NHS HWE ICB Primary Care Board meeting held in Public

Thursday 23 March 2023

Conference Room 2, The Forum, Hemel Hempstead, HP1 1DN

The Forum

Herts, HP1 1 DN

09:30 - 12:20

Meeting Book - NHS HWE ICB Primary Care Board meeting held in Public Thursday 23 March 2023

NHS HWE ICB Primary Care Board meeting held in Public

09:30	1. Welcome, apologies and housekeeping		Chair
	2. Declarations of interest		Chair
09:35	3. Minutes of last meeting held on Thursday 26 January 2023	Approval	Chair
	4. Action Tracker	Approval	Chair
09:40	5. Questions from public	Discuss / Information	Chair
09:45	6. Primary Care Board Governance	Approval/Information	Avni Shah / Iram Khan
10:00	7. Directorate Highlight Report	Discuss/Information	Avni Shah
10:20	8. Primary Care Board updates	Discuss / Information	
	Estates update		Sue Fogden/Alan Pond
	Update on PCN Clinical Strategies		Ashish Dwivedi
10:50	9. GMS Contract changes 23/24	Information	Michelle Campbell
11:05 - 11:15	Comfort Break		
11:15	10. Primary Care Transformation	Discuss / Information	
	10.1 Engagement plan /anticipated areas delivery plan		Prag Moodley/James Gleed
	10.2 Update on ECF 22/23		Avni Shah/Rachel Halksworth
	10.3 Evaluation Respiratory Hubs		Roshina Khan
11:50	11. Primary Care Risk Register	Discussion/Approval	James Gleed
12:10	12. Reports/minutes from the Subgroup	Information	Chair
	Primary Care Digital		Chair
	Primary Care Workforce	Information	Chair

12:15	13. New Risks identified		Chair
	14. Reflections and feedback from the meeting including items to disseminate		Chair
12:20	Close of meeting		Chair
	APPENDICIES - Items for Information only		
	Appendix 1 Delegation of Pharmacy, Optometry and Dental Commissioning - Update	Information	
	Appendix 2 Update from Healthwatch	For Information	

Herts & West Essex Strategic Framework- 2022-2027

Our mission

Better, healthier and longer lives for all

We will achieve this by

- **Improving physical and mental health across our population**
- **Tackling unequal access, experience and outcomes**
- **Enhancing productivity and value for money**
- **Ensuring the NHS supports broader social and economic development.**

In the first 3-5 years we will

- Increase healthy life expectancy, and reduce inequality
- Give every child the best start in life
- Improve access to health and care services
- Increase the numbers of citizens taking steps to improve their wellbeing
- Achieve a balanced financial position annually

The ICB will deliver this by:

- Setting direction for the NHS in Hertfordshire and West Essex
- Allocating NHS resources fairly and effectively
- Supporting, equipping, and empowering our people
- Working with and pooling resources with our partners
- Enabling improvement and driving change, with a focus on quality
- Using data and evidence to generate insight and assess impact

Hertfordshire and West Essex Integrated Care System

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 26 January 2023**			
Time:	**09:30 – 11:41**			
Venue:	**Via MS Teams**			

MINUTES

Name	Title	Organisation
Members present:		
Nicolas Small (NS) **(Meeting Chair)**	Partner Member (Primary Medical Services)	Herts and West Essex ICB
Rachel Joyce (RJ)	Medical Director	Herts and West Essex ICB
Prag Moodley (PM)	Partner Member (Primary Medical Services)	Herts and West Essex ICB
Ian Perry (IP)	Partner Member (Primary Medical Services)	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 (NHS Community Trust)	Herts and West Essex ICB
Amik Ameja (AA)	Primary Care Locality Lead – WE	Herts and West Essex ICB
Rob Mayson (RM)	Primary Care Locality Lead – ENH	Herts and West Essex ICB
Rami Eliad (RE)	Primary Care Locality Lead - SWH	Herts and West Essex ICB
In attendance:		
Heather Aylward (HA)	Public Engagement Manager	Herts and West Essex ICB
Alan Bellinger (AB)	Patient Representative	
Michelle Campbell (MC)	Head of Primary Care Contracting	Herts and West Essex ICB

Toni Coles (TC)	Place Director, West Essex	Herts and West Essex ICB
Corina Ciobanu (CC)	Clinical Lead -Primary Care Transformation - SWH	Herts and West Essex ICB
Sarah Dixon (SD)	Clinical Lead Primary Care Workforce ENH	Herts and West Essex ICB
Heather Eardley (HE)	Project Manager, National Patient Association	National Patient Association
Cathy Galione (CG)	Head of Primary Care Transformation and Integration - ENH	Herts and West Essex ICB
James Gleed (JD)	Associate Director Commissioning Primary Care	Herts and West Essex ICB
Sam Glover (SG)	Chief Executive	HealthWatch Essex
Cath Fenton (CF)	Consultant in Public Health	Hertfordshire County Council
Rachel Halksworth (RH)	Assistant Director for Primary Care Contracting	Herts and West Essex ICB
Iram Khan (IK)	Corporate Governance Manager	Herts and West Essex ICB
Roshina Kahn (RK)	Head of Primary Care Transformation and Integration - SWH	Herts and West Essex ICB
Joanna Marovitch (JM)	VCSFE Representative	Herts and West Essex ICB
Helen Musson (HM)	Chief Officer	Hertfordshire Local Pharmaceutical Committee
Tracey Norris (TN) (minute taker)	Clerk	HFL Education
Joyce Sweeny (JS)	Head of Primary Care Workforce	Herts and West Essex ICB
Emily Perry (EP)	Primary Care Manager – Strategy and Transformation	Herts and West Essex ICB
Annette Pullen (AP)	EA to Director of Primary Care Transformation	Herts and West Essex ICB
Dr Raja (RR)	LMC Representative	Essex LMC
Neil Tester (NT)	Vice Chair	Healthwatch Hertfordshire
Michael Watson (MW)	Chief of staff	Herts and West Essex ICB
Nicky Williams (NW)	LMC Representative	Bedfordshire and Hertfordshire LMC

PCB/01/23	Welcome, apologies and housekeeping
1.1	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.
1.2	Apologies for absence had been received from Elizabeth Disney and the Chair invited Avni Shah to introduce the new attendees who had been confirmed from Place and Primary Care leadership since the last meeting: • Toni Coles • Rob Mason • Rami Eliad • Amik Aneja • Cathy Galione • Roshina Khan • Philip Sweeny (apologies received for this meeting) Primary Care workforce & digital transformation: • Corina Ciobanu • Alison Jackson (apologies received for this meeting) • David Tideswell (apologies received for this meeting) Patient representatives from each of the three places were in the process of joining the committee and would be in attendance at the next meeting.
1.3	Michael Watson, Chief of Staff at the ICB was welcomed as an observer to meeting. The meeting was declared quorate.
PCB/02/23	**Declarations of interest**
2.1	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/03/23	**Minutes from the previous meeting**
3.1	The minutes of the last meeting held on 24 November 2022 were agreed as an accurate record, subject to the following amendments: • Correction to the spelling of Joanne Marovitch's name in the attendance list. • Expansion of item 26.1 Reflections of meeting to include the need for the breadth and depth of primary care and the different organisations and individuals who were part of this to be fully captured in the PCB's terms of reference. An agreed definition of who this covered would be welcomed. Avni Shah noted that a revised terms of reference would be brought before the March meeting, this document was being updated following feedback from the auditors and to incorporate the delegated responsibility for dental, community pharmacy and optometry and to reflect the changes to the membership of the Board.
PCB/04/23	**Action tracker**
4.1	The action tracker was reviewed, and the current status of the following actions noted: • Item 6.6/22: Dashboard framework has been created. Item closed. • Item 7.3/22: Deep dive on training hubs: Item closed, see agenda item PCB/10/23. AS confirmed the schedule of future deep dives as follows: • March meeting: Estates and Digital deep dive.
4.2	**The Primary Care Board noted the updates to the action tracker**
XX/05/22	**Questions from the public**
5.1	A statement from Mr Woodcock had been received (part of an ongoing dialogue with the PCB) and printed in the meeting papers. This related to the provision of a community

	pharmacy in Stansted Mountfitchet. A written response would be provided, and a further meeting had been scheduled. No further comment would be provided at this meeting. No other questions had been raised.
5.3	**The Primary Care Board noted the statement from Mr Woodcock.**
PCB/06/23	**Directorate Report**
6.1	Avni Shah (AS) provided the following verbal update: • There was continued focus on winter and primary care access and for the first time, daily monitoring of demand at practice level was possible through the OPEL framework. • 60% of practice had signed up to this. • The winter response to Strep A led to the development of Acute Respiratory Hubs at pace in December which evolved to take on adult acute respiratory infections from January 2023. • There was continued focus on covid and flu vaccination. • More appointments through PCNs which are not included in the national general practice appointment • Since the implementation of the new digital tools in October including E-consult and AccurX, there is good activity across practices on the use of the additional functions including batch messaging; florey questionnaires. • Continued support for the increasing numbers of vulnerable asylum and refugee migrants. • Estates: good progress in developing PCN clinical strategies (completion date, March 2023). • Lloyd George Digitalisation of notes: completed across 23 practices – a paper would be shared at the next PCB in March. • Patient experience: see agenda item PCB08/23 and ICB Board papers. Alison Jackson was representing HWE in the national pilot to develop meaningful patient experience metrics. • Delegation of community pharmacy, dental and optometry contracts were on track for completion by April 2023.

6.2	Questions and comments were invited:
	• The Chair noted the enormous pressures on primary care and community colleagues – there were unprecedented levels of demand.
	• Q What was being done specifically to support staff in terms of motivation and morale in the face of demand pressures, strikes, recruitment and retention challenges. Were these factors included in the Board's work plan?
	• AS reported the low morale (anecdotal feedback from practice leads) and the high rates of staff sickness. AS highlighted a number of initiatives already in place to support the workforce:
	  ○ Workforce training hubs were providing a range of support, guidance and tools to staff.
	  ○ 256 points/markers in the enhanced commissioning service had been paused in December to support general practice capacity.
	  ○ Capacity of respiratory hubs had been expanded with better links to primary care.
	• This was the third winter in a row of increased demand/service pressures and all agreed that better forward planning could prevent many of the pinch points, it was noted that the reliance on national funding was not the best approach.
	• Further digital integration was required to make this seamless.

	• Staff morale was affected by patient suffering and delays in diagnosis added to this burden. Bottle necks and waiting times at A&E were another cause of distress for patients and GPs, often with some clinically vulnerable patients being turned away and directed back to primary care. • Initiatives such as the "Hospital at Home" could have a big impact (on reducing pressures) - if it was adequately staffed and promoted. • GP members asked for clarity regarding who had responsibility for patients being treated through the Hospital at Home initiative. • GPs welcomed support from the PC team re public messaging and how to deal with patients who were often angry and frustrated re access. • The new half day education sessions which provided GPs and practice staff with time and space for reflection and the sharing of best practice (the four-hour slot 1.30-5.30pm was covered by HUC) was welcomed and it was hoped that some practical training modules on managing difficult conversations, challenging patients etc could be produced to further support PC staff resilience. • Work was needed to improve the system flow of referrals between primary and secondary care. • The Chair recognised that all aspects of primary care, eg community care services, mental health services etc were under equal and growing pressure as well as general practices.
6.3	**The Primary Care Board noted the Directorate report.**
PCB/07/23	**Risk Register**
7.1	James Gleed introduced the risk register (see pages 20-29 of the document pack) highlighting the following points • Risk 320: 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. • 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. • A new risk had been proposed: 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 and provide care for this vulnerable cohort of patients becomes increasingly challenged; RESULTING delays in providing effective care and potential ongoing impact on local 111/A&E services. • The primary/secondary care liaison group were exploring the knock-on implications from changes to the mode of delivering care as raised at the previous meeting, eg relating to ARRs recruitment.
7.2	There were no questions arising and the Board approved the amendments to Risks 320 and 327 and the creation of a new risk relating to asylum seekers.
7.3	**The PCB approved the amendments to the risk register.**
PCB/08/23	**Update from Healthwatch**

8.1	Neil Tester introduced the interim findings from Healthwatch Hertfordshire (see pages 30-44 of the document pack) highlighting the following points:
	• The research had explored the following areas:
	  ○ Carers' views and experiences of accessing support from their GP Practice
	  ○ Residents' views of, and attitudes towards, community pharmacies
	• All field work had been completed and a full report would follow.
	• There was a mixed picture of experiences but some common themes had emerged:

	○ There were many instances of localised good experiences – it would be beneficial to share/promote these within the system. ○ There was often low-level awareness of the services and support available from local pharmacies. ○ There was a general level of scepticism from carers re barriers to access at GP or community pharmacy level – the constraints on the carer's time/capacity to queue for example. The need for flexibility re appointment times when caring for young children.
8.2	Sara Poole introduced the findings from Healthwatch West Essex (see pages 45-49 of the document pack) highlighted the following points: • The research had explored the following areas: ○ Carers' views and experiences of accessing support from their GP Practice ○ Residents' views of, and attitudes towards community pharmacies • All field work had been completed and a full report would follow. • There had been a large response from the residents of Stansted Mountfitchet echoing the views of Mr Woodcock (see correspondence at agenda item PCB/05/23 above). • Some common themes had emerged relating to: ○ Difficulties in getting through to pharmacies via telephone. ○ Issues with low/no stock resulting in prescription not being fulfilled. ○ Friendly/helpful staff. ○ Respondents were happy to seek advice on minor ailments rather than go to GP. ○ Carers were not aware of the benefits they were potentially eligible for. ○ Carers were often faced with inflexibility re access, regardless of their personal circumstances.
8.3	Questions and comments were invited: • Board members noted the rich data collated in the Healthwatch reports and were keen that this patient feedback should be triangulated with the risk register and the work being rolled out by the Directorate. • AS reported that this was key in developing the primary care workplan; the PC team were directing the focus of the Healthwatch research to provide information to help inform decision making. The PC Access workplan was being created and this was where everything was brought together. This would be shared at the March PCB meeting and would hopefully achieve the aim of better integration of community pharmacy within primary care. • Data and metrics would also be collected which would track impact – qualitative and quantitative. • It was noted that national funding decision had resulted in a crisis in community pharmacies with closures and reduced opening hours. The impact of this was evident from the research. As a result, there was a lack of consistency of provision within community pharmacy. • This lack of consistency alongside physical environment constraints (eg lack of privacy) were barriers to community pharmacy increasing its role in delivering on the day access; however, these barriers could be addressed. Some community pharmacies provided excellent advice and support to presenting patients. • System wide comms were needed to publicise the widening role of community pharmacy, eg 70% of Hertfordshire respondents visited a pharmacy on a monthly basis but less than 10% of them used the pharmacy for anything other than collecting prescriptions. • The health and inclusion team would address the issues raised around carers not realising what support they could access through their GP or community pharmacy. It was suggested that aspects of the good practice from the minor eye condition service could be adopted by community pharmacy.

8.4	AS outlined the next phase for Healthwatch who had been commissioned to conduct a series of engagement topics for HWE: • Two topics would be covered each quarter. • The reports would be made available on the HWE website. • The findings would be used to inform workplans. • Feedback to participants would be created by the comms and primary care team: "*you said we did".* • The research would be a mix of focus groups and questionnaires. • The review on dentistry had been paused temporarily and to be considered in the new year once the ICB is delegated. • The next 2 topics including focus groups to understand the barriers to annual health checks for learning disabilities and also use this opportunity to promote the need to health check, self-care and vaccination. • Second topic is self-care in patients with long term conditions. The Chair welcomed this new integrated approach to research.
8.5	**The Primary Care Board noted the findings from Healthwatch Hertfordshire and Healthwatch West Essex interim reports. Final reports will be shared for information with the March papers.**
PCB/09/23	**Patient Participation Groups**
9.1	Heather Aylward, Heather Eardley and Alan Bellinger introduced this agenda item (see pages 50-60 of the document pack) and highlighted the following points: • The ICB commissioned the Patient Association (PA) to provide development support for GP practice patient groups (PPGs) and the take up of participation in the Enhanced Commissioning Framework. • The first phase of the project had been completed; four workshops had been held and an action plan for the next six months had been created. • 42% of practices had responded (there had been two surveys issued) and 33% of these practices had already made changes to their PPGs. • The team would continue to reach out to those practices which had not yet engaged and offer additional support eg buddy scheme, 1:1 support. • Information and guidance have been prepared for practices outlining the benefits of an active PPG.
9.2	Questions and comments were invited: • Effective communication was key to transformation in primary care and patient advocates via PPGs could play an essential part in this. • AS noted the "bottom up" approach and the need to ensure that a definition of primary care was created and agreed; primary care did not just mean general practice and attention to detail/clarity of this definition was needed in all papers/documents. This same approach was needed for non-GP care. • The opportunity to celebrate and promote the good practices which had been identified should not be missed, • Case studies had been made and were available on the HWE website, some of which had been highlighted at the National Patient Association forum. For example, the creation of the HWE Diabetics support group which had been launched last year. • Patient groups had historically just focused on general practice but now they were part of the PCN and were excited to be seen as a community engagement mechanism. • The Chair of the Voluntary Sector Alliance recorded her support for patient groups and hoped that these would move forward being mindful of inequalities and the

	need for all sectors of society to be encouraged to participate. Should another paper be created *"what's in it for patients...*" for example. • HE confirmed that wider diversity was part of the group's action plan and all involved recognised the need for patient groups to be as fully representative as possible. • The best way to disseminate information to patients and staff alike was discussed. RM was in the process of creating a dedicated webpage for PC leads; it was possible that this could be scaled up across the ICB for staff and patients. To be discussed offline.
9.3	**The PCB approved the next steps for the continued support to Patient Participation Groups at practice and primary care network level.**
PCB/10/23	**Deep Dive: Primary Care Workforce Report**
10.1	Sarah Dixon and Joyce Sweeney presented this agenda item (see pages 61-76 of the document pack) and highlighted the following points: • The population of Hertfordshire and West Essex ICB was 1,620,492 at the end of September 2022, this was an increase of 2.4 percent (37,967) since September 2021 and represented a rate of growth which was 6 times higher than the rest of the UK. • There was a slow but steady increase in the number of full-time equivalent roles (see breakdown on pages 5-6 of the report). • Page 7: analysis of staff over 55 (ie approaching retirement) by role and by place. • 461 new ARRs roles have been created. • It was hoped the training hubs could address some of the recruitment and retention challenges.
10.2	Questions and comments were invited: • The report was an excellent start to understanding the specific workforce challenges within primary care but this needed to be expanded beyond general practice. • The unintended consequences of a recruitment drive in one area of care could often result in staff shortages in other areas of the system. • Long term conditions (traditionally managed by a nurse) could be supported by community pharmacy. • There were workforce gaps and pressures in many areas of the system and a coordinated approach to care needed a coordinated approach to workforce. • The number of GPs and nurses approaching retirement was a significant risk – efforts needed to be made to ensure this expertise was not lost and that more flexible working opportunities needed to be offered eg consultant GPs, GP fellowships. • The PCN training teams were working hard to support primary care as a whole, with representation from community pharmacy and general practice in the training hub. • Vacancy rates/exit interviews needed more analysis. • The LMC were currently working on a project looking at the decision making behind changing role/retiring etc and it was hoped that this could be shared with the training hub. • The People Team were keen to establish a medical workforce team or committee to address these issues to create a sustainable workforce. • The information from this workforce deep dive needed to be seen alongside all other community services workforce data. • AS confirmed that there were links in place between PC teams and other workstreams in the People Plan as well as with the LMC. The People Plan had a

	medical focus to work out who is aligned to what with an aim to ensure sustainability of professions in all areas. • Frontline admin staff also need training and support and a development programme has been set up for practice managers. • Investment in PCN training and education was crucial – it takes time for new members of staff grow the confidence and skill to be patient facing. • This work would need to be expanded to cover optometry and dentistry when these sectors were taken on. • Career pathways for ICS staff across all areas of the system rather than just within sectors was an aspiration. • The Chair thanked SD for her work in this area.
10.3	**The Primary Care Board noted the primary care workforce deep dive**
PCB/11/23	**Primary Care Transformation**

11.1	Prag Moodley (PM) and Avni Shah (AS) presented this agenda item and shared the following verbal update:
	• There were three primary care leads representing each of the three places.
	• Two priorities had been identified for transformation:
	  ○ Primary care access
	  ○ Strengthening neighbourhood teams
	• There was wide spread negative press about GP access but primary care access was not just about GPs - it applied to all services delivered in the community.
	• Limitations: workforce, IT, estates.
	• Clarity was needed on the definition of primary care (ie not just GP but community pharmacy, dentistry, optometry, mental health services, HPCT and voluntary sectors etc) and for a blueprint to be replicated in each of the three places with scope for locality differences to be respected. It was hoped that this would also include the voluntary sector.
	• Next steps:
	  ○ Clear understanding and articulation of what is meant by a neighbourhood team.
	  ○ What is already being delivered in each place, for example, the fire department in Stevenage provide support sessions for young people.
	  ○ Identify some meaningful pilots.
	• There was a recognition that there would be different starting points in each neighbourhood depending on what infrastructures were already in place (or not).

11.2	Questions and comments were invited: • There were different starting points within community pharmacy and a much-reduced IT infrastructure compared to general practice. • Barriers between service delivery needed to be removed to effect meaningful change and the commissioning of certain services often exacerbated eg flu vaccinations. • A comms strategy was needed to break the default mindset held by some patients that what they needed was a GP when in fact they could be treated in a number of different ways/by different practitioners. • The digital road map had identified the different starting points each area faced and there was needed significant work to bring everyone to the same level. • The lack of connectivity was a serious impediment to joined up working between service providers.
PCB/12/23	**New risks identified**
12.1	None raised.
PCB/13/23	**Reflections and Feedback from the Meeting including items to disseminate**

13.1	***ACTION: Development of the primary care delivery plan.***
PCB/14/23	**Date and Time of next meeting**
14.1	Thursday 23 March 2023, 09:30
The meeting closed at 11:41	

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 16 March 2023								
Private / Public	**Action Tracker Ref No**	**Date of Meeting**	**Subject**	**Action**	**Responsible Lead**	**Deadline Date**	**Comments and Updates**	**Status**
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**~~ **24/05/2023**	Postponed to 24 May 2023.	**Open**

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

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:**	**23/03/2023**	
Report Title:	**Governance Update**				**Agenda Item:**	**06**	
Report Author(s):	Iram Khan, Corporate Governance Manager						
Report Signed off by:	Simone Surgenor Deputy Chief of Staff, Governance and Policies						
Purpose:	**Approval**	☒	**Decision**	☐	**Discussion**	☐	**Information** ☒
Report History:	• The Primary Care Board Terms of Reference were first adopted by the ICB on 1st July 2022. • It has been noted by the ICB Board that the revised Terms of Reference remain under continual review for the year 2022/23. • The Effectiveness of Committees is assessed on an annual basis. • The Primary Care Board workplan is reported at each Committee meeting.						
Executive Summary:	This report brings Governance updates to the attention of Primary Care Board members, for either approval or noting as specified for each update: 1. Primary Care Board Terms of Reference (Appendix 1) The Primary Care Board is presented with the Terms of Reference. An update has been to reflect: a) Introduction – included definition of the primary care including all primary care independent providers b) Paragraph 4.1 Revised structure chart c) Paragraph 7.1 Addition of Independent Dental Adviser and Chief Pharmacist to the membership d) Paragraph 7.1 – Addition of the Local Dental Network Chairs, representatives from adult social care to the invitee list 2. Committee Effectiveness Survey (Appendix 2) Please refer to paragraph 2 in the main body of this paper 3. Committee Workplan 2023-24 (Appendix 3)						

<table>
<tr><td></td><td colspan="4">The Primary Care Board Workplan template has been drafted for 2023-24, the board is asked to advise the Committee EA or the Governance lead of items to be added to the schedule of business.</td></tr>
<tr><td>Recommendations:</td><td colspan="4">The Primary Care Board is asked to:
Approve the amendments made to the Terms of Reference
Note that the Committee Effectiveness Survey will be reviewed via the survey and discussed at the meeting in May.
Note the work plan for 2023-24.</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:***	An EQIA will be undertaken on the method adopted for the release of this survey to ensure there are no concerns in particular surrounding access and approach
	Quality Impact Assessment:	N/A
	Data Protection Impact Assessment:	A DPIA would be connected to the platform used concerning release of the survey via a virtual route. It will be ensured checks are made to ensure a DPIA is in place.
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. Primary Care Board Terms of Reference

Primary Care Board Terms of Reference (Appendix 1)

The Primary Care Board is presented with the Terms of Reference. An update has been to reflect:

a) Paragraph 4.1 Revised structure chart
b) Paragraph 7.1 Addition of Local Dental Network Chairs to the membership
c) Definition of Primary Care to include all primary care independent contractors – Dental, Optometry, Community pharmacy and General Practice

2. Committee Effectiveness Survey (Appendix 2)

2.1 The board should monitor the [company's] risk management and internal control systems and, at least annually, carry out a review of their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls" Paragraph 29, section 4, UK Corporate Governance Code (2018).

The following effectiveness survey has been developed as part of the ICBs due diligence as part of a programme to evidence the above.

2.2 The first Primary Care Board effectiveness self-assessment survey will be undertaken in line with all HWE Board sub-committees' self-assessment surveys, annually at Q1.

2.3 Purpose of the review –

The annual review is designed to:

- Provide the Board with robust assurance of the committee's functioning and effectiveness;
- Form the basis of the Board's own effectiveness review;
- For the committee to examine its expectations of its members, and they are reminded of their duties;
- Provide an anonymous platform to enable individuals to have a safe environment to offer constructive feedback for the organisation to reflect on.
- Provide evidence of relevant achievements and development needs.

2.4 Methodology

The questionnaire has been designed around six main areas:

- Committee Focus
- Committee Team Working

- Committee Effectiveness
- Committee Engagement
- Committee Leadership
- Enhancing the Committee

2.5 Next Steps:

The questionnaire will be circulated to members following the March committee, via MS Teams Forms, with a two-week timeframe to complete and submit. Responses will remain anonymous and be collated into a feedback report to be brought back to May committee for discussion.

2.6 Reporting

This will inform the assurance process within the annual report.

Appendix 2 – Committee Effectiveness Template

The attached template will be used across the ICB Board and committees with the option of additional questions specific to individual committees to be included at the discretion of the committee chair.

3. Primary Care Board Work Plan 2023-24

Primary Care Board work plan for 2023 – 24 (Appendix 3). The board is asked to review the contents of the work plan and advise of any items to be added.

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

NHS Hertfordshire and West Essex Integrated Care Board

Primary Care Board

Terms of Reference_v2.1

1. Introduction

1.1 These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Hertfordshire and West Essex (HWE) Integrated Care Board (ICB) Primary Care Board.

1.2 **Definition of Primary Care** - Primary care services provide the first point of contact in the healthcare system, acting as the 'front door' of the NHS. Primary care includes general practice, community pharmacy, dental, and optometry (eye health) services.

2. Purpose and Remit

2.1 The Primary Care Board is the key HWE ICS Primary Care forum supporting the ICB with the remit to:

- Propose the strategic direction for local primary care services;
- Identify the key priority areas needing change;
- Enable local clinical perspectives to inform strategic decision-making;
- Set the strategic context for transformation and oversight of its implementation.
- Enable codesign/co-production across areas of primary care transformation and redesign in partnership with patients/citizens and all partners across the wider system

2.2 The Primary Care Board will play a key role in ensuring delivery of key national policy areas such as Long term Plan (LTP) requirements, Fuller Recommendations, GP, Community Pharmacy, Dental and Optometry contractual requirements and strategic direction; and will lead development and delivery of the HWE Primary Care Strategic Delivery plan aligned to national and local strategies of ICS framework, People Plan, Digital, Quality and UEC strategy.

2.3 The Board will set out the principles and methodology for transformation in the strategic delivery plan.

3. Role and Responsibility

3.1 **Strategic Oversight of Transformation**

- Lead the development of the primary care strategy and delivery plan and make recommendations to the Integrated Care Board
- Oversee the implementation and delivery of the primary care strategic delivery plan
- Provide a single forum for the oversight of primary care services transformation and innovation across the Integrated Care System, using best practice and a population health management approach to the development and integration of services at a system, place and neighbourhood level. This includes enabling functions including workforce, digital, estates.

- Oversee the system approach to the transfer of community pharmacy, optometry and dental services to the ICB from April 2023 and opportunities of transformation through integration of these services and delivery of transformation plan.
- To drive quality and reduce unwarranted variation in outcomes for patients in primary care across HWE using quantitative data and appropriate qualitative data from partners including Healthwatch.
- To ensure there is alignment of plans across HWE ICB system and place work programmes.

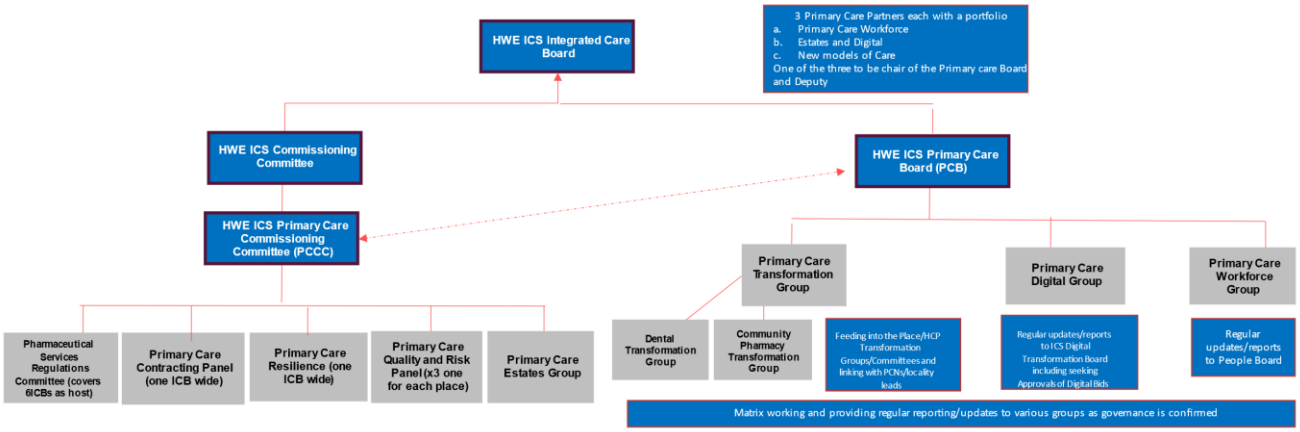
3.2 Communications and Engagement

- To be the 'go-to group' to which any transformational change goes to engage primary care across HWE ICS work streams and ensure there is alignment to each place.
- Ensuring patient/citizen engagement and lived experience is at heart of transformational change through co-design using a population health management approach based on need. This needs to be practice/primary care network/Neighbourhood/locality/place/system.
- To facilitate clear communication between the HWE ICB, Primary Care Board, Primary Care Providers and partners across system and place and all our partner on matters relating to System development.
- Ensuring clinical debate about the key priority areas including impact on primary care in terms of workload, quality which will feed into strategic decision-making.

4. Accountability and Governance Structure

4.1 The Primary Care Board will be underpinned by good governance principles and robust assurance processes, to ensure accountability to the public as patients, citizens or taxpayers.
The Primary Care Board is accountable to the Integrated Care Board. Where there are financial and contractual implications of strategic decisions undertaken by the Primary Care Board, in line with the organisation's SFIs these will be referred to the Primary Care Commissioning Committee for a decision.

Primary Care Governance



Primary Care Commissioning Committee – oversight and assurance	Primary Care Board - strategic oversight
Purpose - Provide oversight and assurance to the ICB Board on the exercise of the ICB's delegated primary care commissioning functions and any resources received for investment in primary care. Will oversee future delegation of commissioned services from NHSEI for Primary Medical, Dental, Optometry and Community Pharmacy In accordance delegation agreement, standing orders and Scheme of Reservation and Delegation (SoRD) but may delegate appropriate decisions to such groups (refer to the respective terms of reference of the subgroups of the committee)	The Primary Care Board is the key HWE ICS Primary Care forum supporting the ICB with the remit to: • propose the strategic direction for local primary care services; • identify the key priority areas needing change, • enable local clinical perspectives to inform strategic decision -making, • set the strategic context for transformation and take oversight of its implementation • Provide reports into various other system wide groups/boards/committees including People Board, Digital Transformation Board and HCP place partnership board, and transformation committees.

Primary Care Board will have specific working groups reporting progress into the primary care board in particular these will include primary care workforce, primary care digital, primary care transformation.

5. Operating Principles

5.1 Each member on the Group is there in an individual capacity bringing in the experience and acting for the benefit of the system as a whole and not for any organisation that they may also be employed by.

6. Reporting Responsibilities

6.1 The Hertfordshire and West Essex Primary Care Board is accountable to the ICS Integrated Care Board.

- The Primary Care Board will be supported by a number of work stream delivery groups, chaired by appropriate senior responsible officers (SROs) focussed on the improvement areas to deliver the required system wide benefits.
- On behalf of the ICS Integrated Care Board, the Chair is responsible for ensuring that workstream Senior Responsible Officer's are held to account for the successful implementation of agreed schemes to support financial, quality and operational improvements.
- Work streams are accountable to the Primary Care Board, which reports into the ICS Integrated Care Board.
- Workstreams will provide regular highlight reports and where necessary exception reports or in-depth reports as required by the Board.
- Board will have 2 way relationship with the Primary Care Commissioning Committee of the ICB.
- Board will receive regular updates from it subgroups and from representatives of the committee from place including locality leadership

7. Membership and Chairing Arrangements

7.1 The Primary Care Board will be representative of the HWE health and social care community to ensure diverse input and decision making.

- Primary Medical Service Partner members (3) each with a portfolio including lead in:
    i. Primary Care Workforce – Chair
    ii. Primary Care Transformation – Deputy
    iii. Primary Care Digital and Estates - Deputy
- Community Trust Partner Member
- Non-executive Director – Gurch Randhawa
- ICB Director of Primary Care Transformation
- ICB Medical Director
- ICB Director of Operations
- 3 Nominated Primary Care (GP/PCN CD) leads across HWE (one from each place)
- Independent Clinical advisor for Dental
- Chief Pharmacist and Associate Director of Allied Healthcare Professionals

7.2 In attendance

- Healthwatch Representative 1 representative for Hertfordshire and 1 for Essex
- Local Professional Committee representatives Hertfordshire and Essex (LMC, LPC, LOC, LDC)
- Patient representatives from each place (3 representatives)
- Voluntary Community and Social Enterprise (VCSE) representative
- ICS Clinical leads for Strategic Programmes/Enablers as appropriate –primary care transformation, primary care prescribing, workforce and digital
- Clinical leads of the Local Dental Networks as appropriate
- ICB Communications lead
- AD/Head of Primary Care at Place (3)
- AD for Primary Care Contracting
- PH leads Hertfordshire and Essex (1 from each as appropriate)
- Representatives from Adult Social Services leads from Hertfordshire and Essex (1 from each as appropriate)
- Other leads including Health Education England; Education sectors; digital and other managerial leads as appropriate

8. Quorum

8.1 This meeting provides strategic oversight and is not a forum for decision-making. A meeting will be considered quorate if 50 per cent of members are present, which must include either the Chair or Vice-Chair and one Executive Director.

8.2 No formal business shall be transacted where a quorum is not reached.

9. Member Roles and Responsibilities

9.1 All members are required to attend or send a deputy.

9.2 Workstream and Portfolio leads must ensure that reports and papers are submitted to enable circulation 5 days before the meeting.

9.3 All members are required to complete assigned actions and provide updates to the Board in line with the action log.

9.4 All members are required to be full and active participants, to ensure that relevant expertise is available to the Board to facilitate effective management of the workstreams.

10. Meeting Arrangements

10.1 The full membership of the Primary Care Board will meet on a bi-monthly basis, with work stream

Senior Responsible Officer's and members supporting programme delivery joining working group meetings in the intervening months.

- Meetings will be online or hybrid of online and in-person to ensure maximum attendance
- Members who cannot attend will be expected to send deputies.
- Papers will be circulated at least five working days before each meeting.
- Action logs will be circulated within 10 working days of each meeting.

11. Monitoring and Review

11.1 The Terms of Reference will be reviewed on an annual basis, or sooner if required. The next review will take place one year from the date of approval stated below.

Date of approval: Friday 01 July 2022

Updated version approval: Friday 18 November 2022

Date of review: *within six months' time*

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

[Insert Committee Name] Effectiveness Survey
April – May 2023

INTRODUCTION

The committee effectiveness survey is an annual activity to gain and evaluate feedback from the members of the [insert Committee name] regarding their thoughts relating to six key topics:

1. Committee Focus (Q1 to 4)
2. Committee Team Working (Q5 to 8)
3. Committee Effectiveness (Q9 to 12)
4. Committee Engagement (Q13 to 14)
5. Committee Leadership (Q15 to 18)
6. Enhancing the Committee (Q19)

TOPIC 1: COMMITTEE FOCUS

Q1. The Committee is clear of their purpose and understand its duties as set out in the Terms of Reference

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree
- Not Applicable

Q 2. The agenda is appropriately set in relation to the balance of the range of issues including quality, performance targets, governance and financial controls, where relevant.

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree
- Not Applicable

Q 3. The Committee and its members have adequate delegated authority as set out in the committee Terms of Reference.

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree

- Strongly Disagree
- Not Applicable

Q 4. The committee has a clear programme of work to ensure the ICB discharges NHSE statutory functions effectively, to provide assurance to NHSE and demonstrate improvement.
- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree
- Not Applicable

TOPIC 2: COMMITTEE TEAM WORKING

Q 5. The Committee has the right balance of experience, knowledge, skills and resources to deliver its role effectively.
- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree
- Not Applicable

Q 6. The Committee ensures that the right levels and balance of attendance or contributions from the ICB and is maintained to enable it to secure the required level of understanding of the papers / information it receives.
- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree
- Not Applicable

Q7. When a decision has been made or action agreed I feel confident that it will be implemented as agreed and to the agreed timescale.
- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree
- Not Applicable

Q 8. Once a decision has been made the Committee supports it irrespective of personal views and opinions.

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree
- Not Applicable

TOPIC 3: COMMITTEE EFFECTIVENESS

Q9. The quality of committee papers received, and committee administration allow me to perform my role effectively. i.e. agenda/papers delivered on time ahead of meetings.

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree
- Not Applicable

Q10. Members provide real and genuine challenge and contribute to problem solving.

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree
- Not Applicable

Q11. The Committee has established a work plan for the year which drives the business of the Committee and is linked back to the objectives of the Committee.

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree
- Not Applicable

Q12. The Committee meets sufficiently frequently to deal with planned matters and enough time is

allowed for questions and discussions.

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree
- Not Applicable

TOPIC 4: COMMITTEE ENGAGEMENT

Q13. Committee members challenge the executive team and other assurance providers to gain clear understanding of their findings.

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree
- Not Applicable

Q14. The committee is clear about its role in relationship to other committees that play a role in relation to clinical governance, quality, and risk management

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree
- Not Applicable

TOPIC 5: COMMITTEE LEADERSHIP

Q15. Committee meetings are chaired effectively and with clarity of purpose and outcome.

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree
- Not Applicable

Q16. The Chair allows debate to flow freely and does not assert their own views too strongly onto the debate.

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree
- Not Applicable

Q17. The Chair has a positive impact on the performance of the Committee
- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree
- Not Applicable

Q18. The Chair is visible within the organisation and is considered approachable
- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree
- Not Applicable

TOPIC 6: ENHANCING THE COMMITTEE

Q19. Please could you take some time to share any views or suggestions about what could be done to enhance the Committee

Comments:

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Hertfordshire and West Essex Integrated Care Board

Primary Care Board

Work Plan and Deadlines for Papers 2023/24

Deadlines for Papers *(Unless alternative arrangements have been agreed with the Chair and Exec Lead)*	**2023**				**2024**	
Date of Meeting	**Thursday 25 May**	**Thursday 27 July**	**Thursday 28 September**	**Thursday 23 November**	**Thursday 25 January**	**Thursday 28 March**
Final Papers to Corporate Governance by 5pm (9 days before the meeting)	**16 May**	**18 July**	**18 September**	**14 November**	**16 January**	**19 March**
Final Papers to Committee Members (7 days before the meeting)	**18 May**	**20 July**	**21 September**	**16 November**	**18 January**	**21 March**
Planning meetings with Chair and Executive Lead						
- **Agenda setting (6 weeks before meeting date)**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**
- **Pre-meet (1 week before meeting date)**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**
- **Post-meeting review (within 1 week following the meeting)**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**
Committee Work Plan	√	√	√	√	√	√
Committee Terms of Reference	√	√	√	√	√	√
Committee Self-assessment of Effectiveness (2023-24)	√					
Committee Summary for escalation to the Board	√	√	√	√	√	√
Session in Public						
1. Welcome & Apologies	√	√	√	√	√	√
2. Declarations of Interest inc. Register of Committee Members	√	√	√	√	√	√
3. Impact assessments for reports: Equality Impact Assessment (EQIA) / Quality Impact Assessment (QIA) / Data Protection Impact Assessment (DPIA)	√	√	√	√	√	√
4. Minutes of previous meeting & Action Log	√	√	√	√	√	√
5. Questions from the public	√	√	√	√	√	√
6. Risk Register	√	√	√	√	√	√
7. Primary Care Transformation Reports	√	√	√	√	√	√
8. ICS Digital Strategy			√	√	√	√
9. Healthwatch Herts / Essex Reports	√	√	√	√	√	√
10. GP Patient Survey results and action plans						

11. Primary Care Workforce Delivery Plan						
12. Development of Patient groups						
13. Deep Dive Sessions	**Digital**					

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:**	**23/03/23**	
Report Title:	**Primary Care – Directorate Highlight Report**				**Agenda Item:**	**07**	
Report Author(s):	Avni Shah Director Primary Care Transformation						
Report Signed off by:	Avni Shah Director Primary Care Transformation						
Purpose:	**Approval**	☐	**Decision**	☐	**Discussion**	☒	**Information** ☒
Report History:	N/A						
Executive Summary:	Highlight Report provides a brief overview on the progress since last board meeting with a view of not duplicating areas of discussion on the agenda and to give a flavour of the forward look of some of the key areas of focus.						
Recommendations:	The Board is asked to • Note and discuss the report						
Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***	☐			
	Financial	☐	***Non-Financial Personal***	☐			
	None identified			☒			
	N/A						

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	☐

Hertfordshire and West Essex Integrated Care System

NHS
Hertfordshire and West Essex
Integrated Care Board

Primary Care – Directorate Brief Update since last meeting

Avni Shah, Director of Primary Care Transformation

Working together
for a healthier future

Since last board

a. Delegation – Pharmacy, Optometry and Dental

Due diligence continues; ICB on track to take on delegation from 1 April for Dental, Optometry and Community Pharmacy Contracts. There are risks associated which is reflected in the papers for discussion/noting today. Governance updated and staff consultation complete with meet and greet staff arranged for week of the 27/3/23

Agreed at Primary Care Commissioning Committee to appoint an independent dental clinical adviser to support the prioritisation of dental areas across HWE. Working closely with Essex and Hertfordshire Local Dental Committee on recruitment of independent advisor

b. Ukraine Family Scheme

At the last meeting, we mentioned the work underway on Asylum/Migrant population into HWE. Pleased to confirm following agreement at Primary Care Commissioning Committee, it was approved to reimburse practices in line with the National Specification a one-off payment of £150 for each Ukrainian having had a Health assessment completed (local funding). Note at present we are looking over 2800 Ukrainian across HWE

c. Asylum/Migrant Population

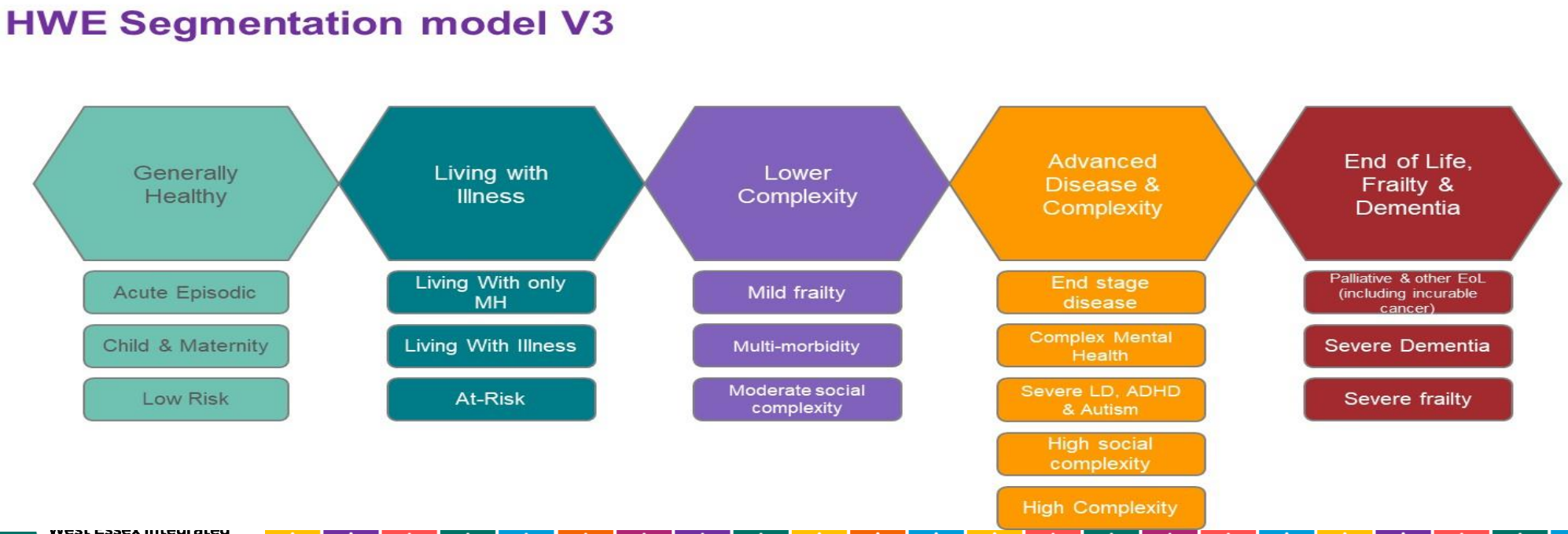
Primary Care managers are finalising the models in primary care to support future Asylum/Migrant population as they arrive into various setting and the initial wrap around for assessing health. This will be update at future board meeting

Since last board

d. Population Health Management Approach

The PCN PHM packs have been refreshed and shared with all PCN CDs and Primary Care Clinical leadership. The aim of the packs is to provide the in depth analysis of a range of indicators through practice and collectively as a PCN in line with a number of the already defined ICS priority areas including urgent care, long term conditions.

In addition the segmentation model has developed further since the last publication of the pack. The next steps are to have detailed discussion at each PCN/locality with system partners to understand the changes in the population but also to reflect and stocktake on the priority areas of work to improve population outcomes



Forward look

National review of GPIT

Following a successful Pilot, the NHSE Primary Care Team have commissioned Channel 3 (through competitive tender) to undertake a regional assessment of GP IT provision, focused on gaining an understanding of:

- Understand the approach and cost of commissioning of GPIT aligned to the requirements of the GPIT Operating Model
- Understand perceptions of quality and value of provisioned digital services
- Enable baselining of GPIT investment and provision of services, identifying if investment is adequate, appropriate and aligned to the requirements of the GPIT Operating Model

Through our quantitative and qualitative data gathering (including appraising existing data sources like the Digital Primary Care Maturity Assessment - DPCMA), the work will examine the provision, maturity, delivery and management of GPIT across commissioners, particularly around:

- Commissioning methods
- GP IT budget management and allocation
- Quality and performance of service provision and delivery partners (as viewed by commissioners and GP practices)
- Challenges faced in delivering the core requirements of the GP IT operating model, including potential need to seek other funding sources to deliver the expected service
- This work will gather insight to provide a baseline regional view of GP IT provision, which in addition to the DPCMA, can identify if investment is appropriate, and where there are opportunities to improvements/efficiencies to be made.

It is a 12 week programme – following discussion at Primary Care Digital Group a number of practices – GP leads/PCNs have been identified to support this work.

The outputs of this will support the work underway locally on review our specification with HBLICT to ensure it is in line with the development of the primary care digital roadmap

Forward look

- **Covid Vaccination Programme – SPRING PROGRAMME**

The Autumn booster programme ended on 12th February 2023 and HWE uptake was 62% of the eligible population.

The JCVI has announced the spring booster programme with the eligible cohorts being:

- Adults aged 75 years and over
- Residents in a care home for older adults
- Individuals aged 5 years and over who are immunosuppressed, as defined in the Green Book

The spring booster programme will commence with visits to care homes beginning Monday 3rd April 2023 and the Spring 2023 COVID-19 Booster Campaign planned to formally commence on Monday 17th April 2023 and end on Friday 30th June 2023. In line with JCVI advice the offer of booster vaccinations will cease outside campaigns.

Across HWE, building on the learning since the start of the COVID vaccination programme the spring booster programme will be delivered via:

- Community Pharmacies
- Primary Care Networks
- Roving and Outreach

Questions

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:**	**23/03/2023**	
Report Title:	**Estates and Primary Care Update:** **ICB Primary Care Development Pipeline including Heatmap** **ICB/ICS Infrastructure Strategy** **Net Carbon Zero**				**Agenda Item:**	**08**	
Report Author(s):	Kieran Haywood – Premises and Estates Officer Sue Fogden – Assistant Director Premises						
Report Signed off by:	Alan Pond – Chief Finance Officer						
Purpose:	**Approval**	☐	**Decision**	☐	**Discussion**	☐	**Information** ☒
Report History:	This is the first presentation.						
Executive Summary:	This paper describes HWE ICB's data base and linked, resulting Heatmap which are used as an accepted methodology of assessing investment priority on primary care development. It has been in use since 2012 during Primary Care Trust tenure and more recently presented at PCCC in February 2023 for use across the HWE ICB. It enables financial forecasting on both revenue and capital over the 194 GP Premises as existing and giving regard to future rent reviews and increased costs associated by the pipeline. The paper explains that more work on financial forecasting is needed on costs associated with increased housing and population and for that greater data is required from all 13 Local Authorities. The paper also explains the awareness and approach on the forthcoming Infrastructure Strategy which will cover meeting the Net Carbon Zero targets by 2045.						
Recommendations:	To note.						
Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***	☐			
	Financial	☐	***Non-Financial Personal***	☐			
	None identified			☒			
	In advance of the committee, any conflicts of interest will be made known and during the committee, the Chair will manage as appropriate.						

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

This paper describes HWE ICB's data base and resulting, linked Heatmap which are used as an accepted methodology of assessing investment priority on primary care development. It has been in use since 2012 during Primary Care Trust tenure and more recently presented at PCCC in February 2023 for use across HWE ICB. It enables financial forecasting on both revenue and capital over the 194 GP Premises as existing and giving regard to future rent reviews and increased costs associated by the pipeline. The paper explains that more work on financial forecasting is needed on costs associated with increased housing and population and for that greater data is required from all 13 Local Authorities.

The paper also explains the awareness and approach on the forthcoming Infrastructure Strategy which will cover meeting the Net Carbon Zero targets by 2045.

2. Background

ICB Primary Care Development Pipeline including Heatmap

The Premises Team has an extensive data set on all 194 GP Premises which originated from Primary Care Trust (PCT) in 2012, it has been further developed, it is a live document and used daily with relevant and accurate updates. It captures information that is usual on an asset data such as tenure information, measurements, revenue costs, capital funding and more.

During PCT tenure, the need to have an equitable methodology that considered existing and future infrastructure needs was identified and a small working group convened. The purpose of the working group was to create a systematic, data driven, assessment process as a tool to guide and inform infrastructure prioritisation, referred to as a Heatmap. The Heatmap transferred to NHS England in 2013 via the 2012 NHS reorganisation, then again to Hertfordshire CCGs under joint and then fully delegation commissioning arrangements in 2017 and 2018. Resulting from the establishment of Hertfordshire and West Essex Integrated Care Board (HWE ICB) on 1 July 2022, the Hertfordshire dataset and Heat Map were merged and the west Essex data collected into a similar format enabling a single data set and Heatmap for HWE ICB. It now informs Places, PCNs and Practices where they are positioned in the overall system. Data can be filtered by Local Authorities, Places, PCNS and practice level.

It covers three main categories which are allocated points to total 100 and are weighted:

1. Existing Premises Data
2. Development Data (subject to Local Planning Trajectory and changes)
3. Patient Survey Data

The database and the Heatmap are linked, the output of all is that practice premises which are of older design, converted from residential or not purpose built, with significant housing growth forecasted sooner rather than in later years and higher scores on patient survey will rank higher than

premises priorities which are of better design, newer, with less immediate housing forecasts and poorer patient survey results. There is a comprehensive set of data that sits behind this Heat Map that contains tenure information, size and age of premises and more. The data base is updated as and when terms change on premises e.g., an increase of GMS area or increase of clinical rooms. The housing trajectories are updated twice throughout the calendar year.

The results are ranked and can be sorted by practice across HWE ICB, highest – lowest, or, lowest – highest. And further sorting as practices within their respective Places and PCNs. The PCN ranking has been calculated based on the average practice ranking in any PCN and we are able to see the PCN order across HWE ICB. Below is an explanation of what has been considered, with relative scores and weighting.

Existing Premises Data

- 1-5 points are allocated against premises capacity in terms of patients per m2 of net internal area (discounting dispensing and training areas): < 20 patients/sqm = 1 point, 20-23 patients/sqm = 2 points, 24-27 patients/sqm = 3 points, 28-31 patients/sqm =4 points and >31 patients/sqm = 5 points. Highest points yield highest priority, and the results are weighted and multiplied by **15.**

- 1-5 points are allocated against premises capacity in terms of patients per consulting room: up to 500 patients per consulting room = 1 point, 501-750 patients per consulting room = 2 points, 751-1,000 patients per consulting room = 3 points, 1,001-2,000 patients per consulting room =4 points and over 2,000 patients per consulting room = 5 points. Highest points yield highest priority, and the results are weighted then multiplied by **15.**

- 2- 5 points are allocated against the style and age of the premises. On style purpose-built scores 1 point and converted scores 2 points. On age, pre 2000 scores 3 points, 2000 – 2010 2 points and post 2010 1 point.

- The sum of these is then weighted and multiplied by **15**. Highest points yield highest priority.

- 1-5 points are allocated to surgery inspections. Ideal = 1-point, Acceptable 2=2 points, Acceptable 3=3 points, Acceptable 4=4 points and below standard = 5 points. Where the premises have not been inspected and to avoid any disadvantage an assumption of 2 points for purpose built and 3 points for converted have been applied. The results are weighted and multiplied by **10.** Highest points yield highest priority.

Total weighting = 55

Development Data (subject to Local Planning Trajectory and changes)

Across HWE ICB there are 13 Local Authorities and 2 County Councils, each are mandated to achieve significant increased housing. It is acknowledged that growth is and must be a major consideration and therefore has an allocated weighting of **35** which is consistent with the premises capacity. Whilst we have obtained Housing Trajectory indicators from each Local Authority, we will be reliant upon the local knowledge of the localities to understand the patient migration of such development. Within the prioritisation higher weighting is given to the more immediate housing delivery. Within the weighting of 35, 15 is applied to housing intended to be delivered between 2021 -2026, 10 to housing between 2026-2031, 6 to housing between 2031-2036 and 4 to housing post 2036. Which aligns with our 5-year commissioning plans. Highest points yield highest priority.

Total weighting = 35

NB This is dependent of data availability and forecasting from each of the 13 Local Authorities and is subject to changes as their respective Local Plans develop. It should also be noted that some of the larger developments will fall into two or more localities and sometimes more than one Local Authority. Many of the new settlements and/or garden communities do not fall into existing practice catchment areas and whilst these could be amended the likelihood is that the development would warrant new or significantly extended premises.

Patient Survey Data

- 1-5 points are allocated against surgery performance based on national data. Responses to questions have been considered and average calculated for each practice. Those with the satisfaction rate below 75% score 1 point, 75%-79% = 2 points, 80%-85% = 3 points, 86%--90% = 4 points and over 90% = 5 points. Results are weighted and multiplied by **10.** The purpose is to acknowledge good performing practices. Highest points yield highest priority.

Total weighting = 10
IN TOTAL 100

Over the past 10 years, this comprehensive data set and linked resultant Heat Map has been accepted as a fair and equitable method of establishing investment priorities and is always used by the relevant commissioner as a reference when considering investment plans within General Practice. An extract from the ICB Heatmap below shows the top 19 practices.

Place	Surgery Name	GP code	PCN	Locality	NIA m2	Actual Patient list size - 1/1/2023	Patients/m2 1/1/2023	Revised NIA m2 after Dispensing & Training deductions	Patients/m2 adjusted to Dispensing & Training 1/1/2023	Points 1-5 acheived	Patients per consulting room 1/1/23	Points 1-5 achieved	Style of premises	Date Built/Converted	Surgery Inspection Reports	Total dwellings	Overall satisfaction %	Points 1-5 acheived	Weighting/ weighted points achieved	Total weighting	Overall score	Overall Score Multiplied	Ranking in ICB	Rank of PCN
							Under 20-green 20-24 amber 25+, red 20 and below = 5		20 and less = 1 point 21-25 =2 points 25-28 =3 points 30 = 4 points	Highest gives highest priority		Under 500=1 500-750=2 751-1000 = 3 1001-2000 =4 over 2000 = 5	Purpose built=1 Converted=2	Pre 2000 – 3 points 2000 – 2010 – 2 points	Ideal = 1 Acceptable 2 = 2 Acceptable 3 = 3 Acceptable 4 = 4 Below Standard = 5			Over 90%=5 86%-90%=4 80%-85%=3 75%-79%=2 Under 75%=1	10	100	Highest gives highest priority	Highest gives highest priority	Smallest gets highest priority	Smallest gets highest priority
SWH	Gade House Surgery	E82068-1	RCS	Watford	318.51	10,327	32.4	318.51	32.4	5	1,147	4	Purpose built	1984	Acceptable 3	1,200	81	3	30		414		1	4
WE	Angel Lane Surgery	F81090-0	South Uttlesford	Uttlesford	408.4	10,961	26.8	368.40	29.8	4	1,096	4	Purpose built	1986	Acceptable 3	1,245	100	5	50		412		2	23
SWH	Manor Street Surgery	E82094-0	Alpha	Dacorum	485.85	12,030	24.8	465.85	25.8	3	1,094	4	Converted	1980	Acceptable 3	940	90	4	40		409		3	13
SWH	Red House Surgery	E82085-1	Herts Five	Hertsmere	361.72	12,027	33.2	341.72	35.2	5	1,002	4	Converted House	1993	Acceptable 2	838	79	2	20		409		3	7
WE	Addison House	F81181-1	Harlow North	Harlow	638.6	17,093	26.8	638.60	26.8	3	1,005	4	Purpose built	Not Available	Acceptable 4	1,238	112	5	50		400		5	9
WE	Maynard Court Surgery	F81725-1	Epping Forest North	Epping Forest	90.13	5,381	59.7	90.13	59.7	5	2,691	5	Converted	1990s	Acceptable 4	550	117	5	50		395		6	12
WE	Elsenham Surgery	F81111-0	South Uttlesford	Uttlesford	298.04	6,995	23.5	258.04	27.1	4	999	3	Purpose built	1989	Acceptable 3	900	102	5	50		395		6	23
ENH	Burvill House Surgery	E82023-0	Hatfield	WelHat	369.43	12,056	32.6	349.43	34.5	5	1,206	4	Purpose built	1970	Acceptable 2	1,149	76	2	20		394		8	3
SWH	Fairbrook Medical Centre	E82012-0	Herts Five	Hertsmere	464.5	14,676	31.6	464.50	31.6	5	1,334	4	Purpose built	1989	Acceptable 3	750	69	1	10		394		8	7
SWH	Elms Surgery (Watford)	E82069-0	Central Watford	Watford	235.07	7,851	33.4	235.07	33.4	5	981	3	Converted	2018	Acceptable 2	2,100	82	3	30		390		10	2
ENH	Potterells Medical Centre	E82058-1	Hatfield	WelHat	346.65	9,694	28.0	326.65	29.7	4	969	3	Converted	1980	Acceptable 3	670	80	3	30		384		11	3
SWH	Garston Medical Centre	E82017-0	Grand Union	Watford	276.68	11,823	42.7	256.68	46.1	5	1,971	4	Purpose built	1988	Ideal	800	70	1	10		382		12	17
WE	Old Harlow Health Centre	F81056-1	Harlow North	Harlow	582.38	10,472	18.0	562.38	18.6	1	952	3	Purpose built	1974	Acceptable 4	1,388	96	5	50		377		13	9
SWH	Schopwick Surgery	E82043-1	Herts Five	Hertsmere	367.75	8,705	23.7	347.75	25.0	3	1,088	4	Purpose built	1984	Acceptable 3	750	79	2	20		374		14	7
SWH	Parkbury House Surgery	E82060-1	Alban Health	St Albans	675.35	19,937	29.5	655.35	30.4	4	1,108	4	Converted	2007	Acceptable 2	660	86	4	40		372		15	1
SWH	Tudor Surgery	E82124-4	Attenborough	Watford	263.38	6,916	26.3	263.38	26.3	3	988	3	Converted	2002	Acceptable 3	1,500	82	3	30		370		16	8
SWH	Midway Surgery	E82055-0	Alban Health	St Albans	524.38	13,573	25.9	504.38	26.9	3	1,044	4	Purpose built	1984	Acceptable 3	1,000	82	3	30		370		16	1
WE	High Street Surgery (Epping)	F81072-0	Epping Forest North	Epping Forest	321.8	7,541	23.4	321.80	23.4	3	1,508	4	Purpose built	1980s	Acceptable 4	700	98	5	50		370		16	12
SWH	Elms Medical Practice	E82071-0	Harpenden	St Albans	464	16,616	35.8	444.00	37.4	5	1,187	4	Purpose built	1996	Acceptable 2	363	83	3	30		360		19	15
WE	Chigwell Medical Centre	F81062-0	Loughton, Buckhurst Hill &	Epping Forest	218.2	8,873	40.7	218.20	40.7	5	1,268	4	Converted	2013	Acceptable 4	270	97	5	50		360		19	22
WE	John Tasker House Surgery	F81118-1	South Uttlesford	Uttlesford	560.55	11,722	20.9	520.55	22.5	2	781	3	Purpose built	Not Available	Acceptable 3	1,300	103	5	50		360		19	23

The table below shows the top 10 PCNs ranking of the combined GP Practices.

PCN	Total points for PCN	No of premis	Points per building	Ranking
Alban Health	1,374	4	343.50	1
Central Watford	1,025	3	341.67	2
Hatfield	2,029	6	338.17	3
RCS	1,347	4	336.75	4
North Watford	980	3	326.67	5
MVPS	1,584	5	316.80	6
Herts Five	2,528	8	316.00	7
Attenborough	1,259	4	314.75	8
Harlow North	1,804	6	300.67	9
Welwyn Garden City	2,095	7	299.29	10

3. Resource implications

The current annual rent reimbursements on GP Premises are approximately £17 million, this excludes Business Rates which is approx. £6 million, therefore at present we are spending £23 million on rent & rates which is funded from our Delegated Commissioning Budget within Primary Care. We anticipate this to increase by 2036 to £22 million rent & £7 million approx. on business rates a combined total of £29 million. This is based on an assumption that all Practice rent reviews will be carried out. Note that all owner occupier rents known as notional rents are carried out every three years instigated by the ICB and GP Owners. The forecast also assumes that on leasehold premises, landlords will exercise their right to review the rent in accordance with the cycle set out in the lease which are usually on three- or five-year cycles, noting that landlords will only exercise their right if they are certain of an increase. The forecast also includes forecasted revenue and capital on pipeline projects which range from PID, OBC, FBC approval. Note that capital on Primary Care projects is usually sourced from General Practitioners borrowing where they choose to develop and own their premises, or the privately

funded route when General Practitioners choose to lease their premises. NHS capital is infrequent and insufficient to meet the demand, the most recent NHS capital programme, called Estates Technology Transformation Fund will end on 31 March 2023; HWE ICB delivered many projects via that funs.

Some projects are on site, some are about to start on site and some are in the development process and managing land acquisitions, planning approval, legals, tendering etc. There are 26 projects in the pipeline and the costs in the forecast have given consideration to:

- The year they might complete.
- Current Market Rent for that year assuming an increase in CMR year on year.
- One-off Capital & Revenue Costs.

One-off Capital Costs & Revenue Costs, these have been arrived at by:

- Using three indicative construction costs (1) new build £5,500/m2 (2) heavy – moderate refurbishment £2,500/m2 and (3) light refurb £1,500/m2
- The Capital Costs are then costed depending on build type x m2 required (calculated from Patient Numbers).
- The One-off Revenue Costs apply consideration to; Stamp Duty, Monitoring Surveyor Fees, Legal Fees and GPIT.

Financial Year	Revenue Costs	% Increase on Previous Year	One off Capital Costs	One off Revenue Costs
FY22-23	£17,091,039.05		£0.00	£0.00
FY23-24	£17,488,465.48	2.27%	£4,757,275.00	£170,000.00
FY24-25	£18,372,221.23	4.81%	£6,711,595.00	£215,000.00
FY25-26	£18,968,314.88	3.14%	£18,676,945.00	£665,000.00
FY26-27	£19,425,366.70	2.35%	£17,321,755.00	£500,000.00
FY27-28	£19,693,666.54	1.36%	£2,788,500.00	£80,000.00
FY28-29	£19,899,053.21	1.03%	£0.00	£0.00
FY29-30	£20,182,742.20	1.41%	£0.00	£0.00
FY30-31	£20,499,770.42	1.55%	£0.00	£0.00
FY31-32	£20,704,140.47	0.99%	£0.00	£0.00
FY32-33	£21,007,352.34	1.44%	£0.00	£0.00
FY33-34	£21,338,813.17	1.55%	£0.00	£0.00
FY34-35	£21,553,302.84	1.00%	£0.00	£0.00
FY35-36	£21,870,572.98	1.45%	£0.00	£0.00
Total	**£278,094,821.52**		**£50,256,070.00**	**£1,630,000.00**

The Heatmap captures future housing growth to 2033 or 2036 as advised/confirmed by each of the 13 Local Authorities (LA) in HWE ICB. Note that all 13 LAs are in different positions regarding their Local Plans, some have adopted, some have been recalled with many being worked on with adoption forecasted for c. 2024. Some LAs have said that the current National Planning Policy Framework (NPPF) under consultation is the reason some work is delayed or on hold. Many LAs are giving greater consideration to housing targets and trajectories and very few LAs can provide delivery dates, the majority of LAs are also not able to confirm residential units delivered against trajectories. This is problematic for the ICB to allocate future costs into the pipeline against the specific projects, we recognise this and are giving consideration on how this can be managed, calculated into the pipeline.

The projects range from new purpose-build premises to minor adaptations and anything in-between. The current market conditions with higher interest rates, increased risk on borrowing, the supply and demand on labour and materials, increased construction costs, increased land values, expectation on higher yields and more are creating viability issues. The larger schemes are on hold waiting out to see what happens in future markets; this is broader than healthcare and many house builders have declared a hold for c.6 months. The response from funders and developers that specialise in primary care development is that the NHS should increase market rents, and/or pay a supplementary rent also known as a top-up-rents to ease the viability. There are issues in doing this as all newly negotiated and agreed market rents will form the new base line on existing and future premises and will place further financial pressures on an already financially resourced NHS. NHSE National have said that ICBs are not authorised to agree top-up-rents as these can only be determined by the National Team under open book discussions and negotiations.

Despite market conditions, we recognise that demand in Primary Care is increasing and that most of our PCNs are experiencing difficulty in accommodating the ARRS roles and there is much work on-going looking at easing some of those pressures. For example, where the ICB is meeting void costs on NHS PS assets, PCNs have been offered that space and to date 10 Practices/PCNs have taken up the offer of additional space under reimbursement criteria:

- South Oxhey – MVPS PCN
- Burkhurst Way Clinic – Loughton, Buckhurst & Chigwell PCN
- Dunmow Community Clinic – South Uttlesford PCN
- Rectory Lane – Loughton, Buckhurst & Chigwell PCN
- Garston Clinic – Grand Union PCN & MVPS PCN
- Barbara Castle – Harlow North PCN
- Nuffield House Health Centre – Harlow North PCN
- Herts & Essex Hospital – Stort Valley & Villages PCN
- Ongar War Memorial Hospital – Ongar Health Centre
- Church Langley – Harlow North PCN

Another project has looked at spaces where Lloyd George Patient records are stored. Where there is scope to repurpose space, the records have been either digitised or moved into storage and the vacated space has been converted to clinical or administrative space, either with no physical work and costs or via a small works programme funded under Grant Agreements between the ICB and the Practice. The funding source of these projects is via

an underspend from the former ENHCG, National Digitisation Programme and Winter Access Fund. So far, an additional 53 workstations have been created and there are more in progress.

Both pieces of work i.e., the void NHS PS areas and the Lloyd George Records have not required additional finance but an adjustment within existing budgets and allocations for better use of the existing estate; making better use of what we have.

HWE ICB/ICS INFRASTRUCTURE STRATEGY

Over recent weeks, NHSE National Estates Team met HWE ICB Finance and Estate colleagues and advised on a non-mandatory programme, where ICBs and ICSs are encouraged to produce Infrastructure Strategies by December 2023. NHSE explained that comprehensive engagement is required from all system partners because increasingly, such strategies will inform and influence central resource allocations, particularly capital planning and bidding. NHSE also believes that the strategy development process will aid system thinking and alignment across the infrastructure components (clinical, estates and facilities, net carbon zero, digital and workforce). NHSE attended the System Capital and Estates Group on 16 February 2023 and explained the process.

HWE ICB's CFO is the SRO leading the process but with the appropriate support from NHSE nationally and regionally. In addition, NHSE have offered support by members of the national team who will initially focus on data, and analytics driven from the nationally collected data (e.g., ERIC). NHSE have sent through first outputs on our system's data packs and the suggested template for the eventual document. NHSE will be keeping track of where HWE is in its process. These will be important as the following develop, NHSE recognise:

- Learnings are starting to emerge from the 11 Pilot ICSs, that knowledge will be shared.
- Each ICS has completed different work to date, is at a different 'starting' point etc. Again, another learning/sharing opportunity.
- Different challenges/opportunities/priorities exist in different ICSs – how are others nationally looking at themes
- ICSs have different resources available for this work

In terms of resource, NHS PS have recently completed an Infrastructure Strategy for Cambridge and Peterborough ICB (C & P), this work completed in advance of the national programme but haven spoken with colleagues at C & P and NHS PS the scope is similar. All strategies look at what we have, what we need and how we are going to get there. We are in discussions with NHS PS on support, aware that there is also a national ask on them. Our plan is to start this programme of work in April 2023.

HWE ICS's approach to its Infrastructure Strategy is that unlike previous versions, it will not state the obvious or e.g., contain generic text explaining the statutory role of the ICB and its partners, list sources of funding, accounting and treatment of funding and each provider having its siloed mini strategy within. Rather, it will be a blend of all, aimed at improved efficiencies, better integration of system services and outcomes, incorporate increased use of digitisation as appropriate to do and a cater for a blended workforce. Aiming to remove organisational boundaries whilst having regard for organisational sovereignty and very dependent on an acceptance of cultural changes which the ICB/ICS makes provision for. HWE ICB has already started looking at HQ and admin spaces but there is much, much more to be done. It will look at options based on varying assumptions of capital ranging maximum – minimum and be realistic on what is deliverable and when.

The timing of this couldn't be more appropriate as all are warned of difficult times ahead, leaner times and an ask on greater savings and efficiencies whist the demand on care and population increase is on a steep upward trajectory. By starting in April 2023, the national PCN Toolkit programme on clinical and estate strategies will have completed and the outputs of the 35 PCNs will be incorporated, and we will, hopefully have greater clarity on the new hospital programmes which are under further scrutiny.

This work will be delivered by HWE ICB/ICS Estate and Capital Group where the membership consists of:

- HWE ICB CFO (Chair)
- HWE ICB Assistant Director of Estates and Premises (Deputy Chair)
- HWE ICB Associate Director of Finance
- HWE ICB Digital lead
- West Herts Hospital NHS Trust
- East & North Herts Hospital NHS Trust
- Princess Alexandra Hospital NHS Trust
- Hertfordshire Partnership University NHS Foundation Trust
- Hertfordshire Community NHS Trust
- Essex Partnership University Foundation Trust
- Central London Community NHS Trust
- Hertfordshire County Council
- Essex County Council
- One Public Estate
- NHSE\I Strategic Estates Lead
- NHS Property Services

NET CARBON ZERO

NHSE and NHS PS have published documents on this subject since c2020 reminding systems of a collective obligation to deliver a net zero health service by 2045 after the NHS became the world's first health service to commit to becoming net zero in response to the profound threat to health presented by climate change. More recently the NHS Net Zero Building Standard, published on 22 February 2023, provides technical guidance to support the development of sustainable, resilient, and energy efficient buildings that meet the needs of patients now and in the future. Developed together with healthcare, industry, and sustainability partners, the Standard will support the NHS to get ready for and align with UK Government building requirements, as well as meet its commitments to deliver a net zero health service by 2045.

As mentioned above under the Infrastructure Strategy, Net Carbon Zero will be covered in the forthcoming edition and worked up within the ICB/ICS Estates and Capital Group; a sustainable plan for the HWE ICB is within the Terms of Reference for that Group.

We know that the NHS estate accounts for 15% of the NHS's total carbon footprint, and to meet the 2045 target; we'll need to invest in greener sources of energy such as heat pumps and energy efficiency measures in all our healthcare buildings. Aside from reducing emissions, smarter healthcare facilities mean more comfortable and provide better quality environments for care. These actions will help to mitigate the health harms of climate change; air pollution along contributes to 1 in 20 deaths in the UK and increases in cases of cancer, heart disease and asthma. One of the initiatives that is available to our primary care practices and other small healthcare facilities is the Boiler Upgrade Scheme (BUS); a government run funding programme that will support our shift to greener sources of energy.

Cheshire Clinical Commissioning Group (as was) produced a 10-point plan in February 2022 to help General Practices reduce their environmental impact in line with NHS net zero ambitions which they have shared with us. We will use their ideas as our starting position and develop this further with the HWE ICBs Net Zero Programme Lead. Each Trust Provider has already started to give consideration to net zero in their estates planning and procurement. HWE ICB supports Agile working and this is already seeing a reduction in transport and travel for all staff.

1. Declare a Practice Climate and Nature Crisis

2. Optimise inhalers

3. Calculate the Practice's carbon footprint

4. Consider switching to a 100% renewable electricity provider

5. Consider switching your business banking provider to a green bank

6. Environmental prescribing and treatment

7. Engage, educate, and empower patients to take individual action on the climate crisis for the benefit of their health

8. Promote active transport for both staff and patients

9. Embed the '3 Rs' into Practice culture – Reduce, Reuse, Recycle

10. Use the Green Impact for Health Toolkit

4. Recommendations

To note the workstreams now and the future.

5. Next Steps

1. Maintain the accuracy and currency of the data base and Heatmap
2. Further develop the primary care pipeline financial forecast
3. Deliver the HWE ICB/ICS Infrastructure Strategy by December 2023
4. Focus and plan to deliver on the NHS Net Carbon Zero agenda

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 held in Public			**Meeting Date:**	**23/03/2023**		
Report Title:	**Update on the Development of PCN Clinical Strategies – National Programme**			**Agenda Item:**	**8.1**		
Report Author(s):	Dr Anushree Jagadambe, Consultant, Health Integration Partnership; Dr Ashish Dwivedi, Director, Health Integration Partnership						
Report Signed off by:	Avni Shah, Director of Primary Care Transformation						
Purpose:	**Approval**	☐	**Decision**	☐	**Discussion**	√	**Information** ☐
Report History:	Regular updates to ICB Primary Care Estates and Primary Care Transformation leads on progress.						
Executive Summary:	NHSEI launched a national programme which provide a framework with practical tools for use to support PCNs and the ICS to identify their local population needs and priorities together with supporting them to develop a workforce plan which will deliver their model in the PCN with a key output on primary care estate change and investment requirements as deemed appropriate. Critical is the optimisation of existing GP and wider estate opportunities. The information from this will support wider discussions with partnerships in neighbourhood/locality wrap around but also future pipeline of estate workplans. The information from this will support NHSE National Primary Care Estates to understand the level of challenges and financial investments needed in the primary and community. Community health Partnerships (CHP) was appointed to lead on the national estates programme who locally in East of England Partnered with Health Integration Partnerships (HIP) to deliver this programme. The programme starts with a focus on PCN engagement and consideration of priorities in line with a population health led approach to care design and aligns with the Primary Care Data Gathering (PCDG) datasets, ICS work books, SHAPE PCDG Atlas analysis and reporting tools, minimising duplication of effort in establishing the initial baseline. HIP have nearly completed developing the clinical strategies at PCN across HWE and are presenting to the Primary Care Board the							

<table>
<tr><td></td><td colspan="4">progress made to date and the themes and learning coming out from this work.

Next steps are to discuss the themes in line with the ICS strategic framework, evolving clinical priorities across the ICS and areas of support required in the PCNs through primary care or others. It also requires for the clinical strategies with the PHM data packs to support the discussion and development of integrated neighbourhood teams to support complex, long term condition/frail patients in the community working in partnership with range of providers as well as how we transform same day access with partners whilst also embedding a number of the operational tools in the practices/PCNs to show benefit such as embedding/integration of digital tools such as Accurx/E Consult, advance telephony etc.</td></tr>
<tr><td>Recommendations:</td><td colspan="4">▪ For discussion only</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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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	☒

Hertfordshire and West Essex Integrated Care System

chp

Clinical model of care development

Primary Care Networks

March 2023

Hertfordshire and West Essex ICS

Health Integration Partners

HEALTH INTEGRATION PARTNERS

www.healthintegrationpartners.co.uk

Hertfordshire and West Essex Integrated Care System

Agenda

- Introduction, who we are
- Local & National Context
- Engagement, Vision statements & Key priorities:
  - West Essex
  - South and West Herts
  - East & North Herts

Hertfordshire and West Essex Integrated Care System

Introduction

Introduction

Background

Hertfordshire and West Essex Integrated Care System

- NHS-E/ I and CHP commissioned HIP to assist PCNs in writing their Clinical Strategies as part of the completion of the wider National Toolkit.
- This toolkit is intended to enable PCNs to identify estates requirements in order to be able to deliver care to address their local population's health needs and priorities; support the development of the workforce; and plan for future service needs.
- The Clinical Strategies form part of a wider programme of work that aims to provide a national framework that will support PCNs and ICS to identify their primary care estate change and investment requirements.
- HIP have been brought in by Community Health Partnerships to undertake PCN engagement to write PCN Clinical Strategies.
- The work begins with a focus on key ICS and PCN stakeholder engagement and consideration of clinical priorities in line with a population health led approach to care model design.
- Each Clinical Strategy will form the basis of the subsequent Estates Strategy by informing on the PCN vision and clinical priorities, underpinned by population health data.
- Aligns with the Primary Care Data Gathering (PCDG) datasets and SHAPE PCDG Atlas analysis and reporting tools, minimising duplication of effort in establishing the initial baseline.

