NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Primary Care Commissioning & Assurance Committee - Meeting held in Public

The focus of this committee is to seek assurance on the commissioning of primary medical, pharmacy, optometry and dental services for the people of Bedfordshire, Luton and Milton Keynes. It has oversight of the decision-making processes and will challenge and assess and ensure that any risks are appropriately managed with the controls and mitigations in place to do so.

Date: 15 March 2024
Time: 0900-1230
Venue: MSTeams

Agenda

No.	Agenda Item	Lead	Purpose	Time
	Opening Actions			
1.	Welcome, Introductions and Apologies	Alison Borrett Chair		0900-0910
2.	Relevant Persons Disclosure of Interests • Register of Interests (29 February 2024)	Chair	Note changes and approve	
3.	Approval of Minutes and Matters Arising - Minutes 15 December 2023	Chair	Note	
4.	Review of Action Tracker	Chair	Note changes and approve	
	Operational Assurance – opportunity for Members to raise issues for clarification or concern			
5.	Primary Care Medical Services Contracting Report	Lynn Dalton Associate Director of Primary Care Contracting and Development	Note / Confirm Assurance / Approve (3.2.1)	0910-0940 Questions from Members For items 5-6.1
5.1.	Primary Care Dental Services Contracting Report		Note / Confirm Assurance	
6.	Pharmaceutical Services Regulatory Committee Report (Quarter 3) 2023-24	Lynn Dalton Associate Director of Primary Care Contracting and Development	Discuss / Note	
6.1	General Ophthalmic Services (GOS) Contracting Report (Quarter 1-3) 2023-24	Lynn Dalton Associate Director of Primary Care Contracting and Development	Discuss / Note	

No.	Agenda Item	Lead	Purpose	Time
7.	Primary Medical Services Financial Report (January 2024)	Roger Hammond Associate Director of Finance	Note	0940-0950
7.1	Primary Care Pharmacy, Optometry and Dental Financial Report (January 2024)		Note	
8.	Primary Care Directorate and Digital Risk Registers	Amanda Flower Deputy Chief Primary Care Officer	Note	0950-1000
Strategy & Integration Assurance				
	Delivering Integrated Primary Care in BLMK			
9.	Report on the Progress in BLMK to achieve the ambitions of the NHSE Delivery Plan for Recovering Access to Primary Care	Amanda Flower Deputy Chief Primary Care Officer	Review / Note	1000-1015
9.1	Primary Care Workforce Programme & Highlight Report	Susi Clarke Associate Director People Transformation - Fuller	Note	1015-1030
10.	Primary Care Estates	Nikki Barnes Associate Director of System & ICB Estates	Note	1030-1045
Governance				
11.	Terms of Reference - Primary Care Commissioning & Assurance Committee (PCCAC) - Executive Led Primary Care Delivery Group (PCDG)	Lynn Dalton Associate Director of Primary Care Contracting and Development / Michelle Evans-Riches Head of Corporate Governance	Discuss / Approve	1045-1100
12.	Communications from the meeting	Chair	Discuss	1100-1110
13.	Review of meeting effectiveness	Chair	Discuss	
14.	Annual Cycle of Business 2023-24	Chair	Note / Discuss	
Closing Actions				
15.	Any Other Business	Chair/All	-	1110-
16.	Date and time of next meeting: ▪ 10 May 2024 at 0900-1230 ▪ MSTeams	Chair	-	-

Item 2.

Members are asked to:
> Review the Register of Interests and confirm their entry is accurate and up to date.

All in attendance are asked to:
> Declare any relevant interests relating to matters on the agenda.
> Confirm that all offers of Gifts and Hospitality received in the last 28 days have been registered with the Governance & Compliance team via blmkicb.corporatesec@nhs.net

Extract from Register of Conflicts of Interest
Primary Care & Commissioning Assurance Committee
(Voting Members and Non-Voting Members where declarations made)
as at 29.2.24

Surname	Forename	Position within, or relationship with the ICB	Interests to Declare	Financial Interest	Non-Financial Professional	Non-Financial Personal	Indirect	Description of Interest	Date From	Date To	Actions to be taken to mitigate risk	Date Declared
Begum	Fatima (Cllr)	Councillor, Luton Borough Council	Yes									22/01/2024
Blackmun	Diana	Chief Executive Officer, Healthwatch Central Bedfordshire	Yes		Y			Chief Executive Office of Healthwatch, Central Bedfordshire	April 2013	Ongoing	Declare in line with conflicts of interest policy	05/12/2022
Blackmun	Diana	Chief Executive Officer, Healthwatch Central Bedfordshire	Yes		Y			Chair of Bedfordshire Autism Voice Alliance	Nov 2022	Ongoing	Declare in line with conflicts of interest policy	05/12/2022
Borrett	Alison	Non Executive Member	Yes	N	N	N	N	Director, 2Billys Ltd, Company no 14038119, Unit 8 Churchill Court, 58 Station Rd, North Harrow HA2 7SA	11/04/2022	Ongoing	No conflict, as our cookie business does not provide goods or services to BLMK ICB. If this was to change in the future I would update my DOI and declare any interest.	21/06/2022

Surname	Forename	Position within, or relationship with the ICB	Interests to Declare	Financial Interest	Non-Financial Professional	Non-Financial Personal	Indirect	Description of Interest	Date From	Date To	Actions to be taken to mitigate risk	Date Declared
Carr	Marimba	Deputy Director of Public Health at Milton Keynes Council, representing the Director of Public Health for Milton Keynes,Central Bedfordshire and Bedford Borough at the Primary Care Commissioning and Assurance Committee	No									05/12/2022
Coker	Patricia	Head of Service for Integration (Health and Adult Social Care), Central Bedfordshire Council	No									29/11/2023
Dalton	Lynn	Associate Director Primary Care Development	No									06/12/2022
Eliot	Elizabeth	Consultant in Public Health, Luton Borough Council	No									13/09/2023
Flower (Hubbard)	Amanda	Associate Director, Primary Care Commissioning and Transformation	Yes		Y			I am a lifetime (unpaid) Trustee for Sophie's Moonbeams Trust who provide support grants to families who have children that would benefit from accessing therapeutic interventions. The grants allow families/children to access that support. Sophie's Moonbeams Trust Registered charity number 1182086	19/09/2018	Ongoing	Declare the interest / exclusion from meetings/decision making where applicable	09/12/2022

Surname	Forename	Position within, or relationship with the ICB	Interests to Declare	Financial Interest	Non-Financial Professional	Non-Financial Personal	Indirect	Description of Interest	Date From	Date To	Actions to be taken to mitigate risk	Date Declared
Freda	Emma	Chief Executive Officer, Healthwatch Bedford Borough	No	Y				Employed by Healthwatch Bedford Borough, 21-23 Gadsby Street, Bedford, Beds MK40 3HP	01/10/2023	Ongoing	I will declare in line with the COI policy. I will remove myself from any decision that we have a conflict or perceived conflict in, if in agreement, and declare our specific interest at all appropriate meetings given the impending agenda item(s)	11/10/2023
Garnett	Fiona	Associate Director and Head of Medicines Optimisation	No									02/11/2022
Gill	Manjeet	Non Executive Member	Yes	Y				Non Executive Director, Sherwood Forest NHS Hospitals Foundation Trust	11/11/2019	Ongoing	Would flag any conflict in agendas	27/09/2022
Gill	Manjeet	Non Executive Member	Yes	Y				Managing Director, Chameleon Commercial Services Ltd, 12 St Johns Rd, LE2 2BL	09/09/2017	Ongoing	Regular 1-1s flag any issue and agenda items	27/09/2022
Gilson	Bruce	Bucks Local Optical Committee (LOC) Chair)	Yes		Y			Chair Local Optical Committee - Bucks	May 2003	Ongoing	Declare in line with conflicts of interest policy	08/02/2024
Gilson	Bruce	Bucks Local Optical Committee (LOC) Chair)	Yes		Y			Optometrist, Olivers Opticians, Chalfont St Peter Bucks	09/01/2002	Ongoing	Declare in line with conflicts of interest policy	08/02/2024

Surname	Forename	Position within, or relationship with the ICB	Interests to Declare	Financial Interest	Non-Financial Professional	Non-Financial Personal	Indirect	Description of Interest	Date From	Date To	Actions to be taken to mitigate risk	Date Declared
Gilson	Bruce	Bucks Local Optical Committee (LOC) Chair)	Yes		Y			Ophthalmology Triage for Buckinghamshire Healthcare Trust (Stoke Mandeville, Bucks)/ BOB ICB (Oxford)	01/04/2023	Ongoing	Declare in line with conflicts of interest policy	08/02/2024
Gilson	Bruce	Bucks Local Optical Committee (LOC) Chair)	Yes		Y			Discipline Specific Practitioner for PAG/PLDP concerns cases advising NHSE South East (Oxford)	August 2013	Ongoing	Declare in line with conflicts of interest policy	08/02/2024
Goel	Ravi John	Bedfordshire Local Dental Committee Secretary	No									20/07/2023
Harrison	Mike	Co-Chief Executive Officer of Beds and Herts Local Medical Committee	Yes		Y			Beds & Herts LMC Ltd, Astonbury Farm, Astonbury Lane, Aston, Stevenage SG2 7EG	03/07/2017	Ongoing	Declare in line with conflicts of interest policy	06/12/2022

Surname	Forename	Position within, or relationship with the ICB	Interests to Declare	Financial Interest	Non-Financial Professional	Non-Financial Personal	Indirect	Description of Interest	Date From	Date To	Actions to be taken to mitigate risk	Date Declared
Keech	Tracey	Deputy CEO, Healthwatch, Milton Keynes	No									02/11/2023
King	Anne-Marie	Chief Officer, Community Pharmacy, BLMK & Northants	No									12/11/2023
Kufeji	Omotayo	Primary Services Partner Member	Yes					The Bridge Primary Care Network Clinical Director	01/04/2021	Ongoing	May need to be excluded from decisions regarding Primary care Networks	11/05/2022
Kufeji	Omotayo	Primary Services Partner Member	Yes		Y			Member, NHS Confederation Primary Care Network	07/07/2019	Ongoing	Declare conflict during discussions	08/09/2022
Kufeji	Omotayo	Primary Services Partner Member	Yes		Y			Member, National Association of Primary Care (NAPC) Council	01/10/2020	Ongoing	Declare conflict during discussions	08/09/2022
Kufeji	Omotayo	Primary Services Partner Member	Yes		Y			Trustee, Arts for Health Milton Keynes	01/04/2020	Ongoing	Declare conflict during discussions	08/12/2022
Kufeji	Omotayo	Primary Services Partner Member	Yes		Y			Chair, Milton Keynes Christian Centre (*was previously Trustee)*	01/09/2023	Ongoing	Declare conflict during discussions	08/12/2022
Kufeji	Omotayo	Primary Services Partner Member	Yes	Y				GP partner, Newport Pagnell Medical Centre	01/02/2004	Ongoing	May need to be excluded from decisions regarding Primary Care Networks	08/12/2022
Kufeji	Omotayo	Primary Services Partner Member	Yes	Y				Trustee, Milton Keynes Urgent Care Centre	01/08/2023	Ongoing	Declare conflict during discussions	26/09/2023
Lister	Craig	Associate Director Covid and 'Flu Immunisation Strategy Lead	No							31/3/2024 end of FTC		07/12/2022
Mattis	Lorraine	Associate Non Executive Member	Yes	Y				CEO, University of Suffolk Dental CIC	Jun-23	Ongoing	Declared in line with conflicts of interest policy	08/08/2023

Surname	Forename	Position within, or relationship with the ICB	Interests to Declare	Financial Interest	Non-Financial Professional	Non-Financial Personal	Indirect	Description of Interest	Date From	Date To	Actions to be taken to mitigate risk	Date Declared
Poulain	Nicky	Chief Primary Care Officer	Yes		Y			Registered nurse and midwife and a member of trhe RCN			Declare in line with conflicts of interest policy, exclusion from involvement in related meetings or discussions and/or decision making as guided by Governance Lead	17/02/2023
Qazi	Uzma	Optometrist, Chair of MK LOC (subcommittee) of Bucks LOC	Yes	Y				Optometrist (Boots opticians)	1999	Ongoing	Declare in line with conflicts of interest policy	29/01/2024
Qazi	Uzma	Optometrist, Chair of MK LOC (subcommittee) of Bucks LOC	Yes		Y			LOC (Chair of MK - subcommittee of Bucks LOC)	2022	Ongoing	Declare in line with conflicts of interest policy	29/01/2024
Shah	Mahesh	Partner Member	Yes	Y				AP Sampson Ltd t/a The Mall Pharmacy, Unit 3, 46-48 George Street, Luton LU1 2AZ, co no 00435961, community pharmacy	Nov-88	Ongoing	Declare in line with conflicts of interest policy, exclusion from involvement in related meetings or discussions and/or decision making as guided by Governance Lead	20/05/2011
Shah	Mahesh	Partner Member	Yes				Y	RightPharm Ltd, 60a Station Road, North Harrow, HA2 7SL, co no 08552235, community pharmacy, son & sisters	28/03/2014	Ongoing	Declare in line with conflicts of interest policy, exclusion from involvement in related meetings or discussions and/or decision making as guided by Governance Lead	20/05/2022

Surname	Forename	Position within, or relationship with the ICB	Interests to Declare	Financial Interest	Non-Financial Professional	Non-Financial Personal	Indirect	Description of Interest	Date From	Date To	Actions to be taken to mitigate risk	Date Declared
Shah	Mahesh	Partner Member	Yes				Y	Calverton Pharmacy Ltd, Ashleigh Mann 60a, Station Road, North Harrow HA2 7SL, co no 07203442, community pharmacy, son & sisters	03/04/2018	Ongoing	Declare in line with conflicts of interest policy, exclusion from involvement in related meetings or discussions and/or decision making as guided by Governance Lead	20/05/2022
Shah	Mahesh	Partner Member	Yes				Y	Gamlingay Pharmacy Ltd, 60a Sation road, North Harrow, HA2 7SL, no no 05467439, son & sisters	01/04/2021	Ongoing	Declare in line with conflicts of interest policy, exclusion from involvement in related meetings or discussions and/or decision making as guided by Governance Lead	20/05/2022
Shah	Mahesh	Partner Member	Yes		Y			Committee Member, Bedfordshire Local Pharmaceutical Committee	1984	Ongoing	Declare in line with conflicts of interest policy, exclusion from involvement in related meetings or discussions and/or decision making as guided by Governance Lead	20/05/2022
Shah	Mahesh	Partner Member	Yes		Y			Community Pharmacy PCN Lead, Oasis Primary Care Network, Luton	06/02/2020	Ongoing	Declare in line with conflicts of interest policy, exclusion from involvement in related meetings or discussions and/or decision making as guided by Governance Lead	20/05/2022

Surname	Forename	Position within, or relationship with the ICB	Interests to Declare	Financial Interest	Non-Financial Professional	Non-Financial Personal	Indirect	Description of Interest	Date From	Date To	Actions to be taken to mitigate risk	Date Declared
Sharp	Andy	Director, Social Care, Health & Housing, Central Bedfordshire Council	Yes	Y				Director, New Vista Homes	01/02/2023	Ongoing	Declare in line with conflicts of interest policy	12/09/2023
Sharp	Andy	Director, Social Care, Health & Housing, Central Bedfordshire Council	Yes	Y				Director, Care is Central	01/02/2023	Ongoing	Declare in line with conflicts of interest policy	12/09/2023
Sharp	Andy	Director, Social Care, Health & Housing, Central Bedfordshire Council	Yes	Y				Director, Central Bedfordshire Group	01/02/2023	Ongoing	Declare in line with conflicts of interest policy	12/09/2023
Somaia	Sonal	Bucks Local Optical Committee (LOC) Secretary										
Soyombo	Bola	Secretary, Milton Keynes Local Dental Committee / Chair, Restorative Dentistry Management Clinical Network covering BLMK and HWE / LDC Rep Primary Care POD Delivery Group / Member, BLMK Health & Care Senate	Yes		Y			Director, Spectrum Associates (London) Ltd	01/10/2006	Ongoing	Declare in line with conflicts of interest policy	16/09/2023
Soyombo	Bola	Secretary, Milton Keynes Local Dental Committee / Chair, Restorative Dentistry Management Clinical Network covering BLMK and HWE / LDC Rep Primary Care POD Delivery Group / Member, BLMK Health & Care Senate	Yes	Y				Director, Spectrum Associates (MK) Ltd	01/10/2006	Ongoing	Declare in line with conflicts of interest policy	16/09/2023

Surname	Forename	Position within, or relationship with the ICB	Interests to Declare	Financial Interest	Non-Financial Professional	Non-Financial Personal	Indirect	Description of Interest	Date From	Date To	Actions to be taken to mitigate risk	Date Declared
Soyombo	Bola	Secretary, Milton Keynes Local Dental Committee / Chair, Restorative Dentistry Management Clinical Network covering BLMK and HWE / LDC Rep Primary Care POD Delivery Group / Member, BLMK Health & Care Senate	Yes	Y				Provider/Performer Soyombo Dental Specialists MK	01/11/1994	Ongoing	Declare in line with conflicts of interest policy	16/09/2023
Soyombo	Bola	Secretary, Milton Keynes Local Dental Committee / Chair, Restorative Dentistry Management Clinical Network covering BLMK and HWE / LDC Rep Primary Care POD Delivery Group / Member, BLMK Health & Care Senate	Yes		Y			Secretary, Milton Keynes Local Dental Committee	01/07/2019	Ongoing	Declare in line with conflicts of interest policy	16/09/2023
Soyombo	Bola	Secretary, Milton Keynes Local Dental Committee / Chair, Restorative Dentistry Management Clinical Network covering BLMK and HWE / LDC Rep Primary Care POD Delivery Group / Member, BLMK Health & Care Senate	Yes		Y			Chair, Restorative Dentistry Managed Clinical Network covering formerly HBLMK but now BLMK and HWE	01/09/2016	Ongoing	Declare in line with conflicts of interest policy	16/09/2023

Surname	Forename	Position within, or relationship with the ICB	Interests to Declare	Financial Interest	Non-Financial Professional	Non-Financial Personal	Indirect	Description of Interest	Date From	Date To	Actions to be taken to mitigate risk	Date Declared
Soyombo	Bola	Secretary, Milton Keynes Local Dental Committee / Chair, Restorative Dentistry Management Clinical Network covering BLMK and HWE / LDC Rep Primary Care POD Delivery Group / Member, BLMK Health & Care Senate	Yes	Y				Advanced Centre Performer/Provider East of England Dental Trauma Pilot	01/04/2021`	Ongoing	Declare in line with conflicts of interest policy	16/09/2023
Soyombo	Bola	Secretary, Milton Keynes Local Dental Committee / Chair, Restorative Dentistry Management Clinical Network covering BLMK and HWE / LDC Rep Primary Care POD Delivery Group / Member, BLMK Health & Care Senate	Yes		Y			Specialist in Peridontics, Smile Creations, Leighton Buzzard	02/07/1995	Ongoing	Declare in line with conflicts of interest policy	16/09/2023
Stanley	Sarah	Chief Nurse	No									08/09/2022
Turner	Philip	Chair, Healthwatch Luton	No									06/12/2022
Westcott	Dean	Chief Finance Officer	Yes		Y			Board Advisor, London School of Commerce	01/12/2022	Ongoing	Declare in line with conflicts of interest policy	13/12/2022
Westcott	Dean	Chief Finance Officer	Yes				Y	Wife is Senior Mental Health Transformation Manager at West Essex CCB	01/06/2021	Ongoing	Declare in line with conflicts of interest policy	14/06/2022
Whiteman	Sarah	Chief Medical Director	Yes			Y		Civil partner, Advanced Nurse Practitioner (Walnut Tree Health Centre, Milton Keynes)	2013	Ongoing	No involvement in relation to decision making	14/06/2022
Whiteman	Sarah	Chief Medical Director	Yes		Y			Stonedean, Practice - Sessional GP/former partner	01/06/2007	Ongoing	No involvement in relation to decision making	14/06/2022

Surname	Forename	Position within, or relationship with the ICB	Interests to Declare	Financial Interest	Non-Financial Professional	Non-Financial Personal	Indirect	Description of Interest	Date From	Date To	Actions to be taken to mitigate risk	Date Declared
Whiteman	Sarah	Chief Medical Director	Yes		Y			General Medical Council Associate	2012	Ongoing	Exclusion of self from involvement in related meetings, projects or decision-making	14/06/2022
Whiteman	Sarah	Chief Medical Director	Yes	Y				Akeso (coaching network) – coach – Executive and Performance Coach	01/04/2021	Ongoing	Open declaration, no monies received	14/06/2022
Whiteman	Sarah	Chief Medical Director	Yes	Y				NHS England – Appraiser	2010	Ongoing	Exclusion of self from involvement in related meetings, projects or decision-making relating to any relevant practitioners	14/06/2022
Whiteman	Sarah	Chief Medical Director	Yes	Y				NED role at James Paget Hospital	01/10/2023	Ongoing	No involvement in relation to decision making	18/10/2023
Whiteman	Sarah	Chief Medical Director	Yes	Y				NED, Lincolnshire Partnership Trust	01/02/2024	Ongoing		01/02/2024
Wrack	Alexandra	Bedford Borough Head of Place	No									01/02/2024

Item 3.

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Date: 15 December 2023
Time: 0900-1130
Venue: MST

Minutes of the: **Primary Care Commissioning & Assurance Committee (PCC&AC)**

Meeting held in Public

Members:		
Name	Role	Initial
Alison Borrett	Chair / Non-Executive Member BLMK ICB	AB
Amanda Flower	Associate Director of Primary Care Commissioning &Transformation BLMK ICB	AF
Craig Lister	Associate Director Prevention Lead, Covid and Flu Immunisation & Vaccination Strategy Lead BLMK ICB	CL
Elizabeth Elliot	Consultant in Public Health, Luton Council *(Deputising for Sally Cartwright)*	EE
Emma Freda	Chief Executive Officer, Healthwatch Bedford Borough	EF
Lorraine Mattis	Associate Non-Executive Member BLMK ICB	LM
Lynn Dalton	Associate Director of Primary Care Development BLMK ICB	LD
Marimba Carr	Deputy Director of Public Health at Milton Keynes Council, representing the Director of Public Health for MK, Central Bedfordshire and Bedford Borough	MC
Mike Harrison	Co-Chief Executive, Bedfordshire & Hertfordshire LMC Ltd	MH
Nicky Poulain	Chief Primary Care Officer BLMK ICB	NP
Patricia Coker	Head of Integration (Health and Adult Social Care) Social Care, Health and Housing, Central Bedfordshire Council *(Deputising for Andy Sharp)*	PC
Phil Turner	Chair, Healthwatch Luton	PT
Roger Hammond	Associate Director Finance (Primary Care & Out of Hospital Services) BLMK ICB *(Deputising for Dean Westcott)*	RH
Sarah Stanley	Chief Nursing Director BLMK ICB	SS
Dr Sarah Whiteman	Chief Medical Director BLMK ICB	SW
Tracy Keech	Deputy Chief Executive Officer, Healthwatch Milton Keynes	TK

Apologies:		
Cllr Fatima Begum	HWBB representative Luton Council	FB
Diana Blackmun	Chief Executive Officer, Healthwatch Central Bedfordshire	DB
Dean Westcott	Chief Finance Officer BLMK ICB *(Roger Hammond Deputising)*	DW
Lauren Sibbons	Senior Contract Manager BLMK ICB	LS
Mahesh Shah	Primary Medical Services Providers Partner Member BLMK ICB	MS
Manjeet Gill	Non-Executive Member BLMK ICB	MG
Dr Matt Mayer	Chief Executive Officer, Berkshire, Buckinghamshire & Oxfordshire LMCs	MM
Dr Tayo Kufeji	Primary Medical Services Providers Partner Member, BLMK ICB	TKU

In attendance:		
Felicity Cox	Chief Executive Officer BLMK ICB	FC
Jill White	Senior Primary Care Contracting & Development Manager BLMK ICB	JW
Nikki Barnes	Head of System & ICB Estates BLMK ICB	NB
Marie Lehane	Head of Primary Care Workforce Programme BLMK ICB	ML
Mark Peedle	Head of Digital Delivery BLMK ICB	MP
Mona He	Audit manager, Internal Auditor Public Sector, BDO LLP	MHE
Rima Makarem	Chair BLMK ICB	RM
Susi Clarke	Associate Director for People Transformation – Fuller Programme	SC

No.	Agenda Item	Action
1.	**Welcome, Introductions and Apologies (Chair)** The focus of the Committee is to seek assurance on the commissioning of primary medical, pharmacy, optometry and dental services for Bedfordshire, Luton and Milton Keynes (BLMK). The Chair confirmed that a second Associate Non-Executive Member of the ICB Board, Lorraine Mattis, had been appointed to the Committee as a non-voting member. The meeting would be recorded for the purpose of the minutes only and the recording deleted. The meeting was confirmed as quorate. No questions had been received from members of the public prior to the meeting.	
2.	**Relevant Persons Disclosure of Interests (Chair)** Members confirmed their entries on the register of interests were accurate and up to date. No other declarations were made prior to or at the meeting for any offers of Gifts and Hospitality received in the last 28 days not registered with the Governance and Compliance team. The following potential declarations of interest to matters on the agenda were made during the discussion at item 6: *RM (Lay Member of General Pharmaceutical Council); FC (Pharmacist) and LM (Chief Executive Officer, University of Suffolk Dental CIC). LM also declared an interest at item 14.* Chair confirmed at the point of declaration that no individual was required to leave the meeting for these items. The items were for discussion and noting only.	
3.	**Minutes and Matters Arising (Chair)** The minutes for the meeting held in public on 16 June 2023 were for information only. Minutes approved by the Committee at a private meeting held on 15 September 2023.	
4.	**Review of Action Trackers 15 September 2023 (Chair)** The action tracker was reviewed, and the following updates agreed: Actions 15 and 18 remained in progress. Action 17 closed.	
5.	***BLMK Fuller Programme*** **BLMK ICS Primary Care Prevention Delivery Plan (Craig Lister)** The plan outlines a coordinated, ambitious approach to prevention across all primary care settings in BLMK. Implementation of the prevention plan will have a positive impact on the health and wellbeing of the BLMK population including a reduction in future demand. The plan was presented to the ICB Board on 8 December 2023. The plan was developed by a wide range of stakeholders including Public Health, Community Pharmacy and the Voluntary, Community and Social Enterprise (VCSE) sector. It is fully aligned with the four Local Authority's prevention programs with the aim to further embed more prevention work in Optometry and Dental settings. The plan takes stock of current preventative work and outlines general priorities that apply to prevention. It highlights gaps and how to maximise the value and effectiveness of prevention work by greater co-ordination and collaboration across the ICS. A final iteration will be presented to the BLMK Primary Care Medical Services Delivery Group on 9 January 2024. The action plan will evolve and be dynamic. Future actions will be shaped and prioritised through the four Place Boards.	

	Promotion of the plan will take place through protected learning times for GP Practices, Primary Care Network Clinical Director's meetings, Local Authority opportunities and VCSE events. The Committee discussed: - the challenge of demonstrating the impact of prevention. SS offered support on how to monitor and deliver utilising the range of measures available to demonstrate change. - MC confirmed the available capacity in public health preventative programmes and noted the decline in referrals to the stop smoking services post covid. Public Health work closely with the ICB to ensure primary care are aware of services available and provide support with training and a straightforward system for referrals into their services. EE emphasised the amount of prevention work already in place behind the plan. The additional support through partnership working to embed prevention is beneficial. - ICB and Local Authorities review and share learning from other care systems to transform health care and improve outcomes. Luton's Marmot Town work and contribution to the Luton 2040 vision with its focus on the wider determinants of health, which have a significant impact on prevention, could be linked into the outcome measures. The learning from Luton to be shared with other BLMK areas. - Prevention in secondary care will form part of the Health Services Strategy. - CL confirmed the involvement of and close working with the VCSE sector and Healthwatch on prevention. Committee **noted** and **confirmed their endorsement** of the progress of the BLMK Primary Care Prevention Delivery plan and the next steps for delivery. Update requested on 15 March 2024 on progress and outcome measurements.	
6.	**Primary Care Workforce Programme & Highlight Report (Susi Clarke)** The report provided an update on the Primary Care Workforce Programme via the detailed highlight report which illustrated progress against the programme's strategic workstreams. The main areas of focus for the next few months were highlighted: ▪ Targeted support to Primary Care Networks (PCNs) to maximise Additional Roles. Reimbursement Scheme (ARRS) funding. Monthly Workforce Forum established for PCN Managers/Clinical Directors to share learning to maximise spend and offer support through peer review and challenge. ICB monitor spend monthly and support PCNs with recruitment and reviewing alternative employment models where there are estates constraints. ▪ Pharmacy Workforce plan has created a route into general practice for newly qualified and third year students through the summer placement programme. The New to Practice fellowship has been extended to Pharmacists. ▪ Festival of Learning event planned for 29 February 2024 to share PCN developments, best practice and learning in BLMK and other areas. ▪ Ongoing programme of development for all Clinical Leads. Future events include a third Personalised Care Conference in March 2024, Community Pharmacist Event 24 January 2024 and a second Clinical Lead event on 16 May 2024. Key themes are the focus on integrated neighbourhood working, sharing case studies and raising level of awareness of the innovative work happening at a PCN and neighbourhood level. ▪ Sharepoint site developed to house all resources on one platform accessible to all primary care workforce.	

	The Committee raised the following points: The following potential declarations of interest were made during this discussion *RM (Lay Member of General Pharmaceutical Council); FC (Pharmacist) and LM (Chief Executive Officer, University of Suffolk Dental CIC).* - SC addressed the challenge to ensure both Community Pharmacy and General Practice were suitably resourced with Pharmacists. A system Pharmacy Workforce Strategy Group will be established to include Community Pharmacists and key stakeholders. The BLMK summer student placement programme offers third year students a six-week placement in General Practice as part of their rotation and promotes retention to BLMK. NP, RM, SW, SC and Martha Roberts (ICB Chief People Officer) are working to influence the pharmacy workforce challenge at a local level. FC offered her support, experience and connections. - There is currently no national additional funding or capacity for the Training Hub to support pharmacy, optometry and dental staff groups. However, BLMK are being flexible to support staff with the skills and expertise it already has in place. For example, the Health & Wellbeing Pilot is open to all primary care staff and the Hub is supporting community pharmacists aligned with the work of the ICS Community Pharmacy Integration Lead. ICB are keen to support training and development of the dental workforce. Discussions taking place at a national level for funding from Health Education England (HEE) to ICB Training Hubs to build on the work already being untaken. ICB are exploring the opportunities to support the dental workforce with the Local Dental Committees (LDCs). - Training Hub team works at both a practice and PCN level to focus on team dynamics and development, culture and practice and organisational development. The Health and Wellbeing Project Manager is focused on equality, diversity and inclusion and what we can share as a system. - SC to invite clinical pharmacists to the community pharmacist event and contact TK to discuss supporting the alignment/relationships vital to integrated neighbourhood working. - MH asked how the ICB planned to address the continuing investment in ARRS alongside the risk of GP Locums being unable to find work (currently an issue in north of England). Feedback from LMC that practices were not hiring but didn't want to reduce GP headcount, however cost was a concern and this could negatively impact new GP trainees. System Partners to work together to understand the systems workforce, particularly as part of the work on the model for same day primary care access. NP requested a strategic piece of work to review staff in the system to consider what a future staffing model could look like. Committee **noted** the contents of the highlight report. **ACTION20: Map staffing across the current urgent same day system.**	**SC**
7.	**Delivering Integrated Primary Care in BLMK – an update on the response to the NHSE 'Delivery Plan for Recovering Access to Primary Care.' (Amanda Flower)** The key aspects of the BLMK response to the NHSE Delivery Plan for Recovering Access to Primary Care were outlined. ▪ ICBs are collating responses to summarise the work happening across BLMK to support residents' experience of access. ▪ NHSE completed an initial review of the draft BLMK plan with positive feedback and support of the progress. The plan will continue to be reviewed and updated to reflect progress and stakeholder feedback.	

	▪ Report detailed progress against each of national four domains and the additional local domains added by BLMK ICB for the integration of primary care, (opportunities with the delegation of Pharmacy, Optometry and Dental and enabling improved access). ▪ ICBs are required to provide assurance on progress against the BLMK ICB Plan to deliver the requirements of the national 2-year 'Delivery Plan for Recovering Access to Primary Care to their public board meetings in December 2023 and March 2024. The report to the ICB Board on 8 December 2023 provided assurance and a request for its support to seek increased Acute Trust Partner executive leadership to drive the opportunities for efficiencies identified within the primary and secondary clinical interface forums. Positive discussions have been held with Trust executive leadership on how to support and improve interface discussions and ensure actions are progressed. ▪ BLMK response to the Delivery Plan is a standing item at the monthly BLMK Primary Care Medical Services Delivery Group alongside the BLMK Fuller Programme. The ICB's vision for the integration and transformation of primary care draws on the ambitions in both reports. ▪ For the full response to the Delivery Plan contact amanda.flower@nhs.net Committee discussed the following points on the NHS APP and digital exclusion: - BLMK practices are all on one IT system (SystmOne) and were early adopters of APPs. The NHS App enables access to a range of NHS services, including ordering repeat prescriptions; book and manage PC appointments; view GP health record. - ICB want to adopt a place-based approach with (i) demonstrations of the functionalities of the NHS App to local Councillors and (ii) embed champions for the APP in each place. ICB will continue to work with Practices to support their increased use of its functionality and with residents to increase their understanding and experience of using the APP. - ICB's work on inequalities is embedded to support the ICB's digital strategy of 'digital first, not digital only', recognising that residents are using other Apps/systems with good results or may have difficulty in navigating these systems. The Committee can be sighted on both the digital enablers and the more personalised care approaches for residents. Committee **confirmed assurance** for the BLMK response to the NHSE Delivery Plan.	
8.	**Delivering Integrated Primary Care in BLMK – an update on the delivery of Integrated Neighbourhood Working in BLMK (Amanda Flower)** The BLMK Fuller system programme aims to anchor transformation at place to deliver the vision for integrated neighbourhood working aligned to local communities. The progress on the place-based plan to deliver the programme principles was reported following Dr Clare Fuller's attendance at the ICB Board in February where the decision was taken to establish place-based approaches to neighbourhood footprints. Via the Place Boards and with ICB support, the four places are defining their place-based neighbourhood footprints which will be used as the foundation for integrated primary care. There are currently 19 described neighbourhood footprints at place. Each place is progressing a series of workshops to engage stakeholders to develop and embed local neighbourhood working and the outcomes required for residents. The neighbourhood footprints at place demonstrate the population range and how PCNs align and support neighbourhoods. PCNs in Luton, Bedford Borough and Milton Keynes will learn into and support more than one neighbourhood.	

