Hertfordshire and
West Essex
Integrated Care Board

NHS HWE ICB Primary Care Board meeting held in Public

Thursday 26 January 2023

MS Teams

09:30 - 11:40

NHS
Hertfordshire and West Essex
Integrated Care Board

Meeting Book - NHS HWE ICB Primary Care Board meeting held in Public

AGENDA Primary Care Board - Thursday 26 January 2023

Time	Item	Purpose	Lead
09:30	1 1. Welcome, apologies and housekeeping		Chair
	2 2. Declarations of Interest		Chair
09:35	3 3. Minutes of last meeting held on 24 November 2022	Approval	Chair
	4 4. Action Tracker	Approval	Chair
09:40	5 5. Questions from public	Discussion	Chair
09:50	6 6. Directorate Highlight Report [Verbal]		Avni Shah
10:00	7 7. Risk Register	Discussion / Approval	James Gleed
10:10	8 8. Update from Healthwatch	Discuss / Information	Geoff Brown/Sam Glover
	8.1 8.1 Healthwatch Hertfordshire		
	8.2 8.2 Healthwatch West Essex		
10:35	9 9. Patient Participation Groups		
	9.1 9.1 Evaluation of the project to reinvigorate patient participation group		Alan Bellinger/Heather Aylward/Heather Eardley
	9.2 9.2 Toolkit for practices on “Why do Practices need Patient Participation Groups		
10:50 - 11.00	10 Comfort Break		
11:00	11 10. Primary Care Workforce Report Deep Dive	Discussion	Joyce Sweeney/Sarah Dixon
11:20	12 11. Primary Care Transformation - Verbal Update		Prag Moodley
11:35	13 12. New risks identified		Chair
	14 13. Reflections and feedback from the meeting including items to disseminate		Chair
11:40	15 14. Close of meeting		Chair
	16 Date of Next Meeting: 23 March 2023		

The Nolan Principles

In May 1995, the Committee on Standards in Public Life, under the Chairmanship of Lord Nolan, established the Seven Principles of Public Life, also known as the "Nolan principles". These principles are the basis of the ethical standards expected of all public office holders.

The Hertfordshire and west Essex Integrated Care Board recognises that in all its work it must seek to meet the highest expectations for public accountability, standards of conduct and transparency. It will therefore ensure that the Nolan principles, set out below, are taken fully into account in its decision making and its policies in relation to standards of behaviour.

1. Selflessness. Holders of public office should act solely in terms of the public interest.

2. Integrity. Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.

3. Objectivity. Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.

4. Accountability. Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.

5. Openness. Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.

6. Honesty. Holders of public office should be truthful.

7. Leadership. Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs.

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

DRAFT MINUTES

Meeting:	**HWE ICB Primary Care Board meeting held in Public**			
	Meeting in public	☒	*Meeting in private (confidential)*	☐
Date:	**Thursday 24 November 2022**			
Time:	**09:30 – 12.05pm**			
Venue:	**Microsoft Teams**			

MINUTES

Name	**Title**	**Organisation**
Members present:		
Nicolas Small (NS) **(Meeting Chair)**	Partner Member	Herts and West Essex ICB
Rachel Joyce (RJ)	Medical Director	Herts and West Essex ICB
Prag Moodley (PM)	Partner Member	Herts and West Essex ICB
Ian Perry (IP)	Partner Member	Herts and West Essex ICB
Gurch Randhawa (GR)	Non-Executive Member	Herts and West Essex ICB
Avni Shah (AS)	Director of Primary Care Transformation	Herts and West Essex ICB
Elliot Howard Jones (EHJ)	Partner Member	Herts and West Essex ICB
In attendance:		
Tim Anflogoff (TA)	Head of Community Resilience	Herts and West Essex ICB
Michelle Campbell (MC)	Head of Primary Care Contracting	Herts and West Essex ICB
Sarah Dixon (SD)	Clinical Lead Primary Care Workforce ENH HCP	
Chris French (CF)	Head of Wellbeing and Public Health	Essex County Council
James Gleed (JD)	Associate Director Commissioning Primary Care	Herts and West Essex ICB
Sam Glover (SG)	Chief Executive	HealthWatch Essex
Rachel Hazeldene (RH)	GP & Chief Clinical Information Officer	Herts and West Essex ICB
Rachel Halksworth (RH)	Assistant Director for Primary	Herts and West Essex ICB

	Care Contracting	
Parul Karia (PK)	GP, Medical Director, Beds and Herts LMC Chief Clinical Information Officer	
Iram Khan (IK)	Corporate Governance Manager	Herts and West Essex ICB
Roshina Khan (RK)	Mass Vaccination Programme Director	Herts and West Essex ICB
Adam Lavington (AL)	Director of Digital Transformation	Herts and West Essex ICB
Joanne Marovick (JM)	VCSFE Representative	Herts and West Essex ICB
Rob Mayson (RM)		
Vanessa Moon (VM)	Communications Manager	Herts and West Essex ICB
Helen Musson (HM)	Chief Officer	Community Pharmacy Hertfordshire to support pharmacies across Hertfordshire
Annette Pullen (AP)	EA to Director of Primary Care Transformation	Herts and West Essex ICB
Joanne Richardson (JR)	Digital First Primary Care Programme Manager	
Anurita Rohilla (AR)	Chief pharmacist and Associate Director for Allied Health Professions	Herts and West Essex ICB
Renate Scheffer (RS)	Community Pharmacy Integration Lead	Herts and West Essex ICB
Karen Samuelsmith (KS)	Chief Officer, Community Pharmacy Essex	Essex LPC
Neil Tester (NT)	Vice Chair	Healthwatch Herts
Tracey Norris (Minute taker)	Clerk	Herts for Learning

PCB/11/22	**Welcome, apologies and housekeeping**
11.1	The Chair welcomed all to the meeting. He confirmed that this was not a public meeting but a meeting being held in public (members of the public were welcome to attend but were not permitted to participate). Questions from the public were welcomed in advance and there were instructions on the website how to do this.
11.2	There were no apologies for absence; the meeting was declared quorate.
PCB/12/22	**Declarations of interest**
12.1	The Chair invited members to declare any declarations relating to matters on the agenda: • None declared. All members declarations are accurate and up to date with the register available on the website: Declaration of interests – Hertfordshire and West Essex NHS ICB

PCB/13/22	Minutes of last meeting
13.1	The minutes of the last meeting held on 22 September 2022 were agreed as an accurate record.
13.2	**The Primary Care Board approved the minutes of the last meeting.**
PCB/14/22	**Action Tracker**
14.1	The action tracker was reviewed, and the current status of all actions noted: • PCB/05.5/22: this item was closed, see risk register at agenda item PCB18/22. • PCB/06.6/22: GP patient survey results: this was due for completion at the end of November. • PCB/07.3/22: PC workforce training plan: a deep dive had been planned for January.
14.2	**The Primary Care Board noted the updates to the action tracker**
PCB/15/22	**Questions from public**
15.1	**Question 1: Tara Mataba** "What has been done to ensure the integration of social prescribing link workers in primary care?"
15.2	**Response:** HWE recognises and the importance of social prescribing link workers across the system through the work across all three places since 2014. There are currently 2 models of social prescribing across HWE, either employed by providers such as primary care networks or other providers or through the Hospital and Community Navigator Service (HCNS), with 9 partner hosts. They are supervised by senior navigators in integrated locality teams alongside colleagues working in the community and hospital. They still have clinical supervision from the relevant PCN and function in Multidisciplinary teams with primary care colleagues but can take referrals from outside primary care, in line with NHSE guidance. Having linked workers fully networked in with the local voluntary sector is critical and their work in this regard depends both on making local relationships and having recourse to good information about community resources. To this end, Linked workers in Herts are linked to Herts Help and those in West Essex to the Essex Wellbeing Service – both of which act as the default contact point for people (including professionals) who are not sure what support may be available. To support social prescribers further, the ICS primary care workforce were fortunate to be part of a pilot through NHS England to understand the developmental needs of social prescribing link workers in 21/22. Feedback of that was fed into the wider programme recently launched of education and training of PCN training teams which aims to support all the Primary Care Workforce and development. These teams comprise of GPs, Nursing and Allied Health Professional Leads who will work together to address the needs of both clinical and non-clinical staff training and development needs within their PCNs. This will include looking at how they can best support their Social Prescribers' development as part of their team role with a view to integrate these roles further in primary care network working in partnership with partners.
15.2	**Question 2: Mr Woodcock** A statement from Mr Woodcock had been received and printed in the meeting papers. This related to the provision of a community pharmacy in Stansted Mountfitchet.

15.4	**Response:** AS confirmed that a meeting would be scheduled between Mr Woodcock and the appropriate team to discuss this further.
15.5	**The Primary Care Board noted the questions and responses**
PCB/16/22	**Primary care board governance: subgroup terms of reference**
16.1	The terms of reference for the two sub-groups already established were shared and noted (see pages 12-22 of the document pack): • Primary Care Workforce Sub-Group • Primary Care Digital Sub-group The terms of reference of the Transformation sub-group would be shared at the next meeting. Reports from each sub-group would be shared at the PCB meeting on a regular basis (see agenda item PCB/24/22)
16.2	**The Primary Care Board noted the subgroup terms of reference**
PCB/17/22	**Directorate Report**

17.1	Avni Shah (AS) provided the following verbal update on the progress of clinical and governance developments:
	Governance
	• The three sub-groups had been established:
	  ○ Digital
	  ○ Transformation
	  ○ Workforce
	• Two GP clinical leads had been appointed per locality across each place.
	• Three primary service providers had been appointed to the HWE board.
	• Delegated responsibility for community pharmacy, optometry and dentistry commissioning would be taken on from 1 April 2023. Hosting arrangements were being finalised with support from NSHE; HWE would provide the host function for all ICBs in the east of England.
	Workforce
	• PCN education teams have been launched; 28 already have full training teams in place.
	• Protected time for PCNs have been established across HWE, to be held on the same day every other month.
	• A First Five and Wise Five event was held in Luton; a good discussion was held on the primary care strategy in light of the Fuller Stocktake report.
	• Development of a medical school at the University of Hertfordshire.
	Estates and access
	• Additional winter appointments had been made possible through local allocation of £1.43 per weighted patient.
	• Cloud based telephony roll out and support continues.
	• 88 out of 134 surgeries have accepted support to reinvigorate PPG at practice or PCN level.
	• The primary care OPEL framework was being implemented.
	• Pressure in the system remained with increased demand also coming from the areas where asylum seekers were being house temporarily.

	• GP access data would be published in the coming days and whilst this would provide quantitative data it did not comment on the quality of care. • Face to face appointments were increasing. Demand in general was 15% above average. • 1 October: Launch of the enhanced commissioning framework. Early findings would be available by the last quarter. • A primary care strategy was being developed (see agenda item PCB/22/22) with PC transformation lead engaging with all delivery areas and neighbourhood teams.
17.2	**Questions and comments were invited:** • PCB members were pleased to note the progress being made behind the scenes and highlighted the link between PC strategy, infrastructure and the risk register. • It was hoped that future reports could highlight the expected improvements for patients from the various investment decisions made by the PCB. • Was HWE at risk from a reduced financial delegation from NHSE re dentistry/ optometry; if this was based on actual spend rather than a fair share formula? • AS confirmed that the potential financial risk from this new delegation was high on the directorate's radar. Current service delivery would be part of the due diligence process. • The overarching aim of reducing access inequality applied equally to dentistry/optometry and community pharmacy as it did to GP access.
17.3	**The Primary Care Board noted the Directorate report**
PCB/18/22	**Risk Register**

18.1	James Gleed introduced the risk register (see pages 23-33 of the document pack) highlighting the following points:
	• Key change: inclusion of risks associated with delegated funds for dentistry/optometry and community pharmacy.
	• Direction from ICB Board meeting to consider how to capture how a decision in one part of the system might create an increased risk in another. This would be considered by the ICB Risk Review Group.
	• Risk 325 and 333 have been closed.
	• Risk 331 risk score has been downgraded from 12 to 6.
	• Two new risks had been identified:
	  ○ Recruitment to the ARR's scheme.
	  ○ Closure of covid community vaccination sites leading to increased pressure on PCN and community pharmacy.

18.2	Questions and comments were invited: • An integrated approach was critical. Many of the workforce risks were interlinked. Eg if the ARR's roles were filled, this would impact on community pharmacy. • Distinction needed to be made between "issues" and "risks"; the risk register was still quite large and many items were issues that were being addressed.
18.3	**The Primary Care Board approved the proposed changes to the risk that have been reviewed and the new risks proposed.**
PCB/19/22	**Update from Healthwatch**

<table>
<tr><td>19.1</td><td>Sam Glover (SG) and Neil Tester (NT) presented the findings from the Healthwatch Hertfordshire and Healthwatch Essex engagement projects, commissioned by HWE ICB (see pages 34-158 of the document pack) which looked at GP access in the 3-month period (August – October) with a specific focus on:

Parents, carers and children and young people across Hertfordshire and West Essex
Residents living in the Borough of Broxbourne (and Harlow and Uttlesford for West Essex)

Four main themes emerged across both counties:

Accessing GP surgery

In general, the public understand the pressure a surgery is under but are frustrated by poor comms).
Some find receptionist a barrier to access and the 8am phone call is not effective.

Lack of choice (digital solution does not suit every patient and is widening the inequalities gap)
Online services
Avoiding access (due to frustration or prior bad experience, this can sometime lead to acute being the first time that care had been accessed).

The reports contained a rich seam of patient experience and feedback which was welcomed by the PCB, they had selected these particular localities knowing that there were access issues to be addressed. Other salient points were:

Young people did not feel heard or listened to.
There was a lack of trust between community and the system and in particular in minority communities.
The reports contained sobering and often emotional messages and care should be taken when sharing these with front line staff.
</td></tr>
<tr><td>19.2</td><td>Questions and comments were invited:

PCB members thanked Healthwatch for such detailed reports which would help the ICS address its first priority of primary care transformation: access.
It was gratifying that patients had noticed a difference after the telephony system had been introduced at a practice.
Population expectation management was a key factor in transformation: patients tended to ask for a GP when this might not be the most appropriate member of the team to support them. Staff should be deployed appropriately.
Some practices in a similar locality with similar list profiles were clearly managing better, learnings from these practices should be shared. How did they achieve good access and good patient satisfaction survey results, for example.
It was noted that even practices with good access struggled with demand on some days.
A way forward was suggested: “You said xx, we did xx” this would help to increase engagement in future surveys and demonstrate that the ICB was listening to and making changes in response to feedback.
The benefits of phone or video consultations to both GPs and the patient needed to be more widely celebrated/highlighted.
</td></tr>
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	• It was disappointing that the feedback on GP access was so negative; this would be hard for many GPs to hear against the back drop of the heavy workload they were under from planned care, safeguarding, social care etc. • Aim: right care, right place, right time. • The comms/messaging to the population was crucial, it was noted that there was always resistance to change initially. • SG explained that in any survey the impassive never responded, the happy sometimes responded and the aggrieved always responded. Most frustrations were in getting to the right professional and there were very few issues with the quality of service once this had been achieved. This was not an HWE-wide survey but a focused review in a particular locality. • The next study would look at community pharmacy across the whole of HWE. • AS noted that the next step would be to share the report findings with a wider audience and the public, highlighting the positive lived experiences as well as the areas for improvement/dis-satisfaction. • Effective communication was critical and openness and transparency about lead times for change. Eg the lead-time for a practice to move to advanced telephony was between 3 to 4 months.
19.3	**The PCB noted the findings of the Healthwatch feedback report**
PCB/20/22	**East of England Partnership strategy for community pharmacy**

20.1	Renate Scheffer introduced the report (see pages 159-211 of the document pack) which had been refined and reviewed with community pharmacy stakeholders and shared the following overview:
	• A five-year strategic vision to ensure community pharmacy developed its full potential.
	• Community pharmacy played a pivotal role in developing the covid vaccination programme (from vision to delivery).
	• Various pilot schemes were already underway to better integrate services between GP and pharmacy, eg:
	  o Medicine service
	  o Hypertension service

20.2	Questions and comments were invited: • PCB members hoped that the benefits to both patients and workforce from this strategy would be well articulated. • It was noted that the overarching concept had been easily agreed, the detail would be more difficult. Clarity was needed to understand the community pharmacy role within each pathway, which might be universal or in other cases a locally enhanced offer. • This East of England strategy has been presented to each board for adoptions, the next step would be to create an action plan to implement the strategy which would cover digital structures, workforces, partnerships with primary care delivery and some public health commissioning.
20.3	**The PCB approved the East of England Partnership strategy for community pharmacy**
PCB/21/22	**ICS Digital strategy**

21.1	Adam Lavington introduced the report (see pages 212-240 of the document pack) highlighting the following points:
	• The strategy had been approved at the ICB Board meeting on Friday 18 November 2022 and would be uploaded to the HWE website.
	• It was based on five strands:
	  o Digital Collaboration – System Wide Collaboration
	  o Digital Platforms – Essential Strategic Digital Platforms
	  o Digital Direct Care – Proven Digital Care Enablers
	  o Digital Innovation – Local Digital Care Innovation
	  o Digital Skills – Digital Inclusion and Workforce Capability

21.2	Questions and comments were invited: • At the moment there were no plans to integrate the IT system between primary care and secondary care. It would be a managed convergence rather than a single system approach. • System collaboration was discussed and the willingness of the different organisations to collaborate; this was potentially a barrier to success. • It was noted that not all patients were digitally literate and for some, paper was the preferred and only option. • The national standards for digital were being pushed, but it was noted that this was a 10-year strategy.
21.3	Primary Care Road Map: see pages 241-250 of the document pack. Rachel Hazeldene introduced this item which was for information: • A project manager had been appointed and a full report would be shared in March 2023 which would address how the ICS digital strategy would cover specific digital solutions for individual organisations. • The existing digital first primary care programme would continue.

21.4	Digital Exclusion: see pages 251 – 255 of the document pack
	Joanne Richardson and Megan Knight introduced this item and summarised the salient points:
	• The digital first project aim: improve efficiency and accessibility and eliminate exclusion.
	• A benefit of digital inclusion would be to provide patients with the opportunity to manage their health independently; at the moment, those with the most to benefit were the least likely to access digital solutions.
	• Research has been commissioned from "We are digital" and the aims were:
	  o To broaden digital literacy and participation for our healthcare staff and patients within primary care.
	  o Raise the awareness of the advantages of accessing health information and services via online avenues.
	  o Create relationships and work in partnership with related, local organisations/projects, who focus on these (excluded) groups most in need, to address the unwarranted disparity in care.
	• The summary of the research was shared in the report which highlighted the disparity between the digitally excluded and others.
	• Agreed next steps (short, medium and long term) were set out in the paper.
	• JR noted that there were a number of "quick wins" which could be implemented to service design to improve inclusion.