Delivery Approach and Outcomes

Hertfordshire and West Essex Integrated Care System

Mobilisation Meeting
ICS/CHP/HIP

- Population Health data | Stakeholder map
- Clinical priorities at ICS, Place and PCN level
- 1-1 meetings with stakeholders

Launch Sessions
All PCNs

- 1 x Launch Sessions - ALL PCNs
- Detailed outline of the programme, expected outcomes and the support available |
- National Toolkit introduction
- Delivery Approach incl. phases and timelines

2 - 3 sessions as reqd.

One to one sessions
All PCNs

- Hands on support for PCNs
- 1-1 meetings with PCNs for clinical vision development
- Current service mapping exercise

One to one sessions
All PCNs

- National and local priorities
- Local vision development
- Workforce implications of vision delivery

One to one sessions
All PCNs

- Local priorities discussion
- Requirements to deliver local priorities
- Enablers discussions

Workshop 1 (if req)
All PCNs

- PCNs work to date showcase
- Shared learning, ideas and thinking
- National and international best practice examples

One to one sessions
All PCNs

- Final draft strategy write up discussion
- Final amendments, if required

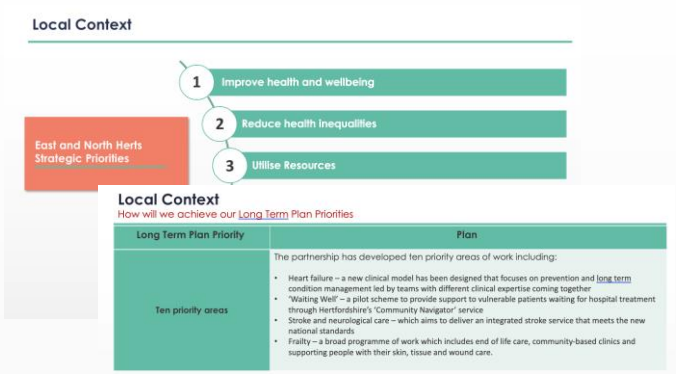
Above delivery cycle repeated for each phase

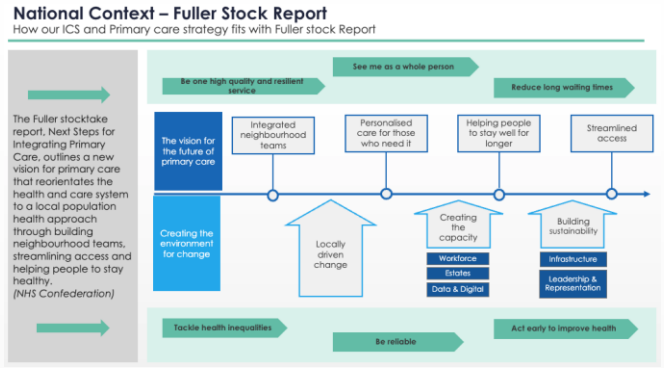
Hertfordshire and West Essex Integrated Care System

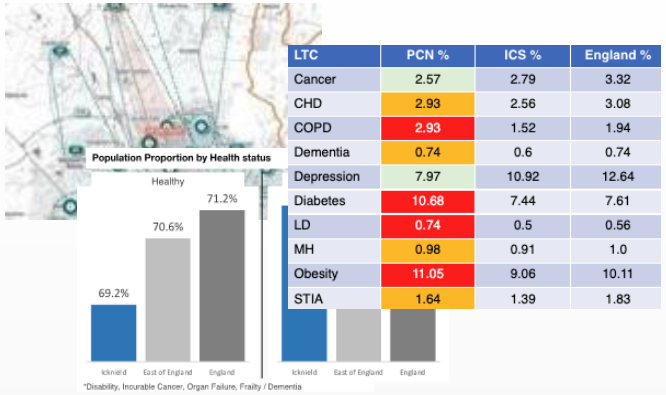
Local and National Context

Local & National Context

Hertfordshire and West Essex Integrated Care System







LTC	PCN %	ICS %	England %
Cancer	2.57	2.79	3.32
CHD	2.93	2.56	3.08
COPD	2.93	1.52	1.94
Dementia	0.74	0.6	0.74
Depression	7.97	10.92	12.64
Diabetes	10.68	7.44	7.61
LD	0.74	0.5	0.56
MH	0.98	0.91	1.0
Obesity	11.05	9.06	10.11
STIA	1.64	1.39	1.83

Local context is derived from the ICS strategy documents

This is aligned with the National context – Fuller Stocktake report

- PCN profile
- Health population data
- 1:1 with PCN's to discuss priorities

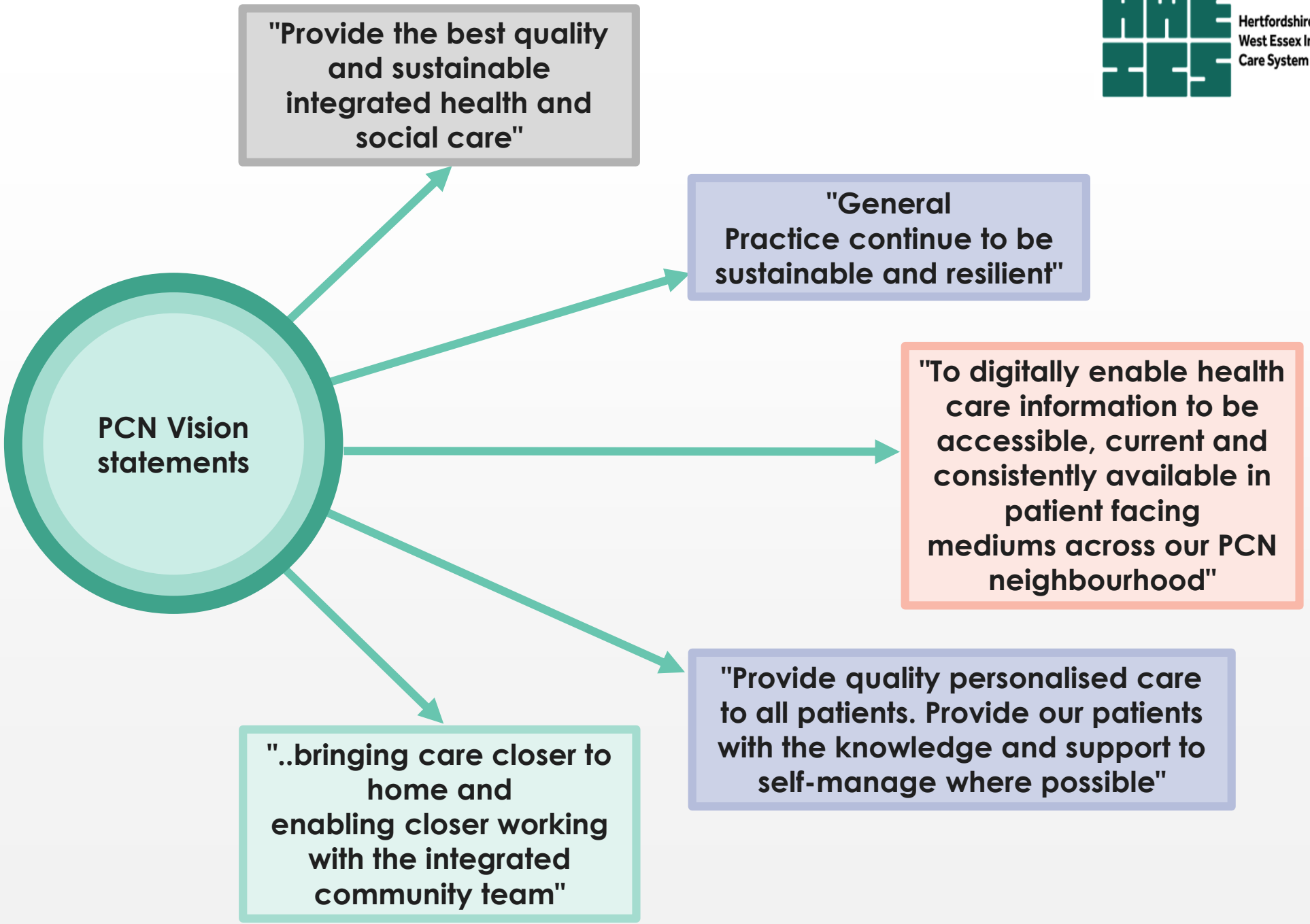
National Toolkit

Hertfordshire and West Essex Integrated Care System

West Essex

West Essex

Hertfordshire and West Essex Integrated Care System



West Essex

Key emerging themes at a glance

Hertfordshire and West Essex Integrated Care System

- Improving access
- Reducing health inequalities
- Prevention
- Proactive anticipatory care - frailty
- Creating a thriving and resilient workforce
- Improving mental health across HWE

West Essex

Key emerging themes at a glance

Hertfordshire and West Essex Integrated Care System

Proactive anticipatory care- Frailty

- Working with voluntary sector and local authorities to bolster/reignite support for our ageing well in a rural community, i.e. befriending services, dementia cafés, mobility awareness.
- Multidisciplinary teams embedded within our primary care network, with access to skills across GP, nursing, social care, mental health, pharmacy, physiotherapy, occupational therapists, and care coordination.
- Build Integrated Neighbourhood Teams approach around the severe frailty patients working with system partners to deliver an MDT approach.
- Explore the support available to patients from local community and voluntary services to maximise the impact of the enhanced housebound care model.

Improving access

- Extend workforce i.e., paramedic, upskill pharmacist for minor illness, GP cover/supervision, ANP, support team (admin/call handling/management).
- Review and monitor demand data for this same day activity across the PCN.
- Review best practice and explore new triage models to support increasing demand, thinking through local implication of any such models.
- Consider a PCN wide triage model for same day access, subject to local discussions.

Prevention

- Investigate cancer screening rates variation amongst PCN practices and increase the number of reviews for diagnosed patients.
- Work with local faith leaders to increase cancer screening uptake in specific communities.
- Work with local partners to educate parents with young children about the benefits of immunisations to reach our aspiration of 90% immunisations for all children.
- Work with system partners to create a hyper local targeted social media campaign for unique communities to promote key individualised messages.

Physical Implications

- Community spaces & increase mobile community space to deliver at bigger scale (use of effective resources).
- Appropriate space to hold MDT sessions.
- Fit for purpose estates in line with current capacity requirements, including expected increase in ARRS roles recruitment and flexibility to accommodate multi-agency staff at practice level.
- Use of existing spaces in communities such as community centres, shopping centres and any other appropriate spaces.
- Appropriate spaces in local temples and mosques.

Key Enablers

- Use of real time-shared care records based on EMIS and SystmOne.
- Partnership working with community and voluntary services.
- System support in building integrated neighbourhood approach.
- ICB funding and provisions of digital (IT, telephony, clinical systems) infrastructure, hardware, software and training.
- Unrestricting ARRS to allow recruitment of other roles, i.e., Management, ANPs, Reception, administration
- Partnership working within PCN practices.
- Data analysis support to understand demand across practices.
- Partnership working with system partners including local communities.
- System support in developing a local social media campaign.

West Essex

Key emerging themes at a glance

Hertfordshire and West Essex Integrated Care System

Creating a thriving and resilient workforce

- Monthly PCN organisational development (OD) sessions to embed staff sense of belonging, security and team working, centrally and in the neighbourhood.
- Sharing of knowledge and skills within the MDT to promote better working relationships.
- Continue with the recruitment of a PCN management team to support and lead growth and transformation.
- Meet the training needs of current and future roles as our team continues to expand.
- Increase the training capacity of workforce to support additional GP trainers and trainees & explore nursing and pre-reg pharmacist training.

Improving mental health management

- Working with system partners to fully scope the resources required to meet actual demand of the loca l population, i.e. clearly identify the pockets of low-level mental health to reduce likely of crisis and secondary care referral.
- Explore alignment of existing pathways between primary and secondary care for mental health and well-being coaches at PCN level and as part of developing integrated neighbourhood teams.
- Work with system partners to review existing and explore alternate MH pathways to increase access and reduce cascading burden between primary & secondary care services.

Reducing health inequalities

- Working with multi- agency (i.e. MIND, foodbanks) to support messaging content and signpost.
- Develop the 'personalised care team' – incl. health and well being coaches, social prescribers working together on lifestyle cohorts, i.e. +55 yrs. with no BP reading.
- Create consistent digital messages to screening on all digital signs in all practice and PCN sites – signposting to services and hints tips to great lifestyle – like the pod case 'change one thing', practical healthy cooking tips, eat healthy, change sugar for fruit, mobility chair exercise.

Physical Implications

- Training space within the practices to support growing number ARRS roles & expanded GP & Undergraduate Training.
- Fit for purpose estates in line with current capacity requirements, including expected increase in ARRS roles recruitment and flexibility to accommodate multi-agency staff at practice level.
- Physical points of access to information and support by local communities to share health promotion activities/services.

Key Enablers

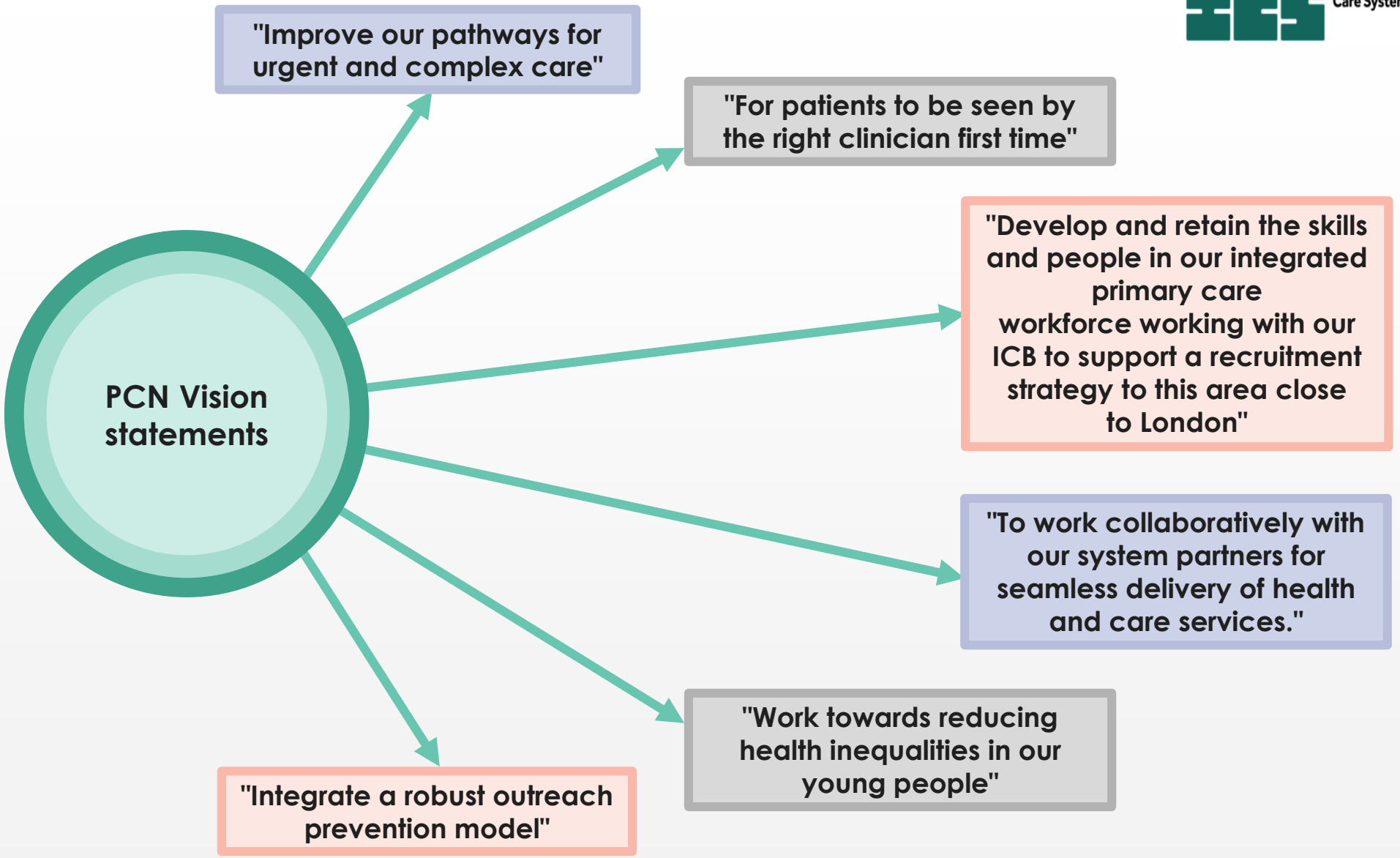
- System wide mental health demand and capacity analysis led by ICB.
- Work with University hospital to re-enable outreach clinics – partnership with ICB/acute.
- Explore community assets to accommodate events.
- Unrestricting ARRS roles funding definitions.
- Work with ICB Estates and digital lead to find innovative ways to help bolster space at practice level – deliver services closer to patients.
- Work in partnership with public health to target public health campaigns with services and group sessions, including signposting ailments to correct primary care services.

Hertfordshire and West Essex Integrated Care System

South and West Herts

South and West Herts

Hertfordshire and West Essex Integrated Care System



South and West Herts

Key emerging themes at a glance

Hertfordshire and West Essex Integrated Care System

- Improving same day access
- Reducing health inequalities
- Managing Long term conditions (LTC)
- Prevention and proactive anticipatory care
- Creating a thriving and resilient workforce
- Improving mental health across HWE

South and West Herts

Key emerging themes at a glance

Hertfordshire and West Essex Integrated Care System

Improving same day access

- A more cohesive and higher-yield approach would be to establish place-based Hubs to facilitate delivery of these offers at place level. This would require new fit for purpose estate to be scoped, identified or established.
- Continue to monitor analysis on access times and days and use this to manage resources in line with demand.
- Replicate the in-hours primary care model into Enhanced Access, including the increase in ARRS roles and consider inclusion of planned care such as smear tests.
- Work with system partners to explore urgent care hub with emergency department team.

Managing Long term conditions (LTC)

- Consider extending benefit of group consultations for selected patient cohorts such as poorly controlled diabetes or hypertension.
- Expand social prescribing for LTC patients maximising the community and voluntary sector support for patients.
- Enhancing holistic care approach: Working with the patients' goals – ensuring personalised care by supporting patients to achieve their goals.
- Work with system partners to develop any outreach programmes for specific communities.

Key Enablers

- ICB Business Intelligence support the verification of demand/capacity for same day activity.
- Training and development of community champions and front-line staff to help as present signposting service options to the population.
- Work in partnership with public health/ICB to target public health campaigns (& its calendar) with services and group sessions, signposting health needs to correct primary care services.
- Organisational Development and Cultural change support for multi-agency hybrid working.
- Population health data triangulated with socio-economic and deprivation factors to enable targeted interventions.
- Fit for purpose community spaces to support diabetes and lifestyle interventions.

Reducing health inequalities

- Through joint working with the ICB understand what additional resource and support is available to support the health inequalities in the PCN area.
- Analysing and targeting people with needs that are not being addressed, i.e. lifestyle needs and diabetes face to face peer support session, deprivation pockets in town population health needs.
- Work with the local barbers as local champions to encourage screening and testing in specific patient cohorts such as hypertension.
- Cascade all service information through PPGs to identify and share with physical and virtual points in the communities.

Physical Implications

- Fit for purpose estates in line with current capacity requirements, including expected increase in ARRS roles recruitment and flexibility to accommodate multi-agency staff at practice level.
- Physical points of access to information and support by local communities.
- New space provision to allow for increased list sizes and development of new models of care.

South and West Herts

Key emerging themes at a glance

Hertfordshire and West Essex Integrated Care System

Prevention and proactive anticipatory care

- Explore ways of extending anticipatory care model in care homes for housebound patients with the lead Pharmacist.
- Further develop the holistic personalised care approach for housebound patients though the support of social prescribers.
- Develop integrated working in home visiting teams with ARRS roles, paramedics, nursing associates.
- Provide holistic care: Working with the patients' goals – ensuring personalised care by undertaking training (motivational interviewing), supporting them to achieve their goals.

Improving mental health

- Working with system partners to fully scope the resources required to meet actual demand (incl. unmet need) of the local population.
- Work with secondary care to streamline current processes.
- Supporting review of existing services and help identify the pressure points across pathways, especially mental health services' provision for children.
- Exploring appropriate digital resources such as apps to encourage self-management and raising awareness.
- Build on existing provision of Health and well-being coaches and social prescribers to maximise community and voluntary sector support.

Creating a thriving and resilient workforce

- Creating an appropriately skilled workforce to interface with(in) the PCN, such as specialist skills that are hard to recruit, as well as upskilling existing staff.
- Increase training capacity of workforce – trainers and trainees to support.
- Start PCN organisational development (OD) sessions as part of protected learning to embed staff sense of belonging, security and team working.
- Continue developing Clinical Pharmacists skills/roles for LTC reviews.

Physical Implications

- Meeting space for community groups, MDTs & PCN OD sessions.
- In line with current capacity requirements, including expected increase in ARRS roles recruitment and flexibility to accommodate multi-agency staff at practice level.
- Physical space to accommodate any CVS support in primary care premises.

Key Enablers

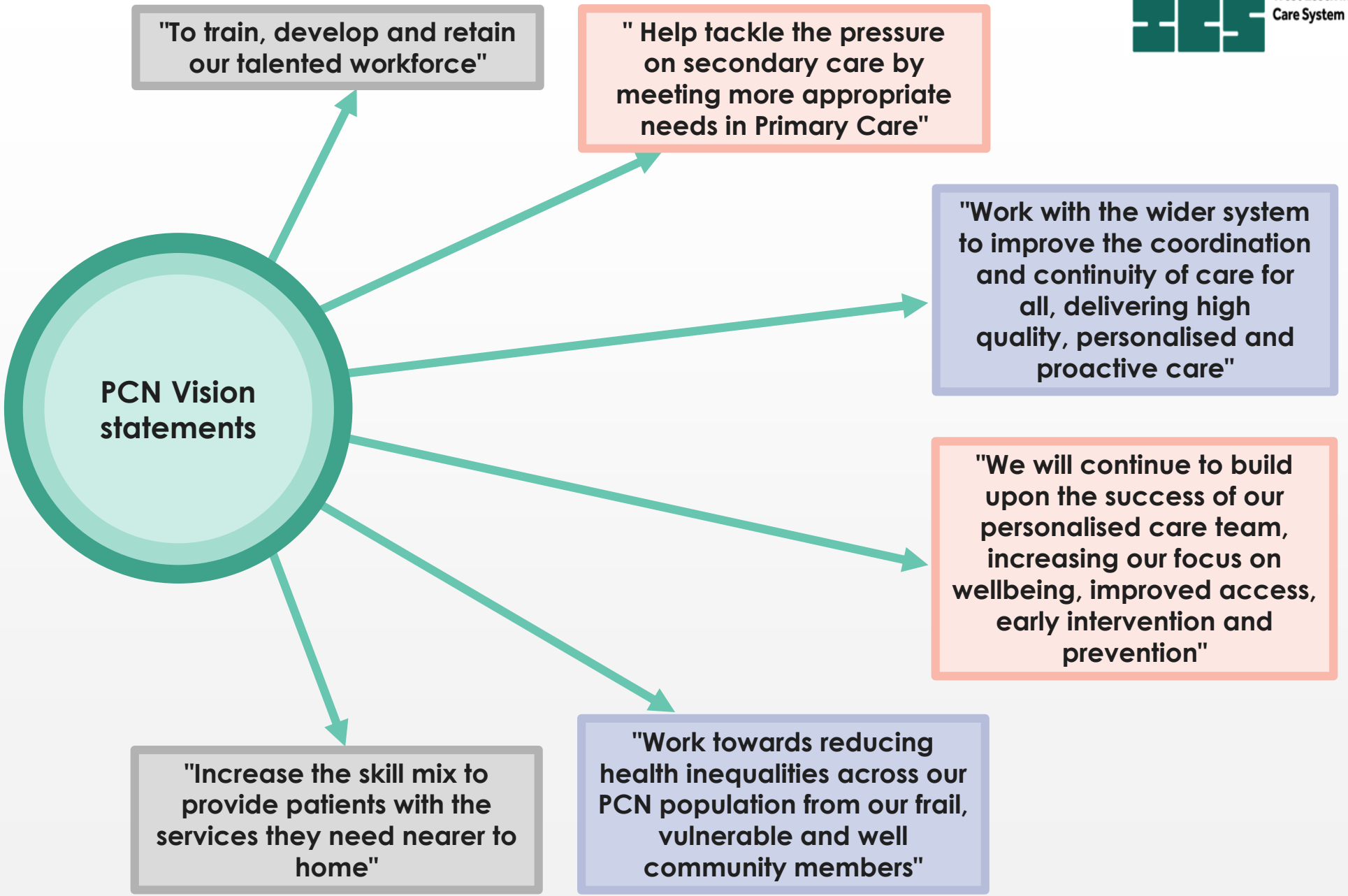
- Partnership working to further develop integrated teams.
- Work with ICB Estates to identify additional fit for purpose estates to provide PCN services.
- Support with recruitment campaigns from system partner.
- Mental health need scoping exercise incl. demand and capacity analysis.
- Capacity review of existing services including IAPT, CAMHS and children's mental health support in schools.
- Streamlining local and national reporting to allow time and space for PCN workforce.
- Digital joined up records from practices including consent.
- Unrestricting ARRS roles funding to allow more flexibility.
- ICB funding for digital technology where appropriate. Centralised systems including IT support functions, i.e. laptops & remote access for all ARRS roles.

Hertfordshire and West Essex Integrated Care System

East and North Herts

East and North Herts

Hertfordshire and West Essex Integrated Care System



East and North Herts

Key emerging themes at a glance

Hertfordshire and West Essex Integrated Care System

- Improving same day access
- Reducing health inequalities
- Managing Long term conditions (LTC)
- Prevention and proactive anticipatory care
- Creating a thriving and resilient workforce
- Improving mental health across HWE

East and North Herts

Key emerging themes at a glance

Hertfordshire and West Essex Integrated Care System

Prevention and proactive anticipatory care

- Provide one place for a range of staff to come together and work as a team around the patient to deliver proactive and preventative care and education, improve self-management and prevent admission.
- Identifying patients with complex and escalating risk: setting mechanisms using data and professional intelligence to identify such people.
- Striving to maintain continuity of care where possible, ensuring our population gets the best possible health outcomes.
- Delivering proactive, personalised and holistic care, taking into account the biopsychosocial model of assessment and care. Focusing on improving their quality of life and considering 'what matters to them'.

Improving mental health

- Further recruitment of mental health and well being coaches at PCN level and as part of integrated teams – face-to-face group well-being/anxiety sessions.
- Working with voluntary sector to ensure optimum use of existing community assets.
- Exploring appropriate digital resources such as apps & training staff in the integrated team of services to signpost.
- MH Practitioners in each member practice for support all neighbourhoods & GP Plus Team.
- Work with system partners to further develop the scope of growing mental health needs in children and young adults.

Creating a thriving and resilient workforce

- Development of a satisfying working environment that offers strong teamwork, collaboration and a sense of identity.
- Optimising ARRS through effective skill mix according to the population need.
- Ensure all roles are integrated into the business and identify as part of practice and PCN teams, with strong, supportive relationships and opportunities for regular interaction.
- Continue PCN OD sessions to embed staff sense of belonging, security and team working supported by the ARRS Line Manager.
- Expand the number of clinical supervisors and GP Trainers also support recruitment and training of staff.

Physical Implications

- Meeting space for community groups, MDTs & PCN OD sessions.
- Fit for purpose estates in line with current capacity requirements, including expected increase in ARRS roles recruitment and flexibility to accommodate multi-agency staff at practice & hub level.
- Community spaces that accommodate face to face group sessions alongside the existing webinar/virtual solutions.
- Accommodation of ARRS roles required to reduce level of remote working.

Key Enablers

- Appropriate and fit for purpose estates to provide PCN and practice staff with a healthy working environment – one site/building.
- Partnership working to further develop integrated teams.
- Sufficient IT / digital equipment and connectivity.
- Mental health need scoping exercise incl. demand and capacity analysis.
- Potential redistribution of funding across system in line with population need.
- Investment to develop Hub.
- Service and pathway design – clear strategies to meet the needs of each patient cohort.
- Access to high quality population health data.

East and North Herts

Key emerging themes at a glance

Hertfordshire and West Essex Integrated Care System

Improving same day access

- Continue to develop the same day minor illness hub and embed model across all PCN practices.
- Offer more appointments on the day through the ARRS roles alongside clinical pharmacist, paramedic and MH worker.
- Clinical supervision and cross working with established primary care teams in practices.
- Review and monitor demand data for this same day activity across the PCN.
- Continue to promote Extended Access sessions allowing patients to be seen outside working hours.
- Work with system partners to explore urgent care hub.

Managing Long term conditions (LTC)

- Development of personalised care plans empowering patients to manage their conditions and make lifestyle changes, reducing complications and admissions.
- Explore joint home visits with Local Authority learning disability team.
- Care coordinators to increase their scope to engage with non-engaging patients and replicate the success for the diabetes patient work.
- Explore the opportunity to enhance secondary care reviews.
- Grow the group consultation proposal. Considering dementia and diabetes, to further educate patients with self-care knowledge.

Key Enablers

- Engagement of voluntary sector, ICTs and MH providers coming together.
- Partnership working with other PCNs and system partners, such as Local Authority.
- Standardisation of clinical operations across PCN practices, if practical.
- Work in partnership with public health to target public health campaigns with services and group sessions, including which signposting ailments to correct primary care services.
- Local Authority & ICB support to identify community spaces across patch for lifestyle sessions.
- Development of pathways and design of the day access service.
- Additional funding for Urgent on the day same day workload – outside.

Reducing health inequalities

- Identifying vulnerable, isolated or people with safeguarding issues in the community using data and local intelligence.
- Recruit a Personalised Care Plan Team to include social prescriber, Care Co-ordinators, Patient Champions and PPGs.
- Expand the Young Persons Social Prescriber role supporting 11-25 yrs - face to face support & group sessions, including the young homeless cohorts.
- Training and development to community champions and front-line staff to signpost to services/support.

Physical Implications

- Fit for purpose estates in line with current capacity requirements, including expected increase in ARRS roles recruitment and flexibility to accommodate multi-agency staff at practice level.
- Estates limitations to accommodate group consultations.
- Physical points of access to information and support by local communities.

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 Primary Care Board meeting held in Public			**Meeting Date:**	**23/03/23**		
Report Title:	**GP CONTRACT CHANGES 2023/24**			**Agenda Item:**	**09**		
Report Author(s):	Michelle Campbell, Head of Primary Care Contracting						
Report Signed off by:	Avni Shah, Director of Primary Care						
Purpose:	**Approval**	☐	**Decision**	☐	**Discussion**	☐	**Information** ☒
Report History:	The Letter from Dr Amanda Doyle has been circulated to all GP Practices and PCN Clinical Directors						
Executive Summary:	This paper provides the Board with a summary of the key changes to the GP Contract and Regulations for 2023-24 and sets out the work underway or planned for 2023-24 to support general practice. The changes are aimed at supporting improving patient experience and satisfaction and a focus on improving access to general practice by significantly reducing the Impact and Investment Fund indicators and changes to some of the QOF indicators. There are also changes to the PCN Additional Roles Reimbursement Scheme to support recruitment and retention within PCNs to further increase capacity by relaxing under the cap of some of the roles and including the addition of Advanced Clinical Practitioner Nurses to the scheme. The Board should note that these changes have not been agreed with the BMA GP Committee; however it is noted that this is the last year of the 5-year framework and NHS England will engage with the profession to agree a new contract which will support the next steps of an integrated primary care. The full letter from Dr Amanda Doyle with the all the changes are shown in **Appendix 1.**						

<table>
<tr><td>Recommendations:</td><td colspan="4">The Board is asked to note the content of paper and the 2023-24 GP Contract Changes and the work undertaken to date by the ICB to support some of these areas.</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">GP Members of the Board are conflicted; however the paper is not seeking approval and is for information only.</td></tr>
<tr><td rowspan="3">Impact Assessments (completed and attached):</td><td colspan="2">Equality Impact Assessment:</td><td colspan="2">N/A</td></tr>
<tr><td colspan="2">Quality Impact Assessment:</td><td colspan="2">N/A</td></tr>
<tr><td colspan="2">Data Protection Impact Assessment:</td><td colspan="2">N/A</td></tr>
<tr><td rowspan="4">Strategic Objective(s) / ICS Primary Purposes supported by this report:</td><td colspan="2">Improving outcomes in population health and healthcare</td><td colspan="2">☒</td></tr>
<tr><td colspan="2">Tackling inequalities in outcomes, experience and access</td><td colspan="2">☒</td></tr>
<tr><td colspan="2">Enhancing productivity and value for money</td><td colspan="2">☒</td></tr>
<tr><td colspan="2">Helping the NHS support broader social and economic development</td><td colspan="2">☐</td></tr>
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1. Executive Summary

The changes to the GP Contract were summarised in a letter from NHS England and published on 6th March 2023 **(full publication is in Appendix 1)**. The changes, which take effect from 1 April 2023, will be made across 6 areas:

a) Access
b) PCN Additional Roles Reimbursement Scheme
c) PCN Impact and Investment Fund (IIF)
d) Quality Outcomes Framework (QOF)
e) Childhood Immunisations
f) Vaccinations and Immunisations

Improving access, patient experience and satisfaction remain a priority for 2023-24 and the proposed changes are aimed at supporting practices to achieve this through a number of ways including releasing capacity through significant changes to the PCN IIF and the QOF.

The Access to Primary Care Recovery Plan is due to be published imminently which will set out the expectations of practices, PCNs and systems to support improved access to general practice which will build on the GP Contract Changes outlined in this paper.

There are no planned changes to the PCN Directed Enhanced Service Specifications in 2023-24, but NHS England will publish guidance supporting best practice for PCNs in these areas.

It should be noted that these changes were not agreed by the BMA GP Committee but it is recognised that 2023-24 is the last year in the 5-year framework *"Investment and Evolution"* and both NHS England and the BMA GPC will continue to engage with the profession, patients and key stakeholders to agree a suitable contract from 2024 onwards.

This paper sets out the work underway or planned to support general practice specifically to support improving access patient experience and satisfaction; with patients involved in the co-design of services.

2. Alignment of the work to date to support Primary Care

The ICB, as part of the primary care recovery and restoration framework following the Covid pandemic, already have a number of workstreams that have been focusing on areas covered in the GP Contract changes above. Over 21-22 and 22-23 we have been building on these workstreams and this section of the paper provides the Board with an update on the work currently underway or planned for 2023-24.

2.1. Improving Access

Improving access to general practice has been a focus for each of the 3 CCG's previously, and now an ICB priority, either through the Restoration and Recovery workplan in 2020, the NHSE Winter Access Fund in 2021 and more recently following the publication of the GP Patient Survey results in 2022.

The ICB has commissioned Healthwatch to undertake quarterly patient surveys, the first one focussing on access to general practice. The results of the surveys was mixed however a strong theme came out of the patient responses and that was being able to get through on the telephone; the ICB has been supporting practices throughout 2022-23 to upgrade their telephony systems.

It was also clear that although patients welcome the range of ways to access general practice, the provision of online tools is not sufficient without supporting patients to access them; therefore the ICB is undertaking a view of practice websites and working with a small number of practices to pilot a consistent format and style, which patients can easily navigate and this will be underpinned with a patient engagement and communications strategy.

Access Dashboard

Following the publication of the GP Patient Survey Results in July 2022, the ICB has been developing an Access Dashboard which pulls in high level indicators to build a picture on access across individual practices and PCNs.

Working as an MDT across directorates in the ICB, including feedback from the place GP Transformation Leads, the dashboard covers 5 main Domains:

- Practice Appointment Data (via General Practice Appointment Dataset - GPAD)
    - Enhanced Access Data is included as a separate dataset as currently not captured in GPAD
- A&E attendances per 1000 population during practice core hours only (only activity recorded as having "No investigation with no significant treatment")
- NHS111 calls during practice core hours (where the dispositions include "contact a local service", previously recorded as "contact a primary care service" or "contact your GP Practice")
- Referrals to the Community Pharmacy Consultation Service
- E-consultation data
- General Practice Patient Survey Results

This dashboard is not intended to be used as a performance tool but is designed to initiate a conversation with a practice or PCN if it seems they are highlighted as an outlier and may be experiencing significant pressures or recruitment issues that the ICB could support with. It should also be noted that this is **not** an indication of bad practice or poor performance as data only gives us a "2D" view at that point in time.

Advanced Telephony

Over 2022-23 practices have been supported to upgrade their telephony systems either through the National Advanced Pilot Programme (£1.3m) or through ICB investment (£1.2m). To date, 52 practices have benefitted from this funding and have implemented an advanced cloud-based telephony system.

These new systems are fully integrated into the practice operating model and provide more phone lines for inbound and outbound calls, and automated queuing. Cloud-based systems can provide data about patient demand to help give feedback about current performance and inform practices about the level of administrative support they need for call-handling.

In addition to the above, the ICB procured a "digital front door" solution which provided further functionality through Accurx and E-Consultation software which allows patient to communicate with their GP practice either through messaging or through a video consultation; Accurx also allows practices to send SMS text messages and patient questionnaires.

All practices have access to these tools and have been supported in the mobilization; 77 practices selected Accurx as their preferred solution and 57 selected E-Consult. Levels of activity vary each month as it does depend on how they are using the tools and their operating models.

- In January 2023 there were 49,885 e-consultations in HWE which demonstrates a 50% increase in the usage of online consultations since March 2022.
- All practices in HWE are using Accurx for SMS text messaging.

Further work is required to understand the full benefits realization of both the upgrades to telephony systems and the Digital Front Door tools and identify the impact on the improvement of patient experience; this is planned to commence during 2023-24.

Patient Participation

The ICB, through the Winter Access Fund programme, commissioned the National Patient Association to support practices and PCNs in developing their Patient Participation Groups (PPG) to ensure that patients are engaged and are part of the co-design of practice/PCN services.

This included advice and guidance on how to setup, develop and maintain an effective PPG; including how the PPG should be structured and outline the roles and responsibilities of a PPG and how they work collaboratively with general practice.

In addition, the ICB GP Enhanced Commissioning Framework, from October 2022, includes a Patient Participation, Engagement and Involvement component which further supports the implementation of this guidance and incentivizes practices to achieve increasing levels of engagement and collaboration across local networks.

Patient Access Online

Currently there are 16 practices that have gone live with providing patient access to their online record across the ICB. The clinical system providers TPP and EMIS schedule "go lives" in groups and inform the ICB when those are going to happen – currently there are no further planned "go-lives" scheduled but we will continue to work with practices to ensure they meet the October 2023 deadline as stated in the GP Contract changes.

Digital Innovation

The ICB has setup a "Digital Innovation Group" (DIG), the purpose of which is to identify and share good practice, substantiated by patient-lived experiences and the impact on primary care; the digital workstreams mentioned above all feed into the DIG where best practice and positive experiences are identified.

Through the Digital Workstream there have been areas identified areas of high digital exclusion and with the use of Captain Toms charity funding and through the work with Districts and the communities, this has enabled provision of IT/electronic kit such as mobiles, laptops and tablets, with data cards and training offered on a one-to-one basis. Further training sessions are being planned on topics such as Digital Health and includes the use of the NHS App supported by printed user guides.

The Digital First Primary Care Programme which is year 4 of the 5year programme has successfully delivered a number of workstreams and full evaluation has been undertaken of "Digital Front Door" which will be presented to the Board in a separate paper.

PCN System Development Plans

The PCN Development Funds in 2022/23 are now combined under one funding stream to support both PCN Development/Transformation and Digital First Primary Care. The ICB were required to bid for this funding and were successful in securing £800,000.

This funding is to be utilized by PCNs following approval of a plan that will deliver on the ICB and national priorities for primary care transformation; one of which includes was to plan, develop and implement an urgent on the day access service linking in with other urgent and emergency care services.

Out of the 35 PCNs across the ICB, 3 PCNs are undertaking a detailed review of their current processes with a view to move to an urgent on the day access hub. There is a PCN in East and North Herts who is scoping a model for same day access in partnership with Hertfordshire Community Trust.

Currently, 34 plans out of 35 have been received by the ICB and the team are working closely with PCNs to ensure all plans are approved by end of March 2023.

PCN – Additional Roles Reimbursement Scheme

The proposed changes to the above scheme in 2023-24 are welcomed so that workforce can be secured by offering permanent contracts; thus, supporting improved recruitment and retention. Changes, or in some cases, removal of the caps on Advanced practitioners; including the role of Advanced Clinical Nurse Practitioners as eligible for reimbursement as an Advanced Practitioner will further support delivery of the PCNs developing clinical strategies and support the priority for improving access and in return increasing patient satisfaction and experience.

We are now analysing the current PCN workforce baseline and looking at how the ICB Training Hub can support training and development of these roles.

3. Other Key Enablers

The detail above is not exhaustive of all the work currently underway and none of the workstreams should be working in silo as there are interdependencies across all. These are supported by key enablers such as Estates, Comms and Engagement and Data in the following ways:

- The ICB is developing a communication and engagement strategy to support these workstreams and the changes that will be seen within primary care and what that means for patients.
- Ongoing discussions with PCNs and system partners through each place Health and Care Partnership on new models of care; including same day access and how this is integrated with urgent and emergency care services.
- Continued support to PCNs in developing their clinical strategies and measure the outcomes to support service provision; including analysis of demand and capacity to enable workforce planning and estates infrastructure.
- Population Health data being provided to PCNs on a regular basis to support the delivery of the PCN Health Inequalities priorities, which supports the development of the Integrated Neighbourhood Teams with services wrapped around the patient.

4. Recommendations

The Board is asked to note and discuss the content of the paper.

4. Next Steps

The ICB Primary Care team, along with other ICB Directorate colleagues will review where support is required to implement the GP Contract changes and support

delivery of the key priorities that will be outlined in the Access to Primary Care Delivery plan when published.

The Board will receive further updates on these work programmes at future meetings.

Classification: Official

Publication reference: PRN00257

To:
- All GP practices in England
- Primary Care Network Clinical Directors

cc.
- ICB Primary Care Leads
- ICB Chief Executives
- Regional Directors
- Regional Directors of Commissioning
- Regional Directors of Primary Care and Public Health
- Regional Heads of Primary Care

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

6 March 2023

Dear colleagues,

Changes to the GP Contract in 2023/24

1. We recognise and appreciate the incredibly hard work of general practice during this period of sustained significant pressure. The past few years have demonstrated the dedication of practice and Primary Care Network (PCN) teams in innovating and responding to the needs of their populations. In January 2023 General Practice delivered 30m appointments, an increase of 11% on January 2020, a testament to the incredible work of GP teams.

2. 2023/24 is the final year of the 5-year framework agreement which was set out in *Investment and Evolution*. Over the course of 2023/24 NHS England will engage with the profession, patients, ICSs, government and key stakeholders, building further on the Fuller Stocktake from May 2022 which set out the next steps towards integrating primary care. In response to feedback from practice teams, GPC England and the Health and Care Select Committee on the Future of Primary Care, in 2023/24 the profession and representative patient groups will be consulted on the Quality and Outcomes Framework (QOF) and its future form.

3. The Chancellor in his Autumn Statement set out a commitment to publish a recovery plan for General Practice access in early 2023. The Delivery Plan for Recovering Access to Primary Care will be published shortly and sets out how practices and PCNs can be supported to improve access during 2023/24 building on the contract changes outlined in this letter and expanded in Annex A.

4. The changes to the GP contract in 2023/24 set out the requirements of General Practice and PCNs with the goal of improving patient experience and satisfaction and we recognise that this will require both time and support to assess, review and implement changes. We intend to provide this support in a number of ways outlined below including freeing up workforce capacity through significant changes to the Impact and Investment Fund (IIF) and through the QOF Quality

Improvement (QI) modules. Further support for practices and PCNs will be outlined in the recovery plan.

Access requirements

5. **Offer of assessment will be equitable for all modes of access:** To ensure consistency in the access that patients can expect, the GP contract will be updated to make clear that patients should be offered an assessment of need, or signposted to an appropriate service, at first contact with the practice. Practices will therefore no longer be able to request that patients contact the practice at a later time. The IIF focus on access will support practices and PCNs working towards achieving this during 2023 recognising the changes that will need to be made.

6. **Prospective (future) record access to be offered by 31st October 2023:** To make it easier for patients to access their health information online without having to contact their practice, the GP contract will be updated so new health information is available to all patients (unless they have individually decided to opt-out or any exceptions apply) by 31 October 2023 at the latest. This builds on the 1,400 practices that are already automatically offering 6.5M patients this access. NHS England will continue to provide support to practices as more patients gain online access to their records. Support will continue nationally and through commissioners to enable practices to make this offer to all their patients.

7. **Mandate use of the cloud based telephony (CBT) national framework:** All practices need to be aware, that from the end of 2025, all analogue ISDN and PSTN lines will be removed for use in all home and business settings. From this point, only cloud-based platforms will be supported. Digital telephony (CBT) provides greater functionality for practices and patients. This includes call queueing or call back which provide a better patient experience when the lines are busy as well as management information and data to support practices gain insight and improve their responsiveness further.

8. Background research and pilot studies have demonstrated how challenging it can be to navigate the telephony market for practices and understand the offers. A Better Purchasing Framework (BPF) has been developed by NHS England to provide recommended suppliers and assure value for money. As part of the 2023/24 GP contract changes, practices will be required to procure their telephony solutions only from the framework once their current telephony contracts expire. The Delivery Plan for Recovering Access to Primary Care will describe further support available for practices who indicate they are interested in making this move in 2023/24.

Changes to Impact and Investment Fund and QOF QI modules

9. The number of indicators in the IIF will be reduced from 36 to five (worth **£59m**) and will focus on a small number of key national priorities: two indicators related

to flu vaccinations, learning disability health checks, early cancer diagnosis and 2-week access indicator.

10. The remainder of the IIF will now be worth £246m and will be entirely focused on improving patient experience of contacting their practice and receiving a response with an assessment and/or be seen within the appropriate period (for example same day or within 2 weeks where appropriate, depending on urgency). 70% of the total funding, equating to £172.2m, will be provided as a monthly payment to PCNs during 2023/24 via the Capacity and Access Support Payment.

11. The remaining 30% of the total funding, equating to £73.8m, will be assessed against an access improvement plan agreed with the commissioner in quarter 1 of 2023/24. At the end of March 2024 ICBs will assess for demonstrable and evidenced improvements in access for patients and then award funding. ICBs will be provided with guidance to assist in determining the appropriate payment.

12. In 2023/24, all the QOF register indicators points will be awarded to practices, based on 2022/23 outturn once finalised, releasing £97m of funding and reduce the number of indicators in QOF from 74 to 55 (a reduction of 25%). Two new cholesterol indicators (worth 30 points~£36m) will be added to QOF along with a new overarching mental health indicator. One indicator (AF007) will be retired and replaced with a similar indicator from IIF in 2022/23.

13. This year's QOF QI modules will focus on workforce wellbeing and optimising demand and capacity in General Practice with an emphasis on using data to analyse potentially avoidable appointments and build on care navigation and use of wider workforce or local services to reduce pressure on General Practice.

Increased flexibility of ARRS

14. Recruitment through the Additional Roles Reimbursement scheme (ARRS) has been strong, and as of 31 December 2022 stands at 25,262 additional FTE. PCNs are on track to meet the 26k target for March 2024 over a year early. Staff are providing significant numbers of additional appointments, improving patient access to general practice, and providing personalised, proactive, care for the populations that they serve. To support PCNs to recruit the teams that they need, there are a number of changes to the ARRS, including adding Advanced Clinical Practitioner Nurses to the reimbursable roles, increasing the cap on Advanced Practitioners to three per PCN and removing the caps on Mental Health Practitioners.

15. During 2023/24 NHS England will review the ARRS to ensure that it is tailored to deliver future ambitions for general practice. Staff employed through the scheme will be considered part of the core general practice cost base beyond 2023/24 as previously confirmed, and PCNs can offer permanent contracts where appropriate. We encourage PCNs to continue to recruit, making full use of their ARRS entitlement.

Immunisations and Vaccinations

16. Following feedback from PCNs and GPC England, there will be changes to childhood vaccinations. These include the removal of the vaccination and immunisations repayment mechanism for practice performance below 80% coverage for routine childhood programmes along with changes to the childhood vaccination and immunisation indicators within QOF which will see the lower thresholds reduced to 81% - 89% (dependent on indicator) and the upper thresholds raised to 96%.

17. In recognition of the current workload pressures in general practice, no additional requirements will be added to the PCN service specifications in 2023/24. NHS England will instead publish guidance which will suggest best practice to PCNs.

18. Further details on the 2023/24 changes will be published ahead of April including a revised Network Contract DES specification. If any changes are required to commissioner allocations, we will adjust this through the regular allocations update process.

Yours sincerely,

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

Annex A – changes to the GP Contract in 2023/24

Changes to the GP Contract Regulations

Access

1. To ensure consistency in the access that patients can expect, the GP contract will be updated to make clear that patients should be offered an assessment of need, or signposted to an appropriate service, at first contact with the practice.

Patient access to their medical records

2. The GP contract regulations will be amended so that patients have online access to their prospective medical records (unless they have individually decided to opt out or any exceptions apply) by 31 October 2023 at the latest.

3. The existing requirements in the GP contract regulations relating to providing online access to historic coded and full records will also be amended so that they are consistent with access to information under the GDPR. Amendment of these existing requirements will also provide clarity on how practices are required to offer, promote and provide online access to patient records.

Supporting Cloud Based Telephony

4. Practices will be required to procure their telephony solutions only from the Better Purchasing Framework once their current telephony contracts expire.

Simplification of GP registration requirements

5. In order to support the simplification of GP registration requirements, the term ’medical cards’ will be removed from the GP contract regulations.

GP retention scheme

6. The four-session cap within the GP retention scheme was lifted during the pandemic and will now be removed permanently. Sessions worked above the cap will be funded by the employing general practice. Any further potential changes to the scheme will be picked up as part of the current review of GP recruitment and retention scheme being led by NHS England.

The Additional Roles Reimbursement Scheme (ARRS)

7. In 2023/24 the following changes will be made to the ARRS:

    a. increasing the cap on Advanced Practitioners from two to three per PCN where the PCN’s list size numbers 99,999 or fewer, and from three to six where the PCN’s list size numbers 100,000 or over.
    b. reimbursing PCNs for the time that First Contact Practitioners spend out of practice undertaking education and training to become Advanced Practitioners.
    c. including Advanced Clinical Practitioner Nurses in the roles eligible for reimbursement as Advanced Practitioners (APs).
    d. introducing apprentice Physician Associates (PAs) as a reimbursable role.

e. removing all existing recruitment caps on Mental Health Practitioners, and clarifying that they can support some first contact activity.
f. amending the Clinical Pharmacist role description to clarify that Clinical Pharmacists can be supervised by Advanced Practice Pharmacists.

8. During 2023/24 the ARRS will be reviewed to ensure that it remains fit for purpose and aligned to future ambitions for general practice.

Changes to the PCN service specifications

9. In recognition of the current workload pressures in general practice, no additional requirements will be added to the PCN service specifications in 2023/24. NHS England will instead publish guidance which will suggest best practice to PCNs.

Enhanced Access

10. Following feedback from GPC England, NHS England has agreed to review the enhanced access requirements in 2023/24 once PCNs have had the opportunity to operate for several months, and to enable links into the wider conversations on urgent and emergency care.

Investment and Impact Fund (IIF)

11. The following changes will be made to the IIF in 2023/24:
    - the number of indicators will be reduced to five to support a small number of key national priorities: flu vaccinations, learning disability health checks, early cancer diagnosis and 2-week access indicator. The value of these indicators will be £59m.
    - the remainder of the IIF will now be worth £246m and will be entirely focused on improving patient experience of contacting their practice and being assessed and/or seen within the appropriate timeframe (for example same day or within 2 weeks where appropriate).
    - 70% of the total funding, equating to £172.2m, will be provided as a monthly payment to PCNs during 2023/24, similar to monthly QOF aspirational payments.
    - the remaining 30% of the total funding, equating to £73.8m, will be assessed against ‘gateway criteria’ at the end of March 2024 by ICBs and paid to PCNs for demonstrable and evidenced improvements in access for patients.

12. The Learning Disability Health Checks Indicator will be amended by adding a requirement to record the ethnicity of people with learning disabilities.

13. A Personal Care Adjustment (PCA) will be added to the indicator on FIT testing (CAN-02) so that PCNs are not being incentivised to refer for FIT testing when there is rectal bleeding. Additional support will be provided where practices are struggling to access tests. This will involve setting up a national ‘supply chain’ escalation system that any GP practice can contact if local supply issues arise.

Additional support is available from the regional cancer alliance to fund FIT kits where needed.

Quality and Outcomes Framework (QOF)

14. QOF will be streamlined in 2023/24 by income protecting all register indicators. This will release £97m of funding and reduce the number of indicators in QOF from 74 to 55 (a reduction of 25%). Funding will be paid to practices based on 2022/23 performance monthly once the 2022/23 QOF outturn is finalised.

15. Two new cholesterol indicators (worth 30 points~£36m) will be added to QOF along with a new overarching mental health indicator. These will be funded by retiring indicator RA002 (the percentage of patients with rheumatoid arthritis, on the register, who have had a face-to-face review in the preceding 12 months) and reducing the value of DEM004 (annual dementia review). The mode of review of DEM004 will also be amended to be determined through shared decision making with the patient.

16. Indicator AF007 will be retired and replaced with the indicator below (which was in the IIF as CVD-05 in 2022/23):
    - AF008: Percentage of patients on the QOF Atrial Fibrillation register and with a CHA2DS2- VASc score of 2 or more, who were prescribed a direct-acting oral anticoagulant (DOAC), or, where a DOAC was declined or clinically unsuitable, a Vitamin K antagonist (12 points, LT 70%, UT 95%).

17. There will also be a number of other small changes to indicator wordings and values in 2023/24.

18. The QOF QI modules in 2023/24 will focus on:
    - workforce and wellbeing
    - optimisation of demand and capacity management in general practice.

19. Work will need to be undertaken during 2023/24 to review QOF in its current form with the aim of making it more streamlined and focussed. The profession, patients and the broader system will be consulted to determine the most appropriate form in 2024/25.

Childhood immunisations

20. The following changes will be made to childhood vaccinations:

    - the removal of the V & I repayment mechanism, removing the payment clawback for practice performance below 80% coverage across the routine childhood programmes.
    - changes to the childhood V & I QOF indicators.
    - clarification of the wording in the SFE that an Item of Service (IoS) fee will be payable for vaccinations administered for medical reasons and incomplete or unknown vaccination status (‘evergreen offer’) for the

programmes outlined in the SFE Part 5 Vaccinations and Immunisation, section 19.

21. The changes to the childhood vaccination and immunisation indicators within QOF will see the lower thresholds reduced to 89% (VI001) 86% (VI002) and 81% (VI003) and the upper thresholds raised to 96%[1]. All the points for each indicator will be put into a sliding scale of reward between the lower and upper threshold. Reducing the lower thresholds will decrease the number of practices receiving no payment across the three indicators.

22. A new Personalised Care Adjustment will also be introduced for patients who registered at the practice too late (either too late in age, or too late in the financial year) to be vaccinated in accordance with the UK national schedule (or, where they differ, the requirements of the relevant QOF indicator).

Vaccination and Immunisations

23. The contract will also be updated to reflect forthcoming changes to the routine vaccination schedule as recommended by the Joint Committee on Vaccinations and Immunisation (JCVI), specifically in relation to Human papillomavirus (HPV), and Shingles.

Human papillomavirus

24. JCVI recommended a move from a two-dose schedule to a one dose schedule for the routine adolescent programme up to the age of 25 years. This change will align HPV vaccine doses across age groups, aligning the school's programme, sexual health and general practice provision, therefore minimising the risk of conflicting or missing doses. This change will not apply to those who are immunocompromised and those known to be HIV positive for whom the three-dose schedule will remain.

25. There will be a change from a two-dose to a one-dose HPV programme for those aged 14 to 25 years from 1 September 2023 to align with the school's programme.

26. General practice delivery remains opportunistic or on request. Eligibility remains up to 25 years of age for girls born after 1 September 1991 and boys born after 1 September 2006. This difference is due to the programme for boys being introduced at a later date (2019).

27. The IoS payment will continue to be paid at £10.06 per dose administered.

[1] VI001: The percentage of babies who reached 8 months old in the preceding 12 months, who have received at least 3 doses of a diphtheria, tetanus and pertussis containing vaccine before the age of 8 months; VI002: The percentage of children who reached 18 months old in the preceding 12 months, who have received at least 1 dose of MMR between the ages of 12 and 18 months; VI003: The percentage of children who reached 5 years old in the preceding 12 months, who have received a reinforcing dose of DTaP/IPV and at least 2 doses of MMR between the ages of 1 and 5 years.

28. Further information on the programme change will be provided in due course.

Shingles

29. The JCVI advised in 2018 that Shingrix had been shown to be effective and cost-effective, recommending its use in the NHS Shingles Programme for individuals for whom the live Zostavax was contraindicated. This change was implemented in the programme in September 2021.

30. In 2019 JCVI recommended the replacement of Zostavax with Shingrix and the expansion of the cohorts in the Shingles Vaccination Programme. JCVI have recognised that there may be more clinical benefit from starting Shingles vaccinations at a lower age, with modelling indicating that a greater number of cases would be prevented with vaccination at 60 years for immunocompetent and 50 years for immunocompromised.

31. From 1 September 2023 changes to the Shingles Programme to implement the JCVI recommendations will be as follows:
    - replacement of Zostavax with the 2-dose Shingrix vaccine as Zostavax goes out of production.
    - 2-dose Shingrix vaccine for the current 70-79-year-old cohort with a period of 26 weeks to 52 weeks between doses following the depletion of Zostavax.
    - expansion of the immunocompromised cohort to offer 2-dose Shingrix to individuals aged 50 years and over with a period between doses of 8 weeks to 26 weeks.
    - expansion of the immunocompetent cohort to offer 2-dose Shingrix routinely to individuals aged 60 years and over with a period between doses of 26 weeks to 52 weeks, remaining an opportunistic offer up to and including 79 years of age.

32. The expansion of the immunocompetent cohort will be implemented over two five-year stages as follows:
    - first five-year stage (1 September 2023 to 31 August 2028): Shingrix will be offered to those turning 70 and those turning 65 years of age in each of the five years as they become eligible.
    - second five-year stage (1 September 2028 to 31 August 2033): Shingrix will be offered to those turning 65 and those turning 60 years of age in each of the five years as they become eligible.

33. Additionally, practice call/recall for the immunocompromised and immunocompetent cohorts as they become eligible for the programme will be implemented from 1 September 2023, as well as catch-up call/recall for the newly eligible immunocompromised 50-69-year-old cohort.

34. Shingles can be delivered at any time during the year thus enabling practices to manage timing for when the individual is invited and can also be opportunistically delivered if clinically appropriate when an individual attends the practice for another reason.

35. The Shingles GPES extraction will be updated to accommodate these changes.

36. Further information on the programme changes and management of the immunocompetent cohort expansion will be provided in due course.

Unchanged programmes

37. The following programmes will continue unchanged for 2023/24:
    - 6-in-1 (DTaP/IPV/Hib/HepB)
    - MenB
    - Rotavirus
    - PCV (infant pneumococcal)
    - Hib/MenC
    - MMR provision to remain unchanged for both the 0-5-year-olds programme and 6 years and over programme
    - 4-in-1 pre-school booster (DtaP/IPV)
    - 3-in-1 booster (td/IPV)
    - Men ACWY (provision for those aged up to 25 years who miss the schools programme)
    - PPV (65-year-olds and 2-64-year olds in defined clinical risk groups)
    - HepB (Babies)
    - Pertussis (pregnant women).

Weight Management Enhanced Service

38. The Weight Management Enhanced Service will continue into 2023/24, retaining the £11.50 referral payment.

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:**	**23/03/2023**	
Report Title:	**Primary Care Transformation update**				**Agenda Item:**	**10.1**	
Report Author(s):	James Gleed, Associate Director Primary Care Strategy and Transformation						
Report Signed off by:	Avni Shah, Director of Primary Care Transformation						
Purpose:	**Approval**	☐	**Decision**	☐	**Discussion**	☒	**Information** ☒
Report History:	A report covering the approach to developing the Hertfordshire and primary care delivery plan came to Board 23 November 2022. A presentation providing an update on development of the plan will be delivered to the primary care Board at its meeting 23 March 2023.						
Executive Summary:	Development of a primary care strategic delivery plan remains a pivotal work stream for HWE ICB and is being steered by clinical and managerial leads. The plan will encompass the key recommendations from the Fuller Stocktake Report. Engagement with GP practices, PCNs and all stakeholders including patients will be key to developing the plan; a large transformation event with all GP practices and system partners was scheduled for 8 March, but unfortunately had to be cancelled due to planned industrial action. We have therefore developed an alternative strategy to progress key discussions. The plan sets out the ICB's commitment to transformation in a discrete number of areas that are considered to have the greatest impact. A targeted approach will help ensure that required input is compatible with practice and PCN capacity and that the desired outcomes will be realised. The plan will set out the objectives in the areas identified, providing clarity on definition of the outcomes being sought and how those outcomes will be measured. The transformation plans to achieve these objectives will need to be developed and implemented at place level on individual neighbourhood footprints as they will vary according to local population demographics, needs, infrastructure and circumstances.						

<table>
<tr><td></td><td colspan="4">The plan will also set out future planned developments in key enabling workstreams including:

➢ Investment
➢ Workforce
➢ Premises
➢ Communications: patient empowerment and education
➢ IT and digital</td></tr>
<tr><td>Recommendations:</td><td colspan="4">▪ For the board to note the key areas of focus that the Primary Care Delivery Plan will encompass
▪ To discuss / highlight any additional areas of focus that the Board would like to see within the delivery plan</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">No conflicts of interest identified</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	☐

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:**	**23/03/2023**
Report Title:	**ENHANCED COMMISSIONING FRAMEWORK – LEARNING FROM 2022/23**		**Agenda Item:**	**9.2**
Report Author(s):	Dr Sam Williamson, Associate Medical Director			
Report Presented by:	Avni Shah, Director for Primary Care			
Report Signed off by:	Avni Shah, Director for Primary Care			

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

Which Strategic Objectives are relevant to this report **[Please list]**	• Increase healthy life expectancy, life expectancy and reduce inequality • Improve access to health and care services • Increase the number of citizens taking steps to improve their wellbeing • Achieve a balanced financial position annually
Report History:	▪ N/A
Executive Summary:	This paper outlines the key early findings from the Enhanced Commissioning Framework for 2022/23 and learning points. The ECF has had a significant impact on patient care, supporting the restoration of core services that provide proactive management of long term conditions, including frailty and mental health conditions, as well as restoration of primary care procedures. Early evidence suggests that the care that has been delivered as part of the ECF is providing HWE with the support they need to receive accurate diagnoses and avoid unplanned care. The implementation of the ECF has had a number of challenges, coming at a time of sustained pressure across health and care services and limited capacity. The learning from the ECF has been incorporated into the plans for 2023/24 and there will be ongoing work to further develop and support practices to deliver high quality care. This forms the foundation of care upon which the ICB can commission and develop further services that meet the needs of the local population.

<table>
<tr><td>Recommendations:</td><td colspan="4">▪ The Primary Care Board is asked to note the reflections on the ECF for 2022/23, including the benefit it has delivered and the challenges that have been encountered.
▪ The Board is asked to endorse further work to develop the support tools for primary care, to improve the quality of information recorded in the clinical record.</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">Primary Care Members of the Board have a direct financial conflict of interest arising as a result of the ECF being a contract with general practice.</td></tr>
<tr><td colspan="5">Implications / Impact:</td></tr>
<tr><td>Patient Safety:</td><td colspan="4">N/A</td></tr>
<tr><td>Risk: Link to Risk Register</td><td colspan="4">N/A</td></tr>
<tr><td>Financial Implications:</td><td colspan="4">N/A</td></tr>
<tr><td rowspan="3">Impact Assessments:
(Completed and attached)</td><td colspan="2">Equality Impact Assessment:</td><td colspan="2">N/A</td></tr>
<tr><td colspan="2">Quality Impact Assessment:</td><td colspan="2">N/A</td></tr>
<tr><td colspan="2">Data Protection Impact Assessment:</td><td colspan="2">N/A</td></tr>
</table>

1. **Background**

The Enhanced Commissioning Framework (ECF) creates a single set of Local Enhanced Services across the ICB, drawing on evidence of best practice and national guidance to deliver care in line with local priorities and to meet the needs of the population in HWE.

The ECF was introduced in 2022/23 to unify the local enhanced services that were previously in place in the three Clinical Commissioning Groups (CCGs).

The total funding for the full year for the ECF was £9.45 per patient, using weighted population list sizes. Implementation of the ECF was delayed by six months as practices were under pressure as a result of pandemic and recovering services. The ECF went live on 1st October 2022. However, activity undertaken at any point during the financial year was considered as part of the contract. This reflected the fact that many of the clinical standards set out in the ECF are annual processes and some patients may have received their care earlier in the year and therefore needed to be included in reporting. As the ECF covered part of the year, this was £4.75, with the remaining funding covered by income protection and covering the first half of the year.

All areas of the ECF were developed closely with clinical leads who are practicing GPs in the local system. They draw on national guidelines and local pathways and build on national contracts to enhance care for the local population. The clinical section of the ECF was allocated funding of £2.35 per weighted population and included funding to deliver care across the following disease areas:

- Disease detection
- Chronic Obstructive Pulmonary Disease
- Cardiovascular Disease (heart failure, atrial fibrillation, chronic kidney disease and lipid management)
- Diabetes (non-diabetic hyperglycaemia and diabetes)
- Mental health (serious mental illness and dementia)
- Learning disabilities
- Frailty and end of life

In December 2022, in response to pressures across the system and other areas of the country reviewing their locally commissioned services, the ICB undertook a review of the ECF to identify areas where reporting could be removed to support practices with workload pressures and financial security. This resulted in approximately half of the funding covered by the ECF effectively receiving protection. In addition to this, remaining indicators were moved to a sliding scale to ensure that practices that did not meet the threshold were still rewarded for the work that they were able to do.

This paper outlines some key achievements that have been delivered through the ECF during 2022/23 and some learning that has been gained. These learning points and achievements have been incorporated into the development of the ECF for 2023/24 and the ongoing work to develop the support tools for practices to deliver good quality care and the ECF.

2. **Learning points and Key messages**

The rollout of the ECF through 2022/23 has identified some useful learning across a number of areas.

Clinical improvement

- Reporting on the ECF has shown that care processes are recovering in primary care, but not uniformly. There is variation by practice and also across different disease areas. Going forward, the information available as part of the ECF can support the ICB and practices to reduce variation in both access as well as outcome, reducing inequalities.
- Delivery of the care processes has supported clinical outcomes. For example, at the start of the year, there were over 26,000 type 2 diabetic patients classified as being high risk. This has since dropped to around 14,000 as care processes have been reintroduced and patients' diabetes is being managed. Whilst there is limited data nationally on emergency admissions for hypoglycaemic events since the introduction of the ECF, there is early indication that the local rate is decreasing and at a faster rate compared to the national average. There is a mixed picture for emergency admissions for hyperglycaemia.
- The introduction of new metrics have begun to address local needs. For example, nearly 2000 patients with advanced disease (e.g. end stage CKD, heart failure, COPD or severe frailty) have had an assessment of their end of life status. This is a group of patients that have historically been under-represented on the end of life register and frequently have emergency admissions in their last year of life. Identifying patients as being end of life allows practices to subsequently get advance care plans in place and discuss patients' preferences around care. At the end of the year, we will assess the outcome of these patients, how many were identified as Green, amber or red and the impact this is having on proactive management. Hospices are also now reporting that they are seeing more patients referred with non-cancer diagnoses.
- A number of indicators were included in the ECF for 2022/23 that assessed the actions that are taken following the delivery care processes, for example consideration of referral to community services if a patient has advanced COPD. Insights form the current financial year show that completing these actions remain low, with variation across the ICB. This may be due to a range of reasons, including clinical appropriateness, clinical coding or as a result of patients who would benefit not being referred. This is an area for further development going forward and can be considered as part of the development of integrated neighbourhood teams.
- The ECF provided practices with funding to support the restart of procedures and wider treatment in primary care. Spirometry is a key procedure that has been a challenge for primary care to deliver through the pandemic and practices were experiencing a backlog of cases requiring spirometry testing to confirm the diagnosis of respiratory conditions. The data show that there has been very positive progress on spirometry activity, with over 3,600 episodes of spirometry delivered through the financial year to date. These levels are significantly higher than other systems in the East of England region.
- Over 45,000 patients have received ambulatory or home blood pressure monitoring to support with diagnosis or monitoring of established hypertension. Whilst wider data is not available yet on the impact this has had on both hypertension prevalence and hypertension management, this will be assessed as the data become available.

The ECF not only support the delivery of good quality, evidence based interventions, it enhances the care that is delivered through core general practice and indicators in the Quality and Outcomes Framework and Impact and Investment Fund and directly addresses issues within our local population. It also supports the delivery of care against metrics that the health system are assessed against, in the System Outcomes Framework.

Supporting general practice to deliver good quality, evidence based care through the ECF creates a solid foundation for further services to be commissioned or developed both in primary care and across other parts of the system. An example of this is the development of the asthma diagnostic hubs across primary care.

Improvements in clinical coding

- A key aspect of the ECF is to improve the quality of clinical coding in primary care. Entering information into the patient's electronic record in a standardised way (using clinical codes) supports i) patient care, ii) integration and interoperability (sharing information between providers for direct care purposes), iii) practice funding (through national contracts and disease registers) as well as iv) population health management analysis.
- Delivery of the ECF has been supported by the commissioning of Ardens Clinical (clinical templates and clinical searches and reports) and Ardens Manager. Templates support clinicians to record information during a consultation using standardised codes. Indicators in the ECF are linked to the codes used in clinical templates.
- Seeing up to date information in Ardens Manager allows practices and the ICB to understand the current position against each indicator, along with how many ECF points have been achieved and the number of patients the practices needs to deliver care to in order to achieve maximum payment. Linked to this, practices can see the specific reports that are used to populate each indicator and the reports that can be run within the GP IT system to identify patients who would benefit from the care.
- There is ongoing work needed to further develop the clinical templates for ease of use and upskill clinicians and promote the use of the clinical templates and searches. These tools are relatively new to some practices and clinicians. Embedding these tools into ways of working will support the clinical consultation and accurate entry of information into the clinical record. Currently, clinicians within general practice adopt a variety of working styles and clinical practice. Further work on the searches and templates will ensure that these tools best support both high quality care and reporting against the ECF contract.

Challenging areas

There have been a number of indicators within the ECF where there has been feedback from practices on the associated workload. Whilst funding was allocated based on the expected workload, there have been some areas where practice staff are taking time to recover ways of working and reinstate usual care.

This feedback has been incorporated into the development of the ECF for 2023/24, with care processes streamlined, a reduction in the number of indicators and/or adjustments to the allocation of funds. An example of this is the requirement for practices to complete a set of clinical assessments for people who are moderately frail (reassess frailty status, assess falls risk, depression and anxiety screening, assess loneliness and carer status and nutritional status). Practices fed back that this represented a significant level of work and that many of these care processes were unfamiliar to practice staff. In order to support practices, a number of these care processes were removed on review in December 2022.

3. **Recommendations**

- The Primary Care Board is asked to note the reflections on the ECF for 2022/23, including the benefit it has delivered and the challenges that have been encountered.
- The Board is asked to endorse further work to develop the support tools for primary care, to improve the quality of information recorded in the clinical record.

4. **Next steps**

- Learning from the ECF in 2022/23 has been considered in the development of the ECF for 2023/24 and will continue to inform further work on the ECF. The 2023/24 specification will be shared with the Primary Care Board.
- Data and insights derived from the ECF will be used to inform discussions within practice, PCNs, localities and Place based partnerships.
- Further development of the ECF will need to consider the direct of travel for national contracts.

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:**	**23/03/2023**	
Report Title:	**Acute Respiratory Hubs Evaluation**				**Agenda Item:**	**9.3**	
Report Author(s):	Julia Lisk, Primary Care Manager, Hertfordshire and West Essex ICB Renate Scheffer, Primary Care Manager, Hertfordshire and West Essex ICB Kathryn Sharp, Primary Care Manager, Hertfordshire and West Essex ICB						
Report Presented by:	Roshina Khan, Head of Primary Care Transformation Integration Development and Delivery, Hertfordshire and West Essex ICB						
Report Signed off by:	Avni Shah, Director of Primary Care Transformation Hertfordshire and West Essex ICB						
Purpose:	**Approval / Decision**	☐	**Assurance**	☐	**Discussion**	☐	**Information** ☒
Which Strategic Objectives are relevant to this report **[Please list]**	▪ Improving outcomes in population health and healthcare ▪ Tackling inequalities in outcomes, experience and access						
Key questions for the ICB Board / Committee:	< Please list two / three key questions for the ICB Board / Committee > ▪ N/A ▪ ▪						
Report History:	N/A						
Executive Summary:	The Acute Respiratory hubs in Hertfordshire and west Essex (HWE) were set up mid-December 2022 as a response to increased winter pressures, including Strep A, activity presenting via NHS 111 and Emergency departments. NHS England had offered funding to Integrated Care Boards (ICBs) to facilitate Acute Respiratory Infection hubs to help manage these pressures. In Herts and west Essex, four community-based hubs were set up, initially for children with suspected Strep A only. As the problem spread to adults, and as part of the system response to winter, the Urgent and Emergency Care board advised to broaden the criteria to allow patients of all ages						

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This paper is an evaluation of these four hubs, including the results of a survey distributed to patients attending the hubs; and also, a survey for the GP practices that referred patients to the hubs.</td></tr>
<tr><td>Recommendations:</td><td colspan="4">To note evaluation</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>
<tr><td colspan="5">Implications / Impact:</td></tr>
<tr><td>Patient Safety:</td><td colspan="4">N/A</td></tr>
<tr><td>Risk: Link to Risk Register</td><td colspan="4">N/A</td></tr>
<tr><td>Financial Implications:</td><td colspan="4">£972,000 provided by NHS England for hubs</td></tr>
<tr><td rowspan="3">Impact Assessments:
(Completed and attached)</td><td colspan="2">Equality Impact Assessment:</td><td colspan="2">N/A</td></tr>
<tr><td colspan="2">Quality Impact Assessment:</td><td colspan="2">N/A</td></tr>
<tr><td colspan="2">Data Protection Impact Assessment:</td><td colspan="2">DPIA_Respiratory hubs survey_2023022
Yes
Attached as appendix</td></tr>
</table>

PROJECT PARTICIPANTS AND RESPONSIBILITIES

NAME	ROLE	RESPONSIBILITIES
ROSHINA KHAN	HEAD OF PRIMARY CARE TRANSFORMATION INTEGRATION DEVELOPMENT AND DELIVERY	• Make key decisions within the project together with Director of Primary Care • Lead team members through each phase of the project • Deliver project responsibilities within deadlines • Approve budget and changes • Pivot directions when problems arise • Communicate to team members and senior management • Take inventory of project resources • Key link between all stakeholders and providers
RENATE SCHEFFER KATHRYN SHARP JULIA LISK	PRIMARY CARE MANAGERS	• Relay the projects' objective • Lead team members through each phase of the project • Key link between all stakeholders and providers • Deliver project responsibilities within deadlines • Communicate on roadblocks • Solve problems with resources • Document progress, setbacks, and new processes • Weekly referral data evaluation • Patient experience/ satisfaction survey evaluation review • Practice experience/ satisfaction survey evaluation review • Presenting ARH overview on progress back to key stakeholders • Lessons learned review • Operational Pressures Escalation Level (OPEL) practice level monitoring and appropriate signposting to the respiratory hubs daily

NAME	ROLE	RESPONSIBILITIES
DR AVANI DEVKARAN	GP; LINCOLN HOUSE SURGERY; CLINICAL LEAD: CYP ASTHMA AND TRANSFORMATION: HWE	• Advise on clinical pathway and service specification (Children Young People's Lead was clinical lead, as service was initially for children with suspected Strep A only)
TOBY SCOTT	COMMUNICATIONS & ENGAGEMENT MANAGER	• Write comms for local providers including GP practices, on the establishment of the hubs
HEATHER AYLWARD/ LOUISE MANDERS	COMMUNICATIONS & ENGAGEMENT	• Advise on contents of patient/practice survey for evaluation of hubs • Assist in building survey in Smart Survey online • Support in completing a DPIA for the evaluation survey
PAUL O'HARE /PHIL LUMBARD	PROGRAMME MANAGER – URGENT CARE / UEC SYSTEM LEAD	• Assist with finding locations for the hubs • Advise on contacts within secondary care providers • Acute Data provided when available
PAULINE ANDERSON/ KEITH BRINGLOE	PRIMARY CARE IT FACILITATOR/ HEAD OF INFORMATICS HBLICT	• Help sites ensure they have EMIS/SystmOne practice/ clinical system requirements needed to run the hub and configure direct booking from 111/ other practices
VIRAL BALLACHANDA	SYSTEM TRANSFORMATION MANAGER, HERTS URGENT CARE	• Ensure Adastra is configured so that 111 can refer into the hubs • Ensuring setup of clinical scope so only relevant respiratory patients can be referred to the hub
MEENA CHANA	DIRECTORY OF SERVICES LEAD	• Set up hubs on DOS so they appear to 111 call handlers as a primary referral option for respiratory patients into the hubs, • Maintaining clinic timetables so that the referral pathway is available at appropriate times

1. SUMMARY

The Acute Respiratory hubs in Hertfordshire and west Essex (HWE) were set up mid-December 2022 as a response to increased winter pressures, including Strep A, activity presenting via NHS 111 and Emergency departments.
NHS England had offered funding to Integrated Care Boards (ICBs) to facilitate Acute Respiratory Infection hubs to help manage these pressures.
In Herts and west Essex, four community-based hubs were set up, initially for children with suspected Strep A only. As the problem spread to adults, and as part of the system response to winter, the Urgent and Emergency Care board advised to broaden the criteria to allow patients of all ages with non-life-threatening respiratory conditions or exacerbated chronic respiratory conditions, to be referred into the respiratory hubs.
This paper is an evaluation of these four hubs, including the results of a survey distributed to patients attending the hubs; and also, a survey for the GP practices that referred patients to the hubs.

