Primary Care Commissioning Committee Part One

Tue 09 May 2023, 13:30 - 16:30

Agenda

13:30 - 13:30
0 min

Agenda

James Bullion

2023 05 09 Item 00 ICB Primary Care Committee Agenda Pt 1.pdf (1 pages)

13:30 - 13:30
0 min

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

James Bullion

13:30 - 13:30
0 min

2. Apologies for Absence

James Bullion

13:30 - 13:30
0 min

3. Declarations of Interest

Information *James Bullion*

2023 05 09 Item 03 Declarations of Interest.pdf (4 pages)

13:30 - 13:30
0 min

4. Review of Minutes & Action Log from April 2023 Meeting

Decision *James Bullion*

2023 05 09 21 Item 04 Action Log Part One.pdf (1 pages)
2023 04 21 Item 04 NWICB PCCC Minutes Part One.pdf (10 pages)

13:30 - 13:30
0 min

5. Forward Planner

Information *Sadie Parker*

2023 05 09 Item 05 ICB PCCC Forward Planner 2023-2024 P1.pdf (1 pages)

13:30 - 13:30
0 min

6. Risk Register

Decision *Sadie Parker*

2023 05 09 Item 06 Risk Register.pdf (23 pages)

13:30 - 13:30
0 min

Service Development

13:30 - 13:30
0 min

7. Workforce & Training Report

Decision

- 2023 05 09 Item 07 Workforce and Training Report.pdf (11 pages)
- 2023 05 09 Item 07 Appendix A - Primary Care Operational Delivery Plan 22-23.pdf (5 pages)
- 2023 05 09 Item 07 Appendix B - NW ICS Primary Care Workforce Strategy 22-25.pdf (29 pages)
- 2023 05 09 Item 07 Appendix C - NW Primary Care Workforce Comms & Engagement Strategy.pdf (16 pages)

13:30 - 13:30
0 min

8. Winter Resilience Schemes 2022 / 2023

Information

- 2023 05 09 Item 08 Winter Resilience Schemes 2022-2023.pdf (5 pages)

13:30 - 13:30
0 min

9. Five Locally Commissioned Services

Information *Shepherd Ncube*

- 2023 05 09 Item 09 Five Locally Commissioned Services.pdf (4 pages)

13:30 - 13:30
0 min

10. Enhanced Services

Information *Carl Gosling*

- 2023 05 09 Item 10 Enhanced Access.pdf (4 pages)

13:30 - 13:30
0 min

11. Resilience Funding for Community Pharmacy Integration

Decision

- 2023 05 09 Item 11 Resilience Funding for Community Pharmacy Integration.pdf (4 pages)
- 2023 05 09 Item 11 Appendix 1 East of England Partnership Strategy for Community Pharmacy.pdf (46 pages)
- 2023 05 09 Item 11 Appendix 2 MOU LCS Pharmacy Integration.pdf (2 pages)

13:30 - 13:30
0 min

12. Norwich Walk in Centre Consultation (Paper to follow on 05.05.2023)

Decision *Sadie Parker*

13:30 - 13:30
0 min

Finance & Governance

13:30 - 13:30
0 min

13. Finance Report

Information *James Grainger*

- 2023 05 09 Item 13 Finance Report.pdf (9 pages)

13:30 - 13:30
0 min

14. Prescribing Report

Information *Michael Dennis*

- 2023 05 09 Item 14 Prescribing Report.pdf (9 pages)

13:30 - 13:30
0 min

Any Other Business

13:30 - 13:30
0 min

15. Questions from the Public

Discussion *James Bullion*

NHS
Norfolk and Waveney
Integrated Care Board

Meeting of the Norfolk and Waveney ICB Primary Care Commissioning Committee
Tuesday 9 May 2023, 13:30 Part 1
Meeting to be held via video conferencing and You Tube

Item	Time	Agenda Item	Lead
1.	13:30	**Chair's introduction and report on any Chair's action**	Chair
2.		**Apologies for absence**	Chair
3.		**Declarations of Interest** To declare any interests specific to agenda items. Declarations made by members of the Primary Care Committee are listed in the ICB's Register of Interests. *For Noting*	Chair
4.		**Review of Minutes and Action Log from the April 2023 meeting** *For approval*	Chair
5.		**Forward Planner** *For Noting*	SP
6.		**Risk Register** *For Approval*	SP
		Service Development	
7.	13:40	**Workforce and Training Report** *For Approval*	JR
8.	13:50	**Winter Resilience Schemes 2022/2023** *For Noting*	SH
9.	14:00	**Five Locally Commissioned Services** *For Noting*	SN
10.	14:10	**Enhanced Access** *For Noting*	CG
11.	14:20	**Resilience Funding for Community Pharmacy Integration** *For Approval*	SG
12.	14:30	**Norwich Walk In Centre Consultation (paper to follow on 5th May)** *For Approval*	SP
		Finance & Governance	
13.	14:40	**Finance Report** *For Noting*	JG
14.	14:50	**Prescribing Report** *For Noting*	MD
		Any Other Business	
15.	15:00	**Questions from the Public**	Chair

Date, time and venue of next meeting
Tuesday 13 June 2023, 13:30 – 16:30 – ICB PCCC
To be held by videoconference and You Tube

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

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

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: Financial Interests	Type of Interest: Non-Financial Professional Interests	Type of Interest: Non-Financial Personal Interests	Is the interest direct or indirect?	Nature of Interest	Date of Interest: From	Date of Interest: To	Action taken to mitigate risk
James Bullion	Partner Member - Local Authority (Norfolk), Norfolk and Waveney ICB	Norfolk County Council		X		Direct	General Dental Practice Committee (BDA) Repres	Ongoing		In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		Skills for Care		X		Direct	Trustee of Skills for Care	Ongoing		Member prepared to leave any meeting where training and development provision might be likely awarded or recommended to be provided by skills for care
Dr Hilary Byrne	Partner Member - Primary Medical Services	Attleborough Surgeries	X			Direct	GP Partner at Attleborough Surgeries	2001	Present	To be raised at all meetings to discuss prescribing or similar subject. Risk to be discussed on an individual basis. Individual to be prepared to leave the meeting if necessary.
		MPT Healthcare Ltd	X			Direct	Director of MPT Healthcare Ltd	2020	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		Norfolk Community Health and Care Trust (NCH&C)				Indirect	Spouse is employee of NCH&C (Improvement Manager)	2021	Present	
		South Norfolk PCN				Indirect	Clinical Director of SNHIP Primary Care Network	2022	Present	
Steven Course	Executive Director of Finance, Norfolk and Waveney ICB	March Physiotherapy Clinic Limited				Indirect	Wife is a Physiotherapist for March Physiotherapy Clinic Limited	2015	Present	Will not have an active role in any decision or discussion relating to activity, delivery of services or future provision of services in regards March Physiotherapy Clinic Limited
Patricia D'Orsi	Executive Director of Nursing, Norfolk and Waveney ICB	Royal College of Nursing		X		Direct	Member of Royal College of Nursing	Ongoing		Inform Chair and will not take part in any discussions or decisions relating to RCN
Hein van den Wildenberg	Non-Executive Member, Norfolk and Waveney ICB	Lakenham Surgery			X	Direct	Registered patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
		College of West Anglia			X	Direct	Governor at College of West Anglia (Note: the College hosts the School of Nursing, in partnership with QEHKL and borough council)	2021	Present	Low risk. If there is an issue it will be raised at the time.
Norfolk and Waveney ICB Attendees										
Mark Burgis	Executive Director of Patients and Communities, Norfolk and	Drayton 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

	Waveney ICB	Castle Partnership				Indirect	Partner is a practice nurse at Castle Partnership	Ongoing		might have an interest
Shepherd Ncube	Head of Delegated Commissioning	Nothing to Declare	N/A			N/A	N/A	N/A		N/A
Sadie Parker	Director of Primary Care, Norfolk and Waveney ICB	Active Norfolk		X		Direct	Represent N&WCCG as a member of the Active Norfolk Board	2019	Ongoing	Low risk. If there is an issue it will be raised at the time
NHS England and NHS Improvement Attendee										
Fiona Theadom	Contracts Manager, NHS England and NHS Improvement	Nothing to Declare	N/A				N/A	N/A		N/A
Local Medical Committee Attendees										
Mel Benfell	Norfolk & Waveney Local Medical Committee Joint Chief Executive	N&W ICB				Indirect	Personal friend of an employee of the ICB	2015	Present	Will not take part in any discussion or decisions relating to the declared interests.
		N&W ICB				Indirect	Close relative is an employee of N&W ICB	Ongoing		Will not take part in any discussion or decisions relating to the declared interests
		Windmill Surgery			X	Direct	Registered patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
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										
James Foster	Member Practice Representative	St. Stephens Gate Medical Practice	X			Direct	Partner at St. Stephens Gate Medical Practice	2019	Present	Will not take part in any discussion or decisions relating to the declared interests.
		One Norwich	X			Direct	Director, One Norwich Practices Ltd (GPPO/PCN)	2019	Present	
		N2S	X			Direct	Director, N2S, Provider of day surgery in a primary care setting	2014	Present	
Health and Wellbeing Board Attendees (Norfolk and Suffolk)										
Bill Borrett	Norfolk Health & Wellbeing Board Chair	North Elmham Surgery			X	Direct	Registered patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice
		Norfolk County Council	X			Direct	Elected Member of Norfolk County Council, Elmham and Mattishall Division	Ongoing		Low risk. In attendance as a representative of the Local Authority. Chair will have overall responsibility for deciding whether I be excluded from any particular decision or discussion.
		Norfolk County Council	X			Direct	Cabinet Member for Adult Social Care and Public Health	Ongoing		
		Norfolk County Council	X			Direct	Chair of Norfolk Health and Wellbeing Board	Ongoing		
		Breckland District Council	X			Direct	Elected Member of Breckland District Council, Upper Wensum Ward	Ongoing		
		Norfolk County Council	X			Direct	Chair of Governance and Audit Committee	Ongoing		
		Manor Farm	X			Direct	Farmer within Dereham patch	Ongoing		Low risk. If there is an issue it will be raised at the time.
James Reeder	Suffolk Health and Wellbeing Board	Suffolk County Council	X			Direct	Cabinet Member for Children and Young People's Services	Ongoing		In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		Suffolk County Council	X			Direct	Children's Services and Education Lead Members Network	Ongoing		
		East of England Government Association	X			Direct	East of England Government Association	Ongoing		

		James Paget University Hospital Trust	X			Direct	James Paget Healthcare NHS Foundation Trust Governors Council	Ongoing		
		Suffolk County Council	X			Direct	Suffolk Safeguarding Children Board	Ongoing		
		Norfolk and Suffolk NHS Foundation Trust	X			Direct	Norfolk and Suffolk Foundation Mental Health Trust – Governors Council	Ongoing		
		Suffolk and North East Essex Integrated Care Partnership	X			Direct	Suffolk County Council representative for Suffolk and North East Essex Integrated Care Partnership	Ongoing		
		Suffolk Chamber of Commerce	X			Direct	Member of the Lowestoft and Waveney Chamber of Commerce board part of Suffolk Chamber of Commerce	Ongoing		
		High Street Surgery, Lowestoft			X	Direct	Patient at a Norfolk and Waveney GP Surgery	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
		Northfields St Nicholas Primary Academy			X	Direct	Governor of Northfields St Nicholas Primary Academy part of the Reach2 Academy Trust.	Ongoing		Low risk. If there is an issue it will be raised at the time.
Healthwatch Attendees (Norfolk and Suffolk)										
Andrew Hayward	HealthWatch Norfolk Trustee	East Harling GP Practice			X	Direct	Registered patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
		HealthWatch Norfolk	X			Direct	Trustee and board member HeathWatch Norfolk	2020	Present	Will not take part in any discussion or decisions relating to the declared interests.
		East Harling Parish Council			X	Direct	Member, East Harling Parish Council	2020	Present	
		NHS England		X		Direct	GP appraiser, NHSE	2015	Present	
Sue Merton	HealthWatch Suffolk	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,	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	Onoing	Non-voting member - risks will be taken in accordance with COI Policy
		General Optical Services	X			Direct	Own a practice which works within primary care and receives money under a General Optical Services Contract	Apr-23	Ongoing	
Tony Dean Webb Sarah 04/05/2023 09:43:12	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

Tania Farrow	Chief Officer of Community Pharmacy Suffolk representing Waveney contractors	Community Pharmacies		X		Direct	Local Representative body for Community Pharmacies involved in negotiation and support for local Community Pharmacy services	Nov-15	Present	Non-voting member - risks will be taken in accordance with COI Policy
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
		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

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

NHS
Norfolk and Waveney
Integrated Care Board

Norfolk & Waveney IBC Primary Care Commissioning Committee - Part One
Action Log 9 May 2023

No	Meeting date added	Agenda Item	Owner	Action Required	Action Undertaken / Progress	Due date	Status	Date Closed
0137	14-Mar-23	6	SP	Risk register - SP would link in with the individual risk owners on new target dates and would set this out within the next update.	All risk owners contacted. In addition new BAF forum has been established to manage risks consistently across the ICB. Propose to close, on agenda	09-May-23		
0138	14-Mar-23	6	SP	Risk register - SP/MB to discuss tolerance of PC14	SP and MB have discussed. In addition new BAF forum has been established to manage risks consistently across the ICB.	09-May-23		
0140	21-Apr-23	4	SW	Signed minutes to Chair	SW sent signed minutes to Chair	09-May-23		24-Apr-23
0141	21-Apr-23	7	SN	LD Health Checks JR requested LD Health checks figures for SNEE at a future Committee.		13th June 2023		
0142	21-Apr-23	8	SW	NW ICS Quality Strategy A paper on PLACE to be brought to a future Committee.	SW added to forward planner for the end of the Summer.	09-May-23		27-Apr-23
0143	21-Apr-23	8	KW	NW ICS Quality Strategy KW to accept help of offer from Healthwatch regarding communication of the the new N&W ICS Quality Strategy.	KW confirmed approach made by email.	09-May-23		27-Apr-23
0144	21-Apr-23	8	KW	NW ICS Quality Strategy KW to respond to comments received on the Quality Strategy from the LMC.	KW confirmed by email.	09-May-23		27-Apr-23
0145	21-Apr-23	15	SW	AOB Questions from the public - SW to ensure full response made available on ICB website	SW actioned	09-May-23		24-Apr-23

NHS
Norfolk and Waveney
Integrated Care Board

Norfolk and Waveney Primary Care Commissioning Committee

Part One

Minutes of the Meeting held on
Friday 21 April 2023
via video conferencing & YouTube

Voting Members - Attendees

Name	Initials	Position and Organisation
James Bullion	JB	Chair, Partner Member – Local Authority (Norfolk) Norfolk & Waveney ICB
Steven Course	SC	Executive Director of Finance, Norfolk and Waveney ICB
Hein Van Den Wildenberg	HW	Non Executive Member, Norfolk and Waveney ICB
Karen Watts	KW	Director of Nursing and Quality (deputising for PD'O)

In attendance

Name	Initials	Position and Organisation
Rashmi Balakrishnan	RB	Primary Care Reporting Finance Manager
Andrew Bell	AB	Vice-Chairman Norfolk Local Dental Committee, General Dental Practitioner in Norfolk and Waveney
Mark Burgis	MB	Executive Director of Patients and Communities, Norfolk & Waveney ICB
Michael Dennis	MD	Associate Director of Medicines Optimisation, Norfolk and Waveney ICB
Carl Gosling	CG	Senior Delegated Commissioning Manager – Primary Care, Norfolk & Waveney ICB
Andrew Hayward	AH	Trustee of Healthwatch Norfolk
Shepherd Ncube	SN	Associate Director of Delegated Commissioning, Norfolk and Waveney ICB
Sadie Parker	SP	Director of Primary Care, Norfolk and Waveney ICB
Cllr James Reeder	JR	Cabinet Member for Children and Young People's Services, Suffolk County Council
Lauren Seamons	LS	Deputy Chief Officer, Norfolk LPC (Community Pharmacy Norfolk)
Clare Sutton	CS	Commissioning Support Administrator, Norfolk and Waveney ICB – minute taker
Fiona Theadom	FT	Head of Primary Care Commissioning

Apologies

Name	Initials	Position and Organisation
Mel Benfell	MBe	Joint Chief Executive Officer, Norfolk & Waveney Local Medical Committee
Dr Hilary Byrne	HB	ICB Board Partner Member – Providers of Primary Medical Services, Norfolk & Waveney ICB
Cllr Bill Borrett	BB	Chair of the ICP and Partner Member of the ICB

Tony Dean	TD	Chief Officer, Norfolk Local Pharmaceutical Committee (now known as "Community Pharmacy Norfolk")
Patricia D'Orsi	PD'O	Executive Director of Nursing, Norfolk & Waveney ICB
James Foster	JF	Practice Manager Committee Attendee
James Grainger	JG	Senior Finance Manager – Primary Care, Norfolk and Waveney ICB
Sue Merton	SM	Healthwatch Suffolk
Jason Stokes	JS	Secretary Norfolk Local Dental Committee (LDC)

Observer

Jonathan Milne	JM	Contract Manager, Delegated Commissioning, Norfolk and Waveney ICB
Brian Robertson	BR	Observer (Dental)

No	Item	Action owner
1.	**Chair's introduction**	**Chair**
	JB welcomed everyone to the meeting.	
2.	**Apologies for absence**	**Chair**
	Noted above.	
3.	**Declarations of Interest** *For Noting*	**Chair**
	None were raised.	
4.	**Review of Minutes and Action Log from the March 2023 Committee** *For Approval*	**Chair**
	The minutes were agreed to be an accurate reflection of the March 2023 Committee and minutes would be sent to the Chair for signing. **ACTION: SW to send HW minutes for signing.** **Action Log:** Actions 122,131,132,134,135 & 136 closed Action 122 proposed to close today. Action 137 remained open. SP confirmed risk owners had been contacted to remind them to update the risk register for the agenda item on 9 May 2023. Action now closed. Action 138 had been reviewed by MB & SP who discussed the risk tolerance around General Practice resilience mindful of the wider work being undertaken around risk management within the ICB. This action would be reviewed at the next meeting. Action 139 MD agreed to reach out to patient groups. SP recommended that it would be sensible to hold conversations with the practices and their Patient Participant Groups, Locality Leads and a formal approach to Healthwatch. **Matters Arising:** JB confirmed that there were no matters arising.	**SW**

5.	**Terms of Reference** *For Noting*	**SP**
	SP requested that Committee members formally note the revised finalised Terms of Reference had been approved by the ICB Board.	
6.	**Forward Planner** *For Approval*	**SP**
	SP asked Committee members to note the forward planner and that the ICB had begun to populate spotlight items on the forward planner in relation to other primary care services for which we were now responsible. It was noted that one item around workforce and training had been postponed to May.	
7.	**Learning Disability Health Checks** *For Noting*	**SN**
	SN provided a verbal update to the Committee. SN confirmed that the Learning Disability Health Checks uptake numbers were strong and recognised the work done to achieve the number of completed health checks. SN asked Committee members to celebrate the progress that had been made this year. SN noted the areas of strengths this year and the areas where the ICB needed to focus for the coming year. SN reported that three of the five localities had managed to complete over 75% of their annual health checks, which was a big achievement; the other two localities did not meet the 75% national minimal target. North Norfolk was the lead in our system with 85% followed by Great Yarmouth and Waveney and South Norfolk both at 77%. West Norfolk achieved 72%, which was a substantial improvement in uptake on previous years. The achievement for Norwich was lower than last year, at 64% and the ICB was reviewing this with them. There were also some data quality concerns that need to be investigated and validated as it was felt that achievement may actually be higher. Approximately 1,000 more people had their health check compared to last year. SN thanked the Committee for prioritising this important matter and the challenges associated with this. It was noted that the ICB's Quality team had spent a considerable amount of time talking to practices, going through individual cases to support and to reach out to every family and practices prioritised this work. SN also highlighted the importance of having the business intelligence support to help track activity month on month. SN highlighted the ICB's commitment to do even better this year. It was noted that the ICB led regionally in improvement and in the number of people that we had seen. Stronger connections with other parts of the system had been established, not just in Norfolk but beyond Norfolk, comparing the work in SNEE and to maximize what could be achieved for these population groups It was reported there were other areas of focus for the improvement in the quality of health checks to bring consistency. SN's final observation was to highlight that most of the challenges were inherent to the challenges around practice resilience, for example, in the areas that had seen a lower uptake, a number of practices had resilience and	

	capacity issues, which meant that they needed additional or a different approach to be able to support them to be able to prioritise this group of people. JB thanked Shepherd for the update report and welcomed the focus on equalities and for highlighting the areas which needed particular attention, as well as the overall acknowledgement of the progress that the system had made. As director of Adult Social Services, JB acknowledged that this was an area where there are broader challenges in the health and social care and housing systems for people with learning disabilities and autism. JB invited questions or comments from the Committee JR welcomed the good news and thanked everybody who had helped to look after our population. JR requested sight of the figures for SNEE for the Lowestoft area and offered to champion the work. JB asked SN to provide the figures breakdown. **ACTION: SN to provide break down figures for SNEE.** KW also thanked SN for his passion to improve the health outcomes for the ICB's most vulnerable patients which had just been evidenced. SP was delighted with the progress that has been made in this area. We had been rightly scrutinised in this area for several years and she was really pleased with the progress that had been made and had ambition to go further. SP also highlighted some information received which indicated that whilst uptake was not as good, it showed progress made towards the achievement of the national 60% target for health checks for people with severe mental illness and was the best uptake ever achieved as a system. Final year figures would be reported in more detail at a future committee. SP noted the ICB had been working on improving uptake of learning disability health checks for several years whereas our focus on SMI health checks was more recent and improvement was expected this year. JB thanked SN for the work of the team in supporting practices.	**SN**
8.	**Norfolk and Waveney ICS Quality Strategy** *For Noting*	**KW**
	KW presented the paper and the Quality Strategy on behalf of PD'O. KW acknowledged the significant work of Evelyn Kelly in engaging with our system partners to create the Strategy. Committee members were asked to note the contents and to consider the primary care committee links to support the development and implementation of the plan. JB acknowledged the good engagement across the system and asked Committee members for their thoughts about how the ICB will use this Strategy. MB acknowledged that it was important for the ICB and to embed and communicate it and highlighted that was about primary and community care, general practice and more broadly he felt that the health inequalities and	

	prevention were the areas that the ICB should particularly focus on in the coming weeks and months with system partners. He asked that the ICB check back in the future and was supportive of the proposals. JB thanked MB and KW and noted the emphasis in the document around what had been said about the role of Place based programme boards and the Place based health and Well-being Partnership meetings. It was highlighted that although members of the Committee would interface with those individually at Place level, the Committee would also need to understand how the Place agenda was going to develop. JB asked if there had been a paper to discuss Place at this Committee and MB felt this would be appropriate. MB acknowledged that discussions were still continuing around Place but that it would be helpful to have an agenda item on this at a future Committee. **ACTION: SW to add an item on Place to the forward planner.** JM felt that it would be helpful for the Committee to provide views from primary care about how it would engage at Place level on issues such as quality and inequalities. AH thanked KW for a really detailed paper. AH offered Healthwatch support with regard to communication to make it more accessible and user friendly. KW accepted the offer and would contact AH. **ACTION: KW to contact AH in respect of the offer to help.** JB noted the Committee had agreed the recommendations made. It should be noted that the LMC had submitted comments offline in respect of this item and these would be responded to accordingly. **ACTION: KW to respond to NW in relation to the comments received.**	**SW** **KW** **KW**
9.	**Appointment of Dental Attendee to the Committee** *For Approved*	**FT**
	FT presented the paper and asked Committee members to agree the process to appoint a dental representative to the Committee. HW asked that the minutes clarify that the appointment was not a representative but someone who would bring dental experience and expertise to the benefit of the wider proceeding. JB noted that the Committee approved the process for the appointment an individual to the Committee line, noting the clarification from HW.	
10.	**NHS Transition – Report on provision of Pharmaceutical Services, Optometry and Dental Services** *For Noting*	**FT**
	FT presented the paper which set out the ICB responsibilities and the key challenges that ICB would manage for pharmacy and optometry and dental services for noting.	

	FT highlighted some of the challenges, noted the common themes for all primary care related to workforce recruitment and retention and the challenges attracting and retaining people in Norfolk and Waveney. FT highlighted that the ICB was working very closely with each of the professions to find the solutions and explained there were no easy answers for solving some of these challenges. In working together with the professions and having listened to our patients and helping to understand their concerns, FT thought the ICB could make positive progress over time. FT highlighted huge challenges around access for patients which was extremely poor, and also that the ICB was keen to support the dental profession. The ICB aimed to agree a short-term plan by the end of September 2023 that sets out short term initiatives that were being worked on and to agree the dental strategy by March 2024. FT highlighted the establishment of the Dental Development Group to work with us to help inform the development of the year one plan and the strategy which would come to this Committee for approval. JB thanked FT for the update and the discussion in due course around workforce would be very welcome. He noted within this document the future proposed strategies for Committee's agreement and the timescales for these. JB noted the Committee would want to express its concern about the accessibility issues, particularly for dentistry and the demanding situation for patients in the Norfolk & Waveney area. JB asked Committee for questions and observations. JR asked for clarification about the appointments that were missed during period July to December (noted as 13000) and whether it was possible to renegotiate with providers who were not fulfilling their UDA (units of dental activity) activity for redistribution to other practices in order that the ICB did not lose the activity. FT responded to the concerns around missed appointments, and highlighted this was not unique to dentistry, and it was an area being worked on with our Communications and Engagement team, with a focus on valuing healthcare services. In terms of UDAs, work would be done with activity. FT explained that there had been a recent change in the dental contract which would allow ICBs to renegotiate contracts where appropriate from next year, but until then there would have to be an agreement with practices. FT thought it was more important to understand the challenges and the reasons why our valued providers were struggling to achieve their activity and try to resolve those with them, to work with them to understand the pressures and what we can do to support that. SP explained that there was an end of year review process which would start soon to look at underperformance, this meant that monies could be returned to the Commissioner if a certain level of activity was not achieved. The team would keep the Committee up to date on what the position will be.	

	It was also important to note that dental services had been delegated to us under a ring-fenced budget for dental commissioning. The ICB had yet to agree our budgets with NHS England, but that was quite a strong indication of how we were expected to use the funding with the delegation responsibility going forward. JB asked whether the ICB expected Committee members to undertake any kind of engagement activity outside of what the ICB was doing in the sphere of commissioning and engagement and strategic work. FT felt that it would be helpful to use every opportunity and every forum available to understand the issues and concerns, particularly, from patient groups that were affected and welcomed support from the Committee in highlighting and raising the profile of primary care. JB thanked FT and the Committee noted the report.	
11.	**CQC Reports** • Mattishall and Lenwade Surgeries *For Noting*	**SN**
	SN presented the paper on the CQC inspection report for Mattishall & Lenwade Surgeries to Committee for noting. SN highlighted the key areas. The three domains which had been rated as inadequate related to leadership, safe services and effectiveness. The other two domains related to caring and responsiveness remained rated good. SN assured the Committee that intensive support was in place through meetings with the practice, CQC and members of the ICB's multi-disciplinary support team and the meetings had been going well. There were no immediate concerns in terms of patient care. SN highlighted the CQC bitesize training in place to support general practice, which included the CQC and the work undertaken around medicines management. AH asked how the ICB communicated with the public around an inadequate CQC rating from a reassurance point of view and whether it was seen as managerial judgement rather than clinical judgement. SN responded by saying that an inadequate rating did not mean that the individual doctor or nurse or clinician was in any way unsafe and unfortunately this was not always communicated very well. AH felt there was misunderstanding of what the CQC does and what the inspection outcomes meant, and therefore it was incumbent on the ICB to communicate to support both the public and the staff. JB thanked AH for his comments and acknowledged the role of clinical and quality regulations and the differences between CQC and the work of other professional bodies was not well understood. JB thought the ICB could do more to explain the differences and how the public could be reassured.	

	KW explained that from a quality and safety perspective, the CQC were there to regulate patient safety. KW further highlighted the matrix working within the ICB to ensure that everybody was supported and if anybody was particularly adversely affected, then people would be referred for the right level of support. There was availability of TRIM practitioners that could visit the practice team if there has been an adverse incident identified. KW explained it was about getting the balance right to provide a level of assurance to the public that the CQC had visited which should be a positive message for patients. JR asked about the mechanism the ICB had to place surgeries onto the support register. SN explained that the register was inclusive and focused on resilience, and also included those that were not highlighted by CQC with an inadequate rating. The ICB had a process to follow to identify practices and was being strengthened working closely with the CQC to share intelligence to support practices at the earliest opportunity. KW commented on the significant amount of training undertaken with general practice and advised that this was about providing the right evidence on the day to CQC to be able to meet those standards. SP noted that in 2022 there were nine inspections, three of which were rated Good, three resulted in Requires Improvement, and three rated as Inadequate. The way in which inspections were conducted had changed quite significantly over the last few years and some of our practices had not been inspected since 2015. SP explained the ICB was trying to shift the focus towards a much more proactive way of supporting practices and spotting areas that might need extra support early. It was very resource-intensive to support practices that had already been inspected, which meant that there was less time available to support other areas of proactive work. SP highlighted the delayed plans to implement a practice visit programme, which would enable the ICB to support practices and to identify issues or resilience concerns and put the right support and training in place. This would be available to all practices. SP also highlighted the annual E-Declaration process as part of GP contract requirements, which would take place in the autumn. The Delegated Commissioning team was currently working on a summary report as part of improving the triangulation of data and intelligence around general practice. The Committee noted the report.	
12.	**GP Contract Update** *For Noting*	**SN**
	SN presented the paper to Committee for noting and JB thanked SN for the paper. JB acknowledged comments had been received from the LMC in relation to this item in particular around digital screening platforms. SP felt that it was important to note the LMC's comments were to set out the BMA's GP Committee and their rejection of the contract and the reason why. The remainder of the comments were more detailed and would be responded to offline.	

