Primary Care Commissioning Committee Part One

Tue 12 March 2024, 13:30 - 16:30

Agenda

13:30 - 13:30
0 min

1. Agenda

Information *Debbie Bartlett*

2024 03 12 Item 00 ICB Primary Care Committee Agenda Pt 1.pdf (1 pages)

13:30 - 13:30
0 min

2. Apologies for absence

Information *Debbie Bartlett*

13:30 - 13:30
0 min

3. Declarations of Interest

Information *Debbie Bartlett*

2024 03 12 Item 03 Declarations of Interest.pdf (2 pages)

13:30 - 13:30
0 min

4. Review of Minutes and Action Log from February 2024 meeting

Decision *Debbie Bartlett*

2024 02 13 Item 04 NWICB PCCC Minutes Part One.pdf (9 pages)
2024 03 12 Item 04 Appendix to 20240214 Part One Minutes.pdf (4 pages)
2024 03 12 Item 04 PCCC Action Log Part One.pdf (1 pages)

13:30 - 13:30
0 min

5. Forward Planner

Decision *Sadie Parker*

2024 03 12 Item 05 ICB PCCC Forward Planner 2023-2024 P1.pdf (1 pages)
2024 03 12 Item 05 NWICB PCCC Forward Planner 2024-2025 Part 1.pdf (2 pages)

13:30 - 13:30
0 min

6. Risk Register

Decision *Sadie Parker*

2024 03 12 Item 06 Monthly risk ratings combined.pdf (9 pages)

13:30 - 13:30
0 min

Service Development

13:30 - 13:30
0 min

7. Strategic Workforce Plan

Information *Jayde Robinson*

2024 03 12 Item 07 Strategic Workforce Plan.pdf (5 pages)

2023 03 12 Item 07 Appendix A - PCWT Targets Master Spreadsheet.pdf (4 pages)

13:30 - 13:30
0 min

8. GP Contract 2024-2025

Information *Sadie Parker*

2024 03 12 Item 08 GP Contracts 2024-2025 - front sheet.pdf (2 pages)
2024 03 12 Item 08 GP Contracts 2024-2025.pdf (12 pages)

13:30 - 13:30
0 min

Finance & Governance

13:30 - 13:30
0 min

9. Dental Clawback Repayment Policy

Decision *Matthew Lewis/Stuart White*

2024 03 12 Item 09 Dental Clawback Repayment Policy - front sheet.pdf (3 pages)
2024 03 12 Item 09 Dental Clawback Repayment Policy.pdf (9 pages)

13:30 - 13:30
0 min

10. Terms of Reference Review

Decision *Fiona Theadom*

2024 03 12 Item 10 Terms of Reference Review - front sheet.pdf (4 pages)
2024 03 12 Item 10 Terms of Reference.pdf (10 pages)
2024 03 12 Item 10 Terms of Reference - Dental Operational Delivery Group.pdf (7 pages)
2024 03 12 Item 10 Terms of Reference - General Practice and Community Pharmacy.pdf (6 pages)

13:30 - 13:30
0 min

11. Operational Delivery Group Report• General Practice• Dental Services

Information *Sadie Parker / William Lee*

2024 03 12 Item 11 Operational Delivery Group Report - General Practice.pdf (4 pages)
2023 03 12 Item 11 Operational Delivery Group Report - Dental.pdf (6 pages)

13:30 - 13:30
0 min

12. Prescribing Report

Information

2024 03 12 Item 12 Prescribing Report.pdf (13 pages)

13:30 - 13:30
0 min

13. Finance Report - M10

Information *James Grainger*

2024 03 12 Item 13 Finance Report - M10.pdf (15 pages)

13:30 - 13:30
0 min

Any Other Business

13:30 - 13:30
0 min

14. Questions from the Public

Discussion *Debbie Bartlett*

NHS
Norfolk and Waveney
Integrated Care Board

Meeting of the Norfolk and Waveney ICB Primary Care Commissioning Committee
Tuesday 12 March 2024, 13:30 Part 1
Meeting to be held via video conferencing and You Tube

Item	Time	Agenda Item	Lead
1.	13:30	**Chair's introduction and report on any Chair's action**	Chair
2.		**Apologies for absence**	Chair
3.		**Declarations of Interest** To declare any interests specific to agenda items. Declarations made by members of the Primary Care Committee are listed in the ICB's Register of Interests. *For Noting*	Chair
4.		**Review of Minutes and Action Log from the February 2024 meeting** *For Approval*	Chair
5.		**Forward Planner** *For Approval*	SP
6.		**Risk Register** *For Approval*	SP
		Service Development	
7.	13:50	**Strategic Workforce Plan** *For Noting*	JRo
8.	14:00	**GP Contract 2024-2025** *For Noting*	SP
		Finance & Governance	
9.	14:10	**Dental Clawback Repayment Policy** *For Approval*	ML/SWh
10.	14:20	**Terms of Reference Review** *For Approval*	FT
11.	14:30	**Operational Delivery Group Report** • **General Practice** • **Dental Services** *For Noting*	SP/WL
12.	14:40	**Prescribing Report** *For Noting*	MD
13.	14:50	**Finance Report – Month 10** *For Noting*	JG
		Any Other Business	
14.	15:00	**Questions from the Public**	Chair

Date, time and venue of next meeting
Tuesday 11 June 2024 13:30 – 16:30 – ICB PCCC
To be held by videoconference and You Tube

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

Questions are welcomed from 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 General Practice Delivery Group

Name	Role	Declared Interest- (Name of the organisation and nature of business)	Type of Interest				Nature of Interest	Date of Interest		Action taken to mitigate risk
			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Is the Interest Direct or Indirect		From	To	
Mark Burgis	Executive Director of Patients and Communities, Norfolk and Waveney ICB	Drayton Medical Practice			X	Direct	Member of a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice
		Lakenham Practice				X	Wife is Nurse Prescriber who is currently undertaking occasional locum work at Lakenham Practice in Norwich	Aug-21	Present	Declare at any relevant meetings and remove myself from any significant discussions or decisions relating to the practice
James Grainger	Head of Finance, Norfolk and Waveney ICB	Attleborough Surgery			X	Direct	Patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
Shepherd Ncube	Head of Delegated Commissioning, Norfolk and Waveney ICB	Nothing to Declare	N/A			N/A	N/A	N/A		N/A
Sadie Parker	Director of Primary Care, Norfolk and Waveney ICB	Active Norfolk Board					Represent N&W ICB as a member of the Active Norfolk Board	2019	Present	Declare interest as applicable at PCCC meetings and agree any action with PCCC chair, and the same for other relevant meetings
		St Stephensgate Medical Practice and One Norwich Practices Ltd					Friendship with Dr Jeanine Smirl who is a GP partner at St Stephensgate Medical Practice and Associate Director of Primary Care for the ICB	2023	Present	Declare interest as applicable. Ensure no conflicted items are discussed. Ensure line manager has oversight and approves all matters in relation to JS' conflicts
Karen Watts	Director of Nursing and Quality, Norfolk and Waveney ICB	Norfolk and Norwich University Hospital				X	Son-in-law is a Locum Cardiology Consultant at NNUH with sessions at JPUH	Jun-23	Present	I declare this as an indirect interest. I always ensure the chair is aware and withdraw from the meeting if cardiology at the NNUH or JPUH is discussed in terms of benefiting the service
		Royal college of Nursing			X		Member of the RCN	1980	Present	I always ensure the chair is aware if any matters to this arise on the agenda
		Coltishall surgery			X		Patient at a Norfolk and Waveney GP Practice			To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
Attendees										
Jon Fox	Head of BI, Norfolk and Waveney ICB	Nothing to Declare	N/A			N/A	N/A	N/A		N/A
Carl Gosling	Senior Delegated Commissioning Manager, Norfolk and Waveney ICB	Old Mill and Millgates Surgery			X		Patient of a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
Lisa Read	Acting Head of Quality and Nursing	First choice home care				Indirect	Sister works for first choice home care that support people with Mental health	2022	Present	Non-attendance at meeting where provider may be discussed

		Old Mill and Millgate Practice			X		Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
Alex Stewart	Chief Executive, Healthwatch Norfolk	Member of Holt 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
Fiona Theadom	Head of Primary Care Commissioning, Norfolk & Waveney ICB	Windmill Surgery			X	Direct	Registered patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
Andy Yacoub	Chief Executive, Healthwatch Suffolk	Nothing to Declare	N/A				N/A	N/A		N/A
Oliver Loveless	Head of Primary Care Strategic Planning (on secondment until end of March 2024)	Cromer Group Practice			X	Indirect	Partner works for the ICB	Oct-22	Ongoing	Withdrawal from any discussions and decision making in which the Practice might have an interest
Mel Benfell	Norfolk & Waveney Local Medical Committee Joint Chief Executive	Norfolk & Waveney Integrated Care Board				X	Close friend is an employee N&W ICB	2015	Mar-24	
		Norfolk & Waveney Integrated Care Board				X	Close relative is an employee of N&W ICB	Dec-22	Mar-24	
		Windmill Surgery			X		Patient at a Norfolk and Waveney GP Practice		Mar-24	To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
Lisa Drewry	Executive Officer, Norfolk & Waveney LMC	Burnham Market			X	Direct	Registered patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
Ian Wilson	Executive Officer with Norfolk & Waveney Local Medical Committee	National Health Service England				Indirect	Father-in-Law is member of national NHSE Sounding Board	Ongoing		
		Norfolk and Waveney Enterprise Services				Indirect	Brother – Senior employee (non-Board member) – Norfolk and Waveney Enterprise Services	Ongoing		
		Drayton & St Faiths Medical Practice			X	Direct	Registered patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
Joni Graham	Executive Officer Norfolk & Waveney Local Medical Council	Orchard Surgery			X	Direct	Registered patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
Naomi Woodhouse	Norfolk & Waveney Local Medical Committee Joint Chief Executive	Long Stratton Medical Practice			X	Direct	Registered patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
Practice Managers drawn from General Practice Attendees										
Sarah Buchan	Practice Manager Speciality Advisor	CEO at Fakenham Medical Practice		X		Direct		2018	Ongoing	Withdrawal from any discussions and decision making in which the Practice might have an interest.
		Member of NN1		X		Direct		2019	Ongoing	Withdrawal from any discussions and decision making in which the PCN might have an interest.
		Patient at Cromer Group Practice		X		Direct	Registered patient at a Norfolk and Waveney GP Practice	2020	Ongoing	Withdrawal from any discussions and decision making in which the Practice might have an interest.
		Chair of NN PM Group		X		Direct		2020	Ongoing	Withdrawal from any discussions and decision making in which the Group might have an interest.

NHS
Norfolk and Waveney
Integrated Care Board

Norfolk and Waveney Primary Care Commissioning Committee

Part One

Minutes of the Meeting held on Tuesday 13 February 2024 via video conferencing & YouTube

Voting Members - Attendees

Name	Initials	Position and Organisation
Debbie Bartlett	DB	Chair, Partner Member – Local Authority (Norfolk) Norfolk and Waveney ICB
James Grainger	JG	Head of Finance Primary Care & Corporate, Norfolk and Waveney ICB (deputising for SC)
Karen Watts	KW	Director of Nursing and Quality, Norfolk and Waveney ICB (Deputising for PD'O)
Hein Van Den Wildenberg	HW	Non Executive Member, Norfolk and Waveney ICB (deputy Chair)

In attendance

Name	Initials	Position and Organisation
Tim Ambler	TA	Blakeney Resident
Duncan Baker	DB	Member of Parliament, North Norfolk
Cllr Bill Borrett	BB	Chair of the ICP and Partner Member of the ICB
Mark Burgis	MB	Executive Director of Patients and Communities, Norfolk & Waveney ICB
Dr Hilary Byrne	HB	ICB Board Partner Member – Providers of Primary Medical Services, Norfolk & Waveney ICB
Lisa Drewry	LD	Executive Officer, Norfolk & Waveney Local Medical Committee
Katie Franklin	KF	Business Manager, Holt Medical Practice
Carl Gosling	CG	Senior Delegated Commissioning Manager – Primary Care, Norfolk and Waveney ICB
Joni Graham	JGr	Executive Officer (Estates, Digital, Pharmacy & Prescribing), Norfolk & Waveney Local Medical Committee
Andrew Hayward	AH	Trustee of Healthwatch Norfolk
Alexandra Hooper	AHo	Chair of Stiffkey Parish Council
William Lee	WL	Senior Primary Care Commissioning Manager – Dental, NHS Norfolk & Waveney ICB
Shepherd Ncube	SN	Associate Director of Delegated Commissioning, Norfolk and Waveney ICB
Sadie Parker	SP	Director of Primary Care, Norfolk and Waveney ICB
James Reeder	JR	Cabinet Member for Children and Young People's Services, Suffolk County Council
Jason Stokes	JS	Secretary Norfolk Local Dental Committee (LDC)
Nigel Sutcliffe	NS	Vice Chair, Blakeney Parish Council
Fiona Theadom	FT	Head of Primary Care Commissioning, Norfolk and Waveney ICB

Rosemary Thew	RT	Chair of Blakeney Parish Council
Sarah Webb	SW	Primary Care Administrator, Minute Taker

Apologies

Name	Initials	Position and Organisation
Andrew Bell	AB	Vice Chairman, Norfolk Local Dental Committee, General Dental Practitioner in Norfolk and Waveney
Mel Benfell	MBe	Joint Chief Executive, Norfolk & Waveney Local Medical Committee
Steven Course	SC	Executive Director of Finance, Norfolk & Waveney ICB
Deborah Daplyn	DD	Chair, Norfolk & Waveney Local Optical Committee Optical Contractor working within ICB boundaries
Tony Dean	TD	Chief Officer, Community Pharmacy Norfolk
Patricia D'Orsi	PD'O	Executive Director of Nursing & Quality, Norfolk & Waveney ICB
Oliver Loveless	OL	Head of Primary Care Strategic Planning, Norfolk and Waveney ICB
Sally Watson	SWa	Community & Engagement Manager, Healthwatch Suffolk

No	Item	Action owner
1.	**Chair's introduction** DB welcomed members to the February 2024 Primary Care Commissioning Committee and introduced herself for the purposes of the members of public attendance at Committee held today.	**Chair**
	Matters Arising There were no matters arising.	
2.	**Apologies for absence**	**Chair**
	Noted above.	
3.	**Declarations of Interest** *For Noting*	**Chair**
	JR confirmed he had stepped down from the Cabinet member role for Children Young People's Services at Suffolk County Council. It had been suggested via discussions held at the Health and Wellbeing Board that JR continued to attend the Committee until another appointee had been made.	
4.	**Review of Minutes and Action Log from the December 2023 Committee** *For Approval*	**Chair**
	The minutes were agreed to be an accurate reflection of the December 2023 Committee and minutes would be sent to the Chair for signing. **ACTION SW to send Chair signed minutes for safekeeping.** **<u>Action Log</u>** 0171 – can be closed 0172 – Consideration of the score and time frame for the dental risk – to be discussed in the Risk Register section – can be closed.	**SW**
5.	**Forward Planner** *For Approval*	**SP**
	SP noted the dental strategy and workforce plan had been listed to be presented at the March meeting but due to the ongoing public engagement work this was likely to be heard at a future Committee.	

	DB thanked SP for the update and the forward planner was approved.	
6.	**Risk Register** *For Approval*	**SP**
	SP confirmed she would present the general practice risk and hand over to FT for the dental one. She noted a number of amendments made in red which included the change of the target delivery date, recognising the ongoing issues and the work to improve the resilience of general practice, along with a number of highlights which reflected work done. SP was pleased to note the ICB had been able to release some funding to general practice over the winter period to support with resilience, although it was recognised it would have been appreciated sooner. There had been some promising growth in workforce numbers and work continued to progress at the interface with secondary care. The Queen Elizabeth Hospital had already launched ICE requesting for pathology and a new working group had been established at the Norfolk & Norwich with the James Paget to progress work. SP handed over to FT. FT confirmed the timeline had been updated for the dental risk and this fitted better with the proposed dental long term plan and timelines associated with this. Work had begun on highlighting individual practices which may be at higher risk, and detailed discussions would take place at the delivery group around these. There was a need to reflect on the long term plan following the publication of the National Dental Recovery Plan last week. DB thanked both SP and FT for the update and the proposed changes to the risk register were approved.	
7.	**Holt Medical Practice – Application to close Blakeney branch surgery** *For Approval* Item format: • Presentation of report • Questions from committee • Questions from the public • Committee discussion and decision	**SP**
	DB outlined her proposition to handle this item and asked for attendees' cooperation with this. DB recognised the interest and views on this application and that it had now come to a point for the Committee to make a decision. • The officers would present the paper. • DB would ask Committee members to ask any questions for clarification. • DB would ask members of the public to ask their questions and seek clarification. • Committee would discuss the paper and reflect on what they had heard and then move to a decision. SP recognised the efforts of the practice, the local community and local stakeholders in the engagement process that had been undertaken.	

	SP then went on to highlight the main issues in some detail from the report for the Committee's attention. HW had a question on Option 3 and the further public involvement by the ICB; he asked who would run that, who would be spoken to and the timeline the ICB envisaged this would take. SP confirmed the Communications and Engagement team would support and SP proposed to hold a conversation in the first instance with the local campaign group, Blakeney Parish Council and other local councils, so that they could advise how best to reach out to local people. **Questions from members of public present** **(Appended to the minutes)** DB thanked members of the public for their questions. DB opened up to Committee members for reflection and views. KW thought it was important to have heard the questions. From her perspective unanswered questions remained and KW agreed with Option 3 to ensure all the details of the public involvement were captured. HW agreed Option 3 would be the right recommendation and would provide the opportunity to review comments and questions received. The environmental aspect would also need to be addressed. SP clarified public questions and answers would be published in due course and these would be publicly available on the website. SP drew on a couple of the points raised. When any application to close a branch surgery was considered, the approach was set out in the Policy Guidance and the entire practice registered patient population would need to be considered, alongside an equality impact assessment and clinical quality risk assessment. This would consider the entire registered population as well as considering the people local to Blakeney as the practice had a contract to deliver services to the entire population. Regarding the issue of commissioner support to the previous decisions made about service levels, there was separate ongoing correspondence with Blakeney Parish Council. Members would also see a proposed advice note, later on the agenda to support further clarification of the process. The ICB would not retrospectively apply a process which was yet to be approved, but it was noted this would be helpful for the ICB and practices in the future. DB agreed it was important to reflect on what had been heard and to consider the impact assessments and DB appreciated this was a difficult decision for everyone involved. DB acknowledged the work that officers had undertaken. DB proposed the voting members approve Option 3, which was to defer the decision today and to undertake further public involvement in line with the recommendation in the paper. Committee approved Option 3.	

8.	**Joint Forward Plan – Primary Care**	**SP**
	In OL's absence, SP presented the paper to Committee for noting and outlined the detail for Committees attention. DB thanked SP for the update. DB reflected upon the national dentistry announcement and asked for a reflection on how this would feed into the plan. SP agreed it was good to see a national plan published and SP felt reassured that the ICB were already working on most, if not all the areas that were put forward for improving access and the recovery of dental services. The national plan would be reviewed in more detail and would feed into our long term plan. FT added there were several initiatives which involved working with local authorities and FT confirmed work was being done with both Norfolk and Suffolk County Council around children's oral health and the ICB would look to include adults. FT confirmed the plan would be brought to Committee once further information had been received. DB confirmed she had listened to a Radio 4 Podcast and this would introduce the nation to units of dental activity. DB confirmed she would send the link. **ACTION: DB to send the link to the Radio 4 Podcast.** JS thanked Chair for the opportunity to speak. JS wanted to congratulate the team on the initiatives to support dentistry. The recent plan did not provide the one fundamental thing the dental profession needed which was a significant change to the contract and it would be very difficult to support all of the practices in the region or to encourage the workforce back into the NHS without that change. BB asked if it was worthwhile the Committee holding an opinion on the dental contract to facilitate change in the centre. DB asked whether it would be beneficial at a future Committee and SP asked if this could be taken offline as the team were focussed on the long term plan and the engagement work and SP suggested that this to be added to the forward planner. **ACTION: SW to add dental contract discussions to the forward planner.** DB confirmed the paper had been noted and thanked members for the useful discussion.	**SW** **SW**
9.	**Advice Note for Branch Surgeries seeking to change their service provision or opening hours** *For Approval*	**FT**
	FT confirmed that she was seeking approval from the Committee for the Advice Note which aimed to provide clearer guidance for general practice who want to apply to change the service provision offered at a branch surgery either on a short/medium term temporary basis or on a permanent basis. FT went on to outline the paper in some detail for Committee's attention. DB asked if this process followed the guidelines set out in NHS regulations.	

	FT confirmed the ICB was trying to offer practices advice on which factors would influence any decisions that might come to us for approval. KW thanked FT and confirmed this was very welcome as a clear process of how to approach this and it offered a clear degree of transparency. KW thought it was important as it would support the ICB demonstrate increased public confidence in decision making and the processes the ICB followed. HB was curious as to how old the statement was from the NHS about branch surgeries who had to operate to the same standards as main surgeries, as it was well known that general practice was changing fast. There were extended roles and additional people who worked in teams and it was perhaps not practical or safe to have people in branch surgeries who do not have the physical capacity to cope, which could result in a discrepancy between what was provided at a branch surgery and a main site. HB referred to the previous comments made earlier in the meeting about considering the whole picture and population and different working arrangements and the need to look at these. FT agreed HB raised good points; it was important to have a clear process for decision making and to consider all of the factors involved. It was recognised that general practice was evolving and developing and with the use of technology and digital it had become a more complex process. KF thought it was helpful to have something set out but was concerned about the imposition of high level of bureaucracy and realistic timescales when there was a difference between main sites and branch sites and there was no guarantee of time scales or what engagement looked like. FT confirmed she would take these comments on board. DB confirmed that his had been presented for approval and approval was confirmed. The advice note would become effective immediately.	
10.	**Operational Delivery Group Report** • **General Practice** • **Dental Services** *For Noting*	**SP/WL**
	SP confirmed she would present the General Practice report. SP was keen to hear feedback from Committee about the information they needed as part of the establishment of these new groups. SP went on to outline a couple of points from the January meeting in more detail for Committees attention. SP then handed over to WL. There had been a slight change to the agenda for responsibility in respect of the dental services report which would be referenced in the minutes. WL introduced himself to Committee and presented the report to Committee for their attention. DB thanked both SP and WL and invited questions or clarifications.	

	MB wanted to say thank you to SP and WL for the reports. MB chaired these meetings and reflected that these had only been in place for a few months and were useful groups. He hoped the Committee found the reports helpful. MB confirmed the groups had gained momentum and the ICB would work with members of the groups to obtain feedback over time. MB went on to thank SP, WL, FT, SN and others that work to support these groups and that there was an opportunity to further explore issues in general practice and dentistry. DB agreed with MB's comments that having the groups enabled the Committee to focus on more strategic issues and the operational groups were to discuss items in more detail to inform work done. The reports were duly noted.	
11.	**Finance Report** *For Noting*	**JG**
	JG presented the month Month 9 Finance Report to Committee for noting. JG ran through the slide pack in some detail for Committee's attention. KW asked how the ICB would evaluate the new dentistry investments made, if benefits were realised and if investment in new services would demonstrate improvement in services. JG confirmed there was an understanding on what had been invested but was unsure of the qualitative benefits of the investment and asked FT if she could update. FT agreed that KW had raised an important point. As an example, FT confirmed the plan was to bring a quarterly report on the Urgent Treatment Service to the Dental Services Delivery Group to address activity and performance. FT confirmed there were approximately 1000 appointments a month with Did Not Attends at around 2 or 3 so this was a positive investment. There would be a need to find a way to monitor and evaluate all investments going forward. HW had a question around Section 10 LCS activity tracker. HW wanted to understand why diabetes was higher and SMI health checks was lower and asked for an update at a future Committee to better understand the variances as HW was concerned that the SMI health checks spend was below budget. JG agreed to bring this back. **ACTION: JG to provide an update on the LCS activity in respect of diabetes and SMI at a future Committee.** There were some historical trends to that activity and this had been seen within LCS. JR asked two questions. One on the underspend in dental services and the ringfencing of dental spending and asked if the ICB had any assurance that whilst the ICB had an underspend that this would benefit the system in the future. The second question was on the eating disorders at 67% of activity which was third lowest. JR asked if this was because of other partner organisations initiatives that were trying to address the problem. JG confirmed the dental activity budget was ringfenced which meant that it	**JG**

	could not be moved anywhere. The ICB were able to reinvest this back within dental services as much as possible and within the resources in the area but this was limited to this financial year. The budget should be reflected next year as it was ringfenced to what the ICB were originally allocated. JG confirmed if there was an underspend at year end it would contribute to the overall ICB financial position as there was no ability to move that into the next financial year. SN confirmed it was good to see the LCS broken down. This was connected to the operational efforts made to strengthen the LCS. SN referenced HW point about an item being brought back and confirmed there had been a great deal of work done on this item. SN would expect more detail to be heard in the General Practice Operational Delivery Group and expected the Committee to receive a summary rather than a report. SN made a comment on the SMI and inclusion health that whilst the numbers in Q1 and Q2 showed low percentages, SN did not expect this to be the position at the end of the year. DB asked for clarification of proactive healthcare services. SP confirmed that this was a service that was offered to practices which used a historical funding pot that was slightly different depending on the locality and which original CCG the practices formed part of. The service specification allowed practices to devise a service that was specific to their population to provide proactive healthcare to prevent the use of urgent and emergency services. There were a different range of services across the patch. It would be evaluated because all practices submitted a baseline when they set out their original plans and the ICB would be able to then review how successful the schemes had been to inform any future commissioning arrangements. JS had a comment on the question JR had around ring fencing. It was clear that there was some misinterpretation of what that meant. There could be a sense that all of this money exists and all of the money would be spent on dentistry. JR came back to the point on the eating disorder as his observation was that other partner organisations may be doing more work in that area and therefore the ICB funding stream was not being used to its full capacity. SP confirmed that each of the services were costed in a different way and for some there was good data. For the SMI health checks there was a clear register of patients and therefore the budget was based on the number of patients that were entitled to that service. For eating disorders thought had been given as to how many patients that service would serve, and it changed from time to time. SP highlighted that reporting had changed because the ICB had moved from an arrangement of block contract funding into something that was activity based. It had taken time to understand some of the data. JG thought there would be a need to reflect once we get to another quarter.	

	SN made an additional point. While the majority of practices had signed up to provide the service, not all practices had the capability to provide for eating disorders and that could be also an element that played into the numbers. DB thought it felt counterintuitive to report publicly or forecast an underspend in an area where there was so much need and there would be a need to communicate on this in order to gain public support. AHo confirmed she would usually send in questions beforehand and asked how the information was shared with the public, as if you did not attend the meeting or view the papers the public would not know what was happening. SP thanked AHo and thought that this was an area where the ICB could do more. The ICB had held a briefing for all of the Norfolk and Waveney Councillors recently to launch the dental engagement process along with briefings for all the Norfolk and Waveney MPs. The ICB use social media, and SP had been on the radio recently, to launch our dental engagement campaign and that there was information on the ICB website. SP was keen to hear where the ICB could do more and suggestions were welcomed. DB agreed that this was a good question and thought that Parish Councils might be an important audience and perhaps the ICB could ask the Districts to engage with District Councillors to become involved. JR confirmed there was a number of initiatives already in place and reminded Committee that Norfolk & Waveney were sometimes ahead of the curve and this was worthwhile noting. AHo agreed it was worthwhile promoting the work done proactively and that the public would know that there was a plan, it would take time to develop and it would be worthwhile distributing information. DB thanked everyone for their comments and the report was duly noted.	
12.	**Any Other Business**	**Chair**
	Questions from the Public There being no further business or questions from the public, the meeting then closed at 15:05	

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

Webb Sarah
07/03/2024 11:43:43

Questions from the public attending Norfolk and Waveney ICB Primary Care Commissioning Committee on 13 February 2024

Item 07 - Holt Medical Practice application to close Blakeney branch surgery
(Please note only the questions are recorded here alongside the answers. All the comments given alongside the questions can be heard verbatim in the recording of the meeting https://www.youtube.com/watch?v=Zrqi8lLO7lg&feature=youtu.be starting at 9 minutes and 10 seconds)

Tim Ambler by email:

I have an uncomfortable feeling that the main reason why HMP seeks to deny Blakeney patients the same service as Melton Constable's is that the HMP partners would trouser considerable sums of money by selling Blakeney surgery?

Answer *– HMP has set out the rationale for its application in its submission to the ICB.*

At the Committee meeting itself:
Tim Ambler - Blakeney Resident
There has been no proper consultation between the practice and the patients ever on this subject.

Answer *– Healthwatch Norfolk has stated they 'consider that HMP have discharged their duty to engage and consult with the constituent patient group that could potentially be affected by the closure of the Blakeney Surgery. Healthwatch have had sight of HMP's report on its engagement exercise and can confirm that it is a fair reflection of the process, content and themes that were followed by HMP and communicated by respondents.'*

The ICB director of primary care was personally copied into many letters to the practice during their engagement period as well as receiving letters directly, and has also had sight of the many items of correspondence, survey results and petitions.

HMP has set out the rationale for its application in its submission to the ICB.

The Committee approved a recommendation for the ICB to undertake public involvement to hear further feedback on the practice's proposal to mitigate the closure by establishing a medicines collection service at an alternative local site.

Alexandra Hooper - Chair of Stiffkey Parish Council
I would like the ICB to explain how the case for closure of Blakeney surgery effectively considers the location specific inequalities in access and outcome the closure will create.