1.1 PROJECT OVERVIEW

1.1.1 OUTLINE

OBJECTIVE
Provide timely and appropriate care for patients with respiratory problems whilst reducing pressure on local acute hospitals and 111, and on practices reporting high Operational Pressure Escalation Levels (OPEL) status.
DELIVERABLES
• Support patients with urgent clinical needs by offering same day access to assessment and advice for respiratory conditions • Seek to reduce ambulance callouts, A&E attendances, and hospital admissions where these can be managed in the community via the local hubs • Reduce the burden on primary care whilst avoiding nosocomial transmission by directing infectious patients to hubs, rather than attending GP waiting rooms • Offer the service in a convenient location with flexible hours e.g., via weekend appointments
MEASURABLES
NHS England asked that systems move to establish these hubs with short notice in December 2022. It was recommended that each hub is created to serve a population of approx. 250,000 people – though a precise scale would depend on local circumstances. Funding was made available to ICBs on this basis to enable a minimum of 15 weeks of new or additional ARI hub capacity to be delivered by 31 March 2023. ARI hub appointments should be prioritised for paediatrics to support current pressures and flexed according to demand. Local data set agreed with providers included the following: Number of referrals into service and appointments that were not attended Referral source Aged 18+ Prescribed antibiotics Discharged no further action Referred to ED Referred to own GP Data review on referrals

1.1.2 PROJECT PLAN

KEY MILESTONES	KEY RISKS	COMMENTS
Set up the respiratory hubs at short notice by mid-December 2022 to start up and see patients by 13 December 2022. Development of the respiratory referral pathway and service specification by the Clinical lead by mid-December 2022 Weekly referral data evaluation by HWE ICB respiratory hub leads and reporting back to key stakeholders started in mid-December once the hubs were up and running Operational Pressures Escalation Level (OPEL) practice level monitoring and appropriate signposting to the respiratory hubs started in January 2023 to alleviate pressures on Primary Care Development of the patient and practice surveys for the respiratory hubs by the start of February 2023	Under utilisation of the respiratory hubs will result in more pressures in A&E, NHS 111 and general practice in terms of capacity, time, and workforce demand to see patients with respiratory conditions. On days that the hub was closed due to staffing and workforce pressures, more patients needed to be seen in primary care and A&E.	The Acute Respiratory Hubs (ARH) are a system rollout respiratory pathway to support general practice, A&E and NHS 111 referrals to local respiratory hubs for people with respiratory conditions. The progress on referrals is monitored weekly and the data shared back with NHSE, internal stakeholders and practices where appropriate

1.1.3 PROJECT COSTS

<table>
<tr><th>INITIAL BUDGET 2022/23</th><th>ACTUAL BUDGET 2022/23</th><th>COMMENTS</th></tr>
<tr><td>£
972,000</td><td>£ 972,000</td><td>Breakdown of the use of NHS England funds is as follows (see description immediately below the table):
<table>
<tr><th>Funding Breakdown</th><th>£</th></tr>
<tr><td>Hertsmere Potters Bar/Borehamwood hub</td><td>178,000</td></tr>
<tr><td>Dacorum Hemel Hempstead hub</td><td>302,000</td></tr>
<tr><td>Lister Medical Centre Hub</td><td>144,000</td></tr>
<tr><td>Stevenage North PCN Hub - Canterbury Way Surgery</td><td>348,000</td></tr>
<tr><td>Total budgeted HWE ICB</td><td>972,000</td></tr>
</table></td></tr>
</table>

In **Hertsmere**, Hertfordshire Community Trust (HCT) started on 21st Dec in Potters Bar Community Hospital. This service transferred to Herts Health Ltd (the Hertsmere GP Federation) from 6th February – 3 days per week at Parkfield Medical Centre in Potters Bar and 4 days per week at Fairbrook Medical Centre in Borehamwood.

Dacorum Healthcare Providers Ltd (the Dacorum GP Federation) started on 16th Jan, based in Hemel Hempstead Hospital.

HCT started on 21st Dec in **Lister Medical Centre** in Harlow, west Essex**.**

In **Stevenage North**, the PCN started a hub in their Canterbury Way surgery on 13th December.

Wherever HCT were commissioned, they worked collaboratively with local GPs who worked as locums for the service.

1.1.4 PROJECT BENEFITS

PREDICTED BENEFITS	ACTUAL BENEFITS (SHOWN IN DATA OR WITHIN COMMENTS)	COMMENTS
Improved patient care	• Opened capacity to general practice for respiratory patient appointments • Health inequalities addressed as patients are seen locally • Better outcomes for patients in being seen in the most appropriate setting for respiratory conditions	The NHS LTP commits to developing more joined-up and coordinated care across primary and community health services and a more proactive approach for the services provided. The respiratory hubs were set up to support patients with urgent clinical needs by offering same day access to assessment and advice for respiratory conditions at local respiratory hubs.
Patient Choice	• Streamlining access to care and advice for people who have respiratory symptoms in winter.	The hubs play a key part in the forward planning and developing of a fully integrated community-based health care system with the focus on winter pressures in this instance.
Ease pressure across NHS system	• Reduce unnecessary attendances/ ambulance journeys and cross infection of patients	By referring and signposting patients into the respiratory hubs, practices and A&E departments were able to see patients for other conditions
Improved workforce	• Integrated working with primary/ secondary/community care and NHS 111	GPs, Practice Nurses, Health Care Assistants & admin staff are part of the workforce at all respiratory hubs. All partners worked together to set these up. The HCT vaccination team were utilised at short notice to support the respiratory hubs in two places.

PREDICTED BENEFITS	ACTUAL BENEFITS (SHOWN IN DATA OR WITHIN COMMENTS)	COMMENTS
Improved Digital Integration	• Shared appointment books remotely accessible to all practices in place/ICB via their own system	Digital interoperability between NHS 111 and GP practices via EMIS, SystmOne
Estates	• Suitable clinical hub spaces were identified and made fit for purpose at short notice	

1.1.5 PROJECT COMMUNICATIONS AND ENGAGEMENT

The respiratory hubs were identified as a priority and were required to be set up at short notice. Stakeholder engagement across the ICB with all relevant teams was pivotal in setting up these respiratory hubs in response to an increase in Strep A activity seen at the start of December 2022.

1.2 LESSONS LEARNED

- Collaborative working with all stakeholders from the start
- Winter Pressure Planning from September would have allowed us to think about standing up services to manage seasonal conditions in advance to any unexpected outbreaks
- Earlier monitoring of trends e.g., significant rise suspected Strep A cases
- A quicker response to the rise in Strep A would have allowed the ICB to stand up a service sooner during the peak of demand and allowed the existing pool of locums to be booked ahead of time, ensuring consistent full staffing of the hubs.
- Funding from NHSE could be allocated from August onwards for future planning

2. EVALUATION

A survey was written for patients, to ask 5 questions about their experience at one of the hubs. This was published online on the Smart Survey website and the link was texted to patients that had attended the hub. A separate survey for practices was also added to Smart Survey and emailed to practices that had referred their patients to one of the hubs. The survey period was one week; however providers sent the link to patients who had previously attended the hub.

Survey responses:
From patients 83
From Practices 14

Patient answers

1. Who arranged your appointment at the hub?				
Answer Choices			**Response Percent**	**Response Total**
1	Your GP practice		83.13%	69
2	A&E		0.00%	0
3	111		16.87%	14
4	Not sure		0.00%	0

2. How good was the healthcare professional that you saw at:						
Answer Choices	**Very Good**	**Good**	**Neither good nor poor**	**Poor**	**Very poor**	**Response Total**
Giving you enough time	84.34% 70	14.46% 12	0.00% 0	0.00% 0	1.20% 1	83
Listening to you	81.71% 67	15.85% 13	1.22% 1	0.00% 0	1.22% 1	82
Clearly explaining your illness and treatment	75.90% 63	22.89% 19	0.00% 0	0.00% 0	1.20% 1	83
Treating you with care and concern	83.13% 69	14.46% 12	1.20% 1	0.00% 0	1.20% 1	83

3. Do you feel that the appointment met your health or treatment needs?				
Answer Choices			**Response Percent**	**Response Total**
1	Yes fully		87.95%	73

2	Yes partly		9.64%	8
3	Not at all		2.41%	2
4	Unsure		0.00%	0

4. How would you rate your experience at the respiratory hub on a scale of 1 – 5 with 1 being poor and 5 being excellent?

Answer Choices			Response Percent	Response Total
1	1		3.61%	3
2	2		1.20%	1
3	3		1.20%	1
4	4		16.87%	14
5	5		77.11%	64

Summary of Patient Survey Responses:

83% of the 83 respondents to the patient survey had been referred to their GP. This matches the proportion of patients referred to the hub by their GP in February (although the figure was lower – 57% in January). Therefore, patients referred to the hub by their GP are over-represented in the survey.

Patients completing the survey appear positive about their attendance at the hub, with at least 76% responding with the most positive response possible in each question. Only one patient reported that they felt the healthcare professional they saw was very poor at each of these: a) giving enough time, b) listening, c) clearly explaining the illness and treatment, and d) treating with care and concern. One patient felt that the listening and treating with care and concern was neither good nor bad. The remainder responded 'good' or 'very good' to these questions.

77% rated their experience at the hub excellent and 17% rated it as 4 out of 5. 3 patients (3.6%) rated it the worst possible score of 1 out of 5 and 1 patient (1%) rated the experience 2 out of 5, 1 patient (1%) rated it 3 out of 5.

5. Please provide any additional comments (good or bad) to add to your answers above that will help us in planning future services for patients.

The comments made in question 5 totaled 48. Of these comments, 38 were positive, appreciating the speed of referral, being seen same day, being seen in a hub for a current common issue, being treated with appropriate

medication, being listened to, friendly and helpful staff, would like hub to be repeated next winter or open all year. Examples below.

“I can’t remember the doctor’s name, but he was fab! Really understood what I was rambling about - reception staff were lovely too! I know you’re all hectic and busy so appreciated the whole experience! Thankyou!!”

“Fantastic service! Doctor was really good, gave me a full examination and listened to my symptoms and concerns”

“Excellent to have an appointment face to face so quickly after contacting 111. Great service!”

Four of the responses reported a good service with one downside:

- that they had not been told they had pneumonia and only finding out by reading it later on the form they were given.
- one had an ‘incredible’ doctor at their first appointment for their toddler, but then was disappointed with the doctor they saw when they had to go again.
- that the access to the building was awkward as their appointment time was when door was closed for lunch with no instructions on how to enter, so they needed to bang on a window.
- one patient saw a staff member trying to rudely force a face mask on someone with asthma and a chest infection who was struggling to breathe.

Two of the patients made recommendations:

- the respiratory hub's doctor could write a recommendation for x-ray, or other hospital appointment, and not ask patients to go back to the original GP for a sample tube.
- arrange a follow[-up] appointment

One patient’s prescription went to the wrong pharmacy and struggled to speak to the GP practice hosting the hub about it, as the staff member seemed unaware of the hub and how a non-registered patient could have attended. Fortunately this was resolved by another staff member.

One patient commented that the hub appointment was only needed as it is not possible to obtain appointments at the surgery, and wanted to know why the service would be stopping.

One patient commented they had to attend the GP surgery 2 days later and was taken from there as an emergency to hospital.

One comment was from a patient who was unable to be seen, despite having an appointment, shown below:

“111 gave us an appointment time of 2pm, we made the journey to the practice, and when we arrived the Dr refused to see my daughter who is 2.5 years old. She stated my daughter was not medically urgent and she closes the practice at 2pm so she turned us away. I am shocked and appalled that a small child could be refused medical attention because a Dr wanted to finish her shift on time. We were given a 2pm appointment, the Dr should have seen my daughter. “

Practice answers

1. How did you find the referral process into the hub? - on a scale of 1 – 5 with 1 being poor to 5 being excellent?				
Answer Choices			**Response Percent**	**Response Total**
1	1		0.00%	0
2	2		7.14%	1
3	3		14.29%	2
4	4		35.71%	5
5	5		42.86%	6

2. Are you receiving the records about your patients' consultations at the hub?				
Answer Choices			**Response Percent**	**Response Total**
1	Yes		100.00%	14
2	No		0.00%	0

3. Has your practice experienced any barriers when booking patients into the service?				
Answer Choices			**Response Percent**	**Response Total**
1	Yes		42.86%	6
2	No		57.14%	8

4. Has the acute respiratory hub helped your practice to manage the demand of winter pressures?

	Answer Choices		Response Percent	Response Total
1	Yes		78.57%	11
2	No		21.43%	3

Summary of Practice Survey Answers

Of the 14 practices responding to the practice survey, 43% found the referral process excellent and 36% rated it at 4 out of 5. The remaining 21% were not so positive. 43% experienced barriers when booking their patients in. This is most likely because direct booking by GP practices was not available until early February. Previously, booking a patient in meant doing so by phone, sometimes involving two phone calls. The comments indicated this, two practices saying that once the booking was integrated into the local clinical system it became much easier.

100% of the 14 practices received the records about their patients' attendances at the hub, and 78.6% reported that the hub helped them manage winter pressure demands.

5. Do you have any comments about the hubs?

Twelve of the practices made comments about the hubs. Six of these were positive, about the hub being local, well organized, helpful for patients and practices. Example below.

"Very good feedback from patients - 'I know there are criticisms of 111 and General Practice but this was seamless, and I am very impressed' (patient booked in and seen 26/2/23 from 111)"

Further comments included that the location of the hub was not ideal for them, being based in a local but different town, because some patients will not leave their town. One practice felt that if the service had been delivered in-house by the practice; tests, referrals and follow-ups would have been easier to manage; appointments would have been open earlier for booking into.

Five comments related to the potential widening of the referral criteria to minor illnesses. It was felt that this would avoid wasting unbooked appointments.

Provider activity data

Our data source is:
East and North Herts hub – PCN from SystmOne
South and West Herts hubs – Hertfordshire Community Trust (HCT) and Herts Health Limited
West Essex hub - HCT data capturing from SystmOne

Data collection was sporadic in the last week of December, hence reporting from January. GP recruitment was impacted by bank holidays and lack of availability at short notice (GPs were needed on site for the service to run). The Lister Medical Centre hub was closed for 2 weeks in January and the Stevenage North hub was closed for 4 weeks from mid-January. In Hertsmere, the service shifted from one provider to another early February. Hence the data are presented for the four sites combined, rather than split by hub.

Referral data

Below are the number of referrals split per month with uptake (referrals as a proportion of appointments available). This is continuously being monitored through regular reporting.

Month	Uptake	Total referrals	Referred from ED	Referred from 111	Referred from GP	DNAs
January	36%	909	1%	41%	57%	6%
February	74%	2063	2%	14%	84%	6%

Uptake increased from 36% to 74% between January and February. Low uptake was observed and hence the service was opened to further practices reporting high Operational Pressure Escalation Levels (OPEL) status. Initially, this was not open for practices to refer in directly. Mid-January, the hubs were opened for practices reporting level 3 (out of a possible 4). This was extended to those reporting level 2 for demand early February. This increased uptake significantly as seen above. Also, services became more established, and practices were able to book in directly via their clinical systems, SystmOne or EMIS (rather than via a phone call).

Emergency department (ED) referrals were low throughout, this is thought to be due to patient resistance to be referred to another place once they have presented in A&E.
GP referrals into the service were 57% of all referrals in January, 41% were from 111. The gap between GP and 111 referrals increased in February, when GPs were 83% of all referrals and 111 just 13%. This is due to a decrease of respiratory calls to 111.
Did Not Attends were at 6% in both months, this was reportedly sometimes due to the patient managing to get into their practice in the meantime.

Outcome data

Month	Aged 18+	Prescribed antibiotics	Discharged no further action	Referred to ED	Referred to own GP
January	52%	25%	64%	4%	2%
February	62%	42%	61%	3%	3%

As the Strep A activity in EDs decreased, the number of children presenting at the hubs decreased and by February there were 10 percentage points more adults aged 18 plus (62% compared to January's 52%) than children. 25% were prescribed antibiotics in January compared to %42 in February. Different hubs were open at different timepoints throughout this period (for example the takeover of the Hertsmere by hub by the local GP Federation from Hertfordshire Community Trust).
Similar proportions of patients were discharged with no further activity in January (64%) compared to February (61%). In terms of referrals back to ED following the appointment at the hub, these were low in both months (4% in January and 3% in February), and referrals back to own GP practice were 2% and 3% in January and February respectively.

Practices' anecdotal feedback includes:

Midway Surgery in St Albans: "demand remains at higher winter levels (hence level 2) but we've been able to put staffing levels to 1 Green as our ability to cope has been improved by the respiratory hub."

Discussion from a south and west Herts Practice Manager meeting 1st February 2023:

- Chorleywood Health Centre – If we run out of appointments and our urgent clinics are overflowing, do we then have to call for additional appointments at the hub and if there's a way of doing any direct booking. *Response* – Currently this week it's phone calls. In the following week for Hertsmere, they will be directly bookable via EMIS. Further communication will follow.
- Is there any thought of having a more local hub in the West Herts area. *Response* – Unfortunately not at the moment, we don't have any plans for a hub at Watford.
- Annandale Medical Centre – Parkfield have only got two days, is there an indication that later on there will be three days for Parkfield in Potters Bar. *Response* – There will be an additional day at the weekend. In the beginning it will be Fairbrook to start with at the weekend, but then it will change to one day at Fairbrook and one day at Parkfield.
- Highview Medical Centre – It's an extra set of appointments and we found it very helpful. We want to keep a full service of three days in Potters Bar because it's the first time that Potters Bar have ever had this service.

Feedback on the Harlow Respiratory Hub:

- At the Uttlesford Locality meeting on the 2nd of February, Lucy from Eden Surgeries mentioned that their experience of using the hub was positive.
- The Harlow respiratory hub (for paediatric patients) was also name checked as useful by Liz Owen (GP) in the Paediatrics Quality Group on the 2nd of February 2023.

Next Steps:

Hubs are due to close at the end of March 2023 due to decrease in demand and uncertainty about future funding.

Planning for Winter pressures for 2023/2024 to start in spring/ summer 2023, ahead of time with plenty of time for planning. The strategic thinking from the Next Steps for Integrating Primary Care: Fuller Stocktake report is to develop a single system-wide approach to managing integrated urgent care to guarantee same-day care for patients and a more sustainable model for practices. This should be for all patients clinically assessed as requiring urgent care, where continuity from the same team is not a priority. Same-day access for urgent care would involve care from the most clinically appropriate local service and professional and the most appropriate modality, whether a remote consultation or face to face.

DATA PROTECTION IMPACT ASSESSMENT V0.5

This Data Protection Impact Assessment form should be completed as part of the business case for all new services, information systems and processes which involve the use of personal/special category data or business sensitive data or a change that will significantly amend the way in which personal/special category data or business sensitive data is handled.

Make a distinction whether this project is a new process where a new dataset is being created or a change in dataset, or a change to an existing one procedurally e.g. a change in system used to collect data. For changes indicate if an existing DPIA has been done

GENERAL OVERVIEW

☒ New data collected ☐ Change of data collected ☐ New system ☐ Change of system ☐ New process ☐ Change of process ☐ New service ☐ Change of service ☐ Has existing DPIA (please include)

1	The name of the data collection, service, process or system:	Respiratory Hubs – patient and practice survey
2	The name of the responsible lead:	Julia Lisk
3	Have the key stakeholders been identified? Please identify them.	Patients, or carers of patients, who have attended the respiratory hubs. Also staff from GP practices who have referred patients into the respiratory hubs.
4	What is the project purpose or main aims?	Data collected from the survey will feed into an analysis of the respiratory hubs which support decision making on future services.
5	List the main activities for the project:	The survey will consist of these sections: For patients that used the service: - Questions on how patient was referred in - What they thought of the health care received - Comments on the service For practices that referred patients into the service: - Questions on how easy they found referral process - Records they get back about their patients appointment at the hubs - Whether the service has helped relieve the practice's winter pressures - Comments on the service The information will be held securely by the ICB and all information shared with the ICB will be anonymous. No individual views will be shared. Where data samples are small, which could potentially lead to identification, this data would not be used in the analysis or reporting presented by the ICB.
6	What are the intended outcomes?	The survey data will be complied into an engagement report. This engagement report will feed into the analysis described in Question 4.

7	Does the planning documentation include all of the purposes for processing the data? Attach all planning documentation with submission.	N/A
	Is there a potential for data collected to be used for new purposes. If yes please elaborate.	☐ **Yes** ☒ **No** Click or tap here to enter text.
SUPPLIER OVERVIEW		
8	Who supplies the system?	Smart Survey
9	What is the suppliers registered address?	SmartSurvey Ltd (registration number: 4885155) Unit 23, Basepoint Business Centre, Tewkesbury, GL20 8SD
10	Is the supplier of the system, registered with ICO? If so please provide details of the registration:	☒ **Yes** ☐ **No** Supplier: As above Registration Number: Z1155070
11	Is the supplier of the system, DSPT (standards Met) (health and social care) If so please provide version details:	☒ **Yes** ☐ **No** https://www.smartsurvey.co.uk/security
12	Has the supplier of the system, implemented ISO27001 or Cyber Essentials Plus. If so please provide a copy of the certification:	CE/CE+: ☒ **Yes** ☐ **No** ISO27001: ☒ **Yes** ☐ **No** Click or tap here to enter text. https://www.smartsurvey.co.uk/security
13	Does the contract state the Data Protection Act and Freedom of Information Act sections? If so please provide a copy of the sections	No contract required
14	What training will the users receive for using the system?	N/A
INFORMATION ASSET REGISTER		
15	Who is the Information Asset Owner?	Nuala Milbourn
16	How long has the information been in use?	N/A
17	What is the Information Asset Register risk rating level?	Click or tap here to enter text.
DATA PROCESSING		
18	Who is the information processed about? (Also known as data subjects) Please select all that apply.	☐ **Employees**
		☒ **Patients**
		☒ **Partner businesses or organisations**
		☐ **Other: Residents in Hertfordshire and west Essex**
19	Type of data being collected.	☒ **Anonymised**
		☐ **Pseudonymised**
		☒ **Personal**
		☐ **Personal Sensitive**

20	What are the Data Fields that will be held on the system or used in the project? Please select all that apply.	☐ **Personal sensitive details** (name, address, Postcode, Date of Birth, NHS number)
		☐ **Family, lifestyle and social circumstances** (marital status, housing, travel, leisure activities, membership of charities)
		☐ **Education and training details** (qualifications or certifications, training records etc)
		☐ **Employment details** (career history, recruitment and termination details, attendance details, appraisals etc)
		☐ **Financial details** (income, salary, assets, investments, payments etc)
		☐ **Criminal proceedings, outcomes and sentences**
		☐ **Goods or services** (contracts, licenses, agreements etc)
		☒ **Racial or ethnic origin**
		☐ **Religious or other beliefs of a similar nature**
		☐ **Political opinions**
		☒ **Physical or mental health conditions**
		☐ **Offences including alleged offences**
		☐ **Sexual health**
		☐ **Trade union membership**
21	Will this system include data which was not previously collected? If yes have you amended existing privacy notices?	New Data: ☒ **Yes** ☐ **No** Amended Privacy notices: ☐ **Yes** ☐ **No**
22	What checks have been made regarding the adequacy, relevance and necessity of data used?	We are collecting the views and suggestions from the public and stakeholders in order to inform our plans, in line with best practice and the requirements of the Health and Social Care Act 2022.
23	Are you transferring any personal or sensitive data to a country outside of the UK the European Economic Area (EEA)? If yes how are individuals made aware that their data will be transferred out of the EEA?	☐ **Yes** ☒ **No** Click or tap here to enter text.
24	Will data collected or processed be shared with others outside of your organisation e.g. third parties, external contractors/consultants etc.	☒ **Yes** ☒ **No**
25	Can the system use pseudonyms or work on anonymous data?	Anonymous: ☒ Yes ☐ No
TECHNOLOGY		
26	Details of IT Lead or Project manager assisting with implementation	**Name: N/A** **e-mail: Nuala.milbourn@nhs.net**

27	Is the use of Cloud technology being used or considered? If yes, provide the data centre location and Tier.	☐ **Yes** ☒ **No** Location: Click or tap here to enter text. Tier: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
28	How will we be alerted to any possible cloud system breaches?	N/A
29	Does the system include new technology that might be perceived as intrusive? (the use of biometrics or facial recognition etc)	☐ **Yes** ☒ **No** Technology: Click or tap here to enter text.
30	Will the system require access to the network provided by xxxxxx? If yes how is this being managed? Include details of location of the system, how this is managed and maintained, any remote support, what is in place to protect Confidentiality, Integrity and Availability. Where required break down responsibilities.	**Is HBL ICT aware** ☐ **Yes** ☒ **No** HLB ICT Contact: **N/A this is not a network** **Does system require access to network?** ☐ **Yes** ☒ **No** Location: Click or tap here to enter text. Management: Click or tap here to enter text.
31	Is DTAC required? All new digital technology should be assessed using the DTAC, even if you are piloting or trialling it. Examples of products include: staff facing and patient facing digital health tech, health apps, medtech and devices with an associated app, systems, web based portals and more. If required, please attach to submission.	☐ **Yes** ☒ **No**
PRIVACY CONSENT		
32	Is there a legal basis for holding and processing the data?	☒ **Yes** ☐ **No** Legal basis: Processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller
33	Do you require the data subjects consent to process or hold the data?	☒ **Yes** ☐ **No**
34	Can the data subjects opt-out of their data being processed? If opt-out available, how will this be managed?	☒ **Yes** ☐ **No** Management: Participation in the survey and provision of data is entirely at the data subject's discretion. There is no obligation to take part in the survey, and for people who do take part, there is no obligation to answer all questions. By taking part in the survey and answering specific questions there is an assumption that participants are consenting for the data they provide to be processed.
35	Is the opt-out widely publicised?	☒ **Yes** ☐ **No** How: Stated clearly on the survey, also alluding to privacy notice on ICB website:

		https://hertsandwestessex.icb.nhs.uk/website/privacy-notice-1/9
36	How will you tell the data subjects about the use of their data?	As above
37	Have you assessed the likelihood of the use of the data causing unwarranted distress, harm or damage to data subjects concerned?	☐ **Yes** ☒ **No** How: Click or tap here to enter text.
38	Have you assessed the likelihood of the loss or damage of the data causing distress, harm or damage to data subjects concerned?	☐ **Yes** ☒ **No** How: Click or tap here to enter text.
39	Could the project result in making decisions and or taking action against the data subjects in ways that can have a significant impact on them?	☐ **Yes** ☒ **No** How: Click or tap here to enter text.
ACCESS		
40	Who will use the system and have access to the data?	The ICB's communications and engagement team and other teams within the ICB who have access to the ICB's Smart Survey account, including the Primary Care Team as commissioners of the survey. They will both use the system to input data from paper surveys and will have access to the data set for the purpose of analysis and reporting. Access is restricted by log-in.
41	What training have users had in patient confidentiality?	All of our staff receive appropriate and on-going training to ensure they are aware of their personal responsibilities and have contractual obligations to uphold confidentiality. They have completed the required mandatory training modules.
42	How will the users access and amend data?	By logging into, and using, Smart Survey portal
43	Is there a usable audit trail in place for the information asset?	☒ **Yes** ☐ **No**
44	How often will the system be audited?	Minimum once a year. Records are reviewed when required such as when a security event or suspicious activity is suspected.
DATA STORAGE		
45	Where will the data be stored?	The data will be stored by Smart Survey, using their secure LAN drive.
46	Could the system change the way data is stored?	☐ **Yes** ☒ **No** How: Click or tap here to enter text.
47	Which format will the data be stored in?	☒ **Electronic**
		☒ **Paper**
		☐ **Verbal**
		☐ **Other:** Click or tap here to enter text.
DATA SHARING		

48	Will the data be shared with any other organisations?	☐ **Yes** ☒ **No**
49	Are there any Information Sharing Agreements or protocols in place? If yes please attach with submission.	☒ **Yes** ☐ **No** https://hertsandwestessex.icb.nhs.uk/website/privacy-notice-1/10
DATA SECURITY		
50	What security measures have been undertaken to protect the data?	Smart Survey publishes its security and data protection measures here: https://www.smartsurvey.co.uk/security#how-smartsurvey-protects-your-data
51	Are there business continuity plans in place in case of data loss or damage? (As a result of human error, virus, network failure, theft, fire, floods etc.) Please attach with submission.	☒ **Yes** ☐ **No** https://www.smartsurvey.co.uk/security#how-smartsurvey-protects-your-data
52	Third Party Supplier due diligence ISQ and outcome	Interpreting this as the privacy of respondents, this is covered in part 2 of the Smart Survey privacy policy: https://www.smartsurvey.co.uk/privacy-policy
DATA QUALITY		
53	Who provides the information for asset?	People who fill in the survey will provide their own views and information.
54	Who inputs the data into the system?	The survey will be available as a paper survey and also available for people to complete on-line. Information will be put into the system by participants completing an online survey. Where people complete the paper version of the survey, members of ICB staff will input the data from the paper form into Smart Survey.
55	How will the information be kept up-to-date and checked for accuracy and completeness?	N/A – the data will not need updating as it is a one-off project
56	Can an individual (or a court) request amendments or deletion of data from the system?	☒ **Yes** ☐ **No**
ON-GOING USE OF DATA		
57	Could the project interfere with the privacy under article 8 of the Human Rights Act? If yes please describe how.	☐ **Yes** ☒ **No** How: Click or tap here to enter text.
58	Will the data be used to send direct marketing messages?	☐ **Yes** ☒ **No**
59	If direct marketing messages will be sent, are consent and opt-out procedures in place?	☐ **Yes** ☐ **No** N/A
60	Does the system change the medium disclosure of publicity available information?	☐ **Yes** ☒ **No** How: Click or tap here to enter text.
61	Will the system make data more readily accessible than before?	☐ **Yes** ☒ **No** How: Click or tap here to enter text.
62	What is the data retention period for this data? (The retention schedules set out in the Records Management NHS Code of Practice.)	For the duration required to complete the dataset's purpose. Information is retained for a certain time after the purpose has been completed

63	How will the data be destroyed when it is no longer required?	Final personal data will be deleted 1 year after the end of the project (proposed April 2024 dependent on start date). The ICB project management system will track required retention dates on project data. Upon the expiry of a retention period, a notification will be sent to the responsible person. Any data classified as sensitive information relating to projects is securely destroyed at the end of the agreed retention period recorded in the Project System. Other sensitive information is reviewed periodically and securely destroyed when the information asset is no longer required. All physical information that needs to be securely destroyed is placed in a secure bin for shredding. These bins are emptied by a supplier listed on the approved suppliers list. If a respondent would like to withdraw their information, then every effort will be made to do this. In some cases it will not be possible to identify a person's response.
DPIA AUDIT		
64	The name of the person who completed this form:	Julia Lisk
65	The role of the person who completed this form:	Primary Care Manager
66	The email address of the person who completed this form:	julia.lisk@nhs.net
67	Form completion date:	**23/02/2023**
Once complete, send a copy to:		

Information Governance Manager
Information Asset Management Coordinator / IG Officer

Risk Assessment

USE THE FOLLOWING RISK MATRIX TO DETERMINE THE RISK RATING FOR EACH IDENTIFIED RISK.
Please refer to the ICB Risk Management Policy.

	LIKELIHOOD				
	1	2	3	4	5
CONSEQUENCES	Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

This is obtained by multiplying the **LIKELIHOOD SCORE (L)** by the **CONSEQUENCES SCORE (C**) L x C = R

IDENTIFY AND ASSESS RISKS			ESTIMATED SCORE			IDENTIFY MEASURES TO MITIGATE THE RISKS	MANAGEMENT SYSTEM	
Risk No.	Date Open	Identified and articulate the risk using **'IF', 'THEN' and 'RESULTING IN'.** Include associated compliance and corporate risks, as necessary.	L	C	R	Possible Solutions to Minimise Risk	Recorded on Risk Register, Yes/No?	Date it risk was recorded
1	People's contact details are accessed inappropriately	- Click or tap here to enter text.	1	3	3	Supplier has ISO27001 accreditation (see section on security measures in place and audit process for full detail)	Choose an item.	Click or tap to enter a date.
2	Data is leaked	Click or tap here to enter text.	2	4	8	Supplier has ISO27001 accreditation (see section on security measures in place and audit process for full detail)	Choose an item.	Click or tap to enter a date.
3	Reputational risks to Smart Survey and the ICB if data is shared inappropriately	Click or tap here to enter text.	1	2	2	Supplier has ISO27001 accreditation (see section on security measures in place and audit process for full detail)	Choose an item.	Click or tap to enter a date.

4	Click or tap to enter a date.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.	Choose an item.	Click or tap to enter a date.
5	Click or tap to enter a date.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.	Choose an item.	Click or tap to enter a date.

PAGE TO BE COMPLETED BY INFORMATION GOVERNANCE	
ICO Registration details received?	☐ **Yes** ☐ **No**
ISO27001 certification received?	☐ **Yes** ☐ **No**
IG Toolkit compliance seen? (Health & Social Care)	☐ **Yes** ☐ **No**
DPA & FOI sections received?	DPA: ☐ **Yes** ☐ **No** FOI: ☐ **Yes** ☐ **No**
Has this been reviewed by the wider IG Team	☐ **Yes** ☐ **No** Who: Click or tap here to enter text.
DPIA OUTCOME – DPO comments	
Click or tap here to enter text.	

Information Governance Reviewer Name: Click or tap here to enter text.

Data Protection Officer Signature: Click or tap here to enter text.

Date of review Click or tap here to enter text.

The name of the owner of the asset/risk: Click or tap here to enter text.

Signed:

Date: Click or tap to enter a date.

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:**	**23/03/23**		
Report Title:	**Primary Care Risk Register**			**Agenda Item:**	**11**		
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:	Specific risks now discussed at various subgroups in the governance structure						
Executive Summary:	The HWE ICB Primary Care Risk Register is a standing agenda item at both the HWE Primary Care Board and Primary Care Commissioning Committee.						
Recommendations:	The Board is asked to • Note the proposed changes to the risks that have been reviewed • Note the update and progress made						
Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***		☐		
	Financial	☐	***Non-Financial Personal***		☐		
	None identified				☒		
	N/A						

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

Previously a summary of the high-level risks associated with Community Pharmacy, Optometry and Dental (POD) delegation was provided. Further work has now been completed and 3 primary care specific risks are being proposed for inclusion on the risk register.

As noted in previous updates, there are a number of workstreams sitting in other directorates (such as Estates, IT and Digital) that have a direct bearing on the development and delivery of primary care services and as such it is important that any significant associated risks are reported to the Primary Care Board. An important milestone has been reached in this regard, with a summary of key Digital First Programme risks now included in the risk register for the first time.

A long-standing risk relating to dental service access has been transferred to the Primary Care Directorate from the Finance Directorate. Further review of this risk is required to reflect the ICB POD delegation responsibility from 1st April onwards.

Some updates have also been made to existing risks and these are outlined below:

Risk 538: related to COVID-19 Mass vaccination centres – On 24 Feb-23 NHSE announced the Spring Booster campaign, focused initially on care homes & housebound patients; subsequently on over 75s & pts aged 5 and over who are immunosuppressed.

Given that this risk specifically concerns mass vaccination centres, a review following the recent NHSE communication has determined that the current risk rating remains appropriate. However, a wider review of the *scope* of this risk will be undertaken.

Risk 617: related to the growth in the placement of asylum seekers in local hotels – this risk has been updated in light of discussions at the February PCCC and identification of the need to develop alternative models of service provision.

Additional control measures & updates have been added to the following **risks 320, 321, 323, 327 and 537**

New text is highlighted in red font on the register, which is included as an appendix.

The primary care risk review group that was established to ensure the risk register is regularly reviewed and updated, continues to meet monthly.

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

2. Background

The HWE ICB Primary Care Risk Register is a standing agenda item at both the HWE Primary Care Board and Primary Care Commissioning Committee.

3. Issues

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. It is expected that estates risks will be included in the next update.

4. Actions

The following new risks have been included:

POD Delegation risks - As noted in the previous section, 3 primary care specific risks related to POD delegation have been included for the first time. These bring together key constituent risks under the headings of finance, TUPE and Quality. Work continues at pace with NHSE to ensure all risks associated with each of the POD services have been fully understood and described, noting the imminent commencement of the ICB's delegated responsibilities (from 1st April).
These risks are currently annotated separately, however the intention is that these will become fully incorporated into the Primary Care Risk Register.

Risk 244 – This long-standing risk recorded on Datix was previously owned and updated by the Finance Directorate, as part of its responsibility for contracting arrangements. In preparation for the impending delegation of POD commissioning responsibility to the ICB, this risk has been transferred to the Primary Care Directorate. This risk focuses on the '*potential lack of access to dental services and subsequent impact on a patient's treatment and care resulting in a potential deterioration of health'.*
Further review of this risk is required to update the key controls, gaps in controls and lines of defence, to reflect the transfer of commissioning responsibility.
Further understanding the challenges facing dental services will be a priority for the Primary Care Team in the coming year.

Digital First Programme risks – 3 key risks from this programme, which are directly relevant to primary care, have been included.
These risks are noted separately and sit outside of the primary care risk register.

Existing risks have been updated as follows:

Risk 538: related to COVID-19 Mass vaccination centres – On 24 Feb-23 NHSE announced the Spring Booster campaign, focused initially on care homes & housebound patients; subsequently on over 75s & pts aged 5 and over who are immunosuppressed.

Given that this risk specifically concerns mass vaccination centres, review following the recent NHSE communication has determined that the current risk rating remains appropriate. However, a wider review of the *scope* of this risk will be undertaken.

Risk 617: related to the growth in the placement of asylum seekers in local hotels – this risk has been updated in light of discussions at the February PCCC and identification of the need to develop alternative models of service provision.

Additional control measures & updates have been added to the following: **risks 320, 321, 323, 327 and 537**. These include the further mitigation via adjustments to the ECF, QOF & IIF, for all practices & PCNs.

New text is highlighted in red font on the register, which is included as an appendix.

The primary care risk review group that was established to ensure the risk register is regularly reviewed and updated, continues to meet monthly.

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

5. Resource implications

Reported capacity constraints in the premises team as noted above.

6. Risks/Mitigation Measures

As noted above.

7. Recommendations

The Committee is asked to:

Note and approve the changes to the risk register – new and existing risks.

Continue to receive the risk register at future meetings (in accordance with the Committee's Annual Cycle of Business), satisfying itself that risks are being appropriately identified, rated and mitigated as far as possible.

8. Next Steps

Ongoing review and update of the risk register.

Ensure that all approved 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	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	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	ENH Head of PC Transformation	**IF** pressures in general practice 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. 15. Feb-23 update - ICB QOF/IIF mitigation support offer made to all practices & PCNs	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	• EQC 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	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. 5. GP Transformation plans are currently being agreed for 22/23 work into 23/24. These have a key focus on the implementation of intergrated neighbourhood teams & urgent on the day access	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	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. 9. GP Transformational are currently being agreed. 10.Estates heatmap and rag rating system to support the practices in most need. 11. Girft data dashboard now accessible to monitor and provide early support to practices. 12. Access data dashboard to be launched shortly to give additional valuable data for practices to use in transformation and development.	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

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PC5	324	04/03/2022	1 2 3 4	Primary Care Commissioning Committee	Director of Primary Care Transformation	AD for Primary Care 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 for Primary Care 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	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. 4. Further ARRS roles have been developed (Transformation/digital role) 5. Engagement with MDT continues, so backlogs can be cleared 6. Feb-23 update - ICB QOF & IIF mitigation support offer made to all practices & PCNs.	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 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**

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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	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 6. Further ARRS roles have been developed (Transformation/digital role)	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**
	538	09/11/2022	1 2 3 4	Primary Care Commissioning Committee	Director of Primary Care Transformation	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 NOTE - 24 Feb-23 announcement of Spring Booster campaign, focused initially on care homes & housebound pts; subsequently on over 75s & pts aged 5 and over who are immunosuppressed. Further review of this risk is required, however given this risk specifically focuses on Mass Vaccination Centres then initial thinking is that this campaign is not considered to change the risk rating. A wide	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**

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	6317	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 District Councils, Voluntary Sector/Hotel Management/Housing Managers to ensure that intelligence is shared and report any issues 2. Collaborative discussion with GP practices, PCNs & LMC to support newly 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. 4. One-off payment to Practices where they have registered a Ukrainian National and undertaken a full Health Assessment (payment @£150 per patient) agreed at February PCCC.	1, New Model of Care initial options discussed at PCCC (February 23) . Further work up required to present the model/spec at the next PCCC (April 23) 2. 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. PCCC February 23 - Updated paper outling costs to date, following the impact of Spot Hotels accross HWE - YTD costs given should the hotels still remain in place, taking into account where NHSE funding offsets some of the ICB costs. 3. New Hotels - since the impact of Spot Hotels (which most have moved to IAC status) there has been no new sites/hotels. We are now aware of a possible 3 new Hotels being stood -up in March 23 (1 in SWH and 2 in WE) potential numbers/occupancy of hotels circa 500 new arrivals 4. There is potential for increased risk if agreement not reached to extend the current arrangements. New Model of Care would need to be procured for potential new sites & woul not take over the current provision. New Model of Care would be to 'work-up and manage' large cohort numbers, before handing back to Primary Care.		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 potentially at risk	**Reviewed and approved by PCB Jan-23**

Transition Risks

Risk Profile															Assurance Mapping							
ID	Datix ID	Date Opened	HWEICS Strategic	Committee	Executive Owner	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 ass	**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 ass	**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**
New risk - Mar-23		13/02/2023		Primary Care Digital Group	Director of Primary Care Transfor	DFPC Programme manager	**IF** The programme is unable to recruit the roles with the relevant skill set knowledge of the systems within primary care and how the OCVC system integrates in to the vacant posts **THEN** The will be a gap in resource and experience needed to develop, deliver and implement the programme **RESULTING IN lack of** progression and delivery of the Programme	9	6	6	No movement↔	1. Roles pitched at a comparative band 2. Workload to be monitored to see whether more resources are needed. 3. Forum set up with Primary Care practice staff to support and learn collaboratively to support the work using their expertise 4. Team embedded into primary care and procurement teams to gain understand of digital systems and ICB functions 5. The function is new, opportunity for development to shape the growth 6. Sufficient resources available form NHSE and those who have digitally transformed 7. Team to attend training sessions and meeting with suppliers to learn the systems in place	1. Programme is short term, roles are on a fixed term contract of 12 months 2. Funding applications to NHSE are annually and not guaranteed for the term of the programme	Digital First Primary Care Programme Management Team	Reasonable	Formal Governance via PC Digital Group	Reasonable	PC & Digital Boards Reporting to NHSE	Reasonable	Only 1 recruitment option available	Drafted for PCB review Mar-23
New risk - Mar-23		13/02/2023		Primary Care Digital Group	Director of Primary Care Transformation	DFPC Programme manager	**IF** Digital maturity/ appetite varies across all practices, primary care staff may not able or willing to commit time and resource to allow digital transformation to take place **THEN** There could then be capacity restraint for GP practices, to embed transformation work within the timeframes set out by the programme **RESULTING IN** A poor experience and potential outcome for patients, continued pressure on workforce with primary care and a greater impact on pressure	12	9	6	No movement↔	1. The DFPC project will is in place to identify pressure points within primary care to seek solutions 2. Digital Facilitators are recruited to work on a one on one basis to guide practices and release pressure of change management 3. Establish links with other ICB teams to ascertain support networks and attend necessary meetings 4. Promote the benefits of digital solutions and evidence how they can reduce pressured on primary care 5. GP contract outlines the requirements practices need to deliver digitally 6. Utilise external resources available and amend to suit practice needs 7. Profile each practice and understand their digital maturity and appetite for digital transformation 8. Set up working forum/ group to share best practices and challenges and work collaboratively	1. Limited resource in the DFPC Team to carry out the work 2. OC/VC Procurement delays limiting the work of the DFPC Facilitators to work on a one on one basis with practices 3. Demand and skill sets in place in general practice to manage the change management needed	Digital First Primary Care Programme Management Team	Reasonable	Formal Governance via PC Digital Group	Reasonable	PC & Digital Boards Reporting to NHSE	Reasonable	ICB and HCP structures fully implemented and embedded	Drafted for PCB review Mar-23
New risk - Mar-23		13/02/2023		Primary Care Digital Group	Director of Primary Care Tra	DFPC Programme manager	**IF** Patients with no access to digital technology cannot remotely connect to primary care **THEN** Their Health and Care could be negatively impacted **RESULTING IN** Poor outcomes and services and widening health Inequalities		10	8	No movement ↔	1. Research carried out in the community to ascertain patient needs and challenges contacting GP remotely 2. External commission negates pre conceived ideas internally. 3. Steering group to work through the commission outputs to aide patients who are digitally excluded 4. Socialise the commissioned report with stakeholder to gain commitment and action plans 5. Digital Inclusion part of the wider ICB Digital Strategy	1. Limited resource in the DFPC Team to carry out the work 2. Practices unwilling to support digital in primary care 3. Service design such as websites, making it difficult and frustrating for patients	Digital First Primary Care Programme Management Team	Reasonable	Formal Governance via PC Digital Group	Reasonable	PC & Digital Boards Reporting to NHSE	Reasonable	Not all proposed measures can be introduced in the short term for all practices.	Drafted for PCB review Mar-23

Transition Risks

Risk Profile														Assurance Mapping								
ID	Datix ID	Date Opened	Committee	Executive Owner	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 ass	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
New risk - Mar-23		20/02/2023	Primary Care Commissioning Committee	AD Primary Care Contracting	Head of POD Delegation	**POD Delegation - Finance** **IF** 1) the projected large overspend in Community Pharmacy for HWE of £2.5 million is confirmed & the ring-fencing of dental contracts proceeds (historically used to cover the overspend.) and 2) allocation of dental budget in each ICB in line with the population. **THEN** potentially there will be large deficits in budgets for both Community Pharmacy & Dental. **RESULTING IN** inability to deliver transformation projects/increase access for these contractual areas & necessitate redeployment of ICB funding from other priorities	12	12	8	No movement ↔	1) Concerns have been highlighted to NHSE as part of the SDC submission 2) the issue is similar across all East of England ICBs and NHSE Region are raising this issue with the National Team 3) given the short time remaining before full delegation from 1st April 23, these are now being escalated by all ICBs. 4) Concerns over the process, lack of information and financial risks have been raised by all ICBs within the East of England Region and escalated to the Director of Primary Care and Public Health		ICB task and finish group are meeting weekly to update on progress and issues Meet regularly with NHSE and other ICBs in the Region to share issues and updates	Reasonable	Reports to PCB and PCCC	Reasonable	ICB Exec	Reasonable		Drafted for PCB review Mar-23
New risk - Mar-23		20/02/2023	Primary Care Commissioning Committee	AD Primary Care Contracting	Head of POD Delegation	**POD Delegation - TUPE** **IF** the staff transferred over from NHSE under TUPE arrangements were then subject to future ICBs may be asked to reduce their headcount and running costs **THEN** the ICB may therefore be inheriting redundancy liabilities with the transfer of these staff & have limited resources to absorb the associated workload **RESULTING IN** financial pressure on the ICB &/or reduced ability to undertake the required contractual management functionality	12	12	8	No movement ↔	1) Concerns have been highlighted to NHSE as part of the SDC submission 2) the issue is similar across all East of England ICBs and NHSE Region are raising this issue with the National Team 3) given the short time remaining before full delegation from 1st April 23, these are now being escalated by all ICBs. 4) Concerns over the process, lack of information and financial risks have been raised by all ICBs within the East of England Region and escalated to the Director of Primary Care and Public Health		ICB task and finish group are meeting weekly to update on progress and issues Meet regularly with NHSE and other ICBs in the Region to share issues and updates	Reasonable	Reports to PCB and PCCC	Reasonable	ICB Exec	Reasonable		Drafted for PCB review Mar-23
New risk - Mar-23		20/02/2023	Primary Care Commissioning Committee	AD Primary Care Contracting	Head of POD Delegation	**POD Delegation - Quality** **IF** 1) as planned, there are no quality staff aligned to POD contracts at NHSE, quality review and input to these provider groups is extremely limited and 2) complaints and the national call centre for complaints are part of delegation, with very limited TUPE resourcing **THEN** likely to be unknown issues across providers particularly dentistry where there are high risk procedures, infection prevention and control risks etc; limited ability to manage the required complaints management functionality **RESULTING IN** limited knowledge of & scope to address potential patient safety issues leading to patient harm	15	15	10	No movement ↔	1) Concerns have been highlighted to NHSE as part of the SDC submission 2) the issue is similar across all East of England ICBs and NHSE Region are raising this issue with the National Team 3) given the short time remaining before full delegation from 1st April 23, these are now being escalated by all ICBs. 4) Concerns over the process, lack of information and financial risks have been raised by all ICBs within the East of England Region and escalated to the Director of Primary Care and Public Health		ICB task and finish group are meeting weekly to update on progress and issues Meet regularly with NHSE and other ICBs in the Region to share issues and updates	Reasonable	Reports to PCB and PCCC	Reasonable	ICB Exec	Reasonable		Drafted for PCB review Mar-23
	244	08/09/2020	Primary Care Commissionin	AD Primary Care Contractin		If there is a lack of access to dental services then this will impact on a patient's treatment and care resulting in a potential deterioration of health	16	15	6		Further review required to ensure risk reflects changed position with commencement of POD delegation from 1st April 2023 onwards											

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

APPROVED

Meeting:	**ICB Primary Care Digital**			
	Meeting in public	☐	*Meeting in private (confidential)*	☒
Date:	**Thursday 09 February 2023**			
Time:	**10:00am**			
Venue:	**VIA MS TEAMS**			

NOTES AND ACTIONS

Name	Title	Organisation
Members present:		
Ian Perry (IP)	Partner member Digital Estates Infrastructure Lead (Chair)	HWE ICB
Avni Shah (AS)	Director of Primary Care Transformation	HWE ICB
David Coupe (DC)	GP System architect	HBLICT
Gopesh Farmah (GF)	Primary Care Clinical Digital Lead	East and North place lead
Indy Sunner (IS)	Snr Pharmacist Lead	HWE ICB
James Gleed (JG)	Associate Director Commissioning Primary Care	HWE ICB
Rachel Hazeldene (RH)	Primary Care Digital Lead	ICS wide and West Essex place lead
Parul Karia (PK)	Primary Care Digital Lead	South and west Herts place lead
Phil O'Meara	Primary Care Finance lead	HWE ICB
Sarah Ost (SO)	Programme Director Digital Transformation Strategy	HWE ICB
Joanne Richardson (JR)	Digital First Primary Care Programme Manager	HWE ICB
Kolade Daodu (KD)	Clinical Director, Stevenage South PCN	HWE ENH
Tito Clark (TC)	Project Manager Digital Strategy Primary Care	HWE ICB
Ewan Maddock (EM)		
Sara Lingard (SL)	Transformation Lead NHSE	NHSE

Deepa Dhawan	GP Waltham Abbey, CD Epping Forest PCN	HWE ICB
Maggie Kain (MK) Notes	EA to Primary Care	HWE ICB

PCD/01/23	**Welcome and apologies & DoI**
	Welcomed Apologies from Shane Scott (SS); Phil Turnock (PT); David Ladenheim (DL); Vanessa Moon (VM);
PCD/02/23	**Action Tracker**
	PCD/05/22 – Operation Issues/updates – To produce a way of what the SMS data indicates and what is the msg/comms to practices - trends. AS asked for an update in SMS data trends in two weeks' time. **PCD/06/22** – JG to follow up with PCN Directors to ensure that CL are up to speed on Digital Strategy/plan. JG to follow up and update at future meeting. **Action Closed**. **PCD/03/23** - VWP – to be picked up in the PC Digital Roadmap. **Action Closed**.
PCD/03/23	**Community Pharmacy IT Integration Pilot Update (SL) NHSE**
	SL shared slides updating where Community Pharmacy is at present and an overview. CP IT Pilot HWE Webinar 09.02.23 SL . In the EoE The aim of the pilot to look at the feasibility of implementing and the clinical record within CP and a proof of concept of how it might improve integration efficiencies and patient safety. They identified 40 pharmacies and engaged with them and install a system one TPP unit. EMIS were not interested. Original timeline was 12 months, pilot period ending December 2023, evaluation by March 2024. There is a mixed model of Pharmacies and Practices who have signed up to an SLA which details how they will use the system during the 12-month period. Current position is that there are 35 units issued by TPP, 31 of those units have been configured and deployed to pharmacies to install. There are seven pharmacies that are up and running with the appointment systems. PK: Of the pilot pharmacies that have come on board, it would be interested to see those that are from deprived areas across the patch. IS: Access to the system if locums in, would the service run just as well? JG: asked how does this impact on the referral process on CPCS? DC: asked what reason EMIS gave for not getting involved DD: added that some pharmacies did not want to engage, why can't all practices refer? IS: Pharmacies involved, CPCS, struggled with the 'multiples' pharmacies, i.e., Boots, Lloyds, Tesco. Access to admin on System1 would that be just the pharmacist or any of the pharmacy team? SL responded: • The RA roles that are set up, there will be clinical & admin roles, clinical only roles, technician, clinical and admin and then non-clinical admin. Therefore, different roles set up through smart card access. • The Locums would only be able to access the system if they have got that role on their smart cards. • The multiples were approached at the start, not many engaged, thinking because of how they are set up in their corporate organisations and have their own IT systems, Governance etc. **Action SL:** AS suggested SL to take on board the questions and to email and come back into the Community Transformation group and for TC to link in with Digital Roadmap. in 2-3 months to show data of pilot.
PCD/04/23	**Feedback from Clinical Leads and other key meetings:**
	a) *ICB Wide Digital Clinical lead forum (RH)* RH updated Clinical and Practitioner Reference group, had given a really interesting presentation from the WHHT and Virtual Hospitals. See links below: Full version: https://youtu.be/9m22kVwDaFs

	Shorter version: https://youtu.be/HZZfprv8ZVc b) *National / Regional (RH)* – RH advised group of key priorities and updated on Regional patient access and supporting practices. c) *Assistive Technology Meeting (PK/GF)* GF updated that looking at options in terms of taking the first iterations of AI to assist the OC and Triage platforms. GF will mention at the GP Event and asking for trial practices. *d) Update on PC Digital Roadmap (TC)* – TC shared slides and updated that they have built a robust plan and developed a PC Digital Strategy group. They have buiilt a stakeholder map that adequately identifies and categorises the group. A survey is going out to primary care shortly to practices, patients, GPs, PMs. Alongside that, commencing interviews coupled with questionnaires to ensure qualitative and quantitive insight to better inform the road map and the effect on all levels of stakeholders. AS added that will need encouragement from the group across the board, localities as well as ICB wide to get the feedback. AS**:** added TC to have discussions with LPC, LDC and LOC colleagues. Action: TC to sent to MK questionnaire to share with group for feedback from group, especially any specialised questions for groups. AS : to add Roadmap from CP link to agenda to April meeting .
PCD/05/23	**Operational Update**
	a. Update from each place – monthly report – trends HBLICT DC updated, start of the tech innovation framework, got representation on 7/8 sessions taking part shortly. Will keep group updated. DC updated – meeting set up for 23rd at Charter House, need representation from all the areas to come along to get the data that is needed to get the question out, to get the best methodology for assigning the laptops. DC confirmed that the AI pilot system they are using is e-Consult. **b. HWE Covid Laptop Support & Maintenance Paper** DC summarised paper asking for some funding the 565 laptops purchased at start of Covid. They came with 3yr support and maintenance contract that was paid for by NHSE and comes to an end on 31/03/23, therefore next year, it will be four years since we brought the laptops and plan is to replace them with an NHSE capital bid. We are looking at get someone in, replace them but have a shortfall on the support side of things. Having looked into this best value to support the 565 laptops for another year is £114, 356. This only covers ENH and S&W. DC advised that each laptop costs £202.40. IS asked if there are any plans to replace the old Care Home laptops? DC to look into. DC confirmed that this support would include clinical system support, reinstalling etc. RH asked to consider how WE is included in this. JR asked if there is any way to find out how much support is actually used to support the renewal costs. AS updated the group, GPIT is a finite pot of money, and asked DC to look at further work and how this tie in with the stocktake? To work with HBLICT and the SLAs and operational detail as to what we are getting in terms of support and value for money and what we need to ensure the rolling programme of replacements of kits. Definitely include Gem & Arden which HBLICT is overseeing the contract.

	Action: DC/AS to arrange and work through in a smaller meeting with Phil O'Meara, Phil Turnock, Avni, Alan Pond to take forward. **c. SMS Contract Renewal Paper** DC updated regarding SMS: Our current contract we pay 0.015p that is due to end shortly, EE/ BT have increased cost to 0.0179p which reps 13% increase. We could go on a pay as you go contract at 0.0185p at 17% increase. Been out to other suppliers, best match was 0.0179p. **AS:** Recommend we sign the new contract with EE/BT for 12 months. AS commented that we are still embedding other areas in this. Are practices maximising use of all the options of SMS, NHS App, AccurX messaging. Suggest we need to put some guidance out in terms of how they use some of the messaging services. **Action:** DC/JR plus Clinical lead and Place Lead, to look at the SMS costs (from SS spreadsheet) to review and adapt it with comms to go out to practices. **d. VDI + Paper** VDI is our virtual desktop that gives access to clinical systems in Herts and WE. This project is a 3-way project being SNEE, HWE and BLMK. This is not shared network drives. Current contract ends end of March. Request funding for VDI, if funding doesn't come from the DFPC pot, conscious there is a funding gap around this. The cost expected for a one-year contract for VDI is around £81k per partner, this is on the premis that SNEE, BMLK and HWE all chip in with the total cost of over £200k. We have over 500 users in HWE. Users vary monthly, generally around 200 per month, data shows many different types of users. VDI added this meets the need straight away while struggling to get laptops. Older laptops can be used using VDI. **Action** DC: AS stated that we need to understand risk if other two partners do not come on board, what is the risk and costs? Business case to be part of wider discussion in November in how this fits with the laptops and strategic side in terms of HBLICT looking at desktops, laptops, and direction of travel. Is there an option for a limited period of time i.e., 3months and to also find out what SNEE and BMLK are considering.
PCD/06/23	**DFPC Update (JR)**
	AS gave an overview on Digital First Primary Care and the primary Care Strategic Delivery Fund (SDF) transfer transformation money. It has been made clear that as part of our direction of travel and where we need to head to, the PCN development funds will be aligned to projects around/or work that needs to happen within the strategic areas, same day access as well as in development or development of integrated neighbourhood teams working with the PCN who have shared their development plans. For 23/24 the money has been put together to include workforce money, etc. A Primary Care plan will need to be developed by end of March that is in line with our trajectory at present to include Digital and the Digital Deep Dive at the PCB along with the event in March to add to the plan. The PCN development plans are critical to inform how we move forward and how things are progressing. JR updated on the DFPC Programme Overview. Outlining the successes from the programme supporting of the CVC implementation and have done a full evaluation of the digital front door that JR will share the draft copy for any feedback. DFPC Update 20230208 v2.pptx DFPC EVALUATION SUMMARY VCKD FIN DFPC EVALUATION SUMMARY GP CPCS I DFPC EVALUATION SUMMARY DIGITAL F

PCD/07/23	**Finance Update on GPIT (PO)**
	• PO to update at next meeting Quarterly finance report on GP Funding for 2023
PCD/08/23	**Any Other Business**
	Deep Dive – not discussed Lloyd George Digitalisation Update: updated slide pack:  PC Digital Team 09.02.23.pptx Caroline Raut updated on the LG Digitalisation update; the contract was awarded to Iron Mountain. Twenty-three practices have had their LG Records digitised, 20 from SW Herts and three from WE (EMIS). 280k records have been digitised 56 desk spaces have been released and three consulting rooms with other practices. Project taken 11 months. AS added this links in with deep dive on with estates leads. Also, the 56 desks spaces released and clinical spaces, have all these been kitted up by Digital? CR has spoken with Kieran Haywood who is reaching out to practices asking what they require and is handling from the estates side and then speaking with HBLICT. Every empty LG wallet has still to be kept. CR advised that the national scheme is for off site storage and then digitise on demand but that still has not started. Within HWE we are looking at off site storage solutions with a company called Restore, this Contract will be going out to tender. If it is a System1 practice it will need to go off site with Restore, if it is an EMIS practice it can be digitised but this will be with the Estates team going forward along with budgets.
PCD/09/23	**Close of meeting**
PCB/10/23	**Date and Time of next meeting**
	Thursday 16th March 2023 – 10.00 am

HERTFORDSHIRE AND WEST ESSEX TRAINING HUB

HWE ICB PRIMARY CARE WORKFORCE IMPLEMENTATION GROUP

23rd February 2023

15:00 – 16:30

Microsoft Teams Meeting

Notes

Attendees		
Dr Nicolas Small (NS)	Training Hub Clinical Lead **(Chair)**	Hertfordshire & West Essex ICB
Joyce Sweeney (JS)	Head of Primary Care Workforce	Hertfordshire & West Essex ICB
Lucy Eldon (LE)	ICS Primary Care Clinical Nurse Lead	Hertfordshire & West Essex ICB
Louise Casey (LC)	Training Hub Operations Manager	Hertfordshire & West Essex ICB
Dr Sarah Dixon (SD)	Primary Care Workforce GP Clinical Lead	Hertfordshire & West Essex ICB
Dr Ankush Sachdev (AnSa)	First 5 GP Lead	Hertfordshire & West Essex ICB
Helen Musson (HM)	Primary Care Workforce Project Manager	Hertfordshire & West Essex ICB
Gaynor Samuel	Primary Care Project Support Officer	Hertfordshire & West Essex ICB
Dr Jayna Gadawala (JG)	Primary Care Workforce GP Clinical Lead	Hertfordshire & West Essex ICB
Frances Barnes (FB)	ICB Senior Finance Manager	Hertfordshire & West Essex ICB
Dr Tareq Abouharb (TA)	Primary Care Workforce GP Clinical Lead	Hertfordshire & West Essex ICB
Jane Scotter (JnSc)	Training Hub Operations Manager	Hertfordshire & West Essex ICB
Cathy Gleeson (CG)		
Mark Edwards (ME)	Associate Director for Workforce Transformation	Hertfordshire & West Essex ICB
James Gleed (JaGl)	AD Primary Care Strategy and Transformation	Hertfordshire & West Essex ICB
Michael Harrison (MH)		Local Medical Committee (LMC)
Avni Shah (AS)	Director of Primary Care Transformation	Hertfordshire & West Essex ICB
Apologises		
Jane Kinniburgh (JK)	ICB Director of Nursing & Quality	Hertfordshire & West Essex ICB
Frances Barnes (FB)	ICB Senior Finance Manager	Hertfordshire & West Essex ICB
Helen Bean (HB)	Education & Workforce Manager	Beds and Herts LMC
Anurita Rohilla (AR)	Chief Pharmacist and Associate Director for Allied Health Professionals	Hertfordshire & West Essex ICB

1	**Welcome & Introductions** Confirmation that meeting is quorate. NS - welcomed attendees to the meeting.

2	**Declaration of Interests** There were no declarations of interest. NS reminded group that forms can be found on the intranet.
3.	**Meeting Notes from the last meeting on 23rd February 2023** The minutes of the meeting confirmed as accurate. The action log was reviewed, and updated as follows: Action 117: The Peoples Board – NS to provide update in AOB Action 119: Invite to WIG Meeting – Closed. New WIG members invited Action 120: Primary Care Staff Survey – Closed. HWE formally withdrawn from pilot. NS – advised there will be a need for frequent conversations with the LMC to prepare for the impact of the eventual national roll out of the survey.
4.	**Community Pharmacy PCN Leads Project** Helen (HM) refers to the previously circulated paper – key milestones to achieve by the end of April; started to recruit the PCN Leads, training development sessions launched and there is an initial evaluation baseline. There are pilots in each of the other ICBs in the East of England, HM working closely with other regions to align and share best practice so that the evaluation takes into account what is happening in all areas. The primary objective is to increase health system integration, in a sustainable way for the future. HM recommends that we follow the Southwest model, which is broader and more sustainable, and being delivered to a larger cohort of approximately 100 people, rather than the North East training model being used by the rest of the East of England. The Budget for the proposal is slightly over budget, but HM has had assurance from JS that this can be supported. NS asked if HM anticipated issues recruiting to these positions. HM replied that as the biggest pilot looking for 35, there may be some areas where it could be difficult to identify someone. JaGl – asked for more information on the evaluation and the return on investment. HM advised that at this juncture there will not really have patient outcome information in the first year, more the feasibility and the effectiveness of the Community pharmacy working with general practice. The group approved the recommendations in the paper
5.	**Oliver McGowan Mandatory Training** Information surrounding this training is a little complex – colleagues from the LMC are stating that this is not mandatory training. Whilst Oliver McGowan training is not mandatory, the learning disability and autism training that meets the Code of Practice will be mandatory for the CQC requirements. Any organisation that is inspected and regulated by the CQC will have to undertake some form of learning disability and autism training that meets that code of practice – this has not been published yet.

	There are three tiers, Primary care would need to complete two tiers, with tier one being for everyone. Training will incorporate some virtual and face to face learning with an expert by lived experience. No guarantee of further funding from national or region beyond the first cohorts in January – March 2023. (ACTION) NS – asked ME to create a synopsis on a page which explains the implications for our GP practices. SD – suggested a staggered approach and making use of the PCN training teams. TA – Suggested mixed group learning, such as Healthcare Assistance, Nurse and GP coming together. MH – Highlighted that communications to practices would need to be carefully worded to not panic them with the mention of the CQC – especially as the rollout process may not have reached them prior to a CQC visit.
6.	**Dr Ankush Sachdev – First 5 Lead - Guest Speaker** The core groups the First 5 Leads are engaging with are GPs in their first five years post qualification, but also GP trainees in the area to try and mare sure they stay working within Hertfordshire and West Essex as well as offering them career development support through the new to practice programme and the GP enhanced fellowship scheme. Held inaugural face to face early career GP conference in January with 20 attendees, which was a success, when compared to previous online webinars with just a handful of attendees. Planning a follow up conference in the summer to include soon to be qualified ST3s. Working alongside SD to overhaul the new to practice programme, making it more structured with more support for early career GPs. Will be speaking at the West Herts VTS scheme in May, Central Herts residential in a few months. Offering career advise and support for GP trainees and explaining what benefits the training hub can offer. Continuing to work closely with Wise 5 lead, Mark Sandler. SD – Could we look at having a group that covers year 6 onwards. Group discussed the possibility of GP LOCUM Chambers advising that HWE Training Hub could support some mandatory training opportunities so that Locums feel more supported. (ACTION) NS – outside of WIG - How can portfolio GPs and new to practice be loosely incorporated into a scheme which will not have any official funding from the Training Hub.
7.	**GPN Update** We have our first two qualified Nursing Associates; one has won a university award. 11 now on the course and have six starting at the university of Hertfordshire 14th March 2023. The Appraisal training with the support of the LMC finishes in April, with the GPNs now looking to complete their compassionate appraisals. There is a lot of interest from other Training Hubs.

	(ACTION) NS – has asked for the feedback / update from the Compassionate Appraisals come to the WIG in May/June. **ARRS Update** JG - 8th March 2023 HWE Transformation event we have been asked to provide an ARRS presentation with a few speakers discussing their journey and also the patient perspective of an ARRS experience. From recent conversations it has been great to hear the development over the last two years and the benefits that have be brought now these roles are embedded into practices.
8.	**Pharmacy Development Update** CG – We have been working with Helen Musson and putting together a bid to investigate the benefits and governance requirements of Community Pharmacists taking on first line prescribing, and it will be aligned when working closely with GP practices. There has been contact between GPs who are geographically close to the Pharmacist that we have or identify the independent prescribers to see if they would be interested in taking the scheme forward. There has been a positive response, although it is to be noted early days. Should have an update on the outcome around Easter, if successful would be looking to start early summer and run for 12 months. This would be a great opportunity for closer collaboration between Community pharmacy and general practice, and increasing access to medicines, reducing workload for GPs, which could have massive implications. Hopefully this informs the community pharmacy contract from 2026 onwards, so that when pharmacists finish university and qualify as independent prescribers, this will increase the number of community independent prescribers available – also the curriculum for higher education institutes has changed to reflect the increase in clinical expectations in terms of their training and undertake far more detailed clinical placements than they currently do. We have been awarded some funding from Health Education England to support our health education institution, University of Hertfordshire in trying to build capacity within the system to support pharmacy placements for undergraduates. CG – highlights that there are 160 students per year in the University of Hertfordshire – which will increase with further cohorts over the years. CG – advised that Anurita has identified a need for a more integrated networking of pharmacists between sectors – pulling together community, practice, and provider pharmacists. From April will be looking to set up a monthly networking meeting which will be owned by attended and not the ICB. NS – highlights we will need even more additional space within our practices to accommodate, whilst we want to support it is a big ask with urgent action required so we do not lose pharmacists from the ICB area – will need to involve Estates. SD – put forward that we would need further details in terms of the pharmacy students coming into practices – are there alternatives as to who can do the training, does it have to be a GP or could a PCN pharmacists from our PCN training teams to do the training – as not only are there limitations on physical space but also actual people to train them. Almost at saturation point in terms of different learners form different places. CG – they will have 90 hours of designated practice in their training year after university, with the underpinning knowledge being part of their university course, and the placement putting them in a stronger position to then undertake the supervised practice that's required for

	becoming an independent practitioner during what would effectively become their sixth year of training.
9.	**Protected Time to Learn** JS summarised that the proposal from HUC has now been received and the times of 13:30 – 17:30 will remain in place. In discussions with Avni Shah (AS) to finalise the funding for HUC as this has increased significantly from £2,705 to £8,779. Approval for the increase will need to be approved before we can proceed. Need to have an answer before the end of February. The dates for the events will alternated Tuesday, Wednesday, or Thursday SD – enquired if the £900 per event will also be available, JS advised that this was included as part of the discussion with AS NS – A discussion is to be had outside of the WIG to clarify which dates will be reserved across the ICB for ICB training events, dates for place events and practices will need to be made aware as soon as possible of these dates to avoid external booking that would then need to be cancelled. SD – enquired if it would be possible to use some of the protected time for trainers to step away from the PCN and have their trainer workshops.
10.	**Any Other Business** i. Peoples Board Update NS – summarised one agenda item from the meeting, which related to GP workforce and primary care workforce in general, where the peoples board have asked for a deep dive or presentation at the next peoples board meeting in three months. Contact to be made to establish what exactly is required. There were several points raised such as the initiatives coming from people in non-GP roles in Acute trust across the ICB, initiatives that support retention. NS suggested that we look to describe what some of the retention difficulties have been. ii. JS - updated with good news that we will be receiving some funding from NHS England towards a number of projects which JS and the GP Clinical leads had proposed in January 2023. iii. JS – called for members to submit agenda items as soon as possible to allow for planning.
	Date of next meeting: 28th March 2023 10:00 – 11:30

Future Meeting Dates

27th April 2023	13:00 – 14:30
23rd May 2023	13:00 – 14:30
22nd June 2023	13:00 – 14:30
27th July 2023	13:00 – 14:30
7th September 2023	13:00 – 14:30

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	NHS HWE ICB Primary Care Board meeting held in Public Thursday 23 March 2023

Appendices – For information only

Appendix 1 - Delegation of Pharmacy, Optometry and Dental Commissioning – Update

Appendix 2 – Healthwatch updates

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 held in Public				**Meeting Date:**	**23/03/2023**	
Report Title:	**Delegation of Pharmacy, Optometry and Dental Commissioning - Update**				**Agenda Item:**	**Appendix 1**	
Report Author(s):	Rachel Halksworth, Assistant Director for Primary Care Contracting						
Report Signed off by:	Avni Shah, Director of Primary Care Transformation						
Purpose:	**Approval**	☐	**Decision**	☐	**Discussion**	☐	**Information** ☒
Report History:	HWE ICB Executive Committee 30th January 2023 Primary Care Commissioning Committee February 2023						
Executive Summary:	On 1 April 2015 the former CCGs accepted full delegated responsibility from NHS England to commission GP primary care services. Delegation to ICBs of the other 3 contractor groups for primary care services, Pharmacy, Optometry and Dentistry, is included within the Health and Care Bill and the expectation is that all ICBs assume this responsibility from April 2023. A delegation agreement will be signed between NHSE and the ICB setting out roles and responsibilities. This is already in place and signed from July for general medical services. From 1st April 2023, ICB's will assume responsibility for pharmaceutical, general ophthalmic and dental services under the terms of a Delegation Agreement with NHSE. Hertfordshire and West Essex ICB will host the pharmacy and optometry (P&O) team for the whole of the East of England (six ICBs) in line with a Memorandum of Understanding (MOU). In addition to developing the MOU, the ICB Primary Care, Finance and Quality teams are working together with ICB governance team and IT to complete the required preparatory work and due diligence for the transfer of responsibilities. The ICB has now signed the Delegation Agreement (Appendix 1), transferring responsibility and accountability for POD services in from 1st April 2023.						

	This paper updates on the work to date, highlighting the risks and issues identified.			
Recommendations:	▪ For **information** only			
Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***	☐
	Financial	☐	***Non-Financial Personal***	☐
	None identified			☒
	N/A			

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

From 1st April 2023, ICB's will assume responsibility for pharmaceutical, general ophthalmic and dental services under the terms of a Delegation Agreement with NHSE.

Hertfordshire and West Essex ICB will host the pharmacy and optometry (P&O) contracting team for the whole of the East of England (six ICBs) in line with a Memorandum of Understanding (MOU).

In addition to developing the MOU, the ICB Primary Care, Finance and Quality teams are working together with ICB governance team and IT to complete the required preparatory work and due diligence for the transfer of responsibilities. The ICB has now signed the Delegation Agreement (Appendix 1), transferring responsibility and accountability for POD services in from 1st April 2023.

This paper updates on the work to date, highlighting the risks and issues identified.

2. Background

On 1 April 2015 CCGs accepted full delegated responsibility from NHS England to commission GP primary care services. The Health and Care Act received Royal Assent on 28 April 2022 and as a result ICBs a became legally and operationally established on 1 July 2022. This fulfils the long-term policy ambition of giving systems responsibility for managing local population health needs, tackling inequalities and addressing fragmented pathways of care. A key enabler to realising this ambition is the delegation of direct commissioning functions to ICBs. By giving ICBs responsibility for a broader range of functions, they will be able to design services and pathways of care that better meet local priorities. They will also have greater flexibility to integrate services across care pathways, ensuring continuity for patients and improved health outcomes for the local population. Delegation to ICBs of the other 3 contractor groups for primary care services, Pharmacy, Optometry and Dentistry, is included within the Health and Care Bill and all ICBs will assume this responsibility from April 2023. A delegation agreement will be signed between NHSE and the ICB setting out roles and responsibilities. This is already in place and signed from July for general medical services. In addition, specialised commissioning is delegated to ICBs from April 2023.

In the longer term, it is proposed that while health and justice, sexual assault and abuse service (SAAS) functions will remain with NHS England, the ambition is to work towards a model of joint working, with full involvement of systems from 1 April 2023. Over the course of 2022/23, national and regional NHS England teams will support progress towards this joint working. For Section 7A NHS public health functions (Screening, cancer and non-cancer), Immunisations including COVID-19 and flu, and

Child Health Information Systems) commissioning responsibility will remain with NHS England. There is detailed work to do due to the complexity of the S7A pathways. Over the course of 2022/23, national and regional NHS England teams will support progress towards joint working and continue to collaborate to determine which services can be delegated and how, with a view to potential delegation from April 2024.

For HWE, this means the delegation of 243 Dental practices, 276 Pharmacies and 225 Opticians. In addition to these there are 2 Community Dental Contracts and a number of pilots currently commissioned in Dentistry which require review and decision on extension, and a number of procurements that need to be progressed over 23/24 such as the dental referral management system provider. Responsibility for secondary care dental also moves to the ICB, although for 23/24 the commissioning sits in specialised commissioning, this will transfer from April 24.

In October 2022 the ICB submitted a Pre-Delegation Assessment Framework to Region which subsequently went to National NHSE Board for agreement. This included a RAG rating of the ICB Current and predicted future position. At that time, this was largely rated RED as there was a lack of detailed information, in all domains.

Following this each ICB has been asked to complete a Safe Delegation Checklist (SDC) which again RAG rates the ICB position along a large number of indicators across Transformation and Quality, Governance and Leadership, Finance, Workforce, Contracts and IG, IT and Records. An ICB task and finish group are meeting weekly to update on progress and issues.

We also meet regularly with NHSE and other ICBs in the Region to share issues and updates. Overall, we have self-assessed as AMBER on a large number of the indicators in this submission. This is the picture across all ICBs in East of England due to financial risk raised following sharing of budgets and the gaps in process and knowledge shared by NHSE. These issues are detailed below and have been escalated to NHSE Director of Primary Care and Public Health.

3. Hosting of Pharmaceutical Services and Optometry Contracting

Hertfordshire and West Essex ICB will host the pharmacy and optometry (P&O) team for the whole of the East of England (six ICBs) in line with a Memorandum of Understanding (MOU). The MOU is not a legally binding agreement and does not change the statutory roles and responsibilities or functions of either Party.

Whilst HWE ICB is hosting the P&O Contracting Team, all ICB's signing up to this agreement have equal responsibility for ensuring the effective commissioning and contracting of P&O services.

The MOU supports the national requirements as set out in the Delegation Agreement and each ICB will be responsible for compliance to the requirements as set out in this.

4. Finance

Allocations and budgets have been shared with ICB finance teams. There has also been confirmation that the recurrent underspend in Dental contracts is ring-fenced to dentistry. This has previously been used by region to cover the large overspend in Community Pharmacy contracts.

This has been flagged to NHSE as it is a national issue of underfunded contracts that local commissioners will have no control over. This issue is similar across all East of England ICBs and NHSE Region are raising this issue with the National Team. Further information has not been received as part of the Mandated Guidance on Dental budgets which notes, where dental budgets are underspent, or forecast to underspend, and the underspend has not been directed to be used on other commissioning priorities by NHSE in discussion with ICB, then NHSE reserves the right to recover some or all of the value of the underspend from ICB budgets.

These concerns have been highlighted to NHSE as part of the SDC submission and a letter of assurance has been provided to all ICBs which indicates of NHSE wanting to work closely with ICBs as we take on this delegated and support us through their new revised model.

5. TUPE/Running Cost Allocation

For HWE we are awaiting the final headcount but indicative whole-time equivalents (WTE) are Finance 2 WTE, 2.6 WTE for Dental, 11.03 WTE for P&O, the full transfer of GP Contracting team at 6 WTE, and 0.5 WTE for Head of Primary Care post – these figures include vacancies. The number of complaints staff is yet to be confirmed, however this transfer will be in July.

NHSE have also noted that with the development of the new operating model of NHSE with the merger of HEE/NHSE/NHSI, currently there are 19.4 WTE primary care transformation staff and it is proposed they will be part of the restructure. The current view is that 12 WTE of this resource will move to ICBs across EoE, however they will be part of the second phase of the consultation with a plan to transfer this resource to ICBs in July 2023.

HR colleagues have raised concerns that the process for transfer from NHSE side is slow and have flagged this as a risk to timely transfer from April 23. With the announcement of ICB's having to make efficiencies in running costs by 2025/26, the staff TUPE'd with this delegated responsibility aligned to HWE will be part of that being part of the ICB. Being a host for Pharmacy and Optometry contracts,

discussions are underway with NHSE and all other ICBs to ensure it is only the proportion aligned to HWE who will form part of our local running costs programme.

6. Quality

There are no quality staff aligned to POD contracts at NHSE, quality review and input to these provider groups is extremely limited. This is a high risk as there is likely to be unknown issues across providers particularly dentistry where there are high risk procedures, infection prevention and control risks amongst other concerns. This is likely to have resourcing impacts for Quality teams workloads which has been highlighted on the risk register for Primary Care Directorate and will be reviewed as assume responsibility and embed the workplan.

There has also been a late addition to the delegated functions to move both complaints and the national call centre for complaints to ICBs. This is currently being scoped by a separate workstream but note that the staff aligned and proposed to transfer under TUPE from July 23 is limited to possibly 1-2 WTE. The workstream also needs to consider the IT and staffing required for the complaints contact function.

7. HWE Governance

As part of the ongoing preparation for the transfer of responsibilities, and as discussed at previous Committees, Terms of Reference (TOR) for Primary Care Commissioning Committee (PCCC - Appendix 2), Primary Care Board and their subgroups have been updated to reflect responsibility for the incoming primary care contracts in Pharmaceutical Services, Optometry and Dental Services. All terms of references of the Primary Care Commissioning Committee and subgroups have been approved by Primary Care Commissioning Committee and ratified at Commissioning Committee this month in preparation for April 2023. In addition, to provide independent clinical input to the PCCC, there is approval to recruit a Dental Clinical Advisor as a member of PCCC. Independent clinical pharmacy advise will be provided by the ICB Chief Pharmacist or deputy.

