation of pharmaceutical services and General Ophthalmic Services (GOS), that the Pharmacy and Optometry Contracting Team (P&O team) would transfer as one team, hosted by HWE ICB. The P&O team would cover both disciplines (pharmacy and optometry) across all six ICBs.

This arrangement was governed by a MoU which sets out how the responsibilities are split between the host ICB, the other ICBs and the interdependent functions that have been retained by NHS England and how they will work together to provide an effective hosted contract management function.

The formal governance of matters relating to pharmaceutical services contracting is through the Pharmaceutical Services Regulations Committee (PSRC) which has

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delegated powers from a relevant committee (through the Terms of Reference) of each of the six ICB Boards (equivalent to the Primary Care Commissioning Committee)

The paper looks to set out the key updates within the new MoU in relation to the previously agreed document from April 2023

Report

Herts and west Essex ICB have been hosting the contracting function for all 6 ICBs in the East of England since 1st April 2023. A MoU has been in place since that delegation. The MoU sets out how the ICBs in the East of England will fulfil their responsibilities and does not replace the requirements set out in the delegation agreement. This was noted by the PCCC at the meeting on the 21st April 2023. Despite the hosting arrangement, by signing the MoU the ICB agrees to have equal responsibility with the HWE pharmacy and optometry contracting team to ensure effective commissioning of the pharmacy and optometry services, meeting the needs of the local population.

Although there was no date on the MoU it was decided at the 12 month point, due to the transfer of unanticipated and un-resourced functions, a review would take place with alterations that could be discussed and made, if required, to improve the service and outcomes. The review took place with all 6 ICBs through a series of touchpoint meetings where amendments were raised, and MoU drafts were discussed, and the final MoU agreed.

In relation to the MoU the main changes that have been introduced are:

- 1) Addition of ICB commissioning responsibilities in relation to Fitness Matters
- 2) Addition of additional processes to provide assurance driven from our internal audit:
Where HWE ICB audit programme includes primary care and specifically pharmacy and optometry contracting, the findings and/or outputs from the audit report (or appropriate aspects of the report) will be shared with respective ICBs.
- 3) Addition of the QiO requirement and future actions needed:
Where HWE ICB audit programme includes primary care and specifically pharmacy and optometry contracting, the findings and/or outputs from the audit report (or appropriate aspects of the report) will be shared with respective ICBs."

In relation to the Terms of reference for the PSRC meeting this has been updated to reflect changes made in the Pharmacy Manual to ensure they are in line with the Pharmacy regulations

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Recommendation to the Committee:

- To approve the amended Mou to enable the hosting of the pharmacy and optometry contracting function by Herts and West Essex ICB
- To approve the updated terms of Reference for the Pharmaceutical Services Regulations Committee (PSRC) which will enable ICB signatory

Key Risks	
Clinical and Quality:	Without the PSRC function the ICB would have an Inability to process fitness applications as part of the market entry process. Inability to respond to clinical concerns around controlled drugs and other regulatory matters which could cause risk to the quality of provision to our population.
Finance and Performance:	Financial risk if this function is not continued by HWE and needs to be introduced to the ICB. This is a statutory function so cannot be dissolved.
Impact Assessment (environmental and equalities):	N/A
Reputation:	Reputational risk from pharmacy contractors and their representatives if pharmacy applications and fitness requirements are not completed with the statutory timeframes which may cause undue delays to the contractor's business strategy and plans, affecting their financial viability.
Legal:	The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013
Information Governance:	N/A
Resource Required:	None identified
Reference document(s):	NHS England » Pharmacy Manual Delegation Agreement Final.docx HWE MoU PSRC terms of reference
NHS Constitution:	The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013
Conflicts of Interest:	None Known
Reference to relevant risk on the Board Assurance Framework	Resilience of Primary Care

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Governance

Process/Committee approval with date(s) (as appropriate)	Audit Committee for information.
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Appendix as attachments

Appendix 1

Final MoU

Appendix 2

P&O Contracting and Fitness Function [taken from the Delegation Agreement]

Appendix 3

PSRC Terms of Reference [to be updated in line with changes to Pharmacy Manual]

Appendix 4

Quality Mapping Swim Lane Diagram

Appendix 5

Pharmacy Optometry Staff Structure – Updated August 2024

Appendix 6

Use of Clinical Advisor in exceptional circumstances when complaints require escalation.

Webb, Sarah
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To be completed by Meeting Secretary

Agenda item: 16b

Paper No:



Meeting/Committee:	Primary Care Commissioning Committee P1
Venue:	Teams Meeting
Date:	10 December 2024

Title of Report	Pharmaceutical Services Regulation Committee (PSRC) – Decisions Made (July to September 2024)	
Presented by	Sharon Gardner – Head of 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 01st July to 30th September 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.	

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.

Webb
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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 July to September 2024:

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

Application	Health and Wellbeing Board	Decision
Application to change core opening hours: Fittleworth Medical Ltd, 8 Longs Business Centre, 232 Fakenham Road, Taverham, Norfolk, NR8 6QW	Norfolk	Granted
Application for inclusion in a pharmaceutical list: no significant change relocation application within Norfolk HWB's area: NW Pharma Ltd, 11 Market Place, North Walsham, Norfolk, NR28 9BP	Norfolk	Refused
Request for a planned temporary suspension of services from: Holt Health Services Ltd, t/a Kelling Pharmacy, Holt Medical Practice, Kelling Hospital, Old Cromer Road, Holt, Norfolk, NR25 6QA	Norfolk	Refused
Application to change core opening hours: Boots UK Ltd, 124 Merchants Hall, Lower Ground, Chapelfield, Norwich, Norfolk, NR2 1SH	Norfolk	Refused
Application for inclusion in a pharmaceutical list: no significant change relocation application within Norfolk HWB's area: NW Pharma Ltd, Lidl Retail Park, Holt Road, Fakenham, NR21 8JG	Norfolk	Refused

Market Entry - Decisions made (outside scheduled PSRC meetings – via e-mail):

Application	Health and Wellbeing Board	Decision
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.
None				

Fitness Decisions (within scheduled PSRC meetings):

Fitness Notifications / Concerns	Health and Wellbeing Board	Decision
Magdalen Medical Supplies Ltd – New Inclusion Pending Change of Ownership	Norfolk	The Committee agreed that Magdalen Medical Supplies Ltd is a fit and proper person to be included on the Norfolk HWB pharmaceutical list pending a successful COO application
Talat K & Co Ltd – New Inclusion Pending Change of Ownership	Norfolk	The Committee agreed that Talat K & Co Ltd is a fit and proper person to be included on the Norfolk HWB pharmaceutical list pending a successful COO application
Thetford EA Ltd – COSI	Norfolk	The Committee concluded that Thetford EA Ltd remains a fit and proper person to be included in the pharmaceutical list for the area of Norfolk HWB following the appointment of a new superintendent
Fitness Review for Foschell Ltd – New Inclusion Pending Unforeseen Benefits Application	Norfolk	The Committee agreed that Foschell Ltd is a fit and proper person to be included on the Norfolk HWB pharmaceutical list pending a successful UB application
Fitness Review for Fircroft Medical Supplies Ltd – New Inclusion Pending Change of Ownership	Norfolk	The Committee agreed that Fircroft Medical Supplies Ltd is a fit and proper person to be included on the Norfolk HWB pharmaceutical list pending a successful COO application

Fitness Decisions (outside scheduled PSRC meetings – via e-mail):

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Fitness Notifications / Concerns	Health and Wellbeing Board	Decision
None		

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 Decision	Appeal Ref.
None				

Regulatory Timescales:

The regulations set out timescales by which the ICB should process and determine applications. The P&O team constantly strive to meet timescales however there are occasions when timescales are exceeded. The timescales vary depending on the type of application, for example, a change of ownership application should be determined within 30 days, an unforeseen benefits application should be determined within 4 months. Consideration is therefore required as to how this can accurately be reflected in a quarterly report.