	• The team would build up a picture of case studies through shared learning events and the digital innovation group (a recent meeting had over 40 practice managers in attendance). • The difficulty in engaging with some minority groups to gain patient feedback was highlighted. Some cohorts were underrepresented in the research. • Long-term aims would require collaboration between primary care, workforce and comms teams.
21.5	Questions and comments were invited: • It was suggested that Healthwatch be included in the list of stakeholders as they could support this piece of work. • Dental, optometry and community pharmacy would also need to be included.
21.6	**The Primary Care Board noted the ICS digital strategy**
21.7	***Action: Deep dive into digital exclusion to come to a future PCB meeting***
PCB/22/22	**Development of primary care strategy**
22.1	James Gleed introduced the report (see pages 256-262 of the document pack) highlighting the following points: • The report described the intention to create a primary care strategy which would focus on delivery plans in each of the three places. • This would be led by place-based primary care teams. • A full update would be provided in March 2023. • The strategy would require a holistic approach to population health management being mindful of the previous primary care strategies in place in each of the CCGs and the various strategies being developed in other areas of the system (IT, digital, estates, PCN etc). • The strategy would also include community partners and VCFSE but the largest stakeholder would be the patients.
22.2	Questions and comments were invited: • The work currently being undertaken by Sam Tappenden on the out of hospital strategy could also feed into the PC strategy. • The BMJ were now reporting on the outcomes of patients being treated at home. • Patient perception was that all organisations can now see everyone's data. This was a misconception and there was still a lag in information sharing in some areas. • Consideration needed to be given to the roll out of patient access to records as this could lead to more enquires at GP level.
22.3	**The Primary Care Board noted the plans to develop the primary care strategy**
PCB/23/22	**Voluntary Community Faith and Social Enterprise VCFSE Health Creation Strategy**
23.1	Tim Anfilogoff introduced the report (see pages 263-289 of the document pack) highlighting the following: • The strategy was co-designed with new VCFSE Alliance to complement all other strategies and developments (ie focusing on the unique contribution of the VCFSE) • The report set out the current make-up of Alliance Steering Group and provided some examples of non-clinical VCFSE interventions with clear clinical outcomes. • There were ten key themes tp the strategy with specific reference to No Wrong Door and Health Inequalities. • Some next steps around developing governance had been created.

	• The VCFSE sector in Hertfordshire alone was comprised of over 14000 organisations with a combined turnover of £1billion. • Examples of outreach work to engage with disadvantage/vulnerable groups were shared. • Proposal to change the language used to describe “out of hospital” to “better at home”. • The work of Herts Help was highlighted.
23.2	Questions and comments were invited: • Recruitment for a secretariate was underway at the moment. • There was a suggestion that the diagram on page 268 should focus more on community provision as this was key to enable prompt and successful discharge. • Acknowledge of admission avoidance and the key work comms could provide to support this. • The waiting well project could only do so much for patients who had been on a list for 18+ months. More impact (and better outcomes) could be gained from better conversations at the start of the process. • AS welcomed this strategy and hoped that there would be collaboration going forward on training support for link workers and volunteers; this could link into the people plan and the PC workforce. • Digital share care records were available to social prescribing as part of the digital road map. • Systems and processes need to support all of the strategies being considered – to make sure the strategy was implemented. • The enormous contribution of the VCFSE within HWE was noted.
23.3	**Primary Care Board noted the VCFSE health creation strategy**
PCB/24/22	**Subgroup reports/minutes**
24.1	The following reports were noted: • Primary care workforce group (page 290-295) • Primary care digital group (page 296-299) • Primary care communication and engagement (page 300-304)
24.2	**The Primary Care Board noted the subgroup reports**
PCB/25/22	**New risks identified**
25.1	The following new risks were suggested/considered: • Patient accessing records: this was part of digital risk and access. • Compliance with GDPR requirements re patient access. Would guidance for GPs be available? • Safeguarding/domestic abuse. JG noted that some risks sat outside of the directorate but would impact primary care. These would be incorporated into the PC risk register and would include digital risks.
PCB/26/22	**Reflections and Feedback from the Meeting**
26.1	The breadth and depth of primary care and the different individuals/organisations involved continued to be explored.
The meeting closed at 12.05 **Date of next meeting: Thursday 26 January 2023**	

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Herts and West Essex Integrated Care Board PRIMARY CARE BOARD Action Tracker Last updated on 17 January 2023								
Private / Public	**Action Tracker Ref No**	**Date of Meeting**	**Subject**	**Action**	**Responsible Lead**	**Deadline Date**	**Comments and Updates**	**Status**
Public	PCB/06.6/22	22/09/2022	GP Patient Survey Results	**Provide development of framework/dashboard**	Michelle Campbell	~~24/11/2022~~ **26/01/2023**	GP patient survey results: this was due for completion at the end of November. Dashboard has now been developed by BI team - demonstration given on 13th Jan and further updates suggested which BI are currently working on. Dashboard being presented to Primary Care Tranformation Leads on 19th Jan to support same day access work and then dashboard will be taken back to Access MDT to identify where support needs to be focussed in consideration with the outcomes of the Healthwatch (Herts and Essex) patient engagement reports on GP Access	**Open**
Public	PCB/07.3/22	22/09/2022	Primary Care Workforce Training Plan	**Add to work plan for a future mtg - date TBC - deep dive in Training Hubs**	Joyce Sweeney/Sarah Dixon	**26/01/2023**	On agenda 26 Jan 23	**Open**
Public	PCB/21.7/22	24/11/2022	ICS Digital strategy	**Deep dive into digital exclusion to come to a future PCB meeting**	A Shah	**23/03/2023**		**Open**

RAG Rating Key:	
Red	Open (overdue)
Amber	Open (on-going)
Green	Completed / Action Closed

Statement to Herts & West Essex Integrated Care Board meeting held on 26th Jan. 2023

Board members, thank you for noting my written statement presented to you during your meeting held on 24th Nov. 2022. For the first time I felt that the 664 community members I represent in Stansted Mountfitchet was being listened to. That became more evident when Ms. Avni Shah had a "Teams" meeting with us on 2nd Dec. 2022. Avni, we thank you.

My understanding is that on 1st April 2023 the H&WE IC Board will take over the responsibility of making decisions concerning new licenses granted to Community Pharmacy applicants. Initially this will be overseen by NHS England – East.

What remains one of my real concerns is, Essex County Council H&W / PNA (ECCH&WPNA) team will continue to be responsible for collating and recommending which localities in Essex need changes to current community Dispensing Pharmacy provision, new dispensing licenses.

Why am I concerned? Since 2018 I and Stansted Mountfitchet Parish Council and Kemi Badenoch MP have written detailed reports, with supporting evidence, explaining why the town of Stansted Mountfitchet in Uttlesford needs a licensed community pharmacy as close as possible to Stansted Surgery. This factual information has been ignored by ECCH&WPNA.

Kemi Badenoch MP sent me an email on 30th Nov. 2022 stating: -

I note that the points that we had raised in the consultation response were addressed in the annexes of the PNA. Specifically, as follows:

Local Terrain:
Local terrain has been considered in travel analysis. Specific comments about a hill have been addressed by an NHS Appeal hearing and not considered to be relevant.

Distance from nearest pharmacy, travel times and methods of travel, environmental concerns about driving:
The PNA is required to analyse times to reach pharmaceutical services. This has been done using driving, public transport and walking at various times of the day and on various days. A full travel times report is provided as part of the PNA. Environmental and climate comments are out of scope of this current assessment.

New housing and population growth:
This has been considered over the lifetime of this assessment

Pharmacy within airport perimeter:
Independence Direct, Coopers End Road, Stansted is a dispensing appliance contractor (DAC) on the NHSE pharmaceutical list. DACs have to be included in the PNA assessment as they provide pharmaceutical services. The pharm. End of quote.

End of Kemis email

Our response, re "*Local Terrain"* PNA comment was nonsense.

Distance/travel times; the PNA does not mention return journey times for public transport or waiting times for medicines.

DRAFT

No mention is made in the PNA that Stansted Mountfitchet *housing stock* has increased by about 950 dwellings since 2011.

No mention is made that Boots on Cambridge Road is NOT Disabled Persons compliant.

The PNA Report for Uttlesford/Stansted Mountfitchet does not consider disabled people's needs.

H&WE ICB will be responsible for Pharmacy provision from April 2023, we now should wait until then before taking further action other than fact finding. But who is responsible for the PNA?

I made an oral statement to Stansted Mountfitchet Parish Council (SMPC) on 18th Jan.2023, it was written by Sonya Pacetti a resident of Stansted Mountfitchet, she asked me to present it to the Council because of her health conditions, it is:-

Hi Ray and All,

It was a pleasure meeting with you all yesterday and a very interesting insight as to what we can do moving forward. If it helps you at all, here is my story.

I am disabled and wheelchair bound as I can't weight bare at all and have difficulty sitting in my chair for long periods of time as it affects my circulation and my COPD.

When I first moved to Stansted there was only one option of a chemist, to which it was impossible for me to use. The hill to reach it has a very sharp incline which uses a lot of power on my wheelchair batteries. Also in places the pavement is too narrow and badly maintained. The junction with St Johns Road is very dangerous. I have bottomed my chair on many occasions and have needed a push as it gets stuck with my back wheels just spinning. Luckily so far I haven't fallen in oncoming traffic but it could be easily done. Also please note the Boots chemist has steps to it which are impossible to access in a motorised chair. I note that from one report that was kindly provided to me from Ray, read that Boots would come out to people like myself in all weathers. Please note, whilst they may come out, I myself have to wait outside in all weather's trying to get noticed.

I take a lot of medication and the facility of a dossett box could **not** be done at Boots as they don't have the time or facility. Also should I need a new medication that wasn't on repeat, I could wait for it but it would sometimes take ¾ of an hour for it to be filled. Obviously this impacts also on my battery life. Furthermore, if I send a carer there instead it costs a lot of money. The average care companies charge £30 per hour, so to get a prescription will cost around £45. Sometimes they don't have the medication in stock and this journey has to be made again even though I've phoned in advance to ask if it's available. All this effort because they don't deliver.

My story does have a sort of happy ending. There is a new pharmacy in town, right next to the surgery. It offers me great service, except for the dispensing of nhs prescription as it's not available at present. They do however get there sister company to fill the orders but it can take a few days to arrive back. It's very spacious so not over crowded. Well lit, which is important to me. It has no steps and is wheelchair friendly.

From Stansted Pharmacy I now get

1. My prescriptions ordered for me
2. They put them in dossett boxes
3. They deliver them and even use my key safe to bring them personally in.
4. The kind driver phones the chemist for advice if she notices I'm unwell
5. I can ask for advice for myself or family about anything
6. They are aware of my allergies so the carers can go there for advice
7. Although I get my jabs at home from the surgery, they still offer them to me
8. They have a diabetic eye testing unit that attends
9. They have a real sense of community about them.

Therefore please accept my plea to licence Stansted Pharmacy and stop Boots having the monopoly. There is more than enough people for both chemists to survive and serve our community.

Sonya Pacetti

End of Sonyas statement.

I understand that H&WEIC Board commissioned a public survey during Dec 2022 which closed on 10th Jan 2023. The survey being conducted by Health Watch Essex. I and another resident of Stansted Mountfitchet have been in contact with Ms. Sara Poole of Health Watch Essex and have invited her to visit our locality when we will show her the area to help her properly understand our need. A provisional date of 27th Jan has been pr. Any member of the Board is welcome to join us to see things as they really are.

Raymond Woodcock

19th Jan. 2023

DRAFT

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public* ☒	*Meeting in private (confidential)* ☐		
	NHS HWE ICB Primary Care Board meeting held in Public		**Meeting Date:**	**26/01/23**
Report Title:	**Primary Care Risk Register**		**Agenda Item:**	**07**
Report Author(s):	Andrew Tarry, Head of Primary Care Commissioning James Gleed Associate Director Commissioning Primary Care			
Report Signed off by:	Avni Shah Director Primary Care Transformation			
Purpose:	**Approval** ☐ **Decision** ☒ **Discussion** ☒ **Information** ☒			
Report History:	A new Risk Register for the HWE ICB Primary Care Directorate has been created; this brings together and replaces risks previously recorded and tracked on individual CCG Risk Registers. Work commenced on this as part of the preparatory work for creation of the Hertfordshire and West Essex Integrated Care Board. The Risk Register was presented to the Primary Care Commissioning Committee in Common of the three Hertfordshire and West Essex CCGs in May 2022 and to the Herts and West Essex ICB Primary Care Board in August 2022. Following discussion at the last Primary Care Board in September, the November update reflected the 2 key actions agreed: • Including risks with delegated and pharmacy, optometry and dental (POD) contracts. • Review of all the risks with lower risk ratings (lower than 12)			
Executive Summary:	A summary is provided following the key updates provided in the November paper. Work continues with NHSE to understand the risks associated with each of the POD services, with a view to including more specific risks on the register in due course the latest As noted at the November Primary Care Board meeting, it is the intention to ensure that key risks from other relevant ICB Directorates and Teams (most notably estates, digital /IT) are shared with the Board in future updates. The work to provide this broader view of risks impacting on Primary Care has been initiated, however this is a significant task as investigation has determined that risks in these areas have not historically been documented and there are currently constraints in within teams - capacity and training in risk management.			

<table>
<tr><td></td><td colspan="4">The assignment of risk leads for all entries on the register has been reviewed and refreshed in light of the new Primary Care Directorate Structure.

As agreed at the Primary Care Board meeting in November, a new risk relating to management of asylum seeker hotels/placements has been added to the risk register - this risk requires review and approval by the Board.

Updates have been made to existing risks as below. Deletions are marked by strikethrough; new text highlighted in red.

Risk 320 related to general practice pressure – the risk definition has been amended by removing specific reference to the COVID-19 pandemic, so the risk now has a wider view on ongoing general practice pressures. Additional control measures have been added regarding adjustments to the 22/23 ECF and the collaborative development of respiratory and other urgent on the day hub capability.

Risk 327 related to general practice recovery and workload prioritisation – this risk has also been updated to reflect the additional control measure regarding the adjustments to the 22/23 ECF.

The primary care risk review group that was established to ensure regular review and updating of the risk register continues to meet monthly.

The risk register is a dynamic document and is presented to the Primary Care Board for review, discussion and information.</td></tr>
<tr><td>Recommendations:</td><td colspan="4">The Board is asked to
• Agree the proposed changes to the risks that have been reviewed
• Note the update and progress made</td></tr>
<tr><td rowspan="4">Potential Conflicts of Interest:</td><td>Indirect</td><td>☐</td><td>Non-Financial Professional</td><td>☐</td></tr>
<tr><td>Financial</td><td>☐</td><td>Non-Financial Personal</td><td>☐</td></tr>
<tr><td colspan="3">None identified</td><td>☒</td></tr>
<tr><td colspan="4">N/A</td></tr>
</table>

Impact Assessments (completed and attached):	***Equality Impact Assessment:***	N/A
	Quality Impact Assessment:	N/A
	Data Protection Impact Assessment:	N/A
Strategic Objective(s) / ICS Primary Purposes supported by this report:	***Improving outcomes in population health and healthcare***	☒
	Tackling inequalities in outcomes, experience and access	☒
	Enhancing productivity and value for money	☐
	Helping the NHS support broader social and economic development	☐
	Successfully complete and embed the transition of staff and functions from the three clinical commissioning groups into the Integrated Care Board	☐
	Develop the ways of working and profile of the Integrated Care System to ensure that its operating model is capturing the opportunities presented by closer system working	☐

1. Executive summary

A summary is provided following the key updates provided in the November paper. Work continues with NHSE to understand the risks associated with each of the DOP services, with a view to including more specific risks on the register in due course the latest

It is proposed that key risks from other relevant areas are shared with the Board in future updates to provide a broader view of risks impacting on Primary Care.

A new risk relating to management of asylum seeker hotels/placements is proposed following discussion at the November Board.

Amendments have been highlighted on risks related to general practice pressure, recovery, and workload prioritisation.

The risk register is a dynamic document and is presented to the Primary Care Board for review, discussion and information.

2. Background

Historically each of the three CCGs in HWE developed and maintained a primary care risk register; risks meeting predetermined thresholds were reported to Board.

Work commenced on a new consolidated risk register across HWE as part of preparations for the creation of the HWE ICB.

Each of the three individual risk registers have now been fully reviewed and archived as part of creating the new consolidated ICB risk register across the three 'places'.

3. Issues

Following on from updates provided to the Board in November paper, we would note the following further updates:

- A summary of the high-level risks associated with Community Pharmacy, Optometry and Dental (POD) delegation was provided. More detailed work has progressed and continues with NHSE to understand, with greater precision and granularity, the risks associated with each of the POD services, with a view to including more specific risks on the register in due course.
- It had been identified that the full content of the risk register had not been included on the Datix system. This has now been rectified, with Datix containing up-to-date comprehensive data (subject to the latest changes proposed in this update being agreed and incorporated).
- It was noted that there are other key areas, such as Estates, IT and Digital which have very direct bearing, with key risks impacting on Primary Care. It had been the intention that these risks would be included in this latest (January) refresh of the risk register, however investigation of the current risk documentation and processes in these areas has determined that this would not be possible. Risks against the digital work plan have previously been logged, however the log requires a substantial review, updating and transposition into the standard ICB risk register format; staff

training in Risk Management is required and this has been arranged by the ICB Governance Team. It hasn't been possible to locate a pre-existing register of risks relating to estates objectives and the key programmes of work, the Premises Team have reported that there is currently insufficient staff capacity within the team to be able to complete this work.

- The ICB Risk Review Group, led by the Associate Director of Integrated Governance and Organisational Alignment has recognised that the key task for the next 6 months is to ensure that all directorate risk registers across the ICB are fully updated and reflective of the key risks. Further training support is being offered to progress this.
- There was discussion at the Primary Care Board previously regarding the risk created to primary care by action or decisions taken in another part of the system, for example changes to acute hospital outpatient appointments. It is critically important that changes to service arrangements involve all relevant system partners to ensure that any associated risks can be identified, recorded and mitigated as appropriate. There are primary-secondary care interface meetings in all three HWE 'places' and it is very important that the agenda planning for (and discussion at) these forums is such that it will fulfil the above requirement. In doing so any identified risks can be appropriately documented and managed at system level.
- In light of the new directorate structure and new appointments, it will be important that there is ownership of the Primary Care Risk Register across the Directorate and that newly assigned leads understand and take responsibility for their respective assigned risks. The existing regular monthly risk review meeting will help to support this.
- There isn't currently a timeline for estates risks to be systematically identified documented and included in future updates, this will need to be resolved.

4. Actions

The following new risk related to the healthcare needs of asylum seekers is proposed following discussion at the previous PCB.

IF the growth in the placement of Asylum seekers in local hotels together with growing pressures in general practice continues;
THEN agreeing suitable arrangements to register & provide care for this vulnerable cohort of patients becomes increasingly challenged;
RESULTING delays in providing effective care & potential ongoing impact on local 111/A&E services

This risk requires review and approval by the Board. It should be noted that a risk relating to provision of care for Asylum seekers is also being recorded by the Nursing and Quality Directorate.

Updates have been made to existing risk as follows:
Risk 320 related to general practice pressure – the risk definition has been amended by removing specific reference to the COVID-19 pandemic, so the risk now has a wider view on ongoing general practice pressures. Additional control measures have been added regarding adjustments to the 22/23 ECF and the collaborative development of respiratory and other urgent on the day hub capability.