	The ICB Board supported in principle the high-level system road map across the four pillars but sought more ambition and a revisit of the timelines for pillar 3, (provision of proactive personalised care and support for people with complex needs and comorbidities).
	
	The work of PCNs to support personalised care was outlined and is a crucial foundation for delivery of integrated neighbourhood working. ICB to facilitate a share and learn approach of the work of the PCNs at the events and place-based workshops outlined in item 6. A lot of the PCN projects are in collaboration with or supported by VCSE organisations.
	
	The Committee discussed the report and raised the following points:
	- the importance of recognising that this is about systems working; neighbourhood working is an evolution of all place partners prioritising what can be done, clarifying timelines and what impact it has made. Examples and opportunities of neighbourhood working were shared and discussed:
	  - Noah (Luton based charity) work with twenty other organisations to offer personalised support to vulnerable people who are homeless.
	  - FC has presented neighbourhood working to Bedfordshire Chiefs from the Police, Fire, Prison, Probation services and with Local Authorities who are all interested in working collaboratively at place. Partners are discussing a shared post across all agencies to work on collaboration areas.
	
	Committee **reviewed** the content of this report and **noted** the progress to date.	

9.	***Primary Care Estates*** **Refresh of Primary Care Estates Strategy (Nikki Barnes)** The ICB Estates team are developing a programme of work to support the strategy refresh in alignment with the development of the system Infrastructure Strategy in 2024. The recommended approach is to complete a strategic estate needs assessment with a focus on efficiency, productivity and value for money. This will build on the existing Primary Care Estates Programme and the prioritisation process (2023) which prioritised 23 estates schemes. Further opportunities for additional space for primary care and potential net savings were identified through a review of NHS void and sessional space in NHS Property Services buildings. ICB supported 16 PCNs to develop clinical strategic and estates plans which, with the system road map across the four pillars, will feed into the refresh. The refresh is required: - to identify priorities going forward, maximise existing assets and opportunities and ensure future investment is channelled to where it is most needed and adds value; - to enable integrated care delivery through greater access to civic spaces to support prevention, early intervention and wider wellbeing activities; access to flexible spaces to bring multi-disciplinary teams together and enable same day primary care services etc.; - to develop a clear strategic plan to address inequalities in access to primary care facilities; - to plan to improve energy efficiency in primary care estate. ICB to complete a comprehensive assessment (heatmap) of challenges with existing estates, including access, patient experience, needs of the population. This will be cross referenced with existing tactical, strategic and workforce plans. All resources will be mapped including	

	S106 funding and a gap analysis completed at a system level. Future projects will be prioritised and discussions held at each place about local priorities and partnership opportunities. A programme of practice visits will support gathering of information and understanding of efficient models of operation in constrained practices. Estates team to work with the Primary Care Medical Services Delivery Group and Local Medical Committees on the metrics for a system heatmap, to close gaps in information and overlay with the existing work programme to identify the biggest challenges. The Committee were asked for their endorsement of the approach to refresh the strategy: - NB confirmed to TK that inequalities highlighted by the Denny Review would be incorporated into the refresh. - ICB ability to cope with emergent change of different levels of offers and support from local authorities to be built into the strategy to ensure all opportunities maximised. Committee **noted and endorsed** the emerging proposal for refreshing the Primary Care Estates Strategy as a key element of the development of the system Infrastructure Strategy.	
10.	**Primary Care Medical Services Contracting Assurance Update (Lynn Dalton)** The report set out the key developments over the past three months to provide assurance that all decisions have been made in a transparent, fair and equitable way in line with regulations, patient and practice needs, and that the ICB's duties as delegated commissioners have been fully discharged. The following items were highlighted: ▪ Five current list closures approved by the Primary Care Medical Services Delivery Group following due consideration of issues presented in the practice's applications. Three to reopen their lists in January 2024. ▪ ICB has one procurement in progress to offer Kingfisher Surgery (Milton Keynes) as a branch of an existing GMS practice. The outcome will be confirmed in January 2024. ▪ Changes to procurement regulations 2015 will come into force on 1 January 2024 with the Provider Selection Regime (PSR). ICB to review its procurement programme and approach for primary medical services in line with the new regulations. - LD confirmed to TK that the ICB would liaise with Fishermead Medical Centre on list closure messaging on their website. Committee **noted** the medical services contracting updates.	
11.	**Primary Care Dental Services Contracting Update (Lynn Dalton)** The Committee received an update on contracting work being undertaken and provided assurance that the ICB is meeting its delegated statutory functions for the commissioning and contracting of dental services. NHS England launched new national guidance "Opportunities for flexible commissioning of primary care dentistry: A framework for commissioners" in October 2023. The ICB have already taken actions towards flexible commissioning and are committed to a local approach. The key areas in 2024-25 are how to utilise financial clawback/reconciliation and reinvest in dental services and or oral health programmes with the four Local Authorities and to review workforce opportunities.	

	NHS England were the commissioner of contracts in 2022-23 and financial clawback returns to region for that period. NHS England have lifted the ringfencing on dental budgets and ICBs can consider using financial clawback in 2023/24 to contribute to support delivery of services. The Committee received assurance that funding had been accrued from the 2023/2024 and 2024/25 financial reconciliation to deliver the new dental access pilot. The 18-month pilot is anticipated to go live in January 2024 subject to clinical pathway redesign, working with the ICBs 111 providers. Dental contractors have submitted expressions of interest to deliver additional access on evenings, weekends and bank holidays. ICB aim to cover all four places and are working through the final details with contractors utilising the finite budget. Patients will access the pilot through the 111 service. The ICB and Public Health are benchmarking dental contractor's current prevention work. The information will be used to align with the Local Authorities oral health prevention initiatives to assist development of a focused system prevention and implementation plan. Committee raised the following questions: - LD confirmed to the Chair that information on how patients access the dental access pilot would be communicated once details on opening hours are finalised with contractors and prior to the service commencing. - ICB will conduct weekly collection and audit of the data to monitor effectiveness of the programme and ensure patients are receiving the right level of access to dental services. - Members discussed the benefit of delegated commissioning to the ICBs e.g., the dental access pilot provides additional capacity and supports the winter resilience plan and the importance of collaborative prevention work with pharmacy, optometry and dental colleagues. Committee **discussed** and **noted** the dental contracting updates.	
12.	**Pharmaceutical Services Regulation Committee Report (PSRC) - Q2 (Lynn Dalton)** The Committee received the second report of the Pharmaceutical Services Regulatory Committee (PSRC) following the delegation of community pharmacy services to the ICB in April 2023. Under the terms of the national delegation agreement, ICBs were required to establish PSRCs to enable them to carry out their statutory functions. The Memorandum of Understanding (MoU) between the ICBs in the East Region and Hertfordshire and West Essex ICB who host the Pharmacy and Optometry teams and the PSRC, is currently being reviewed. The Committee applies the regulatory tests as set out in the 2013 regulations to grant or refuse market entry applications and make decisions on fitness to practice matters. Report outlined the market entry and fitness decisions made at the monthly PSRC meetings between 1 July 2023 to 30 September 2023. The fitness to practice legacy case transferred from NHS England to BLMK ICB has been resolved. Members **discussed** and **noted** the report.	
13.	**Integrated Primary Care Dashboard (Amanda Flower)** The dashboard aims to demonstrate the impact of current initiatives discussed at this meeting to transform and develop integrated primary care. It is organised to correspond with the four	

	pillars of the BLMK Fuller programme. It is not intended as a performance tool as performance is assessed via contractual achievement and CQC assessments. ▪ Indicators currently focussed on general medical services with several still in development. ▪ Indicators to be included that represent the range of primary care provision including Pharmacy, Optometry and Dental. ▪ Data shows continual growth in total number of appointments provided by General Practice with a 4% growth year on year (2021-22 and 2022-23). Total number of appointments has seen a 10% increase on this time last year. ▪ Narrative to be provided with the data to explain the context of indicators. ▪ ICB to work with system partners to extend scope of the dashboard with indicators that demonstrate the breadth of integrated neighbourhood working. ▪ Indicators focused on long term conditions are relevant to general practice for proactive and personalised care. Other indicators are in development to be updated in future iterations. ▪ Dashboard is to illustrate the progress of transformation and the contribution that primary care providers make to residents and the system every day. The Committee were asked for their feedback about future indicators and its support on the progress to develop the dashboard: - dashboard designed to provide a set of indicators to each place to show where there are opportunities for further integrated working to support offers to residents, and consider how to work differently to access people who are not coming forward; - indicator(s) required to (i) show progress on addressing inequalities (Denny Review), (ii) prevention plan/programmes (e.g., national diabetes prevention programme in BLMK), and (iii) show if an increase/decrease is good or bad; - dashboard must be used to identify and share best practice to improve services; - AF confirmed to RM that there were a range of more sophisticated indicators to be considered for practices with cloud-based telephony to demonstrate how different access is being enabled. This alongside the appointment data and the modern general practice access model will help understand patient experience at place and demonstrate if projects on key programmes are having an impact. - AF confirmed to LM that the work the ICB are doing with practices and PCNs on the access delivery plan triangulates these indicators with the national GP patient survey, the Friends and Family Test and patient feedback / complaints. The Committee were thanked for their feedback and the ICB will look at the opportunities to extend the dashboard whilst maintaining the balance of delivering the key messages. Committee **noted** the breadth of primary care delivery in the BLMK system and the progress on developing an integrated primary care dashboard.	
14.	**Primary Medical Services Financial Report (October 2023)** **Primary Care Pharmacy, Optometry and Dental Financial Report (October 2023)** ▪ Primary Medical Services year to date overspend is mainly due to the Additional Roles Reimbursement Scheme (ARRS) and the national reporting requirements of NHSE. NHSE requires ICBs to show ARRS forecast at allocation received rather than expected full year spend. ICB has spent above the received 70% of funding with the additional funding to be	

received later in year. SC outlined in item 6 the ICB's ongoing support to PCNs to continue recruitment to fully utilise funding this year and into next year.

- Local Incentive schemes are below budget but not all claims received.
- GP IT underspend due to reduced IT support contracts and reclassification of some expenditure to other funding streams.
- National factors of volume price/supply issues and original NHSE planning assumptions have influenced the forecast overspend of £11.5m for Prescribing. This is managed across the totality of the ICB budget to ensure the ICB achieves its financial balanced position.
- £400k+ into primary care services for support offered during periods of industrial action. After M7 was reported, further funding was made available to NHSE to support industrial action costs. Flexibilities given to ICBs and wider system on other allocations, including the lifting of ringfencing on the dental budget, provided opportunities to mitigate financial pressures.
- The Primary Care pharmacy, optometry and dental position shows a net overspend at month 7 which, in part, is due to timing differences as the Doctors and Dentists Remuneration (DDRB) pay uplift was paid in October but will not be funded until month 8 (November).
- Ophthalmic position overspent due to increase in price and activity being higher than NHSE plan.
- Pharmacy overspend due to continuation of higher levels of activity from 2022-23 and NHSE planning assumptions.
- Dental position influenced by patient charges income being lower than planned offset by reduced other expenditure.
- ICB had anticipated an in-year underspend on dental and reinvested money into the dental access pilot and other areas.

The Committee discussed the following points:

LM declared an interest (Chief Executive Officer, University of Suffolk Dental CIC).

- LM questioned if clawback in dental provision would be used to support further dental access or be utilised across the ICB.

  NHSE issued guidance and financial support to Integrated Care Systems due to NHS financial pressures and industrial action costs. This included that underspends in the dental ringfence could be retained by the ICB. BLMK ICB has reinvested underspend in dental schemes (where identified) including the access pilot.

  The ICB inherited dental contracts on 1 April 2023 with a planned underspend by NHSE. The ICB Dental Team have been reinvesting where contractors have underperformed and supported the expansion of the community dental service aimed particularly at looked after children and people with learning disabilities and mental health issues. BLMK ICB has had to achieve an additional £25m savings on top of the £90m savings it had made going into the year. The funding to cover industrial action support was passed to the Acute Trusts. NHSE has told ICBs it is imperative that they balance their books and underspend must go into the baseline to support this. The remaining dental underspend will be part of the savings plan for this year. The ICB do not plan to do this on a recurrent basis as it plans to expand dental capacity.

	- FC confirmed to MH that funding for industrial action was predicated on the basis that there would be no further industrial action this year. Currently there is no additional funding for the latest action announced by junior doctors. - ICB monitor and forecast for overspends in all services where there is an increase in activity or costs. Next year's allocation for pharmacy and ophthalmic are being reviewed and NHSE recurrent reserves will support funding the recurrent position on both contracts. - The ICB Pharmacy team have achieved significant savings but the cost pressure behind prescribing costs is a national issue and not due to overprescribing. The ICB are working on local solutions but recognise the limitations. Committee **noted** that the Primary Care Medical Services Delivery Group receives and discusses detailed financial reports; the financial position year to date and forecast 2023-24 as at month 8 and the significant continuing financial pressure on prescribing. Committee **noted** that the Primary Care Pharmacy, Optometry and Dental Delivery Group receives and discusses detailed financial reports and the financial position year to date and forecast 2023-24 as at month 7.	
15.	**Primary Care Directorate and Digital Risk Registers (Amanda Flower)** The Primary Care Directorate risk register is monitored bi-monthly at the Primary Care Interconnectivity Meeting and quarterly at the Primary Care Medical Services Delivery Group (PCDG). The Primary Care Digital risk register is maintained by the Digital Team and reviewed on a regular basis, either monthly or when programmes are updated or closed. The risk registers are embedded in all directorate meetings to identify risks and take the appropriate controls and actions to mitigate them. ▪ PCDG supported the closure of two managed risks on 14 November 2023 (R0006/R0007) and included new risks (PCN0004, 5 and 6 related to PCNs and how the ICB support their continued development. ▪ Risk on 111 capacity (R0011) was de-escalated from the corporate risk register as programme of work, actions and controls are in place to be managed at a directorate level. ▪ Risks PCN0001 and PC0001 are due to be closed subject to approval at the next PCDG. ▪ Risk R0009 GP practices' resilience and ability to transform will be escalated to the corporate risk register recognising that the resilience and issues in the 89 practices has a significant impact for the population and system. The Dental risk register is being developed and will be taken to the Primary Care Pharmacy, Optometry and Dental Delivery Group in January 2024. Committee **noted** that risks relating to the Primary Care Directorate and Digital primary care workstreams were being identified and managed appropriately and that all risks continue to be logged and monitored in the 4Risk system.	
16.	**Communications from the meeting (Chair)** The Committee did not raise any key updates for the Chair to present to the ICB Board.	
17.	**Review of meeting effectiveness (Chair/All)** The Chair thanked the Committee for the challenges and discussion at today's meeting. Members agreed the improvement in the quality of discussions and reports.	

18.	**Annual Cycle of Business (Chair/All)** The annual cycle of business was **reviewed** and **noted**. Members invited to advise the Chair of any additional business items.	
19. 19.1	**Any Other Business (Chair/All)** **Cloud Based Technology (CBT) update (Mark Peedle)** Programme commenced with 34 Practices eligible for an upgrade to their analogue phone systems to Cloud Based Technology. The 7 Practices already on a lower grade CBT solution can apply under phase 2 of the programme to have their systems upgraded. The remaining 27 Practices have signed up to the programme with 26 completing Memorandums of Understanding. 1 Practice to present to their Board on 18 December 2024. 23 Practices selected the same CBT provider which presents opportunities to work across Practices/PCNs to unlock and access data. Installation of the systems to be completed by 31 March 2024. Committee received assurance on the following points: - ICB will discuss with Healthwatch and Patient Participation Groups how to review impact for patients and feed back learning and best practice into the wider regional network. - All Practices will be on a framework system which provides the same outputs although suppliers are different. There will be opportunities in the future to upgrade systems. - Practices will report on key performance indicators. 19.2 ICB has assessed potential impact of the NHS industrial action on 111 services and increased clinical assessment service for additional capacity.	
20.	Date/time of next meeting: 15 March 2024 at 0900-1230.	

Approval of Minutes:		
Name	Role	Date
Alison Borrett	Chair	28.02.24.
Primary Care Commissioning & Assurance Committee		

Item 4.

Primary Care Commissioning & Assurance Committee (PCC&AC) meeting held in Public - Action Tracker

Key

Escalated	**Escalated** - items flagged RED for 3 subsequent meetings - BLACK
Outstanding	**Outstanding** - no actions made to progress OR actions made but not on track to deliver due date - RED
In Progress	**In Progress.** Outstanding - actions made to progress & on track to deliver due date - AMBER
Not Yet Due	Not Yet Due - BLUE
COMPLETE: Propose closure at next meeting (insert date of meeting)	**COMPLETE** - GREEN
CLOSED	Actions to be marked closed and moved to 'Closed Actions" Tab once approved for closure at meeting.

Action No.	Meeting Date	Agenda Item	Action	Action Owner	Past deadlines (Since Revised)	Current Deadline	Current Position (Latest Update)	RAG
20	15.12.23.	Primary Care Workforce Programme & Highlight Report	Map staffing across the current urgent same day system.	Susi Clarke		10.05.24.		**Not Yet Due**

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Report to the Primary Care Commissioning & Assurance Committee 15 March 2024
5. Primary Care (Medical Services) Contracting Report

Vision: "For everyone in our towns, villages and communities to live a longer, healthier life"	
Please state which strategic priority and / or enabler this report relates to	
Strategic priorities	
☒	**Start Well:** Every child has a strong, healthy start to life: from maternal health, through the first thousand days to reaching adulthood.
☒	**Live Well:** People are supported to engage with and manage their health and wellbeing.
☒	**Age Well:** People age well, with proactive interventions to stay healthy, independent and active as long as possible.
☐	**Growth:** We work together to help build the economy and support sustainable growth.
☒	**Reducing Inequalities:** In everything we do we promote equalities in the health and wellbeing of our population.

Enablers			
Data and Digital ☒	Workforce ☒	Ways of working ☒	Estates ☒
Communications ☒	Finance ☒	Operational and Clinical Excellence ☒	Governance and Compliance ☒
Other ☐(please advise):			

Report Author	Jill White, GP Contract and Development Manager & Lauren Sibbons, Senior Primary Care GP Contract & Development
Date to which the information this report is based on was accurate	28 February 2024
Senior Responsible Owner	Nicky Poulain, Chief Primary Care Officer

The following individuals were consulted and involved in the development of this report:
Lynn Dalton, Associate Director of Primary Care Contracting and Development
This report has been presented to the following board/committee/group:
This report has not been presented elsewhere although does contain updates and outcomes from previous contracting papers presented to the Primary Care (Medical Services) Delivery Group (PCDG).

Purpose of this report - what are members being asked to do?

Members are asked to **note and confirm assurance for the following:**

1. **Contracting**
   - List closures
   - Boundary changes
   - Contract reissue project
   - General Practice Annual Electronic Self-Declaration (eDEC)
   - Investment and Impact Fund (IIF) appeals
   - NHS England arrangements for the GP contract 2024/25 (for information, to note only).

2. **Individual practice matters**
   - Cobbs Garden Surgery, Milton Keynes
   - Caretaking arrangements at The Village Medical Centre, Bedford – contract held by Queens Park
   - Wenlock Street Surgery – closure
   - 12 Goldington Road Surgery – planned closure.

3. **The ongoing primary care procurement programme**
   - Contract extensions for clinical waste vendors and Anenta as managing agent (**to approve 12-month extensions – 3.2.1.).**

4. **Planned delegation of public health section 7a services.**

Executive Summary Report

This report sets out key developments relating to primary care contracting over the past three months. The purpose of this report is to provide assurance to the committee members that all decisions have been made in a transparent, fair and equitable way in line with regulations, patient and practice needs and that our duties as delegated commissioners have been fully discharged.

1. Brief background / introduction:

This report gives an overview and update on any issues or concerns relating to BLMK general medical practices that may impact on patient care, service delivery or practice viability and/or risks of a contractual or regulatory nature. All matters in this report have been discussed and noted at the Primary Care (Medical Services) Delivery Group (PCDG) and are now shared with PCCAC members to note, confirm assurance and approve where required.

2. Summary of key points:

The committee is asked to note the following updates from the Primary Care (Medical Services) Delivery Group and confirm assurance:

1. Contracting

1.1 List closures

- The following practice lists have recently reopened following a period of closure:

Practice	Place	Start date	Length	Reopened
COBBS GARDEN SURGERY	MK	3/1/23	12 months	January 2024
DR MIRZA & PARTNERS	Luton	1/8/23	6 months	January 2024
SOVEREIGN MED CENTRE	MK	15/9/23	3 months	December 2023

- The following list closures are still in place and subject to regular review by the GP contracting team:

Practice	Place	Start date	Length	Due to reopen
LINDEN ROAD SURGERY	Bedford	3/5/23	12 months	May 2024
FISHERMEAD MED CENTRE	MK	21/9/23	12 months	September 2024

- No further applications for list closure have been received in recent months.

1.2 Boundary changes

- Bute House Surgery in Luton applied to extend their boundary in February 2024 and following due process the March PCDG has been asked to approve this extension.

1.3 Contract reissue project

- Following the delegation of primary medical services contracts to the ICB, the ICB was requested to undertake a programme of work to re-issue new General Medical Services contracts and/or contract variations to ensure that all GP contractors have contemporaneous contracts. The ICB currently has 89 GP contractors. All ICB practices with the exception of 12 Goldington Road Surgery in Bedford and Kingfisher Surgery in Milton Keynes, (contracts ending imminently as detailed elsewhere in this paper), and Malzeard Road (has applied for incorporation and novation of contract), have now been issued. The GP contracting team is continuing to ensure that all contracts are fully signed.

1.4 General Practice Annual Electronic Self-Declaration (eDEC)

- This is a mandatory annual contractual requirement that all general practices in England must complete. The responses are used by NHS England and the ICB to check practices are fulfilling their contractual requirements. CQC also uses the information to check GP practices meet the CQC registration requirements and the responses form part of the pre-inspection documentation.
- 100% of BLMK GP contractors completed and submitted their eDec within the national timeline. The final data cut has now been received and the GP contracting team are working through the priority flags and assessing the responses as the data reported will feed into the annual practice visit programme that the core primary care teams are managing.

1.5 Primary Care Networks (PCNs) - Investment and impact fund (IIF) appeals

The Investment and Impact Fund (IIF) is an incentive scheme focussed on supporting PCNs to deliver high quality care to their member practice population, and the delivery of the priority objectives articulated in the NHS Long Term Plan and in Investment and Evolution; a five-year GP contract framework. The scheme contains indicators that focus on where PCNs can contribute significantly towards the 'triple aim':

- Once PCNs have submitted their data, IIF targets and calculations on sums payable are undertaken at a national level.
- A number of PCNs submitted appeals against the 2022-23 outcomes for a variety of reasons and with no national guidance. ICBs were left to consider local responses and approaches to IIF 2022-23 outcomes.
- No achievement was recognised for practices who were not in a PCN and where services were provided under a managed contract and for practices which were associate members of a PCN.
- The following approach was agreed and approved at the February PC(MS)DG meeting:
  - To move all PCNs to 100% for targets AC-02 and AC-09 for the following reasons:
  - AC-02: this was the largest target (points wise) and had data recording issues. Less than half of the PCNs achieved any payment.

- AC-09: referral of activity to pharmacy consultation service. Very limited take up of pharmacies and hence practices had limited opportunity to achieve this target. Only two PCNs achieved any payment.
- Practices either not in a PCN or associate members of a PCN – achievement was manually calculated as if they had been a full PCN members and the relevant payments made.

The committee is asked to note the following:

1.6 NHS England announced arrangements for the GMS contract 2024/25

The contract consultation for 2024/25 has now concluded and NHS England has set out the arrangements for GMS contracts for the financial year 2024/25 **(Appendix A).** The letter provides assurance that General Practice is central to the NHS and the hard work of GP's and primary care staff is valued and appreciated. Furthermore, NHSE have stated that over the course of the last year they have listened closely to the view of the profession and patients and worked hard to address these in the GP contract where possible.

The key focus is simpler and more flexible arrangements to enable practices to reduce bureaucracy and free up time to help improve patient access and experience of primary medical services. The arrangements include:

- **Cut bureaucracy for practices** by suspending and income protecting 32 out of the 76 Quality and Outcomes Framework (QOF) indicators. The Investment and Impact Fund (IIF) indicators will be reduced from five to two and the Capacity and Access Payment (CAP) will increase by £46m to £292m by retiring the three Investment and Impact Fund (IIF) indicators.
- **Help practices with cash flow and increase financial flexibilities** by raising the QOF aspiration payment from 70% to 80% in 2024/25 and the Capacity and Access Improvement Payment (CAIP) will now start to be paid at any point in the year, once PCNs confirm to the ICB that they meet the simple criteria for payment.
- **Give Primary Care Networks (PCNs) more staffing flexibility** by including enhanced nurses in the Additional Roles Reimbursement Scheme (ARRS) and giving PCNs and practices more flexibility by removing all caps on all other direct patient care roles.
- **Support practices and PCNs to improve outcomes** by simplifying the Directed Enhanced Service (DES) requirements.
- **Improve patient experience of access** by reviewing the data that digital telephony systems generate to better understand overall demand and that on general practice in advance of winter.

2. Individual practice updates

The committee is asked to note the following updates from the Primary Care (Medical Services) Delivery Group and confirm assurance:

2.1 <u>Cobbs Garden Surgery</u>
Following partner resignations, the practice has accepted that the ICB will not accept a reversion from a partnership to a single-handed contractor but has been equitable and fair in its approach. The three months initial timeframe to recruit a new GP partner was extended to March 2024 and the practice has now been successful in recruiting. This is in addition to the recruitment of a non-clinical managing partner and successful recruitment to other staff posts.

2.2 <u>The Village Medical Centre (TVMC), Bedford – caretaking contract held by Queens Park</u>
When the current caretaker contract comes to an end on 31 March 2024, TVMC will become a branch of Queens Park Health Centre which is held under a General Medical Services (GMS) contract in

perpetuity. The ICB have agreed to financially support the practice with merger costs and financial support of £90,000.

2.3 Wenlock Street – closure

Following the termination by Dr Saleh of his General Medical Services contract the practice closed on 28 July 2023 and all patients have now been registered at new surgeries. The CQC inspection report into the practice has now been published and a lesson learned exercise will be carried out to encompass the 12 Goldington Road closure also.

2.4 12 Goldington Road Surgery – planned closure

Following CQC inspection visit on 7 December 2023, Dr Das resigned her General Medical Services (GMS) contract on 21 December 2023 in advance of CQC taking regulatory action to issue a Notice of Proposal to cancel the practice CQC registration.

The contract will terminate on 31 March 2024 and plans are being put in place for the closure and dispersal of the practice list to a single practice in Bedford. The ICB has undertaken a successful Expression of Interest approach and will imminently confirm which practice the patient list will be dispersed to.

The ICB has already notified patients and stakeholders of the practice closure and further communications will be issued week commencing 11 March 2024 once the details are finalised. The last operational day for the practice will be Thursday 28 March 2024 prior to the Easter Bank Holiday.

The ICB's Primary Care team are working closely with all parties including the LMC, CQC and the current organisation Bedoc who are managing patient services to support a safe practice closedown thereby ensuring all patients are successfully re-registered at the new practice. (As all patients have choice of GP practice providing they live within the practice boundary, patients can re-register with another practice if they wish).

3. Procurement update

The committee is asked to note the following updates from the Primary Care (Medical Services) Delivery Group and confirm assurance, and approve the 12-month contract extensions for clinical waste collection providers.

3.1 General Practice

The following 8 practices currently being delivered under Alternative Provider Medical Services (APMS) contracts form part of the ICB's ongoing procurement programme:

Practice Name	Place	Contract end date	List size Dec 23	Commissioning intention 23-24
Kingfisher	MK	31/3/2024	7,601	Offer as a branch of a GMS practice
Ivel Med Cent	C Beds	30/11/2024	13,397	Procure long-term contract
Cauldwell	Bedford	31/3/2025	10,347	NA – ongoing contract management
Putnoe	Bedford	31/3/2026	17,195	NA – ongoing contract management
Town Centre (Inc UTC)	Luton	31/3/2026	13,136	NA – ongoing contract management
Brooklands	MK	31/8/2028	22,239	NA – ongoing contract management
Whitehouse	MK	31/8/2028	13,953	NA – ongoing contract management
Kingsway	Luton	30/9/2028	19,497	NA – ongoing contract management

The following progress has taken place since the last PCCAC meeting:

- Successful conclusion of procurement exercise to offer Kingfisher Surgery as a branch of a GMS practice. Approval was given at a PCCAC chair's action meeting which took place on 23 January 2024 to award the contract to Newport Pagnell Medical Centre as the successful bidder. The practice becoming a practice of Newport Pagnell Medical Centre will be in perpetuity and will see a saving of £200k per annum on the APMS premium that was put in place at the time of contract award in 2014.
- Following completion of single tender waivers, the current contract holders of Putnoe Medical Centre and Luton Town Centre Surgery have agreed to contract extensions to March 2026 to align with urgent and same-day primary care reprocurement timelines.
- An expression of interest exercise for a new branch surgery in the east Milton Keynes (MK) expansion area is due to go out to Milton Keynes practices shortly.

3.2 <u>Other primary care contracts</u>

Other procurement activity taking place during 2024-25 includes the following:

3.2.1 Clinical waste collection services for general practices and community pharmacies.

To allow for this to take place and ensure continuity of services, the committee is asked to approve:

- 12-month contract extensions to vendor contracts (suppliers of clinical waste services).
- A 12-month contract extension for Anenta, who is the current managing agent for all the clinical waste suppliers**.**

This was being led as a national procurement but NHS England (NHSE) has now informed ICBs that they must procure their own services. The ICB is in discussions with others ICBs in our region to decide whether to adopt a collaborative approach and which procurement route to take.

Further information will be taken to the PCDG for discussion and all decisions will be reported to this committee for approval and assurance purposes. Due to the change of direction by the national team this has been escalated to NHSE (east) and will be discussed at the regional primary care directors meeting in early March. The ICB will now incur the cost of the procurement and require the staffing resource to undertake it. Hence further regional and national discussion is required.

3.2.2 Translation and interpretation services for all primary care contractors

Services are currently provided by two separate providers – DA Languages for spoken (foreign) languages and Language Empire for non-spoken (deaf) languages. The current contracts end on 31 March 2025 so consideration will need to be given to plans for April 2025 onwards.

3.2.3 Occupational health services for primary care providers

This contract is a mandatory requirement for all ICBs and is delivered under a national specification from NHSE. The service provides support to GPs, pharmacists and dentists predominantly for needlestick injuries albeit there are other services provided. Following advice from AGEM, the ICB's procurement advisors, a single tender waiver has been completed and signed off by the ICB executive team to re-award the contract for 4 years to Bedford Hospital occupational health service. To note Bedfordshire Hospitals Trust in an accredited OH provider.

3.2.4 Special allocations scheme (SAS)

GP practices may find themselves in a situation where they are faced by an abusive, violent or aggressive patient. In such cases the patient can be immediately removed from the GP practice

list, following the practice reporting the incident to the police and obtaining a crime reference number.

The SAS contract is held by Medicus and supports and rehabilitates patients that have been removed from their registered general practice for either abusive, threatening or violent behaviour. The contract was a call off from a national framework and was awarded for a period of 4 years with an extension for a further four years subject to mutual agreement and provider performance.

4 Planned delegation of public health section 7a services

The committee is asked to note this update and confirm assurance.

Following the delegation of GP, pharmacy, optometry and dental services by NHS England (east) to the ICB, the next stage of the programme is the delegation of NHSE public health section 7a services commencing with the national vaccination and immunisation services which includes childhood immunisation programme, flu, covid, shingles etc.

Primary care is working jointly with NHS England (east) to plan for the delegation and transfer of the services from April 2025. This will include the ICB completing a pre-delegation framework (PDAF) checklist with board approval to progress this programme of work.

This will be followed by the delegation of 7a cancer screening services anticipated for 2026. The delegation of these services is a requirement under the Health and Social Care Act (2022).

It is anticipated due to the current regional staffing resources there will not be sufficient staff for each ICB to have its own resource, therefore a hub model approach will be put in place and the current public health team will transfer to one ICB under a hosted model consistent with the approach taken for pharmacy and optometry team previously employed by NHSE (east) who were transferred to Hertfordshire and West Essex ICB, but continue to provide the service on behalf of the six ICBs through a memorandum of understanding between all parties. This is also consistent with the approach that will be taken of BLMK hosting the specialist commissioning services on behalf of region from 2025.

The PCDG will be the forum to support and drive this work and regular updates and papers will also be reported to this committee as a recommendation to the board of the ICB who will be required to approve the delegation in March 2025.

The benefit of delegation of these services is the ability of the ICB to work with vaccination providers (GP practices, community pharmacies, community providers, local authority public health and system partners), to improve vaccination uptake at a local level working with patients, and it will also be an opportunity to plan and develop local vaccination initiatives.

1. Are there any options?
As set out in the body of the paper for each item.

2. Key Risks and Issues
As set out in the body of the paper for each item.

Have you recorded the risk/s on the Risk Management system? Click to access system	Yes ☒	No ☐
Risk associated with the Wenlock Street closure has been added to the risk register.		

3. Are there any financial implications or other resourcing implications, including workforce?

No.

4. How will / does this work help to address the Green Plan Commitments? Click to view Green Plan

Care closer to home and the use of telehealth through remote consultations supports the reduction in carbon emissions.

5. How will / does this work help to address inequalities?

By ensuring continuity of primary care medical services, particularly in areas which may be underserved or experiencing deprivation. Consideration has been given to all protected groups and characteristics to ensure that our statutory requirements have been effectively discharged and that patients are not inadvertently discriminated against by any decisions that we make. Any changes to service delivery will have both a quality impact assessment (QIA) and an equality impact assessment (EIA) undertaken.

6. Next steps:

The primary care contracting team will notify practices of application decisions and vary contracts as applicable and/or monitor and oversee the implementation and action of any conditions that have been applied to a decision. The contracting team will report back to the PCDG within the agreed timeframe.

7. Appendices

Appendix A NHS England arrangements for the GMS contract 2024/25.

8. Background reading

All primary care contracts are underpinned by both primary and secondary legislation, which then informs regulations and then the contract.