For this report and future reporting, the ICB will be informed of the number of applications completed within the relevant quarter that have exceeded the timescales. Where timescales have not been met, a brief reason and mitigations will be provided.

Application delayed	Reason for delay	Mitigation
CAS-247546-G2N5Z8 (UB)	Was heard with two other Blofield area applications (3 in total) and therefore had to be "held back" for the latest application to catch up.	UB applications that need to be heard together may not always be determined in 4 months.
CAS-269340-F6Y7X5 (UB)	Fitness was required (no regulatory timescales for fitness). Being heard alongside CAS-278861-Z9SOH6.	UB applications that need to be heard together may not always be determined in 4 months.
CAS-278861-Z9SOH6 (UB)	Was heard together with another application (CAS-269340-F6Y7X5) and therefore had to be "held back" so both applications could be heard together. The other application required fitness.	UB applications requiring full fitness may not always be determined in 4 months.

Recommendation(s):

Note the decisions made at the PSRC meetings between July to September 2024.
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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.

Webb, Sarah
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Agenda item: 16b

Subject:	Pharmaceutical Services Regulation Committee (PSRC) – Decisions Made 01 July 2024 to 30 September 2024
Presented by:	Sharon Gardner – Head of Commissioning – Pharmacy and Optometry
Prepared by:	Gregg Syder – Commissioning Manager – 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:	10 December 2024

Summary of Paper

The attached paper contains the second quarter (Q2) report from the Pharmaceutical Services Regulation Committee (PSRC) relating to the market entry and fitness decisions made at the monthly PSRC meetings 1st July 2024 to 30th September 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 1st July 2024 to 30th September 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 interim may need to be reviewed and changes to the PNA considered.

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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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Webb, Sarah
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To be completed by Meeting Secretary

Agenda item: 17

Paper No:



Meeting/Committee:	Primary Care Commissioning Committee Part 1
Venue:	Teams Meeting
Date:	10 December 2024

Title of Report	General Ophthalmic Services (GOS) Contracting – Quarter End Update Report (Q2 2024/25)
Presented by	Sharon Gardner – Head of Commissioning – Pharmacy and Optometry
Author	Jackie Bidgood, Senior Contract Manager, Pharmacy and Optometry

Summary:

The attached paper contains the second quarter (Q2) report which provides an update on GOS contracting arrangements and sets out the current GOS contracting position for Norfolk and Waveney ICB.

The additional information included below summarises elements of the GOS contract relevant to the commissioning team.

GOS NHS Sight Tests:

In England, NHS sight testing is provided under General Ophthalmic Services (GOS). There are five types of GOS claims that can be submitted, these are:

- GOS1 (NHS sight test) This is an application for an NHS funded sight test that is to be used where a patient is entitled to a free NHS sight test.
- GOS3 (NHS Optical voucher) Complete this claim if, following a GOS sight test, the patient is eligible for a voucher and either requires spectacles for the first time, or the prescription has changed significantly. This voucher can then be used to pay for or towards the spectacles or contact lenses.
- GOS4 (repair and replacement voucher) To be completed where patients who qualify require a repair or replacement voucher, for example if they lose or damage their glasses.
- GOS5 (help with the cost of a private sight test) This is only for use by patients who hold a valid HC3 certificate at the time of the sight test. This patient contribution should then be deducted from your private sight test fee.
- GOS6 (domiciliary/mobile sight test) To be used when claiming a domiciliary fee in respect of a patient who is eligible for a GOS sight test and who is unable to attend a practice unaccompanied (for reasons of physical or mental ill health or disability) and the sight test is carried out at the patient's domicile.

Data on the number of NHS sight test is provided to the ICB via the eOPS system.

GOS Contract Mandatory Requirements

As part of the GOS contract there are several mandatory requirements that NW ICB will need to manage and track. The two primary elements of focus for the next quarter will be:

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-Annual Complaints Declaration: it is a contractual obligation for all contractors to provide NHSBSA with an annual complaints' declaration. Currently the window for this has closed however NHSBSA have provided NW ICB with the data, and we have requested an extension to the window. Compliance Data for NW ICB is at 60.08%, although some contractors may have submitted data at a Head Office level that is not reflected in the individual practice report.

-Quality in Optometry Report: All contractors are obligated to provide the commissioning body with a quality report, via a self-audit, every three years.

-The commissioning team are in the process of establishing a database of confirmed Optometry contractors and their individual contract assurance status with a long-term plan of an established risk register and communication database.

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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To be completed by Meeting Secretary

Agenda item: 17

Paper No:



Meeting/Committee:	Primary Care Commissioning Committee
Venue:	Teams Meeting
Date:	10 December 2024

Title of Report	General Ophthalmic Services (GOS) Contracting – Quarter End Update Report (Q2 2024/25)	
Presented by	Sharon Gardner – Head of 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.

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:

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- 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 report produced for ICBs is reflective of Quarter 2 (Q2) position.

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 throughout the year.

Table 1

Mandatory	Additional
85	6

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	Contracts awaiting signing	Finalised contracts
76*	76	1**	75

*This figure is different to the 85 mentioned in Table 1. Table 1 includes contracts issued to new contractors since the start of the re-issue project.

** contract with practice for signing or with ICB for signing

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.

All mandatory 2023 GOS contracts and variations have been issued and returned for N&W.

New Model Contract Variation for 2024

NHS England published a revised national model contract variation for both mandatory and additional services, effective from January 2024. All variations have been issued and returned.

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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Agenda item: 18a

Subject:	Primary Care Commissioning Committee policies
Prepared by:	Nikki Bartrum, Corporate Governance Senior Manager
Submitted to:	Primary Care Commissioning Committee
Date:	10 December 2024

Purpose of paper:

For information.

Executive Summary:

The Corporate Governance team maintains a database of all the ICB's policies. Each policy is assigned to a committee for oversight and formal approval.

[Appendix A](#) sets out the current status of the policies that the Primary Care Commissioning Committee is responsible for.

Recommendation to the Primary Care Commissioning Committee:

The Committee is asked to note the contents of this paper and ensure all policies are maintained in line with their review date timeline.

Key Risks	
Clinical and Quality:	N/A
Finance and Performance:	N/A
Impact Assessment (environmental and equalities):	N/A
Reputation:	There is a risk to the ICB's reputation if policies are not in place, implemented and regularly reviewed.
Legal:	There may be a risk of legal challenge where the implementation of a policy does not reflect current legislation/statutory guidance
Information Governance:	N/A
Resource Required:	Policy owners
Reference document(s):	N/A
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	N/A

Approved by Sarah
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Appendix A: Primary Care Commissioning Committee policies

Policy Name	Current version	Date of this version	Owner	Team	Reviewed by	Date Approved	Dissemination Date	Review Date
Dental Clawback Repayment	V1	01/03/2024	James Grainger / Matthew Lewis	Finance	DODG	24/03/2024	18/04/2024	Mar-25

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Agenda item: 18b

Subject:	Report to ICB Board on primary care access recovery plan and improving the issues across the primary-secondary care interface
Presented by:	Sadie Parker, Director of Primary Care
Prepared by:	Amanda Sear, Senior Manager Primary Care Strategic Planning
Submitted to:	Primary Care Commissioning Committee
Date:	10 December 2024

Purpose of paper:

For information

Executive Summary:

A paper detailing progress was presented at the General Practice and Pharmacy Delivery Group meeting held on 8 October 2024, ahead of the update required for the ICB Public Board Meeting scheduled for 27 November 2024.