As well as the environmental impact of the need for increased travel and the way in

which this will appropriately dovetail to NHS Net Zero aims compliance with climate legislation and the increased carbon footprint, the increased journeys would result in.

The ICB give assurances that any further consultation and work before a final decision does use location specific data as its basis rather than a broader use of North Norfolk, which is not necessarily an accurate reflection of the situation.

***Answer** – the ICB will consider the application from HMP by reviewing how it can continue to meet the reasonable needs of all its registered patients, noting the practice's registered patients live across a rural and wide geographical area. The ICB will consider the data available to it in doing so, alongside its duties, which include consideration of S.14Z44 – duty to have regard to the need to comply with climate legislation (consideration will be given to the guidance from NHS England), S.14Z35 – duty to reduce inequalities in access and outcomes and S.149 - Equality Act – public sector equality duty.*

Nigel Sutcliffe – Vice Chair of Blakeney Parish Council
If this group do not act on the wishes of patients as demonstrated in the report before you today, then who does look after the interests of the minority of patients within Holt Medical Practice overall patient base to ensure they receive access to NHS services locally as identified in national guidance.

***Answer** – the temporary decision to stop face to face appointments in Blakeney was supported by the ICB as commissioner and is set out in the report.*

When considering an application for branch surgery closure, the ICB must consider a number of factors as set out in clauses 8.15.13 and 8.15.14 of the NHS England Policy Guidance Manual (these are also referenced in the report to the committee):

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

- *any other relevant duties under Part 2 of the NHS Act (for further detail see chapter 4 (General duties of NHS England).*

The committee has approved a recommendation to defer the decision in order to undertake further public involvement to understand patient views on the practice proposal to provide a residual medication collection service in Blakeney to inform the decision.

Rosemary Thew - Chair of Blakeney Parish Council
The report is disingenuous in parts, for example, saying that the surgery reduced before the pandemic in response to patient demand and a question, could you explain please how patient demand was assessed?

The report shows the average age, of North Norfolk to be 50.1 years, but is the practice aware that lately has a much higher population of people over 65 than Norfolk generally? How has that been factored in and what account has been taken of the fact that about 1/3rd of the population of Blakeney may live alone, suggesting limited support network for transport to a remote surgery?

Will the practice please explain how patients are expected to get to Holt or even worse, to Melton Constable given the length of the journey by public transport, and that despite trying to recruit, there is still a shortage of voluntary drivers in Blakeney?

***Answer** – the practice included in their submission how patient demand had been assessed (this can be found on pages 4 and 5).*

The ICB will consider the application from HMP by reviewing how it can continue to meet the reasonable needs of its registered patients, noting the practice's registered patients live across a rural and wide geographical area. The ICB will consider the data available to it in doing so, alongside its duties.

Dr Cllr Victoria Holliday - NNDC Cllr for Coastal Ward
A significant change in service provision were removed from Blakeney before COVID. We are told that this was with the support of the Commissioner, given that we had previously been informed that governance processes were not followed at that time. Is it possible to see the evidence of the Commissioner support for this change in service provision?

Agenda item 9 today is an advice note for branch surgeries seeking to change their service provision or opening hours. I understand the lengthy consultation process with patients and stakeholders both by the practice and the ICB is then required. This consultation did not happen at the time hours and service were reduced at Blakeney surgery. Why isn't the current advice to branch surgeries being followed and a full consultation on the withdrawal of clinical services from Blakeney surgery rather than just on medication provision now being carried out?

***Answer** –The ICB has received correspondence on this from the Blakeney Parish Council Clerk and is responding to it directly. To clarify, the temporary decision to cease face-to-face appointments was taken with the support of the commissioner.*

The committee approved the current advice note at its meeting on 13 February 2024. It was therefore not in place at the time of the previous changes, and so it would not be appropriate to retrospectively apply the advice note before it had been approved. The committee agreed an effective date of 13 February 2024.

Duncan Baker - MP for North Norfolk
Is this the right decision to close vital medical services in a very, very elderly and rural community? And I think you all know the answer to that and therefore put the right mitigation in place if you're going to end up with a decision, I think I know that you're going to have.

***Answer** – Holt Medical Practice has set out its workforce and business viability challenges in its application.*

The application included appendices detailing the patient engagement information, including the Survey Report from the Office of Duncan Baker.

The ICB will consider the application from HMP by reviewing how it can continue to provide general medical services to meet the reasonable needs of all its registered patients, noting the practice's registered patients live across a rural and wide geographical area. The ICB will consider the data available to it in doing so, alongside its duties.

The committee approved a recommendation to defer the decision in order to undertake further public involvement to understand patient views on the practice proposal to provide a residual medication collection service in Blakeney, to inform the decision.

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
12 March 2024

No	Meeting date added	Agenda Item	Owner	Action Required	Action Undertaken / Progress	Due date	Status	Date Closed
0173	13-Feb-24	4	SW	Agree minutes, sign and send to Chair for safekeeping		12-Mar-24		14-Feb-24
0174	13-Feb-24	8	SW	Joint Forward Plan - primary care - Radio 4 PodcastThe Briefing Room – the crisis in dentistry.	DB shared link with SW who circulated to Committee	12-Mar-24		14-Feb-24
0175	13-Feb-24	8	SW	Joint Forward Plan - primary care - dental contract discussions to be added to the forward planner for the April EPCCC	SW had updated the new 2024-2025 Forward planner	12-Mar-24		14-Feb-24
0176	13-Feb-24	11	JG	Finance report - JG to provide an update on the LCS activity in respect of diabetes and SMI at a future Committee		11-Jun-24		

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

		April	May	June	July	August	September	October	December	February	March	Notes
	Proposed date:	21st	9th	12th	11th	8th	12th	11th	12th	13th	12th	
Standing items:	Risk Register		Y		Y		Y		Y	Y	Y	Nov & Jan updates moved to Dec and Feb respectively. Now BAF risks and summary brought to committee
	Monthly Finance Report	Y	Y	-	Y	Y	Y	Y	Y	Y	Y	
	Estates Quarterly		Y	Y			Y				Y	To move to 6-monthly, with operational detail discussed at GP ODG
	Digital Quarterly			Y			Y				Y	To move to 6-monthly, with operational detail discussed at GP ODG
	Prescribing Report	Y	Y	Y	Y	Y	Y		Y		Y	To move to quarterly strategic report with operational detail discussed a GP ODG
	CQC Inspections Report	Y	Y	Y	Y	Y	Y				Y	Individual inspections to move to GP ODG, and reported through their report. Six-monthly update on system picture to PCCC Will include dental report
	Primary Care Performance Report	TBC										Business intelligence work underway. Separate dental dashboard to be developed by end of March. A dental dashboard is also being developed by March 2024
	General Practice Delivery Group Report					Y	Y	Y	Y	Y	Y	
	Dental Delivery Group Report						Y	Y	Y	Y	Y	
	Primary Care Strategic Plan										Y	This item may be delayed due to vacancy controls affecting capacity
	Joint Forward Plan							Y		Y		
	Strategic Workforce Plan	TBC							TBC		Y	To move to next forward planner
	Report on annual changes to primary care contracts and impact analysis										Y	Taken off
	Optometry services – contractual changes and other matters	TBC					Y		Y		Y	Brought as and when required. Quarterly report from hosted team
	Reports from the Pharmaceutical Services Regulations Committee	TBC					Y		Y		Y	Brought as and when required. Quarterly report from hosted team - next report June 24
	Primary Care Resilience (strategic report)						Y				Y	This is heard in part 2
	Dental End of Year report							Y				April DODG
Spotlight Items	Terms of Reference Review							Y			Y	Annually
	Healthcheck Stocktake report					Y						Moved to GPODG
	Dental Strategy and Workforce Plan										Y	Will be heard at an EPCCC in April 2024*
	Oral Health Needs Assessment			Y					Y			
	Place development and interface with PCCC						Y		Y	Y		Postponed to post organisational change
	Delivery Plan for Recovering Access to Primary Care							Y		Y		Postponed and will be circulated offline before going to Board in March
	Complaints and contacts (JP)				Y				Y			Nov update moved to Dec mtg,
Items noted without a date:												

*tbc

Please note this is subject to change once the delivery groups are established and once pharmacy, optometry and dental commissioning has been transferred
As part of the transition, to stand down Nov and January PCCC meetings

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

Norfolk and Waveney
Integrated Care Board

Item	23 April 2024	11 June 2024	13 September 2024	10 December 2024	11 March 2025	Lead officer	Notes
BAF Risks		Y	Y	Y	Y	SP/FT	
Strategic Finance Report		Y	Y	Y	Y	JG	
Strategic Estates Report			Y		Y	PH	
Strategic Digital Report			Y		Y	AH	
Strategic Prescribing Report		Y	Y	Y	Y	MD	
Strategic CQC Inspections Report		Y		Y		CG	
General Practice & Community Pharmacy Delivery Group Report		Y	Y	Y	Y	SN/SG	
Dental Delivery Group Report		Y	Y	Y	Y	WL	
Primary Care Network Direct Enhanced Services						SN	TBC
Delivery Plan for Recovering Access to Primary Care			Y		Y	OL/SN	
Complaints and Contacts		Y		Y		JP	
Primary Care Resilience (Strategic Report)						SN/OL/FT/SG	TBC
Terms of Reference Review					Y	FT	
Primary Care Workforce Recruitment and Retention Programme		Y			Y	JRo	
Optometry Services – contractual changes and other matters		Y			Y	SG	
Pharmaceutical Needs Assessment		Y				SG	
Reports from the Pharmaceutical Services Regulations Committee		Y	Y	Y	Y	SG	

SEE BELOW

Proposed item (no date assigned)	Lead officer	Notes
Deep Dive Ophthalmology	SG	
Dental year end report	FT	
Integrated working with VCSE	TBC	

2023 - 2024

Ref	Risk description	Month risk rating											
		1	2	3	4	5	6	7	8	9	10	11	12
PC1	General Practice – Workforce (GPs and nurses)	12	12	12	12	12	12	12	12	12	12		
PC6	Learning Disability Annual Physical Health Checks	12	9	9	9	9	9	9	9	9	9		
PC9	Hypnotics and anxiolytics prescribing	12	12	12	12	12	12	12	12	12	12		
PC 14 BAF16	The resilience of general practice	16	16	16	16	16	16	16	16	16	16	16	16
PC15	Wave 4B Primary Care Hubs – loss of capital funding	8	8	8	8	6	6	6	6	6	6		
PC16	Severe Mental Illness (SMI) Annual Physical Health Checks	12	12	12	12	12	12	12	12	12	12		
PC17	General Practice – Allied Health Professionals Workforce including PCN Additional Roles	12	12	12	12	12	12	12	12	12	12		
PC18 BAF18	Dental Services Resilience	12	12	20	20	20	20	20	20	20	20	20	20

Commentary

Risks PC1, PC6, PC9, PC15, PC16, PC17 will be presented to March General Practice Operational Delivery Group.
Risks PC1, PC6, PC9, PC15, PC16, PC17 were presented to January General Practice Operational Delivery Group.

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

PC14 (BAF16)

Risk Title	**The resilience of general practice**
Risk Description	There is a risk to the resilience of general practice due to several factors including workforce pressures and increasing workload (including workload associated with secondary care interface issues). There is also evidence of increasing poor behaviour from patients towards practice staff. 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	31/03/2026

Risk Scores

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

Controls

- Locality teams and strategic primary care teams prioritised around supporting the resilience of general practice. All practices have previously been supported to review business continuity plans
- PCN ARRS (additional roles reimbursement scheme) funding has increased again in 2023/24
- Primary care workforce and training team working closely with locality teams to ensure training available to support practices and PCNs in setting up and maintaining services
- 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
- Commencement of LMC General Practice Alert System sitreps

Assurances on controls

Internal: Executive Management Team, workforce steering group, primary care strategic planning meetings, establishment of new medical operational delivery group

External: Primary Care Commissioning Committee, NHS England via delegation agreement and assurance framework, 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
- Vacancies within primary care, workforce, quality, and locality teams impacts the level of support which can be provided to practices. Organisational change is impacting on support available due to vacancy controls.
- Continued reports of poor patient behaviour across practices, decrease in patient satisfaction with general practice through GP patient survey, consistent with national position.
- Progress on interface action planning process across Trusts impacted by ongoing pressures and national strike action.
- Reporting process for inappropriate transfers of workload from community and secondary care providers to general practice not yet fully utilised by practices, leading to under-reporting of issues.
- Workforce and capacity shortages across community pharmacy and dental practices, and ongoing drug shortages, are having an impact on general practice and the rest of the system.
- Pressure on primary care budgets due to the ICB's financial position impacting on our ability to support resilience and transformation in general practice

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion

Nov 2023	• 2 GP Practices have contacted the ICB stating that they are facing resilience issues, including workforce challenges, and are at risk. These practices have been contacted and supported by the ICB to ensure that patient services can continue to be provided. • Further GP Practice resilience issues have been identified through the LD Health Check programme and the completion of the annual practice E-Dec Declaration statement. • 62 Applications have been received from GP Practices applying for the £340k winter monies identified in November. Further funding may potentially be identified and released in the New Year • The CQC have advised they will be implementing their Transformational inspection programme from the 9th January 2024. • System primary care access and improvement plan has been received by ICB Board. Work continues on our interface processes. The ICB is linking with another ICB in England to learn from them and continually improve our processes. • A vacancy in the primary care team has been recruited to on a 3-month secondment, however, there remains concerns about capacity in the team. There is also no dedicated support for the interface programme in the ICB structure. It is expected these matters can be rectified once the ICB's organisational change process has completed. • In October 2023, a 12 month "Work Well Webinar Programme" launched which is based on the themes identified in the June 2023 Health and Wellbeing Survey. These include Burnout, Stress and Harassment) in the survey to support Health and Wellbeing for primary care. • Recruitment is pending for a Primary Care Health and Wellbeing Fellowship, which will help drive this agenda forward. • Primary Care Workforce (PC1 and PC17) has shown an 2% growth in general practice workforce across the system during 23/24. In addition, Primary Care Network Additional Roles Reimbursement Scheme has shown a 42% growth in workforce across the system during 23/24.		31.03.24
Jan 2024	• £750k further winter funding for general practice was released in January, along with a further investment of £750k in ARI (acute respiratory infection) hubs. This funding remains available for investment during quarter 4. • A significant number of practices have reported challenges with the annual health checks requirement for people with a learning disability and have requested additional support. Appropriate support has been agreed with respective practices. • The LMC has launched their General Practice Alert System, designed to monitor the resilience of general practice in a similar way to the Opel system. Anonymous sitreps are being provided to the primary care team. • Work remains underway to improve the issues caused at the interface between primary and secondary care. A new reporting form is proposed for implementation to automate the process and reduce administrative burden for all providers, LMC and the ICB. QEH has launched ICE requesting for pathology and radiology and a working group has been set up at the NNUH to seek to progress the project there, including colleagues from JPUH. A plan will be developed for 2024/25 and		31.03.24

	agreed through the interface group. The additional Interface task and finish groups continue and are reported against monthly in terms of progress. The primary care and locality teams continue to work with individual practices at resilience risk to support them to stabilise.		
February 2024	• Good progress has been made with the practice visiting programme and, the first practice visit to Magdalene in Norwich was successfully completed in January 2024. Plans are underway for the next visit, which will take place in West Norfolk and dates are currently being discussed. There were no resilience concerns identified or reported at Magdalene practice during the visit. The practice benefits from stable partnership arrangements, stable workforce, and experienced practice manager. • An additional £357k resilience funding has been made available to practices. As a result, practices have submitted request for extra clinics including but not limited to enhancing support for learning disability annual health checks and asthma clinics. • Despite the changes in contractual arrangements in Norwich recently, the ICB continues to work with the new medical service provider to ensure continuity of service provision for patients. A proposal to change the current network arrangements has been received from Norwich practices, the ICB is working closely with PCN leadership to understand the proposal and the risk associated with the changes. • In February 38 practices requested and received Transition Cover Funding totalling £305,089 spread across the practices. Transition Cover Funding is available to support practices in moving into delivering via the Modern General Practice Access Model and N&W ICB are encouraging all practices to access this support. • The other 67 practices have been individually contacted with information on how to access the funding and how much is available to them. Practices must request this funding by the 11th of March to allow for payment before the end of March. • N&W ICB had 8 practices sign up to the final cohort of the GP Intermediate Support Programme run nationally – bringing our total practices who have engaged in the current phase of the GP improvement programme to 23 to date. • LD HC support to practices to improve the uptake and the quality of the annual LD HC continues with specific support with complex cases. • The GP contract letter was published on 28 February which is detailed on the March agenda. The financial settlement will be challenging for practices and we may well see further resilience issues as a result.		31.3.24

Visual Risk Score Tracker – 2023/24												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	16	16	16	16	16	16	16	16	16	16	16	16
Change	→	→	→	→	→	→	→	→	→	→	→	→

PC18 (BAF18)

Risk Title	Resilience of NHS General Dental Services in Norfolk and Waveney			
Risk Description	Primary Care Services became the responsibility of the Integrated Care Board from 1st April 2023, the risk is the unknown resilience, stability and quality of dental services, and critical challenges relating to the recruitment and retention of dentists and dental care professionals and the limitations of the national dental contract, leading to a poor patient experience for our local population with a lack of access to NHS general dental services and Level 2 dental services.			
Risk Owner	**Responsible Committee**	**Operational Lead**	**Date Risk Identified**	**Target Delivery Date**
Mark Burgis	Primary Care	Sadie Parker	01/04/2023	31/03/2026

Risk Scores

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

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

Gaps in controls or assurances

- The level of the unmet need for general dental services and the associated financial consequence of this once addressed (if possible) given the transfer for funds was based on 2022-23 current expenditure which are below budget required to meet population need

- Concern around the financial consequences due to dental contracts currently being returned or removed from providers, resulting in temporary and more expensive contracts with reduced activity and higher UDA (Unit of Dental Activity).
- Lack of access to NHS dentistry services is an area of quality concern. This impacts on some of our most vulnerable patient groups.
- Significant workforce shortfalls across general dental services, Level 2 services and secondary care dental services and a lack of comprehensive workforce data to support planning
- Lack of knowledge about the resilience and stability of existing dental services

Updates on actions and progress

Date opened	Action / Update	BRAG	Target completion
Sept 2023	The ICB has approved an Urgent Treatment Service pilot that is being mobilised and will be live during September for patients with an urgent dental need to receive urgent care. Nearly 30% of practices across Norfolk and Waveney have signed up to offer urgent treatment appointments. The pilot will be in place for 12 months with an option to extend for a further 6 months. A short-term initiative for 2023/2024 to support children's oral health education has also been agreed and providers have been invited to submit expressions of interest to the ICB. Other initiatives are under development as part of the ICB's short term plan. The Dental Development Group has supported the ICB's short term plan which will be published in September subject to final ICB approval by Primary Care Commissioning Committee and Executive Management Team. This includes identifying areas for access improvement in areas of greatest need using the Oral Health Needs Assessment as an evidence base to inform commissioning intentions, support to practices for quality improvement and workforce plans. Development of the ICB's long term dental plan is underway and subject to approval will be published in March 2024. All opportunities are being taken to actively engage with the dental profession which will help inform these plans in addition to a wider stakeholder engagement. Meetings of the ICB Dental Services Operational Delivery Group are taking place enabling the ICB and key stakeholders to take a deep dive when making decisions about important and urgent matters related to NHS dental services within the Scheme of Delegation of the Primary Care Commissioning Committee. The year end process for activity in 2022/2023 is underway which has identified a high level of underperformance largely due to difficulties in recruitment. The ICB is working with all providers to manage the financial impact of clawback. A lack of access to NHS dental services also has an impact on patient charge revenue		31/03/24
Dec 2023	The Mid Year Review of contracts achieving less than 30% by Sept has been completed by the ICB with NHS BSA to support. A number of practices at risk of achieving their activity by end of year have been contacted by the ICB to discuss how they can be supported. The key reason relates to recruitment challenges.		31/03/24

	The ICB has agreed a targeted reinvestment of monies freed up from contract terminations during 2023 to improve access and providers will be invited to bid for additional funding during Q4 2023/2024. Launch of Dental Workforce Retention Programmes and CPD training packages to support the upskilling and recruitment of the dental workforce supply. These are linked to the short-term dental workforce plans approved by the Primary Care Commissioning Committee in October 2023. To date the success of these incentives has increased N&W dental workforce by the following: • 3 x NHS Foundation Dentists - 2-year employment contract, once qualified. • 7 x NHS Dental Professionals – 1 year employment signed contracts • 3 x NHS Dental Professional - 1 year employment contract offered, awaiting signature. • 3 x NHS Dental Practices being supported with International Tier 2 Visa Sponsorship • 2x NHS Clinical Dental Fellowships in place to support with Children and Young People and Health Inequalities programmes The ICB has agreed in principle to supporting a review of UDA values. Practices with UDA values less than the current ICB average of £30 will be contacted individually during Q4 to agree their new contracts. The aim is to support recruitment and enable local providers to be more competitive in offers to dental performers.		
Feb 2024	A small number of practices have been identified as being at higher risk of instability due to historical decisions about commissioning. Potential support is being discussed with them. A risk register relating to dental matters is being developed for Dental Services Delivery Group. A four week engagement about the ICB's proposed Dental Long Term Plan proposals for next 2 years and beyond with members of the public and key stakeholders across Norfolk and Waveney, including the dental profession, was launched on 24 January 2024. Feedback will help inform ICB's plans due to be published Spring 2024.		31/3/2024
March 2024 Webb Sarah 07/03/2024 11:43:43	ICB Engagement survey closed 21 February 2024 with over 2000 responses to be analysed for the Long Term Dental Plan to be finalised for approval. NHS England Dental Recovery Plan 2024/2025 published 7 February 2024 (Faster, simpler and fairer: our plan to recover and reform NHS dentistry - GOV.UK (www.gov.uk)) and the ICB is working to mobilise the individual elements of the Plan as details are released and adapt ICB plans accordingly: • New patient premium to encourage dentists to see individuals who've not seen a dentist for more than two years, effective from 1 March 2024		30/04/2024

	• UDA uplift to £28 minimum. This is superceded by the ICB's agreed plan to uplift to £30 minimum UDA rate from 1 April 2024 • Mobilisation of a mobile dental van to improve access and oral health prevention schemes. • Golden Hello to retain dentists working in NHS services for 3 years. This is addition to the ICB initiative. 14 dentists have benefited from the ICB's workforce schemes to date. An early review of the Urgent Treatment Services pilot is underway to see if any learning can be applied to improve services going forward. The total patient appointments offered since November 2023 is 5339, and only 8 Did Not Attends. The average number of appointments offered per month to date is 1779.		

Visual Risk Score Tracker – 2023/24												
Month	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Score	16	16	20	20	20	20	20	20	20	20	20	20
Change	→	→	↑	→	→	→	→	→	→	→	→	→

Norfolk and Waveney
Integrated Care Board

Agenda item: 07

Subject:	**Workforce and Training Update**
Presented by:	**Jayde Robinson, Head of Primary Care Workforce Transformation**
Prepared by:	**Keri Robinson, PC Workforce Manager - Planning and Governance**
Submitted to:	**Primary Care Commissioning Committee**
Date:	**12 March 2024**

Purpose of paper:

To provide the Primary Care Commissioning Committee members with an assurance update on Primary Care Workforce Team Delivery against our objectives shared at the PCCC 12/10/23.

Executive Summary:

This paper provides an update on all workforce and education workstreams (Appendix A). This paper also provides an update on the activity undertaken towards external bidding applications that were presented as still awaiting outcome in our previous paper.

Primary Care workforce Update

The below screenshot shows the General Practice Workforce in Norfolk and Waveney as at 31/01/2024 (Data from NHS England). This shows an 2.36% increase in the number of GPs from January last year of which there were 509 GPs.

GP (excl GPs in Training Gr..	GPs in Training Grade	Nurses	Direct Patient Care	Admin	Grand Total
521	140	447	638	1,734	3,481

Norfolk and Waveney (N&W) area is now second in the country for lowest numbers of under 40s GPs leaving the profession, and fourth in the country for lowest numbers of all GPs leaving the profession. The below tables 1 and 2 show this position. This highlights the impact of the work of the Primary Care Workforce team to support the recruitment and Retention of GPs in N&W.

	Under 40s ONLY GP Leavers - including moving out of ICB (permanent GP WTE) - % leaving in the 12 months to...					
ICBs	01/12/2022	01/03/2023	01/06/2023	01/09/2023	01/12/2023	Change Dec to Dec (percentage points)
NHS North Central London ICB	20%	20%	19%	15%	11%	-9.7%
NHS Norfolk and Waveney ICB	15%	15%	14%	11%	8%	-7.0%
NHS Sussex ICB	12%	12%	11%	9%	7%	-5.3%
NHS West Yorkshire ICB	13%	13%	14%	11%	8%	-4.6%
NHS Derby and Derbyshire ICB	12%	11%	11%	10%	8%	-4.3%
NHS Humber and North Yorkshire ICB	10%	11%	10%	8%	6%	-4.2%
NHS North East London ICB	17%	15%	14%	14%	13%	-3.7%
NHS Cheshire and Merseyside ICB	12%	12%	11%	9%	9%	-3.1%
NHS Surrey Heartlands ICB	12%	9%	10%	11%	9%	-2.4%
NHS Bedfordshire, Luton and Milton Keynes ICE	10%	9%	10%	9%	8%	-2.4%
NHS North East and North Cumbria ICB	9%	10%	9%	9%	7%	-2.0%
NHS North West London ICB	16%	16%	17%	16%	14%	-1.9%
NHS South Yorkshire ICB	13%	14%	12%	11%	12%	-1.9%
NHS South West London ICB	12%	12%	12%	11%	11%	-1.8%
NHS Black Country ICB	13%	13%	12%	13%	11%	-1.8%

Table 1 shows the percentage of GPs under the age of 40 leaving the profession for the top 15 ICBs between Dec 2022- Dec 2023.

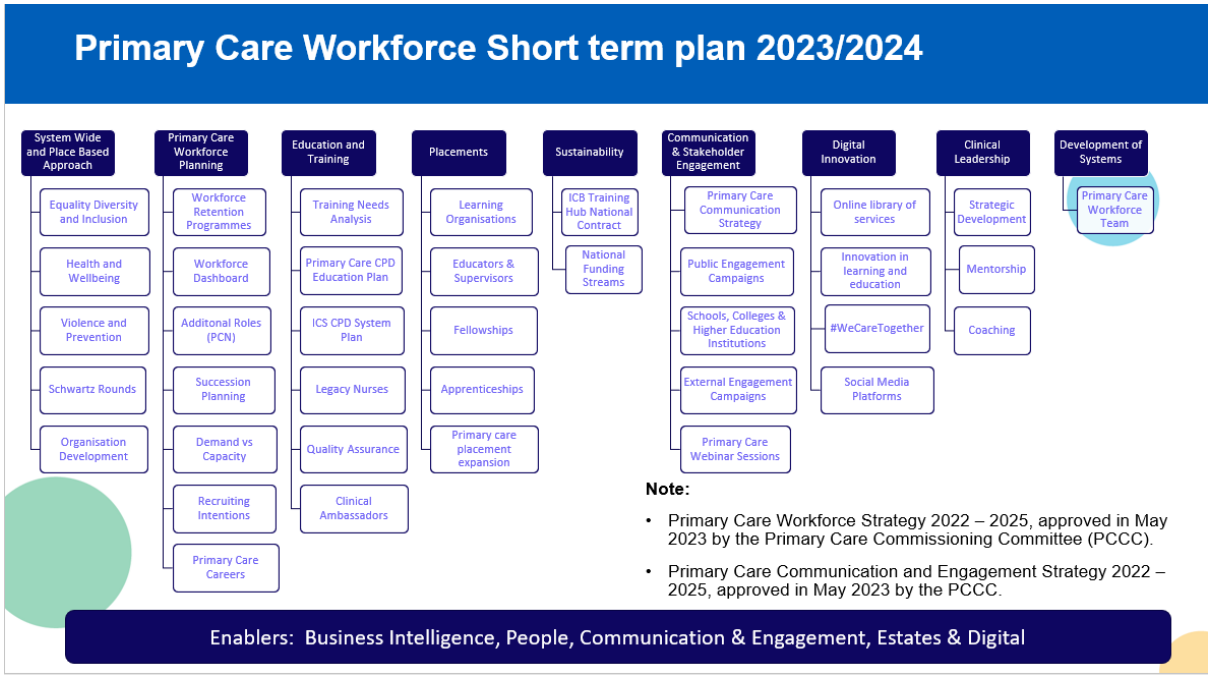
	GP leavers - including moving out of ICB (permanent GP WTE) -% leaving in the 12 months to...					
	01/12/2022	01/03/2023	01/06/2023	01/09/2023	01/12/2023	Change Dec to Dec (percentage points)
NHS North Central London ICB	12.6%	12.9%	11.8%	8.7%	7.6%	-5.0%
NHS Derby and Derbyshire ICB	13.2%	13.5%	12.5%	11.1%	9.4%	-3.8%
NHS Staffordshire and Stoke-on-Trent ICB	11.7%	12.0%	11.8%	9.6%	8.1%	-3.6%
NHS Norfolk and Waveney ICB	10.0%	10.0%	9.9%	7.9%	6.3%	-3.6%
NHS West Yorkshire ICB	10.5%	10.5%	11.1%	8.2%	6.9%	-3.5%
NHS South Yorkshire ICB	10.2%	8.9%	8.5%	7.6%	7.1%	-3.0%
NHS Dorset ICB	14.0%	13.3%	12.9%	10.7%	11.3%	-2.8%
NHS Cheshire and Merseyside ICB	9.5%	8.6%	8.7%	7.5%	6.9%	-2.6%
NHS North East London ICB	10.5%	9.9%	9.6%	9.1%	8.2%	-2.4%
NHS North East and North Cumbria ICB	9.1%	9.3%	8.6%	8.2%	7.0%	-2.2%
NHS Somerset ICB	10.6%	11.9%	12.0%	11.2%	8.5%	-2.2%
NHS Kent and Medway ICB	9.9%	8.2%	7.1%	7.7%	7.9%	-2.0%
NHS Northamptonshire ICB	9.5%	9.7%	8.7%	8.7%	7.9%	-1.6%
NHS Bath and North East Somerset, Swindon and	8.8%	9.1%	9.2%	7.8%	7.2%	-1.6%
NHS Sussex ICB	10.3%	10.3%	9.5%	8.5%	8.8%	-1.5%

Table 2 shows the change in percentage of GPs leaving the profession for the top 15 ICBs between Dec 2022- Dec 2023.