	HW referenced the upcoming review of the additional roles reimbursement scheme (ARRS) and asked for some further information of the roles created as welcomed in some areas but the influx of clinical pharmacists had meant a drain on pharmacists elsewhere in the system. SN acknowledged that Norfolk and Waveney were leading recruitment regionally on the ARRS recruitment programme and had more people recruited to these roles. SN had been informed by workforce colleagues that this was a national piece of work and there was a task and finish group that had met and the ICBs had been included in these discussions. The plan locally was to set up our own task and finish group to work through what this meant in terms of support for the ambitions for improving patient access and experience. HW noted that with the emergence of the Delivery Groups the aim was to make Committee discussions more strategic, this item would fit within this more strategic discussion. JB thanked SN for his report. The Committee noted the report.	
13.	**Finance Report** *For Noting*	**RB**
	RB presented the Finance report to Committee and highlighted the key areas to note. There being no comments or questions JB, HW and SC thanked RB for her thorough report.	
14.	**Prescribing Report** *For Noting*	**MD**
	MD presented his usual brief report to Committee for noting. JB opened for questions. KW thanked MD for the paper and asked if there was any targeted work planned for the ten practices that identified as high prescribers of antibiotics. MD responded by saying it was ICB's plan was to talk to the practices to offer support and confirmed support was available from a clinical pharmacist. KW thanked MD for the update. HW sought clarification about the data in table for the broad-spectrum antibiotics. MD explained previously the ICB had listed only those above 14% but had now listed every practice above 10% which was the national target, and this would be more challenging to achieve. If there were low prescribers of antibiotics, then it would be more difficult to achieve those relative percentages, given the more appropriate use of broad spectrum antibiotics. This data showed where prescribers were above target rather than those most concerned about on this occasion. There being no further questions JB thanked MD for the update and report was noted.	
15.	**Any Other Business** **Questions from the public**	**Chair**
	One question from a member of the public was noted. It was not directly relevant to the agenda.	

	SP confirmed that this would be published on the ICB's website. Question: What plan does the ICB have to develop a process to consider potential proposals, stroke partnership, opportunities with industry, potentially of mutual interest and mechanism to engage with industry, stroke, pharmaceutical companies? SP explained that the person who submitted the question said that they had some ideas and one of them had just been accepted in Cambridge & Peterborough ICB The ICB's response: The ICB had a draft policy around sponsorship, which was currently progressing through internal governance routes in the ICB and would be published in June. In the meantime, an invitation would be extended to industry representatives to write the ICB for the attention of our medicines management team, with detailed information on their request or proposal. In considering a response, the Medicines management team would have regard to the ICB's formulary, and the cost effectiveness of the pharmaceutical companies request or proposal. **ACTION: Question and response to be added to ICB website.** JB thanked Committee members and closed the meeting. Part One Meeting closed at: 13.20.	**SW**

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

Norfolk and Waveney ICB – Primary Care Committee – 2023/24 PART ONE

		April	May	June	July	August	September	October	November	December	January	February	March
	Proposed date:	21st	9th	13th	11th	8th	12th	10th	14th	12th	9th	6th	5th
Standing items:	Risk Register		Y		Y		Y		Y		Y		Y
	Monthly Finance Report	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Estates Quarterly		Y	Y		Y	Y		Y	Y		Y	Y
	Digital Quarterly			Y			Y			Y			Y
	Prescribing Report	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Workforce and Training	Y	Y		Y			Y			Y		
	PCN DES		Y	Y			Y				Y		
	CQC Inspections Report	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Spotlight items:	Annual or Bi Annual Report on Delegation tbc	TBC											
	Terms of Reference Review tbc							Y			TBC		
	Learning Disability /Autism Health checks	Y		Y		Y		Y		Y		Y	
	PCCC Self Assessment tbc										TBC		
	Severe Mental Illness Health checks			Y			Y			Y			Y
	Healthcheck Stocktake report					Y							
	Dental Short Term Plan							Y					
	Dental Strategy and Workforce Plan												Y
	Oral Health Needs Assessment			Y									
	Place development and interface with PCCC						Y						
Items noted without a date:													

Workforce and training no time critical items - deferred

Estates brought forward one month

PCN DES brought forward one month

Please note this is subject to change once the delivery groups are established and once pharmacy, optometry and dental commissioning has been transferred

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2023 – 2024

Ref	Risk description	Month risk rating											
		1	2	3	4	5	6	7	8	9	10	11	12
PC1	General Practice – Workforce (GPs and nurses)	12	12										
PC6	Learning Disability Annual Physical Health Checks	12	9										
PC9	Hypnotics and anxiolytics prescribing	12	12										
PC 14 BAF16	The resilience of general practice	16	16										
PC15	Wave 4B Primary Care Hubs – loss of capital funding	8	8										
PC16	Severe Mental Illness (SMI) Annual Physical Health Checks	12	12										
PC17	General Practice – Allied Health Professionals Workforce including PCN Additional Roles	12	12										
PC18 BAF18	Transition and delegation of Primary Care Services (Dentistry, Optometry and Community Pharmacy)	12	12										

2022 – 2023

Ref	Risk description	Month risk rating											
		1	2	3	4	5	6	7	8	9	10	11	12
PC1	General Practice – Workforce (GPs and nurses)				12	12	12	12	12	12	12	12	12
PC6	Learning Disability Annual Physical Health Checks				12	12	12	12	12	12	12	12	12
PC9	Hypnotics and anxiolytics prescribing				16	16	16	16	12	12	12	12	12
PC10	Gabapentinoids prescribing in primary care				9	9	9	9	9	9	9	9	6
PC 14 BAF16	The resilience of general practice				12	12	16	16	16	16	16	16	16
PC15	Wave 4B Primary Care Hubs – loss of capital funding				8	8	8	8	8	8	8	8	8
PC16	Severe Mental Illness (SMI) Annual Physical Health Checks				12	12	12	12	12	12	12	12	12
PC17	General Practice – Allied Health Professionals Workforce including PCN Additional Roles				12	12	12	12	12	12	12	12	12
PC18	Transition and delegation of Primary Care Services (Dentistry, Optometry and Community Pharmacy)								16	16	16	16	12

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

PC1	
Risk Title	General Practice – Workforce (GPs and Nurses)
Risk Description	Lack of general practice GPs and Nurse workforce due to vacancies and impending staff retirements. The impact on the service delivery to patients.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Sadie Parker	Primary Care Committee Commissioning (PCCC)	Jayde Robinson	01.06.2020	31.03.2025

Risk Scores								
Unmitigated			**Mitigated**			**Tolerated**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	3	4	12	2	4	8

Controls	Assurances on controls
• Workforce team recruited in ICB structure. • Primary Care Workforce Transformation Team supported by Medical SRO Lead, two clinical roles recruited to support Placement and Quality of Learning Organisations and Educators (GP and Nurse) and GPN Development lead. • 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 2023/24 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 Professional leads recruited. • Wide range of initiatives in place to support GP retention • Advanced Practice Forum established • Workforce and Communication Engagement strategies updated to reflect PCN development updates and post pandemic environment. • Workforce data to measure trajectory levels against actual recruitment. • Succession planning lead recruitment to support practice and PCN with demand vs capacity requirements. • Training Needs Analysis completed for 23/24. • Coastal and Rural project to support geographical areas facing greater challenges in recruitment, e.g. West and East	**Internal:** Reporting to Primary Care Commissioning Committee (PCCC) and the People Board. Reporting to the Norfolk & Waveney People Board. **External**: NHSEI returns monthly as part of the NSHE 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 2023 and 2024 • 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.

Updates on actions and progress			
Date	**Action**	**RAG**	**Target completion**
February 2023	Latest HEE workforce data illustrates the following: • 1.5% growth in Nursing workforce roles across N&W during the period of Dec 21 vs Dec 22. 449 WTE are in place across the system. • -5.2% decline in GP workforce roles (excluding training GPs) during the same period. 513 WTE are in place across the system. A contributing factor in the decline is the loss of GP Partners (8 WTE in the last quarter). 158 WTE GP salaried, • 12.9% growth in GP Trainees across N&W during the same period. 130 FTE are in place across the system. New pilot programmes launched to attract "New to GP partnership scheme" with a local context. 5 new GP partners have been signed since January 2023, with 5 new GP partners likely to sign up by March 23. A full evaluation of the pilot will be carried out to determine if the programme should continue in the new financial year. International Nurse recruitment pilot programme launched to support two practices with recruitment in areas of deprivation. 8 Primary Care Networks have agreed to take part in the 12-month project for "PCN Learning organisations" to support GP practices to become a training practice by August 2023 and increase their Tier 3 educators and student placements across their network. Expansion of training practices and educators has increase in the last quarter, which is shown below: • Tier 3 educators: 6% increase • Tier 2B educators: 8% increase • 1 new GP practice approved as a Learning Organisation • 1 reapproval of a GP practice fallow Learning Organisation • 5 reapprovals of GP practices as Learning Organisations New programme being scoped to encourage ST3's who have trained in the area to stay within Norfolk & Waveney once qualified.		March 2023

April 2023	Latest HEE workforce data illustrates the following: • 1.8% growth in Nursing workforce roles across N&W during the period of Feb 22 vs Feb 23. 444 WTE are in place across the system. • -4.6% decline in GP workforce roles (excluding training GPs) during the same period. 513 WTE are in place across the system. A contributing factor in the decline is the loss of GP Partners (12 WTE in the last quarter). 158 WTE GP salaried, • 24.5% growth in GP Trainees across N&W during the same period. 137 FTE are in place across the system. Apprenticeships and Fellowships have seen an increase within Norfolk & Waveney for primary care, this includes: • 33 Training Nurse Apprenticeships • 34 GP Fellowships • 2 Nursing Fellowships General Practice Partnership Model - 19 new GP partnerships have been supported during Q4 as part of this pilot concept. This pilot required a commitment of 6 clinical sessions to be delivered per week and a 2-year commitment in partnership with their N&W practice. This incentive also provided additional support through mentoring and training pathways for the new partners. A summary of the incentive uptake included: • 17 new General Practitioner Partners joined N&W • 1 Advanced Pharmacist Practitioner joined N&W • 1 General Practitioner returned to N&W. 61% of practices responded to the Training Needs Analysis, which closed at the end of March 23. A full analysis and review of the results will be undertaken shortly so the Primary Care Workforce Team can scope and plan the training provision for 2023-24.		July 2023

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

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	PC6
Risk Title	Learning Disability Annual Physical Health Checks
Risk Description	The ICB is at risk of failing to meet its commitment to improve health and wellbeing for people with a learning disability if the quality and uptake of the annual physical health checks are not completed in line with the NHS national guidance. Access to an annual physical health check is intended to help reduce this risk, however, there are variable rates of uptake across Norfolk & Waveney GP practices. The ICB will not be able to fully meet its commitment to transform the lives of people with Learning Disabilities. National delivery targets to improve the uptake and quality of annual health checks for people aged 14 and over with a learning disability have been set for commissioners. All GP practices in Norfolk and Waveney have voluntarily signed up to the national Directed Enhanced Service (DES) which does not set a target for achievement, but requires practices to identify all registered patients, aged 14 years and over, with a learning disability, with the aim of reducing their health inequalities. The contract specification requires the practice to 'invite patients on the health check learning disabilities register for an annual health check.' Practices may resign from the DES at any time by giving not less than 1 months' notice.
ICB priority	

Risk Owner	**Responsible Committee**	**Operational Lead**	**Date Risk Identified**	**Target Delivery Date**
Sadie Parker	Primary Care Commissioning Committee	Shepherd Ncube	01.07.2022	31.03.2024

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

Controls	**Assurances on controls**
• Plan in place to increase uptake of LD health checks across practices • All practices signed up to the LD DES (bar 1 - UEA as they feel their student population does not meet the criteria) • Regular monitoring by Norfolk Health Overview and Scrutiny Committee • CQC inspections usually include review of LD health checks performance • Transformation funding secured for a small peripatetic team, this will help support practices that are behind their trajectory. • Peripatetic team and GP with a special interest are now in post • Regular assurance reports to NHSE/I & PCCC	**Internal:** Primary Care Commissioning Committee **External**: NHSE Checkpoint and Assurance Framework, Health Overview and Scrutiny Committee Reports to NHSE/I

Gaps in controls or assurances
LDAHCs are now being undertaken face to face.

Updates on actions and progress			
Date	**Action**	**RAG**	**Target completion**
March 2023	The ICB remains on track to meet the national requirements for annual health. However, a drop in activity has been observed in the December and January, and the drivers for this are related to the holiday season and		31.3.23

	related winter pressures. Activity is expected to increase in February and March period. While the target date for this risk has now completed, it is suggested the risk is extended for a further year to enable this to embed.		
May 2023	Significant progress has been achieved in 2022/23, the ICB has met its national set target for Learning Disability Annual Health Checks (LDAHC). The Health Facilitation Team within the nursing directorate remains in place to provide additional support for struggling practices. Additional support will be made available to practice via the new initiative agreed with NHSE-Point of Care Testing Kit (POCT). The recommendation is that the risk score is reduced to a moderate score (from 16 to 9) to reflect our end of year landing position and structures in place to continue supporting delivery.		31.7.23

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

PC9	
Risk Title	Hypnotics and anxiolytics prescribing
Risk Description	High prescribing rate of hypnotics and anxiolytics in primary care - 3rd nationally on volume per 1,000 patients. These medications have negative side effects on patients and should not routinely be used long term.
ICB priority	

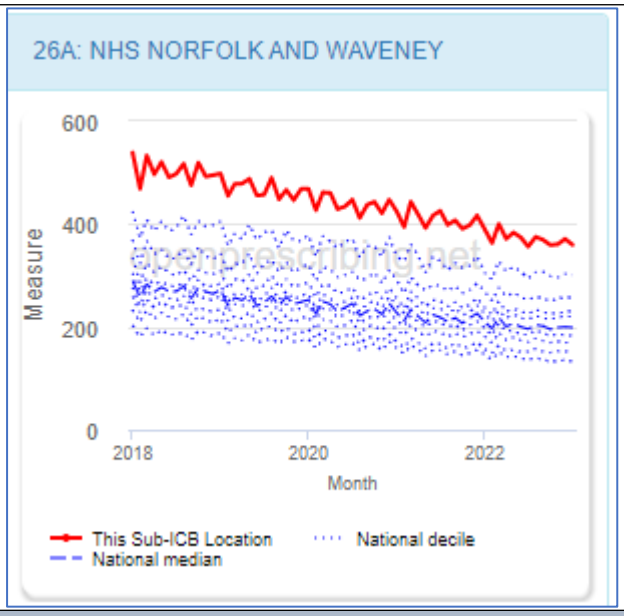
Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Dr Frankie Swords	Primary Care Commissioning Committee (PCCC)	Michael Dennis	28.07.2020	31.3.2024

Risk Scores								
Unmitigated			**Mitigated**			**Tolerated**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	4	3	12	3	3	9

Controls	Assurances on controls
Practices have been encouraged to review their use of hypnotics/anxiolytics however not all practices have taken decisive action to reduce this. This years' Prescribing Quality Scheme (PQS) incentivises work to reduce prescribing.	**Internal:** Review Open Prescribing data each month, report progress to PCCC. Identify practices with the highest prescribing rates. **External**: NHS England

Gaps in controls or assurances
The Prescribing Team has formed a new structure and is carrying some vacancies. This workstream is supported by the prescribing quality scheme but practices need to have capacity to deliver.

Updates on actions and progress			
Date	**Action**	**RAG**	**Target completion**
Mar 2023	Dec 22 data = ADQ/1000 patients = 371.118 97th percentile (31 days this month) Rate per day = 11.97. It is recommended that the risk target date is extended for a further year.		30.4.23
May 2023	Jan 23 data = ADQ/1000 patients = 359.627 96th percentile (31 days this month) Rate per day = 11.60		31.3.24



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

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PC14 BAF16	
Risk Title	The resilience of general practice
Risk Description	There is a risk to the resilience of general practice due to several factors including the ongoing Covid-19 pandemic, 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. Individual practices could see their ability to deliver care to patients impacted through lack of capacity and the infrastructure to provide safe and responsive services will be compromised. This will have a wider impact as neighbouring practices and other health services take on additional workload which in turn affects their resilience. This may lead to delays in accessing care, increased clinical harm because of delays in accessing services, failure to deliver the recovery of services adversely affected, and poor outcomes for patients due to pressured general practice services.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Mark Burgis	Primary Care	Sadie Parker	01/09/2020	31/03/2024

Risk Scores								
Unmitigated			**Mitigated**			**Tolerated**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	4	20	4	4	16	3	4	12

Controls	Assurances on controls
• Locality teams and strategic primary care teams prioritised around supporting the resilience of general practice, dedicated resource to support the Covid vaccination programme. All practices have previously been supported to review business continuity plans • PCN ARRS (additional roles reimbursement scheme) funding has increased again in 2022/23 • Primary care workforce and training team working closely with locality teams to identify clinical and volunteer workforce and to ensure training available to support practices and PCNs in setting up and maintaining services • Resilience funding process has been completed earlier this year (Q2) to provide practices with more opportunity to bid and respond • Interface group with representation from primary, community and secondary care system partners • Standard contract requirements on interface – gap analysis and action plans, including monitoring being reviewed by contracts team	**Internal:** Executive Management Team, Senior Management Team, workforce steering group, primary care strategic planning meetings **External**: Primary Care Commissioning Committee, NHS England via delegation agreement, Health Education England, Norfolk and Waveney Local Medical Committee

Gaps in controls or assurances

- Practice visit programme, CQC inspections focused on where there is a significant risk or concern
- Unplanned risk associated with Covid and flu outbreaks or positive cases, as well as higher levels of sickness absence in general
- Impact of ambulance delays diverting practice teams from routine and urgent care to respond to emergencies
- Continued reports of poor patient behaviour across practices, decrease in patient satisfaction with general practice through GP patient survey, consistent with national position

- Progress on interface action planning process across Trusts impacted by ongoing winter pressures
- Reporting process for inappropriate transfers of workload from community and secondary care providers to general practice not yet fully worked through
- 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

Updates on actions and progress			
Date	**Action**	**RAG**	**Target completion**
16.2.23	Nationally, routine CQC inspections have been suspended. Practice plans submitted to access local discretionary support contained a number of resilience themes: • Recruitment and retention issues, mainly for GPs, nursing staff, receptionists and clinical pharmacists • High levels of staff sickness • Pressures on estates capacity as a result of increasing PCN ARRS roles • Increased and unsustainable winter demand, eg suspected and actual Strep A cases, flu and Covid • Impact on their ability to manage patients in the community and continue to provide services due to ambulance delays • Inability to undertaken phlebotomy on Saturdays as part of enhanced access Colleagues from workforce, digital and estates have been linking in with individual practices accordingly. Additional £150k funding for each locality is now in place until end of March and ARI hubs have all been established to provide additional capacity. Resilience 'handbook' under development to signpost practices to support available. Additional interim capacity from within the ICB has been identified to support the PID inbox process to enable practices to report interface issues. The LMC office is also lending support to analysing themes reported.		31.3.23
25.4.23	• CQC inspections have recommenced. • Practices have declared QOF and IIF achievement and the finance team is working through QSSP calculations, expect to be able to make payments to practices within QOF deadlines. • Interface reporting procedure has been finalised with input from LMC and interface group members. Themes being reported monthly to interface group. Contracts team leading discussions with Trusts on action planning to prevent inappropriate transfer of work. Radiology requesting programme of work ongoing and slow to progress due to complexities identified relating to national IRMER guidelines • Working through new GP contract requirements to identify where support can be provided. • Updated comms campaign being planned to provide information to patients on clinical triage and the different roles now operating as part of the general practice team • Awaiting final budgets so programmes of work can be finalised, eg resilience funding		30.6.23

	• Target date and tolerated risk score will be reviewed as part of new BAF group work		

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

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PC15	
Risk Title	Wave 4B Primary Care Hubs – loss of capital funding
Risk Description	There is a risk that there could be a loss of £25m capital funding if the Wave 4b Primary Care Hubs are not operational by March 2024. The Programme Business Case was revised and resubmitted June 2022, following NHSE feedback, reducing the programme from 5 schemes to 4. Programme Business Case was approved September 2022, Full Business Cases to be approved by Summer 2023. The Thetford scheme was approved by DHSC in March 2023.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Sadie Parker	Primary Care Commissioning Committee (PCCC)	Paul Higham	31.03.2021	31.03.2024

Risk Scores								
Unmitigated			**Mitigated**			**Tolerated**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	2	4	8	2	2	4

Controls	Assurances on controls
The Wave 4b Primary Care Hub Programme is managed by the Wave 4b Programme Board which includes representatives from the ICB, NHSE, NHSPS, NorLife and the LMC. Below this: 1. NHSPS have teams in place to develop the FBCs for 2 of the 4 schemes. 2. NorLife (existing landlord) are developing the FBC for 1 scheme. 3. PHP (existing landlord) are developing the FBC for 1 scheme. All schemes report into the programme board for ICB oversight.	INTERNAL: Wave 4B Programme Board, Primary Care Estates Team, PCN Teams, PCCC, ICB EMT. EXTERNAL: NHSE/I, LMC, Provider Trusts, Third Party developers (tbd), County, City and District Councils

Gaps in controls or assurances
Programme plan monitored by Programme Board. Feedback awaited from NHSE around approval process which could put the delivery of the programme at risk.

Updates on actions and progress			
Date	**Action**	**RAG**	**Target completion**
March 2023	NHSE regional team approved the Thetford SFBC on 23/02/2023. The case was due to be reviewed by the national team on the 28/02/2023 but the item was rescheduled for 14/03/2023. The delay in committee has no impact on programme. ICB EMT reviewed approaches to ownership model on 27/02/2023. Additional legal advice and further work to explore potential additional revenue costs of NHSPS ownership model has been requested by EMT.		31.03.23
April 2023	New completion date reflects the project progressing to its next stage and the next milestone in terms of business case approval. Due to the timescale for the project, the ICB can no longer be in a position to take on ownership of the new build schemes initially. NHS Property will assume ownership with the intention of ownership transferring to the ICB when the national policy to enable this is reinstated.		30.08.23

	Scheme full business cases for the Sprowston, Rackheath and King's Lynn schemes are now in progress and – pending NHS England confirmation of dates – would reach the final stage of approval in August 2023.		

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

PC16	
Risk Title	Severe Mental Illness (SMI) Annual Physical Health Checks
Risk Description	1. The ICB is at risk of failing to meet its commissioning commitment to meet the needs of its SMI population which leads to a **clinical risk** that patients with SMI will experience significant health inequalities and a 15-20% higher mortality when compared to their peers. 2. There is also a **performance risk** identified with regards to delivering the national target of the Norfolk and Waveney system delivering 60% of SMI health checks. 3. Out of a total of 9,463 patients, 3,398 checks were done or 35.9% (according to Q4 2021-22 data). 4. Access to a SMI annual health check is recommended to reduce this risk, however there are variable rates of patient uptake across GP practices.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Sadie Parker	Primary Care Commissioning Committee	Shepherd Ncube	10/05/2022	31.03.2024

Risk Scores								
Unmitigated			**Mitigated**			**Tolerated**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	3	4	12	2	3	6

Controls	Assurances on controls
• Plan in place to increase uptake of SMI checks across N&W reviewed by PCCC and MH boards. • A 2-year improvement trajectory has been agreed with NHS England. • Monthly steering group has been established with input from Mental Health and Locality colleagues. • All practices signed up to the SMI LCS; letter sent to practices highlighting end of year position and plan for improvement by June 2022. • Funding from Mental health for additional clinical capacity has been secured to trial a small clinical team to provide checks across a PCN. The resource is expected to start from Quarter 3. This will help support practices that are behind their trajectory. • Regular assurance reports to NHSE/I & PCCC	**Internal:** Primary Care Commissioning Committee, monthly steering group **External**: NHSE Checkpoint and Assurance Framework, Health Overview and Scrutiny Committee Reports to NHSE/I.

Gaps in controls or assurances
• Planned additional resources are not expected to have an impact until Quarter 3 (22-23).

Updates on actions and progress			
Date	**Action**	**RAG**	**Target completion**
March 2023	• The ICS is on track to deliver against its recovery trajectory submitted to NHSE. A small drop in activity in December was expected due to the holiday season and winter pressures. • Activity patterns are expected to normalise in Q4 The SMI improvement board is collaborating with the mental health teams to launch specific clinical coding training for SMI;		30.4.23

	dedicated website resources for staff training, and patient roadshows which should see a continued rise in activity delivered. • It is recommended this risk is extended for a further year to enable our processes and progress to embed		
May 2023	• Steady progress continues to be made and more checks have been completed this year compared to last year. • Achieved slightly above 55% completed checks against a national target of 60%, which is the best uptake seen in Norfolk and Waveney • System wide improvements have been observed across all the 4 quarters in 22-23 and provide organisations in General practice and at NSFT. It is intended these will be embedded during 2023/24		31.7.23

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

PC17	
Risk Title	General Practice – Allied Health Professionals Workforce including PCN Additional Roles
Risk Description	Lack of general practice (GP) Additional Roles (ARRS) and Direct Patient Care roles in the workforce due to vacancies and recruitment and retention challenges. The impact on the service delivery to patients.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Sadie Parker	Primary Care Committee (PCC)	Jayde Robinson	30.06.2022	31.03.2024

Risk Scores								
Unmitigated			**Mitigated**			**Tolerated**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	3	4	12	2	4	8

Controls	Assurances on controls
• Workforce team recruited in ICB structure. • Primary Care Workforce Transformation Team supported by clinical leadership via 6 Ambassador roles, Medical SRO Lead and GP Quality and Differential Lead. • 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 2023/24 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). • ICS Social Prescribing Lead recruited. • Primary Care Health & Wellbeing Professional leads recruited. • Workforce and Communication Engagement strategies updated to reflect PCN development updates and post pandemic environment. • Workforce data to measure trajectory levels against actual recruitment. • Succession planning lead recruitment to support practice and PCN with demand vs capacity requirements. • Training Needs Analysis completed for 23/24.	**Internal:** Reporting to Primary Care Commissioning Committee (PCC). Reporting to the Norfolk & Waveney People Board. **External**: NHSEI returns monthly as part of the NSHE Primary Care Oversight Board KPI's and quarterly assurance meetings.

Gaps in controls or assurances
• Recruitment of mental health practitioners, community pharmacists and technicians remain challenging. Similar roles recruited into PCNs from community pharmacy • System approach for paramedic rotational roles agreed approach subject to national and regional review. • Understanding general practice resilience as work challenges increase may lead to higher numbers of the workforce leaving/retiring during 2023 and 2024 • Ability to attract new workforce to Norfolk and Waveney and may be mitigated by system level action

- Some geographical areas facing greater challenges in recruitment, e.g. West and East
- Challenges of recruitment, retention and integration can only be addressed if PCNs and commissioning bodies can understand the huge values the additional roles can bring.
- Data quality discrepancies against ARRS reporting on the national reporting service is reflective across the system which is impacting trajectory targets.

Updates on actions and progress			
Date	**Action**	**RAG**	**Target completion**
Feb 23	Latest HEE workforce data illustrates the following: • 9.6% growth in Direct Patient Care workforce roles across N&W during the period of Dec 21 vs Dec 22. • 600 WTE are in place across the system. • 26.1% (157 WTE) are over the aged of 55 years Additional Roles across Norfolk Waveney has seen an increase to 501.5 WTE during the month of December 2022. Four roles that have seen the highest increased during this period include: • Clinical Pharmacist by 15% • Training Nurse Associates by 64% • General Practice Assistant by 100% and • Care Coordinators by 20%. An updated position on each PCN workforce vacancy and recruiting intentions has been completed until the end of March 23. Norfolk and Waveney will show a utilisation of 93% of the ARRS budget into primary care. Succession planning through student placements, recruitment drives and exploring joint roles between general practice, community pharmacy and acute providers will continue to be developed. Non-clinical roles are being supported through confidential coaching support and training requirements. These roles have increased from Q1 to Q3 within the system by 184 WTE. A further review of what support is needed will be identified through our Training Needs Analysis, which commenced in February 2023.		March 2023
March 23	Latest Health Education England workforce data illustrates the following: • 9.7% growth in Direct Patient Care workforce roles across N&W during the period of March 22 vs March 23. • 611 WTE are in place across the system. • 25.6% (156 WTE) are over the age of 55 years • 6.2% (28 WTE) are under the age of 25 years Additional Roles (ARRS) across Norfolk and Waveney utilised 96% of the national funding up to the end of February 2023, which recruited a total of 582.6 WTE into the system. However, the National Workforce Reporting tool is showing 370 WTE for this period. To support the data quality discrepancies, we are working with each PCN to ensure they are reporting their ARRS staff accurately. System plans for allied health professionals, ARRS and non-clinical roles recruitment for 23/24 within general practice have been submitted. The trajectory predicted will show an increase of 381 WTE by the end of Q4.		July 2023

	Succession planning through student placements, recruitment drives and exploring joint roles between general practice, community pharmacy was launched during Q4 of 22/23. Non-clinical roles are being supported through confidential coaching support and training requirements. 61% of practices responded to the Training Needs Analysis, which closed at the end of March 23. A full analysis and review of the results will be undertaken shortly so the Primary Care Workforce Team can scope and plan the training provision for 2023-24. Apprenticeships has seen an increased within Norfolk & Waveney for primary care, this includes: • 26 Pre-Registration Pharmacy Technician • 10 Administration from L2 and L3 • 4 Non-clinical Management.		