The PCARP paper incorporated within the ICB Board Pack is included here for information. Whilst no material changes were made, a number of updates on targets were incorporated into the Board paper where these became available.

Report

Recommendation to the Board:

Note the report taken to November Board meeting.

Key risks and governance are noted on the Board paper.

Webb Sarah
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Agenda item: 18b
PCCC

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:	Amanda Sear, Senior Manager Primary Care Strategic Planning, supported by Community Commissioning, Digital, Planned Care and Primary Care Teams
Submitted to:	Norfolk and Waveney ICB Public Board
Date:	27 November 2024

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 on-going work to support improvements across the primary-secondary care interface and overview of Pharmacy First.

The paper was prepared for review for the General Practice and Pharmacy Delivery Group meeting held on 8 October 2024, and updated where additional information has become available.

Background

This paper sets out progress made against national requirements set out by NHS England (NHSE)

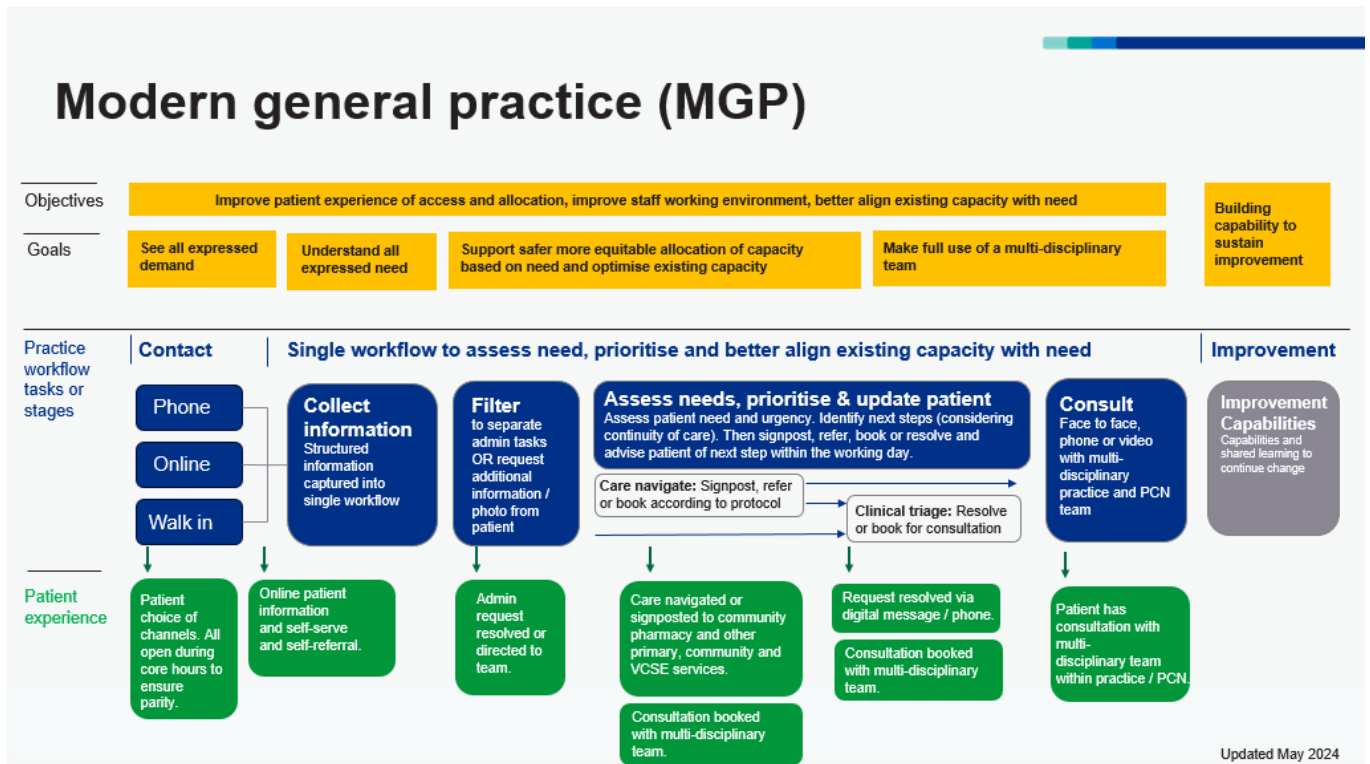
Primary Care Access Recovery Plan (PCARP)

Key outcomes expected for the first half of 2024/25 included:

- Development of our interface programme of work and delivery against key areas, including the roll-out of appropriate access to test requesting for allied health professional working in primary and community care settings
- Increased sign up to and usage of the NHS App and support for educational events for our population
- Installation of cloud-based telephony system across all GP surgeries to support managing the "08:00 hours rush", so patients get a better experience of contacting their practice

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- Utilise transition funding to enable more GP surgeries to manage workload and better respond to patient needs through the implementation of *Modern General Practice* (see picture below)
- Promote a culture of quality improvement across primary care, harnessing the power of technology where appropriate to support this



Progress Update

Progress against key deliverables under PCARP during the first half of 2024/25 can be found below:

Increase the use of NHS App and other digital channels to enable more patients access to their prospective medical records and manage repeat prescriptions.

The NHS App Roadmap is continuing to grow with proxy access (managing health services for another person via the App) being at the forefront. Proxy access is available to patients not registered at the same practice and child access available from birth, as well as being available across care settings such as hospitals. It is subject to ID checks to ensure appropriate use by those acting for someone else.

Digital Team work carried out:

- Promotion of the NHS app via practice events utilising GP Surgery Patient Participation Group members
- Screen messaging made available in GP surgery waiting areas
- Redmoor Social Managed Media Campaigns offer to GP surgeries to promote the NHS App and increase patient sign up

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- Working with practices to optimise both their websites having the NHS App front and centre, and enabling the 4 core functionalities
- Created a toolkit with resources and guidance videos [NHS App Optimisation portal](#)
- Supported practices to ensure that when hosting an event, they take into consideration the digital exclusion and deprivation of their population [page](#).

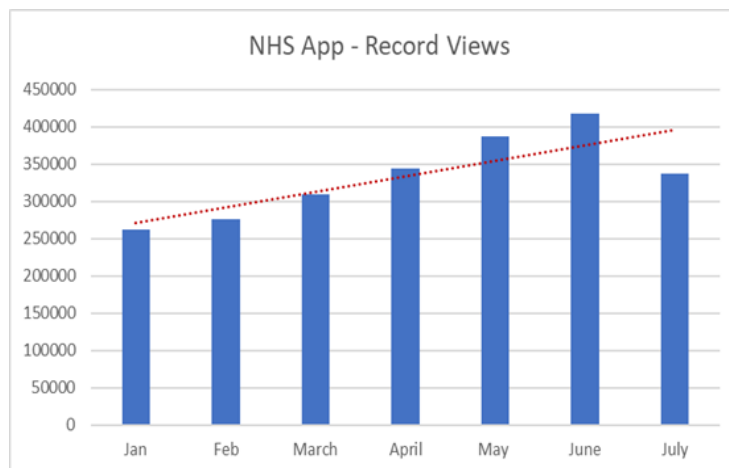
Next steps:

- Continued growth of NHS App usage, with proxy access
- To refresh the NHS App Toolkit
- Tailored approach for working with GP surgeries with lower than 50% uptake.
- Promotion of NHS App and Ambassador programme
- Gather feedback for further case studies