Primary Care Workforce Short Term Plan and Targets update

In May 2023, the Primary Care Commissioning Committee approved the Primary Care Workforce Strategy and Communication and Engagement Strategy for 2022 - 2025.

The graphic below outlines the short-term programmes of work to stabilise primary care services in line with our ICS Joint Forward Plan, whilst delivering the objectives and aims of the contract specification and operational guidance set for 2023/24. This programme of work now includes the four sectors of primary care (General Practice, Dental, Community Pharmacy and Optometry).



As outlined in our October 23 Paper, and approved by PCCC, each of the primary care short term plans pillar targets were linked to nationally set targets in relation to the delivery plan for recovering access to primary care, NHS long term workforce plan and the ICS Level Primary Care Training Hubs contract. These programmes were scoped within the financial envelope set nationally and bidding applications submitted. **Appendix A** sets out the Delivery status against each of the Short-Term Pillar Targets.

Below is an executive summary on the 45 programmes outlined in **Appendix A**, that have been delivered at the time of writing this report:

Number of Programmes	Status	Comments
8	Above Target	
19	Met Target	
17	<1 Target not fully met	Working is ongoing to meet the remaining targets by year end. These domain areas include Clinical Leadership, Workforce Planning, Education and Training, System Wide and Place Based Approach and Placements.
1	Not Delivered	No uptake by primary care staff to take part in the Higher Development Award

External Funding Bids

The below section updates on funding bids that were identified in our last paper as awaiting outcome.

1. **Community Employability Grant - UK Shared Prosperity Fund (UKSPF)**
   - Broadland and South Norfolk County Council have identified that they will

have access to funding in 2024/25 to support Skills and Training across the two districts. This is a single year offer and no further funding will be available. Applications formally opened in February 2024 and we have submitted the following and we anticipate a decision by April 2024.

a. **Non-Clinical Training**
    i. **£47,961.50** bid to upskill and retain non-clinical staff working in 35 x general practices that fall under these areas. We have proposed to utilise this funding, if successful, on 26 training courses which would provide education for up to 878 staff.

b. **Non-Clinical Apprenticeships**
    i. Two expression of interest forms were submitted for bids to fund the apprenticeship Co-Investment fee and provide a recruitment incentive to Practices for funding towards non-clinical apprentices' wages for the initial 6 months of apprenticeship. The bid submitted for both areas would support 20 apprenticeships totalling **£23,500**. We have

c. **Pharmacy Training**
    i. **Accuracy Checking for Dispensers** – **£2700** bid for this course to support the implementation of 10x Pharmacy accuracy checkers in Norfolk and Waveney area to obtain a certificate which will demonstrate achievement of competence to GPhC accredited standards for accuracy checking.

    ii. **Level 2 RSPH Award in understanding health improvement** – **£820** bid to provide the above course for 10 Pharmacists to support them by enabling them to have a better understanding of health improvement strategies, enabling them to provide more informative guidance and support to patients to sustain a healthier lifestyle which in turn will decrease pharmacy attendances.

    iii. **Support Staff Course for Dispensing Assistants (NVQ Level 2)** - **£1,944** bid for 10x Applications. The Support Staff Course for Dispensing Assistants offers in-depth knowledge in person-centred care, teamwork, health & safety, assembly, and supply of medicines and working with pharmaceutical stock across the community and hospital pharmacies and dispensing practice.

d. **Ophthalmology Training**
    i. **Insight Level 2 training** - **£11,000** bid for 5 applicants - The Level 2 course leads to a NCFE-endorsed qualification in optics. Upon completion, individuals will possess essential skills that are applicable to their current roles, enabling them to excel in their professional endeavours.

    ii. **Optical Assistant Course** - **£4,875** bid for 5 Applications. This course is designed for support staff in optics, providing

foundational knowledge and skills to assist professionals and customers.

The application deadline is Friday 8 March 2024, and the projects will then be reviewed by an independent appraiser and a judging panel, and a decision made on whether the funding will be allocated. Awarded funding will be able to use from 1 April 2024, and must be fully spent by March 2025.

2. **ENHANCE Generalist Pilot** - The goal of enhance is to address the educational requirements that can support sustainable workforce planning and delivery of integrated person-centred care whilst safeguarding staff wellbeing and self-directed professional development. It is a flexible place-based offer to support systems in tackling local health priorities. We have successfully won a bid for £100,000 to deliver the programme in Rural & Coastal locations through Norfolk & Waveney during 24/25.

3. **Diabetes Awareness & Foot Screening HCA Training** - £16,000 bid to upskill Healthcare Support Workers and Trainee Nursing Associates, working within general practice across Norfolk and Waveney. This would enable us to train up to 60 staff. We anticipate a decision by the Diabetes Norfolk board in April 2024.

Recommendation to the Board:

To note the Primary Care Workforce assurance update on the workforce and educational delivery plans up to the 31st March 2024 (Appendix A).

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):	Work is ongoing to support workforce programmes across our system to support the reduction of health inequalities
Reputation:	Delivery of Primary Care Workforce function ensures successful achievement of HEE and NHSEI objectives and development of primary care workforce
Legal:	Supports delivery of our requirements under our contract with NHSE
Information Governance:	None
Resource Required:	Workforce team
Reference document(s):	Various NHSE guidance documents
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.

Targets MASTER Spreadsheet

Target: Targets in projects are a set of fixed goals or objectives that determine how a given project is expected to be done and what result or effect is supposed to be produced by the project. Targets may refer to a subset of the files and preferences that build a product, such as a library, executable, or framework. Targets are also related to result indicators and milestones, which help to measure and chart the progress of the project.

Target Met RAG - Green: Delivered, **Amber:** 1 target not fully delivered, **Red:** Not Delivered

Primary Care Workforce Short Term Plan Pillars	Programme Name	KPI's - These are the contractual KPI's as set out by NHSE - See KPI tab for a list	Aims - What are the aims of your project, these can be specific or wider, you might have one overall aim and then individual aims for parts of the project	NHSE/ Pre-set Targets Please list all targets set out in relation to NHSE requirements, the delivery plan for recovering access to primary care, long term forward plan etc.	PCW Targets These are the locally set targets, they should SMART targets closely linked to the aims of the project.	Delivery Outcome	Met, Above, below Target
Primary Care Workforce Planning	ST3 Incentive	Number of newly qualified health professionals who are supported to take up a primary care role.	The aim of the ST3 Incentive is to retain GP trainees within Norfolk and Waveney General Practice, to help aid practices with recruitment of newly qualified salaried GPs and alleviate existing pressures as well as providing incentives for newly qualifies to seek employment within Norfolk and Waveney.	Reform 1. Grow the number & proportion of NHS staff working in primary to enable more preventative & proactive care increase these roles by 73% by '36/'37	1. 25 ST3 newly qualified GP's signed within Norfolk & Waveney by 31st March 2024. 2. Increase of GP salaried WTE actual figures reported within NWRS, for Norfolk & Waveney ICB, by 31st March 2024.	**Delivered** - A total of 25 newly qualified GPs supported within this incentive with a further 4 pending awaiting invoicing.	**Above**
Primary Care Workforce Planning	GP Partnership Model Pilot	Number of newly qualified health professionals who are supported to take up a primary care role.	The aim of the GP partnership model is to help practices to recruit new or returning GP partners within Norfolk and Waveney General Practice and to alleviate existing recruitment pressures as well as providing incentives for GPs to consider partnerships within Norfolk and Waveney.	Retain By better supporting staff throughout their careers, helping them stay in work through flexible working, and improving culture & leadership, we will:" Reform 1. Grow the number & proportion of NHS staff working in primary to enable more preventative & proactive care increase these roles by 73% by '36/'37	1. 10 New /Returning GP Partners signed in Norfolk & Waveney by 31st March 2024. 2. Increase of GP Partner WTE actual figures reported within NWRS, for Norfolk & Waveney ICB, by 31st April 2024.	**Delivered -** A total of 13 GP Partnerships supported within this incentive with a further 2 pending awaiting invoicing.	**Above**
System Wide and Place Based Approach	EoE Rural & Costal	% of PCNs who are actively engaged in promoting new roles and how new ways of working in primary care can support population health needs.	The regional ambition for the project is to raise the voice of R&C Communities as a whole, highlighting not only the challenges faced, but also capitalising on the unique benefits of a R&C lifestyle.	Reform 1. Grow the number & proportion of NHS staff working in primary to enable more preventative & proactive care increase these roles by 73% by '36/'37	1. Recruitment of 2 Digital GP Fellow & 1 VtC by Oct 23 2. Recruitment of 5 Volunteers in Primary Care (VtC) by Mar 24 3. Creation of Rural Careers Strategy by Mar 24 4. Delivery ENHANCE Generalist school by Mar 24 (Pending Bid) 5. To pilot a proof on concept medic role that will be time split between acture and primary care settings.	**Delivered -** 2x Digital Fellows recruited **Below -** 4 VtC Employers recruited, recruitment of volunteers ongoing **In Progress -** Rural Careers Strategy integrated into "N&W Grow Your Own" Faculty **Delivered** - ENHANCE Bid Successful - Delivery	**Below and in proress**
Primary Care Workforce Planning	GP Fellowship	1. Number of newly qualified health professionals who are supported to take up a primary care role. 2. % of PCNs who are actively engaged in promoting new roles and how new ways of working in primary care can support population health needs.	The aim of the GP Fellowship programme is to support newly qualified GPs to transition into substantive careers within Norfolk and Waveney's Primary Care sector from structure education.	Building Capacity - Retention and Return of experience GP's. 1. Fellowships offered to 100% of trainees, including NTP nurses 2. Increased conversion of newly qualified GPs into substantive roles (converting from locum) 3. Increased participation by newly qualified GPs and Nurses, contributing to increasing the overall numbers of GP FTEs 4. Monthly updates on actual figures reported through PCMS, ongoing evaluation and sharing of lessons learned to National Team Retain 1. improve leaver rates by 15% 2. By better supporting staff throughout their careers, helping them stay in work through flexible working, and improving culture & leadership	1. Attend three VTS event within each locality of Norfolk and Waveney (Norwich, East and West), to promote and increase awareness of Fellowship opportunities to ST2 and ST3 doctors, before March 2024. 2. Support 20 new GP Fellows to commence a Fellowship by 31/03/24. 3. Accurately report Fellowship activity in a timely manner via PCMS by 10th of each month until 31/03/2024. 4. Improve parity in Fellowship uptake across the localities by ensuring at least three new GP Fellowships applications are received each locality by 31/03/24.	**Delivered -** 100% achievement for attendance at local VTS events. **Below -** 95% achievement of recruiting new GP Fellows. 19 GP Fellows in place with no funding to support any new GP Fellows. **Delivered -** 100% achievement of PCMS reporting each month. **Below -** 100% recruitment of GP Fellows in North, Norwich, and GYW localities. 66% achievement of recruitment of GP Fellows in South locality, and 33% achievement of recruitment in West locality. It should be noted that the previous financial year saw South and West with higher numbers of GP Fellows which may have impacted the number of applications from those areas in this financial year.	**Below and in proress**
Clinical Leadership	Supporting Mentors	1. Number of newly qualified health professionals who are supported to take up a primary care role. 2. % of PCNs who are actively engaged in promoting new roles and how new ways of working in primary care can support population health needs.	The aim of this programme is to upskill existing workforce with Coaching & Mentoring training to utilise their existing skills and experience by providing Mentorship to colleagues within Primary Care.	Building Capacity - Retention and Return of experience GP's. 1. Increase the number of matches between mentors and mentees from the previous year (2022/2023) 2.Achieve a mentor-to-mentee ratio of at least 1:4 3.Maintain current mentor numbers, ensuring training, ongoing peer networking and CPD activities are made available 4.Ensure that the scheme meets the mentoring needs of GPs on the General Practice Fellowship programme 5.Increase retention of experienced GPs through access to mentor training and opportunities, and increased retention of local GPs through high quality mentoring support, contributing to increasing the overall numbers GP FTEs 6.Submit a system delivery plan outlining forecast number of mentors, number of mentees and anticipated number of mentoring sessions Retain 1. improve leaver rates by 15% 2. By better supporting staff throughout their careers, helping them stay in work through flexible working, and improving culture & leadership	1. Increase the average mentor to mentee ratio to 1:4 by 31/03/24 2. Continue to support 12 mentors to remain active on the scheme by 31/03/24 3. Procure external management scheme for Supporting Mentors Scheme by 31/03/24 to commence 01/04/24, to support infrastructure within PCWT and existing pool of Mentors. 4. Routinely promote opportunities of mentorship to Primary Care workforce (offer includes up to 6 sessions of mentorship by a Mentor on the pool) via newsletter and social media once per quarter by 31/03/24. 5. Ensure all new GP Fellows are offered up to 12 sessions of mentoring per year upon commencement of Fellowship Programme by 03/04/24.	**Below -** Mentor:mentee ratio remains 1:3. Those who are eligible for mentorship through the scheme have been contacted amd reminded about the availability of mentorship. **Delivered -** 100% achievement. 12 mentors remain on the scheme with a further 2 pending training if required. **In progress -** pending internal review and authorisation or new scheme proposal. **In progress -** promotion has continued to be shared with those eligible for the scheme based on NHSE guidance and not publicly promoted as set out in targets. Requirement for target to be amended. **Delivered -** 100% achievement. All GP Fellows have been offered mentorship, however, some have not taken up the offer.	**Below and in proress**
Primary Care Workforce Planning	Advanced Practice	1 % of PCNs who are actively engaged in promoting new roles and how new ways of working in primary care can support population health needs.	The aim of this project is the increase the number of staff in Primary Care to become qualified Advanced Practitioners within Norfolk and Waveney, utilising commissioned funding provided from NHSE for training, with a focus on targeting staff in "Deep-End" practices, to support population health needs. This will help to improve retention rates within general practice by upskilling workforce and helping staff reach career goals.	Building capacity 1. Support PCNs to use their full ARRS budget and report accurate complement of staff using NWRS portal. Train 1. expansion of advanced practice training by 46% Retain 1. improve leaver rates by 15% 2. By better supporting staff throughout their careers, helping them stay in work through flexible working, and improving culture & leadership Reform 1. Grow the number & proportion of NHS staff working in primary to enable more preventative & proactive care increase these roles by 73% by '36/'37	1. For 2024/25 scoping, increase by 20% (6 learners) 2. For 2024/25 - engage with Deep End / Rural & Coastal Project and areas of inequality, to increase learner applications from these areas. 3. Increase number of Advanced Practice supervisors. 4. Pastoral survey to monitor learner satisfaction and support learner retention and governance.	**Delivered** - 16 EOIs - 8 potential learners for 2024/25 **Delivered** - Deep End Project now closed. 14 learners currently studying from Deep End Practices. **Not Delivered** - No training has been available through NHSE in 2023/24 to support this. **Delivered -** First survey distributed to learners in January 2024.	**Below and in proress**
Education and Training	CPD	1. % of nurses and allied health professions (AHP) staff offered continuing professional development (CPD) funding. 2. % increase of nurses and AHP staff take-up of CPD funding. 3. % of primary care workforce offered training provided by the ICS Training Hub. 4. Breakdown of professions undertaking training 5. Training Hubs to deliver education and training activity based on ICS plans to reduce health inequalities	This project oversees the utilisation of the CPD budget we receive from NHS England both from a strategic and training facilitation perspective. This project aims to ensure all Registered Nursing Associates, Registered Nurses, Registered Midwives and Registered Allied Health Professionals are offered and undertaking Quality CPD opportunities.	Modern general practice access 1. Co-ordinate nominations and allocations to care navigator training, and digital and transformation PCN leads training and leadership improvement training. 2. Cohort 1 (PCN Digital & Transformation leads) nominated by 7 June 2023. 3. National Care Navigation Training Programme, nationally nominated by 31 July. 4. 50% of 23/24 nominations to be coordinated by the 31st of July 23. 5. Agree with practice/PCN support needs (training, capacity backfill) by 15th June 2023.	1. Carry out Training Needs Analysis with practices across N&W and analyse results to influence CPD planning by June 2023. 2. To fully utilise our CPD budget £211,333.33 (2023/24) by 31/03/2024. 3. Monitor utilisation of CPD Top Slice £42k approx. by 31/03/2024, linked to JFP priorities. 4. Co-ordinate nominations to Care Navigator training, Digital Transformation PCN Leads training and Leadership Improvement training by 31/08/2023 as part of the Primary Care Recovery Access Plan (ICB responsibilities). 50% of 23/24 nominations to be coordinated by 31/07/23. 5. Increase in % of staff offered / accessing CPD training by 25% (841 staff) in 2023/24 in comparison to 2022/23 financial year by 31/03/24. 6. 100% of courses will be measured for EDI using monitoring forms by 31/03/2024.	**Delivered** - TNA complete, 61% of practice engaged and analysis complete in May 2023. **Delivered** - CPD budget fully utilised by February 2024. **Delivered** - CPD topslice training currently running, monitoring uptake from Primary Care. **Delivered** - As of 08/02/24, 59% of practices have taken up Care Navigation Training. **Delivered** - Over 50% uptake from staff. **Delivered** - All courses monitored for EDI.	**Above**
Digital Innovation	#WeCareTogether Website & Virtual Careers Website	% of PCNs utilising Knowledge and Library Services (KLS)	To access a 'one stop shop' digital platform for Primary Care colleagues. This platform will provide information and guidance for: workforce staff in the following 1. Continuous professional development 2. Training and education 3. Recruitment and employment opportunities 4. Career pathways 5. Retention programmes and initiatives 6. Health and Wellbeing support 7. Resources 8. Contact details	Enablers 1. Maintain an up-to-date Directory of Services and deliver training to all practices/PCNs.	1. Maintain and publish a monthly an up-to-date Directory of Services and training to all practices/PCNs through #WeCareTogether Primary Care Workforce and other digital platforms. Updated on a monthly basis. 2. Carry out a dental workforce marketing campaign to attract dental workforce to N&W by 31s March 2024.	**Delivered -** Monthly up-to-date Directory of Services published monthly **Delivered** - Dental Workforce Marketing campaign	**Met**
Clinical Leadership	Nurse/AHP Fellowships	1. Number of newly qualified health professionals who are supported to take up a primary care role. 2. % of PCNs who are actively engaged in promoting new roles and how new ways of working in primary care can support population health needs.	The Fellowship Programme supports the delivery of General Practice Fellowship programme supporting newly-qualified and new to practice Nurses/AHPs in Primary Care. Funding is received from NHS England to provide this opportunity.	Building Capacity 1. Fellowships offered to 100% of trainees, including NTP nurses 2. Increased conversion of newly qualified GPs into substantive roles (converting from locum) 3. Increased participation by newly qualified GPs and Nurses, contributing to increasing the overall numbers of GP FTEs 4. Monthly updates on actual figures reported through PCMS, ongoing evaluation and sharing of lessons learned to National Team Retain 1. improve leaver rates by 15% 2. By better supporting staff throughout their careers, helping them stay in work through flexible working, and improving culture & leadership	1. To enrol 5 GPN Fellowships by 31/03/2024.	**Delivered** - 2 x Nurse fellows complete, x2 currently active, 2 x withdrawn.	**Below and in proress**
Placements	PCN Learning Organisation	1. Compliance with regulatory standards and HEE Quality Framework. 2. All professions to be offered practice placements. 3. % of placements increase. 4. Engage with HEEs Differential Attainment (DA) Leads to access the support toolkit and guidance on reducing differential attainment.	The PCN LO to expand placement capacity to support multi-professional learners across their constituent practices and partners creating a rich training environment to grow and retain a skilled primary care workforce now and for the future.	Building capacity 1. Support PCNs to use their full ARRS budget and report accurate complement of staff using NWRS portal. Train: 1. increasing GP training places by '31/'32 by 50% 2. 40% increase in Nursing Associate training places by '28/'29 3. 16% of clinical training places as apprenticeships by '28/'29 4. Increase AHP training places to by 25% by '31/'32. 5. 27% increase in training places in the next 5 years	1. Appoint 30 Education Leads by 5th September 2023 within the 6 Primary Care Networks. 2. To hold a PCN PCN LO induction day by 5th September 2023 to 6 Primary Care Networks 3. All GP practices within the PCN LO to be a learning organisation by September 2024. 4. Obtain the 6 approved PCN LO General Practice placement baseline position by 31st December 2023. 5. Increase PCN LO General Practice placements by 20%, from the 23 baseline, by September 2024 across the PCN LO. 6. Expand GP Trainee PCN LO placements by 50% (18 new placements) across PCN LO by September 2024. 7. Expand PCN LO Trainee Nurse Associates and Direct Nursing student placements by 20% (3 new placements) across PCN LO by September 2024. 8.To increase Practice Assessors and Supervisors by 20% (8 new applications) across PCN LO by September 2024. 9. To increase pharmacist training pathway by 20% (2 new applications) across PCN LO by September 2024.	**Not Delivered** - 14 Education Leads in role. PCNs have struggled to fill some roles, particularly AHP and nurse lead roles. **Delivered** - Induction Day completed with good feedback **Not Delivered** - 3. 1 new LO. 1 site declines to become LO. 1 site not in postition to become LO. 2 applications pending. **Delivered -** Baseline data recieved from all PCNs **In Progress** - Placement increase sitting at around 10% at present **In Progress** - In process of setting of ITP at ECCH, prison. New GP trainers approved from Aspiring Educator Programme. Increase information pending. **Delivered -** 20% placement increase achieved **Delivered -** 20% increase achieved **Not Delivered** - No movement with pharmacy training pathways. No AHP education leads. Medical and Project Leads are considering the options.	**Below and in proress**