Risk 327 related to general practice recovery and workload prioritisation – this risk has also been updated to reflect the additional control measure regarding the adjustments to the 22/23 ECF.

5. Resource implications

Reported capacity constraints in the premises team as noted above.

6. Risks/Mitigation Measures

As noted above.

7. Recommendations

The Board is asked to:

Agree the proposed changes to the risks that have been reviewed and the new risks proposed.

Note the stated ambition in terms of the ICB approach to joined-up risk identification, the focus on ensuring that all ICB Directorate risk registers are fully updated and the intention to share key relevant risks from other Directorates impacting on general practice with the Board.

Receive the risk register at future meetings (in accordance with the Primary Care Board's Annual Cycle of Business) for review and discussion in order to satisfy itself that risks are being appropriately captured and rated and that relevant/proportionate mitigation and controls are in place.

8. Next Steps

Ongoing review and updating of the current and any new risks on the register

Ensure that the recent proposed updates to the risk register are entered onto the Datix system

Work with other Directorates to ensure that key risks from relevant areas are shared with the Board in future updates.

Transition Risks

11 November 2021

Risk Profile															Assurance Mapping							
ID	Datix ID	Date Opened	HWEICS Strategic	Committee	Executive Owner	Risk Lead	Revised Risk Lead	CCG Risk Description	Rating (initial)	Rating (current)	Rating (Target)	Risk Movement	Controls	Gaps in controls	**1st Line** Operational functions enforcing required behaviours and working practices throughout the organisation's day-to-day activities	1st Line - Level of assu	**2nd Line** Oversight functions undertaking scrutiny and monitoring of the governance framework to ensure that it operate in an efficient and effective	2nd Line - Level of assu	**3rd Line** Functions providing independent and objective challenge and assurance with regards to the organisation's governance arrangements	3rd Line - Level of assurance	Gaps in assurance	Approval status
PC1	318	10/11/2021	1 2 4	Primary Care Commissioning Committee	Director of Primary Care Transformation	Head of Primary Care Transformation at Place	ENH Head of PC Transformation	**IF** points of participation and influence for primary care in the new ICB and HCP structures are not made clear during the transitional period... **THEN** meaningful engagement with primary care may not be sustained into the new ICB arrangements... **RESULTING IN** challenges enacting ICB plans for delivery at place.	20	12	8	No movement ↔	1. Agreement of ICB governance structure 2. Oversight of previous CCG leadership roles in the initial transitionary period 3. Use all avenues to engage Primary Care, such as existing CD/Primary Care meetings 4.Appointment of key Primary Care roles 5. Embedding of Primary Care leadership roles & agreement of appropriate engagement fora	1. Further development of engagement fora & embedding of PC leadership roles. Clinical Leads induction event held. 2. Commencement of engagement in key ICP & ICB meetings requiring PC engagement	Primary Care SMT and wider team meetings. Primary Care attendance at place SMT meetings	Reasonable	Updates to the ICS Partnership Board, Healthcare Partnership Boards and Audit Committees.	Reasonable	Transformation assurance processes with NHSE/I	Reasonable	ICB and HCP structures fully implemented and embedded	The risk was approved for inclusion by Committees meeting in common, March 2022. **Reviewed by PCB Sept-22 & agreed to risk score reduction from 20 to 12**
PC2	320	10/11/2021	1 2 4	Primary Care Commissioning Committee	Director of Primary Care Transformation	Head of Primary Care at Place	ENH Head of PC Transformation	**IF** pressures in general practice~~, exacerbated by the Covid-19 pandemic and pent up non-Covid demand,~~ remain at the current high level... **THEN** there may be insufficient capacity for GP practices, primary care networks and federations to deliver against transformation of care priorities in a way that demonstrates tangible improvements for patients... **RESULTING IN** sub-optimal patient experience due to continued pressures across the system and especially in acute services.	20	12	8	No movement ↔	1. ICB providing support to GP practices, PCNs and GP federations in planning for the transformation of delivery of care in Hertfordshire and West Essex. 2. Primary care teams have implemented the national GP Forward View transformational programme which includes extended access. 3. 'E-consultation' has been accelerated due to the pandemic and national and local initiatives are being implemented to develop practice telephony to deal with increased demand. 4. Organisational development programmes for PCN clinical directors and PCN managers are being supported. 5. PCN DES sign up: national requirement now met with all practices in a PCN, or non-participating practices covered by other PCNs as a local agreement. 6. Primary Care Input in ICS clinical strategy. 7. Training for Primary Care Networks to equip them to develop at pace in line with national requirements and for GP Federations to help them to understand their role in the development of PCNs. 8.Further ICB investment for PCNs to support training and implementation of services at PCN level, including additional workforce, training provision and backfill to attend. 9. Further training being identified to support GPFV/NHSLTP priorities. 10. Introduction of ICB wide ECF scheme, including Primary Care OPEL status reporting as part of the wider system reporting and improve understanding of pressure points for general practice. 11. Continue to support practices with IT infrastructure to mitigate the impact of workforce challenges with increasing numbers of primary care staff needing to work remotely and isolate. 12. Fora for regular engagement between ICB and PCN CDs, primary care and clinical leads in all 3 places 13. Dec-22 update - recognising significant winter pressures a review of ECF requirements was undertaken. A risk-based approach has been taken to prioritising key areas, balancing operational pressures (both within primary care and across the wider health system) with the health needs of the population. Aim is to ensure that practices will be able to release clinical capacity to better manage the increase in on the day demands. 14. ICB working collaboratively with PCNs & wider system providers to implement hub solutions to support increase in respiratory & other urgent on the day capability.	1. Arrangements for appropriate primary care input at all key ICB and HCP meetings and sub groups have been agreed and being implemented 2. Primary Care Strategy for the ICB being developed.	• Primary Care Working Groups support the preparation and monitoring of plans with any risks or issues escalated. Risk registers monitor resilience in all practices. • Resilience panels receive applications for support • ICS population health management group. • Practices are compliant with national and regional guidance during the Covid 19 pandemic.	Reasonable	• Place based delivery boards have a strong primary care presence and monitor delivery against locality plans. • All overseen by the Primary Care Commissioning Committees and Primary Care Board and reported to ICB Boards as appropriate. • Primary Care updates and assurance papers to other ICB Committees and groups as appropriate. • Approval of expenditure above PCCC authorisation limit is escalated to another Committee or Board meeting. •-Audit and Assurance Committee receives internal audit reports and updates on risk register	Reasonable	• CQC reporting shared with ICB. • NHSE/I remedial actions discussed with ICB • Internal audits of Primary Care Networks and Delegated Commissioning provide reasonable or substantial assurance.	Reasonable	ICB and HCP structures fully implemented and embedded	Approved by Committees meeting in common March 2022 **Reviewed by PCB Sept22**
PC3	321	04/03/2022	1 2	Primary Care Commissioning Committee	Director of Primary Care Transformation	Head of Primary Care Transformation at Place	ENH Head of PC Transformation	**IF** Primary Care is not supported to optimise capacity and address variation, **THEN** patients may not experience improved access to urgent, same day primary care, **RESULTING IN** negative impact on patient experience, patient safety, system resilience and commissioner reputation.	16	12	8	**No movement ↔**	1. All HWE practices have access to a time limited (to April-23) additional outbound functionality enabled through MS Teams and negotiated nationally. This solution will enable staff to use MS teams to make outbound only calls independently of the existing telephone solutions. This will free up the existing lines for incoming calls. 2. Improvements in practice telephony infrastructure: 55 practices across Hertfordshire and west Essex bids have been approved for implementation in line with the national advance telephony specification. The vast majority of the new system installations having been completed. 3.22/23 Winter Pressure funding of £1.43 per patient & a further £0.602 pp from IIF redeployment 4. Further work in train to reinvigorate patient groups and help promote new healthcare roles and access to services, aligning expectation with offer.	1. Additional demand and constraints of the pandemic. 2. Release of pent-up demand, accumulated during the pandemic when people were less likely to consult their practice or seek specialist care. 3. Need for general practice to take a pivotal role catching up on the backlog of care for patients on its registered list who have ongoing conditions. 4. Tailored practice plans and visits have revealed some themes re barriers to improvements: access to additional IT; premises constraints; workload prioritisation. 5. Actions may require longer term solutions relating to capital investment and workforce development. 6. Expansion of acute in-hours visiting to HV and WE is challenging in the short term due to increased system demand and pressure.	Reports to ICS Executive and Partnership Board Oversight Group discussed emerging issues.	Reasonable	Reports to PCCC	Reasonable	Reports to NHSE/I	Reasonable	Not all proposed measures can be introduced in the short term for all practices.	Approved by Committees meeting in common with the addition of reference to reputational risk. **Reviewed by PCB Sept22**
PC4	323	13/04/2022	1 2 4	Primary Care Commissioning Committee	Director of Primary Care Transformation	Head of Primary Care Transformation at Place	WE Head of PC Transformation	**IF** the pace of organisational development for primary care networks does not increase.. **THEN** there may be insufficient capacity for GP practices, primary care networks and federations to deliver against transformation of care priorities and a limited amount of collaboration between PCNs and other local delivery partners... **RESULTING IN** delays in delivery of transformation objectives to improve quality and accessibility of services.	16	12	8	**No movement ↔**	1. Provision of additional investment and support to primary care to develop PCNs in planning for the transformation of delivery of care in Hertfordshire and West Essex. 2. PCN DES sign up: national requirements now met for all PCNs and practices. 3. Directorate has a suite of projects designed to increase resilience and sustainability of primary care. 4. Individual work programme risks reviewed at team meetings. 5. HWE ICB Training hub offers/provides training and educational support to PCNs 6. PCN Workforce & PCN Development Plans 7. PCNs provided with Population Health Management support, to develop plan to support specific patient cohorts. 8. Recruitment to ARRS roles.	1. Further ARRS recruitment to be completed. 2. 2022/23 GP Transformational Support Plans to be agreed and remaining (H2) funding drawn down	Progress reports provided to ICS Primary Care Exec and Partnership Board	Reasonable	Reports to PCB and PCCC	Reasonable	NHSE/I receive PCCC papers	Reasonable		Approved at the PCCCs meeting in common in May 2022. **Reviewed by PCB Sept22**

Transition Risks

11 November 2021

Risk Profile															Assurance Mapping							
ID	Datix ID	Date Opened	HWEICS Strategic	Committee	Executive Owner	Risk Lead	Revised Risk Lead	CCG Risk Description	Rating (initial)	Rating (current)	Rating (Target)	Risk Movement	Controls	Gaps in controls	**1st Line** Operational functions enforcing required behaviours and working practices throughout the organisation's day-to-day activities	1st Line - Level of assu	**2nd Line** Oversight functions undertaking scrutiny and monitoring of the governance framework to ensure that it operate in an efficient and effective	2nd Line - Level of assu	**3rd Line** Functions providing independent and objective challenge and assurance with regards to the organisation's governance arrangements	3rd Line - Level of assurance	Gaps in assurance	Approval status
PC5	324	04/03/2022	1 2 3 4	Primary Care Commissioning Committee	Director of Primary Care Transformation	AD Primary Care Commissioning and Contracting	AD Contracting	**IF** there are not consistent and rigorous processes for monitoring quality and performance of contracts and investments... **THEN** there is potential for variable outcomes in improvements across the three geographical areas... **RESULTING IN** inequalities in the quality and performance of ICB primary care services and disparities in costs for the same services in different locations.	20	12	8	No movement ⟺	1) Individual processes are in place for ICB, for example: -Inclusion of PC data in Quality and Performance reporting to ICB Board - PCCC meeting has independent input from an out of area GP. - PCCC membership has a non-GP majority. - Risk and information sharing meetings with all relevant teams, LMC, Nursing & Quality and CQC. - Support packages in place for all practices with an existing ratings of 'Inadequate' or 'Requires Improvement' - Quality visits to practices and Extended Access sites - Practice Manager meetings 2. Healthwatch action plan 3. Reporting to single ICB Primary Care Board, with non-GP majority membership. Single Primary Care Contracting Panel now in place	1. Review of different approaches in the 3 ICB places **ACTIONS BEING TAKEN**: - Identify current arrangements; compare and identify differences; assess differences in outcomes - Agree which process (or combination of processes) produces the best results - Implement one process across the ICS footprint 2. In process of establishing contractual/performance delivery monitoring processes across the ICS 3. Reviewing approach to joint Quality/Contracts visits. Propose using current WE risk dashboard format as a consistent ICB wide format. 4. Assessment of PCNs needs further consideration - relationship between PCNs & member practices, supervision of PCN staff	Internal quality and performance monitoring processes in each place. Support to practices with 'inadequate' or 'requires improvement' rating. Support to practices with access challenges, e.g. staffing or premises.	Reasonable	Reports to PCB and Quality Group Assurance to PCCC Liaison with CQC and LMC	Reasonable	Liaison with CQC and LMC Internal audit opinions Updates to patient groups e.g. Patient Network Quality (PNQ) Monthly meetings with Healthwatch Presentations at Local Authority Overview and Scrutiny Groups	Reasonable	Extent of reporting of primary care quality and performance to Public Board - for discussion: terms of reference and work plans for ICB committees are being developed by the ICS. There is also discussion of Quality Groups at place at request of the ICS. Some practices reluctant to engage or nor highlighted as potential risks may be inspected by CQC, with further unknown risks emerging.	Approved at the PCCCs meeting in common in May 2022. **Reviewed by PCB Sept-22 & agreed to risk score reduction from 16 to 12**
PC7	326	04/03/2022	1 2 3	Primary Care Commissioning Committee	Director of Primary Care Transformation	AD Primary Care Commissioning and Contracting	AD Contracting	**IF** Primary Care sustainability is not robust enough... **THEN** we may not be able to ensure continued delivery of primary medical services... **RESULTING IN** a reduction in quality, patient safety and experience.	16	12	4	No movement ⟺	1. Routine practice and extended access hub visits. Individual practice visits to support mergers, resource and capacity issues, estates and infrastructure issues 2. Business Continuity Plans - Support for PCNs to develop BCPs and facilitate mutual aid 3. Targeted support for practices who are rated 'inadequate' or 'requires improvement' by the CQC 4. Support offered to all practices for preparation for CQC inspection or other CQC Reviews including 'mock visit' 5. Targeted support where practices have access challenges such as workforce or premises 6. Regular monthly meetings with the CQC 7. Meetings with the LMC 8. Monitor workforce levels through audit 9. Support to practices in the further development of Primary Care Networks as part of the delivery of The Long Term Plan 10. Targeted workforce initiatives through the ICS funding available 11. Supporting practices to access GP Resilience Funding. 12. Primary Care OPEL Framework introduced as part of ECF 13. Potential Practice Closure plans 14. Action plan to identify and investigate opportunities to improve patient access, including promotion of self-care, self-referral and community pharmacy scheme. 15. Additional Roles Reimbursement Scheme for PCNs 16. Additional winter capacity funding for 2022/23 to support the demands faced across the system as a result of the pandemic 17. Support for PCNs to deliver services at scale e.g. Asthma diagnostic hubs	Solutions to substantive workforce and premises limitations take time to implement. Interim arrangements may need to be actioned.	Available and monitored data sources to gauge practice sustainability: QOF achievement and exception reporting CQC rating GP Patient Survey results Workforce audit information Premises concerns Acute utilisation Quality (complaints & PALS) ICB support requests Risk rating for practice GPAD data	Reasonable	The Primary Care Commissioning Committee reviews the forecast risk resilience tool routinely and also on an ad hoc basis if new information is received. Reports to PCB	Reasonable	CQC inspections and reports	Reasonable		Approved at the PCCCs meeting in common in May 2022. **Reviewed by PCB Sept22**
PC8	327	04/03/2022	1 2 3	Primary Care Commissioning Committee	Director of Primary Care Transformation	Head of Primary Care Transformation at Place	WE Head of PC Transformation	**IF** primary care recovery and prioritisation of workload is not adequately supported... **THEN** meeting of primary care contractual requirements may be affected, particularly relating to routine and preventative work... **RESULTING IN** negative impact on patient access, care and experience, QOF outcomes and wider system pressures.	15	12	6	No movement ⟺	1. Additional Winter Capacity Funding support 2. Introduction from Oct-22 of ICB wide ECF scheme to support general practice prioritisation, deliver LTC management etc 3. Dec-22 update - recognising significant winter pressures a review of ECF requirements was undertaken. A risk-based approach has been taken to prioritising key areas, balancing operational pressures (both within primary care and across the wider health system) with the health needs of the population. Aim is to ensure that practices will be able to release clinical capacity to better manage the increase in on the day demands.	1.Unable to meet high BAU demand 2.Unable to clear back logs for: complex long term conditions; health checks; medication reviews; screening; and spirometry diagnostics. **Actions:** Establish key actions and timescales and monitor progress.	Place based recovery plans for primary care services	Reasonable	Reports to PCB	Reasonable	CQC inspections and reports Internal audit reports External audit conclusions	Reasonable	Ongoing exceptionally high demand in primary care.	Approved at the PCCCs meeting in common in May 2022. **Reviewed by PCB Sept22**
PC9	328	04/03/2022	2	Primary Care Commissioning Committees meeting in common	Director of Primary Care Transformation	AD for Primary Care Strategy and Digital lead	AD Contracting	**IF** the quality of data available to practices and Primary Care Networks is not adequate ... **THEN** this will limit the ability for primary care to meet new responsibilities relating to population health management… **RESULTING IN** failure to achieve forecast outcomes in population health and healthcare and tackle inequalities in outcomes, experience and access.	16	12	4	No movement ⟺	1. Procurement of one solution across ICS on data platform i.e. Ardens - Upgraded Ardens Manager 'National Contracts' package procured for practices and PCNs for 2022-23 2. Development of Primary Care Dashboard 3. PCN DES "Tackling Health Inequalities" service implementation 4. Primary Care teams aligned to PCNs/Localities to support development of PCN PHM Plans	1. Currently variance in IT solutions and processes across the CCGs - single BI platform to be implemented 2. Confidence of data recording/reporting 3.Regular /consistent health outcomes and activity data set shared with primary care needs to be established	Co-ordination of consistent BI data reporting across ICS; PHM training to PCNs, Primary Care Managers	**Reasonable**	Assurance to PCCC	**Reasonable**	Reporting into ICB	**Reasonable**	None identified	Approved at the PCCCs meeting in common in May 2022. **Reviewed by PCB Sept22**