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

PC18 BAF18	
Risk Title	Transition and delegation of Primary Care Services (Dentistry, Optometry and Community Pharmacy) including complaints service and potential transition of Contact Centre for these areas.
Risk Description	Primary Care Services will become the responsibility of the Integrated Care Board from 1st April 2023, the risk is there will be a lack of additional capacity, resources and finance to effectively commission these services within existing ICB teams (Finance, Complaints, Quality, Workforce, Contracts and Delegated Commissioning) during and following the transition process, leading to a poor patient experience for our local population.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Andrew Palmer	Primary Care	Sadie Parker	31/10/22	31/10/2023

Risk Scores								
Unmitigated			**Mitigated**			**Tolerated**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	4	20	4	4	16	3	2	6

Controls	Assurances on controls
• Dental staff to be aligned to ICB's • Single ICB host agreed for the region for community pharmacy and optometry contracting • Pre-delegation assurance framework (PDAF) and safe delegation checklist (SDC) published in draft to support transition work. • Weekly regional task and finish group in place to support the transition and share workload • Regular regional primary care directors and finance directors meetings in place • CSU Medicines Optimisation Team already have working relationships with Community Pharmacies around quality. • Proposal for complaints/Contact Centre transition to be delayed to April 2024.	**Internal:** ICB Task and Finish Group, ICB Finance and Primary Care Directors meetings, EMT, Primary Care Commissioning Committee **External:** NHS England, Norfolk and Waveney LDC

Gaps in controls or assurances

- Visibility, decision and agreement on transfer of budget from regional team to ICB.
- Alignment of staff members from region to ICB to be agreed, with focus on contracting only.
- Lack of dental staff transferring to ICB
- Pharmacy and Optometry services to be aligned to ICB's hosted by HWE ICB
- Lack of resource to support management of finance.
- The level of the unmet need for Dentistry and the associated financial consequence of this once addressed (if possible) given the transfer for funds are to be based on 2022-23 current expenditure which per NHSEI forecasts are also below budget (suggesting a growing unmet need). Non-clinical financial pressures are also likely to arise in relation to resourcing costs given the loss of the economies of scale held in the current model for which the ICB are not funded adding pressure to their Running Costs control target.
- 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 resource to support management of clinical quality, safety and patient experience for these services and for the governance of these functions i.e. managing complaints quality visits and specialist advice and support for providers.
- Access to NHS dentistry services has consistently been an area of quality concern that the local system has escalated to NHSE. This impacts on some of our most vulnerable patient groups.

- Significant workforce shortfalls across dentistry, optometry and community pharmacy.
- Hosting arrangements for pharmacy and optometry services are not yet confirmed, drafting of memorandum of understanding is underway.
- Final versions of PDAF and SDC not yet available.
- The ICB has not been provided with sufficient information to fully complete the PDAF and SDC prior to submission of initial draft in September.
- No confirmation yet as to whether NHSE Contact Centre work/staff to be transferred to ICBs and no data as to staff numbers/workload this would bring. Concern break-up of regional/national team will lead to inefficiencies, remove economies of working to scale and concern there will not be team resilience due to small numbers of staff transferred.
- No data on the complaints service such as numbers of staff and activity levels for complaints work leaving little time to ensure an effective transition of services.
- Unclear decision-making process for transition of complaints with infrequent regional meetings and currently no access to the project group who will be making the recommendation for transfer of complaints service to December Board for approval.

Updates on actions and progress

Date opened	Action / Update	BRAG	Target completion
Jan 2023	Internal governance established Board paper November 2022. Further submission to Board in February 2023 PDAF submitted to NHSE Sept 2023. Safe Delegation checklist updated and submitted to NHSE in Sept and Dec. Final submission due 8/2/23 Terms of Reference for Primary Care Commissioning Committee and proposal for a Scheme of Delegation and establishment of two Operational Delivery Groups for medical and dental services to PCCC Jan 2023 for agreement. To Board in February for approval Complaints model – decision made to delegate to ICBs from April 2023, staff to transfer July 2023. Complaints data has been shared. NHSE ContactUs will be delegated from July 2023, with risk of unknown activity and workload. Memorandum of Understanding with HWE for hosting Pharmacy & Optometry services final draft available for ICB EMT agreement Jan 2023 Understanding of financial risk has improved through information sharing and assurance has improved Regional oversight & decision making provided by ICB PC Directors (fortnightly meetings) Multiple task and finish groups (NHSE and ICBs in region) in place re Finance, Quality, IG & Digital; also weekly General mtg for ICB leads, to discuss concerns and issues, share learning and information NHSE has arranged multiple masterclasses to share learning with ICB teams and will continue		28/02/23
Mar 2023	Final submission of Safe Delegation Checklist on 8 Feb with a deep dive meeting with NHSE on 21 Feb to discuss progress and concerns. Task and Finish Group with NHSE and ICBs has facilitated shared learning and discussion about concerns and agree resolution or escalation as appropriate, has been beneficial. Audit Committee and Board have received detailed reports in February on progress, risks and mitigations being taken. Governance arrangements through Primary Care Commissioning Committee approved by the Board		30/06/2023

	Finance team continue to work with NHSE team to understand financial controls and budgets. Access to payment and contracting systems to be enabled for ICB staff from 1 April 2023 TUPE process for staff transfer to ICB confirmed. Vacancies being recruited where no staff being transferred including Finance, Quality, Complaints and Primary Care Commissioning teams. The ICB has secured a contract with Primary Care Contracting to provide expert advice, guidance and training during 2023/24. Delays to national data migration process is resulting in interim arrangements being agreed for continued access to NHSE data with a Data Protection Impact Assessment and updated Data Sharing Agreement to be completed. Complaints model to be completed by July 2023, discussions underway to agree how this will happen. Staff will be aligned from April 2023. Engagement with key stakeholders in each of the professions (pharmacy, optometry and dental) has commenced with regular meetings in place.		
May 2023	Board adopted all necessary governance documentation at its meeting in March 2023 to enable the transfer of responsibilities under the Delegation Agreement with NHS England Transition of primary care services and staff within primary care and Finance teams to ICBs completed on 1 April. Recruitment to the Primary Care Commissioning Team continues. Impact of the additional workload on ICB directorates and teams remains unknown and a risk. Transfer of responsibility for complaints also completed on 1 April with a phased staff transition planned for July 2023 subject to consultation when staff resources will be confirmed Data migration of electronic files to be managed during 2023/24, interim digital and governance arrangements for staff to have continued access to NHSE data in place MOU with HWE ICB commenced for managing ICB responsibilities for pharmaceutical and optometry services Informal Touchpoint meetings with all ICBs in the region continues on a fortnightly basis to share learning & raise concerns. Regional Primary Care Directors Transition forum last meeting 27/4/23. ICB Primary Care Transition project team stood down and replaced with targeted team meetings relating to outstanding transition work. The ICB's Primary Care Commissioning Committee confirmed agreement to the new Terms of Reference on 21 April 2023; plans underway to set up the governance for managing the operational Delivery Groups reporting into the Committee. The Committee received two reports on the transition and provision of pharmaceutical, optometry and dental services at its meeting on 21/4/23. Access to management/reporting and payment systems is in place for dental, pharmacy and optometry contracts Finance to confirm all budgets with NHSE, including primary care delegated services (forecast plans shared with Committee 21/4/23). ICB's Dental Development Group established to engage with clinicians from across Norfolk and Waveney primary, community and secondary care. The Group includes Healthwatch to represent the patient voice. The ICB aims to set out a short term plan for dental services by Sept 2023 and a dental strategy and workforce plan by March 2024		30/09/23

	using an evidence based approach (updated Oral Health Needs Assessment and other surveys/intelligence) to identify unmet need and ICB priorities. Workforce data being collated to fully understand the workforce recruitment & retention challenges across primary care services and to begin to develop plans Following successful transition and discussion at EMT, this risk covering the Transition of Services will be refocused towards specific dental risks relating to quality, access and workforce, and will be updated to reflect this at the next Board meeting.		

Visual Risk Score Tracker

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	20	16	12									
change		↓	↓									

Norfolk and Waveney
Integrated Care Board

Agenda item: 07

Subject:	**Workforce and Training Report**
Presented by:	**Jayde Robinson, Head of Primary Care Workforce Transformation**
Prepared by:	**Keri Robinson, PC Transformation Manager - Workforce Planning and Governance**
Submitted to:	**ICB Primary Care Committee**
Date:	**9 May 2023**

Purpose of paper:

To provide Primary Care Commissioning Committee members with an update on the work of the Primary Care Workforce Team, including the transfer of responsibility of Dental, Pharmacy and Optometry.

This paper presents also seeks approval from the committee for the following:
- Primary Care Workforce Strategy and
- Communication and Engagement Strategy.

Executive Summary:

The Norfolk and Waveney ICB contract with Health Education England (HEE) for the provision of ICS Level Primary Care Training Hubs commenced in April 2022.

The ICB's Primary Care Workforce team, embedded within the ICS Workforce team from 1 September 2022, is responsible for delivery of the objectives and aims of the contract specification and operational guidance.

This paper provides an update on workforce and education matters. The paper also gives an update on new areas transferred under the remit of the Primary Care Workforce team, these are the Dental Pharmacy and Optometry workforce and the Health and Wellbeing Lead work.

This paper presents for approval the final versions for the Primary Care Workforce Strategy and Communication and Engagement Strategy following stakeholder engagement and feedback.

Report

1. Risk

There are two general practice workforce risks to note which may impact the service delivery to patients. These include:

- PC01 - Workforce (GPs and Nurses) and
- PC17 - Allied Health Professionals Workforce including PCN Additional Roles

Both risks have been reviewed and are featured on item 6 of the agenda, due to the mitigations in place as per the operational delivery plan, the risk level remains the same.

2. Workforce update

The Primary Care Workforce Transformation Team is expanding to allow additional capacity to take on the increased workload of the additional responsibility of Dental, Optometry and Pharmacy. At present there is no confirmation of funding from NHSE to support this.

The below screenshot shows the General Practice workforce in Norfolk and Waveney as at 28 February 2023. Workforce numbers remain relatively stable with Norfolk and Waveney having a significantly improved number of Direct Patient Care roles compared to other areas at 18% of total roles in N&W being DPC roles compared to 11% nationally, 13% Nurses compared to 12% nationally.

GP (excl GPs in Training Gr..	GPs in Training Grade	Nurses	Direct Patient Care	Admin	Grand Total
505	137	444	611	1,734	3,431

The refreshed Primary Care Network Contract Direct Enhanced Service (DES) sets out a number of positive changes to ARRS (additional roles reimbursement scheme) workforce to support PCNs and general practice, as below:

- increasing the cap on Advanced Practitioners from two to three per PCN where the PCN's list size numbers 99,999 or fewer, and from three to six where the PCN's list size numbers 100,000 or over;
- reimbursing PCNs for the time that First Contact Practitioners spend out of practice undertaking education and training to become Advanced Practitioners;
- including Advanced Clinical Practitioner Nurses in the roles eligible for reimbursement as Advanced Practitioners. Advanced practice is a level of practice where a practitioner has demonstrated their ability to work autonomously at a high level (level 7/ Masters level) across all four pillars of advanced practice.
- introducing apprentice Physician Associates as a reimbursable role.
- removing all existing recruitment caps on Mental Health Practitioners and clarifying that they can support some first contact activity.
- amending the Clinical Pharmacist role description to clarify that Clinical Pharmacists can be supervised by Advanced Practice Pharmacists.

During 2022/23, Norfolk and Waveney utilised 92% of the ARRS funding, which increased the ARRS staff to 593.2 WTE across the system. We are however aware of the discrepancy of data between the national workforce reporting to the ARRS claims process. We are working to ensure all ARRS are reported correctly at a PCN level, across the system, as this will impact the trajectory of workforce numbers.

3. Finance

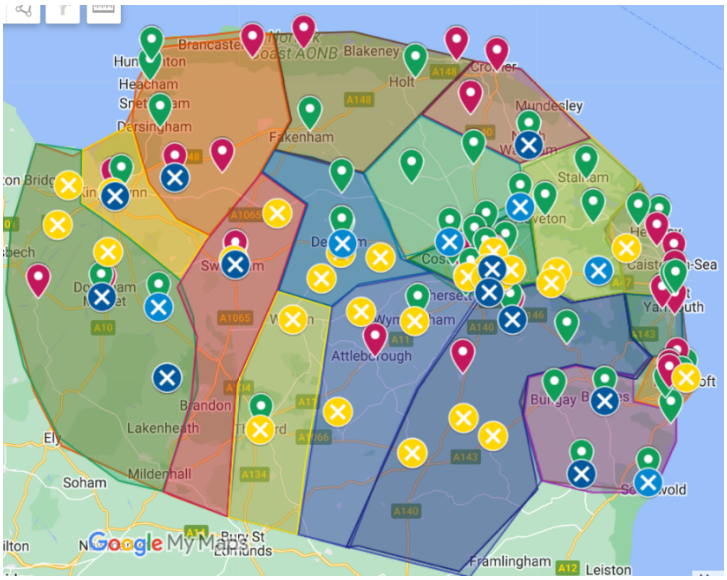
We are working within our financial budget limits with no concerns to be raised.

PCCC members should also note that £368k of funding bids were awarded to Norfolk & Waveney to support programmes for Coastal and Rural, Pharmacy and ST3 to salaried roles from the primary care workforce team. This additonal funding has been built into the 2023/24 delivery plan.

4. Programme updates

Quality and sustainability
As part of our sustainability work for the primary care workforce we are looking at expansion of GP practices hosting GPs in training, as well as learners from the wider workforce including nurses, paramedics, pharmacists, physician associates and non-clinical roles. This requires GP practices to apply as dedicated learning organisations and have approved GP trainers.

We have developed incentives around this work to increase placement capacity. During 2022/23 we increased our GP educators by 35% and increased our training practices by 4.5%.



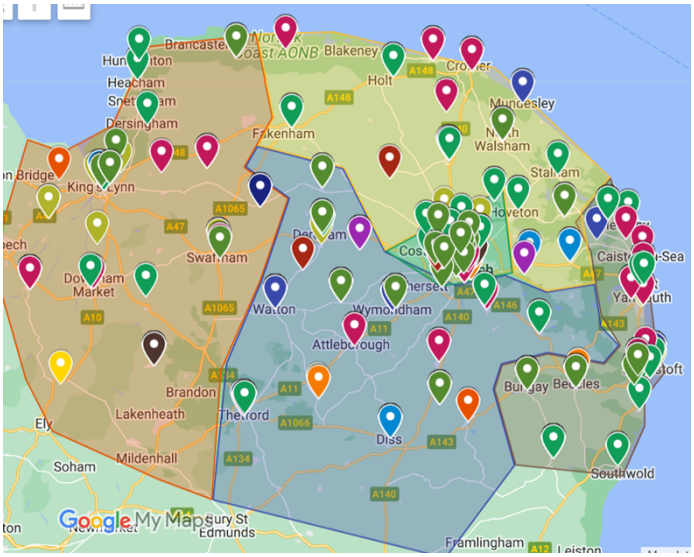
The above diagram indicates the ongoing work undertaken. The icon with a circle and X marked inside of them are the areas in which we need to increase our learning organisations or trainers within the area. This will be our continued focus during 2023/24 so it meets the demand of our future workforce pipeline.

Training and Education
The Primary Care Workforce Team fully utilised the CPD (continuing professional development) budget allocation to support primary care during 2022/23 for clinical staff. The funding we receive from Health Education England is to provide clinical training for some of the general practice roles. To ensure all our general practice roles can receive the training needed, during 2022/23 we ensured that all "non-clinical" courses were funded using some of the previous year underspend. The operational delivery plan, as featured in Appendix A, shows the breakdown of the courses delivered during this period.

In summary:

- 919 Learners supported in general practice with CPD training opportunities, these were for clinical and non-clinical staff members.
- 73 Apprenticeships achieved in general practice
- 37 Fellowships delivered in general practice
- 7 Primary Care Network Learning Organisation Projects -12-month pilot established

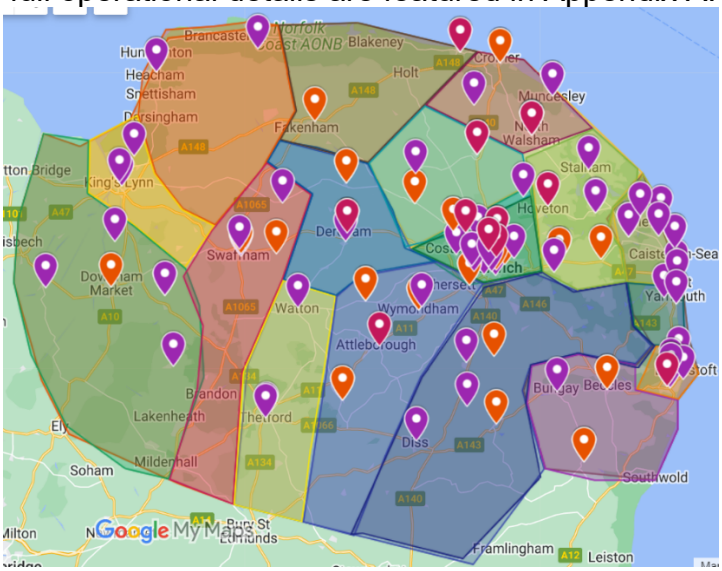
These activities have been reflected in a visual representation below, to show the uptake across the system of the activities delivered to general practice during 2022/23.



Retention Schemes
During 2022/23 the Primary Care Workforce Team delivered the following programmes:

- Return to Work
- Schwartz Rounds
- Coaching and Mentoring
- Mentoring Scheme
- Flexible Staff Pool
- GP Partnership Model Pilot*

The visual representation below shows the uptake across the system for these programmes and full operational details are featured in Appendix A.



*This programme was introduced in Quarter 4 by the Head of Primary Care Workforce Transformation and was specifically designed to mitigate PCCC risk PC01 with GP and Nurse recruitment.

Primary Care Careers:
Provision of the Primary Care Careers recruitment, attraction and retention solution began in October 2022. Following a period of communications and engagement the service is being utilised across the patch. Practice engagement is now at 48% with 29 known roles filled, 17 live adverts at present and 60 roles with recruitment in progress. To provide continuity of service the provision of this support has been extended to March 2024.

5. Clinical Ambassador Updates

Physician Associate Ambassador:
Our Physician Associate (PA) Ambassador has been working to help develop the understanding employers have of the PA role and how this relates to primary care. On the back of this, he has been liaising with employers and the UEA to form a strong synergistic relationship to help with placements, recruitment and retention of PAs trained in the east. This has been achieved through careers events held at the UEA and developing training opportunities for both established PAs and students alike. We are currently developing a pastoral service to support qualified PAs.
In March we supported a CPD event aimed at Physician Associates at the West Suffolk Hospital, as a joint enterprise with Suffolk and North East Essex ICB, the event was very well attended, with overwhelmingly positive feedback. We are hoping to host a similar event in Norfolk later in the year. This event was an opportunity to network with PAs in the region face to face and to hear any concerns/feedback about working in primary care in Norfolk and Waveney ICS.

Clinical Pharmacy Ambassador:

Our Clinical Pharmacy Ambassadors key focus of this year has been to increase the number of placements available to pharmacy students within Primary Care. This includes placements as part of their undergraduate studies and summer placement opportunities. Working collaboratively with other ICBs to deliver a summer placement programme within Norfolk and Waveney. The Pharmacy Ambassador is supporting placement providers to complete relevant documentation and engage with training providers to support taught learning for Foundation Pharmacist Training Year. In addition to remaining a key contact for students who have completed placement to support career opportunities within Norfolk and Waveney. She is promoting development of Learning Organisations within GP Practices and community pharmacy to ensure a consistent number of placement providers across Norfolk and Waveney.

Paramedic Ambassador:
Our Paramedic Ambassador regularly works with paramedics new to post on their options for progression including the FCP roadmap (portfolio and taught), Advanced Practice MSc and standalone modules. In addition, he advises employers on learning needs for their new/prospective starters and organises CPD events for paramedics and other healthcare professionals.

First Contact Physiotherapy:
Our FCP physiotherapy Ambassador has built a network across the region to enable peer support and improved support. There are four main providers in the region including directly employed FCP physios. Ensuring that the Physios and supervisors understand a clear point of contact for support had been identified as a risk which is now being addressed.

Additionally, as a joint enterprise between our Paramedic and FCP Physio Ambassadors we have arranged an FCP peer support and study day for the end of April to strengthen and build peers support, educational networks, and the retention of these roles. This will be multidisciplinary and aims to provide a framework for better peer support and knowledge dissemination going forward. Over the next year we aim to support further local based FCP supervisor courses to grow the local FCP supervisor number as we have identified there is a lack of local HEE (Health Education England) accredited supervisors. These can be delivered without cost by our FCP ambassador as he is an accredited sentinel trainer for the HEE roadmaps.

Advanced Practice:
The Advanced Practice Ambassador has formed a dedicated Advanced Practice Forum with over 100 members across Primary Care facilitating effective communication with clinicians across a wide demographic area to share local, regional and national updates and incentives from strategic partners. Regular Forum Microsoft Teams meetings are held which provides clinical educational updates alongside peer-to-peer supervision.

Educational scoping for potential Advanced Practice Trainees is undertaken twice yearly, this process has undergone scrutiny and transformation to ensure the process is timely, constructive, and applicable for all interested parties, including the applicant and their employer, the ICB and Health Education England. The

Ambassador works closely with the UEA Advanced Practice course Directors and CPD Leads to provide a clinical voice to their academic objectives.
Current work focusing on workforce development and sustainability has begun by reaching out to PCN Leads and General Practice employers. The aims are firstly to increase interest and an awareness of the many benefits Advanced Practitioners have on patient service and secondly to facilitate workforce growth that is fit for the future.

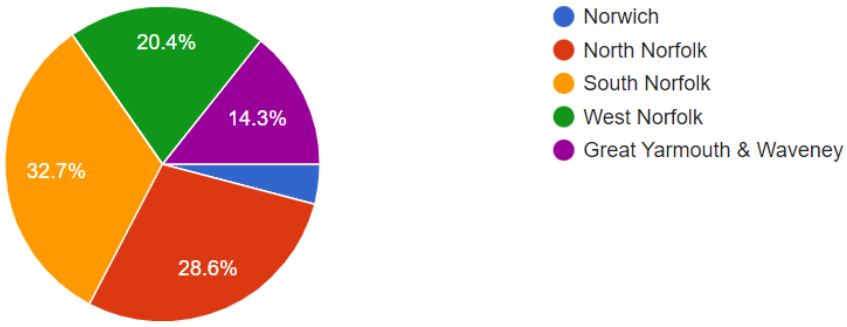
6. Key Performance Indicator (KPI) Update

Our next Key Performance Indicator (KPI) report to NHS England is due 13 May, we are reporting full compliance against all KPIs.

7. Training Needs Analysis

As the system moves towards a restoration and reset of services delivered to the population of Norfolk and Waveney, the Primary Care Workforce Team launched a Training Needs Analysis to understand Practices workforce and organisational plans, as well as training needs for the forthcoming year. All 105 practices in Norfolk and Waveney were invited to participate.

A total of 64 out of 105 practices responded (60.95% response rate) which is up 8.95% from the previous Training Needs Analysis, carried out in 2021. For all localities except Norwich, less than 70% of practices engaged. Norwich practices engagement given as 100% as Norwich Practices Ltd collated a single response for Norwich, rather than responding to the survey as individual practices.

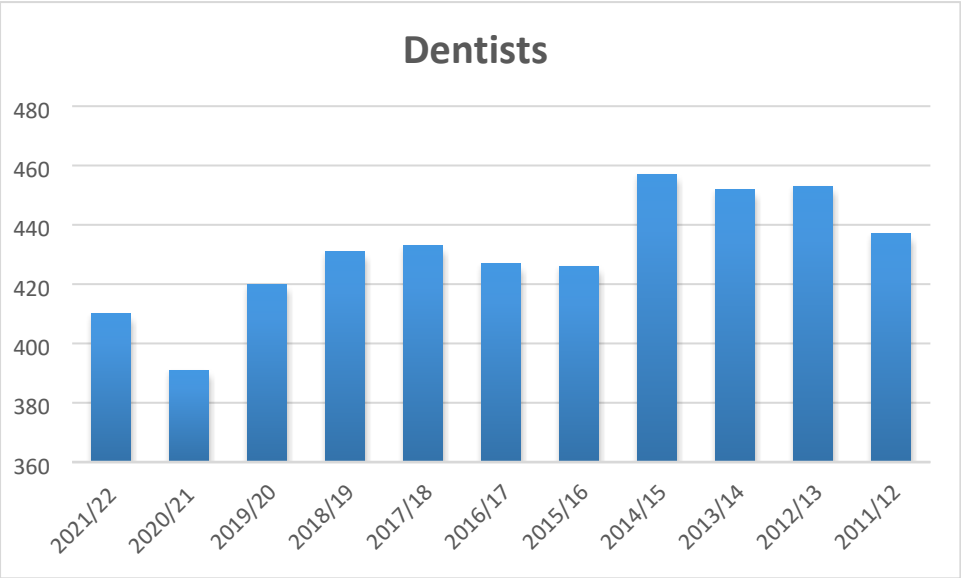


A full analysis and review of the results will be undertaken shortly so the Primary Care Workforce Team can scope and plan the training provision for 2023-24.

8. Our Position on Dental, Pharmacy and Optometry

Dental
NHS Digital have published Dentistry workforce figures from 2011 to 2021. At the end of March 2021, a headcount of 410 dentists were reported, who perform NHS activity across our system.

A summary of the headcount from the period of 2011 to 2021 is shown below:



There is currently no information available to understand the vacancy levels for this primary care service or the wider workforce position for the following roles:

- Dental Hygienist
- Dental Nurse
- Dental Technicians
- Dental Therapists

There are also 7 practices involved with Dental Foundation Training across Norfolk & Waveney, these are located within Norwich and Great Yarmouth and Waveney areas.

Optometry

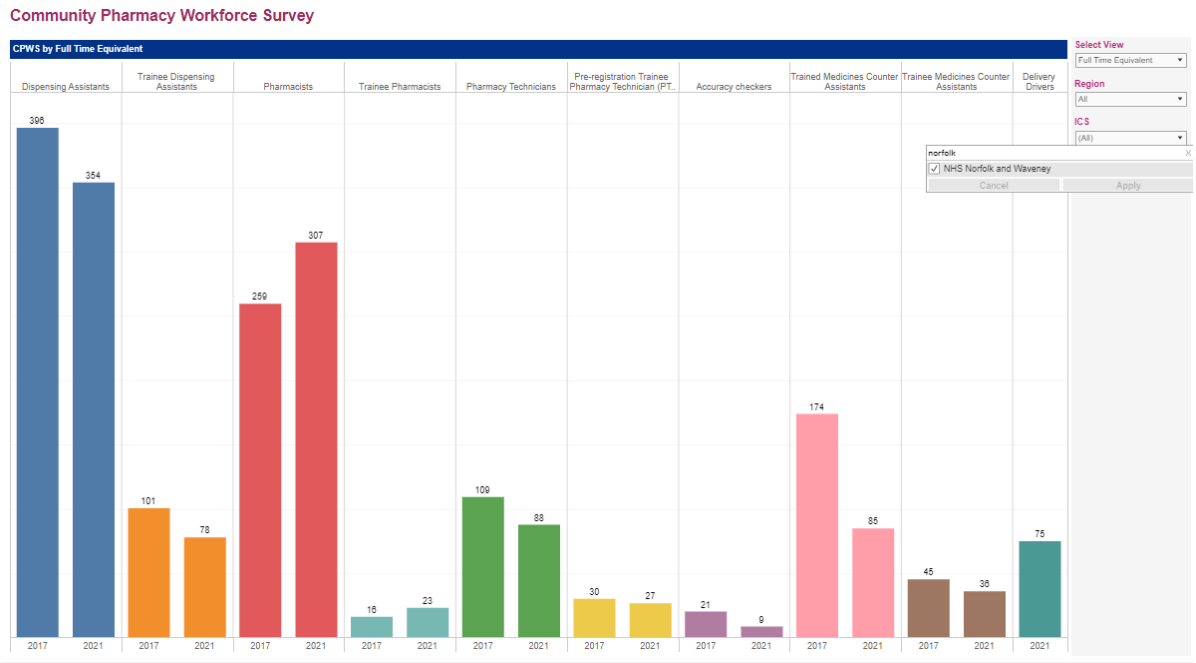
NHS Digital published Optometry workforce figures for the East of England (EoE) in December 2019, unfortunately this is the latest position we have access to. The information provided does not break it down to an ICS level or WTE (whole time equivalent), however, we are working with NHS Digital to see if this information can be made available. The 2019 headcount data, for the EoE is as follows:

Optometrists	Ophthalmic Medical Practitioners
1,570	39

There is currently no information available to understand the vacancy levels for this primary care service.

Pharmacy

Health Education England has carried out an annual Community Pharmacy Workforce Survey, which will provide the latest workforce position for 2022, however this information has not yet been published. The information below is the baseline position of 2021 for Norfolk & Waveney, which shows a total of 1,208 WTE. The vacancy level for this workforce in 2021 was reported at 7%.