8. Pharmaceutical Services Regulations Committee (PSRC)

The TOR for the Pharmaceutical Services Regulations Committee (PSRC) will be updated in line with the Pharmacy Manual and shared once available reflecting the change from NHSE to HWE as hosts

The substantive change here is that in EoE Region, Fitness to Practice for Pharmacists has to date been delegated to the Professional Advisory Group (PAG) in the medical directorate. This delegation is no longer permitted so from April 2023 this will sit with PSRC. HWE is working through this with NHSE Medical Directorate

how this is safely transferred. It is proposed that later in the year the administrative support for this function also transfer to HWE. This group will be chaired by Director for Primary Care Transformation.

9. Recommendations

The Board is asked to note the content of this report.

10. Appendices

Appendix 1 – Delegation Agreement
Appendix 2 – PCCC TOR

Dated 2023

(1) **NHS ENGLAND**

- and -

(2) **NHS HERTFORDSHIRE AND WEST ESSEX INTEGRATED CARE BOARD**

Delegation Agreement in Respect of

(i) Primary Medical Care Services
(ii) Primary Dental Services and Prescribed Dental Services
(iii) Primary Ophthalmic Services
(iv) Pharmaceutical Services and Local Pharmaceutical Services

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DELEGATION AGREEMENT FOR SPECIFIED FUNCTIONS

1. PARTICULARS

1.1 This Agreement records the particulars of the agreement made between NHS England and the Integrated Care Board (ICB) named below.

Integrated Care Board	Herfordshire and West Essex
Area	[Insert Area of the ICB as defined in its Constitution]
Date of Agreement	[Date]
	[Date]
ICB Representative	[Insert details of name of the manager of this Agreement for the ICB]
ICB Email Address for Notices	[Insert Address]
NHS England Representative	[Insert details of name of the manager of this Agreement for NHS England]
NHS England Email Address for Notices	[Insert Address]

1.2 **The following Delegated Functions are included in this Agreement[1]:**

Delegated Functions	Schedule	Included	Effective Date of Delegation
Primary Medical Services Functions	Schedule 2A –	Yes	1st July 2022
Primary Dental Services and Prescribed Dental Services Functions	Schedule 2B –	Yes	1st April 2023
Primary Ophthalmic Services Functions	Schedule 2C –	Yes	1st April 2023
Pharmaceutical Services and Local Pharmaceutical Services Functions	Schedule 2D –	Yes	1st April 2023

1.3 This Agreement comprises:

1.3.1 the Particulars (clause 1);

[1] This table must be completed to indicate which services are included in the Delegation.

1.3.2 the Terms and Conditions (clauses 2 to 31);

1.3.3 the Schedules; and

1.3.4 the Mandated Guidance

Signed by **NHS England**

[Name]

[Title]

(for and on behalf of NHS England)

Signed by **[Insert name] Integrated Care Board**

[Insert name of Authorised Signatory]

[Insert title of Authorised Signatory]

[for and on behalf of] [ ] Integrated Care Board

TERMS AND CONDITIONS

2. **INTERPRETATION**

2.1 This Agreement is to be interpreted in accordance with Schedule 1 (Definitions and Interpretation).

2.2 If there is any conflict or inconsistency between the provisions of this Agreement, that conflict or inconsistency must be resolved according to the following order of priority:

2.2.1 the Particulars and Terms and Conditions (clauses 1 to 31);

2.2.2 all Schedules excluding Local Terms;

2.2.3 Mandated Guidance; and

2.2.4 Local Terms.

2.3 This Agreement constitutes the entire agreement and understanding between the Parties relating to the Delegation and supersedes all previous agreements, promises and understandings between them, whether written or oral, relating to its subject matter.

2.4 Where it is indicated that a provision in this Agreement is not used, that provision is not relevant and has no application in this Agreement.

2.5 Where a particular clause is included in this Agreement but is not relevant to the ICB because that clause relates to matters which do not apply to the ICB (for example, if the clause only relates to functions that are not Delegated Functions in respect of the ICB), that clause is not relevant and has no application to this Agreement.

3. **BACKGROUND**

3.1 By this Agreement NHS England delegates the Delegated Functions to the ICB under section 65Z5 of the NHS Act while retaining the Reserved Functions.

3.2 Arrangements made under section 65Z5 may be made on such terms and conditions (including terms as to payment) as may be agreed between NHS England and the ICB.

3.3 This Agreement sets out the terms that apply to the exercise of the Delegated Functions by the ICB and the Parties' associated responsibilities and measures required to ensure the effective and efficient exercise of the Delegated Functions and Reserved Functions.

4. **TERM**

4.1 This Agreement has effect from the Date of Agreement set out in the Particulars and will remain in force unless terminated in accordance with clause 26 *(Termination)* below.

5. **PRINCIPLES**

5.1 In complying with the terms of this Agreement, NHS England and the ICB must:

5.1.1 at all times have regard to the Triple Aim;

5.1.2 at all times act in good faith and with integrity towards each other;

5.1.3 have regard to the intention that commissioning functions in respect of Primary Medical Services, Primary Dental Services and Primary Ophthalmic Services will in future be directly conferred on the ICB;

5.1.4 consider how it can meet its legal duties to involve patients and the public in shaping the provision of services, including by working with local

communities, under-represented groups and those with protected characteristics for the purposes of the Equality Act 2010;

5.1.5 consider how in performing their obligations they can address health inequalities;

5.1.6 at all times exercise functions effectively, efficiently and economically;

5.1.7 act in a timely manner;

5.1.8 share information and best practice, and work collaboratively to identify solutions and enhance the evidence base for the commissioning and provision of health services, eliminate duplication of effort, mitigate risk and reduce cost; and

5.1.9 have regard to the needs and views of the other Party and as far as is lawful and reasonably practicable, take such needs and views into account.

6. DELEGATION

6.1 In accordance with its statutory powers under section 65Z5 of the NHS Act, NHS England hereby delegates the exercise of the Delegated Functions to the ICB to empower it to commission a range of services for its Population, as further described in this Agreement ("**Delegation**").

6.2 The Delegated Functions are the functions described as being delegated to the ICB as have been identified as included in clause 1 (*Particulars*) and included as a Schedule to this Agreement.

6.3 The Delegation in respect of each Delegated Function has effect from the relevant Effective Date of Delegation.

6.4 NHS England may by Contractual Notice allocate Contracts to the ICB such that they are included as part of the Delegation. The Delegated Functions must be exercised both in respect of the relevant Contract and any related matters concerning any Provider that is a party to Contract or Arrangement.

6.5 Subsequent to the Effective Date of Delegation and for the duration of this Agreement, unless otherwise agreed any new Contract entered into in respect of the Delegated Functions shall be managed by the ICB in accordance with the provisions of this Agreement.

6.6 NHS England may by Contractual Notice add or remove Contracts to or from the list of those allocated to the ICB for the purposes of this Agreement. In particular, NHS England may add or remove Contracts where this is associated with an extension or reduction of the scope of the Delegated Functions.

6.7 Decisions of the ICB in respect of the Delegated Functions and made in accordance with the terms of this Agreement shall be binding on NHS England and the ICB.

6.8 Unless expressly provided for in this Agreement, the ICB is not authorised by this Agreement to take any step or make any decision in respect of Reserved Functions. Any such purported decision of the ICB is invalid and not binding on NHS England unless ratified in writing by NHS England in accordance with the NHS England Scheme of Delegation and Standing Financial Instructions. NHS England may, acting reasonably and solely to the extent that the decision relates to the Delegated Functions, substitute its own decision for any decision which the ICB purports to make where NHS England reasonably considers that the impact of the ICB decision could, in relation to the Delegated Functions, cause the ICB to be acting unlawfully, in breach of this Agreement including Mandated Guidance, or in breach of any Contract. The ICB must

provide any information, assistance and support as NHS England requires to enable it to determine whether to make any such decision.

6.9 The terms of clause 6.8 are without prejudice to the ability of NHS England to enforce the terms of this Agreement or otherwise take action in respect of any failure by the ICB to comply with this Agreement.

7. EXERCISE OF DELEGATED FUNCTIONS

7.1 The ICB agrees that it will exercise the Delegated Functions in accordance with:

7.1.1 the terms of this Agreement including Mandated Guidance;

7.1.2 any Contractual Notices;

7.1.3 all applicable Law and Guidance;

7.1.4 the ICB's constitution;

7.1.5 the requirements of any assurance arrangements made by NHS England, and;

7.1.6 Good Practice.

7.2 In exercising the Delegated Functions, the ICB must comply with the Mandated Guidance set out at Schedule 9 (*Mandated Guidance)* or otherwise referred to in the Schedules to this Agreement and such further Mandated Guidance as may be issued by NHS England from time to time, including on the Direct Commissioning Guidance Webpage.

7.3 NHS England may, at its discretion, issue Contractual Notices from time to time relating to the manner in which the Delegated Functions must be exercised by the ICB. Contractual Notices will have effect as variations to this Agreement.

7.4 The ICB must establish effective, safe, efficient and economic arrangements for the discharge of the Delegated Functions.

7.5 The ICB must give due consideration to whether any of the Delegated Functions should be exercised collaboratively with other NHS bodies or Local Authorities including, without limitation, by means of arrangements under section 65Z5 and section 75 of the NHS Act.

7.6 The ICB must develop an operational scheme(s) of delegation defining those individuals or groups of individuals, including committees, who may discharge aspects of the Delegated Functions. For the purposes of this clause, the ICB may include the operational scheme(s) of delegation within its general organisational scheme of delegation.

7.7 Subject to clauses 7.1 to 7.6, the ICB may determine the arrangements for the exercise of the Delegated Functions.

7.8 The ICB must perform the Delegated Functions:

7.8.1 in such a manner as to ensure NHS England's compliance with NHS England's statutory duties in respect of the Delegated Functions and to enable NHS England to fulfil its Reserved Functions; and

7.8.2 having regard to NHS England's accountability to the Secretary of State and Parliament in respect of both the Delegated Functions and Reserved Functions.

8. **PERFORMANCE OF THE RESERVED FUNCTIONS**

8.1 NHS England will exercise the Reserved Functions, including but not limited to those set out in the relevant Schedules to this Agreement.

8.2 For the avoidance of doubt, the Parties acknowledge that the Delegation may be amended, and additional functions may be delegated to the ICB, in which event consequential changes to this Agreement shall be agreed with the ICB pursuant to clause 25 (*Variations*) of this Agreement.

8.3 Where appropriate NHS England will work collaboratively with the ICB when exercising the Reserved Functions.

8.4 If there is any conflict or inconsistency between functions that are named as Delegated Functions and functions that are named as Reserved Functions, then such functions shall be interpreted as Reserved Functions unless and until NHS England confirms otherwise. In the event that an ICB identifies such a conflict or inconsistency it will inform NHS England as soon as is reasonably practicable.

8.5 The Parties acknowledge that where the ICB shall provide administrative and management services to NHS England in relation to certain Reserved Functions these shall be as set out in clause 9.14. and Schedule 10 *(Administrative and Management Services*).

8.6 The Parties further acknowledge that NHS England may ask the ICB to provide certain administrative and management services to NHS England in relation to other Reserved Functions.

8.7 Notwithstanding any arrangement for or provision of administrative or management services in respect of certain Reserved Functions, NHS England shall retain and be accountable for the exercise of such Reserved Functions.

9. **FINANCE**

9.1 Without prejudice to any other provision in this Agreement, the ICB must comply with such financial processes as required by NHS England for the management, reporting and accounting of funds used for the purposes of the Delegated Functions.

9.2 The ICB acknowledges that it will receive funds from NHS England in respect of the Delegated Functions (the "Delegated Funds") and that these are in addition to the funds allocated to it within its Annual Allocation.

9.3 Subject to clause 9.4 and any provisions in the Schedules or Mandated Guidance, the ICB may use:

9.3.1 its Annual Allocation and the Delegated Funds in the exercise of the Delegated Functions; and

9.3.2 the Delegated Funds and its Annual Allocation in the exercise of the ICB's functions other than the Delegated Functions.

9.4 The ICB's expenditure on the Delegated Functions must be no less than that necessary to:

9.4.1 ensure that NHS England is able to fulfil its functions, including without limitation the Reserved Functions, effectively and efficiently;

9.4.2 meet all liabilities arising under or in connection with all Contracts allocated to the ICB in accordance with clauses 6.4 to 6.6 in so far as they relate to the Delegated Functions;

9.4.3 meet national commitments from time to time on expenditure on specific Delegated Functions including, without limitation, the Community Pharmacy Contractual Framework.

9.5 NHS England may increase or reduce the Delegated Funds in any Financial Year, by sending a notice to the ICB of such increase or decrease:

9.5.1 in order to take into account any monthly adjustments or corrections to the Delegated Funds that NHS England considers appropriate, including without limitation adjustments following any changes to the Delegated Functions, changes in allocations, changes in Contracts, to implement Mandated Guidance under Clause 7.4 or otherwise;

9.5.2 in order to comply with a change in the amount allocated to NHS England by the Secretary of State pursuant to section 223B of the NHS Act;

9.5.3 to take into account any Losses of NHS England for which the ICB is required to indemnify NHS England under clause 15;

9.5.4 to take into account any adjustments that NHS England considers appropriate (including without limitation in order to make corrections or otherwise to reflect notional budgets) to reflect funds transferred (or that should have been transferred) to the ICB in respect of the Delegated Functions and/or funds transferred (or that should have been transferred) to the ICB and in respect of which the ICB has management or administrative responsibility under Schedule 10 of this Agreement; or

9.5.5 in order to ensure compliance by NHS England with its obligations under the NHS Act (including without limitation, Part 11 of the NHS Act) or any action taken or direction made by the Secretary of State in respect of NHS England under the NHS Act.

9.6 NHS England acknowledges that the intention of paragraph 9.5 is to reflect genuine corrections and adjustments to the Delegated Funds and may not be used to change the allocation of the Delegated Funds unless there are significant or exceptional circumstances that would require such corrections or adjustments.

9.7 The ICB acknowledges that it must comply with its statutory financial duties, including those under Part 11 of the NHS Act to the extent that these sections apply in relation to the receipt of the Delegated Funds.

9.8 NHS England may in respect of the Delegated Funds:

9.8.1 notify the ICB regarding the required payment of sums by the ICB to NHS England in respect of charges referable to the valuation or disposal of assets and such conditions as to records, certificates or otherwise;

9.8.2 by notice, require the ICB to take such action or step in respect of the Delegated Funds, in order to ensure compliance by NHS England of its duties or functions under the NHS (including without limitation, Part 11 of the NHS Act) or any action taken or direction made by the Secretary of State under the NHS Act.

9.9 The Schedules to this Agreement identify further financial provisions in respect of the exercise of the Delegated Functions including but not limited to Schedule 5 (*Financial Provisions and Decision Making Limits*).

9.10 NHS England may issue Mandated Guidance in respect of the financial arrangements in respect of the Delegated Functions.

Payment and Transfer

9.11 NHS England will pay the Delegated Funds to the ICB using the revenue transfer process as used for the Annual Allocation or using such other process as notified to the ICB from time to time.

9.12 Without prejudice to any other obligation upon the ICB, the ICB agrees that it must use its resources for the purposes of the Delegated Functions in accordance with:

9.12.1 the terms and conditions of this Agreement including any Mandated Guidance issued by NHS England from time to time in relation to the use of resources for the purposes of the Delegated Functions (including in relation to the form or contents of any accounts);

9.12.2 the business rules as set out in NHS England's planning guidance or such other documents issued by NHS England from time to time;

9.12.3 any Capital Investment Guidance; and

9.12.4 the HM Treasury guidance *Managing Public Money* (dated September 2022)

9.13 Without prejudice to any other obligation upon the ICB, the ICB agrees that it must provide:

9.13.1 all information, assistance and support to NHS England in relation to the audit and/or investigation (whether internal or external and whether under Law or otherwise) in relation to the use of or payment of resources for the purposes of the Delegated Functions and the discharge of those functions;

9.13.2 such reports in relation to the expenditure on the Delegated Functions as set out in Mandated Guidance, the Schedules to this Agreement or as otherwise required by NHS England.

Administrative and/or Management Services

9.14 The provisions of Schedule 10 (*Administrative and Management Services)* in relation to Administrative and/or Management Services shall apply.

Pooled Funds

9.15 Subject to the provisions of this Agreement, the ICB may, for the purposes of exercising the Delegated Functions under this Agreement, establish and maintain a pooled fund in respect of any part of the Delegated Funds with:

9.15.1 NHS England in accordance with sections 13V or 65Z6 of the NHS Act;

9.15.2 one or more ICBs in accordance with section 65Z6 of the NHS Act as part of a Further Arrangement; or

9.15.3 NHS England and one or more ICBs in accordance with section 13V of the NHS Act; and

9.15.4 NHS England and one or more ICBs in accordance with section 65Z6 of the NHS Act.

9.16 At the date of this Agreement, details of the pooled funds (including any terms as to the governance and payments out of such pooled fund) of NHS England and the ICB are set out in the Local Terms.

10. INFORMATION, PLANNING AND REPORTING

10.1 The ICB must provide to NHS England:

10.1.1 all information or explanations in relation to the exercise of the Delegated Functions (including in relation to this Agreement), (and in such form) as requested by NHS England from time to time; and

10.1.2 all such information (and in such form), that may be relevant to NHS England in relation to the exercise by NHS England of its other duties or functions including, without limitation, the Reserved Functions.

10.2 The provisions of this clause 10 are without prejudice to the ability of NHS England to exercise its other powers and duties in obtaining information from and assessing the performance of the ICB.

Forward Plan and Annual Report

10.3 Before the start of each Financial Year, the ICB must describe in its joint forward plan prepared in accordance with section 14Z52 of the NHS Act how it intends to exercise the Delegated Functions.

10.4 The ICB must report on its exercise of the Delegated Functions in its annual report prepared in accordance with section 14Z58 of the NHS Act.

Risk Register

10.5 The ICB must maintain a risk register in respect of its exercise of the Delegated Functions and periodically review its content. The risk register must follow such format as may be notified by NHS England to the ICB from time to time.

11. FURTHER ARRANGEMENTS

11.1 The ICB must give due consideration to whether any of the Delegated Functions should be exercised collaboratively with other NHS bodies or Local Authorities including, without limitation, by means of arrangements under section 65Z5 and section 75 of the NHS Act.

11.2 The ICB may only make arrangements with another person (a "Sub-Delegate") concerning the exercise of the Delegated Functions ("Further Arrangements"), including without limitation arrangements under section 65Z5 and section 75 of the NHS Act, with the prior written approval of NHS England.

11.3 The approval of any Further Arrangements may:

11.3.1 include approval of the terms of the proposed Further Arrangements; and

11.3.2 require conditions to be met by the ICB and the Sub-Delegate in respect of that arrangement.

11.4 All Further Arrangements must be made in writing.

11.5 The ICB must not:

11.5.1 terminate Further Arrangements; or

11.5.2 make any material changes to the terms of Further Arrangements,

11.5.3 without the prior written approval of NHS England.

11.6 If the ICB enters into a Further Arrangement it must ensure that the Sub-Delegate does not make onward arrangements for the exercise of any or all of the Delegated Functions without the prior written approval of NHS England.

11.7 The terms of this clause 11 do not prevent the ICB from making arrangements for assistance and support in the exercise of the Delegated Functions with any person, where such arrangements reserve the consideration and making of any decision in respect of a Delegated Function to the ICB.

11.8 NHS England requires the ICB to make arrangements for assistance and support in the exercise of the Delegated Functions with those persons described in the Schedules including, but not limited to Schedule 6 (*Mandated Assistance and Support*) and with such other persons as NHS England may require from time to time.

11.9 Where Further Arrangements are made, and unless NHS England has otherwise given prior written agreement, any positive obligation or duty on the part of the ICB under this Agreement that is relevant to those Further Arrangements shall also require the ICB to ensure that all Sub-Delegates comply with that positive obligation or duty and support the ICB in doing so. In the same way, any negative duty or obligation on the part of the ICB under this Agreement that is relevant to Further Arrangement shall also require the ICB to ensure that all Sub-Delegates comply with that negative obligation or duty and support the ICB in doing so.

12. STAFFING AND WORKFORCE

12.1 The Staffing Model in respect of each Delegated Function shall at the Effective Date of Delegation be as approved by the relevant National Moderation Panel.

12.2 Where the staffing arrangements include the deployment of NHS England Staff to the ICB for the purposes of carrying out the relevant Delegated Functions then the provisions of Schedule 8 (*Deployment of NHS England Staff to the* ICB) shall apply.

12.3 The ICB must comply with any Mandated Guidance issued by NHS England from time to time in relation to the NHS England Staff.

12.4 For the avoidance of doubt, any breach by the ICB of the terms of this clause 12 (Staffing), including any breach of any Mandated Guidance issued in accordance with clause 12.3 above, will be a breach of the terms and conditions of this Agreement for the purposes of clauses 9.5 and 15.2.

13. BREACH

13.1 If the ICB does not comply with the terms of this Agreement, then NHS England may:

13.1.1 exercise its rights under this Agreement; and/or

13.1.2 take such steps as it considers appropriate in the exercise of its other functions concerning the ICB.

13.2 Without prejudice to clause 13.1, if the ICB does not comply with the terms of this Agreement (including if the ICB exceeds its delegated authority under the Delegation), NHS England may (at its sole discretion):

13.2.1 waive its rights in relation to such non-compliance in accordance with clause 13.3;

13.2.2 ratify any decision in accordance with clause 6.8;

13.2.3 substitute a decision in accordance with clause 6.9;

13.2.4 revoke the whole or part of the Delegation and terminate this Agreement in accordance with clause 26 *(Termination)* below;

13.2.5 exercise the Escalation Rights in accordance with clause 14 *(Escalation Rights)*; and/or

13.2.6 exercise its rights under common law.

13.3 NHS England may waive any non-compliance by the ICB with the terms of this Agreement provided that the ICB provides a written report to NHS England as required by clause 13.4 and, after considering the ICB's written report, NHS England is satisfied that the waiver is justified.

13.4 If:

13.4.1 the ICB does not comply (or, based on the risk register maintained by the ICB in accordance with clause 10.5 or any other information available to it the ICB considers that it may not be able to comply) with this Agreement; or

13.4.2 NHS England notifies the ICB that it considers the ICB has not complied, or may not be able to comply with, this Agreement,

then the ICB must provide a written report to NHS England within ten (10) Operational Days of the non-compliance (or the date on which the ICB considers that it may not be able to comply with this Agreement) or such notification pursuant to clause 13.4.2 setting out:

13.4.3 details of and reasons for the non-compliance (or likely non-compliance) with the Agreement and/or the Delegation; and

13.4.4 a plan for how the ICB proposes to remedy the non-compliance.

14. ESCALATION RIGHTS

14.1 If the ICB does not comply with this Agreement, NHS England may exercise the following Escalation Rights:

14.1.1 NHS England may require a suitably senior representative of the ICB to attend a review meeting within ten (10) days of NHS England becoming aware of the non-compliance; and

14.1.2 NHS England may require the ICB to prepare an action plan and report within twenty (20) days of the review meeting (to include details of the non-compliance and a plan for how the ICB proposes to remedy the non-compliance).

14.2 Nothing in clause 14 *(Escalation Rights)* will affect NHS England's right to substitute a decision in accordance with clause 6.9, revoke the Delegation and/or terminate this Agreement in accordance with clause 26 *(Termination)* below.

15. LIABILITY AND INDEMNITY

15.1 NHS England is liable in respect of any Losses arising in respect of NHS England's negligence, fraud, recklessness or deliberate breach in respect of the Delegated Functions and occurring after the Effective Date of Delegation and, if the ICB suffers any Losses in respect of such actions by NHS England, NHS England shall make such adjustments to the Annual Allocation (or other amounts payable to the ICB) in order to reflect any Losses suffered by the ICB (except to the extent that the ICB is liable for such Losses pursuant to clause 15.3).

15.2 For the avoidance of doubt, NHS England remains liable for a Claim relating to facts, events or circumstances concerning the Delegated Functions before the Effective Date of Delegation.

15.3 The ICB is liable to (and shall pay) NHS England for any Losses suffered by NHS England that result from or arise out of the ICB's negligence, fraud, recklessness or breach of the Delegation (including any actions that are taken that exceed the authority

conferred by the Delegation) or this Agreement and, in respect of such Losses, NHS England may, at its discretion and without prejudice to any other rights, either require payment from the ICB or make such adjustments to the Delegated Funds pursuant to clause 9.5. The ICB shall not be liable to the extent that the Losses arose prior to the Effective Date of Delegation.

15.4 Each Party acknowledges and agrees that any rights acquired, or liabilities (including liabilities in tort) incurred, in respect of the exercise by the ICB of any Delegated Function are enforceable by or against the ICB only, in accordance with section 65Z5(6) of the NHS Act.

15.5 The ICB indemnifies NHS England and shall keep it indemnified on a continuing basis from and against any and all Losses which NHS England may incur by reason of any claim by any NHS England Staff:

15.5.1 arising out of a breach of duty by the ICB (whether under common law, statute or otherwise) to the extent that such claim is not met by either the ICB's or NHS England's insurance or indemnity cover;

15.5.2 under the Equality Act 2010 or Part V of the Employment Rights Act 1996 arising out of acts or omissions by the ICB (or any of its employees, directors or officers);

15.5.3 arising from any acts or omissions by the ICB resulting in the termination of their employment, including any claim arising from any instruction by the ICB to NHS England to discipline or dismiss any person.

15.6 Each Party shall co-operate with the other in making all reasonable efforts to minimise any liabilities and Losses in connection with the employment of NHS England Staff in Delegated Functions.

15.7 Each Party will at all times take all reasonable steps to minimise and mitigate any Losses or other matters for which one Party is entitled to be indemnified by or to bring a claim against the other under this Agreement.

16. CLAIMS AND LITIGATION

16.1 Nothing in this clause 16 *(Claims and Litigation)* shall be interpreted as affecting the reservation to NHS England of the Reserved Functions.

16.2 Except in the circumstances set out in clause 16.5 and subject always to compliance with this clause 16 *(Claims and Litigation)*, the ICB shall be responsible for and shall retain the conduct of any Claim.

16.3 The ICB must:

16.3.1 comply with any policy issued by NHS England from time to time in relation to the conduct of or avoidance of Claims and/or the pro-active management of Claims;

16.3.2 if it receives any correspondence, issue of proceedings, claim document or other document concerning any Claim or potential Claim, immediately notify NHS England and send to NHS England all copies of such correspondence;

16.3.3 co-operate fully with NHS England in relation to such Claim and the conduct of such Claim;

16.3.4 provide, at its own cost, to NHS England all documentation and other correspondence that NHS England requires for the purposes of considering and/or resisting such Claim; and/or

16.3.5 at the request of NHS England, take such action or step or provide such assistance as may in NHS England's discretion be necessary or desirable having regard to the nature of the Claim and the existence of any time limit in relation to avoiding, disputing, defending, resisting, appealing, seeking a review or compromising such Claim or to comply with the requirements of the provider of an Indemnity Arrangement in relation to such Claim.

16.4 Subject to clauses 16.3 and 16.5 and Schedule 5 (*Financial Provisions and Decision Making Limits*) the ICB is entitled to conduct the Claim in the manner it considers appropriate and is also entitled to pay or settle any Claim on such terms as it thinks fit.

NHS England Stepping into Claims

16.5 NHS England may, at any time following discussion with the ICB, send a notice to the ICB stating that NHS England will take over the conduct of the Claim and the ICB must immediately take all steps necessary to transfer the conduct of such Claim to NHS England unless and until NHS England transfers conduct back to the ICB. In such cases:

16.5.1 NHS England shall be entitled to conduct the Claim in the manner it considers appropriate and is also entitled to pay or settle any Claim on such terms as it thinks fit, provided that if NHS England wishes to invoke clause 16.5.3 it agrees to seek the ICB's views on any proposal to pay or settle that Claim prior to finalising such payment or settlement; and

16.5.2 the Delegation shall be treated as being revoked to the extent that and for so long as NHS England has assumed responsibility for exercising those of the Delegated Functions that are necessary for the purposes of having conduct of the Claim; and

16.5.3 NHS England may, at its discretion and without prejudice to any other rights, either require payment from the ICB for such Claim Losses or make an adjustment to the Delegated Funds pursuant to clause 9.5.3 for the purposes of meeting any Claim Losses associated with that Claim.

Claim Losses

16.6 The ICB and NHS England shall notify each other within a reasonable time period of becoming aware of any Claim Losses.

16.7 The ICB acknowledges that NHS England will pay to the ICB the funds that are attributable to the Delegated Functions. Accordingly, the ICB acknowledges that it must pay any Claim Losses out of either the Delegated Funds or its Annual Allocation. NHS England may, in respect of any Claim Losses, at its discretion and without prejudice to any other rights, either require payment from the ICB for such Claim Losses or pursuant to clause 9.5.3 make such adjustments to the Delegated Funds to take into account the amount of any Claim Losses (other than any Claim Losses in respect of which NHS England has retained any funds, provisions or other resources to discharge such Claim Losses). For the avoidance of doubt, in circumstances where NHS England suffers any Claim Losses, then NHS England shall be entitled to recoup such Claim Losses pursuant to clause 9.5.3. If and to the extent that NHS England has retained any funds, provisions or other resources to discharge such Claim Losses, then NHS England may either use such funds to discharge the Claim Loss or make an upward adjustment to the amounts paid to the ICB pursuant to clause 9.5.3.

17. DATA PROTECTION, FREEDOM OF INFORMATION AND TRANSPARENCY

17.1 The Parties must ensure that all Personal Data processed by or on behalf of them in the course of carrying out the Delegated Functions and Reserved Functions is processed in accordance with the relevant Party's obligations under Data Protection

Legislation and Data Guidance and the Parties must assist each other as necessary to enable each other to comply with these obligations.

17.2 The ICB must respond to any information governance breach in accordance with IG Guidance for Serious Incidents. If the ICB is required under Data Protection Legislation to notify the Information Commissioner's Office or a Data Subject of an information governance breach then as soon as reasonably practical and in any event on or before the first such notification is made the ICB must fully inform NHS England of the information governance breach. This clause does not require the ICB to provide NHS England with information which identifies any individual affected by the information governance breach where doing so would breach Data Protection Legislation.

17.3 Whether or not a Party is a Data Controller or Data Processor will be determined in accordance with Data Protection Legislation and any Data Guidance from a Regulatory or Supervisory Body. The Parties acknowledge that a Party may act as both a Data Controller and a Data Processor.

17.4 Each Party acknowledges that the other is a public authority for the purposes of the Freedom of Information Act 2000 (**"FOIA"**) and the Environmental Information Regulations 2004 (**"EIR"**).

17.5 Each Party may be statutorily required to disclose further information about the Agreement and the Relevant Information in response to a specific request under FOIA or EIR, in which case:

17.5.1 each Party shall provide the other with all reasonable assistance and co-operation to enable them to comply with their obligations under FOIA or EIR;

17.5.2 each Party shall consult the other regarding the possible application of exemptions in relation to the information requested; and

17.5.3 subject only to clause 16 *(Claims and Litigation)*, each Party acknowledges that the final decision as to the form or content of the response to any request is a matter for the Party to whom the request is addressed.

17.6 NHS England may, from time to time, issue a FOIA or EIR protocol or update a protocol previously issued relating to the dealing with and responding to FOIA or EIR requests in relation to the Delegated Functions. The ICB shall comply with such FOIA or EIR protocols.

17.7 Schedule 4 (*Further Information Governance and Sharing* Provisions) makes further provision about information sharing and information governance.

18. IT INTER-OPERABILITY

18.1 NHS England and the ICB will work together to ensure that all relevant IT systems operated by NHS England and the ICB in respect of the Delegated Functions and the Reserved Functions are inter-operable and that data may be transferred between systems securely, easily and efficiently.

18.2 The Parties will use their respective reasonable endeavours to help develop initiatives to further this aim.

19. CONFLICTS OF INTEREST AND TRANSPARENCY ON GIFTS AND HOSPITALITY

19.1 The ICB must and must ensure that, in delivering the Delegated Functions, all Staff comply with Law, with Managing Conflicts of Interest in the NHS and other Guidance, and with Good Practice, in relation to gifts, hospitality and other inducements and actual or potential conflicts of interest.

19.2 Without prejudice to the general obligations set out in clause 19.1, the ICB must maintain a register of interests in respect of all persons making decisions concerning the Delegated Functions. This register must be publicly available. For the purposes of this clause, the ICB may rely on an existing register of interests rather than creating a further register.

20. PROHIBITED ACTS AND COUNTER-FRAUD

20.1 The ICB must not commit any Prohibited Act.

20.2 If the ICB or its Staff commits any Prohibited Act in relation to this Agreement with or without the knowledge of NHS England, NHS England will be entitled:

20.2.1 to revoke the Delegation; and

20.2.2 to recover from the ICB the amount or value of any gift, consideration or commission concerned; and

20.2.3 to recover from the ICB any loss or expense sustained in consequence of the carrying out of the Prohibited Act.

20.3 The ICB must put in place and maintain appropriate arrangements, including without limitation Staff training, to address counter-fraud issues, having regard to any relevant Guidance (including from the NHS Counter Fraud Authority).

20.4 If requested by NHS England or the NHS Counter Fraud Authority, the ICB must allow a person duly authorised to act on behalf of the NHS Counter Fraud Authority or on behalf of NHS England to review, in line with the appropriate standards and counter-fraud arrangements put in place by the ICB.

20.5 The ICB must implement any reasonable modifications to its counter-fraud arrangements required by a person referred to in clause 20.4 in order to meet the appropriate standards within whatever time periods as that person may reasonably require.

20.6 The ICB must, on becoming aware of:

20.6.1 any suspected or actual bribery, corruption or fraud involving public funds; or

20.6.2 any suspected or actual security incident or security breach involving Staff or involving NHS resources;

20.6.3 promptly report the matter to NHS England and to the NHS Counter Fraud Authority.

20.7 On the request of NHS England or NHS Counter Fraud Authority, the ICB must allow the NHS Counter Fraud Authority or any person appointed by NHS England, as soon as it is reasonably practicable and in any event not later than 5 Operational Days following the date of the request, access to:

20.7.1 all property, premises, information (including records and data) owned or controlled by the ICB; and

20.7.2 all Staff who may have information to provide;

20.7.3 relevant to the detection and investigation of cases of bribery, fraud or corruption, or security incidents or security breaches directly or indirectly in connection with this Agreement.

21. CONFIDENTIAL INFORMATION OF THE PARTIES

21.1 Except as this Agreement otherwise provides, Confidential Information is owned by the disclosing Party and the receiving Party has no right to use it.

21.2 Subject to clauses 21.3 to 21.5, the receiving Party agrees:

21.2.1 to use the disclosing Party's Confidential Information only in connection with the receiving Party's performance under this Agreement;

21.2.2 not to disclose the disclosing Party's Confidential Information to any third party or to use it to the detriment of the disclosing Party; and

21.2.3 to maintain the confidentiality of the disclosing Party's Confidential Information.

21.3 The receiving Party may disclose the disclosing Party's Confidential Information:

21.3.1 in connection with any Dispute Resolution;

21.3.2 in connection with any litigation between the Parties;

21.3.3 to comply with the Law;

21.3.4 to any appropriate Regulatory or Supervisory Body;

21.3.5 to its Staff, who in respect of that Confidential Information will be under a duty no less onerous than the Receiving Party's duty under clause 21.2;

21.3.6 to NHS Bodies for the purposes of carrying out their functions;

21.3.7 as permitted under or as may be required to give effect to clause 20 (*NHS Counter-Fraud*); and

21.3.8 as permitted under any other express arrangement or other provision of this Agreement.

21.4 The obligations in clauses 21.1 and 21.2 will not apply to any Confidential Information which:

21.4.1 is in or comes into the public domain other than by breach of this Agreement;

21.4.2 the receiving Party can show by its records was in its possession before it received it from the disclosing Party; or

21.4.3 the receiving Party can prove it obtained or was able to obtain from a source other than the disclosing Party without breaching any obligation of confidence.

21.5 This clause 21 does not prevent NHS England from making use of or disclosing any Confidential Information disclosed by the ICB where necessary for the purposes of exercising its functions in relation to the ICB.

21.6 The Parties acknowledge that damages would not be an adequate remedy for any breach of this clause 21 by the receiving Party, and in addition to any right to damages, the disclosing Party will be entitled to the remedies of injunction, specific performance and other equitable relief for any threatened or actual breach of this clause 21.

21.7 This clause 21 will survive the termination of this Agreement for any reason for a period of 5 years.

21.8 This clause 21 will not limit the application of the Public Interest Disclosure Act 1998 in any way whatsoever.

22. **INTELLECTUAL PROPERTY**

22.1 The ICB grants to NHS England a fully paid-up, non-exclusive, perpetual licence to use the ICB Deliverables for the purposes of the exercise of its statutory and contractual functions.

22.2 NHS England grants the ICB a fully paid-up, non-exclusive licence to use the NHS England Deliverables for the purpose of performing this Agreement and the Delegated Functions.

22.3 The ICB must co-operate with NHS England to enable it to understand and adopt Best Practice (including the dissemination of Best Practice to other commissioners or providers of NHS services), and must supply such materials and information in relation to Best Practice as NHS England may reasonably request, and (to the extent that any IPR attaches to Best Practice), grants NHS England a fully paid-up, non-exclusive, perpetual licence for NHS England to use Best Practice IPR for the commissioning and provision of NHS services and to share any Best Practice IPR with other commissioners of NHS services (and other providers of NHS services) to enable those parties to adopt such Best Practice.

23. **NOTICES**

23.1 Any notices given under this Agreement must be sent by e-mail to the other Party's address set out in the Particulars.

23.2 Notices by e-mail will be effective when sent in legible form, but only if, following transmission, the sender does not receive a non-delivery message.

24. **DISPUTES**

24.1 This clause does not affect NHS England's right to exercise its functions for the purposes of assessing and addressing the performance of the ICB.

24.2 If a Dispute arises out of or in connection with this Agreement then the Parties must follow the procedure set out in this clause:

24.2.1 either Party must give to the other written notice of the Dispute, setting out its nature and full particulars ("**Dispute Notice**"), together with relevant supporting documents. On service of the Dispute Notice, the Agreement Representatives must attempt in good faith to resolve the Dispute;

24.2.2 if the Agreement Representatives are, for any reason, unable to resolve the Dispute within twenty (20) days of service of the Dispute Notice, the Dispute must be referred to the Chief Executive Officer (or equivalent person) of the ICB and a director of or other person nominated by NHS England (and who has authority from NHS England to settle the Dispute) who must attempt in good faith to resolve it; and

24.2.3 if the people referred to in clause 24.2.2 are for any reason unable to resolve the Dispute within twenty (20) days of it being referred to them, the Parties may attempt to settle it by mediation in accordance with the CEDR model mediation procedure. Unless otherwise agreed between the Parties, the mediator must be nominated by CEDR Solve. To initiate the mediation, a Party must serve notice in writing ('Alternative Dispute Resolution' (**ADR**) **notice**) to the other Party to the Dispute, requesting a mediation. A copy of the ADR notice should be sent to CEDR Solve. The mediation will start not later than ten (10) days after the date of the ADR notice.

24.3 If the Dispute is not resolved within thirty (30) days after service of the ADR notice, or either Party fails to participate or to continue to participate in the mediation before the

expiration of the period of thirty (30) days, or the mediation terminates before the expiration of the period of thirty (30) days, the Dispute must be referred to the Secretary of State, who shall resolve the matter and whose decision shall be binding upon the Parties.

25. VARIATIONS

25.1 The Parties acknowledge that the scope of the Delegated Functions may be reviewed and amended from time to time including by revoking this Agreement and making alternative arrangements.

25.2 NHS England may notify the ICB of a Variation Proposal in respect of this Agreement.

25.3 The Variation Proposal will set out the variation proposed and the date on which NHS England requires the variation to take effect.

25.4 The ICB must respond to a Variation Proposal within thirty (30) Operational Days following the date that it is issued by serving notice on NHS England confirming either:

25.4.1 that it accepts the Variation Proposal; or

25.4.2 that it refuses to accept the Variation Proposal, and sets out reasonable grounds for that refusal.

25.5 If the ICB accepts the Variation Proposal, the ICB agrees (without delay) to take all necessary steps (including executing a variation agreement) in order to give effect to any variation by the date on which the proposed variation will take effect as set out in the Variation Proposal.

25.6 If the ICB refuses to accept the Variation Proposal or to take such steps as are required to give effect to the variation, NHS England may terminate this Agreement in respect of some or all of the Delegated Functions.

25.7 The provisions of this clause 25 are without prejudice to the ability of NHS England to issue Contractual Notices which have the effect of varying this Agreement.

26. TERMINATION

26.1 The ICB may:

26.1.1 notify NHS England that it requires NHS England to revoke the Delegation; and

26.1.2 terminate this Agreement;

with effect from the end of 31 March in any calendar year, provided that:

26.1.3 on or before 30 September of the previous calendar year, the ICB sends written notice to NHS England of its requirement that NHS England revoke the Delegation and intention to terminate this Agreement; and

26.1.4 the ICB meets with NHS England within ten (10) Operational Days of NHS England receiving the notice set out at clause 26.1.3 above to discuss arrangements for termination and transition of the Delegated Functions to a successor commissioner,

in which case NHS England shall revoke the Delegation and this Agreement shall terminate with effect from the end of 31 March in the next calendar year.

26.2 NHS England may revoke the Delegation in whole or in part with effect from 23.59 hours on 31 March in any year, provided that it gives notice to the ICB of its intention to

terminate the Delegation on or before 30 September in the year prior to the year in which the Delegation will terminate, and in which case clause 26.4 will apply.

26.3 The Delegation may be revoked in whole or in part, and this Agreement may be terminated by NHS England at any time, including in (but not limited to) the following circumstances:

26.3.1 the ICB acts outside of the scope of its delegated authority;

26.3.2 the ICB fails to perform any material obligation of the ICB owed to NHS England under this Agreement;

26.3.3 the ICB persistently commits non-material breaches of this Agreement;

26.3.4 NHS England is satisfied that its intervention powers under section 14Z61 of the NHS Act apply;

26.3.5 to give effect to legislative changes, including conferral of any of the Delegated or Reserved Functions on the ICB;

26.3.6 failure to agree to a variation in accordance with clause 25 *(Variations)*;

26.3.7 NHS England and the ICB agree in writing that the Delegation shall be revoked and this Agreement shall terminate on such date as is agreed; and/or

26.3.8 the ICB merges with another ICB or other body.

26.4 This Agreement will terminate upon revocation or termination of the full Delegation (including revocation and termination in accordance with this clause 26 *(Termination)*) except that the provisions referred to at clause 28 (*Provisions Surviving Termination*) will continue in full force and effect.

26.5 Without prejudice to clause 13.3 and to avoid doubt, NHS England may waive any right to terminate this Agreement under this clause 26.5 *(Termination)*. Any such waiver is only effective if given in writing and shall not be deemed a waiver of any subsequent right or remedy.

26.6 As an alternative to termination of the Agreement in respect of all the Delegated Functions, NHS England may alternatively terminate the Agreement in respect of specified Delegated Functions (or aspects of such Delegated Functions) only, in which case this Agreement shall otherwise remain in effect.

27. CONSEQUENCE OF TERMINATION

27.1 Termination of this Agreement, or termination of the ICB's exercise of any of the Delegated Functions, will not affect any rights or liabilities of the Parties that have accrued before the date of that termination or which later accrue.

27.2 Subject to clause 27.4, on or pending termination of this Agreement or termination of the ICB's exercise of any of the Delegated Functions, NHS England, the ICB and if appropriate any successor delegate will:

27.2.1 agree a plan for the transition of the Delegated Functions from the ICB to the successor delegate, including details of the transition, the Parties' responsibilities in relation to the transition, the Parties' arrangements in respect of those staff engaged in the Delegated Functions and the date on which the successor delegate will take responsibility for the Delegated Functions;

27.2.2 implement and comply with their respective obligations under the plan for transition agreed in accordance with clause 27.2.1 above; and

27.2.3 act with a view to minimising any inconvenience or disruption to the commissioning of healthcare in the Area.

27.3 For a reasonable period before and after termination of this Agreement or termination of the ICB's exercise of any of the Delegated Functions, the ICB must:

27.3.1 co-operate with NHS England and any successor delegate in order to ensure continuity and a smooth transfer of the Delegated Functions; and

27.3.2 at the reasonable request of NHS England:

(a) promptly provide all reasonable assistance and information to the extent necessary to effect an orderly assumption of the Delegated Functions by a successor delegate;

(b) deliver to NHS England all materials and documents used by the ICB in the exercise of any of the Delegated Functions; and

27.3.3 use all reasonable efforts to obtain the consent of third parties to the assignment, novation or termination of existing contracts between the ICB and any third party which relate to or are associated with the Delegated Functions.

27.4 Where any or all of the Delegated Functions or Reserved Functions are to be directly conferred on the ICB, the Parties will co-operate with a view to ensuring continuity and a smooth transfer to the ICB.

28. PROVISIONS SURVIVING TERMINATION

28.1 Any rights, duties or obligations of any of the Parties which are expressed to survive, including those referred to in clause 28.2, or which otherwise by necessary implication survive the termination for any reason of this Agreement, together with all indemnities, will continue after termination, subject to any limitations of time expressed in this Agreement.

28.2 The surviving provisions include the following clauses together with such other provisions as are required to interpret and give effect to them:

28.2.1 Clause 9 (*Finance*);

28.2.2 Clause 12 (*Staffing and Workforce*);

28.2.3 Clause 15 *(Liability and Indemnity*);

28.2.4 Clause 16 (*Claims and Litigation*);

28.2.5 Clause 17 (*Data Protection, Freedom of Information and Transparency*);

28.2.6 Clause 24 (*Disputes*);

28.2.7 Clause 26 (*Termination*);

28.2.8 Schedule 4 (*Further Information Governance and Sharing Provisions*).

29. COSTS

29.1 Each Party is responsible for paying its own costs and expenses incurred in connection with the negotiation, preparation and execution of this Agreement.

30. **SEVERABILITY**

30.1 If any provision or part of any provision of this Agreement is declared invalid or otherwise unenforceable, that provision or part of the provision as applicable will be severed from this Agreement. This will not affect the validity and/or enforceability of the remaining part of that provision or of other provisions.

31. **GENERAL**

31.1 Nothing in this Agreement will create a partnership or joint venture or relationship of principal and agent between NHS England and the ICB.

31.2 A delay or failure to exercise any right or remedy in whole or in part shall not waive that or any other right or remedy, nor shall it prevent or restrict the further exercise of that or any other right or remedy.

31.3 This Agreement does not give rise to any rights under the Contracts (Rights of Third Parties) Act 1999 to enforce any term of this Agreement.

SCHEDULE 1

Definitions and Interpretation

1. The headings in this Agreement will not affect its interpretation.

2. Reference to any statute or statutory provision, Law, Guidance, Mandated Guidance or Data Guidance, includes a reference to that statute or statutory provision, Law, Guidance, Mandated Guidance or Data Guidance as from time to time updated, amended, extended, supplemented, re-enacted or replaced in whole or in part.

3. Reference to a statutory provision includes any subordinate legislation made from time to time under that provision.

4. References to clauses and schedules are to the clauses and schedules of this Agreement, unless expressly stated otherwise.

5. References to any body, organisation or office include reference to its applicable successor from time to time.

6. Any references to this Agreement or any other documents or resources includes reference to this Agreement or those other documents or resources as varied, amended, supplemented, extended, restated and/or replaced from time to time and any reference to a website address for a resource includes reference to any replacement website address for that resource.

7. Use of the singular includes the plural and vice versa.

8. Use of the masculine includes the feminine and all other genders.

9. Use of the term “including” or “includes” will be interpreted as being without limitation.

10. The following words and phrases have the following meanings:

Additional Pharmaceutical Services	Services provided in accordance with a direction under section 127 of the NHS Act (also referred to as advanced services and enhanced services in the Pharmaceutical Regulations);
Agreement	means this agreement between NHS England and the ICB comprising the Particulars, the Terms and Conditions, the Schedules and the Mandated Guidance;
Agreement Representatives	means the ICB Representative and the NHS England Representative as set out in the Particulars;
Annual Allocation	means the funds allocated to the ICB annually under section 223G of the NHS Act
APMS Contract	means an agreement or contract for the provision of primary medical services made under section 83(2) of the NHS Act (including any arrangements which are made in reliance on a combination of that section and other powers to arrange for primary medical services);
Area	means the area described in the Particulars;

Assigned Staff	means those NHS England staff as agreed between NHS England and the ICB from time to time;
Best Practice	means any methodologies, pathway designs and processes relating to this Agreement or the Delegated Functions developed by the ICB or its Staff for the purposes of delivering the Delegated Functions and which are capable of wider use in the delivery of healthcare services for the purposes of the NHS, but not including inventions that are capable of patent protection and for which patent protection is being sought or has been obtained, registered designs, or copyright in software;
Caldicott Principles	means the patient confidentiality principles set out in the report of the Caldicott Committee (December 1997 as amended by the 2013 Report, The Information Governance Review – "*To Share or Not to Share?"*) and now included in the NHS Confidentiality Code of Practice, as may be amended from time to time;
Capital	shall have the meaning set out in the Capital Investment Guidance or such other replacement Mandated Guidance as issued by NHS England from time to time;
Capital Expenditure Functions	means those functions of NHS England in relation to the use and expenditure of Capital funds (but excluding the Premises Costs Directions Functions);
Capital Investment Guidance	means any Mandated Guidance issued by NHS England from time to time in relation to the development, assurance and approvals process for proposals in relation to: • the expenditure of Capital, or investment in property, infrastructure or information and technology; and • the revenue consequences for commissioners or third parties making such investment;
CEDR	means the Centre for Effective Dispute Resolution;
Claims	means, for or in relation to the Delegated Functions (a) any litigation or administrative, mediation, arbitration or other proceedings, or any claims, actions or hearings before any court, tribunal or the Secretary of State, any governmental, regulatory or similar body, or any department, board or agency or (b) any dispute with, or any investigation, inquiry or enforcement proceedings by, any governmental, regulatory or similar body or agency;
Claim Losses	means all Losses arising in relation to any Claim;
Combined Authority	means a body of that name established under the provisions of the Local Democracy, Economic Development and Construction Act 2009;
Community Dental Services	means specialised dental services commissioned for patients who are unable to access treatment from Primary Dental

	Services due to a disability or medical condition, being a form of Prescribed Dental Service;
Community Pharmacy Contractual Framework	means the Community Pharmacy Contractual Framework as published by the Department of Health and Social Care from time to time;
Complaints Regulations	means the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009/309;
Confidential Information	means any information or data in whatever form disclosed, which by its nature is confidential or which the disclosing Party acting reasonably states in writing to the receiving Party is to be regarded as confidential, or which the disclosing Party acting reasonably has marked 'confidential' (including, financial information, strategy documents, tenders, employee confidential information, development or workforce plans and information, and information relating to services) but which is not information which is disclosed in response to a FOIA request, or information which is published as a result of NHS England or government policy in relation to transparency;
Contracts	Means any Prescribed Dental Services Contract, Primary Care Contract or Arrangement or other contract or arrangement in respect of the commissioning of any other Delegated Services;
Contractual Notice	means a contractual notice issued by NHS England to the ICB, or some or all ICBs (as the case may be), from time to time and relating to the allocation of contracts for the purposes of the Delegated Functions and/or the manner in which the Delegated Functions should be exercised by the ICB;
CQC	means the Care Quality Commission;
Data Controller	shall have the same meaning as set out in the UK GDPR;
Data Guidance	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement regarding information governance, confidentiality, privacy or compliance with Data Protection Legislation to the extent published and publicly available or their existence or contents have been notified to the ICB by NHS England and/or any relevant Regulatory or Supervisory Body. This includes but is not limited to guidance issued by NHS Digital, the National Data Guardian for Health & Care, the Department of Health and Social Care, NHS England, the Health Research Authority, the UK Health Security Agency and the Information Commissioner;
Data Processor	shall have the same meaning as set out in the UK GDPR;
Data Protection Legislation	means the UK GDPR, the Data Protection Act 2018 and all applicable Law concerning privacy, confidentiality or the processing of personal data including but not limited to the Human Rights Act 1998, the Health and Social Care (Safety

	and Quality) Act 2015, the common law duty of confidentiality and the Privacy and Electronic Communications (EC Directive) Regulations 2003;
Data Sharing Agreement	means a data sharing agreement which should be in substantially the same form as the Data Sharing Agreement template shared by NHS England in respect of this Agreement;
Data Subject	shall have the same meaning as set out in the UK GDPR;
Delegated Functions	means the statutory functions delegated by NHS England to the ICB under the Delegation and as set out in detail in this Agreement;
Delegated Funds	means the funds defined in Clause 9.2;
Delegated Services	Means the services commissioned in exercise of the Delegated Functions;
Delegation	means the delegation of the Delegated Functions from NHS England to the ICB as described at clause 6.1;
Dental Care Services	means: (i) Primary Dental Services; and (ii) the Prescribed Dental Services;
Dental Services Contract	means: (i) a GDS Contract; (ii) a PDS Agreement (except for any Community Dental Services PDS Agreement, which constitutes a Prescribed Dental Services Contract); and (iii) any other contract for the provision of health services made pursuant to NHS England's functions under Part 5 of the NHS Act; in each case as amended or replaced from time to time and including all ancillary or related agreements directly relating to the subject matter of such agreements, contracts or arrangements;
Dental Services Provider	means a natural or legal person who holds a Dental Services Contract;
Direct Commissioning Guidance Webpage	means the webpage maintained by NHS England at https://www.england.nhs.uk/commissioning/how-commissioning-is-changing/;
Dispute	a dispute, conflict or other disagreement between the Parties arising out of or in connection with this Agreement;
Effective Date of Delegation	means the Effective Date of Delegation as set out in the Particulars;

EIR	means the Environmental Information Regulations 2004
Enhanced Services	means the nationally defined enhanced services, as set out in such directions made by the Secretary of State pursuant to his powers contained in sections 98A, 114A, 125A and 168A of the NHS Act as are in force from time to time, or which may be prescribed by NHS England under its Reserved Functions, and any other enhanced services schemes locally developed by the ICB in the exercise of its Delegated Functions (and excluding, for the avoidance of doubt, any enhanced services arranged or provided pursuant to the Section 7A Functions);
Escalation Rights	means the escalation rights as defined in clause 14 *(Escalation Rights)*;
Financial Year	shall bear the same meaning as in section 275 of the NHS Act;
FOIA	the Freedom of Information Act 2000;
Further Arrangements	means arrangements for the exercise of Delegated Functions as defined at clause 11.2;
GDS Contract	means a General Dental Services contract made under section 100 of the NHS Act;
GMS Contract	means a General Medical Services contract made under section 84(1) of the NHS Act;
Good Practice	means using standards, practices, methods and procedures conforming to the law, reflecting up-to-date published evidence and exercising that degree of skill and care, diligence, prudence and foresight which would reasonably and ordinarily be expected from a skilled, efficient and experienced commissioner;
Guidance	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement to which the ICB has a duty to have regard (and whether specifically mentioned in this Agreement or not), to the extent that the same are published and publicly available or the existence or contents of them have been notified to the ICB by any relevant Regulatory or Supervisory Body but excluding Mandated Guidance;
HSCA	means the Health and Social Care Act 2012;
ICB	means an Integrated Care Board established pursuant to section 14Z25 of the NHS Act and named in the Particulars;
ICB Deliverables	all documents, products and materials developed by the ICB or its Staff in relation to this Agreement and the Delegated Functions in any form and required to be submitted to NHS England under this Agreement, including data, reports, policies, plans and specifications;

IG Guidance for Serious Incidents	IG Guidance for Serious Incidents NHS Digital's Checklist Guidance for Information Governance Serious Incidents Requiring Investigation June 2013, available at: https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-informationgovernance/data-security-and-protection-toolkit
Indemnity Arrangement	means either: (i) a policy of insurance; (ii) an arrangement made for the purposes of indemnifying a person or organisation; or (iii) a combination of (i) and (ii);
Information Law	the UK GDPR, the Data Protection Act 2018, regulations and guidance made under section 13S and section 251 of the NHS Act; guidance made or given under sections 263 and 265 of the HSCA; the Freedom of Information Act 2000; the common law duty of confidentiality; the Human Rights Act 1998 and all other applicable laws and regulations relating to processing of Personal Data and privacy;
IPR	means inventions, copyright, patents, database right, trademarks, designs and confidential know-how and any similar rights anywhere in the world whether registered or not, including applications and the right to apply for any such rights;
Law	means any applicable law, statute, rule, bye-law, regulation, direction, order, regulatory policy, guidance or code, rule of court or directives or requirements of any regulatory body, delegated or subordinate legislation or notice of any regulatory body (including any Regulatory or Supervisory Body);
Local Authority	means a county council in England, a Combined Authority, a district council in England, a London borough council, the Common Council of the City of London or the Council of the Isles of Scilly;
Local Incentive Schemes	means an incentive scheme developed by the ICB in the exercise of its Delegated Functions to extend the range or quality of essential and additional services provided under a Primary Medical Services Contract and support national frameworks in order to meet differing local population needs;
Local Pharmaceutical Services Contract	means • a contract entered into pursuant to section 134 of the NHS Act; or • a contract entered into pursuant to Paragraph 1 of Schedule 12 to the NHS Act;
Local Terms	means the terms set out in Schedule 7 *(Local Terms)* and/or such other Schedule or part thereof as designated as Local Terms;
Losses	means all damages, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional

	services) proceedings, demands and charges whether arising under statute, contract or common law;
Managing Conflicts of Interest in the NHS	the NHS publication by that name available at: https://www.england.nhs.uk/about/board-meetings/committees/coi/
Mandated Guidance	means any protocol, policy, guidance, guidelines, framework or manual relating to the exercise of the Delegated Functions and issued by NHS England to the ICB as Mandated Guidance from time to time, in accordance with clause 7.2 which at the Effective Date of Delegation shall include the Mandated Guidance set out in the Schedules**;**
National Moderation Panel	Means the NHS England panel in respect of the relevant Delegated Function that will have the delegated authority to approve the ICB arrangements in respect of a Delegated Function;
Need to Know	has the meaning set out in paragraph 6.2 of Schedule 4 (*Further Information Governance and Sharing Provisions)*;
NHS Act	means the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022 or other legislation from time to time);
NHS Business Services Authority	means the Special Health Authority established under the NHS Business Services Authority (Establishment and Constitution Order) 2005 SI 2005/2414;
NHS Counter Fraud Authority	means the Special Health Authority established by and in accordance with the NHS Counter Fraud Authority (Establishment, Constitution, and Staff and Other Transfer Provisions) Order 2017/958;
NHS England	means the body established by section 1H of the NHS Act;
NHS England Deliverables	means all documents, products and materials NHS England in which NHS England holds IPRs which are relevant to this Agreement, the Delegated Functions or the Reserved Functions in any form and made available by NHS England to the ICB under this Agreement, including data, reports, policies, plans and specifications;
NHS England Functions	means all functions of NHS England as set out in Legislation excluding any functions that have been expressly delegated;
Non-Personal Data	means data which is not Personal Data;
Out of Hours Contract	means a primary medical services contract for the provision of primary medical services solely during the out of hours period (6.30pm Monday to Thursday until 8am the next day, 6.30pm Friday to 8am Monday, Christmas Day, Good Friday and bank holidays);
Operational Days	a day other than a Saturday, Sunday, Christmas Day, Good Friday or a bank holiday in England;

Particulars	means the Particulars of this Agreement as set out in clause 1 *(Particulars)*;
Party/Parties	means a party or both parties to this Agreement;
PDS Agreement	means a Personal Dental Services Agreement made under section 107 of the NHS Act;
Performers Lists	The lists of healthcare professionals maintained by NHS England pursuant to the National Health Service (Performers Lists) (England) Regulations 2013;
Personal Data	shall have the same meaning as set out in the UK GDPR and shall include references to Special Category Personal Data where appropriate;
Pharmaceutical List	means a list of persons who undertake to provide pharmaceutical services pursuant to regulation 10 of the Pharmaceutical Regulations;
Pharmaceutical Regulations	means the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013/349;
Pharmaceutical Services	means:- (i) services provided pursuant to arrangements under section 126 of the NHS Act; and (ii) Additional Pharmaceutical Services
Pharmaceutical Services Arrangement	means an arrangement for the provision of Pharmaceutical Services, including inclusion in a Pharmaceutical List;
Pharmaceutical Services Provider	means a natural or legal person who is party to a Pharmaceutical Services Arrangement or Local Pharmaceutical Services Contract;
PMS Agreement	means an agreement made in accordance with section 92 of the NHS Act;
Population	means the individuals for whom the ICB is responsible for commissioning health services;
Premises Agreements	means tenancies, leases and other arrangements in relation to the occupation of land for the delivery of services under the Primary Medical Services Contracts;
Premises Costs Directions	means the National Health Service (General Medical Services Premises Costs) Directions 2013, as amended;
Premises Costs Directions Functions	means NHS England's functions in relation to the Premises Costs Directions;
Prescribed Dental Services	means the dental services prescribed by such regulations made pursuant to section 3B(1)(a) of the NHS Act as are in force from time to time (including, for the avoidance of doubt,

	services commonly known as secondary care dental services and Community Dental Services);
Prescribed Dental Services Contract	means any contract for the provision of Prescribed Dental Services;
Primary Care Contract or Arrangement (PCCA)	means: (i) a Primary Medical Services Contract; (ii) a Dental Services Contract; (iii) a Primary Ophthalmic Services Contract; (iv) a Local Pharmaceutical Services Contract; and (v) a Pharmaceutical Services Arrangement.
Primary Care Functions	means:- (i) the statutory functions conferred on NHS England under Parts 4, 5, 6 and 7 of the NHS Act and secondary legislation made under those Parts; and (ii) the other statutory functions conferred on NHS England by either primary legislation, secondary legislation or by arrangement with another person in so far as they are applicable to the discharge of those functions set out at (i) above;
Primary Care Provider	means a natural or legal person who holds a Primary Care Contract, or is a Pharmaceutical Services Provider;
Primary Care Provider Personnel	means all persons (whether clinical or non-clinical) employed or engaged by a Primary Care Provider or by any Sub-Contractor (including volunteers, agency, locums, casual or seconded personnel) in the provision of Services or any activity related to or connected with the provision of the Services;
Primary Care Services	means the services in respect of which NHS England has a duty or power to make arrangements pursuant to the Primary Care Functions;
Primary Dental Services	means primary dental care services provided under arrangements made pursuant to Part 5 of the NHS Act, and in accordance with a Dental Services Contract;
Primary Medical Services	means primary medical services provided under arrangements made pursuant to Part 4 of the NHS Act, and in accordance with a Primary Medical Services Contract;
Primary Medical Services Contract	means: (i) a PMS Agreement; (ii) a GMS Contract; (iii) an APMS Contract; and

(iv) any other contract for the provision of health services made pursuant to NHS England's functions under Part 4 of the NHS Act;

in each case as amended or replaced from time to time and including all ancillary or related agreements directly relating to the subject matter of such agreements, contracts or arrangements but excluding any Premises Agreements and excluding any Out of Hours Contracts[2];

Primary Medical Services Provider means a natural or legal person who holds a Primary Medical Services Contract;

Primary Ophthalmic Services Contract means:

(i) a General Ophthalmic Services Contract; and

(ii) any other contract for the provision of health services made pursuant to NHS England's functions under Part 6 of the NHS Act;

in each case as amended or replaced from time to time and including all ancillary or related agreements directly relating to the subject matter of such agreements, contracts or arrangements;

Primary Ophthalmic Services Provider means a natural or legal person who holds a Primary Ophthalmic Services Contract;

Principles of Best Practice means the Mandated Guidance in relation to property and investment which is to be published either before or after the date of this Agreement;

Prohibited Act the ICB:

(i) offering, giving, or agreeing to give NHS England (or any of their officers, employees or agents) any gift or consideration of any kind as an inducement or reward for doing or not doing or for having done or not having done any act in relation to the obtaining of performance of this Agreement, the Reserved Functions, the Delegation or any other arrangement with the ICB, or for showing or not showing favour or disfavour to any person in relation to this Agreement or any other arrangement with the ICB; and

(ii) in connection with this Agreement, paying or agreeing to pay any commission, other than a payment, particulars of which (including the terms and conditions of the agreement for its payment) have been disclosed in writing to NHS England; or

(iii) committing an offence under the Bribery Act 2010;

QOF means the quality and outcomes framework;

[2] Arrangements for Out of Hours Contracts are dealt with under separate Directions outside of this Agreement and do not form part of any Delegated Functions.

Regulatory or Supervisory Body	means any statutory or other body having authority to issue guidance, standards or recommendations with which the relevant Party and/or Staff must comply or to which it or they must have regard, including: (i) CQC; (ii) NHS England; (iii) the Department of Health and Social Care; (iv) the National Institute for Health and Care Excellence; (v) Healthwatch England and Local Healthwatch; (vi) the General Medical Council; (vii) the General Dental Council; (viii) the General Optical Council; (ix) the General Pharmaceutical Council; (x) the Healthcare Safety Investigation Branch; and (xi) the Information Commissioner;
Relevant Information	means the Personal Data and Non-Personal Data processed under the Delegation and this Agreement, and includes, where appropriate, "confidential patient information" (as defined under section 251 of the NHS Act), and "patient confidential information" as defined in the 2013 Report, The Information Governance Review – "*To Share or Not to Share?"*);
Reserved Functions	means statutory functions of NHS England that it has not delegated to the ICB including but not limited to those set out in the Schedules to this Agreement;
Secretary of State	means the Secretary of State for Health and Social Care from time to time;
Section 7A Functions	means those functions of NHS England exercised pursuant to section 7A of the NHS Act and relating to Primary Care Services;
Section 7A Funds	shall have the meaning in Schedule 10 Part 2;
Special Category Personal Data	shall have the same meaning as in UK GDPR;
Specified Purpose	means the purpose for which the Relevant Information is shared and processed, being to facilitate the exercise of the ICB's Delegated Functions and NHS England's Reserved Functions as specified in paragraph 2.1 of Schedule 4 *(Further Information Governance and Sharing Provisions)* to this Agreement;

Staff or Staffing	means the Parties' employees, officers, elected members, directors, voluntary staff, consultants, and other contractors and sub-contractors acting on behalf of either Party (whether or not the arrangements with such contractors and sub-contractors are subject to legally binding contracts) and such contractors' and their sub-contractors' personnel;
Staffing Model	means the employment model for the exercise of the Delegated Functions including those as defined in Appendix 2 of the NHS England and NHS Improvement operating models: HR Framework for developing Integrated Care as may be amended or replaced from time to time;
Statement of Financial Entitlements Directions	means the General Medical Services Statement of Financial Entitlements Directions 2021, as amended or updated from time to time;
Sub-Delegate	shall have the meaning in clause 11.2;
Transfer Regulations	means the Transfer of Undertakings (Protection of Employment) Regulations 2006, as amended;
Triple Aim	means the duty to have regard to the wider effects of decisions, which is placed on each of the Parties under section 13NA (as regards NHS England) and section 14Z43 (as regards the ICB) of the NHS Act;
UK GDPR	means Regulation (EU) 2016/679 of the European Parliament and of the Council of 27th April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data (General Data Protection Regulation) as it forms part of the law of England and Wales, Scotland and Northern Ireland by virtue of section 3 of the European Union (Withdrawal) Act 2018;
Variation Proposal	means a written proposal for a variation to the Agreement, which complies with the requirements of clause 25.3.

SCHEDULE 2

Delegated Functions

Schedule 2A: Primary Medical Services

Part 1: General Obligations

1. Introduction

1.1 This Part 1 of Schedule 2A *(Primary Medical Services)* sets out further provision regarding the carrying out of those Delegated Functions relating to Primary Medical Services, being in summary:

1.1.1 decisions in relation to the commissioning and management of Primary Medical Services;

1.1.2 planning Primary Medical Services in the Area, including carrying out needs assessments;

1.1.3 undertaking reviews of Primary Medical Services in respect of the Area;

1.1.4 management of the Delegated Funds in the Area;

1.1.5 co-ordinating a common approach to the commissioning and delivery of Primary Medical Services with other health and social care bodies in respect of the Area where appropriate; and

1.1.6 such other ancillary activities that are necessary in order to exercise the Delegated Functions.

2. General Obligations

2.1 The ICB is responsible for planning the commissioning of primary medical services.

2.2 The role of the ICB includes:

2.2.1 carrying out needs assessments, and regular reviews of such assessments, to determine the needs of the population in the Area; and

2.2.2 identifying and implementing changes to meet any unmet needs which may be met through the delivery of Primary Medical Services.

2.3 In respect of integrated working, the ICB must:

2.3.1 take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Authorities, Healthwatch, acute and community providers, the Local Medical Committee, and other stakeholders;

2.3.2 work with NHS England and other ICBs to co-ordinate a common approach to the commissioning of Primary Medical Services generally; and

2.3.3 work with NHS England to coordinate the exercise of their respective performance management functions.

2.4 In relation to the Delegated Functions, the ICB agrees to perform the following general obligations:

2.4.1 to manage the Primary Medical Services Contracts and perform all of NHS England's obligations under each of the Primary Medical Services Contracts

in accordance with the terms of the Primary Medical Services Contracts as if it were named in the contract in place of NHS England;

2.4.2 actively manage the performance of the Primary Medical Services Provider in order to secure the needs of people who use the services, improve the quality of services and improve efficiency in the provision of the services including by taking timely action to enforce contractual breaches, serve notices or provide discretionary support;

2.4.3 ensure that it obtains value for money on behalf of NHS England, and avoids making any double payments under any Primary Medical Services Contracts;

2.4.4 notify NHS England immediately (or in any event within two (2) Operational Days) of any breach by the ICB of its obligations to perform any of NHS England's obligations under the Primary Medical Services Contracts;

2.4.5 undertake any investigations relating (among other things) to whistleblowing claims, infection control and patient complaints;

2.4.6 keep a record of all of the Primary Medical Services Contracts that the ICB manages setting out the following details in relation to each Primary Medical Services Contract:

2.4.6.1 name of the Primary Medical Services Provider;

2.4.6.2 the name by which the Primary Medical Services Provider is known (if different to the name recorded under paragraph 2.4.6.1);

2.4.6.3 location of provision of services; and

2.4.6.4 amounts payable under the Primary Medical Services Contract (if a contract sum is payable) or amount payable in respect of each patient (if there is no contract sum).

2.5 Without prejudice to clause 9 (*Finance*) of the Agreement or paragraph 2.4 above, the ICB must actively manage each of the relevant Primary Medical Services Contracts including by:

2.5.1 reviewing the performance of the relevant Primary Medical Services Contract, including in respect of quality standards, incentives and the QOF, observance of service specifications, and monitoring of activity and finance;

2.5.2 assessing quality and outcomes (including clinical effectiveness, patient experience, patient safety and addressing inequalities);

2.5.3 managing variations to the relevant Primary Medical Services Contract or services in accordance with national policy, service user needs and clinical developments;

2.5.4 agreeing information and reporting requirements and managing information breaches (which will include use of the NHS Digital Data Security and Protection Toolkit);

2.5.5 agreeing local prices, managing agreements or proposals for local variations and local modifications;

2.5.6 conducting review meetings and undertaking contract management including the issuing of contract queries and agreeing any remedial action plan or related contract management processes; and

2.5.7 complying with and implementing any relevant Mandated Guidance issued from time to time.

2.6 This paragraph is without prejudice to clause 10 (*Information, Planning and Reporting*) or any other provision in this Agreement. The ICB must provide NHS England with:

2.6.1 such information relating to individual Primary Medical Services Providers in the Area as NHS England may reasonably request, to ensure that NHS England is able to continue to gather national data regarding the commissioning or performance of Primary Medical Services Providers;

2.6.2 such data/data sets as required by NHS England to ensure population of any national dashboards;

2.6.3 any other data/data sets as required by NHS England; and

2.6.4 the ICB shall procure that providers accurately record and report information so as to allow NHS England and other agencies to discharge their functions.

2.7 It should be noted that while the ICB is also required to exercise functions in respect of dispensing doctors, arrangements in respect of these functions are described in Schedule 2D (Pharmaceutical Services).

Part 2: Specific Obligations

1. Introduction

This Part 2 of Schedule 2A (Delegated Functions – Primary Medical Services) sets out further provision regarding the carrying out of each of the Delegated Functions.

2. Primary Medical Services Contract Management

The ICB must comply with any future national Mandated Guidance on equitable funding as may apply from time to time.

3. Enhanced Services

3.1 The ICB must manage the design (where applicable) and commissioning of any Enhanced Services, including re-commissioning these services annually where appropriate.

3.2 The ICB may consider any local enhanced services entered into with Primary Medical Services Providers in its Area using NHS Standard Contracts. Where these would continue to be beneficial to the Area, the ICB may manage the ongoing design and commissioning (including re-commissioning) of these services via a Local Incentives Scheme.

3.3 The ICB must ensure that it complies with any Mandated Guidance in relation to the design and commissioning of Enhanced Services.

3.4 When commissioning newly designed Enhanced Services the ICB must:

3.4.1 consider the needs of the local population in the Area;

3.4.2 develop the necessary specifications and templates for the Enhanced Services, as required to meet the needs of the local population in the Area;

3.4.3 when developing the necessary specifications and templates for the Enhanced Services, ensure that value for money will be obtained;

3.4.4 consult with Local Medical Committees and other stakeholders and comply with the duty of public involvement and consultation under section 14Z45 of the NHS Act;

3.4.5 liaise with system providers and representative bodies to ensure that the system in relation to the Directed Enhanced Services, NHS England Enhanced Services and Local Enhanced Services will be functional and secure;

3.4.6 support Data Controllers in providing 'fair processing' information as required by the UK GDPR; and

3.4.7 support Primary Medical Services Providers in entering into data processing agreements with data processors in the terms required by the UK GDPR.

4. Design of Local Incentive Schemes

4.1 The ICB may design and offer Local Incentive Schemes for Primary Medical Services Providers, sensitive to the differing needs of their particular communities. This includes in addition to or as an alternative to the national contractual frameworks (including as an alternative to QOF or Enhanced Services), provided that such schemes are voluntary, and the ICB continues to offer the national schemes.

4.2 There is no formal approvals process that the ICB must follow to develop a Local Incentive Scheme, although when designing and implementing any proposed new Local Incentive Scheme the ICB must:

4.2.1 consider the needs of the local population in the Area;

4.2.2 develop the specifications and templates for the Local Incentive Scheme;

4.2.3 consult with Local Medical Committees and other stakeholders and comply with the duty of public involvement and consultation under section 14Z45 of the NHS Act;

4.2.4 liaise with system providers and representative bodies to ensure that the system in relation to the Local Incentive Schemes will be functional and secure;

4.2.5 support Data Controllers in providing privacy information as required by the UK GDPR; and

4.2.6 support Primary Medical Services Providers in entering into data processing agreements with data processors in terms required by the UK GDPR.

4.3 The ICB must be able to:

4.3.1 demonstrate improved outcomes, reduced inequalities and value for money;

4.3.2 support ongoing national reporting requirements (where applicable); and

4.3.3 must reflect the changes agreed as part of the national PMS reviews (https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/05/implement-pms-fund-changes.pdf).

4.4 The ongoing assurance of any new Local Incentive Schemes will form part of the ICB's assurance process under any applicable assurance framework.

4.5 Any new Local Incentive Scheme must be implemented without prejudice to the right of Primary Medical Services Providers operating under a GMS Contract to obtain their entitlements which are negotiated and set nationally.

4.6 NHS England will continue to set national standing rules, to be reviewed annually, and the ICB must comply with these rules which shall for the purposes of this Agreement be Mandated Guidance.

5. Making Decisions on Discretionary Payments or Support

5.1 The ICB must manage and make decisions in relation to any discretionary payments or discretionary support to be made to Primary Medical Services Providers in a consistent, open and transparent way.

5.2 The ICB must exercise its discretion to determine the level of payment or type of support to Primary Medical Services Providers, in accordance with any relevant Mandated Guidance.

6. Making Decisions about Commissioning Urgent Care for Out of Area Registered Patients

6.1 The ICB must manage the design and commissioning of urgent care services (including home visits as required) for its patients registered out of area (including re-commissioning these services annually where appropriate).

6.2 The ICB must ensure that it complies with any Mandated Guidance in relation to the design and commissioning of these services.

6.3 For the purposes of paragraph 6.1, urgent care means the provision of primary medical services on an urgent basis.

7. Transparency and freedom of information

7.1 The ICB must:

7.1.1 Respond to requests for information from members of the public and the media, including requests made pursuant to the FOIA, whose subject-matter relates to the performance of the Delegated Functions in the ICB's Area; and

7.1.2 Provide information and assistance as required to support NHS England in the preparation of responses to parliamentary questions in connection with the Delegated Functions.

8. Planning the Provider Landscape

8.1 The ICB must plan the primary medical services provider landscape in the Area, including considering and taking decisions in relation to:

8.1.1 establishing new Primary Medical Services Providers in the Area;

8.1.2 managing Primary Medical Services Providers providing inadequate standards of patient care;

8.1.3 the procurement or award of new Primary Medical Services Contracts (in accordance with any procurement protocol or Guidance issued by NHS England from time to time);

8.1.4 closure of practices and branch surgeries;

8.1.5 dispersing the patient lists of Primary Medical Services Providers; and

8.1.6 agreeing variations to the boundaries of Primary Medical Services Providers.

8.2 In relation to any new Primary Medical Services Contract to be entered into, the ICB must, without prejudice to any obligation in paragraph 14 (*Procurement and New Contracts*) below, and paragraph 2.5 of Part 1 of this Schedule 2A:

8.2.1 consider and use the form of Primary Medical Services Contract that will ensure compliance with NHS England's obligations under Law taking into account the persons to whom such Primary Medical Services Contracts may be awarded;

8.2.2 provide to NHS England confirmation as required from time to time that it has considered and complied with its obligations under this Agreement and the Law; and

8.2.3 for the avoidance of doubt, Schedule 5 (Financial Provisions and Decision Making Limits) deals with the sign off requirements for Primary Medical Services Contracts.

9. Primary Care Networks

9.1 In managing the design and commissioning of the Network Contract Directed Enhanced Services, including re-commissioning these services annually where appropriate, the ICB must plan and manage the Primary Care Networks in the Area, complying with published specifications and Mandated Guidance, including to:

9.1.1 maintain or establish identified Network Areas to support the local population in the Area;

9.1.2 review any waived PCN list size requirements wherever possible and appropriate to best support the local population in the Area;

9.1.3 ensure that each PCN has at all times an accountable Clinical Director;

9.1.4 align each PCN with an ICB that would best support delivery of services to the local population in the Area; and

9.1.5 collaborate and work with other ICBs as appropriate to agree which ICB will be the lead ICB for the PCN.

10. Approving Primary Medical Services Provider Mergers and Closures

10.1 The ICB is responsible for approving Primary Medical Services Provider mergers and Primary Medical Services Provider closures in the Area.

10.2 The ICB must undertake all necessary consultation when taking any decision in relation to Primary Medical Services Provider mergers or Primary Medical Services Provider closures in the Area, including those set out under section 14Z45 of the NHS Act (duty for public involvement and consultation). The consultation undertaken must be appropriate and proportionate in the circumstances and should include consulting with the Local Medical Committee.

10.3 Prior to making any decision in accordance with this paragraph 10 (*Approving Primary Medical Services Provider Mergers and Closures*), the ICB must be able to clearly demonstrate the grounds for such a decision and must have fully considered any impact on the Primary Medical Services Provider's registered population and that of surrounding practices. The ICB must be able to clearly demonstrate that it has considered other options and has entered into dialogue with the Primary Medical Services Provider as to how any closure or merger will be managed.