In addition, primary medical care contracts need to be assessed against the criteria that is set out within the Policy Guidance Manual (PGM) to ensure that all contractors nationally are treated equitably by following due process. Policy Guidance Manual

BLMK ICB in addition take into consideration the sustainability of practices, taking a supportive approach to ensure continuity of and support to the primary care workforce and consider the impact on patient care. This is through our Primary Care Strategy.

Date published: 28 February, 2024
Date last updated: 29 February, 2024

Arrangements for the GP contract in 2024/25

Publication (/publication)

Content

To:

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

cc.

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

Dear colleagues,

Arrangements for the GP contract in 2024/25

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

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

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

1. **Cut bureaucracy for practices** by suspending and income protecting 32 out of the 76 Quality and Outcomes Framework (QOF) indicators. The Investment and Impact Fund (IIF) indicators will be reduced from five to two and the Capacity and Access Payment (CAP) will increase by £46m to £292m by retiring three Investment and Impact Fund (IIF) indicators.
2. **Help practices with cash flow and increase financial flexibilities** by raising the QOF aspiration payment from 70% to 80% in 2024/25 and the Capacity and Access Improvement Payment (CAIP) will now start to be paid at any point in the year, once PCNs confirm they meet the simple criteria for payment.
3. **Give Primary Care Networks (PCNs) more staffing flexibility** by including enhanced nurses in the Additional Roles Reimbursement Scheme (ARRS) and giving PCNs and GPs more flexibility by removing all caps on all other direct patient care roles.
4. **Support practices and PCNs to improve outcomes** by simplifying the Directed Enhanced Service (DES) requirements.
5. **Improve patient experience of access** by reviewing the data that digital telephony systems generate to better understand overall demand on general practice in advance of winter.

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

Now we are outside of the five-year framework, we will return to the pay review body process (Doctors and Dentists Review Body, DDRB) as the established process for determining pay uplifts for public sector workers, when workforces are not in multi-year deals. As the DDRB has not yet made recommendations to Government, we have included a planning assumption of 2% for pay growth (https://www.gov.uk/government/publications/autumn-budget-and-spending-review-2021-documents) in the GP contract. A further uplift may be made following the Government's response to the DDRB for 2024/25.

Cutting bureaucracy for practices

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

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

Helping practices with cash flow and increasing financial flexibilities

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

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

- To help improve practice cash flow, the QOF aspiration payment threshold will be raised from 70% to 80% in 2024/25.
- The Capacity and Access Payment (CAP) will increase by £46m to £292m by retiring three Investment and Impact Fund (IIF) indicators. As in 2023/24, 70% of the funding will be paid to PCNs without any conditions via the Capacity and Access Support Payment (CASP) proportionate to their Adjusted Population, in 12 equal payments. PCNs have the discretion to use the funding according to local needs – for example, the supervision of ARRS staff or to increase the care home premium within the PCN.
- As above, the remaining 30% of the Capacity and Access Payment (CAP) will be paid to PCNs via the Capacity and Access Improvement Payment (CAIP). To improve cashflow, this will be paid to PCNs at any point in the year in monthly instalments once the PCN Clinical Director (CD) confirms to their ICB that all practices within a PCN have put in place one or more of the three individual components of the Modern General Practice Access model, which each attract 1/3 of the overall CAIP funding.

Give PCNs more staffing flexibility

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

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

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

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

Streamlining the PCN DES requirements and increasing autonomy

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

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

- While the Enhanced Access specification will remain as a separate specification with the arrangements unchanged in 2024/25, the remaining eight PCN service specifications will be replaced by one simpler overarching specification.
- We are simplifying the PCN Clinical Director role specification by articulating the following key responsibilities: co-ordination of service delivery, allocation of resources, supporting transformation towards Modern General Practice and supporting the PCN role in developing Integrated Neighbourhood Teams.
- We will roll the PCN Clinical Director and PCN Leadership and Management Payment (£89m combined) into core PCN funding to give £183m in total. This is intended to provide PCNs with greater autonomy and to allow PCN Clinical Directors to lead their PCN in the way that best suits local arrangements.

Improving patient experience of access

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

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

We will shortly be publishing an update to the Delivery Plan including progress to date and the key milestones for 24/25. We will continue to support PCNs through contract funding – notably the increased CAP funding of £292m – as well as other available support offers (https://www.england.nhs.uk/gp/national-general-practice-improvement-programme/).

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

Next steps

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

NHS England will also host a webinar on Thursday 29 February at 5pm, to discuss the 24/25 contract. You can sign up online (https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.events.england.nhs.uk%2Fevents%2Fgeneral-practice-webinar-series&data=05%7C02%7Cgareth.tracey%40nhs.net%7Ce0c4026c402747dea62708dc384b0bc5%7C37c354b285b047f5b2

The consultation on the role of incentives schemes in general practice (https://www.gov.uk/government/consultations/role-of-incentive-schemes-in-general-practice/role-of-incentive-schemes-in-general-practice#how-to-respond) remains open until 7 March 2024 and we would like to hear all views.

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

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

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

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

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

Yours sincerely,

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

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

GP contract finance

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

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

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

Core practice contract

The Quality and Outcomes Framework (QOF)

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

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

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

Clinical/policy area	ID	QOF points
Mental Health	MH021	6
Depression	DEP004	10
Asthma	AST008	6
Register Indicators x 19 covering a range of clinical areas	CAN001, CKD005, CHD001, HF001, HYP001, PAD001, STIA001, DEM001, DM017, EP001, LD004, MH001, OB003, OST004, PC001, AF001, AST005, COPD015, RA001.	81

Clinical/policy area	ID	QOF points
QI indicators x 6	All	74
COPD	COPD014	2
Smoking	SMOK005	25
Cancer	CAN004	6
Cancer	CAN005	2

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

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

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

Digital Telephony data requirements

9. The amendments to the 2023/24 GP Contract require that when practices enter into any new digital telephone contract, it must be procured through the national framework. (https://digital.nhs.uk/services/digital-services-for-integrated-care/advanced-telephony-better-purchasing-framework/buyers-guide)

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

11. These eight metrics are:

1. call volumes
2. calls abandoned
3. call times to answer
4. missed call volumes
5. wait time before call abandoned
6. call backs requested
7. call backs made
8. average call length time

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

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

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

Performers list

14. During the COVID-19 pandemic there was an amendment to the Performers List Regulations that intended to allow doctors other than GPs to deliver primary care services without being on the Medical Performers List (MPL) if they had a prescribed connection to a designated body in the Medical Profession (Responsible Officers) Regulations 2010; or were granted permission to practise as medical practitioners in hospitals owned or managed by such bodies.

15. Flexibilities similar to the COVID-19 amendment will be made permanent. Doctors that are employed or registered with bodies designated by the Medical Profession (Responsible Officers) Regulations 2010 (Schedule, Part 1 only) will be able to deliver primary care services without being on the MPL. There will be a corresponding change to the GP contract

regulations.

16. These changes will permit GP practices and PCNs to employ doctors who are already employed, for example, by an NHS trust, NHS foundation trust or health board without the requirement for the doctor to also be registered on the MPL.

17. Supporting guidance will also be issued to clarify that non-GP doctors should not see undifferentiated patients, and that they continue to be required to operate within their sphere of competence.

Registering with a GP

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

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

Recognising the importance of continuity of care

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

Vaccinations and Immunisations

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

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

Changes to workforce data collection

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

Digital tools for catchment areas

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

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

Armed forces veterans

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

The Network Contract DES

The Additional Roles Reimbursement Scheme (ARRS)

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

- Enhanced practice nurses will be included in the roles eligible for reimbursement. This will allow nurses working at an enhanced level of practice and holding a (level seven or above) postgraduate certification or diploma in one or more specialist areas of care to be recruited via ARRS. As a new role, this will initially be capped at one per PCN (two where the list size is 100,000 or over).
- PCNs will be able to recruit other direct patient care non-nurse and non-doctor MDT roles, if agreed with their ICB.

- Where PCNs already have one mental health practitioner (MHP) in place, 50:50 funded by the PCN and the mental health provider, funding arrangements for subsequent MHP roles will be for agreement between the PCN and the mental health provider, subject to ICB approval. This could include additional MHPs being up to 100% funded through ARRS. All mental health practitioners will continue to be employed or engaged by the mental health provider.
- Caps on advanced practitioners will be removed.
- PCNs will be able to claim reimbursement for the time personalised care roles spend out of practice undertaking training or apprenticeships to obtain a level three occupational standard.

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

The Capacity and Access Payment (CAP)

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

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

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

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

MGPA priority domain	
1) Better digital telephony	Digital telephony solution implemented, including call back functionality; and each practice has agreed to cc Digital telephony data is routinely used to support capacity/demand service planning and quality improveme
2) Simpler online requests	Online consultation (OC) is available for patients to make administrative and clinical requests at least for the Practices have agreed to the relevant data provision notice (https://gbr01.safelinks.protection.outlook.com/? practice&data=05%7C02%7Ckeira.moulds%40nhs.net%7C1f3f83e6aee945be9bd408dc36c9886e%7C37c (DPN) so that data can be provided by the supplier to NHS England as part of the 'submissions via online c 2023&data=05%7C02%7Ckeira.moulds%40nhs.net%7C1f3f83e6aee945be9bd408dc36c9886e%7C37c354 publication.
3) Faster care navigation, assessment, and response	Consistent approach to care navigation and triage so there is parity between online, face to face and teleph Approach includes asking patients their preference to wait for a preferred clinician if appropriate, for continu

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

The Investment and Impact Fund (IIF)

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

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

PCN Clinical Directors requirements and funding

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

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

The Network Contract DES service requirements

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

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

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

Enhanced services

Weight Management Enhanced Service

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

Date published: 28 February, 2024
Date last updated: 29 February, 2024

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Report to the Primary Care Commissioning & Assurance Committee - 15 March 2024
5.1 Primary Care (Dental Services) Contracting Report
Vision: "For everyone in our towns, villages and communities to live a longer, healthier life"
Please state which strategic priority and / or enabler this report relates to

Strategic priorities	
☒	**Start Well:** Every child has a strong, healthy start to life: from maternal health, through the first thousand days to reaching adulthood.
☒	**Live Well:** People are supported to engage with and manage their health and wellbeing.
☒	**Age Well:** People age well, with proactive interventions to stay healthy, independent and active as long as possible.
☒	**Growth:** We work together to help build the economy and support sustainable growth.
☒	**Reducing Inequalities:** In everything we do we promote equalities in the health and wellbeing of our population.

Enablers			
Data and Digital ☒	Workforce ☒	Ways of working ☒	Estates ☐
Communications ☒	Finance ☒	Operational and Clinical Excellence ☐	Governance and Compliance ☒
Other ☐(please advise):			

Report Author	Lynn Dalton, Associate Director of Primary Care Diane Crew, Dental Primary Care Support Officer Debbie Wintle, Dental Commissioning Support Administrator
Date to which the information this report is based on was accurate	5 March 2024
Senior Responsible Owner	Nicky Poulain, Chief Primary Care Officer

The following individuals were consulted and involved in the development of this report:
Local Dental Committees.
This report has been presented to the following board/committee/group:
Primary Care (Pharmacy, Optometry and Dental) Delivery Group.

Purpose of this report

Members are asked to **note and confirm assurance for** the following dental contracting actions as recommended by the Primary Care (Pharmacy, Optometry and Dental) Delivery Group:

1. Opportunities for flexible commissioning in primary care dentistry
2. Year-end 22/23 and mid-year reconciliation 2023/24
3. Breach of contracts
4. Biopsy Pilot Service – Leagrave Sedation Service update
5. BLMK Dental Access Pilot
6. Collaborative working with Public Health
7. Dental work programme with East of England Region
8. Dental Reform Plan (2024) – faster, simpler and fairer.

Executive Summary Report

NHS England delegated commissioning responsibility for community pharmacy, optometry and dental services to the ICB on 1 April 2023. This is in addition to primary medical services contracts, which were re-delegated to the ICB on 1 July 2022 following changes to the Health and Social Care Act 2022.

The ICB has commissioning responsibility for 148 dental contracts (to note some contractors hold more than 1 contract), this includes 2 acute dental contracts and 2 Specialist Community Dental Services (SCDS) contracts. Also within the realm of dental contracts are acute dental contracting arrangements, and NHS England are supporting ICBs with on-going training sessions.

1. Brief background / introduction:

This report is a standing agenda item, to provide members of the Primary Care Commissioning and Assurance Committee with assurance and to seek approval where required. The purpose of the report is to provide the group with a current overview of dental contracting issues or concerns that may impact on patient care, service delivery, practice viability and or risks of a contractual or regulatory nature.

2. Summary of key points:

Dental Contracting update on actions taken following delegation.

1. Opportunities for flexible commissioning in primary care dentistry that have been implemented by the Primary Care team following NHSE releasing national guidance in October 2023.
2. Year-end 2022/2023 and mid-year reconciliation 2023/20244 – this remains work in progress and the committee is asked to note the appeals by dental contractors who provided urgent dental services during covid prior to NHS England stepping them down in April 2022. Appeals upheld as NHS England (east) agreed to extend the service for a final quarter during quarter 1 of 2022/23. Also, the mid-year position of 14 BLMK dental contractors in October 2023.
3. Breach of contracts - this is an update and confirms the contract for one dental provider terminated on 31 December 2023. Planning and scoping is currently taking place to utilise the budget and retain activity. These plans will be subject to the new procurement Provider Selection Regime procurement regulations (2024).
4. Biopsy Pilot Service – Leagrave Sedation Service update and plans for next steps to support a reduction in waiting time in secondary care at Bedfordshire Hospitals Trust.
5. BLMK Dental Access Pilot – update and next steps.
6. Collaborative working with Public Health.
7. Dental work programme with East of England region – this provides a summary of the key work programmes the ICB is actively involved in with regional ICB colleagues and region and some of the recent outcomes from the programme.
8. Dental Reform Plan (2024) – Faster, simpler and fairer - newly announced dental reform plans the actions taken to date by BLMK and previous actions taken by the ICB and next steps.

1. **Are there any options?**		
As set out in this paper.		
2. **Key Risks and Issues**		
As set out for each item.		
Have you recorded the risk/s on the Risk Management system? Click to access system	Yes ☒	No ☐
See separate risk register paper (item 8).		
3. **Are there any financial implications or other resourcing implications, including workforce?**		
As set out at each item.		
4. **How will / does this work help to address the Green Plan Commitments?** Click to view Green Plan		
For review.		
5. **How will / does this work help to address inequalities?**		
The ICB has given a commitment to stabilise existing dental contracts in 2023/24 and ensure continuity of services and retain access. The ICB will review opportunities within the delegated dental budget to review and commission dental services. The ICB will work in collaboration with NHS England, Dental Public Health Consultant, Public Health Consultant representing the four Local Authorities across BLMK. This work will support the planning and development of BLMK dental oral health prevention, once this work is complete it will be embedded in the ICB prevention and implementation plan to ensure system support to deliver the plans to address dental oral health inequalities.		
6. **Next steps:**		
7. **Appendices**		
Appendix A Dental Reform plans – faster, simpler and fairer.		
8. **Background reading**		
All primary care dental contracts are underpinned by both Primary and Secondary legislation, it is this that informs Regulations and the contracts. In addition, Primary Dental Care Contracts need to be assessed against the criteria that is set out within the 'Policy Book for Primary Dental Services' to ensure that all contractors nationally are treated equitably by following due process. NHS England » Policy book for primary dental services and NHS England » Opportunities for flexible commissioning in primary care dentistry: A framework for commissioners BLMK ICB in addition will take into consideration the sustainability of practices, taking a supportive approach to ensure continuity of and support to the primary care workforce and consider the impact on patient care. This will be developed through the Primary Care (Fuller Programme) Strategy.		

1. Opportunities for flexible commissioning in primary care dentistry – A framework for commissioners

In October 2023, NHS England launched new national guidance "Opportunities for flexible commissioning of primary care dentistry. Included at Appendix A is 'A framework for commissioners'. The guidance provides a framework for commissioners to explore opportunities for flexible commissioning to prevent poor oral health, protect and expand access and delivery high quality care.

The Primary Care team has implemented a number of opportunities as a result of flexible commissioning of primary care dental services as set out in the paper provided in December 2023. There are further opportunities for flexible commissioning that the ICB will want to explore with the Local Dental Committees and particularly what opportunities are there to support change in the dental workforce; it is intended to commence this work imminently:

1. Supporting contractors with low indicative Units of Dental Activity (UDA) values.
2. Redistribution of resources.
3. Additional investment into new contracts – scoping work for a new contract in Luton is current taking place as a result of the resignation of a dental contract held by IDH dental services. The ICB is planning to reprocure a new Personal Dental Services contract through a competitive procurement process that will commence in 2024.
4. Dental Public Health Services and further services – the ICB has commenced working with the Public Health Consultants for our four Local Authorities, with the aim of developing our dental oral health prevention plan to address oral health inequalities. Dental contractors are contractually obliged to provide dental oral health prevention advice; this can be done in practice or e.g., training practices through programmes of outreach. Under the Health and Social Care Act, Local Authority Directors of Public Health have a statutory duty to commission oral health programmes. To support this work the Associate Director of Primary Care will work with public health colleagues representing four Local Authorities and also the place-based teams in each area to build on current good work that is taking place and plan additional opportunities.
5. In December 2023 – to support improving access to dental services and reduce mid-year and year-end financial reconciliation, the ICB has advised contractors of mandatory dental and orthodontic services the opportunity to deliver up to 110% of their mandatory contract value on a non-recurrent basis in 2023/24 financial year. The additional capacity will be funded at contractors existing UDA value.

2. Dental year-end 2022/23 and mid-year 2023/24.

The ICB was informed the dental year-end budget for 2022/23 would see an increase in reconciliation from BLMK dental contractors required to repay the NHS funding that they have received in the previous financial year where they have not met their contracted activity.

In 2022/23 NHS England (east) was the commissioner of dental contracts and monies deducted/clawed back from dental contractors are returned to NHSE (east) to NHS England for further investment.

Dental contractors have a right of appeal if they do not agree with their year-end position. Noting that the dental activity is the information contractors submit to NHS Business Services Authority by way of FP17 which detail their dental activity. It is this information that is used to ascertain contractors' performance against their contracted activity.

During the peak of the covid-19 pandemic NHS England (east) commissioned Urgent Dental Centre (UDC) services across the region. Nationally UDC services were stepped down in April 2022 when dental contractors were required to return to business-as-usual. However, NHS England (east) region agreed to continue the UDC services in quarter one of 2022/23 stepping them down from 1 July 2022. A number of appeals were received by contractors of UDC services for Quarter 1 of 2022/23, their appeals were upheld and this has reduced the financial reconciliation due to be returned to NHSE. This will see a reduction in the financial deduction/clawback due by BLMK contractors of UDC services as outlined in table 1.

Although, at the start of 2023/24 delegated dental budgets were ringfenced, this position changed mid-November when NHS England confirmed with ICBs that ring fencing of dental budgets would be lifted.

Table 1 BLMK dental contractor contracted activity 2022/23 and mid-year position 2023/24.

BLMK ICB	No of dental contracts	Contracted Units of Dental Activity (UDA)	Activity achieved 2022/23	Year End 2022/23	Year end 2022/23 after appeals	Indicative Debt 2023/24 for contracts under 30%	Number of contracts under 30% in October 2023
Milton Keynes	28	301,305	254,364	£1,315,655.71	£1,194,178.07	£287,612.40	2
Luton	25	326,044	254,641	£2,400,127.33	£2,143,974.33	£1,249,534.06	4
Central Beds	35	330,219	268,100	£1,842,409.01	£1,585,921.52	£1,150,588.52	5
Beds borough	32	253,116	223,457	£918,975.01	£918,975.01	£485,208.67	3
Totals	**120**	**1,210,684**	**1,000,562**	**£6,477,167.06**	**£5,843,048.93**	**£3,172,943.65**	**14**

1. *This will be subject to any further appeals by dental contractors for 2022/23.*

The indicative debt is the position in January 2024, contractors have until the 31 March to meet their contracted activity and or submit their claims for work completed by 31 May 2024.

The ICB has commenced the mid-year reconciliation process for 2023/24 financial year, we anticipate this to be higher than previous years. NHSE BSA has written to 14 dental contractors who have not met the threshold to deliver 30% of their contracted activity by mid-year. They had 28 days to submit a plan of how they will meet their contracted activity by year-end. Contractors had until 28 February to submit their plans which will be reviewed by the dental team in early March.

3. Breach of Contracts

Remedial Breach Notices Issued	**Remedial Actions**	**Outcome of remedial notice**
2 Remedial Breaches issued: 1 Provider unable to attain contracted working hours from 2 separate contracted Locations (Bedford & Luton), due to workforce issues.	Luton Contract Provider requested to add another of their Luton contracts as an additional location to remedy lost hours provision. Bedford Contract Ongoing workforce rotas tested to ensure provision.	Luton contract Both Luton contract locations placed on each other's contracts for patient access ensuring stability to both practices and neighbouring practices. Bedford Contract Continual workforce realignment to cover contractual opening hours obligation. Update March 2024: The contractor is delivering contracted activity but is not going to achieve full contracted activity. The remedial breach is still in place whilst the contractor tries to rectify the situation through recruitment but is working with the ICB to try and resolve this.
1 Remedial Breach issued: Another Provider unable to attain contracted working hours from contracted Location (Luton), due to workforce issues.	Luton Contract No service delivery since April 2023. Dental team instructed a freeze in contract payments. Provider was in process of applying to changing the status of the organisational structure through disincorporation subject to ICB approval. The provider did not progress this option. The dental team continued to meet with the contractor on a weekly basis. At the end of the remedial breach period, the contractor served 3 months termination notice due to workforce recruitment pressures. The dental team continued to work with the practice and to ensure patient expectations are met until its termination date of 31 December 2023.	Remedial deadline not yet attained. Update March 2024: The contract has terminated and the ICB is scoping the re-procurement of this service with the aim to commence the procurement in 2024. Patients on the contractors orthodontic waiting list have been transferred to another orthodontic contractor.

4. Biopsy Pilot Service by Leagrave Sedation Clinic

In early 2022, NHS England instructed Deloitte to conduct a report into the number of patients waiting for treatment within secondary care oral surgery in the East of England. The findings of the report highlighted that there were many patients waiting for treatment. In response to this report a regional steering group was formed, led by the Regional Director of Primary Care and Cambridge & Peterborough Hospitals University Foundation Trust and attended by the Managed Clinical Networks Chairs (MCN), Trusts consultants, NHS England and ICBs The Minor Oral Surgery MCN chair is supportive of the pilot and clinical governance has been undertaken.

As region commenced the development of the biopsy pilot prior to delegating dental services to the ICB in April 2023, the ICB agreed to progress a pilot with one hundred patients to test if an accredited sedation clinic (at Leagrave Sedation Clinic) could successfully treat patients within a primary care setting. If the pilot concludes this is a viable option to support the shift of secondary care to primary care activity, reducing pressure on the Trust and reducing waiting times for patients. The total cost of the pilot is £27,400.

There was a delay in starting the pilot due to costs the provider Trust sought for processing pathology samples. As a result, the ICB has commissioned pathology services from the Spire Hospital Group, which enabled the pilot to commence on 28 September 2023.

Biopsy referrals waiting for treatment were allocated via our Dental Referral Management Service (prior to being placed on the acute Trust waiting list) to Leagrave Sedation Clinic. The clinic has completed 19 of 20 advance IV sedation cases and 46 biopsy cases as of 31 January 2024. The pilot will continue until the contractor has completed 100 cases. Preliminary patient feedback is positive, and patients received their follow up appointment within 3 weeks either by telephone or face to face appointment.

There are currently no outstanding referrals waiting for the service. Following discussion at the regional dental clinical pathway meeting the ICB has commenced working with the Bedfordshire Hospital NHS Foundation Trust to consider the feasibility of transferring patients who meet the clinical criteria from the Trusts waiting list to the pilot though sub-contracting arrangements. The Trust is currently reviewing its waiting list of patients waiting over 40 weeks who do not have an appointment within the next circa 8 weeks and who could be eligible to request a move to a different hospital/setting to be treated sooner to be directed to Leagrave Sedation Clinic. This would assist the Trust, also the contractor in achieving the pilot target number of patients to be seen and treated.

5. BLMK Dental Access Pilot

The ICB is planning to implement an 18-month dental access pilot in the four places in BLMK. The ICB issued a specification to dental contractors in November 2023, seeking expressions of interest from dental contractors who would be willing to take part in the pilot to provide additional appointments evenings, weekends and bank holidays utilising a finite budget.

The ICB received a number of Expressions of Interest and will be commissioning 8 dental contractors to take part in the pilot. The contractors will be paid for additional practice time and able to claim against their contracted Units of Dental Activity (UDA's). Patients will access the additional appointments via the 111 service. The ICB has been in dialogue with our two providers operating in BLMK area and this includes developing a new clinical pathway, clinical coding to ensure patients can access the appointments. The aim was to implement the pilot as soon as practicable to do so. The commencement of the pilot has been delayed for reasons outside of the ICBs control which we will shortly resolve. The dental team have kept all dental providers updated on the start date and once ready to commence we will be contacting the providers to firm up the final details and ensure they have adequate notice for operational planning prior to issuing the necessary contract variation notices. It is likely this will commence in early April 2024.

6. Collaborative working with Public Health Consultants representing Local Authorities.

The Primary Care team are working in collaboration with Luton's Public Health Team and Chair of Luton Dental Alliance Group. Prior to the ICB moving to delegated commissioning of dental contracts the Council had previously commissioned pop-up clinics in Luton for the under 8's, which included supervised tooth brushing and prevention advice. The Council commissioned and implemented 10 sessions throughout the year in community settings and provided funding for a 3.5-hour session led by dental health nurses.

The Primary Care team are collaboratively planning on-going commissioning for oral health activities and utilising NHS governance processes. To assist the Chair of the meeting the ICB made an introduction to the Bedfordshire Secretary of the LDC with the aim of joining the alliance meeting providing advice, guidance and representing the voice of all Luton dental contracts. This will also ensure any services commissioned by public health are open to all Luton dental contractors.

In addition, the ICB dental and prevention teams have engaged with our Public Health consultants for the four Local Authority areas to discuss oral health prevention within BLMK. Agreed the next steps to survey and benchmark the public health prevention work that BLMK dental contractors are undertaking either in-practice prevention or outreach. This will be triangulated with dental oral health initiatives being undertaken in each of the four LAs. This will be supported by the work the dental access needs assessment being undertaken by NHSE Public Health Dental Consultant to develop a BLMK oral dental health prevention plan to address health inequalities that will support the wider Integrated Care System (ICS) prevention and implementation plan with a focus on key priorities, which as a minimum we anticipate will be children's oral health prevention. Once the dental oral health prevention plan is ready it will be presented to the Delivery Group to review bringing the patient voice prior to the draft being socialised with dental contractors for their views and feedback.

5. Dental work programmes with East of England region

The Primary Care team are involved in a number of dental work programmes including the regional Local Dental Network and four Managed Clinical Networks. The team are working with NHS England (east) who prior to April 2023, had commenced a programme of work to review clinical priorities and pathways of oral and maxilla-facial surgery (OMFS) and secondary care dental services. Following a review of clinical priorities In November 2022, 5 region-wide task and finish groups were established to consider improvements in five key areas. The next phase of work is focusing on the development of business cases which is work currently in progress.

The key areas are:

1. Tempero-mandibular Joint (TMJ) pathway – paper will go to the clinical committee in March 2024.
2. Paediatric dentistry – East of England vision and recommendations developed in March 2024 and further exploratory work.
3. Sedation Services
4. Primary/Secondary Care Opportunities
5. Workforce – to be undertaken in collaboration with Local Dental Network, Managed Clinical Networks and NHSE/HEE and with Local Dental Committees.

When the business cases are ready, each ICB in the East of England, will be requested to consider and use their governance processes to approve the business cases (both clinical and financial approval). The first business case will be the Tempero-mandibular Joint (TMJ) pathway.

6. Dental Reform Plan (2024) – Faster, simpler and fairer

NHS dentistry has been under pressure for a number of years. Primary Care teams have been working with partners to meet rising demand and although there are steady improvements in access, this remains a priority area of focus.

The changes announced build on the first reforms to the dental contract in 15 years that NHSE announced in July 2022 and the new plan is an important next step in improving patient access to NHS dental care and supporting dental services to return to pre-pandemic levels of activity.

Measures include:

- NHS dentists will be given a 'new patient' payment of between £15-£50 (depending on treatment need) to treat patients who have not seen an NHS dentist in two years or more. This will begin from March 2024 and is time limited to end of financial year 2024/2025. BLMK has implemented this change for dental contracts in 2023/24 and 2024/25.
- Targeted funding to encourage dentists to work in areas which historically have been difficult to recruit to – further information is currently pending.
- A further increase in the minimum indicative UDA value from the £23 announced in July 2022 to £28 from April 2024. BLMK increased its minimum UDA rate to £27.50 in September 2023, this is an additional uplift for some BLMK contractors. The ICB will be reviewing the delegated dental budget to see what additional flexibility we have in 2024/25.
- Improving access in underserved areas through the use of dental vans. BLMK has been advised that it is not one of the areas that will receive funding for dental vans. However, the ICBs Specialist Community Dental Services (SCDS) do have dental vans and we will work with them to review their contracts and how we may be able to utilise their dental vans to support public health initiatives with our Public Health colleagues.

N.B. the ICB will shortly be meeting with our two Local Dental Committees and Dental Clinical Advisor and Healthwatch to consider additional opportunities for dental contractors.

In addition to these activities, the plan announces a range of government-delivered public health initiatives to improve the oral health of children and recommits to the workforce growth and development outlined in the Long Term Workforce Plan.

For the first time ever, a water fluoridation programme will be rolled out by government, which could reduce the number of tooth extractions due to decay in the most deprived areas of the country. Subject to consultation, the programme would enable an additional 1.6 million people to benefit from water fluoridation, first expanding across the North East.

BLMK has developed a draft dental workplan that has been shared with the Delivery Group. The plan will be refreshed and updated in view of the new reforms and presented to a future PCCAC meeting. The ICB will continue to work closely with NHSE on the delivery of the national commitments.

.

GOV.UK

NHS England

Department of Health & Social Care

Policy paper

Faster, simpler and fairer: our plan to recover and reform NHS dentistry

Published 7 February 2024

Applies to England

Contents

This publication is available at https://www.gov.uk/government/publications/our-plan-to-recover-and-reform-nhs-dentistry/faster-simpler-and-fairer-our-plan-to-recover-and-reform-nhs-dentistry

Foreword

Victoria Atkins, Secretary of State for Health and Social Care

Dentistry is a priority for this government. As the newly appointed Secretary of State for Health and Social Care, who represents a rural and coastal constituency in Lincolnshire where there are challenges around access to dental services, I understand the need to deliver real and immediate improvements for patients.

The impact of the pandemic on dental services was devastating. While the data is showing that the situation has improved (https://digital.nhs.uk/data-and-information/publications/statistical/nhs-dental-statistics/2022-23-annual-report) since the first year of the pandemic, there is much more work to be done - particularly to improve the provision of care across England.

I am delighted to announce this plan to make dental services faster, simpler and fairer. It aims to improve dental services by making them:

- faster for patients through our new patient premium to support dentists to take on new patients and a new marketing campaign to help everyone who needs one to find a dentist
- simpler for patients and for dental staff by streamlining and tackling bureaucracy, with a wider set of workforce reforms to maximise the skills across the entire dental clinical team
- fairer, particularly for our rural and coastal communities, by introducing new dental vans to bring dental care to our most isolated communities, offering ‘golden hello’ incentives to encourage dentists into under-served areas and supporting those practices with the lowest rates of payment for their work

This plan will fund more than 1.5 million additional NHS dentistry treatments or 2.5 million NHS dentistry appointments. A course of treatment can include more than one appointment for some patients.

Our plan has 3 components.

1. In 2024, we will significantly expand access so that everyone who needs to see a dentist will be able to. This will begin with measures to ensure those who have been unable to access care in the past 2 years will be able to do so - by offering a significant incentive to dentists to deliver this valuable NHS care. We are introducing mobile dental vans to take dentists and surgeries to isolated under-served communities.

2. We will launch ‘Smile for Life’ - a major new focus on prevention and good oral health in young children, to be delivered via nurseries and other settings providing Start for Life services, and promoted by Family Hubs. We will also introduce dental outreach to primary schools in under-served areas, and take forward a consultation on expanding fluoridation of water to the north-east of England - a highly effective public health measure.
3. We will ramp up the level of dental provision in the medium and longer term by supporting and developing the whole dental workforce, increasing workforce capacity as we have committed to do in the NHS Long Term Workforce Plan, reducing bureaucracy and setting the trajectory for longer-term reforms of the NHS dental contract.

This plan sets out a meaningful and practical set of actions that will help all of us look after our teeth now and in the future.

Andrea Leadsom, Minister for Public Health, Start for Life and Primary Care

Good oral health is essential for every one of us. Yet, since COVID-19 when most dentists had to close their doors, the recovery of NHS provision has been too slow, and many are still unable to access the treatment they need.

So, this recovery plan addresses the urgent need to boost access, and we aim to make sure everyone needing NHS dentistry will be able to access it. Not only that, but we are building capacity for the long term, supporting our excellent dental staff to work at the top of their training, and encouraging more hard-working dentists to those areas of England that are currently under-served.

But my real passion is for every baby to have the best start for life. And oral health begins even before birth. In our Family Hubs and settings that provide Start for Life services, we will promote the importance of good oral hygiene in pregnant mums. Parents-to-be will be offered guidance in how to care for baby gums and milk teeth to make sure good oral health is there from the start. In nursery settings, babies and toddlers will have toothbrushing as part of the daily routine, and it is our ambition that, by the time they reach primary school, every child will see toothbrushing as a normal part of their day. Supporting every parent to give their baby the best start for life is my top priority in my ministerial role.

Jason Wong, Chief Dental Officer, England (interim)

Good oral health is essential for good general health. Dental and oral health teams have been working hard to recover NHS services from the impact of the pandemic and meeting rising demand. However, we know that for some people it continues to be difficult to access NHS dental care. We know we must do more to help those who need access to our services, and I endorse the ambition of everyone who needs NHS dentistry to be able to access it.

The publication of this recovery plan is a significant step on the journey to improve and transform access to NHS dentistry and deliver care that meets the diverse oral health needs of people across England.