Placements	Tier 3 and LO Incentive Programme	1. % increase in the number of approved educators and supervisors. 2. Number of educators and supervisors who have attended educational update training provided by Training Hubs	To increase the number of approved GP Tier 3 educators across Norfolk and Waveney to build resilience and capacity within general practice.	Building capacity 1. Support PCNs to use their full ARRS budget and report accurate complement of staff using NWRS portal. Train: 1. increasing GP training places by '31/'32 by 50% 2. 40% increase in Nursing Associate training places by '28/'29 3. 16% of clinical training places as apprenticeships by '28/'29 4. Increase AHP training places to by 25% by '31/'32. 5. 27% increase in training places in the next 5 years	1. Increase Tier 3 Educators by 20% (26 new applications) across Norfolk and Waveney by December 2023.	**Delivered** - 20% increase of Tier 3 Educators across the system	**Met**
System Wide and Place Based Approach	Health and Wellbeing of Primary Care	1. Number of newly qualified health professionals who are supported to take up a primary care role. 4. % of primary care workforce offered training provided by the ICS Training Hub. 11. Number of EDI events to support the ICS EDI strategy. 13. Training Hubs are expected to demonstrate their process for dealing with complaints and quality concerns to include a) Number of quality concerns raised. b) Number of complaints received.	Develop a comprehensive health and wellbeing website tailored to the primary care workforce, offering resources, tools, and information to support their physical, mental and emotional wellbeing ultimately enhancing job satisfaction, work-life balance and over quality of care. There will also be clear signposting to other source materials through either 3rd party websites, locally hosted events and workshops, health ambassadors which will be places within the PCN's and other suitable placements.	Retain 1. improve leaver rates by 15% 2. By better supporting staff throughout their careers, helping them stay in work through flexible working, and improving culture & leadership 3. Support the health and wellbeing of the NHS workforce and, working with local leaders, ensure integrated occupational health and wellbeing services are in place for all staff. Reform 1. Grow the number & proportion of NHS staff working in primary to enable more preventative & proactive care increase these roles by 73% by '36/'37"	1. To have a fully functional website with updated health and wellbeing materials by January 2024 2. Ensure remaining 40 licences for Shapes toolkit to be utilised by end of December 2023 3. Recruit and support the implementation of 1x wellbeing fellow by November 2023	**Delivered** - Health and Wellbeing materials available on #WeCareTogether Website **Delivered** - Shapes Toolkit licences utlised **In Progress** - HWB Fellowship appointment, awaiting start date	**Met**
Primary Care Workforce Planning	Recruitment, Succession & Rotational Roles	Training Hub KPI 1 - % of PCNs offered support on workforce planning, advice, and identification of needs for patients and populations - Region to establish a baseline date with an ambition to meet 100% coverage by April 2025 Training Hub KPI 19 - % of PCNs actively engaged in promoting new roles and ways of working in Primary Care supporting population health needs Training Hub KPI 20 - Number of newly qualified health professionals who are supported to take up a role in Primary Care	Evaluate the succession planning and recruitment mapping processes which are currently being used across all sectors of Primary Care and create or procure a mapping tool and/or process to support with forward workforce planning.	Retain : Commit to ongoing national funding for continuing professional development for nurses, midwives and allied health professionals, so NHS staff are supported to meet their full potential.	1: Evaluate the current processes being used for planning staff succession and complete a gap analysis, completing a report of findings by the end of September 2023, use this information to identify how the ICB can offer support, and make decisions around inclusion of dentistry, community pharmacy and optometry. 2: By the end of April 2024 100% of practices and PCNs identified as benefiting from support will be offered support with workforce planning. 3: By the end of September 2023 evaluate and report on the appetites within Primary Care for system support with rotational roles. 4: By the end of April 2024 an evaluation of early project impact has taken place with lessons learned and recommendations for sustainable continuation where appropriate.	**Delivered** - all processes to be planned for transferability to other sectors once the workforce priorities allow forward planning **In progress** - anticipate all practices having access to tools by April 2024 **Delivered** - evaluation showed minimal interest in system support or liklihood of engagement **In Progress** - some concerns around ability to evidence impact at practice level, however lessons learned and recommendations can be achieved	**Below and in proress**
Placements	Pharmacy Projects – Summer Placements	4. % of primary care workforce offered training provided by the ICS Training Hub. 7. Number of clinical apprenticeships supported across primary care.	To successfully complete the 2023 Pharmacy Summer Student Placements with the support of BLMK and to have a clear plan for how to proceed with 2024 cohort.	Train - Provide 22% of all training for clinical staff through apprenticeship routes by 2031/3 Train: significantly increasing education and training to record levels, as well as increasing apprenticeships and alternative routes into professional roles, to deliver more doctors and dentists, more nurses and midwives, and more of other professional groups, including new roles designed to better meet the changing needs of patients and support the ongoing transformation of care.	1. To have 4x Summer Students in placement and complete their 5 week placement and achieve their certification by 25th August 2023 2. To have evaluated 2023 summer placement cohort by November 2023, with a recommendation on whether this should continue into next year.	**Delivered -** 4 students successfully completed placement **Delivered** - Project evaluated as viable to continue but due to ICB restructure not confirmed for 24/25	**Met**
Placements	Pharmacy Projects – Undergraduate Pharmacy Tender	4. % of primary care workforce offered training provided by the ICS Training Hub. 7. Number of clinical apprenticeships supported across primary care.	To identify and support additional Student Placements Providers to create placements, which are suitable to host apprentices and students for the current available training being offered by local universities and the Norfolk and Waveney ICB.	Train - Increase the number of GP training places by 50% to 6,000 by 2031/32. We will work towards this ambition by increasing the number of GP specialty training places to 5,000 a year by 2027/28. The first 500 new places will be available from September 2025 Retain - Commit to ongoing national funding for continuing professional development for nurses, midwives and allied health professionals, so NHS staff are supported to meet their full potential.	1. Send out expression of interest form to Gp practice and community pharmacy. Collate information by end Oct 2023 2. Confirm dates of placement providers agreed with UEA end Sept 2023	**Delivered -** Placements confirmed with UEA - full annual placement programme **Delivered** - EOI sent in Oct 2023	**Met**
System Wide and Place Based Approach	Pharmacy Project – PCN Integration Pilot	11. Number of EDI events to support the ICS EDI strategy.	Establish a network of 5 dedicated PCN integration leads within Norfolk and Waveney region by end of 23/24 financial year, tasked with facilitating seamless collaboration and communication among Primary Care providers, specialists, and community resources, thereby enhancing patient centred care, improving health outcomes, and optimising the healthcare delivery system.	Train - Increase the number of GP training places by 50% to 6,000 by 2031/32. We will work towards this ambition by increasing the number of GP specialty training places to 5,000 a year by 2027/28. The first 500 new places will be available from September 2025 Train more NHS staff domestically. This will mean that we can reduce reliance on international recruitment and agency staff. In 15 years' time, we expect around 9– 10.5% of our workforce to be recruited from overseas, compared to nearly a quarter now.	1. Recruit to remaining 2 PCN integration lead positions in Norfolk and Waveney by January 2024 2. Create a sharing platform to support, advise and provide suitable materials on NHS Futures by September 2023 published by October 2023 3. Obtain a positive feedback increase via survey performed by PCN integration leads within by the end of March 2024.	**Delivered -** 5 PCN Integration leads in place. **In Progress -** NHS Futures platform deemed not fit for purpose, local whatsapp group between practices and leads have been created for short term solution **Delivered -** PCN Reports have been collated and reviewed against regional programme containing positive feedback and results. Regional meeting to confirm next steps set for April 2024	**Below and in proress**
Education and Training	Pharmacy Project - Independent Prescribers Pathfinder	KPI 2 - % of nurses and allied health professions (AHP) staff offered continuing professional development (CPD) funding.	Introduce a prescribing model to support existing independent prescribers in community pharmacy to increase the opportunities to utilise these additional skills.	Retain : 1. improve leaver rates by 15% 2. By better supporting staff throughout their careers, helping them stay in work through flexible working, and improving culture & leadership Commit to ongoing national funding for continuing professional development for nurses, midwives and allied health professionals, so NHS staff are supported to meet their full potential.	1. Establish 3 sites as per funding to trial the programme by December 2023, In Preparation to prescribe in Jan 24, Feb 24 and March 24 2. Utilise the data collected from the 3 pathfinders to adapt future processes. All data to be collected by end of May 24. 3. To identify clinical models which will be shared with other pharmacies, by end of financial year 24/25.	**Delivered** - 3 sites identified and in sign up process. Significant delays in IT infrastructure have resulted in national delays in this project.	**Met**
Education and Training	Pharmacy Apprenticeships - PTPT	KPI 5 - Breakdown of professions undertaking training provided KPI 6 - Number of non-clinical apprenticeships supported across primary care KPI 14 - % of placements increase. KPI 15 - All professions being offered placements, by breakdown of profession.	To increase the number of Registered Pharmacy Technicians in Norfolk and Waveney through the facilitation of an appropriate education offers and number of placements. Create a robust, transferable platform to cover advertisement, application, recruitment and enrolment of the PTPT programme across all areas of pharmacy.	Retain 1. improve leaver rates by 15% 2. By better supporting staff throughout their careers, helping them stay in work through flexible working, and improving culture & leadership Reform 1. Grow the number & proportion of NHS staff working in primary to enable more preventative & proactive care increase these roles by 73% by '36/'37"	1.Have a robust induction platform, easily accessible and link with UEA/Buttercups in time for February 2024 cohort. This platform will aim to be published by January 2024. 2.To ensure 100% of National and Regional funding is allocated and utilised per cohort throughout the project lifespan. 3.To ensure a minimum of 5 candidates are identified and enrolled for each bi-annual cohort.	**Delivered** - SOP and indcution platform in place **Delivered -** 100% of regional funding will be utilised by March 2024 **Delivered** - 5 candidates enrolled for September 2023 and 5 for Feb 2024.	**Met**
Primary Care Workforce Planning	Dentistry Projects - Overseas Recruitment	1. % of PCNs offered support on workforce planning, advice, and identification of needs for patients and populations. All professions to be offered practice placements.	Implement Overseas process to support EU/NON EU dentists and clinical staff to achieve their GDC certification number to be able to treat NHS patients within the Norfolk and Waveney area	Train - Expand dentistry training places by 40% so that there are over 1,100 places by 2031/32. To support this ambition, we will expand places by 24% by 2028/29, taking the overall number that year to 1,000 places.	1. Fill dentistry vacancies by appointing overseas applicants by at least 10%. *Date to be confirmed depending on confirmation of funding*	**Delivered -** 4 Tier 2 Visa Support for practices **In Progress** - evaluation of overseas recruitment has met the 10% threshold	**Met**
Education and Training	Dentistry Projects - Continuous Professional Development (CPD)	% of nurses and allied health professions (AHP) staff offered continuing professional development (CPD) funding. % of primary care workforce offered training provided by the ICS Training Hub. Number of non-clinical apprenticeships supported across primary care	The project is to expand the current CPD provision into Dentistry to support their CPD requirement. This project aims to enhance clinical skills, Improve patient care, ensure ethical and legal compliance is met and to improve specialist training and skills.	Train - Expand dentistry training places by 40% so that there are over 1,100 places by 2031/32. To support this ambition, we will expand places by 24% by 2028/29, taking the overall number that year to 1,000 places. Train more NHS staff domestically. This will mean that we can reduce reliance on international recruitment and agency staff. In 15 years' time, we expect around 9– 10.5% of our workforce to be recruited from overseas, compared to nearly a quarter now. Retain - Commit to ongoing national funding for continuing professional development for nurses, midwives and allied health professionals, so NHS staff are supported to meet their full potential. Explore measures with the government such as a tie-in period to encourage dentists to spend a minimum proportion of their time delivering NHS care in the years following graduation.	1. Complete the Dental Training Needs Analysis by November 2023 2. The target is to have at least 3 courses funded and delivered out to the primary workforce team by December 2023.	**Delivered -** Dentistry TNA completed and transferred into BI dashboard. **Delivered:** 3 Courses fully funded which includes: Complaints Handling, Leadership and Patient engagement training fulled funded with workshops ongoing into 2024.	**Met**
System Wide and Place Based Approach	Schwartz Rounds	N/A - SDF Funding not a HEE KPI From Local GP Retention Fund Guidance: Regional and local office teams should use this fund to facilitate the establishment of local schemes and initiatives that enable local GPs to stay in the workforce, through promoting new ways of working and offering additional support.	The aims of this project is to offer a safe and confidential group reflective practice forum for staff, that will help to combat isolation within Primary Care thus improving morale and increasing workforce retention.	N/A	1. To have a consistent attendance of 20 attendees per virtual Round 2. Increase Schwartz Steering Group from 8 to 10 by March 2024, to support the identification of speakers 3. Deliver five face to face Rounds, one in each locality by March 2024 4. Fourteen virtual Rounds to be delivered by March 2024	**Not Delivered -** We did not meet the target of 20 consistent attendees per virtual Round during 2024 **Delivered** - Combing the ICS and the Primary Care Steering Group membership **Not Delivered** - we have delivered one face to face Round, however we have F2F sessions booked in from April 24 **Delivered** - 14 virtual Rounds have been delivered by 2024.	**Below and in proress**
Digital Innovation	Social Media	2. % of nurses and allied health professions (AHP) staff offered continuing professional development (CPD) funding. 3. % increase of nurses and AHP staff take-up of CPD funding. 4. % of primary care workforce offered training provided by the ICS Training Hub. 6. Number of non-clinical apprenticeships supported across primary care 7. Number of clinical apprenticeships supported across primary care. 8. % of PCNs utilising Knowledge and Library Services (KLS) 11. Number of EDI events to support the ICS EDI strategy.	To have a presence on social media across Norfolk and Waveney and to reach Primary Care staff that we would not usually reach in other means to advertise what we do.	N/A	1. Be live on 4 social media platforms by September 2023 2. By end of 2023 have review of all national days and events planned in Social Media planner, with drafts of posts. 3. Continuously Have two months worth of social media posts completed/ drafted into the calendar plan completed.	**Delivered -** Live on 4 platforms. **In Progress** - National days logged and started to be taken by posts. **In Progress** - Continuously got either posts written or allocated.	**Met**
Education and Training	Non-Clinical Apprenticeships	4. % of primary care workforce offered training provided by the ICS Training Hub. 6. Number of non-clinical apprenticeships supported across primary care	To increase the number of non-clinical workforce by providing training and education and entry into non-clinical careers via apprenticeships.	N/A	1. Secure Levy Transfers for Practices apprenticeships to access Levy Transfers for at least 70% of new apprenticeships that need it before 31st March 2024. 2. Recruit a minimum of 5 candidates for each management apprenticeship course per year (Level 3 and 5) by 31st March 2024. 3. Support recruitment of 10 Level 2 and 3 admin apprentices within each locality before 31st March 2024.	**Delivered -** 100% of Nursing apprenticeships have received Levy Transfers. 100% of Pharmacy Technician apprenticeships have received Levy Transfers. 83% of non-clinical apprenticeships have received Levy Transfers, 11% did not require funding support due to funding rules regarding apprenticeship age and remaining 6% is pending confirmation of funding route. **Delivered -** 100% achievement of management apprenticeship recruitment. Five candidates for Level 5 and nine Level 3. **Not Fully Delivered -** North: 5, Norwich: 2, South: 3, West: 1, GYW: 3 have been supported or offered support and confirmed successful recruitment. Support is continued to be offered ad-hoc to Practices to enable them to make informed decisions on recruiting apprentices and how this can be done. Many Practices still independently recruit and resource their apprentices.	**Below and in proress**
Education and Training	Nursing Apprenticeships	3. % of placements increase. 7. Number of clinical apprenticeships supported across primary care. 20. Number of newly qualified health professionals who are supported to take up a primary care role.	To increase the number of nursing in the primary care workforce through increasing apprenticeships.	37 new Apprentice Nursing Associates each year (Jan-Dec)	1. Deliver at least 25 new Apprentice Nursing Associates by 31st March 2024.	**Below -** 11 new Apprentice Nursing Associates have commenced this financial year. This is a national trajectory and has not been set internally but should be noted that the recruitment to this apprenticeship continues to increase each year.	**Below and in proress**
Education and Training	General Practice Assistant (GPA) Programme		To recruit and train more GPAs in General Practice	TBC	1. Ensure 25 GPAs from 22-23 cohort have completed their portfolios and have been signed off by by the GP Lead by September 2023 2. Undertake an evaluation of the 23-24 with a recommendation for 24/24 cohort by December 2023	**Below -** Programme has been completed and portfolios signed off with 19 GPAs complete. **Not delivered -** An evaluation has not been completed at this time.	**Below and in proress**

Primary Care Workforce Planning	Primary Care Careers	N/A - SDF Funding not a HEE KPI This project does support the following KPI's: 1. % of PCNs offered support on workforce planning, advice, and identification of needs for patients and populations. 2. All professions to be offered practice placements. 3. % of placements increase. 6. Number of non-clinical apprenticeships supported across primary care 7. Number of clinical apprenticeships supported across primary care. 20. Number of newly qualified health professionals who are supported to take up a primary care role.	The Aim of this project is to support Primary Care in the attraction and recruitment of new staff through procurement of a bespoke recruitment service.	N/A	1. Increase Practice engagement to 60% of practices (63 practices) using PCC within 6 months by March 2024 2. Increase PCN engagement to 60% of PCNs (10 PCNs) using PCC within 6 months by March 2024 3. To fully utilise 10 DOP Pilot placements by January 2024 4. 90% of those using the service find it beneficial compared t o alternative options. 5. Complete a review of the core GP/PCN service by January 2024, with a view to re procurement	**Delivered -** 65% of practices are actively using the service **Below -** 53% of PCNs are actively using the service **Delivered** - 10 Pilot placements identified **Below** - survey still open, 75% of survey respondents so far said the service was Definitely beneficial compared to alternative options **Behind -** low response rate has pushed back timelines, this is on-track to be delivered by March 2024.	**Below and in proress**
Clinical Leadership	Akeso Coaching	N/A - SDF Funding not a HEE KPI From Local GP Retention Fund Guidance: Regional and local office teams should use this fund to facilitate the establishment of local schemes and initiatives that enable local GPs to stay in the workforce, through promoting new ways of	To enhance the retention of healthcare professionals in the workforce by providing coaching that can help refine skills, foster leadership, and promote well-being.	N/A	1. To procure continued coaching provision up to March 2025 by September 2023. 2. To utilise 150 coaching sessions between October 2023 and March 2025.	1. **Delivered -** Provision secured to March 2025 2. **On Track**	**Met**
Primary Care Workforce Planning	Flexible Staff Pool	N/A - Not HEE KPI. From Flexible Stuff Pool fund. Implementation of a digital platform to enable practices to find and allocate Locum staff to available shifts. Supporting the implementation of GP/GPN recruitment and retention as an integral part of ICS workforce programmes and ensuring that they are meeting the ongoing training and development needs of the primary care sector. Increase in the number and use of flexible staff pools, increase in the number of GPs registered to and employed through flexible pooling arrangements, and increased GP FTE'	The aim of this programme is to support the LTP commitment to ensure there are enough people working in the NHS to support patients, through the procurement of innovative staff matching technology using digital solutions for deployment of sessional clinical capacity.		1. Expand the platform to include practice nurses by the end of October 2023. 2. Expand the platform to the wider workforce including roles such as Clinical pharmacists, Dispensers, HCA's and admin staff by May 2024.	**Delivered** - 5 ANP's and 12 PN's are currently in the onboarding process. **Ongoing** - wider workforce still to be engaged for the programme within the timeline.	**Met**
Education and Training	Supporting Primary Care Clinicians	1. % of PCNs offered support on workforce planning, advice, and identification of needs for patients and populations. 2. % of nurses and allied health professions (AHP) staff offered continuing professional development (CPD) funding. 3. % increase of nurses and AHP staff take-up of CPD funding. 4. Training Hubs have an equality, diversity, and inclusion (EDI) strategy with an operational plan to support the ICS EDI strategy. 5. Training Hubs are expected to demonstrate their process for dealing with complaints and quality concerns to include: A: Number of quality concerns raised. B: Number of complaints raised. 6. Number of newly qualified health professionals who are supported to take up a primary care role.	The aim of the programme is to offer support to clinical professionals out of work for under 2 years to return to work or those in need of additional support to stay in the work place by provision of bi-monthly CPD and support sessions.	N/A	1. Number of clinical professionals attending all sessions is at or above 15. 2. Ensure 100% of participants are offered the EDI questionnaire at sessions. 3. 90% positive feedback from those that complete the feedback survey.	**Delivered -** Across the last 2 sessions. **Delivered -** All have been offered the EDI questionnaire. **Delivered -** Feedback above 90%.	**Above**
Primary Care Workforce Planning	GP Careers Plus	N/A - SDF Funding not a HEE KPI From Local GP Retention Fund Guidance: Regional and local office teams should use this fund to facilitate the establishment of local schemes and initiatives that enable local GPs to stay in the workforce, through promoting new ways of working and offering additional support.	The programme seeks to support and retain GP's who may otherwise consider leaving the area of Norfolk & Waveney, Primary Care, or clinical practice. This includes supporting newly qualified GPs who have not yet chosen a path/practice, those stepping back or reducing hours mid-career, and those considering early retirement.	N/A	1. To onboard and maintain a group size of 75 Locum GP's on to the membership by March 2024. 2. Produce a map of where locums are located and distance they are willing to travel to be done once all new members have been signed up and to be updated as and when new members join end December 2023. 3. 100% of existing members moved to the new offer have singed and returned the MOU by the end of October 2023. 4. Preplanned peer group events to be sent out to the members by end of August and updated to new members by end of September 2023.	**Below** - currently on 45 members, 75 target unrealistic. **Ongoing -** as new members are joining the programme. **Below** - due to members not returning MOU, majority have, some legacy members have been removed due to a period of non response. **Delivered -** Peer groups are well attended with good feedback	**Below and in proress**
Clinical Leadership	FCP Supervisor Project	3. % of primary care workforce offered training provided by the ICS Training Hub.	To support FCP's moving towards supervisor status as we have identified a lack of accessible FCP supervisors across the locality.	N/A	1. To Hold x2 FCP training days in 2023/24. 2. To provide a minimum of 15 (20% of FCPs) training grants by March 2024 supporting them towards supervisor status. 3. Develop and support a peer network of FCP's to reduce siloed and isolated working and improve adherence, recognition and progression through Health Education England's road maps to practice that has 80% (56 of 71) of FCPs attending throughout the year.	**Delivered** - Events held Nov 23 and booked March 24 **Delivered** - 23 training grants provided, and 1 abnormal bloods course funded for 50 FCPs **Delivered** - FCP Networks set up on Teams and Whatsapp	**Met**
Education and Training	Physician Associate MH Upskilling Project	3. % of primary care workforce offered training provided by the ICS Training Hub.	To upskill PAs to increase their confidence and knowledge in mental health treatment and conditions and increase multidisciplinary working	N/A	1.Scope the mental health training needs of PAs by May 2023 2.Offer mental health upskilling (crisis prevention, suicide prevention, eating disorders, substance misuse, dementia awareness) courses to PAs by September 2023 3.Scope PA specific mental health upskilling to add to the offer By May 2023 4.Enable access to upskilling programme via a single access and market offer directly to PAs by September 2023 5.Provide ambassador support to PAs to access and plan their upskilling continuous up to January 2024 in how many - how will it be measured. 6.Evaluate and write a report outlining future recommendations for post registration mental health upskilling for PAs by January 2024	**Delivered** **Delivered** **Delivered** **Delivered** **Delivered** **In Progress** - Evaluation ongoing report being drafted, delay due to 6 month course end date being end of Jan. Some students chose the 12 month course ending in the Summer.	**Met**
Education and Training	Higher Development Award	3. % of primary care workforce offered training provided by the ICS Training Hub.	To support staff to develop their career within Primary Care where they may not have achieved the functional skills in Math's and English and would like to develop into a clinical or non-clinical role.	N/A	1.To ensure 1 person from Norfolk and Waveney is signed up to the national HDA by 31st March 2023.	**Not Delivered** - No interest in courses and have been constantly advertised.	**Not delivered**
Placements	Foundation Dental Training Practices Programme	Not Applicable	The Foundation Dental Training Practices programme is to expand N&W dental training placements by creating a rich training environment to grow and retain a skilled primary care workforce now and for the future.	Train - Expand dentistry training places by 40% so that there are over 1,100 places by 2031/32. To support this ambition, we will expand places by 24% by 2028/29, taking the overall number that year to 1,000 places.	1. Increase by 50% (6 new applications) of Foundation Dental Training Practices cross Norfolk & Waveney by 31st March 2.. Expand Foundation Dentists placements by 50% (3 new placements) across PCN LO by September 2024. 3. To increase nurse dental apprenticeships pathway by 8 across N&W by March 2024.	**Actual:** Increase of **25%** (2 new applications) **In Progress** - Foundation Dental Placements are allocated in May 2024 **Delivered:** 10 x L3 Dental Nurse Apprenticeships allocated for September 2024 cohort	**Below and in proress**
Placements	Foundation Dental Supervisors Incentive Programme	Not Applicable	To increase the number of approved Dental Supervisors across Norfolk and Waveney to build resilience and capacity within primary care.	Train - Expand dentistry training places by 40% so that there are over 1,100 places by 2031/32. To support this ambition, we will expand places by 24% by 2028/29, taking the overall number that year to 1,000 places.	1. Establish Dental Educational Supervisor baseline position by December 2023 2. Increase Dental Supervisors by 50% (from baseline) across Norfolk and Waveney by March 2024.	**Delivered** - Educational Supervisor baseline **Actual - 66%** increase of Dental Supervisors from baseline (3 new approvals and 12 reaccredited)	**Above**
Education and Training	Dental Nursing Apprenticeships	Not Applicable	To increase the number of nursing dental apprenticeships in the primary care	Train - Expand dentistry training places by 40% so that there are over 1,100 places by 2031/32. To support this ambition, we will expand places by 24% by 2028/29, taking the overall number that year to 1,000 places.	1. Secure Levy Transfers for Practices apprenticeships to access Levy Transfers for at least 70% of new apprenticeships that need it before 31st March 2024. Allocate 8 Dental Nurse Apprentice placements by 1st February 2024 (pilot) with a local college. 2. Identify 8 Dental Nurse apprenticeships placements by 1st September 2024 (pilot 2) with a local college.	**Delivered:** Local College procurement completed **In Progress**: Levy Transfer status **Not Delivered** - 8 Apprenticeship placements for February 2024 cohort. **Delivered:** 10 placements secured for September 24 cohort.	**Below and in proress**
Primary Care Workforce Planning	Post Foundation Years Dental Professional Incentive	Not Applicable	The aim of the Foundation Dental Professional incentive is to support the uptake of substantive roles within Norfolk and Waveney Primary Care, to help aid practices with recruitment of foundation dental professionals.	Reform 1. Grow the number & proportion of NHS staff working in primary to enable more preventative & proactive care increase these roles by 73% by '36/'37	1. Recruit 2 Foundation Dentists and 2 Foundation Dental Therapists within Norfolk & Waveney by 31st March 2024 2. Increase of Foundational Dentists and Foundation Therapists WTE actual figures, for Norfolk & Waveney ICB, by 31st March 2024. 3. Scope with the Primary Care Delegated Commissioning Team a UDA offering for Foundation Dentists/Therapists to be piloted by 31st March 2024 (subject to increased activity and cost pressures)	**Actual:** 3 Foundation Dentists recruited for 2 years employment contract **Actual** - 1 Foundation Therapists WTE **Not Delivered:** UDA Offering being scoped within the long term dental plan	**Above**
Primary Care Workforce Planning	N&W Golden Hello Dental Professional Incentive	Not Applicable	The aim of the Golden Hello Dental Professional incentive is to support the uptake of substantive roles within Norfolk and Waveney Primary Care, to help aid practices with recruitment of dental professionals.	Reform 1. Grow the number & proportion of NHS staff working in primary to enable more preventative & proactive care increase these roles by 73% by '36/'37	1. Recruit 5 Dentists and 5 Dental Nurses within Norfolk & Waveney by 31st March 2024. 2. Increase of Foundational Dentists and Foundation Nurses WTE actual figures, for Norfolk & Waveney ICB, by 31st March 2024.	**Actual:** 12 Dentists appointed (1 year contract) and retained 3 Dentists (to keep NHS contract)	**Above**
Primary Care Workforce Planning	Primary Care Dental Fellowship	Not Applicable	The aim of the Dental Fellowship programme is to support newly qualified Foundation Dentists transition into substantive careers within Norfolk and Waveney's Primary Care sector from structure education.	Building Capacity - Retention and Return of experience GP's. 1. Fellowships offered to 100% of trainees, including NTP nurses 2. Increased conversion of newly qualified into substantive roles (converting from locum) 3. Increased participation by newly qualified Dentists and Nurses, contributing to increasing the overall numbers of Primary Care FTEs Retain 1. improve leaver rates by 15% 2. By better supporting staff throughout their careers, helping them stay in work through flexible working, and improving culture & leadership	1. Attend one Foundation Dentists event, to promote and increase awareness of Fellowship opportunities for Norfolk & Waveney, before March 2024. 2. Support 2 Dental Fellows to commence a Fellowship by 31/03/24.	**Delivered -** 2 Clinical Dental Fellowships in place until 30th September 2025.	**Met**
Clinical Leadership	Coaching and Mentoring Support for dental teams	Not Applicable	The aim of this programme is to upskill existing workforce with Coaching & Mentoring skills to support dental teams. This cohort would then have an opportunity to upskill this to an ILM level 3 qualification as part of the long term dental workforce plan	Train - Expand dentistry training places by 40% so that there are over 1,100 places by 2031/32. To support this ambition, we will expand places by 24% by 2028/29, taking the overall number that year to 1,000 places.	1. To upskill a cohort of 14 in Coaching and Mentoring skills for dental teams by 31/03/24 2. To identify out of this cohort applications for the ILM Level 3 qualification by 31/03/24. 4. Routinely promote opportunities of coaching and mentorship support to dental workforce teams via newsletter and social media once per quarter by 31/03/24.	**Delivered** - 19 Attendees on 24th January for Leadership (Coaching and Mentoring) training	**Above**
Education and Training	ENHANCE Generalist School	% of nurses and allied health professions (AHP) staff offered continuing professional development (CPD) funding.	To deliver the national ENHANCED generalist programme to cohorts based in Rural & Coastal locations.	Retain 1. improve leaver rates by 15% 2. By better supporting staff throughout their careers, helping them stay in work through flexible working, and improving culture & leadership Train 1. Increase the generlaist skill level of staff based in Rural & Coastal locations.	1. To train a total of 60 participants during the Apr 24 - Apr 25 cohort. 2. To create a network of 60 Enhanced Rural Practioners who act as TTT for their local areas and mentors for future cohorts by Apr 25. 3. To create a business case for future cohorts funding to be approved by PCCC by September 24.	**Delivered** : Sucessful Bid - Programe due to commence 24/25	**Met**

Education and Training	ENT CPPE Training Event	4. % of primary care workforce offered training provided by the ICS Training Hub.	To offer a one-off training session for community pharmacy professionals, in partnership with CPPE, to support 120 pharmacists in upskilling in ENT assessments	N/A	1. Fill 120 spaces on a PCWT funded CPPE ENT training event on February 25th 2024. 2. Utilise allocated budget to improve stakeholder relationships and provide training course.	**Delivered** - All 120 spaces are full **Delivered** - 100% of budget to be utilised to provide location, training course and refreshments to promote ICB PCWT in the stakeholder community	**Met**
Education and Training	DPP Incentive	2. % of nurses and allied health professions (AHP) staff offered continuing professional development (CPD) funding. 3. % of primary care workforce offered training provided by the ICS Training Hub. 4. % of primary care workforce offered training provided by the ICS Training Hub.	To offer a support to community pharmacists who are seeking a DPP to complete their IP course, by providing the DPP's organisation with an incentive.	N/A	1. Utilise 100% of allocated budget to support 2 community pharmacists by incentivising the provision of a DPP from a primary care organisation.	**Delivered -** 100% of budget utilised to fill 2 spaces on the UEA IP course.	**Met**
Education and Training	Pharmacy First CPD workshop	4. % of primary care workforce offered training provided by the ICS Training Hub.	To deliver a cross sector CPD event focussed on pharmacy first to allow for peer network discussions and specialised feedback.	N/A	1. Fill 100 spaces, with delegates from across general practice and community pharmacy. 2. Create a robust evening presentation encompassing pharmacy first feedback methods and opportunities to network.	**In Progress** - Budget secured and intitial investigations into location and plans for evening underway.	**Met**

Norfolk and Waveney
Integrated Care Board

Agenda item: 08

Subject:	**GP contract 2024-25**
Presented by:	**Sadie Parker, Director of Primary Care**
Prepared by:	**Sadie Parker, Director of Primary Care**
Submitted to:	**Primary Care Commissioning Committee**
Date:	**12 March 2024**

Summary

The attached letter was issued by NHS England on 28 February 2024 and provides details of the GP contract for 2024/25. It is a one-year contract, which has attempted to provide greater clarity on income for practices, and greater flexibilities recognising there is very limited funding available to uplift prices.

It is acknowledged the funding uplift is disappointing and will place greater strain on practices, which have had limited funding uplifts in previous years of the five-year contract deal which is coming to an end. It is noted there may be a further uplift for pay, depending on the outcome of the DDRB process (doctors and dentists review body).

The one-year contract aims to target the following areas, building on work already underway:

- Cut bureaucracy for practices.
- Help practices with cashflow and increase financial flexibilities.
- Give PCNs more staffing flexibility.
- Support practices and PCNs to improve outcomes.
- Improve patient experience of access.

The British Medical Association's General Practitioner Committee will be undertaking a referendum of GP practices to determine any response to this one-year contract and this will be reported in due course. There is a possibility that GP practices may vote to strike or work to rule.

In the meantime, this contract should be noted in the context of our BAF risk – the resilience of general practice, noting that we already have 13 practices who are being supported by the ICB because of resilience issues. A further year of below inflation pricing could well lead to increasing numbers of practices experiencing resilience issues, or, in a worst case scenario, unable to continue to provide services

to their patients. this will be kept under close review and we will continue to liaise closely with the Norfolk and Waveney Local Medical Committee.

Recommendation

Members are asked to note the contract and the potentially increasing risk to the resilience of general practice.

Key Risks	
Clinical and Quality:	The ICB is responsible for ensuring quality and performance in relation to the provision of general medical services in Norfolk and Waveney.
Finance and Performance:	The requirements and funding are nationally negotiated. This could lead to further investment required in section 96 agreements.
Impact Assessment (environmental and equalities):	This could mean practices have more financial pressures and have to reduce services, such as in branch surgeries or staffing, leading to greater health inequalities.
Reputation:	Failure to adhere to the regulations can have reputational issues for the ICBs. Worsening access will cause reputational issues.
Legal:	General medical services regulations and contract
Information Governance:	N/A
Resource Required:	Primary Care, Locality and Quality teams
Reference document(s):	General medical services regulations and contract
NHS Constitution:	N/A
Conflicts of Interest:	General practice partners and staff may be conflicted.
Reference to relevant risk on the Board Assurance Framework	The resilience of general practice

Governance

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

NHS England

To:
- All GP practices in England
- Primary care networks: clinical directors

cc.
- Integrated care boards:
- Primary care leads
- Chief executives
- NHS England regions: regional directors, regional directors of commissioning, regional directors of primary care and public health, regional directors of primary care

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

28 February 2024

Dear colleagues,

Arrangements for the GP contract in 2024/25

The contract consultation for 24/25 has now concluded and I am writing to inform you of the final arrangements for the upcoming financial year.

General practice is central to the NHS, and the hard work of GPs and primary care staff is hugely valued and appreciated. Over the course of the last year, NHS England and the Department of Health and Social Care have listened closely to the views of the profession and patients and have worked hard to address these in the GP contract where possible. We have heard loud and clear the need for simpler and more flexible arrangements, which help practices free up time and improve patient access and experience.

In response to what we have heard, from April we will:

1. **Cut bureaucracy for practices** by suspending and income protecting 32 out of the 76 Quality and Outcomes Framework (QOF) indicators. The Investment and Impact Fund (IIF) indicators will be reduced from five to two and the Capacity and Access Payment (CAP) will increase by £46m to £292m by retiring three Investment and Impact Fund (IIF) indicators.

2. **Help practices with cash flow and increase financial flexibilities** by raising the QOF aspiration payment from 70% to 80% in 2024/25 and the Capacity and Access Improvement Payment (CAIP) will now start to be paid at any point in the year, once PCNs confirm they meet the simple criteria for payment.