10.4 In making any decisions pursuant to this paragraph 10 (*Approving Primary Medical Services Provider Mergers and Closures*), the ICB shall act in accordance with relevant Mandated Guidance and also take account of its obligations as set out in paragraph 14 *(Procurement and New Contracts)*, below, where applicable.

11. Making Decisions in relation to Management of Poorly Performing Primary Medical Services Providers

11.1 The ICB must make decisions in relation to the management of poorly performing Primary Medical Services Provider including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the Performers List).

11.2 In accordance with paragraph 11.1 above, the ICB must:

11.2.1 ensure regular and effective collaboration with the CQC to ensure that information on general practice is shared and discussed in an appropriate and timely manner;

11.2.2 ensure that any risks identified are managed and escalated where necessary;

11.2.3 respond to CQC assessments of Primary Medical Services Providers where improvement is required;

11.2.4 where a Primary Medical Services Provider is placed into special measures, lead a quality summit to ensure the development and monitoring of an appropriate improvement plan (including a communications plan and actions to manage primary care resilience in the locality); and

11.2.5 take appropriate contractual action, including (without limitation) in response to CQC findings.

12. Premises Costs Directions Functions

12.1 The ICB must comply with the Premises Costs Directions and will be responsible for making decisions in relation to the Premises Costs Directions Functions.

12.2 In particular, but without limiting paragraph 12.1, the ICB shall make decisions concerning:

12.2.1 applications for new payments under the Premises Costs Directions (whether such payments are to be made by way of grants or in respect of recurring premises costs); and

12.2.2 revisions to existing payments being made under the Premises Costs Directions.

12.3 The ICB must comply with any decision-making limits set out in Schedule 5 (*Financial Provisions and Decision Making Limits*) when taking decisions in relation to the Premises Costs Directions Functions.

12.4 The ICB will comply with any Guidance issued by the Secretary of State or NHS England in relation to the Premises Costs Directions, including the Principles of Best Practice, and any other Mandated Guidance in relation to the Premises Costs Directions.

12.5 The ICB must work to ensure that the premises estate is properly managed and maintained, including by ensuring strategic estates planning is in place, and work cooperatively with other ICBs as appropriate.

12.6 The ICB must ensure it maintains comprehensive records of the primary care estate and any changes to it.

12.7 The ICB must liaise where appropriate with NHS Property Services Limited and Community Health Partnerships Limited in relation to the Premises Costs Directions Functions.

12.8 The ICB must prioritise the following measures in respect of management of the primary care estate in the Area:

12.8.1 working collaboratively with landlords and tenants to maximise the use of existing estate;

12.8.2 effective asset management practices including (without limitation) regularisation of the occupation of the estate, lease events, rent reviews and up-to-date documentation management; and

12.8.3 seeking the resolution of premises disputes in a timely manner.

13. Maintaining the Performers List

On receiving a notice from a practitioner (who is party to a Primary Medical Services Contract) of an amendment to information recorded about them in the Performers List, pursuant to regulation 9(1) of the National Health Service (Performers Lists) (England) Regulations 2013, the ICB must support NHS England's amendment of the Performers List as soon as possible after receiving the notice using the Primary Care Support services provided by NHS England, insofar as that amendment relates to a change in contractor details.

14. Procurement and New Contracts

14.1 Until any new arrangements for awarding Primary Medical Services Contracts comes into force, the ICB will make procurement decisions relevant to the exercise of the Delegated Functions and in accordance with the detailed arrangements regarding procurement set out in the procurement protocol issued and updated by NHS England from time to time.

14.2 In discharging its responsibilities set out in this Schedule 2A, the ICB must comply at all times with Law and any relevant Guidance (including any applicable procurement law and/or guidance on the selection of, and award of contracts to, providers of healthcare services).

14.3 On the coming into force of new arrangements for awarding Primary Medical Services Contracts, the ICB will make decisions on awarding new contracts relevant to the exercise of the Delegated Functions.

14.4 When the ICB makes decisions in connection with the awarding of Primary Medical Services Contracts it should ensure that it is able to demonstrate compliance with requirements for the award of Primary Medical Services Contracts, including that the decision was:

14.4.1 made in the best interest of patients, taxpayers and the population;

14.4.2 robust and defensible, with conflicts of interests appropriately managed;

14.4.3 made transparently; and

14.4.4 compliant with the rules of the regime as set out in NHS England guidance.

14.5 Where the ICB wishes to develop and offer a locally designed contract, it must ensure that it has consulted with the relevant Local Medical Committees in relation to the proposal and that it can demonstrate that the scheme will:

14.5.1 improve outcomes for patients;

14.5.2 reduce inequalities in the population; and

14.5.3 provide value for money.

15. Complaints

15.1 The ICB will handle complaints made in respect of Primary Medical Services in accordance with the Complaints Regulations.

16. Commissioning ancillary support services

16.1 The ICB must procure, and undertake the management and monitoring of contracts for the provision of, such ancillary support services as are required to support the ICB in the effective discharge of the Delegated Functions, including, but not limited to the following:

16.1.1 collection and disposal of clinical waste;

16.1.2 provision of translation and interpretation services;

16.1.3 occupational health services.

17. Finance

Further requirements in respect of finance will be specified in Mandated Guidance.

18. Workforce

18.1 The arrangements for the provision and maintenance of sufficient and appropriately qualified, trained and experienced Staff in order for the ICB to fulfil its responsibilities for each of the Delegated Functions ("the Staffing Model"), will be communicated formally to the ICB by NHS England following recommendations made by the National Moderation Panel.

18.2 The ICB is not permitted to vary the Staffing Model agreed with NHS England as part of its application for delegation of the said functions however a variation can be applied for by the ICB and considered by the National Moderation Panel at any time.

Schedule 2B: Dental Care Services

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

Part 1A: General Obligations – Primary Dental Services

1. Introduction

1.1 This Part 1A of Schedule 2B *(Dental Care Services)* sets out general provisions regarding the carrying out of those Delegated Functions relating to Primary Dental Services, being in summary:

1.1.1 decisions in relation to the commissioning and management of Primary Dental Services;

1.1.2 planning Primary Dental Services in the Area, including carrying out needs assessments;

1.1.3 undertaking reviews of Primary Dental Services in the Area;

1.1.4 management of the Delegated Funds in the Area;

1.1.5 co-ordinating a common approach to the commissioning and delivery of Primary Dental Services with other health and social care bodies in respect of the Area where appropriate; and

1.1.6 such other ancillary activities that are necessary in order to exercise the Delegated Functions.

2. General Obligations

2.1 The ICB is responsible for planning the commissioning of Primary Dental Services.

2.2 When planning and commissioning Primary Dental Services, the ICB must comply with Mandated Guidance issued by NHS England.

2.3 In respect of integrated working, the ICB must:

2.3.1 take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Dental Professional Networks, Local Authorities, Healthwatch, acute and community providers, the Local Dental Committee, and other stakeholders;

2.3.2 work with NHS England and other ICBs to co-ordinate a common approach to the commissioning of Primary Dental Services generally; and

2.3.3 work with NHS England to coordinate the exercise of their respective performance management functions.

2.4 In relation to the Delegated Functions, the ICB agrees to perform the following general obligations with regard to Dental Services Contracts:

2.4.1 to manage the Dental Services Contracts and perform all of NHS England's obligations under each of the Dental Services Contracts in accordance with the terms of the Dental Services Contracts as if it were named in the contract in place of NHS England;

2.4.2 working with other organisations, including the NHS Business Services Authority and the NHS England specialised commissioning team as appropriate, actively manage the performance of the Dental Services Provider in order to secure the needs of people who use the services,

improve the quality of services and improve efficiency in the provision of the services including by taking timely action to enforce contractual breaches, serve notices or provide discretionary support;

2.4.3 ensure that it obtains value for money on behalf of NHS England, including by avoiding making any double payments under any Dental Services Contracts and reducing the number of contracts which are under-delivering so that funds can be reallocated to meet local oral health needs;

2.4.4 notify NHS England immediately (or in any event within two (2) Operational Days) of any breach by the ICB of its obligations to perform any of NHS England's obligations under the Dental Services Contracts;

2.4.5 undertake any investigations relating (among other things) to whistleblowing claims, infection control and patient complaints;

2.4.6 keep a record of all of the Dental Services Contracts that the ICB manages on behalf of NHS England setting out the following details in relation to each Dental Services Contract:

2.4.6.1 name of Dental Services Provider;

2.4.6.2 any practice or trading name by which the Dental Services Provider is known (if different to the name recorded under paragraph 2.4.6.1);

2.4.6.3 location of provision of services; and

2.4.6.4 amounts payable under the contract (if a contract sum is payable) or amount payable in respect of each patient (if there is no contract sum).

2.5 Without prejudice to clause 9 *(Finance)* or paragraph 2.4 above, the ICB must actively manage each of the relevant Dental Services Contracts including by:

2.5.1 reviewing and monitoring spending on services provided pursuant to Dental Services Contracts in the Area;

2.5.2 reviewing and monitoring spending on Primary Dental Services commissioned in the Area;

2.5.3 creating purchase orders, coding invoices and making appropriate amendments within the Compass contractor payments system;

2.5.4 managing the relevant Dental Services Contract, including in respect of quality standards, incentives, observance of service specifications, and monitoring of activity and finance;

2.5.5 assessing quality and outcomes (including clinical effectiveness, patient experience and patient safety);

2.5.6 managing variations to the relevant Dental Services Contract or services in accordance with national policy, service user needs and clinical developments;

2.5.7 agreeing information and reporting requirements and managing information breaches (which will include use of the NHS Digital Data Security and Protection Toolkit);

2.5.8 undertaking annual contract activity negotiations, including agreeing local prices, managing agreements or proposals for local variations and local modifications;

2.5.9 conducting review meetings and undertaking contract management including the issuing of contract queries and agreeing any remedial action plan or related contract management processes;

2.5.10 allocating sufficient resources for undertaking contract mediation; and

2.5.11 complying with and implementing any relevant Mandated Guidance issued from time to time.

2.6 This paragraph is without prejudice to clause 10 *(Information, Planning and Reporting)* or any other provision in this Agreement. The ICB must provide NHS England with:

2.6.1 such information relating to individual providers of Primary Dental Services in the Area as NHS England may reasonably request, to ensure that NHS England is able to continue to gather national data regarding the commissioning or performances of providers of Primary Dental Services;

2.6.2 such data/data sets as required by NHS England to ensure population of any national dashboards;

2.6.3 any other data/data sets as required by NHS England; and

2.6.4 the ICB shall procure that providers accurately record and report information so as to allow NHS England and other agencies to discharge their functions.

Part 1B: Specific Obligations – Primary Dental Services only

1. Introduction

1.1 This Part 1B of Schedule 2B *(Dental Care Services)* sets out further provision regarding the carrying out of each of the Delegated Functions in relation to Primary Dental Services.

2. Dental Services Contract Management

2.1 The ICB must:

2.1.1 comply with all current and future relevant national Mandated Guidance regarding contract reviews;

2.1.2 monitor contract performance and primary care dental spending, with a view in particular to achieving a reduction in the number of contract holders who are under-delivering, and the reallocation of unused resources to meet the oral health needs of the Area; and

2.1.3 in cooperation with the NHS Business Services Authority, monitor contract performance with a view in particular to addressing patient safety concerns and promoting patient safety.

2.2 The ICB must undertake the annual reconciliation of monies claimed by providers against the services provided under any contract for the provision of Dental Care Services made pursuant to NHS England's functions under Part 5 of the NHS Act procuring such ancillary support services as are required for the performance of this function.

3. Transparency and freedom of information

3.1 The ICB must:

3.1.1 respond to requests for information from members of the public and the media, including requests made pursuant to the FOIA, whose subject-matter relates to the performance of the Delegated Functions in the ICB's Area; and

3.1.2 provide information and assistance as required to support NHS England in the preparation of responses to parliamentary questions in connection with the Delegated Functions.

4. Planning the Provider Landscape

4.1 The ICB must plan the provider landscape in the Area, including considering and taking decisions in relation to:

4.1.1 establishing new Dental Services Providers in the Area;

4.1.2 managing Dental Services Providers providing inadequate standards of patient care;

4.1.3 the procurement or award of new Dental Services Contracts (in accordance with any procurement protocol or Guidance issued by NHS England from time to time); and

4.1.4 closure of practices.

4.2 In relation to any new Dental Services Contract to be entered into, the ICB must, without prejudice to any obligation in paragraph 9 (*Procurement and New Contracts*), below:

4.2.1 consider and use the form of Dental Services Contract that will ensure compliance with NHS England's obligations under Law taking into account the persons to whom such Dental Services Contracts may be awarded;

4.2.2 provide to NHS England confirmation as required from time to time that it has considered and complied with its obligations under this Agreement and the Law; and

4.2.3 for the avoidance of doubt, Schedule 5 (*Financial Provisions and Decision Making Limits*) deals with the sign off requirements for Dental Services Contracts.

5. Finance

5.1 Further requirements in respect of finance will be specified in Mandated Guidance.

6. Staffing and Workforce

6.1 Subject to the terms of this Agreement, the Delegated Functions will be carried out by NHS England Staff in accordance with decisions concerning the Delegated Functions made by the ICB unless the Staff carrying out the Delegated Functions have transferred to the ICB (and/or the ICB has engaged or employed Staff for that purpose).

6.2 The arrangements for the provision and maintenance of sufficient and appropriately qualified, trained and experienced Staff in order for the ICB to fulfil its responsibilities for each of the Delegated Functions ("the Staffing Model"), will be communicated formally to the ICB by NHS England following recommendations made by the National Moderation Panel. Further requirements in respect of workforce will be specified in Mandated Guidance.

6.3 The ICB is not permitted to vary the Staffing Model agreed with NHS England as part of its application for delegation of the said functions however a variation can be applied for by the ICB and considered by the National Moderation Panel at any time.

7. Integrating dentistry into communities at Primary Care Network level

7.1 The ICB must exercise the Delegated Functions with a view to achieving greater integration of dentists into the Integrated Care System at the Primary Care Network level.

8. Making Decisions in relation to Management of Poorly Performing Dental Services Providers

8.1 The ICB must make decisions in relation to the management of poorly performing Dental Services Provider including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the Performers List).

8.2 In accordance with paragraph 8.1 above, the ICB must:

8.2.1 ensure regular and effective collaboration with the CQC to ensure that information is shared and discussed in an appropriate and timely manner;

8.2.2 ensure that any risks identified are managed and escalated where necessary;

8.2.3 respond to CQC assessments of Dental Services Providers where improvement is required;

8.2.4 where a Dental Services Provider is placed into special measures, lead a quality summit to ensure the development and monitoring of an appropriate improvement plan (including a communications plan and actions to manage primary care resilience in the locality); and

8.2.5 take appropriate contractual action including (without limitation) in response to CQC findings.

9. Maintaining the Performers List

On receiving a notice from a practitioner (who is party to a Dental Services Contract) of an amendment to information recorded about them in the Performers List, pursuant to regulation 9(1) of the National Health Service (Performers Lists) (England) Regulations 2013, the ICB must support NHS England's amendment of the Performers List as soon as possible after receiving the notice using the Primary Care Support services provided by NHS England, insofar as that amendment relates to a change in contractor details.

10. Procurement and New Contracts

10.1 Until any new arrangements for awarding Dental Services Contracts come into force, the ICB will make procurement decisions relevant to the exercise of the Delegated Functions and in accordance with the detailed arrangements regarding procurement set out in the procurement protocol issued and updated by NHS England from time to time.

10.2 In discharging its responsibilities set out in this Schedule 2B, the ICB must comply at all times with Law and all relevant Guidance (including any applicable procurement law and/or guidance on the selection of, and award of contracts to, providers of healthcare services).

10.3 On the coming into force of new arrangements for awarding Dental Services Contracts, the ICB will make decisions on awarding new contracts relevant to the exercise of the Delegated Functions.

10.4 When the ICB makes decisions in connection with the awarding of Dental Services Contracts it should ensure that it is able to demonstrate compliance with requirements for the award of Dental Services Contracts, including that the decision was:

10.4.1 made in the best interest of patients, taxpayers and the population;

10.4.2 robust and defensible, with conflicts of interests appropriately managed;

10.4.3 made transparently, and

10.4.4 compliant with the rules of the regime as set out in NHS England guidance.

11. Complaints

11.1 The ICB will handle all complaints made in respect of Primary Dental Services in accordance with the Complaints Regulations.

12. Commissioning Ancillary Support Services

12.1 The ICB must procure, and undertake the management and monitoring of contracts for the provision of, such ancillary support services as are required to support the ICB in the effective discharge of the Delegated Functions, including, but not limited to the following:

12.1.1 provision of translation and interpretation services; and

12.1.2 occupational health services.

Part 2A: General Obligations – Prescribed Dental Services

1. Introduction

1.1 This Part 2A of Schedule 2B *(Dental Care Services)* sets out general provisions regarding the carrying out of those Delegated Functions relating to Prescribed Dental Services. Prescribed Dental Services constitute Community Dental Services and Secondary Care Dental Services. These include:

1.1.1 decisions in relation to the commissioning and management of Prescribed Dental Services;

1.1.2 planning Prescribed Dental Services in the Area, including carrying out needs assessments;

1.1.3 undertaking reviews of Prescribed Dental Services in the Area;

1.1.4 management of the Delegated Funds in respect of Prescribed Dental Services in the Area;

1.1.5 co-ordinating a common approach to the commissioning and delivery of Prescribed Dental Services with other health and social care bodies where appropriate; and

1.1.6 such other ancillary activities that are necessary in order to exercise the Delegated Functions.

1.2 For the purposes of this Schedule 2B, "Secondary Care Dental Services" refers to Prescribed Dental Services which are not Community Dental Services.

2. General Obligations

2.1 The ICB is responsible for commissioning Prescribed Dental Services for its Population which for the purpose of this Part 2A of Schedule 2B *(Dental Care Services)*, shall refer to a group of people for whom the ICB has core responsibility, as established under the rules published by NHS England under section 14Z31 of the Act.

2.2 In respect of integrated working, the ICB must take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Dental Professional Networks, Local Authorities, Healthwatch, acute and community providers, the Local Dental Committee, managed clinical networks and other stakeholders.

2.3 When planning and commissioning Prescribed Dental Services, the ICB must comply with Mandated Guidance issued by NHS England.

2.4 The provisions of Paragraph 2.4, 2.5 and 2.6 of Part 1A of this Schedule 2B shall apply in respect of Prescribed Dental Services as if "Dental Services Contract" includes all contracts for Prescribed Dental Services and "Primary Dental Services" include Prescribed Dental Services.

2.5 In awarding any new contract for Prescribed Dental Services, the ICB must:

2.5.1 comply with Law and all relevant Guidance (including any applicable procurement law and/or guidance on the selection of, and award of contracts to, providers of healthcare services);

2.5.2 use the current NHS Standard Contract published by NHS England from time to time; or an appropriate contract for the provision of Dental Care Services made pursuant to NHS England's functions under Part 5 of the NHS Act; and

2.5.3 where the NHS Standard Contract is used, pay for the Services in accordance with the NHS Payment Scheme (as defined in the Health and Social Care Act 2012).

Part 2B: Specific Obligations – Prescribed Dental Services

1. Introduction

1.1 This Part 2B of Schedule 2B *(Prescribed Dental Care Services)* sets out further provision regarding the carrying out of each of the Delegated Functions in relation to Prescribed Dental Services.

2. Community Dental Services Commissioning Obligations

2.1 Community Dental Services may currently be contracted for by way of either an NHS Standard Contract or a PDS Agreement, as appropriate to the particular service. Accordingly:

2.1.1 where Community Dental Services are commissioned on PDS Agreement terms (or it is appropriate to commission a new agreement for Community Dental Services on a PDS Agreement or other agreement made pursuant to NHS England's functions under Part 5 of the NHS Act), those contracts must be managed in accordance with the relevant provisions of Part 1A and Part 1B of this Schedule 2B as if they were Primary Dental Services for the purposes of that Part. The provisions of this Part 2A of Schedule 2B also apply; and

2.1.2 where Community Dental Services are commissioned on NHS Standard Contract terms, the provisions of this Part 2A of Schedule 2B apply in full.

3. Secondary Care Dental Services Commissioning Obligations

3.1 For the first financial year following delegation of Secondary Care Dental Services to the ICB (the "Initial Year of Delegation"), the Secondary Care Dental Services shall be commissioned through wider NHS Standard Contracts made between NHS England and the relevant providers that a) cover the whole population of England; and b) typically also cover other services. Accordingly, unless otherwise stated within a Contractual Notice, for the Initial Year of Delegation ONLY the following shall apply:

3.1.1 The commissioning responsibility for the Secondary Care Dental Service elements of the relevant NHS Standard Contracts is delegated to the ICB to the extent that they relate to its Population;

3.1.2 NHS England is, and will remain, the "co-ordinating commissioner" (as defined in the NHS Standard Contract) for those contracts, meaning that NHS England retains core contract management responsibility;

3.1.3 Delegation of commissioning responsibility for the Secondary Care Dental service elements of the relevant NHS Standard Contracts is permitted by clause GC12 of those contracts. NHS England has confirmed these delegation arrangements by letter to each affected provider so that they are aware of the ICB's role as Secondary Care Dental Services commissioner.

3.1.4 whilst the ICB is commissioner of the Secondary Care Dental Service elements of the contract that relate to its Population, it does not have any direct contract management role and must work with NHS England as co-ordinating commissioner, raising any contractual issues with NHS England for consideration and any appropriate action;

3.1.5 The ICB shall ensure that contractual payments are made to providers for the provision of Secondary Care Dental Services in respect of the ICB's Population, as required by the terms of those contracts. This may represent only a proportion of the overall payment due to the provider for Secondary Care Dental Services delivered more widely under that contract.

3.2 For all subsequent financial years following the Initial Year of Delegation the ICB will be responsible for ensuring that appropriate contractual arrangements are in place to ensure continuity of Secondary Care Dental Services for its Population.

4. Prescribed Dental Services Contract Management

4.1 Subject to Paragraph 4.2 of this Part 2B of Schedule 2B, the ICB must:

4.1.1 comply with all current and future relevant national Mandated Guidance regarding contract reviews;

4.1.2 monitor contract performance and prescribed care dental spending, with a view in particular to ensuring the delivery of agreed contract activity, and the reallocation of unused resources to meet the oral health needs of the Area;

4.1.3 monitor contract performance with a view in particular to addressing patient safety concerns and promoting patient safety; and

4.1.4 ensure appropriate oversight of the Prescribed Dental Services, including, where appropriate, procuring such ancillary support services as are required for the performance of this function.

4.2 For the Initial Year of Delegation in respect of Secondary Care Dental Services the requirements set out in paragraph 4.1 of this Part 2B of Schedule 2B do not apply and the terms of the relevant Contractual Notice shall apply.

5. Transparency and freedom of information

5.1 The ICB must:

5.1.1 respond to requests for information from members of the public and the media, including requests made pursuant to the FOIA, whose subject-matter relates to the performance of the Delegated Functions in the ICB's Area; and

5.1.2 provide information and assistance as required to support NHS England in the preparation of responses to parliamentary questions in connection with the Delegated Functions.

6. Planning the Provider Landscape

6.1 The ICB must plan the provider landscape in the Area, including considering and taking decisions in relation to:

6.1.1 establishing new providers of Prescribed Dental Services in the Area;

6.1.2 managing providers of Prescribed Dental Services providing inadequate standards of patient care; and

6.1.3 the procurement or award of new contracts for Prescribed Dental Services (in accordance with any procurement protocol or Guidance issued by NHS England from time to time).

6.2 In relation to any new contracts for Prescribed Dental Services to be entered into, the ICB must, without prejudice to any obligation in paragraph 11 (*Procurement and New Contracts*):

6.2.1 consider and use the form of contract that will ensure compliance with NHS England's obligations under Law taking into account the persons to whom such contracts may be awarded;

6.2.2 provide to NHS England confirmation as required from time to time that it has considered and complied with its obligations under this Agreement and the Law.

7. **Staffing and Workforce**

7.1 The provisions of paragraph 6 of Part 1B of this Schedule 2B shall apply.

8. Finance

8.1 The ICB must ensure the financial delivery of the Prescribed Dental Services in accordance with any Mandated Guidance provided by NHS England.

9. Integrating dentistry into communities at Primary Care Network level

9.1 The ICB must exercise the Delegated Functions with a view to achieving greater integration of dentists into the Integrated Care System at the Primary Care Network level.

10. Making Decisions in relation to Management of Poorly Performing Dental Services Providers

10.1 The ICB must make decisions in relation to the management of poorly performing providers of Prescribed Dental Services and including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards.

10.2 In accordance with paragraph 9.1 above, the ICB must:

10.2.1 ensure regular and effective collaboration with the CQC to ensure that information is shared and discussed in an appropriate and timely manner;

10.2.2 ensure that any risks identified are managed and escalated where necessary;

10.2.3 respond to CQC assessments of providers of Prescribed Dental Services where improvement is required;

10.2.4 where a providers of Prescribed Dental Services is placed into special measures, lead a quality summit to ensure the development and monitoring of an appropriate improvement plan (including a communications plan and actions to manage primary care resilience in the locality); and

10.2.5 take appropriate contractual action in response to CQC findings.

11. Maintaining the Performers List

On receiving a notice from a practitioner (who is party to a contract for Prescribed Dental Services) of an amendment to information recorded about them in the Performers List, pursuant to regulation 9(1) of the National Health Service (Performers Lists) (England) Regulations 2013, the ICB must support NHS England's amendment of the Performers List as soon as possible after receiving the notice using the Primary Care Support services provided by NHS England, insofar as that amendment relates to a change in contractor details.

12. Procurement and New Contracts

12.1 Until any new arrangements for awarding contracts for Prescribed Dental Services come into force, the ICB will make procurement decisions relevant to the exercise of the Delegated Functions and in accordance with the detailed arrangements regarding procurement set out in the procurement protocol issued and updated by NHS England from time to time.

12.2 In discharging its responsibilities set out in this Schedule 2B, the ICB must comply at all times with Law and all relevant Guidance (including any applicable procurement law and/or guidance on the selection of, and award of contracts to, providers of healthcare services).

12.3 On the coming into force of new arrangements for awarding contracts for Prescribed Dental Services, the ICB will make decisions on awarding new contracts relevant to the exercise of the Delegated Functions.

12.4 When the ICB makes decisions in connection with the awarding of contracts for Prescribed Dental Services it should ensure that it is able to demonstrate compliance with requirements for the award of contracts for Prescribed Dental Services, including that the decision was:

12.4.1 made in the best interest of patients, taxpayers and the population;

12.4.2 robust and defensible, with conflicts of interests appropriately managed;

12.4.3 made transparently, and

12.4.4 compliant with the rules of the regime as set out in NHS England guidance.

13. Commissioning Ancillary Support Services

13.1 The ICB must procure, and undertake the management and monitoring of contracts for the provision of, such ancillary support services as are required to support the ICB in the effective discharge of the Delegated Functions, including, but not limited to the following:

13.1.1 provision of translation and interpretation services; and

13.1.2 occupational health services.

14. Complaints

14.1 The ICB shall be responsible for handling complaints made in respect of Prescribed Dental Services.

Schedule 2C: Primary Ophthalmic Services

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

Part 1: General Obligations

1. Introduction

1.1 This Part 1 of Schedule 2C *(Primary Ophthalmic Services)* sets out general provisions regarding the carrying out of the Delegated Functions, being, in summary:

1.1.1 decisions in relation to the management of Primary Ophthalmic Services;

1.1.2 undertaking reviews of Primary Ophthalmic Services in the Area;

1.1.3 management of the Delegated Funds in the Area;

1.1.4 co-ordinating a common approach to the commissioning of Primary Ophthalmic Services with other commissioners in the Area where appropriate; and

1.1.5 such other ancillary activities that are necessary in order to exercise the Delegated Functions.

2. General Obligations

2.1 The ICB is responsible for managing the provision of Primary Ophthalmic Services.

2.2 When carrying out Delegated Functions in respect of Primary Ophthalmic Services, the ICB must comply with all Mandated Guidance issued by NHS England.

2.3 The role of the ICB includes identifying and seeking to address any unmet needs which may be met through the delivery of Primary Ophthalmic Services.

2.4 In respect of integrated working, the ICB must:

2.4.1 take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Eye Health Networks, Local Authorities, Healthwatch, acute and community providers, Local Optical Committees, and other stakeholders;

2.4.2 work with NHS England and other ICBs to co-ordinate a common approach to the commissioning of Primary Ophthalmic Services generally; and

2.4.3 work with NHS England to coordinate the exercise of their respective performance management functions.

2.5 In relation to the Delegated Functions, the ICB agrees to perform the following general obligations:

2.5.1 to manage the Primary Ophthalmic Services Contracts on behalf of NHS England and perform all of NHS England's obligations under each of the Primary Ophthalmic Services Contracts in accordance with the terms of the Primary Care Contracts as if it were named in the contract in place of NHS England;

2.5.2 working with other organisations, including the NHS Business Services Authority and NHS England as appropriate, actively manage the performance of the Primary Ophthalmic Services Provider in order to secure the needs of people who use the services, improve the quality of services and improve efficiency in the provision of the services including by taking

timely action to enforce contractual breaches, serve notices or provide discretionary support;

2.5.3 ensure that it obtains value for money on behalf of NHS England and avoids making any double payments under any Primary Ophthalmic Services Contracts;

2.5.4 notify NHS England immediately (or in any event within two (2) Operational Days) of any breach by the ICB of its obligations to perform any of NHS England's obligations under the Primary Ophthalmic Services Contracts;

2.5.5 undertake any investigations relating (among other things) to whistleblowing claims, infection control and patient complaints;

2.5.6 keep a record of all of the Primary Ophthalmic Services Contracts that the ICB manages on behalf of NHS England setting out the following details in relation to each Primary Ophthalmic Services Contract:

2.5.6.1 name of the Primary Ophthalmic Services Provider;

2.5.6.2 any practice or trading name by which the Primary Ophthalmic Services Provider is known (if different to the name recorded under paragraph 2.5.6.1);

2.5.6.3 location of provision of services; and

2.5.6.4 amounts payable under the Primary Ophthalmic Services Contract (if a contract sum is payable) or amount payable in respect of each patient (if there is no contract sum).

2.6 Without prejudice to clause 9 *(Finance)* or paragraph 2.5 above, the ICB must actively manage each of the relevant Primary Ophthalmic Services Contracts including by:

2.6.1 managing the relevant Primary Ophthalmic Services Contract, including in respect of quality standards, incentives, observance of service specifications, and monitoring of activity and finance;

2.6.2 assessing quality and outcomes (including clinical effectiveness, patient experience and patient safety);

2.6.3 managing variations to the relevant Primary Ophthalmic Services Contract or services in accordance with national policy, service user needs and clinical developments;

2.6.4 agreeing information and reporting requirements and managing information breaches (which will include use of the NHS Digital Data Security and Protection Toolkit);

2.6.5 conducting review meetings and undertaking contract management including the issuing of contract queries and agreeing any remedial action plan or related contract management processes; and

2.6.6 complying with and implementing any relevant Mandated Guidance issued from time to time.

2.7 This paragraph is without prejudice to clause 10 (*Information, Planning and Reporting*) or any other provision in this Agreement. The ICB must provide NHS England with:

2.7.1 such information relating to individual providers of Primary Ophthalmic Services in the Area as NHS England may reasonably request, to ensure that NHS England is able to continue to gather national data regarding the

commissioning or performances of providers of Primary Ophthalmic Services;

2.7.2 such data/data sets as required by NHS England to ensure population of any national dashboards;

2.7.3 any other data/data sets as required by NHS England; and

2.7.4 the ICB shall procure that providers accurately record and report information so as to allow NHS England and other agencies to discharge their functions.

Part 2: Specific Obligations

1. Introduction

1.1 This Part 2 of Schedule 2C *(Primary Ophthalmic Services)* sets out further provision regarding the carrying out of each of the Delegated Functions.

2. Primary Ophthalmic Services Contract Management

2.1 The ICB must:

2.1.1 comply with all current and future relevant national Mandated Guidance regarding General Ophthalmic Contract reviews and any other contract reviews;

2.1.2 take on the responsibility for existing services provided pursuant to a Primary Ophthalmic Services Contract, and for commissioning new services;

2.1.3 assume the responsibility for the award of new Primary Ophthalmic Services Contracts; and

2.1.4 monitor contract performance with a view to achieving assurance and improvement in the delivery of services in the context of the ICB;

in each case acknowledging that the NHS Business Services Authority provides end-to-end support services in relation to these functions, as referred to in Schedule 6 (*Mandated Assistance and Support*). The ICB accordingly agrees to co-operate with the NHS Business Services Authority in the delivery of these functions.

3. Transparency and freedom of information

3.1 The ICB must:

3.1.1 Respond to requests for information from members and the public and the media, including requests made pursuant to the FOIA, whose subject-matter relates to the performance of the Delegated Functions in the ICB's Area; and

3.1.2 Provide information and assistance as required to support NHS England in the preparation of responses to parliamentary questions in connection with the Delegated Functions.

4. Maintaining the Performers List

4.1 On receiving a notice from a practitioner (who is party to a Primary Ophthalmic Services Contract) of an amendment to information recorded about them in the Performers List, pursuant to regulation 9(1) of the National Health Service (Performers Lists) (England) Regulations 2013, the ICB must support NHS England's amendment of the performers list as soon as possible after receiving the notice using the Primary Care Support

services provided by NHS England, insofar as that amendment relates to a change in contractor details.

5. Finance

5.1 Further requirements in respect of finance will be specified in Mandated Guidance.

6. Workforce

6.1 The arrangements for the provision and maintenance of sufficient and appropriately qualified, trained and experienced Staff in order for the ICB to fulfil its responsibilities for each of the Delegated Functions ("the Staffing Model"), will be communicated formally to the ICB by NHS England following recommendations made by the National Moderation Panel. Further requirements in respect of workforce will be specified in Mandated Guidance.

6.2 The ICB is not permitted to vary the Staffing Model agreed with NHS England as part of its application for delegation of the said functions however a variation can be applied for by the ICB and considered by the National Moderation Panel at any time.

7. Integrating optometry into communities at Primary Care Network level

7.1 The ICB must exercise the Delegated Functions with a view to achieving greater integration of optometrists into the Integrated Care System at the Primary Care Network level.

8. Complaints

8.1 The ICB will handle complaints made in respect of primary ophthalmic services in accordance with the Complaints Regulations.

9. Commissioning ancillary support services

9.1 The ICB must procure, and undertake the management and monitoring of contracts for the provision of, such ancillary support services as are required to support the ICB in the effective discharge of the Delegated Functions, including, but not limited to the following:

9.1.1 provision of translation and interpretation services; and

9.1.2 occupational health services.

Schedule 2D: Delegated Functions – Pharmaceutical Services

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

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

Advanced Services	has the meaning given to that term by the Pharmaceutical Regulations;
Conditions of Inclusion	means those conditions set out at Part 9 of the Pharmaceutical Regulations;
Delegated Pharmaceutical Functions	the functions set out at paragraph 2 of this Schedule;
Designated Commissioner	has the meaning given to that term at paragraph 2.3 of this Schedule;
Dispensing Doctor	has the meaning given to that term by the Pharmaceutical Regulations;
Dispensing Doctor Decisions	means decisions made under Part 8 of the Pharmaceutical Regulations;
Dispensing Doctor Lists	has the meaning given to that term by the Pharmaceutical Regulations;
Drug Tariff	has the meaning given to that term by the Pharmaceutical Regulations;
Electronic Prescription Service	has the meaning given to that term by the Pharmaceutical Regulations;
Enhanced Services	has the meaning given to that term by the Pharmaceutical Regulations;
Essential Services	is to be construed in accordance with paragraph 3 of Schedule 4 to the Pharmaceutical Regulations;
Fitness to Practise Functions	has the meaning given to that term at paragraph 2.1.10 of this Schedule;
Locally Commissioned Services	means services which are not Essential Services, Advanced Services, Enhanced Services or services commissioned under an LPS Scheme;
LPS Chemist	has the meaning given to that term by the Pharmaceutical Regulations;
LPS Scheme	has the meaning given to that term by Paragraph 1(2) of Schedule 12 to the NHS Act;
NHS Chemist	has the meaning given to that term by the Pharmaceutical Regulations;
Pharmaceutical Lists	has the meaning given to that term at paragraph 2.1.1. of this Schedule and any reference to a Pharmaceutical List should be construed accordingly;

Pharmaceutical Regulations	means the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 and reference to a Regulation refers to a provision of the Pharmaceutical Regulations, unless otherwise stated;
Rurality Decisions	means decisions made under Part 7 of the Pharmaceutical Regulations;
Terms of Service	means the terms upon which, by virtue of the Pharmaceutical Regulations, a person undertakes to provide Pharmaceutical Services;

Delegated Pharmaceutical Functions

2. Except in so far as they fall within the scope of the Reserved Functions, and subject to paragraphs 2.2, 2.3, 4 and 5, the ICB agrees to perform the following functions of NHS England in respect of the Area (the "Delegated Pharmaceutical Functions"), in all cases in accordance with relevant Law, Mandated Guidance and other Guidance:

2.1 preparing, maintaining and submitting for publication by NHS England lists of persons, other than medical practitioners or dental practitioners, who have undertaken to provide pharmaceutical services from premises situated within the Area[3], specifically:

2.1.1 lists of persons who have undertaken to provide pharmaceutical services in particular by way of the provision of drugs;

2.1.2 lists of persons who have undertaken to provide pharmaceutical services only by way of the provision of appliances; and

2.1.3 lists of persons participating in the Electronic Prescription Service[4]

collectively referred to in this Schedule as the "Pharmaceutical Lists". In doing so, it is sufficient for the lists referred to at paragraphs 2.1.1.1 and 2.1.1.2 to include a marker showing which persons are also participating in the Electronic Prescription Service, rather than preparing a separate list for the purposes of paragraph 2.1.1.3.

2.1.4 managing and determining applications by persons for inclusion in a Pharmaceutical List[5];

2.1.5 managing and determining applications by persons included in a Pharmaceutical List;

2.1.6 responsibilities for financial resources related to the Delegated Pharmaceutical Functions as described in Mandated Guidance issued by NHS England;

2.1.7 overseeing the compliance of those included in the Pharmaceutical Lists with:

2.1.7.1 their Terms of Service and identifying and investigating breaches, including possible breaches, of those terms;

[3] Including (without limitation) updates to those lists following any removal under regulation 115 of the Pharmaceutical Regulations
[4] Regulation 10 of the Pharmaceutical Regulations
[5] Schedule 2 of the Pharmaceutical Regulations

2.1.7.2 relevant Conditions of Inclusion; and

2.1.7.3 requirements of the Community Pharmacy Contractual Framework.

2.1.8 exercising powers in respect of Performance Related Sanctions and Market Exit[6];

2.1.9 exercising all other rights, and complying with all other obligations, of NHS England in respect of the Terms of Service and Conditions of Inclusion of those included in the Pharmaceutical Lists;

2.1.10 communicating to those included in the Pharmaceutical Lists any announcement made by NHS England modifying Terms of Service of any person included in the Pharmaceutical Lists as a consequence of a disease being, or in anticipation of a disease being imminently:

2.1.11 pandemic; and

2.1.12 a serious risk or potentially a serious risk to human health[7];

2.1.13 communicating to those included in the Pharmaceutical Lists any other matters which NHS England may require the ICB to communicate from time to time;

2.1.14 performing functions in respect of the disqualification of practitioners, and related measures concerning a practitioners inclusion in the Pharmaceutical Lists, set out in Chapter 6 of Part 7 to the NHS Act and the provisions of the Pharmaceutical Regulations made under that Chapter ("the Fitness to Practise Functions");

2.1.15 performing functions in respect of enforcement, reviews and appeals relating to the Fitness to Practise Functions[8];

2.1.16 making LPS Schemes[9], subject to the requirements of paragraph 5;

2.1.17 overseeing the compliance of those who are party to Local Pharmaceutical Services Contracts with the terms of those contracts and identifying and investigating breaches, including possible breaches, of the terms of those contracts;

2.1.18 exercising all rights, and complying with all obligations, of NHS England under Local Pharmaceutical Services Contracts;

2.1.19 determining LPS matters[10] in respect of LPS Schemes;

2.1.20 determining Rurality Decisions and other rurality matters[11];

2.1.21 determining Dispensing Doctor Decisions[12];

2.1.22 preparing and maintaining Dispensing Doctor Lists[13];

[6] Part 10 of the Pharmaceutical Regulations
[7] Regulation 11(3) of the Pharmaceutical Regulations
[8] Part 11 of the Pharmaceutical Regulations
[9] Section 134 NHS Act and Part 13 of the Pharmaceutical Regulations.
[10] Part 13 of the Pharmaceutical Regulations
[11] Part 7 of the Pharmaceutical Regulations
[12] Part 8 of the Pharmaceutical Regulations
[13] Regulation 46 of the Pharmaceutical Regulations

2.1.23 making arrangements for the provision of adequate pharmaceutical service delivery across the ICB area;

2.1.24 making arrangements for the delivery of Essential Services, Advanced Services and Enhanced Services;

2.1.25 supporting implementation and delivery of all elements of the Community Pharmacy Contractual Framework;

2.1.26 consulting with patients, the public and other stakeholders to the extent required by the duty of public involvement and consultation under section 14Z45 of the NHS Act;

2.1.27 responding to Appeals to the Secretary of State and First Tier Tribunal in respect of the Delegated Pharmaceutical Functions[14];

2.1.28 responding to Claims in respect of the Delegated Pharmaceutical Functions;

2.1.29 recovering overpayments from NHS Chemists, LPS Chemists, Dispensing Doctors and Primary Medical Services Providers[15];

2.1.30 bringing any legal proceedings in respect of the Delegated Pharmaceutical Functions;

2.1.31 making any notifications to, and consulting with, third parties in respect of the Delegated Pharmaceutical Functions;

2.1.32 recognising one or more Local Pharmaceutical Committees which it considers are representative of Pharmaceutical Services Providers in the ICB's Area and liaising with and consulting such Local Pharmaceutical Committees as required by the Pharmaceutical Regulations;

2.1.33 commissioning the provision of NHS Smartcards to Pharmaceutical Services Providers and their staff by registration authorities;

2.1.34 making any payments due to NHS Chemists suspended from a Pharmaceutical List in accordance with the determination made by the Secretary of State in respect of such payments; and

2.1.35 undertaking any investigations relating (among other things) to whistleblowing claims (relating to a superintendent pharmacist, a director or the operation of a pharmacy contractor), infection control and patient complaints.

2.2 Where the Area comprises the areas of two or more Health and Wellbeing Boards in their entirety:

2.2.1 the Delegated Pharmaceutical Functions shall be exercised so as to maintain separately in respect of each Health and Wellbeing Board area:

2.2.1.1 Pharmaceutical Lists in respect of premises in that Health and Wellbeing Board area;

2.2.1.2 a list of LPS Chemists providing local pharmaceutical services at or from premises in that Health and Wellbeing Board area[16]; and

[14] Schedule 3 of the Pharmaceutical Regulations
[15] Regulation 94 of the Pharmaceutical Regulations
[16] Regulation 114 of the Pharmaceutical Regulations

2.2.1.3 a Dispensing Doctor List (together the "Relevant Lists"); and

2.2.1.4 the ICB shall comply with such Contractual Notices as NHS England may issue from time to time concerning the arrangements for the exercise of the Delegated Pharmaceutical Functions across two or more Health and Wellbeing Board areas.

2.3 Where the Area comprises part of the area of a Health and Wellbeing Board (the "Relevant Health and Wellbeing Board"):

2.3.1 NHS England shall by Contractual Notice designate:

2.3.1.1 the ICB;

2.3.1.2 another ICB whose area comprises in part the area of the Relevant Health and Wellbeing Board; or

2.3.1.3 NHS England;

as the body responsible for maintaining the Relevant Lists (as defined in paragraph 2.2.1 of this Schedule 2D) in respect of the Relevant Health and Wellbeing Board ("the Designated Commissioner");

2.3.2 the ICB shall exercise the Delegated Pharmaceutical Functions in respect of that part of the Relevant Health and Wellbeing Board's area that falls within the Area but in doing so shall liaise with any Designated Commissioner for the purposes of maintaining the accuracy of the Relevant Lists (as defined in paragraph 2.2.1 of this Schedule 2D) in respect of the Relevant Health and Wellbeing Board; and

2.3.3 the ICB shall comply with all Contractual Notices issued by NHS England for the purposes of determining responsibilities in the circumstances described in this paragraph 2.3.

Prescribed Support

3. Notwithstanding the inclusion of the following within the Delegated Functions, the ICB shall discharge the functions set out at:

3.1 Paragraph 2.1.1 (maintaining Pharmaceutical Lists)

3.2 Paragraph 2.1.2 (managing applications for inclusion)

3.3 Paragraph 2.1.3 (managing applications from those included in a list)

3.4 Paragraph 2.1.5 (overseeing compliance with Terms of Service and Conditions of Inclusion)

3.5 Paragraph 2.1.10 (Fitness to Practise)

3.6 Paragraph 2.1.18 (maintaining and publishing Dispensing Doctors Lists)

3.7 Paragraph 2.1.25 (recovery of overpayments)

with the assistance and support of the NHS Business Services Authority, Primary Care Support England or such other person as NHS England shall designate by Contractual Notice for these purposes from time to time and in accordance with the allocation of operational responsibilities described by NHS England in Mandated Guidance.

LPS Schemes

4. The ICB shall not without the prior written consent of NHS England make any new LPS Schemes.

Barred Persons

5. The ICB must ensure that persons barred from involvement in specific elements of the Delegated Functions are excluded from such involvement in accordance with the Pharmaceutical Regulations.

Other Services

6. The provisions of this schedule are without prejudice to the ability of the ICB to make arrangements for the provision of Locally Commissioned Services for the purposes of the NHS in accordance with its own commissioning functions and using its own financial resources.

Payments

7. In exercising the Delegated Pharmaceutical Functions, the ICB must ensure that:

    7.1 all payments to which the Drug Tariff applies are made solely in accordance with the Drug Tariff; and

    7.2 any other payments for services (including without limitation those relating to LPS Schemes and Enhanced Services) are made in accordance with recognised contractual mechanisms intended to apply to those services.

Flu vaccinations

8. The Parties acknowledge and agree that:

    8.1 responsibility for arranging any national scheme for flu vaccinations remains with NHS England as part of its Section 7A Functions; and

    8.2 where any such national scheme is arranged by NHS England, the ICB is required to commission flu vaccines as Advanced Services. For the purposes of this Agreement, this forms part of the ICB's responsibilities under this Agreement.

Integration

9. In respect of integrated working, the ICB must:

    9.1 take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Authorities, Healthwatch, acute and community providers, professional representative groups, contractor representative groups and other stakeholders;

    9.2 work with NHS England and other ICBs to co-ordinate a common approach to the commissioning of Pharmaceutical Services generally; and

    9.3 work with NHS England to coordinate the exercise of their respective performance management functions.

Integrating pharmacy into communities at Primary Care Network level

10. The ICB must exercise the Delegated Functions with a view to achieving greater integration of community pharmacy into the Integrated Care System at the Primary Care Network level including participation in network governance arrangements.

Complaints

11. The ICB will handle complaints made in respect of Pharmaceutical Services and Local Pharmaceutical Services in accordance with the Complaints Regulations.

Commissioning ancillary support services

12. The ICB must procure, and undertake the management and monitoring of contracts for the provision of, such ancillary support services as are required to support the ICB in the effective discharge of the Delegated Functions, including, but not limited to the following:

12.1 collection and disposal of clinical waste; and

12.2 provision of translation and interpretation services; and

12.3 occupational health services.

Finance

13. Further requirements in respect of finance will be specified in Mandated Guidance.

Workforce

14. Further requirements in respect of workforce will be specified in Mandated Guidance.

SCHEDULE 3

Reserved Functions

1. Introduction

1.1 In accordance with clause 8.4 of this Agreement, all functions of NHS England other than those defined as Delegated Functions are Reserved Functions.

1.2 This Schedule 3 (*Reserved Functions*) sets out further provision regarding the carrying out of the Reserved Functions.

1.3 The ICB will work collaboratively with NHS England and will support and assist NHS England to carry out the Reserved Functions.

2. Management of the national performers list

2.1 Subject to Paragraph 2.2, NHS England will continue to perform its functions under the National Health Service (Performers Lists) (England) Regulations 2013.

2.2 The ICB will carry out administrative tasks in respect of the Performers Lists as described at:

2.2.1 Paragraph 9 of Part 2, Schedule 2A;

2.2.2 Paragraph 9 of Part 2, Schedule 2B; and

2.2.3 Paragraph 6 of Part 2, Schedule 2C.

2.3 NHS England's functions in relation to the management of the national performers list include:

2.3.1 considering applications and decision-making in relation to inclusion on the national performers list, inclusion with conditions and refusals;

2.3.2 identifying, managing and supporting primary care performers where concerns arise; and

2.3.3 managing suspension, imposition of conditions and removal from the national performers list.

2.4 NHS England may hold local Performance Advisory Group ("PAG") meetings to consider all complaints or concerns that are reported to NHS England in relation to a named performer and NHS England will determine whether an initial investigation is to be carried out.

2.5 NHS England may notify the ICB of all relevant PAG meetings at least seven (7) days in advance of such meetings. NHS England may require a representative of the ICB to attend such meetings to discuss any performer concerns and/or quality issues that may impact on individual performer cases.

2.6 The ICB must develop a mechanism to ensure that all complaints regarding any named performer are escalated to the Local NHS England Team for review. The ICB will comply with any Mandated Guidance issued by NHS England in relation to the escalation of complaints about a named performer.

3. Management of the revalidation and appraisal process

3.1 NHS England will continue to perform its functions under the Medical Profession (Responsible Officers) Regulations 2010 (as amended by the Medical Profession (Responsible Officers) (Amendment) Regulations 2013).

3.2 All functions in relation to GP appraisal and revalidation will remain the responsibility of NHS England, including:

3.2.1 the funding of GP appraisers;

3.2.2 quality assurance of the GP appraisal process; and

3.2.3 the responsible officer network.

3.3 Funding to support the GP appraisal is incorporated within the global sum payment to Primary Medical Services Provider.

3.4 The ICB must not remove or restrict the payments made to Primary Medical Services Provider in respect of GP appraisal.

3.5 Appraisal arrangements in respect of all other primary care practitioner groups shall also be Reserved Functions.

4. Administration of payments and related performers list management activities

4.1 NHS England reserves its functions in relation to the administration of payments to individual performers and related performers list management activities under the National Health Service (Performers Lists) (England) Regulations 2013 and other relevant legislation.

4.2 NHS England may continue to pay practitioners who are suspended from the national performers list in accordance with relevant determinations made by the Secretary of State.

4.3 For the avoidance of doubt, the ICB is responsible for any ad hoc or discretionary payments to Primary Medical Services Providers (including those under section 96 of the NHS Act) in accordance with Schedule 2A (*Delegated Functions*) Part 2 paragraphs 5.1 and 5.1 of this Agreement, including where such payments may be considered a consequence of actions taken under the National Health Service (Performers Lists) (England) Regulations 2013.

5. Section 7A and Capital Expenditure Functions

5.1 NHS England retains the Section 7A Functions and will be responsible for taking decisions in relation to the Section 7A Functions.

5.2 In accordance with Schedule 10 Part 2, the ICB will provide certain management and/or administrative services to NHS England in relation to the Section 7A Functions.

5.3 NHS England retains the Capital Expenditure Functions and will be responsible for taking decisions in relation to the Capital Expenditure Functions.

5.4 In accordance with Schedule 10 Part 1, the ICB will provide certain management and/or administrative services to NHS England in relation to the Capital Expenditure Functions.

6. Such other ancillary activities that are necessary in order to exercise the Reserved Functions

6.1 NHS England will continue to comply with its obligations under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

6.2 The ICB must assist NHS England's controlled drug accountable officer ("CDAO") to carry out its functions under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

6.3 The ICB must nominate a relevant senior individual within the ICB (the "ICB CD Lead") to liaise with and assist NHS England to carry out its functions under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

6.4 The ICB CD Lead must, in relation to the Delegated Functions:

6.4.1 on request provide NHS England's CDAO with all reasonable assistance in any investigation involving the Delegated Functions;

6.4.2 report all complaints involving controlled drugs to NHS England's CDAO;

6.4.3 report all incidents or other concerns involving the safe use and management of controlled drugs to NHS England's CDAO;

6.4.4 analyse the controlled drug prescribing data available; and

6.4.5 on request supply (or ensure organisations from whom the ICB commissions services involving the regular use of controlled drugs supply) periodic self–declaration and/or self-assessments to NHS England's CDAO.

7. Reserved Functions – Primary Medical Services

7.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Primary Medical Services Functions"):

7.1.1 determining the outcomes expected from Primary Medical Services and the main characteristics of high quality services, taking into account national priorities for improving NHS outcomes and the Department of Health and Social Care mandate;

7.1.2 designing and delivering national transformation programmes in support of national priorities;

7.1.3 the negotiation and agreement of matters concerning General Medical Services contracts with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of primary medical services nationally;

7.1.4 the development of national standard Primary Medical Service contracts and national contract variations and guidance to ensure an equitable approach to applying nationally agreed changes to all Primary Medical Services providers;

7.1.5 the provision of commissioning and contracting policy and guidance to support ICBs to meet their delegated duties;

7.1.6 the provision of nationally contracted services delivering digital, logistical and support services for Primary Medical Services in England (including but not limited to):

7.1.6.1 Payments;

7.1.6.2 Pensions;

7.1.6.3 Patient Registration;

7.1.6.4 Medical Records;

7.1.6.5 Performer List;

7.1.6.6 Supplies;

7.1.6.7 Call and Recall for Cervical screening (CSAS); and

7.1.6.8 Pharmacy Market Management.

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

8. Reserved Functions – Primary Dental Services

8.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Primary Dental Services Functions"):

8.1.1 determining the outcomes expected from Primary Dental Services and the main characteristics of high quality services, taking into account national priorities for improving NHS outcomes; designing and delivering national transformation programmes in line with any applicable commissioning policies and guidance;

8.1.2 the negotiation and agreement of matters concerning Dental Services Contracts with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of primary dental services nationally;

8.1.3 the development of national standard Dental Service Contracts and national contract variations and guidance to ensure an equitable approach to applying nationally agreed changes to all Primary Dental Services providers;

8.1.4 the provision of all dental commissioning and contracting policy and guidance to support ICBs to meet their delegated duties; and

8.1.5 the provision of nationally contracted services delivering digital, logistical and support services for Primary Dental Services in England (including but not limited to):

8.1.5.1 Payments;

8.1.5.2 Pensions;

8.1.5.3 Performer List; and

8.1.5.4 Market Management.

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

9. Reserved Functions – Primary Ophthalmic Services

9.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Ophthalmic Functions"):

9.1.1 the Primary Ophthalmic Services Contracts policy and associated documentation;

9.1.2 the negotiation and agreement of matters concerning Primary Ophthalmic Services with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of Ophthalmic Services nationally; and

9.1.3 the provision of nationally contracted services delivering digital, logistical and support services for Primary Ophthalmic Services in England (including but not limited to):

9.1.3.1 Payments;

9.1.3.2 Performers List;

9.1.3.3 Market Management/Entry; and

9.1.3.4 Contract management, assurance and post-payment verification.

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

10. Reserved Functions – Pharmaceutical Services and Local Pharmaceutical Services

10.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Pharmaceutical Functions"):

10.1.1 publication of Pharmaceutical Lists;

10.1.2 functions of NHS England as a determining authority in relation to pharmaceutical remuneration under Part 12 of the Pharmaceutical Regulations;

10.1.3 functions in respect of lists of performers of pharmaceutical services and assistants, noting that as at the date of this Agreement regulations for the purposes of these functions have not been made[17];

10.1.4 the negotiation and agreement of matters concerning NHS pharmaceutical services with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of Pharmaceutical Services nationally;

10.1.5 the provision of commissioning and contracting policy and guidance to support ICBs to meet their delegated duties; and

10.1.6 administration of the pharmacist pre-registration training grant scheme.

11. Reserved Functions – Primary Dental Services

11.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Primary Dental Services Functions"):

11.1.1 determining the outcomes expected from Primary Dental Services and the main characteristics of high quality services, taking into account national priorities for improving NHS outcomes; designing and delivering national transformation programmes in line with any applicable commissioning policies and guidance;

11.1.2 the negotiation and agreement of matters concerning Dental Services Contracts with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of primary dental services nationally;

11.1.3 the development of national standard Dental Service Contracts and national contract variations and guidance to ensure an equitable approach to applying nationally agreed changes to all Primary Dental Services providers;

11.1.4 the provision of all dental commissioning and contracting policy and guidance to support ICBs to meet their delegated duties;

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

11.1.5 the provision of nationally contracted services delivering digital, logistical and support services for Primary Dental Services in England (including but not limited to):

11.1.5.1 Payments

11.1.5.2 Pensions

11.1.5.3 Performer List

11.1.5.4 Market Management.

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

12. Reserved Functions - Prescribed Dental Services

12.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Prescribed Dental Services Functions"):

12.1.1 determining the outcomes expected from Prescribed Dental Services and the main characteristics of high quality services, taking into account national priorities for improving NHS outcomes; designing and delivering national transformation programmes in line with any applicable commissioning policies and guidance;

12.1.2 in respect of any Prescribed Dental Services contracted pursuant to NHS England's functions under Part 5 of the NHS Act the negotiation and agreement of matters concerning those contracts with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of primary dental services nationally;

12.1.3 in respect of any Prescribed Dental Services contracted pursuant to NHS England's functions under Part 5 of the NHS Act, the development of standard contracts and national contract variations and guidance;

12.1.4 the provision of all dental commissioning and contracting policy and guidance to support ICBs to meet their delegated duties;

12.1.5 in respect of any Prescribed Dental Services contracted pursuant to NHS England's functions under Part 5 of the NHS Act, the provision of nationally contracted services delivering digital, logistical and support services in England (including but not limited to):

12.1.5.1 Payments

12.1.5.2 Pensions

12.1.5.3 Performer List

12.1.5.4 Market Management.

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

SCHEDULE 4

Further Information Governance and Sharing Provisions

1. Introduction

1.1 The purpose of this Schedule 4 *(Further Information Governance and Sharing Provisions* is to set out the scope for the secure and confidential sharing of information between the Parties on a **Need To Know** basis, in order to enable the Parties to exercise their functions in pursuance of this Agreement.

1.2 References in this Schedule 4 *(Further Information Governance and Sharing Provisions)* to the **Need to Know** basis or requirement (as the context requires) should be taken to mean that the Data Controllers' personnel will only have access to Personal Data or Special Category Personal Data if it is lawful for such personnel to have access to such data for the Specified Purpose in paragraph 2.1 and the function they are required to fulfil at that particular time, in relation to the Specified Purpose, cannot be achieved without access to the Personal Data or Special Category Personal Data specified.

1.3 This Schedule and the Data Sharing Agreements entered into under this Schedule are designed to:

1.3.1 provide information about the reasons why Relevant Information may need to be shared and how this will be managed and controlled by the Parties;

1.3.2 describe the purposes for which the Parties have agreed to share Relevant Information;

1.3.3 set out the lawful basis for the sharing of information between the Parties, and the principles that underpin the exchange of Relevant Information;

1.3.4 describe roles and structures to support the exchange of Relevant Information between the Parties;

1.3.5 apply to the sharing of Relevant Information relating to Delegated Functions in respect of

1.3.5.1 Primary Care Providers and Primary Care Provider Personnel; and

1.3.5.2 Dental Services Providers and their personnel;

1.3.5.3 All other providers of Delegated Functions.

1.3.6 apply to the sharing of Relevant Information whatever the medium in which it is held and however it is transmitted;

1.3.7 ensure that Data Subjects are, where appropriate, informed of the reasons why Personal Data about them may need to be shared and how this sharing will be managed;

1.3.8 apply to the activities of the Parties' personnel; and

1.3.9 describe how complaints relating to Personal Data sharing between the Parties will be investigated and resolved, and how the information sharing will be monitored and reviewed.

2. Purpose

2.1 The Specified Purpose of the data sharing is to facilitate the exercise of the ICB's Delegated Functions and NHS England's Reserved Functions as described in this Agreement.

2.2 ICBs must ensure that they have in place appropriate Data Sharing Agreements to enable data to be received by it from NHS Digital (or the successor to the relevant statutory functions of NHS Digital) and any other third party organisations from which the ICB must obtain data for the purpose of exercising the Delegated Functions. Specific and detailed purposes must be set out the Data sharing Agreement that complies with all relevant Legislation and Guidance.

3. Benefits of information sharing

3.1 The benefits of sharing information are the achievement of the Specified Purpose set out above, with benefits for service users and other stakeholders in terms of the improved delivery of the NHS services to which this Agreement relates.

4. Lawful basis for Sharing

4.1 Each Party shall comply with all relevant Information Law requirements and good practice in relation to the processing of Relevant Information shared further to this Agreement.

4.2 The ICB shall ensure that there is a Data Protection Impact Assessment ("DPIA") that covers all Delegated Functions. The ICB shall identify the lawful basis for sharing Relevant Information for each purpose and data flow, and where appropriate, enter into a Data Sharing Agreement.

5. Relevant Information to be shared

5.1 The Relevant Information to be shared shall be set out in a Data Sharing Agreement.

6. Restrictions on use of the Shared Information

6.1 Each Party shall only process the Relevant Information as is necessary to achieve the Specified Purpose, and, in particular, shall not use or process Relevant Information for any other purpose unless agreed in writing by the Data Controller that released the information to the other. There shall be no other use or onward transmission of the Relevant Information to any third party without a lawful basis first being determined, and the originating Data Controller being notified.

6.2 Access to, and processing of, the Relevant Information provided by a Party must be the minimum necessary to achieve the Specified Purpose. Information and Special Category Personal Data will be handled at all times on a restricted basis, in compliance with Information Law requirements, and the parties' personnel should only have access to Personal Data on a justifiable **Need to Know** basis.

6.3 Neither the provisions of this Schedule 4 *(Further Information Governance and Sharing Provisions)* nor any Data Sharing Agreements entered into in accordance with this Schedule should be taken to permit unrestricted access to data held by any Party. It lays the parameters for the safe and secure sharing and processing of information on a justifiable **Need to Know** basis.

6.4 Neither Party shall subcontract any processing of the Relevant Information without the prior written consent of the other Party. Where a Party subcontracts its obligations, it shall do so only by way of a written agreement with the sub-contractor which imposes the same obligations as are imposed on the Data Controllers under this Agreement.

6.5 Neither Party shall cause or allow Data to be transferred to any territory outside the United Kingdom without the prior written permission of the responsible Data Controller.

6.6 Any particular restrictions on use of certain Relevant Information are included in the Personal Data Agreement annexed to this Schedule.

7. Ensuring fairness to the Data Subject

7.1 In addition to having a lawful basis for sharing information, the UK GDPR generally requires that the sharing must be fair and transparent. In order to achieve fairness and transparency to the Data Subjects, the Parties will take the following measures:

7.1.1 amendment of internal guidance to improve awareness and understanding among personnel;

7.1.2 amendment of respective privacy notices and policies to reflect the processing of data carried out further to this Agreement, including covering the requirements of articles 13 and 14 UK GDPR and providing these (or making them available to) Data Subjects;

7.1.3 ensuring that information and communications relating to the processing of data is easily accessible and easy to understand, and that clear and plain language be used; and

7.1.4 giving consideration to carrying out activities to promote public understanding of how data is processed where appropriate.

7.2 Each Party shall procure that its notification to the Information Commissioner's Office and record of processing maintained for the purposes of Article 30 UK GDPR reflects the flows of information under this Agreement.

7.3 Each Party shall reasonably cooperate with the other in undertaking any Data Protection Impact Assessment associated with the processing of data further to this Agreement, and in doing so engage with their respective Data Protection Officers in the performance by them of their duties pursuant to Article 39 UK GDPR.

7.4 Further provision in relation to specific data flows should be included in Data Protection Agreements.

8. Governance: personnel

8.1 Each Party must take reasonable steps to ensure the suitability, reliability, training and competence, of any personnel who have access to the Personal Data (and Special Category Personal Data) including reasonable background checks and evidence of completeness should be available on request by each Party.

8.2 The Parties agree to treat all Relevant Information as confidential and imparted in confidence and must safeguard it accordingly. Where any of the Parties' personnel are not healthcare professionals (for the purposes of the Data Protection Act 2018) the employing Parties must procure that personnel operate under a duty of confidentiality which is equivalent to that which would arise if that person were a healthcare professional.

8.3 Each Party shall ensure that all personnel required to access the Personal Data (including Special Category Personal Data) are informed of the confidential nature of the Personal Data and each Party shall include appropriate confidentiality clauses in employment/service contracts of all personnel that have any access whatsoever to the Relevant Information, including details of sanctions for acting in a deliberate or reckless manner that may breach the confidentiality or the non-disclosure provisions of Information Law requirements, or causes damage to or loss of the Relevant Information.

8.4 Each Party shall provide evidence (further to any reasonable request) that all personnel that have any access to the Relevant Information whatsoever are adequately and appropriately trained to comply with their responsibilities under Information Law and this Agreement.

8.5 Each Party shall ensure that:

8.5.1 only those personnel involved in delivery of the Agreement use or have access to the Relevant Information; and

8.5.2 that such access is granted on a strict **Need to Know** basis and shall implement appropriate access controls to ensure this requirement is satisfied and audited. Evidence of audit should be made freely available on request by the originating Data Controller.; and

8.5.3 specific limitations on the personnel who may have access to the Information are set out in the relevant Data Sharing Agreement

9. Governance: Protection of Personal Data

9.1 At all times, the Parties shall have regard to the requirements of Information Law and the rights of Data Subjects.

9.2 Wherever possible (in descending order of preference), only anonymised information, or strongly or weakly pseudonymised information will be shared and processed by Parties, without the need to share easily identifiable Personal Data. The Parties shall cooperate in exploring alternative strategies to avoid the use of Personal Data in order to achieve the Specified Purpose. However, it is accepted that some Relevant Information shared further to this Agreement may be Personal Data/Special Category Personal Data.

9.3 Processing of any Personal Data or Special Category Personal Data shall be to the minimum extent necessary to achieve the Specified Purpose, and on a **Need to Know** basis. If either Party:

9.3.1 becomes aware of any unauthorised or unlawful processing of any Relevant Information or that any Relevant Information is lost or destroyed or has become damaged, corrupted or unusable; or

9.3.2 becomes aware of any security vulnerability or breach,

in respect of the Relevant Information it shall promptly (and within 48 hours) notify the other Party. The Parties shall fully cooperate with one another to remedy the issue as soon as reasonably practicable, and in making information about the incident available to the Information Commissioner and Data Subjects where required by Information Law.

9.4 In processing any Relevant Information further to this Agreement, each Party shall:

9.4.1 process the Personal Data (including Special Category Personal Data) only in accordance with the terms of this Agreement and otherwise (to the extent that it acts as a Data Processor for the purposes of Article 27-28 GDPR) only in accordance with written instructions from the originating Data Controller in respect of its Relevant Information;

9.4.2 process the Personal Data (including Special Category Personal Data) only to the extent as is necessary for the provision of the Specified Purpose or as is required by law or any regulatory body;

9.4.3 process the Personal Data (including Special Category Personal Data) only in accordance with Information Law requirements and shall not perform its obligations under this Agreement in such a way as to cause any other Data

Controller to breach any of their applicable obligations under Information Law; and

9.4.4 process the Personal Data in accordance with the requirements of Information Law and in particular the principles set out in Article 5(1) and accountability requirements set out in Article 5(2) UK GDPR.

9.5 Each Party shall act generally in accordance with Information Law requirements, and in particular shall implement, maintain and keep under review appropriate technical and organisational measures to ensure and to be able to demonstrate that the processing of Personal Data is undertaken in accordance with Information Law, and in particular to protect the Personal Data (and Special Category Personal Data) against unauthorised or unlawful processing and against accidental loss, destruction, damage, alteration or disclosure. These measures shall:

9.5.1 Take account of the nature, scope, context and purposes of processing as well as the risks of varying likelihood and severity for the rights and freedoms of Data Subjects; and

9.5.2 Be appropriate to the harm which might result from any unauthorised or unlawful processing, accidental loss, destruction or damage to the Personal Data (and Special Category Personal Data) and having regard to the nature of the Personal Data (and Special Category Personal Data) which is to be protected.

9.6 In particular, each Party shall:

9.6.1 ensure that only personnel authorised under this Agreement have access to the Personal Data (and Special Category Personal Data);

9.6.2 ensure that the Relevant Information is kept secure and in an encrypted form, and shall use all reasonable security practices and systems applicable to the use of the Relevant Information to prevent and to take prompt and proper remedial action against, unauthorised access, copying, modification, storage, reproduction, display or distribution, of the Relevant Information;

9.6.3 obtain prior written consent from the originating Party in order to transfer the Relevant Information to any third party;

9.6.4 permit the other Party or their representatives (subject to reasonable and appropriate confidentiality undertakings), to inspect and audit the data processing activities carried out further to this Agreement (and/or those of its agents, successors or assigns) and comply with all reasonable requests or directions to enable each Party to verify and/or procure that the other is in full compliance with its obligations under this Agreement; and

9.6.5 if requested, provide a written description of the technical and organisational methods and security measures employed in processing Personal Data.

9.7 Each Party shall adhere to the specific requirements as to information security set out in the Data Sharing Agreements.

9.8 Each Party shall use best endeavours to achieve and adhere to the requirements of the NHS Digital Data Security and Protection Toolkit.

9.9 The Parties' Single Points of Contact set out in paragraph 14 *(Governance: Single Points of Contact)* below will be the persons who, in the first instance, will have oversight of third party security measures.

10. Governance: Transmission of Information between the Parties

10.1 This paragraph supplements paragraph 9 *(Governance: Protection of Personal Data)* of this Schedule.

10.2 Transfer of Personal Data between the Parties shall be done through secure mechanisms including use of the N3 network, encryption, and approved secure (NHS.net / gcsx) email.

10.3 Wherever possible, Personal Data should be transmitted (and held) in pseudonymised form, with only reference to the NHS number in 'clear' transmissions. Where there are significant consequences for the care of the patient, then additional data items, such as the postcode, date of birth and/or other identifiers should also be transmitted, in accordance with good information governance and clinical safety practice, so as to ensure that the correct patient record/data is identified.

10.4 Any other special measures relating to security of transfer should be included in a Data Sharing Agreement.

10.5 Each Party shall keep an audit log of Relevant Information transmitted and received in the course of this Agreement.

10.6 The Parties' Single Point of Contact notified pursuant to paragraph 14 *(Governance: Single Points of Contact)* will be the persons who, in the first instance, will have oversight of the transmission of information between the Parties.

11. Governance: Quality of Information

11.1 The Parties will take steps to ensure the quality of the Relevant Information and to comply with the principles set out in Article 5 UK GDPR.

11.2 Special measures relating to ensuring quality are set out in the Personal Data Agreement annexed to this Schedule.

12. Governance: Retention and Disposal of Shared Information

12.1 The non-originating Party shall securely destroy or return the Relevant Information once the need to use it has passed or, if later, upon the termination of this Agreement, howsoever determined. Where Relevant Information is held electronically the Relevant Information will be deleted and formal notice of the deletion sent to the Party that shared the Relevant Information. Once paper information is no longer required, paper records will be securely destroyed or securely returned to the Party they came from.

12.2 Each Party shall provide an explanation of the processes used to securely destroy or return the information, or verify such destruction or return, if requested by the other Party and shall comply with any request of the Data Controllers to dispose of data in accordance with specified standards or criteria.

12.3 If either Party is required by any law, regulation, or government or regulatory body to retain any documents or materials that it would otherwise be required to return or destroy under this paragraph 12 *(Governance: Retention and Disposal of Shared Information)*, it shall notify the other Party in writing of that retention, giving details of the documents or materials that it must retain.

12.4 Retention of any data shall comply with the requirements of Article 5(1)(e) GDPR and with all good practice including the Records Management NHS Code of Practice, as updated or amended from time to time.

12.5 Any special retention periods should be set out in the Data Sharing Agreements.

12.6 Each Party shall ensure that Relevant Information held in paper form is held in secure files, and, when it is no-longer needed, destroyed using a cross cut shredder or

subcontracted to a confidential waste company that complies with European Standard EN15713.

12.7 Each Party shall ensure that, when no longer required, electronic storage media used to hold or process Personal Data are destroyed or overwritten to current policy requirements.

12.8 Electronic records will be considered for deletion once the relevant retention period has ended.

12.9 In the event of any bad or unusable sectors of electronic storage media that cannot be overwritten, the Party shall ensure complete and irretrievable destruction of the media itself in accordance with policy requirements.

13. Governance: Complaints and Access to Personal Data

13.1 Each Party shall assist the other in responding to any request made under Information Law made by persons who wish to access copies of information held about them ("**Subject Access Requests**"), as well as any other purported exercise of a Data Subject's rights under Information Law or complaint to or investigation undertaken by the Information Commissioner.

13.2 Complaints about information sharing shall be routed through each Party's own complaints procedure but reported to the Single Points of Contact set out in paragraph 14 *(Governance: Single Points of Contact)* below.

13.3 The Parties shall use all reasonable endeavours to work together to resolve any dispute or complaint arising under this Agreement or any data processing carried out further to it.

13.4 Basic details of the Agreement shall be included in the appropriate log under each Party's Publication Scheme.

14. Governance: Single Points of Contact

14.1 The Parties each shall appoint a Single Point of Contact to whom all queries relating to the particular information sharing should be directed in the first instance.

15. Monitoring and review

1. The Parties shall monitor and review on an ongoing basis the sharing of Relevant Information to ensure compliance with Information Law and best practice. Specific monitoring requirements must be set out in the relevant Data Sharing Agreement.

SCHEDULE 5

Financial Provisions and Decision Making Limits

Part 1 - Financial Limits and Approvals for Primary Care

1. The ICB shall ensure that any decisions in respect of the Delegated Functions and which exceed the financial limits set out below are only taken:

   1.1 by the following persons and/or individuals set out in column 2 of Table 1 below; and

   1.2 following the approval of NHS England (if any) as set out in column 3 of the Table 1 below.

2. NHS England may, from time to time, update Table 1 by sending a notice to the ICB of amendments to Table 1.

Table 1 – Financial Limits		
Decision	**Person/Individual**	**NHS England Approval**
General		
Taking any step or action in relation to the settlement of a Claim, where the value of the settlement exceeds £100,000	ICB Chief Executive Officer or Chief Finance Officer or Chair	NHS England Head of Legal Services and Local NHS England Team Director or Director of Finance
Any matter in relation to the Delegated Functions which is novel, contentious or repercussive	ICB Chief Executive Officer or Chief Finance Officer or Chair	Local NHS England Team Director or Director of Finance or NHS England Region Director or Director of Finance or NHS England Chief Executive or Chief Financial Officer
Revenue Contracts		
The entering into of any Primary Care Contract or Arrangement which has or is capable of having a term which exceeds five (5) years	ICB Chief Executive Officer or Chief Finance Officer or Chair	Local NHS England Team Director or Director of Finance
Capital Note: As at the date of this Agreement, the ICB will not have delegated or directed responsibility for decisions in relation to Capital expenditure (and these decisions are retained by NHS England) but the ICB may be required to carry out certain administrative services in relation to Capital expenditure under paragraph 13 *(Financial Provisions and Liability).*		

SCHEDULE 6

Mandated Assistance and Support

1. Primary Dental Services

1.1 NHS Business Services Authority has existing agreements with NHS England to support its delivery of the following services:

1.1.1 Contract management – end-to-end administration of contract variations and other regional team/ICB support activities;

1.1.2 Performance management - provide mid and end of year administration process to support regional teams and ICBs and undertake risk based assurance reviews - PPV can also be instigated by the ICS or Counter Fraud;

1.1.3 Clinical assurance reviews – provide clinical assurance of quality of dental services delivered, working in collaboration with regional teams/ICBs to identify and seek to address any concerns;

1.1.4 Provide data reports to teams defining quantity and service delivery at a contractor level.

2. Primary Ophthalmic Services

2.1 NHS Business Services Authority have existing agreements with NHS England to support its delivery of the following services:

2.1.1 Contract management. End-to-end administration of new contract applications, contract variations and contract terminations.

2.1.2 Contract assurance. Administration of the annual contractor assurance declaration and additional in-depth assurance declaration where appropriate. Provision of assurance reports at ICS and contractor level, supporting further assurance decisions.

2.1.3 GOS complaints. Administration of the annual GOS complaints survey.

2.1.4 Post-Payment Verification (PPV). End-to-end process for identifying and verifying GOS claims as part of the national PPV framework. This includes obtaining and reviewing claims and carrying out a financial recovery where appropriate. PPV can also be instigated by the ICS or Counter Fraud.

2.1.5 GOS 4 pre-authorisation of repair or replacement glasses.

3. Pharmaceutical Services and Local Pharmaceutical Services

3.1 NHS Business Services Authority has existing agreements with NHS England to support ICBs to discharge their assurance responsibilities by the delivery of the following services to ICBs:

3.1.1 Performance management – direct support to commissioners and community pharmacy contractors to implement corrective and preventative intervention;

3.1.2 Contract assurance – administration of the annual contractor assurance declaration and additional in-depth assurance declaration where

appropriate, provision of assurance reports at ICS and contractor level supporting further assurance decisions by the ICB;

3.1.3 Post-Payment Verification (PPV) – end-to-end process for identifying and verifying claims as part of the national PPV framework to support ICBs to play their part in ensuring compliance with contractual requirements and delivery of quality and value for money. This includes obtaining and reviewing claims, investigation of outliers and other potential inappropriate claims, along with referrals and investigatory reports to the ICB to consider and decide overpayment recoveries, and carrying out the financial recovery where appropriate. PPV can also be instigated by the ICS or Counter Fraud.

4. Support Services directed by DHSC

4.1 NHS Business Services Authority is directed by DHSC to undertake specific activities as well as having existing agreements with NHS England to support its delivery of primary care services. These include (without limitation):

4.1.1 The administration of national payment platforms for primary care services to dentists, pharmacy contractors, appliance contractors, oxygen contractors and special school eye care providers;

4.1.2 The calculation of payment for covid-19 and flu vaccinations to PCNs and GP practices as well as payments to Dispensing Doctors and prescribing only doctors for personal administration claims and sharing this information accurately and in a timely manner;

4.1.3 Clinical advisory support;

4.1.4 Administration functions;

4.1.5 Assurance services - performance and contract management of primary care providers;

4.1.6 The provision of information to primary care organisations for all contractor groups via standardised reporting (eg. ePACT2, eDEN and eOPS);

4.1.7 Working with NHS England and ICB Counter Fraud Teams to reduce loss across the system.

SCHEDULE 7

Local Terms

Primary Care staffing (incl. Finance)	The employment of the identified Primary Medical Care, Dental and Finance staff delivering contracting and commissioning functions will be transferred to Hertfordshire and West Essex ICB with effect from 1st April 2023. The employment of the Pharmacy and Optometry team will transfer to HWE only to support the hosting arrangement agreed between the six East of England ICBs.
Fitness to Practice	Fitness to practice (FTP) will continue to be managed by the Medical Directorate for a transitional period post 1st April 2023. The governance of FTP will revert to PSRC with effect from 1st April 2023, supported by continued input from the Professional Standards Team. The administration of FTP will transfer to the P&O team employed by HWE after a managed handover and readiness assessment circa August 2023.
Professional Networks (Dental, Eye, Pharmaceutical)	The professional networks will be retained by NHSE for a transitional year 2023/24, reporting to the Medical Directorate and direct links into the ICBs. During 2023/24 there will be a review of the structure and reporting lines of the professional networks.
Complaints	On 1st April 2023, the Complaints Team will align to ICBs to support the delegated responsibility for Primary Care complaints. Employment of the team is planned to transfer to ICBs on 1st July 2023.