9. Strategy Update

In October 2022 preliminary approval of the Primary Care Workforce Strategy and Communications and Engagement Strategy was given, subject to the outcome of stakeholder engagement exercise.

As part of this stakeholder engagement exercise undertaken in Quarter 4, the Primary Care Workforce Strategy is featured as Appendix B. Overall, the strategy and its components have been well received amongst stakeholders, with a particular focus on a place-based approach. All existing operational programmes have been reviewed, to ensure they maximise the ICS primary care workforce strategy.

The Primary Care Workforce strategy will be reviewed by the end of Quarter 2 2023/24, to reflect the transfer of responsibilities for the other primary care services (dental, pharmaceutical and optometry).

A refresh of the Communication and Engagement Strategy has been carried out in Quarter 4, featured as Appendix C.

We are now seeking approval from the committee for the following:

- Primary Care Workforce Strategy and
- Communication and Engagement Strategy.

10. Health and Wellbeing

The past two years have been particularly tough for all primary care teams in Norfolk and Waveney with a specific toll on health and wellbeing (HWB). Primary care professionals have been struggling to balance life and work and meet high levels of service demand. Good health and wellbeing provision is recognised as a key factor in helping people feel better, control their workload, and thrive at work. Primary care

staff have historically been unable to access HWB support due to the fact that they are not NHS employees and as a result many have been questioning whether to remain in healthcare at all.

In early 2022, Norfolk and Waveney invested a significant level of funding to answer the question 'Who Cares?' for Healthcare Professionals aimed specifically at primary care staff with a focus on support staff. It is free to these colleagues with the emphasis on helping with Pressure and Burnout, Mental Health, Work / Life Balance and Physical Health.

The programme offers access to #WeCareTogether which has been tailored to the specific needs of all primary care staff in Norfolk & Waveney, both NHS and private. This is a one stop shop offering access to all the HWB resources provided by the professional bodies nationally, as well as about 150 of the best NHS HWB resources.

Supporting this with practical help is funded access to the Resilient Team Academy for those in a position of leadership in the healthcare team and the Shapes Programme for all staff. These two platforms provide an established network of Health and Social Care professionals coming together to share best practice and tackle problems.

The focus of the professional leads within the project has been to raise awareness, work across our networks and ensure all primary care colleagues are aware of the support and resources available, regardless of who they work for and at what professional level.

We have worked with proof-of-concept sites across General Practice and Dentistry to offer an enhanced and tailored level of support to gauge the outcome of offering a deeper level of intervention for all staff working across the practice.

As this project is of a finite period and due to complete in September 2023, we have surveys (beginning and 24 months) in place of the 2-year programme to help to establish the benefits in retention of staff and patient experience and understand if this can be rolled out on a substantive basis going forward.

Recommendation to the Board:

Members are invited to note the updates and to approve the two strategies noted in section 8.

Key Risks	
Clinical and Quality:	Function of the workforce and training function supports the delivery of clinical service
Finance and Performance:	Delivery of function within agreed budget

Impact Assessment (environmental and equalities):	None
Reputation:	Delivery of Primary Care Workforce function ensures successful achievement of HEE and NHSEI objectives and development of primary care workforce
Legal:	None
Information Governance:	None
Resource Required:	N/A
Reference document(s):	N/A
NHS Constitution:	N/A
Conflicts of Interest:	None Identified
Reference to relevant risk on the Board Assurance Framework	PC1, PC17, PC14/GBAF06 – resilience of general practice

Governance

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

Appendix A - Primary Care Operational Delivery Plan 22/23

Training and Education Programmes

Spirometry
In 2022/23, the Primary Care Workforce Team commissioned Rotherham Respiratory and purchased 120 places and to fulfil demand, we purchased an additional 20 places, utilising underspend from the Clinical / Non-clinical budget. We have utilised 97% of the places on the course and are confident the remaining three places will be utilised by the end of June 2023.

Spirometry ARTP assessment
Since August 2022, we have had a 50% uptake with 55 learners commencing their ARTP assessment, supported by the Respiratory Nurse Education Lead for the ICB. ARTP did not take any enrolments for December 2022 & January 2023.

Cytology
The first cohort of 10 delegates commenced mid-October 2022, we are expecting students to get to the Final Assessment stage shortly. A second cohort of 15 delegates commenced in February 2023, they have all completed their theoretical course, and have begun their mentored practical training period. Learners have up to 9 months to complete their training.

Fundamentals of General Practice
UEA have withdrawn the Fundamentals of General Practice course whilst they undertake a strategic review of their education provision. As a mitigation measure, UEA ran x5 GPN Study Days, funded by the Primary Care Workforce Team. Two staff commenced the course with Anglia Ruskin University in January 2023, funded by HEE. HEE will be undertaking a national procurement exercise for 2023/24 delivery, awaiting confirmation of funding for future courses.

Phlebotomy
To ensure standardised training across the system which mirrors what acute & community staff receive, we commissioned NNUH to deliver Phlebotomy training. So far, 94 staff across Norfolk & Waveney have accessed the training, funded by the Primary Care Workforce Team.

Immunisation & Vaccination
Awaiting dates/booking links for May, August, September & October for the UEA's Immunisation and Vaccination courses for registered and un-registered staff, including an update course.

Advanced Practice Professional

- 41 active trainees.
- September 2022 – 8 x Full MSc enrolled.
- January 2023 – 7 x Full MSc and 2 x Top Up enrolled.

- September 2023 – 3 x Full MSc and 2 x Top Up to be enrolled subject to HEE funding confirmation.

Care Navigation
Care Navigation is a course designed to help staff learn how to signpost patients to the appropriate healthcare practitioner to help free up GP consultation time so they can care for those with most complex needs. 50 Primary Care staff have attended a 3-hour webinar in February and a fourth session is planned for 30.03.2023 – this is fully booked.

AMSPAR
On top of the 5 x places that were approved as part of the Non-Clinical Training Programme, we purchased a further 11 x places on the AMSPAR Level 5 courses, utilising underspend due to the high interest for this course from Practice Managers. Learners commenced their training in December 2022.

CARE Programme
Following the engagement event in February, only four Primary Care staff applied for this 8-week course, so we were unable to meet minimum numbers to run a N&W cohort funded by HEE. However, all four staff will be offered a place on a nationally funded cohort starting later in 2023.

British Sign Language
This training was procured to raise awareness of the Accessible Information Standard, after rolling out to Primary Care staff, the training was offered out to all staff within the ICB to utilise all 300 licences before the end of 2022. 300 staff have now signed up and they have 24 months to complete the online learning.

General Practice Assistant Programme:
The General Practice Assistant Programme continues to be led by the Norfolk and Waveney Primary Care Workforce Team for the East of England region. In 22/23, it was agreed for the region to be provided 30 places on the accredited programme by HEE. Places were filled through communication resources being created and shared through all East of England Training Hub comms channels. There has been some attrition in March due to work pressures. All learners on the programme are due to complete their programmes by July 2023.

Due to the inclusion of the GPA role within the ARRS, interest has increased significantly. HEE are undergoing a procurement process for a new GPA cohort, all those who express an interest in the programme are being advised to apply to be included on a waiting list or being provided guidance on commencing training using the available resources but without accreditation. The next GPA Collaborative meeting with HEE and all Lad Hubs is due to take place 18th April 2023. Most recent communication from HEE advises that they are in the bidding stage of the procurement process. We do not have a timeline from HEE to share with Training

Hubs, PCNs and Practices of when procurement may be completed and information about a new accredited cohort may be available.

The 2022-23 cohort of GPA learners saw three referrals for Norfolk and Waveney, only one of which remains on the programme to date.

Fellowships

GP Fellowships
There are currently 9 GP Fellows who are due to commence their Fellowship programme, pending CCT, change in roles/employment or an agreed future starting date. A further 17 GPs are in their first year of their Fellowships and six in their second year. To date, ten GP Fellowships have been completed. There is further interest from GPs and trainee GPs in Fellowship for the 23-24 funding budget. There is currently a significantly higher number of GP Fellows in Norwich and West Norfolk, with the smallest number of Fellows in North Norfolk, closely followed jointly by Great Yarmouth & Waveney and South Norfolk.

Four Health Inequality GP Fellowships were created in conjunction with Quality colleagues. All four were successfully appointed to, however, the Learning Disability and Maternity Fellows have since withdrawn due to alternative opportunities becoming available. The Learning Disability Fellowship opportunity is being promoted through communication channels and the Maternity Fellowship opportunity will be promoted in April 2023.

Nurse Fellowships:
We have one nurse fellowship completed in 2022. Alongside this two physician associate fellowships and one nurse fellowship currently in progress and an additional two nurse fellowships in development.

Apprenticeships

Nursing:
To date, 7 Trainee Nursing Associates (TNA) have completed their course in Primary Care. There are currently 22 TNAs within Norfolk and Waveney, with a further 12 pending interviews for the September 2023 intake.

7 Nursing Associate and Assistant Practitioner colleagues are completing their Registered Nursing Degree or Top Up apprenticeships at present, with a further 8 pending interviews for the October 2023 intake. The UEA, ARU and OU are all providing these apprenticeships.

Pharmacy:
15 Pre-Registration Trainee Pharmacy Technician apprentices (PTPT) are within Norfolk and Waveney. Currently undergoing recruitment for a new cohort to commence in September 2023 with the UEA.

Non-clinical:
There are currently 9 non-clinical apprenticeships within Norfolk and Waveney, 3 management and 6 administrations. Applications are currently open for further management apprenticeships to commence in June 2023 through Poultec.

Ongoing support is in place for Practice to recruit and obtain apprenticeship funding for these apprenticeships.

Retention Programmes

Return to Work:
The purpose of the programme is to support GPs within General Practice who are or are at risk of absence from role due to burn out, maternity leave, sick leave or any other reason. We have worked with the provider to ensure robust reporting and agreed KPI's on this programme including how many attendees felt the programme positively impacted their thoughts and feelings about returning to work. The programme continues to get 100% positive feedback.

We are pleased to confirm the provider has agreed to open out the provision at no extra cost to all clinicians in general practice, to work preventatively as well as supporting those who have been absent from clinical practice. The programme will be rebranded to clearly convey the support available and the cohort to whom it is available to 'Supporting Primary Care Clinicians'.

Schwartz Rounds:
Schwartz online rounds continue to run monthly for Primary Care with topics planned throughout 2023. We have had 127 attendees since the relaunch in May 22. Feedback continues to be good, out of 50 responses 30 felt the Rounds were Excellent, 11 found them to be Good, 6 stated that they were Exceptional and 3 rated them as Fair.

In addition to the online rounds the team will provide 5 face-to-face rounds, one in each Norfolk and Waveney locality, staring in April 2023 in the North Locality.

Mentoring Scheme:
There are currently 12 active mentors providing mentorship in Primary Care to all colleagues as well as GP Fellows. Mentorship is being undertaken monthly for 18 GP Fellows.

Flexible Staff Pool:
The digital flexible staff pool now has 59 locum GPs approved to work in the area, and one Nurse. 76% of practices within Norfolk and Waveney are registered on the platform. 71% of shifts posted received at least one application in January-March 2023 with February reaching a high of 90%.
The ICB is beginning to collate data about non-GP locum workers in Norfolk and Waveney in preparation for expanding the use of this platform to other roles.
There is still geographical inconsistency in the success of the provision, and plans are in place to support this. We have agreed an extension to provision for a further

12-months to allow for continued growth of this across the region, and across all roles within Primary Care.

International Nurse Recruitment Pilot:

3 practices expressed interest in this pilot, however, were not able to progress before year end. It is anticipated this pilot will commence during Q2 of 23/24.

General Practice Partnership Model:

19 new GP partnerships have been supported during Q4 as part of this pilot concept. This pilot required a commitment of 6 clinical sessions to be delivered per week and a 2-year commitment in partnership with their N&W practice.

This incentive also provided additional support through mentoring and training pathways for the new partners. A summary of the incentive uptake included:

- 17 new General Practitioner Partners joined N&W
- 1 Advanced Pharmacist Practitioner joined N&W
- 1 General Practitioner returned to N&W.

First 5 Events:

The purpose of supporting the RCGP event is to build relationships with early career GPs and collect data to inform workforce planning. The March event was well received by 35 newly qualified and First 5 GPs. The attendance by the ICB allowed for promotion of the work being done and comments were made by multiple GPs that they were not aware of the wider remit and programmes of support available to them. Enquiries were made about programmes, particularly the GP educator programmes, fellowships and deep end work. The second First 5 events will be held in collaboration with the RGCP in August 2023.

Improving lives **together**
Norfolk and Waveney Integrated Care System

Norfolk and Waveney Integrated Care System

Primary Care Workforce Strategy 2022-2025

Document Control Sheet

Name of document:	Primary Care Workforce Strategy
Version:	1.8
Owner:	Jayde Robinson
Date of this version:	20 March 2023
Produced by:	Jayde Robinson
Synopsis and outcomes of consultation undertaken:	NHSE/I HEE LMC PCCC
Synopsis and outcomes of Equality and Diversity Impact Assessment:	The service, policy or function will only impact under exceptional circumstances
Approved by (Committee):	Primary Care Commissioning Committee
Date ratified:	11th October 2022
Next review due:	September 2023 to include dental and optometry services, when further guidance has been released.
Enquiries to:	nwicb.primarycareworkforce@nhs.net

Revision History

Revision Date	Summary of changes	Author(s)	Version Number
16/08/22	1st Draft	FT	1.1
18/08/2224/08/22	Re-phrasing of Introduction. Last para on Why Workforce Strat How we will do this – system wide approach	KL	1.2
20/09/2022	Multiple contributions and workforce data added	FT	1.4
28/9/2022	Final draft review & amendments	EW	1.5
03/10/2022	Final draft	FT	1.6
22/01/2023	Structure chart update	JR	1.6
30/01/2023	Multiple contributions and December 22 workforce data added	JR	1.7
20/03/2023	Multiple contributions after consultation with stakeholders and latest workforce data added	JR	1.8

Approvals

This document requires the following approvals either individual(s), group(s), or board.

Name	Title	Date of Issue	Version Number
Primary Care Commissioning Committee	Primary Care Commissioning Committee – Part One	11th October 22	1.6
Primary Care Commissioning Committee	Primary Care Commissioning Committee – Part One	21st April 2023	1.8

Contents

Primary Care Workforce Strategy 2022 - 2025

1. Executive Summary

1.1 Primary Care Landscape

The NHS is facing the biggest workforce challenge to date, and this has never been truer for primary care. Nationally, all primary care services, including general practice are facing ever greater challenges due to workforce shortages, an increasingly complex workload, rising public expectations, and working alongside multiple health and care providers as part of an Integrated Care System. In addition, more locally in Norfolk and Waveney, we face constraints to recruitment across all professional groups due to our unique geography, but in understanding these challenges and constraints we will be able to develop our system plans to transform our approach to recruitment and retention.

The timing of this Primary Care Workforce Strategy and Plan is critical. We have an opportunity as a newly formed Integrated Care System (ICS) to adopt a whole system approach to ensure a happy and healthy workforce for the present and future.

1.2 The new national NHSE/I & HEE headline for workforce

The new national NHSE/I & HEE headline for workforce is *"Our overarching aim is to maximise supply and retention of a talented workforce to deliver services for the future: more people, working differently, in an inclusive culture".*

Health and care services in Norfolk and Waveney have been working together closely over the past few years to improve services and provide more joined up care for local people. But we need to do much more of this, and at pace. Our staff across health and social care are key in bringing about this change and moving forward we need to improve the way in which we engage and listen to what's working well, what can be improved, and empower people to lead the change required.

Creating a transformational workforce plan for the primary care workforce 2025 is critical to stabilise primary care services in line with our ICS strategic objectives for our population. These challenges need to be tackled on all levels within the ICS: at system, at Place, in developing Primary Care Networks (PCN), and in general practice.

This document describes why we need a workforce strategy, our vision for primary care workforce in the future and how Norfolk and Waveney ICS will

work with partners to ensure Norfolk and Waveney is the best place to work in health and care.

1.3 #WeCareTogether – the Norfolk and Waveney Workforce strategy for our people working in health and care

This primary care workforce transformation plan is directly linked to #WeCareTogether Norfolk and Waveney ICS People Plan 2020-2025 for all health and care workforce. #WCT was launched in 2020 following engagement from over 1,200 people. Norfolk and Waveney were the first system to launch our plan after the national NHS People Plan and we were recognised nationally for this.

The four pillars of #WCT are set out below and this plan for Primary Care Workforce will map across accordingly:
- Creating new opportunities for our people;
- Promoting good health and wellbeing for our people;
- Maximising and value the skills of our people;
- Creating a positive and inclusive culture for our people

Supporting our people to deliver the best care as part of multidisciplinary teams will improve the working lives of our workforce, and support our local populations to receive high quality, personalised and compassionate care. We need to use every opportunity to make Norfolk and Waveney the best place to work and create a workforce transformation plan that supports variation in primary care at Place, PCN and practices.

The approach taken also reflects and responds to the workforce profile of primary care teams recognising the important of growing our own, attracting talented individuals, and supporting people to remain in our workforce. This plan for workforce in primary care is dynamic as it will evolve, in line with the development of the Norfolk and Waveney ICS. In particular, bringing dental, pharmacy, ophthalmology and social care in more depth once the ICB assumes responsibilities during 2023/2024.

Building on #WCT, our focus is on transforming and delivering a more innovative approach to supporting the primary care workforce includes the pivotal role of the Primary Care Workforce team.

Through the Primary Care Workforce team, we will support workforce planning, recruitment, and retention, providing opportunities to all for education, training, and development of the whole primary care workforce.

This Strategy document will be updated in May 2023 to reflect the transfer of responsibilities for other primary care services (dental, pharmaceutical services and optometry) to ICBs Support from Primary Care Workforce team is already available to community pharmacy and is described in detail within the Community Pharmacy Workforce plan (2022) which also forms part of the ICS People Plan.

2. Primary Care in Norfolk and Waveney

2.1 Practices and Primary Care Networks

General practice in Norfolk and Waveney comprises 105 General Practice contractors, all of whom work independently from each other, these are all members of one of 17 Primary Care Networks (PCNs) who are all at different stages of maturity and development. They may also work in collaboration with local general practice provider organisations and GP federations.

General practice provides more than 80% of urgent care in Norfolk and Waveney and therefore an essential and critical element of the ICS partnership. The nature of how general practice services operate provides opportunities as well as challenges in determining how the ICS can support their workforce. The development and maturity of PCNs is dependent on closer integration and collaboration with all primary care services, secondary and tertiary care providers, as well as collaboration with our VCSE and local communities.

2.2 Fuller report – future of Primary Care Services

The vision described in the Fuller Report is for a fully integrated primary care incorporating the four pillars of general practice, community pharmacy, dentistry, and optometry across all systems. At the heart of this report is a new vision for integrating primary care, improving the access, experience and outcomes for our communities, which centres around three essential offers:

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

As primary care commissioning changes come into effect from 1st April 2023, which will include Optometry, Dentistry and Community Pharmacy. We will use the themes from this plan to enhance support for transformation in these areas.

2.3 Our geography

Norfolk and Waveney has a unique geography potentially impacting on recruitment and attraction of new workforce to the area. Norfolk and Waveney is the furthest easterly point in the East of England region, with vast coastline and a mix of rural and urban landscape.

2.4 What can we expect in the future?

- The pandemic has changed the way in which we think about health & care delivery
- Greater integration of health and social care
- New care models with increased focus on multi-professional working and community-based care
- Ongoing development of primary care working at scale
- Increased funding pressures
- More complex service users with higher expectations
- Digital technology changing the way primary care operates, staff interact with each other and how patients interact with services
- Patients take greater self-management and understanding of their health and care needs
- Significant staffing pressures arising from an aging population and insufficient numbers choosing careers in health & care
- Resilience of general practice is unstable in many areas
- More positive, collaborative, and integrated approaches to care and workforce planning are emerging
- Increased patient expectations about how and when care is available

2.5 What challenges does this bring to service delivery?

- Development and maturity of PCNs varies which makes transformation at scale complicated
- Community Pharmacy not being fully integrated within a system approach to support urgent care provision and signposting for right care, right person, right time
- Funding determined annually, preventing forward planning or step-change
- Funding is also disproportionally allocated favouring NHS Providers and general practice over Social Care, and Voluntary sector
- Data is limited, inconsistent & provides minimal insight or assurance
- Increasing pressures on staff time leading to inequity in learning opportunities

3. Workforce overview

3.1 Workforce data

Norfolk and Waveney has an aging GP and nursing workforce. 27.2% of our GPs, 33.8% of our GPNs, 25.7% of direct patient care roles and 30.2% of our non-clinical staff roles (i.e Admin) are aged >55years.

Workforce data tools are dated and use multiple data systems, therefore quantifying the data quality will continue to be reviewed. In recognition of our workforce profile and anticipated challenges to replace leavers and increase workforce in line with increasing demand, our general practice workforce model has evolved over the last 5 years with support from national funding streams, education, commissioning, and fresh thinking from leaders supporting discussions around new ways of working and new roles.

Current workforce data shows (January 2023)[1]:

	WTE	Headcount	Age	Gender split
GP	513	648	1.8% unknown 7.6% <34 yrs 31.7% <44rs 31.8% > 45 yrs 27.2% > 55 yrs	63% Male 37% Female
GP in Training Grades	130	133		
Nursing	449	617	2.2% unknown 1.2% <24 yrs 16.2% <34 yrs 19.8% <44rs 26.8% > 45 yrs 33.8% > 55 yrs	47% Male 51% Female 2% Other
Direct Patient Care	600	825	3.9% unknown 6.1% <24 yrs 22.3% <34 yrs 18.7% <44rs 23.3% > 45 yrs 25.7% > 55 yrs	6% Male 93% Female 1% Other
Additional Roles	364*			
Admin	1742	2333	1.9% unknown 11.1% <24 yrs 18.2& <34 yrs 14.8% <44rs 23.8% > 45 yrs 30.2% > 55 yrs	9% Male 90% Female 1% Other

[1] Source: Health Education England's eProduct Intelligence Portal

*National and local NWRS claims portal, showing WTE variation. This is a national problem, currently looking to be resolved.

Unlike larger NHS provider organisations, we are unable to quantify vacancies within local practices currently. Vacancies are largely hidden as may be filled by alternative staff or locums.

National work is underway to improve workforce reporting, streamlining it for our practices and allowing the Primary Care Workforce Team to use data more effectively in workforce planning in future. In addition to workforce data on posts, we regularly undertake training need analysis, and have recently conducted a health and wellbeing survey for the first time to better understand the impact and opportunities for staff working locally.

3.2 Additional Roles in Primary Care

The growth and expansion of the new Additional Roles in Primary Care Networks has led to new ways of working in general practice through multi-disciplinary teams supporting general practitioners. The Additional Roles are wide and varied and each PCN will determine the skill mix best suited to meeting their population health needs and ability to recruit to the individual roles.

The ICS target for ARRS recruitment to end March 2023 is 379 WTE across all roles. To end of January 2023, 543.1 WTE are being claimed for by our PCNs, however there is variation across Norfolk and Waveney as to how successful PCNs have been in their recruitment.

The role of the Primary Care Workforce team in supporting this diverse workforce is critical for the stability and resilience of general practice and the development of Primary Care Networks.

3.3 Supply – GPSTs, AHP and other non-clinical roles

Retaining our newly qualified workforce and making N&W the best place for them to work in, is the most cost-effective way to ensure quality care is delivered by our staff and received by our patients.

This section sets out the learning group supply to Higher Education Institutions, per financial year, over the next 3 years. Our ambition is to maximise and value the skills of these people to grow and develop our future primary care workforce.

Learning Group (by Headcount)	22/23	23/24	25/26
Doctors			
GP Speciality Trainees	137 (33 projected to qualify)	149 (36 projected to qualify)	169 (41 projected to qualify)
Allied Health Professionals			
Nursing – General Practice	28	34	Information not yet available
Physician Associates	25	28	30
Paramedics	171	2	Information not yet available
Clinical Pharmacists	65	82	Information not yet available
Pharmacy Technicians	100	130	Information not yet available
Pre-registration Trainee Pharmacy Technician (PTPT) Integrated Training Pilot	39	13	4
First Contact Physiotherapist	250	280	Information not yet available
Occupational Therapists	Information not yet available	Information not yet available	Information not yet available
Dietitians	Information not yet available	Information not yet available	Information not yet available
Training Nurse Associate	9	15	25
Non-Clinical			
General Practice Assistant	2	Procurement underway by Health Education England	Information not yet available by Health Education England

3.4 Clinical Leadership

Across our system we have a range of formalised leadership roles, ranging from practice level (managers, GP partners) to PCN (Clinical Directors) to those involved in system activities such as education and commissioning. Our leaders largely balance these roles in addition to substantive posts in General practice which provides a challenge for sufficient time and capacity. With our aging profile, this also presents the risk of loss of organisational memory through retirements, but also provides the opportunity for us to support the development of new leaders and fresh thinking.

4 Workforce challenges

Like many other parts of the country, Norfolk and Waveney faces challenges in recruiting appropriately qualified staff across health and social care services, with vacancies in a variety of jobs, from consultants to care assistants. However, historically this has been compounded in N&W by our geographical landscape, in particular:

i. Newly qualified GPs study in the area but leave, attracted to larger cities
ii. GP partnerships declining numbers, which has a destabilising impact on practices
iii. A significant number of experienced staff, GPs and general practice nurses will reach retirement age in the next few years. This impacts not only on delivery of services, but our organisational memory, leadership, and placement capacity to support good quality learning environments
iv. Significant vacancies in community pharmacy are also impacting the delivery of general practice business as usual and in development of PCN services.
v. 51% of general practice staff is made up through non-clinical roles. Only 11% of non-clinical staff are under the age of 25 years, where 54% are the over the age of 45 years. Recruitment challenges seen across the area due to increase patient abuse and this has resulted in a loss of organisational memory.

Following the pandemic, we are starting to notice changes in lifestyle choices and hope that we will start to recognise opportunities to attract and retain trainees and experienced staff from outside of Norfolk and Waveney who are now more attracted to the work life balance offered by a rural and coastal system over densely populated urban areas.

Our other challenges are complex and vary across the ICS. These have been themed against our workforce transformation priorities:

Creating new opportunities for our people

- Increased competition from outside the health and social care sector offering job opportunities
- Varying and evolving expectations from generations of current and future workforce with very different expectations for work life balance, flexible working, career development, and remuneration/benefits
- Rapid expansion of multi-disciplinary team planning with a lack of new recruits moving into Norfolk and Waveney or being grown locally
- Development of Place-based operational delivery and commissioning is driving changes which may unsettle staff initially
- Challenges with international GP recruitment – high levels of resourcing with a minimal return
- Career pathways vary and largely lack a system wide or PCN perspective

- The ‘Educator’ career is undervalued & pathways unclear

Promoting good health and wellbeing for our people

- 20% post Covid retirement flight risk
- General practice sustainability and resilience impacts on the wellbeing of our workforce
- Increasing pressure from patients for appointments
- Increases in sickness and absence levels, correlation to increasing service pressures and resulting from the pandemic
- The cost-of-living crisis, and the impact of the pandemic is impacting people’s health and wellbeing – physically, mentally, financially, and socially

Maximising and value the skills of our people

- PCNs in different stages of development and maturity with varying approach to support Additional Roles and workforce development which impacts on recruitment and retention of staff
- Lack of mid-career opportunities for professional development
- Risk of reduced education and development capacity to support development of staff. This includes access to levy to fund apprenticeships, release of staff for development (outside of statutory and mandatory training), estate space to accommodate learners, processes for effective appraisal and development discussions, and aging profile of our educators, mentors, and supervisors.
- Rotational workforce models are yet to be fully developed between primary care and other system partners
- We have an aging profile of educators, particularly in General Practice which poses a risk for placements and expanding learning opportunities

Creating a positive and inclusive culture for our people

- Our colleagues from ethnic minority backgrounds have disproportionately lower access to education, training, and career development[2]

A recent ICS Health and Wellbeing survey (2022) for primary care staff across Norfolk and Waveney highlighted the following:

- Over 60% of primary care staff feel “worn out at the end of the day” and 25% feel their home life is impacted
- Burnout levels are moderate and lower than primary care nationally however 20% suffer “high” burn out rates levels including 100% BAME staff and 25% of managers/leaders

[2] Workforce Race and Equality Standard (WRES)

- 50% of staff have come into work in last 3 months despite feeling unwell although there is no evidence that staff are pressured into coming to work
- 20% of staff have indicated they are likely to leave in next 12 months although this is lower in Norfolk and Waveney than in other parts of the NHS locally
- Unacceptable high levels of harassment by the public, significantly above local NHS Trusts
- Workplace bullying appears highest in GP staff with 20% of staff concerned about the issue and only moderately satisfied with support they receive
- 85% of staff feel their role makes a different to patients/service users
- Staff value their work but want greater recognition and involvement in how its done; 40% of staff are dissatisfied with the influence they have over their roles although it is lower (20%) for those delivering direct patient care
- Primary care staff enjoy mature, supportive relationships, but want more focus on their health and wellbeing

Our workforce challenges are not new however the scale of our challenge is increasing. No 'one' provider can resolve the workforce challenges and it requires all the partners within the system to work through current and future challenges together to see how system level solutions can also enhance primary care workforce planning, training, and education plans.

5. Our vision for the primary care workforce

5.1 Our foundation – transformation to date

Since the last workforce strategy was produced in 2019, workforce in general practice has changed significantly. The Primary Care Workforce team has had to adapt and refresh its objectives as a result in order to support recruitment, retention, education and training; and to build relationships across the ICS with different teams and organisations within the ICS to represent and highlight primary care as a critical partner within the system.