3. **Give Primary Care Networks (PCNs) more staffing flexibility** by including enhanced nurses in the Additional Roles Reimbursement Scheme (ARRS) and giving PCNs and GPs more flexibility by removing all caps on all other direct patient care roles.

4. **Support practices and PCNs to improve outcomes** by simplifying the Directed Enhanced Service (DES) requirements.

5. **Improve patient experience of access** by reviewing the data that digital telephony systems generate to better understand overall demand on general practice in advance of winter.

Further changes and detail on the new arrangements are below in the annex to this letter.

Now we are outside of the five-year framework, we will return to the pay review body process (Doctors and Dentists Review Body, DDRB) as the established process for determining pay uplifts for public sector workers, when workforces are not in multi-year deals. As the DDRB has not yet made recommendations to Government, we have included a planning assumption of 2% for pay growth in the GP contract. A further uplift may be made following the Government's response to the DDRB for 2024/25.

Cutting bureaucracy for practices

We have heard concerns about bureaucracy with the GP contract. We are taking action, and as part of a higher trust approach, there will be a net reduction in the conditionality attached to QOF which will be streamlined through suspending and income protecting 32 indicators (out of 76 QOF indicators). For the income protected indicators, this will mean that practices will be awarded QOF points based on their performance in previous years, while points for the remaining live indicators continue to be conditional on their performance in the year at hand.

The Investment and Impact Fund (IIF) will be streamlined by reducing the number of indicators from five to two. Funding from the three retired indicators, relating to flu and access, will be redirected into the Capacity and Access Payment (CAP). The two retained indicators will be health checks for people with a learning disability and the use of FIT testing in cancer referral pathways, worth £13m.

Helping practices with cash flow and increasing financial flexibilities

We have heard from practices and the profession that economic pressures over recent years have been challenging, and that flexibilities are needed to help practices and networks to develop innovative delivery models and meet local patient priorities.

We are therefore making three changes in 2024/25 to support this:

- To help improve practice cash flow, the QOF aspiration payment threshold will be raised from 70% to 80% in 2024/25.
- The Capacity and Access Payment (CAP) will increase by £46m to £292m by retiring three Investment and Impact Fund (IIF) indicators. As in 2023/24, 70%

of the funding will be paid to PCNs without any conditions via the Capacity and Access Support Payment (CASP) proportionate to their Adjusted Population, in 12 equal payments. PCNs have the discretion to use the funding according to local needs – for example, the supervision of ARRS staff or to increase the care home premium within the PCN.

- As above, the remaining 30% of the Capacity and Access Payment (CAP) will be paid to PCNs via the Capacity and Access Improvement Payment (CAIP). To improve cashflow, this will be paid to PCNs at any point in the year in monthly instalments once the PCN Clinical Director (CD) confirms to their ICB that all practices within a PCN have put in place one or more of the three individual components of the Modern General Practice Access model, which each attract 1/3 of the overall CAIP funding.

Give PCNs more staffing flexibility

We know that the ARRS has been hugely successful in expanding teams, increasing appointments and supporting the delivery of proactive care, but we have heard that PCNs would welcome more flexibility in how the scheme operates.

We are widening the number of reimbursable roles and removing role restrictions including:

- Enhanced nurses will be included in the scheme (capped at one per PCN - two where the list size is 100,000 or over).
- Caps on all other direct patient care roles will be removed.
- The recruitment of other direct patient care, non-nurse and non-doctor MDT roles will be allowed if agreed with the ICB.
- More flexibility will be introduced in funding arrangements for mental health practitioners.
- PCNs will now be able to claim reimbursement for the time personalised care roles undertake in training or apprenticeships.

We are changing the contract to make permanent the flexibilities to the Performers List Regulations, brought in during the COVID-19 pandemic. These enable practices to continue to engage a variety of medical professionals to operate as part of the primary care team.

Streamlining the PCN DES requirements and increasing autonomy

We have heard that the Network Contract DES has helped to establish at-scale working and the delivery of new services in general practice, but that practices and PCNs want more autonomy over how they can improve outcomes.

In response to feedback received, we are making the following three changes:

- While the Enhanced Access specification will remain as a separate specification with the arrangements unchanged in 2024/25, the remaining eight PCN service specifications will be replaced by one simpler overarching specification.
- We are simplifying the PCN Clinical Director role specification by articulating the following key responsibilities: co-ordination of service delivery, allocation of resources, supporting transformation towards Modern General Practice and supporting the PCN role in developing Integrated Neighbourhood Teams.

- We will roll the PCN Clinical Director and PCN Leadership and Management Payment (£89m combined) into core PCN funding to give £183m in total. This is intended to provide PCNs with greater autonomy and to allow PCN Clinical Directors to lead their PCN in the way that best suits local arrangements.

Improving patient experience of access

We have heard that while many practices and networks have implemented some elements of the new operating model, they need time to embed all the changes that enable the delivery of Modern General Practice Access, which is why the Delivery Plan was a two-year plan.

In December 2023, GPs and their teams delivered an increase of 9% more appointments compared to pre-pandemic. This is an impressive achievement and we are determined to help practices continue to support patients.

We will shortly be publishing an update to the Delivery Plan including progress to date and the key milestones for 24/25. We will continue to support PCNs through contract funding – notably the increased CAP funding of £292m - as well as other available support offers.

We are asking PCNs and practices to review the data that digital telephony systems generate with a quality improvement focus, ahead of national extraction of this data from October 2024. The purpose of extracting this data will be to better understand overall demand on general practice in advance of winter.

Next steps

NHS England will now begin the process of implementing the 2024/25 contract changes with detailed guidance and further information to be published in the coming weeks.

NHS England will also host a webinar on Thursday 29 February at 5pm, to discuss the 24/25 contract. You can sign up online.

The consultation on the role of incentives schemes in general practice remains open until 7 March 2024 and we would like to hear all views.

DHSC will build on the engagement with the Expert Advisory Group - which brought together representatives of the profession including the GPCE, patients, Integrated Care Systems and other key stakeholders over to discuss the GP contract for 2024/25 – to convene a Taskforce on the Future of General Practice over the spring and summer. This will be a key opportunity for the Department and NHS England to hear from stakeholders about priorities for change, including through the 2025/26 contract.

Additionally, we will continue to work towards supporting general practice on significant issues that we know to be of concern, such as by improving the primary and secondary care interface. Further information will be provided in the coming next steps update on the Primary Care Access Recovery Plan (PCARP).

We will also continue to support people currently on the Fellowship Scheme, which has been positively received, throughout 2024/25 and are considering the future of recruitment and retention schemes as we look at how best to support general practice.

We hope that the arrangements we are putting in place will further support you in delivering high quality healthcare to our patients.

The pace, determination and dedication of general practice is inspiring and on behalf of patients, we are grateful for your continued hard work.

Yours sincerely,

Dr Amanda Doyle OBE, MRCGP
National Director for Primary Care and Community Services
NHS England

Annex 1 – changes to the GP Contract in 2024/25

GP contract finance

1.There will be an overall increase in investment of £259m taking overall contract investment to £11,864m in 2024/25. This includes:

a. a planning assumption of 2% pay growth for contractor GPs, salaried GPs, and other practice staff.
b. a planning assumption of 2% pay growth uplift to the overall Additional Roles Reimbursement Scheme (ARRS).
c. 1.68% inflation, in line with the Government's November 2023 GDP deflator.
d. 0.38% ONS population growth.

2. As we are now outside the 5-year contract framework, GP contractors have returned to the remit of the Doctors' and Dentists' Pay Review Body (DDRB).

Core practice contract

The Quality and Outcomes Framework (QOF)

3. In response to feedback from the profession to streamline QOF and reduce bureaucracy, 32 indicators (out of the total 76 QOF indicators) will be income protected in 2024/25. This equates to 42% of QOF indicators. These indicators account for 212 of the 635 points that can be earned through the QOF scheme. For the income protected indicators, practices will be awarded QOF points based on their performance in previous years, while points for the remaining live indicators remain conditional on their performance in 2024/25.

4. The indicators selected for income protection have been assessed by a Clinical and Technical Reference Group chaired by NHS England as carrying a lower risk of deteriorating patient outcomes from incomed protection in 2024/25.

5. The 32 indicators which will be income protected (listed in the table below) include the 19 register indicators protected in 2023/24.

Clinical/Policy Area	ID	QOF points
Mental Health	MH021	6
Depression	DEP004	10
Asthma	AST008	6
Register Indicators x 19 covering a range of clinical areas	CAN001, CKD005, CHD001, HF001, HYP001, PAD001,	81

	STIA001, DEM001, DM017, EP001, LD004, MH001, OB003, OST004, PC001, AF001, AST005, COPD015, RA001.	
QI indicators x 6	All	74
COPD	COPD014	2
Smoking	SMOK005	25
Cancer	CAN004	6
Cancer	CAN005	2

6. Updated QOF guidance will be published setting out the detail of the suspension and income protection arrangements.

7. QOF aspiration payments will be increased from 70% to 80% in 2024/25 to support practice cash flow.

8. Indicator CHOL002 will be updated so that it is aligned with the new NICE NM252 indicator definition from 1 April 2024, ensuring that QOF maintains its strong link to the latest evidence-based guidance.

Digital Telephony data requirements

9. The amendments to the 2023/24 GP Contract require that when practices enter into any new digital telephone contract, it must be procured through the national framework.

10. In 2024/25 the GP Contract will be amended to require practices to provide data on eight metrics through a national data extraction, for use by PCN Clinical Directors, ICBs and NHS England.

11. These eight metrics are:

    a. call volumes
    b. calls abandoned
    c. call times to answer
    d. missed call volumes
    e. wait time before call abandoned
    f. call backs requested
    g. call backs made
    h. average call length time

12. This data will be used by ICBs and NHS England to support service improvement and planning, for example:

    - better insight into patient demand and access trends which systems can use to support understanding of operational pressure in general practice; and
    - better understanding patterns of demand and period of surge activity to inform commissioning of local services.

13. The requirement will come into force from October 2024 to allow practices time to review and understand their own data before it is shared as outlined.

Performers List

14. During the COVID-19 pandemic there was an amendment to the Performers List Regulations that intended to allow doctors other than GPs to deliver primary care services without being on the Medical Performers List (MPL) if they had a prescribed connection to a designated body in the Medical Profession (Responsible Officers) Regulations 2010; or were granted permission to practise as medical practitioners in hospitals owned or managed by such bodies.
15. Flexibilities similar to the COVID-19 amendment will be made permanent. Doctors that are employed or registered with bodies designated by the Medical Profession (Responsible Officers) Regulations 2010 (Schedule, Part 1 only) will be able to deliver primary care services without being on the MPL. There will be a corresponding change to the GP contract regulations.
16. These changes will permit GP practices and PCNs to employ doctors who are already employed, for example, by an NHS trust, NHS foundation trust or health board without the requirement for the doctor to also be registered on the MPL.
17. Supporting guidance will also be issued to clarify that non-GP doctors should not see undifferentiated patients, and that they continue to be required to operate within their sphere of competence.

Registering with a GP

18. NHS England has co-developed a new registration solution with patients and practices to make registering with a GP easier, simpler and standardised. Over 2000 practices have already adopted the solution which consists of an online registration service and a new paper form. Practices will be contractually required to adopt and offer both formats.

19. There will be a mobilisation period with both formats to be in place from October 2024.

Recognising the importance of continuity of care

20. In order to highlight the importance of continuity of care, whilst ensuring practices have flexibility to deliver services to best meet the needs of their patient population, the provisions in the GP Contract Regulations will be amended to explicitly require continuity of care to be considered when determining the appropriate response when a patient contacts their practice.

Vaccinations and Immunisations

21. The GP Contract will be changed in 2024/25 so that practices are required to:

- share vaccination status (both vaccinated and unvaccinated) with the local Child Health Information Services (CHIS), and any other system nationally required, and support CHIS data cleansing.
- improve data recording of vaccination status for all patients, including where they have arrived from overseas and where there is an unknown or incomplete history to offer vaccinations in line with the UK Schedule and Green Book.
- improve data quality for vaccination events, with this being supported through a rationalisation of SNOMED codes used for vaccination event recording. following an impact assessment by NHS England, with practices ensuring they are using the relevant codes within their clinical system templates; and
- maintain accurate and up-to-date patient vaccination records, including correcting vaccination records as and when they are made aware of any errors.

Changes to workforce data collection

22. Practices and PCNs will be required to submit workforce information on a quarterly basis to the National Workforce Reporting Service (NWRS) via changes to the GP contract and the Network Contract DES.

Digital tools for catchment areas

23. The GP Contract Regulations will be amended to require GP practices to use digital tools provided by NHS England to reproduce a digital copy of their practice boundary (including any branch site areas, whether coterminous or not). Practices will also be required to review and where necessary update GP practice boundaries where data quality is insufficient for the intended purpose.

24. Practices will also be required to produce a digital copy of a practice's agreed practice boundary where a new practice is established or merged or a catchment area change is agreed, either as part of a new contract or variation procedures.

Armed Forces Veterans

25. The GP Contract will be updated so that practices must have due regard for the requirements, needs and circumstances of Armed Forces Veterans when offering services and making onward referrals.

<u>The Network Contract DES</u>

The Additional Roles Reimbursement Scheme (ARRS)

26. The following changes will be made to the ARRS in 2024/25. They are intended to the increase the flexibility of the scheme by widening the reimbursable roles and removing role restrictions where possible:

- Enhanced practice nurses will be included in the roles eligible for reimbursement. This will allow nurses working at an enhanced level of practice and holding a (level seven or above) postgraduate certification or diploma in one or more specialist areas of care to be recruited via ARRS. As a new role, this will initially be capped at one per PCN (two where the list size is 100,000 or over).
- PCNs will be able to recruit other direct patient care non-nurse and non-doctor MDT roles, if agreed with their ICB.
- Where PCNs already have one mental health practitioner (MHP) in place, 50:50 funded by the PCN and the mental health provider, funding arrangements for subsequent MHP roles will be for agreement between the PCN and the mental health provider, subject to ICB approval. This could include additional MHPs being up to 100% funded through ARRS. All mental health practitioners will continue to be employed or engaged by the mental health provider.
- Caps on advanced practitioners will be removed.
- PCNs will be able to claim reimbursement for the time personalised care roles spend out of practice undertaking training or apprenticeships to obtain a level three occupational standard.

27. In 2024/25 the mechanism which allows commissioners to redistribute unclaimed funding from the Additional Roles Reimbursement Sum between PCNs will be removed from the Network Contract DES. We continue to encourage PCNs to recruit up to their individual entitlements.

The Capacity and Access Payment (CAP)

28. The Capacity and Access Payment (CAP) will continue in 2024/25. The overall amount of funding allocated to the CAP in 2024/25 will increase by £46m to £292m.

29. As was the case in 2023/24, 70% of funding will be paid to PCNs via the Capacity and Access Support Payment (CASP) without reporting requirements, proportionate to their Adjusted Population, in 12 equal payments.

30. The remaining 30% of funding will be available to PCNs via the Capacity and Access Improvement Payment (CAIP). This will be paid to PCNs in monthly instalments over the remainder of the financial year[1] once all practices within a network have put in place the components of the Modern General Practice Access model shown in the table below:

[1] Unless confirmation is provided in March 2025, in which case payment would be made in April 2025.

MGPA priority domain	All PCN practices to have following components in place and these continue to remain in place
1) Better digital telephony	Digital telephony solution implemented, including call back functionality; and each practice has agreed to comply with the Data Provision Notice so that data can be provided by the supplier to NHS England. Digital telephony data is routinely used to support capacity/demand service planning and quality improvement discussions.
2) Simpler online requests	Online consultation (OC) is available for patients to make administrative and clinical requests at least for the duration of core hours. Practices have agreed to the relevant data provision notice (DPN) so that data can be provided by the supplier to NHS England as part of the 'submissions via online consultation systems in general practice' publication.
3) Faster care navigation, assessment, and response	Consistent approach to care navigation and triage so there is parity between online, face to face and telephone access, including collection of structured information for walk-in and telephone requests. Approach includes asking patients their preference to wait for a preferred clinician if appropriate, for continuity.

31. Each PCN Clinical Director will need to provide assurance of this to their ICB. These conditions can be met at any point during the year and PCNs will receive payment in-year once they are met.

The Investment and Impact Fund (IIF)

32. As part of the changes to the GP Contract in 2023/24, the Investment and Impact Fund (IIF) was significantly streamlined with the number of indicators in the scheme reduced from 36 to 5 (worth £59m in 2023/24).

33. In 2024/25 the number of IIF indicators will be reduced further from 5 to 2 (retaining the indicators on learning disability health checks and FIT testing) and the funding from the other 3 indicators (flu and access) will be redirected into the Capacity and Access Payment (CAP). This will leave approximately £13m worth of funding within IIF for 2024/25.

PCN Clinical Directors requirements and funding

34. The PCN Clinical Director role description will be simplified and refocussed in 2024/25. It will focus on the following key responsibilities: co-ordination of service delivery, allocation of resources, supporting transformation towards Modern General Practice and supporting the PCN role in Integrated Neighbourhood Teams.

35. A more flexible funding pool will also be created for PCNs by rolling the Clinical Director Payment and PCN Leadership and Management funding (£89m combined) into Core PCN funding to give £183m in total.

The Network Contract DES service requirements

36. There are currently nine service requirements which are detailed in the Network Contract DES. A number of these are supported by non-contractually binding guidance documents.

37. Eight of the current PCN service specifications will be replaced by one simple overarching specification with a greater outcomes-focus. The new overarching specification will focus on supporting resilience and care delivery, improving health outcomes, reducing health inequalities and targeting resource to deliver proactive care.

38. The Enhanced Access specification will remain as a separate specification with the arrangements unchanged in 2024/25.

Enhanced Services

Weight Management Enhanced Service

39. The Weight Management Enhanced Service will continue in 2024/25. Practices will receive £11.50 per referral with total funding of £7.2m for the Enhanced Service.

Norfolk and Waveney
Integrated Care Board

Agenda item: 09

Subject:	**Draft Dental Clawback Policy**
Presented by:	**Matthew Lewis: Primary Care & POD Finance Officer** **Stuart White: Finance Manager Delegated Primary Care**
Prepared by:	**Matthew Lewis: Primary Care & POD Finance Officer** **Stuart White: Finance Manager Delegated Primary Care** **James Grainger: Head of Finance Primary Care**
Submitted to:	**Primary Care Commissioning Committee**
Date:	**12 March 2024**

Purpose of paper:

This paper seeks approval from the committee for the following:

- **Appendix A** - Primary Dental Contract Clawback Policy

Executive Summary:

Delegation of dental commissioning from NHS England to the ICB included the responsibility around "clawing back" financial amounts for undelivered dental activity. In 22/23 this amounted to circa £16.5m in Norfolk and Waveney, due to the access and workforce issues dental practices currently encounter.

A policy is required to **fairly** consider individual practice circumstances when considering an extended repayment period for underactivity clawback. This paper sets out the principles and process that will be used in making these decisions.

Background

More than a third of contracted dental activity (£16.5m) was not delivered in financial year 22/23 for a variety of reasons and the expectation is for a similar underperformance in 23/24. This is a significant amount of money and higher than other ICB's in our region and the national average of under delivery.

The clawing back of this money represents a significant challenge to our dental providers and can lead to cash flow issues, insolvency or the cessation of NHS

contracts, we therefore have need for a policy on providing extended financial terms to cover the claw back of the money.

NHS England and NHS BSA have no specific policy for offering extensions beyond the standard BSA clawback terms.

The criteria that the policy is based upon were proposed for discussion in the Dental Operational Delivery Group on 5th October and 2nd November 2023, the feedback from which have been incorporated into the proposal.

Policy application

As well as setting a timeline to ensure timely responses, the policy lists specific information that will be requested for consideration; this includes the relevant exceptional circumstance(s), a proposed repayment plan and performance against mid-year business recovery plans.

These criteria will form the basis of a meeting held between finance and commissioning members to frame the discussions around the provider's eligibility for extended repayment terms.

This framework enables deliberation between the financial risks of extending the repayment terms against the potential impacts on health inequalities and reduced access in the community, as well as enabling a fair platform for all providers across Norfolk and Waveney.

Recommendation

To approve the following: • **Appendix A** - Primary Dental Contract Clawback Policy

Key Risks	
Clinical and Quality:	Dental care resilience has a significant impact on service provision to patients across some parts of the system.
Finance and Performance:	The financial implications of this policy would be increasing the level of bad debt risk.
Impact Assessment (environmental and equalities):	There is an opportunity to tackle local health inequalities through increasing the resilience of dental services
Reputation:	There would be reputational damage to the ICB if dental contracts are handed back or practices become insolvent due to unachievable repayment terms for practices in financial difficulties.
Legal:	Formal delegation agreement with NHSE&I, delegation assurance framework and dental contracts
Information Governance:	Not identified

Resource Required:	Primary care finance team & dental commissioning team resource required to evaluate and manage specific cases. Also manage appeals.
Reference document(s):	Delegation agreement, primary care assurance framework and dental contracts.
NHS Constitution:	N/A
Conflicts of Interest:	None identified
Reference to relevant risk on the Board Assurance Framework	BAF18 – the resilience of dental services

Governance

Process/Committee approval with date(s) (as appropriate)	Dental Operational Delivery Group 2nd November 2023 Audit Committee TBA

NHS
Norfolk and Waveney
Integrated Care Board

Norfolk and Waveney ICB

Primary Dental Contract Clawback Policy

Document Control Sheet

This document can only be considered valid when viewed via the ICB's intranet. If this document is printed into hard copy or saved to another location, you must check that the version number on your copy matches that of the one online.

Approved documents are valid for use after their approval date and remain in force beyond any expiry of their review date until a new version is available.

Name of document	Dental Contract Clawback Policy
Version	1
Date of this version	January 2024
Produced by	This policy has been prepared by the ICB Finance team.
What is it for?	Formalise the process surrounding approval of extended repayment terms.
Evidence base	
Who is it aimed at and which settings?	Dental Commissioners and Primary Care Finance staff
Consultation	This is an internal document that does not need further engagement It will be presented at the March 2024 PCCC meeting.
Impact Assessment:	
Other relevant approved documents	Not applicable
References:	
Monitoring and Evaluation	
Training and competences	Not applicable.
Reviewed by:	
Approved by:	
Date approved:	
Signed:	
Dissemination:	
Date disseminated:	
Review Date:	
Contact for Review:	Head of Primary Care Finance

Version Control

Revision History	Summary of changes	Author(s)	Version Number

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Contents

1 Introduction and Purpose

More than a third of contracted dental activity (£16.5m) was not delivered in financial year 22/23 for a variety of reasons and the expectation is for a similar underperformance in 23/24. This is a significant amount of money and higher than other ICB's in our region and the national average of under delivery. The clawing back of this money represents a significant challenge to our dental providers and can lead to cash flow issues, insolvency, or the cessation of NHS contracts. We therefore have need for a policy to balance the needs of the providers and the cashflow implications for the ICB.

NHS England and NHS BSA have no specific policy for offering extended terms beyond the standard BSA clawback terms.

With a formalised process, requests for extended repayment terms can be considered against pre-determined criteria. This will enable fair consideration to be offered to all providers, as a well as a framework for presenting these requests for approval by senior colleagues at the ICB.

Repayment terms default to 3 months following agreement of the year end review. For the year ending 31 March 2023, a majority of contracts began their repayments in September 2023 and made their last payments in November 2023.

2 Criteria

The **provider should propose a repayment plan** alongside their request for extended terms, otherwise this process should not begin. Without a proposed repayment plan, the ICB would be unable to meaningfully review the request. The dental commissioning team will acknowledge receipt of the request, with the final decision being communicated to the provider within one calendar month of the request.

The following information will be compiled upon the request of a provider to extend the terms of repayment.

- Extended repayment terms are **only** approved in exceptional circumstances.
    - Exceptional circumstances could include retirement of a partner during the year, extraordinary levels of staff sickness or very high staff turnover.
- The ratio of private to NHS work needs to be considered. Where the provider has been reimbursed for rates, an NHS against Private work percentage is visible. Where this is less than 60%, extended terms are unlikely to be considered.
- The strategic importance of the practice in question needs to be considered.
    - Is the provider located in an area of high deprivation?
    - What are the implications on the neighbouring practices if the contract is handed back due to financial difficulties? If the demise of a practice in question leaves a geographical gap in patient services.
    - What other services does the practice offer other than standard dental services e.g. orthodontics, minor oral surgery, etc.
- What is the YTD activity for the current year, as per eDEN? Are they on track to achieve their contractual value? If they are not, then there is a risk of overlapping

repayments and a high likelihood that current contract payments would be cashflowing the extended repayments.

- What % of our overall contracted UDA's are with this current provider? Where this percentage is high and current year performance is on track, we would need to consider the strategic importance.

- Was the provider flagged as underperforming at the mid-year review for the period of underperformance? If so, has the business recovery plan been enacted to improve the long term performance?

- Where a provider claims a lack of financial resilience, this must be substantiated by financial data and a cashflow forecast. Note that when an underperformance is enacted, the provider retains patient charge revenue during that period, which will aid their cashflow.

- The finance team will prepare an estimate for the period of the repayment to ensure that the underperformance will be repaid during that time and what the potential impact on monthly cashflow would be.

3 Decision making

Upon compilation of the above information, a meeting will occur between finance and the commissioning team to discuss the provider's performance against the listed criteria.

The decision to approve the request for extended terms must be unanimously decided by **both the finance and commissioning teams**.

The commissioning team will communicate the decision to the provider. Where the request is approved, the commissioning team will inform the provider and make the necessary entries on Compass.

Where the request is denied, the decision will be shared with the provider by the commissioning team and they will be informed that the underperformance will be adjusted for as per standard clawback procedures. The provider may appeal the outcome and offer any additional mitigating circumstances to support their request.

APPENDIX A1 EQUALITY IMPACT ASSESSMENT

Step 1: Aims and purpose of the proposal / policy being assessed
(This should reflect what the policy is intending to achieve and how it seeks to achieve, it is this intention that the assessment seeks to measure, consider who benefits and how and who doesn't and why, also consider the impact of associated aims).
To decide whether a dental provider qualifies for extended repayment terms.

Step 2: Screening process for relevance to equality & diversity issues	
Does this proposal / policy have any equality & diversity relevance in the following areas? (This should be considered in relation to the formulation and application of the policy. As far as possible engagement with the relevant staff network groups should take place to identify any potential areas of relevance).	
A Age	**N/A**
B Disability	**N/A**
C Gender reassignment	**N/A**
D Marriage and Civil Partnership	**N/A**
E Pregnancy and maternity	**N/A**
F Race	**N/A**
G Religion or belief	**N/A**
H Sex	**N/A**
I Sexual orientation	**N/A**
J Other issues	**N/A**

Step 3: If you have answered, “Yes”, to any of the protected characteristic boxes in Step 2, a full impact assessment is required	
Are any of the protected characteristic boxes in Step 2 marked “Yes”?	**N/A**

Step 4: Examination of available information (sources can include but are not restricted to – ESR data; MI relating to Recruitment /Employee Relations/Attrition; Industry best practice; legal overview; research articles; matters arising from judgements tested during consultation; consider four-fifths rule to assess difference).
All information submitted by providers in support of the extended repayment claims will be assessed on its own merits.

Step 5: Full Impact Assessment Process			
Step 5a: Consultation Log			
Where are the consultation records stored? N/A			
Step 5a: Consultation Log	Step 5a: Consultation Log	Step 5a: Consultation Log	Step 5a: Consultation Log
DODG on 02/11/2023			
PCCC on 12/03/2024			

Step 5b: EIA Action Plan: Workforce Impacts (internal)				
Potential issues or impacts (positive and negative)				
None				

Step 5c: EIA Action Plan: Service Delivery Impacts (external)		
Potential issues or impacts **(positive and negative)**		
Unsuccessful extended repayment claims may limit access to services	The consideration of reduced service has been incorporated into the decision-making process for provider requests.	

Step 6: Monitoring and review arrangements
How will the implementation of the proposal / policy be monitored, and by whom?
During the decision-making meetings occurring between the finance and commissioning teams, equality impacts will be part of the criteria.
What is the timetable for monitoring, with dates?
Annual review of the policy to reflect changes in national guidance and contracting terms.

Step 7: Public availability of reports / result
Internal decision-making regarding non-publicly available contracting relationship between ICB and provider.

Norfolk and Waveney
Integrated Care Board

Agenda item: 10

Subject:	**Proposed Changes to the Terms of Reference for Primary Care Commissioning Committee 2024/2025**
Presented by:	**Fiona Theadom, Head of Primary Care Commissioning**
Prepared by:	**Fiona Theadom, Head of Primary Care Commissioning**
Submitted to:	**Primary Care Commissioning Committee**
Date:	**12 March 2024**

Purpose of paper:

To consider proposed changes to the Terms of Reference for the Primary Care Commissioning Committee and two Delivery Groups to take effect for 2024/2025 and to recommend for approval to the Board in March 2024.

The proposed changes have been reviewed by the General Practice Delivery Group and the Dental Services Delivery Group and agreed by both Groups with minor amendments included in this paper.

Executive Summary:

In March 2023, the Primary Care Commissioning Committee (PCCC) Terms of Reference were updated to reflect the expanded responsibilities for all primary care services under the Delegation Agreement with NHS England from 1 April 2023.

To facilitate and streamline discussions and decision making, two delivery groups, one for dental services and the other for general practice, were established under a Scheme of Delegation for PCCC. At the time, it was acknowledged that the primary care governance framework may need to be amended and would evolve as the Committee became more familiar with the role and responsibilities of the Delivery Groups.

The ICB has now reviewed how this governance framework has been working since April 2023 and this paper proposes a number of amendments to make the Committee more effective from April 2024.