The NHS dental service is an essential cradle-to-grave prevention service. The government's launch of Smile for Life and the focus on early years is welcome, particularly for England's most deprived communities. The consultation on expanding water fluoridation in some parts of England is an opportunity to improve the oral health of communities for generations to come.

New funding is being made available from government that will provide millions of additional treatments for patients and make the service more attractive to staff.

Deploying dental vans, while longer-term solutions are established, will be welcomed by areas who are struggling with access, particularly our rural and coastal communities.

Offering dental teams a new patient premium to treat patients who've not seen an NHS dentist in over 2 years will help more patients access NHS dental care.

Changes such as uplifting the minimum unit of dental activity (UDA) value to £28 will make NHS dentistry provision more attractive and the service more sustainable. More importantly, it will make the NHS dental service fairer.

Growing the workforce so that more patients can access NHS dental care is critical in helping us improve and expand services. We will support government and the General Dental Council (GDC) in the introduction of provisional registration and making it easier for international graduates to work in England while maintaining our high standards. I have always been a strong advocate of the use of skill mix and look forward to further developing this in the provision of NHS care, and we will support the implementation of the NHS Long Term Workforce Plan.

Dentistry is an important service for the NHS and the government. This plan ensures dental teams are better supported to provide high-quality NHS dental care, so we can deliver for our patients.

Summary

Between 2020 and 2022, at least 7 million fewer patients saw an NHS dentist compared with pre-pandemic levels (https://digital.nhs.uk/data-and-information/publications/statistical/nhs-dental-statistics) (2022 data compared with 2019). As those patients have returned to dental practices, they have found it difficult to get the care they need.

Our commitment is to improve access to NHS dental care for people who need it, especially in under-served parts of the country, and improve preventative care for the youngest children.

We want everyone who needs NHS dentistry to be able to access it - wherever they live and whatever their background. And we want to embed good oral health habits across all parts of society - including a renewed focus on early years and our most deprived communities. Our hugely ambitious and far-reaching plan will tackle the different factors that make accessing dental care too difficult for too many patients.

We will support parents and families to protect the oral healthcare of babies and children, reducing the number of children having to go into hospital to remove their decaying teeth - a procedure that should be largely avoidable.

We will deploy new mobile dental vans into those areas where there are no NHS dental practices - bringing dental care directly to under-served, more isolated communities.

We will introduce a new patient premium for dentists treating new patients, because we know that if patients do not already have a relationship with a dental practice, they have struggled more to get appointments and treatment following the pandemic.

We will offer a ‘golden hello’ to dentists who want to move to those areas that persistently struggle to attract dentists into NHS work and make it easier for dentists from overseas who meet our regulatory standards to work in the NHS.

Our investment will deliver more than 1.5 million additional NHS dentistry treatments or 2.5 million NHS dentistry appointments for patients across England.

This plan takes bold steps to improve access for patients immediately and make changes so more dental therapists, hygienists, dental nurses and dentists can treat more NHS patients. We will support integrated care boards (ICBs) to improve care delivery, meaning more care for more people. Longer term, we will grow the workforce and work with dentists and other dental care professionals so that more people will want to deliver valuable, high-quality NHS dental care.

We aim to make dental services faster, simpler and fairer for patients and the dedicated workforce.

Launch Smile for Life: a new ambitious programme to promote good oral health across the life course

Working to improve prevention, in particular for younger children, we will:

- support Family Hubs and other settings that provide Start for Life services across England to promote prevention initiatives to improve the oral health of pregnant mums, and guidance for parents about how to protect baby gums and milk teeth from decay
- support nurseries and other early years settings to incorporate Smile for Life good oral hygiene into the daily routines of infants and toddlers so that, by the time they reach primary school, every child sees daily toothbrushing as a part of their normal routine
- starting later this year, deploy mobile dental teams into schools in under-served areas to provide advice and deliver preventative fluoride varnish treatments to more than 165,000 children, strengthening their teeth and preventing tooth decay
- consult on expanding water fluoridation, initially to the north-east of England, so more people benefit from the prevention of dental decay

Make access faster and fairer for patients by investing in care delivered to new patients and rolling out new ways of delivering care in rural and coastal areas through dental vans

We will:

- increase access for new patients by immediately introducing a new patient payment of either £50 or £15 for each patient, depending on treatment need, in addition to the funding the practice would already receive for their care
- support dentists to treat around a million new patients and launch a new public health campaign to raise awareness of how to find and access a dentist when you need one. The new patient payment will be in place until March 2025
- launch a new dental van service for the most rural and communities, with the first vans up and running later this year
- raise the minimum UDA value[footnote 1] to £28 this year, making NHS work more attractive and sustainable
- attract dentists into areas in need with ‘golden hello’ payments, starting with a first cohort of up to 240 dentists later this year
- apply a firmer ringfence on NHS dentistry budgets for 2024 to 2025 so ICBs can seek to improve dental access with this budget

- commence work this year to ensure that the funding provided to ICBs for NHS dentistry better reflects changing population demographics, such as ageing in coastal communities
- bring forward legislation early this year to enable dental care professionals to work to their full scope of practice

Reducing bureaucracy and making NHS dentistry simpler for patients and all dental professionals

We will:

- as part of the NHS Long Term Workforce Plan (https://www.england.nhs.uk/publication/nhs-long-term-workforce-plan/), build a pipeline of new dentists for the future by expanding dental undergraduate training places by 40% to more than 1,100 per year by 2031 to 2032, with an initial 24% increase to 1,000 places by 2028 to 2029
- consult this spring on ‘tie-ins’ to NHS for dentist graduates
- increase the number of dental therapists and other dental care professionals, through a 40% increase to more than 500 training places per year by 2031 to 2032
- make it easier for NHS practices to recruit overseas dentists who meet the UK’s highest regulatory standards

This plan is a significant step on the journey to improve and transform NHS dentistry and deliver care that meets the diverse needs of people across England. We will evaluate the plan and report on its implementation. The NHS and government look forward to working with patients and our brilliant dentists and dental staff, taking into careful consideration their views and advice on implementing this plan.

Smile for Life - taking action to prevent poor oral health

Prevent poor oral health, particularly in the very youngest children

Tooth decay is a significant, yet largely preventable public health problem in England. It affects people at all stages of life and is the most common oral disease affecting children and young people (https://www.gov.uk/government/publications/child-oral-health-applying-all-our-health). Those in the most deprived 20% of areas of the country are 2.5 times as likely to have experience of tooth decay (https://www.gov.uk/government/statistics/oral-health-survey-of-5-year-old-children-2022/national-dental-epidemiology-programme-ndep-for-england-oral-health-survey-of-5-year-old-children-2022#:~:text=Experience%20of%20dentinal%20decay%20by%20level%20of%20deprivation&text=In%202021%20to%202022%205,(see%20Figure%2017%20below).) as those in the least deprived 20% of areas. Tooth decay can disrupt children's learning and development as pain and infections from decayed teeth can result in school absences.

Tooth decay also has a considerable impact on the NHS. The costs to the NHS of hospital admissions for tooth decay-related extractions in children were £50.9 million in 2021 to 2022. (https://www.gov.uk/government/statistics/hospital-tooth-extractions-in-0-to-19-year-olds-2022) Improving prevention is key to reducing the burden on other health services, such as visits to A&E and secondary care services, for tooth extractions. That is why we are taking a number of steps centred around children to improve prevention of tooth decay.

Support oral health improvement in Family Hubs and other settings that provide Start for Life services

Family Hubs bring existing family services together to improve access to and connections between families, professionals, services and providers, and put relationships at the heart of family support. They are a 'one-stop shop' that make it easier and simpler for families to get the support they need, including oral health support.

At the 2021 Autumn Budget and Spending Review, the government announced around £300 million to fund a 3-year Family Hubs and Start for Life programme (https://www.gov.uk/government/collections/family-hubs-and-start-for-life-programme), which will create Family Hubs across 75 upper tier local authorities in England and support the provision of services so that every family can give their baby the best start in life.

We have published guidance for all local authorities on rolling out Start for Life (https://www.gov.uk/government/publications/family-hubs-and-start-for-life-programme-local-authority-guide), which sets out the universal Start for Life services we expect them to provide. As part of our plan, we will also provide guidance on how to promote good oral health in pregnant mums and the very youngest children. This will aim to help families access oral health improvement information and support, both online and within Family Hub networks. Family

Hubs and other settings that provide Start for Life services can also play an important role in signposting local oral health services.

We will promote a national universal offer of refreshed and new advice and education materials for all families to support and improve oral health in babies and younger children. We will work closely with local areas to share and promote good practice on oral health improvement support and learn from its implementation. We will ensure that the oral health prevention guidance can work effectively in a Family Hub or other setting providing Start for Life services, and consider how it can be strengthened and improved. We will work with local areas to explore the role that dental therapists and other dental health professionals can play to best support oral heath improvement for the youngest children and their families.

Improve oral health of children by providing oral health advice to parents and a Smile for Life programme into early years settings

Research shows that daily use of fluoride toothpaste reduces the incidence and severity of tooth decay in children (https://www.gov.uk/government/publications/delivering-better-oral-health-an-evidence-based-toolkit-for-prevention/chapter-9-fluoride). Several local authorities have already put public health grant funding towards supervised toothbrushing programmes. These have mostly been focused on school-age children, by which point the window of opportunity to embed behaviours for life in these children has narrowed.

We are keen to embed good oral health habits at an earlier stage, given the evidence that doing so later - for example, through supervised toothbrushing programmes in the later school years - will have less impact on outcomes but add administrative burdens to primary school teachers. To improve prevention for our youngest children, we will roll out support and education, targeting children aged 1 to 3 in a new Smile for Life programme. We will work closely with local areas to ensure our national advice and educational materials are tailored appropriately for nurseries and other early years settings.

Deploy dental teams to schools in areas of the country where oral health and NHS access is worst

We know that many, including children, still struggle to access dental care, and recovery of dental activity for children is not yet back to the same levels as it was pre-pandemic. We must go further to ensure that children can access

preventative care. That is why we will be deploying dental teams to bring preventative dental services such as fluoride varnish directly to children.

Dental teams will visit state primary schools in under-served areas, and provide fluoride varnish treatments and advice. By offering vital prevention measures to reception-age children, we can give them the best chance at reducing dental decay and having a healthy smile for life. We aim to have every child see toothbrushing as part of their daily routine by the time they go to primary school.

Improve prevention of tooth decay through the first national programme of water fluoridation

Water fluoridation is a safe and effective public health intervention (https://www.gov.uk/government/publications/water-fluoridation-health-monitoring-report-for-england-2022) to reduce the incidence of tooth decay and oral health disparities. The UK Chief Medical Officers have concluded there is strong scientific evidence that water fluoridation is effective (https://www.gov.uk/government/publications/water-fluoridation-statement-from-the-uk-chief-medical-officers/statement-on-water-fluoridation-from-the-uk-chief-medical-officers) alongside other methods of increasing fluoride use. Around 1 in 10 people in England currently have fluoride added to their drinking water supplies, mostly in the West Midlands and north east, including Newcastle and Gateshead. The benefits are clear. The latest health monitoring report in 2022 (https://www.gov.uk/government/publications/water-fluoridation-health-monitoring-report-for-england-2022) showed that, if all children and young people in the most deprived 20% of areas with lower fluoride concentrations (less than 0.2mg/l) instead received water adjusted by a fluoridation scheme, 56% of tooth extractions due to tooth decay in these areas would be prevented. Lower levels of decay and fewer tooth extractions would also reduce school absences and the need for further dental treatment over time.

Despite these benefits, there has been no significant expansion of water fluoridation in England since the 1980s. Ireland and the USA both have fluoridation covering 73% of the population[footnote 2][footnote 3], while Australia's covers 89% of the population.[footnote 4] This compares with around 10% in England.

Under new legislation, we have made it simpler to start new water fluoridation schemes. Our long-term ambition is to systematically bring fluoridation to more of the country, with a particular focus on the most deprived areas, which stand to benefit most from fluoridation.

As a first step, we are taking forward proposals announced in autumn 2022 to expand water fluoridation across the north east into Northumberland, County Durham, Sunderland, South Tyneside and Teesside, including Redcar and

Cleveland, Stockton-on-Tees, Darlington and Middlesbrough. The north east was chosen based on a combination of factors including the oral health needs of the region and water company experience operating schemes. Subject to consultation, this expansion would enable an additional 1.6 million people to benefit from water fluoridation. We will launch a consultation early this year.

Boosting patient access to NHS dentistry by increasing activity

Deploy dental vans in under-served areas while longer-term solutions are established

We know that there are some areas where patients struggle more to access the NHS dental care they need. We want to ensure that these patients can see an NHS dentist when they need to. To achieve this, we will deploy dental vans offering appointments to patients in targeted rural and coastal communities, starting later this year in the most under-served areas, while longer-term arrangements are set up.

These dental vans will provide care to patients in need, and patients will be able to have dental examinations and straightforward treatments, such as fillings. This builds upon the early successes with the use of mobile vans to boost access in Cornwall and other areas. The appointments offered in vans will rapidly enable more patients who have had to go without NHS care to have faster access to the treatment they urgently need.

Case study: Cornwall and Devon - Smiles at Sea UK

In Cornwall and Devon, Smile Together Dental community interest company (CIC) visits local fishing communities with its mobile dental unit every year to provide oral cancer screening and urgent or emergency dental care to fishermen and their dependent family members who can otherwise struggle to access traditional high-street dental care.

The service provides a range of dental treatment from oral health education, check-ups and x-rays to fillings and tooth extractions.

This service has helped to improve the oral health of fishermen who struggle to access a dentist due to their work and location. Funded by Smile Together and Seafarers Hospital Society and delivered in partnership with the Fishermen's Mission as part of their national 'SeaFit' service, including their partner network of healthcare providers, it is an excellent integrated health initiative.

Offer 'golden hello' payments to attract dentists into new areas

We are committed to increasing the availability of NHS dentistry in all areas with low provision but know that recruitment and retention is difficult in certain parts of the country. To support practices in areas where recruitment is particularly challenging, we will launch a new 'golden hello' scheme.

We will implement schemes working with ICBs that are struggling to recover their activity levels and would significantly benefit. A ‘golden hello’ of £20,000 will be offered per dentist for up to 240 dentists. Payments will be phased over 3 years, requiring a commitment from the dentist to stay in that area delivering NHS work for at least 3 years. We will decide on locations in the coming months, and we will review the effectiveness of this scheme before considering whether to extend the scheme in the future.

Make it easier for patients to access NHS treatment by introducing a new patient premium

We want to make it faster and simpler for new patients to access NHS dental care. To help services recover from the pandemic, we will offer dental practices an additional payment for each new patient requiring treatment. The purposes of this scheme will be to support anyone who has not been able to receive NHS dental care in the preceding 2 years. The payment level, of £15 or £50 depending on the treatment required, is in addition to the NHS funding a practice would already receive for this care, and recognises the additional time that may be needed for practices to assess, stabilise and manage the oral health needs of patients who have not received NHS dental care for more than 2 years.

The new patient premium will be a time-limited scheme launching in March 2024 and ending in March 2025. Patients are able to see which practices in their area are accepting new patients via the NHS website or the NHS app, and the public will be provided guidance via the NHS app and website on eligibility and details of the scheme. We will issue guidance to practices and ICBs on the operation of this new incentive scheme. We will measure the impact of this new payment on the number of new patients accessing the system and on wider access to NHS dentistry.

Uplift to UDA where rates are lowest

It can be harder for dentists to sustain their NHS work where the rates paid for each UDA are lowest. Having introduced a minimum UDA rate of £23 in 2022, we will now go further and raise the rate to £28. This will mean that almost 1,000 contracts will see an uplift to their UDA rate this year, supporting them and making treatment of NHS patients more sustainable.

We have also developed guidance to support local commissioning by ICBs (https://www.england.nhs.uk/long-read/opportunities-for-flexible-commissioning-in-primary-care-dentistry-a-framework-for-commissioners/), including how they can

consider addressing UDA rates locally to support better delivery of dental care for patients.

Reform the contract to make NHS work more attractive

We have listened to concerns from dental professionals around how NHS dental care is funded and how the current contract and business models may not support the high-quality, personalised and prevention-focused care dental teams want to provide. While our new patient premium will support practices to accept patients who are struggling to access care they urgently need, and contract changes already delivered last year reward practices more fairly for complex care, we know that further change is still needed for care of some patients who require more significant and ongoing treatment to improve their oral health.

Building on our guidance to support ICBs who are seeking to develop local services, we are developing further recommendations for dental contract reform to properly reflect the care needed by different patients and more fairly remunerate practices. We will also review what further action we can take to support professional development and skill mix within NHS dentistry, to make NHS dental care an attractive career choice where all professionals can work to their full scope of practice.

We expect to develop options for consultation with the dental profession in advance of a further announcement later this year. Any changes would be phased in from 2025 onwards.

Enable practices to deliver more NHS care if they are willing and able

Prior to our improvements to the NHS dental contract in 2022, practices were only able to deliver up to 104% of the activity committed to in their contract, with the extra 4% of activity carried forward into the next year. This meant practices that wanted to go further and treat more patients were limited in doing so.

NHS England will work with ICBs over the course of 2024 to 2025 to identify opportunities to support contractors to deliver additional capacity beyond their existing contractual requirements (up to 110%).

Free up funding for practices that can deliver more by addressing persistent contract under-performance

Unfortunately, at present, not all practices deliver the full amount of activity they have committed to and been funded for in their NHS contract. The amount of care that was commissioned but not delivered was equal to around £150 million in 2021 to 2022 (https://www.nhsbsa.nhs.uk/dental-data/nhs-payments-dentists). Even before the pandemic, there was a substantial volume of practices that failed to deliver their expected contracted activity, leading to a loss of NHS oral healthcare, which could have been available for patients.

We recently took the first step in enabling commissioners to tackle persistently under-performing dental contracts. Commissioners will be able to permanently and unilaterally amend NHS dental contracts that fail to deliver their contracted amount of dental activity over 3 consecutive non-COVID-19 years, releasing these UDAs to others to deliver instead. We will keep these new powers under review and consider whether further action is required.

Ringfencing NHS dentistry budgets for dental care

We currently invest more than £3 billion in NHS dental services each year. We are committed to protecting this funding for dentistry purposes and we will ringfence this funding in 2024 to 2025. We will issue guidance to ICBs shortly through NHS England's 2024 to 2025 revenue finance and contracting guidance. To ensure compliance against this requirement, and to strengthen oversight of funding that is used to deliver access to NHS dental care, NHS England will meet with and collect monthly returns from all ICBs to establish current and planned spend against the ringfenced dental allocations budget.

Give local commissioners the tools they need

Since April 2023, ICBs have been responsible for commissioning dental services. This creates the opportunity for much greater local accountability about performance and service availability. To support this, we have started to publish monthly data on local NHS dental activity at the ICB level, including the proportion of UDAs being delivered in different places. We will also publish new workforce data early this year to support ICBs with their commissioning function, including employment and working trends. We will also consider publishing data on community dental services, which provide care to the most vulnerable patients, and we will explore opportunities to link to other community data sets and help join-up of local services.

While ‘golden hellos’, the increase to the minimum UDA value and the new patient payment will support practices with existing contracts to deliver more access for their local populations, we recognise that some commissioners will also be looking to commission new dentistry capacity to support under-served areas. We will support ICBs to ensure they understand how commissioning teams can encourage development of their local provider market, and to identify what further support they may need to develop new capacity, where they would otherwise be dependent on existing contractors and facilities to deliver improvements in access.

The distribution of funding across England for NHS dentistry has historically been set in line with contractual commitments and activity from 2006 (when the current NHS dental contract was first introduced) and then grown and carried forward. Work has been commissioned to understand the relative distribution of need for dental services. This will inform future decisions about dental allocations to ICBs across England.

Reduce bureaucracy in NHS dentistry

There are clear opportunities in NHS dentistry for increasing efficiencies and improving digital capacity to make the system simpler for the dental workforce and for patients. To reduce unnecessary bureaucratic burdens for the profession and enhance patient experience, we will establish and work with a new stakeholder reference group for dentistry and oral health to identify the changes that would make the greatest difference to practices providing NHS care and their patients.

Supporting and developing the whole dental workforce

Expand dental undergraduate training places by 40%

As set out in the NHS Long Term Workforce Plan (https://www.england.nhs.uk/publication/nhs-long-term-workforce-plan/), we will grow the dental workforce in England by expanding undergraduate dentist training places to a record-breaking level. We will expand dental undergraduate training places initially by 24% to 1,000 places by 2028 to 2029. We will then expand training places by 40% from current levels to over 1,100 places by 2031 to 2032. making access to NHS care faster and fairer for patients.

We recognise that a significant proportion of dental graduates are likely to live and work near their dental school after graduation. Therefore, we wish to undertake this expansion in a way that is targeted to improve provision in areas of the country where it is most needed. We will set out further detail on how we will allocate places. If required to deliver our ambitions on workforce expansion, we will explore the creation of new dental schools in currently under-served parts of the country.

Consult on mandating NHS service for dentistry graduates

Having more dentists is not the sole solution to current workforce challenges in NHS dentistry. We have a large number (35,232) of dentists registered with the General Dental Council (https://www.gdc-uk.org/about-us/what-we-do/the-registers/registration-reports) in England as of January 2024. However, only 24,151 of them delivered at least some NHS care in 2022 to 2023 (https://digital.nhs.uk/data-and-information/publications/statistical/nhs-dental-statistics/2022-23-annual-report). We need dentists to do more NHS work alongside, or instead of, their private work.

Most, but not all, dentistry graduates develop their career in the NHS by taking up postgraduate dental foundation training (DFT). We are concerned that a proportion are opting to go straight into private practice after graduating, or are choosing to deliver little to no NHS work shortly after completing their foundation training.

The taxpayer makes a significant investment in the education and training of dentists in England. It is fair that the public expects this investment to be reflected in access for patients to NHS dentistry. We will launch a consultation this spring on introducing a ‘tie-in’ for graduate dentists. This would ensure that graduates spend at least some of their time delivering NHS care in the years following the completion of undergraduate training.

Subject to consultation, we will consider the impact of these measures and explore whether we need to go further - for example, tie-in periods related to specialty training or a tie-in for other dental professional groups.

Increase the number of dental care professionals

Dental care in England could not function without the vital contribution of its dental care professionals, including dental therapists, hygienists and nurses. As set out in the NHS Long Term Workforce Plan, we will expand dental therapy

and dental hygiene undergraduate training places by 28% by 2028 to 2029, and expand training places by 40% from current levels to over 500 places by 2031 to 2032.

Dental therapists' scope of practice means that they can deliver much of the routine care that dentists provide[footnote 5] so more therapists means more care for NHS patients. In addition to dental therapists and hygienists, we will also encourage greater numbers of dental nurses and clinical dental technicians into relevant education and training programmes.

Enable patients to access care from a variety of dental professionals

Enabling dental care professionals (DCPs) to work to their full scope of practice would improve access to NHS dental care for patients and allow dentists to focus on delivering more complex care, which only they can provide. However, there needs to be a shift in mindset to change the current ways of working.

To encourage this culture change, we have published guidance clarifying how skill mix in NHS practice (https://www.england.nhs.uk/long-read/building-dental-teams-supporting-the-use-of-skill-mix-in-nhs-general-dental-practice-long-guidance/) can be used within existing regulations. This guidance confirmed that dental therapists and dental hygienists can open and close NHS courses of treatment and provide direct access to NHS care. We have also removed administrative barriers that prevented dental therapists and other dental professionals from opening courses of treatment. We are also developing a national return to dental therapy programme, to support dental therapists who have been working as hygienists to refresh their dental therapy skills.

Promote therapist-led models of care

Current regulations prevent dental therapists from administering medicines, including certain antibiotics and local anaesthetics, without a written direction from a dentist, even though this is within their current professional expertise. In August to September 2023, we consulted on the potential to enable dental therapists to deliver these medications to patients with fewer unnecessary administrative barriers (https://www.gov.uk/government/consultations/use-of-exemptions-by-dental-hygienists-and-dental-therapists). Removing these barriers would enable practices to fully utilise the skill mix of their teams, improving access for patients.

Make it easier for overseas dental professionals to work in the NHS

Patients receiving NHS dental care benefit greatly from overseas-qualified dentists and dental care professionals. Around 30% of all dentists on the GDC register qualified outside of the UK and, in 2022, 46% of new additions to the register were trained overseas. However, we are concerned that a lack of flexibility in international registration processes can create unnecessary delay to overseas-qualified dental professionals who meet the UK regulatory standards providing NHS dental services.

We have already passed legislation that enables GDC to amend and expand its registration processes for international applicants (https://www.legislation.gov.uk/uksi/2023/162/made) and will continue to work with GDC on further expansion, making sure that overseas-qualified applicants who meet UK regulatory standards can join the GDC's register as easily and as quickly as possible so they practise NHS dentistry at the earliest opportunity. We expect GDC to play its part fully in helping open up the profession to suitably qualified professionals.

Increase exam capacity for overseas-qualified dentists

To practise in the UK, dentists that have trained and qualified overseas (outside of the European Economic Area (EEA) or Switzerland) are required to take the GDC's overseas registration exam (ORE) or the Royal College of Surgeons' (RCS) Licence in Dental Surgery (LDS) exam. This is to ensure that applicants meet the high clinical standards required. However, limited exam capacity restricts the number of overseas dentists joining the register. The candidate list for the ORE has also increased in recent years, in part due to sittings being suspended during the COVID-19 pandemic.

We welcome GDC's decision to expand capacity of the ORE exams in 2023 to 2024, creating an additional 1300 places. We also welcome GDC's action to expand the size of its registration casework team. We will work with GDC to explore if exam capacity can be further expanded and consider ways to further reduce registration processing times and clear the registration backlog of dentist and DCP applicants.

We are working with the RCS to explore expansion of the LDS. We will support the RCS to develop and provide resources to prepare candidates, improve the pass rate and maximise the number of dentists eligible for GDC registration.

Introduce provisional registration to streamline the registration of overseas dentists

We will work to introduce legislation that creates a new provisional registration status, providing a new route for overseas-qualified dentists whose qualifications are not currently automatically recognised by GDC to join the register and practise in the UK faster.

Under this model, individuals holding provisional registration would be able to work as a dentist under supervision of a fully registered individual, while working to demonstrate that they are of the required standard for full registration. We will work with GDC and other stakeholders to ensure that the sector uses this new route, once it becomes law.

Explore automatic recognition of international qualifications from outside the EEA

To be entered onto the dentists' register, an individual must hold:

- a recognised UK dentistry qualification
- an EEA or Swiss qualification recognised under EU exit standstill arrangements
- a qualification from one of the overseas universities recognised by GDC before 1 January 2001 (https://www.gdc-uk.org/registration/route-to-registration/recognised-overseas-qualifications)

or they must sit the ORE or LDS exams.

Under legislative changes that came into force in March 2023, GDC has greater flexibility to recognise additional qualifications that it deems sufficient for registration as a UK dentist. We will press GDC to ensure it is making full use of its new legal flexibilities so that more qualified dentists can practise in the UK.

Continue to improve the dental performers list (DPL)

Once registered with GDC, all dentists wanting to provide dental care for the NHS in England need to apply to join the DPL. Dentists do not have to join the DPL to go into private practice, meaning the DPL could be a barrier to providing NHS work.

We have already made improvements to streamline and improve the DPL. We amended regulations so that experienced dentists can be swiftly accepted onto

the DPL and abolished the fees linked to applying to the DPL. There is more that we can do to improve the DPL. We will aim to ensure that dentists that have the necessary skills and qualifications can deliver NHS dental activity within 3 weeks after their full application to the DPL has been received by NHS England, and work to prevent applicants waiting longer than 6 weeks.

We will undertake a review of the DPL, including considering whether it could be streamlined further. This review will also consider whether commissioners should be able to use dentists working only in the private sector as a 'provider of last resort' - for example, to support access to dentistry for a short period in circumstances where there is short-term pressure on NHS supply.

Evaluation of this plan

We will track local experience as the plan is rolled out and keep its impact for patients under close review. We will look to evaluate elements within the plan, working closely with stakeholders including the British Dental Association and Healthwatch England.

Annex: recent dentistry reforms

In March 2021, health ministers asked NHS England to lead on dental system reform (https://www.england.nhs.uk/coronavirus/documents/nhs-dental-contract-reform-and-arrangements-letter/#annex), to start to address some of the underlying concerns about operation of the NHS contract and its impact on access by patients.

As a result, the first major changes made to the contract since 2006 were announced in 2022 (https://questions-statements.parliament.uk/written-statements/detail/2022-07-19/hcws223). These included the following.

To support dentists to treat patients with higher needs, we increased the payments for more complex or high-volume treatments within band 2 (https://faq.nhsbsa.nhs.uk/knowledgebase/article/KA-01976), meaning fairer remuneration for dentists where 3 or more teeth require filling or extraction, or complex treatment is needed. We saw this as a first step in a series of changes to ensure that remuneration more fairly reflects the treatment that patients need.

To reduce the number of clinically unnecessary check-ups and free up capacity for those that need treatment, we made changes to the FP17 form used to claim payment for NHS care delivered. The changes support adherence

to NICE guidance around personalised recall intervals (https://www.nice.org.uk/guidance/cg19), which indicates that adults at low risk of poor oral health can wait up to 2 years, and children up to a year, for a check-up.

For those practices receiving the lowest rates for their NHS care, we established a new minimum UDA value of £23. This was a start to addressing historic variation between practices.

We addressed misunderstandings around use of skill mix in NHS dental care by publishing new skill mix guidance (https://www.england.nhs.uk/long-read/building-dental-teams-supporting-the-use-of-skill-mix-in-nhs-general-dental-practice-long-guidance/), supporting DCPs to work within the NHS. We also removed some of the administrative barriers in FP17s to support recording of the work of DCPs and facilitate dental therapists and hygienists, not just dentists, to open courses of treatment within their scope of practice.

We enabled willing and able practices to deliver up to 110% of their contracted activity, where this was agreed by commissioners.

We made regulatory changes to improve information for patients about where to go for NHS dental care. The changes mean that dental practices with an NHS contract are now required to regularly update the NHS website to state whether they are accepting new NHS patients.

This initial package was designed to support NHS dentistry as the wider healthcare system emerged from the pandemic and began its recovery. The changes therefore focused on supporting practices to return to usual activity levels and maximising care using existing resources. This, and further detailed engagement with a wide range of stakeholders in the sector, has also informed the development of the policies and changes outlined in this plan.

Patients also need to be well informed about how NHS dentistry works and the care they are entitled to. NHS England has created a new group of patient and public voice (PPV) partners and is working to raise awareness of how often patients should go to the dentist and how non-dentists (for example, dental therapists and hygienists) can be used to deliver patient care.

It is also now a contractual requirement that all dental practices must review and update their NHS website profile information every quarter, which includes what services they offer and whether they are accepting new NHS patients. NHS England has recently put in place additional measures to monitor and improve this.

18 months on, the NHS continues to commission a similar amount of activity across the country compared with before COVID-19, and delivery against contracts has slowly increased. These initial signs of recovery are encouraging - however, delivery of NHS care is still below pre-pandemic levels overall and we know there is a great deal more to do. We have always recognised that the

changes announced in 2022 were the first step in an important process of reform, which needs to tackle a series of long-standing challenges facing NHS dentistry.

In June 2023, we published the first ever NHS Long Term Workforce Plan to help ensure that we have the right numbers of staff with the right skills to transform and deliver high-quality services fit for the future. In the workforce plan, we committed to expanding and supporting the NHS dental workforce by:

- expanding training and education to record levels, including dentistry training places by 40%, to over 1,100 places by 2031 to 2032. To support this ambition, we will expand places by 24% by 2028 to 2029, taking the overall number that year to 1,000 places
- increasing training places for dental therapists and hygiene professionals by 40%, to more than 500 places by 2031 to 2032
- exploring measures such as a tie-in period to encourage dentists to spend a minimum proportion of their time delivering NHS care in the years following graduation
- exploring opportunities to support the professional development of dentists and dental care professionals, promoting fulfilling career paths and use of full scope of practice, while considering how to minimise the bureaucracy around starting to practise in the NHS
- reforming contractual arrangements to encourage more dentists back into NHS practice and make it easier for therapists and hygienists to provide NHS care directly

References

1. Payments for primary care dentistry are made for UDAs up to a maximum negotiated annual contract value agreed in each dental provider's contract.
2. Powell N. 'Ireland reviews water fluoridation.' Canadian Medical Association Journal 2014: volume 186, issue 10, pages E343 to E344.
3. Centres for Disease Control and Prevention. Water Fluoridation Data and Statistics. (https://www.cdc.gov/fluoridation/statistics/index.htm)
4. National Health and Medical Research Council. Public Statement: Water Fluoridation and Human Health in Australia. (https://www.nhmrc.gov.au/about-us/publications/2017-public-statement-water-fluoridation-and-human-health) 2017.
5. Gallagher JE, Lim Z and Harper PR. 'Workforce skill mix: modelling the potential for dental therapists in state-funded primary dental care.' International Dental Journal 2013: volume 63,pages 57 to 64.

↑ Back to top

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Report to the Primary Care Commissioning & Assurance Committee 15 March 2024
6. Pharmaceutical Services Regulatory Committee report Period Quarter 3 October 2023 – December 2023

Vision: "For everyone in our towns, villages and communities to live a longer, healthier life"	
Please state which strategic priority and / or enabler this report relates to	
Strategic priorities	
☒	**Start Well:** Every child has a strong, healthy start to life: from maternal health, through the first thousand days to reaching adulthood.
☒	**Live Well:** People are supported to engage with and manage their health and wellbeing.
☒	**Age Well:** People age well, with proactive interventions to stay healthy, independent and active as long as possible.
☒	**Growth:** We work together to help build the economy and support sustainable growth.
☒	**Reducing Inequalities:** In everything we do we promote equalities in the health and wellbeing of our population.

Enablers			
Data and Digital ☐	Workforce ☒	Ways of working ☒	Estates ☐
Communications ☒	Finance ☒	Operational and Clinical Excellence ☒	Governance and Compliance ☒
Other ☐(please advise):			

Report Author	Martyn Pretty, Commissioning Support Officer (HWEICB) Reviewed/Updated by: Jackie Bidgood, Senior Contract Manager, Pharmacy and Optometry (HWEICB)
Date to which the information this report is based on was accurate	Quarter 3 October 2023 – December 2023
Senior Responsible Owner	Nicky Poulain, Chief Primary Care Officer

The following individuals were consulted and involved in the development of this report:
Lynn Dalton, Associate Director of Primary Care and ICB Representative at the Pharmaceutical Services Regulatory Committee.
This report has been presented to the following board/committee/group:
This report was presented to the Primary Care Pharmacy, Optometry & Dental Delivery Group on 6 February 2024.