Primary Care Networks have been created with the development and expansion of multi-disciplinary team working through the creation of the Additional Roles Reimbursement Scheme (ARRS). There has also been a significant increase in Allied Health Professionals involved in direct patient care, not employed through ARRS.

- GP workforce has changed as well with a decrease in the number of full-time equivalents and a move to greater part time working.
- GP in training grades have increased from 94 FTE to 130 FTE
- Nursing workforce has increased slightly but with a shift towards part time working

- Direct Patient Care roles have increased significantly in the past three years through the recruitment of healthcare assistants, dispensers, pharmacists, phlebotomists, paramedics, physician associates and apprenticeships
- 37 Fellowships in total offered to GP's, ANP and Physician Associates
- 59 Clinical apprenticeships in nursing and pharmacy
- 14 Admin and Management apprenticeship
- Increased the number of GP educators and learning organisations
- GP Careers Plus has supported 61 GPs
- 81 staff supported by Return to Work
- Reintroduction of Schwartz rounds after pausing for Covid
- Growth in admin and clinical apprenticeships, trainee nurse associates, pre-registration pharmacy technicians
- Training needs analysis completed for CPD 2022 & 2023 plans
- Directory of education and training resources created for primary care to access
- 47 New GP Partners supported on national New to Practice Partnership programme
- 19 New GP partners support through the local New to Partnership Model

As a result of the Health and Care Act, the Norfolk and Waveney ICS has legal status which provides a new and exciting way of creating a genuine partnership that will make a positive difference to local people and help join up health and social care. Working together in partnership, we can really improve the health and wellbeing of people in Norfolk and Waveney and support our brilliant front-line staff.

The ICS has successfully created health and wellbeing leads to support the whole primary care workforce and there is a wide range of support to the workforce available both nationally and locally, including coaching.

The Primary Care Workforce team will build upon these successes to support the general practice workforce and build resilience in primary care.

5.2 Norfolk & Waveney 2022-25 Primary Care Plan

To meet patient, need and changing demands over time, including more complex cases and long-term conditions, as well as acknowledging the changes to how patients consult with increasing technology at our fingertips, the make-up of the general practice team must evolve. We have already seen the adoption of the new ARRS roles in general practice, successfully shared across PCNs to support clinical capacity as well as adding new clinical capability. We need to support our general practice and PCNs to build on this, working collaboratively to be more innovative in recruitment as well as retention.

In Norfolk and Waveney, we recognise that general practice underpins the foundation of our maturing PCNs. Investing and supporting these multi-disciplinary teams through PCNs will help to ensure that people receive more joined-up and coordinated care, near to where they live, from primary and community health and care services. They will be responsive to the characteristics and needs of their local populations.

Further to our vision for PCN multi-disciplinary teams and reiterated by the Fuller Report (May 2022), integrated teams are at the heart of local communities, embracing a population health approach to improve the health and wellbeing of the local population; working in partnership to address health inequalities through the Core20plus5 approach.

Maximising the opportunities for enabling an integrated and collaborative approach to PCN development and maximising the skills of the whole primary care workforce, enabling and signposting patients to receive right care, right time, and right person.

5.1.1 System collaboration

Our focus, attention and energy must be directed to support the development of the new model of the general practice team. But this cannot take place in isolation, we need to work across all partners of the ICS to maximise opportunities for the workforce and ensure that one part of the health service is not promoted to the detriment of another.

Through collaboration with system partners, working across organisational boundaries, we can tackle shared workforce challenges, be innovative and offer the workforce a unique approach to career development and progression in respective professional fields to create a stable, resilient, and healthy primary care workforce.

Using the framework of #WeCaretogether and opportunities to embed transformation at scale, our plan will:

Create new opportunities for our people

- We will take a system-wide approach to workforce planning and ensure equal opportunity for all learners, but also recognise the critical importance of Place and delivery at local level, and make the most efficient use of all resources, while embedding quality of care through consistent standards across health & social care
- We will support primary care to recruit and retain their staff, providing support for their health and wellbeing, training, education, and professional development. We will create an environment that supports the expansion of placement capacity in Norfolk and Waveney encouraging and supporting new educators to emerge
- We will provide the organisational framework to encourage and support primary care to grow our own staff, actively raising awareness in

schools and colleges across Norfolk and Waveney about the wide range of skills and roles within health and social care, encourage and support apprenticeships and professional development pathways (e.g., TNA to nurse to ANP)

- We want our people to remain in roles across our health and care organisations and we will support people to move across those boundaries more flexibly
- Technology developments improving the quality, flexibility, and cost of learning
- Recognising variations in both career aspirations and learner needs
- expansion of PCN and at scale service delivery through employment of a multi-disciplinary clinical workforce beyond March 2024
- Enable successful recruitment to a multi-disciplinary primary care workforce
- Support opportunities for working at scale within PCNs and enable PCNs to collaborate and with system partners and at Place
- Support a GP partnership model where appropriate, through a localised incentive scheme

Promote good health and wellbeing for our people

- Ensure a sustainable Health and Wellbeing offer to the whole workforce
- We will continue to provide timely and appropriate access for health and wellbeing resources to our people
- We will continue the work of our health and wellbeing champions, providing opportunities to hear from our people, provide safe spaces to raise concerns, and act upon feedback
- We want to promote good health and wellbeing, flexible working and recognise the importance of work / life balance

Maximise and value the skills of our people

- Enable the development of a workforce in primary care to deliver the vision for integrating primary care, improving access, experience, and outcomes for our communities
- We want to enable people to continue to learn new skills throughout the lifetime of their career and achieve their ambitions
- Our education vision is to equip everyone working in primary care with the right knowledge, skills, and values to deliver outstanding, evidence-based, person-centred care, now and in the future.
- We will support primary care to be the very best by delivering education flexibly, collaboratively, and embracing technology to allow you to learn in the way that best suits a multi-disciplinary primary care workforce.
- Improve retention across Norfolk and Waveney on a system wide basis, not just in primary care
- Increase placement capacity and educators

Create a positive and inclusive culture for our people

- Our people are our most important resource, as stated #WCT, recognising the value primary care workforce bring to the Integrated Care system.
- We will endeavour to create more diversity in our workforce and to support all learners to fulfil their potential.
- A focus on creating diversity in our staffing
- Recognise the importance of the Fuller report vision in creating a truly integrated workforce

6. How will we do this?

6.1 System Wide and Place Based Approach

It has never been more important to pull on our collective expertise and experience to share the workforce challenge facing our ICS. We understand the importance of working at various levels of scale, across system, place, PCNs, neighbourhoods and practices. We want to support general practice to work collaboratively and to develop an integrated approach across primary care and PCNs as part of a longer-term solution to workforce development.

As a system and a priority, we must strengthen our plans to grow our own workforce, develop and implement rotational workforce models, secondments, and movement of workforce across all organisations where possible and necessary to retain the workforce within Norfolk and Waveney. To develop and provide the organisational development framework to enable this to happen to support recruitment and retention of individuals within Norfolk and Waveney.

We will utilise our links with all our partner universities and colleges to plan for and develop the primary care workforce of the future through innovation and alternative learning and education pathways to support and encourage individuals to find the career pathway of their choice.

We will work in collaboration with schools, colleges, and academies to identify the workforce of the future, raising awareness and understanding of the diversity and varied roles in primary care, and in creating the opportunities for work placements.

We will recognise the different challenges at local level at Place, partner with local organisations and develop localised plans according to need.

6.2 Primary Care Workforce Planning

- Understand the workforce needs of the future
- Support general practice to recruit, expand, educate, and develop their multi-disciplinary clinical and non-clinical workforce
- Support PCNs and their provider partners to undertake effective multi-disciplinary clinical and administration workforce planning to inform ICS, regional and national workforce plans, to help find which roles best meet the needs of patients and PCN population
- Help embed new staff into roles through the Additional Roles Reimbursement Scheme by developing an Organisation Development Framework and induction to primary care
- Create career pathways that will support a multi-disciplinary workforce regardless of their educational start
- Flexibility – support an inclusive approach to workforce recruitment and retention, increasing diversity

6.3 Education and Training

- Understanding our workforce training and development needs and create a framework to support a changing general practice workforce environment
- Work in collaboration with system education leads to ensure a system wide consistent approach and in creating efficiencies of scale
- Deliver a consistent training opportunity across primary care and professions to support the achievement of population health and learner needs, and supporting the management of health inequalities with reference to Core20plus5 approach
- Provide and/or support education and training supporting workforce retention programmes
- Utilise our Ambassadors and clinical infrastructure roles to identify training and development needs for Allied Health Professional roles and encourage peer to peer networking
- Utilise our GPN Development Lead role to identify and develop a career structure for the nursing profession from apprenticeships to senior leadership roles providing support through education, learning and mentorship
- Supporting the development of primary care professionals in autonomy, belonging and contribution

6.4 Placements

- Enable our Quality Attainment leads to actively work with practices and PCNs to develop placement opportunities and with educational providers to find placements which meet the needs of learners and programmes

- Clinical Learning environment development
- Work with educational providers and HEE quality team to ensure all placements meet appropriate professional standards required and are aligned to HEE quality framework, enabling learners to develop the capabilities required
- Increase placement capacity in general practice by using placements in Primary Care Networks as a development opportunity
- Create opportunities for apprenticeships and on the job learning, providing the system level framework that encourages uptake in primary care
- Grow, support, and develop our Fellowship programme for newly qualified and mid-career clinicians sharing learning and achievements

6.5 Sustainability

- Ensure use of annual funding secured through HEE and NHSE is agreed by the ICB's Primary Care Commissioning Committee and appropriately used for primary care education and training and is overseen by effective governance
- Establish appropriate and flexible primary care education infrastructure which includes leadership, educator, and programme management roles

6.6 Communication and Stakeholder Engagement

- Have a clear and proactive communication strategy that articulates the Norfolk and Waveney vision for primary care workforce planning and education working across an ICS footprint
- Have a clear engagement strategy that sets out how we will engage with the whole primary care workforce and other key stakeholders to better understand their training and development needs to support retention plans
- Help patients to understand how different roles within general practice can support their individual care needs including how they can manage their own health and seeking the correct help
- Engage with health education institutes to develop programmes to support recruitment, retention, and development of career pathways

6.7 Digital innovation

- Empower our workforce to use technology to enhance and support their working lives to reduce duplication and streamline processes
- Create an accessible Library and Knowledge Sharing environment
- Use innovation in online training and educational development

- Use of social media to maximise opportunities to engage with the whole primary care workforce to understand their needs for education, training and health and wellbeing support

6.8 Development of Systems

Ensure that appropriate resources are in place within the Primary Care Workforce team and fully supported to develop workforce plans and to provide a level of education and training, in a consistent manner, for primary care.

The Ambassadors and Clinical Infrastructure in the Primary Care Workforce team have a critical role to play in understanding the role needs and in helping to shape and develop the workforce of the future. The ICS has an important role in supporting them through a clinical network to successfully deliver these objectives.

6.9 Clinical leadership

We will support leaders in primary care to develop their leadership capabilities. Our aim is to value and support the leadership at all levels and ensure lifelong learning in primary care, supporting inclusion and belonging for all, creating a great experience for staff. This will be through using innovation to provide high quality learning.

Professions in primary care can differ a lot in how much structure, progression, choice, and expectations around leadership development are built into roles. Primary Care Workforce teams have an important role to play both in attracting primary care staff into leadership roles and creating structures through which emerging leaders could find support, development, and encouragement. These leaders can help support and develop the workforce of tomorrow.

We will align to the Norfolk and Waveney Clinical Care and Professional Leadership Strategy and encourage our primary care leaders to innovate, and to work together to improve our services.

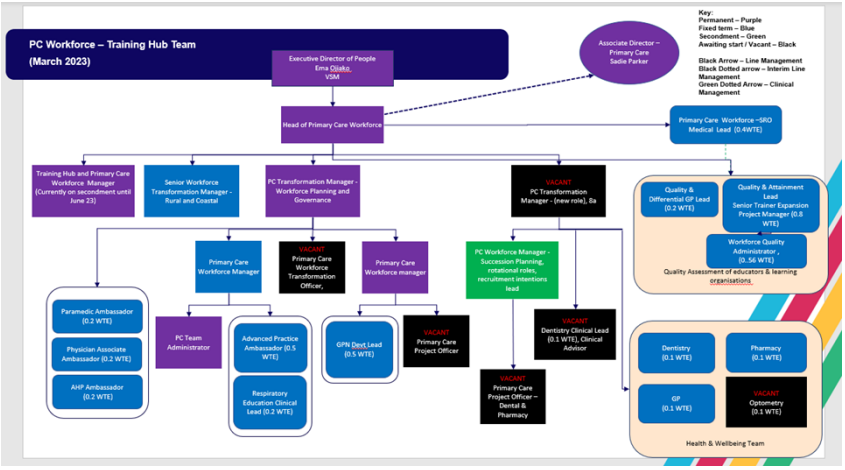
Further details are described in Appendix A.

7 Our Primary Care Workforce Transformation Team

7.1 Team structure

Over the past year, the Primary Care Workforce team has had to adapt and develop in order to support recruitment, retention, education and training of a multi-disciplinary general practice workforce. The team has been successful

in recruiting both to the clinical infrastructure and ambassador roles as well as the administrative and management team.



7.2 Governance and operating model

The governance framework reflecting the key formal reporting relationships within the ICB and the engagement with strategic primary care is described below.

8 Close

Our Primary Care workforce team was embedded within the ICS Workforce Transformation team in September this year. The team has been refreshed, and now has a broad mix of skills, experience, and clinical roles across primary and secondary care. From October, the team will be led by our new

Head of Workforce Transformation which sets the conditions for us to formally launch our Primary Care plan for 2022-25. Our communication and engagement plan, and updated governance structure will provide the foundations for the team to collaborate with our system partners to embed our vision.

Appendix A - Detailed delivery plan

#A system wide approach

Our Goals

To enable PCNs to develop to full maturity supported by a resilient and stable primary care workforce in general practice, encouraging working at scale model of care and integrated working with local partners at Place level

To support PCNs to expand and develop their multi-disciplinary workforce through successful recruitment and retention of ARRS

To support the general practice workforce to recruit, retain and develop their clinical and non-clinical workforce and support the health and wellbeing of their staff

To achieve a joined-up, consistent approach to education across the system and at local level that supports workforce needs.

Ensuring staff are equipped with the skills to deliver the care required, using innovative educational styles that widen opportunities for the whole workforce. Transferability of skills and knowledge will be encouraged and actively supported with initiatives such as skills passports.

Evidence-based with a shared understanding of best practice and systems in place to support learners across the ICS and at Place level. Collaborative working on skills training, sharing expertise and trainers.

Governance structures developed across the system, with shared decision making and a unified approach.

Key initiatives (link to KPIs)	**Key performance indicators (Health Education England)**
Refresh workforce plans to develop a workforce fit for the future to meet population needs recognising variation and local challenges	100% of PCNs offered support on workforce planning, advice, and identification of needs for patients and populations.
Develop and EDI strategy for primary care	Training Hubs have an equality, diversity, and inclusion (EDI) strategy with an operational plan to support the ICS EDI strategy
International recruitment	Number of newly qualified health professionals who are supported to take up a primary care role.

#Workforce planning

Key initiatives (link to KPIs)	Key performance indicators
Refresh workforce plans by Dec 2022 recognising variation and local challenges and population health needs	
New GP retention	Number of newly qualified health professionals who are supported to take up a primary care role.
Additional Roles Scheme	% of PCNs who are actively engaged in promoting new roles and how new ways of working in primary care can support population health needs.
Legacy Nurses	
Apprenticeships	Number of clinical apprenticeships supported across primary care.
	All professions to be offered practice placements
	Number of newly qualified health professionals who are supported to take up a primary care role

Local versus Central Processes

National

- International recruitment
- Establishment of policy and funding
- New GP and Nurse workforce training plans
- Primary Care Network Directed Enhanced Service specification and long-term plans beyond April 2024

Regional

- Develop workforce plan for primary care
- Sharing of expertise and learning
- Regional faculty etc

Local

- Understand local workforce challenges and population health needs
- Understand gaps in workforce
- Training and educational development needs analysis
- Expansion of Placement capacity across the workforce working collaboratively at N&W system level
- Work with all education providers to develop education and training programmes fit for the future
- Grow and retain our own workforce within the ICS

Agree a common philosophy, but adapt to meet local requirements and variation in the challenges at local level within Norfolk and Waveney

#Interdisciplinary/Team - Based Education and Training

Our Goals

Ensuring staff are equipped with the skills to care for patients in a holistic manner, preventing duplication and ensuring a streamlined service. Creating a culture of interdisciplinary working, understanding the services involved in an individual's care and the pathways this entails. Valuing the expertise of all professions. Development of roles and training that are delivered in a multi-disciplinary way. Supporting individuals to learn and develop collaboratively, embedding multidisciplinary working into our culture.

Clearly defined learning opportunities identified, with a timetable of multi-professional teaching sessions available for all. Integrating learning and development needs across services and professional groups. Looking across disciplinary (professional) boundaries considering other viewpoints and comparing/contrasting across subject specific areas.

Enabling our workforce to view different things through different lenses, promoting self -management and adaptability. Creating a culture where our workforce can draw on knowledge and learning across disciplines to identify solutions, practically or technically

Key initiatives	**Performance indicators (HEE)**
Provide support to educators and supervisors	% increase in the number of approved educators and supervisors
Education and Professional Development	Number of educators and supervisors who have attended educational update training provided by the Primary Care Workforce team
	the Primary Care Workforce team to deliver education and training activity based on ICS plans to reduce health inequalities
	% of nurses and allied health professions (AHP) staff offered continuing professional development (CPD) funding.
	% increase of nurses and AHP staff take-up of CPD funding.
	% of primary care workforce offered training provided by the ICS Primary Care Workforce team
	Breakdown of professions undertaking training
Implement appropriate governance arrangements for decision making and to ensure compliance with the Quality Framework	Compliance with regulatory standards and HEE Quality Framework. Governance arrangements for oversight through the ICB's Primary Care Commissioning Committee in place

#Placements

Key initiatives	Performance indicators (HEE)
Increase workforce training and education capacity	Number of non-clinical apprenticeships supported across primary care.
	Number of clinical apprenticeships supported across primary care.
	Number of clinical apprenticeships supported across primary care.
	Engage with HEEs Differential Attainment (DA) Leads to access the support toolkit and guidance on reducing differential attainment.
	% of placements increase
	All professions to be offered practice placements

#Communication and Engagement

We will develop and implement our Communications and Engagement Strategy setting out our plans for next three years (2022 – 2025)

Key initiatives	Performance indicators (HEE)
PCN Development Plans N&W approach to raising awareness with public and patients about new roles Engagement with whole primary care workforce Engagement with key stakeholders	% of PCNs who are actively engaged in promoting new roles and how new ways of working in primary care can support population health needs.

#Digital technology to support the workforce

Empower and encourage primary care workforce to utilise technology and digital tools to help improve their health and wellbeing, work more effectively and to support their learning and personal development.

Key initiatives	Performance indicators
Create an online library of services and a website for easy access to primary care	% of PCNs utilising Knowledge and Library Services (KLS)
Create a pathway for all individuals in primary care to provide feedback about training and development needs	
Innovation in learning and education pathways optimising the use of digital technology	
Build upon existing digital pathways to support health and wellbeing	

#Development of Systems

Key initiatives
Recruitment and retention of clinical infrastructure roles, including Ambassadors

Retain staff in the Primary Care Workforce team
Effective governance arrangements for decision making in place
Integrated system wide approach to recruitment and retention recognising Place and PCNs

N&W Workforce Plan – Overview (Enablers)

Primary Care estate

- Primary care estate fit for purpose and able to support expansion of primary care workforce
- Wave 4B Hubs to facilitate integrated care and closer collaboration between system partners

IT and Digital innovation

- To support the health and wellbeing of the workforce
- To enable effective communication between primary care and other system partners to support patient care, avoid duplication
- To enhance the learning and education environment through use of technology and online support

Communication and Engagement strategy 2022 – 2025

- To better understand primary care workforce recruitment and retention challenges
- To better understand training and education needs across the primary care workforce
- Development of a Primary Care Workforce website within the ICS website
- Development of a Knowledge and Information Directory of Services
- Utilise social media to engage with the whole primary care workforce
- Engage with key stakeholders across Norfolk and Waveney and in the East of England

People Enablers

- Culture change programme to value experience gained by moving across providers
- Culture change to understand value and benefits of working at scale, and truly integrated workforce vision at Place and across the ICS system
- Education and understanding of the value of a system-wide approach

- NHS People Promise ‘to work together to improve the experience of working in the NHS for everyone, where we are part of one team that brings out the very best in each other

Business Intelligence Enablers

- Improve quality of primary care workforce data and market intelligence
- Enable PCNs and general practice to develop workforce capacity and demand planning models

Improving lives **together**
Norfolk and Waveney Integrated Care System

Norfolk and Waveney Integrated Care System

Primary Care Workforce Community and Engagement Plan

2022-2025

Document Control Sheet

Name of document:	**Primary Care Workforce Community and Engagement Plan 2022-2025**
Version:	**V1.3**
Owner:	Head of Primary Care Workforce Transformation
Date of this version:	**25 April 2023**
Produced by:	**Paul Martin, Communications & Engagement Lead**
Synopsis and outcomes:	This strategy reflects on the established work NHS Norfolk and Waveney ICB Primary Care Workforce Team to further builds on its future vision and intentions within the ICS. It contains strategic thinking on communications and engagement within primary care.
Approved by (Committee):	Primary Care Commissioning Committee
Date ratified:	11th October 2022
Next review due:	September 2023 to include dental and optometry services, when further guidance has been released.
Enquiries to:	nwicb.primarycareworkforce@nhs.net

Revision History

Revision Date	Summary of changes	Author(s)	Version Number
16/08/22	1st Draft	PM	1.1
04/04/2023	Multiple contributions	PM	1.2
25/04/2023	Formatting	JR	1.3

Table of Contents

1. Overview

This communications and engagement strategy sets out high level context, narrative and opportunities which will help support the Primary Care workforce across the Norfolk and Waveney Integrated Care System (ICS), to understand the significant role the Primary Care Workforce Team have in future workforce planning, as well as coordination of training and education across the ICB and wider ICS. The Primary Care Workforce Team is a relatively new national concept, and there is a need to rebrand its identity and further mature its workstreams under an umbrella concept. This is not only within General Practice, but also across the Pharmacy, Ophthalmology and Dentistry sectors.

This plan will be dynamic – it will change regularly and continue to evolve, in line with the development of the Norfolk and Waveney ICS, in particular evolving and updating strategy to bring in dental, pharmacy & ophthalmology in more depth once assumes responsibilities from April 2023

The Comms and Engagement strategy needs to have significant “cut through”, a strong visual identity, the endurance to run for 36 months, and to work across digital (incl. websites/email/apps), social and printed media, as well as identifying engagement opportunities. This plan will support the sharing of best practice, identify gaps that may exist and build solutions, embracing technology and supporting all types of learners. Robust education, training and support underpinned by Clinical Supervision is essential and will be available and accessible for all. The intention of the forthcoming year will be to work together with our educational partners to align our efforts to increase the support to learners, expand apprenticeships and ensure we achieve equality of opportunities across the system.

2. Background and context

The remit of an ICS Primary Care Workforce Team is to bring together education and training resources from NHS organisations and community providers, as well as local authorities. ICS level Primary Care Workforce Teams are the ‘go to’ place for any information about primary care workforce, education, and development to address local needs.

Primary Care Workforce Teams:

- Have a key role in understanding, influencing, supporting, and leading educational interventions around population health needs and health inequalities
- Provide advice on workforce planning and training needs analysis, to help find which roles best meet the needs of the population. For example, actively supporting workforce planning by understanding population health needs and the training needs required to support new care pathways
- Help new staff, appointed through the Additional Roles Reimbursement Scheme (ARRS) scheme, embed into roles, for example supporting the roll out of the First Contact Practitioner (FCP) programme

- Facilitate and/or deliver opportunities for Continuing Professional Development (CPD) programmes, based on scoping CPD requirements across PCNs
- Provide career support at all stages for all primary care workforce
- Train and, where appropriate, recruit more educators
- Develop and help to keep staff through retention programmes, for example mentoring, and preceptorships
- Support practices and PCNs, who are looking to become learning environments, to increase the number of placements for a variety of trainees and students

Norfolk and Waveney Primary Care Workforce Team provides exposure and breadth of placement experience for healthcare learners through a 'hub' and 'spoke' model approach to recruit and retain a future healthcare workforce. This will ensure staff are equipped with the skills and confidence to deliver the best care now and in the future. Investing in our people and truly valuing educational developments, is key to attracting and retaining our people.

It is also designed to also meet the educational needs of the multi-disciplinary primary care team, Norfolk and Waveney Primary Care Workforce Team works in partnership with NHS organisations, community providers, local authorities, and Higher Educational Institutes (HEIs). The strategy will set out how we will engage our people in the design of innovative patient pathways supported by new roles and new ways of working recognising the important role educators provide in supporting the associated workforce changes.

3. Our vision, values and aims

Our vision - what the Norfolk and Waveney partnership want to achieve:

- **To make sure that people can live as healthy a life as possible.** This means preventing avoidable illness and tackling the root causes of poor health. We know the health and wellbeing of people living in some parts of Norfolk and Waveney is significantly poorer – how healthy you are should not depend on where you live. This is something that must be changed.
- **To make sure that you only have to tell your story once**. Too often people have to explain to different health and care professionals what has happened in their lives, why they need help, the health conditions they have and which medication they are on. Services have to work better together.
- **To make Norfolk and Waveney the best place to work in health and care**. Having the best staff, and supporting them to work well together, will improve the working lives of our staff, and mean people receive high quality, personalised and compassionate care.

The aim will be to provide high quality primary and community care and deliver, co-ordinate and lead education and training across their ICS. Our ambitions will be to have good, clear communications and engagement with our stakeholders helping to codesign Primary Care Workforce Team activities, which is cascaded at the right time.

The importance will be for this Strategy to align under the #WeCareTogether Norfolk and Waveney Health & Care Partnership: People Plan 2020-2025, which sets out the roadmap for all educators and staff across Norfolk and Waveney (N&W) to guide our actions with the intention to enable N&W to be the best place to work by 2025. The Norfolk and Waveney Primary Care Workforce Team's aim is to complement this People Plan within Primary Care.

4. Current challenges faced in Norfolk & Waveney

The primary care sector is highly fragmented with over 300 practices across 200+ organisations outside of General Practice. Except for email cascades, there are no communications channels with significant reach and there is considerable variation between sectors and staff groups. Consequently, we are obliged to use all media from social media and apps through email/e-newsletters to attendance at key locality/profession/role-specific meetings, with the objective of generating word of mouth cascade and endorsement. Developing appropriate cascade materials is an essential aspect of our strategy. "Word of mouth" campaigns are slow burn, necessitating an on-going communication programme with a distinctive identity to generate continued interest.

Email cascades are significantly overused, rarely get past the first point of contact at an individual practice level (typically the lead clinician or business owner) and gets lost amongst other priorities. It's essential that content has arresting headlines, strong visuals and is succinct with a clear call to action.

General Practice differs from the rest of primary care in having more established, wider reach communication channels and geographical/clinical networks that cluster practices together. The volume of communications is also significantly greater. It also has a stronger NHS orientation and identity, despite practices being privately owned.

Another issue is how we expanding MDT workforce & how do we reach out them. A way to overcome this would be to introduce a range of multi-professional career champions within the ICB, who are actively work to help communicate what's currently available, celebrate their role, identify gaps in provision, and assist in developing solutions. A baseline audit and regular pulse check of staff will ensure primary care voices are at the heart of all future innovations and support their colleagues locally.

5. Current Target audience insight

The following points are intended to provide an insight into the mindset of primary care employees:

- The psychological impact of work-place stress on primary care workers is significant, with two in five (43%) saying that workplace stress has led them to resigning or considering resigning from their jobs. (MIND).
- Turnover is rising across primary care as staff report they have quite simply "had enough". The loss of experienced staff adds to the pressure on those who remain, creating a downward spiral.

- 89% of respondents to a pharmacy workforce Health and Wellbeing survey were evaluated as being at high risk of burnout. (RPS Mental Health and Wellbeing Survey 2020)
- “The expectations are overwhelming, the public treats us like garbage, the funding is non-existent, and the staffing levels are appalling. Combine that with the Covid-19 pandemic and you have the perfect recipe for a mental breakdown.” (Royal Pharmaceutical Society workforce wellbeing survey).
- The general consenous from Healthcare sector employees are that they are caught in a moral dilemma – they are reluctant to let their colleagues down by not turning up to work, but at the same time aware they need to look after their Health and Wellbeing for their own, as well as patients’ sake.

6. Core narrative

The core narrative for the N&W Primary Care Workforce Team programme will build and change over time. Initially, the core messages for all primary care staff wherever they work:

The new national NHSE/I & HEE mantra for workforce is **“Our overarching aim is to maximise supply and retention of a talented workforce to deliver services for the future: more people, working differently, in an inclusive culture”.**

- More People – Recruit more (with clear rationale about what we need), look at recruitment processes and make better, career progression & talent.
- Working Differently – increase capacity looking at new models of workforce and service delivery, focus on hotspots e.g., harder to recruit roles in certain areas of N&W, use of ARRS roles, etc. supported by robust leadership.
- Culture – support Health and well-being, EDI and environment, deliver People promise.
- Finance - We have huge financial challenges, e.g., more money spent on workforce than we have. Lots of inefficiencies and waste, leading to long waiting lists, variable quality.
- Doing nothing to address this challenge is not an option, we all need to take part and build the future.