The Terms of Reference with proposed amendments highlighted together with those in the Scheme of Delegation are attached as Annex A and Annex B respectively.

Report

The establishment of the two Delivery Groups have enabled and supported in depth discussions around operational contracting and commissioning matters, about quality and about resilience which could not have happened at PCCC due to their expanded responsibilities across all primary care contractors, following delegation by NHS England. It is therefore proposed that the governance structure to support Delivery Groups remaining in place be continued but with the proposed changes to both the Primary Care Commissioning Committee (PCCC) and Delivery Groups highlighted below.

Proposed Amendments to PCCC Terms of Reference

PCCC agendas should be freed up to allow more time for strategic oversight and delivery of its assurance role, receiving reports from the operational delivery groups and to allow time for planning and deep dives into specific topics.

It is proposed that PCCC meets quarterly as a minimum, unless there is urgent business to discuss.

Membership of Part 2 to include Healthwatch and representatives from Health and Wellbeing Boards

The primary care BAF (Board Assurance Framework) risks will continue to be presented to PCCC for strategic assurance and discussion. All other risks will be overseen by the Delivery Groups with a summary provided to PCCC in the regular assurance reports and an annual update.

In line with its duties to reduce health inequalities in primary care, the Committee will also receive reports and be responsible for decision making in regard to this duty.

Delivery Groups

It is proposed that the Delivery Groups meet concurrently on the same day for two months running and PCCC will meet in the following month on a cyclical basis throughout the year. It is proposed that all meetings take place on a Tuesday as now.

The PCCC Chair and Vice Chair will have an open invitation to attend any of the Delivery Group meetings to inform Committee oversight and with the opportunity to ask questions of the Group about agenda items.

Voting Members of the Delivery Groups will be required to nominate named deputies to enable decision making within the ICB's Detailed Delegated Financial Limits (DDFL).

Risk registers are being developed for each service area for operational management by the relevant Delivery Group with reporting and escalation to PCCC as required.

General Practice Delivery Group

It has become clear since April that there are an increasing number of decisions in relation to local pharmaceutical contracting and commissioning that need to be discussed, and due to the synergies and close working relationship between general practice, PCNs and community pharmacy, it is proposed that responsibility for community pharmacy fall within the remit of an expanded and renamed General Practice Delivery Group. The Terms of Reference have been amended to reflect this.

The ICB representation is expanded to include Pharmacy leadership and the Local Pharmaceutical Committee will be invited to attend the meetings.

For clarity, reports from the Pharmaceutical Services Regulations Committee will continue to be received by PCCC on a quarterly basis for assurance and oversight.

Dental Services Delivery Group

Minor amendments are proposed for the Dental Services Delivery Group aligned to relevant changes to the General Practice Delivery Group where appropriate.

Next steps

Each of the Delivery Groups have had an opportunity to review and consider the proposed changes and are fully supportive. PCCC is asked to approve the changes at their meeting in March and to recommend approval to the Board in March 2024 so that the proposed changes can take effect from 1 April 2024.

Recommendation to the Delivery Group:

To agree the proposed amendments to the Committee Terms of Reference and changes to the Scheme of Delegation and delivery groups and recommend them to the ICB Board for approval.

Key Risks	
Clinical and Quality:	Primary Care Commissioning Committee has responsibility for quality in primary care
Finance and Performance:	Strong governance and oversight through the updated Terms of Reference and regular reporting and oversight of the primary care budget which is the responsibility of PCCC.
Impact Assessment (environmental and equalities):	In regards to its duties to reduce inequalities (14T), in the exercise of its functions, the Committee will have regard to the need to:

	a) Reduce inequalities between patients with respect to their ability to access health services, and b) Reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services
Reputation:	The Terms of Reference for the Primary Care Commissioning Committee are designed to set out the responsibilities of the Committee in relation to primary care matters to ensure strong governance, transparency, assurance and robust decision making processes to ensure the ICB fulfils its responsibilities under the Delegation Agreement
Legal:	Primary Care Regulations relating to general practice, dental services, pharmaceutical services and optometry services
Information Governance:	No information governance issues identified
Resource Required:	All of the ICB teams involved in primary care matters
Reference document(s):	Delegation Agreement with NHS England 2023, NHS England Primary Care Policy Manuals
NHS Constitution:	N/A
Conflicts of Interest:	The Committee and both Delivery Groups have formal arrangements in place to manage conflicts of interest
Reference to relevant risk on the Board Assurance Framework	BAF14 and BAF18

Governance

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

~~Item No 5~~

APPENDIX F

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

Revision History

Revision Date	Summary of changes	Author(s)	Version Number
January 2023	Changes made to reflect transition of responsibility for pharmacy, dental and ophthalmic from NHS England to ICB		
March 2024	Changes made to update the Terms of Reference to improve effectiveness		

Approvals
This document has been approved by:

Approval Date	Approval Body	Author(s)	Version Number
1 July 2022	ICB Board		1
28 March 2023	ICB Board		2

1 Constitution

1.1 The Primary Care Commissioning Committee (the Committee) is established by the Norfolk and Waveney Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution.

These Terms of Reference (ToR), which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

1.2 The Committee is a non-executive committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

2 Authority

2.1 The Committee is authorised by the Board to:

- Investigate any activity within its terms of reference.
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these terms of reference.
- Create a Primary Medical Services Delivery Group and a Dental Services Delivery Group that will undertake specific agreed tasks and decision making as set out in the ICB Governance. The Committee shall appoint the Chair and agree the membership and terms of reference of these groups in accordance with the ICB's constitution, standing orders and SoRD.

2.2 For the avoidance of doubt, the Committee will comply with the ICB Standing Orders, Standing Financial Instructions and the SoRD.

3 Purpose

3.1 To contribute to the overall delivery of the ICB's objectives to create opportunities for the benefit of local residents, to support Health and Wellbeing, to bring care closer to home and to improve and transform services by providing oversight and assurance to the ICB Board on the exercise of the ICB's delegated primary care commissioning functions and any resources received for investment in primary care.

The duties of the Committee will be driven by the ICB's objectives and the associated risks. An annual programme of business will be agreed before the start of the financial year, however this will be flexible to new and emerging priorities and risks.

3.2 The Committee has no executive powers, other than those delegated in the SoRD and specified in these terms of reference.

4 Membership and attendance

Membership

4.1 The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

The Board will appoint no fewer than 4 members of the Committee based on their specific knowledge, skills and experience.

4.2 The members of the Committee who will attend Part 1 and Part 2 meetings are:

- A Local Authority Partner Member from the ICB Board (Chair)
- Non-Executive ~~Director~~ Member from the ICB Board (Deputy Chair)
- Executive Director of Nursing or their nominated deputy
- Executive Director of Finance or their nominated deputy

4.3 Where a member of the Committee is unable to attend a meeting, a suitable deputy may be agreed with the Committee Chair. The nominated deputy will count in the quorum for the meeting and be able to cast a vote if required.

Chair and Vice Chair

4.4 The Chair of the ICB will appoint a Chair of the Committee who has the specific knowledge, skills and experience making them suitable to chair the Committee.

Committee members may appoint a Vice Chair from amongst the members.

4.5 In the absence of the Chair, or Vice Chair, the remaining members present shall elect one of their number to Chair the meeting.

The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these Terms of Reference.

Attendees

4.6 Only members of the Committee have the right to attend Committee meetings. The following individuals, who are attendees and not members of the Committee, will be invited to attend Part 1 and Part 2 meetings subject to s.4.~~10~~7:

- ICB Board Partner Member – Providers of Primary Medical Services
- Local Representative Committee members – Local Medical Committee, Local Dental Committee, Local Pharmacy Committee and Local Optical Committee
- Director of Patients and Communities
- Director of Primary Care
- One practice manager (or other suitably experienced individual) from primary medical services and one individual from (NHS) primary dental services

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

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

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

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

Attendance

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

5 Meetings Quoracy and Decisions

5.1 The Committee will meet at least 4 times a year in public subject to the application of 5.4 below. The Committee will operate in accordance with the ICB's Standing Orders. The Secretary to the Committee will be responsible (or delegate where appropriate) for giving notice of meetings. This will be accompanied by an agenda and supporting papers and sent to each voting member and non-voting attendee at least 7 calendar days before the date of the meeting. When the Chair of the Committee deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as s/he/they shall specify. Additional meetings may take place as required in public or private as appropriate for the nature of the business to be transacted.

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

5.2 In accordance with the Standing Orders, the Committee will normally meet virtually unless a face to face meeting is deemed necessary.

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

Quorum

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

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

5.4 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken. If an urgent decision is required, the process set out at 5.~~11~~ 7 and 5.~~12~~ 8 may be followed.

Decision making and voting

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

call a vote.

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

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

Urgent Decisions

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

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

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

6 Responsibilities of the Committee

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

Schedule 2A: Primary medical services

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

Schedule 2B: Primary dental services and prescribed dental services

- decisions in relation to the commissioning, ~~and~~ management and quality of ~~Primary~~ Dental~~,~~ Services; for clarity this includes primary care, community care/special care dental services and secondary care dental services;
- planning ~~Primary~~ Dental Services in the Area, including carrying out needs assessments;
- undertaking reviews of Primary Dental Services in the Area;
- management of the Delegated Funds in the Area;

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- co-ordinating a common approach to the commissioning and delivery of Primary Dental Services with other health and social care bodies in respect of the Area where appropriate; and
- such other ancillary activities that are necessary in order to exercise the Delegated Functions.

Schedule 2C: Primary ophthalmic services

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

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

Schedule 2D: Pharmaceutical services and local pharmaceutical services

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

NHS England has established a mandated local committees to be known as the Pharmaceutical Services Regulations Committees (PSRC). The PSRC is an ICB committee with representatives from all East of England ICBs attending. NHS England has delegated decision making to each PSRC in relation to matters under the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 as amended.

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

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

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

The Norfolk and Waveney ICB remains responsible and accountable for the provision of this service and for the direct commissioning, management and quality of local pharmaceutical services.

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

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

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

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

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

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

b) The needs assessment and plan for primary ~~medical~~ care services in the areas covered by the ICB including the resilience of all primary care providers;

c) The co-ordination of a common strategic and operational approach to the commissioning of primary care services generally including supporting developments in respect of integration with providers and local authority services including co-location of services;

d) The management of the budget for commissioning of primary care services in the area covered by the ICB;

e) In accordance with its duties to reduce inequalities,14T, in the exercise of its functions, the Committee will have regard to the need to:

- Reduce inequalities between patients with respect to their ability to access health services, and
- ~~reduce~~ Reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services

7 Behaviours and Conduct

ICB values

7.1 Members will be expected to conduct business in line with the ICB values, objectives and follow the seven principles of public life (the Nolan Principles), comply with the standards set out in the Professional Standards Authority guidance.

Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy and Conflicts of Interest Policy.

Equality and diversity

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

Conflicts of Interest

7.3 Members and those attending a meeting of the Committee will be required to declare any relevant interests to the ICB in accordance with the ICB's Conflicts of Interest Policy.

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

Confidentiality

7.4 Issues discussed at Committee meetings held in private, including any papers, should be treated as confidential and may not be shared outside of the meeting unless advised otherwise by the Chair.

8 Accountability and reporting

8.1 The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

The Chair of the Committee, if not a member of the ICB Board, may be invited to attend Board meetings at the request of the Chair of the ICB.

8.2 The Chair of the Committee will be accountable to the Chair of the ICB for the conduct of the Committee.

The minutes of the meetings, including any virtual meetings, shall be formally recorded by the secretary. A report of the Committee's work will be submitted to the Board following each meeting.

8.3 The Committee Chair shall draw to the attention of the Board any issues that require disclosure to the Board or require action.

9 Secretariat and Administration

9.1 The Committee shall be supported with a secretariat function which will include ensuring that:

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

Webb Sarah 07/03/2024 11:43:43

developments.

- Action points are taken forward between meetings and progress against those actions is monitored.

10 Review

10.1 The Committee will review its effectiveness annually.

These terms of reference will be reviewed annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the ICB Board for approval.

Date of approval: XX~~28 February 2023~~March 2024

Version 3~~2~~

NORFOLK AND WAVENEY ICB - PRIMARY CARE COMMISSIONING COMMITTEE

Primary Care Commissioning Committee Scheme of Delegation ~~(Interim)~~ for Dental Services

This Scheme of Delegation should be considered in conjunction with the Terms of Reference for the Primary Care Commissioning Committee. It will be reviewed ~~in September 2023~~annually to determine its effectiveness and fitness for purpose.

Purpose

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

The purpose of the Delivery Group~~s~~ is to provide a framework for effective decision making in relation to certain contractual and commissioning matters for ~~general practice and~~ dental services under delegated authority from the ICB's Primary Care Commissioning Committee.

The PCCC Scheme of Delegation also allows for certain decisions to be made by an appropriate member of the Primary Care Commissioning Team as outlined in detail in Appendix A.

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

Membership

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

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

The voting members for ~~each~~ the Delivery Group will be:

- Chair – Executive Director of Patients and Communities
- Director – Primary Care (Deputy Chair)
- Associate Director - Primary Care Commissioning
- Finance – Head of Finance – Primary Care and Corporate/Reporting
- ~~Associate~~ Director of Nursing and Quality

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

Dental Services Delivery Group
• Head of Primary Care Commissioning (Dental and Medical)
• Head of Primary ~~and Community~~ Care Strategic Planning
• Senior Primary Care Commissioning Manager (Dental)
• Representative of the Local Dental Committee
• Healthwatch Norfolk and Healthwatch Suffolk
• ~~Representation from general dental practice team or community dental services~~Dental Speciality Advisor for PCCC
• Representative of the Local Dental Professional Network
• Consultant in Dental Public Health
• Head of Primary Care Workforce Transformation

The Chair and Vice Chair of the Primary Care Commissioning Committee may attend meetings of the Delivery Group.

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

Where an attendee of the Group who is not a member of the Group is unable to attend a meeting, voting members will nominate a named deputy who can attend in their absence. The named deputy must be agreed with the Chair of the Delivery Group.
~~a suitable alternative may be agreed with the Chair~~

Quoracy of Group Meetings and Decisions

~~Each~~The Delivery Group will meet at least ~~4~~ 6 times a year or more often to meet business needs. ~~Each~~ The Group will operate in accordance with the ICB's Standing Orders and Detailed Delegated Financial Limits. The Secretary to ~~each~~ the Group will be responsible (or delegate where appropriate) for giving notice of meetings. This will be accompanied by an agenda and supporting papers and sent to each voting member and non-voting attendee at least 7 calendar days before the date of the meeting. When the Chair of the Group deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as s/he/they shall specify. Additional meetings may take place as required as appropriate for the nature of the business to be transacted.

In accordance with the Standing Orders, the Group will normally meet virtually unless a face to face meeting is deemed necessary.

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

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

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

Decision making and voting

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

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

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

Urgent Decisions

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

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

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

General Responsibilities of the Delivery Groups

There will be two Delivery Groups directly reporting to PCCC:

- General Practice and Community Pharmacy ~~Operational~~ Delivery Group
- Dental Services ~~Operational~~ Delivery Group

Commented [PS(NAWI21]: We call them delivery groups in some places and operational delivery groups in others. I don't mind which one we use but we should probably pick one term? What's best?

The responsibilities of each Delivery Group are described in section 6 of the Primary Care Commissioning Committee's Terms of Reference as set out in Schedule 2 of the Delegation Agreements with NHS England.

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

- Activities and decisions made by each Group since the last meeting
- Changes/updates to national policy/strategy
- Quality and Safety – emergent issues and thematic review and response
- Risk and finance assessment
- Forward plan for the year and monthly Forward Planner

Matters for escalation to PCCC

- Recommendations to PCCC (where required)

In addition to the two Delivery Groups acting as sub-groups of PCCC, the ICB may form other groups for primary care matters as required reporting to the ~~People~~ Patients and Communities Board or to PCCC. For example, a Dental ~~Taskforce~~ Development Group to focus on dental transformation and strategy, or a ~~c~~Community ~~p~~Pharmacy ~~s~~Strategy ~~g~~Group. If established, each group will prepare a report to ~~PCCC~~the appropriate Delivery Group four times per year.

~~Phased introduction~~ ~~to Scheme of Delegation~~Decisions made by the Primary Care Commissioning Team

Commented [PS(NAWI22]: Is this still being phased or should we update the title?

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

Decisions will be made in accordance with the Detailed Delegated Financial Limits (DDFL) agreed by the ICB's Executive Management Team from time to time.

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APPENDIX A – Primary Care Commissioning Committee Scheme of Delegation

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

Commission service intentions (>£1m)				
Contract Award (>£1m over lifetime of contract)				

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SECONDARY CARE DENTAL	Primary Care Commissioning Team (in line with Finance delegated budget authority) from September 2023	Dental Services Delivery Group	Primary Care Commissioning Committee	Financial impact, risk or cost pressure
Commission intentions (<£100k)				
Commission intentions (<£1m)				
Contract Award (<£1m over life time of contract)				
Commission intentions (>£1m)				
Contract Award (>£1m over life time of contract)				

NORFOLK AND WAVENEY ICB - PRIMARY CARE COMMISSIONING COMMITTEE

Primary Care Commissioning Committee Scheme of Delegation ~~(Interim)~~ for Primary Medical and ~~Pharmaceutical~~ Community Pharmacy Services

This Scheme of Delegation should be considered in conjunction with the Terms of Reference for the Primary Care Commissioning Committee. It will be reviewed ~~in September 2023~~ annually to determine its effectiveness and fitness for purpose.

Purpose

The Primary Care Commissioning Committee ("PCCC") have agreed the establishment of a Primary Medical Services and Community Pharmacy Delivery Group that will undertake specific agreed tasks and decision making as set out in the Scheme of Reservation and ~~delegation~~ Delegation as delegated to the appropriate director. The Committee shall determine the membership and terms of reference of these groups in accordance with the ICB's ~~constitution~~Constitution, ~~s~~Standing ~~o~~Orders and Scheme of Reservation and Delegation (SoRD).

The purpose of the Delivery Group is to provide a framework for effective decision making in relation to certain contractual and commissioning matters for general practice and community pharmacy under delegated authority from the ICB's Primary Care Commissioning Committee. For clarity, the Pharmaceutical Services Regulations Committee remains responsible for decisions under its Terms of Reference as set out in NHS England's Pharmacy Manual.

The PCCC Scheme of Delegation also allows for certain decisions to be made by an appropriate member of the Primary Care Commissioning Team as outlined in detail in Appendix A.

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

Membership

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

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

The voting members for ~~each~~ the Delivery Group will be:

- Chair – Executive Director of Patients and Communities
- Director – Primary Care (Deputy Chair)

- Associate Director - Primary Care Commissioning
- Finance – Head of Finance - **Primary Care & Corporate/Reporting**

- ~~Associate~~ Director of Nursing and Quality

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

General Practice and Community Pharmacy Delivery Group
• Head of Primary Care Commissioning (Dental and Medical)
• Head of Primary ~~and Community~~ Care Strategic Planning
• Head of Primary Care Workforce Transformation
• Head of Primary Care Commissioning (Pharmacy and Optometry)
• Senior Primary Care Commissioning Manager (General Practice)
• Representative of the Local Medical Committee
• Representative of the Local Pharmacy Committee
• Healthwatch Norfolk and Healthwatch Suffolk
Practice Manager - general practice Speciality Advisor for PCCC
Representative from the ICB's BI team

The Chair and Vice Chair of the Primary Care Commissioning Committee may attend meetings of the Delivery Group.

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

Where an attendee of the Group who is not a member of the Group is unable to attend a meeting, voting members will nominate a named deputy who can attend in their absence. The named deputy must be agreed with the Chair of the Delivery Group.
~~a suitable alternative may be agreed with the Chair~~

Quoracy of Group meeting and decisions

The Delivery Group will meet at least ~~4~~ 6 times a year or more often to meet business needs. The Group will operate in accordance with the ICB's Standing Orders and Detailed Delegated Financial Limits. The Secretary to the Group will be responsible (or delegate where appropriate) for giving notice of meetings. This will be accompanied by an agenda and supporting papers and sent to each voting member and non-voting attendee at least 7 calendar days before the date of the meeting. When the Chair of the Group deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as

s/he/they shall specify. Additional meetings may take place as required as appropriate for the nature of the business to be transacted.

In accordance with the Standing Orders, the Group will normally meet virtually unless a face to face meeting is deemed necessary.

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

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

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

Decision making and voting

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

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

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

Urgent Decisions

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

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

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

General Responsibilities of the Delivery Groups

There will be two Delivery Groups directly reporting to PCCC:

- General Practice and Community Pharmacy ~~Operational~~ Delivery Group

- Dental Services ~~Operational~~ Delivery Group

The responsibilities of each Delivery Group are described in section 6 of the Primary Care Commissioning Committee's Terms of Reference as set out in Schedule 2 of the Delegation Agreements with NHS England.

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

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

In addition to the two Delivery Groups acting as sub-groups of PCCC, the ICB may form other groups for primary care matters as required reporting to the People and Communities Board or to PCCC. For example, a Dental ~~Taskforce~~ Development Group to focus on dental transformation and strategy, or a ~~community~~ Community pPharmacy ~~s~~Strategy ~~g~~Group. If established, each group will prepare a report to ~~PCCC~~the appropriate Delivery Group at least four times per year.

~~**Phased introduction to Scheme of Delegation**~~
Decisions made by the Primary Care Commissioning Team

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

Decisions will be made in accordance with the Detailed Delegated Financial Limits (DDFL) agreed by the ICB's Executive Management Team from time to time.

APPENDIX A – Primary Care Commissioning Committee Scheme of Delegation

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

Change of practice boundary (increasing)				
Change of practice boundary (decreasing)				
Commission intentions (<£100k)				
Commission intentions (<£1m)				
Contract Award (<£1m over life time of contract)				
Commission intentions (>£1m)				
Contract Award (>£1m over life time of contract)				

Community Pharmacy (For clarity, this excludes responsibilities that fall to the Pharmaceutical Services Regulations Committee)	**Primary Care Commissioning Team** *(in line with ICB Finance delegated budget authority) from September 2023*	**General Practice & Community Pharmacy Delivery Group**	**Primary Care Commissioning Committee**	**Financial impact, risk or cost pressure**
Pharmacy First				
Locally Commissioned Services				
Commission intentions (<£100k)				
Commission intentions (<£1m)				
Contract Award (<£1m over life time of contract)				
Commission intentions (>£1m)				
Contract Award (>£1m over life time of contract)				

Norfolk and Waveney
Integrated Care Board

Agenda item: 11

Subject:	**General Practice Operational Delivery Report**
Presented by:	**Sadie Parker, Director of Primary Care**
Prepared by:	**Sadie Parker, Director of Primary Care** **Shepherd Ncube, Associate Director of Primary Care**
Submitted to:	**Primary Care Commissioning Committee**
Date:	**12 March 2023**

Purpose of paper:

To provide the Board with a report of the General Practice Operational Delivery Group meetings held on 20 February 2024

Group:	General Practice Operational Delivery Group
Chair:	Sadie Parker, Director of Primary Care
Meetings since the previous update:	20 February 2024
Overall objectives of the GPODG:	The purpose of the Delivery Group is to provide a framework for effective decision making in relation to certain contractual matters for general practice under delegated authority from the ICB's Primary Care Commissioning Committee.
Main purpose of meeting:	To contribute to the overall delivery of the ICB's objectives to create opportunities for the benefit of local residents, to support Health and Wellbeing, to bring care closer to home and to improve and transform services by providing oversight and assurance to the Primary Care Committee on the exercise of the ICB's delegated primary care commissioning functions and any resources received for investment in primary care.
BAF and any significant risks relevant / aligned to this Group:	There are two BAF risks – • The resilience of general practice • The resilience of NHS dental services

Key items for assurance/noting:	• The work to support those practices experiencing resilience issues was noted. • The Stalham Staithe practice had recently been rated Good following a CQC inspection. • The TIAA internal audit action plan was reviewed, and good progress was noted with 11 of the 13 actions completed and the others remaining on track. • The work to improve the uptake of Learning Disability Health Checks was reviewed. The report focused on West Norfolk and Great Yarmouth and Waveney localities. West Norfolk practices had seen a register increase and had delivered more health checks than the previous year, maintaining their overall percentage uptake at this stage of the year. GYW had the highest rate of declines but also the highest rate of health action plans. It also has the largest LD register. Specific actions to support continued uptake had been put into place in each locality. Overall performance at the end of quarter 3 was 39.5%. National data errors reported by NHS England in November are yet to be resolved. The registers remain inflated at the moment and performance is expected to be slightly higher when data has been corrected at the end of February. • Regarding the uptake for serious mental illness, there would be changes to the requirements on the ICB from April 2024. There would be a change to the way registers are calculated, as well as an increase to the target uptake to 75%. Clinicians expressed concern about the national change to the register and this would be investigated further. At this stage there was no proposed change to our local commissioning arrangements. There are 5 practices, 1 from each locality, that have already achieved in excess of 70% uptake. Learning is being reviewed and will be shared. Overall performance at the end of quarter 3 was 54.3%. • The proposed Patient Safety Incident Reporting Framework was noted, which was designed to support practices learn from incidents and manage them appropriately. There was helpful feedback from the 4 practices involved in developing the pilot and workshops would be held for practices during March.
Items for escalation to Committee:	• There were no items for escalation.
Items requiring approval:	• The group approved the proposal to proceed to business case development for an extension to Cutlers Hill Surgery in Halesworth.

	• The group approved a project initiation document for planned reconfiguration and improvement works to the Orchard Surgery in Dereham.
Confirmation that the meeting was quorate:	Yes. Attendance at the meeting is set out below: **Voting members** Sadie Parker, Director of Primary Care, NWICB (chair) Shepherd Ncube, Associate Director, Primary Care Commissioning, NWICB James Grainger, Head of Finance, Primary Care & Corporate/Reporting, NWICB Sarah Taylor, Senior Nurse for Patient safety Primary care, Senior Nurse for NCHC and small contracts NWICB (deputising for KW) **In attendance** Cath McWalter, Senior Primary Care Estates Manager, NWICB Lisa Townshend, Clinical Director, South Norfolk Healthcare CIC Julian Dias, Senior Primary Care Commissioning Manager, (Medical) NWICB Lisa Drewry, Executive Officer, LMC Joni Graham, Executive Officer, LMC Andrew Hayward, Healthwatch Norfolk Alex Stewart, CEO, Healthwatch Norfolk Ian Wilson, Executive Officer, LMC Michael Dennis, Associate Director of Pharmacy & Medicines Optimisation, NWICB.

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

Reference document(s):	Primary medical services regulations, statement of financial entitlements, premises directions and policy guidance manual, delegation agreement with NHS England
NHS Constitution:	No risks identified.
Conflicts of Interest:	Arrangements are in place to manage conflicts of interest

Norfolk and Waveney
Integrated Care Board

Agenda item: 11

Subject:	**Dental Services Operational Delivery Group report**
Presented by:	**William Lee, Senior Primary Care Commissioning Manager – Dental**
Prepared by:	**William Lee, Senior Primary Care Commissioning Manager – Dental**
Submitted to:	**Primary Care Commissioning Committee**
Date:	**12 March 2024**

Purpose of paper:

To provide the Committee with a report of the meetings of the Dental Services Operational Delivery Group ("DSODG") held on 8th February 2024

Group:	**Dental Services Operational Delivery Group**
Chair	Mark Burgis, Executive Director of Patients & Communities, Norfolk and Waveney ICB
Meetings since previous update	8th February 2024
Overall objectives of DSODG	The purpose of the meeting is to provide a framework for effective decision making in relation to certain contractual matters for dental services under delegated authority from the ICB's Primary Care Commissioning Committee ("PCCC")
Main purpose of the meeting	To contribute to the overall delivery of the ICB's objectives to create opportunities for the benefit of local residents, to support Health and Wellbeing, to improve access and transform services by providing oversight and assurance to PCCC on the exercise of the ICB's delegated primary care commissioning functions and any resources available for investment in primary, community and secondary dental care
BAF and significant risks relevant / aligned to this Group	At this stage, the risk register is monitored by PCCC however work is being undertaken to agree how operational and strategic risks can be monitored across DSODG and PCCC respectively. The BAF risk has been updated to include workforce matters.

Key items for assurance / noting	• The group discussed changes to the Terms of Reference, which will be presented in March-24 PCCC. The proposal is for both Delivery Groups to continue beyond April, with the GP Delivery Group expanding to include Community Pharmacy. The other change, which has been discussed with the Chair and Deputy Chair of the PCCC, is the proposal to move PCCC meetings to four times per year with Delivery Groups taking place in April and May and the PCCC in June with the cycle continuing beyond this. This will enable PCCC to provide strategic leadership and oversight of the Delegation Agreement responsibilities. The other change to the DODG and GPDG is that voting members will be asked to nominate a named deputy to enable decision making at meetings. The Proposed changes to Terms of Reference were agreed and recommended to PCCC for approval in March. They will be reviewed in six months' time. • The Group discussed a paper for approval pertaining to a six-month extension to the current the Out of Hours service contract, and for work to commence on developing a longer-term service specification and procurement during this 6-month period. The group considered the contractual and commissioning options for the out of hours service noting the proposed end date of 31 December 2024 and bank holiday cover for new year. The paper received oversight from both procurement and finance, who have highlighted no risk to the ICB for the six-month extension. The paper was approved. • The Group discussed a report for approval relating to a contractor requesting a permanent increase in their UDAs of 500, from April-24. It was highlighted this provider are the sole domiciliary services provider to those who are house bound. This proposal was put forward to provide some stability and resilience for this very important service. It was highlighted the provider works very closely with the Community Dental service, who also provide services into care homes. The possible longer-term implications have been discussed with the finance and procurement teams and the paper was approved.