SCHEDULE 8

Deployment of NHS England Staff to the ICB

Note: This schedule relates to the Deployment of Staff who are employed by NHS England only.

Deployment of NHS England Staff

1. NHS England may deploy Staff to the ICB for the purposes of carrying out the Delegated Functions.

2. The Parties have agreed that arrangements for the provision of NHS England Staff and the associated employment model envisaged by section 5.9 of the HR Framework **https://www.england.nhs.uk/wp-content/uploads/2021/06/B1427-Human-resources-framework-for-developing-integrated-care-boards-version-2-March-2022.pdf**) will be determined by the National Moderation Panel convened for this purpose and endorsed by NHS England's Executive Group.

3. The Parties agree and acknowledge that the Staffing Models will be developed in conjunction with the ICB and are subject to the decision of the National Moderation Panel and cannot be varied without the express agreement of NHS England.

4. A proposal for a variation to any Staffing Model must be made by means of a formal submission to the National Moderation Panel which will determine the proposal, following which the proposal if approved, will be endorsed by NHS England's Executive Group.

5. Subject to any variation made in accordance with paragraphs 3 and 4 above, a Staffing Model determined in accordance with paragraph 2 will apply for the duration of this Agreement.

Availability of NHS England Staff

6. In addition to any Staff deployed in any communicated Staffing Model arrangement, NHS England may deploy additional Staff to the ICB to perform administrative and management support services together with such other services specified in SCHEDULE 7 (Local Terms) (the "Services") so as to facilitate the ICB in undertaking the Delegated Functions pursuant to the terms of this Agreement.

7. NHS England will take all reasonable steps to ensure that the NHS England Staff deployed for the purposes of carrying out the Delegated Functions shall:

    a. faithfully and diligently perform duties and exercise such powers as may from time to time be reasonably assigned to or vested in them; and

    b. perform all duties assigned to them pursuant to this Schedule 8.

8. The ICB shall notify NHS England if the ICB becomes aware of any act or omission by any NHS England Staff which may have a material adverse impact on the provision of the Services or constitute a material breach of the terms and conditions of employment of the NHS England Staff.

9. NHS England shall use all reasonable efforts to make its Staff available for the purposes of this Schedule 8 whilst the NHS England Staff are absent:

    a. by reason of industrial action;

    b. as a result of the suspension or exclusion of employment or secondment of any Staff by NHS England;

c. in accordance with the NHS England Staff's respective terms and conditions of employment and policies, including, but not limited to, by reason of training, holidays, sickness, injury, trade union duties, paternity leave or maternity or where absence is permitted or required by Law;

d. if making the NHS England Staff available would breach or contravene any Law;

e. as a result of the cessation of employment of any individual NHS England Staff; and/or

f. at such other times as may be agreed between NHS England and the ICB.

Employment of the NHS England Deployed Staff

10. NHS England shall employ their Staff and shall be responsible for the employment of their Staff at all times on whatever terms and conditions as NHS England and their Staff may agree from time to time.

11. NHS England shall pay their Staff their salaries and benefits and make any deductions for income tax liability and national insurance or similar contributions it is required to make from the Staff's salaries and other payments.

12. NHS England shall not, and shall procure that the NHS England Staff shall not, hold themselves out as employees of the ICB.

Management of NHS England staff

13. NHS England where appropriate, shall in consultation with the ICB, make arrangements to ensure the day-to-day control of the activities of their Staff is shared with the ICB and deal with any relevant management issues concerning their Staff including, without limitation, performance appraisal, discipline and leave requests.

14. The ICB agrees to provide all such assistance and co-operation that NHS England may reasonably request from time to time to resolve grievances raised by NHS England Staff and to deal with any disciplinary allegations made against NHS England Staff arising out of or in connection with the provision of the Services which shall include, without limitation, supplying NHS England with all information and the provision of access to all documentation and NHS England Staff as NHS England requires for the purposes of considering and dealing with such issues and participating promptly in any action which may be necessary.

Conduct of Claims

15. If the ICB becomes aware of any matter that may give rise to a claim by or against a member of NHS England Staff, notice of that fact shall be given as soon as possible to NHS England. NHS England and the ICB shall co-operate in relation to the investigation and resolution of any such claims or potential claims.

16. No admission of liability shall be made by or on behalf of the ICB and any such claim shall not be compromised, disposed of or settled without the consent of NHS England.

Confidential Information and Property

17. For the avoidance of doubt, this paragraph 17 (Confidential Information and Property) is without prejudice to any other provision of this Agreement in relation to confidential information.

18. It is acknowledged that to enable the NHS England Staff to provide the Services, the Parties may share Confidential Information.

19. The Parties agree to adopt all such procedures as the other party may reasonably require and to keep confidential all Confidential Information.

Intellectual Property

20. All IPR made, written, designed, discovered or originated by Staff (People Resources) deployed by NHS England, shall be the property of NHS England to the fullest extent permitted by Law and NHS England shall be the absolute beneficial owner of the copyright in any such IPR.

SCHEDULE 9

Mandated Guidance

Primary Medical Care

- Primary Medical Care Policy and Guidance Manual.
- The 'Principles of Best Practice' and any other guidance relating to *the Premises Cost Directions 2013.*
- Guidance relating to the Minimum Practice Income Guarantee.
- Guidance relating to Primary Medical Care discretionary payments.
- Guidance for Commissioners: Interpreting and Translation Services in Primary Care.
- Framework for Patient and Public Participation in Primary Care Commissioning.
- NHS England National Primary Care Occupational Health Service Specification.
- Guidance relating to list cleansing in relation to Primary Medical Care providers.
- Guidance relating to mergers and closures of GP practices and/or Primary Medical Care providers.
- Guidance relating to Primary Medical Care and POD contract reviews.
- Guidance relating to the escalation of complaints from a named 'performer'.
    - Including: *Framework for Managing Performer Concerns.*

Pharmaceutical Services and Local Pharmaceutical Services

- Pharmacy Manual.
- NHS England National Primary Care Occupational Health Service Specification.
- The NHS Pharmacy Regulations Guidance 2020[1].
- Guidance for ICSs and STPs on transformation and improvement opportunities to benefit patients through integrated pharmacy and medicines optimisation.

Primary Ophthalmic Services

- Policy Book for Eye Health.
- NHS England National Primary Care Occupational Health Service Specification.

Primary and Prescribed Dental Services

- Policy Book for Primary Dental Services.
- Securing Excellence in Commissioning NHS Dental Services.
- Securing Excellence in Commissioning NHS Dental Services: Key facts.
- Securing Excellence in Commissioning NHS Dental Services: FAQs.
- Quick Guide: Best use of unscheduled dental care services.
- How to update NHS Choices for Dental Practices.
- Flowchart for managing patients with a dental problem/pain.
- Guidance on NHS 111 Directory of Services for dental providers.
- Definitions – Unscheduled Dental Care.
- Introductory Guide for Commissioning Dental Specialties.
- Guide for Commissioning Dental Specialties: Orthodontics.
- Guide for Commissioning Dental Specialties: Oral Surgery and Oral Medicine.
- Guide for Commissioning Dental Specialties: Special Care Dentistry.
- Guide for Commissioning Service Standards: Conscious Sedation in a Primary Care Setting.
- Commissioning Standard for Dental Specialties: Paediatric Dentistry.
- Commissioning Standard for Urgent Dental Care.
- Commissioning Standard for Restorative Dentistry.

[1] https://www.england.nhs.uk/primary-care/pharmacy/pharmacy-manual/nhs-pharmacy-regulations-guidance-2020/

- Commissioning Standard for Dental Care for People with Diabetes.
- Accreditation of Performers and Providers of Level 2 Complexity Care.
- NHS England National Primary Care Occupational Health Service Specification.
- Dental Access Controls.

Finance

- Guidance on NHS System Capital Envelopes.
- Finance and Payments Guidance for Community Pharmacy, Dental and Primary Care Ophthalmology Services Delegated to ICBs from 2022.
- Managing Public Money (HM Treasury).
- Guidance relating to Personal Service Medical Reviews.
    - Including: *Implementing Personal Medical Services Reviews.*
- Dental Commissioning and Financial Management Guidance.

Workforce

- Guidance on the Employment Commitment.

Other Guidance

- National Guidance on System Quality Groups.
- Managing Conflicts of Interest in the NHS.
- Arrangements for Delegation and Joint Exercise of Statutory Functions.
- Guidance relating to procurement and provider selection.
- IG Guidance relating to serious incidents.
- All other applicable IG and Data Protection Guidance.
- Any applicable Freedom of Information protocols.
- Any applicable guidance on Counter Fraud, including from The NHS Counter Fraud Authority.
- Any applicable guidance relating to the use of data and data sets for reporting.
- Any applicable guidance relating to the commissioning and management of clinical waste in primary care e.g.
    - Including: Management and disposal of healthcare waste.

SCHEDULE 10

Administrative and Management Services

1. The ICB shall provide the following administrative and management services to NHS England:

    1.1 the administrative and management services in relation to the Capital Expenditure Functions and the Capital Expenditure Funds as more particularly set out in this Part 1 of this Schedule 10 (*Administrative and Management Services*); and

    1.2 the administrative and management services in relation to the Section 7A Functions and Section 7A Funds as more particularly set out in Part 2 of this Schedule 10.

    1.3 the administrative and management services in relation to other Reserved Functions as more particularly set out in Part 3 of this Schedule 10 (*Administrative and Management Services*).

Part 1: Administrative and/or Management Services and Funds in relation to the Capital Expenditure Functions

1. The Parties acknowledge that the Capital Expenditure Functions are a Reserved Function.

2. The Parties further acknowledge that:

    2.1 accordingly, the Delegated Funds do not include any funds in respect of amounts payable in relation to the Capital Expenditure Functions (**"Capital Expenditure Funds"**); and

    2.2 NHS England remains responsible and accountable for the discharge of the Capital Expenditure Functions and nothing in Part 1 of this Schedule 10 (*Administrative and Management Services*) shall be construed as a divestment or delegation of NHS England's Capital Expenditure Functions.

3. Without prejudice to paragraph 3 above, the ICB will comply with any Mandated Guidance issued in relation to the Capital Expenditure Functions and shall (on request from NHS England) provide the following administrative services to NHS England in respect of the Capital Expenditure Funds:

    3.1 the administration and payment of sums that NHS England has approved as payable in relation to the Capital Expenditure Functions;

    3.2 if requested by NHS England and taking into account (i) any other support or services provided to NHS England by NHS Property Services Limited or otherwise and (ii) any Mandated Guidance issued in respect of the Capital Expenditure Functions, the provision of advice and/or recommendations to NHS England in respect of expenditure to be made under the Capital Expenditure Functions; and

    3.3 such other support or administrative assistance to NHS England that NHS England may reasonably request in order to facilitate the discharge by NHS England of its responsibilities under or in respect of the Capital Expenditure Functions.

4. NHS England may, at the same time as it allocates the Delegated Funds to the ICB under Clause 9.11, transfer to the ICB such amounts as are necessary to enable the discharge of the ICB's obligations under this Part 1 of Schedule 10 (*Administrative and Management Services*) in respect of the Capital Expenditure Functions.

Part 2 - Administrative and/or Management Services and Funds in relation to Section 7A Functions

1. The Parties acknowledge that the Section 7A Functions are part of the Reserved Functions.

2. The Parties further acknowledge that:

   2.1 accordingly, the Delegated Funds do not include any funds in respect of amounts payable in relation to the Section 7A Functions (whether such arrangements are included in or under Primary Care Contracts or Arrangements or not) (**"Section 7A Funds"**); and

   2.2 NHS England remains responsible and accountable for the discharge of the Section 7A Functions and nothing in this Schedule 10 Part 2 shall be construed as a divestment or delegation of the Section 7A Functions.

3. The ICB will provide the following services to NHS England in respect of the Section 7A Funds:

4. the administration and payment of sums that NHS England has approved as payable under or in respect of arrangements for the Section 7A Functions; and

5. such other support or administrative assistance to NHS England that NHS England may reasonably request in order to facilitate the discharge by NHS England of its responsibilities under or in respect of the Section 7A Funds.

6. NHS England shall, at the same time as it allocates the Delegated Funds to the ICB under Clause 9.11, allocate to the ICB such amounts as are necessary to enable the discharge of the ICB's obligations under this Schedule 10 Part 2 in respect of the Section 7A Funds.

Part 3: Administrative and/or Management Services and Funds in relation to other Reserved Functions

1. NHS England may ask the ICB to provide certain management and/or administrative services to NHS England (from a date to be notified by NHS England to the ICB) in relation to the carrying out of any of the Reserved Functions.

2. If NHS England makes such a request to the ICB, then the ICB will, but only if the ICB agrees to provide such services, from the date requested by NHS England, comply with:

3. provisions equivalent to those set out above in relation to the Capital Expenditure Functions (Part 1 of this Schedule 10) and the Section 7A Functions (Part 2 of this Schedule 10) including in relation to the administration of any funds for such functions but only to the extent that such provisions are relevant to the management or administrative services to be provided; and

4. such other provisions in respect of the carrying out of such management and administrative services as agreed between NHS England and the ICB.

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

NHS Hertfordshire and West Essex Integrated Care Board

Primary Care Commissioning Committee

Terms of Reference_v1

1. Introduction

1.1 These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Hertfordshire and West Essex (HWE) Integrated Care Board (ICB) Primary Care Commissioning Committee.

2. Purpose and Remit

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

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

2.3 The Delegated Primary Care Commissioning Committee has no executive powers, other than those delegated from NHSE in the SoRD and specified in these terms of reference. The Committee will create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members.

The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance delegation agreement, standing orders and Scheme of Reservation and Delegation (SoRD) but may delegate appropriate decisions to such groups (refer to the respective terms of reference of the subgroups of the committee)

Subgroups of the Committee will include but are not limited to:

- Primary Care Contracting Panel (across HWE)
- Quality and Risk Panel (at each place)
- Resilience Panel (across HWE)
- Pharmaceutical Services Regulatory Committee
- Primary Care Estates Group

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

The Primary Care Board (committee of the ICB) will set out the overarching strategy for primary care and the principles and methodology for transformation.

3. Role and Responsibility

3.1 The Committee's duties are as follows:

- To oversee implementation of the delivery of quality commissioning and contracting within Primary Care inclusive of Primary Medical services, Dental, Community Pharmacy and Optometry across Herts and West Essex.
- To provide assurance that action plans and risks relating to primary care quality are being addressed and that practices are being supported to improve quality.
- To approve bids or returns on behalf of the ICB e.g. estates/capital submissions.
- To liaise directly with the regional and national teams of NHSE on matters relating to Primary Care.
- To take an overview of the financial position for primary care in Herts and West Essex, including tracking investment against the agreed financial plan. Financial position to include the delegated budget, system development funding and other resource received, or utilised, for investment in primary care, ensuring value for money.
- To monitor and review risks within the Committee's remit and identify any additional risks.
- To oversee the robustness of the arrangements for and assure compliance with the ICB's responsibilities around primary care prescribing and medicines optimisation
- To exercise the ICB's delegated primary care commissioning functions in relation to:
    - GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract).
    - Newly designed Local Enhanced Services and Directed Enhanced Services.
    - Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF).
    - Decision making on whether to establish new GP practices in an area,
    - Delegation of Pharmacy, Optometry and Dental Commissioning, Section 7A Public health functions and Health and Justice Commissioning – oversight of future model, governance and financial impacts.
- Working closely with the Primary Care Board to agree the primary care priorities that are included in the ICB strategy/annual plan including priorities to address variations and inequalities
- To review primary care provider performance through quantitative and qualitative information

across system and place and neighborhood to continuously improve outcomes

- To evaluate primary care commissioned services and provide assurance as appropriate to the Commissioning Committee and others.
- Primary Care Commissioning Committee will provide regular assurance update to the Commissioning Committee.

4. Accountability and Governance Structure

4.1 The Primary Care Commissioning Committee will be underpinned by good governance principles and robust assurance processes, to ensure accountability to the public as patients, citizens or taxpayers.

The Primary Care Commissioning Committee is accountable to the Integrated Care Board and shall report to the Board on how it discharges its responsibilities.
The Chair of the committee may be invited to attend the ICB as requested by the Chair of the ICB.

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

The minutes of the meetings, including any virtual meetings, shall be formally recorded by the secretary and submitted to the Commissioning Committee in line with the ICB constitution

The Committee Chair will provide assurance reports to the Commissioning Committee at each meeting and shall draw to the attention any issues that require disclosure to the Integrated Care Board or require action.

Insert Revised Governance Structure once approved at Primary Care Board

5. Operating Principles

5.1 Members must ensure that they have the necessary delegated permissions and processes are in place for them to act on behalf of the organisations which they represent.

5.2 Each member on the Group is there in an individual capacity, acting for the benefit of the system as a whole and not for any organisation that they may also be employed by.

6. Reporting Responsibilities

6.1 The Hertfordshire and West Essex Primary Care Commissioning Committee is accountable to the ICB Commissioning Committee. Th Commissioning Committee will receive minutes of the Primary Care Commissioning Committee. Where required the Commissioning Committee will report to the ICB Board.

7. Membership and Chairing Arrangements

7.1 The membership with voting rights will comprise:

- ICS Director of Primary Care Transformation Executive Member (Chair)
- ICS Director of Finance (Vice Chair)
- ICS Medical Director /nominated deputy
- ICS Director of Nursing or nominated deputy
- ICS Assistant Director for Primary Care Contracting
- Independent GP member x2
- ICS Assistant Director of Primary Care – Place x3
- Independent Dental Advisor member (for agenda items relating to Dentistry)
- Independent Pharmacy Advisor member (for agenda items relating to Pharmacy)
- Independent Optometry Advisor member (for agenda items relating to Optometry)

7.2 Where a member of the Committee is unable to attend a meeting, a suitable deputy may be agreed with the Committee Chair. The deputy may not vote on behalf of the absent Committee member.

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

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

7.5 **Attendees – non voting**
Only members of the Committee have the right to attend Committee meetings, however meetings of the Committee will also be attended by the following individuals who are not members of the Committee:

- Local Professional Committee representative/s (LMC/LPC/LOC/LDC)
- Healthwatch
- Leads from enabling workstreams – Estates/Digital/Workforce etc.

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

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

8. Quorum

8.1 For a meeting to be quorate a minimum of 3 Members of the Committee are required, including the Chair or Vice Chair of the Committee [Independent Clinician, Director of Finance and Primary Care Contracting representative].

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

8.3 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

9. Conflicts of Interest and Decision Making

9.1 Conflicts of interest identified in the Board agenda should be raised with chair or Vice-chair either at the start of each meeting, or when the conflict is identified. At the Chair's discretion, they may be asked to leave the meeting while a particular topic is being discussed.
All members and attendees will follow the HWE Conflicts Interest Policy, and Standards of Business Conduct.

10. Member Roles and Responsibilities

- All members are required to attend or send a deputy.
- Workstream and Portfolio leads must ensure that reports and papers are submitted to enable circulation 5 days before the meeting.
- All members are required to complete assigned actions and provide updates to the Board in line with the action log.
- All members are required to be full and active participants, to ensure that relevant expertise is available to the Board to facilitate effective management of the workstreams.

10. Meeting Arrangements

10.1 The full membership of the People Board will meet on a bi-monthly basis.

- Meetings will be online or hybrid of online and in-person to ensure maximum attendance
- Members who cannot attend will be expected to send deputies.
- Papers will be circulated at least five working days before each meeting.
- Action logs will be circulated within 10 working days of each meeting.

11. Monitoring and Review

11.1 The Terms of Reference will be reviewed on an annual basis, or sooner if required. The next review

will take place one year from the date of approval stated below.

Date of approval: Tuesday 21 February 2023

Date of review: *August 2023*

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

Engagement: November 2022 – February 2023

Authors: Asha McDonagh and Chloe Carson

healthwatch Hertfordshire

Contents

About Healthwatch Hertfordshire

Healthwatch Hertfordshire (HwH) represents the views of people in Hertfordshire for health and social care services. We provide an independent consumer voice for evidencing patient and public experiences and gathering local intelligence with the purpose of influencing service improvement across the county. We work with those who commission, deliver and regulate health and social care services to ensure the people's voice is heard, and to address gaps in services quality and/or provision.

Hearing Patient Views about Primary Care in Hertfordshire and West Essex

Healthwatch Hertfordshire and Healthwatch Essex have been commissioned by the Hertfordshire and West Essex Integrated Care System (ICS) Primary Care Workstream to undertake a series of engagement projects. The aims of the engagement projects include:

- Gathering lived experiences to feed directly into the Hertfordshire and West Essex ICS Primary Care Workstream
- Supporting and enabling the Hertfordshire and West Essex ICS to achieve wider participant engagement
- Engaging patients and the public on programmes covering key priorities and areas of importance at a regional and local level
- Making recommendations to the Hertfordshire and West Essex ICS Primary Care Workstream so improvements can be implemented

Using patient and public feedback, each engagement project will focus on improving the relevant service(s) within different areas of primary care by making recommendations to the Hertfordshire and West Essex ICB Primary Care Board.

From November 2022 to February 2023 the Director of Primary Care Transformation at the ICB has requested Healthwatch Hertfordshire and Healthwatch Essex to explore whether unpaid carers are registered as a carer with their GP practice, and if so, whether they are receiving the additional support they should be entitled to.

Background

Unpaid Carers in the UK

The NHS describes an unpaid carer as anyone, including children and adults, who looks after a family member, partner or friend who needs help because of their illness, frailty, disability, a mental health problem or an addiction, and cannot cope without their support[1]. It is important to recognise that many carers do not see themselves as carers and it takes them an average of two years to acknowledge their role as a carer. This is often because it can be difficult for carers to see their caring role as separate from the relationship they have for whom they care for[2].

In January 2023 the Office for National Statistics (ONS) published its Census 2021 data which revealed that across England and Wales, 5 million people aged five and over provided unpaid care[3]. Given the number of people not recognising themselves as a carer, it is likely that this figure is much higher, with Carers UK estimating that there are in fact 10.6 million unpaid carers in the UK[4].

Carers are of great importance to the NHS and help relieve the burden on health and social care services. During the COVID-19 pandemic, the support cares provided equated to around £530 million per day, or the equivalent of £193 billion per year[5].

Impact on Physical and Mental Health

Caring for someone can have a negative impact on an individual's physical health, with Carers UK identifying that one-fifth of carers feel that their physical health is "bad" or "very bad"[6] and Carers Week finding that 46% of carers were concerned about the impact their caring role is having on their physical and mental health[7]. Common health problems include high blood pressure, arthritis, musculoskeletal pain, fatigue and difficulty sleeping. This is often because caring responsibilities can be physically demanding and exhausting on a an individual's body.

Carers are also more likely to be older people, with the majority aged between 55 and 74 years old[8]. They are also more likely to have health issues themselves, with the 2021 GP Patient Survey finding that 60% of carers have a long-term condition or disability compared to 50% of non-carers[3].

[1] NHS commissioning » Who is considered a carer? (england.nhs.uk)
[2] NHS commissioning » Who is considered a carer? (england.nhs.uk)
[3] Provision of unpaid care - Office for National Statistics (ons.gov.uk)
[4] carers-week-2022-make-caring-visible-valued-and-supported-report_final.pdf (carersweek.org)
[5] carers-week-2022-make-caring-visible-valued-and-supported-report_final.pdf (carersweek.org)
[6] cukstateofcaring2022report.pdf (carersuk.org)
[7] carers-week-2022-make-caring-visible-valued-and-supported-report_final.pdf (carersweek.org)
[8] cukstateofcaring2022report.pdf (carersuk.org)

The demands and pressures of caring responsibilities often means that carers negate their own health and wellbeing and prioritise the needs of the person they care for before their own.

Caring not only affects an individual's physical health but can lead to poor mental health as well. In 2022 Carers UK found that 30% of carers said their mental health was either "bad" or "very bad" and over a quarter of (29%) "often" or "always" feel lonely. Carers are far more likely to experience anxiety and depression, as well as stress, isolation and loneliness as a result of their caring role and the demands their caring responsibilities impose.

With extra pressures on NHS services and the rising Cost of Living, it is likely that the health and wellbeing of carers will continue to decline, with 62% of carers reporting that the increase in the Cost of Living was having a negative impact on their mental and/or physical health[9].

Role of GP Services

Given the demands caring responsibilities impose, it is important that carers are supported by health and social care services. GP practices in particular play a significant part in ensuring carers are supported in their caring role, and for ensuring their physical and mental health is cared for. However, through national literature and local anecdotal feedback, we know that unpaid carers are always not always receiving the support they need from GP services.

If someone is registered as a carer with their GP practice, they should be offered the following additional support[10]:

- Free NHS annual health checks, flu vaccinations and repeat prescriptions
- Signposting to health and social care services, and information and support
- Flexibility when booking appointments, and arranging "double appointments" for carers and the person they care for
- Access to Carers Assessment and benefit checks
- Access to "Carer Champion" – an allocated member of staff within each GP practice
- Discussions about physical and mental health and the impact of the caring role
- Involvement in the care planning of the person they care for

We greatly appreciated working with *Carers in Herts* and the insight and expertise they brought. Through our engagement with *Carers in Herts*, we found many carers are not getting the support to which they are entitled. According to *Carers in Herts*;

- Carers are not often aware they can register as a carer with their GP practice to access additional support

[9] cukstateofcaring2022report.pdf (carersuk.org)
[10] The importance of registering as a carer with your GP - Dementia UK

- Many cares are also not aware of their GP practices allocated carers champion
- Those who are registered frequently do not receive the support they are entitled to
- There is no equitable service across Hertfordshire, some practices support carers better than others
- Lack of recognition of the issues carers face and how this impact carers' physical and mental health

Carers UK found that nationally, 49% of carers felt that NHS staff did not provide them with the information, advice and support they need to be able to care well and safely, and 19% had to wait over a month for a GP appointment[11]. This research also found that many carers had difficulties contacting their GP practice and were not given any flexibility when making an appointment, despite mentioning they are a carer and the constraints of their caring responsibilities.

Anecdotally, local carers shared the struggles they face in accessing a GP appointment for themselves or the person they care for, and felt that there is a clear lack of recognition regarding the issues carers' face, and how the caring role can impact an individual's physical and mental health.

Identification of Carers

Carers are unlikely to receive the support listed above if they are not registered as a carer with their GP practice. However as emphasised, there are many carers who do not identify as a carer, seeing themselves as simply looking after a parent, child, partner, or friend. People become carers by gradually doing small tasks for someone which slowly increase, meaning it can take people a while to identify a carer – with Carers UK finding that for 51% of respondents it took a year to recognise themselves as a carer.

GP practices are in a unique position, in that they are usually the first place that carers have contact with the NHS, meaning that staff are well placed to recognise whether someone is, or is about to become a carer[12]. As such, it is important that GP practices are proactive in identifying carers, and in ensuring they are formally registered as a carer on their patient records.

Efforts are being made to improve the identification of unpaid carers, for example NHS Long Term Plan commits to better supporting and identifying carers and improving their health outcomes as well as the person they care for[13]. While in October 2022, NHS England distributed a letter to all GP practices to remind them of the importance of both identifying and supporting unpaid carers, and included guidance to help GP practices record and code unpaid carers correctly[14].

[11] cukstateofcaring2022report.pdf (carersuk.org)
[12] We can help GPs identify carers | Carers Support Centre
[13] NHS England » NHS Long Term Plan
[14] How-to-identify-and-support-unpaid-carers-October-2022.pdf (england.nhs.uk)

Aims

The aims of this research include:

- To understand whether unpaid carers are registered as a carer with their GP, and if GP practices are encouraging carers to get registered.
- To explore whether those who are registered as a carer are aware, and receiving, the additional support they should expect from their GP practice.
- To understand whether carers know a Carers Champion, and whether their GP practice has allocated this role.
- To identify how GP practices could encourage carers to formally register as a carer, and how they could better support carers.

Methodology

Online Survey

To explore the above aims, we ran an online survey to hear from unpaid carers living in Hertfordshire. Participants had the option to request the survey in an alternative format to suit their needs, and/or contact us for support. Given the timescales, we decided an online survey was the most feasible data collection method to give us an overview of the key issues carers face when accessing support from their GP practice.

One respondent requested a telephone interview, from which the findings have been incorporated. Although efforts were made through our communications to hear from those who do not identify as a carer, the majority of respondents have identified as a carer for many years. We would recommend that the Hertfordshire and West Essex ICB looks to further engage with carers, with a specific focus on hearing from those who might not self-identify. Young carers were also outside the scope of this engagement, as such we would recommend that the Hertfordshire and West Essex ICB looks to understand the challenges they may face.

The engagement period for the online survey ran from 17th November 2022 to 4th January 2023. The survey was promoted via social media and shared with NHS and other statutory services and the Voluntary, Community, Faith and Social Enterprise sector across Hertfordshire to share and distribute via their networks, contacts and social media channels.

Audit of GP Websites

To supplement the online survey, an audit of all GP practice websites was carried out to identify whether GP practice websites have information on how to register as a carer, as well as the benefits of registering as a carer. Findings from this audit have been included in the key findings below.

Key Findings

Demographics

Through our online survey, we heard from **622** carers living in Hertfordshire.[15] **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. Given the small number of respondents aged under 44, we would recommend that the Hertfordshire and West Essex ICB considers conducting specific engagement with this age bracket.

Most respondents were female (**78%**) female and **20%** were male. **81%** were of a White British background and **14%** were from an ethnically diverse background[16].

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

Regarding 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 as a carer with their GP practice. Lack of awareness about the need to, and/or the importance of registering, was the main reason why respondents are not formally registered as carers with their GP practice.

"I have never been offered or asked about my caring role by the surgery."

"Who tells you to register? How do you go about registering? Just tell them?"

"I didn't realise it was something that I should do. I just assumed that if they knew I was caring for my elderly mother with Alzheimer's that was sufficient."

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 patient records.

"I have told my doctor I am a carer but I'm not sure whether he registered this."

[15] Please note that percentages do not always add up to 100% due to some respondents choosing not to share demographic data with us, or choosing the "prefer not to say" option.
[16] Ethnicities engaged with included: Bangladeshi, Indian, Pakistani, other Asian/Asian British backgrounds, Black African, Black Caribbean, other Black/Black British backgrounds, Asian and White, Black Caribbean and White, White Irish, White Polish, White Italian and other White backgrounds.

"I asked if they know I am a carer and was told yes I was. But I am not sure if it means I am registered.."

Another significant barrier was the belief that there are no benefits to registering as a carer with their GP practice, with many respondents believing that it would make no difference to the support they, or the person they care for, receive.

"I feel that telling the surgery that I am an unpaid carer will not change anything for me even though my caring duties impact greatly upon my own wellbeing, mental and physical health."

"The surgery is not interested. It's not worth the time and effort."

For some respondents, practical barriers such as lack of time, caring and/or work responsibilities, and problems getting through to their GP practice has prevented them from registering as a carer. A few respondents said that the person they care for does not want them to be registered as a carer, in case this means healthcare professionals finding out about the problems they are facing.

"I have been far too busy with the demands of my life, husband and children."

"My partner does not wish it to be known that he has addiction issues."

Interestingly, men were less likely to register as a carer, with **66%** of men registered compared to **73%** of women. **64%** of men in comparison to **57%** of women were also less likely to be aware of the additional support GP practices can provide carers with.

Despite this, **86%** of those who are not currently registered 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.

"Your email prompted me to call my doctor. I have now been asked to email the surgery asking to be registered as a carer which I have now done. Was told a week for it to be processed."

"No one has asked me so I will contact and find out."

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: their GP practice (particularly receptionists, leaflets, and posters), charities and support groups, and word of mouth.

Interestingly, our audit of GP websites identified that across most websites, (**81%**) information about how to register as a carer, and **73%** explained why it is important to register as a carer. Although in some cases this information was given in general terms.

The majority of websites (**75%**) also had a form which patients could fill in to register themselves as a carer with the GP practice. However only a few had a consent form to share the information of the person being cared for.

Concerningly, over half (**58%**) of practice websites did not explain what an unpaid carer is. Given that there are many people do not identify themselves as a carer, and the length of time it often takes for someone to recognise their caring responsibilities, a definition as to what an unpaid carer is would prove useful in helping patients self-identify.

Barriers to Accessing their GP Practice

When asked what barriers they face in accessing their GP practice, the majority of respondents (**57%**) mentioned the inability to get through to their GP practice, particularly via telephone. Given their work and/or caring responsibilities, waiting up to or over an hour to speak to a receptionist to request an appointment or to raise a query is not always possible, and can prove very stressful.

"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."

"Takes 40 – 60 minutes waiting on the phone to speak to someone."

26% of respondents do not have time to access their GP practice, and **29%** said it is difficult to fit appointments around their caring and/or work responsibilities. This is exacerbated by the fact they often have to call at a certain time to try get an appointment, or visit their GP practice in person, with many carers unable leave the person they care for on their own, meaning this is not a feasible option.

"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."

"Leaving a husband in a house on this own is tricky as every day is different. It's hard to plan."

A large number of respondents shared that they are not offered any flexibility when booking an appointment for themselves or the person they care for, even when they remind the receptionist that they are registered as a carer and need extra consideration.

"When I told them I was an unpaid carer I was told that it doesn't make any difference."

"It makes no difference if I am a carer to my GP, they do not care. Even when I'm on the phone trying to get an appointment and explain that I'm a carer, it means nothing to them. They don't care."

Respondents also shared that they are not offered any choice in the type of appointment they are given. For some carers, having a face-to-face appointment was important as they do not have access to online technology, or because their concern was one that needs to be physically examined. For others, the person they care for is housebound and requires a home visit, but was only offered a remote appointment, despite this being inadequate.

"My husband is housebound and it's hard to get home visits."

"GP surgery reluctant to give face-to-face appointments, I do not own a computer let alone a smartphone for online calls."

The general lack of appointments was problematic for respondents, with many being told there are no available appointments, or having to wait weeks to see a healthcare professional.

"GPs do not have available appointments, only emergency ones."

"Appointments never available unless ringing weeks in advance – 3+ weeks wait for appointments."

Positively, a few respondents shared that they have faced no barriers when trying to access their GP practice, noting that the GP practice is helpful and easily contactable.

"I don't face any barriers they are brilliant."

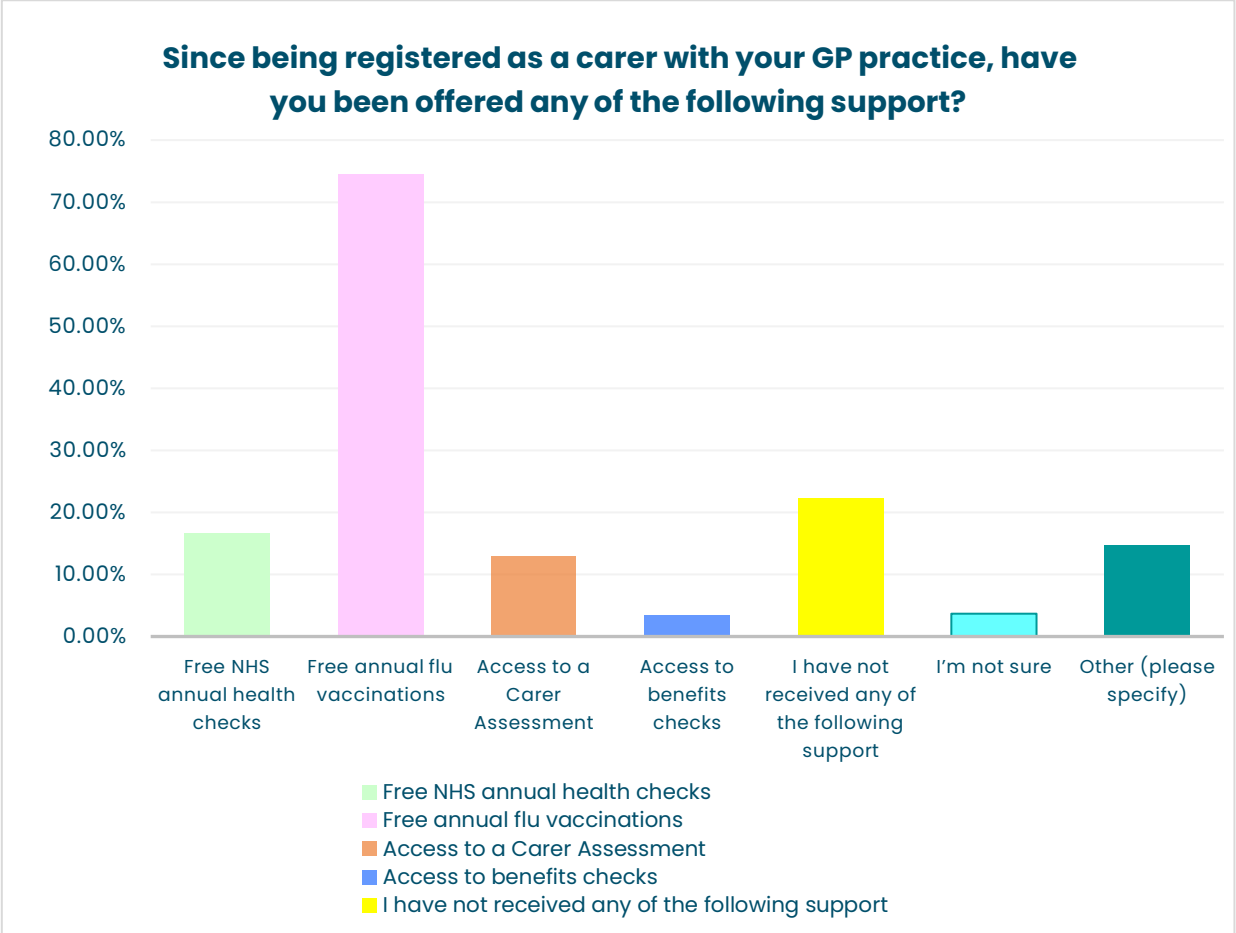
"No issues – my GP practice is very good."

Access to Support

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 support in the graph below, and **72%** were not aware they could even access this range of support from their GP practice. This information is displayed in the graph below.

Our audit of GP websites supports the above findings, with **63%** of websites only explaining in very basic terms the support carers should be entitled to, and **25%** did not provide this information at all. There were examples of good practice, for instance, one website said a practice nurse would be in contact to offer a referral for support and funded breaks, and others went into detail about the support carers should expect once registered.



For those who selected "other" the common responses included referral to a social prescriber or link worker and priority access to the COVID-19 vaccine.

NHS annual health check

An NHS annual health check should entail a physical examination, including measuring your height and weight, taking your blood pressure and doing a blood test. For carers, this should also include asking questions about their physical and mental health in relation to their caring role.

Out of the small number of respondents who had received an NHS annual health check, only **32%** said they had received a thorough examination of their physical and mental health. The majority felt it was treated a "tick-box exercise" and said that the healthcare professional did not ask whether their mental health is impacted by their caring role.

"Complete waste of time. They weighed me, did my height and blood pressure. Did not offer any support or advice. I was angry when I came out."

"Healthcare assistant was dismissive when I answered I had some dark days to questions on depression and suicidal thoughts."

Flexibility and Availability of Appointments

It is good practice to ensure that anyone registered as a carer is offered greater flexibility and availability when booking an appointment for either themselves, or the person they care for. Those registered as a carer should also be given the option to book a "double appointment" for themselves and the person they care for, or to provide more time to discuss concerns. This is particularly important given the time commitments and pressures of caring responsibilities, and many carers are in full-time or part-time employment, adding an additional barrier.

However, our engagement found that **76%** of carers did not receive greater flexibility when booking an appointment for themselves or someone else. Respondents felt that being registered as a carer made "no difference" to the appointment times available, leaving many feeling "unsupported" by their GP practice.

"Absolutely not. The service makes no allowance whatsoever."

"No. Never. They don't seem to care or understand how hard it is."

'I feel the practice is at breaking point and I must fight to get an appointment or consultation for myself, and it takes ages on the phone. So, I only contact them now for something serious as I think I'll be fobbed off with anything more minor than a serious health risk. I certainly don't think they would be interested in my daughter's needs (who is registered at a different practice), or anything related to my caring role.'

A few respondents have been offered greater flexibility, including the provision of "double appointments", home visits and a choice of time and date.

"Yes – the practice knows to offer the person I care for longer appointments."

"Yes – the GP organised a home visit for us."

Mental and Physical Health

Likewise, by being registered as a carer, carers should expect healthcare professionals to discuss their physical and mental health in relation to their caring role. However, our this engagement found that **87%** of carers have not had their physical or mental health examined in regards to their caring role.

"Never in the past 40 years of caring for my son with complex needs."

'When I went to the doctor as my shoulder was playing up. They explained I'm a carer. I was told it was my fault for not working. my shoulder doesn't get enough use. As a carer, I lift my husband in and out of the bath and push his wheelchair."

Many respondents stressed that GPs need to be more aware of the impact caring for someone can have on many different facets of life, and felt it was important that healthcare professionals are proactive in asking carers about their caring role, and whether this is affecting their health and wellbeing.

"GPs need to be more aware of the huge burden/stress etc of being a carer has on mental health and well being, ability to earn / work, reduced social opportunities, loneliness, isolation, etc."

Furthermore, many highlighted how carers are often hesitant to ask for emotional support, and presume that their GP would be dismissive of their concerns.

> ***"I think the support I might have wanted to access would have been emotional support, and people are often really reticent about asking for this. I believe that if I had needed practical or medical support I would have approached the surgery without hesitation."***

A few respondents noted that their GP practice is proactive in asking about their caring responsibilities, and whether this is impacting their physical or mental health. These respondents praised their GP practice for being attentive and empathetic.

> ***"Yes. They are attentive with this. Even if I've phoned up about my husband, I am asked how I am, do I need anything."***

> ***"I recently made an appointment to discuss health concerns exacerbated by my caring role and was treated very sympathetically and supportively."***

Signposting and Support

If an individual is registered as a carer, the GP practice should provide signposting information and support as part of good practice. However, we found that for **79%** of carers, this was not the case.

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.

> ***"No I researched the support available and found help that way."***

Likewise, only **12%** of carers have been referred to, or encouraged to speak to, a social prescriber, and **28%** said they do not know what a social prescriber or link worker is.

Positively, the audit of GP practice websites found that **91%** of practice websites had signposting information available for carers. However, for the majority the information available was fairly basic and did not signpost to local support available in particular. There were examples of good practice, with some practice websites providing a "Carers Pack" for carers to download, containing a wealth of information and resources.

Carers Champion

A Carers Champion is an existing member of staff who facilitates the identification and support of carers within their GP practice. Carers Champions are the key information point and have the following responsibilities:

- Improving carer's health and wellbeing and ensuring they are healthy enough to care.
- Amplifying carer's voices and ensuring they are involved in discussions about the health of the person they care for.

However, this survey found that only **13%** of respondents know if their GP practice has a Carers Champion, although **63%** would seek information or support from a Carers Champion if given the opportunity.

For those that know that their GP practice has a Carers Champion, only **52%** had spoken to, or received support, from the Carers Champion. The majority of which had a positive experience, sharing that the information, advice, and support they received was very useful.

Concerningly, the audit of GP practice websites found that only **20%** of practice websites mentioned Carers Champion. Of the 20%, many did provide information on how to contact the Carers Champion, and a few noted how a Carers Champion can provide information and support.

"The Carers Champion has helped me to get a specific appointment time for my son."

"They were good, and I have confidence that she would be able to help if called upon."

Feeling Unsupported

Unsurprisingly then, only **23%** of carers described the support they receive from their GP practice as "very good" or "good", while **34%** described the support they receive as "bad" or "very bad". Most respondents (**44%**) were neutral, stating the support as "neither good nor bad".

The general sentiment amongst respondents was that they feel "alone", "unsupported" and often have to put aside their "own issues" in favour of the person they care for. For many carers, they would like to receive more support from their GP practice, and for healthcare professionals to have a better understanding of the challenges carers face, and how this can impact their physical and mental health.

"I suspect many like me are dropping through the cracks."

"As a carer I feel as though I have just been left to get on with it."

"Personally, I feel that I am on my own when it comes to support from my GP practice, which is disappointing. Perhaps GP practices could acknowledge that carers are supporting them as well as the person they are caring for."

Some carers often felt that they were made to feel guilty for seeking support, and many did not want to burden the NHS, despite desperately needing help.

"We are made to feel guilty seeking the advice of a GP even when we are in pain and discomfort."

"I have never been advised as indicated here or had check-ups, often when I tried to get help with things like weight which is an emotional issue linked to my caring role, it's been by telephone, and I feel like a fraud or guilty or not listened to as a carer."

"I do feel that because I am an unpaid carer and 57 years old that I'm not worthy of the doctor's extra time, but my caring role has taken a huge toll on my life and still does."

Personal Story: Angela's* Experience of Accessing Support

After completing our survey, Angela reached out to Healthwatch Hertfordshire to share her views and experience in more detail.

Angela and her partner care for multiple people. When we spoke, Angela called her GP practice a few days ago to see what support is available, and to ensure she is registered as a carer with her GP practice.

Angela noticed through speaking to her mother-in-law, that support provided to carers appears to vary between GP practices, noting that there is "no equitable service." She pointed out that carers often must proactively seek out support instead of it being offered to them, and suggests that GP practices can better support carers by providing more information and signposting.

Seeking Help

According to Angela, GP practices often struggle to identify and support carers, meaning the onus is on the carer to seek help, and to look for information and advice to support them in their caring role: ***"You have to seek help yourself, the onus is on you to seek out your own help – which becomes harder the more you struggle and you have to be quite confident to seek that out. Professionals or GPs must be able to actively think about what other forms or support might this family or patient need."***

She also shared the difficulties her partner, who is also a carer, faced when trying to access support from their GP. Her partner has physical health issues, as well as depression and anxiety. Due to his caring responsibilities, her partner often struggles to take care of his own health needs. When Angela encouraged him to see a doctor because she was concerned that "he might drop dead", the doctor them told: ***"I can't guarantee life, and my partners in his 40s. I wasn't asking him to guarantee life, we were just asking for help and support to address the health issues he has."***

Angela shared how her partner's mental health issues were addressed in isolation to his caring role: ***"GP would focus on one particular issue but not look at the bigger picture, he didn't see the fact he is a carer and the challenges that brings***."

Making Improvements

Angela suggested that healthcare professionals should look at carers more holistically, and address their physical and mental health in relation to their caring responsibilities. She praised the support their Carers Champion provides, and the importance of this role: ***"GPs don't have a huge amount of time to spend with patients whereas Carers Champions can talk to carers holistically about the whole picture. The Carers Champion can identify where the GP can be most effective and look at other ways other people might be able to help."*** Angela was inspired to seek support from her Carers Champion after completing our survey. She had a positive experience, stating that the Carers Champion ***'was kind and set my partner up with an appointment with the surgery's life and wellness coach'.*** However Angela had trouble the contacting the Carers Champion, stating that the ***'only [way carers get] support is if you have the strength to push and chase for it.'***

Angela also felt that although there is plenty of information about carers in her GP practice, she does not feel represented by the images used in the resources. Angela highlighted how most leaflets featured "grey-haired old people with walking frames" and felt that a wider diversity of carers needs to be presented in communication materials.

A pseudonym has been used to protect the respondent's identity.

Positive Feedback

Although there are clear areas for improvements, we did hear many examples of good practice, with respondents praising their GP practices for being supportive, responsive, and offering greater choice and flexibility where possible to accommodate their caring responsibilities and/or the needs of the person they care for. Below are some examples of GP practices going above and beyond for carers, offering emotional as well as practical support.

"When I had a breakdown recently, the GP was extremely sympathetic as he is going through the caring process as well."

"One of the GPs has provided brilliant support for me in getting help for my son. I have received excellent support when I have approached for help with my mental health. Twice I have received a same day appointment. One GP after discussion supported a request to my employer for a month of reduced hours which helped me through an extremely challenging period."

"They are always kind, considerate, and helpful. When I'm upset they give me time to say/explain/ask what I need to. If the person I'm talking to cannot help they will always find someone that can, even if that's a call back phone call. They are willing to go above and beyond to help me as a carer even for someone who is not in their practice. The surgery has on occasions phoned me to ask how my husband (whom I care for) is and me, when we have been through a particularly bad patch or his been rushed into hospital. They couldn't be more caring. I feel they do very well, especially with the constraints Government is putting on them."

"I'm very lucky with my GP he is outstanding. He has supported me with my husband over the past 16 years and my daughter over the past 9 years. They both have complex medical conditions."

"My doctors and all their team to a fantastic job. They are very caring in everything they do."

Suggestions for Improvements

The findings outlined in this report indicate areas for improvements, however as part of the survey we asked carers how GP practices could better support them, and how they could encourage unpaid carers to formally register as a carer with their GP practice.

Encouraging Registration

When asked how GP practices could encourage unpaid carers to register as a carer with their GP practice, the majority of respondents said that there needs to be more promotion and advertisement about how to register as a carer, as well as the importance of registering. Respondents suggested that this could be through noticeboards, posters and leaflets within GP practices, as well as through online resources such as the GP practice website. Some respondents said that GP practices could also send out text messages and emails, asking patients if they have taken on caring responsibilities and/or to check whether their patient records are up to date.

> ***"Annual communications or texts asking if you are a carer and to make sure you're registered."***

> ***"By proactively making information about registering as a carer accessible on boards in their GP practice, and through posters and leaflets."***

> ***"Posters in the waiting room and information on their website!"***

Linked to this, most respondents felt that GP practices could do more to promote the benefits of registering as a carer, and the additional support they should be offered.

> ***"Promote the benefits of registering as a carer – most people are probably not aware."***

> ***"Telling carers tangible things that will be a benefit to them and to the person they care for if they do."***

Some respondents noted that GP practices could be more proactive in asking whether someone has a carer, of if they care for someone. Given that many people do not identify are a carer, using this term would not help them to self-identify, meaning it is important that other language and phrasing is used to help people recognise themselves as an unpaid carer.

"By GP practices telling people they are a carer as you do not realise until you are told. You just do what you have to do."

"Additional fuss or label of carer, we are husband and wife. I accept that I sometimes must use the "carer" label as a way of conveying our different lifestyles and needs but this isn't something I am comfortable with."

Similarly, respondents said that offering more face-to-face appointments could help with the identification of carers, as these interactions tend to be more in-depth and pick up on subtle cues which would otherwise go unnoticed in a remote consultation. Face-to-face appointments are also when someone is likely to accompany the person they care for, providing another opportunity for GP practices to ask if they are a carer.

"The practice nursing staff and GPs could ask relevant questions of patients to find out if they are caring for someone or if they have a carer."

"When accompanying my husband for his appointments the doctor could ask me if I am a carer."

Provision of Support

When asked how GP practices could better support carers, the majority of respondents would like to see carers offered more available appointments, more flexibility when making an appointment for themselves and/or the person they are 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 the person they care for needs.

"Offering flexibility when trying to book appointments. Be more understanding that the people you care for may need to see a particular doctor as they can't deal with change."

"Offer some flexibility when appointments are impossible to make due to caring responsibilities."

"Be more flexible when booking appointments and understanding that we can't call first thing and drop everything that same day to go to an appointment – it needs to be planned. And don't cancel last minute when we've put a lot of effort and resources into attending the appointment."

Another common suggestion was that GP practices could increase the contact they have with carers, for example by inviting carers to an NHS annual health check and checking in with carers to see how they are coping and if they are facing any difficulties in regards to their physical or mental health. Some respondents suggested that the Carers Champion could be in an ideal position to offer this type of support.

"Keep in contact at least annually and offer longer appointments for answering questions and giving appropriate health checks."

"More contact, enquiries, encouragement and checking in with carers (and with the patient too) would make me feel less abandoned. I feel like I'm doing their job for them sometimes."

A large number of respondents said that GP practices could better support carers by showing carers greater compassion, understanding and empathy. They noted that GP practices need to acknowledge the pressures and responsibilities carers face, and listen to carers about how this can impact them emotionally, mentally and physically.

"I understand that they are busy but just listen to what I'm saying about the patient and understand when I ask for help with my own health to support me. I once went in with a continuous cough and because I left it for a few weeks I was told it couldn't be serious. Even though I explained that I was a carer and never had time to help myself. I just stood there and cried because I felt so ill."

"I find our surgery to be very unaware about the stress and anxiety that unpaid carers suffer. I dread getting in touch with our practice these days as I fear I will be told more of what they can't do than what they should do. The stress of caring has multiplied. Our GP surgery used to be the one place where I felt assured of some extra help at all. If I need (not want) help from our surgery, sometimes, I have to really stand my ground."

Some respondents felt that reception staff could receive more training in regards to identifying and supporting carers. A few respondents said that receptionists did not seem to check their patient records, and did not seem to respond appropriately when they told them that they are a carer.

"Train their telephone and reception staff to understand the strains that unpaid carers are under when trying to access healthcare."

"There should be more training done for staff about what a caring role is, and maybe speak to carers when they do training to get a carers' perspective."

Recommendations

Recommendations

Based on the findings outlined in this report, it is recommended that the Hertfordshire and West Essex ICB Primary Care Workstream should encourage GP practices to take forward the following recommendations. The ICB is providing significant support to enable GP practices to improve access and further investment of this will help address some of the challenges.

Identifying Carers

We know that there are many unpaid carers who do not identify themselves as a carer, and in turn are not receiving support with their caring role from health and care services. GP practices are often a first point of contact for unpaid carers, and in an ideal position to ensure they are identified. This could be through:

1. Providing information and resources (such as posters, leaflets) in their practice and on their website, outlining what it means to be an unpaid carer.

2. Encouraging patients to self-identify by distributing letters, text messages and emails to patients asking whether they have taken on caring responsibilities. This information could also be shared in the GP practice and on the practice website.

3. Encouraging patients to check their patient records are up-to-date.

4. Proactively asking patients if they have a carer, or if they are a carer.

For the above recommendations, consideration should be given to the language used, as many people do not resonate with the term "carer." Staff should also avoid making gendered or cultural assumptions about caring.

Encouraging Registration

Our findings highlighted that some unpaid carers are not formally registered as a carer with their GP practice, which often prevents them from accessing and finding out about the support available. GP practices could encourage registration by:

5. Ensuring that carers are aware of the need to, importance of, and benefits of registering as a carer with their GP practice. Information on how to register should be available within GP practices and on the practice website. Communications could also be delivered via text messages, letters and emails.

6. Sending confirmation to patients once they have registered as a carer with their GP practice – either via letter, email or text message.

Access

The findings indicated that carers are facing difficulties accessing their GP, whether this be for themselves or the person they care for. GP practices should strive to improve access for carers by:

7. Continuing to improve telephone systems to reduce delays and waiting times.

8. Offering greater flexibility in contact hours and opening hours to account for caring responsibilities.

9. Reviewing and addressing waiting times for appointments for carers.

10. Being more mindful of caring responsibilities and demands when offering appointments.

11. Providing more choice and flexibility when offering appointments, including offering "double appointments" when necessary.

Support for Carers

Patients who are registered as a carer should receive additional support from their GP practice to help carers manage their health and wellbeing. GP practices should ensure carers feel supported in their caring role by:

12. Ensuring that they offer registered carers the following support on a regular basis:
    - NHS annual health check
    - Flu vaccinations
    - Carer Assessment
    - Benefits checks

13. Ensuring NHS annual health checks include a thorough examination of carers' physical and mental health.

14. Having discussions with carers about their physical and mental health, particularly in relation to their caring role.

15. Signposting carers to health and social care services, as well as support provided by the VCFSE sector.

16. Referring to, or encouraging, carers to speak to a social prescriber or link worker. Awareness about how social prescribers can support carers should also be raised.

17. Updating their websites to include the following information:
    - Benefits of registering as a carer, and the support they should receive.
    - Signposting information and support to local and national organisations.

18. Treating carers with respect, compassion and empathy, and acknowledging the demands of the caring role. Reminders and refresher training on engaging with carers should be considered.

19. Ensuring that receptionists are checking patient records to see if someone is registered as a carer, and offering greater flexibility when booking an appointment, where possible.

Carers Champion

Each GP practice should have a Carers Champion. Carers Champion play an important role in ensuring that carers feel supported and are a key point of contact should a carer having any concerns.

20. All GP practices should have a Carers Champion if they do not already.

21. If a GP practice has a Carers Champion, their contact details should be given to registered carers, available in GP practices, and provided on the GP practice website. An email, letter or text message to registered carers could also be distributed.

Appendix

Named GP Practices[17]

District	Name of GP Practice	Respondents
Broxbourne	Amwell Surgery	4
	Cromwell and Wormley Medical Centre	2
	Cuffley and Goffs Oak Surgeries	3
	Hailey View Surgery	4
	High Street Surgery	1
	Park Lane Surgery	9
	Stanhope Surgery	1
	Stockwell Lodge Surgery	4
	The Limes Surgery	8
	The Maples	1
	Valley View Surgery	4
	Warden Lodge Surgery	5
Dacorum	Bennetts End Surgery	14
	Coleridge House Medical Centre	1
	Everest House Surgery	4
	Fernville Surgery	6
	Gossoms End Surgery	2
	Grovehill Medical Centre	2
	Highfield Surgery	1
	Lincoln House Surgery	2
	Longmeadow Surgery	2
	Manor Street Surgery	4
	Markyate Surgery	1
	Parkwood Drive Surgery	16
	Rothschild Surgery	14
	Wood Hall Farm Medical Centre	1
East Hertfordshire	Central Surgery	8
	Castlegate Surgery	3
	Church Street Surgery	8
	Dolphin House Surgery	7
	Hanscombe House Surgery	4
	Knebworth and Marymead Surgery	14

[17] Please note that the total does not equate to the total number of respondents due to some respondents choosing not to share the name of the GP practice they are registered with.

	Much Hadham Health Centre	2
	New River Health	8
	Parsonage Surgery	1
	Puckeridge & Standon Surgery	3
	South Street Surgery	10
	Wallace House Surgery	7
Hertsmere	Annadale Medical Centre	3
	Attenborough Surgery	11
	Little Bushey Surgery	2
	Fairbrook Medical Centre	7
	Gateways Surgery	2
	Grove Medical Centre	4
	Highview Medical Centre	2
	Longrove Surgery	1
	Manor View Practice	14
	Parkfield Medical Centre	6
	Red House Surgery	6
	Schopwick Surgery	7
North Herts	Baldock Surgery	10
	Ashwell Surgery	1
	Bancroft Medical Centre	5
	Birchwood Surgery	5
	Buntingford Medical Centre	4
	Garden City Surgery	2
	Granta Medical Practice	2
	Larksfield Surgery Medical Partnership	1
	Nevells Road Surgery	16
	Orford Lodge	1
	Portmill Surgery	4
	Regal Chambers Surgery	3
	Royston Health Centre	7
	Sollershott Surgery	2
	Whitwell Surgery	1
St. Albans	Colney Medical Centre	1
	Davenport House Surgery	8
	Grange Street Surgery	3
	Harvey House Surgery	6
	Hatfield Road Surgery	1
	The Lodge Surgery	10
	The Maltings Surgery	18
	The Elms Surgery	7
	Midway Surgery	11

	Parkbury Surgery	8
	Summerfield Health Centre	4
	The Village Surgery	6
Stevenage	Bedwell Medical Centre	14
	Bedwell and Roebuck Surgeries	8
	Broadwater Surgery	1
	Chells Surgery	6
	King George Surgery	8
	Manor House Surgery	3
	Shephall Health Centre	1
	St. Nicholas Surgery	2
	Stanmore Medical Group	9
	Symonds Green Health Centre	1
Three Rivers	Abbotswood Medical Centre	3
	Baldwins Lane Surgery	1
	Chorleywood Medical Centre	1
	The Colne Practice	3
	Consulting Rooms	4
	Gade Surgery	6
	Haverfield Surgery	3
	Kings Langley Surgery	7
	New Road Surgery	4
	Vine House Surgery	9
Watford	Bridgewater Surgeries	14
	Callowland Surgery	2
	Garston Medical Centre	4
	Sheepcot Medical Centre	6
	Suthergrey House Medical Centre	6
	Watford Health Centre	3
Welwyn and Hatfield	Bridge Cottage Surgery	10
	Burvill House Surgery	4
	The Garden City Practice	5
	Hall Grove Surgery	5
	Lister House Surgery	6
	Peartree Surgery	7
	Potterells Medical Centre	5
	Spring House Medical Centre	1
	Wrafton House Surgery	3

healthwatch Hertfordshire

Views on Community Pharmacies

Engagement: Nov. 2022 – Feb. 2023

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Authors: Miriam Blom-Smith and Chloe Carson

Contents

About Healthwatch Hertfordshire

Healthwatch Hertfordshire represents the views of people in Hertfordshire on health and social care services. We provide an independent consumer voice evidencing patient and public experiences and gathering local intelligence to influence service improvement across the county. We work with those who commission, deliver and regulate health and social care services to ensure the people's voice is heard and to address gaps in service quality and/or provision.

About the Hertfordshire and West Essex Integrated Care System

The Hertfordshire and West Essex Integrated Care System (ICS) was established as a statutory body on 1st July 2022. Integrated Care Systems are geographically based partnerships that bring together providers and commissioners of NHS services with local authorities and other local partners to plan, coordinate and commission health and care services[1]. The Hertfordshire and West Essex ICS is made up of two key bodies – an Integrated Care Board (ICB) and Integrated Care Partnership (ICP).

Integrated Care Board (ICB)

The Integrated Care Board (ICB) is an NHS organisation responsible for planning and overseeing how NHS money is spent across Hertfordshire and West Essex, with the aim of joining up health and care services, improving health and wellbeing and reducing health inequalities. The board of the ICB includes representations from NHS trusts, primary care and from Hertfordshire County Council and Essex County Council[2].

This report will be sent to the Hertfordshire and West Essex ICB Primary Care Board to inform how it can further support Community Pharmacies.

Integrated Care Partnership (ICP)

The Integrated Care Partnership (ICP) is made up of representatives from different organisations involved in health and care. This includes NHS organisations, local authorities and the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector. The partnership is responsible for developing an Integrated Care Strategy which will set out the priorities for Hertfordshire and West Essex for the next 10-20 years[3].

Hearing Patient Views about Primary Care in Hertfordshire and West Essex

Healthwatch Hertfordshire and Healthwatch Essex have been commissioned by the Hertfordshire and West Essex Integrated Care Board (ICB) Primary Care Workstream to undertake a series of engagement projects. The aims of the engagement projects include:

[1] Integrated care systems: how will they work under the Health and Care Act? | The King's Fund (kingsfund.org.uk)
[2] https://hertsandwestessexics.org.uk/ics/health-wellbeing-decisions/3
[3] Health and wellbeing decisions – Hertfordshire and West Essex Integrated Care System (hertsandwestessexics.org.uk)

- Gathering lived experiences to feed directly into the Hertfordshire and West Essex ICS Primary Care Workstream
- Supporting and enabling the Hertfordshire and West Essex ICS to achieve wider participant engagement
- Engaging patients and the public on programmes covering key priorities and areas of importance at a regional and local level
- Making recommendations to the Hertfordshire and West Essex ICS Primary Care Workstream so improvements can be implemented

Using patient and public feedback, this engagement project will focus on improving the relevant services within different areas of primary care by making recommendations to the Hertfordshire and West Essex ICB Primary Care Board.

From November 2022 – February 2023 the Director of Primary Care Transformation at the ICB has requested Healthwatch Hertfordshire and Healthwatch Essex to explore public views of, and attitudes towards Community Pharmacies, with a specific focus on:

- Awareness of services
- Why someone might not access a community pharmacy
- How people access support if they do not use a community pharmacy

Background

National Context

Community pharmacies in England are one of the four pillars of primary care services in England, alongside GPs, dentists and opticians. Pharmacies are designed to be one of the easiest and quickest ways to access non-urgent health care and advice in England, considering they are situated in most high streets, supermarkets and deprived or rural communities. In fact, the Pharmaceutical Services Negotiating Committee (PSNC) estimate that 1.6 million people visit a pharmacy in England every day and have established that **89%** of the population live within a 20-minute walk of a community pharmacy[4]. In Hertfordshire, this figure stands at **87%**[5], and there are 291 registered pharmacies in Hertfordshire and West Essex[6].

With all community pharmacies coming under the remit of the ICB from April 2023, it is a crucial time to evaluate the role and future of community pharmacy, and how they can best continue to evolve and support the NHS as well as patients[7]. The current strategic context places a strong emphasis on community pharmacies further embedding within health and social care and playing a greater role in "developing a fully integrated community-based health care system".

[4] About community pharmacy - PSNC Website
[5] Hertfordshire Pharmaceutical Needs Assessment 2022 (hertslpc.org.uk)
[6] East-of-England-Partnership-Strategy-for-Community-Pharmacy_December-2022.pdf (hertslpc.org.uk)
[7] NHS England and NHS Improvement's direct commissioning functions - NHSEngland

Integration into Primary Care

On a national scale, the NHS Long Term Plan identifies pharmacies as playing a key role in supporting with self-care, self-management and urgent care, striving to make better use of community pharmacists' skills whilst also recognising the pressures on capacity. More specifically, the Community Pharmacy Contractual Framework[8] (CPCF) is currently in its fourth year of a five-year deal that works towards better integration of pharmacies into the NHS, including providing more clinical services, supporting with minor illnesses, and helping to manage the demand on general practice and urgent care.

Regionally, the recent East of England Partnership Strategy for Community Pharmacy report outlines a very similar vision wherein pharmacies are:[9]

- An integral and integrated part of primary care, leading to improved outcomes for patients and facilitating better access
- Part of integrated care pathways for primary and urgent care
- The first point of contact for many patients
- Integral to the delivery of self-care and avoiding ill health
- Integral to addressing health inequalities
- Valued and respected as clinicians in their own right

The Future of Pharmacy

Health Education England's pharmacy reform programme[10] means that from 2026, newly qualified pharmacists will become prescribers at qualification, having undergone the necessary training as part of their degree. This will require efficient integration and strategic planning to fully provide benefit. Due to community pharmacy's unique position in the centre of nearly all communities, this increased responsibility in prescribing might also work to help address health inequalities. By increasing the clinical role of pharmacists, the accessible community hub of a pharmacy will be even more important in enhancing population health through support with self-care, and early interventions and preventions.

The Kings Fund[11] have also published their vision for what community pharmacy services could and should look like in the future. Their "professional vision for pharmacy practice in 2032" explores the next 10 years of fully integrated pharmacy services. It describes the potential for much more advanced digitisation and automation of systems to increase safety, but also relieve pharmacists of some duties, allowing them to provide more direct clinical and personalised services to patients.

Awareness of Services

The Pharmaceutical Needs Assessment conducted in 2022[12] identified no gaps in the provision of community pharmacies in Hertfordshire, and indicated good public awareness (over **90%** of respondents) of the essential services they provide. However, it is important to note that the

[8] The Community Pharmacy Contractual Framework for 2019/20 to 2023/24 (publishing.service.gov.uk)
[9] East-of-England-Partnership-Strategy-for-Community-Pharmacy_December-2022.pdf (hertslpc.org.uk)
[10] standards-for-the-initial-education-and-training-of-pharmacists-january-2021_1.pdf (pharmacyregulation.org)
[11] Vision for Pharmacy Practice in England Themes 1.8 FINAL.pdf (rpharms.com)
[12] Hertfordshire Pharmaceutical Needs Assessment 2022 (hertslpc.org.uk)

general public might not always fully understand the range and type of services pharmacies can offer, and how this is not universal across pharmacies.

There was limited awareness of the additional services pharmacies might provide, and a desire for more services to be available or better publicised. Around a fifth of respondents also wanted a better, faster, or a more knowledgeable service in order to consider pharmacy a first port of call.

Perception of Pharmacy

A nationwide report from 2017[13] found that whilst pharmacy services were generally viewed positively, the clinical skills of pharmacists were under-recognised by both patients and other clinicians within the NHS. This report also found that pharmacists were not considered to be "as legitimate" as other healthcare professionals, impacting public perceptions, trust and confidence in accessing community pharmacies. This lack of trust arose from a combination of concerns around the commercial or financial influences on pharmacists, and a lack of understanding regarding their training.

However, more recent findings from The East of England Strategy for Community Pharmacy survey[14] found many respondents were keen for pharmacies to take a greater role in patient healthcare. They also shared that pharmacists and pharmacy staff are often knowledgeable, helpful and provide excellent customer care.

There was concern that pharmacists should not be seen as replacing GPs, but rather work in a more integrated and communicative way with them. Respondents also supported more clinical services being provided by community pharmacies, such as vaccinations, pain management, routine blood tests and blood pressure monitoring. However, common areas for improvement were shorter waiting times, longer opening hours, more privacy and discretion within pharmacies, and better advertisement of services available.

Aims

The aims of this project included:

- Understanding public attitudes and views towards community pharmacies
- Identifying the reasons why someone might not access a community pharmacy
- Exploring public understanding and awareness of the range of services community pharmacies can provide
- Exploring how people access support if they do not use a community pharmacy

Methodology

To explore the above aims, Healthwatch Hertfordshire created an online survey. Participants had the option to request the survey in an alternative format and/or contact us for support. The survey

[13] Patient and public perspectives of community pharmacies in the United Kingdom: A systematic review (Hindi et al. 2017)).

[14] East-of-England-Partnership-Strategy-for-Community-Pharmacy_December-2022.pdf (hertslpc.org.uk)

was directed at all Hertfordshire residents, whether or not they regularly use community pharmacies. Collecting data via a survey was the most efficient and wide-reaching choice within the timeframe of the research.

The engagement period for the survey ran between November 2022 to January 2023. The survey was promoted via social media and shared with the NHS, other statutory services, and the Voluntary, Community, Faith and Social Enterprise sector across Hertfordshire to share and distribute via their networks, contacts and social media channels.

A digital promotional flyer with a QR code was produced and distributed this alongside the survey. In some instances, pharmacies printed the flyer and displayed it in their window. One respondent requested a hard copy and their response was inputted digitally.

Key Findings

Summary

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. Overall, respondents were very positive in their views of community pharmacies and demonstrated a good awareness of essential services. Awareness of additional services was very mixed, but there was a desire for services to be better promoted, and a willingness to access these services if they were offered. Trust in pharmacists was also quite high, despite some uncertainty about their role and expertise, particularly in comparison to the GP, and between different roles within a pharmacy.

Common reasons that prevented respondents from using their pharmacy were that there were significant waiting times and queues, and sometimes a poor and inefficient service. Some respondents did have a lack of confidence in pharmacy staff and were unlikely to visit a pharmacy for medical advice, often due to having a previous poor experience or concerns around the expertise and knowledge of pharmacists and pharmacy staff. There were also a substantial number of respondents who had experienced accessibility issues, including needing evening or weekend opening hours, or closer parking. Others raised issues around the cost, availability and efficiency of delivery services not always accommodating their needs, particularly for housebound patients.

As attitudes towards community pharmacies were mostly positive, it correlates that many respondents were supporting of their role expanding, particularly concerning being able to treat minor conditions and prescribe certain medication. Furthermore, respondents felt that pharmacies should be doing more to promote the services they offer. Multiple respondents were particularly interested in finding out more about diabetes testing, blood pressure monitoring and emergency prescription supply. These findings echo the national picture quite accurately, and demonstrate that, although there are some areas for improvement and negative perceptions that need attention, there is a general appetite for increased responsibility and integration for community pharmacies across Hertfordshire.

Demographics

In total 310[15] Hertfordshire residents shared their views and experiences with us. **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[16].

[15] Please note that percentages do not always add up to 100% due to some respondents choosing not to answer, or preferring not to say

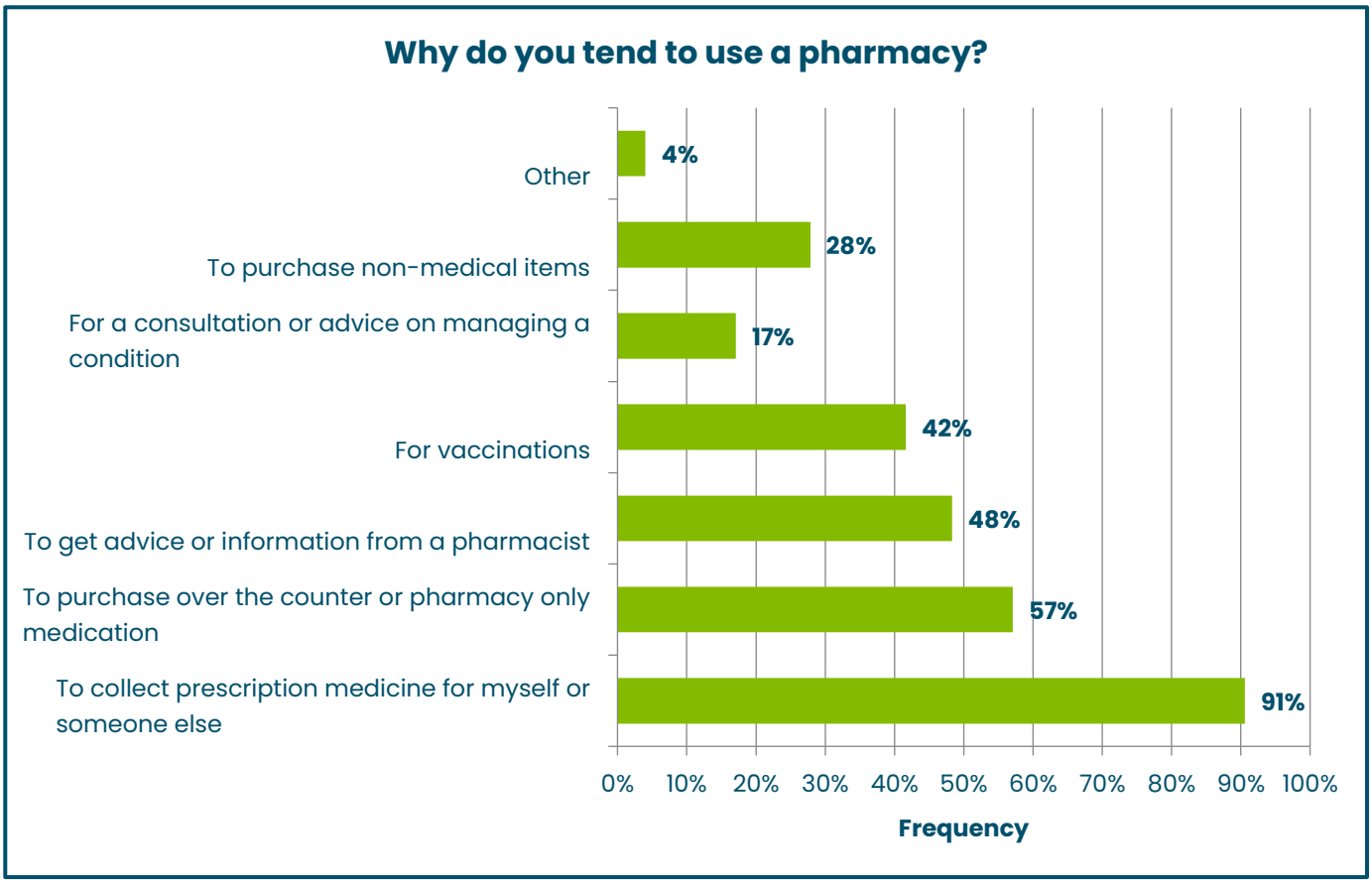
[16] Ethnicities engaged with included: Pakistani, Indian, other Asian/Asian British backgrounds, Black Caribbean, Black African, other Black/Black British backgrounds, Asian and White, Black Caribbean and White, White Irish, White Italian, White Polish, other White backgrounds, and other ethnic backgrounds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

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 **13%** using one weekly. **81%** of respondents are normally choosing to access a high street pharmacy[17], with **7%** using a GP dispensary, **1%** using an online pharmacy and **9%** using a combination of them.

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 over-the-counter or pharmacy-only medication, and to seek advice and information. The percentage of respondents who selected each reason is shown in the chart below. The respondents who selected the option "other", most often specified that they used a pharmacy delivery service.



57% of respondents do not seek information or advice from elsewhere before, or instead of, visiting a pharmacy.

> ***"My local pharmacy is excellent, and I often go to them or help and advice."***

[17] Supermarket-based pharmacies are also included under this bracket.

"I'm very happy with the pharmacy. One of the staff is especially lovely and really patient, especially if I'm feeling really low or anxious"

"It's local, I trust the pharmacists' advice and it saves contacting our GP which is already understaffed for getting our children's repeat prescriptions"

For those that did look elsewhere, **43%** said they would go online first, using the internet, NHS Choices, or NHS 111. Some respondents said that they always go to their GP first, or looked for natural or holistic self-care, and others asked friends and family who work in healthcare.

"It's easier to go online. More serious things I would need a doctor anyway."

"Online is much more convenient and not disturbing the busy pharmacist unless necessary."

"Not sure about taking medication as prefer natural remedies."

When asked why they would not visit a pharmacy, respondents reported that it was often easier to look online for information, or to visit their GP, particularly if the condition was more concerning. Other respondents also mentioned that they sometimes ask family members or friends in the healthcare profession for their advice.

"I have a friend who is an experienced nurse."

"I would possibly speak to a doctor first with regard to an ongoing condition because the doctor would have access to my medical history and my husband's."

"I do use the pharmacy but often they are not confident in giving advice and direct me to the GP."

Accessibility, particularly in relation to opening hours and location was another common reason for not using a pharmacy, as well as delays, long queues and waiting times.

"My pharmacy is very busy and you can wait a long time to speak to a pharmacist."

"They are often busy and I am made to feel like an inconvenience."

Other reasons included concerns around the lack of privacy available in pharmacies, and the level of expertise of pharmacy staff and pharmacists in comparison to that of other healthcare professionals, especially GPs. High prices, especially in comparison to supermarkets, also was noted as a reason for not visiting a pharmacy.

"Lack of privacy when talking to a pharmacist."

"I don't trust their level of competence."

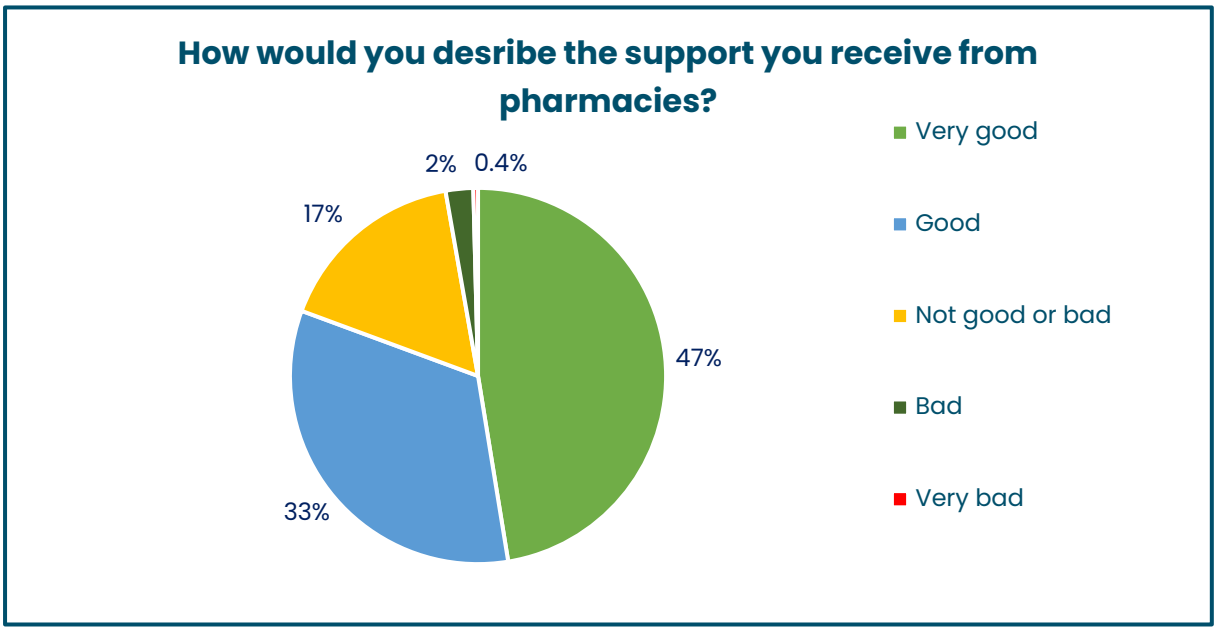
"Higher prices in my local pharmacy. Can buy cheaper over the counter medications in supermarkets."