Targets include increasing NHS App record views from 9.9m to 15m per month by March 2025 and increasing repeat prescription numbers from 2.7m to 4.2m per month by March 2025

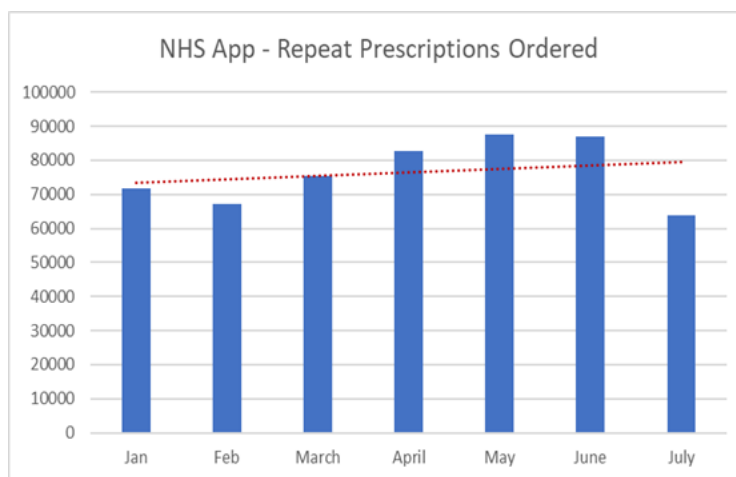
Engagement:

- 54 GP surgery staff are NHS App Ambassadors in Norfolk and Waveney (as at 30/08/24)
- 516,081 patients had the NHS App (54% of population age 13+)
- 12 GP surgeries had 60% of patients registered to use the NHS App
- 45 GP surgeries had all 4 core functionalities enabled
- 39 GP surgeries had offered appointment booking via the NHS App in the month of July



Record Views:
 April 344,680
 May 387,169
 June 418,521

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Repeat Prescriptions:
 April 82,632
 May 87,623
 June 87,064

Make on-line registration available in all practices by October 2024

Target: more than 90% of practices using the on-line registration system by 31st October 2024

Background: NHS England co-developed a new registration solution with patients and practices to make registering with a GP surgery easier, simpler, and standardised. GP surgeries are contractually required to adopt and offer this online registration system along with the new paper form by 31st October 2024. Norfolk and Waveney GP surgeries already had an online offer which had previously been developed by our digital team., so in many cases they had to move across to the national offer.

Digital team work carried out:

- 1 to 1 support for all GP surgeries providing information and answering questions
- Promotion of weekly NHSE webinars through dedicated channels
- Working with the NHSE Registration Team, alongside the Local Medical Committee (LMC) to support GP surgeries
- Creation of a dedicated training portal page, including access to a demo environment for GP surgeries to test the service
- Resources are also available for:
 - How to enrol through profile manager
 - GP Registration Roadmap
 - Contact details for NHSE Team

Support continues to be available for the last GP surgery to enrol, but at the end of October the target had been achieved.

Work continues to support the delivery of the Primary Care Access Recovery Plan to move to a modern general practice model, including:

- Working with GP surgeries to assess their current digital tools suggesting how they might be used to underpin the development of triage models aligned to patient need and workforce model.
- Migrate online consultation providers where required
- Sharing best practice to enable processes to be streamlined without the need to

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- increase digital “add-ons” by streamlining within one digital package
- Support offer and advice for GP Surgeries to ensure their websites meet NHS Website Accessibility Standards
- Create and update resources for GP surgeries to support informed decision making for digital tools
- Working with Primary Care Network (PCN) Digital Transformation Leads to support PCNs to access funding opportunities for, and increase their effective use of, digital tools

Continue to expand Self-Referrals to appropriate services

As part of the 2023/24 operational planning guidance, with a refresh of expectations in 2024/25, ICBs were asked to implement self-referral pathways in 7 named pathways. 5 of these are measured by Community Services Data Set (MSK, Audiology (Elderly hearing) Podiatry, Weight Management and Wheelchair), the remaining 2 are Community Equipment Services and Falls Service.

Self-referral is in place across Norfolk and Waveney for all pathways except for community equipment. We are exploring opportunities for self-referral within community equipment with our commissioning partners.

National standardised rates are in place for MSK, audiology and podiatry, the latest regional data (for July 2024) showed locally we are exceeding these for MSK and audiology.

Community Pharmacy Update

The target for Pharmacy First appointments by March 2025 is 5,240 per month. Data for August 2024 recorded 3,179 consultations. Payment threshold for practices increased to 20 per month from September 2024. The total number of pharmacies is 172 and we have 160 community pharmacies signed up. Of those who are not signed up to deliver Pharmacy First:

- 1 is a DAC (Dispensing Appliance Contractor) and has not been signed up from the start.
- 3 are DSPs (Distance Selling Pharmacy)
- 7 are recent change of ownerships and this can sometimes mean it takes a little while to complete registration
- 1 has not been registered from the start due to not having a consultation room

The target for oral contraception prescriptions coming directly by March 2025 is 250 per month. Data for August 2024 recorded 179 consultations. The target for Community Pharmacy Blood Pressure check appointments by March 2025 is 3,500 per month. Data for August 2024 recorded 3,121 appointments.

We are currently on track to meet the targets set by NHSE, and alongside this we are looking to strengthen relationships on the ground with Community Pharmacies. We are planning to run a soft relaunch of Pharmacy First in November 2024 targeting GP surgeries, which will include the release of a GP toolkit to provide support with training on the service. The relaunch will also see the introduction of a ‘Friends and Family’ test to gain patient feedback on the service. We are also looking to introduce a pharmacy visit programme during November 2024 to those pharmacies who have not completed 30 consultations since the service launched to understand what the barriers are and how we may be able to help support. Arrangements are in place to increase engagement leads to support work with GP surgeries to upskill their teams on Pharmacy First to promote a positive experience for patient and providers.

Other noteworthy data available for Community Pharmacy shows:

- There have been 16,402 Pharmacy First Clinical Pathway consultations and 4470 minor illness consultations from 1 February to 31 August 2024
- There has also been a total of 7,180 urgent supplies of medicines over the same period
- There have 667 GP referrals into the clinical pathway, 264 referrals from NHS 111 and 13,471 self-referrals from the patient population, highlighting the need for further focus on our referral pathways to support GP resilience and out of hours provision

Implementing 'Modern General Practice' Access Update

Cloud-based telephony (CBT) is split into **3 Phases** across Norfolk and Waveney:

- **Phase 1** included 30 GP surgeries on sub-optimal phone systems, including 7 on pure analogue systems and is now complete
- **Phase 2**, introduced during December 2023, covered a further 20 GP surgeries with equipment which did not meet the Phase 1 criteria, or where they might have had some digital or cloud features, but lacked NHS England's updated (Phase 1) requirements for Cloud Telephony – 18 are complete with 2 remaining
- **Phase 3, The Migration Phase** targets 3 GP surgeries who were part of the 2021-23 NHS England Pilot scheme and will see the migration from the *Wavenet* to *GP Voice* platform, which is also being rolled out under Phases 1 and 2 from the National Framework and will align them with NHS England's updated requirements. 14 of the 35 surgeries are now live

All 3 Phases meet, or exceed NHS England's updated requirements for Cloud Telephony, supporting the Modern General Practice model under the National Framework for CBT suppliers.

The remaining surgeries have CBT but not all were part of the project and do not necessarily meet all the requirements (e.g. call back). Reasons for keeping with existing suppliers include recently agreed contracts which it was not practical to change; existing suppliers not being on the national framework; and contracts which can facilitate call back for an additional charge.