Health and care services in Norfolk and Waveney have been working together closely over the past few years to improve services and provide more joined up care for local people. But we need to do much more of this, and at pace. Our staff across health and social care are catalysts of change and are key in bringing about this change and we need to engage with this workforce to listen to their concerns and suggestions to help over an extended period.

Having the best staff, and supporting them to work well together, will improve the working lives of our staff, and mean people get high quality, personalised and compassionate care.

7. Audience / Stakeholders

All staff working across primary care, irrespective of their sector, job type, or employer. There is a focus on patient-facing staff (incl. support roles) outside of the national and regional chains.

It will be important to identify key audiences at the earliest opportunity to assess their impact and interest to help support the co-production of products provided by the Primary Care Workforce Team to avoid making assumptions.

There are a number of key partners and stakeholders that need to be communicated and engaged with at different levels to ensure that messaging is communicated effectively.

A clear Stakeholder register needs to be revised to ensure we have the right contacts, in order to ensure the messaging / invitations are being noted and received to the right people at the right time.
For example, PLACE based and locality Leads will have knowledge of localised recruitment issues within their areas, and it will be important to adapt initiatives to support localised solutions.

The roles can be stratified into:

- PCN Clinical Directors and lead managers,
- Practice Partners, independent owners, regional management in multiple chains
- Senior clinical leaders -typically working across multiple practices or a specific geography
- Salaried lead professional staff (e.g., GPs, dentists, optometrists, pharmacists)
- Other registered healthcare professionals (e.g. nurses, hygienists, opticians, pharmacy technicians)
- Management staff (e.g. Practice Managers)
- Support staff (e.g. receptionists, optician sales assistants)
- PLACE based and locality Leads
- NHS England regional team – through established formal channels and escalation routes.
- Health Overview and Scrutiny Committees (Norfolk and Suffolk_ and Norfolk and Waveney Local Medical Committee written project briefing supplied, face to face and written briefings as required.
- Local Representative Committees (Local Dental Committee, Local Optometrical Committee, Local Pharmaceutical Committee) and Local Professional Networks
- MPs with proactive/reactive ongoing correspondence as required.
- Health Education England – regional team
- Higher Education Institiutes

8. Communications channels

Branding

The first task will be to create and generate a strong rebranded identity for the Primary Care Workforce Team. Materials should be jointly branded with the #WeCareTogether and new ICS branding. This will be visualised via comms products including roller banners, social media, videos, pens etc.

The Communications team will directly deliver (as well as support colleagues where appropriate) the following established outputs:

- **Frontline staff**: combination of visual communications (posters, graphics for video screens in staff areas, and screensavers), written communications (internal newsletters and emails), and virtual face-to-face communications (ad-hoc briefings, manager cascade, and monthly staff briefing sessions).
- **Website:** The Primary Care Workforce Team are in the proposal and draft stages of developing a new Primary Care Workforce Team and Learning Academy website. Prior engagement of this project has been initiated and there is a need to revive this steering group to support its development. There is no shortage of training and education resources, the challenge will be to identify a gated repository that General Practices can access the best and most appropriate ones. This will be a single point of access website which will offer all primary care staff a curated selection of the best resources nationally, including those specific to individual professions. Previous information and bulletins can also be highlighted and stored here so all information is held within one area.
- **Social Media:** Comprising of social media channels including Instagram, Twitter, LinkedIn and Facebook. This will be used to drip-feed generate interest in the lead up to campaigns. Written copy will be limited as we want to sell the concept and generate intrigue. This could involve Primary Care social media channels which are private groups to share job opportunities, training dates and celebrate success of new initiatives.
- **M/S Teams channels:** This can be seen as another channel to engage with General Practice with urgent communications and help to combat practices receiving excessive emails.
- **Practice Managers**: combination of visual communications (posters, graphics for video screens in staff areas, and screensavers), written communications (on the intranet, in internal newsletters and communications), and virtual face-to-face communications (ad-hoc briefings, manager cascade, and monthly staff briefing sessions).

- **Senior leaders**: ICS Executive Management Team, CEO calls and briefings, (ad-hoc briefings, manager cascade, and monthly staff briefing sessions).
- **Communications and engagement staff**: supporting cascade of messages to colleagues at all levels in organisations across the ICS, supporting engagement events and sessions, being ambassadors of the programme.
- **Media**: Proactive and reactive media statements with updates on the programme / initiatives as and when required.
- **Schools / Colleges and HEIs** – how do we grow our "Get-in" programmes to support access to Primary Care roles / higher education. Look at increasing our brand identify to improve on innovation and different ways of learning to work with schools and colleges – e.g. our systemwide Health Care Academies, T-Levels, Next-Gen programmes. This will be to anticipate how primary care will evolve and what the workforce will look like in the future – adapting our comms and engagement to meet local needs.

9. Engagement objectives

As previously stated, continual engagement with our stakeholders will be key to maintain momentum of the Primary Care Workforce Team's activities and explain what the next steps are and how they can get involved.

- Identify workshop opportunities on a tier-staff list basis and frequency. What are the key discussions and how can we develop solutions going forward?
- Maintain an informed and updated with mapped out dates with agendas to ensure attendance.
- To co-produce the development of the Primary Care Workforce Team and Workforce website, with their support to generate the look and feel together as a resources that they would want to use.
- To develop pre-engagement questions and surveys staff have about the Primary Care Workforce Team to help coordinate the themes presented at subsequent engagement sessions and how we implement the wider plan.
- To understand what impact people think our Workforce plan will have on them, so that we can support positive outcomes and engage people in this work.
- Engage with primary care/PCNs around new initiatives / proposed changes / workforce development initiatives as well as training and development to inform decision making
- Training Needs Analysis – be more informed using comms channels to reach whole workforce to inform annual plans

10. Engagement approaches and tools

We will use a range of Workforce workshops approaches and tools to get people's views to really drill down the need to take action and why there is need our staff to listen.

These will include:

- Running pre / post surveys to log attendance and reporting on a range of training topics
- Access via online M/S Teams, with the occasional f-2-f meetings. Ringfenced attendance with protected learning time.
- Working with practice participation focus groups to sense check their knowledge of the Primary Care Workforce Team and the impact of improved services / outcomes has had on their care.

11. Proposed Engagement Plan – tiered- monthly engagement sessions

Method	How will it work?	Who else needs to be involved?
i) Primary Care colleagues		
Shared Decision-Making engagement sessions	• Giving professionals the tools and support needed to be able to work together to design how they access training and education. • Work with local GPs and other healthcare professionals to make sure good quality resources and services are available that will help their training, career progression and education. • Work with healthcare professionals and other relevant stakeholders in the planning and design of these services and resources. • How to promote regular and reliable training and development opportunities to enable them to do their job effectively • Understand what they can expect from the ICS Primary Care Workforce Team • Need to ensure these groups are involved and valued through regular engagement. By understanding and listening to the key issues of our workforce, we will be in a stronger position to co-produce relevant materials to prevent professionals from leaving and help keep them to stay happy and healthy within the workforce.	General Practice Primary Care Networks General Practice provider organisations Governing Body All primary care workforce Oversight Group Local Medical Committee ICS People Board
ii) People that use services		
Patient Participation Groups (PPGs)	• Work with practices to support and maintain their PPGs.	PPG members

	• Facilitate the wider co-operation between the PPGs across Norfolk and Waveney ICB areas by developing a dedicated section of our website and publicising the work they do. • Work in addressing health inequalities – for example the positive engagement work with Deaf Connexions to support patients with hearing impairments access primary care services • Ensure we listen and action upon responses through our work with underrepresented groups i.e. our pre-engagement work with local charities and support networks regarding the Walk in Centre in Norwich to meet the needs of patients who don't access healthcare through conventional means.	Practice Managers Health Inclusion Group Support Local charities and support networks
iii) Strategic Partners & strategic planning		
External Stakeholders in Education	• Have wide and varied influence • Provide wide range of contact points with potential new workforce, current workforce • Provide education, training and placements • Having regular dialogue and communications with stakeholders provides a continuous link between the groups and organisations they represent and the ICB.	Health Education England Higher Educational Institutes Schools and Colleges Training and Education private providers

12. Communications and engagement timeline of activities – as currently perceived

Audience	Objective	Message	Channel	Date	Lead
All	Online presence	Development of the website and Learning Academy to create content for website which provides tailored education and training resourcing for existing staff in practice. Secondly, to actively showcase GP career roles, case studies and career development to present Norfolk and Waveney as a potential life and career destination. TH – to map out content and resources on the site	ICS website – with external developer	June - December 2023	Paul Martin / Digital Comms Lead / Keri Robinson / Newly recruited PM
Staff / Managers Webb Sarah 04/05/2023 09:43:12	Promote monthly tiered webinars sessions • PCNS • GPs	Advertise a range of awareness sessions – Legacy Nurses, International Nurses, Reservists etc Create expression of interest forms and messaging	M/S Teams	Ongoing	TBC

	• Practice staff • HEIs				
All	Development of Social Media platforms and 3 monthly toolkits	These platforms will be private for intended audiences Each week Social Media content is drip-fed to maintain conversations	• Instagram • Twitter • Facebook	May 2023 onwards	• PM • TH team
Wider - audiences	External Marketing	Forward plan detail around initiatives and recruitment opportunities that we may want to communicate/market e.g. Legacy Nurses, International Nursing Personalisation's Ambassadors TNAs Apprentices	Press Release Case Studies	May onwards	TH team / PM

13. Evaluation / Monitoring

The Communications and Engagement team are committed to continuous improvement and development of its delivery and will continue to grow in response to feedback and the requirements of the general practice, as well as our role within the wider health and care system locally.

The success of this communications and engagement plan will be monitored using several evaluation metrics. An example of these is as follows:

- Number of staff attending ICS wide engagement events led by professionals
- Number of staff attending organisation wide engagement events
- Positive sentiment/evaluation from staff attending events
- Positive sentiment on social media:
    - LinkedIn
    - Facebook
    - Twitter
    - Instagram
- Website hits – dedicated pages/section on Primary Care Workforce Team website
- Number of media stories
- Positive examples of staff working differently/displaying different behaviours in line with the system

As part of the mobilisation plan and contract delivery, we will be seeking feedback in a variety of ways, including but not limited to the following:

- Norfolk and Waveney ICS Primary Care Workforce Team receives feedback through a variety of routes, including:
- Compliments, comments, concerns and complaints: Primary Care Workforce Team formally captures all comments and complaints received.
- Feedback from Primary care Commissioning Committee, Primary Care Workforce Team and Workforce Implementation group, Health Education England, NHSE&I.
- Practice and Primary Care Network, two-way communication with Primary Care Workforce Team
- Survey and Training Needs Analysis outcomes
- Interation and engagement via our MS Teams channels
- Continued engagement and involvement with LMC

Norfolk and Waveney
Integrated Care Board

Agenda item: 08

Subject:	**General Practice Winter Resilience Funding 2022/23**
Presented by:	**Sarah Harvey, Head of Primary and Community care Strategic Planning**
Prepared by:	**Sarah Harvey, Head of Primary and Community care Strategic Planning**
Submitted to:	**Primary Care Commissioning Committee**
Date:	**09 May 2023**

Purpose of paper:

The purpose of this paper is to provide an overview of the General Practice winter resilience funding for 2022/23 and the benefits reported by practices.

Executive Summary:

To support the resilience of general practice throughout winter, a bid for funding of £750,000 was supported by the ICB with an allocation of £150,000 per locality to be shared with each general practice based on weighted population.

Locality teams worked with practices to develop schemes to best meet the needs of each practice or PCN. Use of funding was determined on the greatest need for individual practices and ability to operationalise schemes within limited timescales, as such there is variation of how the funding was used across the system.

The main use of funding was for additional locum staff or overtime for existing staff, and additional administrative resource, to manage the additional workload. An overarching summary for each locality is summarised in the main body of the paper.

Report

1. Background

To support the resilience of general practice throughout winter, a bid for funding of £750,000 was supported by the ICB with an allocation of £150,000 per locality to be shared with each general practice based on weighted population (from Quarter 3 2022/23 data).

It was agreed that the fund could be used to support practices with additional resources to increase capacity over winter such as additional locum staff or overtime for existing staff, and additional administrative resource, to manage the additional workload.

2. Locality Schemes

Locality teams worked with practices to develop schemes to best meet the needs of each practice or PCN. Use of funding was determined on the greatest need for individual practices and ability to operationalise schemes within limited timescales, as such there is variation of how the funding was used across the system. An overarching summary of the schemes at locality level is provided below.

a) Great Yarmouth and Waveney

PCN Clinical Directors were asked to work with their practices to agree a model for additional appointments that were bookable on a network basis. Clinical Directors and the locality teams working together was key to successful delivery of additional capacity. Wherever possible, the planning and delivery of additional capacity incorporated key themes of resilience, connected care and partnership working.

Appointment models and delivery were agreed on a network basis and were delivered through a mixture of Livi GP appointments and additional in-house capacity. Livi is a digital healthcare provider which offers primary care telephone and video consultations to support general practice using GMC registered NHS GPs who work alongside practices using local referral pathways and processes.

The use of Livi provided a number of benefits. Practices who might not otherwise have worked with Livi had the opportunity to assess whether it could form part of a practice/PCN model of delivery going forward, including a proactive response to resilience. PCNs were able to offer additional capacity without putting an additional ask on their clinical teams and to test the increased flexibility for appointment availability offered under the PCN Livi model.

The additional in-house capacity was delivered at PCN level and a mixture of face-to-face appointments were delivered in-hours and alongside enhanced access using a multi-disciplinary skill mix of GPs, Advanced Nurse Practitioners, Health Care Assistants, Physio and other additional roles.

Recognising areas of need, some provision of the additional in-house capacity was targeted at specific interventions such as coil fittings and immunisations. These appointments were delivered by individuals with appropriate skills working additional hours.

Approximately 4,000 additional appointments were delivered as a result of the winter resilience fund.

b) North Norfolk

Practices within the North Norfolk locality utilised the winter resilience funding to provide additional in-house appointments and associated administrative cover through use of additional locum staff and additional sessions for existing staff. Appointments were provided alongside existing models of appointment delivery, including Enhanced Access.

c) Norwich

Practices within the Norwich locality utilised the winter resilience funding to provide additional in-house appointments and associated administrative cover through use of additional locum staff and additional sessions for existing staff.

Recognising that planning was an important factor to ensure that the funding was spent in the most effective way, one practice who recognised a need to overhaul their appointment ledger used some of the funding to have a strategic meeting outside of normal working hours to develop a model of appointment delivery to maximise capacity and efficiencies within the practice, without the need to reduce planned activity levels.

From their new model of appointment delivery, the practice has been able to offer more face-to-face appointments. They have also self-reported a positive impact on staff wellbeing, with staff reducing the number of hours they are working outside of the normal working day resulting in improved staff morale.

d) South Norfolk

Practices within the North Norfolk locality utilised the winter resilience funding to provide additional in-house appointments and associated administrative cover through use of additional locum staff and additional sessions for existing staff. Appointments were provided alongside existing models of appointment delivery, including Enhanced Access.

e) West Norfolk

Due to the challenges faced with recruiting appropriately trained locum staff within this locality, practices were offered the choice of utilising the funding for additional Livi appointments or to use a weighted allocation to source their own locums.

Practices across West Norfolk utilised the winter resilience funding to build on the work from the previous winter in relation to use of Livi appointments offer the opportunity to utilise external virtual GP appointments at scale. From this work, two GP Practices went on to contract directly with Livi for business as usual support and three of the PCNs have contracted with Livi to support the Enhanced Access requirements.

Patient feedback about Livi appointments has been good and using the service has allowed practices to focus on providing higher levels of face-to-face appointments and more targeted interventions for patients with long term conditions.

The winter resilience funding has supported practices to deliver 1,345 additional Livi appointments and 3,420 additional in-house appointments.

3. Appointments data

Data on the additional appointments is limited at locality level, however, positive benefits can be seen in the system level appointments data and comparisons to the pre-pandemic period 2019/20.

Actual Activity	2022/23			Var to 2019/20 (%)		
	Jan	Feb	Mar	Jan	Feb	Mar
Face-to-Face	462,358	432,659	506,978	-3% ▼	1.9% ▲	33% ▲
Home Visit	3,412	3,280	3,781	-0% =	-2.7% ▼	34% ▲
Telephone	112,851	97,568	114,318	85% ▲	76.4% ▲	7% ▲
Video Conference/Online	2,980	3,217	3,591	-47% ▼	-32.4% ▼	-13% ▼
Unknown	23,261	22,143	25,988	25% ▲	37.3% ▲	45% ▲
Total	604,862	558,867	654,656	6.5% ▲	10.8% ▲	27% ▲

Recommendation to the Primary Care Commissioning Committee:

PCCC is asked to note the update.

Key Risks	
Clinical and Quality:	The time-limited nature of the funding meant the risks associated with 'burn out' of clinical teams in medium/ longer term was mitigated.
Finance and Performance:	Funding allocations were based on practice weighted population to ensure equity across the system.
Impact Assessment (environmental and equalities):	N/A
Reputation:	N/A
Legal:	N/A
Information Governance:	N/A
Resource Required:	N/A
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

Governance

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

Norfolk and Waveney
Integrated Care Board

Agenda item: 09

Subject:	**Locally Commissioned Services**
Presented by:	**Shepherd Ncube, Associate Director of Delegated Primary Care Commissioning**
Prepared by:	**Gemma Claridge, Primary Care Commissioning Manager**
Submitted to:	**Primary Care Commissioning Committee**
Date:	**9 May 2023**

Purpose of paper:

Following the approval by PCCC in March to recommission the following five Locally Commissioned Services and roll over the current specifications for a further 3 months, we have now finalised the updated specifications that would have expired 31st March 2023.

- PSA Monitoring: To expire 31st March 2024
- Diabetes: To expire 31st March 2024
- Monitoring Eating Disorders: To expire 31st March 2024
- Supporting SMI Health Checks: To expire 31st March 2025
- Inclusion Health: To expire 31st March 2024

Executive Summary:

This paper build on the previous paper to PCCC in March and provides a brief update on the process undertaken during the review and requests committee to note the five Locally Commissioned Service specifications have been reviewed and updated following discussions with the LMC.

Recommendation to Governing Body/ Committee:

To note the process undertaken throughout the review.
To note the five Locally Commissioned Service specifications for Norfolk & Waveney ICB practices have been reviewed and updated.

1. Introduction

The purpose of this paper is to update Committee members on the process undertaken to review five of the Locally Commissioned Services (LCS) that were due to expire on 31st March 2023 and note the plan to issue the updated service specifications. This paper builds on the paper brought to the March committee meeting.

2. Overview

Following last year's extensive review of the Norfolk and Waveney LCS, 5 of the LCS were due to expire on 31st March 2023.

The review process commenced with an aim to review the current detail within the specifications and ensure any changes or updates to guidance were included.

The Integrated Care Board (ICB) along with the Clinical Leads responsible for each area have reviewed the following five LCS:

- ***PSA Monitoring***
- ***Monitoring Eating Disorders***
- ***Supporting SMI Health Checks***
- ***Inclusion Health***
- ***Diabetes***

These contracts were originally let on a 1-year basis due to either anticipated changes in the national frameworks, ie QOF, PCN DES, NICE guidelines, or anticipated local changes with regard commissioned services.

3. The Process

Each of the five LCS have undergone a review with each of the specified clinical leads and with the engagement of the LMC in providing feedback on behalf of the practices.

Minimal changes and amendments have been made to the specifications due to the extensive review that took place last year.

Each LCS has been updated with current guidance, amendment to guidelines and streamlined reporting requirements and context of the specifications.

Ongoing engagement between the LMC Executive team and the review programme team has enabled rapid discussion of identified issues and enabled collaborative working.

Each of the specifications have been subsequently ratified and approved.

All proposed changes and updates have been submitted to the LMC for consultation, with resulting comments being considered and accommodated where appropriate. The original documents, with all corresponding consultation comments and responses, have been shared with the LMC throughout the review process.

The five LCS under review will be commissioned for the following time frames:

LCS Specification	Term of Contract	New Expiry Date
Diabetes	1 Year	31/03/2024
Monitoring eating disorders	1 Year	31/03/2024
Supporting SMI Health Checks	2 Year	31/03/2025
PSA Monitoring	1 Year	31/03/2024
Inclusion Health	1 Year	31/03/2024

For information the other LCS details are:

LCS Specification	Term of Contract	Expiry Date
Phlebotomy	5 Years	31/03/2027
Shared Care	5 Years	31/03/2027
Warfarin	5 Years	31/03/2027
Treatment Room	5 Years	31/03/2027
Spirometry	5 Years	31/03/2027
Care Homes Enhancement	2 Years	31/03/2024
Pro Active Healthcare	2 Years	31/03/2024

4. Funding

Ongoing discussions continue to take place between the Norfolk and Waveney ICB Primary Care Finance team and the LMC regarding finalising the spend for 2022/23 and finalising the budget spend for 2023/24. The Finance team are currently reviewing the GP Practice 2022/23 activity data submitted via CQRS Local (the system we are using for practices to submit their claims) for the Locally Commissioned Services (LCS) and a meeting to discuss the activity levels is due to be held with the LMC on 11th May 2023 and next steps.

Whilst we expect no significant changes to the overall funding for each LCS, discussions will be held with the LMC around the accuracy of the costings of each component of service payment within each LCS. Also, we are awaiting confirmation of the outcome of the Doctors and Dentist Remuneration Board (DDRB) review of the annual up lift to be applied to the staff pay element of the funding of the LCS services. Once known, any annual uplift will be considered for application to all LCS contracts where applicable and in line with contract terms, and the budget spend will be adjusted accordingly.

5. Risks

- Block payment review: Currently being agreed how practices are going to be paid for these services moving forward but no conclusion has yet been reached due to the ongoing potential data quality issues

- Practices not signing up to the services and creating a gap in provision.

6. What Next – Launch and Engagement

The programme team anticipate launching the reviewed specifications prior to the 1st July 2023, when the current roll over arrangements for these specifications expire:

- Launch letter
- The five updated specifications to be shared with GP Practices
- Engagement plan for drop in sessions
- MS Teams Channel update

7. Recommendation

Members are invited to:

- Note the planned release of the updated Locally Commissioned Service specifications and the process that has been undertaken:
    - PSA Monitoring
    - Diabetes
    - Monitoring Eating Disorders
    - Supporting SMI Health Checks
    - Inclusion Health

GOVERNANCE

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

Norfolk and Waveney
Integrated Care Board

Agenda item: 10

Subject:	**Progress Update - Enhanced Access Service – Primary Care Network Direct Enhanced Service**
Presented by:	**Carl Gosling – Senior Delegated Primary Care Commissioning Manager**
Prepared by:	**Carl Gosling – Senior Delegated Primary Care Commissioning Manager**
Submitted to:	**Delegated Primary Care Commissioning Committee**
Date:	**9 May 2023**

Purpose of paper:

To provide the ICB PCCC Committee with a progress update on the implementation and delivery of the Enhanced Access Service arrangements, contained within the Network Contract DES, across the 17 Norfolk and Waveney PCNs

Executive Summary:

Background

Following receipt of the letter B1375 "General Practice contract arrangements" dated 1st March 2022, NHS England (NHSE) confirmed, as previously agreed in 2019, that the two enhanced access (Improved Access and Extended Hours) schemes will be brought together to provide a single, combined and nationally consistent access offer with updated requirements, to be delivered by Primary Care Networks (PCNs), under the Network Contract Directed Enhanced Service (DES) from the 1st October 2022.

The new Enhanced Access service is based on PCNs providing bookable appointments outside core hours within the Enhanced Access period of 6.30pm-8pm weekday evenings and 9am-5pm on Saturdays, utilising the full multi-disciplinary team, and offering a full range of general practice services, including 'routine' services such as screening, vaccinations and health checks, in line with patient preference and need. PCNs will also be able to provide a proportion of Enhanced Access outside of these hours, for example early morning or on a Sunday, where this is in line with patient need locally and it is agreed with the commissioner.

To prepare for delivery of the Enhanced Access service from 1st October 2022, each of the 17 PCNs in Norfolk and Waveney delivered an Enhanced Access Plan to the ICB, each setting out how the PCN is planning to deliver Enhanced Access from October 2022. The the governance process for the review and approval of the 17 individual Norfolk and Waveney PCN plans were approved by this committee at the September PCCC meeting.
To approve the 17 individual Norfolk and Waveney Enhanced Service Plans and to provide feedback and seek amendments, if required, a Panel was set up in order to review the draft

Primary Care Network (PCN) Enhanced Access Plans and agree a final iteration of individual PCN Enhanced Access Plans with the PCN's Core Network Practices by 31 August 2022. The panel included colleagues from the Local Medical Committee and Healthwatch to ensure adequate independent oversight.

The panel reviewed each PCN plan to ensure that each one was compliant with the core requirements of the PCN DES as described in PCN DES contract and summarised below.

> Each PCN must provide a full range of general medical services during Network Standard Hours: Monday – Friday, 6.30 – 8.00 pm and Saturdays 9.00 am – 5.00 pm
> Full range of general practice services to be made available;
> All appointments within a PCN area must be available to all patients within the PCN;
> Provide a mix of services provided during Network Standard Hours, including planned care appointments;
> Advance booking and on the day booking available, and ability to cancel appointments on the day;
> Enable NHS 111 to book into unused slots on the day.
> Each plan has due regard to health inequalities, population health needs and demonstrates engagement with patients and other key stakeholders

A Review meeting for the Norfolk and Waveney Enhanced Access was held on the 10th August 2022 in order to review each PCN plan to ensure that each one was compliant with the core requirements as described in PCN DES contract. The Group approved PCN plans, in some cases subject to further information or areas of clarification being received by 31 August.

Since the review meeting on 10th August, PCNs have been submitting updated plans for final approval, which have been shared and approved by Panel members, to ensure service delivery can be implemented by the 1st October 2022.

Current Position

All 17 PCN Enhanced Access plans were approved and are being delivered across Norfolk and Waveney.

PCNs are required to provide a minimum of 60 minutes of appointments per 1,000 PCN adjusted patients per week during the Network Standard Hours, calculated using the following formula:

additional minutes* = the PCN adjusted population** ÷ 1,000 x 60
convert to hours and minutes and round, either up or down, to the nearest quarter hour
**PCN adjusted population is based on the CCG Primary Medical Care weighted population as at 1 January 2022

Based on an ICB Primary Medical Care Weighted population of 1,120,324 a total of 67,245 Enhanced Access minutes are required to be contracted under the 2022/23 Primary Care Network Contract DES. Please see Appendix A for a full breakdown by individual PCN.

PCNs must provide bookable clinical appointments during the Network Standard Hours that are available to all PCN Patients and are for any general practice services and services pursuant to the Network Contract DES that are provided to patients.Bookable appointments, may be made in advance or on the same day, by the PCN's Core Network Practices,

Individual PCNs, across Norfolk and Waveney have commenced Enhanced Access service delivery and have given assurances to Primary Care Locality Teams that the delivery of Enhanced Access Hours appointments has commenced from the 1st October 2022, as per their agreed delivery plans.

Apointments are being delivered by a multi-disciplinary team of healthcare professionals employed or engaged by the PCN's Core Network Practices, including GPs, nurses and Additional Roles and other persons employed or engaged by the PCN to assist the healthcare professional in the provision of health services. These appointments may be a mixture of in person face to face and remote (telephone, video or online) appointments, provided that the PCN ensures a reasonable number of appointments are available for in person face-to-face consultations to meet the needs of their patient population, ensuring that the mixture of appointments seeks to minimises inequalities in access across the patient population;

In order that ongoing assurance is provided, PCNs are providing monthly data reports confirming the number of Enhanced Access minutes that are being provided on a daily basis, the appointment type and method of appointment (i.e.face to face, telephone etc).

There have been no significant concerns raised regarding the implementation of the Enhanced Access service, however there have been some delivery issues that we are working together with the individual PCNs to address and resolve.

The primary care team is due to write again to PCNs with the updated requirements for 2023/24, noting that there have been population changes since implementation.

Risks

We are working with the National Team and the ICB Digital Team to find a solution to the national IT interoperability issue which impacts how IT systems interface with each other to ensure the core requirements of the Enhanced Access service will operate.

It is also recognised that some plans may evolve during the coming months and a process has been put in place to agree any significant changes to PCN plans.

The introduction of Saturday Blood collections from Practices/PCN Hubs, by ISS and the testing of Saturday bloods has been delayed due to ongoing contract negotiations. This has meant a delay in Practices/Hubs booking patients into Blood letting appointments.

Recommendation

Members of the PCCC are asked to note the progress update on the delivery of the 17 individual Norfolk and Waveney PCN Enhanced Access plans.