Transition Risks

Risk Profile															Assurance Mapping							
ID	Datix ID	Date Opened	HWEICS Strategic	Committee	Executive Owner	Risk Lead	Revised Risk Lead	CCG Risk Description	Rating (initial)	Rating (current)	Rating (Target)	Risk Movement	Controls	Gaps in controls	1st Line Operational functions enforcing required behaviours and working practices throughout the organisation's day-to-day activities	1st Line - Level of assurance	2nd Line Oversight functions undertaking scrutiny and monitoring of the governance framework to ensure that it operate in an efficient and effective manner	2nd Line - Level of assurance	3rd Line Functions providing independent and objective challenge and assurance with regards to the organisation's governance arrangements	3rd Line - Level of assurance	Gaps in assurance	Approval status
PC10	329	04/03/2022	1 2	Primary Care Commissioning Committee	Director of Primary Care Transformation & Director of Workforce	Head of Primary Care Workforce		**IF** there were no forecasting or forward planning for changes and challenges in general practice workforce... **THEN** we would be unable to foresee changes in workforce and act proactively to address expected shortfalls in any profession... **RESULTING IN** threat to patient care as patients may not have access to a range of skilled professionals in primary care.	9	6	3	No movement ↔	1. Monitoring workforce trends 2. Taking novel approaches to recruitment and retention 3. Providing updates to PCNs including ARRS position 4. Primary Care Teams working with PCNs to submit forward ARRS workforce plans 5. PCN workforce teams connected to current /future issues in practices/PCNs 6. Plan with system partners to avoid destabilising the workforce	1. Increasing numbers of GPs and GPNs taking retirement mean further plans necessary to address retention or recruitment. 2. Difficulties recruiting to some AHP roles due to competition for their skills. 3. PCNs have autonomy for ARRS recruitment plans and have identified finances (shortfall in salary cap and management overheads) and risk (liability for staff given uncertainty about future of PCNs) and perceived value of some non-GP roles as barriers	Quarterly Workforce Data Collection Annual Skill Mix Collection	Substantial	Update reports to PCB and PCCC Progress monitored in ICS Workforce Group	Substantial	Reports to NHSEI	Substantial	None identified	Approved at the PCCCs meeting in common in May 2022. **Reviewed by PCB Sept22**
PC11	330	04/03/2022	1 2	Primary Care Commissioning Committee	Director of Primary Care Transformation & Director of Workforce	Head of Primary Care Workforce		**IF** there is a lack of career development opportunities in primary care ... **THEN** primary care may be less attractive as a career choice... **RESULTING IN** doctors, nurses and other allied health professionals leaving primary care and choosing alternative career paths, making primary care less resilient and creating instability in patient access.	12	9	3	No movement ↔	1.International GP Recruitment Programme 2. Qualified Nurses Return to Practice Campaign 3. Qualified Nurses to make PC career choice 4. GP Fellowship Scheme 5. New to Practice Fellowship programme for GPNs and GPs 6. First5 Networking/support forums 7. Wise5 Networking/support forums 8. GPN/HCA networking/support forums 9. Monthly lunch time educational webinars for all Primary Care staff clinical and non clinical 10. Monthly evening educational webinars for clinicians 11. GPN Appraisal support programme 12 .Leadership programmes for GPNs 13. Advanced Care Practitioner networking/support forum 14. GPN Leadership networking/support forum 15. Apprenticeship webinars for clinical and non clinical roles 16. Clinical supervision sessions for GPNs/HCAs 17. HWE ICB Training hub offer all primary care staff career clinic sessions 18. Creation of PCN Training Teams	1. Increasing numbers of GPs and GPNs stepping down due to system pressures/ taking early retirement are exacerbating the risk. 2. Difficulties recruiting to primary care roles due to competition for their skills. 3. Underutilisation of ARRS budget	121 line management meetings Workstreams reviewed at Workforce Team meetings Workstreams reviewed at WIG meetings	Reasonable	Reports to PCB and PCCC	Reasonable	Reports to NHSEI Review of workforce position and work programmes at LMC Operational and Liaison Meetings	Reasonable	None identified	Approved at the PCCCs meeting in common in May 2022. **Reviewed by PCB Sept22**
PC12	331	03/05/2022	1 2	Primary Care Commissioning Committee	Director of Primary Care Transformation	AD for Primary Care Contracting		**IF** the transfer/commencement of the GP Extended Access Service to PCNs is not proactively supported... **THEN** workforce challenges & sub-optimal service delivery is likely ... **RESULTING IN** a.Staff may leave the incumbent provider due to uncertainty caused by the GP Extended Access transfer, resulting in a risk for future provision b.Incumbent providers may lose experienced staff through TUPE which could destabilise their remaining services c. service delivery potentially not meeting patient need, poor utilisation of appointments	16	6	3	Risk rating improved	1. Proactive support to incumbent provider with TUPE. (West Essex specific issue) 2. Agreement of Exit Plan. (West Essex specific issue) 3. Monitor project plan and deliverables and escalate appropriately any deviations - Oct-22 - all staff have transferred to the PCNs now – there are some outstanding issues with a couple of members of staff but the risk is low. 4. Liaison with PCNs to review & agree plans that adequately meet patient need 5. Monthly monitoring of key data - hours provided vs patient utilisation	1. Two West Essex Extended Access Operational Service Leads have resigned- however HUC are recruiting permanently to these positions and provided reassurance that even if EA is no longer provided by HUC there will be positions for these staff within the IUC contract. 2. More detailed performance monitoring, including use of multi-disciplinary roles, to be agreed 3. Some IT infrastructure issues, especially re the deployment of EMIS hubs, means there will be a transition to full service delivery arrangements 4. Perceived lack of clarity in the PCN specification requirements, especially in terms of % of provision by GPs vs other staff	Exit plan agreed and TUPE support in place (West Essex specific) Monitoring and escalation processes in place.	Reasonable	Reports to PCB and PCCC	Reasonable	LMC engagement	Reasonable	None identified	Approved at the PCCCs meeting in common in May 2022. **PCB Nov22 - reviewed and agreed proposed risk score reduction from 16 to 6**
PC13	332	03/05/2022	1	Primary Care Commissioning Committee	Director of Primary Care Transformation	Head of Primary Care Workforce		**IF** there were a lack of further training and education opportunities in primary care... **THEN** there would be a failure to keep knowledge relevant and up to date. Capabilities will not be kept up to the same pace as others in the same profession. **RESULTING IN** a. Practice colleagues being unable to maintain and enhance their knowledge and skills needed to deliver primary care to patients. b. Practices would fail their CQC Inspection c. Mental Health issues would increase across the GP population. d. General Practice would have a lack of registered nurses.	6	3	3	No movement ↔	1. Trained Infection Prevention and Control Champions in each practice. 2. The mid-career GP initiative 3. Qualified Practice Nurse Revalidation support 4. Business Fundamentals for GPs 5. Student Placements - nurses and Graduate Managers 6. CPD funding offer for all GPNs/AHPs 7. HWE ICB Career clinics 8. Monthly educational webinars for all health care professionals clinical and non clinical 9. Supporting PCNs to run Protected time to Learn events monthly (reinstated from Nov 2022) 10. Creation of PCN Training Teams	1. Apprenticeships in Primary Care 2. School Engagement and Work Experience Placements 3. Student Placements - other professions	ICS Training Hub ICB Training lead appointed	Reasonable	Reports to PCB and PCCC	Reasonable	National funding in place for Training Hub	Reasonable	Further opportunities to be developed	Approved at the PCCCs meeting in common in May 2022. **Reviewed by PCB Sept22**
	537	09/11/2022	1 2 3 4	Primary Care Commissioning Committee	Director of Primary Care Transformation	Head of Primary Care Transformation at Place	SW Head of PC Transformation	**IF** the Additional Role Reimbursement (ARR) scheme budget is not fully utilised by PCNs **THEN** this available funding for additional primary care roles is lost to individual PCNs & the ICB system **RESULTING IN** a. missed opportunities to provide further additional capacity in general practice b.further pressure on existing workforce c. PCNs may be less able to continue collaborative development d.PCNs less able to meet the requirements of the PCN DES, meaning key prioritise may not be met e. variance in service provision between PCNs	12	12	8	New risk	1. Primary Care Team engagement with PCNs to support with ARRS plans 2. sharing of PCN experiences with ARRS roles via CD/PCN forums 3. Recruitment support offered via Essex Primary Care Careers 4. Further national funding deployed, including PCN Leadership & Management support to improve PCN operational capacity 5. PCN Training Teams being launched to support ARR scheme & wider general practice workforce	1. Further work required on liaison with HPFT re Mental Health PCN roles 2. Reliance on PCN engagement & appetite on recruitment 3. Awaiting further national clarity on ARR scheme funding beyond 23/24	Review by Primary Care SMT	Reasonable	Reports to PCB and PCCC	Reasonable	Reporting to and liaison with NHSE/I Regional Team	Reasonable		**Reviewed and approved by PCB Nov-22**

Transition Risks

Risk Profile															Assurance Mapping							
ID	Datix ID	Date Opened	HWEICS Strategic	Committee	Executive Owner	Risk Lead	Revised Risk Lead	CCG Risk Description	Rating (initial)	Rating (current)	Rating (Target)	Risk Movement	Controls	Gaps in controls	**1st Line** Operational functions enforcing required behaviours and working practices throughout the organisation's day-to-day activities	1st Line - Level of assu	**2nd Line** Oversight functions undertaking scrutiny and monitoring of the governance framework to ensure that it operate in an efficient and effective	2nd Line - Level of assu	**3rd Line** Functions providing independent and objective challenge and assurance with regards to the organisation's governance arrangements	3rd Line - Level of assurance	**Gaps in assurance**	**Approval status**
	538	09/11/2022	**1** **2** **3** **4**	**Primary Care Commissioning Committee**	**Director of Primary Care Transformation**	**Program Director C19 vaccinations**	**SW Head of PC Transformation**	**IF** - the closure of Mass COVID-19 Vaccination Centres proceeds as planned, with insufficient contingency **THEN** – there will be increased pressure on PCNs and Community Pharmacy capacity **RESULTING IN** – limited ability to respond to a surge in the C19 vaccination programme, potentially leading to reduction in vaccination availability, lower vaccination rates & consequent wider impact on the healthcare system	**9**	**9**	**6**	**New risk**	1. Ability for Community Pharmacy & General Practice to scale up operation 2. Working with NHSE to understand likelihood of surge & potential required steps in this scenario	1. Working with HCT and region to understand the financial impact of maintaining a roving HCT team to support surge 2. PCNs giving notice not to be part of the programme post Autumn program	Contingency plan in the process of being agreed post Autumn program	Reasonable	Reports to PCB and PCCC	Reasonable	National and regional directives being followed	Reasonable	None identified	**Reviewed and approved by PCB Nov-22**
New Risk - Jan23	**TBC**	13/01/2023	1 2	**Primary Care Commissioning Committee**	**Director of Primary Care Transformation**	**Senior Primary Care Manager - Transformation,Intergration & Delivery**		**IF** the growth in the placement of Asylum seekers in local hotels together with growing pressures in general practice continues.. **THEN** agreeing suitable arrangements to register & provide care for this vulnerable cohort of patients becomes increasingly challenged **RESULTING** delays in providing effective care & potential ongoing impact on local 111/A&E services	**12**	**12**	**6**	**New risk**	1. System wide meetings in place involving various key partners from Home Office, Local Authority/ and Disrtric Councils, Voluntary Sector/Hotel Management/Housing Managers to ensure that intelligence is shared and report any issues 2. Colloborative discussion with GP practices, PCNs & LMC to support nelwy opened hotel facilities 3. Local Enhanced Service spec offered to practices to support with extra workload. ICB has also committed to making this funding available to support spot booking locations, which are not currently supported by NHSE funding.	1, New Model of Care business case being drafted - identification of a sustainstable model that can be utilised and reduce local pressures on Primary Care 2. ICB to consider a one-off payment to Practices where they have registered a Ukrainian National and undertaken a full Health Assesment (payment @£150 per patient) - scoping work underway for next PCCC. 3. NHS England is keeping the funding position under review e.g. to establish if spot booked hotels become an enduring feature of Home Office accommodation strategy, whilst recognising the funding pressures on its core and contingency initial accommodation budgets due to unprecedented arrival numbers but acknowledging there is an additional cost pressures on ICBs. A final position on reimbursing from the contingency fund for initial accommodation is expected to be confirmed in January 2023.	Review by Primary Care SMT	Reasonable	Reports to PCB and PCCC	Reasonable	1. National and regional directives being followed 2. Reporting to and liaison with NHSE/I Regional Team 3 - LMC Liaison and supporting Local Practices/PCN meetings	Reasonable	Primary Care often rarely notified of various new arrivals and/or new sites various (Asylum Seekers, Afghan) - service levels potentiallly at risk	**For review and approval by PCB Jan-23**

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐
	NHS HWE ICB Primary Care Board meeting held in Public	**Meeting Date:**	**26/01/2023**	
Report Title:	**Update from Healthwatch Hertfordshire –** **a. Findings from Carers' Views and Experiences of Accessing Support from their GP Practice** **b. Findings from Hertfordshire Residents' Views of, and Attitudes towards, Community Pharmacies**	**Agenda Item:**	**8.1**	
Report Author(s):	Geoff Brown, Chief Executive, Healthwatch Hertfordshire Chloe Carson, Senior Research Manager, Healthwatch Hertfordshire Miriam Blom-Smith, Research Officer, Healthwatch Hertfordshire Asha McDonagh, Research Officer, Healthwatch Hertfordshire			
Report Signed off by:	Avni Shah, Director of Primary Care Transformation			
Purpose:	**Approval** ☐	**Decision** ☐	**Discussion** ☒	**Information** ☐
Report History:	N/A			
Executive Summary:	Healthwatch Hertfordshire (HwH) and Healthwatch Essex (HwE) have been commissioned by the Hertfordshire and West Essex Integrated Care System (ICS) Primary Care Workstream to undertake a series of engagement projects. From November 2022 to January 2023 the Director of Primary Care Transformation at the Integrated Care Board (ICB) requested HwH and HWE to explore the following topics: • Carers' Views and Experiences of Accessing Support from their GP Practice • Views of, and Attitudes towards, Community Pharmacies **Key Findings: Carers' Views and Experiences of Accessing Support from their GP Practice**			

Through an online survey we heard from **622** carers living in Hertfordshire.

Registering as a Carer

- 68% of carers are formally registered as a carer with their GP practice.
- Barriers to registering as a carer with their GP practice included:
    - Lack of awareness regarding the need and/or importance of registering
    - Poor or no communication from their GP practice
    - Practical barriers, including time and caring/work responsibilities
    - Belief that there are no benefits to registering as a carer
    - Previous poor experiences when accessing their GP practice

Accessing GP Services

- Most carers struggle to access their GP practice because they cannot get through, particularly via telephone.
- Other access barriers included:
    - Fitting appointments around work/caring responsibilities
    - Flexibility in appointment times
    - Choice regarding the type of appointment
    - Availability of appointments

Support from their GP Practice

- Since being registered, 75% have been offered an annual flu vaccination. Only 17% have been offered an NHS annual health check – and for many this was treated as a tick box exercise. 16% have been offered access to a Carer Assessment and/or benefits check.
- 72% were not aware they could access this range of support from their GP practice.
- 76% have not been offered flexibility when booking an appointment for themselves or the person they care for.
- 87% said their GP practice has never discussed their physical or mental health in relation to their caring role.
- 79% have not received signposting information or support.
- Only 13% know if their GP practice has a Carers Champion, however 63% would seek information or support from a Carers Champion if given the opportunity.

Key Findings: Views of, and Attitudes towards, Community Pharmacies

Through an online survey **309** Hertfordshire Residents shared their views.

Use of Pharmacies

	• 70% of respondents use a pharmacy on a monthly basis, and for 91% the main reason they use a pharmacy is to collect medication.
	• 57% visit a pharmacy before looking for information or advice elsewhere.
	• Barriers to using a pharmacy included:
	  o Delays, queues and waiting times
	  o Accessibility
	  o Concerns around privacy and levels of expertise
	  o High prices
	
	Support from Pharmacies
	
	• 80% said the support they receive from a pharmacy is either good or very good. Respondents felt that staff are friendly, supportive and approachable. They also felt that pharmacies are reliable, efficient, and knowledgeable in providing advice and information.
	
	Awareness of Services Offered
	
	• Awareness of the essential services provided was very good, while awareness of additional services was more varied.
	• Reason for not accessing these services included:
	  o No need to access
	  o Lack of information and awareness
	  o Concerns around what is a private or NHS service
	  o Accessibility
	  o Concerns around privacy
	  o Delays, queues and waiting times
	
	Trust and Confidence
	
	• 68% would trust a pharmacist to give medical advice and 71% were either likely or very likely to visit a pharmacy for support.
	• 90% were either very confident or somewhat confident in understanding a pharmacist's role.
	• There were some concerns about receiving advice from support members of staff and confusion around who has the expertise.
	
	Improvements
	
	• Respondents would like pharmacies to be less busy and more accessible. They would also like pharmacies to promote the services they can offer, and to provide information about their expertise. Other suggestions included: more privacy, providing more health and wellbeing information, and more staff and training.

<table>
<tr><td></td><td colspan="4"></td></tr>
<tr><td>Recommendations:</td><td colspan="4">The Board is asked to note and discuss the findings across the two areas of work across HWE.</td></tr>
<tr><td rowspan="4">Potential Conflicts of Interest:</td><td>Indirect</td><td>☐</td><td>Non-Financial Professional</td><td>☐</td></tr>
<tr><td>Financial</td><td>☐</td><td>Non-Financial Personal</td><td>☐</td></tr>
<tr><td colspan="3">None identified</td><td>☒</td></tr>
<tr><td colspan="4">N/A</td></tr>
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<table>
<tr><td rowspan="3">Impact Assessments (completed and attached):</td><td>Equality Impact Assessment:</td><td>N/A</td></tr>
<tr><td>Quality Impact Assessment:</td><td>N/A</td></tr>
<tr><td>Data Protection Impact Assessment:</td><td>N/A</td></tr>
<tr><td rowspan="6">Strategic Objective(s) / ICS Primary Purposes supported by this report:</td><td>Improving outcomes in population health and healthcare</td><td>☒</td></tr>
<tr><td>Tackling inequalities in outcomes, experience and access</td><td>☒</td></tr>
<tr><td>Enhancing productivity and value for money</td><td>☐</td></tr>
<tr><td>Helping the NHS support broader social and economic development</td><td>☐</td></tr>
<tr><td>Successfully complete and embed the transition of staff and functions from the three clinical commissioning groups into the Integrated Care Board</td><td>☐</td></tr>
<tr><td>Develop the ways of working and profile of the Integrated Care System to ensure that its operating model is capturing the opportunities presented by closer system working</td><td>☐</td></tr>
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Hertfordshire and West Essex Integrated Care Board Engagement Topics (November 2022 – January 2023): Key Findings from Healthwatch Hertfordshire

1. Carers' Views and Experiences of Accessing Support from their GP Practice

The aim of this engagement was to identify whether unpaid carers are formally registered as a carer with their GP practice, and if so, whether they are receiving the additional support they should be entitled to.

Demographics

Through our online survey, we heard from 622 carers living in Hertfordshire[1]. 10% were aged between 25 and 44 years old, 47% were aged between 44 and 64 years old, and 26% were aged between 65 and 74 years old. 16% were aged over 75 years old.

78% of carers were female and 20% were male. 81% were of a White British background and 14% were from an ethnically diverse background[2].

17% considered themselves to have a disability and 33% considered themselves to have a long-term condition.

In regards to caring responsibilities, 52% dedicate over 50 hours per week to unpaid care, and 41% have been a carer for over 10 years.