General Practice Improvement Programme (GPIP)

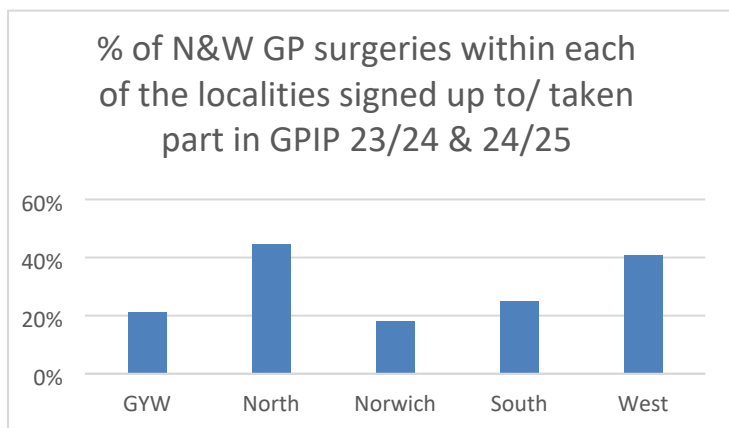
The General Practice Improvement Programme (GPIP) started in 2023/24 as part of *Capacity and Access Improvement* work and continues to evolve. During 2023/24 GPIP provided a suite of training and support offers, ranging from online resources to in-person facilitated workshops both for GP Surgeries and PCNs.

During 2024/25 the GPIP support offer was scaled back by NHSE, offering only GP surgeries a 13 week support programme delivered by new training facilitators, Royal College of General Practitioners. Uptake under the 2024/25 offer has decreased, with 6 GP surgeries undertaking the programme, compared to 25 under the 2023/24 programme. 2 GP surgeries have undertaken GPIP twice during both the 2023/24 & 2024/25 programmes. GP surgeries participating multiple times allowed them to utilise the data from cloud based telephony and online consultations (as well as other digital solutions) to further streamline internal processes and improve patient experience.

NHSE is currently undertaking a review of the GPIP offer to enable learning across ICBs and from April 2025, NHSE is planning to delegate responsibility for GPIP to ICBs to allow for localised training and support. Work is being undertaken to understand the resources and opportunities available to ensure GP surgeries can access support, where needed, to promote continuous improvements enabled through *modern general practice*.

GPIP summary:

- 31 GP surgeries had signed up or have taken part in the GP Improvement Programme during 2023/24 and 2024/25
- The North locality had the highest uptake in percentage terms, by GP surgeries (44%) whilst the West locality had the largest number of GP surgeries participating in the offer (9)
- 19 GP surgeries (61%) who participated in GPIIP represent communities with an Index Multiple Deprivation (IMD) score of between 2-5. 10 had an IMD of 6-7, and 2 with an IMD of 8-9



Capacity & Access Improvement funding 2024/25

- As in 2023/24, 70% of the Capacity & Access Improvement funding is being paid to PCNs without any conditions via the Capacity and Access Support Payments (CASP) proportionate to their Adjusted Population, in 12 equal payments. PCNs have the discretion to use the funding according to local needs, for example, the supervision of ARRS staff or to increase the care home premium
- The remaining 30% of the Capacity and Access Payment (CAP) is being paid to PCNs via the Capacity and Access Improvement Payment (CAIP). To support cashflow, this is being paid to PCNs at any point in the year in monthly instalments once the PCN Clinical Director (CD) confirms to the ICB that all GP surgeries within the PCN have put in place one or more of the three individual domains of the Modern General Practice Access model, which each attract one third of the overall CAIP funding

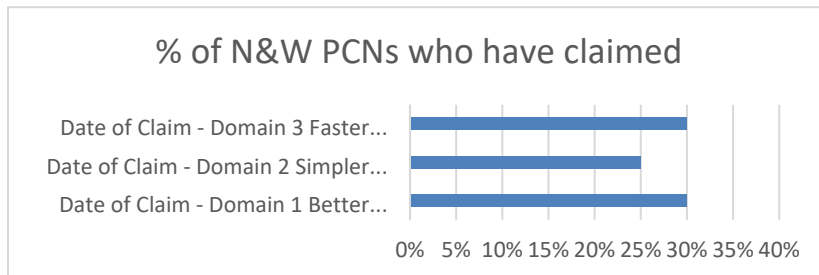
NHSE has set ICBs the target that over 90% of PCNs will meet CAIP payment criteria & claim for all three domains

- Currently 8 N&W PCNs have claimed for one or more domains, with only 4 PCNs having claimed for all three domains to date in 2024/25.
- The British Medical Association's (BMA) GP committee England (GPCE) released recommendations in June 2024 stating that *"Practices should defer signing declarations of completion for 'better digital telephony' and 'simpler online requestes' until further GPC England guidance is issued in early 2025"*

Our understanding is that the main reasons for delaying claiming for domains is a concern from PCN Clinical Directors that they ensure all practices have the necessary components in place, as well as some PCNs expressing concerns about agreeing to share data (following the BMA recommendations). The delay in claiming will not affect the amount of funding the PCN can receive since once a claim is made, payment is pro-rated over the remaining months of the year. It does

mean there are different levels of funding being accessed across N&W PCNs currently due to claims. N&W ICB continues to support PCNs with their queries regarding data sharing and the expectation is that with the August 2024 GP contract variation, which makes the sharing of CBT data metrics contractual, there will be an increase in claims for Domain 2.

Details of claims and the three domains can be found below:



MGPA priority domain	All PCN practices to have following components in place and these continue to remain in place
1) Better digital telephony	<ul style="list-style-type: none"> Digital telephony solution implemented, including call back functionality; and each practice has agreed to comply with the Data Provision Notice so that data can be provided by the supplier to NHS England. Digital telephony data is routinely used to support capacity/demand service planning and quality improvement discussions.
2) Simpler online requests	<ul style="list-style-type: none"> Online consultation (OC) is available for patients to make administrative and clinical requests at least for the duration of core hours. Practices have agreed to the relevant data provision notice (DPN) so that data can be provided by the supplier to NHS England as part of the 'submissions via online consultation systems in general practice' publication.
3) Faster care navigation, assessment, and response	<ul style="list-style-type: none"> Consistent approach to care navigation and triage so there is parity between online, face to face and telephone access, including collection of structured information for walk-in and telephone requests. Approach includes asking patients their preference to wait for a preferred clinician if appropriate, for continuity.

Complete implementation of highly usable and accessible online journeys for patients

- All N&W GP surgeries have accepted the CBT (Cloud based Telephony) DPN (Data Provision Notice) via CQRS (Calculating Quality Reporting Metrics Service)
- All N&W GP surgeries have also accepted the Online Consultation DPN.

Prospective Records Access: As of 19th September 2024, Step 1 ("Organisational Settings to allow prospective Access") is now enabled across all except 1 surgery. There is still work to do to ensure all surgeries have undertaken Steps 2-4 for full contractual compliance (Step 2: practices undertake enhanced reviews for patients where necessary; Step 3: Practices set it as default that all new NHS App users have prospective access to their records on the

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app; Step 4: Patients have online accounts with full prospective access). Surgeries are being supported to ensure full compliance.