	• The Group reviewed a paper for approval, relating to a contract split due to a dispute between the partners, which has been ongoing since 2022. NWICB have tried to resolve the conflict between the partners but have been unsuccessful. There is no proposed increase in the financial value of the contract, but a risk was highlighted, that by splitting the contract, the ICB holds a higher risk if both providers request a repayment plan for any clawbacks. The Quality team highlighted that they had met with one of the proposed new providers to discuss accessibility in the event of a contract split and the positive engagement with the ICB about measures they could put in place. . The contract split was approved, with provision the Delivery Group will be kept appraised of any issues and a brief update to be provided in 2-3 months. • The Group reviewed two papers together as similar requests had been submitted. One seeking approval from a provider requesting a reduction of 650 UDAs to enable the contractor to stabilise their practice in the coming years and afford the opportunity and time to recruit staff permanently, utilising the support of the Primary Care workforce initiatives. The provider had previously expressed a desire to terminate the contract but felt they could continue with a reduction. The group approved the temporary reduction in activity to maintain provision and enable the provider's long-term plans to be achieved. • The Group also considered a paper relating to the reduction of activity at 3 different sites, owned by the same provider, due to workforce challenges. These respective reductions were proposed to take effect from 1st April 2024 on a temporary basis, they totalled 2,000 UDAs across all sites. Following a provider meeting this was the only solution to stabilise the provider in the interim and avoid a contract termination. The ICB have offered workforce support and the paper was agreed. • The group received a presentation from the workforce team, including information on Primary

	Care Dental Workforce and Retention Programmes. This included information on the Training Needs Analysis and Workforce Dashboard, used to help plan educational requirements for programmes alongside understand vacancy levels across the system. A short film was shown to the group, to showcase the roles within primary care teams and to be used for marketing purposes. An overview of the targets for dental incentives was presented and shown to have met or exceed their targets. Finally, confirmation Two Senior Clinical Leadership Dental Fellows have been appointed to support the Norfolk and Waveney Area. Their area of focus is on Children and Young People and Health Inequalities. The presentation received positive feedback from the group members. • The group received a presentation and information on the 5-year Long Term Dental Plan, which is being taken to the March 2024 Dental Development Group for discussion, followed by the PCCC consideration. This included the challenges already faced, the achievements which have been made and the opportunities and challenges which are expected. The seven key areas highlighted in the plan are: - Improving Access, Oral Health Prevention, Secondary Care, Level 2 Services, Workforce, Quality Improvement and Clinical Engagement. During the presentation, it was highlighted in the next two years the ICB aims to support the recovery of access to NHS dental services by focusing on three key areas; improving access and addressing health inequalities, empowering, and supporting our local population to manage their own oral health and building capacity to improve recruitment and retention of the dental workforce. The group provided positive feedback to the 5-year plan and Public Health have offered more support, particularly relating to data. The Group were informed that a survey was published on 24th January 2024 and closes on 21st February 2024 which gives public and key

	stakeholders the opportunity to give their feedback on the priorities in the Long-Term Plan.
Items for escalation to Committee	Feedback from public and key stakeholder survey (to be confirmed) to be taken to April PCCC
Items requiring DSODG approval	• Approved a contract extension for the OOH Service for 6-month period. • Approved a permanent increase in a provider's UDA contract size (500). • Approved a contract split due to a partner dispute. • Approved a contract reduction of 650 UDAs, to maintain the contract and enable the provider time to stabilise. • Approval of 3 contracts reducing their activity by 500, 1000 and 500 UDAs respectively from 1st April 2024, all owned by the same performer due to workforce challenges.
Confirmation that the meeting was quorate	Yes. Attendance at the meeting is set out below: <u>Voting Members:</u> Mark Burgis (Chair). Executive Director of Patients & Communities, Norfolk and Waveney ICB Sadie Parker. Director of Primary Care, Norfolk and Waveney ICB Shepherd Ncube. Associate Director of Primary Care Commissioning, Norfolk and Waveney ICB James Grainger. Head of Finance – Primary Care & Corporate/Reporting, Norfolk and Waveney ICB Alaina Barber. Head of Nursing and Quality, Norfolk and Waveney ICB <u>In attendance:</u> Fiona Theadom. Head of Primary Care Commissioning, Norfolk and Waveney ICB Sally Weston Price, Consultant in Dental Public Health. Brigit Chisholm Healthwatch Norfolk William Lee, Senior Primary Care Commissioning Manager – Dental, Norfolk and Waveney ICB Ben Oakenfold, Primary Care Commissioning Support Officer – Dental, Norfolk and Waveney ICB Rashmi Purkayastha, Commissioning Manager (Dental), Norfolk and Waveney ICB Louise Wilson, Quality Improvement Dental Nurse, Norfolk and Waveney ICB

Recommendation to the Committee:

To note the report for assurance purposes

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

Norfolk and Waveney
Integrated Care Board

Agenda item: 12

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:	**12 March 2024**

Purpose of paper:

For information

Executive Summary:

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

1. Prescribing team focus areas.

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

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

1.3 At time of writing the proposed new PQS and low risk cost effective switch scheme has yet to have its funding approved.

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

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

1.6 Our five are

- Addressing problematic polypharmacy
- Addressing low priority prescribing
- Best value biologics in line with NHSE commissioning recommendations
- Improving valproate safety
- Switching IV antibiotics to oral (hospital in-patients)

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

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

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

2. ICB Prescribing Performance

2.1 The price drop of apixaban and our high use of edoxaban now skews our cost per ASTROPU. We currently have the highest percentage use of edoxaban in the country. The cost of this is mitigated by and NHSE brokered rebate. This now makes our bottom line figure look bigger than other ICB's who use more apixaban and so benchmarking is not that useful at the moment.

2.2 **Price concessions (previously called NCSO (no cheaper stock obtainable))**

Price concessions 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 YTD and projected for the following 2 months.

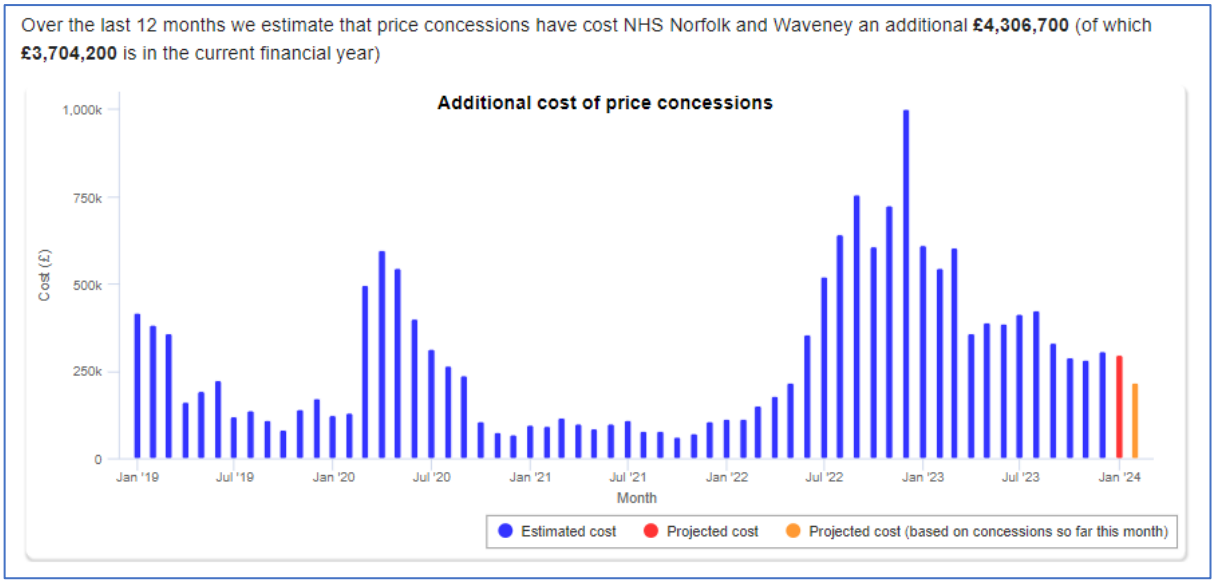
Table 1. Cost Pressure Report Feb 2024, Dec 2023 data

	YTD 2023/24 (Dec data)	Projected Jan	Projected Feb

NCSO and other price concessions	£3,326,047	£350,962	£211,247
Back into DT at increased prices	£2,838,219	£389,898	£377,128
Decrease in Cat M Q2 and Q3 and Q4	-£853,017	- £381,346	-£381,396
Total	£5,311,249	£359,514	£206,979

* 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 and continuous glucose monitoring.

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 data around individual practices performance is now taken to the primary care operational delivery group meeting.

3.3 The national indicators for DFMs for Dec 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 – stayed at 83rd, 22nd percentile on high dose opiate items as percentage of regular opiates
- Gabapentinoids – dropped to 25th, 77th percentile, previously on defined daily doses of gabapentin and pregabalin
- Hypnotics and anxiolytics – dropped to 4th position nationally 97th percentile volume per 1000 patients – the trend (below) is however an improving one (yellow dotted line is Norfolk and Waveney performance and trend respectively)

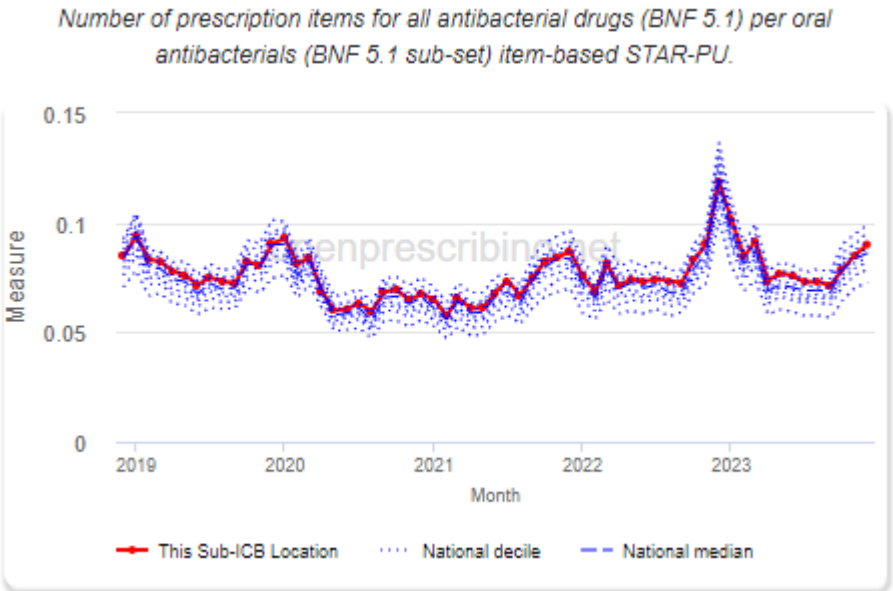
  The second chart compares NWCCG performance with national percentiles (NW is the red line and national average is the blue line)

4 Antibiotic Prescribing

4.1 NHS System Oversight Framework (SOF) Antimicrobial Prescribing Metrics for 2023-24 remained the same as 2022-23. 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 Norfolk and Waveney are now seeing a downward trend for **overall antimicrobial prescribing**. Prescribing is above the second volume target of 0.965 with a value of **1.039 antibacterial items per STAR-PU** in the 12 months to December 2023. Table 3 below shows that prescribing in December 2023 has peaked at a much lower position than December 2022 when we had the Invasive group A streptococcal (iGAS).

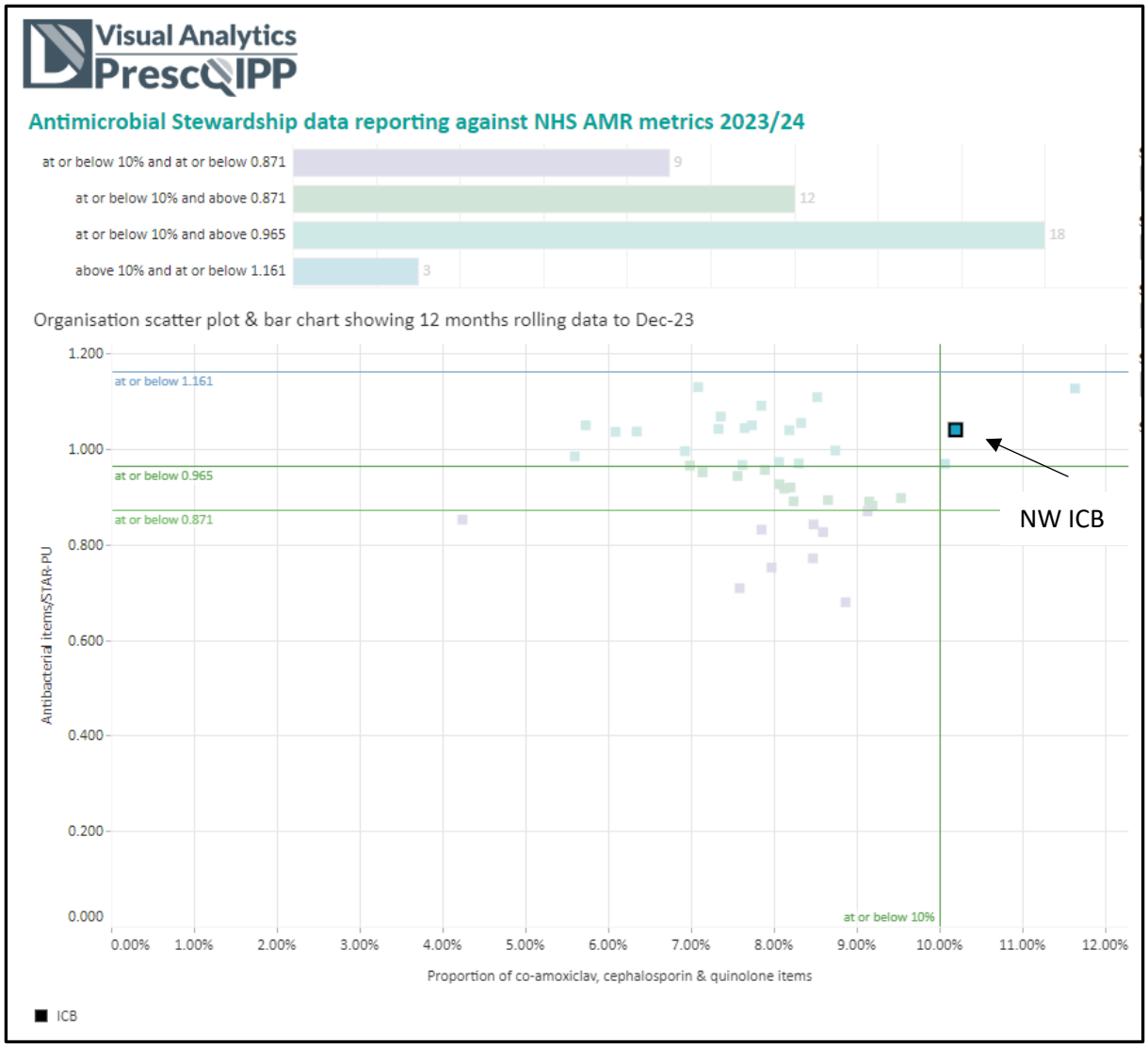
Table 3. Number of prescription items for all antibacterial drugs (BNF 5.1) per oral antibacterials (BNF 5.1 sub-set) item-based STAR-PU.



4.3 Norfolk and Waveney ICB continue to follow an upward trajectory for **broad spectrum prescribing**. Prescribing is just above the national target of no more than 10% of all antibiotics at **10.20%** in the 12 months to December 2023 (increase of 0.32%). We are the second worst ICB in England for the percentage of Broad-Spectrum antibiotics prescribed.

4.4 Table 4 shows the position of the Norfolk and Waveney ICB for antimicrobial prescribing against the rest of England. The best performing ICBs are towards the bottom left of the chart. Norfolk and Waveney are currently the second worst performing ICB for Broad spectrum antibiotics.

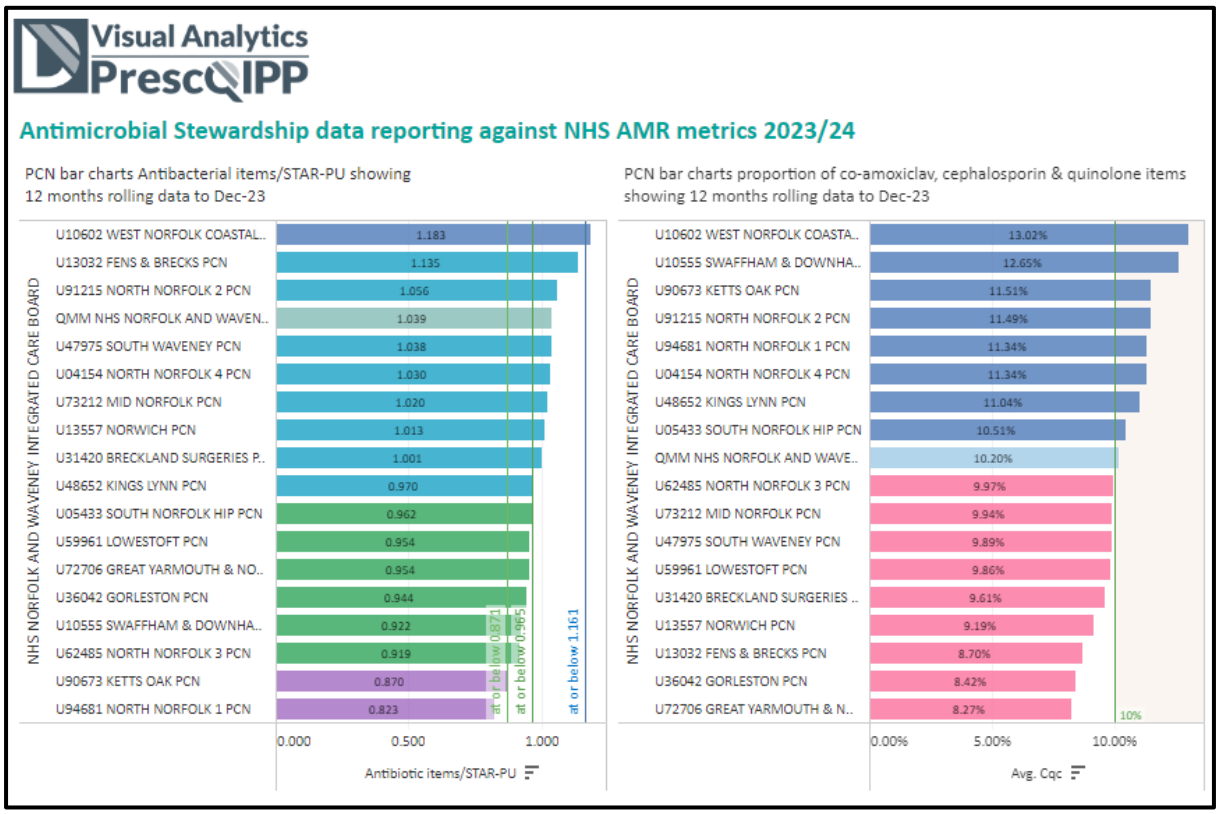
Table 4. ICB scatter chart – Antimicrobial prescribing 12 months to end December 2023



4.5 Antibiotic volumes, the bar chart on the left (Table 5) shows the volume of antibiotic prescribing by PCNs

4.6 Percentage of broad-spectrum antibiotics, the bar chart on the right (Table 5) shows the percentage by PCN.

Table 5. PCN bar charts – Antimicrobial prescribing 12 months to end December 2023



4.7 The Medicines Optimisation Team are continuing to engage with Outlier practices as described in previous reports.

4.8 Following an ICS Clostridium difficile workshop held in October the ICB Medicines Optimisation team and ICB Infection Prevention and Control team are holding joint visits to three of outlier practices (high antimicrobial prescribing and high Clostridium difficile cases per 100,000 population) to discuss current practice and identify an action plan for improvement.

4.9 Practices are reminded that when prescribing a broad-spectrum antimicrobial, they must record the justification for prescribing in the patient notes with either of the following.

- Indication recommended in the NICE Summary of antimicrobial prescribing guidance – managing common infections with local amendments for Norfolk & Waveney STP - December 2023

  or

- Recommended after sensitivity testing by microbiologist

4.10 Our outlier practices (90th percentile or above) that are driving the higher percentage of Broad-spectrum antibiotics in December data are shown in Table 6

Table 6: Outlier Practices for prescribing Broad Spectrum Antibiotics (90th percentile or above)

Practice Name	Percentage of broad-spectrum antibiotics Dec 2023	Sum of percentile
E HARLING & KENNINGHALL MEDICAL PRACTICE	17.38%	99.59
BURNHAM SURGERY	14.72%	99.07
THE WOOTTONS SURGERY	14.37%	98.83
GRIMSTON MEDICAL CENTRE	13.55%	98.35
HOWDALE SURGERY	13.31%	98.11
ST JOHN'S SURGERY	13.13%	98.03
TOFTWOOD MEDICAL CENTRE	12.94%	97.90
HINGHAM SURGERY	12.87%	97.84
FLEGGBURGH SURGERY	12.79%	97.75
MUNDESLEY MEDICAL CENTRE	12.38%	97.02
BRIDGE STREET SURGERY	12.20%	96.66
BECCLES MEDICAL CENTRE	12.10%	96.44
HUMBLEYARD PRACTICE	12.05%	96.38
BRUNDALL MEDICAL PARTNERSHIP	11.92%	96.16
SHERINGHAM MEDICAL PRACTICE	11.91%	96.09
BACON ROAD MEDICAL CENTRE	11.89%	96.03
HOLT MEDICAL PRACTICE	11.75%	95.65
LITCHAM HEALTH CENTRE	11.71%	95.59
ALEXANDRA & CRESTVIEW SURGERIES	11.68%	95.51
ELMHAM SURGERY	11.65%	95.42
CROMER GROUP PRACTICE	11.59%	95.31
REEPHAM & AYLSHAM MEDICAL PRACTICE	11.57%	95.29
WATLINGTON MEDICAL CENTRE	11.32%	94.64
ROUNDWELL MEDICAL CENTRE	11.23%	94.41
FAKENHAM MEDICAL PRACTICE	11.21%	94.27
ANDAMAN SURGERY	11.20%	94.25
MANOR FARM MEDICAL CENTRE	11.01%	93.57
EAST NORWICH MEDICAL PARTNERSHIP	10.88%	93.13
VIDA HEALTHCARE	10.83%	92.94
BUNGAY MEDICAL CENTRE	10.80%	92.77
THE LIONWOOD MEDICAL PRACTICE	10.71%	92.50
CASTLE PARTNERSHIP	10.71%	92.49
PLOWRIGHT MEDICAL CENTRE	10.70%	92.45
PASTON SURGERY	10.51%	91.68

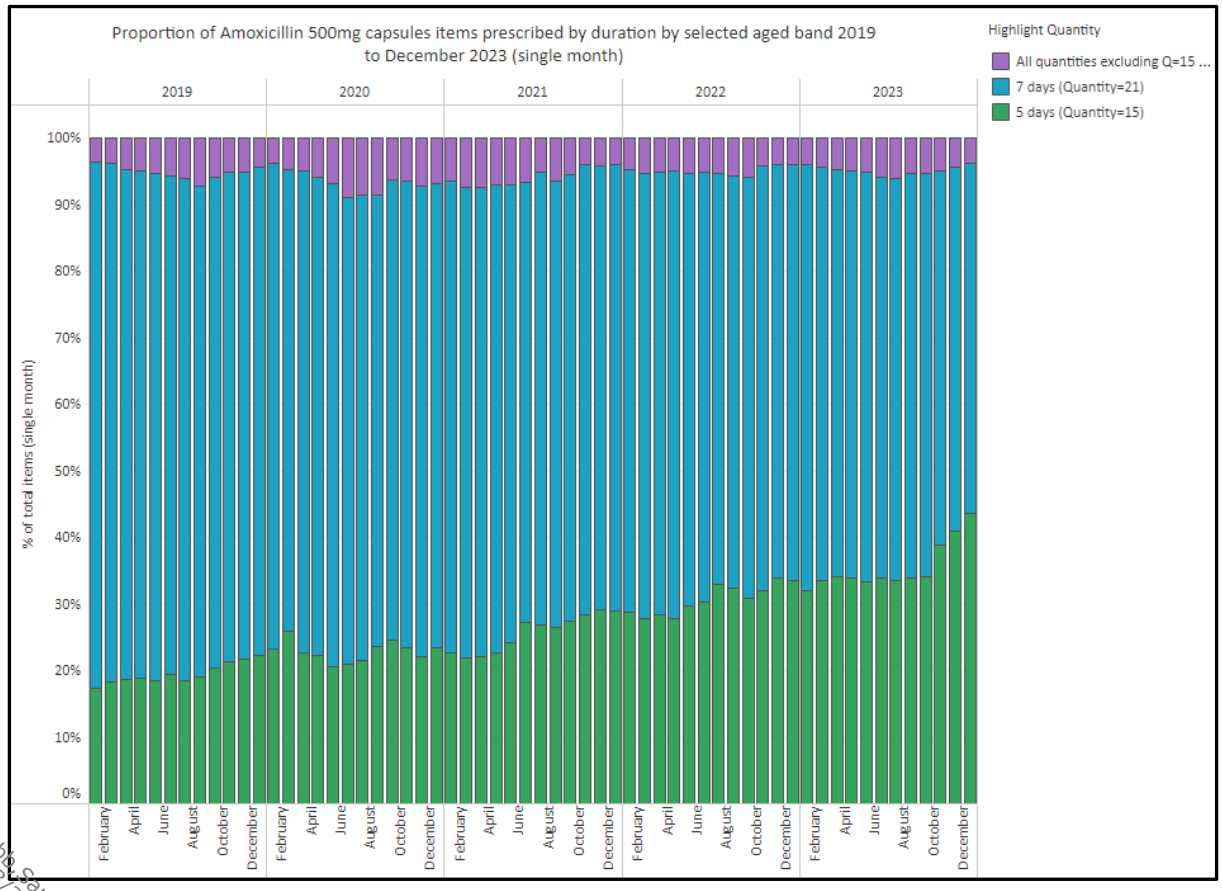
SOLE BAY H/C	10.51%	91.65
SCHOOL LANE PMS PRACTICE	10.34%	90.82
SOUTHGATES SURGICAL & MEDICAL CENTRE	10.29%	90.58
WELLS HEALTH CENTRE	10.23%	90.30
STALHAM STAITHE SURGERY	10.10%	89.78
BLOFIELD SURGERY	10.05%	89.32

4.11 NHS England have introduced a new antimicrobial metric. Reducing amoxicillin 500mg three times a day from a 7-day to a 5-day duration. This will deliver a 29% reduction in Defined Daily Doses (DDD).

The NHS England target is 75% of all prescriptions prescribing amoxicillin 500mg caps should be for a 5-day duration.

This metric was introduced to practices at the October Prescribing Leads Meetings. The current achievement for Norfolk and Waveney in December 2023 is 43.66% an increase of nearly 10% from September 2023. See Table 7.

Table 7: Proportion of Amoxicillin 500mg capsule items prescribed by duration in Dec 2023 (single month) in Norfolk and Waveney.



Resources to support Primary Care prescribe the appropriate number of days

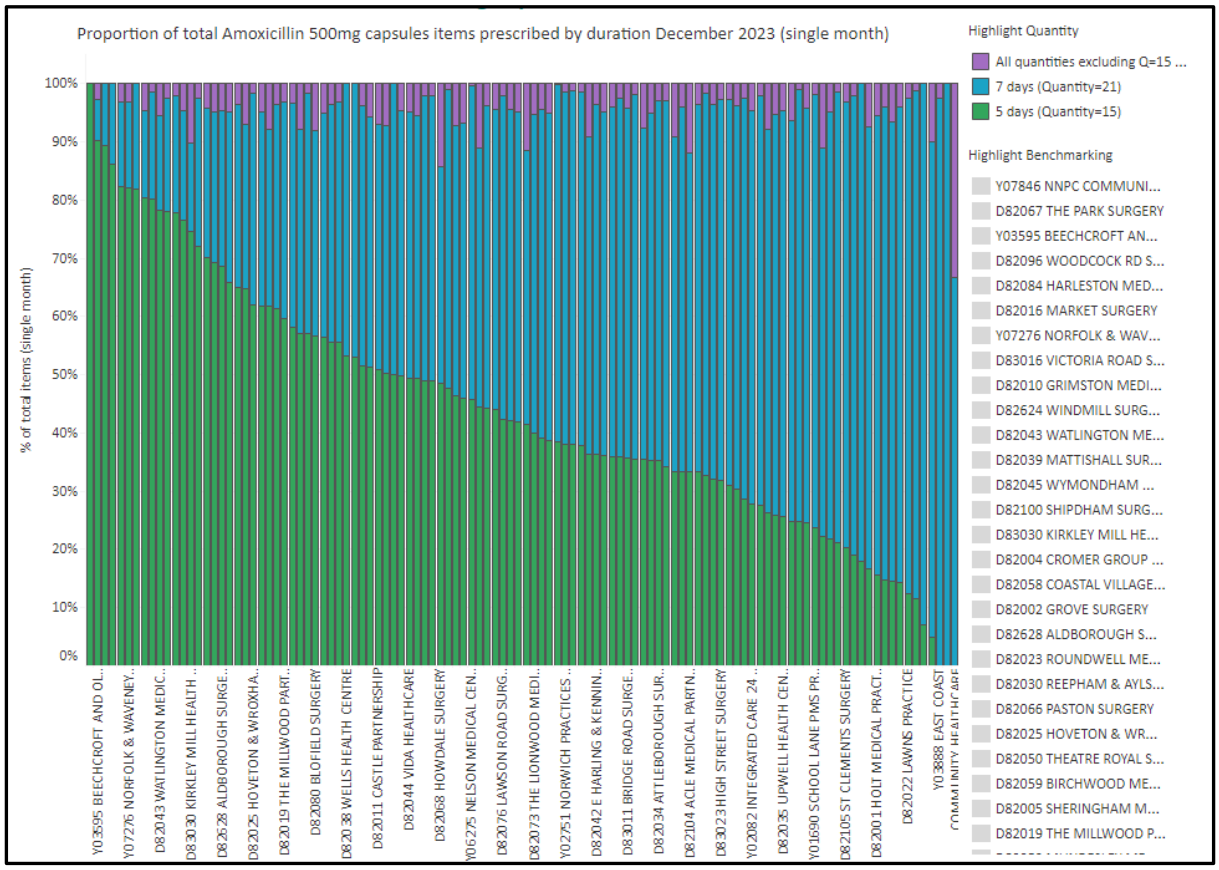
- NetFormulary
- OptimiseRx – on practice system
- Ardens Templates – on practice system

NICE Summary of antimicrobial prescribing guidance – managing common infections with local amendments for Norfolk & Waveney STP - December 2023

There is a large variation in performance across practices in Norfolk and Waveney. The best performing practice has issued 100% of prescriptions for Amoxicillin 500mg capsules as a five-day duration. The lowest performing practice have issued 2.4% of prescriptions for Amoxicillin 500mg capsules as a five-day duration.