Purpose of this report - what are members being asked to do?

The members are asked to **note / discuss** the following:

A) To enable the ICB to carry out its statutory functions the ICB, in common with national process, is required to establish a Pharmaceutical Services Regulatory Committee (PSRC).

B) During the preparations for the delegation of community pharmacy services the six regional ICBs agreed the regional Pharmacy and Optometry team would be hosted by one ICB, this was agreed as Hertfordshire and West Essex ICB. It was also agreed on this basis that HWEICB would host the PSRC.

C) Each ICB has a commissioning representative attend the PSRC.

D) Under the new national delegation agreement responsibility for individual performance issues has transferred from the Regional Medical Directors responsibility to the responsibility of the PSRC with effect from April 2023.

Executive Summary Report

This quarterly report summary provides an overview of the Pharmaceutical Services Regulatory Committee (PSRC) following the delegation of community pharmacy service to the ICB in April 2023. Under the terms of the national delegation agreement ICBs are required to establish a PSRC. The ICB delegated responsibility to the PSRC as part of the NHSE/ICB delegation agreement in March 2023.

During the preparation for the transition of delegated functions it was identified that the regional NHSE Pharmacy and Optometry team was a small team of eleven staff of varying grades from band 4 to band 8b providing commissioning responsibility for over 600 contractors. On this basis ICBs agreed with NHSE that the Pharmacy and Optometry team would remain as one team and be hosted by an individual ICB. Hertfordshire and West Essex ICB (HWEICB) agreed to host the Pharmacy and Optometry team. H&WE ICB also host the PSRC. In addition to the ICB signing of the national delegation agreement, there is a Memorandum of Understanding (MoU) in place between each of the ICBs in the region and Hertfordshire and West Essex ICB. The MoU will be subject to review by all parties.

1. Brief background / introduction:

During 2022/23 ICBs were invited to attend the regional PSRC held by NHSE. This was to give commissioners an understanding of the role of the committee and its functions. From April 2023, ICBs in East of England region established a new PSRC hosted by Hertfordshire and West Essex ICB. The PSRC membership includes access to specialist advice both clinical and regulatory advice including the national Primary Care Commissioning Pharmacy Regulation Lead attends each meeting and with other specialist advisors ensure the terms of the regulations are considered and upheld in the committee's decision-making process.

2. Summary of key points:

2.1 Note the content of the quarter 3 PSRC report.
2.2 Market Entry decisions.
2.3 Remedial breach notices – none in quarter 3.
2.4 Market Entry application under appeal.
2.5 Fitness decisions – three in last quarter.
2.6 Fitness decisions appeal – one appeal resolved prior to going to tier 1 tribunal, the contractor is working under conditions which are being monitored by the Pharmacy & Optometry contracting team. Issues will be escalated to PSRC.

3. Are there any options?

The PSRC is a statutory requirement of ICBs in delegated commissioning arrangements. The committee ensure thorough its membership that it has specialist regulatory and clinical advice. The report presented to the Delivery Group and the Primary Care Commissioning & Assurance Committee is one of six individual reports prepared by the pharmacy and optometry team on behalf of each ICB.

4. Key Risks and Issues

Ensuring community pharmacy provision across BLMK is in partnership with Health and Wellbeing Boards, whose role and function is to develop a pharmaceutical needs assessment (PNA) on a three yearly cycle. Ensuring that Health and Wellbeing Boards, with Public Health consultants, review and refresh the PNA upon notifications of e.g., pharmacy closures, market entry applications etc., via the established communication processes from the PSRC.

Have you recorded the risk/s on the Risk Management system? Click to access system	Yes ☒	No ☐

5. Are there any financial implications or other resourcing implications, including workforce?

Community pharmacy contractors are under similar staffing pressures to other primary care contractors including GPs and dentists. Further training and development support for pharmacy, optometry and dental contractors is expected centrally. The ICB is providing support to our contractors and accessing funding support when made available from region.

Amendment to the pharmaceutical regulations in July 2023 for 100-hour pharmacies has been varied and 100-hour pharmacies can request to reduce their opening hours to not less than 72 hours. This option was not previously available and therefore the PSRC may receive applications from contractors to reduce their opening hours.

6. How will / does this work help to address the Green Plan Commitments?

Click to view Green Plan

Work that community pharmacists and general practice are undertaking specifically with reducing the usage of metered dose inhalers for the treatment of respiratory disease is a national commitment by NHSE.

7. How does this work help to address inequalities?

The PSRC role is to ensure that the national pharmaceutical regulations (j2013) are consistently applied and any subsequent changes to the regulations.

8. Next steps:

The Committee is requested to note and discuss the report. The ICB will continue to ensure that a member of the Primary Care team participates at the monthly PSRC meeting where decisions are made on BLMK contractors. Quarterly reports will be standard agenda items.

The Community Pharmacy Clinical Lead is supporting community pharmacy contractors with support from the wider medicines optimisation team. There is also close working with Public Health colleagues who already support the Primary Care prevention delivery plan.

The Primary Care and Public Health teams are reviewing the implications of the national closure and or sale of Lloyds pharmacies in high street shops and 100-hour pharmacies located in branches of Sainsburys supermarkets. A review is currently taking place of provision on Saturdays, Sundays and Bank holidays. Data has been requested from the P&O team to support this work and once a position is determined work will take place to stimulate the market. One area in particular is Central Bedfordshire of Biggleswade. However, we are starting to see the roll out by some community pharmacies of medication collection lockers similar to Amazon lockers. These are legal but there are medications this option would not be suitable for e.g., medication stored in fridges and controlled drugs.

9. Appendices

Appendix A - Pharmaceutical Services Regulatory Services - Quarterly report October 2023- December 2023, Quarter 3 of 2023/24.

10. Background reading

The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 (legislation.gov.uk)

Item 6 Appendix A

Meeting/Committee:	**Primary Care Commissioning & Assurance Committee**
Venue:	**Teams Meeting**
Date:	**15 March 2024**

Title of Report	**Pharmaceutical Services Regulation Committee (PSRC) – Decisions Made (1 October 2023 – 31 December 2023)**	
Presented by		
Author	Martyn Pretty, Commissioning Support Officer Reviewed/Updated by: Jackie Bidgood, Senior Contract Manager, Pharmacy and Optometry	
Commercially Sensitive	No	
Status	For:	Information & to note
Finance Lead sign off (if required)	Name: NA	Date: NA
Conflict of Interest	None known.	
Governance and reporting – at which other meeting has this paper already been discussed (or not applicable)	This paper has not been discussed at other meetings however all decisions reported in this paper were made at the PSRC meetings held between 01 October 2023 to 31 December 2023.	Outcome of Discussion: All decisions made at the PSRC meetings are made in line with the Pharmaceutical Services Regulations 2013 (as amended)
ICS Engagement (Describe engagement and co-creation with ICS colleagues)	PSRC is hosted and chaired by NHS Hertfordshire and West Essex Integrated Care Board (HWE ICB) working on behalf of the 6 ICBs in the East of England. All ICBs are invited to attend. The meetings are governed by Terms of Reference (TOR) as set out in the Pharmacy Manual and have been ratified by PSRC. TOR were shared with ICBs as part of the Q1 report.	

Executive Summary:

Following the delegation of pharmaceutical services by NHS England to Integrated Care Boards (ICBs) with effect from 1 April 2023, the six ICBs in the East of England have formed a Pharmaceutical Services Regulations Committee (PSRC) under section 65Z5 of the National Health Service Act 2006 (hereafter referred to as the 2006 Act).

By virtue of NHS England's Pharmacy Manual this Committee is responsible for making decisions required by the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013, as amended (hereafter referred to as the 2013 regulations). For the avoidance of doubt, this includes use of the fitness powers set out in the 2006 Act and the 2013 regulations. The PSRC is hosted by Hertfordshire and West Essex (HWE) ICB on behalf of the six ICBs.

The PSRC is required to apply the regulatory tests as set out in the 2013 regulations to grant or refuse market entry applications and make decisions on fitness matters. PSRC meetings are held in two parts, the first to consider market entry applications and the second to consider and review fitness and matters of concern. ICBs are invited to Part 2 where there is an issue / concern that is relevant to their ICB, noting the sensitivities and confidential aspects of some discussions.

The Committee is required for certain applications to consider the information published in the Health and Wellbeing Boards (HWB) Pharmaceutical Needs assessment (PNA). Each Health and Wellbeing Board is required to publish a PNA every three years.

The following are the market entry and fitness decisions made at the monthly PSRC meetings between 1 October 2023 – 31 December 2023:

Market Entry - Decisions made:

Application	Health and Wellbeing Board	Decision
Application from Avicenna Retail Limited for inclusion in a pharmaceutical list: consolidation onto an existing site within the Luton HWB. • Site 1 – premises remaining open: 361 Dunstable Road, Luton, Bedfordshire LU4 8BY. • Site 2 – premises closing: 213-217 Dunstable Rd, Luton, Bedfordshire LU4 8BN.	Luton	Granted
Application for inclusion in a pharmaceutical list: no significant change relocation application within Bedford Borough HWB's area. Manor Pharmacy (Wheathampstead) Ltd, T/A Speedwell Pharmacy. • From: 98 Bedford Road, Kempston, Bedfordshire, MK42 8BG. • To: 178 Bedford Road, Kempston, Bedford, MK42 8BL.	Bedford Borough	Granted

Breach/Remedial Notices Issued

None.

Market Entry Applications under Appeal

The following applications were sent to NHS Resolution, appealing the decisions made by PSRC:

Application	HWB Area	Commissioner Decision	NHS Resolution Decision	Appeal Ref.
Distance Selling Application by Luton based company.	Luton	Refused – 26 April 2023	Granted	SHA/26052

Fitness Decisions:

Fitness Notifications / Concerns	Health and Wellbeing Board	Decision
Luton contractor - Change of Director Notification	Luton	Agreed to "stop the clock" and request missing information. (29 November meeting)
Bedford contractor - New Inclusion Pending Change of Ownership	Bedford Borough	Would be a fit and proper person to be included onto the relevant pharmaceutical list.
Luton contractor Change of Director Notification	Luton	Remains a fit and proper person to be included in the relevant pharmaceutical list. (December meeting)

Fitness Decisions under Appeal:

It is to be noted that fitness appeals do not go to NHS Resolution, instead they are heard by the First Tier Tribunal.

Application	HWB Area	Commissioner Decision	First Tier Tribunal	Appeal Ref.
Pharmacy - Appeal against conditions placed.	Luton	Contingent removal (Conditions)	Pharmacy agreed to the contingent removal and are working under conditions which are being monitored by the P&O contracting team. Issues will be escalated to PSRC.	4998

Recommendation(s):

Note the decisions made at the PSRC meetings between October 2023 and December 2023.

Next Steps:

- Reporting will occur on a quarterly basis.
- Members and colleagues in ICBs are welcome to attend any future PSRC meetings should they wish to learn more about the regulatory processes that are followed.

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Report to the Primary Care Commissioning and Assurance Committee 15 March 2024
6.1 General Ophthalmic Services (GOS) Contracting Report (Qtr. 1-3) 2023/2024.

Vision: "For everyone in our towns, villages and communities to live a longer, healthier life"	
Please state which strategic priority and / or enabler this report relates to	
Strategic priorities	
☒	**Start Well:** Every child has a strong, healthy start to life: from maternal health, through the first thousand days to reaching adulthood.
☒	**Live Well:** People are supported to engage with and manage their health and wellbeing.
☒	**Age Well:** People age well, with proactive interventions to stay healthy, independent and active as long as possible.
☒	**Growth:** We work together to help build the economy and support sustainable growth.
☒	**Reducing Inequalities:** In everything we do we promote equalities in the health and wellbeing of our population.

Enablers			
Data and Digital ☐	Workforce ☒	Ways of working ☒	Estates ☐
Communications ☒	Finance ☒	Operational and Clinical Excellence ☒	Governance and Compliance ☒
Other ☐(please advise):			

Report Author	Jackie Bidgood, Senior Contract Manager, Pharmacy and Optometry
Date to which the information this report is based on was accurate	Quarter 1- 3 2023/24
Senior Responsible Owner	Nicky Poulain, Chief Primary Care Officer

The following individuals were consulted and involved in the development of this report:
Lynn Dalton Associate Director of Primary Care Contracting and Development.
This report has been presented to the following board/committee/group:
This report was presented to the Primary Care Pharmacy, Optometry & Dental Delivery Group on 6 February 2024.

Purpose of this report - what are members being asked to do?

The members are asked to **note** the following:

A) This is the first report the committee has received from the pharmacy and optometry (P&O) contracting team, hosted by Hertfordshire and West Essex.
B) The report provides an overview of the contracting programme of work undertaken by the P&O team.
C) The report provides an overview of national changes, the contract reissue programme that is currently being undertaken to ensure General Optical Services contractors have contemporaneous contracts in place following the delegation of their services to the ICB.

Executive Summary Report

The report is the first General Ophthalmic Services (GOS) report the Primary Care Commissioning and Assurance Committee (PCCAC) has received. These will be received on a quarterly basis going forward.

From 1 April 2023, the Pharmacy and Optometry Contracting Team, manage the GOS contracting function on behalf of the six ICBs in the East of England.

1. Brief background / introduction:

GOS contracting is in summary, the provision of NHS sight tests to eligible patients either from a fixed premises (mandatory services contract) or from a patient's usual place of residence or at a Day Centre (additional services contract). The contracting aspect of NHS sight tests is the only element managed by the contracting team.

All other eye health services are commissioned by individual ICBs (excluding specialised services) or retained by NHS England at this stage (this may be subject to change). This includes:

- Regional Eye Health Network Board (n.b. ICBs are members of this Board) and the leadership for regional transformation programmes from this Board.
- Diabetic Eye Screening.

The purpose of this report is to provide an update on GOS contracting arrangements and set out the current GOS contracting position for the ICB.

2. Summary of key points:

2.1 Note this is the first report received on General Ophthalmic Services contracts.
2.2 Note the Pharmacy and Optometry contracting team are hosted in Herts & West Essex ICB working under a Memorandum of Understanding between the 6 ICBs in NHS England (east) region.
2.3 The contracting aspect of NHS sight tests is the only element managed by the contracting team and which the ICB is responsible for meeting the costs.
2.4 To note the contracting of services is not activity or needs led and there is no limit on the number of eye tests which can be performed.
2.5 GOS services are not actively procured.
2.6 To note national regulatory changes to ophthalmic contracts
2.7 Contract re-issue programme to mandatory contractors only.

3. Are there any options?

Unlike, GP, dental and pharmacy contracts there is not a “market entry” or “procurement” process. Therefore, there are no restrictions on how many contracts are in place across the ICB and or where they are located. The ICB is responsible for meeting the costs of NHS sight tests and this can have an implication on the budget should the number of opticians increase across the ICB.

4. Key Risks and Issues

The key risk is the cost of sight tests.

Have you recorded the risk/s on the Risk Management system? Click to access system	Yes ☐	No ☒

5. Are there any financial implications or other resourcing implications, including workforce?

As mentioned the ICB is responsible for paying for NHS sight tests this includes a set standard fee for domiciliary eye tests. Ophthalmic contractors receive an NHS sight test fee, but as independent contractors their main income is through the sale of glasses, contact lenses etc., for which the ICB is not liable.

6. How will / does this work help to address the Green Plan Commitments?

Click to view Green Plan

7. How does this work help to address inequalities?

The ophthalmic contracts are not activity or needs based, but opticians play a key role in supporting patients with sight tests and providing glasses. The ICB is responsible for commissioning – Ophthalmic additional services e.g., community urgent eye services (CUES), secondary care/acute ophthalmic services including choice.

8. Next steps:

The Committee is requested to note and discuss the report.

9. Appendices

Appendix A General Ophthalmic Services (GOS) Contracting report.
Appendix B General Ophthalmic Services update 2023
Appendix C Changes to General Ophthalmic Services (GOS) Regulations 2023

10. Background reading

NHS England » Model contracts and contract variations: general ophthalmic services

Item 6.1 Appendix A

Meeting/Committee:	**Primary Care Commissioning & Assurance Committee**
Venue:	**Teams Meeting**
Date:	**15 March 2024**

Title of Report	**General Ophthalmic Services (GOS) Contracting – Quarter End Update Report (Q3)**	
Presented by	Lynn Dalton, Associate Director of Primary Care	
Author	Jackie Bidgood, Senior Contract Manager, Pharmacy and Optometry	
Commercially Sensitive	No	
Status	For:	Information and to note
Finance Lead sign off (if required)	Name: NA	Date: NA
Conflict of Interest	None known.	
Governance and reporting – at which other meeting has this paper already been discussed (or not applicable)	This paper has not been discussed at other meetings however an update report on GOS contracting was requested by ICBs following delegation on 1 April 2023.	Outcome of Discussion: NA
ICS Engagement (Describe engagement and co-creation with ICS colleagues)	The Pharmacy and Optometry Team is employed and hosted by NHS Hertfordshire and West Essex Integrated Care Board (HWE ICB) but works on behalf of the 6 ICBs in the East of England. It was recognised by all ICBs following delegation that there was no report to update ICBs on matters relating to GOS contracting. It was requested that a report be prepared for PCCC (or equivalent committees) and it is anticipated that this request will be set out in the Memorandum of Understanding (MOU) between 6 ICBs.	

Executive Summary:

Following the delegation of General Ophthalmic Services (GOS) by NHS England to Integrated Care Boards (ICBs) on 1 April 2023, the Pharmacy and Optometry Contracting Team, manage the GOS contracting function on behalf of the six ICBs in the East of England.

GOS contracting is in summary, the provision of NHS sight tests to eligible patients either from a fixed premises (mandatory services contract) or from a patient's usual place of residence or at a Day Centre (additional services contract). The contracting aspect of NHS sight tests is the only element managed by the contracting team.

All other eye health services are commissioned by individual ICBs (excluding specialised services) or retained by NHS England at this stage (this may be subject to change). This includes:

- Regional Eye Health Network Board (ICBs are members of this Board) and the leadership for regional transformation programmes from this Board.
- Diabetic Eye Screening.
- Community Urgent Eye Screening services.

The purpose of this report is to provide an update on GOS contracting arrangements and set out the current GOS contracting position for the ICB.

Introduction and Background

In advance of the delegation of GOS services to ICBs, the Pharmacy and Optometry Team held several “masterclasses” on GOS and, where requested, individual “deep dives” to review GOS contracting more specifically at an individual ICB level.

The masterclasses provided detail on what GOS contracting is, the key stakeholder organisations we are interdependent with in view of GOS contract administration and financial reimbursement mechanisms. All masterclass presentations can be reviewed at **Appendix 1** where more detail is provided on GOS contracting. (A masterclass presentation given by the NHS Business Services Authority (NHSBSA) has also been included for information).

In summary, general principles are:

- The contracting of services is **not** activity or needs led and there is no limit on the number of eye tests which can be performed; GOS services are not actively procured.
- There is no “market entry” process therefore there are no restrictions on how many contracts are in place.
- GOS contracts can be made with any eligible person and contracts can be made with an individual, partnership or body corporate. (Eligibility criteria set out in masterclass slides - see **Appendix 1**).
- All applications are submitted to the NHSBSA who process all applications on behalf of ICBs in line with NHS England Policy Book for Eye Care
- All new GOS contracts (and relocations) require a practice site visit before they are approved to carry out NHS sight tests. This involves inspection of equipment, facilities and policies. This site visit is organised by the NHSBSA and undertaken by an Optometry Clinical Advisor from the NHSBSA or the HWE ICB (recently transferred from NHS England). A case worker for the NHSBSA attends to cover administrative aspects of the visit.
- Contracts continue indefinitely unless voluntarily terminated by the contractor or terminated by the ICB (very infrequent). In the event of any contractual action or ICB initiated terminations, a paper would be brought to the PCCC Committee, or equivalent, for decision.
- GOS contracts are national contracts and do not contain a financial element as contractors are paid per NHS sight test claimed. All GOS contracts and variations are signed and approved by individual ICBs.

- Responsibility for contractual management of additional services contracts, sits with the ICB in which the contractor is providing services however financial transactions are made to the ICB in which the Head Office is located. For example, an additional services contractor may provide services in Hertfordshire, Peterborough, Leicester and Manchester but have their Head Office in Liverpool. The contract management (signing of contracts, practice visits, contract variations) will sit with the local ICB however all financial transactions will be attributed to Liverpool. This was a central NHS England decision and allocations were adjusted for 23/24 – some ICBs had their allocation increased, some reduced. The financial allocations team at NHS England will undertake the same process for 24/25.
- Primary Care Support England (PCSE) process GOS claims on behalf of ICBs. In 2022/23 a sight test fee was £22.14. If multiple patients are seen at the same address e.g. residential home, contractors received the sight test fee (£22.14) and £39.04 for the first and second patient at the same address and £9.77 for the third patient (onwards) at the same address.

New Regulations

Proposed changes to the GOS regulations were set out in a letter to all ICBs in July 2023 and a follow up letter dated 11 October 2023 confirmed that all proposed regulatory changes were laid in parliament on 20 July 2023. Both letters have been shared with all ICBs **(Appendices B & C).**

The changes are summarised in brief below and were effective from 1 November 2023:

- **Death of contractor arrangements** – current contract arrangements require the GOS contract to terminate after 7 days unless agreement reached between interested parties and the commissioner. This time has been extended from 7 days to 28 days.
- **Removing the need to collect data on GOS contract applicants' sex** – applicants will no longer have to declare their sex as part of the application process.

Changes effective from 1 January 2024:

- **Mandating electronic claims** - all GOS claims must be submitted electronically through PCSE Online or a practice management system's eGOS function.
- **Reduction to the claim window for sight test claims** – the claim period to submit GOS forms is reduced from 6 months to 3 months.

GOS Contracting Overview

An overview of the number of contractors for mandatory and additional services are set out below. ICBs should note that the numbers detailed in this paper will be subject to change as new applications are made and contracts are terminated by contractors. ICBs should therefore expect to see different numbers at Q4 reporting.

Table 1

Mandatory	Additional
70	9

Contract Re-issue (Mandatory Contractors only)

In December 2021, NHS England East of England commenced a GP and optometry contract re-issue project. NHS England wanted to ensure that in advance of the delegation of optometry services on 1 April 2023, all contractors had an up to date 2018 mandatory contract in place. NHS England engaged a third-party organisation to undertake the work due to lack of resource in the Pharmacy and Optometry (P&O) Team.

Due to a variety of reasons, the contract re-issue project was not completed prior to arrangements with the third-party organisation ceasing and was not completed prior to delegation. The contract re-issue project has returned to the P&O Team who continue the project as part of business as usual.

The information below sets out the position for the ICB:

Table 2

Number of Mandatory contracts	Number of contracts issued	Number of contracts still to be issued
68*	50	18

*This figure is different to the 70 mentioned in Table 1. Table 1 includes contracts issued to new contractors since the start of the re-issue project.

New Model Contract and Contract Variation (CV) for 2023

In September 2023, NHS England (national) issued a revised national model GOS contract and model contract variation for both mandatory and additional services.

- Mandatory services contractors - Those contractors who had a 2018 contract were sent the 2023 variation. Those that did not have a 2018 contract in place were sent the 2023 contract.
- Additional services contractors – prior to September 2023, additional services contractors were working on a 2013 contract. Additional services contractors were not included in the contract re-issue project and the P&O team have inherited through multiple re-organisations and staff changes, gaps in records. It is anticipated that there will be contractors who we do not have an electronic contract in place. Where this is the case, the P&O team will issue a September 2023 additional services contract rather than the variation.

The table below shows there are 11 mandatory contracts still to be issued where we do not have a contract on file for the contractor. They have not responded as part of the contract re-issue project. 50 variations have been issued to contractors who have a 2018 contract and this variation will bring them in line with the 2023 contract.

Table 3

Mandatory Contracts	
Contract	**Contract Variations**
11	50
Additional Contracts	
Contact	**Contact Variations**
3*	2*

*(*There are a number of additional contracts that are held by other ICB teams, but the contractor performs NHS services in your ICB)*

Future CVs

It is anticipated that following the changes to the regulations as set out earlier in this paper, further CVs will be issued to reflect the changes.

There is a risk that due to work pressures and capacity issues a "baseline" position for mandatory and additional contract holders will not be reached. To mitigate this risk and with agreement of all ICBs in the East of England, HWE ICB have engaged AGEM CSU to support with the GOS contract re-issue project and administrative processes for the contract variations administration until June 2024. There may be an opportunity to extend this arrangement if required and this will be assessed nearer the time.

Post Payment Verification

As mentioned in the **Introduction and Background** section of this report, GOS services are not procured, and contractors are paid on claims made for each NHS sight test they deliver. Post payment verification is undertaken by the NHSBSA and the guidance issued by NHSBSA on PPV, setting out what they review and how frequently can be reviewed at **Appendix 2.** Please note this is marked as "private and confidential" and should not be shared outside the ICB.

Recommendation(s) and Next Steps:

The Committee are to:

- Note the content of this report.
- Note that any contractual issues requiring escalation (outside the remit of what is set out in this paper forming BAU), will be sent to the relevant ICB Committee for decision as appropriate.
- Note that reporting will occur on a quarterly basis.

Appendix 1 – Masterclass Presentations

Optometry Masterclass 14 Oct 22-Update optom only.p

DoF 23 June 22masterclass presentat

Ophthalmic

Appendix 2 – PPV Guidance

PPV Guidance FINAL v1.docx

Embedded documents available upon request

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

To: General Ophthalmic Services (GOS) contract holders

Cc: Commissioners of GOS
Representative membership bodies for optometry

3 July 2023

Dear colleague

I am writing to provide an update on key developments affecting the General Ophthalmic Services (GOS) regulations and service provision.

Capturing the patient's address on a GOS form

As you will be aware the population of an address within all GOS forms is a mandatory field. In most cases this will be a patient's home address but where the patient has no fixed abode this can be a barrier in accessing services. To help ensure access is available for all we are writing to confirm that an alternative address may be used. This can include your practice address, the address of patient's GP should they have one, a friend/relative's address or a temporary accommodation provider. To summarise, there is no legal requirement to provide a permanent home address in order that a patient can receive GOS services.

Proposed changes to General Ophthalmic Services (GOS) regulations

NHS England has submitted a number of proposals for regulatory changes to the Department of Health and Social Care (DHSC) following engagement with the Optometric Fees Negotiating Committee (OFNC). These proposals have been granted ministerial approval and will now be subject to standard parliamentary processes with a view to laying the regulations on 20 July 2023. Whilst any regulatory changes will not be confirmed until they are laid before Parliament, we wanted to give you advance notice in order that you have sufficient time to consider how the changes may affect you, your staff and businesses, and to make any necessary preparations that may be required.

The proposed changes and implementation dates are detailed below.

Mandating electronic claims – anticipated implementation date: 1 January 2024

PCSE (Primary Care Support England) introduced an electronic payment claims system in 2019 which is accessible via PCSE Online and several practice management systems (PMS). From 1 January 2024 it will be a contractual requirement that all GOS claims are submitted electronically via your practice

management system or PCSE Online. Ongoing support via PSCE will remain in place in order that practices are supported in transition to electronic submission.

We are aware that unplanned system outages may occur on occasion and some domiciliary service contractors operate in low signal areas. To mitigate against these instances, we will be introducing a new paper slip in order that a patient's signature can be collected. Once the system is accessible, the performer should complete the claim electronically, leaving the patient signature blank, and retain this slip either in the form of hard or scanned copy within the practice. At the same time, we will also amend the regulations for GOS 3 vouchers to reflect that in the scenarios as detailed above these vouchers may be issued to patients once the system is available.

A new process for submitting claims electronically in respect to uncollected glasses and back vertex distance changes will be introduced at the same time. PCSE will share more detailed user guides for the above system changes ahead of the implementation date.

Reduction to the claim window for GOS 1, 5 and 6 forms - anticipated implementation date: 1 January 2024

We will be reducing the claim period for submission of sight test forms from six months to three months to enable more timely data and prompt payments for contractors.

We recognise that there may be exceptional circumstances where it may not been possible for contractors to submit claims within any regulated timescale. In such cases ICBs can review the circumstances and where it is appropriate to do so, arrange with PCSE for the claim to be paid. Both OFNC and NHS England will monitor these arrangements to ensure they are working in the interests of patients and contractors without adding unnecessary bureaucracy for contractors or the NHS.

Death of contractor – anticipated implementation date: 1 November 2023.

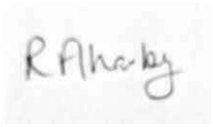
In the event of the death of a contract holder current regulations detail that the GOS contract terminates after 7 days unless arrangements have been made to extend the contract by up to 3 months. We recognise that in these circumstances families and next of kin may not always have adequate time to make any alternative arrangements. We are therefore proposing that this period will be extended to 28 days to allow adequate time for any such arrangements to be put in place.

Removing the need to collect data on GOS contract applicants' sex - anticipated implementation date: 1 November 2023

Current regulations state that it is a requirement for the sex of a contractor to be declared when submitting an application to hold a GOS contract. The award of the contract is not dependant on the sex of a contractor and therefore we propose to remove this requirement from the regulations and for this to be reflected in the application form.

If there are any questions, please contact your ICB commissioning team or OFNC representative membership organisation.

Yours faithfully



Rachel Foskett-Tharby
Deputy Director for Dental and Ophthalmic Contracts
NHS England

NHS England

To:
- General Ophthalmic Services (GOS) contract holders

cc.
- Commissioners of GOS
- Representative membership bodies for optometry

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

11 October 2023

Dear Colleagues,

Changes to General Ophthalmic Services (GOS) regulations

Further to our letter on 3 July 2023 which set out proposed regulatory changes, I am writing to confirm that all regulatory changes were laid in parliament on 20 July 2023. If you have not yet received a copy of the previous letter, please contact your commissioning team.

Mandating electronic claims

The first change, effective from 1 January 2024, is that all GOS claims must be submitted electronically through Primary Care Support England (PCSE) Online or a practice management system's eGOS functionality. If you have not yet switched to an electronic system, you are encouraged to start planning the transition as soon as possible.

PCSE has produced a range of support materials for contractors who are considering the use of PCSE Online, which includes a welcome pack, helpful user guides and several videos. They have also commenced a series of communications to contractors submitting paper claims.

Continuity arrangements and system changes

To support these regulatory changes a revised business continuity plan is currently being produced. This will outline the processes to follow in the event of unplanned system outages, domiciliary visits in areas with low or poor mobile signal or disruption to practices' internet connections. We will disseminate the revised business continuity plan shortly which will also be published on the PCSE website.

In addition to the above changes, the regulations providing for the issue of GOS 3 vouchers have also been amended. As of 1 January 2024, the default position is that, wherever possible, the vouchers should be issued at the time of a sight test. However, should a

contractor be unable to do so due to systems not being available, as detailed above, these vouchers may be issued to patients once the system is available.

A number of PCSE Online system changes will be introduced before 1 January 2024 to enable all claims to be submitted electronically. PCSE will share more updated user guides, incorporating these changes by December 2023.

Reduction to the claim window for sight test claims

Regulations have also been amended to reduce the claim period for submission of GOS 1, 5 and 6 forms from six months to three months. This will enable more timely data for NHS-funded sight tests and avoid lengthy delays between activity and payment. The reduced claim window will apply to claims with a completion date on or after 1 January 2024. Claims with a completion date prior to the 1 January 2024 will be processed under existing arrangements.

We recognise that there may be exceptional circumstances where contractors have been unable to submit claims within any regulated timescale. This should be flagged with your commissioner so they can review the circumstances and where it is appropriate to do so, arrange with PCSE for the claim to be paid.

We would also like to notify you that further two contractual changes will become effective on 1 November 2023.

Death of contractor arrangements

Current contractual arrangements require the GOS contract to terminate after 7 days unless agreement is reached between interested parties and the responsible commissioner. We recognise that in these circumstances this time frame have not always provided adequate time for families and next of kin to make alternative arrangements.

We are therefore extending the period of termination from 7 to 28 days. This allows more time for making any necessary business arrangements which could include extending the contract by up to three months.

Removing the need to collect data on GOS contract applicants' sex

The requirement for declaring the sex of a contract applicant during the GOS contract application process will be removed from 1 November 2023 and all relevant application paperwork will be updated in readiness for this change.

Finally, for patients with no fixed abode I would like to confirm that you can use an alternative address. This can include your practice address, the address of the patient's GP should they have one, a friend/relative's address or a temporary accommodation provider.

I hope this letter has provided further clarity on the changes to the regulations and the forthcoming system and process changes. We are in the process of updating the policy book for GOS, which will incorporate specific guidance for the regulatory changes. If there are any questions, please contact your ICB commissioning team or OFNC representative membership organisation.

Yours sincerely,

Ali Sparke
Director of Optometry, Dental and Pharmacy
NHS England

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Report to the Primary Care Commissioning & Assurance Committee – 15th March 2024
7. Primary Medical Services Financial Report (January 2024)

Vision: "For everyone in our towns, villages and communities to live a longer, healthier life"	
Please state which strategic priority and / or enabler this report relates to	
Strategic priorities	
☒	**Start Well:** Every child has a strong, healthy start to life: from maternal health, through the first thousand days to reaching adulthood.
☒	**Live Well:** People are supported to engage with and manage their health and wellbeing.
☒	**Age Well:** People age well, with proactive interventions to stay healthy, independent and active as long as possible.
☒	**Growth:** We work together to help build the economy and support sustainable growth.
☒	**Reducing Inequalities:** In everything we do we promote equalities in the health and wellbeing of our population.

Enablers			
Data and Digital ☐	Workforce ☐	Ways of working ☐	Estates ☐
Communications ☐	Finance ☒	Operational and Clinical Excellence ☐	Governance and Compliance ☐
Other ☐(please advise):			

Report Author	Roger Hammond Associate Director of Finance (Primary Care)
Date to which the information this report is based on was accurate	31st January 2024
Senior Responsible Owner	Nicky Poulain Chief Primary Care Officer

The following individuals were consulted and involved in the development of this report:
Nicky Poulain (Chief Primary Care Officer) and Stephen Makin (Deputy Chief Finance Officer).
This report has been presented to the following board/committee/group:
The Delivery Group reviewed the detailed January 2023 finance report at its meeting on 5th March 2024.