Build capacity

- The Primary Care Workforce Strategy and Operational Delivery Plan was approved by the Primary Care Commissioning Committee on 10th September 2024 supporting the themes of “Train, Retain and Reform”. The plan includes 46 programmes, designed for delivery during 2024/25, all with key performance indicators (KPIs) to reflect both national and local targets
- Our Newly Qualified GP Incentive scheme received national recognition, and has been shortlisted for the HSJ (Health Service Journal) 2024 “Workforce Initiative of the Year”. Winners will be announced 21st November 2024. To date, 17 newly qualified ST3 (Speciality Training Year 3) GP Trainees have received substantive primary care employment offers through the 2024/25 scheme
- ‘Golden Hello’ national and local incentive for dental professionals are in place, 26 dental professionals are being supported to secure substantive roles within primary care settings to date
- We have appointed our first Equality, Diversity, and Inclusion (EDI) Fellow for Primary Care to support the development and management of the EDI training programme which is paramount across all primary care settings

Cutting bureaucracy

Context

- Our Systems Interface Group, chaired by the ICB Executive Medical Director meets monthly, bringing together primary, secondary, community and mental health, to build on a collective understanding that when the interface between providers works well the patient experience is more positive
- As part of the ICB reorganisation a new post was created within the primary care team to focus on interface and ensure that key areas (e.g. self-assessment requirements) are built into system-led workplans
- To ensure interface processes remain 'fit for purpose' we held a workshop with system partners to share ideas on how interface can work better. This has given us the opportunity to reflect on how we can ensure ideas are shared and concerns are transparent

Progress update against the four National Primary Care Secondary Interface recommendations includes:

Self-Assessment

NHSE published a self-assessment toolkit under PCARP, for providers to evaluate their performance against five key areas in supporting the primary secondary care interface.

- The regional overview for initial assessments can be seen below, N&W data reflects a local request for all our main providers to complete these, rather than the national ask for acute providers to complete this. These initial responses were reviewed by the System Interface Group.

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ICB name	No. Primary/Secondary Care Interface Assessment Tool Returns	Onward Referrals			Fit notes			Discharge Summaries And Outpatient Letters			Call and Recall			Clear Points of Contact		
		Level 0	Level 1	Level 2	Level 0	Level 1	Level 2	Level 0	Level 1	Level 2	Level 0	Level 1	Level 2	Level 0	Level 1	Level 2
		0	1	2	0	1	2	0	1	2	0	1	2	0	1	2
East of England	14	0	4	10	10	2	2	4	8	2	1	9	4	5	5	4
NHS Norfolk and Waveney ICB	5	0	1	4	5	0	0	0	4	1	0	2	3	2	1	2
National	134	24	56	174	168	70	70	84	134	36	29	161	64	105	77	72

- Updated submissions (due in at the end of September 2024) have been received from the three Acute Trusts and will be discussed in detail at the December System Interface Group. Updates from other providers were being finalised at the time of writing this report.
- The annual self-assessment plans required under the terms of the national contract, also due at the end of September) from which actions plans can be developed will also be discussed at the December meeting. At the time of writing these have been received from the three Acute Trusts.

Cutting bureaucracy sits under our wider Interface workstream, key areas of focus during the first six months of 2024/25 include:

- Ensuring non-medical health professionals can appropriately 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
 - *The working group for the Norfolk & Norwich and James Paget Hospitals has now successfully agreed and started to implement their roll out plan for non-medical referrers with GP Surgeries to be able to request and receive their own pathology results. This has opened up the next steps to ensuring that those in the community are able to request the same. The size of the project and resource impact led to a collective decision to implement this as a phased project*
- Ensuring allied health professionals working in the community, can appropriately request imaging via the WebICE system after completing 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
 - *Now that the first phase of non-medical referrers access is being implemented in GP surgeries, we are able to open the next stage for radiology requesting. The identified Task & Finish Group, including representation from three acutes, community providers and the LMC, are committed to implementing this work to allow allied health professionals to refer appropriately according to their professional competency.*
- Enabling private consultants to refer patients directly into Trusts, rather than requesting the patient's registered GP makes the referral on their behalf
 - *Private consultants are now able to refer routine patients directly into secondary care without going via the patient's registered GP. Currently, urgent and suspected cancer patients still need to be referred by their registered GP to ensure these patients are upgraded and managed on the appropriate cancer pathway*
- Trusts offering complete care, for example making onward referrals as appropriate; providing

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urgent medications directly to patients; their own follow up phlebotomy, and checking and acting on results, as well as other necessary follow up care

- *Whilst the trust self- assessments indicate processes are in place, incidents continue to be reported, albeit with no pattern for a particular organisation of department. A co-ordinated approach, including following up incidents raised; education*
- Trusts issuing fit notes for the full duration of absence as opposed to passing these requests back to GPs
 - *11 incidents were reported from Jan – Sept 2024. recognising there is likely to be under-reporting, and continue to engage with their workforce to ensure they are aware and adhere to this requirement. Next step for the Trusts is to enable electronic fit notes, however, there remain technical issues to overcome*
- Improving communication, such as timely discharge letters which appropriately and clearly signal any actions or important information for general practice
 - *This is currently one of the highest issues reported. during January – September 2024, 104 concerns were raised through our reporting system. A task & finish group set up under the System Interface Group to address improvements in common language, response times and template discharge letters to support effective and consistent communication has been established*
- Developing and implementing a process for reviewing and agreeing new pathways of care, to ensure there are no unintended consequences on general practice
 - *Well established processes are in place to consider unintended consequences on primary care, reviewing pathways, all stakeholders, including the LMC continue to work together to ensure processes are well-understood and transparent*

Interface Challenges and Achievements

- All stakeholders remain positive and engaged, with effective engagement between Medical Directors across the system to effect positive change
- Increased opportunities for system partners understand the unintended consequences of processes/ways of working
- Following feedback from a stakeholder workshop, in the New Year our monthly System level meeting will become quarterly and focus on the overall clinical and operational management of interface, support Task & Finish groups and respond to resource queries
- Local groups will be developed, meeting more frequently with a wider membership and a focus on relationships, to support improvements around interface
- In order to gain a deeper understanding of where improvements could be made, an engagement exercise with general practice is being developed
- GP collective action, which started on 1 August 2024, has been noted as a positive in highlighting and working through areas which can cause high levels of frustration
- Positive feedback from those involved in the National Community of Practice for Interface

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Recommendation

The ICB Board are asked to review and note the report and determine if they are assured the ICB will deliver on the progress against the ambitions of the *Delivery Plan for Recovering Access to Primary Care and General Practice and Secondary Care: Working Better Together*.

Key Risks

Clinical and Quality:	<p>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</p> <p>GP Collective Action is ongoing as part of a national dispute between the British Medical Association (BMA) and NHS England</p> <p>The National Pharmacy Association (NPA) ran a six week ballot (from 23 September) for collective action, with member support. It is unclear at this time on the timelines or impact</p>
Finance and Performance:	<p>Capacity of care can be impacted due to inefficient working arrangements across the primary- secondary care interface</p> <p>GP Collective Action by general practice has the potential to impact on the performance of other healthcare partners</p> <p>Failure to progress against the interface requirements of the plan will affect the ICB's and ICS assurance process</p> <p>The ICB may have to consider commissioning enhanced services or developing alternative pathways to meet any service provision gaps.</p>
Impact Assessment (environmental and equalities):	<p>Reduced capacity could constrain the ability to address health inequalities.</p>
Reputation:	<p>Non-delivery of the ambitions outlined within the plan poses a significant system reputational risk due to the high profile of the plan nationally.</p> <p>Lack of perceived progress against primary secondary interface poses a reputational risk with primary care providers</p>
Legal:	<p>None identified</p>
Information Governance:	<p>System IG group established in response of challenges working across providers highlighted in previous report.</p>