Appendix A

PCN	Total PCN Pop (CCG Primary Medicak Care weighted population	Minutes per week	Contracted No of Hrs (to nearest 15mins)	Contrcated Number of Minutes (to nearest 15 minutes)
Gorleston Primary Care Network	47,123.98	2,827	47hrs	2,820
Gt. Yarmouth & Northern Villages PCN	74,907.57	4,494	75hrs	4,500
Lowestoft Primary Care Network	88,371.35	5,302	88hrs 15mins	5,295
SWAN	58,096.13	3,486	58hrs 15mins	3,495
NN1	47,530.79	2,852	47hrs 30mins	2,850
NN2	44,486.94	2,669	44hrs 30mins	2,670
NN3	45,032.12	2,702	45hrs	2,700
NN4	50,886.54	3,053	51hrs	3,060
Norwich PCN	235,404.08	14,124	235hrs 30mins	14,130
Breckland Surgeries	43,808.53	2,629	43hrs 45mins	2,625
Ketts Oak Primary Care Network	58,655.37	3,519	58hrs 45mins	3,525
Mid Norfolk	47,212.51	2,833	47hrs 15mins	2,835
SNHiP	82,900.35	4,974	83hrs	4,980
Coastal	39,936.44	2,396	40 hrs	2,400
Fens and Brecks	42,130.93	2,528	42hrs 15mins	2,535
Kings Lynn	63,778.42	3,827	63hrs 45mins	3,825
Swaffham and Downham Market	50,062.15	3,004	50hrs	3,000
Total	**1,120,324**	**67,219**	**1,120hrs 45mins**	**67,245**

Norfolk and Waveney
Integrated Care Board

Agenda item: 11

Subject:	**Resilience Funding for Community Pharmacy Integration**
Presented by:	**Sharon Gardner, ICS Community Pharmacy Clinical Lead**
Prepared by:	**Sharon Gardner and Catherine Hedges, Dental, Optometry and Pharmacy Primary Care Manager**
Submitted to:	**Primary Care Commissioning Committee**
Date:	**9 May 2023**

Purpose of paper:

The purpose of this paper seeks to

- agree to the distribution of the funds from NHS England to the ICB for the provision of 'Community Pharmacy Integration' for 2023/2024
- clarify how the funding will be used to support the Community Pharmacy integration programme in Norfolk and Waveney.
- to provide assurances that this is in line with our vision as set out Appendix 1

Executive Summary:

The NHS Long Term Plan commits to developing more joined-up and coordinated care across primary and community health services and a more proactive approach in services provided.

It supports expanded community multidisciplinary teams aligned with primary care networks (PCNs)

ICS and ICB are central to the delivery of the Long-Term Plan through enabling service integration to meet local needs, bringing together providers and commissioners of NHS services and other local partners, to make shared decisions on population health, service, design and implementation.

This is in line with our vision as set out in Appendix 2.

NHS England are acutely aware of the current pressures being experienced across all parts of the health service in the East of England, including community pharmacy. The increase in acute respiratory infections, winter demand and Covid-19 have continued to add pressure on services.

Within that context, robust and effective communication channels between community pharmacies and wider primary care partners, specifically general practice, helps to streamline and improve care and experience for patients.

Experience has demonstrated that, when issues such as exceptional stock shortage arise, and where new and existing services require understanding for integration, the best outcomes are achieved, where communication channels locally between healthcare partners have already been established by mutual agreement.

This funding from NHS England is intended to support the Community Pharmacy Integration programme by ensuring, as a minimum, every community pharmacy in Norfolk and Waveney have a named lead and deputy as a single point of communication and contact.
This information will then be shared across the PCN networks through the appropriate channels to ensure that the starting point for communication and collaborative working is available to all parties

Report

This resilience funding from NHS England, is intended to support the community pharmacy integration programme. This will help develop the community pharmacy communication channels in Norfolk and Waveney and help to meet the Community Pharmacy Integration Programme Objectives set out below.

Community Pharmacy Integration Programme Objectives
The Community Pharmacy Integration programme intends to ensure that every community pharmacy across the region, has the opportunity to engage and connect with their local Primary Care Network (PCN), Place Leader or Integrated Neighbourhood Team (INT) Lead either via the Community Pharmacy PCN Lead or designated PCN Clinical Pharmacist

As a minimum each community pharmacy should nominate a named lead and deputy, as a single point of communication and contact for other local partners.

The nominated lead and deputy, should be prepared to constructively communicate with their PCN Community Pharmacy Lead or other designated PCN or Practice contact as reasonably required on matters such as:

- Exceptional stock shortage issues which may impact significantly on patient care.
- Preferred communication pathways for, e.g., local notification of pharmacy closure or temporary suspension of service delivery such as CPCS (Community Pharmacist Consultation Service) etc.
- Efficient and effective repeat management pathways including the benefits of increased uptake of electronic Repeat Dispensing

- Pharmacy sign-up and capacity for delivery of existing and new national advanced and locally commissioned services and the development of local referral pathways for these.
- Engage with a brief evaluation of this service and the wider “Community Pharmacy PCN Lead” initiative.
- Support the community pharmacy to increase understanding and awareness of Place based/ PCN priorities relating to population health needs and the role that Community Pharmacy plays in helping to deliver those priorities.

The Norfolk and Waveney ICB (Integrated Care Board) has worked in collaboration with Local Pharmaceutical Committees to plan a fair and transparent approach to utilising the funding to meet the stipulated programme objectives. This compromises a single one-off payment to each community pharmacy split evenly from the total sum received from NHS England.

This funding has also been allocated to other ICBs in our region and NHS England through a Memorandum of Understanding, have recommended a consistent approach to how it is used. The one-off funding received by Norfolk and Waveney ICB (Integrated Care Board) is £263,000.

The ICB continues to work with our locality teams to engage the PCNs with the purpose of this funding and how collaborative working moving forward with an increased communication pathway can support elements of the GP access and recovery plans.

Outcomes

The ICB in conjunction with the LPCs will design an assurance form to ensure that the minimum requirements of providing a named contact are achieved before any funding is released to the contractor.

In our locations that have a PCN clinical pharmacy lead appointed (3 sites), pharmacies will be supported through their leads to ensure the funding is claimed for and that the minimum requirements are met. Throughout the year the PCN lead will ensure that the communication pathways that are opened, with the release of these funds, are used proactively and within the objectives of their pilot. The outcomes of their pilot, which nationally will be collated, will be integral to future developments of Community Pharmacy integration.

The locations without a pilot PCN appointed pharmacy lead will be supported with regular engagement from the LPC and ICB to ensure that the communication pathways are used appropriately and, in a manner, consistent with the outcomes required.

The payment of the funding will be via the Business Services Authority utilising the local enhanced service scheme. This method of delivery is already used for distributing funding, for our commissioned out of hours emergency supply scheme, meaning all pharmacies are already set up for this payment mechanism.

Recommendation to the Board:

PCCC members are asked to support the distribution of this Integration funding to individual community pharmacies as outlined in the report to support the community pharmacy integration programme and in turn supporting the vision of the East of England Partnership Strategy for Community Pharmacy

Key Risks	
Clinical and Quality:	N/A
Finance and Performance:	N/A
Impact Assessment (environmental and equalities):	N/A
Reputation:	
Legal:	
Information Governance:	N/A
Resource Required:	N/A
Reference document(s):	Resilience Funding MoU East of England Partnership Strategy for Community Pharmacy
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	N/A

Governance

Process/Committee approval with date(s) (as appropriate)	9 May PCCC

East of England Partnership Strategy for Community Pharmacy

Rolling 5 years from December 2022

Contents

East of England Partnership Strategy for Community Pharmacy

Vision

COMMUNITY PHARMACY IS INTEGRATED INTO **PRIMARY AND COMMUNITY CARE** WITH **BETTER ACCESS** AND **IMPROVED OUTCOMES**

COMMUNITY PHARMACY SERVICES ARE **PATIENT CENTRED** AND THE **FIRST POINT OF CALL FOR MANY PATIENTS**

COMMUNITY PHARMACY IS EMBEDDED IN PATHWAYS ACROSS THE **WIDER HEALTH AND CARE SYSTEM**

COMMUNITY PHARMACY SUPPORTS **SELF CARE** AND IMPROVES **POPULATION HEALTH**

COMMUNITY PROFESSIONALS AND WIDER TEAMS ARE **VALUED AND RESPECTED**

COMMUNITY PHARMACY IS INTEGRAL TO REDUCING **HEALTH INEQUALITIES**

Priorities

Increase health system integration and partnership	Optimise services and outcomes	Improve population health and address health inequalities	Develop the workforce for delivery

Actions

Work in partnership with GP practices, Primary Care Networks. Local Authorities and other healthcare providers Develop integrated service models and whole system approaches to delivering services and reducing inequalities	Promote community pharmacy as a clinical provider Collaborate on pathway redesign Support extension of services to address unmet needs	Ensure services are consistently delivered, visible and actively promoted Consider innovative approaches to increase accessibility Develop greater understanding of the characteristics and needs of the local community	Optimise use of workforce skill mix within services Focus on the recruitment, retention and wellbeing of the community pharmacy workforce Develop an integrated workforce strategy for primary and community care

Enablers

IT and digital infrastructure and data services	**Communication and engagement**
Financial and contractual arrangements	**Estates**

Foreword

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

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

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

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

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

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

William Rial, Regional Chief Pharmacist

Introduction

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

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

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

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

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

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

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

Vision

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

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

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

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

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

Community pharmacy is integral to addressing health inequalities

Community pharmacy professionals and wider teams are valued and respected

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

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

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

Strategic context

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

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

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

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

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

ICSs and ICBs are central to the delivery of the LTP through enabling service integration to meet local needs, bringing together providers and commissioners of NHS services with local authorities and other local partners, to make shared decisions on population health, service redesign and implementation.

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

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

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

The CPCF supports:

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

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

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

- Expanding the Community Pharmacist Consultation Service to enable urgent and emergency care settings to refer patients to a community pharmacist for a consultation for minor illness or urgent medicine supply
- Expanding the New Medicines Service to include antidepressants to enable patients who are newly prescribed an antidepressant to receive extra support from their community pharmacist
- Introducing Tier 2 of the Pharmacy Contraception Service, enabling community pharmacists to also initiate oral contraception, via a Patient Group Direction, and provide ongoing clinical checks and annual reviews
- The service specifications for the Blood Pressure Check Service and Smoking Cessation Service will be amended to allow delivery by pharmacy technicians, helping pharmacies to make best use of their skill-mix

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

Integrated Care Systems

ICSs have four key aims:

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

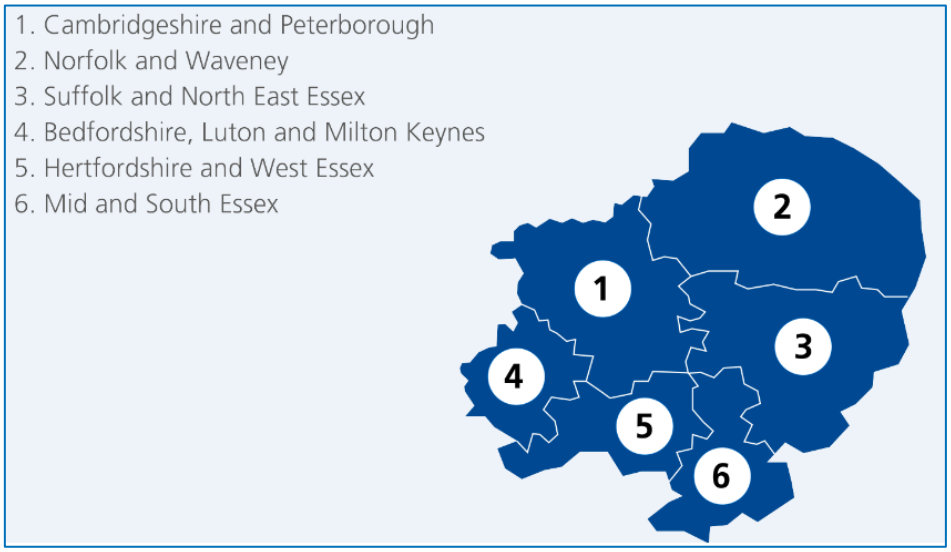
The responsibility for community pharmacy commissioning is being delegated from NHSE to ICBs in April 2023 in the East of England. The CPCF will continue to be negotiated and set nationally, systems will have delegated responsibility for the commissioning and contracting locally.

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

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

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

There are six systems in the East of England.



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

Views from service users

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

> *"Pharmacies are vital to communities and a very valuable [community] asset"*

Clear themes emerged in the analysis of the survey results.

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

There was strong agreement and support for :

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

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

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

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

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

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

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

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

Views from pharmacy teams and healthcare professionals

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

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

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

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

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

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

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

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

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

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

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

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

Vision, priorities and actions

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

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

The vision	Strategic priorities	Potential Actions	Enabled by
2. Community pharmacy is embedded in pathways across the wider health and care system	Establish community pharmacy as a core service element of the primary care system enabling patients to access care at the right time in the optimal setting Provide better access to assessment, advice and medicines for patients requiring treatment for low acuity conditions Increase reach of community pharmacy to promote self-care and preventative strategies for ill health	Promote the expertise and knowledge of community pharmacy, including services offered to the public to encourage uptake and to other healthcare professionals to support referral Further implementation and optimisation of currently commissioned services Local commissioning of Patient Group Directives and independent prescriber-led services for the treatment of low acuity conditions in all community pharmacies Review the range of services currently offered by community pharmacies and support extension of services to cover gaps	Community pharmacy involvement in health awareness campaigns Peer network to share best practice, review learning and determine potential for local implementation Better communications platforms/services Improved interoperability of IT systems (including appropriate access to patient records) Data sharing Sufficiently funded pharmacy workforce (pharmacists and other staff)

The vision	Strategic priorities	Potential Actions	Enabled by
3. Community pharmacy is a patient centred service that is the first point of contact for many patients	Improve public and patient awareness of community pharmacy expertise and services Enable onward referral or signposting between community pharmacy and other healthcare teams such as general practice, NHS 111 or A&E Improve service accessibility Optimise the Community Pharmacist Consultation Service	Promote community pharmacy as a clinical provider Ensure services are consistently delivered, visible and actively advertised to patients/other healthcare providers Review demand against current provision to identify accessibility issues and options to address inaccessibility Consider innovative approaches to service provision to increase accessibility	Better communication platforms/services Improved interoperability of IT systems (including appropriate access to patient records) Funding for piloting and implementation of new service technologies and approaches Sufficiently funded pharmacy workforce (pharmacists and other staff) Contractual support for alternative service provision approaches

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

The vision	Strategic priorities	Potential Actions	Enabled by
5. Community pharmacy is integral to addressing health inequalities	Develop services to tackle local population health inequalities and address unwarranted variation Maximise community pharmacy contribution to Core20PLUS5[1]	Work in partnership with GP practices, PCNs, Local Authorities and other healthcare providers to develop whole system approaches to inequalities Assess and understand local population health inequalities and unmet need	Availability and accessibility of population health data

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

The vision	Strategic priorities	Potential Actions	Enabled by
6. Community pharmacy professionals and wider teams are valued and respected	Maximise the skills of community pharmacists, pharmacy technicians, wider pharmacy teams and associated healthcare professionals Address workforce shortages Create a structure that offers workforce development and opportunities	Review commissioning arrangements to actively encourage and optimise appropriate use of workforce/skill mix within services Develop a community pharmacy workforce strategy which is integrated into wider system workforce planning and resourcing Focus on recruitment, retention and wellbeing of the community pharmacy workforce Consider flexible, cross-sector workforce models including shared posts with GP practices and hospitals Reinforce positive image through public messaging, communications and engagement Embed the Quality Improvement approach to learn and expand best practice	Collaborative working with Health Education England (HEE), professional leads (including Local Pharmaceutical Committee) and higher education institutes Promotion of careers in Community Pharmacy Changes to pharmacy training and qualifications Increased community pharmacy placements for trainees Protected learning time Multidisciplinary training opportunities Pharmacy Integration Fund[2] investment Facilitation of independent prescriber training

[2] NHS England » Pharmacy Integration Programme

Delivery of actions

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

Pillar 1

Increase health system integration and partnership

Pillar 2

Optimise services and outcomes

Pillar 3

Improve population health and address health inequalities

Pillar 4

Develop the workforce for delivery

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

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

Pillar 1 Increase health system integration and partnership

Why is this important?

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

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

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

What needs to change?

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

ICBs and ICSs are responsible for providing system leadership and bringing commissioners and providers together in new collaborative ways of working. Building a culture of collaboration and alignment of community pharmacy with PCNs, GPs and other primary care teams requires protected time and space in which to plan and problem solve together. **Cross service referrals and multi-disciplinary teams will need to be developed to provide agile service delivery teams and treatment pathways**. This will need to be supported with the sharing of expertise and insights, and the pooling of data and information. Multi-disciplinary teams will combine learning, best practice and case studies in determining what 'good' may look like.

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

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

Actions to be delivered under this pillar

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

Pillar 2 Optimise services and outcomes

Why is this important?

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

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

What needs to Change?

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

Priority clinical areas in the LTP include:

Prevention
Smoking
Obesity
Alcohol
Antimicrobial resistance
Action on health inequalities
Hypertension

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

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

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

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

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

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

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

Actions to be delivered under this pillar

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

Pillar 3 Improve population health and address health inequalities

Why is this important?

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

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

Creating healthy communities

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

- Chronic respiratory disease
- Early cancer diagnosis
- Hypertension case-finding
- Maternity
- Severe mental illness

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

What needs to change?

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

Actions to be delivered under this pillar

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

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

Pillar 4 Develop the workforce for delivery

Why is this important?

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

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

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

What needs to change?

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

- Identify capacity and skills gaps and support staff in moving beyond traditional roles to meet changing needs
- Identify new workforce models that consider the roles of different pharmacy team members including pharmacy technicians, prescribing pharmacists, multi-sector foundation pharmacists and opportunities for portfolio working across service teams
- Consider how development of digital and IT infrastructure will change the composition and skill requirement of the future workforce
- Identify how to reposition community pharmacy and its developing workforce models as a compelling service to work in
- Ensure commitment to supporting the emotional, mental and physical health and wellbeing of staff working in community pharmacy

A summary of development priorities is given at Appendix C.

Actions to be delivered under this pillar

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

Enablers

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

IT and digital infrastructure and data services

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

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

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

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

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

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

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

Communication and engagement

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

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

Financial and contractual arrangements

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

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

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

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

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

Estates and facilities

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

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

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

Future opportunities for community pharmacy

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Next steps

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

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

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

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

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

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

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

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

Further information

For further information please contact:

Cambridgeshire & Peterborough Integrated Care System NHS Cambridgeshire & Peterborough Integrated Care Board Contact us - Cambridgeshire & Peterborough Integrated Care System (cpics.org.uk)	Improving lives together Norfolk and Waveney Integrated Care System NHS Norfolk and Waveney Integrated Care Board Contact - Norfolk & Waveney Integrated Care System (ICS) (improvinglivesnw.org.uk)
Suffolk & North East Essex Integrated Care System CAN DO HEALTH & CARE NHS Suffolk and North East Essex Integrated Care Board Contact - Suffolk & North East Essex Integrated Care System (sneeics.org.uk)	Bedfordshire, Luton and Milton Keynes Health and Care Partnership NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board Contact us - Bedfordshire, Luton and Milton Keynes Integrated Care Board (icb.nhs.uk)
HWE ICS Hertfordshire and West Essex Integrated Care System NHS Hertfordshire and West Essex Integrated Care Board Contact us - Hertfordshire and West Essex Integrated Care System (hertsandwestessexics.org.uk)	Mid and South Essex Integrated Care System NHS Mid and South Essex Integrated Care Board Contact - Mid and South Essex Integrated Care System (ourpeopleyourfuture.co.uk)

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

Appendix A – East of England integrated care systems

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

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

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

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

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

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

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

Our Plans for Community Pharmacy

- Increase the use of the Discharge Medicines Service
- Improve digital connectivity between providers through the local and national SystmOne pilot
- Maximise the use of community pharmacy PGDs e.g. the insect bite service
- Increase referrals via the Community Pharmacy Consultation Service
- Supporting pharmacies to deliver self-care & self-management for both minor ailments & long-term conditions
- Make best use of prevention services – vaccination services, hypertension case finding, smoking cessation, weight management etc.
- Increase the number of prescriptions ordered via the electronic repeat dispensing service.
- Expand the current oral contraceptive pilot
- Support workforce to minimise unexpected closures

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

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

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

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

Recognising that our community pharmacies are, facing significant and challenging workforce shortages, we have been developing a pharmacy workforce plan, which is now well-advanced and is currently being integrated into our wider workforce planning. It is unfortunately true, though, that the pharmacy workforce shortage has and is affecting the sector's ability to consistently engage with some developments, and has had an impact on service delivery, and perhaps confidence in some pharmacy services. Supporting pharmacies through this challenging time and seeking to maintain and improve working relationships between our pharmacies and surgeries/PCNs are fundamental to securing the foundations for future integration and development.

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

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

Our Norfolk and Waveney landscape

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

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

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

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

Successes

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

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

System partners are also clear that integration needs to happen, not only in terms of service development but also the enablers that underpin true integration. SNEE has supported an initiative around the integration of community pharmacies with Primary Care Networks across the ICS and this will be developed further over coming years. Community pharmacy has been included in the Digital Strategy for the system so that the unique challenges the sector has around digital interoperability and data sharing can be addressed. The ICS has agreed and adopted a comprehensive pharmacy workforce strategy across all pharmacy sectors. This will ensure we have a sound foundation for optimising the role that pharmacists can play in all sectors in improving the health and wellbeing of our population. We are also starting to see the commissioning of locally funded community pharmacy services targeted to the support of patient need such as the Palliative Care Service.

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

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

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

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

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

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

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

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

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

Successes

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

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

Quotes from Community Pharmacists across HWE

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

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

-Rachel Solanki

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

Easter pharmacy has been working closely with the local PCN enabling the housebound patients to receive their Covid and Flu vaccinations promptly. We are starting to also work closely with local surgeries regarding monitoring of blood pressure. We provide advice and assistance to local patients via GP CPCS with regards minor ailments ultimately saving GP appointments.

-Babatunde Sokoya

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

Challenges

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

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

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

Nationally commissioned Services

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

Locally commissioned services-

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

Integration of community pharmacy and GP practices through the framework and PCN DES contract: e.g. CPCS, hypertension case finding; vaccinations; NMS; IIF- carbon inhalers and DOACs.

Innovation within MSE

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

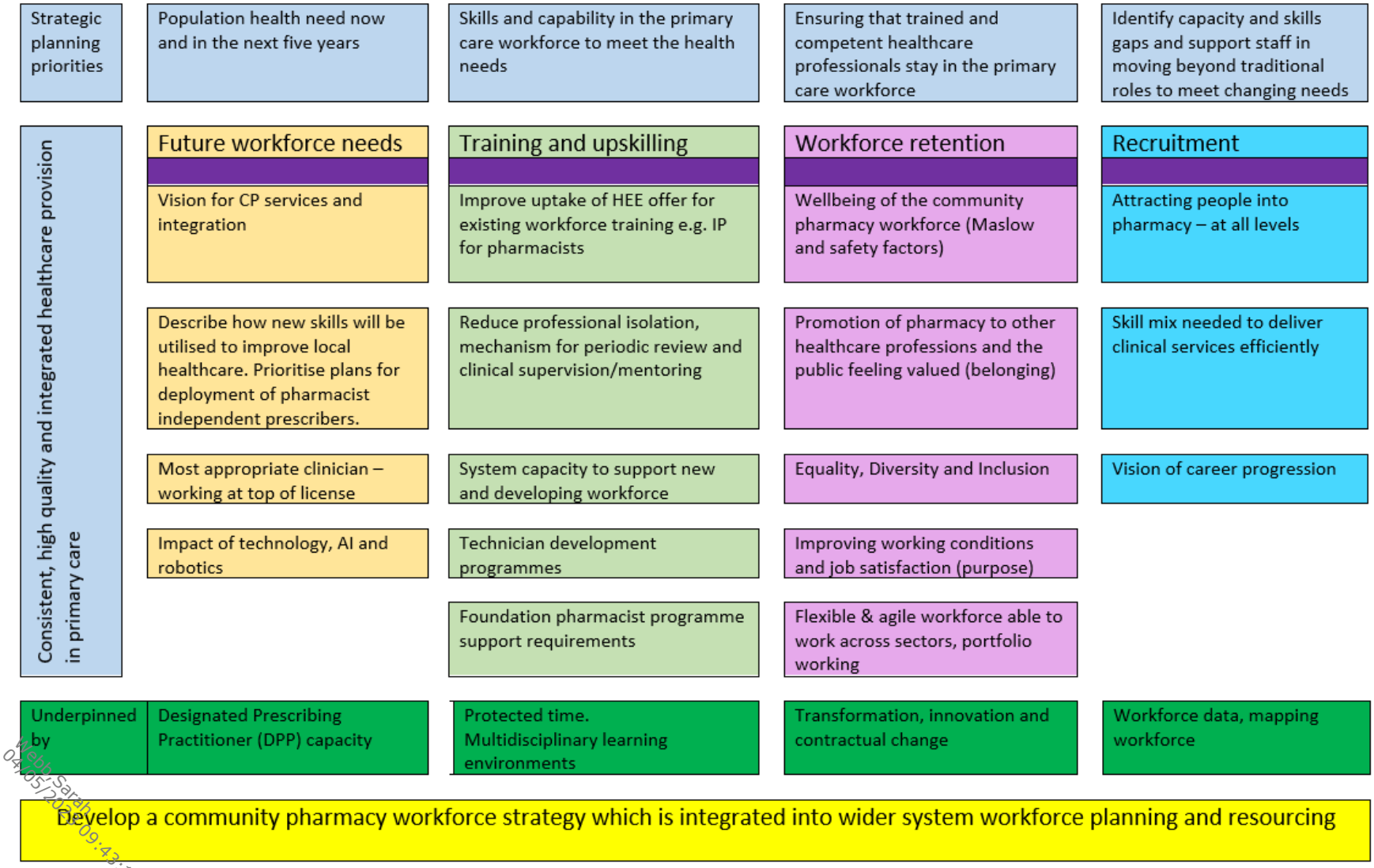
Appendix B – CPCF services as of 2022/23

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

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

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

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



Appendix D - Horizon Scan Review

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

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

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

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

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

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

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

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

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

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

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

A new pharmacy in Letchworth, Hertfordshire, has considerably invested in new technologies to improve efficiency and their dispensing robot frees up pharmacists' time. *Automation and services: 'Pharmacy of the 21st century' opens in Letchworth* (Automation and services: 'Pharmacy of the 21st century' opens in Letchworth|Chemist+Druggist :: C+D (chemistanddruggist.co.uk), February 2022). After a patient requests their prescriptions electronically, the pharmacy dispenses it and sends the patient a text once it's ready. Patients can then collect their prescription from collection points which operate 24 hours a day.

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

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

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

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

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

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

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

Memorandum of Understanding between NHS England East of England Region and

NHS Norfolk and Waveney ICB

For the provision of "Community Pharmacy Integration" in 2023/24

1. Introduction

1.1. This Memorandum of Understanding (MoU) has been developed to provide both parties with an agreed set of terms for using the resource provided over the duration of the MoU.

1.2. The signing of this MoU provides both parties with the assurance that the funding will be utilised in line with the terms outlined below.

2. Programme Overview

2.1. Objectives

2.1.1 The Community Pharmacy Integration programme intends to ensure that every community pharmacy across the region has the opportunity to engage and connect with their local Primary Care Network (PCN)/ Place Leader/ Integrated Neighbourhood Team (INT) Lead either via the Community Pharmacy PCN Lead or designated PCN Clinical Pharmacist:

2.1.2 As a minimum each community pharmacy should nominate a named lead and deputy, as a single point of communication and contact for the PCN/ INT/ Place.

2.1.3 Establish a local communication process for business including:

- Exceptional stock shortage issues which may impact significantly on patient care.
- Preferred communication pathways for, e.g. local notification of pharmacy closure or temporary suspension of service delivery such as CPCS etc.
- Efficient and effective repeat management pathways including the benefits of increased electronic Repeat Dispensing
- Pharmacy sign-up and capacity for delivery of existing and new national advanced and locally-commissioned services and the development of local referral pathways for these.
- Engage with a brief evaluation of this service and the wider "Community Pharmacy PCN Lead" initiative.

2.1.4 Support the community pharmacy to increase understanding and awareness of Place based/ PCN priorities relating to population health needs and the role that CP plays in helping to deliver those priorities.

2.1.5 The ICB to work in collaboration with Local Pharmacy Committees to plan a fair and transparent approach to utilising the funding to meet the stipulated programme objectives (as set out in this section 2 of the MOU).

2.2 Reporting

2.2.1 Provide an update on progress against the programme via the regional assurance and oversight reporting mechanism.

2.2.2 Ensure that related deliverables are reflected in the ICB single Primary Care Implementation Plan.

3. Details of resource provided

3.1. **Service/function:** Primary Care Integration

3.2. **Duration:** 2022/23 and 2023/24 financial years

3.3. **Coverage:** Norfolk and Waveney

3.4. **Lead Organisation:** n/a

3.5. **Location:** n/a

3.6. **Funding Provided:** £263,000

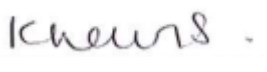
4. Payment Mechanism

4.1. On approval of this MoU, Norfolk and Waveney ICB to invoice NHS England for the agreed amount.

5. Signatures and Contact Details

5.1. The updated MoU must be signed by all Parties.

5.2. Signatories must be officially authorised to sign on behalf of the client's organisation.

Signed on behalf of the **NHS ENGLAND AND IMPROVEMENT**	
Name:	Kate Lewis
Job title:	Deputy Director Primary Care Transformation and Delivery
Signature:	
Date:	24th March 2023
Signed on behalf of Norfolk and Waveney ICB	
Name:	
Job title:	
Signature:	
Date:	
Telephone number:	
Email:	

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Norfolk and Waveney Integrated Care System

2022/23 Primary Care Commissioning Committee

Finance Report Norfolk & Waveney ICB

March 2023

Primary Care Commissioning Committee 9th May 2023

Contents

1.0 Executive Summary

- As the financial reporting for Primary Care and Prescribing is produced in arrears this report will relate to M12 (March-23) of the ICB accounts. Since the ICB (Integrated Care Board) was formed July 2022 the forecast included is for the ICB for 9 months from July-March 2023.