Purpose of this report - what are members being asked to do?
The members are asked to **note** the following: A) That the GMS Delivery Group receives and discusses detailed financial reports; B) Financial position year to date (ytd) and forecast 2023-24 as at month 10 (31st January 2024); C) Significant continuing financial pressure on prescribing.

The paper seeks to assure the Committee that the Primary Care Delivery Group is discharging its responsibilities, delegated to the ICB Chief Primary Care Officer, to oversee and manage the GMS primary care funds delegated to it by the Committee.

The Delivery Group receive detailed financial reports summarising total BLMK GMS primary care spend along with further splits at place level. Reports include forecasts and basis of any assumptions made along with risks and mitigations. The Delivery Group is then able to scrutinise the finances, discuss risks and make informed decisions in overseeing the delegated budget to promote increased quality, efficiency, productivity and value for money across primary care services.

The Delivery Group reviewed the detailed January 2024 report at its meeting on 5th March 2024. A high-level summary of the financial position is shown below.

Executive Summary Report

Whilst there are some small variances emerging as at month 10, these are considered not material across the totality of primary care services and manageable. Consequently, with the exception of prescribing, current expenditure and commitments are not adversely impacting upon the year end forecast.

As with last year, national factors continue to influence the prescribing position. YTD is a £12m overspend and forecast at £13.8m overspend by year end. National supplies issues are impacting on costs and PrescQIPP software continues to indicate significant pressures. NHSE national planning assumptions for 2023-24 have not materialised.

The prescribing forecast position is having to be managed across the totality of the ICB budget to ensure that the ICB may achieve its financial balanced position.

Summary
Any net overspends from primary care services, particularly prescribing, will need to be managed across the totality of ICB expenditure to ensure that overall the ICB and system partners achieve the financial targets across the system.

1. Brief background

The table below summarises the BLMK ICB ytd and current forecast for the year:

BLMK

ICB EXPENDITURE ANALYSIS	Year to Date			
	Plan £000	Actual £000	Variance £000	Variance %
Primary Care Delegated	147,827	151,215	(3,388)	(2.3%)
Local Incentive Schemes	2,201	1,863	338	15.4%
GP IT	3,736	3,532	204	5.5%
GP Investments	6,143	5,654	489	8.0%
Precribing and Drugs	124,364	136,425	(12,061)	(9.7%)
Total Primary Care (Other)	136,444	147,474	(11,030)	(8.1%)

ICB EXPENDITURE ANALYSIS	Forecast Net Expenditure			
	Plan £000	Actual £000	Variance £000	Variance %
Primary Care Delegated	176,669	177,189	(520)	(0.3%)
Local Incentive Schemes	2,703	2,272	431	15.9%
GP IT	4,483	4,315	168	3.7%
GP Investments	8,120	8,049	71	0.9%
Precribing and Drugs	148,935	162,702	(13,767)	(9.2%)
Total Primary Care (Other)	164,241	177,338	(13,097)	(8.0%)

Primary Care Delegated Expenditure

Small variances are arising across various expenditure lines which is a combination of year-end accruals, budget phasing and activity. These variances, at present, are not considered as a significant risk to the current forecast position.

The main driver behind the net £3.4m ytd (2% of budget) overspend arises from Additional Roles Reimbursement Scheme (ARRS) and the national reporting requirements of NHSE. NHS reporting requires the ICBs to show ARRS forecast at allocation received rather than forecast expenditure which is why the overall forecast position does not reflect the year-to-date run-rate. Additional ARRS funding is expected in month 11.

Allowing for estimated recruitment, the current ARRS forecast is £19.9m utilising 86% of the budget available. Recruitment over the past few months will lead to a higher monthly spend going into next year and hence a higher utilisation of the funds available in 2024/25.

A small forecast overspend is emerging on the total delegated budget once additional funding for ARRS is considered.

Other Primary Care Services

Local Incentive Schemes: Currently levels of claims are below that anticipated at budget setting but not all claims have been received. Forecast is similar to previous months.
GP IT: Underspend emerging due to reduced IT support contracts and reclassifying some expenditure against Service Development Funding (SDF)
GP Investments: Includes resilience, GP Access, workforce and training hub allocations Some funds are being spent and other elements are being developed to fully utilise allocations received within primary care by year end. Included is expenditure in primary care additional services/costs to offset impact to patients from NHS industrial action. Overspend driven by the NHS industrial actions where no direct national funding has been made available.

Prescribing

As with last year, national factors continue to influence the position. YTD is a £12m overspend and forecast at £13.8m overspend by year end. National supplies issues are impacting on costs and PrescQIPP software continues to indicate significant pressures. NHSE national planning assumptions for 2023-24 have not materialised.

The prescribing forecast position is having to be managed across the totality of the ICB budget to ensure that the ICB may achieve its financial balanced position.

2. Summary of key points:

2.1 Extent of overspending across primary care, particularly prescribing, has being mitigated by the ICB across other service lines and reserves to ensure overall, the ICB remains within it financial plan.

2.2 Prescribing:- pressures continue to be seen and NHSE 2023-24 planning assumptions have yet to impact on expenditure levels. The prescribing trend is a significant risk to the ICB and system achieving its financial target.

3. Are there any options?

None.

4. Key Risks and Issues

Prescribing expenditure is currently above planned budget and forecast to overspend. The prescribing trend is a significant risk to the ICB and system achieving its financial target. This may then impact upon other patient services and proposed investments to ensure the that overall the ICB achieves its financial targets.

Have you recorded the risk/s on the Risk Management system? Click to access system	Yes ☐	No ☒

Not Applicable.

5. Are there any financial implications or other resourcing implications, including workforce?

Overspends may impact upon any future ICB investments.

6. How will / does this work help to address the Green Plan Commitments?

Click to view Green Plan

Improved social prescribing via Primary Care Network pharmacists.
Increased use of online services for patients reducing travel requirements.

7. How will / does this work help to address inequalities?

Work continues to develop and fund primary care to offer similar opportunities to all patients across BLMK and to address historic inequity of access to primary care services.

8. Next steps:

Committee is asked to note the YTD and Forecast position of primary care budgets as at January 2024.

9. Appendices

N/A

10. Background reading

None.

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Report to the Primary Care Commissioning & Assurance Committee – 15th March 2024
7.1 Primary Care Pharmacy, Optometry and Dental (POD) Financial Report (January 2024)

Vision: "For everyone in our towns, villages and communities to live a longer, healthier life"	
Please state which strategic priority and / or enabler this report relates to	
Strategic priorities	
☒	**Start Well:** Every child has a strong, healthy start to life: from maternal health, through the first thousand days to reaching adulthood.
☒	**Live Well:** People are supported to engage with and manage their health and wellbeing.
☒	**Age Well:** People age well, with proactive interventions to stay healthy, independent and active as long as possible.
☒	**Growth:** We work together to help build the economy and support sustainable growth.
☒	**Reducing Inequalities:** In everything we do we promote equalities in the health and wellbeing of our population.

Enablers			
Data and Digital ☐	Workforce ☐	Ways of working ☐	Estates ☐
Communications ☐	Finance ☒	Operational and Clinical Excellence ☐	Governance and Compliance ☐
Other ☐(please advise):			

Report Author	Alison Johnson Senior Finance Manager (POD)
Date to which the information this report is based on was accurate	31st January 2024
Senior Responsible Owner	Nicky Poulain Chief Primary Care Officer

The following individuals were consulted and involved in the development of this report:
Nicky Poulain (Chief Primary Care Officer) and Stephen Makin (Deputy Chief Finance Officer).
This report has been presented to the following board/committee/group:
Not Applicable.

Purpose of this report - what are members being asked to do?

The members are asked to **note** the following:

A) That the Pharmacy, Optometry and Dental (POD) Delivery Group receives and discusses detailed financial reports;
B) Financial Position year to date (YTD) and Forecast 2023-24 as at month 10 (31st January 2024).

The paper seeks to assure the Committee that the Primary Care (POD) Delivery Group is discharging its responsibilities, delegated to the ICB Chief Primary Care Officer, to oversee and manage the POD primary care funds.

The Delivery Group receive detailed financial reports summarising total BLMK POD primary care spend. Reports include forecasts and basis of any assumptions made along with risks and mitigations. The Delivery Group is then able to scrutinise the finances, discuss risks and make informed decisions in overseeing the delegated budget to promote increased quality, efficiency, productivity and value for money across primary care services.

A high-level summary of the financial position is shown below.

Executive Summary Report

This financial report considers the total BLMK Integrated Commissioning Board (ICB) POD primary care related expenditure as at January 2024.

Whilst there are some variances emerging across services as at month 10, these are considered not material and consequently, current expenditure and commitments are not adversely impacting upon the year end forecast.

1. Brief background

This financial report summarises the total BLMK Integrated Commissioning Board (ICB) primary care Pharmacy, Ophthalmology and Dental (POD) related expenditure as at January 2024.

Primary Care Delegated POD position

The table below shows the BLMK ICB POD delegated Year to Date (YTD) and forecast position.

ICB Expenditure Analysis	YTD 31/01/2024				ICB Expenditure Analysis	Forecast Net Expenditure			
	Plan £'000	Actual £'000	Variance £'000	Variance %		Plan £'000	Actual £'000	Variance £'000	Variance %
Ophthalmic	7,699	8,098	(399)	-5.2%	Ophthalmic	9,239	9,718	(479)	-5.2%
Pharmacy	13,471	14,570	(1,099)	-8.2%	Pharmacy	16,165	17,452	(1,287)	-8.0%
Community Dental	6,217	6,191	26	0.4%	Community Dental	7,460	7,460	0	
Primary Dental	35,220	32,709	2,512	7.1%	Primary Dental	42,264	37,264	5,000	11.8%
Secondary Dental	11,340	11,361	(21)	-0.2%	Secondary Dental	13,570	13,570	0	
Property Costs	171	49	121	71.0%	Property Costs	205	92	113	55.1%
POD Reserves	1,429		1,429		POD Reserves	1,715	0	1,715	
Total POD	75,548	72,979	2,569	3.4%	**Total POD**	90,619	85,557	5,062	5.6%

Overall, the Primary Care POD position shows a net underspend of £2.5m (3.4% of budget) at month 10 which in part, is due to activity performance in Primary Dental.

For dental services, NHSE has recently confirmed that any underspends in the dental ringfence can be retained by the ICB for 2023-24 only. There are several variables to estimating the forecast dental position, but an early estimate is the dental clawback for 2023/24 may be approximately £5m. This has now been reflected in the Dental forecast and year to date position.

In anticipation of an underspend and to maximise dental provision as much as possible, the ICB has proactively worked with dental providers to re-invest funds to improve access to dental services by offering additional UDAs to dentists that are able to increase their capacity and by seeking expressions of interest to provide a dental access pilot scheme.

The Ophthalmic position is forecasting an overspend of £479k and this results from the increase in price and activity being higher than NHSE plan.

The Pharmacy overspend of £1.3m is due to a continuation of the higher levels of activity from 2022/23 and NHSE planning assumptions. NHSE has confirmed that the anticipated reduction in SAF (single activity fee) expected in year will now not take place. However, the National team have recognised the overperformance in SAF and have indicated additional non-recurrent allocations totalling £36m will be distributed to ICBs in March. BLMK's share is awaited.

The financial pressures on Ophthalmic and Pharmacy services are mitigated by the ICB receiving £1.7m from NHSE East of England POD reserves and this has reduced the risk of not maintaining at least a breakeven forecast on these services.

2. Summary of key points:

At month 10, it is expected that the POD expenditure for 2023-24 will underspend by £5.1m. Whilst a risk exists of overspending against the Pharmacy and Ophthalmology elements, a share of further non-recurrent funds is expected in month 12.

3. Are there any options?

None.

4. Key Risks and Issues

At present, it is considered that financial risk across POD services is low.

Have you recorded the risk/s on the Risk Management system? Click to access system	Yes ☐	No ☒

Not Applicable.

5. Are there any financial implications or other resourcing implications, including workforce?

Overspends against POD services may impact upon any future ICB investments proposed in other services across the local system.

6. How will / does this work help to address the Green Plan Commitments? Click to view Green Plan

7. How will / does this work help to address inequalities?

Work continues to develop and fund primary care to offer similar opportunities to all patients across BLMK and to address historic inequity of access to primary care services.

8. Next steps:

Committee is asked to note the year to date and Forecast position of POD primary care budgets as at January 2024.

9. Appendices

N/A

10. Background reading

None.

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Report to the Primary Care Commissioning & Assurance Committee – 15 March 2024
8. Primary Care Directorate & Digital Risk Registers

Vision: "For everyone in our towns, villages and communities to live a longer, healthier life"	
Please state which strategic priority and / or enabler this report relates to	
Strategic priorities	
☒	**Start Well:** Every child has a strong, healthy start to life: from maternal health, through the first thousand days to reaching adulthood.
☒	**Live Well:** People are supported to engage with and manage their health and wellbeing.
☒	**Age Well:** People age well, with proactive interventions to stay healthy, independent and active as long as possible.
☒	**Growth:** We work together to help build the economy and support sustainable growth.
☒	**Reducing Inequalities:** In everything we do we promote equalities in the health and wellbeing of our population.

Enablers			
Data and Digital ☒	Workforce ☒	Ways of working ☒	Estates ☒
Communications ☒	Finance ☒	Operational and Clinical Excellence ☒	Governance and Compliance ☒

Report Author	Jill White Senior Primary Care Contracting Manager
Date to which the information this report is based on was accurate	28/2/24
Senior Responsible Owner	Nicky Poulain Chief Primary Care Officer

The following individuals were consulted and involved in the development of this report:
Risk leads as named on the risk registers.
This report has been presented to the following board/committee/group:
None.
Purpose of this report - what are members being asked to do?
The members are asked to **note** that risks relating to the primary care directorate (including pharmacy, optometry and dental - POD) and digital primary care workstream are being identified and managed appropriately. All risks continue to be logged and monitored in the 4Risk system.

Executive Summary Report

The primary care directorate and digital risk registers are attached for information and assurance that risks have been correctly identified and are being suitably managed.

1. Brief background / introduction:

The primary care directorate risk register is monitored bi-monthly at the Primary Care (Medical Services) Delivery Group and quarterly at this committee.

The following changes have taken place since the register was last reviewed at this committee in December:

1. Risks which have been closed:
   - Risk PC001 Asylum seeker accommodation – primary care funding
     All actions have been completed and the risk mitigated.

2. Risks which have been added:
   - PCN0006 PCN performance
   - R0012 Shared care drugs monitoring locally commissioned service
   - R0013 12 Goldington Road

3. Risk R0009GP practices' resilience and ability to transform has been escalated to the corporate risk register in order to ensure greater visibility and support from across the ICB due.

These changes will be reviewed and approved at the Primary Care (Medical Services) Delivery Group in March.

The POD risk register has been developed and will be reviewed at the Primary Care Delivery Group.

The primary care digital risk register is maintained by the digital team and reviewed on a regular basis, either monthly or when programmes are updated or closed.

2. Summary of key points:

All risks are outlined on the attached registers and managed as part of the relevant programmes of work.

3. Are there any options?

Not applicable.

4. Key Risks and Issues

See risk register attachments.

Have you recorded the risk/s on the Risk Management system? Click to access system	Yes ☒	No ☐

Risk references as given on the registers.

5. Are there any financial implications or other resourcing implications, including workforce?

As outlined on the risk registers.

6. How will / does this work help to address the Green Plan Commitments?

Click to view Green Plan

Managing risks well will ensure greater long-term sustainability.

7. How will / does this work help to address inequalities?
Managing risks well will help to address inequalities in delivery of services.
8. Next steps:
To continue to manage and monitor risks as part of each programme of work.
9. Appendices
Appendix A – Primary Care Directorate risk register Appendix B – Pharmacy, Optometry, Dental risk register Appendix C – Primary Care Digital risk register.
10. Background reading
Not applicable.

Bedfordshire, Luton and Milton Keynes Health and Care Partnership

Generated Date	16 Feb 2024
Risk Area	Primary Care

Risk Detail	Initial Priority	Controls		Current Priority	Actions				Linked Risks	Target Priority
		Detail	Owner		Detail	Owner	Variable Target	Last Update Text	Risk Title	
Prefix: R0011 **Created**: 29 Mar 2023 **Risk Lead**: Amanda Flower **Risk Title**: 111 capacity and resilience **Risk Description**: As a result of high patient reliance and demand and high turnover of call handling staff within the BLMK system there is a risk of continued: - 111 high call abandonment rates (due to high demand) - contract value increases (due high demand) - increasing call length (due to staff turnover). This could result in an increase in inappropriate use of urgent and emergency services or patients failing to seek help at all.	High (4:4=16)	Fuller programme - urgent and same-day primary care workstream in BLMK	Amanda Flower	Medium (3:2=6)	Implementation of 111 single virtual call centre (regional call management) - planned go live anticipated May 23 tbc	Steve Gutteridge	31 Mar 2024	Live pilot now underway; target go-live date now end Feb 24 subject to sign-off following conclusion & evaluation of pilot		Medium (3:2=6)
		National integrated urgent care (IUC) modelling work is ongoing to support demand profiling	Steve Gutteridge		Develop the implementation plan to deliver step change required for same day access in general practice as per the Fuller recommendations	David Picking	31 Mar 2024	Action remains ongoing		
		Local IUC modelling and forecasting as part of annual contract planning	Steve Gutteridge		Map urgent and same-day demand and capacity and current activity flows to inform future commissioning of services	Steve Gutteridge	31 Mar 2024	Mapping is ongoing and will need to be completed by the end of March 24 in line with the end of the engagement for the new integrated 24/7 urgent and same day model		
		Collaborating with commissioners across HUC footprint to identify 111 call demand management schemes and IUC efficiencies	Steve Gutteridge		Develop a system-wide self-care approach to support residents to reduce reliance on commissioned services (inc development of MiDOS).	Craig Lister	31 Mar 2024	Action still ongoing		
		Monthly provider/commissioner meetings with national IUC team	Steve Gutteridge							
		Continue to work with practices and PCNs to deliver modern general practice access	Beth Collins							
Prefix: R0004 **Created**: 29 Mar 2023 **Risk Lead**: Amanda Flower **Risk Title**: Access to primary care - rising patient demand **Risk Description**: Risk Description: As a result of continued high demand for general practice services and rising activity levels compared to pre pandemic levels, coupled with resilience challenges due to staff recruitment and retention there is a risk to resident experience of access. This may result in an increase in inappropriate use of urgent and emergency services or patients failing to seek help at all To note: • BLMK is ranked highest for face-to-face appointments • Year on year total appointment numbers provided by practice teams is rising • The GP Survey published in July 22 indicates BLMK at 64% are below the national figure of 72% for 'Good' experience at their GP practice and BLMK has a higher percentage of people having difficulty getting through on the phone than the national average	High (4:4=16)	Collaborative approach with population and system partners to develop and deliver the Fuller Programme to support development and transformation of integrated primary care, organised around 4 pillars: 1. Development of neighbourhood working 2. Provision of same day and urgent primary care 3. An integrated approach to prevention 4. Providing continuity of care through a coordinated MDT approach to the population most at risk of adverse health outcomes.	Amanda Flower	Medium (3:3=9)	Facilitate discussions with practice/PCN/primary care providers to deliver the step change required to improve same day primary care access	Amanda Flower	31 Mar 2024	Action ongoing	GP practices' resilience and ability to transform	Medium (3:2=6)
					Support practices/PCNs to implement the changes that are focused on supporting access	Amanda Flower	31 Mar 2024	Action ongoing		
		Data driven approach - practices receive monthly dashboard using national GPAD and local data	Amanda Flower		Launch and develop quarterly place-based communications campaign/approach explaining primary care/general practice services and changes	Amanda Flower	31 Dec 2023	Action ongoing		
		Continue to work with practices and PCNs to deliver modern general practice access	Beth Collins		Continue practice visits to establish best practice to share to support developments across BLMK	Amanda Flower	31 Mar 2024	Action ongoing		
		Ongoing programme of work to address primary care access across BLMK	Amanda Flower		Implementation of the Delivery Plan for Recovering Access to Primary Care (PRN00283) in partnership with regional team.	Amanda Flower	31 Mar 2024	Action remains ongoing		
		Provide bespoke support to practices with most significant challenge	David Picking							

Risk Detail	Initial Priority	Controls		Current Priority	Actions				Linked Risks	Target Priority
		Detail	Owner		Detail	Owner	Variable Target	Last Update Text	Risk Title	
Prefix: R0008 **Created**: 29 Mar 2023 **Risk Lead**: Nikki Barnes **Risk Title**: GP premises constraints **Risk Description**: As a result of population growth and increased demand for services, along with budget constraints for the ICB, there is a risk that some practices across BLMK will not have sufficient premises capacity to support delivery of the full range of face-to-face services and to enable them to keep their patient lists open to new registrations. This could result in an inability for practices to participate in workforce development schemes and a negative impact on the reputation of primary care amongst our partners. UPDATE Oct 2022 Announcement of national capital funding has been made but does not include recurrent revenue funding so does not alleviate this risk	High (3:4=12)	Primary Care Estates Strategy identifies projects likely to be required to ensure adequate primary care…	Nikki Barnes	Medium (3:3=9)	Primary Care estates strategy aligned with One Public Estates plan	Nikki Barnes	30 Apr 2024	Programme plan being developed for estates strategy refresh - timeline tbc but expect significant progress by April	GP practices' resilience and ability to transform	Medium (3:3=9)
		Number of premises projects underway at various stages (delivered / under construction / at planning stage / not yet started)	Nikki Barnes							
		Heads of PC at place maintain good working relationships with local authority partners and provide assurance to overview & scrutiny committees.	Nikki Barnes							
		Prioritisation panel took place during Nov 2022 confirming which schemes ICB can afford to support, including quantification of risks associated with not progressing projects identified as being required, and decisions were ratified by chair's action group Dec 2022.	Nikki Barnes							
		Ongoing discussions within ICB around management of this risk, including Board seminar 24/02/23	Nikki Barnes							
		Estates development in line with local and national priorities	Nikki Barnes							
		Continue to progress work plan following outcome of prioritisation panel…	Nikki Barnes							
Prefix: PC0001 **Created**: 07 Jul 2023 **Risk Lead**: Nicky Poulain **Risk Title**: Asylum seeker accommodation - primary care funding **Risk Description**: As a result of national funding ceasing for GP practices at the end of 22/23 financial year, and there being no indication of what funding will be made available for 23/24, there is a risk that our eight GP practices aligned with asylum accommodation will cease to provide comprehensive health checks for this cohort on June 30th 2023 due to the work-intensive nature of registering and promptly offering comprehensive health checks to all new-to-country arrivals. Without these health checks mental and physical health (including infectious diseases) conditions may go untreated, as well as the possibility of missed safeguarding concerns, resulting in this population group continuing to suffer from poor health, and the wider population being at risk of communicable diseases (e.g. TB, HIV, hepatitis). Risk closed	High (4:3=12)	Practices have asked to continue registering all residents from their aligned hotels and offering standard health checks and services, as they would with any other new patient.	Beth Collins	Medium (2:2=4)						Medium (2:2=4)
		Luton public health team screening teams are supporting the communicable disease testing	Beth Collins							
		The flow-through in existing hotels is minimal with only few dozen arrivals per month, although this may change as new hotels are commissioned	Beth Collins							
		Additional block funding has been received by ICB to support primary care services for asylum seekers	Beth Collins							
		Ongoing liaison with Home Office and system partner colleagues regarding potential capacity increases/new hotels	Beth Collins							
		New specification for the additional funding has been developed & commissioned from practices	Beth Collins							

Bedfordshire, Luton and Milton Keynes Health and Care Partnership

Risk Detail	Initial Priority	Controls		Current Priority	Actions				Linked Risks	Target Priority
		Detail	Owner		Detail	Owner	Variable Target	Last Update Text	Risk Title	
Prefix: R0009 **Created**: 14 Jul 2023 **Risk Lead**: Amanda Flower **Risk Title**: GP practices' resilience and ability to transform **Risk Description**: As a result of multiple factors including: • population growth • increasing cost pressures • recruitment & retention challenges • difficulties in maintaining training and mentorship provision • increasing demand from patients (cf R0004) • estates pressures (cf R0008) there is a risk that GP practices will become increasingly unable to maintain acceptable levels of service provision. This may result in further contract resignations and patients failing to receive the services they need. To be escalated to corporate risk register	High (4:4=16)	Support from place-based teams including: • Facilitating practice merger discussions where needed • Patient and stakeholder engagement to improve understanding and support for practices who are struggling to meet patient demand • Ongoing primary care network development	David Picking	High (4:3=12)	Ongoing review of controls as outlined in workplans for all teams identified.	Amanda Flower	31 Mar 2024	Recent review of most challenged practices has identified 13 who will get bespoke support		Medium (4:2=8)
		Support from quality team including: • Pre/post-CQC support • PC Quality Dashboard to monitor individual practices which are struggling	Sarah Watts							
		Estates development in line with local and national priorities	Nikki Barnes							
		Focused clinical leadership for access to embed practice/PCN engagement and drive the access task group's work	Amanda Flower							
		Workforce Development Programme including more innovation and transformation, recruitment & wellbeing support	Susi Clarke							
		Technology development in line with local and national priorities (including cloud-based telephony)	Mark Peedle							
Prefix: R0010 **Created**: 27 Jul 2023 **Risk Lead**: Lynn Dalton **Risk Title**: Closure of Wenlock St Surgery **Risk Description**: As a result of the imminent closure of Wenlock St Surgery following the resignation by the GP contract holder at short notice, and the dispersal of patients to other local practices, there is a risk that negative patient feedback about the closure will result in reputational damage to the ICB. The increased pressure on other practices could also have a negative impact on the quality of care they are able to deliver.	High (4:3=12)	Regular meetings with CQC to ensure coordinated approach	Lynn Dalton	Medium (2:2=4)	Lessons learned review	Lauren Sibbons	31 May 2024	CQC report has now been published but will do single lessons learnt to encompass 12 Goldington Rd as well		Medium (2:2=4)
		Local practices have agreed how many patients they are able to take and understand protocols for new patient checks	Lynn Dalton							
		Robust contract closure checklist being worked through	Lynn Dalton							
		Patients have been allocated to new surgeries and notified of which one; can contact ICB if have not received letter	Lynn Dalton							
		Continue to monitor local feedback and respond accordingly	Nicky Poulain							

Bedfordshire, Luton and Milton Keynes Health and Care Partnership

Risk Detail	Initial Priority	Controls		Current Priority	Actions				Linked Risks	Target Priority
		Detail	Owner		Detail	Owner	Variable Target	Last Update Text	Risk Title	
Prefix: PCN0004 **Created**: 22 Sep 2023 **Risk Lead**: Amanda Flower **Risk Title**: Primary care networks **Risk Description**: As a result of: • Differing levels of maturity and stability amongst different PCNs • Variations in patient experience of services offered by different PCNs • Lack of clarity over future commissioning plans for PCNs at a national level • The need for PCNs to embrace new ways of neighbourhood working • Difficulties in recruiting to ARRS roles there is a risk that some PCNs will fail develop as they should and fully engage with the wider health and care system. As a result, the effectiveness of services built around the neighbourhood and the patient may be impacted and the intended benefits of PCNs for the population fail to be delivered.	High (3:4=12)	Development of neighbourhood working and engagement from wider health and care system	Amanda Flower	Medium (3:3=9)	Support PCNs to engage with public health and other service providers in the development of neighbourhoods and neighbourhood working	Amanda Flower	31 Mar 2024		Maximising ARRS allocation PCN performance	Medium (3:2=6)
		Measurement and monitoring of: • Capacity and access plans • IIF outcomes • Use of ARRS • Health inequalities projects	Beth Collins		Flag concerns from this data or 'soft intelligence' with primary care place teams	Beth Collins	31 Mar 2024			
		Interventions based on this information through strategic clinical leads, training hub support and development	Amanda Flower		Work with system colleagues to review PCN engagement	Beth Collins	31 Mar 2024			
		Targeted recruitment support to PCNs from the training hub	Susi Clarke							
Prefix: PCN0005 **Created**: 14 Oct 2023 **Risk Lead**: Susi Clarke **Risk Title**: Maximising ARRS allocation **Risk Description**: As 2023-24 is the final year of the current PCN DES contract and PCNs have been informed that future years' allocations will depend on this year's drawdown, there is a risk that PCNs do not recruit to their full ARRS allocation this year. This would result in reduced financial support in future years.	Medium (3:3=9)	Targeted recruitment support to PCNs from the training hub	Susi Clarke	Medium (2:2=4)	Continue to increase focus on retention as well as on recruitment for this particular staff group	Susi Clarke	31 Mar 2024			Low (1:1=1)
		PCN workforce forum	Susi Clarke		Personalised care recruitment campaign	Susi Clarke	31 Mar 2024			
		Monthly monitoring of spend at place	Susi Clarke		Promote alternative employment models to meet estates, supervision & lead-in time challenges	Susi Clarke	31 Mar 2024			
Prefix: PCN0006 **Created**: 01 Dec 2023 **Risk Lead**: David Picking **Risk Title**: PCN performance **Risk Description**: Because the payments for achievement of IIF indicators are made at a PCN level, there is a risk that some PCNs may wish to remove practices who fail to fully engage or who perform poorly resulting in a negative impact on PCN income. This could result in some practices not belonging to a PCN and their patients not receiving the benefits of PCN membership. This risk is compounded by the current uncertainty over the future of PCNs. New risk	High (3:5=15)	Place team relationship management	David Picking	Medium (3:3=9)	Prepare to respond to new PCN DES arrangements when published	David Picking	31 Mar 2024			Medium (3:2=6)
		Supporting PCN CDs and managers with practices who are not fully engaged in PCN work	David Picking		Ongoing implementation of controls	David Picking	31 Mar 2024	Control are in place and remain ongoing		
		Managed network services provided to patients of practices not in a PCN	David Picking							

Bedfordshire, Luton and Milton Keynes Health and Care Partnership

Risk Detail	Initial Priority	Controls		Current Priority	Actions				Linked Risks	Target Priority
		Detail	Owner		Detail	Owner	Variable Target	Last Update Text	Risk Title	
Prefix: R0012 **Created**: 03 Jan 2024 **Risk Lead**: Fiona Garnett **Risk Title**: Shared care drugs monitoring locally commissioned service **Risk Description**: Background Currently three locally commissioned services (LCSs) exist across Bedfordshire, Luton and Milton Keynes for the monitoring of high-risk drugs and they vary in the drugs reimbursed and payments received. An additional service exists in MK for the administration of gonadorelin analogues. These services were established to ensure that monitoring and administration of certain medications can be completed in primary rather than secondary care. As part of the current review of locally commissioned services which is part of the wider GP Universal Offer workstream, these services will be aligned and brought together under one new service to ensure that payments and drugs reimbursed are the same across BLMK. Risk Under the new service it is possible that some practices will see a reduction in overall payments for the monitoring of shared care drugs. As a result of this, there is a risk of practices declining shared care and stopping prescribing or monitoring certain medications, placing patients at clinical risk. This would result in a significant flow of patients back to secondary care which could not be safely accommodated. It would also impact future transition of work into primary care required for transforming services. New risk	Medium (3:3=9)	Current locally commissioned services for shared care drug monitoring in place until March 24 with good signup and robust systems in place	Matthew Davies	Medium (3:2=6)	Consult practices on the LCS through the UO/LCS review groups and ensure agreement is reached prior to the new service starting	Matthew Davies	31 Mar 2024	An initial proposed LCS for drug monitoring was taken to the November 23 UO/LCS review group meeting		Low (3:1=3)
		Proposed LCSs have been reviewed and payments and drugs to be included in new service under discussion at the UO/LCS review group	Matthew Davies		Consider whether funding from any other LCSs could be repurposed to the drug monitoring LCS	Matthew Davies	31 Mar 2024	Looking at funding for all locally commissioned services as part of the wider review		
Prefix: R0013 **Created**: 16 Feb 2024 **Risk Lead**: Lynn Dalton **Risk Title**: 12 Goldington Road **Risk Description**: Following a recent CQC inspection where a number of significant quality and safety concerns were identified at 12 Goldington Road GP surgery, there is a risk that contractual action will need to be taken. This could result in needing to close the practice and possible reputational damage to the ICB. It could also result in increased pressure on other local practices which may have a negative impact on the quality of care they are able to deliver. New risk	High (3:4=12)	Close working with CQC established	Lynn Dalton	High (3:4=12)	Continue to liaise with CQC regarding outcome of inspection	Lauren Sibbons	31 Mar 2024	CQC attend weekly task & finish group meetings		Medium (3:2=6)
		Place & contract teams supporting practice to address concerns	Lynn Dalton		Establish T&F group to deal with practice closure	Lauren Sibbons	30 Apr 2024	T&F group set up and meeting regularly		
					Get legal advice	Lynn Dalton	31 Mar 2024	LD in regular contact with legal team		
					EOI to Bedford practices for list dispersal	Lauren Sibbons	29 Feb 2024	EOI responses received and evaluated 16/2/24		

Bedfordshire, Luton and Milton Keynes Health and Care Partnership

Generated Date	28 Feb 2024 11:16
Risk Area	Dental, Pharmacy

Dental

Risk Detail	Initial Priority	Controls		Current Priority	Actions				Linked Risks	Target Priority
		Detail	Owner		Detail	Owner	Fixed Target	Last Update Text	Risk Title	
Prefix: DNT0001 **Created**: 24 Nov 2023 **Risk Lead**: Lynn Dalton **Risk Title**: Financial and Workforce Pressures **Risk Description**: As a result of financial and workforce pressures, there is a risk of some dental contractors being unable to deliver their contracted activity levels. This could result in dental contractors requesting to reduce their dental activity or resigning their NHS dental contracts.	High (4:3=12)	Dental contractors with the lowest UDA rates across BLMK have been increased to just below BLMK average	Lynn Dalton	Medium (3:3=9)	Review the opportunities to have a BLMK flexible dental commissioning programme	Lynn Dalton	31 Oct 2023			Medium (2:3=6)
		Dental team are working closely with dental committees on supporting workforce issues and dentists to be given access to the eLearning for healthcare platform April 2024	Lynn Dalton							
		National guidance issued in October 2023 which will help the ICB to develop its flexible commissioning approach for primary care dental services	Lynn Dalton							
Prefix: DNT0002 **Created**: 24 Nov 2023 **Risk Lead**: Lynn Dalton **Risk Title**: Termination of dental contracts **Risk Description**: As a result of financial and workforce pressures, there is a risk of termination of dental contracts which could result in a lack of dental provision in the area	Medium (3:3=9)	When dental contractors request to reduce their NHS contracted activity, ICB will offer the UDAs and funding to dental contractors within the same place-based area or across BLMK if needed	John Hooper	Medium (3:3=9)	Where contractors resign their dental contract, ICB will review the commissioning options prior to re-procuring dental services using contract value to commission a new dental service in the same place-based area or where that is not feasible, consider widening the option to sustain dental services.	John Hooper	24 Nov 2024			Medium (2:4=8)
		Planning for procurement of new dental contracts is underway	John Hooper							

Pharmacy

Risk Detail	Initial Priority	Controls		Current Priority	Actions				Linked Risks	Target Priority
		Detail	Owner		Detail	Owner	Fixed Target	Last Update Text	Risk Title	
Prefix: PH0001 **Created**: 16 Feb 2024 **Risk Lead**: Lynn Dalton **Risk Title**: Provision of pharmacy services **Risk Description**: As a result of: • business decisions (e.g., pharmacies going online) • workforce pressures • individual performer issues There is a risk of community pharmacies closing which may result in gaps in pharmacy provision across BLMK.	Medium (3:3=9)	Pharmaceutical Services Regulatory Committee (PSNC) review & oversee regulatory community pharm requests	Lynn Dalton	Medium (3:3=9)	ICB contracting & meds optimisation teams to work collaboratively with public health teams on review of PNAs as required	John Hooper	31 Jul 2024			Medium (3:2=6)
		H&WB boards & other stakeholders are asked to give feedback on requests which will impact on service delivery	Lynn Dalton		One place in BLMK appears to have a gap at weekends and on bank holidays as a result of a closure of a national company – inform PSRC to request expressions of interest	Lynn Dalton	31 Jul 2024			
		H&WB boards, public health & ICB review provision and make recommendations to PSRC	Lynn Dalton							
		H&WB boards have a statutory responsibility to review and/or refresh pharmacy needs assessments to identify if there is adequate pharmacy provision	Lynn Dalton							

Item 8 Appendix C ICS Digital and IG Risk Report

Generated Date	20 Feb 2024 15:26
Risk Criteria	
Project	LIVE - Risk
Risk Lead	Peedle, Mark
Risk Area	Digital Social Care, Digital Transformation, Information Governance, IT Services
Action Criteria	
Project	LIVE - Action

Prefix	Risk Detail	Initial Priority	Controls Summary	Current Priority	Actions Action Details	Target Priority
ITS0003	Risk Title: Cyber attack on third party software Risk Description: There is a risk that as a result of a cyber attack on a third the affected service provider will be in business continuity response for a protracted amount of time which will adversely affect service provision, services to vulnerable people Risk Owner: Dean Westcott Risk Lead: Mark Peedle	Medium (5:1=5)	SIEM installed to support full network monitoring of HSCN connection… All devices/PCs have been double checked to ensure that they have Microsoft Defender for endpoint ICB Incident Management Team in place Actions taken to patch all systems against known vulnerabilities Business Continuity plans are robust and in place Testing to be applied during restoration Dynamically reviewing BCP processes to streamline service delivery Sharing of risk assessment and decision-making processes undertaken to reach any decision around restoration. Procurement Cycle	Low (3:1=3)		Low (3:1=3)
ITS0001	Risk Title: Cyber Risk Description: There is a risk that a Cyber Attack, unpatched devices or user introduced malware (from for example a phishing email link being clicked) could take individual, multiple, departmental or organisational wide system offline. Risk Owner: Dean Westcott Risk Lead: Mark Peedle	High (4:3=12)	All Anti-virus and malware patching is complete and up to date All operating systems are regularly updated to the latest version, the latest windows 10 version on 202h and the upgrade… HBL have Geolocation enabled on the firewalls, RU Ukraine and Chinese domains and IP addresses are blocked… HBL ICT ensure all perimeter controls (firewalls on HSCN connections) are in place, fully operational and compliant. All desktop and laptop devices are upgraded to Windows 10 (from legacy operating systems) Penetration Test	Medium (4:2=8)		Medium (4:2=8)
ITS0004	Risk Title: MFA implementation Risk Description: National NHS and non NHS systems which are internet enabled that we are unable to implement Multi Factor Authentication with due to either supplier constrain or procurement cycle. Risk Owner: Dean Westcott Risk Lead: Mark Peedle	Medium (2:2=4)		Medium (2:2=4)		Medium (2:2=4)

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Report to the Primary Care Commissioning & Assurance Committee 15 March 2024
9. Report on the Progress in BLMK to achieve the ambitions of the NHSE Delivery Plan for Recovering Access to Primary Care

Vision: "For everyone in our towns, villages and communities to live a longer, healthier life"	
Please state which strategic priority and / or enabler this report relates to	
Strategic priorities	
☒	**Start Well:** Every child has a strong, healthy start to life: from maternal health, through the first thousand days to reaching adulthood.
☒	**Live Well:** People are supported to engage with and manage their health and wellbeing.
☒	**Age Well:** People age well, with proactive interventions to stay healthy, independent and active as long as possible.
☐	**Growth:** We work together to help build the economy and support sustainable growth.
☒	**Reducing Inequalities:** In everything we do we promote equalities in the health and wellbeing of our population.