Resource Required:	Primary Care Workforce Transformation, Commissioning, Medical Directorate, Mental Health Directorate and Digital and Primary Care resource must be retained to support the delivery of this plan.
Reference document(s):	<p>Delivery plan for recovering access to primary care (england.nhs.uk)</p> <p>Delivery Plan for Recovering Access – Update published 9th May 23 updated 3rd September 2024 https://www.england.nhs.uk/long-read/delivery-plan-for-recovering-access-to-primary-care-2/</p> <p>Delivery Plan for Recovering Access – Update and Actions published April 2024</p> <p>NHS England » Delivery plan for recovering access to primary care: update and actions for 2024/25</p> <p>Cloud Based Telephony https://www.england.nhs.uk/long-read/funding-for-practices-moving-to-digital-telephony/</p> <p>DPN Data Provision notice https://digital.nhs.uk/binaries/content/assets/website-assets/corporate-information/directions-and-data-provision-notices/data-provision-notices/cloud-based-telephony/20240816-cloudbasedtelephonydataprovisionnoticev1.0.pdf</p> <p>https://www.england.nhs.uk/gp/national-general-practice-improvement-programme/modern-general-practice-model/.</p>
NHS Constitution:	NHS Standard Contract
Conflicts of Interest:	Declarations of interest for any GP and Trust partners are held on record
Reference to relevant risk on the Board Assurance Framework	Risk to resilience of primary care and transformation, on BAF and monitored through Primary Care Commissioning Committee, current score of 20
Governance	
Process/Committee approval with date(s) (as appropriate)	An update paper was presented to the General Practice and Pharmacy Delivery Group meeting held on 8 October 2024.

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Agenda item: 18c

Subject:	Primary Care Vision & Principles
Presented by:	Sadie Parker, Director of Primary Care
Prepared by:	Amanda Sear, Senior Manager, Primary Care
Submitted to:	Primary Care Commissioning Committee
Date:	10 September 2024 & 10 December 2024

Purpose of paper:

To share, and gain feedback on, the work to date around *Primary Care Vision and Principles** with a view to gaining approval from the Primary Care Commissioning Committee for adoption

*outlined under Ambition 2a Primary Care Resilience and Transformation of the Joint Forward Plan
<https://improvinglivesnw.org.uk/~documents/route%3A/download/1108/>

Executive Summary:

Following the refresh of the Joint Forward Plan earlier in the year, a commitment was made to:

- agree **principles** and develop an **overarching vision** for those receiving, delivering, or planning **primary care** services

Draft vision and principles have been developed for consideration by the Primary Care Commissioning Committee, who are asked to consider the draft document, share any feedback, and request any further information/engagement required to support the adoption of an agreed version.

The principles and vision will underpin the next stages of the primary care strategic workstreams sitting under the Joint Forward Plan, including:

- setting out a **framework** with our approach to **integrated neighbourhood working** to support a localised approach to building integrated neighbourhood teams
- developing a **long-term plan for general practice**, describing our approach to supporting resilience and enabling transformation

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A steer on what “good” engagement with the Committee would look like, within available resources, for the next stages will also be welcome

Report

Recommendation to the Committee:

PCCC is asked to:

- consider the draft vision and principles for primary care and provide feedback, and any amendments, to allow the adoption of Norfolk and Waveney Primary Care Vision and Principles
- provide a steer on engagement with them for next phases of primary care strategic workstreams

Key Risks	
Clinical and Quality:	This workstream will be a key building block to future planning and provision of access to high quality services across primary care
Finance and Performance:	Internal secondment arrangements are supporting delivery against this workstream
Impact Assessment (environmental and equalities):	The adoption of the health inequalities framework is central to the principles for primary care commissioning
Reputation:	Principles adopted should provide clarity on the direction of travel for primary care and allocation of resource
Legal:	None identified
Information Governance:	None identified
Resource Required:	Engagement resource will be required to support the ongoing primary care strategic workstreams
Reference document(s):	Joint Forward Plan
NHS Constitution:	None identified
Conflicts of Interest:	None identified
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

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

Integrated Care Board, Executive Management Team – August 2024

An overarching system vision for primary care

Norfolk & Waveney Integrated Care System Vision for Primary Care

Primary care providers working collaboratively, embedded in their communities, at the heart of our ICS, improving health and wellbeing throughout the population of Norfolk & Waveney in a way that brings joy and meaning to the workforce

Primary Care

Community Pharmacy	Dentistry	General Practice	Optometry
<i>consistent offer available 'on the high street' for advice, services and medicines</i>	<i>access to NHS dentistry for those who need it preventative and urgent care universal oral health promotion</i>	<i>access to expert generalist care from 'cradle to grave'</i>	<i>first point of call 'on the high street' for eye related screening, advice and treatment</i>

Enablers

Digital	N&W Digital Transformation Strategic Plan and Roadmap for creating a secure and safe system to deliver better care
Estates	N&W ICS and GP Primary Care Estates Strategies to realise service development, expansion and transformation to modernise care and improve access
Workforce	N&W Primary Care Workforce Strategy with a clear focus on Train, Retain and Reform
Data & Insight	N&W Population Health Strategy to support delivery of proactive, targeted care to help people and communities live healthier lives
Interface	Consensus on primary and secondary care interface across Norfolk and Waveney providers
Community	Connected communities, working in partnership to support and build on local assets to help improve health outcomes and wellbeing

Principles to serve as our foundation for what we do

A commitment to place primary care first, at the heart of our ICS - enhanced, accessible primary care is the foundation of any health and care system in providing preventative, curative, rehabilitative and palliative services

Workforce wellbeing is prioritised

Adoption of N&W health inequalities framework and population health approach through joint planning for primary care

Making the best use of **all** estates and community assets alongside national initiatives in a way which supports primary care services tailored to meet the future needs of our communities

Evidence-based commissioning with a data-led approach, utilising the benefits of technology and integration that allows every contact to make a positive different

Self-care, local communities and primary care first - integrated working where there is benefit in doing so, acute only when necessary

Financial and other incentives aligned to future population need and improved outcomes - *a differential funding approach will be adopted where necessary (e.g. to support transition or tackle health inequalities; avoid destabilising services; additional activity; etc.)*

Commissioning cycles to support providers to plan, promote integration and access to holistic care at a neighbourhood level

Quality improvement approach with evaluation to capture collective outcomes

Be bold, remain flexible and recognise when there may be 'trade offs' in patient relationships, continuity of care, etc. - continually monitor the impact on patients, workforce and available resource

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ICS Primary Care Vision & Principles

Principles and an overarching Primary Care Vision for all those planning delivering, receiving, or working with primary care services across Norfolk and Waveney

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Patients and Communities Directorate
November 2024

Introduction



The ICS Strategy **reflects feedback about what matters to our population** and how they would like to see local health and care services develop in the future. It has four key themes:

- **Driving integration:** Collaborating in the delivery of people-centred care to make sure services are joined-up, consistent and make sense to those who use them
- **Prioritising prevention:** A shared commitment to supporting people to be healthy, independent, and resilient throughout life. Offering our help early to prevent and reduce demand for specialist services
- **Addressing inequalities:** Providing support for those who are most vulnerable using resources and assets to address wider factors that impact on health and wellbeing
- **Enabling resilient communities:** Supporting people to remain independent whenever possible, through promotion of self-care, early prevention, and digital technology where appropriate

It should be assumed that these themes will be reflected in the planning. delivery and development of primary care services across all providers, organisations and communities

Following the Covid-19 pandemic, further engagement by the ICS on immediate priorities for health and care services took place, these are reflected in the **Joint Forward Plan**, and include **primary care** - local doctors, also known as general practice alongside the other services that make up primary care: local pharmacies, dentists and opticians

Context

The ambition for **primary care**, as described in the **Joint Forward Plan** is to ***integrate primary care services to deliver improved access to a wider range of services from a multi-disciplinary team to deliver more proactive care, preventing illness and improving outcomes, for local communities closer to home***