Registering as a Carer

Although 73% of respondents said that their GP practice knows they care for someone, only 68% are formally registered.

Lack of awareness about the need to, and/or the importance of registering, was the main reason as to why respondents are not formally registered as a carer with their GP practice. ***"I have never been offered or asked about my caring role by the surgery."***

Respondents also noted that they received either poor or no communication from their GP practice as to whether they are formally registered, meaning they could not be certain whether this information was listed on their medical records. ***"I have told my doctor I am a carer for my mum but I'm not sure whether he registered this."***

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[1] Please note that percentages do not always add up to 100% due to some respondents choosing not to share demographic data with us.

[2] Ethnicities engaged with included: Bangladeshi, Indian, Pakistani, other Asian/Asian British backgrounds, Black African, Black Caribbean, other Black/Black British background, Asian and White, Black Caribbean and White, White Irish, White Polish, White Italian and other White backgrounds.

Other factors included:

- Practical barriers such as time, caring and/or work responsibilities, and problems getting through to their GP practice ***"I have been far too busy with the demands of my life, husband and children."***
- Belief that there are no benefits to registering as a carer ***"I feel that telling my surgery that I am an unpaid carer will not change anything for me."***
- Previous poor experiences when accessing their GP practice "***The GP practice is terrible and does not care about me or my child."***

Despite this, 86% said they would now register as a carer if they were given the opportunity and/or support to do so. In fact, in response to this survey, some respondents have taken the initiative to register, or check if they are registered, with their GP practice.

For those who are formally registered as a carer, the majority found out about the need and/or importance of registering through Carers in Hertfordshire. Other sources included: through their GP practice (particularly receptionists, leaflets and posters), charities and support groups, and word of mouth.

Barrers in Accessing their GP Practice

When asked what barriers carers face in accessing their GP practice, the majority mentioned the inability to get through to their GP practice, particularly via telephone ***"I can't spend hours on the phone waiting in a queue when I need to care for my son. It brings me to tears, it's so stressful."***

Other key barriers included:

- Fitting appointments around their caring and/or work responsibilities ***"They only make appointments on the day and by the time I get round to phoning due to my caring responsibilities, they are all gone."***
- Flexibility in appointment times: ***"When I told them I was an unpaid carer I was told that doesn't make any difference."***
- Choice regarding the type of appointment e.g. face-to-face or virtual/remote ***"GP surgery reluctant to give face-to-face appointments, I do not own a computer let alone a smartphone for online calls."***
- Availability of appointments ***"Lack of appointments when the phone is finally answered."***

Support from their GP Practice

Since being registered as a carer with their GP practice, 75% have been offered an annual flu vaccination, 17% have been offered an NHS annual health check, and 16% have been offered access to a Carer Assessment and/or benefits checks.

However, it is important to note that 22% have not been offered any of the following support, and 72% were not aware they could even access this range of support from their GP practice.

NHS Annual Health Check

For the small number of respondents who have been offered an NHS annual health check, only 32% said they received a thorough examination of their physical and mental health. The majority felt it was treated as a "tick-box exercise" and neglected to discuss their emotional wellbeing in particular ***"Only a basic consultation and didn't discuss my mental health at all."***

Flexibility of Appointments

76% of respondents said they have not been offered greater flexibility when booking an appointment for themselves or the person they care for, with many feeling that being registered as a carer makes no difference. ***"They never offer any flexibility. They don't seem to care or understand how hard it is."***

Mental and Physical Health

87% of respondents said that their GP practice has never discussed their physical or mental health in relation to their caring role: ***"No I've tried. I went to the doctor as my shoulder was playing up. Explained I'm a carer. Was told it's my own fault for not working, shoulder doesn't get enough use. As a carer I lift my husband in and out the bath and push his wheelchair."***

Signposting and Support

79% of respondents have not received signposting information or support from their GP practice, and only 12% have been referred to, or encouraged to speak to, a social prescriber or link worker ***"No, I had to research support available and found help that way."***

Unsurprisingly then, 71% of respondents have looked for information and advice from elsewhere instead of contacting their GP practice. Key sources included: Carers in Hertfordshire, Hertfordshire County Council, other health and social care services, and other charities and support groups.

Overall, 24% of respondents described the support they received from their GP practice as either "good" or "very good" while 34% said it was "bad" or "very bad". 43% felt it was neither good nor bad. This was reflected in their sentiments, with many carers stating that they feel alone and unsupported. ***"There is no guide book when you become a carer and you don't know what is needed/required/expected etc until you need it. You then have to go out to find it yourself through trial and error. I am not aware of what I need as I don't know what is available."***

Carer Champions

Only 13% of respondents know if their GP practice has a Carers Champion. However, 63% would seek information or support from a Carers Champion if given the opportunity.

For those that had spoken to a Carers Champion, the majority had a positive experience, sharing that the information, advice and support they received was very useful ***"They were good, I have confidence that she would be able to help if called upon."***

Recommendations

When asked what GP practices are doing well to support carers, the responses received were largely negative. However, we did hear some examples of good practice, with some respondents praising their GP practice for being supportive, empathetic, responsive, and offering greater choice and flexibility where possible to accommodate their caring role and/or the needs of the person they care for. ***"My doctors and all their team do a fantastic job. They are very caring in everything they do."***

However, when asked how GP practices could better support carers, the majority would like to see carers offered more flexibility when making an appointment for themselves and/or the person they care for, as well as greater choice in the type of appointment offered, with many noting that remote or virtual consultations are not appropriate for addressing their or their loved one's needs. Other suggestions included:

- Increased and more regular contact with carers
- Listening to carers and greater acknowledgement of the emotional and physical impact caring can have
- Offering more available appointments, and easier access in getting through to the GP practice

When asked how GP practices could encourage carers to register, the majority suggested more advertisement about how, and the need to, register as a carer, as well as promoting the benefits. Other suggestions included:

- Writing, texting or emailing patients to confirm whether they have taken on caring responsibilities
- Offering more face-to-face contact, as through these discussions GPs are more likely to identify whether someone has caring responsibilities

Audit of GP Practice Websites

As part of this engagement, an audit of 102 GP practice websites was carried out to identify whether there is information on how to register, as well as the benefits of registering as a carer. Key findings were:

- On **81%** of websites, information about how to register as a carer was generally easy to find, and **75%** had a form available for patients to complete.

- Across **73%** of websites, there was information about why it is important to register as a carer. However, **87%** provided either very vague, or no information about the additional support carers should be entitled to.

- Only **40%** of websites explained what an unpaid carer is.

- **91%** of websites provided signposting or support information for carers, and this information was generally easy to find on the website.

- Only **20%** of websites mentioned Carers Champions. For those that did, the majority of GP practices were based in South and West Hertfordshire. Positively, how to contact the Carers Champion or their specific contact details were provided on each of the following websites.

Examples of good practice was noted across websites, including:

- A Carers Pack developed by the GP practice which could be downloaded via the website.
- Signposting information to local support groups, as well as national organisations
- Having a prominent link to the Carers page throughout the website
- Introduction letter about Carers Champion, outlining the benefits, contact details and working hours
- Providing a consent form to share the information of the person being cared for

2. Views of, and Attitudes towards, Community Pharmacies

The aim of this engagement was to hear from Hertfordshire residents about their views of, and attitudes towards, community pharmacies, and how they could be improved.

Demographics

309 Hertfordshire residents shared their views and experiences with us[3]. 5% were aged between 18 and 34 years old, 22% were aged between 35 and 54 years old and 52% were aged between 55 and 74 years old. 20% were aged over 75 years old.

70% of respondents were female and 28% were male. 77% were of a White British background and 13% were of an ethnically diverse background[4].

15% of respondents identified as a carer, 15% considered themselves to have a disability, and 41% considered themselves to have a long-term condition.

Use of Community Pharmacies

70% of respondents use a pharmacy on a monthly basis, with 81% normally choosing to access a high street pharmacy.

For 91% of respondents, the main reason they use a pharmacy is to collect prescription medication for themselves or someone else. Other common reasons included:

- Purchasing medication
- For information and advice
- Purchasing non-medical items
- For vaccinations
- For a consultation or advice on managing a specific condition

57% of respondents do not seek information or advice from elsewhere before, or instead of, visiting a pharmacy. For those that did look elsewhere, key sources included: the internet, the NHS website, NHS 111, their GP practice and friends and family.

When respondents were asked why they would not visit a pharmacy, the main reason was because it is more often easier to look online, or more appropriate to see a GP if the condition appears more serious: ***"It's easier to go online. More serious things I would need a doctor anyway."***

Other common reasons included:

- Long queues and waiting times: ***"My pharmacy is very busy and you can wait a long time to speak to a pharmacist."***

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[3] Please note that percentages do not always add up to 100% due to some respondents choosing not to share demographic data with us.

[4] Ethnicities engaged with included: Pakistani, Indian, other Asian/Asian British backgrounds, Black Caribbean, Black African, other Black/Black British backgrounds, Asian and White, Black Caribbean and White, White Irish, White Italian, White Polish, other White backgrounds and other ethnic backgrounds not listed as options.

- Accessibility, including opening hours and location: ***"Not usually necessary but not a local one available."***
- Concerns around privacy ***"Lack of privacy when talking to a pharmacist."***
- Concerns about the level of expertise of pharmacy staff and pharmacists in comparison to that of other healthcare professionals, particularly GPs. ***"I don't trust their level of competence."***
- High prices, particularly in comparison to supermarkets: ***"Higher prices in my local pharmacy. Can buy cheaper over the counter medications in supermarkets."***

Support from Community Pharmacies

80% of respondents described the support they receive from their pharmacy as either "very good" or "good." Multiple participants did state that their experiences vary between pharmacies, and pharmacists, but generally sentiments were very positive: ***"The staff at the pharmacy are excellent. They keep me coming back and I'm sure that's the case for a lot of their customers."***

When asked what pharmacies were doing well, participants shared that the attitudes of staff were friendly, supportive and approachable. They also felt that pharmacies are efficient and reliable, knowledgeable when providing advice and information, and take the pressure off GP practices and other health care services: ***"Always helpful and informative, a 'safe place' to discuss health and wellbeing matters."***

Awareness of Services Offered

Amongst the respondents, awareness of the essential services pharmacies provide was very good. Services which the public could have more information about included promotion of healthy lifestyles, discharge medicines service, signposting, and support for self-care.

Awareness of the additional services some pharmacies can provide was more varied, and there was confusion as to why some pharmacies offer some of these services, and others do not.

The majority of respondents were aware of services such as vaccinations, purchasing over the counter medicine, lateral flow tests and the stop smoking service, but less likely to know of services such as diabetes screening, sexual health services and blood pressure monitoring, to give a few examples. However, 39% would use one or more of these services now they have been made aware of them.

Respondents were particularly interested in accessing blood pressure monitoring, as well as diabetes screening. Emergency supply of medication was also noted as a useful service for the public to be aware of.

When asked what prevents respondents from accessing any of the following essential and/or additional services, the main reason was simply because there was no need for it: ***"I haven't needed any of the following services but I'm glad to know that they are there."***

Other common reasons included:

- Lack of information and awareness regarding what is offered (especially between different pharmacies and providers): ***"Lack of knowledge of what is available. Every NHS GP, Urgent Care Centre, Pharmacy and Community Health service operate in a different and fragmented way. Patients don't stand a chance of navigating this chaotic situation."***
- Concerns around what is a private, or NHS service: ***"It's not clear what the charge of these services are."***
- Lack of convenience and accessibility: ***"Convenience. I do prefer having an appointment rather than queueing. And being able to do things online suits me."***
- Concerns regarding privacy: ***"There's little privacy in a busy high street pharmacy so it's uncomfortable having some discussions."***
- Long queues and delays: ***"Pharmacies tend to be busy, people are always waiting for something."***

Seeking Advice and Information

68% of respondents would trust a pharmacist to give medical advice or information, 26% said they sometimes would, and only 4% said they would not. It was often the case that respondents would trust a pharmacist with common illnesses, within a certain remit: ***"A pharmacist is extremely knowledgeable and worth visiting with certain issues."***

Similarly, 71% of respondents were either "likely" or "very likely" to visit a pharmacy for advice or information. Interestingly, men and those aged 18-34 years old were less likely to visit a pharmacy in comparison to women, and those aged over 55 years old: ***"I trust they are qualified and knowledgeable enough to deal with most queries and if not I am confident they would signpost me to the correct path."***

There were clear uncertainties and concerns about receiving advice from support members of staff, and confusion around who has the expertise. Some respondents had previous poor experiences when had also affected their levels of trust in pharmacists: ***"I'm not always sure if I'm speaking to the pharmacist or just their assistant."***

Trust and Confidence

Positively, 90% of respondents were either "very confident" or "somewhat confident" in their understanding of a pharmacist's role, with only 7% stating they are not confident. Interestingly, confidence was greater amongst those aged over 55 in comparison to those aged 18-34: ***"Pharmacists are very skilled and qualified clinicians. I feel confident in the service they provide."***

Similarly, 62% said they would trust a pharmacist to access their medical record, 22% sometimes would, and only 9% stating they would not trust a pharmacist to do this.''

Integration with Primary Care

46% of respondents felt that their pharmacy and GP practice worked well together, with 30% stating that this was only sometimes the case. Although most respondents were generally satisfied, there were some cases of miscommunication regarding repeat prescriptions, and lack of taking responsibility: ***"Neither GP surgery or pharmacy willing to own up to mistakes with prescription, usually results in having to explain what has gone on several times to both GP surgery and pharmacy."***

Recommendations

When asked how pharmacies could be improved, and what would encourage them to use pharmacies more often, the majority of respondents noted the need for greater accessibility, particularly in terms of opening hours.

Other suggestions included:

- Reducing delays and waiting times
- More information about the expertise of pharmacists and staff members
- Greater privacy through implementing more private spaces and/or consultation rooms
- Greater responsibility in prescribing for minor conditions and offering more services
- More promotion and advertisement of the services they can offer
- More staff and better training for staff members

When asked what pharmacies could support the public more with, the majority of respondents suggested that they could do more to promote their services, as well as providing more information about health and wellbeing more generally. Other suggestions included offering general health checks, ability to prescribe medication for minor conditions, weight loss clinics, and longer opening hours.

Healthwatch Hertfordshire: Carers' Support from their GP Practice

Explored:

- Whether carers are registered as a carer with their GP practice
- What support carers receive if they are registered as a carer with their GP practice
- Awareness of, and support from, Carers Champions

Key Findings:

Registering as a Carer

- Heard from **622** carers. Of which **68%** are formally registered as a carer with their GP practice.
- Barriers to registering as a carer with their GP practice included:
  - Lack of awareness
  - Poor or no communication
  - Practical barriers e.g. time, caring/work responsibilities
  - Belief that there are no benefits to registering as a carer
  - Previous poor

Access Barriers

- Most carers struggle to access their GP practice because they cannot get through, particularly via telephone.
- Other barriers included:
  - Fitting appointments around caring/work responsibilities
  - Flexibility in appointment times
  - Choice regarding the type of

Support from their GP Practice

- **76%** have not been offered flexibility when booking an appointment for themselves or the person they care for.
- **87%** said their GP practice has never discussed their physical or mental health in relation to their caring role.
- **79%** have not received signposting information or support.
- Only **13%** know if their GP practice has a Carers Champion. However, **63%** would

Entitled Support

- Since being registered, **75%** have been offered an annual flu jab.
- Only **17%** have been offered an NHS annual health check – and for many it was treated as a tick-box exercise
- **16%** have been offered access to a Carer Assessment and/or benefits check.
- **72%** were not aware they could access this range of support from their GP practice.

Healthwatch Hertfordshire: Views on Community Pharmacies

Explored views of, and attitudes towards, community pharmacies amongst Hertfordshire residents.

Key Findings:

Use of Pharmacies

- Heard from **309** Hertfordshire residents. Of which **70%** use a pharmacy on a monthly basis.
- For **91%** of respondents, the main reason they use a pharmacy is to collect medication.
- **57%** visit their pharmacy before looking for information or advice from elsewhere.
- Barriers to using a pharmacy included: Delays, Accessibility, Concerns around Privacy, Level of

Support from Pharmacies

- **80%** said the support they receive from their pharmacy is either "good" or "very good".
- Respondents felt that staff are friendly, supportive and approachable.
- Respondents felt that pharmacies are reliable, efficient, and knowledgeable in providing advice and information.

Awareness of Services Offered

- Awareness of **essential** services provided was very good, while awareness of **additional** services was more varied.
- Reasons for not accessing these services included: No Need, Lack of Information and Awareness, Concerns around what is a Private or NHS

Trust and Confidence

- **68%** would trust a pharmacist to give medical and information, and **71%** were either likely or very likely to visit a pharmacy for support.
- **90%** were either very confident or somewhat confident in understanding a pharmacist's role.
- There were concerns about receiving advice from support

Improvements

- Suggestions for improvements included:
  - Greater Access
  - Reduced Delays
  - Information about the Expertise of Pharmacists
  - More Privacy
  - Promotion of the Services they can offer
  - More Staff and Better Training
  - More Responsibility in Prescribing for Minor Conditions
  - Provide more

Hertfordshire and West Essex Integrated Care System

NHS
Hertfordshire and West Essex
Integrated Care Board

Meeting:	*Meeting in public* ☒		*Meeting in private (confidential)* ☐	
	NHS HWE ICB Primary Care Board meeting held in Public		**Meeting Date:**	**26/1/2023**
Report Title:	**West Essex Community Pharmacies-experiences and feedback.** **Support and Help for People Who Care for Others in West Essex**		**Agenda Item:**	**8.2**
Report Author(s):	**Sara Poole, Information and Guidance Officer, Healthwatch Essex** **Fergus Bird, Information and Guidance Officer, Healthwatch Essex**			
Report Signed off by:	Avni Shah, Director of Primary Care Transformation, HWE ICB			
Purpose:	**Approval** ☐	**Decision** ☐	**Discussion** ☒	**Information** ☒
Report History:	N/A			
Executive Summary:	**Healthwatch Essex were approached by Hertfordshire and West Essex ICB to undertake a series of projects focussing on the lived experiences of people in the area in relation to their health, care and wellbeing.** The aim of the first project is to explore people's experiences of accessing community pharmacies in West Essex. Over 150 people responded to the survey with a number of one-to-one interviews conducted. Case studies were also obtained from members of the public. **Main points:** • High volume of feedback from residents of Stansted Mountfitchet-very unsatisfied with only having one dispensing pharmacy in the village. Many issues around access, parking, queues, small premises etc. • Difficult communication-telephones not being answered, issues with electronic systems-ordering medication etc, feeling unable to ask staff for advice due to them being busy.			

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- Some medication not being available, having to phone numerous pharmacies to find what is required.
- Helpful and friendly staff in many pharmacies.

The aim of the second project is to explore people's experiences of caring for others in West Essex.

Over 100 people responded to the survey with a number of one-to-one interviews conducted. Case studies were also obtained from members of the public.

Carers provide enormous support to the health and wellbeing of the person/s they care for and alleviate a significant amount of strain from the care system.

They often do not recognise themselves as carers (especially if the person they support is immediate family) but provide a vital care role.