This data was presented to practices at the February ICB Prescribing Leads meeting.

Table 8: Proportion of Amoxicillin 500mg capsule items prescribed by duration in Dec 2023 (single month) in Norfolk and Waveney per practice.



The Medicines Optimisation Team are continuing to engage with Outlier practices as described in previous reports.

Two visits with The Burnham Surgeries, second visit with ICB IPC team.

- Action plan being implemented by dispensary team, nursing team and partners.
    - weekly audit of all broad-spectrum prescriptions issued and action plan
    - dispensary team challenging Amoxicillin prescribing greater than 5 days to ensure formulary compliance
    - UTI triage being reviewed, stopping samples being dropped in without consultation first
- Initial discussions with St Clements, formal meeting planned
- Meeting with Watlington Medical Centre
- AMS meeting with West Locality Pharmacy professionals

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

Improving lives **together**

Norfolk and Waveney Integrated Care System

2023/24 Primary Care Commissioning Committee

Finance Report Norfolk & Waveney ICB

January 2024

Primary Care Commissioning Committee 12th March 2024

Contents

1.0 Executive Summary

- As the financial reporting for Primary Care and Prescribing is produced in arrears this report will relate to M10 (January-2024) of the ICB accounts.

- As at Month 10 (January), the Year to Date (YTD) spend is £ 441.4 m as against a plan of £448.7m leading to an underspend of £7.3m for Primary Care and Prescribing in combination.

- The forecast spend is £529.4m as against a plan of £543.8m leading to a forecast underspend of £14.3m. The Primary care spend is a combination of Prescribing, Local Commissioning, Delegated Commissioning, Pharmacy Optometry and Dental (POD).

- The Efficiencies this year have been identified at 5% for all areas and whilst in Prescribing, most efficiencies are identified, it is not the case in other areas and hence the majority of adverse variance is due to Unidentified Efficiencies.

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

2.0 Total Financial Summary

23/24 Primary Care & Prescribing:	12months Budget ICB	Year to Date(January)			Forecast (ICB)		Forecast as at December		Comments on material Forecast Variances and M09 and M010 FOT movements
	Budget £m	Budget £m	Actual £m	Variance (Fav)Adv £m	Actual £m	Variance (Fav)Adv £m	Actual £m	Movement in FOT (Fav)Adv £m	
GP & Other Prescribing									
GP Prescribing	190.5	159.2	162.9	3.7	195.0	4.5	194.2	0.7	The FOT adverse variance of £4.5m is due to the year on year increase in SGLT 2 £2.3m, Continuous Glucose Monitoring £0.8m, Reduced Edoxoban rebate £1.2m, Lower flu recharges to NHSE and 0.6m in Direct Oral Anticoagulants (DOAC) between April to November 23/24. This is partly mitigated by Prior Year benefits of £1.3m. The FOT movement between M9 and M10 is due to lower Flu rebates £0.5m and general increase £0.2m.
Other Prescribing costs	18.1	15.0	15.7	0.7	19.0	0.9	19.0	(0.1)	The FOT adverse variance of £0.9m is due to budget reduced in Central Drugs and Oxygen due to unidentified efficiencies £0.5m and increased electricity cost pressures in oxygen mitigated partly by improvements in dressings costs.
Total GP & Other Prescribing	**208.6**	**174.2**	**178.6**	**4.4**	**213.9**	**5.3**	**213.3**	**0.7**	
Primary Care									
Delegated Primary Care	213.1	177.4	178.2	0.8	207.8	(5.3)	207.7	0.1	The favourable FOT variance of £5.4m is offset against £4.3m adverse variance in LES as budget is reported In Delegated and spend is reported separately in LES due to NHSE directives. The remaining favourable variance is due to prior year benefits. The movement in FOT between M9 and M10 is due to increased dispensing fees within delegated co-commisioning.
Local Enhanced Services (LES)	9.5	7.0	10.9	3.9	13.8	4.3	13.8	0.0	The FOT variance is due to the budget being reported in the Delegated Primary Care line
Other Primary Care	15.0	9.6	8.1	(1.4)	13.0	(2.0)	12.7	0.3	£2m favourable FOT variance is made up of £0.7m underspend in surge capacity funding and balance in non-recurrent prior year benefits. There is a movement in FOT between M9 and M10 due to new allocation received in GPIT £0.75m and further prior year release in M10
Total Primary Care	**237.6**	**193.9**	**197.2**	**3.3**	**234.5**	**(3.1)**	**234.1**	**0.4**	
DOP									
Dental	65.5	54.2	38.1	(16.0)	47.3	(18.2)	47.2	0.1	£18.3m favourable FOT variance is in historic underperformance which is partly offset by funding for workforce incentives, childrens oral health pathway, emergency dental pathway and rate reviews.
DOP Delegated pay	0.9	0.5	0.5	(0.0)	0.9	(0.0)	0.8	0.0	On Plan
Optom	10.2	8.5	9.3	0.8	11.1	1.0	11.2	(0.1)	There have been increased home visits, NHS funded sight test and NHS funded glasses which is driving the adverse variance in this area.
Pharmacy	20.9	17.4	17.7	0.3	21.7	0.7	21.6	0.1	The FOT adverse variance is due to higher professional fees £0.5m and advanced services £0.8 mitigated by reductions in the quality Payment scheme £0.6m
Total DOP	**97.5**	**80.5**	**65.6**	**(14.9)**	**81.0**	**(16.6)**	**80.8**	**0.1**	
Total Prescribing and Primary Care	**543.8**	**448.7**	**441.4**	**(7.3)**	**529.4**	**(14.3)**	**528.2**	**1.2**	
Variance as a % of Budget				*-1.6%*		*-2.6%*		*0.2%*	

Variance Signage: (Favourable)/Adverse

3.0 GP And Other Prescribing

23/24 Primary Care: Prescribing	12months Budget ICB	Year to Date(January)			Forecast (ICB)		Forecast as at December		Comments on material Forecast Variances and M09 and M10 FOT movements
	Budget £m	Budget £m	Actual £ m	Variance (Fav)Adv £m	Actual £ m	Variance (Fav)Adv £m	Actual £ m	Movement in FOT (Fav)Adv £m	
GP Prescribing Costs	199.7	166.6	169.8	3.2	203.0	3.3	202.7	0.2	The FOT adverse variance of £3.3m is due to year on year increase in SGLT 2 £2.3m ,Continuous Glucose Monitoring £0.8m, £0.6m in Direct Oral Anticoagulants (DOAC), Reduced Edoxoban rebate £1.2m between April to November 23/24 mitigated by Prior Year benefits of £1.3m. The £0.2m adverse movement between M9 and M10 is due to general usage increase.
Recharges to Local Authorities & NHS England	(5.6)	(4.6)	(4.3)	0.4	(4.7)	0.9	(5.2)	0.5	There is an overall lower flu rebate as against the full year plan contributing to the FOT variance. The Nov flu recharges were lower than estimates by £0.5m
Rebates from pharmaceutical companies	(3.5)	(2.8)	(2.6)	0.2	(3.3)	0.2	(3.3)	0.0	There is a marginally lower rebate as against full year plan contributing to the FOT variance £0.2m
Central Drugs	5.1	4.3	4.6	0.3	5.5	0.4	5.4	0.0	Unidentified efficiency is the reason for adverse FOT variance.
Dressings & wound care	5.3	4.4	4.0	(0.4)	4.8	(0.4)	4.9	(0.0)	A reduction in dressings due to efficiency work creating a favourable FOT variance.
Others (Medicine Management, Oxygen, incentives etc.)	7.7	6.3	7.1	0.8	8.6	0.9	8.7	(0.1)	The £0.9m adverse FOT variance is due to unidentified efficiencies in Oxygen and the Medicine Management budget in addition and increase in electricity costs for both Oxygen and Medicine Management.
Total Prescribing	**208.6**	**174.2**	**178.6**	**4.4**	**213.9**	**5.3**	**213.3**	**0.7**	
Variance as a % of Budget				*2.5%*		*2.5%*		*0.3%*	

Variance Signage: (Favourable)/Adverse

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

4.0 Delegated GP Commissioning

23/24 Primary Care: Delegated	12months Budget ICB	Year to Date(January)			Forecast (ICB)		Forecast as at December		Comments on material Forecast Variances and M09 and M10 FOT movements
	Budget £m	Budget £m	Actual £m	Variance (Fav)Adv £m	Actual £m	Variance (Fav)Adv £m	Actual £m	Movement in FOT (Fav)Adv £m	
Contractual	133.71	111.21	110.66	(0.6)	133.07	(0.6)	133.1	0.0	Favourable FOT variance is due to benefit in contract and contract KPI's, where intially the contract is paid out in full and clawed back where necessary.
QOF	16.17	13.47	13.47	0.0	16.17	0.0	16.2	0.0	On Plan
Premises cost reimbursements	15.56	12.97	13.29	0.3	15.80	0.2	15.7	0.1	The FOT variance is due to rent reviews and arrears payments (due to DV revaulations), partially offset by historic business rate clawbacks collected.
Other - GP Services	14.89	12.41	13.30	0.9	15.75	0.9	15.8	(0.0)	The FOT variance is due to emergency locum spend at a South practice and raised dispensing fee costs.
Enhanced services	11.19	9.32	9.44	0.1	11.33	0.1	11.3	0.0	The the adverse variance is due to increased activity in both minor surgery and translation fees
CCG Spend	0.57	0.47	0.45	(0.0)	0.55	(0.0)	0.5	0.0	On Plan
PCN ARRS Staff	17.40	14.50	19.77	5.3	17.40	0.0	17.4	(0.0)	On Plan
PMS to GMS	4.18	3.48	0.00	(3.5)	0.00	(4.2)	0.0	0.0	The FOT variance offset in LCS cost centre.
Prior Year	(0.53)	(0.44)	(2.17)	(1.7)	(2.26)	(1.7)	(2.3)	(0.0)	Negative budget from allocation shortfall for current year spend, mitigiated by PY releases in various areas.
Total Delegated	**213.1**	**177.4**	**178.2**	**0.8**	**207.8**	**(5.3)**	**207.7**	**0.1**	
Variance as a % of Budget				*0.5%*		*-2.5%*		*0.1%*	

Variance Signage: (Favourable)/Adverse

- The above table details the category of expenditure within Delegated Co Commissioning
- The Forecast variance is underspent as predominantly the PMS GMS budgets are in Delegated and the spend is recorded in Local Enhanced Services.

5.0 System Development Fund / GPFV

23/24 Primary Care: SDF / GPFV	12months Budget ICB	Year to Date(January)			Forecast (ICB)		Forecast as at December		Comments on material Forecast Variances and M9 and M10 FOT movements
	Budget £m	Budget £m	Actual £m	Variance (Fav)Adv £m	Actual £m	Variance (Fav)Adv £m	Actual £m	Movement in FOT (Fav)Adv £m	
Training Hub	0.26	0.21	0.21	(0.00)	0.28	0.02	0.3	0.0	On Plan
Training Hub Default	0.32	0.23	(0.05)	(0.28)	(0.06)	(0.38)	0.3	(0.4)	Favourable variance due to released PCN Network Funding as paid through winter non recurrent funding.
Online Consultation System	0.18	0.18	0.18	0.00	0.18	(0.00)	0.2	(0.0)	On Plan
GP Fellowships	0.19	0.19	0.19	0.00	0.44	0.25	0.19	0.3	Contra in Nurse Fellowship
Nurse Fellowships	0.00	0.00	0.03	0.03	(0.31)	(0.31)	0.0	(0.3)	Contra in GP Fellowship
Supporting Mentors	0.09	0.09	0.09	(0.00)	0.13	0.04	0.09	0.0	On Plan
GP Retention	0.33	0.27	0.26	(0.01)	0.22	(0.11)	0.3	(0.1)	On Plan
Flexible Staff Pools	0.12	0.10	0.10	0.00	0.19	0.07	0.1	0.1	On Plan
Practice Resiliance	0.13	0.11	0.00	(0.11)	0.00	(0.13)	0.1	(0.1)	Favourable variance due to released Resilience Funding as paid through winter non recurrent funding.
ARI Hubs	0.00	0.00	(0.00)	(0.00)	0.09	0.09	0.0	0.1	On Plan
GP Accelerate	0.00	0.00	0.00	0.00	(0.01)	(0.01)	0.0	(0.0)	On Plan
Total SDF	**1.6**	**1.4**	**1.0**	**(0.4)**	**1.1**	**(0.5)**	**1.6**	**(0.5)**	
Variance as a % of Budget				*-26.5%*		*-29.0%*		*-29.1%*	

- The above table details the schemes within the System Development Fund (SDF).
- NHSE have awarded the allocation under Transformation Fund and work is carried out by the Primary Care Commissioning Team to allocate funding to different projects.
- The ICB received separate allocation for GP Fellowship, GP Supporting Mentors.

6.0 Dental

23/24 Primary Care: Dental	12months Budget ICB	Year to Date(January)			Forecast (ICB)		Forecast as at December		Comments on material Forecast Variances and M9 and M10 FOT movements
	Budget	Budget	Actual	Variance (Fav)Adv	Actual	Variance (Fav)Adv	Actual	Movement in FOT (Fav)Adv	
	£m	£m	£m	£m	£m	£m	£m	£m	
Primary Dental									
Patient Revenue	(20.0)	(16.7)	(10.6)	6.0	(12.9)	7.1	(13.3)	0.5	The FOT Variance is due to ongoing gap between targeted patient revenue and actuals received, as this was set on 19/20 levels and access is still limited.
Baseline Payments (Inc Perf Adj)	59.7	49.8	32.0	(17.7)	39.1	(20.6)	39.7	(0.5)	The FOT Favourable variance of £20.6m is due to £17m forecasted clawback for current year underperformance and £3m recurrent contractual underspend (handbacks).
Pay & Pensions	1.8	1.5	1.3	(0.2)	1.6	(0.2)	1.6	(0.0)	The FOT variance broadly on Plan
Minor Oral Surgery	0.4	0.4	0.4	0.0	0.4	0.0	0.4	0.0	The FOT variance broadly on Plan
Other Primary Dental	0.8	0.7	0.8	0.1	1.3	0.5	1.2	0.1	The FOT contains £0.6m workforce incentives, offset by pension and property underspends (£0.2m).
General Reserve	5.1	4.3	0.0	(4.3)	(0.0)	(5.1)	(0.0)	(0.0)	Reserve budget funds underperformance in patient charge revenue and contributes to overall underspend.
Total Primary Dental	**47.8**	**39.9**	**23.9**	**(16.0)**	**29.6**	**(18.2)**	**29.6**	**0.1**	
Secondary Dental									
Baseline payments	13.8	11.5	11.7	0.2	14.0	0.2	13.9	0.1	The FOT variance broadly on Plan
Low Volume Activity & NCA	0.1	0.1	0.1	0.0	0.1	0.0	0.1	0.0	The FOT variance broadly on Plan
Other	0.5	(0.1)	(0.2)	(0.2)	0.3	(0.2)	0.4	(0.1)	Pay budget recategorised to pay cost centre
Total Secondary Dental	**14.4**	**11.5**	**11.5**	**0.0**	**14.4**	**0.0**	**14.3**	**0.0**	
Community Dental									
Baseline Payment	2.6	2.2	2.1	(0.1)	2.5	(0.1)	2.6	(0.0)	The FOT variance broadly on Plan
Specific Items	0.7	0.6	0.6	(0.0)	0.7	(0.0)	0.7	0.0	The FOT variance broadly on Plan
Other	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	The FOT variance broadly on Plan
Total Community Dental	**3.4**	**2.8**	**2.7**	**(0.1)**	**3.3**	**(0.1)**	**3.3**	**0.0**	
DOP Delegated Pay									
Pay	0.5	0.4	0.4	(0.0)	0.4	(0.0)	0.5	(0.0)	The FOT variance broadly on Plan
Other	0.4	0.1	0.1	0.0	0.4	0.0	0.4	0.1	The FOT variance broadly on Plan
Total Delegated Property Costs	**0.9**	**0.5**	**0.5**	**(0.0)**	**0.9**	**(0.0)**	**0.8**	**0.0**	
Total Dental	**66.5**	**54.7**	**38.6**	**(16.1)**	**48.2**	**(18.3)**	**48.0**	**0.2**	
Variance as a % of Budget				*-29.5%*		*-27.6%*		*0.3%*	

Variance Signage: (Favourable)/Adverse

6.0 Dental Reserves

	Actual FOT 000's	Budget 000's	Variance 000's	Comment
Contractual				
Revenue	(12,871)	(19,996)	7,125	Revenue based on 19/20 outturn so hugely overvalued
Missing Revenue			-	Some additional revenue may be forthcoming
Contract	55,463	59,718	(4,255)	Contract hand backs. Does not include underperformance of current year contracts
Reserve		5,139	(5,139)	NHSE Reserve budgeted for 23/24
Performance Adjustment 23/24	(17,409)	-	(17,409)	Underperformance in contracted activity not yet known. Based on forecast model
Performance Adjustment 22/23	(10,400)	-	(10,400)	Per NHS England, this will be retained by them NHS England
Claw back ICB to NHSE	10,400	-	10,400	Clawback as per NHSE
Sub-Total Contractual	25,183	44,860	(19,677)	
Investments				
Emergency Pathway	1,000	-	1,000	
Children's Pathway	400	-	400	
Flexed contract to provide add'nl activity			-	
UDA Rate Reviews	400		400	
Other UDA & Activity Changes	91		91	
Workforce Incentives	600		600	
Sub-Total Investments	2,491	-	2,491	
Other	2,666	2,800	(134)	
Sub-Total Other	2,666	2,800	(134)	
Net variance			(17,320)	
Bottom Line Requirements				
Closing the Gap Requirement	509		509	Closing the Gap requirement after unmet need allocation
Problem / (Additional Reserve)			**(16,811)**	

This Reconciliation is essentially on “off-ledger” schedule of the general reserve within dental, and the additional **potential** for claw back within year.

In addition, there is an amount of budget held outside of the dental cost centre (due to ring fenced reasons). This reconciliation considers all these items for **illustrative purposes only**.

This does however show the affordability of the current investments agreed through PCCC and those in the pipeline for dental.

7.0 Optometry

23/24 Primary Care: Optom	12months Budget ICB	Year to Date(January)			Forecast (ICB)		Forecast as at December		Comments on material Forecast Variances and M09 and M10 FOT movements
	Budget £m	Budget £m	Actual £m	Variance (Fav)Adv £m	Actual £m	Variance (Fav)Adv £m	Actual £m	Movement in FOT (Fav)Adv £m	
Optician Sight Tests	6.2	5.1	5.5	0.3	6.6	0.4	6.6	(0.1)	The adverse FOT variance is due to increased home visits, NHS funded sight test and NHS funded glasses.
Vouchers for SuppSpec	3.3	2.8	2.9	0.2	3.5	0.2	3.5	0.0	Same as above
Domestic Visits	0.3	0.3	0.5	0.2	0.6	0.3	0.7	(0.0)	Same as above
Other	0.4	0.3	0.4	0.1	0.4	0.1	0.4	(0.0)	Same as above
Total Optom	**10.2**	**8.5**	**9.3**	**0.8**	**11.1**	**1.0**	**11.2**	**(0.1)**	
Variance as a % of Budget				*9.4%*		*9.4%*		*-1.2%*	
Variance Signage: (Favourable)/Adverse									

8.0 Pharmacy

23/24 Primary Care: Pharmacy	12months Budget ICB	Year to Date(January)			Forecast (ICB)		Forecast as at December		Comments on material Forecast Variances and M09 and M10 FOT movements
	Budget £m	Budget £m	Actual £m	Variance (Fav)Adv £m	Actual £m	Variance (Fav)Adv £m	Actual £m	Movement in FOT (Fav)Adv £m	
Prescription Charges	(11.9)	(9.9)	(10.0)	(0.1)	(12.0)	(0.1)	(12.1)	0.1	Broadly on plan
Professional Charges	26.6	22.1	22.5	0.4	27.0	0.5	27.1	(0.0)	Forecast adverse variance is due to increased activity.
Essential Services	2.4	2.0	2.0	(0.1)	2.4	(0.1)	2.4	(0.0)	Broadly on plan
Advanced Services	2.1	1.8	2.5	0.7	3.0	0.8	2.9	0.0	Forecast adverse variance is due to increased activity 7 services available for Pharmacies to offer.
Quality Payment Scheme	1.4	1.2	0.4	(0.7)	0.8	(0.6)	0.8	(0.0)	Forcast adverse variance is due to reduced activity
Other	0.3	0.2	0.4	0.1	0.5	0.2	0.5	0.0	Broadly on plan
Total Pharmacy	**20.9**	**17.4**	**17.7**	**0.3**	**21.7**	**0.7**	**21.6**	**0.1**	
Variance as a % of Budget				*1.9%*		*3.5%*		*0.4%*	
Variance Signage: (Favourable)/Adverse									

9.0 Efficiencies (Planned)

23/24 Primary Care: Efficiencies	Scheme Reference	Planned / CTG	Area	12months Budget ICB	Year to Date(January)			Forecast (ICB)		Comments on material Forecast Variances
				Budget	Budget	Actual	Variance (Fav)Adv	Actual	Variance (Fav)Adv	
				£m	£m	£m	£m	£m	£m	
Continuation of 22/23										
Low Risk, cost effective switching programme	22/23 FYE	Planned	Prescribing	300.0	300.0	182.0	118.0	182.0	118.0	Underperformance in 22/23 continuation of plan is mitigated by 23/24 overperformance below so net effect is on plan
Opioid costs (supported by PQS/rebates) - 10%	22/23 FYE	Planned	Prescribing	600.0	600.0	208.0	392.0	208.0	392.0	
Greener/lower cost inhalers (supported by PQS/rebates) - 5%	22/23 FYE	Planned	Prescribing	450.0	450.0	565.0	(115.0)	565.0	(115.0)	
Oral Nutritional Supplements (supported by PQS/FK rebate) - 5%	22/23 FYE	Planned	Prescribing	150.0	150.0	46.0	104.0	46.0	104.0	
Over the counter	22/23 FYE	Planned	Prescribing	150.0	150.0	47.0	103.0	47.0	103.0	
Specials (supported by PQS) - 5%	22/23 FYE	Planned	Prescribing	90.0	90.0	84.0	6.0	84.0	6.0	
Subtotal Continuation of 22/23 Schemes				**1,740.0**	**1,740.0**	**1,132.0**	**608.0**	**1,132.0**	**608.0**	Underperformance in Low risk cost effective switches 22/23 continuation of plan is mitigated by 23/24 overperformance below so net effect is on plan
Switches & Medicines Review										
Transformation and expansion of Prescription Ordering Direct (POD)	MED034	Planned	Prescribing	1,506.0	330.0	161.0	169.0	321.0	1,185.0	Restructure resulting in reduced savings
Blood glucose testing strips (PQS and switch)	MED040	Planned	Prescribing	450.0	150.0	293.0	(143.0)	584.0	(134.0)	
Lancets (PQS and switch)	MED041	Planned	Prescribing	15.0	7.0	13.0	(6.0)	22.0	(7.0)	
Novarapid vs Trurapi	MED042	Planned	Prescribing	200.0	80.0	42.0	38.0	104.0	96.0	
Sitagliptin windfall and switch	MED043	Planned	Prescribing	250.0	100.0	55.0	45.0	173.0	77.0	
Home Oxygen targeted reviews	MED044	Planned	Prescribing	75.0	28.0	28.0	0.0	76.0	(1.0)	
OptimiseRx	MED045	Planned	Prescribing	1,800.0	900.0	951.0	(51.0)	1,917.0	(117.0)	
Low Risk Cost Effective Switches (facilitates all other switches)	MED046	Planned	Prescribing	100.0	40.0	336.0	(296.0)	532.0	(432.0)	
Opioid Costs (supported by PQS/rebates)	MED047	Planned	Prescribing	500.0	200.0	45.0	155.0	286.0	214.0	
DOAC edoxaban rebate and overall costs	MED048	Planned	Prescribing	1,000.0	500.0	441.0	59.0	831.0	169.0	
Lower cost greener inhalers (Luforbec switch)	MED049	Planned	Prescribing	750.0	300.0	0.0	300.0	410.0	340.0	
Oral Nutritional supplements (supported by PQS and FK rebates)	MED050	Planned	Prescribing	90.0	30.0	45.0	(15.0)	120.0	(30.0)	
Self Care	MED051	Planned	Prescribing	50.0	20.0	0.0	20.0	10.0	40.0	
Outlier Practices	MED052	Planned	Prescribing	150.0	60.0	60.0	0.0	150.0	0.0	
Specials and high cost items	MED053	Planned	Prescribing	75.0	37.0	37.0	0.0	75.0	0.0	
Dressings	MED054	Planned	Prescribing	300.0	0.0	0.0	0.0	300.0	0.0	
Repeat prescribing audit	MED056	Planned	Prescribing	75.0	28.0	28.0	0.0	75.0	0.0	
Stoma managed service pilot	MED057	Planned	Prescribing	100.0	40.0	0.0	40.0	30.0	70.0	
Subtotal Switches & Review				**7,486.0**	**2,850.0**	**2,535.0**	**315.0**	**6,016.0**	**1,470.0**	Restructure resulting in reduced savings
Unidentified Efficiencies as in July now identified in August				**1,885.0**	**170.0**	**191.0**	**(21.0)**	**3,219.0**	**(1,334.0)**	windfall savings sitagliptin and apixaban
Total Efficiency				**11,111.0**	**4,760.0**	**3,858.0**	**902.0**	**10,367.0**	**744.0**	
Variance as a % of Budget							*18.9%*		*6.7%*	
Variance Signage: (Favourable)/Adverse										

10.0 LCS Activity Tracker

Locally Commissioned Service	H1 Activity Budget (£)	H1 Claimed (£)	Utilisation %	Comment
Care Homes	172,927	143,730	83%	
Diabetes	192,562	214,685	111%	Over performance on the Key Care Processes and Treatment Targets elements of Diabeties
Eating Disorders	181,692	122,389	67%	
Inclusion Health	301,035	178,133	59%	
Mental Health SMI Health Checks	214,208	125,322	59%	
Phlebotomy	2,513,794	2,534,211	101%	
Proactive Healthcare	2,090,117	2,083,003	100%	
PSA	137,912	139,042	101%	
Shared Care	638,817	668,406	105%	
Spirometry	179,569	199,646	111%	Qtr 1 claimed in Qtr 2
Treatment Room	759,735	946,587	125%	Injections, Minor injuries and Post Op Wound Care based on activity hence overperformance
Warfarin	438,360	380,885	87%	
	7,820,728	**7,736,039**	**99%**	Qtr 1 and Qtr 2 windows in the CQRS Local portal now closed

- The above shows the take up of claims for Locally Commissioned Services for Q1 and Q2 23/24 combined.
- The above is a mixture of block and activity-based schemes up until first 6 months of 23/24 only.

Appendix Financial Risk(s)

Risk	Mitigation
2023/24 outturn position deteriorates from the current forecast	There is robust management and oversight arrangements, detailed review of the underlying position, via monthly review of actual expenditure compared to plan and specific mitigations agreed with budget managers.
Full Year Impact of 22/23 NICE Guidelines in 23/24	NICE guidance which was published in March-22 led to additional costs in the 2022/23 expenditure as a result of Continuous Glucose Monitoring (CGM) and prescribing of Sodium-glucose Cotransporter-2 (SGLT2) inhibitors. The full year impact of the same would be seen for the first time in 23/24, whilst this is included in Forecast numbers but there could be volatility.
Non delivery or under delivery of £14.2m Transformation Savings assumed in the financial position for Prescribing and Primary Care.	Practice Level Prescribing budgets, based on a scientific process to include deprivation, care home beds and list size has been calculated. Actual spend is being compared on a monthly basis to understand the outlying practices and take corrective steps. There is an oversight group also setup to monitor and take corrective action. Similar processes in the Dental and Primary Care areas.
Chance of clawback of dental underspends from NHSE	Regular monitoring and engagemnet with regional teams

Appendix Financial Risk(s)

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