Enablers			
Data and Digital ☒	Workforce ☒	Ways of working ☒	Estates ☒
Communications ☒	Finance ☒	Operational and Clinical Excellence ☒	Governance and Compliance ☒
Other ☐(please advise):			

Report Authors	Amanda Flower, Deputy Chief Primary Care Officer.
Date to which the information this report is based on was accurate	1 March 2024
Senior Responsible Owner	Nicky Poulain, Chief Primary Care Officer.

The following individuals were consulted and involved in the development of this report:
Mark Peedle, Head of Digital Delivery. Craig Lister, Associate Director – Primary Care Transformation and Prevention Lead.
This report has been presented to the following board/committee/group:
BLMK ICB Board, Primary Care Delivery Group, 4 Place Boards, Working with Patients and Communities Group, Clinical Interface Forums, and BLMK Clinical Leads and PCN Clinical.
Purpose of this report - what are members being asked to do?
The members are asked to: • **Review** the content of this report and **note** progress to date.

1. Brief background / introduction:

As previously reported, the 'Next Steps for Integrating Primary Care: Fuller Stocktake Report' (May 2022) has informed our implementation for integrated neighbourhood working – 'teams of teams' being established. This way of working is gradually bringing together any previously siloed teams to wrap around support and care to residents to meet the broader health and wellbeing needs. BLMK has established an asset-based approach to neighbourhood work in each place. Currently there are 19 neighbourhoods in development across the four Places. See Appendix A for the BLMK high level Fuller roadmap and how the proposed neighbourhoods and PCNs align.

The implementation plans embedded the Fuller recommendations including:

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

In May 2023 the 'Delivery Plan for Recovering Access to Primary Care' acknowledged that in order for the Fuller Stocktake to be delivered there is a need to take the pressure off general practice and support tackling the 8am rush. Whilst the recovery plan is an enabler to all components of the Fuller vision it is focused on access, and the provision of streamlined same day access to the population. The recovery plan described four areas of work to support primary care demand and capacity.

- *Empower patients to self-care - roll out tool's patients can use to manage their own health, and expand the services offered by community pharmacy.*

- *Implement 'Modern General Practice Access' – further roll out of Cloud Based Telephony to support improvements in patients being able to contact their practice. Support practice teams to transition to a Modern General Practice Access Model (or total triage) through the General Practice Improvement Programme. This transformation will lead to improved experience for patients – they will know on the day how their request will be handled, based on clinical need and continuing to respect their preference for a call, face-to-face appointment, or online message.*

- *Build capacity – continue to develop and integrate the multi-disciplinary team in primary care through the Additional Role Reimbursement Scheme and ensure innovative approaches to improve recruitment and retention.*

- *Reduce bureaucracy – support improved interface working with primary and secondary care and extend this to community services this will ensure the maximum time is available for patient care in general practice.*

2. Summary of key points:

Progress update on the Four Domains of the NHSE Delivery Plan for Recovering Access to Primary Care:

National Domain 1: Empowering patients to manage their own health

The implementation of Cloud Based Telephony in BLMK is on track utilising the NHSE programme. All practices in BLMK will have a Cloud Based System in place by the end of June 2024.

The ICB is continuing to promote the NHS App, accompanied with strategic guidance to service providers with regards to digitally enabled access and service improvement. We are using opportunities to influence

further development of the NHS App to benefit BLMK residents by including more languages. The ICB is also working with existing Primary Care system suppliers as part of the devolved NHS England GPIT responsibilities to drive further adoption of NHS App notifications and Online Consultation systems that integrate with the NHS App. We rely on our NHS Provider partners to continue their Patient Portal journeys, to ensure integration with the NHS App as they expand/develop:

- Ensure additional information/services in the MKUHT patient portal is made available via the NHS App as it evolves.
- BHFT delivery of a patient portal in line with strategic plans, ensuring it can link to the NHS App. Where possible Community and Mental Health providers to enable patient portals that link to the NHS App.
- Our Local Authority partners can also help support increased adoption through providing residents with access to free public internet access (e.g., community buildings such as libraries) to enable residents without access to a Smartphone/personal device to access NHS App services.

There is an opportunity for collective ICS partner support for national NHS App Communications campaign. Each of our Communications teams can bring all the above opportunities together using locally adapted national comms materials into compelling reasons for our residents to use the NHS App as their gateway to our combined services.

- Inform our population what is available by the NHS App - as a convenient gateway to services.
- Inform our population how to get the NHS App.
- All BLMK providers to pro-actively promote the NHS App at population access points.
- Continue engagement with Healthwatch and Patient Participation Group's to promote and understand local challenges/barriers to usage.
- Ensure that any promotion of the NHS App is accompanied by a reminder to enable smartphone notifications.

In BLMK we are compliant (services accepting self-referral) with the required 7 national self-referral Pathways (MSK, Falls, Podiatry, Audiology, Wheelchair, Community Equipment and Weight Management); locally further work is planned to map available self-referral pathways, consider where self-referral routes should be opened up and ensure a clear communication campaign to support residents understanding.

Pharmacy first was launched officially on the 31st of January. 151 out of 158 pharmacy contractors in BLMK signed up to provide this service. Several meetings have been held where pharmacy first has been presented across the ICB. Whilst it is early days for 'Pharmacy First', the old element of pharmacy first previously known as Community Pharmacy Consultation Service (CPCS) is still being delivered and we are starting to see an uptake on the new element, which is the 7 clinical pathways. Pharmacies and surgeries who previously had good engagement and delivery of CPCS are seeing continued service delivery including the new clinical pathways - where patients are given prescription medicines under Patient Group Directions (PGDs). The existing barriers to CPCS would still be applicable to Pharmacy First, these include community pharmacy capacity and readiness, pre-existing local relationship issues, and patient awareness and acceptance. The ICB Community Pharmacy Integration Lead continues to collaborate with Community Pharmacies, Practices and Primary Care Networks to further local integration.

On January 25th 2024 we held an inaugural ICB Community Pharmacy event where we brought together over 60 local practitioners for an evening of sharing and learning together. The event received excellent feedback with delegates welcoming the opportunity to hear about the ICBs vision and strategy for primary care and to have the opportunity to network with colleagues.

Launched on 10th January 2024, as part of the ICB's vision for access to primary care and reducing inequalities, the Primary Care Prevention Plan describes our ambition to improve peoples' opportunities and ability to manage their own health and mitigate the growing burden of a range of diseases. The plan

was developed with strong collaboration from colleagues across the ICB, Public Health, colleagues from the VCSE, Healthwatch and others. The plan focuses on primary and secondary prevention across primary care, while considering tertiary prevention for continuity. The full plan is attached as Appendix B to this document.

National Domain 2: Implementing 'Modern General Practice Access'

Modern General Practice Access is the central vision in the NHSE Delivery Plan which has two essential requirements: tackling the 8am rush and reducing the number of people struggling to contact their practice; and patients no longer asked to call back another day to book an appointment.

The delivery plan comes with the General Practice Improvement Programme offer designed to support practices transformation to deliver a modern general practice access model; this includes a universal offer (demand and capacity webinars and care navigation training) and an intermediate and intensive support which (these are tailored 13 and 26 week programmes) guide practices through the transformation journey). So far, 34 practices have participated in the Universal Offer, 19 in the Intermediate/Intensive offer, and 4 Primary Care Networks (PCNs) are engaged in the PCN support offer.

As of 26 Jan 2024, 59.7% of practices/PCNs had participated in national care navigation training offer however this provides limited flexibility to support attendance therefore a local offer is also being considered as this is central to delivery of Modern General Practice Access. The ICB primary care team continue to work with NHSE and practices/PCNs to promote the GPIP programme and 'recruit' practices to participate. The BLMK primary care team are commencing work with the national primary care team to codesign future transformation and support offers.

The ICB Primary Care team have reestablished a proactive practice visit support programme which will see every one of our 89 practices visited in the next 12 months. These visits will provide an opportunity to review and discuss areas of challenge and good practice to foster support across BLMK through a learn and share approach to support practices with their transformation programme.

82 practices have set out their plan to deliver modern general practice access by May 2025 and how they will utilise the support offers, and transition and transformation funding available. Additional support is being offered to the 7 remaining practices.

As part of its work to support residents understanding of primary care and the way that services are developing and transforming 5 resident workshops are planned for March as follows:

Areas:	Date	Time	Venue
Central Bedfordshire	12 March	2.30 - 4.30pm	The Rufus Centre, Flitwick
Bedford Borough	18 March	10.30am - 12.30pm	The Addison Centre, Bedford
Bedfordshire, Luton and Milton Keynes	18 March	7.00 - 8.30pm	Online via MS Teams
Luton	21 March	2.30 - 4.30pm	Luton Irish Forum, Luton
Milton Keynes	22 March	10.30am - 12.30pm	Holiday Inn Central, Milton Keynes

In these workshops the 24/7 primary care offer will be explained, and residents' feedback will be sought on streamlining primary care.

National Domain 3: Building Capacity

All 25 PCNs have been supported to maximise the utilisation of available Additional Role Reimbursement funding to recruit diverse teams with a mix of skills in general practice. The Primary Care Training Hub's capacity is fully utilised to target support to both practice and PCN teams.

In November 2023 a development event was held for primary care services that brought together over 60 primary care clinical leaders to codesign the transformation plan for a sustainable primary care. The

feedback from the event was positive with all delegates welcoming the opportunity to understand more about the ICB vision and to network with colleagues.

A 'Festival of Learning' event took place on Thursday 29th February at which well over 100 primary medical services colleagues came together to further explore integrated neighbourhood working and primary care capacity, demand and development in BLMK. The event guided participants through some aspects of demand and capacity; the vision for Fuller integrated neighbourhood working along with a focus on 7 hot topic areas - EDI & wellbeing; OD and culture; recruitment and retention; learning and development; leadership and management; collaboration and integration and innovation.

Item 9.1 provides the full primary care workforce programme update and highlight report.

National Domain 4: Cutting bureaucracy and supporting the primary/secondary interface

As reported previously, there are two well established Clinical Interface Forums to support the primary/secondary interface – a forum in Milton Keynes and a forum in Bedfordshire & Luton. The forums are jointly chaired by primary/secondary care clinical leaders. In Bedfordshire alongside the 4 priority areas described in the Delivery Plan for Recovering Access to Primary Care priorities have been set to consider neurology, cardiology, ENT, gastro and gynae – which are high volume specialties that have a number of operational issues that frequently impact primary care – these specialities will be worked on jointly to consider opportunities for different ways of working that will improve patient experience and support productivity. In Milton Keynes a community services liaison forum has also been established and this is currently being consider in Bedfordshire.

In respect of the four priority areas in the primary care delivery plan our assessment in BLMK is as follows:

Onward referrals – Amber

This has been raised at almost every Interface meeting and communications have gone out to all secondary care colleagues. There remains a mixed picture with some secondary care clinicians/departments adhering to the changes better than others. There are still examples where things have not worked well with onward referrals on a weekly basis. This is a regular discussion item at both interface forums.

Complete care (fit notes and discharge letters) – Amber

Again, a regular feature in interface discussions; paper fit notes are widely available and both providers have plans to introduce electronic fit notes however this work will continue throughout 2024. There remains a mixed picture across both provides regarding quality and timeliness of discharge letters and there are still frequent reports of missed discharge letters or poor information.

Call and recall (including follow-ups) – Red

Whilst secondary care appreciate the need for their clinicians to systematically review and act upon test results, there are still regular requests back to primary care. BHT have confirmed where a service has a patient on a Patient Initiated follow up pathway there are mechanisms to recall if needed. Services with surveillance and screening pathways have clear call and recall processes. From an MKUH perspective, Primary Care report no systematic call/recall systems in place.

Clear points of contact – Amber

MKUHT are promoting the use of the My Care patient portal through which patients have access to results, letters and they can also make contact through the portal. More and more patients are getting signed on however there are still lots of requests to practice teams to chase results, letters, appointments etc. So, work in progress. No specific plan for dedicated liaison phone number at MKUHT as yet. BHFT advice is for patients to use usual contact points including PALS, For GPs the advice is to use the speciality general managers – contact details have been provided to all GPs.

Continued work will be facilitated through the Clinical Interface Forums but also via the NHS Standard Contract and specifically through negotiation of a Service Development and Improvement Plan for secondary care.

3. Are there any options?

N/A

4. Key Risks and Issues

Primary Care R0004 – Access to primary care – rising patient demand.

R0009 – GP practices resilience and ability to transform.

Have you recorded the risk/s on the Risk Management system? Click to access system	Yes ☒	No ☒

5. Are there any financial implications or other resourcing implications, including workforce?

There are significant constraints in primary care workforce and estates.

6. How will / does this work help to address the Green Plan Commitments?

Click to view Green Plan

The implementation will work on digital first where appropriate and any estates will be built in line with the Green Plan.

7. How will / does this work help to address inequalities?

Implementation will provide continuity of care for those in Core20plus5.

8. Next steps:

The BLMK response to the NHSE Delivery Plan for Recovering Access to Primary Care will be continually reviewed and updated to reflect stakeholder feedback and progress to date. Noting the plan is a two-year work programme that commenced in May 2023.

9. Appendices

Appendix A Delivering Integrated Primary Care (Fuller Roadmap and proposed neighbourhoods).

Appendix B Primary Care Prevention Plan.

10. Background reading

NHS England » Delivery plan for recovering access to primary care

Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Delivering Integrated Primary Care

Amanda Flower
Deputy Chief Primary Care Officer

Amanda.flower@nhs.net

High Level System ‘Fuller’ Road Map

	Develop neighbourhood working aligned to local communities	Streamlined and flexible access for people who require same day primary care	Proactive and personalised care for people with complex needs and co-morbidities	An ambitious, joined up approach to prevention
By 31 March 2024	Each ‘Place’ to define neighbourhoods that are recognisable to residents and to agree a communication and implementation plan. Complete a full stakeholder and asset mapping.	To agree with partners the same day and urgent primary care transformation plan across BLMK and present proposals for codesign.	Identify the system support required for MDT working using PHM data – establish dialogue with partners regarding MDT resource and models for delivery.	Implementation of agreed ’Place’ prevention plans with aligned outcome measures
By 30 Sept 2025	Neighbourhood working rollout well underway. A majority of neighbourhoods and new ways of working are operational.	Plan Implementation - a coordinated, scaled and integrated model for delivery of same day and urgent primary care	Proactive Care will initially focus on specific cohorts of people living with Multiple Long Term Conditions who are at risk of needing unplanned care.	Rollout of place prevention plans. Continued work with local communities, local authorities and VSCE ensuring local voices and choices are acted upon at place
By 31 March 2026	Integrated neighbourhood working is fully operational across BLMK.	New models of same day and urgent primary care are being fully delivered with benefits.	MDT working is integral to all neighbourhoods.	Fully joined up preventative care embedded in place plans and activity being delivered.

Common use of language for a shared understanding

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Developing a Glossary of Terms	
General Practice	A **multi-disciplinary** healthcare team, led by a general practitioner (doctor), in the community providing a range of services and continuity of care to a registered population.
Primary Care	Includes **general practice (GPs) optometry, dentists, community pharmacy, 111, urgent treatment centres, and urgent GP clinics**. These are usually the first step for the population in accessing health services.
Primary Care Networks	Groups of **practices working together to deliver a scaled primary care** offer – where it is efficient & effective to do so - to the population.
Integrated Neighbourhoods	**Multi-agency, multi-disciplinary 'teams of teams'** working collaboratively using an embedded population health management approach. The teams will largely be virtual (co-located in some areas where physically possible) and connected around the residents and the community and bound together by their understanding of and commitment to the population.

Fuller Neighbourhoods & PCNs

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Neighbourhood	Neighbourhood Population	Primary Care Networks
Central Bedfordshire:		
West Mid Beds	70,931	Green Vale, Hillton
Leighton Buzzard	48,036	Leighton Linslade Connections
Ivel Valley	91,652	Ivel Valley South, Sandhills, 2 Managed PCN services practices
Chiltern Vale	83,629	Chiltern Hills, Titan
Bedford Borough:		
Urban South	44,325	East Bedford, Caritas, Unity
Urban North East	45,179	East Bedford, North Bedford, Caritas, Unity
Urban North West	31,082	Caritas, North Bedford, Unity, East Bedford
Rural North	29,384	Unity, North Bedford , East Bedford, Caritas
Rural South	33,854	Caritas, East Bedford, North Bedford, Unity

Fuller Neighbourhoods & PCNs

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Neighbourhood	Neighbourhood Population	Primary Care Networks
Luton:		
West Luton	44,960	Hatters Health, eQuality, Phoenix Sunrisers, Wheatfield Surgery from Titan PCN in Central Beds
West Central	48,289	Hatters Health, eQuality, Phoenix Sunrisers, Medics
North Luton	48,072	Hatters Health, Phoenix Sunrisers, Lea Vale, Medics
East Luton	39,027	eQuality, Oasis
South and Town Centre	45,454	Oasis, Lea Vale, Medics, Phoenix Sunrisers, Hatters Health.
Milton Keynes:		
Bletchley (Pathfinder)	68,759	Crown, South West
North East	36,414	One Mk, Bridge,
Central	80,841	One Mk, Watling Street, Bridge, Nexus, East Mk, Ascent
West	86,035	One Mk, South West, Watling Street, Nexus, Crown, East Mk
South East	62,029	One Mk, Ascent, Bridge, Crown, Nexus, East Mk

A Delivery Plan for Prevention in Primary Care Settings across BLMK

An ambitious and joined up approach to prevention.
Fuller Programme - Integrated Neighbourhood Working

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Bedfordshire, Luton and Milton Keynes
Health and Care Partnership

Contents

Key messages

- This delivery plan articulates a commitment from across the BLMK ICS to have a far greater focus on prevention across primary care settings, allocating resources to pro-actively support the prevention agenda.
- Delivering this plan will require organisations across the ICS to be more collaborative, with strong partnership working.
- This plan stipulates that the greatest effort and focus is on those most likely to experience health inequalities e.g., people living in the most deprived areas, people from ethnically diverse communities, LGBTQ+. Population Health Management (PHM) techniques will be used to target our preventative work across the ICS. These techniques can help to identify groups of people who have a higher prevalence of risk factors for LTCs, who are less likely to attend vaccination and screening offers that they are eligible for, or where LTCs are less well managed. We can then target interventions to support these groups and reduce health inequalities in access and outcomes.
- Across primary care, we need to recognise the great potential within Community Pharmacies (particularly the Health Living Pharmacies), as well as dentistry and optometry to deliver more preventative healthcare, including in signposting or making referrals into preventative services, identification of undiagnosed long-term conditions, their role in better management of LTCs via monitoring and structured medicines reviews and earlier initiation of therapies where appropriate.
- A principle thread throughout this plan is how prominent, consistent action from primary care professionals, supporting people to (re)introduce physical activity in their day-to-day lives, with an additional emphasis on enhancing social interaction, will have significant benefits across many of the common health challenges we face (ref). The good news is that the greatest benefits and lowest risks come from when people move from sedentary to a moderate level of activity.
- We need to strengthen our support to the Voluntary, Community and Social Enterprise (VCSE) sector across BLMK to support the shift towards greater prevention and self-care.

For General Practice settings

- Have more brief, focused and high-quality conversations with people about the importance of healthy behaviours in preventing future illness.
- More referrals into preventative services (e.g., stop smoking, weight management, drugs and alcohol), either making the referrals or signposting as appropriate.
- More proactive management of diagnosed long-term conditions, following evidence-based care processes and pathways.
- Improved management of people with hypertension and care processes for people with diabetes (particularly completing urine albumin creatine ratio).
- Offer more fitting of more LARC devices in primary care settings and smoking cessation services in-house.

For pharmacies

- Have more brief, focused, and high-quality conversations with people about the importance of healthy behaviours in preventing future illness.
- Increased awareness of the local and national preventative services (such as stop smoking, drugs and alcohol, weight management services) and refer into these services or signpost as appropriate.
- Offer case finding for hypertension within pharmacy settings to support with improved identification and recording of hypertension and monitoring of blood pressure.

For dentistry

- Have more brief, focused, and high-quality conversations with people about the importance of healthy behaviours in preventing future illness.
- Increased awareness of the local and national preventative services (such as stop smoking, drugs and alcohol, weight management services) and refer into these services or signpost as appropriate.
- Further discussion with LDC to agree additional interventions.

For optometry

- Have more brief, focused, and high-quality conversations with people about the importance of healthy behaviours in preventing future illness.
- Increased awareness of the local and national preventative services (such as stop smoking, drugs and alcohol, weight management services) and refer into these services or signpost as appropriate.
- Further discussion with LOC to agree additional interventions.

For BLMK ICB

- Develop and share the Better Health branding toolkit within our system wide approach to prevention.
- Create opportunities to support the work of the Voluntary, Community and Social Enterprise (VCSE) sector working within the system.
- Strengthen the relationships with the newly delegated pharmacy, optometry and dental services based within the ICB.
- Support primary care services with proactive management of long-term conditions, using population health management techniques, to identify improvement opportunities and inequalities.
- Increase the delivery of annual health checks to our eligible SMI and LD population. Continue to support primary care services to understand their cohorts living with an SMI and/or learning disability and identify which people require their annual Physical Health Checks.

For Local Authority Public Health

- Work with commissioned providers to design and deliver tailored education, training, and support for healthcare professionals across primary care settings to increase the engagement with, and referrals into, preventative services.
- Work with PH preventative services and primary care to streamline the referral process into these services where possible.
- Work with individual practices to ensure targeted uptake and delivery of NHS health checks to increase the uptake in our eligible population. Develop innovative, opportunistic approaches to promoting the NHS Health Check service and use PHM methodology to ensure that all population groups have equal access to NHS Health Checks. Maximise onward referrals into preventative services.
- Consider options for outreach to improve access for those who currently find it challenging to access the NHS Health Check.
- Support primary care services with proactive management of long-term conditions, using PHM techniques, to identify improvement opportunities and inequalities.

For other organisations across BLMK ICS

- Work with communities to develop meaningful relationships, especially with those communities that the NHS has traditionally struggled to engage with.
- Deliver services and projects that support individual health needs.
- Have confidence in commencing conversations with people about the importance of healthy behaviours in preventing future illness. Deliver culturally competent communication to raise awareness of health promotion and preventative services.
- Increase awareness of the local and national preventative services (such as stop smoking, drugs and alcohol, weight management services) and refer into these services or signpost as appropriate.
- Utilise social prescribing to connect people to interventions provided by the VCSE such as befriending services, practical information including benefits and financial advice, community activities, arts, and culture, and those that take place in nature.

Introduction

Foreword

Many people across Bedfordshire, Luton and Milton Keynes (BLMK) spend many years in poor health, with people living with more complex illnesses for longer. The increasing prevalence of long-term conditions (LTC), increasing multi-morbidity and an ageing population is leading to an ever-increasing demand for health care services.

The pressures on primary care and the wider NHS services are significant and growing. Without an ambitious, joined up approach to prevention, these services eventually risk becoming overwhelmed. Preventative health care is cost effective and has the potential to reduce future need and demand for health care.[i,ii] A shift to a greater focus on prevention and preventative healthcare is therefore crucial to improving the health of the whole population, reducing inequalities across BLMK, and helping to secure the health and social care services we value and rely on.

We know that good or bad health is not simply the result of individual behaviours, genetics, and medical care. Housing, education, work arrangements, access to and affordability of good quality food, air quality and social connections all have a significant impact on our health and wellbeing as shown in Figure 1. Whilst recognising this, we want to empower people to look after and improve their own health and wellbeing. Each of us has a responsibility to look after our own health and wellbeing so far as we can, taking responsibility for that which we can influence. This is not easy, and it is harder for those with lower household wealth or with other challenges, so this plan takes a proportionate universalism approach, underpinned by population health management techniques. This is the resourcing and delivery of universal services at a scale and intensity proportionate to the degree of need, directed intelligently using population wide datasets.

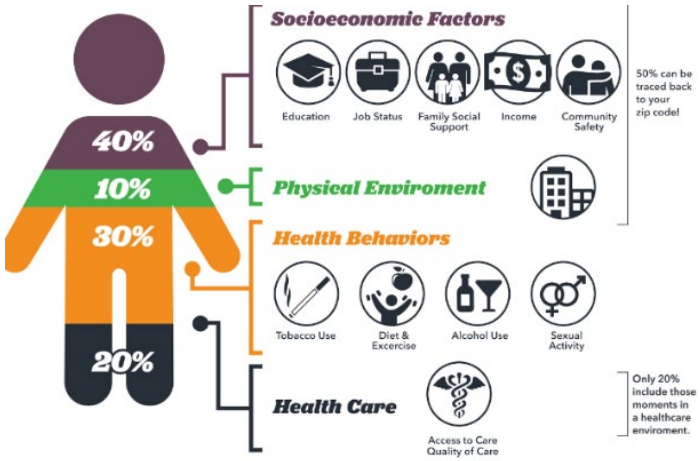


Figure 1: Determinants of health.

Frontline professionals working in primary care settings are in a unique position to highlight, influence and support people towards healthier behaviours.[iii] In addition, frontline professionals play a key role at

identifying conditions at an early stage and supporting the ongoing management LTCs, in line with evidence-based guidance.

This prevention plan articulates a commitment for a far greater focus on the prevention agenda across primary care settings.

Recognising the different determinants of health, this delivery plan has been developed with colleagues from across the Integrated Care System (ICS) including pharmacy, Public Health, the Voluntary, Community and Social Enterprise (VCSE) sector and through wider consultation.

Craig Lister
Associate Director of Primary Care and Prevention
Bedfordshire, Luton, and Milton Keynes
Integrated Care Board

Aims

This delivery plan outlines an **ambitious and joined up approach** to prevention within primary care settings across the BLMK footprint, as part of the Fuller neighbourhood programme of work.

There is a significant amount of work being done on prevention across different primary care settings and across different organisations. This delivery plan takes stock of the current preventative work occurring across primary care settings and outlines general priorities that apply to prevention. It also highlights where the gaps are and how to maximise the value and effectiveness of prevention work by greater co-ordination and collaboration across the ICS.

These documents are aimed at key professional partners across the ICS who deliver, commission, or influence primary care services, and allied services that support prevention in primary care settings.

Scope

This delivery plan focuses on **primary, secondary, and tertiary prevention** within **primary care** settings across BLMK. Primary care settings include general practices, community pharmacies, NHS dental practices and optometry practices.

NHS England delegated the commissioning of pharmacy, optometry and dental (POD) services to the ICB in April 2023. The focus in year one (2023/24) will be to stabilise existing contracts, with further work in 2024/25 and 2025/26 to improve access to POD services including targeting inequalities in access, experience, and outcomes. The focus of this delivery plan will therefore focus primarily on GP practices and pharmacies initially with the view to embed more prevention work in optometry and dental settings in future. A task and finish group has been established to progress prevention discussions in POD services.

Prevention in secondary care is not within scope of this delivery plan, but it does take into consideration the interface between primary and secondary care services and NHS community services (e.g., ELFT, CNWL, CCS).

Whilst this delivery plan intends to improve access to primary care in the longer term by reducing the demand for primary care services through prevention, other work is being completed across the ICS to address access to primary care more broadly which is not outlined in detail in this

prevention delivery plan. For more information on this work, please contact Craig Lister (Craig.lister4@nhs.net) or Faith Haslam (Faith.haslam2@nhs.net).

We have not focused in detail on many of the traditional 'wider determinants' of health. These are workstreams that are being focused on elsewhere in the system and across the ICS. Please see links to related strategies and plans in the Appendix. This delivery plan focuses on specific actions that can be carried out within primary care settings and those that are under the control or gift of colleagues working in these settings to strongly influence.

Context

The importance of prevention within primary care settings is becoming more recognised than ever within national healthcare policy- for example Green Paper on Prevention (2019) and CORE20Plus5. [iv,v,vi] Our work within the BLMK system is shaped by progression within NHS programmes, focused upon proactive, preventative, and outcome-focused career.

The NHS Long Term Plan has a strong focus on the treatment and prevention of illness by supporting people to adopt improved healthy behaviours. We are taking forward the specific commitments set out in the NHS Long Term Plan whilst supporting the NHS to drive a consistent focus on prevention across all services. This is an exciting and significant challenge.

The 'Next Steps for Integrating Primary Care: Fuller Stocktake Report' has provided the mandate for BLMK to develop a detailed vision for integrating primary care, improving access, and improving the experience and outcomes for our residents. Delivering effective primary care services requires close working between partners across health and care, including (not exhaustive) Public Health, Local Authorities, community, and mental health services, acute hospitals, and the voluntary sector. In BLMK, we see this being achieved through an operating model that draws inspiration from the Fuller Stocktake Report for Integrated Primary Care. In essence this means our work to transform primary care will be anchored firmly at "place" with Primary Care Networks (PCNs) and stakeholders owning and driving the plans.

There is strong emphasis at all levels for ICSs to utilise place partnerships, integrated neighbourhood teams and provider collaboratives to improve both allocative and technical efficiency.

Current health of our population

BLMK ICS footprint

The resident populations of Bedford Borough, Central Bedfordshire, Milton Keynes, Luton, and part of Buckinghamshire, are within the geographic BLMK ICS footprint. The Joint Strategic Needs Assessment for Bedford Borough, Central Bedfordshire and Milton Keynes can be found here: https://bmkjsna.org/.,Luton can be found here: https://www.luton.gov.uk/Community_and_living/Lists/LutonDocuments/PDF/JSNA/jsna-overview-health-social-care-needs-2022.pdf and for Buckinghamshire can be found here: https://www.buckinghamshire.gov.uk/health-wellbeing-and-sports/joint-strategic-needs-assessment. If you are viewing this as a hard copy, you can access the Joint Strategic Needs Assessment (JSNA) for each Place by going onto the relevant Local Authority website.