Interestingly, some respondents felt they had no choice but to use their pharmacy in order to speak to a health care professional, given the pressures on other services, particularly GP practices and NHS 111.

"I have no choice. GP services are difficult to access, vaccinations are no longer given by my GP, I feel that I am on my own and the pharmacy is the only reliable service."

Experience of Support

Most respondents were very positive about the support they receive from community pharmacies, with **80%** describing the support as "very good" or "good", and only **2%** describing it as "bad", and one respondent as "very bad", as shown in the graph below.



"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."

"I have had a recent diagnosis of cancer and my local pharmacy has been invaluable in advice and coordinating the care between the dietician, my GP and the hospital consultant."

Carers, and those with disabilities or long-term conditions had higher overall satisfaction with pharmacy services:

- **62%** of carers describe the support they receive as "very good" and **32%** as "good"
- **57%** of those with a disability describe the support as "very good" and **35%** as "good"
- **55%** of those with a long-term condition describe the support as "very good" and **30%** as "good"

However, one participant did mention that pharmacy staff should have a ***"greater understanding of learning disabilities."***

When asked what pharmacies were doing well, respondents 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."***

> ***"I know my pharmacist will listen and give me good advice and not just sell me a product."***

> ***"I think they are more flexible and personalised in their approach than the GPs. You can walk in and be seen almost immediately, they're professional and you can talk in private if you feel you need to."***

Although, multiple respondents were keen to state that their experiences and attitudes did vary a lot between pharmacies and pharmacists.

> ***"I trust my local pharmacist because I know him and trust him. I would not be so happy at an unknown pharmacy."***

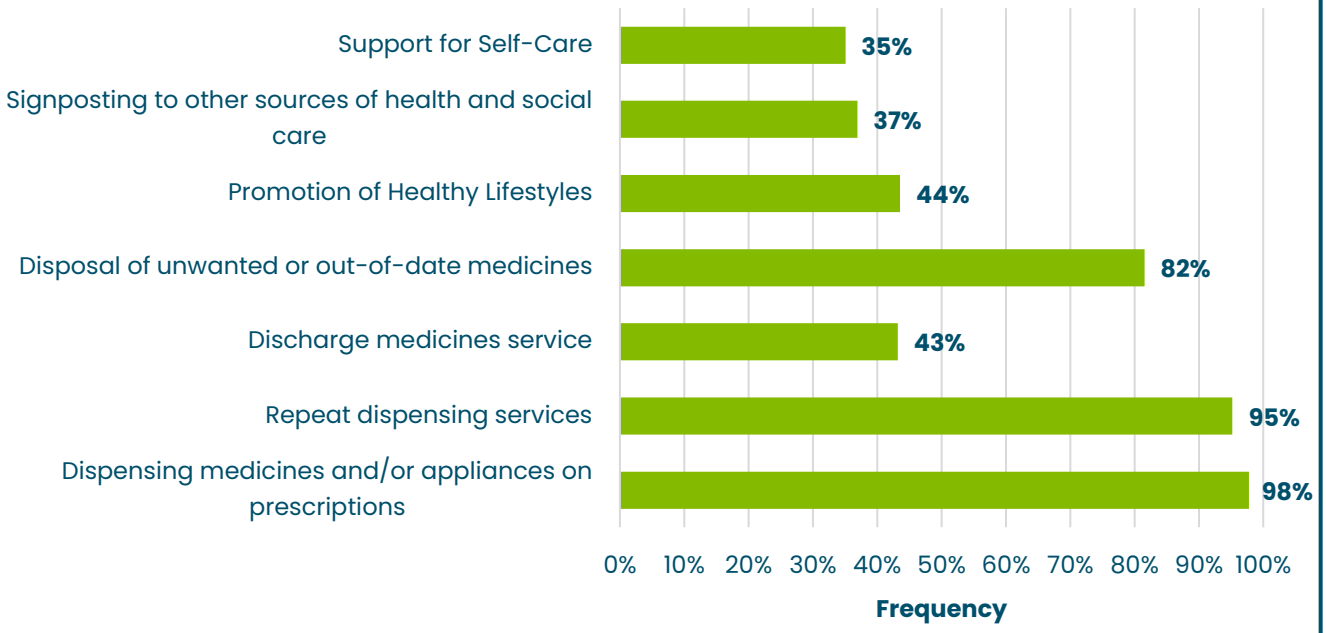
> ***"My experience with my current pharmacist is extraordinary. I completely trust their advice and knowledge. I have had difficulties with other pharmacists though where I was not a regular customer of theirs where I felt dismissed and rushed."***

Awareness of Services

Amongst the respondents, awareness of the essential services[18] pharmacies provide was very good, although the public could receive more information about discharge medicine service, signposting and self-care. The graph below shows the percentage of respondents who were aware of each essential service.

[18] These 'essential services' are offered by all pharmacies/pharmacy contractors, in accordance with the NHS Community Pharmacy Contractual Framework – the pharmacy contract (PSNC Website).

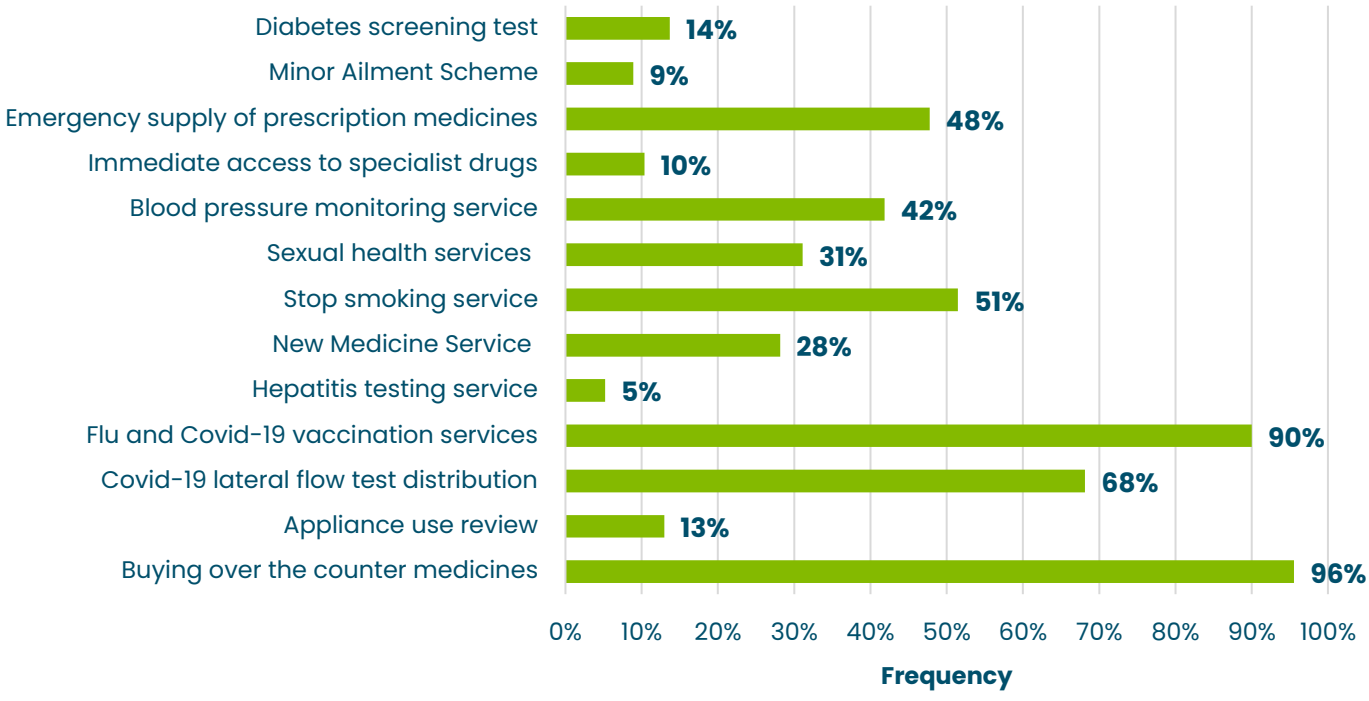
Are you aware that all pharmacies provide the following essential services? Please select all of the options that apply.



Awareness of the additional services[19] 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.

Whilst many participants were very aware of some services such as buying over-the-counter medicine, vaccines, lateral flow Covid-19 tests and smoking cessation, other services were less well known. The graph below shows the percentage of respondents who were aware of each additional service.

Are you aware that a pharmacy might also provide the following additional services? Please select all of the options that apply.

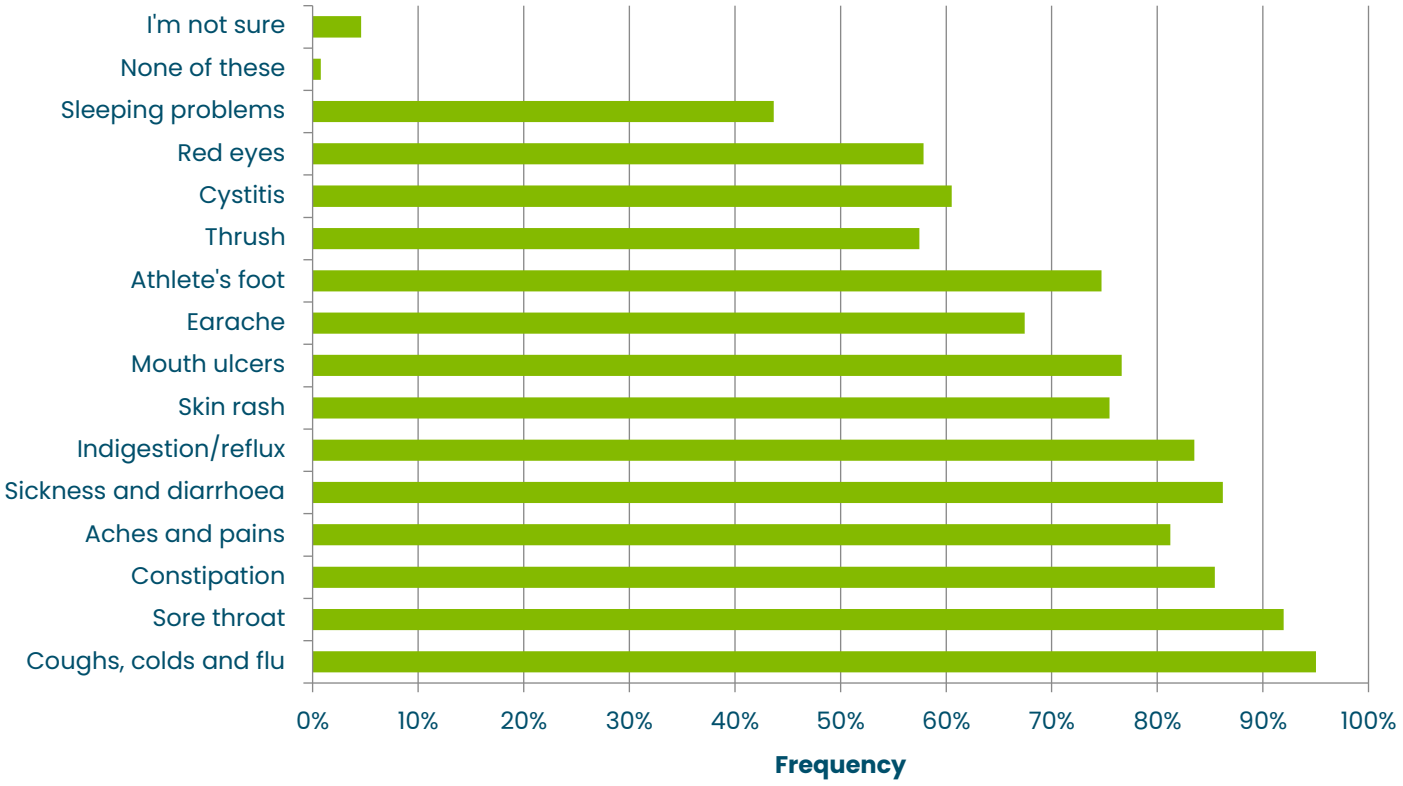


Positively, **39%** of respondents would consider using one of these services now that they are aware of them, in particular blood pressure testing, diabetes testing, and to a lesser extent, emergency supply.

> ***"I would definitely seek the advice of my local pharmacist for the above conditions. Relieving pressure on GPs is very important ... as long as pharmacists are supported adequately in an expanded role."***

Furthermore, participants' awareness of different ailments that a pharmacist could treat was quite high, as shown in the graph below.

Which of the folllowing conditions are you aware that pharmacists can treat or give advice on?



When asked what prevents respondents from accessing any of the following essential and/or additional services, the main reason was simply because they did not need to use them.

> ***"I haven't needed any of the following services but I'm glad to know that they are there."***

Another common response was that there was a lack of information and awareness regarding what services are 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."

Many respondents also considered much of their healthcare to be outside the remit of a pharmacist.

"The fact that pharmacists can't prescribe or do examinations, so I end up seeing a GP anyway."

As mentioned previously, accessibility, long queues and waiting times, and concerns regarding privacy and discretion within pharmacies, were noted as factors preventing respondents from accessing the following services from a pharmacy.

"There's little privacy in a busy high street pharmacy so it's uncomfortable having some discussions."

"Convenience. I do prefer having an appointment rather than queueing. And being able to do things online suits me."

"No confidentiality if there is a personal issue."

"Pharmacies tend to be busy – people are always waiting for something."

Some respondents said their concerns about what is a private or NHS service stopped them from using their local pharmacy.

"It's not clear what the charge of these services are."

Seeking Advice and Information

Positively, **71%** of respondents were either "likely" (**39%**) or "very likely" (**32%**) to visit a pharmacy for advice or information. Respondents said they were likely to because it is the quickest way to speak to someone in person for a mild or common condition, and they wanted to avoid bothering their GP.

"A pharmacist is extremely knowledgeable and worth visiting with certain issues."

"Pharmacists are very skilled and qualified clinicians. I feel confident in the service they provide."

"Much easier & more convenient than getting advice/some services than trying to contact my GP centre."

Interestingly, fewer male respondents (**63%**) and respondents aged 18-34 years old (**62%**) were "likely" or "very likely" to visit a pharmacy in comparison to women (**70%**), and those aged over 55 years old (**73%**). Carers were most likely to seek advice from a pharmacist, at **84%**.

Those who visited frequently, and those with long-term conditions were also slightly more likely to visit a pharmacy:

- **84%** of respondents visited the pharmacy daily, weekly or monthly, **75%** of whom were likely or very likely to seek advice from a pharmacist.
- **33%** of respondents had a long-term condition, of whom **77%** were likely or very likely to seek advice from a pharmacist.

Those that were unlikely (**7%**) or very unlikely (**3%**) cited previous bad experiences as the reason, in addition to considering it outside the remit of pharmacist, or being concerned about not speaking to a suitably qualified member of staff.

"I feel more comfortable discussing some things with a GP. Privacy and confidentiality concerns."

"They have got it wrong a few times and conditions have worsened."

"Too often I end up talking with someone more like shop assistant instead a real pharmacist. "

One participant was concerned about whether pharmacists are adequately prepared for the increasing responsibility and workload they are being given.

"Need more clarity on pharmacy expertise. If in doubt, I'd contact GP. Feeling would be pressure on NHS funding pushes for more use of Pharmacy without necessarily providing adequate training and checks on competency and processes. Also fear that consequences of incorrect diagnosis could be severe for some conditions. Hence clarity and reassurance would be required to increase confidence in using pharmacy more."

Trust

68% of all participants would trust their pharmacist to give medical advice or information, **26%** said they sometimes would, and only **4%** said they wouldn't. It was often the case that they would trust a pharmacist with every day, mild issues, within a certain remit.

"Staff and pharmacist need to be helpful and approachable - my now chosen chemist is both and professional. and you need to be able to able to know your medication is able to be available especially if it is of the type which should not just stopped. You need to have confidence in the pharmacist."

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.

"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."

"Very confident in my local pharmacist who helped me when I had a concern about contraindications of a new drug that I had been prescribed."

"I feel confident to give the pharmacist the first chance of treating my condition. I am starting to experience some good value in doing so and I'm amazed how helpful and competent they are and cautious at the same time."

However, some participants had had previous poor experiences that they felt had affected their level of trust in pharmacists.

"It's a bit hit and miss with advice."

"Twice I consulted a pharmacy and followed instructions and ended up in out of hours service, they should have sent me to the GP."

Furthermore, the setting of the pharmacy meant that although they trusted the pharmacist, they didn't feel able to share their issue, as there was not enough privacy.

"I trust their expertise but their consultations room don't always feel that private."

Again, carers (**82%**), those with a disability (**76%**) and those with a long-term condition (**74%**) had slightly higher levels of trust in their pharmacist, with the least trusting group being 18–34 year olds at **62%**.

Understanding of the role

Closely linked with trust was that there were clear uncertainties and concerns about receiving advice from support members of staff, and confusion around who has which expertise. **42%** of

respondents were "very confident" in their understanding of a pharmacist's role, with a further **48%** saying they felt "somewhat confident" in their understanding. Only **7%** stated they are not confident.

> ***"I would trust the qualified pharmacist. Not so much any shop assistant type people they may have working there."***

> ***"I don't know what expertise pharmacists have. I would be cautious discussing something other than a cough, cold etc with them."***

Confidence was greater amongst those aged over 55, in comparison to those aged 18-34, of whom only **15%** felt "very confident". This is perhaps interlinked with their also being less trusting of pharmacist's advice overall.

Those with more confidence in understanding of the role were slightly more likely to visit a pharmacy for advice, with **76%** of those who were "somewhat" or "very confident" also being "likely" or "very likely" to visit for advice.

> ***"I think there could be more awareness about the qualifications and expertise pharmacists have."***

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. This second figure rose to **40%** amongst those with a long-term condition, who are more likely to have repeat medication.

Although most respondents were generally satisfied, **8%** said they did not work well together, and there were multiple cases of miscommunication regarding repeat prescriptions. There was also frustration for many respondents that services were not taking enough responsibility for when medication was not ready, or when processes had been inefficient.

> ***"There are still frustrations between the two. I feel they should have a better understanding of each other's businesses and their priorities."***

> ***"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."***

> ***"The patient should be able to see the electronic prescription. You need to include the patients in the working well together."***

Suggestions for Improvement

When asked what would encourage them to use pharmacies more, and how they could be improved, many respondents cited that they would feel more inclined if pharmacies were less busy and had shorter queues and waiting times.

"My local is understaffed, they are rude, inefficient and so slow […] I have never waited less than an hour in there and the queue might only be 4 or 5 people."

"The organisation in my nominated pharmacy is shocking, resulting in delays in waiting for medicines, whether that is the same day or afterwards. They do not look at prescriptions until you arrive and then if they don't have the medicines, you have to make multiple trips - madness."

Some respondents said they would be more likely to use pharmacies if they had more confidence in the expertise of staff members. They were often confused about the level of competency of pharmacy staff, and pharmacists in comparison to that of GPs, and would prefer to visit their GP because they had more trust in their knowledge and expertise. Some also noted that staff could be more approachable, friendly and helpful.

"Not always clear the demarcation between knowledge of pharmacist vs GP."

"Once I asked if a certain product might be good for what I had, the assistant went to ask the pharmacist and came back with the answer "Well it can't do any harm." This sort of attitude is obviously poor."

"Staff and pharmacist need to be helpful and approachable and you need to be able to able to know your medication is available, especially if it is of the type which should not just be stopped. You need to have confidence in the pharmacist."

As previously emphasised, opening times and accessibility were concerns for many respondents, leaving some to use online pharmacies or to visit supermarkets instead. Unsociable opening hours was particularly problematic for those with work and/or caring responsibilities.

"I have recently had to switch pharmacy as local one now does not open on Saturday which is good time to pick up meds when you work all week.

"If I felt the pharmacy was the right place I would go but it's not easy to get to one and the last couple of years their opening hours haven't been consistent - often closed due to lack of staffing. It's easier to look online or speak to a nurse at the GP surgery."

"Time needed to travel to and go to the pharmacy. Lack of parking."

Linked to accessibility, a few respondents emphasised the need for pharmacies to offer free delivery services, as provided by online pharmacies. This was particularly important to those who are housebound and/or vulnerable.

"Online pharmacies provide free delivery for repeat medication and those who are vulnerable and older in society aren't able to use these services and need to rely on their high street shops, most of who don't provide free delivery which is unfair"

"Home delivery of prescriptions."

"Delivering medication to people who can't travel to collect it."

The need for greater privacy was also another factor that would encourage the use of a pharmacy. Some respondents shared that their pharmacy did not have a private space to discuss concerns, and that often they would have to share information about their health concerns within earshot of other customers which they found uncomfortable.

"A private space where one could ask a question and not be overheard."

"There's a lack of privacy to discuss details in the pharmacy."

"An easier way to have more discreet conversations. People already have to announce a lot of personal information when collecting prescriptions to a room full of strangers."

When asked how pharmacies could support the public more, some respondents were in favour of pharmacists having greater responsibility in terms of prescribing medication for minor conditions, and offering more services.

"If the chemist was allowed to prescribe antibiotics, and giving them more power to prescribe and treat minor ailments like dressings and taking blood and urine and more."

"Diagnosis and treatment of minor ailments and/or referral to primary care."

A large number of respondents felt that pharmacies could make the public more aware of the essential and additional services they can offer. Linked to this, a few respondents said that pharmacies could play a key role in promoting information and education campaigns to support people in living a healthy lifestyle.

"I think they offer a brilliant range of services, but national and local communications about what they are do poor."

"Maybe the pharmacies should list their services on their windows and in the pharmacy so people know all the services they offer?"

"Information campaigns could work wonders to both pharmacies' reputation and the public's wellbeing."

Although most respondents were positive about pharmacy staff, some felt that they could receive more training, and emphasised the need for more staff to help manage waiting times, queues and delays.

"Better training and more counter staff."

"Customer service and confidentiality training."

Interestingly, a few respondents mentioned that pharmacies should become more digitalised, for example, sending customers text messages when their prescriptions are ready to collect, and setting up accounts for customers to access their prescriptions and records.

"Digitise - i.e. ability to see online or get a text when prescriptions are actually ready in the shop. (I've had text to say mine is ready and it's not, staff say the system is automated.)"

Finally, some respondents felt that pharmacies are in an optimum position to signpost customers to other services, particularly those provided by the Voluntary, Community, Faith and Social Enterprise sector. They also suggested that pharmacies could offer more health prevention services, such as NHS annual health checks and support with weight loss.

"They could help the public with things like weight loss like they do with smoking."

"Offer health prevention services."

Recommendations

These recommendations have been drawn from the suggestions of survey respondents. Most of these recommendations are practical rather than strategic, but it is important that these are seen in the context of the wider role of community pharmacy in primary care, as outlined in the recent East of England Partnership Strategy for Community Pharmacy report[20].

It is suggested that the Hertfordshire and West Essex ICB implement the following recommendations:

Expertise of Pharmacies

1. Promote the expertise, knowledge and qualifications of pharmacists to educate and reassure the public, and to prevent misconceptions.

Awareness of Services

2. Promote the essential services pharmacies offer, with a particular focus on advertising:
    - Discharge medicines services
    - Promotion of healthy lifestyles
    - Signposting to other sources of health and social care
    - Support for self-care

The Hertfordshire and West Essex ICB Primary Care Workstream should also encourage community pharmacies to consider the following recommendations:

Accessibility

3. Review accessibility and communication – for example, opening hours, medication delivery availability and text reminder services.
4. Review procedures and staffing deployment with a view to improving queuing, delays and waiting times.

Greater Privacy

5. Pharmacies should, where possible, ensure they promote and use a private space for customers to discuss their concerns.
6. Pharmacists and pharmacy staff should ensure they are discreet when engaging with customers by being proactive and offering to discuss the customer's query in private.

Awareness of Services

7. Pharmacies should promote the additional services their individual pharmacy offers.

[20] East-of-England-Partnership-Strategy-for-Community-Pharmacy_December-2022.pdf (hertslpc.org.uk)

8. As well as signposting to health and social care services, pharmacies should look to promote the services and support the Voluntary, Community, Faith and Social Enterprise sector offers.

Integration with Primary Care

9. Pharmacies and GP practices should work together to strengthen their communication and collaboration with one another in order to better integrate the primary care system.

Support and help for people who care for others in West Essex

Produced by Healthwatch Essex
Fergus Bird
Information & Guidance Officer
November 2022 - February 2023

Contents

1.0 Introduction

1.1 Healthwatch Essex

Healthwatch Essex is an independent charity which gathers and represents views about health and social care services in Essex. Our aim is to influence decision makers so that services are fit for purpose, effective and accessible, ultimately improving service user experience.

One of the functions of a local Healthwatch under the Health and Social Care Act 2012, is the provision of an advice and information service to the public about accessing, understanding, and navigating health and social care services and their choices in relation to aspects of those services.

The Healthwatch Essex Information and Guidance team are dedicated to capturing the health and social care experiences that people in Essex are encountering daily. The team respond to enquiries relating to health and social care and are equipped through training, to offer specific information to the public or other professionals. The team are well placed to listen, reflect on and support people to share difficult experiences such as the one's shared in this report.

1.2 Topic Background

In 2021, Carers UK estimated there were over 13million people caring for a disabled, older or seriously ill relative or friend across the country.

In many, many cases, this means juggling work and other commitments while care giving or caring full time on a carers allowance of £69.70 (2022/23).

These 'unpaid' carers are estimated to save the government a staggering £135bn per annum.

However, we know that many do not consider themselves 'carers' and are not registered as such – thus the estimates above.

As our population ages and life expectancy with a long-term illness increases, more and more people are taking on caring roles.

The cost of private healthcare makes that option restricted for many, and the reputation of the care sector pushes many more into caring for their loved ones themselves.

New unpaid carers are often completely untrained, and unprepared for what they are taking on. For them to succeed, and maintain some sort of quality of life, it's important that the support and advice is not only in place, but easily sourced and accessible to all.

1.3 Acknowledgements

Healthwatch Essex would like to thank the members of the public who participated in this project through completing the survey. Our thanks are also made to those individuals who took the time to speak with us and share their personal stories. We would also like to thank our partners, contacts, and networks who helped publicise the survey.

1.4 Disclaimer

Please note that this report relates to findings and observations carried out on specific dates and times, representing the views of those who contributed anonymously during the engagement period. This report summarises themes from the responses collected and puts forward recommendations based on the experiences shared with Healthwatch Essex during this time.

2.0 Purpose

NHS England has set out the following as the four core purposes of ICSs:
a) improve outcomes in population health and healthcare
b) tackle inequalities in outcomes, experience and access
c) enhance productivity and value for money
d) help the NHS support broader social and economic development.

Unpaid carers provide a vital role in population health and healthcare, ensuring the elderly, those with a disability and those with long term conditions get round the clock physical care, emotional support, love and understanding at marginal cost to the NHS and Government.

Taking these roles and ensuring these committed carers have access to the best support, advice, and respite, and ensuring they are listened to, valued and respected, delivers across all four of the core purposes.

Through this report, Healthwatch Essex aims to voice the lived experiences of carers in West Essex, to highlight their support needs, and allow comparison to be made between those needs and what is being delivered through the ICS. This will provide insight into what is going well, what could be improved, where there might be blockages in the system, and what on-going programmes should be in place.

2.1 Engagement methods

Participants were contacted through the Healthwatch Essex website and newsletters, partners, other organisations in West Essex, relevant online communities and through word of mouth. They were engaged in two ways:

Survey
A survey was created to gain perspective and insight from residents who have had experience of caring for family members, loved ones, friends and neighbours.

Interviews
Individual interviews were conducted to collect personal stories from members of the public. Interviews took place by telephone during December 2022 and January 2023, and all participants gave their consent to have their interviews recorded. Participants were willing for their experiences to be shared within this report, however, to ensure their anonymity and confidentiality of information they provided, all names used are pseudonyms to protect identities.

2.2 The Survey

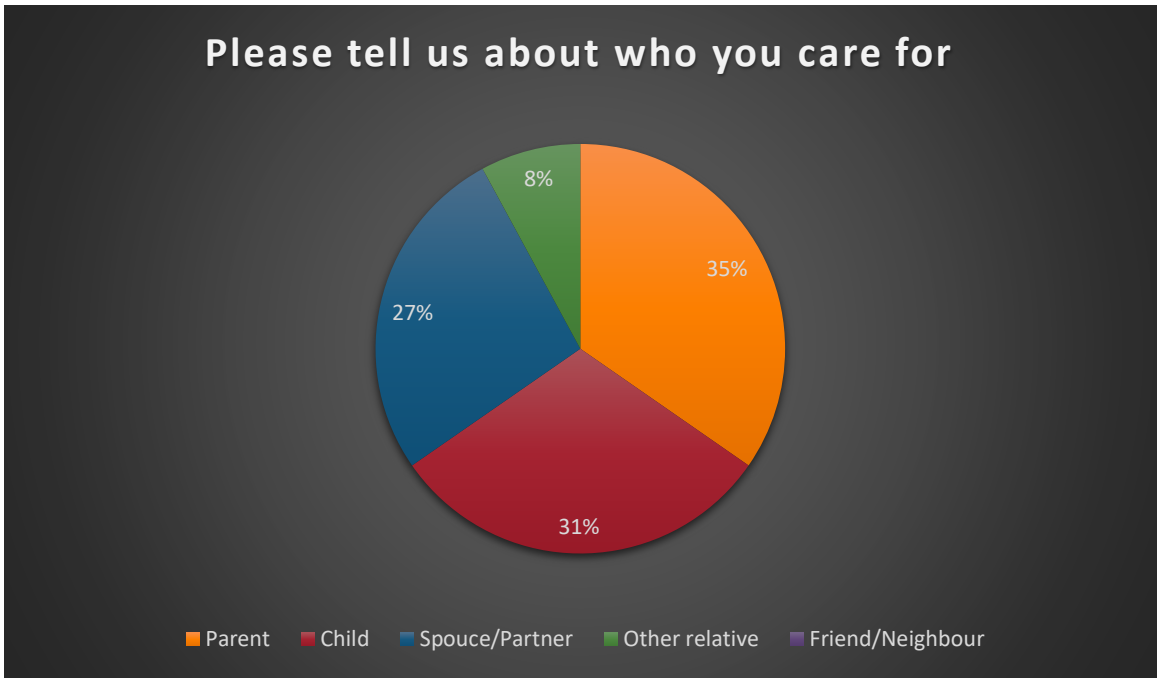
The survey consisted of 13 questions including 3 'free text' answer boxes enabling the participants to give expansive answers sharing their experiences and thoughts.

It was devised to encompass:

- Who they are caring for.
- How many 'caring hours' they perform each week.
- Their knowledge of Carers Allowance.
- What support they would like.
- Their relationship with their GP.

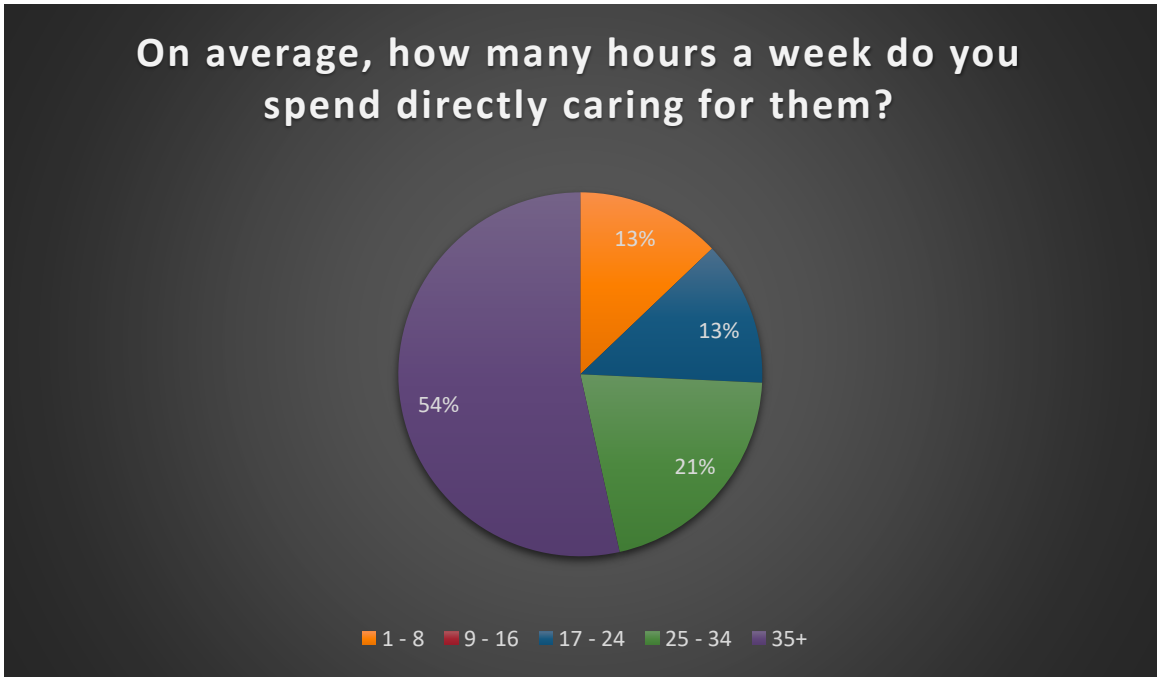
The survey was primarily in an online format but was also available to be printed off and filled out manually as required. The Information and Guidance Team at Healthwatch Essex were also available if the survey needed to be completed in any other format, such as over the telephone. The questions, and responses received, were as follows:

In our first question, we asked about who the respondents are caring for:



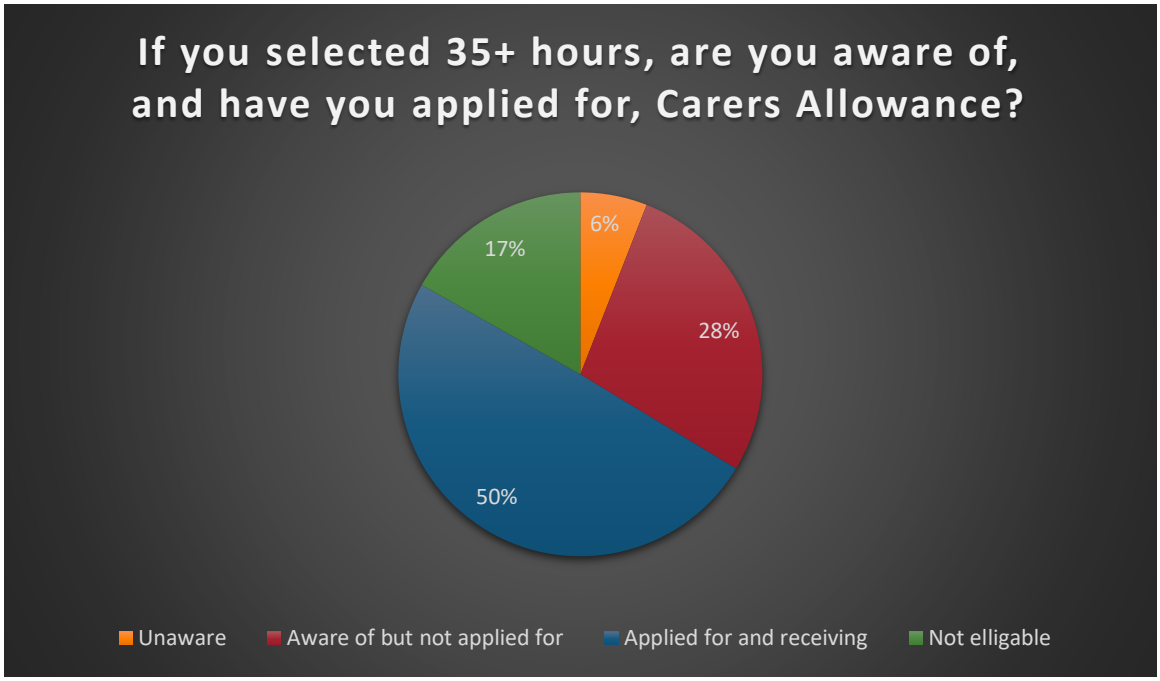
None of our respondents were carers for a friend or neighbour.

The second question asked how many hours they spend caring:



75% of the responses were from people caring for someone for 25 hours or more a week, with 54% caring over 35 hours, and thus potentially eligible for Carers Allowance.

Question 3 asked about their awareness of Carers Allowance:



This shows very positive feedback that only 6 percent of respondents are unaware of Carers Allowance. The area of concern is the 45% who are either not eligible or are aware of it but have not applied. What are the reasons for this, why have they not applied? If you are caring for someone for 5 or more hours a day, surely it is only right that you receive financial help as you are inevitably helping take some strain off health and social care resources.

Question 4 was a free text response:

'What support could be offered directly to you that would help with your physical and/or emotional wellbeing?'

Here is a representative selection of the answers:

- *Knowing what support is in my area so I can talk to other people in my situation.*
- *Care support much earlier in parent's decline in health.*
- *Respite care.*
- *A welfare check on me, someone to talk to when I can't cope.*
- *Get help from the social workers - they are disgraceful and never call.*

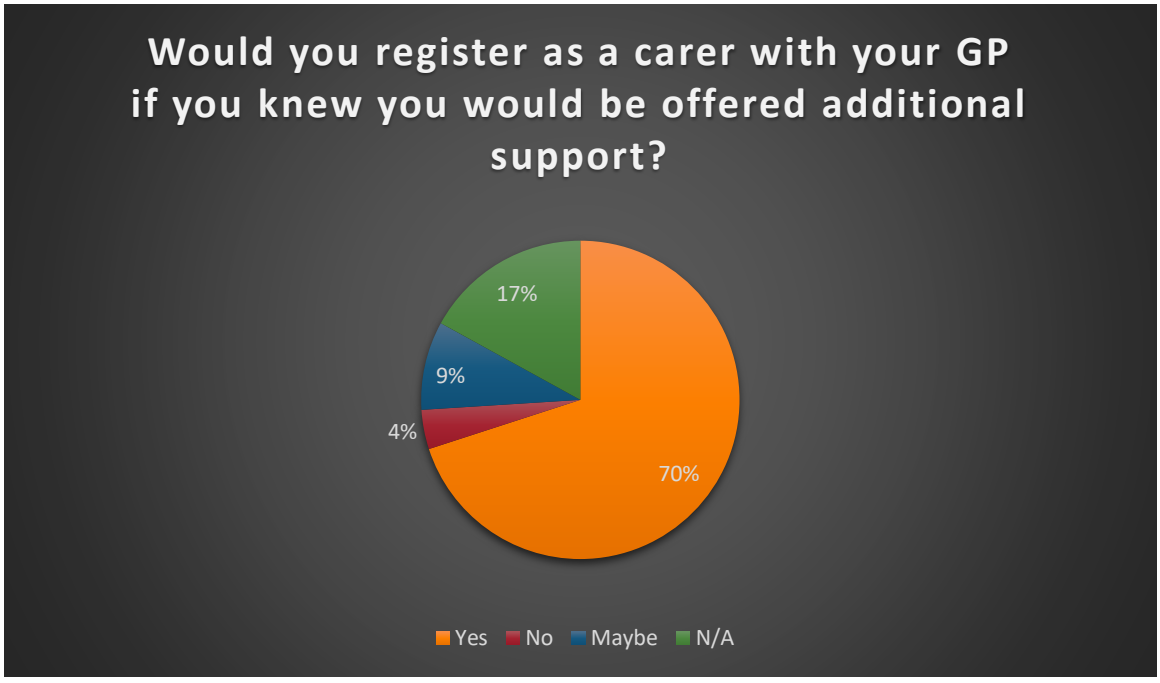
- *Receiving support by social care to find appropriate support and access to specialist healthcare.*
- *Support group, access to information and advice.*
- *Someone else to do the 24/7 role that has been foisted on me so that I can have a life.*
- *Respite, safe care for my autistic son and his brother so I can have a date with my husband as we have no childcare other than during school hours when my husband is working.*
- *Respite.*
- *Fund a break from this role for 4 weeks a year which allows my mum to stay in her home with support. This should not affect her or myself financially. Any other job includes paid leave and it's seen as a legal right.*
- *A chance to stop and breathe.*
- *Someone to talk to.*
- *Advice on how to cope with severe dementia.*
- *More flexible medical appointments for myself.*
- *A place to talk and meet others and get expert advice over a coffee.*

The next five questions all relate to the relationship with their GP.

Question 5:

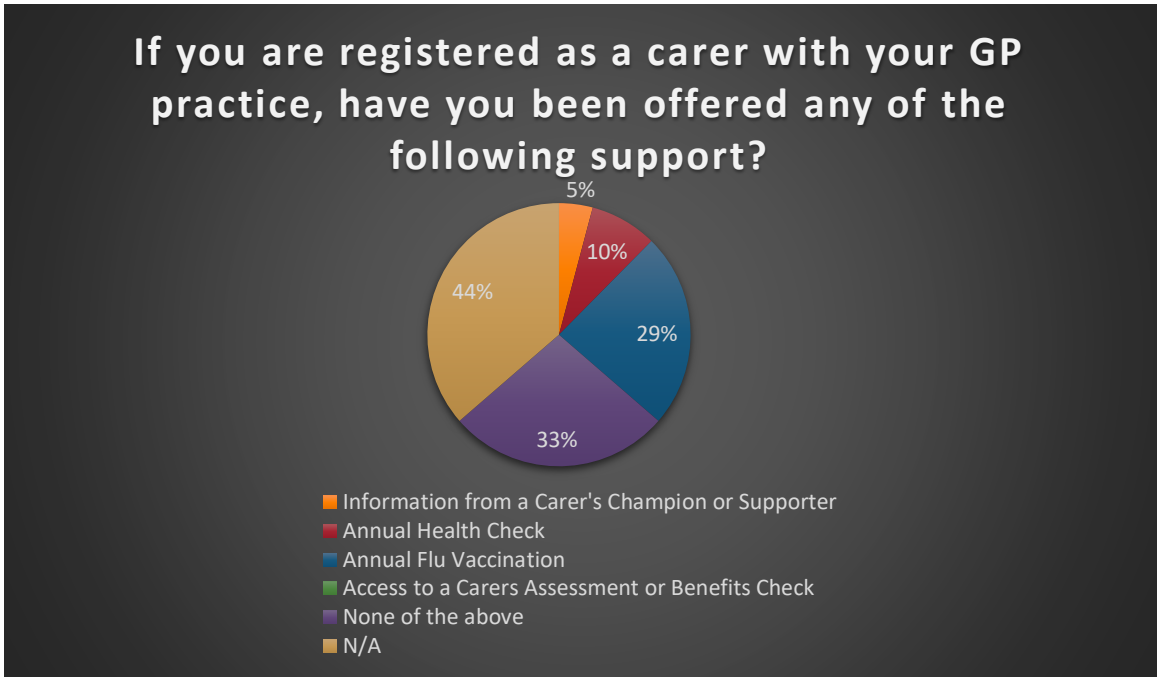
42% not being registered with their GP as a carer is extremely high and highlights a clear breakage in the system.

Question 6



Unsurprisingly, the significant majority would register with GPs if they knew there was additional support available.

Question 7 asked about the specific support being offered:



Only 5% were offered support from a Carer's champion, so unsurprisingly as a consequence, not a single person was offered access to a Carers Assessment or benefits check. Furthermore, 33% selected 'None of the above'.

Question 8 asked for details about support given by the GP practice.

Unfortunately, no-one described their support as very good. It may be that the 'neither good nor bad', 'bad', and 'very bad' could all be grouped together as a result of GPs just not offering any real type of support and not pro-actively questioning if patients are caring for someone.

Question 9 returns to an open text answer format:

'How do you think GP practices could better support carers?'

Responses included:

- *A separate telephone number so we don't have to sit on the phone for hours only to find all the appointments have gone.*
- *I was unaware of this.*
- *Yes, but they are snowed under.*
- *Phone call to check on us and people we care for flexible appointments around our caring duties.*
- *Just to be bothered about us would help.*
- *unfortunately we are Herts & West Essex health area, I no longer think about it , the system is what it is, and we just adapt to the services available.*
- *Make time.*
- *Awareness of caring responsibility.*
- *They dont support.*
- *More flexibility with appointment times. Giving information for further support/advice.*
- *Being more considerate and making appointment booking in general easier. When working full time and trying to book appointments for the person you are caring for is even harder. Being told to call at 8 in the morning to make yet another appointment is impossible. I run out of days leave as it is to care for my Mum so I can't not go to work on a day in the hope I may get her an appointment. My mother's GP practice are also very unsympathetic to her circumstances and make life very difficult and are often very rude. They are definitely not dementia friendly.*

- *Help and advice would be wonderful, I've had so much difficulty trying to find services, groups and benefits, it's exhausting and very worrying. I want the best for my husband for his remaining years.*
- *Appointments around caring duties, a mental health and welfare check.*
- *Make it easier to get appointment, deal with more than one thing at a time.*
- *Proactively offer me support as well as guidance ref health conditions of those I care for.*
- *Checking in on their mental health.*
- *By showing an interest in the patient. My husband was not contacted or seen for 4 years after his dementia diagnosis.*
- *It is very hard for them due to poor infrastructure and terrible services.*
- *Make appointment booking easier.*
- *Looking out for them more, holding meetings.*
- *Making sure they know about registration with them.*
- *Doing less stuff online would help as my elderly mother isn't great with booking things online. She's much better just doing it the old way of telephoning and making appointments. She likes to do these sorts of things but more and more things are moving to online and automated which make her a bit nervous.*
- *The majority of appointments were held with the GP, but a quarter of them were with a practice nurse.*

Following this, question 10 was a very open question:

'Do you have any other experiences or thoughts you'd like to share?'

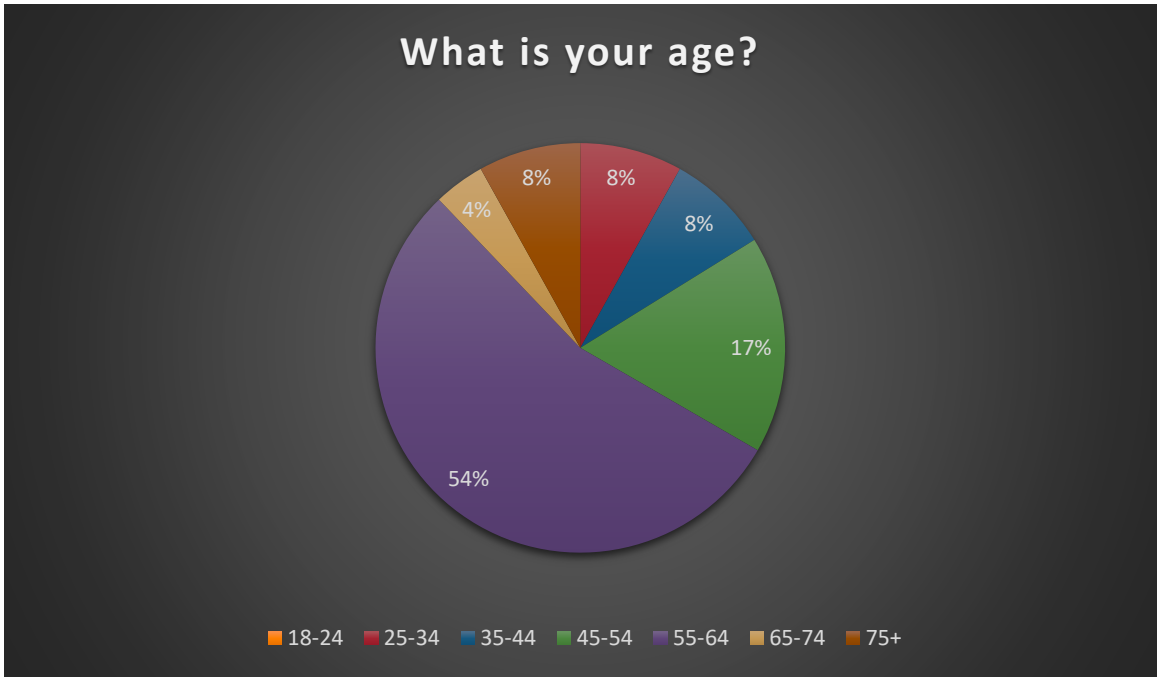
- *My mum died recently, and I was her carer up until she did. It was a long and slow decline meaning this impacted my wellbeing over a period of time. It wasn't until the last 2 weeks of her life that we were offered any type of emotional or physical support (when the hospice was involved).*
- *My daughter has been very ill recently, and we've had very little support and part of the reason she got so bad was we couldn't get a GP appointment.*

- *There is currently limited support for carers. Care assessments for the cared for and care support provided for them, but not carer. Carers assessment is so limited.*
- *I wasn't aware of any support for me as a carer.*
- *Once my daughter became an adult a lot of support for me stopped. GP doesn't care despite my daughter having been very ill for over a year no one bothered to see how I was coping mentally, physically or financially.*
- *I have a lot of problems getting my prescriptions.*
- *My husband was diagnosed (dementia and sight loss). We were given ZERO info and support by anyone. I have had to research and fight every inch of the way to get what we are entitled to.*
- *Dunmow in particular is very poorly served and has poor MH/LD healthcare and no integrated services for adults.*
- *I feel totally overwhelmed at times and underappreciated, nobody cares.*

Demographic Questions:

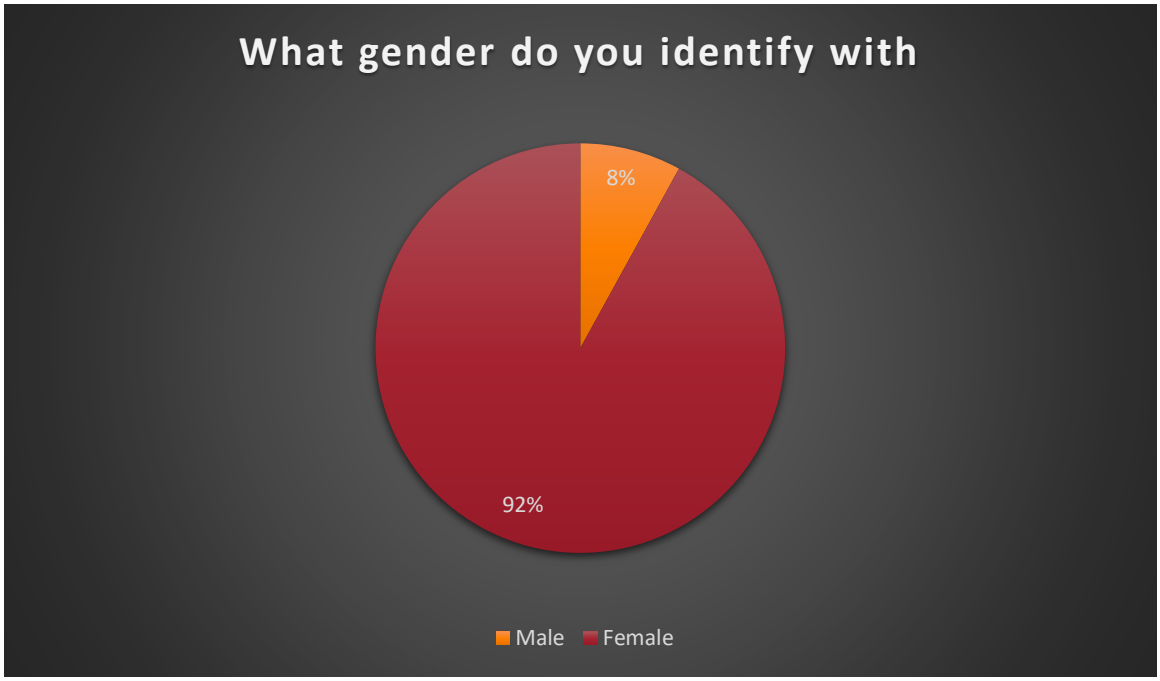
The next section of the survey asked for details of the individual respondent.

Question 11



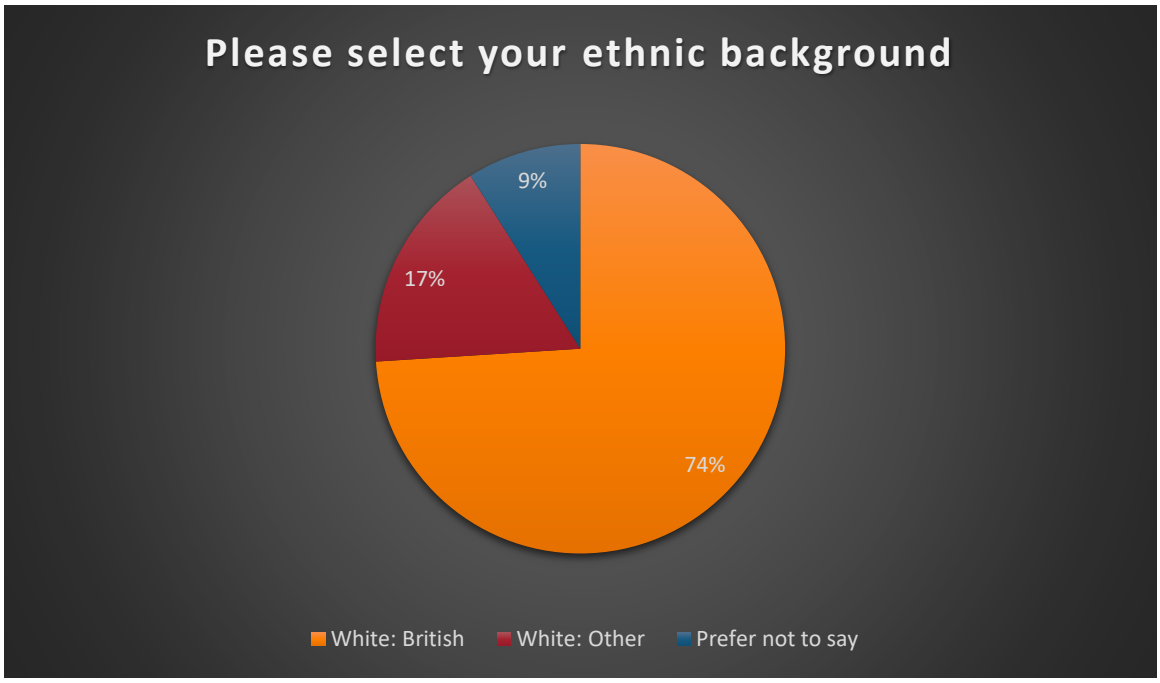
Nobody under the age of 25 completed the survey, while over half of the respondents were aged 55-64.

Question 12



Other options were available, but all our respondents identified as Male or Female.

Question 13



All options were available, but respondents selected only these three choices.

2.3 Interviews

Many people offered to talk to us directly and tell us about their stories in depth. We would like to thank everyone who took the time to talk to us and share their experiences. We have highlighted some of these lived experiences below with names changed to protect identities.

Case Study 1

Alison

'I think of myself as a dogsbody, not listened to and constantly ignored.'

Alison has been a carer for her daughter since she was born 31 years ago.

'I worked initially, but the demands became too much to cope with and I had to stop.'

In more recent years, Alison has also taken on caring for her mother who has developed dementia.

'With my mother, there has been a certain amount of understanding from the GP, but they wouldn't refer her to a Dementia team, saying they would deal with her directly.'

After time her mum went into a care home, but when she had to go to hospital, she struggled to get any information:

'I was kept completely out of the loop.'

During the whole of the period since her mum's dementia diagnosis, Alison felt let down by the system that should have been in place:

'I got no advice, no help from Social Care, no help regarding finances, benefits or choices.' 'Eventually I got our MP involved and that finally seemed to get some results, although the social worker was pretty rude and dismissive of the MP, saying 'you don't think we listen to what they say do you.''

The lack of care and understanding for her daughter is very upsetting for Alison:

'Nobody wants to stand up and take responsibility, everyone wants to pass her on to somebody else.'

'It's always been me pursuing all different angles on her health so she can be supported.'

'Her social worker doesn't understand her needs, social care are ignoring her continually and it all comes back to me.'

Alison had breast cancer recently and wanted to organise support for her daughter while she was in hospital.

'I was told I would get a support plan, various types of help etc, but the social worker then seemed dismissive, and we never received a support plan.'

'She was left out to dry.'

Alison gets no respite.

'I get depressed about the future in every respect. I have no quality of life.'

She needs her daughter to be helped – that's the one thing that in turn will help her.

'My daughter needs a good social worker, alongside appropriate and responsive healthcare.'

'The GP surgery is good, but they acknowledge that they know little about what to do. They asked me to research what they can do, to do the fact-finding!'

Alison's thoughts about being a carer are not uncommon:

'I don't want to be a carer, so I'm resisting applying for a carers allowance as I think that will be the final nail in the coffin.'

She constantly worries about the future and is desperate to get things in place for when she dies.

‘I don’t know how my daughter will be able to cope emotionally when I die, especially if a whole load of new people come in and take over.’

‘I’m worried she will be overlooked, and her vulnerability will result in her getting into dangerous situations and getting taken advantage of.’

Very reluctantly and guiltily, Alison admits that sometimes when her daughter’s mental health dips, she almost hopes she has to go into full time care, which would possibly be an institution.

Case Study 2

Julie

‘My mum was in and out of Princess Alexandra Hospital three or four times in one year. She had complications with her cancer treatment and on the last occasion was in for six weeks.’

‘When she was discharged after her last visit, no support was put in place or even discussed.’

‘When I asked why there was no support, I was told ‘because she has family’. That was despite the fact that she couldn’t walk on her own.’

Julie’s dad worked and was initially her main carer. Julie worked full time and supported him as best she could.

After time, her Dad cut his work hours by half, Julie did the same and they did shared caring.

There was no care package in place:

‘We were told she would be referred for help, but nothing happened and no-one came.’

Julie was worried for her Dad, not herself:

‘He got no support, was never asked by anyone.’

‘Dad was offered nothing, no advice or help or signposting anywhere.’

Towards the end before her mum went into the hospice, the district nurses paid a visit:

‘They said they would come again if she needed help, but every time we called them, we got no answer and they never came again.’

When she took her mum to GP appointments they were great, but they never offered to help with support or signposting or any ongoing advice.

‘At one point I was trying to find a nutritionist, but they didn’t help at all.’

‘If the person you are caring for gets the right care, it helps hugely with your own mental health. That’s what I wanted in place.’

Case Study 3

Fiona

Fiona cares for her husband who has cognitive impairment / vascular dementia and macular degeneration. She also cares for her mum who is elderly and needs general care.

She had to take early retirement from a long and successful career. Her pension now pays for all her husband’s care.

She wants him to live at home for as long as possible and do what they can together.

‘I use a tracker to make sure I know if he wonders off while I pop out.’

‘I get no other regular care help as you have to pay for it. I’d rather spend the money on doing stuff with him while possible.’

‘Respite would be great, but even a sitting service costs a lot of money and all they do is sit there and don’t do anything.’

Dementia Adventure and Alzheimer’s Society have been helpful, but it’s Carers First who have been wonderful, according to Fiona.

However, she points out:

‘Nobody told me about Carers First, we just got lucky hearing about them.’

‘It’s taken 2 years to find everything we currently access, but I got no help from anyone.’

‘I’m registered as a carer with my GP, but I get nothing. I’ve not had a single conversation with them about help.’

‘I found out about social prescribers from another person, but the GP surgery had never mentioned it!’

‘As soon as we got the diagnosis, I should have been given a list of people and places to register, visit, join etc.’

‘A social worker did his needs assessment and put some things in place. The NHS did the carers assessment, but why don’t they use that opportunity to put a plan in place for my needs as a carer? I didn’t qualify for the money and never heard anything from them again.’

Fiona feels incredible stress and strain from having to attend different consultants in different hospital, travelling around and having to constantly push for results, follow up, and treatment.

She is constantly frustrated by trying to navigate a system that is rigid and inflexible and lacking in any common sense:

'Once, the GP told me he needed another appointment in 2 weeks. I went to reception but was told the only way I could make an appointment was on the phone. So I stepped outside, called the surgery, spoke to the same woman I'd just been speaking to on reception and made the appointment for 2 weeks' time.'

Case Study 4

Jackie

After persuading her mum to move to Harlow to be nearer her, Jackie stopped working and became her full time carer.

She was increasingly worried that her mum was less able to look after herself, and was very relieved to have her living close by.

'I get tax or national insurance credits to ensure Mum keeps her benefits as I was told she would lose them if I got Carers Allowance.'

'Mum has multiple health problems and mobility issues, but is in a bungalow now and gets around with walking aids and so on.'

'Adult Social Care came and assessed her and helped a lot, including helping organising for a carer to help her shower, which is so important for her dignity. They also pointed me towards carers organisations, groups and Facebook pages which have been really useful.'

Jackie does her washing and cleaning etc, and also has power of attorney which helps when doing various bits of paperwork and finances.

'I use her account on the NHS app on my phone which is great for keeping up with letters, follow-ups, and things like that.'

They joined a group in Harlow who meet at the Latton Bush centre in Harlow and go along when they can.

The Carers group organised some respite so she and her husband could have a couple of nights away:

'Respite care is so valuable, it makes such a big difference'

She is also happy with the response from her GP:

'I am registered as a carer and have had my health check and flu jab. They have a carer specialist who has been very helpful and supportive.'

'The GP is on the ball regarding my mum and liaises very well with me.'

To improve things, she would like a support group for herself with people of a similar age in a similar situation, but finding one has proved difficult.

She would also like to leave her Mum at a group meeting:

'It would benefit both of us a lot, but I'm not allowed to because she's in a wheelchair.'

Apart from the one break she had, respite is very rare, and she admitted that it 'puts additional strain on my relationship with my husband.'

3.0 Key Findings and Recommendations

There are a number of easily identifiable tools and structures that can be implemented to offer the help and support that can make a significant impact in the health and wellbeing of carers and those they care for.

Much of the support is there – the positive comments in this report reflect that.

Many of the issues that need addressing are centred around disseminating the information and enabling access to these services.

Too many carers feel ignored and lost, they need to be recognised and have pro-active support and guidance from professionals who show they care and understand.

- **Care for the cared-for person**

First and foremost, we must not lose sight that the best thing that can be done for carers is to ensure the person they care for is getting the level and quality of care they need and deserve.

Listening to and understanding their needs respectfully and with compassion and working hard to find the best possible solutions.

Taking responsibility, not passing them on.

There is little point investing significant time, resource and effort into other fields if this core principle is not working fairly and efficiently across the board.

- **Respite**

Caring is draining and exhausting, both physically and mentally. Carers give up a 'normal' life and often take a big financial hit to do something they simply have to. While they are happy to do it, the fact is that they feel duty bound to do it.

It can be relentless, and it impacts everything.

Even the shortest bit of respite can make a huge difference.
However, often (but certainly not always) the carers who most need the respite are the ones who care for people with the most complex needs, so specialist carers are needed to cover.

This is an area that needs careful and thorough consideration. Whether it's being able to leave a person in a wheelchair at a support group for 2 hours, or finding appropriate care overnight for someone with specific medication requirements while their carer can stay a night away, all factors and variables need to be provided for wherever possible.

- **The role of the GP Surgery**

Pivot point

The GP surgery remains the cornerstone of the health service. The shop window, the consistent and reassuring presence, the first port of call when you're unwell.

They are busy, they are pressurised, but they are uniquely placed to be the pivot point between carers, the people they care for, social workers, support groups, charities and others.

GP's must start by questioning and registering people as carers. They then schedule relevant health checks, and vaccinations. There should also be consideration to developing some flexibility in their systems for appointment booking.

Pro-active dissemination of information and resources

Carer leads within GP surgeries, linked in with social prescribers / care advisors / Community Agents etc. don't need to know everything, but it is they who can click the system into gear and give appropriate initial signposting and support. The tentacles then continue to reach out to source the specific help that will provide the greatest benefit.

- **Key areas to always cover**

Respite (e.g., Carers First)

Local support groups (e.g., Essex Map)

Emotional Support (e.g., Essex Wellbeing Service)

Financial help (e.g., Citizens Advice)

Social Care (Essex County Council)

- **Hospitals and other healthcare settings**

When people are diagnosed, when they are discharged, when they are seen by a mental health unit, when they are seen at a falls clinic, wherever it might be, it provides an opportunity to question them and their carer about the wider support they are getting. Physical health, mental health, wellbeing, isolation, living conditions and many other factors.

A simple recommendation (or direct referral) to a GP Carer Lead, or even some key relevant fliers (Alzheimer's Society, Essex County Council Adult Social Care, Essex Wellbeing Service, Mind, etc).

Being pro-active in approach remains key. Staff could give them a 'Please register me as a carer' card to hand to their GP, and fliers must be handed directly to them, not just placed in racks where they are easily missed.

4.0 Conclusion

By listening to the lived experience of carers and their family, it is hoped that the findings in the report will help the HWE ICB to identify areas of structural change, alongside key services to develop and commission to match and reflect the increasing numbers of unpaid carers and their core needs.

The services come from across the board, including the NHS, Local Authority, Community Voluntary Groups, CICs and Charities.

Adapting and moving forwards

Much of the support and understanding that carers want, exists.

There are so many organisations doing so much good work, developing new and innovative programmes, and between them trying to provide something for everyone.

The 'explosion' in the number of carers means that the 'institutional' structure to support them needs to be updated, streamlined, and simplified.

Focusing on a pro-active approach where people are clearly recognised as having a caring role, and ensuring they have a sense of support and a clearly signposted pathway, laid out to find the services and communities they need.

Carers care deeply and often unconditionally for the people they care for. The emotions they invest are huge, and they can often live on a knife edge, close to despair.
It's only right that they are recognised, respected, and helped to continue doing the amazing work they do.

It cannot be over-estimated and must not be overlooked.

5.0 Terminology and Acronyms

CIC – Community Interest Company

ECC – Essex County Council

GP – General Practice or General Practitioner

HWE - Hertfordshire and West Essex

ICB – Integrated Care Board

ICS – Integrated Care System

PAH – Princess Alexandra Hospital, Harlow

Respite – Taking a break from caring while the person you care for is looked after by someone else.

Experiences of Community Pharmacies in West Essex.

Sara Poole, Information & Guidance Officer
Healthwatch Essex

For Hertfordshire and West Essex ICS

November 2022 – February 2023

Contents

1.0 Introduction

1.1 Healthwatch Essex

Healthwatch Essex is an independent charity which gathers and represents views about health and social care services in Essex. Our aim is to influence decision makers so that services are fit for purpose, effective and accessible, ultimately improving service user experience. We also provide an information service to help people access, understand, and navigate the health and social care system.

1.2 Background

Healthwatch Essex were approached by Hertfordshire and West Essex Integrated Care System to undertake a series of projects focussing on the lived experiences of people in the area in relation to their health, care and wellbeing. This project was focussed upon gathering peoples lived experience of accessing community pharmacies in west Essex.

1.3 Acknowledgements

Healthwatch Essex would like to thank the public who engaged with us and our network of stakeholders and partners who supported in sharing the project.

1.4 Terminology

PNA - Pharmaceutical Needs Assessment, conducted by Essex County Council

1.5 Disclaimer

Please note that this report relates to findings and observations carried out on specific dates and times, representing the views of those who contributed anonymously during the projects time frame. This report summarises themes from the responses collected and puts forward recommendations based on the experiences shared with Healthwatch Essex during this time.

2.0 Purpose

The aim of this project is to explore people's experiences of accessing community pharmacies in west Essex in order to inform the Hertfordshire & West Essex Integrated Care System.

2.1 Engagement methods

Survey.

A survey was created and distributed via our network of stakeholders and partners, as well as on our social media platforms and a dedicated page on our own website.

Interviews.

In order to gain a more in-depth understanding of resident's experiences with community pharmacies we conducted a number of one-to-one interviews with participants.

Case Studies.

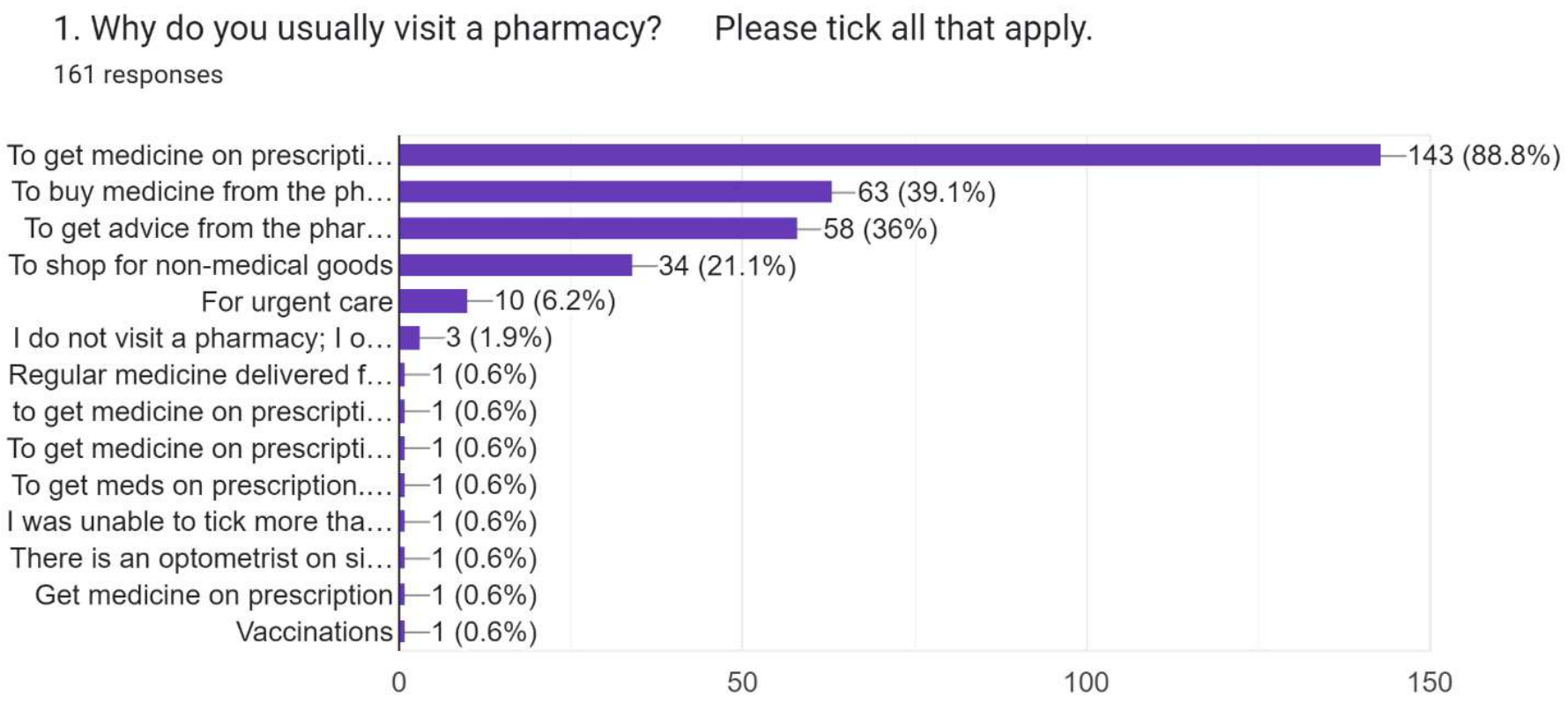
To further understand the experience of using community pharmacies, we gathered details of lived experience from members of the public which are presented here as case studies

3.0 Key Findings

3.1 The Survey

In order to better understand residents lived experience/feedback regarding community pharmacies, we circulated a survey which garnered the following data.

Our first question asked why residents visited the pharmacy, and as part of that we asked them to tick all the answers that applied. 161 responded and the majority - nearly 89% - attended the pharmacy to collect medication on prescription.

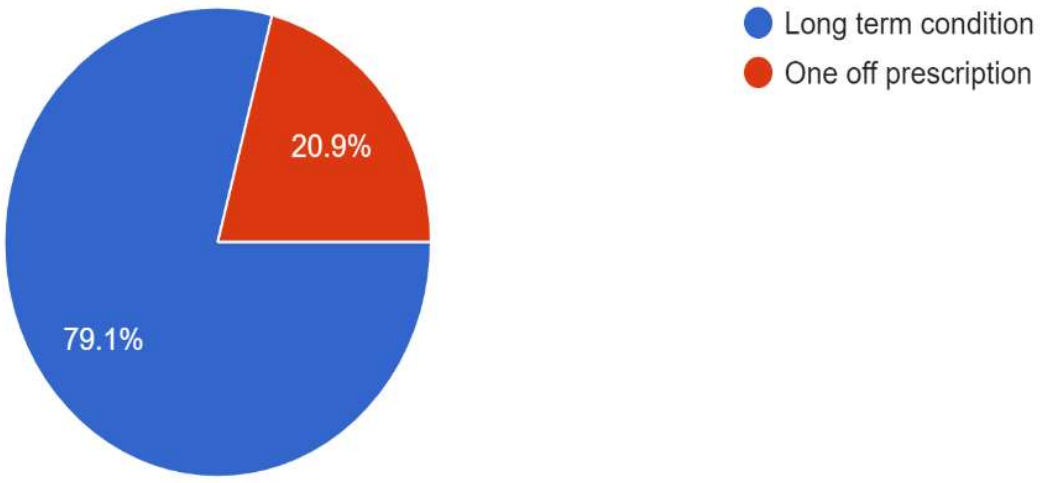


Responses can be quantified as follows:
To get medicine on prescription-143
To buy medicine from the pharmacy-63
To get advice from the pharmacy-58
To shop for non-medical goods-34
For urgent care-10
I do not visit a pharmacy; I order medication online and have it delivered-3

The second question asked if respondents were collecting long term or one-off medication, and over 79% of respondents used the pharmacy to collect medication for a long-term condition.

1a If you answered 'to get medicine on prescription' is this medication for a long-term condition or a one-off prescription?

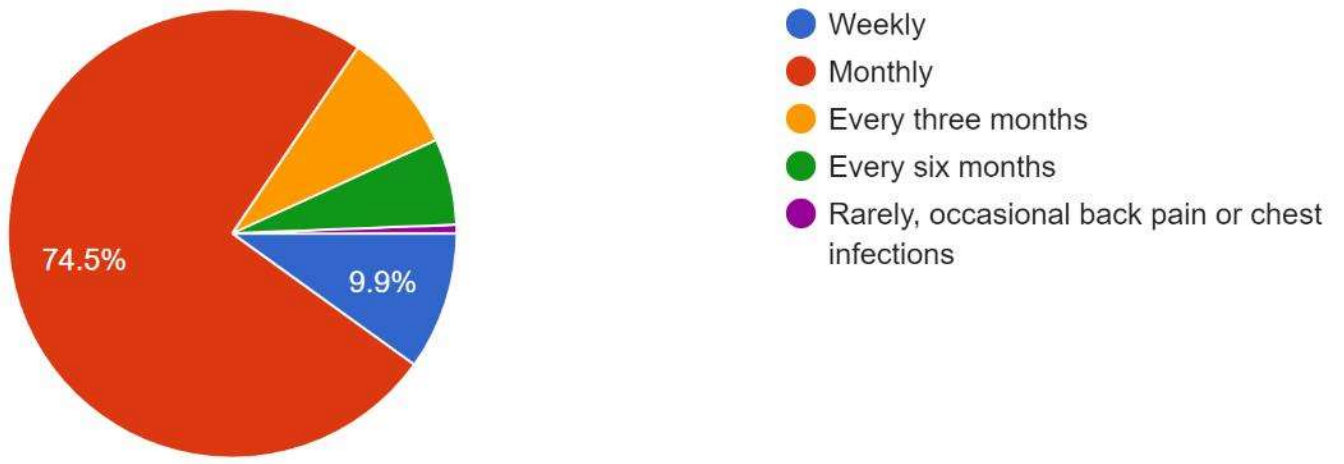
158 responses



We then went on to explore the frequency with which our respondents used their pharmacy. Over 74% of respondent's used the pharmacy on a monthly basis, just under 10% used the pharmacy weekly, 9% every three months and 6% every six months.

2. How often do you use a pharmacy?

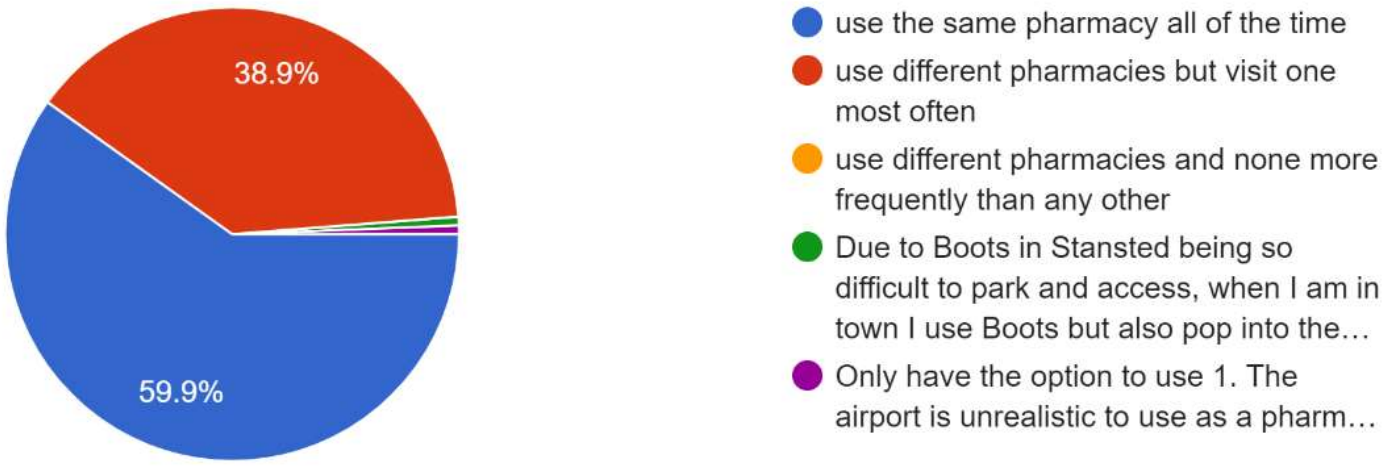
161 responses



In addition, just under 60% used the same pharmacy and 39% used different pharmacies but visited the same one most often.

3. Do you use the same pharmacy or different pharmacies?

162 responses



We then asked respondents for feedback of what works well and what doesn't work well at the community pharmacy they use.

The overwhelming theme of the feedback received was in recognising helpful and friendly staff. Many respondents observed that pharmacy staff were under pressure and very busy, but they still delivered a service that met the customer's needs. Below is a selection of the positive feedback received.