This ambition is framed as ***Primary Care Resilience and Transformation*** – it should be assumed that delivery against commitments in the **Joint Forward Plan** will focus on these areas and mitigate the risk relating to primary care resilience recorded on the ICB Board Assurance Framework

Ambition 2a within the Joint Forward Plan includes agreeing an over-arching vision for primary care and a set of principles, to underpin the development of strategies, including:

- developing long-term plans for community pharmacy and general practice for publication during 2024/25 and optometry during 2025/26 (dentistry plan published in April 2024)
- agreeing a model of care framework to support partners working at Place to consider and test new ways of organising and delivering healthcare together to meet the needs of their local population

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Alignment to national ambitions and plans

Integrated Care Partnership Objectives	Driving integration, prioritising prevention, addressing inequalities and enabling resilient communities
Core20PLUS5	A national NHS England approach covering all ages, defining a target population – the ‘Core20PLUS’ – and ‘5’ focus clinical areas requiring accelerated improvement
Next Steps for Integrating Primary Care: <i>Fuller Stocktake report</i> , May 2022	Vision for integrating primary care, improving the access, experience and outcomes for our communities, which centres around three essential offers: <ul style="list-style-type: none"> • streamlining access to care and advice for people who get ill but only use health services infrequently • providing more proactive, personalised care with support from a multidisciplinary team • helping people to stay well for longer through a joined-up approach to prevention
NHS Long Term Workforce Plan June 2023	15-year plan focused on NHS workforce need and supply, with three priority areas: <i>Train, Retain, and Reform</i>
NHS Impact	NHS IMPACT (Improving Patient Care Together) supports all NHS organisations, systems and providers to have the skills and techniques to deliver continuous improvement
Primary Care Patient Safety Strategy – September 2024	Launched in September 2024, this strategy outlines implementation of the NHS Patient Safety Strategy, across all areas of primary care
Delivery Plan for recovering access to primary care – May 2023	Two-year plan centred around four themes: <ul style="list-style-type: none"> • Empowering patients • Implementing Modern General Practice Access • Building capacity • Cutting bureaucracy
Delivery Plan for recovering urgent and emergency care services – January 2023	Reducing demand for UEC, reducing ED attendances and reducing emergency admissions by taking a population health management approach to development of integrated neighbourhood working and improving same day access in primary care.

Key areas are listed above, this is not an exhaustive list – ongoing commitment to meeting all responsibilities under the NHS Constitution for England alongside the adoption of NHS policy and guidance documents should be assumed across the development of local strategies and implementation of work programmes

Alignment to key Norfolk & Waveney ICS ambitions



Joint Forward Plan	Our five-year plan, and ambitions, setting out how we are going to improve health and care services for our local population, their families and carers
Clinical Strategy 2022-2027	Seeing me as a whole person, working together to be once high-quality NHS, tackling waiting times, acting early to improve health, ensuring services are reliable and addressing health inequalities
Health Inequalities Strategic Framework for Action 2024-2034	Helping individuals, families, communities and organisations to tackle avoidable differences in the health of our residents
Population Health Management Strategy 2024-2029	Embedding a PHM approach across the ICS to drive delivery of proactive, personalised, and preventative healthcare for every community
Quality Strategy 2022-2025	Commitment to the people of N&W to deliver quality, based on what matters most to the people using our services and the insight and expertise of our compassionate, skilful, and innovative workforce
Digital Transformation Strategic Plan	Strategic roadmap through to 2026, to improve safety and quality of care, give staff more time to care for people, empower people to manage their health and wellbeing better through use of technology
Estates Strategy 2022-2027	Providing estate that allows delivery of the right care in the right place, enables better patient outcomes, and empowers health, social care and third sector staff to provide the best possible care
Primary Care Workforce Strategy 2024-2027	Primary care workforce transformation plan (refreshed in 2024) and mirroring the themes of the NHS Long Term Workforce Plan - <i>Train, Retain and Reform</i>
Long-Term Dental Plan 2024-2029	Building stability and resilience across our NHS dental services and improving access to oral health care for our population
Primary Care Commissioning Principles	Agreed during September 2023 by the Primary Care Commissioning Committee to support decision making for the commissioning of primary care services

Key areas are listed above, this is not an exhaustive list and ongoing work through the Systems Strategy Group will continue to ensure meaningful connections are made for those planning primary care to build in enablers which promote contractors and communities to embrace national and system programmes including *Research and Innovation, FLOURISH, Ageing Well, #WeCareTogether People Plan, Sustainable Commissioning, etc.*

Overarching system vision for primary care

Norfolk & Waveney Integrated Care System Vision for Primary Care

Primary care providers working collaboratively, embedded in their communities, in a way which brings joy and meaning to the workforce and improves outcomes for the residents of Norfolk and Waveney

Primary Care

Community Pharmacy	Dentistry	General Practice	Optometry
<i>consistent offer available for advice, clinical services and medicines 'on the high street' and online</i>	<i>access to NHS dentistry for those who need it preventative and urgent care universal oral health promotion</i>	<i>access to holistic medical care from 'cradle to grave' for registered patient lists</i>	<i>first point of call 'on the high street' for eye related screening, advice and treatment</i>

Enablers

Digital	N&W Digital Transformation Strategic Plan and Roadmap for creating a secure and safe system to deliver better care
Estates	N&W ICS and GP Primary Care Estates Strategies to realise service development, expansion and transformation to modernise care and improve access
Workforce	N&W Primary Care Workforce Strategy with a clear focus on Train, Retain and Reform
Data & Insight	N&W Population Health Strategy to support delivery of proactive, targeted care to help people live healthier lives alongside meaningful and ongoing engagement with communities about what matters to them
Interface	Consensus across all providers across Norfolk and Waveney to ensure that workload and clinical risk is clearly communicated and appropriately undertaken and funded
Community	Connected communities, working in partnership with organisations, to support and build on local assets to help improve health outcomes and wellbeing for all
Funding & Contracting	Terms of national contracts are outside our control, but we will seek to leverage any changes or flexibility within these to further integration and prevention. Local commissioning will mirror identified population need and support provider resilience

Principles for achieving our vision

We will come together to provide access to primary care services, connected to their local communities – as a foundation for our health and care system in providing preventative, curative, rehabilitative and palliative services. We will do this by listening to all those who receive, deliver or plan primary care, and adopting the following principles:

Thinking prevention, self-care, local communities and primary care first - integrated team working where there is benefit in doing so, hospital only when necessary

Making workforce wellbeing everybody's business

Embracing primary care leadership, with flexible use of corporate resources to support co-ordinated input from primary care into all stages of planning and decision-making

Embedding the NHS Impact approach across primary care

Adopting the Norfolk and Waveney Health Inequalities Framework, Population Health Strategy and Digital Roadmap in planning and delivery of primary care services

Understanding and making best use of all estates and community assets, alongside digital technology where appropriate and national initiatives and toolkits, in a way which supports resilient primary care services tailored to anticipate and meet the future needs of their communities

Using financial and other incentives to reflect population need and target improved outcomes for residents - *a flexible approach will be adopted where necessary, for instance to support a transition to 'telling your story once', addressing health inequalities, access to enhanced care within neighbourhoods, or to avoid destabilising services, etc.*

Aligning commissioning cycles, where possible, to support providers in their long-term business and workforce planning, both as independent contractors, local networks and as part of the Norfolk and Waveney Integrated Care System

Allowing ourselves to be bold, but remaining flexible and recognising when there may be 'trade offs' so the impact on outcomes, workforce