- The 2022-23 budgets for the ICB are from July – March 2023 and are based upon the final financial plans as submitted on the 20th June 2022

- As at Month 12 (March), the 9 months actual spend is £334.7m as against a plan of £331m leading to a final total overspend of £3.8m for Primary Care and Prescribing in combination.

- As at Month 12 (March), the 12 months actual spend (including the CCG) is £436.1m as against a plan of £435.3m leading to a final total overspend of £0.8m for Primary Care and Prescribing in combination.

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

2.0 Financial Summary

Primary Care: Financial Summary	9 months (ICB Only) Budget £m	Actual £ m	Variance (Fav)Adv £m	12 months (CCG & ICB) Budget £m	Actual £m	Variance (Fav) Adv £m	9 Months Forecast at Month 11 (February) Actual £m	Movement (Fav) Adv £m	Comments on material Movement between February and March	*Detailed Variance Analysis*
GP & Other Prescribing	150.9	157.6	6.7	204.3	198.8	6.7	150.4	7.1	The No Cheaper Stock Obtainable (NCSO) cost pressures and increase in Sodium glucose cotransporter 2 (SGLT2) prescriptions and revised rebates and incentive forecasts have resulted in an increase in FOT at M12,Also provision for legal case for Oxygen contracting is included in the position.	*3.1*
Primary Care										
System Development Fund	4.4	4.3	(0.1)	6.9	6.7	(0.1)	3.6	0.7	New Allocation in M12	
Local Enhanced Services	12.5	12.5	0.0	16.5	16.7	0.0	12.4	0.1		
Other Primary Care	2.1	1.8	(0.3)	2.6	2.8	(0.3)	1.8	(0.0)		
Primary Care Delegated Co-Commissioning	153.6	151.5	(2.0)	197.5	201.4	(2.0)	149.6	2.0	Higher Dispensing fees (pressure on FOT seen all year)	*3.2*
Primary Care IT	7.4	7.0	(0.4)	8.4	8.8	(0.4)	5.7	1.2	SBS Project Funding (Externally funding)	
Total Primary Care	180.1	177.2	(2.9)	231.8	231.8	177.2	173.1	4.0		
Total Directorate	331.0	334.7	3.8	436.1	436.1	334.7	323.6	11.1		
Variance as a % of Budget			*1.1%*			*101.1%*		*96.7%*		
Retrospective ARRS allocation to be received	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		
Total Primary Care	331.0	334.7	3.8	436.1	436.1	334.7	323.6	11.1		

The detailed explanations are provided in 3.0 Detailed variance analysis.

3.0 Detailed Variance Analysis

Primary Care: Detailed Variance Analysis		9 months ICB Only			12 months CCG & ICB			Narrative
		Budget £m	Actual £ m	Variance (Fav)Adv £m	Budget £m	Actual £m	Variance (Fav)Adv £m	
3.1	GP and Other Prescribing	150.9	157.6	6.7	204.3	198.8	5.5	The GP Prescribing costs are reported nationally 2 months in arrears, hence actuals from July to January and estimates for February and March are considered in the final position. The final position is overspent by £6.7m.This is driven by cost pressures of No Cheaper Stock Obtainable (NCSO) due to supply chain issues and increase in SGLT2 prescriptions mitigated by prior year benefits.Further provision for Oxygen contract is included in position.
3.2	Primary Care Delegated Co-Commissioning	153.6	151.5	(2.0)	201.4	197.5	(3.9)	The underspend here is due to prior year release .

4.0 System Development Fund

Primary Care: System Development Fund	Final Position M12		
	Budget	Actual	Variance (Fav) Adv
	£m	£ m	£m
GP Retention	0.2	0.2	0.0
Training Hubs	0.2	0.2	0.0
Online Consultation	0.2	0.2	(0.0)
Flexible Pool	0.1	0.1	(0.0)
Infrastructure & Resilience	0.2	0.2	0.0
GP Fellowship	0.5	0.5	0.0
Improved Access	1.8	1.6	(0.3)
Practice Resilience	0.1	0.1	0.0
Transformational Support	0.0	0.0	0.0
Supporting Mentor	0.1	0.1	(0.0)
Nurse Fellows	0.1	0.1	0.0
GP Accelerate Programme	0.1	0.1	0.0
ARI Hubs	0.8	0.8	(0.0)
Others	0.0	0.1	0.1
	4.4	**4.3**	**(0.1)**
Variance as a % of Budget			*-3.2%*

Variance Signage: (Favourable)/Adverse

- The above table details the schemes within the System Development Fund (SDF). The final position matches the plan in all areas bar some small immaterial differences.

5.0 Delegated Co Commissioning Analysis

Primary Care: Delegated Co Commissioning	Final Postion M12 Budget	Actual	Variance (Fav)Adv
	£m	£ m	£m
Contractual	94.0	94.5	0.5
QOF	11.9	12.0	0.1
Premises cost reimbursements	11.1	11.4	0.3
Other - GP Services	10.7	13.0	2.3
Enhanced services	7.0	7.0	0.0
CCG Spend	0.3	0.3	(0.0)
PCN ARRS Staff	15.4	15.4	(0.0)
PMS to GMS	3.1	0.0	(3.1)
Prior Year	0.0	-2.1	(2.1)
Total	**153.6**	**151.5**	**(2.0)**
Variance as a % of Budget			*-1.3%*

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

Areas of material forecast variances:

- **Contractual:** The major overspend is due to the Impact and Investment Fund (IIF), being funded to a level set by NHSE there is a prudent argument to increase this creating a cost pressure.
- **PMS to GMS:** Budgets held within Delegated PC as per NHSE guidance costs shown in Locally Commissioned Scheme.
- **Prior Year:** Prior year benefits £2.1m crystallised.
- **Other GP Services:** This is due to overspend in Locum and Dispensing Fees.

6.0 GP And Other Prescribing

22/23 Primary Care: GP And Other Prescribing	Final Position M12			Forecast as at February		Comments on material Movement in Forecast Outturn (FOT) between February & March
	Budget £m	Actual £ m	Variance (Fav)Adv £m	Actual £ m	Movement in FOT (Fav)Adv £m	
GP Prescribing Costs	141.3	148.2	6.8	143.6	4.5	The NCSO cost pressures and SGLT2 increased usage continue .The estimates NCSO cost pressures from April to March is £6.8m
Recharges to Local Authorities & NHS England	(3.9)	(4.3)	(0.4)	(4.5)	0.2	January Flu Rebates lower than estimate
Rebates from pharmaceutical companies	(2.2)	(1.3)	0.8	(2.4)	1.0	DOAC Q3 Rebates received as allocation within GP Prescribing costs and hence forecast reduced in rebates line
GP Prescribing Subtotal	**135.3**	**142.5**	**7.3**	**136.8**	**5.7**	
Central Drugs	3.6	3.9	0.3	3.8	0.1	increased usage
Dressings & wound care	4.4	4.3	(0.1)	4.3	(0.0)	
Others (Medicine Management, Oxygen, incentives etc.)	7.6	6.8	(0.9)	5.5	1.3	New Provision for legal costs for Oxygen procurement £0.7m and balance is increased expected incentive payments to match budget
Total Spend	**150.9**	**157.6**	**6.7**	**150.4**	**7.1**	
Variance as a % of Budget			*4.4%*		*4.7%*	
9 months budget is the 9 months plan for 22/23 *Variance Signage: (Favourable)/Adverse*						

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

Appendix 1

Summary	NW Final Position 22/23	NW Allocation 22/23	Variance against allocation
Pharmacy	22,202	20,983	(1,219)
Primary dental	36,771	42,330	5,559
Community dental	3,253	4,081	828
Secondary dental	9,132	9,348	215
Optometry	9,714	10,528	815
Grand Total	**81,073**	**87,271**	**6,198**

- Allocations have been adjusted slightly across Pharmacy, Primary Dental and Optom to reflect some re-allocation amongst regionally shared contracts.
- Primary Dental has slipped further due to the same access issues and the clawing back of funding from NHSE.
- As the ICB gains control of these areas from April-23 a more detailed analysis of these areas will be provided in the next PCCC update.

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Norfolk and Waveney Integrated Care System

Agenda item: 14

Subject:	**Prescribing team report**
Presented by:	**Michael Dennis, Associate Director of Pharmacy and Medicines Optimisation**
Prepared by:	**Michael Dennis, Associate Director of Pharmacy and Medicines Optimisation**
Submitted to:	**Primary Care Commissioning Committee**
Date:	**9 May 2023**

Purpose of paper:

Information

Executive Summary:

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

Also attached is our guidance and processes to deal with medicines shortages for information and comment. This has been agreed with both the LMC and LPC.

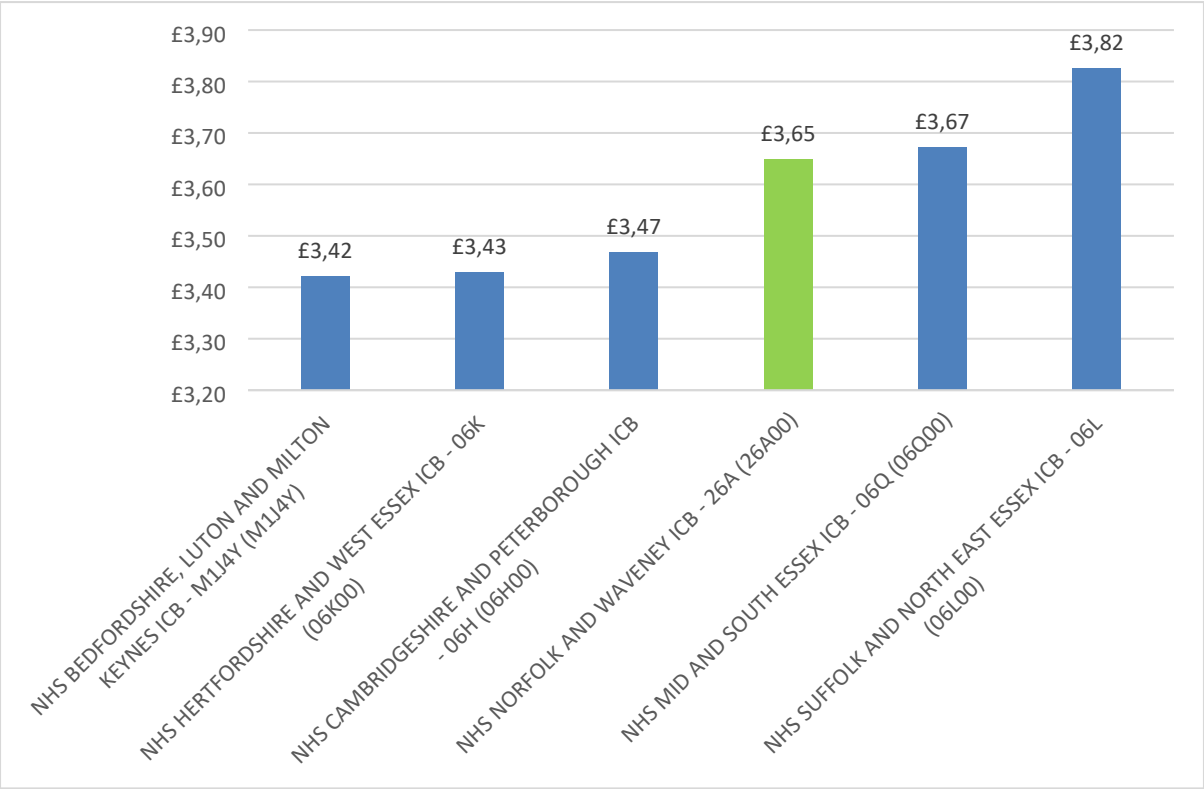
1. Prescribing team focus areas

1.1 The prescribing team is focused on supporting the prescribing quality scheme and potentially an additional switch scheme.

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

2. ICB Prescribing Performance

2.1 Net ingredient cost (NIC) per AstroPU (an attempt to normalise practice demographics) below is a proxy measure of relative cost-effectiveness. However, this does not take account of deprivation which is a key driver of prescribing spend. Norfolk and Waveney have remained at 3rd out of 6 in February data. The available deprivation score can be accessed here (registration required).



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

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

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

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

NCSO (no cheaper stock obtainable)

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

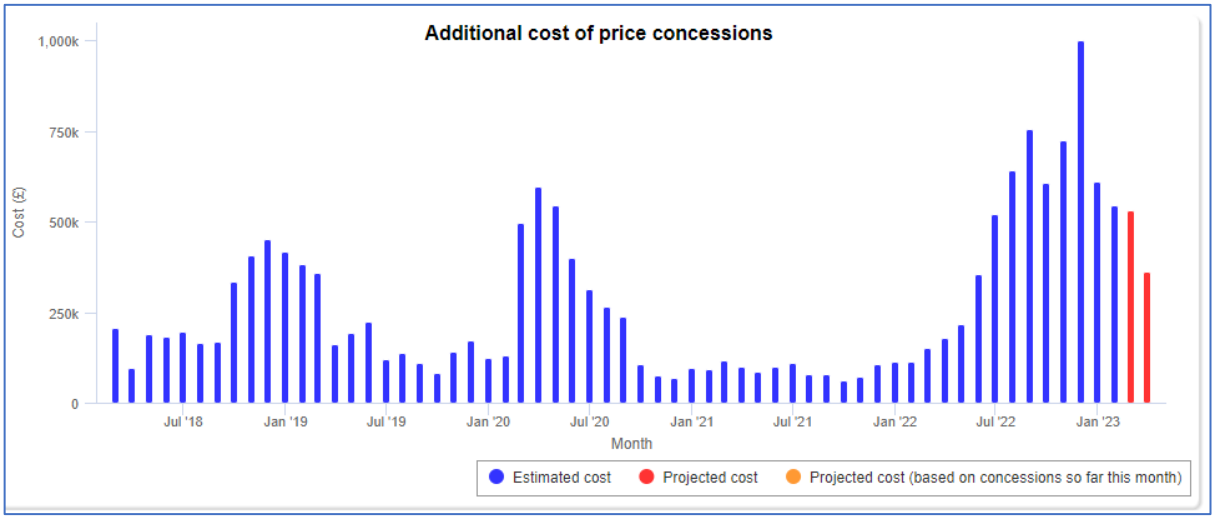
There is a continued impact of price concessions since when they are no longer subject to the price concession, they tend to go back into the drug tariff at an increased price. The table below shows the impact year to date and projected for the following 2 months.

Table 1. Cost Pressure Report May 2023, February 2023 data

	YTD April-Feb	Projected Mar*	Projected April*
NCSO and other price concessions	£6,316,184	£532,171	£361,058
Back into DT at increased prices	£1,323,543	£363,691	£391,126
Increase In cat M	£630,978	£344,624	£344,563
Total	£8,103,485	£1,265,992	£1,348,876

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

Table 2. Bar chart of NCSO additional costs over time



Some drugs have grown in costs due to an increase in the number of indications for their use e.g., SGLT 2s.

3 Dependence forming medicines (DFMs)

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

3.2 The national indicators for DFMs for February 2023 are below. This was out of the 134 organisations on OpenPrescribing with position 1 being the highest (usually worst). Since April there are only 106 organisations listed due to further mergers of ICBs.

- High dose opiates – a further increase in use to 79th (83rd previously) out of 106 organisations, 24th percentile (previously 22nd) on high dose opiate items as percentage of regular opiates

- Gabapentinoids – increased to 27th ,74th percentile (29th, 73rd percentile previously) on defined daily doses of gabapentin and pregabalin

- Hypnotics and anxiolytics – is at 5th position nationally 96th percentile (previously 6th nationally 96th percentile) volume per 1000 patients – the trend (below) is however an improving one (yellow dotted line is Norfolk and Waveney performance and trend respectively)

  The second chart compares Norfolk and Waveney performance with national percentiles (NW is the red line and national average is the blue line)

Table 4. Anxiolytics and hypnotics volume trend over time by top prescribing ICB's nationally

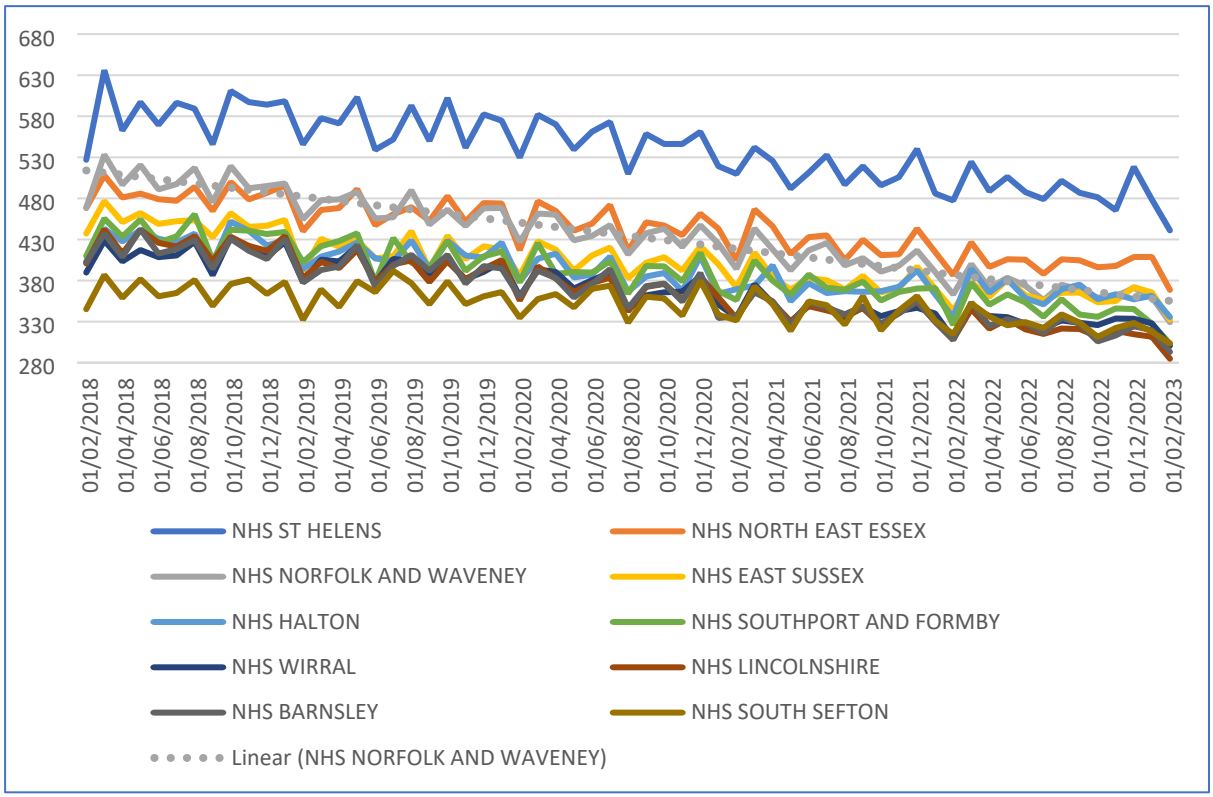
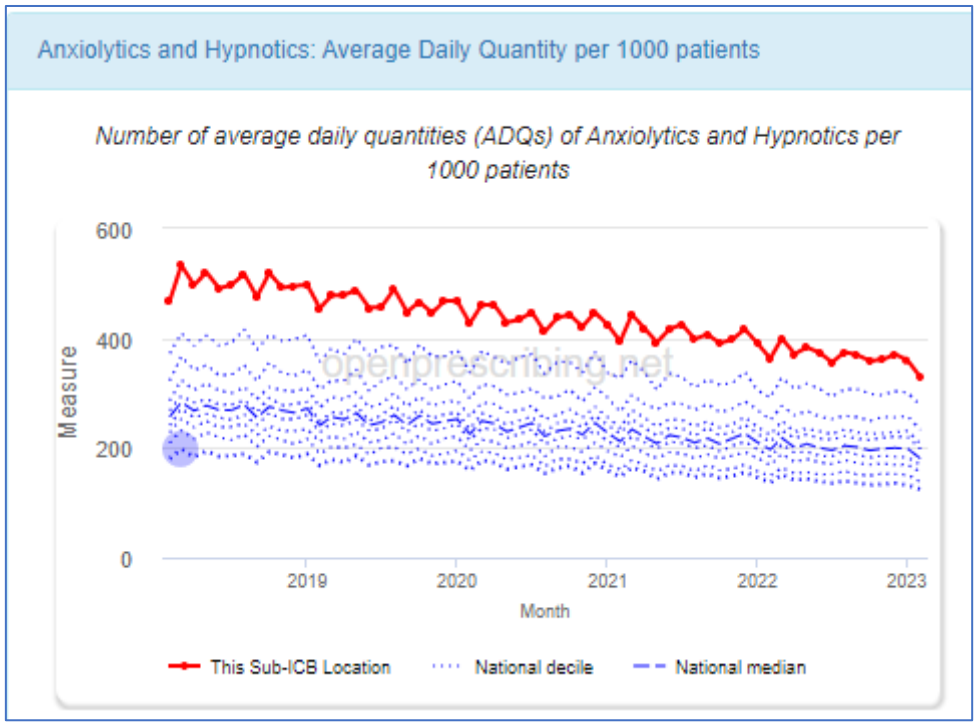


Table 5. Anxiolytics and hypnotics volume trend over time (red line is Norfolk and Waveney and darker blue line is national average)



4 Antibiotic Prescribing

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

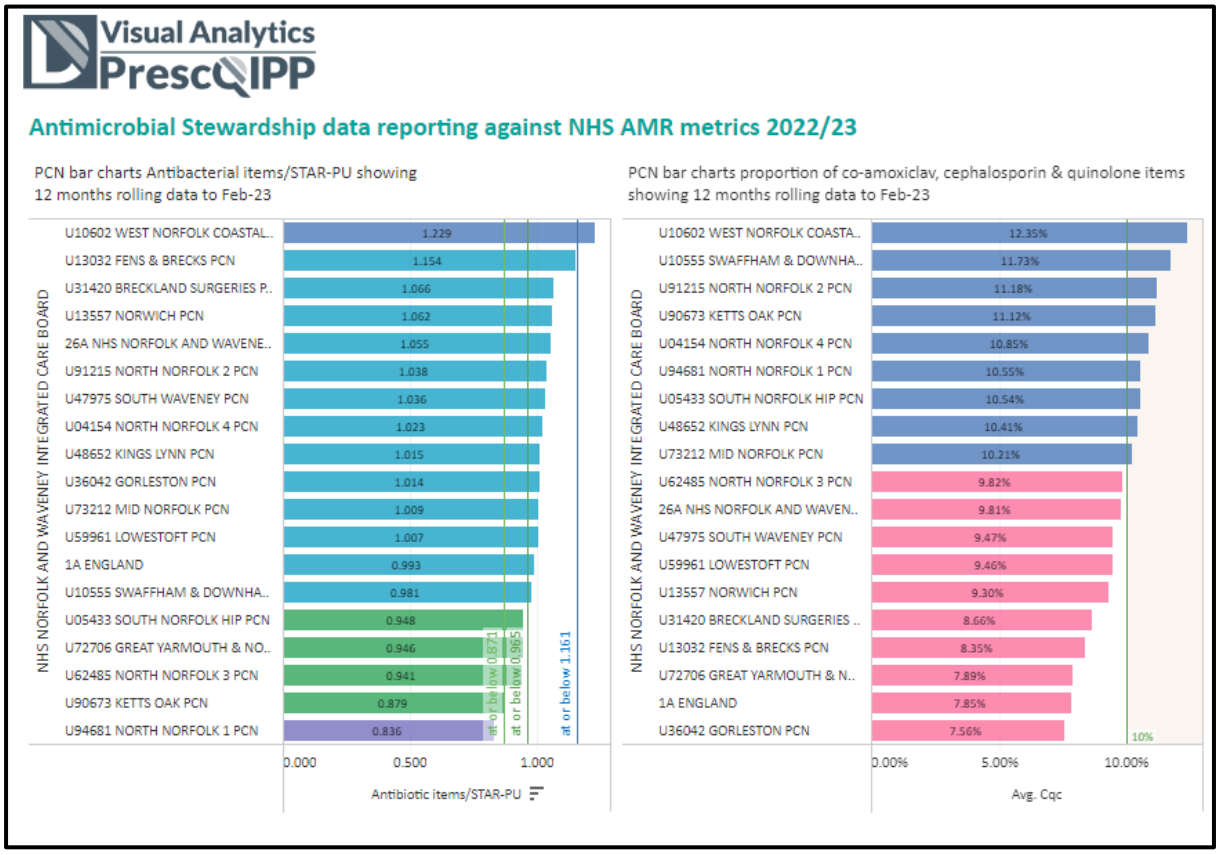
4.2 National AMS leads advise that targets will not be amended despite the recent uprise in antimicrobial prescribing, due to the National Action Plan ambition being a five-year plan from 2019-2024.

4.3 December 2022 saw a change in guidance for the threshold for prescribing antimicrobial agents due to a rise in Strep A cases in children. National stock shortages of antimicrobials led to alternative antibiotics being prescribed. Both factors have distorted the data for our practices and nationally. The trend observed shows that overall antimicrobial prescribing increased, and the percentage of broad-spectrum antimicrobials decreased. This month data analysis therefore continues to have a different focus.

4.4 Antibiotic volumes, the bar chart on the left (Table 6) shows the volume of antibiotic prescribing by PCNs. Norfolk and Waveney are continuing in an upward trend above the second volume target of 0.965 with a value of 1.055 antibacterial items per STAR-PU in the 12 months to February 2023, following the national trend.

4.5 Percentage of broad-spectrum antibiotics, the bar chart on the right (Table 6) shows the percentage by PCN. Norfolk and Waveney ICB are currently following a downward trajectory below the national target of no more than 10% of all antibiotics at 9.81%in the 12 months to February 2023, following the national trend.

Table 6. PCN bar charts – Antimicrobial prescribing 12 months to end February 2023



4.6 Clinicians have been reminded at Prescribing Lead meetings in April that all antimicrobial prescribing should be in line with the local formulary and documented in the patient's record. Any prescribing outside of formulary guidance should be noted in the patient's record with the rationale for the clinical decision. Outlier practices (90th percentile or above) for overall antimicrobial prescribing are shown in Table 7.

Table 7: Outlier Practices for overall antimicrobial prescribing (90th percentile or above)

Practice	Sum of percentile
NORWICH PRACTICES HEALTH CENTRE	99.95
BURNHAM SURGERY	98.72
HEACHAM GROUP PRACTICE	97.46
OLD MILL AND MILLGATES MEDICAL PRACTICE	96.71
ST CLEMENTS SURGERY	96.66
SCHOOL LANE SURGERY	96.09
BRUNDALL MEDICAL PARTNERSHIP	95.15
ANDAMAN SURGERY	94.92
LONGSHORE SURGERIES	92.98
GRIMSTON MEDICAL CENTRE	92.83
CHURCH HILL SURGERY	92.73
SOUTHGATES SURGICAL & MEDICAL CENTRE	92.36
MUNDESLEY MEDICAL CENTRE	91.92
PARISH FIELDS PRACTICE	91.13
BOUGHTON SURGERY	91.05
FLEGGBURGH SURGERY	90.92

4.7 Our outlier practices (90th percentile or above) that are driving the higher percentage of Broad-spectrum antibiotics in february data are shown in Table 8

Table 8: Outlier Practices for prescribing Broad Spectrum Antibiotics (90th percentile or above)

Practice	Sum of percentile	Percentage of broad-spectrum antibiotics
MUNDESLEY MEDICAL CENTRE	99.72	20.10%
BURNHAM SURGERY	99.58	17.91%
LITCHAM HEALTH CENTRE	99.35	16.76%
E HARLING & KENNINGHALL MEDICAL PRACTICE	98.66	14.84%
ST JAMES MEDICAL PRACTICE	98.48	14.55%
ELMHAM SURGERY	98.23	14.26%
GRIMSTON MEDICAL CENTRE	98.04	14.04%
HOLT MEDICAL PRACTICE	97.71	13.82%
ACLE MEDICAL PARTNERSHIP	97.56	13.72%
BRIDGE STREET SURGERY	97.12	13.32%
BRUNDALL MEDICAL PARTNERSHIP	96.77	13.13%
WELLS HEALTH CENTRE	96.35	12.82%

MANOR FARM MEDICAL CENTRE	95.94	12.61%
HOWDALE SURGERY	95.29	12.35%
BUNGAY MEDICAL CENTRE	94.70	12.10%
TOFTWOOD MEDICAL CENTRE	93.98	11.88%
REEPHAM & AYLSHAM MEDICAL PRACTICE	93.46	11.71%
THORPEWOOD MEDICAL GROUP	93.42	11.71%
BLOFIELD SURGERY	93.30	11.66%
LONG STRATTON MEDICAL PARTNERSHIP	92.49	11.47%
THE LIONWOOD MEDICAL PRACTICE	90.42	11.02%
SHERINGHAM MEDICAL PRACTICE	90.33	10.97%

4.8 A Bite- Size Primary Care session was held in April with a focus on anti-microbial stewardship and the tools to support appropriate prescribing. This was presented by Dr Naomi Fleming the East of England Antimicrobial Stewardship Lead. A recording is available on the Primary Care Teams platform for practices to be able to view.

Recommendation to Committee:

The committee is asked to note this report

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

Reference to relevant risk on the Governing Body Assurance Framework	Prescribing cost risk noted on register

GOVERNANCE

Process/Committee approval with date(s) *(as appropriate)*	Monthly report to PCCC