'Helpful, knowledgeable staff.'

'The pharmacy I use most is quite good with some technology. They do send me a text when my prescriptions have been dispensed and are ready for collection. The staff are lovely, and the pharmacists will answer any questions you might have.'

'The pharmacy staff are all qualified and knowledgeable. They are very helpful with one-to-one private consultations. They are often able to diagnose a problem without having to make an appointment to see the GP.'

'My local pharmacy is in our village and is run by an excellent family with the father as the qualified pharmacist. I get a tremendous amount of help from the pharmacist whenever I need it and I have complete trust in my very efficient pharmacist. Apart from prescriptions and medical needs the shop sells many useful articles that are needed by all those in need medical or personal equipment. It is a place of constant requirements and minor medical advice. We couldn't manage without it.'

'Sometimes helpful if they have time. They use text messaging when medications are ready to pick up.'

'Always helpful and professional. Very helpful staff.'

'An excellent source of advice, my prescription is usually ready for me.'

‘The vaccination service has been very good.’

‘I use Boots in Stansted, and although always short staffed, the staff are always friendly and helpful, despite working under great continual pressure. I collect both my monthly prescription and use the store for other items like cold remedies etc.’

‘Getting Flu vaccinations at the pharmacy has worked well.’

‘Convenience, promptness of getting medication and wonderful staff members.’

‘Normally staff are friendly and helpful. Service in the whole is good.’

‘Tesco pharmacy is usually ok.’

‘Staff try to be pleasant. Staff appear to be quite well informed.’

‘Staff are helpful, and until recently were knowledgeable enough to give prompt advice as they knew us. There has been a change of staff recently, so it’s a bit of a learning curve. They are convenient for my husband as he can get there from work (on foot) and collect his medication. If fully staffed the hours are extra to the 9 to 5/5.30.’

‘Accessibility and helpful, friendly staff.’

‘During Covid I had an eye infection and the pharmacy suggested I went to the doctor. I had to be referred to the hospital. I wouldn’t have got it sorted without their advice.’

‘I always get a message when my repeat is ready to pick up. Good service, helpful staff.’

‘It’s good being told when my prescription is ready; no long wait to be served; helpful, knowledgeable staff.’

‘Direct communication between surgery and pharmacy is helpful.’

‘Good service and helpful staff, and also good location.’

‘Fantastic service, efficient, friendly, great staff from Stansted pharmacy.’

‘Great service, efficient and helpful.’

‘Friendly, helpful staff. Accessible and friendly pharmacists. A reasonable range of products to buy. To get advice on healthcare problems that crop up in my family.’

‘Good friendly service usually.’

‘The process works between the GP and pharmacy.’

‘Having a pharmacy next to the GP surgery is ideal, and in easy walking distance so that I can get there whilst working or when unwell. The staff are really helpful.’

‘Fantastic staff who treat you as a human being rather than a number plus very good and quick service.’

‘Helpful staff who always get the prescription correct.’

‘Good service, small queues, helpful and knowledgeable staff.’

‘Helpful staff working under pressure.’

‘The customer service has improved recently at Boots, but it couldn’t have got any worse, plus they text when prescriptions are ready to collect.’

‘Good friendly service.’

‘Very efficient and friendly service for repeat prescriptions.’

‘Friendly, hardworking staff.’

‘Great service at all times and staff are helpful and friendly.’

‘The Boots pharmacy gives good service, once you are being served.’

‘Friendly and professional staff - although overworked and very busy.’

‘It’s my most local pharmacy. It’s very helpful.’

‘The Stansted pharmacy has easy access for my wheelchair, they are friendly and always willing to offer advice.’

‘I use Boots in Stansted. The staff are always very helpful, although overstretched. I order my repeat prescription online with Boots, which works well for me.’

‘Helpful polite staff, short queues, easy access, easy parking.’

‘Fast to dispense.’

‘It is well stocked, and the staff are very friendly and knowledgeable. I have often gone in there for advice.’

‘Good staff but overworked.’

‘Knowledgeable staff, good selection of non-medical goods.’

‘They give good advice.’

‘Staff are polite.’

‘Professional, extremely helpful, knowledgeable, they go beyond expectation.’

‘Staff are usually helpful but often appear under pressure.’

‘The pharmacy is a short distance from where I live, so is easily accessible. They are very organised, and my prescription items are always ready. The staff are warm and friendly. In addition to regular prescriptions, I have been able to book appointments for COVID and Flu jabs which makes it very convenient.’

‘On occasion I have needed to ask the pharmacist' advice on treating ailments e.g., an eye problem, an allergic reaction and they have been both reassuring and competent.’

‘Very helpful, friendly and knowledgeable.’

‘My prescriptions are dispensed and ready for collection.’

‘Very helpful pharmacists.’

We then asked for feedback regarding what doesn't work well at their community pharmacy. Slow service, frustrations with the ordering system, being unable to talk to staff over the phone and some medications not being available were common statements. Below is a selection of the positive feedback received.

'Slow service or goods not available.'

'It can take a time to find my prescription.'

'I would prefer it if the pharmacy could automatically request my regular prescriptions for me from the GP instead of me having to do it each month. A more automated system and communications with the GP would be helpful.'

'It's just a hopeless service.'

'On occasion there is no private space to consult the pharmacist as the small consulting room is being used for medicine storage and boxes of pre-delivered products.'

'I have to get someone to go for me as I cannot wait in long queues for a long time (I cannot stand for long).'

'There is sometimes confusion about managed prescriptions ready for collection; my partner has been turned away several times then I phone, and it is ready.'

'It's very busy, staff are under a lot of pressure and can be very abrupt.'

'I have not been so pleased with the prescription service for the following reasons: -
1. Two pharmacies said they were unable to provide my prescribed medication (saline eye ointment). I thought all pharmacies were meant to source all prescribed medication. Also there was no way of finding a pharmacy that was able to provide the medication without visiting or ringing around.
2. The pharmacy I now get my medication from has their own ordering system, as well as using the NHS app - their own system has a delay of several weeks before processing the prescriptions.
3. I normally order through the NHS app - I was surprised to find recently that the pharmacy has requested my medication on my behalf, without me requesting this. I don't think this is appropriate.'

'It is always busy, and people have to queue. You can easily be queuing outside for 15 minutes and another 15 minutes inside the store. This is not great if you feel unwell or are elderly. It also has a step so mums with pushchairs or elderly with walking difficulties have trouble accessing. The shop is too small, and you can't shop and queue with ease. They often don't have what you need and take too long to dispense. I hate being in the shop too well because you don't know what viruses/infections people have while queuing!'

'The last time I tried to collect a prescription, it took me four visits. The pharmacy was closed during published opening hours, then the surgery had forgotten to send the order, then the surgery sent it to the wrong pharmacy, then I finally found it.'

‘The previous time it took six visits to get what I needed. Between random closures and orders being stuck or sent to the wrong place, it was a very frustrating experience.’

There is always a queue. Often the queue is out of the shop as the shop is so small. The shop is always cluttered with deliveries. The counter is cluttered, and the screens make it impossible to have a confidential conversation. Staff try to be pleasant but can rude when they are under pressure, which they frequently are. There is no predictability in collecting monthly prescriptions, sometimes prescriptions are ready in three days, one time this year it was 17 days and the pharmacists had to issue emergency supplies. There is no nearby parking for my disabled partner, so he is often not able to get his own prescriptions. We had to return one prescription when a container bottle of 30 tablets had had the seal opened and two taken out to meet the 28-tablet prescription. During this procedure the tablets were tainted with a strong spice flavour and made my partner feel sick (and he is a chef).’

‘The pharmacy obviously shop around and obtain the cheapest brand of medication so very often the size, shape and colour of the tablets change from one month to another. I am able to manage this by being really careful when I load my partners pill dockets. How someone with poor eyesight, English as a second language or disability would cope, I dread to imagine.’

‘Prescribed medication is often not available, so you are only given part prescription then upon returning for the rest along with the docket I was given to claim it, I was told I’d already collected it! Awful service and presumably fraudulent.’

‘Our family put in prescriptions every month. They contacted my daughter recently and told her that they were unable to get her regular medication and that she would have to come and collect the prescription and source the items elsewhere. Luckily, she sourced it elsewhere, but the chemist suggested she changed chemists.’

‘Closed at lunch time - why?’

‘The current dispensing pharmacy in Stansted is very busy, small, long queues and often a long wait for prescriptions. Not great when with a child or in a small, enclosed space with people with respiratory illness. Parking is difficult. I have waited over 25 mins for a simple prescription (inhalers) that was called through by the surgery five hours previous.’

‘Always a long queue, limited parking which isn’t conveniently close being 37 weeks pregnant, unable to call them ahead due to how busy they are. Sometimes I feel rushed by staff due to how busy they are in the store.’

‘The staff work in cramped conditions and service is very slow - things always seem disorganised which typically means there is a long queue and unacceptable queuing times - normally 20 minutes is a good outcome.’

‘One of the assistants is VERY quietly spoken. I am slightly hard of hearing and can never hear a word she says.’

‘When you are immuno-suppressed, standing in a queue in a small shop is not great. Then they hardly have whatever you need in stock, so you have to go again on another day to collect it

and stand in the queue. If you wait for a text asking you to come and collect your meds it can take days which is useless if you need antibiotics or pain relief urgently.'

'In December 2022 my prescription was sent to Boots Pharmacy from my GP. I waited about three hours before going to collect. It was very busy. When I got to the front of the queue, I was told it had not yet been downloaded from the computer. It would take at least 15 minutes to make up. Feeling unwell and coughing badly I left it for later. Later I felt worse and did not want to go out in the cold. I picked it up the next morning after queuing for about 30 minutes as the till was down. As I do not pay for my prescriptions and did not need to go through the till then I was again a little annoyed.'

'I was told informed they were dealing with 500 prescriptions and were overrun. I posted my experience on Facebook and there were many instances of people having to wait for an hour or longer.'

'I changed from Boots to Copes Pharmacy for my monthly prescriptions because of issues with not getting the prescriptions correct or not having the correct amount of medicine in stock. These are ongoing problems.'

'When I try and contact Boots Pharmacy by phone it is never answered.'

'They're usually very busy and it takes a while to be served. It sometimes takes days to dispense repeat prescriptions and they don't always have stock.'

'They are aways busy and rushed off their feet! Most of the times not being able to provide me with the correct medicine, as they have run out.

3.2 The Interviews

We followed on from the survey by carrying out a number of one-to-one interviews with members of the public. Some examples are detailed below.

Diana*

Diana uses Yogi Pharmacy in Takeley.

She is very happy with the service; 'they are absolutely wonderful'. They are busy but they go above and beyond. She orders her monthly medication through the NHS app. They will always try to get her medication that doesn't cause any side effects - she has had breast cancer in the past so this is an ongoing concern. They are her first port of call for advice regarding minor ailments.

Laura*

Laura talked about the current pharmacy service in Stansted Mountfitchet: 'We don't understand the response that we get when we find reports that say things like, well, you could always use the one at the airport, or you could travel to Bishops Stortford, etcetera

etcetera. Clearly, the people who are making those decisions have never actually visited the site for the current pharmacy.

My particular concerns are that it is a very, very small shop. That it has stepped access. There's no disabled parking. My partner is disabled and I'm his carer and he's on about twelve medications every day, so he has a big pharmacy requirement. Although he can access the building, it's not easy and if he can't park outside, and his arthritis is particularly bad, then it's not something he can do and he likes to be independent. So, there's no encouragement there for him to do things like that while I'm at work. So, it's a very small shop, and you go in there and there is a single queue for the counter, and ninety percent of people are queuing for prescriptions. That's all they're doing. So, it doesn't function as a chemist shop, and the staff clearly can't cope with running the pharmacy and running the shop. The shelves are constantly empty. The shop is dirty.

When they receive their supplies, there's nowhere for them to store them and they're left on the shop floor in boxes. Often those boxes are open or they're in the sort of crates that products get delivered in, and they're literally just sort of piled up around the counter area. I mean I've taken photos inside the shop because I've been shocked by it. You don't see the pharmacist because they're hidden behind, they're so busy. I have on one occasion spoken to the pharmacist when we had to go in and make a complaint about a dispensing item, and they did come out, and we squeezed our way into a tiny little office at the side for consultations which is about three feet by four feet. I mean it was an absolute joke. They were great, they were absolutely great, but it wasn't easy to speak to the pharmacist and I never feel that I can ask to speak to the pharmacist because I'm in a queue of five or six people. All waiting for their prescriptions and I just feel you know; we're being encouraged to use our pharmacist to discuss minor ailments and I just don't feel we can because they never appear to be not under so much pressure.

The turnaround in terms of getting prescriptions ready is really variable, sometimes it's two days, I think the longest I've ever had to wait was seventeen days, when they were struggling to get particular drugs, luckily, I'd ordered early, but it can be very variable, very variable. I think it's just not big enough and suitable enough for the ever-increasing population of the town, and you know there is now an alternative that could be used with disabled parking, no step access at all, and you know, it would take the burden off and enable both premises to function as pharmacy and a chemist. You know the town is split geographically, and I think there's one side of the town that would use Boots and the other because it suits them, and the other half would use the premise next to the doctors because it would suit them. So, I don't think there's an issue about only one being able to you know, be viable at all. So, I mean they're my main concerns. It's just not fit for purpose.'

Belinda*

'Well, I think that, personally, having been a person that picks up prescriptions for myself and my two sons, for forever kind of thing, and also other people from time to time, there is no set pattern. It really is dependent on what that particular pharmacy does, so one is really different to another. If I go to my closest one, say, which is round the corner, they're quite efficient, they text you when your prescription's come in. But what they don't do is offer a service like Pharmacies For You, where they actually request your medication. They don't do that. But they are good at letting you know that it's in. And then if I go to the other

one, which is in Morrisons, just down the road, they don't ever text you when it's in. You have to just keep going in and asking them, but they do reorder on repeat prescriptions, and they're really nice people as well. So, they're lovely people and they will do anything if you phone them up or you talk to them, but it's a hit-and-miss as to you just have to go in and say, 'Have you got this or have you got that?' kind of thing. So, they vary so much, that's what I think. There's no standard process, is there?

The other thing that I found really difficult was a couple of years ago when my mum died, I had bags of medication that I needed to get rid of, right? And I knew I couldn't put them in bin or anything. It was really strong medication; it was just loads and loads of it. And I went into so many pharmacies and said, 'Would you take this medication and destroy it, or whatever?' And they said, 'No, we don't take it in.' It took me ages to find one that said that they would take it in. So, it should be standard, shouldn't it?'

Rob*

'Until fairly recently I've only had very ad hoc connections with pharmacies and things and for straightforward items just ad hoc basis, it's been absolutely no problem at all. Recently because of an eye condition I've had to have some repeat prescription for items that are not so common, and I've had some more difficulties with that, but I suppose on the plus side, it tested out the system a little bit, which is positive.'

Rob had been prescribed some solution for an eye problem by a consultant at hospital, but the pharmacist wasn't able to source it, so Rob had to contact the consultant to issue another prescription:

'They were very good straight away, said okay, we'll send you a prescription. Again, not on the system and a written prescription, which was put in the post. This was during the recent postal strikes. So, it took three weeks to get it. Now, I'd already run out of the prescription so what I had to do is drive over to Queens just before Christmas, physically pick up a prescription and bring it back and give it into the pharmacy back here again. If it had been an electronically joined up system that the consultant could access, then that would have been much better. Also, there's some confusion between the pharmacy's own system and the NHS app system. And some things you can only do online and somethings you can only do in the NHS system and from what I can see, the pharmacy owned system isn't necessarily looked at very much. So, I put in a prescription with the pharmacies own system that wasn't looked at, I did it with the NHS system and then about four, five weeks later, they turned up on the pharmacy system. I think this is true, you know, not just with prescription side of things, but across the NHS. You know, you've got the GP system, you've got the pharmacy system, you've got the NHS app. Why is there not one system that all areas of the NHS can access?'

3.2 Case studies

In addition to these interviews, we also gathered a number of case studies for additional insight into the lived experiences of the people of the area.

Dawn

‘I suffer from severe osteoporosis and fibromyalgia. I have many different drugs every month to combat nerve pain, depression, gastro issues, vitamins for low levels in blood tests etc. I have to order my prescriptions every month and collect them from the pharmacy. I could really do with them being delivered but haven't asked about that yet. I am regularly in the chemist or various chemists getting my and my son's regular prescriptions. It would be so much better if it was all automated and send out directly to each patient and then if a review was required, the doctor contacts the patient to make an appointment not just stopping the medicine normally prescribed. Another major issue that I have with Pharmacies/GP's is that they won't allow you to order your prescription earlier than the following month when due but every pill package only contains 28 days’ worth of tablets so regularly you need to order earlier and earlier. This is a major issue because GPs don't want to give you the next prescription early and they are forcing patients like me to go short on tablets. What do they think you are going to do with the prescription if it's ordered a bit early. Why can't tablets be in boxes of 31 to coincide with the longest months of the year???? Does anyone know the answer to this?’

Dave

‘I have long-term high blood pressure and my wife suffers with COPD. We are both getting on in years and a trusted local Community Pharmacy is an essential part of our life.’

Amir

‘I collect a prescription for my 91-year-old mum. Sadly, the GP practice is not so efficient in being timely with the prescription, so the pharmacist has to make contact with them directly on my mum's behalf in order she gets her medication in a timely manner.’

Brian

‘I’m a relatively healthy 72-year bloke, sadly widowed a few years ago so live on my own in a village. Completely reliant on having to drive - hence it seems crazy that the nearest fully dispensing chemist is not the one in the same building as my doctor's surgery. This means I either have to drive back a few days later, or if more urgent I have to drive elsewhere. No way am I a 20-minute walk from a chemist, and worse, my doctor's surgery is more than 20 mins walk from a fully licensed pharmacy.’

Annabel

‘My husband has medical needs which are long term and have restricted his modes of transport. I do not yet have these concerns. We live in a thriving community of nearly 10,000 people (which pretty much matches the patient list of the Stansted Surgery), and our community pharmacy needs to be able to meet those needs. If Stansted surgery and Elsenham surgery join together the needs of patients of both practices must be

met. NHS England don't think there is an issue. I am sincerely hoping you can change their mind.'

Steve

'I have multiple sclerosis (diagnosed July 1978). I am 70 years old and live alone. I still drive my car but use my battery buggy for local trips. I worry how I will cope with accessing Boots in the future and wish the pharmacy adjoining the surgery was able to dispense medication as the access is on the level.'

Susan

'My husband and I are in our mid-sixties, and at the moment we are completely fit and well. But looking into the future, and therefore thinking of the less able people in the village, the only licensed pharmacy is up a steep hill, a small car park is still a distance away, the entrance into it has steps so wheelchair access could present a problem, and difficulty for anyone with mobility issues. Considering the growing population of the village it makes sense to have a second licensed pharmacy-next to the surgery, easy access and large car park.'

Bob

'I am semi-disabled, am no longer allowed to drive (due to medical conditions) and rely entirely on my wife either taking me to the chemist or collecting my prescriptions for me. I collect 18 separate prescription medicines every 28 days.'

The final questions in the survey asked for demographic information regarding the respondents:

There were a relatively even number of responses from the older age groups. Of the 162 respondents:

48 were aged 65-74

46 were aged 55-64

20 were aged 35-44

20 were aged 75+

19 were aged 45-54

5 were aged 25-34

3 were aged 18-24

And one person preferred not to give their age.

Overwhelmingly, responses were from females; 120 identified as female, 40 males and two preferred not to say.

143 respondents stated that their gender was not different to the sex they were assigned at birth. Twelve respondents stated their sex was different and two preferred not to answer.

142 people stated their ethnic background was White: British/English/Northern Irish/Scottish/Welsh, ten were White: any other white background, three were White; Irish, one was Asian/Asian British; Indian and six people preferred not to say.

81 respondents stated that they were not carers or considered themselves to have a disability or a long-term condition.

63 considered that they did have a long-term condition.

21 considered they had a disability.

18 considered they were a carer.

One preferred not to say.

3.4 Stansted Mountfitchet

A particularly significant number of respondents to the survey came from residents of Stansted Mountfitchet. They have numerous issues and concerns regarding the community pharmacy provision in their village.

They are extremely frustrated that there is only one NHS dispensing pharmacy in the village which is located at the top of a steep hill with limited parking, no disabled access, long queues (often outside the store), waiting times for prescriptions to be filled, no adequate space for private one to one consultation with a pharmacist if required etc.

The growth of the village over the last 10 years and future housing plans are also a major concern for the residents, they feel that the current provision struggles to meet their needs and can only assume that it will get worse over time as the need increases.

The pharmacy next to the GP surgery is not an NHS dispensing pharmacy so must send prescriptions to their branch in London and then wait for the medication to be sent

back before it can be given to the patient. The Boots pharmacy is the only pharmacy able to dispense same day medication.

I have conducted interviews with numerous residents and members of the parish council.

Below is a summary of their concerns and feedback:

‘Stansted badly needs another dispensing pharmacy. It's a ridiculous waste of resources that the one by the surgery can't dispense, so patients have to walk up the hill, or drive and park again, to get their prescriptions.’

‘The local pharmacy (Boots) is not suitable. Its position in the village is not good.’

‘Boots is too small to deal with the demand of the village, having a second pharmacy supporting the surgery in Stansted would be better.’

‘There are often long queues going outside of the Boots pharmacy meaning you have to queue in the cold/rain. I would use the pharmacy more but it’s so busy I feel bad asking for help on non-urgent health matters.’

‘I have to visit a pharmacy out of area as the one dispensing pharmacy in our village is useless; they don’t answer the phone, are rude, keep you waiting, and you can’t wait in the pharmacy. Stansted needs another pharmacy.’

‘We have stopped using our local Boots in Stansted as we have found them to be inefficient, at times unfriendly and unhelpful. It seems unable to deal with the demands placed on it by the growing population in Stansted.’

‘The pharmacy is closed at weekends and can't dispense on the same day as they have to send it off. We need another pharmacy in Stansted as Boots can't cope with the volume. There is always a long wait at Boots.’

‘Copes cannot dispense a prescription on the same day as prescribed and so this does not work for me when I need a prescription on 'the day'. I then have to go to Boots Pharmacy in Stansted which means going out twice when I feel ill. Boots Pharmacy is overloaded with work.’

‘On the occasions that I have had a prescription given due to illness, I have not been able to walk to Boots as it is too far from my home to access when unwell. Sadly, Copes has not been given a dispensing license, so cannot give an immediate prescription. This situation needs to be changed as it adversely affects the health of those people who are not close to Boots. When I have been obliged to use Boots, the wait is very long for prescriptions as they are being asked to complete more than they can handle.’

‘Staff are taking time to serve customers as they are very busy. We need to have another pharmacy for prescriptions - why not the chemist next door to surgery?’

‘I have an issue with not being able to receive medicine from a prescription the same day from the pharmacy next to the surgery as it doesn’t have a license to prescribe itself but has to send the prescription to another pharmacy in London. If I want the medicine urgently, I have to walk up the hill to Boots and join the queue. Even then it often means I have to return later as they are extremely busy and just can’t cope with the number of prescriptions. The staff can be rude and unhelpful there as they are so stressed.’

‘If the weather's good, or I fancy an uphill walk I will walk to the pharmacy - otherwise I have to drive and try and park on the main road - my husband uses the pharmacy next to the doctor’s surgery which is more convenient, but they are not a 'dispensing in store' pharmacy - only ordered medications. They are much easier for us to access.’

‘Boots in Stansted are understaffed, have variable opening times and are often overrun or out of stock. They are too small and have inadequate parking provision.’

‘Copes not being able to dispense immediately is a problem, as apparently you think one dispensing pharmacy in the village is sufficient, or that we should drive to the airport and somehow get airside to use a pharmacy there.’

‘Boots is not as close geographically so harder to get to if ill. It doesn’t always have medication so there is no other option. It often has large queues and is very small so holds limited stock.’

‘Boots is too small, the parking is difficult, it is too often closed due to staff shortage, there is a delay on issuing prescriptions, and they are understaffed.’

‘Boots has no convenient car park, only very limited street parking. The service is slow resulting in queues and staff often abrupt. It is at the top of Chapel Hill which is impossible to walk up from the shops, station or car park for most people, especially for the elderly, people with pushchairs and prams and those with health conditions. I am in my late 70's and have grandchildren. The biggest drawback of Stansted Pharmacy is not being able to dispense medicines as it can take time to get prescriptions delivered to them from their supplier and not opening on Saturdays as a result delays the time when customers can collect.’

‘The pharmacy (Copes) is adjacent to the town central carpark and for physically challenged people this is a very great help as the other town pharmacy is a considerable walk away up a very steep hill. The staff are helpful but as medicines have to be sent from their London based branch, delivery can be delayed and therefore a fully licenced pharmacy would be much more convenient.’

‘I have no complaints, the only point I would raise is that the shop is not easily accessible for people with disabilities. The doorstep is quite high and there is no ramp. The shop is also geographically a distance from the village health centre, up a very

steep hill, making it difficult for people who live at the bottom end of the village to get to the chemist.'

'There are different staff every time I visit. No disabled access. The premises are too small, with bad working conditions.'

'The Boots chemist has no wheelchair access. I'm left sitting in all weathers just waiting for someone to notice me from outside.'

'Boots in Stansted is always busy, has long waits and is not very efficient, staff can be abrupt and unhelpful, it's also a distance from the doctor's surgery. It's really annoying as there is a lovely chemist right next door to the doctors but hasn't a licence for prescriptions, Boots seem to have the monopoly!'

'Stansted's only pharmacy is always really busy with a long queue. Staff seem overburdened with their jobs, so service is slow. The step into the shop is very awkward and when my son was in a wheelchair he couldn't get in without great difficulty.'

'Boots Chemist in Stansted Mountfitchet is approximately 0.5 miles away from the GP Surgery, up a steep hill, which makes it difficult to walk to when you're unwell. I try to avoid using the car, because the pharmacy is competing with Tesco Express and other businesses for very limited parking space. Opening hours used to be restricted for a long time due to staff shortages and I went in vain on at least one occasion, although that appears to have been rectified. There are frequent queues, including people waiting outside the pharmacy. Inside the pharmacy it looks dated, tired, and is quite small. Service can be very slow.'

'My local pharmacy is Boots / Stansted. I have often had to queue many times, and would rather a pharmacy closer to the surgery, where I would have just visited and collected the prescription.'

'Long waits and poor parking are the norm. Boots is not in close proximity to the doctor's surgery meaning you need to drive between the surgery and the pharmacy and repark which is a pain as parking is scarce.'

'I use Copes pharmacy beneath Stansted surgery as they never have queues, and the staff are polite and helpful unlike Boots which is always busy, and staff overstretched.'

'This is the only pharmacy in the village with a dispensing licence; despite there being another unlicensed pharmacy adjacent to our surgery. This pharmacy is clearly under a high degree of pressure due to the high demand being placed on it for prescription provision. It is I feel, an unsustainable situation. They don't do dosset boxes or deliver to customers. I tend to place orders online or attend Boots in other locations, if I need a better choice of non-prescription products.'

‘Boots pharmacy is inadequate for the size of the village. A second pharmacy at the other end of the village is badly needed.’

‘With only one pharmacy in walking distance that can fill a prescription it means they are constantly too busy and takes ages. Typically, it means we need to then drive to other locations to get faster service.’

‘Very helpful staff: they have a welcoming environment, easy for all to access, close to the GP practice. The only drawback is that they don’t have a dispensing licence so one had to wait 24 hours or longer for a prescription to be fulfilled. Boots is the alternative; a steep, uphill walk - great if you’re infirm or feeling unwell - small, unwelcoming premises: transient staff battling to stem the tide of irate customers who have to wait queuing for unacceptable times.’

‘Copes Pharmacy is unable to dispense medicine, meaning a delay when I get a new prescription. This was a huge problem when I was offered painkillers after a recent injury as I had to get up the hill to Boots. This caused me considerable pain that could have been avoided by Copes having a dispensing license.’

‘Boots Pharmacy in Stansted is abysmal, it’s hit and miss, they can’t locate prescriptions, huge queues in a tiny shop, so we have to queue outside in all weathers.’

‘They are hard to get hold of on the phone and hard to visit in person as I live in a rural area. There are huge queues for the pharmacy (e.g., in Boots) and long waits for dispensed medications (again, e.g., Boots).’

‘Having a pharmacy at the top of a hill when the doctor's surgery at the bottom is not helpful. The hill is difficult when one is feeling healthy but if needing a prescription after a surgery visit then usually not feeling good.’

‘I have lived in Stansted for 25 years and have seen it grow enormously. Unfortunately, Boots is unable to keep up with the demand of such a large population, so a second chemist with a dispensing license is vital. The airport is not a viable option, as anybody with local knowledge would know.’

‘The fact that Boots is the only licensed pharmacy in Stansted Mountfitchet Village. The people who make the licensing decisions need to listen to the people who live in the village and need to use the pharmacy services.’

Many residents of Stansted Mountfitchet also offered one to one interviews. Below is a summary of these.

Ray:

Ray has a long history of campaigning for a second licensed pharmacy in Stansted. He explained that the village is rapidly expanding, and the current Boots store is unable to cope; it is an unsuitable building, with no disabled access, a very small private room, lack of staff, poor parking nearby, and is at the top of a very steep hill.

The other pharmacy in the village is next door to the GP surgery but is not a dispensing pharmacy, so Boots is the only option or travelling outside of the village.

Ray is unhappy with the recent PNA and the survey that went with it, stating that people found it difficult to complete.

He has had lots of involvement with the local MP and parish council to garner support for the pharmacy next to the GP surgery to be given the ability to dispense prescriptions directly.

John:

The Boots pharmacy in the village has no parking, no step free access, and is always very busy with long queues.

The growing population is a real concern as the infrastructure is not in place to support it.

He feels very strongly about the situation.

He found the PNA survey to be very long and complicated.

Joerg:

The Boots pharmacy is up a steep hill, has low staff numbers, the building looks tired, and it doesn't meet the needs of the community. Parking issues affect many residents and there is no disabled access.

Joerg feels that the staff can give a good service but are very slow due to the level of demand they have to cope with.

The other pharmacy can offer more services, is bigger, has better parking and is next door to the GP surgery. It would make sense for them to be able to provide prescriptions directly, rather than having to send them to their London store to be processed and then back to Stansted Mountfitchet, which is the current arrangement.

He also feels that the general prescription system is very long winded.

Ashley:

It is frustrating having to use Boots as it is always packed. The queues have not improved but the staff have recently-they are good.

He states that you have to wait 48 hours to collect from the pharmacy next to the GP due to them not being able to dispense straight away.

He has monthly medication which he orders on the NHS app. He has been using for this for six months with no issues.

Chris:

Had an incident at Boots where she was given the wrong strength of medication so will not use them anymore. She instead travels to use a pharmacy in Bishops Stortford, who she reports give a 'super service'. They request her medication then text her when it is ready to collect.

Michael:

Uses Pharmacy 4 You as they deliver medication direct to your home. Boots is at the top of a steep hill and always has a large queue so isn't practical for a lot of people.

Rachel:

Suffers from undiagnosed mobility issues and is currently in a lot of pain. She is unable to walk up the hill to the Boots store. She uses the pharmacy next to the GP surgery for repeat prescriptions and is happy with the service. She feels that due to Boots being so busy, their relationship with the residents of the town is suffering. She cannot understand why residents would be expected to travel to the airport to use the pharmacy there. The cost of parking is very expensive, and the store is airside so after security, therefore you can't access it without a plane ticket.

As the response from Stansted Mountfitchet was so significant, we approached the parish council for their viewpoint.

Interview with members of the parish council:

'Well, this parish council has supported the community to lobby for a second licensed pharmacy. Primarily because we've got a brand-new state-of-the-art GP surgery in the south of the village. Actually, it's a town, but people like it to be called a village. So, in the south, and an unlicensed pharmacy sits next door to it. The license for the person who runs that is in London. So, you can get your prescriptions made up, but you wait 48 hours. So, if you want an antibiotic today, you can't get it from there. The village is divided in two by a steep hill. We do have a very small pharmacy on the top access road at the top of the hill run by birds. There is no disabled access into that pharmacy. And there are double yellow lines along the majority of the road. You can park outside, but then you've got two steps up onto the pavement and then you've got to ask for assistance to get in up over the step to the pharmacy. They are very often short-staffed. They very often work limited hours, and the village is growing. We've got a new development for 350 houses proposed as we speak. We are approximately 10,000, population.

We have a railway station, again, in the south of the village, not far from the farm from the GP surgery. And that station serves Elsenham, Henham, Manuden, various locations to the north of the village, as well as we are so close to Bishop Stopford. People come here to get on the train before it stops in Bishop Stopford. They will want to use a pharmacy as well. Some of them, in fact over, I think it was over 2,000, wasn't it? Use the GP surgery as well. Because there's a new development on the edge of Bishop Stopford, which really, you know, we're now the meat in the sandwich between Newport and Bishop Stopford. So currently our GP surgery is also supporting the Elsenham surgery. Elsenham do have the ability to dispense for people who attend the surgery who live in Elsenham. But quite a number of Elsenham patients also use our surgery, so it's split. So basically, the demand on services is growing and growing. In

Covid Boots didn't deliver, they can't do deliveries or won't do deliveries or whatever, but they didn't do any deliveries. And in the current situation where you can't see a doctor, you know, you go to a pharmacist or you're recommended, certainly at the moment, to go to a pharmacist. Well, they're so busy up there that they can't cope basically. And that's no criticism of them, that's just how it is. If we had a second dispensing pharmacy then, you know, as the village is growing, it would help. And I can prove, and I've sent when they did the PNA to say that there will be enough work for everybody to make a living. We don't want to lose one, we want two. But people are very, very reluctant to do anything about this situation and I can't understand why. Our MP is supportive. Our county councillor is supportive. Our district councillors from here are supportive. As for district council, I haven't got a clue to be absolutely honest, and I don't mind you repeating that word for word. Not a Scooby Doo. They didn't know that the PNA was going to start, we told them.

When the PNA came out, it was over the Christmas period, so we asked for an extension to that because no one was going to fill it in over Christmas. So, we did get an extension on that. But Dipti Patel, who is the lead or was the lead in Essex, continually explains to us, although she doesn't need to, that they are not the deciding body on the registration for a second pharmacy. We understand that, but the way in which the PNA was constructed and the questions that were asked, there was no way they were going to change their minds. Already made up. Is that they haven't considered any of the representations that we've made. I think Dipti has taken it as a personal issue, that we are creating these waves. Well, I'm sorry, but we have to represent what our community wants.'

Healthwatch Essex visit to Stansted Mountfitchet:

On Friday 27th January 2023 I visited Stansted Mountfitchet and was shown around the town and the current pharmacy services by some of the local residents who have been campaigning for a second licenced pharmacy for some time now. I was shown the GP surgery, both pharmacies and the geographical nature of the town.

I was first shown the pharmacy directly next to the GP surgery. This is a large unit with easy access for disabled customers, ample parking next to the building, various consulting rooms and various other services. They also provide blister/dosett packs of medication for customers and free delivery (Boots no longer provides blister/dosett packs). One member of staff explained that the delivery service wasn't just about dropping off medication to a customer but the importance of face-to-face contact and checking their general wellbeing.

I also took the opportunity to walk up the hill to the Boots pharmacy at the top of the town. The hill is long and steep. I can fully understand that anyone with mobility issues, a wheelchair user, respiratory conditions, young children etc would find walking up that hill a difficult or an impossible task depending on their situation. At the top of

the hill is the Boots store, the road is very busy and the on-street parking at the front of the store is first come first served so a space is not always available. There are also three kerbs to get up from the road to the pavement. The store itself has a substantial step at the front door so makes it inaccessible for wheelchair users. I could see the button outside the front door for anyone unable to access the store to push and I understand a member of staff will attend to them. it is not however an acceptable option for a disabled person to have wait outside in possible poor weather conditions for assistance.

I then had a short tour of the town and surrounding area. The town is spread out over a varied terrain and geographical area with various housing developments over the recent years and planning permission being sort for more. Many residents already feel that the current service that Boots provide is unable to cope and they have concerns that this will only deteriorate in the future as demand increases.

Any suggestion that residents can use the pharmacy at Stansted airport is not a viable one as the pharmacy is situated airside which means that it is beyond security and cannot be accessed without a boarding pass.

Having visited the area and listening to the feedback from many residents, it is clear that the community here feel a great deal of frustration that the current situation causes and that this is reinforced by the logistical factors of the pharmacy provision.

Recommendations

Healthwatch Essex recognises some of the difficulties that the ICB will have regarding pharmacies as they do not have any control over NHS England contracts or how private companies manage their businesses. However, there are a number of actions that we recommend which could assist with developing a positive relationship between pharmacies and their customers and develop the pharmacist's role in primary care.

- Promoting the use of the NHS app to order repeat prescriptions.
- Promoting the services that pharmacists can offer outside of medication and prescriptions.
- Offering training sessions to pharmacy staff to develop customer service skills and recognising that certain customers may need extra assistance, e.g., those with dementia, neurodiversity, deaf/blind, disabled etc.
- Supporting communities to ensure future services meet the needs of the expanding population.
- Increasing awareness and accessibility of pharmacy services to difficult to reach residents-the travelling community, older people, carers, neurodiverse etc.

'The entire system – from frontline staff to policymakers to NHS leaders – must show more imagination of what pharmacy can do. Pharmacies provide a vast network of healthcare

professionals across local communities, connecting with hard-to-reach communities and vulnerable groups. Pharmacies act as a safety net, addressing health inequalities, driving improvements in early disease detection, promoting self-care, alleviating pressures in primary and urgent care, and leading public health initiatives. We cannot put too high a value on this.' (All-Party Pharmacy Group "The Future of Pharmacy Manifesto" report - 23 January 2023)

4.0 Conclusion

Our engagement with the residents of west Essex focussed on the request of feedback and lived experience regarding their use of community pharmacies and garnered in excess of 160 responses. Most respondents used the pharmacy once a month to collect medication for long term conditions. Whilst a number of individuals are generally satisfied with the service provided by their community pharmacy, many took the opportunity to express their concerns and dissatisfaction around a number of issues. The issues raised mainly centred around the waiting time for prescriptions to be filled, unable to contact pharmacies by telephone and feeling that staff were too busy to ask for advice.

Residents want to feel able to ask their local pharmacists for advice when required. It is important for them to be able to build a relationship with that provider and have trust and confidence with the service they deliver. There were some difficulties pointed out regarding use of NHS apps to reorder medication and how that links up electronically with the different systems that pharmacies use. Some respondents had concerns that their medication was being requested by the pharmacists from the GP surgery without their knowledge.

The residents of Stansted Mountfitchet are not satisfied with their current community pharmacy provision and have concerns that it will not be able to meet the future needs of their population. The community here is clearly mobilised to address this issue and to represent the needs of its members, which a significant proportion do not feel are being adequately met currently. There is certainly work to be done in communicating with the residents here and achieving the best possible outcome.

healthwatch Hertfordshire

Accessing GP Services: Views from Hertfordshire's Parents and Carers

Engagement: August – October 2022

Published: March 2023

Contents

About Healthwatch Hertfordshire

Healthwatch Hertfordshire represents the views of people in Hertfordshire on health and social care services. We provide an independent consumer voice evidencing patient and public experiences and gathering local intelligence to influence service improvement across the county. We work with those who commission, deliver and regulate health and social care services to ensure the people's voice is heard and to address gaps in service quality and/or provision.

About the Hertfordshire and West Essex Integrated Care System (ICS)

The Hertfordshire and West Essex Integrated Care System (ICS) was established as a statutory body on 1st July 2022. Integrated Care Systems are geographically based partnerships that bring together providers and commissioners of NHS services with local authorities and other local partners to plan, coordinate and commission health and care services[1]. The Hertfordshire and West Essex ICS is made up of two key bodies – an Integrated Care Board (ICB) and Integrated Care Partnership (ICP).

Integrated Care Board (ICB)

The Integrated Care Board (ICB) is an NHS organisation responsible for planning and overseeing how NHS money is spent across Hertfordshire and West Essex, with the aim of joining up health and care services, improving health and wellbeing and reducing health inequalities. The board of the ICB includes representations from NHS trusts, primary care and from Hertfordshire County Council and Essex County Council[2].

This report will be sent to the Hertfordshire and West Essex ICB Primary Care Board to inform how it can further support GP services.

Integrated Care Partnership (ICP)

The Integrated Care Partnership (ICP) is made up of representatives from different organisations involved in health and care. This includes NHS organisations, local authorities and the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector. The partnership is responsible for developing an Integrated Care Strategy which will set out the priorities for Hertfordshire and West Essex for the next 10-20 years[3].

[1] Integrated care systems: how will they work under the Health and Care Act? | The King's Fund (kingsfund.org.uk)
[2] Health and wellbeing decisions – Hertfordshire and West Essex Integrated Care System (hertsandwestessexics.org.uk)
[3] Health and wellbeing decisions – Hertfordshire and West Essex Integrated Care System (hertsandwestessexics.org.uk)

Hearing Patient Views about Primary Care in Hertfordshire and West Essex

Healthwatch Hertfordshire and Healthwatch Essex have been commissioned by the Hertfordshire and West Essex Integrated Care Board (ICB) Primary Care Workstream to undertake a series of engagement projects. The aims of the engagement projects include:

- Gathering lived experiences to feed directly into the Hertfordshire and West Essex ICS Primary Care Workstream
- Supporting and enabling the Hertfordshire and West Essex ICS to achieve wider participant engagement
- Engaging patients and the public on programmes covering key priorities and areas of importance at a regional and local level
- Making recommendations to the Hertfordshire and West Essex ICS Primary Care Workstream so improvements can be implemented

Using patient and public feedback, each engagement project will focus on improving the relevant service(s) within different areas of primary care by making recommendations to the Hertfordshire and West Essex ICB Primary Care Board.

From August to November 2022 the Director of Primary Care Transformation at the ICB has requested Healthwatch Hertfordshire and Healthwatch Essex to explore access to GP services with a specific focus on engaging with:

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

Reasons for exploring access to GP services, as well as parents, carers and children and young people are outlined below.

Please note a separate report has been published which outlines the findings from our engagement with residents living in the Borough of Broxbourne. This report can be found on our website.

Background

National Context

Before the Covid-19 pandemic, GP practices across the county were facing significant and growing strain, with increasing staff shortages and workloads, rising patient demand and struggles recruiting and retaining staff. This started to have a negative impact, with patients finding it increasingly difficult to access their GP practice – whether this be for an appointment, information and advice, or general support. Patients were also seeing a reduction in choice when making an appointment, with many not able to choose the location, time or date of their

appointment, the type of appointment they received, and changes to which healthcare professional they could see or speak to.

The Covid-19 pandemic only worsened these existing pressures and even now as we learn to live with Covid-19, GP practices are still facing increased workloads and higher consultation rates than ever before. As a result, patients are struggling even more to access their GP practice or to get an appointment, and patient choice is further restricted.

The pandemic also necessitated new ways of working, including a rapid uptake of digital technology and services to deliver care, for example through the use of remote consultations and online booking systems. Although this has provided a number of benefits, patients had concerns that face to face appointments in particular would be replaced with online or remote alternatives.

This decline in patient satisfaction with GP services is reflected in the results of the national GP Patient Survey (2022)[4] which highlights a significant decrease in the number of people stating that they had a good experience when accessing GP services, with many noting a lack of choice, availability in appointments, and increased difficulty getting through to their GP practice. Particularly concerning is the rise in the number of people who are avoiding accessing their GP practice despite needing care. This could have a significant impact on people's long-term health and could lead to an increase in demand elsewhere in the NHS, such as in A&E, evidence of which we can already see.

The following is reflected within the recent Fuller Stocktake report published in May 2022, which also outlines the opportunities Integrated Care Systems have for integrating primary care and improving the access, experiences and outcomes for communities[5].

Local Context

Parents, Carers and Children and Young People

Although we are aware of the problems adults tend to face when accessing their GP practice for themselves, we often do not hear about their experiences when trying to get support from the GP practice for their child or the young person they care for.

It is important to hear the lived experience of parents and carers and whether they can access the GP practice with ease and confidence for their child or the young person they care for. This is particularly important as children cannot always communicate their symptoms or health needs. The need of a clinical examination in these cases is particularly important for avoiding and preventing ill health in children and young people.

[4] GP Patient Survey 2022 results - GOV.UK (www.gov.uk)
[5] Microsoft Word - FINAL 003 250522 - Fuller report[46].docx (england.nhs.uk)

Both nationally and locally, stakeholders often do not hear from children and young people about their experiences of accessing their GP practice and whether their experiences differ from those of adults. With many children and young people able to call, visit or use online s GP services without needing consent, it is important to understand what support is needed to ensure this process is as accessible as possible.

Aims

The aims of this engagement project included:

- Identifying the barriers parents, carers and children and young people encounter when accessing GP services
- Understanding the challenges parents, carers and children and young people face when making an appointment with their GP practice
- Exploring the factors preventing parents, carers and children and young people, despite needing care, from accessing GP services
- Understanding how the use of technology is being used by parents, carers and children and young people and whether this is hindering or supporting access to GP services
- Making recommendations to the Hertfordshire and West Essex ICS Primary Care Workstream with the aim of ensuring greater ease and confidence when accessing GP services

Methodology

To explore the above aims, Healthwatch Hertfordshire created two online surveys. One survey was for parents and carers who have a child or care for someone under the age of 18, and the other was at aimed children and young people aged between 13 and 18 years old. Participants had the option to request the survey in an alternative format and/or contact us for support.

Although there was the option to request the surveys in an alternative format, all respondents completed the survey online. This indicates that all of the respondents not only have access to online technology, but also feel competent using it. We would recommend that the ICB looks to engage with those who do not have digital access to ensure their experiences and views are heard.

This age bracket was chosen as children and young people within this age range are more inclined to contact their GP practice independently without needing consent. From the age of 13, children and young people are also able to consent and participate in research without requiring supervision.

The engagement period for both surveys ran from 15th August to 17th October 2022. The surveys were promoted via social media and shared with the NHS and other statutory services and the , voluntary, community, faith and social enterprise sector across Hertfordshire to share and distribute via their networks, contacts and social media channels.

Key findings: Views and Experiences of Parents, Carers and Children and Young People

Demographics and Context

In total 231 parents and carers shared their views and experiences with us[6]. 70% were aged between 25 and 44 years old and 29% were aged between 45 and 64 years old. One respondent was aged over 65. 93% of respondents were female and 5% were male.

Over a quarter (28%) of respondents were from ethnically diverse communities, with 70% of a White British background[7].

33% of respondents identified as a carer, 6% considered themselves to have a disability and 9% considered themselves to have a long-term condition.

Parents and carers shared which GP practice their child or the young person they care for is registered with. The full list of GP practices can be found in the appendix.

It is important to note that we acknowledge the significant challenges faced by GP practices and the findings highlight good practice as well as areas for potential improvement.

Making an Appointment

The majority of parents and carers had a recent experience of trying to get an appointment with the GP practice for their child or the young person they care for, with 79% having tried to do so in the last six months.

Before trying to make an appointment for their child or the young person they care for, 49% looked for information and advice elsewhere. Common routes included searching for information online, the NHS website, NHS 111 and the local pharmacy.

When trying to make an appointment for their child or the young person they care for, 83% called the GP practice, with only 10% using online services and 4% visiting the GP practice in person. Most parents and carers had problems when trying to make an appointment, particularly those who had tried to contact by telephone, with many respondents having to wait in the telephone queue or on hold for over an hour before speaking to a receptionist.

"Took about 2 hours waiting on hold to get through."

"Had to dial 48 times before getting through to the long winded message saying to call back another time because they are experiencing high volumes of calls (this message is always on). Eventually I got through where I had to wait even longer before talking to a receptionist."

[6] Percentages do not always add up to 100% due to some respondents choosing not to share demographic data with us.
[7] Ethnicities included: Indian, Pakistani, Chinese, Bangladeshi, Arab, Asian and White, Black African, Black Caribbean, Black Caribbean and White, White Irish, other White backgrounds, and ethnicities not listed as options.

"I had a one and a half hour wait in the queue on the phone."

"It's crazy you either can't get through at all and when you do wait for anything it's at least 30 minutes. Last time it took 27 calls to get through in the morning."

Some respondents found it difficult to contact the GP practice due to their own work or caring responsibilities preventing them from being able to call for an appointment at the typical morning slot. Parents and carers also shared that it can be hard to get an appointment for their child or the young person they care for due to opening times for appointments being during school hours.

"I phoned at exactly 8:30am and was on hold for 45 minutes before being told that all appointments had been allocated for the day and that I would need to call back the following day. I work in a school and had to take 45 minutes off to call without success."

"I have to arrange care for my son so I can be at the surgery for 8:00am to queue for an appointment for him. It's easier than phoning from 8:00am as it usually takes forever to get through and then they have no appointments left for that day."

"Telephone waiting times are ludicrous. As the main carer I haven't got time for this."

"There is no appreciation of the difficulty of phoning at 8:30am when parents are either at work or on the school run."

Other parents and carers tried to contact the GP practice for an appointment but were immediately told that no appointments were available for their child or the young person they care for, even if the parent or carer was looking to book an appointment weeks in advance.

"I can never get through to my surgery and when I do they always say there are no appointments even though I've called first thing in the morning. They always tell me they have 80,000 patients and it's luck."

"No appointments available that day as lack of doctors on site. No way of booking an appointment in advance either."

"Recorded message said there were no appointments that day. I called when the appointment line first opened."

As a result, some parents and carers felt they had no choice but to contact NHS 111 or to take their child or the young person they care for to A&E to receive medical attention.

"It's almost impossible to get a GP appointment. I have repeatedly had to take my son to A&E as there is no viable option. It's appalling."

"On one occasion I couldn't get an appointment so we ended up at A&E."

"Couldn't get through. Tried for 3-4 days and ended up going through 111."

However, other parents and carers had a positive experience when trying to make an appointment for their child or the young person they care for. This was often because they had used an online booking system such as eConsult and received a timely response. A few respondents noted that the GP practice had improved its telephone system meaning it was now much easier to get through to a receptionist.

"There was always a long queue on hold but this has now changed with the installation of a new phone system."

"The new call back service is helpful as you don't have to wait on hold in the queue."

"For my 2 year old I am able to use their online consult system and that works very well."

Choice in Appointments

For the parents and carers who were given an appointment for their child or the young person they care for by the GP practice, 51% were not offered any choice when making the appointment.

Type of Appointment

Only 16% of parents and carers could choose the type of appointment their child or the young person they care for was given – whether this be a phone call, video call or face to face. A large number of parents and carers felt their child or the young person they care for needed a face to face appointment because of their age and/or the symptoms they were displaying. Despite raising their concerns, their request was denied and a telephone appointment was given instead which parents and carers felt was inappropriate and unacceptable.

"My daughter had a rash. We were asked to upload images and a phone appointment was made in which the doctor said it's hard to tell from a photo. Waste of everyone's time and this is a 4 year old!"

"The issue was one with his stomach and we were offered a telephone appointment which meant no one could actually feel or see his stomach and ascertain why he was in pain."

"I had to do a phone call first even though they couldn't listen to his lungs over the phone!"

"I wasn't given a choice. Just told a doctor would call me back for an assessment. As I was calling about a rash and temperature on my child I didn't feel a telephone appointment would be helpful."

One parent shared that they contacted their GP practice because their baby was having breathing difficulties. However, they were only given a telephone appointment in which the GP simply advised them to keep their baby in the same room. The parent was very upset with this response and felt unsupported by their GP practice.

"My son was denied face to face when he presented with breathing issues, despite having history of breathing issues due to being premature which was mentioned to the GP. The GP would only discuss over the phone and prescribed an inhaler and advised that I put him in a pram and in the room with me whilst I had a shower."

Having the option to choose a face to face appointment rather than a remote or online consultation was particularly important to parents and carers caring for a child or young person with complex needs.

One parent was not offered a home visit by the GP practice even though their child is on a ventilator and was showing clear signs of deterioration.

"He is currently on a ventilator fighting for his life and no doctor felt it was serious enough to be seen."

Another parent whose child has complex needs was also not given a face to face appointment, despite explaining that their child is non-verbal and cannot communicate their symptoms or health needs.

"My son is autistic, non-verbal and has cerebral palsy. Despite me giving this information to the receptionist and the doctor I was only given a video call. This isn't acceptable for a child who cannot communicate what he is feeling or what is wrong. Absolutely disgusting service from my GP. It's not the first time this has happened with my son either."

In some cases, not receiving a face to face appointment led to the child or the young person being misdiagnosed and/or receiving inappropriate treatment for their condition or symptoms. A few parents even had to take their child or the young person they care for to A&E in order to get the care and support they needed. Parents and carers noted that this could have been avoided if their concerns were listened to and if a face to face appointment was initially offered.

"My child needed a face to face meeting but weekend telephone appointments with locums were the only option and this delayed diagnosis by several months."

"We were only offered a telephone appointment despite my request for a face to face. My child was therefore not examined thoroughly and ultimately ended up requiring emergency treatment in A&E due to lack of intervention by the GP."

"I was given a phone call where I was simply told he had a 'virus' and he'd be fine. Gut instinct and previous experience told me he definitely has a chest infection. I had to fight to convince the GP to see my child face to face. Shock horror he has a severe chest infection and needed antibiotics. It seems phone appointments are the default option at the surgery now and only after that can you possibly get a face to face."

"Last 3 appointments were via call to get antibiotics for his chest infection. Although I am experienced I am not qualified to make a diagnosis. We ended up in A&E which could have been avoided."

Choice of Healthcare Professional

Just 5% of parents and carers were able to choose which healthcare professional their child or the young person they care for could see. For some, seeing the same healthcare professional and receiving continuity of care was vital for ensuring their child or the young person they care for felt comfortable and did not have to repeat their story. This was particularly important to parents and carers caring for a child or young person with a learning disability or complex needs.

"My daughter has a learning disability so it is really important that she sees the same doctor who she trusts."

"I could not have a face to face and not given the opportunity to see her own GP who knows her complexities."

"My child has complex needs so we needed to see his allocated GP."

Choice of Time and Date

23% of parents and carers could choose the time or date of the appointment offered to their child or the young person they care for. For some parents and carers, having this choice was essential due to their own work or caring responsibilities, or for meeting the needs of their child or the young person they care for.

"You pretty much have to accept the appointment you're offered. Despite telling them I'm a carer and he's disabled it never seems to be taken into account. It's what appointment they have or nothing."

"Telephone appointments at any time in the morning or afternoon are not helpful for people trying to work, especially when it immediately needs a face to face appointment which was obvious from the beginning."

Similarly, some parents and carers were told that their child or the young person they care for would have to wait up to five weeks for an appointment. Parents and carers were frustrated with this delay and felt their child or the young person they care for needed an appointment much sooner than what was offered.

"Three weeks waiting time for an appointment for a child is too long."

"I could only get a phone call or wait five weeks for a face to face appointment for her."

One parent even made the decision to access a private GP to get an appointment for their child after struggling to get an appointment with their own GP practice within a reasonable timeframe.

"I was extremely dissatisfied. I had to wait a day to be triaged and then waited for at least another week to get an appointment. This was one of a few examples where my children did not get a proper NHS service. We had to go private as a result."

Lack of Appointments

13% of parents and carers were not offered an appointment for their child or the young person they care for when they contacted the GP practice. For most respondents, they were not given an appointment simply because there were none available, even if they were looking to book in advance.

"My daughter needed a routine check up for her condition. I was looking for a couple of weeks time and even then I was told there were none."

"Couldn't get an appointment and I was on hold for nearly an hour to then be told there are no appointments available."

However, some respondents were denied an appointment or signposted elsewhere by the GP practice. This was despite the parent or carer telling the GP practice that their child or the young person they care for was displaying symptoms which they felt required medical attention.

"No appointments available and no way to talk to anyone."

"They told me to take him out of hours as they were busy."

"Even though it is on his medical records from the hospital that he has to be seen by a doctor straight away, they would not see him."

"They refused to see my son when he had an allergic reaction and came up in hives and had diarrhoea."

Timely Response and Support

Unsurprisingly, most parents and carers shared negative experiences and their desire for improved services. However, it is important to acknowledge that some parents and carers praised the support they and their child or the young person they care for received from their GP practice.

"I have never had a problem getting my child an appointment. My doctor is amazing and so helpful. The team of people that work there are so helpful, kind and always there to help. I've never experienced any problems. Best surgery I've ever had."

"I think the GP surgery is great and I never have any issues with them or getting support from them for my child."

"The GP practice is excellent and holistically supportive of our daughter's care – I cannot fault them."

Specific examples included parents and carers receiving a face to face appointment for their child or the young person they care for, in addition to, or instead of, an online or remote consultation. This was important to parents and carers as it meant they felt listened to by healthcare professionals, and that their concerns about their child or the young person they care for were being respected and valued.

"Always an excellent service. We needed a face to face appointment which we got on the same day."

"They took my concerns seriously. Seen face to face and my child was thoroughly assessed."

"My surgery is doing a superb job, always get an appointment and always get through on the phone quickly."

"Had an initial same day consultation and then my child was invited in to be seen by the same doctor an hour later."

Some respondents shared that they often receive a timely response from the GP practice and given support for their child or the young person they care for within a quick timeframe.

"I wasn't offered a choice of time, date location etc but that didn't matter as it was so quick and the appointment given for my child was suitable."

"The surgery has always been easy to get hold of and very responsive. Especially for my young child."

"Sent a photo of my granddaughter's aliment. Then the GP rang back with a diagnosis and prescribed medication."

Improving the Process

Access and Communication Routes

39% of parents and carers said their experience of making an appointment for their child or the young person they care for was either "good" or "very good" while 41% said it was "bad" or "very bad."

When respondents were asked how the process of making an appointment could be improved, many parents and carers felt having access to an online booking system would be beneficial as it would be more accessible and provide another option for making an appointment, rather than having to rely on the telephone.

"I should be able to book online for an in person appointment. We have to call – we cannot go into the practice or book online."

"I would love to have an online booking system where you can choose an appointment."

Likewise, the majority of parents and carers felt it would be easier to make an appointment for their child or the young person they care for if telephone systems were improved and if waiting times on hold or in the telephone queue were significantly reduced.

"The phone system takes quite awhile to get through and becomes a little frustrating when trying to comfort a child with additional needs."

"Do something about the long queues for appointments in the morning – by the time you get through all the appointments are gone."

"Less queue times so you can get through to a receptionist quicker. I have had to ring 111 in the past as I just couldn't get through."

More Choice

A large number of parents and carers emphasised that they should be offered more choice when making an appointment for their child or the young person they care for. Access to face to face appointments was a priority for most parents and carers, especially as children and young people are not always able to communicate their symptoms and health needs. Being able to choose the time and dare of the appointment, as well which healthcare professional they could

see was also particularly important to first time parents, and parents and carers who care for a child or young person with a disability, complex needs or a long-term condition.

"The phone appointments are useless as I personally think it's impossible to diagnose a child who can't tell you what's wrong over the phone without physically seeing them."

"I would have hoped by now for medically complex children like mine or any child that a parent is concerned about should be offered a face to face appointment."

"If a parent wants a face to face appointment they should be able to get one, especially for a child that cannot speak yet. We are first time parents and I am not a healthcare professional. My son is on an inhaler (blue and brown) and we are constantly told it's just a phase!"

"Covid-19 has impacted GPs but I do feel that children who are vulnerable/unable to articulate what is wrong/go downhill fast should have been prioritised for face to face."

"Children with diagnosed physical conditions or who are completely non-verbal should be seen face to face without parents having to fight for it."

Being able to see the same healthcare professional, or receiving an appointment within a short timeframe, was essential for parents and carers whose child or the young person they care for has ill mental health. In some cases, parents and carers had to access private therapy to get the mental health support their child or the young person they care for needed, as they could not get an appointment with their GP practice soon enough.

"I was very unsatisfied. We couldn't get an appointment for up to six weeks. We are fortunate that we could access private medical and psychological care. Most parents are not in this position and would be left to feel unsupported in trying to help their child through a mental health crisis."

"It worked great when my 6 year old had tonsillitis. We were seen the same day and collected the medicine straight away. When my 13 year old had mental health problems I was offered an appointment five weeks away. We have now gone private for the help we need."

"They insisted on a phone appointment even though I explained that it was difficult for a 15 year old to talk about a sensitive issue over the phone. A phone appointment was not suitable for a mental health related complaint and was too far away."

More Appointments and Priority for Children

Parents and carers felt that more appointments need to be made available for children and young people, as well as the ability to book routine and non-urgent appointments in advance and with greater ease. Respondents also noted that GP practices should be more mindful of work and caring responsibilities when speaking to and arranging appointments with parents and carers on behalf of their child or the young person they care for.

"Appointments need to be bookable in advance, not just on the day."

"Telephone times to take account of working parents – if one call is missed you're then unable to get back to the surgery and have to start all over again."

"Offer more book in advance appointments, especially for those with children. Working parents can't always drop everything all of a sudden to bring their child to an appointment in the next 30 minutes."

"Even if you can't get an appointment that day they could offer another instead of saying you will have to call tomorrow or take your chances."

Equally, parents and carers said that children and young people should be given priority when it comes to getting an appointment with the GP practice, especially face to face appointments. Parents and carers shared that they are increasingly concerned with how difficult it can be to get an appointment for their child or the young person they care for, with their age and/or severity of their symptoms or condition not seeming to make a difference.

"There needs to be more appointments available for babies and very young children."

"Children should be seen. People are being misdiagnosed, this is a child!"

"Children should be given priority for face to face as they are often unable to articulate properly what's wrong and can go downhill fast. There needs to be a specific line/triage so children are dealt with without delay."

Avoiding GP Services

Access

49% of parents and carers said they have avoided making contact with the GP practice for their child or the young person they care for in the last 12 months.

Instead of contacting the GP practice, 80% looked for information and advice elsewhere. The most common routes included searching for information online, visiting the local pharmacy, contacting NHS 111 and accessing private GPs.

Most parents and carers have been reluctant to access the GP practice because they have found it too difficult to get through, especially when trying to contact by telephone. Particularly concerning is the number of parents and carers who said they will avoid accessing the GP practice until their child or the young person they care for is too unwell.

"It's too much hassle so I put it off until my child is too poorly to avoid it any longer."

"It's too difficult. You're looking at a 40-50 minute wait on the phone which a) isn't practical and b) means appointments are usually gone."

"I am astounded at how unbelievably hard it has been to access basic medical care for my child. It has taken hours of my time and has been very stressful."

Some parents and carers have not contacted the GP practice because they assume that there will be no appointments available for their child or the young person they care for, or because there will not be an appointment that is either soon enough and/or face to face.

"I knew it would be hard to get an appointment."

"There are never any appointments available."

"I felt there wouldn't be any face to face appointments for him."

In some cases, parents and carers contacted NHS 111 or took their child or the young person they care for to an Urgent Care Centre because they feared that they would not get an appointment with the GP practice soon enough. A few respondents even accessed a private GP in order to get support for their child or the young person they care for.

"You can't get an appointment so we have used NHS 111."

"I visited the Urgent Care Centre for fear of not getting an appointment the next day or not getting through."

"We ended up paying to go private due to it being so difficult."

"We paid for a private GP as we were so frustrated."

Poor Experiences and Mistreatment

Other parents and carers have avoided contacting the GP practice for their child or the young person they care for after receiving a lack of support and mistreatment from the GP practice. Common examples included their child or the young person they care for being misdiagnosed, not listening to the concerns of the parent or carer, and receiving poor quality of care.

"My son was misdiagnosed 3 times and we ended up being referred to the hospital by an optician! Really disappointed by the service we received. My son was not seen once over a 5 week period despite contacting the surgery 4 times regarding the same issue!"

"I was not satisfied with the care my son received previously as they were too busy to help or care for his needs."

"My son has been in and out of hospital since the beginning of the year with a mystery illness but I have little to no help from the GP regarding this. We end up at the hospital every time as I know he will be seen by them and cared for by them. Whereas when I speak to the GP or try to speak to the GP I get nowhere."

One parent shared how healthcare professionals did not listen to their concerns about their child which resulted in a misdiagnosis of pneumonia and sepsis. As a result, the parent has avoided contacting the GP practice for their child after this serious incident.

"I have had such terrible experiences with misdiagnoses, incorrect treatment and lack of care. I have found that in the past GPs at my practice do not listen to me, feeling that they know more about my child than I do. This has resulted in misdiagnosis of pneumonia and sepsis, and multiple occasions where we have been sent away with advice and treatments that do not improve my child's symptoms. Unfortunately this is a known flaw in medical provision for women and their children and something that needs to change."

Similarly, a large number of parents and carers said they have not accessed the GP practice for their child or the young person they care for because of the previous poor treatment they have received from either reception staff and/or healthcare professionals. Parents and carers now feel hesitant to contact the GP practice in fear of being dismissed by staff, seen as a burden on the NHS, or judged for making contact about their child or the young person they care for.

"Fear of being dismissed by the GP as an anxious mother."

"I feel judged, as such we have been made to feel that we should wait until his symptoms become worse/don't get better."

"The receptionists aren't always kind, they make it difficult and I feel anxious before speaking to them."

"Made to feel guilty for asking someone to see my child."

Encouraging Access to GP Services

When respondents were asked what would encourage them to make contact with the GP practice for their child or the young person they care for, as previously emphasised, many parents and carers said they would be more inclined to access the GP practice if telephone systems were improved, or if they could book an appointment using an online system.

"Ability to get through on the phone or book appointments online."

"I'd contact the GP if I knew I wouldn't have to sit for hours redialling."

"Easier to get in touch with and getting an appointment. It's near impossible to get through to anyone right now."

As mentioned earlier in the report, parents and carers would also be more likely to contact the GP practice if they knew an appointment would be available for their child or the young person they care for, and if they were given greater choice when making an appointment.

"Knowing a) I could see her own doctor and b) knowing we could see them face to face within a reasonable timeframe and c) given the choice of face to face or phone call/video call dependent on the urgency."

"Being able to book in advance for your child and if I knew my child would be seen face to face."

However, the majority of parents and carers said they would be far more inclined to contact the GP practice if reception staff and/or healthcare professionals listened and respected their concerns as a parent or carer, provided greater reassurance and understanding, and treated them with more kindness.

"Going to the doctors should not be a battle between patient and doctors to get the child well. Too many times doctors dismiss symptoms and send the child away. This leaves the child unwell or in pain, and in my case, being told they are ok. Doctors should listen to parents and trust what is reported."

"Some of the receptionists could be a little kinder and not so patronising. I understand they have to deal with lots of people but please realise some people genuinely just want to see a doctor and aren't out to cause problems."

"The NHS constantly 'judge' parents for what they have done or not done. There is not enough information about what to do and how we can help the NHS and our children. The last thing I want to do is waste a GP's time or any member of the NHS, however when I do call out for help, a level of understanding would be appreciated. Whilst healthcare professionals see things everyday, it could be a first time for parents!

Using Online Services

Accessing Online Services

49% of parents and carers do not have access to online services for their child or the young person they care for. For most, this is because they did not know they could have access to online services for their child or the young person they care for. Some respondents also shared that they did not know their GP practice offered online services, or what the benefits of using online services are.

A few respondents said they cannot access online services for their child or the young person they care for because this function has not been enabled by their GP practice.

"I have my own access but was told I can't use it for my children."

"Not available for under 18s. Not even via the parent log in."

Other respondents have encountered difficulties when trying to register with or access online services for their child or the young person they care for.

"Problems with access for my child on several occasions and I've now given up!"

"The registration/log in has been ridiculous since the system changed a few years ago. I haven't successfully logged in for my child despite repeatedly registering."

"I have issues accessing for my child due to errors when the account was set up and I've not be able to resolve this with reception staff at the GP practice."

However, it is important to note that despite these barriers, 82% of parents and carers would request access to online services on behalf of their child or the young person they care for if they were given the opportunity and/or support to do so.

Improving Online Services

In comparison, 37% of parents and carers do have access to online services for their child or the young person they care for. When these respondents were asked how online services could be improved, most said that they should be able to use online services to book an appointment for their child or the young person they care for. For the majority, this option is not available.

"My GP practice will not allow us to book appointments for children online, only to view their medical record."

"Please let us book appointments online and be able to send the GP a message! I don't have time or the ability to sit in a phone queue for hours to talk to a receptionist who doesn't understand the medical information I'm trying to explain. It causes so much stress and wastes everyone's time."

"We can no longer make online appointments which stopped during Covid-19 and never resumed."

Some parents and carers noted that although their GP practice does offer the option to book appointments online for their child or the young person they care for, there is never availability, even if they look weeks or months in advance.

"I believe I can book appointments for my child but in reality there are never any available."

"Technically you can book an appointment for children but even if you select in a month's time it says there are no appointments!"

Parents and carers also felt that online services could be improved by enabling access to the medical records of their child or the young person they care for, and if they could share this information with other healthcare professionals to support with continuity of care.

"I can no longer access my child's records through my access which I used to be able to do before Covid-19."

"Need to be able to access my child's medical records to enable more efficient transfer of information across healthcare settings."

"Make sure parents can access their child's full medical records if the parent has set up access."

Significantly, a large number of respondents said there needs to be more information and communication on how parents and carers can access online services for their child or the young person they care for, and the benefits online services can offer, as most parents and carers are not aware. Respondents felt that the use of online services should be promoted more widely and that GP practices should work to build trust with parents and carers to ensure they feel confident accessing and using online services.

"I think communications about online services should be sent out either at the time of birth or upon undertaking the caring responsibility. I could have been provided with this information at one of my son's standard check ups or immunisation appointments. Communication materials could also be provided to childcare/school settings for onward circulation to parents and carers."

"There needs to be more information about online services for parents and carers. I wasn't aware about them."

"I think there needs to be better communication regarding alternative methods of making appointments could be put in place, for example the use of online services. I would also say that trust needs to be built with patients that if they use an online triage process/appointment booking that they will receive a timely response."

Findings from Children and Young People

Unfortunately only 10 children and young people aged between 13 and 18 years old completed our survey. Given this low response, we would recommend that the Hertfordshire and West Essex ICB looks to undertake specific engagement with children and young people about their experiences of accessing GP services.

Across the respondents, 50% said they have never accessed their GP practice before. For all of these respondents, this is because their parent or guardian contacts the GP practice for them.

For the 50% of respondents who had accessed their GP practice, the majority had a positive experience. The greatest barrier was choice, with almost all respondents not offered any choice when making an appointment.

"I was given an appointment but they told me the day and time."

"The appointment was too far away and too long to wait."

When asked how accessing their GP practice could be improved, as emphasised amongst parents and carers, children and young people would also like to be able to book appointments using an online system.

"Let us have online access to book appointments."

"Be better to make an appointment online than call."

Respondents also noted that there should be more information about consent, and when children and young people are able to, or need to, contact their GP practice independently. For example, one respondent shared that they did not know that their parent could not contact their GP practice on their behalf because they are over 16 years old.

"I didn't know you have to ring yourself if you're over 16. My mum rang at first and I had to try again so I missed out on a same day appointment."

As we found with parents and carers, 50% of children and young people said they have avoided contacting their GP practice in the last 12 months. For the majority, this is because they find their GP practice too difficult to access, or because they are concerned about being a burden on the NHS.

When asked about online services, 38% of respondents said they do not have access to online services. For all respondents, this is because they did not know they could have their own account. However, all respondents said they would use online services if they were given the opportunity and/or support to do so.

38% of children and young people do have access to online services, and when asked about the benefits of using online services, all respondents noted that it is much easier and quicker than contacting by telephone.

"You don't have to wait in a queue on the phone."

"It is easier than calling sometimes."

"You get help quicker than waiting on a phone."

When asked how online services could be improved, respondents said that the online forms can be confusing and difficult to complete.

"Takes ages to do the online form. Options are so limited it's hard to explain what's wrong to get an appointment."

"I can't fill in the online forms to get an appointment as they are too long, too complicated and I don't understand lots of the questions. I need to speak to people to understand things."

Respondents also shared that certain appointments, such as for contraception, cannot be booked online. Children and young people said they would like this to be an option, instead of having to contact the GP practice by telephone.

"You can't book contraception appointments online as a child, it's not an option, only for adults."

"Couldn't book my regular contraception injection online even though I am over 16. Have to spend an hour on the phone instead to book."

Summary

Our engagement shows that the majority of parents and carers are struggling to access GP services for their child or the young person they care for. Access is particularly difficult via

telephone, with many parents and carers spending hours trying to get an appointment for their child or the young person they care for, only to be told there are no appointments available, even weeks in advance.

Choice, especially in the type of appointment offered, is a priority for parents and carers. The findings highlight clear cases in which the child or young person should have been given this choice when making the appointment, whether that be due to their age, condition(s) or the severity of their symptoms. Babies and young children, and those with complex needs, disabilities, long-term conditions or mental ill health are at greater risk with reports of misdiagnosis, poor quality of care, or the parent or carer having to take their child or the young person they care for elsewhere to get the medical attention they need. This emphasises the importance of the concerns of the parent or carer being listened to, so the needs of the child or young person can be addressed.

Difficulties in contacting the GP practice and previous poor experiences with reception staff and/or healthcare professionals is encouraging parents and carers to avoid accessing GP services entirely for their child or the young person they care for. Instead, parents and carers are opting to visit an Urgent Care Centre or A&E – often because this route is easier to access rather than being the preferred option– or even paying for a private GP in efforts to get the support their child or the young person they care for requires.

Parents and carers also want online services to be utilised further, with the ability to book appointments online seen as essential for many. Surprisingly, many parents and carers are not aware that they can use online services for their child or the young person they care for, and most would access this if made available to them.

It is important to recognise that the challenges faced by GP practices across the county are significant. However, it is evident that most of the improvements parents and carers want to see are about the process of making an appointment, and easier access to their GP practice, rather than improving the quality of care their child or the young person they care for received. It is clear that some systems currently in place are not designed to meet patient needs and the adoption of improved systems was seen very positively by respondents.

Recommendations

Based on the findings outlined in this report, it is recommended that the Hertfordshire and West Essex ICB Primary Care Workstream should encourage GP practices to take forward the following recommendations. The ICB is providing welcome support to enable GP practices to improve access and the continuation of this will help address some of the challenges.

Improving access to GP services would instil greater confidence in patients. This could be achieved through:

1. Enabling a variety of access routes, including the use of online services and visiting the GP practice in person, to accompany all needs and preferences.

2. Continuing to improve telephone systems to reduce delays and waiting times for patients.

3. Greater flexibility in contact hours and opening times to account for school hours, work, and caring responsibilities.

Making appointments more readily available is important, particularly for children and young people and vulnerable groups. This includes:

4. Appointments that are bookable in advance, especially if the concern is either routine or non-urgent.

5. Reviewing and addressing waiting times for appointments, with particular consideration given to:
    - Children and young people
    - Those with a disability, complex needs, or a long-term condition
    - Those with ill mental health

Providing greater choice when offering appointments would improve the quality of care received. This includes:

6. Being mindful of work and caring responsibilities, as well as school hours, when offering appointments.

7. Providing more choice when offering appointments to patients, with a particular focus on offering more face to face appointments where possible. Specific consideration and greater choice should be given to:
    - Children and young people
    - Those with a disability, complex needs, or a long-term condition
    - Those with ill mental health

8. The ICB should work with Primary Care Networks and GP practices to identify ways of ensuring there is greater choice for patients.

Providing high quality of care would ensure all patients feel respected and heard. This includes:

9. Listening to and respecting the concerns of all patients, particularly parents and carers, to prevent misdiagnosis and/or mistreatment.

10. Providing thorough assessments and high quality care to all patients, at all times.

11. Healthcare professionals and reception staff to treat all patients with respect. This should be monitored to ensure staff are not dismissing concerns, or judging patients for making contact. Reminders and refresher training should also be considered.

12. Delivering Customer Care training for GP receptionists to improve their customer service and communication skills.

GP practices should offer greater information and support, particularly in regards to the use of online services. This includes:

13. Continuing to encourage patients, particularly parents and carers and vulnerable groups, to contact their GP practice if they have concerns about their health.

14. Enabling parents and carers online access for their child or the young person they care for, if this function is not already available.

15. Continuing to increase awareness amongst parents and carers on how they can access online services for their child or the young person they care for, and encourage or support them to register. The ICB should encourage GP practices to work with other healthcare professionals, Hertfordshire County Council and the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector to raise the profile and benefits of using online services.

16. Enabling all patients full access to the functions available via online services, including:
    - Booking appointments
    - Test results
    - Prescriptions
    - Medical records

17. By 1st November 2022 all GP practices should have updated their organisation settings for online services in order to be able to provide record access to patients – whether this be

via the NHS App, TPP or EMIS systems[8]. The ICS should look to review and monitor whether improvements have been made.

[8] GP Online Services clinical system configuration: Immediate action required - NHS Digital

Appendix

Named GP Practices: Parents, Carers and Children and Young People Survey[9]

District	Name of GP Practice	Number of Respondents
Broxbourne	Warden Lodge Medical Centre	5
	The Maples Medical Centre	5
	Park Lane Surgery	4
	Amwell Surgery	4
	Cuffley Village Surgery	2
	Stanhope Surgery	1
Dacorum	Parkwood Surgery	5
	Fernville Surgery	4
	Bennetts End Surgery	3
	Haverfield Surgery	2
	Everest House Surgery	1
	Lincoln House Surgery	1
	Highfield Surgery	1
	Woodhall Farm Medical Centre	1
	Manor Street Surgery	1
	Gossoms End Surgery	1
East Herts	Church Street Surgery	18
	South Street Surgery	11
	Castlegate Surgery	4
	Dolphin House Surgery	3
	Hanscombe House Surgery	3
	Buntingford Medical Surgery	3
	New River Health (Castlegate Surgery and Church Street Surgery)	2
	Watton Place Clinic	2
	Knebworth and Marymead Surgery	2
	Elsenham Surgery	2
	Central Surgery	1
Hertsmere	Manor View Practice	3
	Theobald Medical Practice	1
North Herts	Birchwood Surgery	6
	Nevells Road Surgery	4
	Sollershott Surgery	2
	Bancroft Medical Centre	2
	Orford Lodge Surgery	2
	Royston Health Centre	2

[9] Please note that the total does not equal to the total number of respondents due to some respondents choosing not to share the name of the GP practice their child or the young person they care for is registered with.

	Regal Chambers Surgery	1
St. Albans	The Maltings Surgery	9
	Harvey Group Practice (Harvey House Surgery and Jersey Farm Surgery)	7
	Parkbury House	6
	Summerfield Health Centre	4
	The Lodge Surgery	3
	The Lodge Health Partnership	3
	The Village Surgery	3
	The Elms Medical Practice	2
	Midway Surgery	1
	Hatfield Road Surgery	1
	Davenport Surgery	1
	Redbourn Health Centre	1
	Grange Street Surgery	1
Stevenage	Chells Surgery	3
	Stanmore Medical Group	3
	Shephall Health Centre	3
	The Poplars Surgery	1
	Symonds Green Health Centre	1
	King George Surgery	1
Three Rivers	Vine House Health Centre	5
	New Road Surgery	4
	Gade Surgery	1
Watford	Manor View Practice	5
	Bridgewater Surgery	3
	Watford Health Centre	2
	Sheepcot Medical Centre	1
	Garston Medical Centre	1
	Coach House Surgery	1
	Suthergrey House Medical Centre	1
Welwyn Hatfield	The Garden City Practice	8
	Bridge Cottage Surgery	4
	Hall Grove Group Practice	3
	Spring House Medical Centre	2
	Peartree Lane Surgery	2
	Burvill House Surgery	1
	Moors Walk Surgery	1
	Parkway Surgery	1
	Potterells Medical Centre	1