It's important to ensure these carers get the emotional, physical, financial and practical support they deserve.

Early identification, signposting, understanding, listening and recognising their needs can make a huge difference to everyone involved – be they service users or professionals.

This report will highlight blockages in the system, successes, quick wins, areas for improvement, training requirements, best practice and opportunities for ongoing improvement and streamlining

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<tr><td>Recommendations:</td><td colspan="4">The Board are asked to note the contents of the report</td></tr>
<tr><td rowspan="4">Potential Conflicts of Interest:</td><td>Indirect</td><td>☐</td><td>Non-Financial Professional</td><td>☐</td></tr>
<tr><td>Financial</td><td>☐</td><td>Non-Financial Personal</td><td>☐</td></tr>
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<tr><td>Quality Impact Assessment:</td><td>N/A</td></tr>
<tr><td>Data Protection Impact Assessment:</td><td>N/A</td></tr>
<tr><td rowspan="6">Strategic Objective(s) / ICS Primary Purposes supported by this report:</td><td>Improving outcomes in population health and healthcare</td><td>☒</td></tr>
<tr><td>Tackling inequalities in outcomes, experience and access</td><td>☒</td></tr>
<tr><td>Enhancing productivity and value for money</td><td>☐</td></tr>
<tr><td>Helping the NHS support broader social and economic development</td><td>☐</td></tr>
<tr><td>Successfully complete and embed the transition of staff and functions from the three clinical commissioning groups into the Integrated Care Board</td><td>☐</td></tr>
<tr><td>Develop the ways of working and profile of the Integrated Care System to ensure that its operating model is capturing the opportunities presented by closer system working</td><td>☐</td></tr>
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Healthwatch Hertfordshire and Essex: Carer Support Reports

Explored experiences of support from health and social care services for:

- **Carers of relatives, friends and neighbours**
- **Residents living in West Essex**

Key Findings:

Carers Allowance & Social Care

- Vast majority of respondents caring for someone for 35+ hours a week are aware of Carers Allowance.
- Significant number of respondents who are aware of and eligible for carers allowance do not claim it.
- Respondents have highlighted that social workers could be a great source of help and support directly for themselves as carers, not just for the cared for person

GP Registration & Support

- There is a lack of awareness that additional support is available through GPs for those who are registered as carers.
- Approximately three quarters of respondents would register as a carer with their GP if they were aware of the additional support they could receive.
- Many respondents registered as a carer with their GP have not been offered additional

What else they want

- There is consistent feedback throughout the survey & interviews that carers would really benefit from support groups and simply having someone to talk to.
- Respite for a holiday or even just a single evening 'date night' – but only if the cared for person is able to remain at home and be well looked after.
- Pro-active help and

Flexibility and priority

- More flexibility when making GP appointments, and maybe a degree of priority due to their caring responsibilities.
- However, respondents realise that GP and Social Care resources are very stretched.
- Option to make appointments outside

Healthwatch Hertfordshire and Essex: Community Pharmacy report

Explored experiences of accessing Community Pharmacies:

- **Residents living in west Essex**

Key Findings:

Stansted Mountfitchet

- Large response from the residents of this village.
- Only one NHS dispensing pharmacy in the area.
- The current Boots store is too small, queues of people waiting, some outside in poor weather, no disabled access, limited parking facilities etc.
- Concerns regarding the rapidly expanding village and services not being able to cope as they are struggling as it is.

Communication

- Unable to get through on the phone to many pharmacies, calls not being answered.
- Lack of consistency regarding ordering systems. Variations in pharmacy systems.
- Residents not feeling able to ask a pharmacist for advice due to how busy they are.

Medication issues

- Problems sourcing certain medications, residents having to find their own alternatives. Some having to return to the GP to ask for further information.
- Length of time waiting in store for prescriptions to be completed.

Positives

- Friendly and helpful staff were mentioned numerous times.
- When ordering/delivery systems worked well residents found it a positive experience.
- Use of the NHS app to reorder medication has been helpful for many.

Hertfordshire and West Essex Integrated Care System

NHS
Hertfordshire and West Essex
Integrated Care Board

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<tr><td rowspan="2">Meeting:</td><td>Meeting in public</td><td>☒</td><td>Meeting in private (confidential)</td><td>☐</td></tr>
<tr><td colspan="2">NHS HWE ICB Primary Care Board meeting held in Public</td><td>Meeting Date:</td><td>26/01/2023</td></tr>
<tr><td>Report Title:</td><td colspan="2">Primary Care Communications and Engagement</td><td>Agenda Item:</td><td>09</td></tr>
<tr><td>Report Author(s):</td><td colspan="4">Heather Aylward: ICB Engagement Manager</td></tr>
<tr><td>Report Signed off by:</td><td colspan="4">Avni Shah, Director of Primary Care Transformation
Hertfordshire and West Essex ICB</td></tr>
<tr><td>Purpose:</td><td colspan="4">Approval ☒ Decision ☐ Discussion ☐ Information ☒</td></tr>
<tr><td>Report History:</td><td colspan="4">N/A</td></tr>
<tr><td>Executive Summary:</td><td colspan="4">This report outlines the evaluation of the work with the Patients Association in developing GP practice patient groups, details next steps and, for approval, a paper ‘What’s in it for practices’.</td></tr>
<tr><td>Recommendations:</td><td colspan="4">To note evaluation, agree next steps and approve the paper ‘What’s in it for practices’.</td></tr>
<tr><td rowspan="4">Potential Conflicts of Interest:</td><td>Indirect</td><td>☐</td><td>Non-Financial Professional</td><td>☐</td></tr>
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Impact Assessments (completed and attached):	***Equality Impact Assessment:***	EQIA to be undertaken for Communications and Engagement strategy
	Quality Impact Assessment:	N/A
	Data Protection Impact Assessment:	N/A
Strategic Objective(s) / ICS Primary Purposes supported by this report:	***Improving outcomes in population health and healthcare***	☒
	Tackling inequalities in outcomes, experience and access	☒
	Enhancing productivity and value for money	☐
	Helping the NHS support broader social and economic development	☐
	Successfully complete and embed the transition of staff and functions from the three clinical commissioning groups into the Integrated Care Board	☐
	Develop the ways of working and profile of the Integrated Care System to ensure that its operating model is capturing the opportunities presented by closer system working	☐

1. Executive summary

Herts and West Essex Integrated Care Board (ICB) commissioned the Patients Association (PA) to work with ICB engagement leads to provide development support for GP practice patient groups (PPGs). The work also supports the take up of the participation Enhanced Commissioning Framework (ECF).

This report provides an evaluation of the work with PA, outlines some next steps and presents a paper for approval on the role of patient groups, '*What's in it for practices'*. (Appendix one). This paper was developed by patients of the project steering group with input from other members and verified by Healthwatch Herts. This paper will be used as a resource for practices; outlining the benefits of having active patient groups / networks and as a tool for one to one practice support which has been identified as the next phase of the project.

The next steps have been identified as:

- The establishment of a practice patient group resource page on the ICB website, including links to workshops and toolkits.
- Continue to build resources, share good practice and information and build links between patient groups by continuing to develop an active and involved patient group network across the ICB.
- The offer of targeted support, with the introduction of a buddy scheme particularly to practices who have not engaged in the project but also to those keen to develop their groups.
- Establish, build links with primary care networks.
- Approval for the paper 'what's in it for practices', to be shared, when required, with practice managers, added to the resource page and used to deliver targeted support.
- Establishing a stronger link with the participation ECF, to help identify practices that may benefit from more targeted support.

2. Background

The aim of the ICBs partnership with PA has been to work with local practice staff and patient volunteers to ensure that GP patient groups have the tools and support structures to increase patient involvement and diversity in a sustainable, practical and realistic way.

The set up involved the following:

- Presentations at locality practice managers meetings and an engagement session which over 100 people registered for. A recording was shared with those not able to attend.
- Establishing a steering group of patients, primary care leads, practice managers and Healthwatch Herts to guide and advise the project
- Baseline survey for practice staff and patient members:
  - 250 responses from 88 practices.
  - 33 responses were from unnamed practices, providing around 65-70% coverage from practices in the ICB

- Delivery of three online workshops on topics identified from feedback as needing support:
    1. **Topic One**: Getting started – why have a patient group and what's in it for the practice and patients?
    2. **Topic Two:** Effectively working together in partnership
    3. **Topic Three:** Recruitment, increasing diversity and communicating with the wider patient population
    4. Development of **Topic Four** (based on feedback and still to be delivered). A step by step guide to establishing an active patient group.
- Task and finish patient group developing a model of engagement and 'what's in it for practices' paper on the benefits of having active patients.

	Attended	Viewed Recording	Total views
Getting started, why have a patient group and what's in it for practices and patients	64	140	204
Effectively working together in partnership	48	108	156
Recruitment, increasing diversity and communicating with the wider patient population	43	77	120
Total		325	

Evaluation

(Based on current feedback – survey timescale has been extended to encourage more response and deeper analysis)

90 people completed a second survey after the initial three workshops from 48 different practices. Several practices had more than one representative take part.

- 81% (71) of respondents were patients, 16% (14) practice staff, 1 GP, 2 ICB staff and 11 people skipped the question.
- 97% (75) reported having an established patient group with 18% (14) having activity at Primary Care Network (PCN) level.
- The feedback on the workshops was varied, with between 43% - 66% rating them as excellent / good. Comments supporting this question suggested people liked to view the recording in their own time, they would have liked more opportunity for questions and answers, the presentations were too general and more consideration was needed for practices still to develop their groups.
    - In response to the last point a further workshop was organised for 24 January with a 'step by step' guide to establishing a patient group.
- Respondents were asked what additional support they would like and this again was varied, but some patients felt they were not getting co-operation or encouragement from practice staff so would appreciate help building partnerships. There has also been some discussion re the wider and perceived 'disconnect' currently between patients and GP practices.

- Many felt that more targeted (one to one support) was required, with just under a half interested in a 'buddy scheme'. The role and involvement of PCNs was mentioned, as was help building links with other practice groups.

Outcomes of the project

- 35% of survey respondents have made changes as result of the project
- 65% have not but some of these have identified actions and plans in place going forward

Key changes /plans initiated as a result of the project

- Better links with community and GP practice and better promotion of both
- Meeting with social prescriber and community groups
- Building plans to have email and text contact with patients
- Improved newsletters and wider readership
- Awareness sessions reactivated by practice
- GP lead for patient group reintroduced
- Items from workshops on patient group agendas to take things forward
- Heightened areas of improving relationships with the practice
- Considering new activities and initiatives to increase membership and diversity
- Better links with PCN and more engagement with other local patient groups

What's in it for practices' paper

This paper has been put together by patient members of the task and finish group to provide information and guidance for practices on the benefits of having an active patient group or network. The work has been led by Alan Bellinger a trustee of Healthwatch Herts, who have supported this approach, and shared with a steering group of other patients, practice managers and ICB staff.

The paper was initiated in response to feedback above, which suggested that some practices were reluctant to engage with a patient group and information on the benefits of having an active group / network would be useful in encouraging this.

The task and finish group have requested that the ICB endorse the paper which would be used as a tool in one to one support offered to practices.

3. Issues

There have been some issues engaging with all practices, particularly during a period where resources are stretched.

Workshop topic content has also been a challenge to deliver at a relevant level for all patient groups; those that are well developed and those not established or functioning.

Some practices have reported having issues recruiting to their groups, whilst some patients have felt that the practice hasn't provided support, encouragement or co-operated in the

development of a group. In response to this issue the paper 'what's in it for practices' was developed.

4. Options

1. To continue to work with PA to build support for patient groups
2. To deliver the support from within current resources.

5. Resource implications

Continued support will be offered by the ICB communications and engagement team within current resources. However, extending the project with PA is being explored to ensure that the momentum from this work is not lost and more tailored support can be offered to individual practices. This may include establishing a patient led 'buddy scheme' and more focused work with primary care networks.

6. Risks/Mitigation Measures

There is concern that momentum may be lost if the next steps identified as requiring support are not addressed in a timely manner. Involvement of the Patients Association will help to mitigate this risk as they will focus on direct and targeted support for practices requiring it. Their involvement also provides opportunity to be engaged at a national level, sharing learning from the project and linking in with other work that PA are involved in.

7. Recommendations

To note activity and approve next steps and agree the paper *'What's in it for practices'.*

8. Next Steps

- The establishment of a patient group resource page on the ICB website, including links to workshops and toolkits.
- Continue to build resources, share good practice and information and build links between patient groups.
- The offer of targeted support, with the introduction of a buddy scheme particularly to practices who have not engaged in the project but also to those keen to develop their groups.
- Establish and build links with primary care networks
- Approval for the paper 'what's in it for practices', to be shared, when required, with practice managers, added to the resource page and used to deliver targeted support.
- Establishing a stronger link with the participation ECF, to help identify practices that may benefit from more targeted support.

Appendix one

What's in it for practices?

Why do GP Practices/Primary Care Networks need a Patient Group?

This paper has been put together by patients (a task and finish group) to provide information and guidance for practices on the benefits of having an active patient group or network. The work has been led by Alan Bellinger a trustee of Healthwatch Herts, who have supported this approach, and shared with a steering group of other patients, practice managers and ICB staff.

1. Summary

1.1 Although GP practices are expected to have a patient group under their GMS contract it would be much better if they had one because they **wanted one** as opposed to **needing one**.

1.2 This paper, which has been shared with Practice Managers representing practices across Herts and West Essex, argues that there are many ways in which a patient group provides benefit to a practice when there is goodwill from all parties.

1.3 The benefits a patient group can bring to the practice are:

- **Communications** – ensuring that the information the practice wants to communicate with patients is both consistent and engaging.
- **Support** – patients are an invaluable source of additional resource in stressful times and increased demand for GP services, such as supporting flu clinics, winter pressures, practice campaigns.
- **Equality of access** – getting patients from different community backgrounds and groups to fully engage with the practice can sometimes be difficult but patient groups can target these groups through peer support and through networks they establish as a local resident.
- **Patient engagement** – a proactive patient group can support the practice's desire to promote wellbeing and self-management through face-to-face and online activities that the patient group can facilitate and develop.
- **Co-design of services** – the lived experience that patients have can be extremely helpful in co-designing services that meet the needs of both the practice and their patients.
- **Winning hearts and minds** – the patient group can be an agent of change in communicating and establishing attitudes and behaviours that benefit both the practice and its patients.

1.4 To develop a patient group that can support the practice in this way it is critical that a **high level of trust** is established between the two parties. An open collaborative approach is far more effective than a combative approach and therefore the traditional 'critical friend' role is no longer fit for purpose. 'Agent of change' or patient partner is more positive and emphasises the collaborative and partnership approach.

2. Communications

2.1 Practice managers often ask “If I want to talk to all patients, who do I talk to?”; the simple answer is **to talk to your patient group!**

2.2 A regular newsletter is a good start to effective communications. With appropriate content, you will be able to manage the expectations of your patients and avoid unexpected confrontations. Your patient group may have someone with communications experience and so developing content collaboratively and distributing it widely is an effective way to start.

2.3 A good way to manage the distribution is to put the newsletter on the web site and send texts to mobile phones to link to the site. NB in all probability you have far more patient mobile numbers than email addresses so this method is the easiest (and cheapest) way to let all of your patients know. The use of mobile numbers in this way does need to be GDPR/DPA (the Data Protection Act is the UK law that brought GDPR under UK law after Brexit compliant (see section 9 below).

2.4 Whilst a newsletter is a good start, social media can support this too. Issues raised in the newsletter can be reiterated in social media to encourage feedback and information from patients in general and link directly to more information on the website.

2.5 Surveys are an excellent way to better understand current **patient experience** and highlight issues that are impacting them. There are different approaches that vary between a comprehensive survey conducted at fixed intervals (e.g. annually), and short sharp surveys that concentrate on immediate issues such as call waiting times. A comprehensive survey provides information on changes over time whilst shorter (e.g. 1-3 questions) surveys provide the ability to gauge sentiment at a particular moment in time.

2.6 The whole subject of communications is closely linked to that of engagement (see 5 below).

3. **Support**

3.1 There is a significant level of sentiment and goodwill towards Practices, not just remembering those occasions when patients’ worries were eased by the treatment they received, but also in recognising the challenges that primary care is facing at the current time. This goodwill can be leveraged by the practice to address short-term staffing challenges, using patient volunteer initiatives such as supporting flu or Covid booster vaccination sessions.

3.2 Patients spreading good humour, support and bonhomie can easily diffuse any pressures that build up while people are waiting and can encourage the use of blood pressure monitors, carer identification, recruiting new people to the patient group etc.

3.3 Patients can also support short-term staff shortages where appropriate – especially facilitating staff re-distribution in order to preserve patient confidentiality. This could include helping in back office duties.

4. **Equality of Access**

4.1 One of the areas that has been highlighted as an area of concern is the lack of equality of access to healthcare services; the recent Healthwatch Hertfordshire

report identifies the extent of this as far as Black and Asian Communities are concerned:
(https://www.healthwatchhertfordshire.co.uk/news/2022-09-27/local-healthcare-needs-tackle-discrimination-say-black-and-asian-communities)
This not only applies to people from ethnic minorities but includes a range of different people and communities.

4.2 Personalising messages and content to different communities requires lived experience to make it effective. Your patient group can develop these relationships and manage this on behalf of the practice.

5. **Patient Engagement**

5.1 The biggest challenge that a patient group faces is to engage deeply with the diversity of the practices' patients. This can be addressed by the patient group building the appropriate contacts with churches, mosques, other religious groups, condition specific and other voluntary groups, schools, clubs etc. Although the newsletter (see 2 above) is a great start as a broad untargeted approach, deepening the engagement involves much more targeted multi-layered approaches. Patient group members will be active in many areas of their local community and can provide a link to building communication and networking.

5.2 Patients have identified a series of effective ways at driving engagement including:

- Online Health Webinars
- Face-to-Face Health Events (including Pre Diabetes sessions in a Mosque)
- Community Hub
- Community cafes, to combat loneliness
- Carer and long term condition support groups

5.3 Having your patient group develop activities such as these means that you will be able to create deep engagement with patients and the wider community. This activity will also enable a practice to pursue wellbeing and self-management without reducing practice resources.

6. **Co-design**

6.1 There are multiple examples of the need to re-design processes within practices and across primary care networks. In re-designing processes, a practice may tend to focus on efficiency whilst people with lived experience will bring a totally different perspective to the subject.

6.2 Examples of successful co-design that patients have completed include:-

- Reducing the number of ways that patients can re-order prescriptions
- Protocol for managing telephone queues and call-backs
- Triage/ assessment methodologies
- Support for Carers;
- Supporting the interview and induction of new staff
- Medicine reviews.

6.3 There are numerous ways in which patient groups can support the practice on co-design; it's dependent on opportunities and the willingness of the practice and the patients to participate.

7. **Attitudes**

7.1 Although it's a real challenge**,** as a key agent of change your patient group will, over time, be able to help the practice. There are various aspects in creating a shared destiny:

- Wellbeing and self-care through engagement activities
- Keeping patients up to date through communication activities
- Understanding through co-design
- Appreciation of each others perspectives through discussion

7.2 The more success your patient group has with influencing a more active approach to keeping fit and healthy will be in line with the practice's goals and help reduce the need for valuable clinical input.

8. **Membership Model**

8.1 There are two patient group models that are being deployed across Herts and West Essex:

- **Selective Membership** – patients need to apply to become members of the patient group:
- **Universal Membership** – all patients are automatically members of the patient group but can opt out of patient group communications

8.2 The main benefit of the Universal Membership model is that it facilitates engagement between the patient group's leadership team and the patient body. Contribution is far more important than membership, and the ask for non-engaged members is so much simpler. (From: 'do you want to be a member of the patient group' to 'can you help with this task' or simply 'would you be interested in finding out more about your condition')

8.3 There are implications here for processing personal data; these are highlighted in a comprehensive paper providing guidance on this subject that has been developed by the patient group that developed this paper and approved by Ruth Boughton Information Governance Manager for the HWE ICS.

9. **A patient group's – success measures**

9.1 In the interests of openness and shared destiny, the patient group and the practice need to agree targets and actions at the start of each year or when required. These could take the form of Key Performance Indicators (KPIs) which are a great way to ensure that the practice and the patient group have shared aims.

9.2 It is suggested that there are three critical KPIs that a high performing patient group should work towards:

- **Open governance** – it is critical that the patient group operates under good governance principles and should avoid the syndrome of a leader who sees the patient group as their personal fiefdom.
- **Engaging content** – the content (communications and engagement) needs to be rich and engaging to ensure that the patient group maximises its contribution.

- **Reach** – the extent to which the patient group has been able to extend its reach to all patients – especially those that are under-represented and those that could potentially experience health inequalities.

10. Conclusions

10.1 This paper focuses on the fact that a well-run patient group can be a real asset to **a** GP practice and something to be encouraged rather than avoided. Strong patient groups are also a valuable source of lived experience for the ICB as a whole.

11. **Provenance**

11.1 This paper was initially developed by a patient led task and finish group and has been reviewed and refined by both Practice Managers, the ICB and endorsed by Healthwatch Herts

Alan Bellinger
Task and Finish Group
Trustee Healthwatch Hertfordshire
January 2023

Hertfordshire and West Essex Integrated Care System

NHS
Hertfordshire and West Essex
Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐
	NHS HWE ICB Primary Care Board Meeting held in Public	**Meeting Date:**	**26/01/2023**	
Report Title:	**HWE ICB Training Hub – Deep Dive into the Primary Care Workforce**	**Agenda Item:**	**10**	
Report Author(s):	Joyce Sweeney, Head of Primary Care Workforce Dr Sarah Dixon, Primary Care Workforce GP Clinical Lead			
Report Signed off by:	Avni Shah, Director of Primary Care Transformation			

Purpose:	**Approval**	☐	**Decision**	☐	**Discussion**	☐	**Information**	☒

Report History:	N/A
Executive Summary:	This paper aims to provide a deep dive into the Primary Care Workforce across the HWE area. In as far as the existing data allows it explores the demographic changes that will impact on the demand for staff groups, identifies those staff groups which are difficult to recruit to and shows in which areas where a large number of staff are likely to retire over the next few years.
Recommendations:	For discussion and information

Potential Conflicts of Interest:	***Indirect***	☒	***Non-Financial Professional***	☐
	Financial	☐	***Non-Financial Personal***	☐
	None identified			☐
	All GP members and attendees and conflicted indirectly in light of workforce/primary care development initiatives/funding			

Impact Assessments (completed and attached):	***Equality Impact Assessment:***	< Yes/ No / N/A >
	Quality Impact Assessment:	< Yes/ No / N/A >
	Data Protection Impact Assessment:	< Yes/ No / N/A >
Strategic Objective(s) / ICS Primary Purposes supported by this report:	***Improving outcomes in population health and healthcare***	☒
	Tackling inequalities in outcomes, experience and access	☐
	Enhancing productivity and value for money	☒
	Helping the NHS support broader social and economic development	☐
	Successfully complete and embed the transition of staff and functions from the three clinical commissioning groups into the Integrated Care Board	☐
	Develop the ways of working and profile of the Integrated Care System to ensure that its operating model is capturing the opportunities presented by closer system working	☐

Executive summary

This paper aims to provide a deep dive into the Primary Care Workforce across the HWE area. In as far as the existing data allows it explores the demographic changes that will impact on the demand for staff groups, identifies those staff groups which are difficult to recruit to and shows in which areas where a large number of staff are likely to retire over the next few years.

This report contains a selection of data from the NHS National Workforce Reporting System (NWRS), Office for National Statistics (ONS), population and person insight (Papi) dashboard and HWE ICB internal reporting.

1. The Introduction

This paper provides an overview of the current Primary Care workforce. Data used in this report relates predominately to the years 2021/22. It gives an outline of the changes we envisage to our workforce over the next 3 years and beyond.

The term workforce refers to all occupations of health professions clinical and non clinical. Workforce reflects the need to have a sufficient number, skill mix, and distribution of appropriately training health personnel to meet population health needs and promote equitable access to quality care.

The Fuller Stocktake Report (May 2022) states that it is important to have a deep understanding of the Primary Care workforce and focus on using data to inform and drive improvement. The report states that it is important to have available robust workforce data and that data is an integral part of system thinking, planning and delivery and it is essential as it 'Supports the development of training and supervision, recruitment and retention and increased participation of the workforce, including GPs'.

The NHS People Plan recognises and promotes the necessary growth in the workforce to meet future demand, particularly tackling nursing vacancies in Primary Care. The plan stresses the need to improve recruitment and retention and development opportunities for staff i.e., growing for the future particularly by building on the renewed interest in NHS careers to expand and develop the NHS workforce, as well as retaining colleagues for longer.

Invest in our workforce (NHS 2022/23 priorities and operational planning guidance) is a key message from NHS England (NHSE). NHSE are asking systems to transform and grow the substantive workforce i.e., further understand and support the recruitment and retention of the Primary Care workforce.

When the NHS was established in 1948, it was supported by 144,000 staff. The trends of levels of staffing have been variable across time periods and professions. However, it is difficult to piece together long-term trends due to how the data has been collected over

time, but the available data suggests levels of staffing has not increased in line with the population growth in the Hertfordshire and West Essex ICB.

In Hertfordshire and West Essex, 135 GP practices serve the communities, working in groups of 35 'Primary Care Networks (PCN)'.

According to the Office for National Statistics (ONS) the resident population in Hertfordshire and West Essex has increased by 2.4 percent as at the end of September 2022 this is six times greater than that of the UK (0.4 per cent increase).

In Hertfordshire and Wests Essex (HWE) ICB the total workforce constitutes 3,273 full time equivalent (FTE) staff (all roles) as of September 2022. This is an increase of 4.6 per cent since September 2021. This follows a 4.9 percent increase between September 2020 to September 2021.

The data in this report has been analysed against the National Workforce Reporting System (NWRS) and Health Education England (HEE) portals and the population and demographics was accessible from the population and person insight (Papi) dashboard. These workforce data portals were critical for this piece of work and give an accurate picture of staff in post against each sub-ICB location broken down by GP surgery.

South and West Herts has the highest number of GPs per 100,000 population (46) and the fewest nurses (16). This contrasts with West Essex that had fewer GPs and more nurses per 100,000, (40 GPs and 22 nurses), (National Workforce Reporting System).

The Ratio between GPs to nurse in each Practice shows that there is a very large variance. This could relate to the ability to recruit to other roles. (Figure 2 & 3).

The data shows a large amount of Administrative/non clinical roles ie reception staff, secretaries, administrators, coders, practice managers, reception team leads etc. This shows that Primary Care is heavy reliant on this group of staff. (Figure 2 & 3).

2. The resident population

The population of Hertfordshire and West Essex ICB was 1,620,492 at the end of September 2022, this is an increase of 2.4 percent (37,967) since September 2021.

The breakdown of the population data is given as at June 2021, which was the recent data available supplied by the Population and Person Insight (Papi) dashboard.

As of September 2022 the rate of population increase in Hertfordshire and West Essex is six times greater than the UK average which was 0.4 per cent between mid-year 2019 and mid-year 2020. This is the most recent ONS data[i].

The table below illustrates the sub location population within the ICB. This is the position reported as at June 2021.

Table 1

Sub-Area of H&WE	Population	Population rate
East & North Herts	609,125	38%
South & West Herts	661,981	42%
West Essex	311,419	20%
Total	**1,582,525**	**100%**

3. Primary Care Workforce

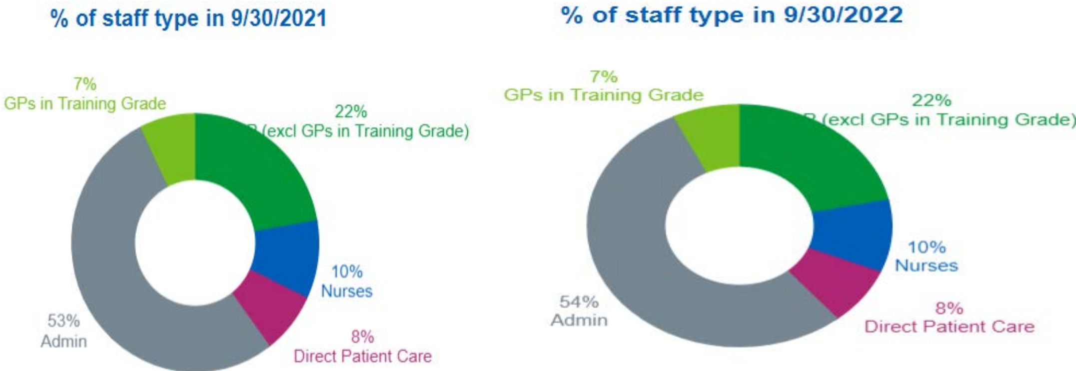
The total ICB Primary Care workforce was 3,273 in October 2022, which represents an increase of 4.6 percent since September 2021. This follows a 4.9 percent increase between September 2020 to September 2021.

3.1 Overall view of the workforce in Primary Care broken down by roles – skill mix

The charts below presents (Full time equivalent (FTE)) as a percentage the growth of staff in the different staff types as at 30 September 2021 compared to 30 September 2022.

The data shows that there is a one per cent increase in administrative/non clinical roles. The remaining staff groups have not increased as a percentage in comparison.

Fig 1



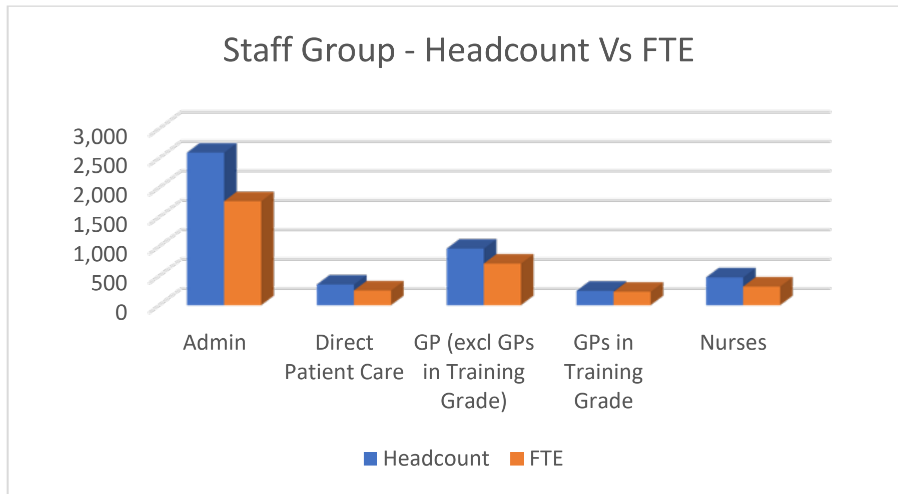
Staff Types

- **GP in training** are fully qualified and registered physicians who are undergoing further training specifically for general practice.
- **Direct Patient Care roles** are Advanced Paramedic Practitioners, Advanced Pharmacist Practitioners, apprentices, Health Care Support Workers/Assistants,

Nursing Associates, Paramedics, Pharmacists, Physiotherapists, social prescribing link workers, Phlebotomists,

- **Nurses** include Advanced nurse practitioners, nurse specialists, practice nurses, trainee nurses
- **Admin/Non Clinical** includes Practice Managers, medical secretaries, management partners, receptionists, telephonists, apprentices, other non clinical roles

Fig 2 – Staff Groups- Headcount vs FTE



Skill mix

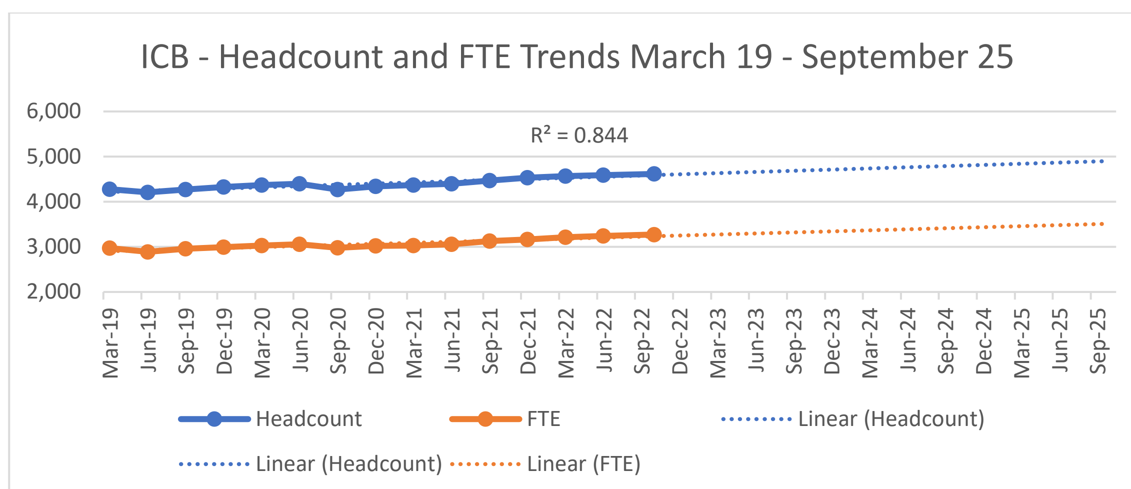
The data shows a ratio of GPs to nurses of 1:82, by FTE

3.2 What are the Primary Care FTE Trends?

Since March 2020 the data shows that there has been a steady increase in the overall FTE roles by 298 and an average of 3,066 FTE roles per quarter. The linear line is corresponding to the data set from March 2019 – September 2022 and works out the pattern throughout the period. The liner forecast line is currently showing an increase in FTE roles at a steady rate up to September 2025.

The below graph is showing a linear trendline that clearly shows that the FTE workforce have consistently risen over a 2-year period. The R-squared value is 0.844, which is a good fit of the line to the data.

Fig 3



3.3 Number of Staff who are over 55 and approaching retirement?

There is a threat to Primary Care posed by the ageing demographic of staff for some groups for example the nursing professions as there is a large cohort fast approaching pensionable age.

Breakdown of nurses/GPs and other staff over 55

Table 1 - September 2021

East & North Hertfordshire

Staff Group	Under 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65 and over	Unknown	Total	Age 55+
Admin/Non-Clinical	98	37	32	43	61	90	140	108	46	11	666	44%
GP	24	55	59	56	51	37	39	21	10	1	353	20%
Direct Patient Care	8	22	5	12	3	9	13	8	1	1	82	27%
Nurses	7	12	6	14	15	25	25	20	9	3	136	40%
Total	**137**	**126**	**102**	**125**	**130**	**161**	**217**	**157**	**66**	**16**	**1237**	**36%**

South West Hertforshire

Staff Group	Under 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65 and over	Unknown	Total	Age 55+
Admin/Non-Clinical	76	39	34	37	59	103	133	110	59	3	653	52%
GP	43	51	70	48	62	43	39	17	8	2	383	17%
Direct Patient Care	4	10	8	11	7	11	14	11	4	1	81	36%
Nurses	5	6	8	18	18	15	15	14	3	3	105	30%
Total	**128**	**106**	**120**	**114**	**146**	**172**	**201**	**152**	**74**	**9**	**1222**	**37%**

West Essex

Staff Group	Under 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65 and over	Unknown	Total	Age 55+
Admin/Non-Clinical	36	21	18	17	30	55	66	62	29	4	338	46%
GP	16	36	27	32	23	19	14	14	6	0	187	18%
Direct Patient Care	6	8	9	5	9	9	14	11	5	3	79	38%
Nurses	3	5	3	8	11	6	13	10	6	1	66	44%
Total	**61**	**70**	**57**	**62**	**73**	**89**	**107**	**97**	**46**	**8**	**670**	**37%**

Table 2 – September 2022

East & North Hertfordshire

Staff Group	Under 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65 and ov	Unknown	Total	Age 55+
Admin/Non-Clinical	85	41	34	55	55	93	129	123	54	12	681	**45%**
GP	23	54	66	55	51	43	37	20	11	0	360	**19%**
Direct Patient Care	8	17	8	8	9	11	14	10	1	1	87	**28%**
Nurses	6	11	11	17	13	26	22	21	10	3	140	**37%**
Total	**122**	**123**	**119**	**135**	**128**	**173**	**202**	**174**	**76**	**16**	**1268**	36%

South West Hertforshire

Staff Group	Under 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65 and ov	Unknown	Total	Age 55+
Admin/Non-Clinical	94	46	42	56	60	99	140	111	68	2	718	**44%**
GP	32	65	74	52	55	43	37	15	9	1	383	**16%**
Direct Patient Care	11	13	9	9	8	10	14	10	5	1	90	**32%**
Nurses	3	5	7	19	16	20	17	11	5	2	105	**31%**
Total	**140**	**129**	**132**	**136**	**139**	**172**	**208**	**147**	**87**	**6**	**1296**	34%

West Essex

Staff Group	Under 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65 and ov	Unknown	Total	Age 55+
Admin/Non-Clinical	41	21	26	24	33	56	64	55	35	3	358	**43%**
GP	13	42	34	27	25	17	18	12	6	0	194	**19%**
Direct Patient Care	4	10	8	8	6	12	12	12	6	3	81	**38%**
Nurses	1	5	6	8	14	8	11	11	6	1	71	**38%**
Total	**59**	**78**	**74**	**67**	**78**	**93**	**105**	**90**	**53**	**7**	**704**	35%

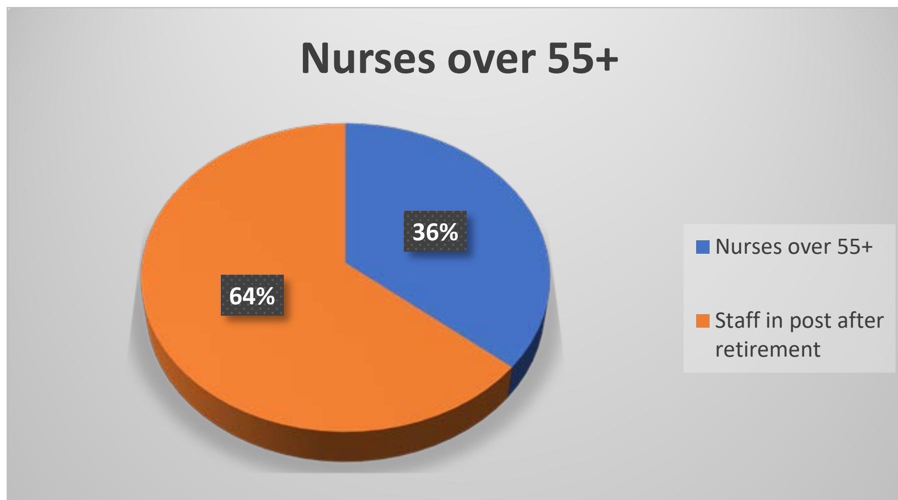
The data shows that GPs coming up to retirement represented 19 percent of the workforce in East and North Hertfordshire and West Essex compared with 16 percent in Herts Valley. The largest age group was 35-39 in East & North Hertfordshire with 66 GPs, as was the case in Herts Valley (74 GPs).

Still looking at GPs the 30 to 34 age group shows an overall higher cohort of staff other than those aged 50 plus.

According to the ONS the workforce in Primary Care is older than the national average, with 35 per cent of staff over the age of 55 in HWE; compared to 28.9 per cent nationally.

As can be seen in table 2 the issue is prevalent in the nursing staff, where 36.08 per cent of HWE nurses are over 55, compared to 33.2 per cent nationally. The situation could be even worse as some nurses are eligible to consider retirement at the age of 55.

Fig 6



3.4 What Vacancies is there in Primary Care?
To date we are unable to capture vacancy data. This is an area we intend on exploring with NHSE, Primary Care Careers and the Primary Care Network (PCN) Education Leads.

To support recruitment the Primary Care Careers link will be made available on the HWE ICB Training hub website.

3.5 Understanding Population by Condition – Connecting Job Roles to Conditions
Prevalence of long-term conditions within HWE is generally lower than the national average. Compared to estimated rates of long-term conditions as well as prevalence in similar areas in the country, there is potentially an under diagnosis for a range of long-term conditions, particularly hypertension, atrial fibrillation, and chronic kidney disease (NSE/ONS).

In view of the condition prevalence (Fig 11) connecting job roles to conditions Primary Care now has a much more multidisciplinary team that focusses on integrated working and improved communication with roles including clinical pharmacists, physiotherapists, social prescribers, care coordinators etc. This enables different health care workers to focus on specific conditions whilst linking to the wider team and working in a more integrated way when other needs are identified.

Staff FTE's per 100,000 population

Fig 7

Sub area of H&WE	GPs	Nurses	Direct Patient Care	Admin/ Non-clinical
East & North Herts.	43	23	14	110
South & West Herts	46	16	14	106
West Essex	40	22	24	109

South and West Herts has the highest number of GPs per 100,000 population (46) and the fewest nurses (16). This contrasts with West Essex that has fewer GPs and more nurses per 100,000, (40 GPs and 22 nurses). West Essex had the highest ratio of direct care staff (24) to 100,000 population as compared with the other two districts that had 14.

Population by Condition by sub-location

Fig 8

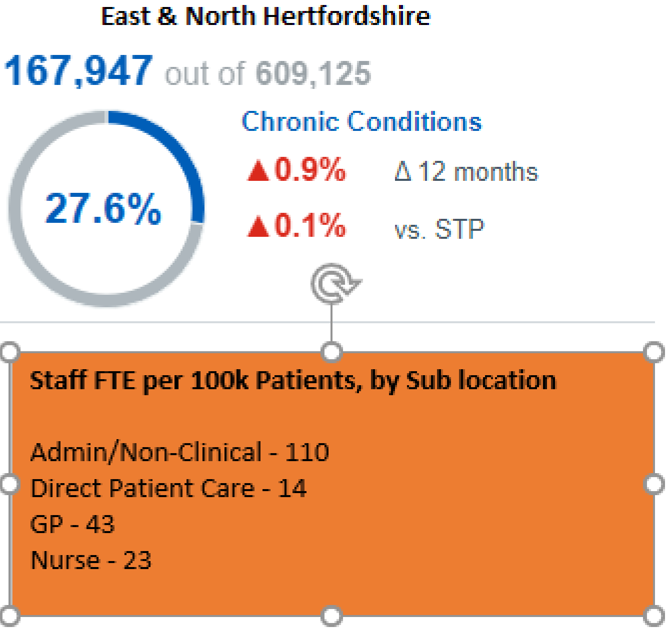


Fig 9

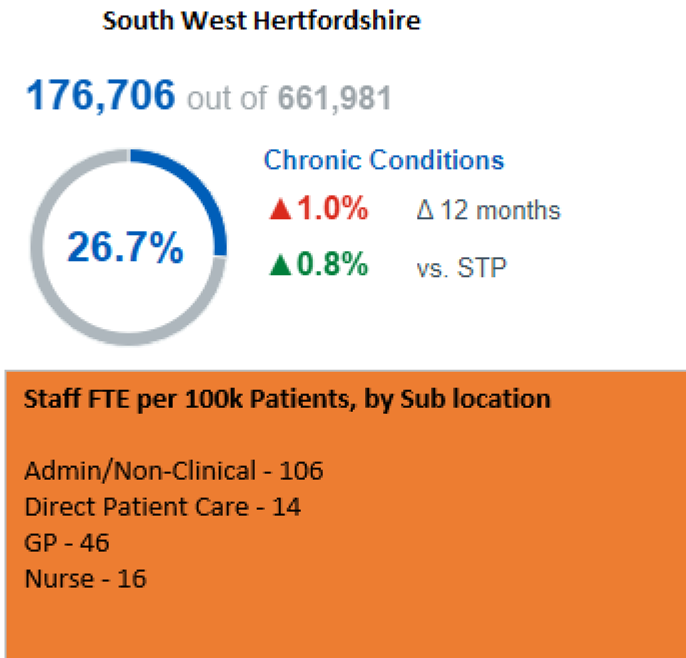
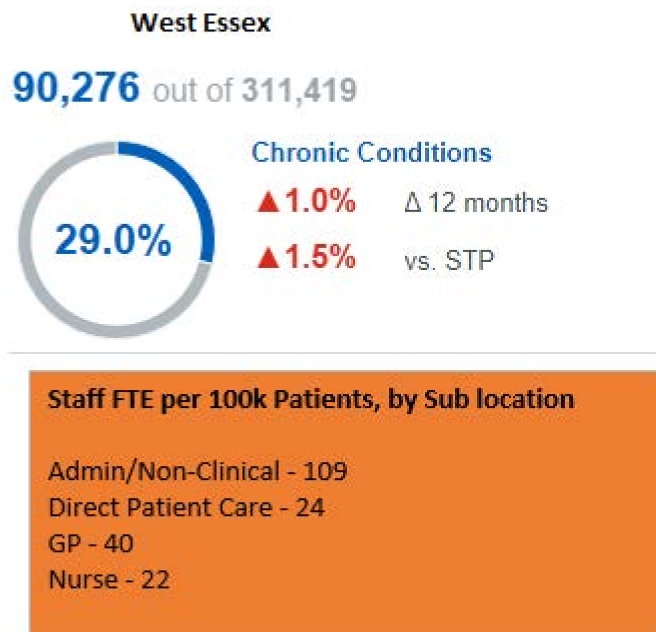


Fig 10

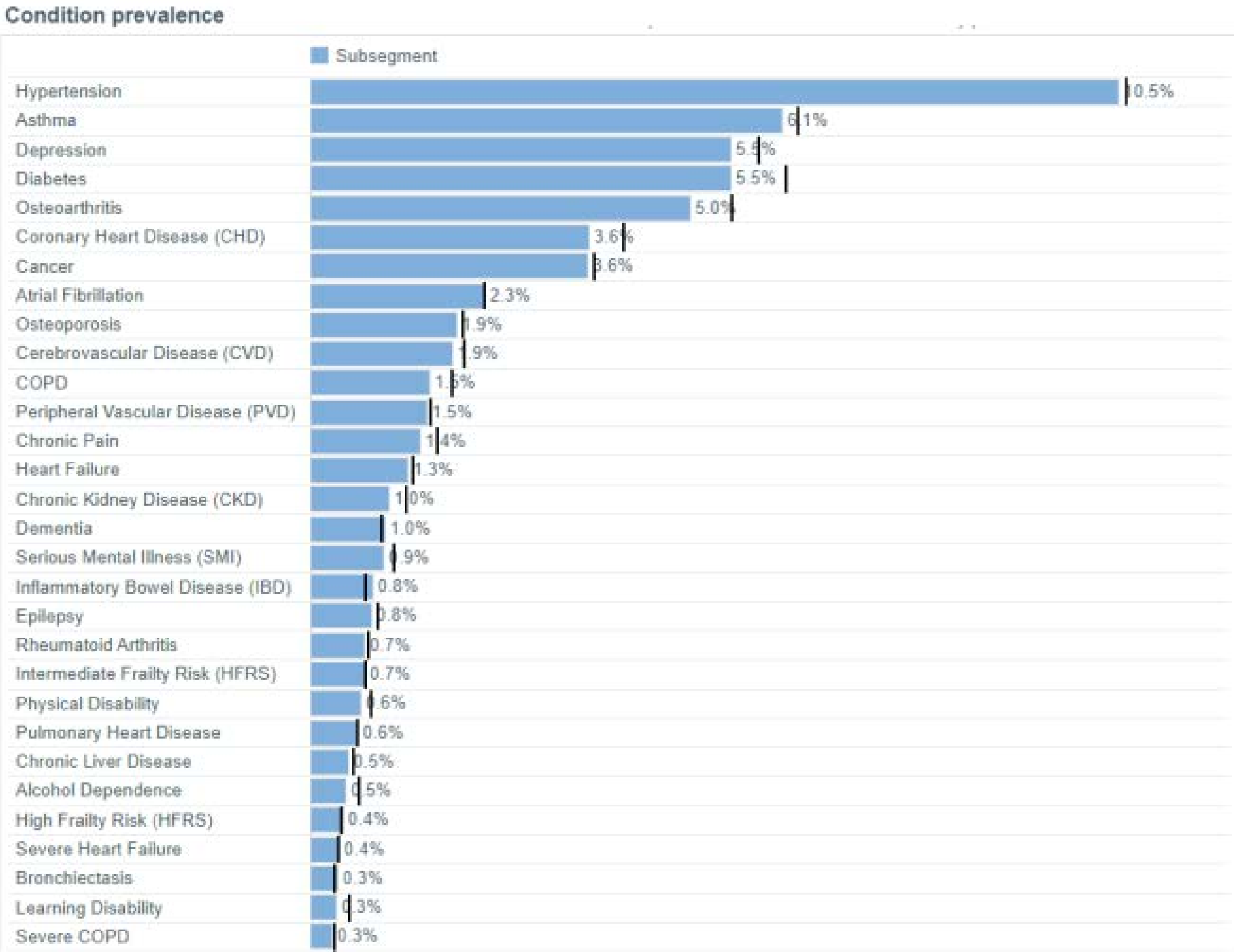


3.6 Overall Conditions across HWE ICB

The chart below shows that hypertension, asthma, depression and diabetes and osteoarthritis are the top four conditions across the HWE ICB. Knowing this information will enable the building of a picture of the needs of the population that HWE ICB serve and influence the workforce model moving forward.

General Practice Nurses (GPN) currently provide much of the reviews and monitoring for long term conditions such as diabetes therefore this highlights the need for nurse recruitment or looking at different ways of working and skill mix for example using practice and PCN pharmacists and physician associates to deliver some of this work. There is potential for delivering some of this work at scale in PCNs and working with other providers in the PCN areas such as community nursing teams and community pharmacy to meet the needs together for these patients i.e. working in neighbourhood teams as discussed in the Claire Fuller report.

Fig 11



3.7 Recruitment to the Additional Recruitment Reimbursement Scheme (ARRS) roles

The ARRS recruitment has given Primary Care a real opportunity to do things differently. It has enabled patients to be seen by the right healthcare professional at the right time. It has enabled a joined up system.

As at April 2022 a total of 395 FTE ARRS roles were in place across Primary Care. This has increased to 461 in November 2022 which is an increase of 66 posts. However, the data shows that there is a lot of movement in the system ie Clinical Pharmacists in post was 128 in April 2022 and peaked to 144.9 in August 2022; in November 2022 the total had fallen by 13.9 posts to 131 in November 2022 there is a similar pattern showing for the Social Prescribing link worker and Advanced Practitioner.

Overall the data shows a slow growth of recruitment to the ARRs roles.

Fig 12

	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	October 2022	November 2022
Advanced Pharmacist Practitioner	0.0	0.0	0.0	0.0	0.0	1.5	4.9	6.1
Advanced Practitioner	10.0	10.8	11.0	10.0	10.0	11.8	3.0	2.0
Care Coordinator	98.0	102.5	107.7	106.6	108.5	113.7	111.8	112.5
Clinical Pharmacist	128.0	130.7	133.5	132.8	144.9	141.8	143.3	131.0
Digital and Transformation Lead	0.0	0.0	0.0	0.0	0.0	0.0	4.1	6.4
First Contact Physiotherapist	32.3	31.7	33.1	29.2	31.2	32.0	31.2	31.5
General Practice Assistant	0.0	0.0	0.0	0.0	0.0	0.0	0.7	3.0
Health and Wellbeing Coach	18.3	17.3	20.5	17.2	19.9	22.8	22.0	19.8
Mental Health Practitioner Band 6	0.0	0.0	0.0	0.0	3.0	1.0	1.0	2.0
Mental Health Practitioner Band 7	1.0	1.0	7.0	6.0	9.0	13.0	26.0	13.0
Mental Health Practitioner Band 8a	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0
Nursing associate	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4
Occupational therapist	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Paramedic	17.7	17.5	16.6	15.8	16.7	17.9	17.5	16.1
Pharmacy Technician	8.6	9.6	10.6	12.4	13.4	12.1	16.1	13.3
Physician Associate	16.2	18.2	18.2	16.4	16.6	16.5	20.0	18.3
Social Prescribing Link Worker	53.7	60.7	62.6	56.8	77.8	81.1	72.1	69.0
Trainee nursing associate	6.3	6.7	5.3	5.4	5.8	6.3	5.7	5.3
Dietician	3.0	2.0	3.0	1.5	3.0	1.5	2.0	2.5
Podiatrist	1.0	1.0	1.0	1.0	1.0	2.0	1.0	1.0
Advanced Podiatrist Practitioner	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0
Advanced Paramedic Practitioner	0.0	0.0	0.0	0.0	0.0	0.0	1.0	1.0
Advanced Physiotherapist Practitioner	0.0	0.0	0.0	0.0	0.0	0.0	3.5	4.3
Total	**395.4**	**411.0**	**431.7**	**412.4**	**462.3**	**476.3**	**488.2**	**461.3**

4. Conclusion

This report has highlighted some key workforce metrics. When looking at the current overall picture of the workforce it important for us to recognise that this is a much longer piece of work. It is also important to mention that working in Primary Care is seen as a positive place to work as it offers a rewarding and varied career; with a broad mix of roles in lots of different settings.

The data that has been used shows that since March 2020 there has been a steady increase in FTE of overall roles by 298 and an average of 3,066. FTE per quarter.

The Ratio between GPs to nurses in each Practice shows that there is a very large variance. However, it is important to note that it is well known that GP Practices are experiencing significant and growing strain with rising demands to recruit and train staff.

The data shows a large amount of Admin/Non clinical roles. This shows that its heavy reliant on this group of staff. More work is needed to understand the data around this.

It has identified that we have an ageing staff profile and an aging population, particularly within key primary care services. Staff who volunteered to remain within service to support the ICB through the pandemic are now choosing to retire or change roles to suit their lifestyles.

It is important that we continue to review the workforce data and provide analysis of the requirement of new areas of responsibility relating to primary care to gain a better understanding of our workforce and to produce a more meaningful workforce plan.

It is crucial to acknowledge that NHS staff have been overwhelmed since Covid-19 and are facing stress and burnout and this is likely to continue for sometime.

This information needs to be at the heart of plans to address the current and predicted shortages.

To support the Primary Care Workforce with recruitment and retention the HWE Training Hub offer various educational programmes and support for example the New to Practice programme for GPs and Nurses; Enhanced Fellowship schemes for new GPs; GP career grants and funding to support continuous professional development for GPNs and all other staff in the Primary care clinical and non clinical.

The Training hub offers an impartial career support service for all Primary Care Workforce clinical and non clinical ie supportive career conversations from any of the workforce leads in the team. The Wise 5 and First 5 workforce GP Clinical Leads offer networking and support sessions.

The Training hub is currently working with Primary Care Careers to have a link from their website onto the HWE Training hub website to further support the recruitment of staff.

The recent set up of the Primary Care PCN Training teams across the 35 PCNs adds further support to the recruitment and retention of the Primary Care workforce.

The Training hub is also working with providers of vaccinations clinics to support clinical and non clinical staff who are now looking for a career in Primary Care.

Despite the

5. Issues

Increasing vacancy rates are evident across Primary Care however, currently there is no vacancy or turnover data therefore that makes it difficult to see the overall picture of the primary care workforce.

6. Options

The Training Hub will continue to work closely with the ICS Workforce Transformation Lead and HEE/NHSE to better understand the systems where we can source workforce data as we need accurate data to better understand the Primary Care Workforce and add value to development of workforce strategies

7. Resource implications

The available resources to support Primary Care are sourced by HEE/NHSE of which are provided on a recurrent basis.

8. Risks/Mitigation Measures

Risks

- The lack of financial resource available to support Primary Care
- The lack of interest from the Primary Care workforce due to current workforce pressures

Migrations measures

- Project group to focus on workforce planning for current workforce and determine future workforce needs
- Have a robust communication plan in place to drive forward the various development opportunities for Primary Care staff
- Primary Care PCN Training Teams to support with training, education and workforce planning

9. Recommendations

The Training hub to continue to build on the collection of workforce data and use the data to support future workforce planning.

10. Next Steps

The collation and analysis of workforce data helps to develop new initiatives and opportunities. The next steps for HWE Training hub is to use the data from this report to inform the training hub workforce planning process for all Primary Care Staff, clinical and non clinical for example: -

- Developing existing and further schemes for those GPs and Nurses nearing retirement;
- To keep recruitment of FTE on an upward trend ie start to develop the Fellowships programmes, recruitment campaigns and events etc;
- Continue with the offer of CPD funding, career grants, coaching and mentoring to support the retention of staff;
- Continue to support/embed the ARRs roles into Practices enabling increased multidisciplinary working;
- Continue to support staff who have been away from work for an extended period of time such as maternity leave, shared parental leave, illness or other reason;
- Working with Primary Care on developing education for tomorrow's workforce ie focus on inspiring students placements, work experience;
- Working closely with Primary Care PCN Training teams to further understand the needs of the Primary Care workforce.

A project group is set up to meet on 2 February 2023 to start the process of focussing on workforce planning.

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[i] https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/articles/overviewoftheukpopulation/2020

https://apps.model.nhs.uk/a-z (Population & Person Insight (PaPI) Dashboard)