Current picture across BLMK ICS

Note: infographic in development - this will use information in the JSNA and long-term conditions health needs assessment to outline the prevalence of health behaviours, risk factors and prevalence of LTCs across BLMK. Population projections and future demand modelling being performed as part of the health services strategy which will consider the scale of potential mitigation through preventative interventions (e.g., if health need is **reduced** because of reasonably effective preventative interventions). Will update health inequalities infographic below if possible.

For more information, please see the supporting document.

Health Inequalities BLMK

Hospital Activity

In 2020/21, the number of **unplanned admissions** per 1,000 patients was **1.4 x higher** in the most deprived areas than the least deprived.

A&E attendances were **1.4 x higher** in the most deprived areas, compared with the least deprived areas.

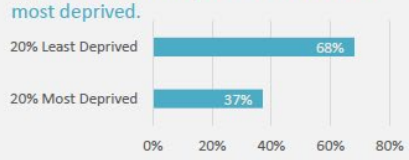
Diet

In 2021/22, **46 in 100 year 6 children were overweight or very overweight** in the 20% most deprived areas, compared to just over **31 in 100** in the 20% least deprived areas.*

In 2020/21, approximately **66 in 100 adults** across BLMK were **overweight or obese**.

Cancer Screening

In 2020/21, the percentage of **50-70 year olds screened for breast cancer within 6 months of invitation** was just over **1.8 x** higher in the least deprived areas than the most deprived.



Smoking and Alcohol

In 2021/22 **54 in 100** people **successfully quit smoking after 4 weeks** in the 20% least deprived areas, compared with just over **46 in 100** people in the 20% most deprived areas.*

In 2016/17 – 20/21, the **hospital admissions rate for alcohol attributable conditions** in the most deprived area was over **2.3 x higher** than that in the least deprived.

Mental Health & Wellbeing

In 2016/17 - 2020/21, rates of **self-harm admissions** in the most deprived area were over **3 x higher** than the least deprived.

Premature Mortality

In 2016-20, **preventable mortality** in the most deprived area was **3.6 x** that in the least deprived.

Under 75 circulatory disease mortality was **7.3 x more** in the most deprived area than the least deprived in 2016-20.

Under 75 cancer mortality in the most deprived area was **double** that of the least deprived in 2016-20.

Life Expectancies & General Health

The **life expectancy at birth** inequality gap in 2018-20 ranged from **8.9 years** in Bedford Borough and **5 years** in Central Bedfordshire for males and from and **7.8 years** in Bedford Borough to **5.9 years** in Central Bedfordshire for females.

The **life expectancy at 65 years** inequality gap in 2018-20 ranged from **6.4 years** in Bedford Borough to **3.9 years** in Central Bedfordshire for males and **6.1** years in Bedford Borough to **3.5 years** in Central Bedfordshire for females.

Major Diseases & Health Checks

The rate of **COPD admissions** in the most deprived area was **over 3.5 x higher** than that of the least deprived area.

In 2021/22, **46 in 100 health checks were completed of those offered** in the 20% least deprived areas, compared with just under **35 in 100** in the 20% most deprived areas.*

*** Data does not include Luton**

Overall goal and priorities for preventative work

Overall goals

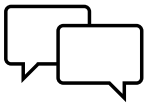
- Decrease or halt the increase in the prevalence of LTCs.
- Improve quality of life for our residents.
- Decrease health inequalities.

Reduce the variation in our population including in:

- Risk factors for long-term conditions e.g., smoking rates, physical inactivity, excess weight.
- Access to preventative and primary care services.
- Uptake of screening and immunisation offers.
- Management and outcomes of long-term conditions

Cross cutting themes and enablers – see page below.

Place boards will be used as a forum to shape key priorities at place and prioritise items on the action plan.



More conversations with people about the importance of healthy behaviours in preventing future illness.

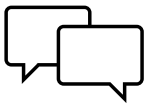
More referrals into preventive services e.g., stop smoking, weight management and drug and alcohol services.

More people attending the vaccination programmes they are eligible for and reduce the variation in uptake across our population.

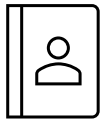
Better access to contraceptive services including more LARC fittings offered within primary care.

Ensuring health inclusion groups are registered with primary care.

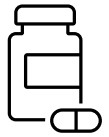
Further work being discussed to add pre-conception component.



Promote social prescribing to support wider determinants of health.



More people attending the screening programmes that they are eligible for and reduced variation in uptake.



Medicines optimisation and a reduction in waste. Reduce polypharmacy.
Regular medication reviews.

Increase delivery and uptake of NHS Health Checks and annual LD/SMI health checks. Appropriate follow up and treatment/management of any LTC or risk factor identified.

Earlier identification of risk factors for, and/or the presence of LTCs. In particular, improved recording of blood pressure monitoring within primary care settings.

Enhanced management of LTCs. In particular- improving hypertension management; improving diagnostic capacity for common chronic respiratory conditions; improved evidence-based management of diabetes.

Further improve completion of care processes for LTCs (e.g., diabetes care processes), stroke rehabilitation and transformation of heart failure pathways.

Cross cutting themes and enablers

Population health management and reducing health inequalities	Social prescribers	Self-care	Enabling the VCSE sector	Enivronmental sustainability
•Data-driven approach to intelligently tailor and direct interventions for residents and patients to maximise efficiency and outcomes. •This can support a proportionate universalism approach, where universal services are resourced and delivered at a scale and intensity proportionate to the degree of need – a key method for addressing health inequalities. •Use PHM principles (including segmentation and risk stratification tools) to target preventative work- identify a group of people (cohort) with shared characteristics who could benefit from more proactive or joined-up preventative support and then co-produce an intervention or support to meet their needs. Test interventions, measure their impact and then act on the learning.	•Social prescribers are already connecting people to interventions provided by the VCSE sector such as befriending services, practical information including benefits and financial advice, community activities, arts, and culture, and those that take place in nature can alleviate issues relating to loneliness, stress, mild to moderate depression, and anxiety. Improvements in mental health and wellbeing, confidence and community knowledge have been reported in people attending social prescribing programmes.	•Self-care is about people keeping fit and healthy, understanding when they can look after themselves, when a pharmacist can help, and when to get advice from your GP or anothe health professional. •For those living with a long-term condition, self-care is about understanding that condition and how to live with it. However, some people might require additional support with self-care and management of their long-term condition. Social prescribing and VCSEs, as outlined above, could provide some of this additional support.	•The Voluntary, Community and Social Enterprise (VCSE) sector in BLMK is essential to supporting a greater shift towards prevention and self-care. • Our population is growing rapidly and tackling the growth in demand and complexity is only possible if we work together in partnership with our colleagues in the VCSE. •There are estimated to be 4000 such organisations in BLMK, bringing diverse expertise, insight, and a range of services to the area.	•By preventing illness, we can reduce the need for healthcare services – which are typically environmentally damaging, with high emissions and high waste. The BLMK ICS Green Plan (2022-2025) and associated Health Impact Assessment provide further information on this topic. •It is noteworthy that those living in the most socioeconomically deprived areas tend to be those most at risk of the impacts of climate change, therefore promoting environmental sustainability will naturally support a reduction in health inequalities (ref)

QI, research, personalisation, harnessing the power of our communities, social contracts and patient activation will be added as enablers.

How are we going to do this?

Detailed actions for how the ICS can more strongly embed these prevention priorities are outlined in a live action plan. For each of the key areas of focus, this specifies the actions, the relevant organisations that need to be involved, timescales and progress measures. Please email Craig.lister4@nhs.net for an up-to-date copy of the action plan. Key actions are highlighted below.

General Practice settings

Health improvement and promoting preventative services	• Be aware of, and promote, free local and national resources that support healthy behaviours and are available to everyone. For example: Better Health, Every Mind Matters, Couch to 5k. • Have more conversations with people about the importance of healthy behaviours in preventing future illness using MECC principles (e.g., stop smoking, weight management, recommended alcohol limits, harms of UV exposure and staying safe in sun). There will be local training offers from Public Health to support this. • Encourage and support referrals into preventative services, such as smoking cessation support (the Stop Smoking service, Total Wellbeing Luton), exercise on prescription, Tier 2 weight management programmes (MoreLife, Total Wellbeing Luton, NHS Diabetes Prevention Programme, NHS Digital Weight Management Programme); Drugs and Alcohol services (Path 2 Recovery (P2R), Addiction Recovery Community (Arc) Milton Keynes, SAMAS and ResoLUTiONs). This includes making referrals or signposting people to complete a self-referral where appropriate. There will be local training offers from PH to support this. There are Enhanced Service payments available for referral into Tier 2 weight management services. • Particularly target and support cohorts of the population who have a higher prevalence of the modifiable risk factors, using proactive practice level data and population health management techniques to support this. To achieve this, have better monitoring and completion of records which are maintained and as up-to-date as possible e.g., opportunistic BP and BMI measurements. • Increase access to contraception services, particularly to long-acting reversible contraception devices through increased fitting of LARC devices in primary care settings. Increase access to post-natal contraception. Encourage self-care around testing for STIs and protected sexual intercourse, sign-posting people to the local service website (iCASH) • Actively advertise information on the mental health support available, particularly crisis provision and signpost to local services/resources (MH Directory BLMK). • Ensure that health inclusion groups are registered with primary care e.g., people who are rough sleeping, statutory homeless or from the Gypsy, Roma, Traveler community. • Priorities on pre-conception care (healthy mothers, healthy pregnancy) and falls/frailty prevention priorities to be added

Immunisations, cancer screening and non-cancer screening	• Build on current work to promote vaccinations and screening. • Have a strong focus on targeting populations traditionally harder to reach and those at risk, including those who are under-vaccinated or do not attend screening in your practice. Use a population health management approach to identify and target these groups of people, with proactive follow up with these cohorts.
NHS Health Checks and annual LD and SMI health checks	• Targeted work to increase the uptake of NHS Health Checks for eligible population and annual health checks for people with SMI and LD. Use PHM techniques to target communications, engagement and outreach events to increase uptake in populations where we know uptake is low. • Maximise opportunities from these health checks to refer onwards to preventative support if applicable and for onwards management of LTCs. Management of abnormal blood pressure, lipids, and blood glucose results as per local pathways. • Work with the ICB and LA Public Health to reduce the inequalities in uptake of health checks across our population.
Early identification of, and evidence-based management, of LTCs	**Earlier identification:** • Earlier diagnosis of LTCs such as respiratory conditions (asthma, chronic obstructive pulmonary disease [COPD]), cardiovascular disease (including hypertension and atrial fibrillation) and Type 1 and Type 2 Diabetes management; mental health support and onwards referrals to secondary care and community services as applicable. Focused work supported by the ICB and LA Public Health to improve blood pressure monitoring and recording. • Earlier identification of risk factors that may make people more likely to experience mental health difficulties, as outlined in the supporting document. Earlier intervention and support for people experiencing mental health difficulties, including referral into NHS Talking Therapies Increased awareness of, and identification of people who are in crisis and/or experiencing suicidal ideation. Referrals for crisis support including crisis cafes. • Increased testing for sexually transmitted infections and referral to sexual health services if required, for treatment, contact tracing and specialist support. Increased awareness of clinical indications to test for HIV (e.g., shingles), earlier testing for HIV within GP settings and, if applicable, referral into specialist HIV services for support and treatment. HIV testing for individuals at higher risk e.g., new registrants. • Earlier identification of drug and alcohol harms (using tools such as AUDIT-C); more recognition of risk factors that might make a patient more likely to misuse drugs and alcohol or where they might be used as a coping mechanism e.g., when someone has experience trauma or mental health difficulties. Acknowledging that treatment is not just substitute prescribing, refer to drugs and alcohol services for specialist support, including psycho-social interventions. • Targeted work to support with Drugs and Alcohol secondary and tertiary prevention as per supporting document and action plan. **LTC management:** • Ensuring that local pathways for LTC management are being followed and optimised, in line with NHS England Secondary Prevention guidelines on high impact interventions- working with BLMK ICB and LA Public Health to do:

	• Focused work on cardiovascular disease, improve hypertension management (adopting the revised local BLMK hypertension pathway) and lipid optimisation for secondary prevention of CVD. Follow heart failure pathways, including rapid initiation/up titration of key evidence-based therapies. • Focused work on respiratory disease, including increasing spirometry recording in people with asthma/COPD diagnosis, supporting the management of asthma in people with highest risk of exacerbations, admissions and poor outcomes and having an asthma plan for children. • Greater adoption of inhaled therapies for managing common respiratory conditions with reduced environmental impact – for example increasing uptake of propellant free short acting B agonist inhalers (SABAs) and better disease control through inhaled corticosteroids. • Further improve the completion of all 8 care processes for diabetes management, particularly focusing on improving completion of urine albumin-creatine ratio. Improved evidence-based management of diabetes as per supporting document. • Focused work to improve glycaemic management, CV risk reduction and adequate planning for pregnancy in people with young onset type 2 diabetes. • Use a population health management approach to identify cohorts with suboptimal management of their LTC for proactive follow up. For example, where diabetes care processes not being met e.g., urine albumin-creatine ratio, hypertensive people with BP outside target range. Greatest effort on those mostly likely to experience health inequalities e.g., people from ethnically diverse communities, LGBTQ+, people living in the most deprived areas. • Earlier identification of when a patient needs more comprehensive mental health support, with pro-active referrals into mental health community services if appropriate (ELFT, CNWL) and then onward referral into inpatient services if it is required. • Regular medication reviews, including reviews into whether preventative or secondary care services are required. For example, performing regular reviews for people who are taking anti-depressants to assess whether psychology support is required or support from other services e.g., drugs and alcohol services, support from social prescribing. • Take a compassionate community type approach to end-of-life care and prevent unnecessary suffering e.g., through preventing pressure sores.
Medicines optimisation	• Optimise medications such as inhalers and a reduction in medicines waste. As per section above, use medications with reduced environmental impacts (e.g., propellant SABAs). • Reduce polypharmacy through regular medicines reviews. • Support service users with Medicines Concordance- support and education to service users so that they better understand their medical condition, the treatment options and so that they actively participate in shared decision making. • Further work with medicines optimisation team to be completed

Wider determinants of health and social prescribing	• Recognise where the wider determinants of health are having a current or could have a future impact on people's physical and mental health and health behaviours. Either signpost or refer into sources of support e.g., Citizens Advice Bureau where applicable and work with PCN and practice social prescribers to support registered population. For example, where the cost of living, relationship breakdowns, social isolation, might increase a patient's risk of suicide or use of drugs and alcohol, refer to appropriate support. This principle is also applicable to the secondary and tertiary prevention principles where these wider determinants might already be having a detrimental impact on their mental and physical wellbeing. • Where possible, proactively identify people who might benefit from social prescribing support or other sources of support using data and intelligence about resident population.

Pharmacies

Health improvement and promoting preventative services	• Be aware of, and promote, free local and national resources that support healthy behaviours and are available to all people/the public. For example: Better Health, Every Mind Matters, Couch to 5k. • Have more, focused and high-quality conversations with people about the importance of healthy behaviours in preventing future illness using MECC principles (e.g., stop smoking, weight management, recommended alcohol limits, harms of UV exposure and staying safe in sun). There will be local training offers from PH to support this. • Signpost people into preventative services where it is appropriate, such as smoking cessation support (Stop Smoking service, Total Wellbeing Luton), exercise on prescription, Tier 2 weight management programmes (MoreLife, Total Wellbeing Luton, NHS Diabetes Prevention Programme, NHS Digital Weight Management Programme); Drugs and Alcohol services (Path 2 Recovery (P2R), , SAMAS, Addiction Recovery Community (Arc) Milton Keynes and ResoLUTiONs) and signpost to sexual health services (iCASH). There will be local training offers from PH to support this. • For those pharmacies who have signed up to the PH Enhanced Service (PHES), continue to offer emergency hormonal contraception for all age groups and increase the number of pharmacies signed up to the PHES to improve community access. Increase testing for Chlamydia within the community and refer onto specialist sexual health services where applicable. • Continue to develop the role of Healthy Living Pharmacies, ensuring that the pharmacy team are informed and aware of all services offered by their service. These teams are well placed to offer advice and support to patients effectively with accurate signposting and referral when the need arises. • Priorities on pre-conception care (healthy mothers' healthy pregnancy) to be added in discussion with Dr Chakrabarti
Immunisations	• Continue to promote vaccinations, having a strong focus on targeting populations traditionally harder to reach and those at risk, including those who are under-vaccinated.

NHS Health Checks	• Work with ICB and primary care colleagues to maximise opportunities from the NHS Health Checks to identify and manage LTCs, including clinical management and onward referrals to preventative services.
Early identification of, and evidence-based management, of LTCs	• Continue to work with the ICB and Local Authority Public Health to understand the great potential that Community Pharmacy has for the early identification and management of LTCs and strengthen this prevention work. For example: - Identification of undiagnosed diabetes. - Management of LTCs via structured regular medicines reviews for patients with patients with CVD, Hypertension, AF, Heart Failure, Asthma, COPD and diabetes. • Focused work, with the support of the ICB and Public Health, to support with improved identification of hypertension via community case finding and onward monitoring and management. • Continue pilot work (with ICB) looking at earlier initiation of therapy e.g., treatment of hypertension confirmed by ambulatory blood pressure monitoring.
Medicines optimisation	• Consider non-pharmacological treatments either instead of medicines or alongside medicines as an equally beneficial treatment. Many long terms conditions – such as chronic pain, diabetes, cardiovascular and respiratory conditions benefit from a holistic approach from the clinician and shared decision making with the patient as to what can help them manage their condition. • Support service users with Medicines Concordance- support and education to service users so that they better understand their medical condition, the treatment options and so that they actively participate in shared decision making. • Further work with medicines optimisation team to be completed

BLMK ICB

Health improvement and promoting preventative services	• Lead on the development of MiDoS, a professional and a public facing directory which covers organisations supporting primary and secondary prevention. • Develop the Better Health branding toolkit within our system wide approach to prevention. • Deliver the Treating Tobacco Dependency programme to pregnant women and their partners, with a new smokefree pregnancy pathway including focused sessions and treatments. • Ensure that all people admitted to hospital who smoke will be offered NHS-funded tobacco treatment services. • Priorities on pre-conception care (healthy mothers' healthy pregnancy) to be added in discussion with Dr Chakrabarti • Frailty/falls prevention priority being developed

Immunisations, cancer screening and non-cancer screening	• Work across the ICS system to increase the number of people across BLMK taking up the offers for all immunisation and screening programmes (cancer and non-cancer screening) that they are eligible for. Continue to use a community engagement approach. Expand on innovation and risk stratification within the system. • Maximise the offer and take up in primary care for all age immunisations including COVID vaccinations and delivery of the annual flu campaign, especially in the 'at risk' and typically under-represented groups. • Assess the variation across PCN populations of screening and immunisation uptake to allow targeted promotion. • Continue ongoing work on cancer prevention, including earlier diagnosis, supporting timely presentation (awareness raising to people and health providers), risk stratification. • Case finding by proactive clinical systems searches and using a Population Health Management approach including segmentation and risk stratification tools
LD and SMI health checks	• Work with primary care settings (and other settings e.g., Housing Associations) to increase the delivery of annual health checks to our eligible SMI and LD population. Continue to support primary care services to understand their SMI cohorts and identify which people require Physical Health Checks. • Promote our enhanced and outreach Physical Health Check services throughout the system to increase referrals and uptake. • Collaborate with VCSE sector colleagues to raise awareness of SMI Physical Health Checks through their networks and contacts in the community, with specific focus in communities where uptake is low. Continue to prioritise the promotion of Learning Disability Annual Health Checks through collaborative work with primary care, health facilitation, NHS trust and local authority partners. • Explore opportunities to deliver Learning Disability Annual Health Checks and SMI Annual Health Checks simultaneously for those with a dual diagnosis.
Early identification of, and evidence-based management, of LTCs	• Undertake focused work with Primary Care and LA Public Health on the secondary and tertiary prevention of cardiovascular, diabetes and respiratory disease as highlighted in the General Practice table. • Case finding (e.g., undiagnosed hypertension, undiagnosed diabetes), by proactive clinical systems searches and using a Population Health Management approach including segmentation and risk stratification tools. • Support primary care to use a population health management approach to identify cohorts with suboptimal management of their LTC for proactive follow up. Address unwarranted variation in the prevalence of primary CVD risk factors and management of LTCs and preventable hospital admissions to inform targeted secondary prevention activity. • Explore digital support offers to lead to improved self-management of hypertension. • Develop process for data flow from Sisu machine to GP to enable appropriate follow up of people with potential hypertension (LB).
Medicines optimisation	• Build on government recommendations to develop integrated templates that support referrals for culturally competent, evidence-based alternatives to a medicine (including physiotherapy, talking therapies, local social prescribing options) which support Shared Decision Making and which can be adapted for local use.

Governance	• Have oversight of, and monitor, prevention activities and priorities for primary care settings across the ICS via BLMK Prevention Delivery Group, reporting to the BLMK Primary Care Medical Services Delivery Group. • Once this delivery plan has been finalised, work with the ICB place leads and Public Health teams to localise the action plan to each place. • Continue strategic conversations regarding the role and opportunities of prevention within primary care settings, linking with ICB clinical strategic leads, PCN Clinical Directors, Strategic Long-Term Conditions ICB lead, pharmacy leads, Local Pharmacy Committee.
Wider determinants	• Continue leading collaborative work across the ICS to consider how the NHS supports wider social and economic development, including environmental sustainability to promote health and wellbeing and with a strong focus on prevention. Continue working with partners to maximise the value of our Anchor organisations to improve the wider determinants of health e.g., employment, income, education, wellness promotion, occupational health, nature, built environment.

Local Authority Public Health

Health improvement and promoting preventative services	• Design and deliver tailored education, training, and support for healthcare professionals across primary care settings to increase the engagement with, and referrals into, preventative services such as weight management services, smoking cessation, drugs, and alcohol services. Target training for those practices with highest need e.g., those with higher prevalence of risk factors, those that are in areas of higher deprivation, have lower referral rates or less complete disease registers. • Offer training on 'see the signs' suicide prevention for professionals working in primary care settings. • Review and streamline referral process from primary care settings into preventative services where possible. • Work with primary care settings to understand how primary care settings could deliver more stop smoking services in house with future funding opportunities.
Immunisations, cancer screening and non-cancer screening	• Provide data and analytical capabilities to support the ICB in their work to assess the variation across PCN populations of screening and immunisation uptake to allow targeted promotion. • Support the ICB with their work to increase the uptake of all age immunisations and screening by promoting uptake through outreach and engaging with community partners, focusing on groups with the lowest uptake.
NHS Health Checks	• Work with individual practices to ensure targeted uptake and delivery of NHS health checks to increase the uptake in our eligible population. Develop innovative, opportunistic approaches to promoting the NHS Health Check service, building on the Making Every Contact Count approach.

	• Use population health management methodology to ensure that all population groups have equal access to NHS Health Checks. • Work with ICB and primary care colleagues to maximise opportunities from the NHS Health Checks to identify and manage LTCs, including clinical management and onward referrals to preventative services. • Consider options for outreach to improve access for those who currently find it challenging to access the NHS Health Check.
Early identification of, and evidence-based management, of LTCs	• Undertake focused work with Primary Care and ICB, focusing on the secondary and tertiary prevention of cardiovascular, diabetes and respiratory disease as highlighted in the General Practice table. • Provide data and analytical capabilities to support the ICB and primary care with addressing unwarranted variation in management of LTCs and preventable hospital admissions to inform targeted secondary prevention activity. • Support primary care to use a population health management approach to identify cohorts with suboptimal management of their LTC for proactive follow up.

Other organisations across the ICS

Health promotion and promoting preventative services	• Be aware of, and promote, free local and national resources that support healthy behaviours and are available to all people/the public. For example: Better Health, Every Mind Matters, Couch to 5k. • Be confident in commencing conversations with people about the importance of healthy behaviours in preventing future illness using MECC principles (e.g., stop smoking, weight management, recommended alcohol limits, harms of UV exposure and staying safe in sun). • Signpost people into preventative services where it is appropriate, such as smoking cessation support (Stop Smoking service, Total Wellbeing Luton), exercise on prescription, Tier 2 weight management programmes (MoreLife, Total Wellbeing Luton, NHS Diabetes Prevention Programme, NHS Digital Weight Management Programme); Drugs and Alcohol services (Path 2 Recovery (P2R), , SAMAS, Addiction Recovery Community (Arc) Milton Keynes and ResoLUTiONs) and signpost to sexual health services (iCASH). • Deliver culturally competent messaging around health promotion and preventative services to increase understanding and uptake.
Medicines optimisation	• Continue to support with certain elements of medical prevention, either by supporting the timely transfer of care around medicines, supporting shared decision making, and enabling deprescribing by offering non-medical interventions through social prescribing.

Wider determinants of health and social prescribing	• Connect people to interventions provided by the VCSE such as befriending services, practical information including benefits and financial advice, community activities, arts and culture, and those that take place in nature. • Recognise where the wider determinants of health are having a current or could have a future impact on people's physical and mental health and health behaviours. Either signpost or refer into sources of support e.g., Citizens Advice Bureau where applicable and work with PCN and practice social prescribers to support registered population. For example, where the cost of living, relationship breakdowns, social isolation, might increase a patient's risk of suicide or use of drugs and alcohol, refer to appropriate support. This principle is also applicable to the secondary and tertiary prevention principles where these wider determinants might already be having a detrimental impact on their mental and physical wellbeing.

Monitoring and evaluation

The BLMK Prevention Group (to be established) will be responsible for the operational delivery of this plan and will report to the BLMK Primary Care Delivery Group. This work programme will be monitored by the BLMK Primary Care Commissioning and Assurance Committee using outcome measures outlined in the action plan. A process evaluation of the primary care prevention work programme will be conducted in a year.

Updates on delivery will be reported to the BLMK Health Inequalities Steering Group on a quarterly basis.

Any current prevention work will continue to report to the established board (e.g., cancer screening rates to the cancer board) therefore, the purpose of the BLMK prevention group is to co-ordinate and bring a summary together to review and share learning.

Conclusion

This primary care delivery plan outlines a coordinated ambitious approach to prevention across all primary care settings, involving professionals working across the ICS who deliver, commission, or influence primary care. Whilst undertaking these actions will require time and effort, prioritising and maximising opportunities for prevention across primary care will have a positive impact on the health and wellbeing of the BLMK population. Such a focus on prevention should lead to a reduction in future demand on primary care settings.

Appendix

Related documents

Health and wellbeing strategies

Central Bedfordshire Health and Wellbeing

Luton Health and Wellbeing Strategy 2(

Milton Keynes Health and Wellbeing Strate

Bedford Borough Joint Health and Wellk

Please note that the BB and CB health and wellbeing strategies are currently being refreshed.

ICS documents

BLMK Joint Forward Plan.pdf

BLMK Health and Care Strategy.pdf

BLMK ICS Green Plan 2022-2025.pdf

Additional BLMK ICB strategies are available here: https://bedfordshirelutonandmiltonkeynes.icb.nhs.uk/our-strategies/

References

[i] [i] Secondary prevention: reducing disparities and improving life expectancy. NHS England [cited August 2023). Available from: https://www.england.nhs.uk/ourwork/prevention/secondary-prevention/

[ii] Health Matters- preventing cardiovascular disease. Public Health England 2019 [cited October 2023] Available from: https://www.gov.uk/government/publications/health-matters-preventing-cardiovascular-disease/health-matters-preventing-cardiovascular-disease

[iii] Let's Talk About Weight Step-by-Step guide. Public Health England. 201 [cited October 23] Available from: https://assets.publishing.service.gov.uk/media/5b8d54d2e5274a0bd7d11928/weight_management_toolkit_Let_s_talk_about_weight.pdf

[iv] Advancing our health: prevention in the 2020s- consultation document. July 2019 [accessed November 2023] Available at: https://www.gov.uk/government/consultations/advancing-our-health-

[v] Core20PLUS5 – An approach to reducing health inequalities for children and young people. NHS England. Accessed November 2023. Available at https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/core20plus5-cyp/

[vi] Core20PLUS5 – An approach to reducing health inequalities (adults). NHS England. Accessed November 2023. Available at: https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Report to the Primary Care Commissioning & Assurance Committee – 15 March 2024
9.1 Primary Care Workforce Programme & Highlight Report

Vision: "For everyone in our towns, villages and communities to live a longer, healthier life"	
Please state which strategic priority and / or enabler this report relates to	
Strategic priorities	
☒	**Start Well:** Every child has a strong, healthy start to life: from maternal health, through the first thousand days to reaching adulthood.
☒	**Live Well:** People are supported to engage with and manage their health and wellbeing.
☒	**Age Well:** People age well, with proactive interventions to stay healthy, independent and active as long as possible.
☒	**Growth:** We work together to help build the economy and support sustainable growth.
☒	**Reducing Inequalities:** In everything we do we promote equalities in the health and wellbeing of our population.

Enablers			
Data and Digital ☐	Workforce ☒	Ways of working ☒	Estates ☐
Communications ☐	Finance ☐	Operational and Clinical Excellence ☐	Governance and Compliance ☐
Other ☐(please advise):			

Report Author	Marie Lehane, Head of Primary Care Workforce Programme
Date to which the information this report is based on was accurate	26/02/24
Senior Responsible Owner	Nicky Poulain, Chief Primary Care Officer

The following individuals were consulted and involved in the development of this report:
This report has been presented to the following board/committee/group:
Primary Care Delivery Group & People Board.

Purpose of this report - what are members being asked to do?
The members are asked to **note** the contents of the highlight report.

Executive Summary Report

1. Brief background / introduction:

This paper includes an update on the Primary Care Workforce Programme via the highlight report, illustrating progress against the programme's strategic workstreams which have been aligned to the three key principles of the Long-Term Workforce Plan;

1. Train - Wellbeing, Education, Training & Development
2. Retain - Recruitment, Retention, Career Development, Equality, Diversity & Inclusion
3. Reform - Leadership Development, new ways of working, integrated team working, organisational development.

In addition to a progress update, the report provides financial allocations, a RAG rating and highlights the risks or challenges for each of the projects / workstreams.

2. Summary of key points:

2.1 Excellent progress with PCN Training Teams, however, funding is non-recurrent, so long term sustainability is challenged.
2.2 Changes to funding for Supporting Mentors Scheme and New to Practice Fellowship Programme after March 2024 (funding will remain in place for those recruited to programme before end of March 2024 for duration of two-year programme).
2.3 Festival of Learning event (29th February 2024) for over 170 primary care colleagues focused on integrated team working, including expert speakers, interactive table discussion and showcasing of innovation and best practice.

3. Are there any options?

N/A

4. Key Risks and Issues

- Insufficient capacity & resource within the current team to deliver against all NHSE priorities, ambitions outlined in the Long-Term Workforce Plan, in addition to local priorities and need.
- Uncertainty re future funding streams for the Training Hub infrastructure and operational plans. The costs of the Primary Care Training Hub infrastructure will be a priority for any NHSE Primary Care Transformation allocation in 2024/25 to ensure continued delivery against the NHSE Training Hub KPIs.
- PCN Training Teams were pump primed with a one-off payment from HEE. A long-term sustainable funding solution is required.
- Primary Care staff workload and potential burnout impacting on ability / capacity to engage with training & development initiatives.
- Primary Care staff workload & potential burnout impacting on retention.
- Estates constraints impacting ability to grow workforce, embed new ARRS roles and increase student placement capacity.
- POD contract responsibility, capacity & resource to support with training & development requirements.

Have you recorded the risk/s on the Risk Management system? Click to access system	Yes ☒	No ☐

5. Are there any financial implications or other resourcing implications, including workforce?
Uncertainty regarding future funding streams to support the programme. 65% of the Primary Care Training Hub team are on fixed term contracts due to expire in 2024.
6. How will / does this work help to address the Green Plan Commitments? Click to view Green Plan
Supporting innovative new ways of working and new models of care. Embedding sustainability into workforce. Green wellbeing offers e.g., Allotment project & BLMK Walking Group. Digital innovation e.g., Shiny Mind App and digital prescriptions via Shine Project. Virtual delivery of training & development reducing travel.
7. How will / does this work help to address inequalities?
All initiatives and activities within the Primary Care Workforce Programme consider how they can address inequalities within their delivery.
8. Next steps:
Development of Place level programme following outputs from Festival of Learning.
9. Appendices
Appendix A – Primary Care Workforce Programme Highlight Report.
10. Background reading

Item 9.1 Appendix A Primary Care Workforce Programme

NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board

STRATEGIC WORKSTREAM	DELIVERABLE	ALLOCATION / INVESTMENT	TASK DESCRIPTION	ASSIGNED TO	STATUS OF TASK	PROGRESS/ UPDATES	PLAN START	PLAN END
TRAIN - Wellbeing, Education, Training & Development	1. Continuing Professional Development	139K	CPD Programme	Jay Willett	On Track	Plan submitted & programme on track for delivery	01/04/23	31/03/24
		26k	Specialist CPD commissioning	Jay Willet	On Track	Plan submitted & agreed delivery commenced	01/04/23	31/03/24
			ACP development & scoping	Jo Finney	AMBER (At Risk)	Strategy complete, identifying ACPs in Primary Care to support. Jointly working with providers to support network development	01/04/23	01/10/24
			HCA Training Programme	Jay Willet / Kirsty Shanley	GREEN (On-Track)	Training programme developed and in delivery	01/04/23	01/04/24
	2. PCN Learning Environment Development		Student Pharmacist & Physician Associate Summer Placement Programme	Rajiv Nandha / Lydia Jacks	GREEN (On-Track)	Planning underway for 2024 programme subject to funding availability	01/04/24	01/07/24
			Learning Organisation Approval	Hannah Baker / Sadaf Javed	AMBER (At Risk)	No. of LO increasing steadily, with pipeline also being managed within limited capacity	01/04/23	01/04/25
		550k	PCN Training Teams - support & evaluation	Hannah Baker / Yuliya Baker	GREEN (On-Track)	Excellent progress with project plans - challenge no sustainable funding. Best practice shared at September PCNTT Networking Event (Sept 2023). PCNs will share further learning & development at Feb Festival of Learning.	01/04/23	01/04/24
	3. Student Education, Supervision & Placement		Expanding Supervisory Capacity	Hannah Baker	GREEN (On-Track)	No of supervisors & educators increasing with multi-professional pipeline also being managed, mindful of estate capacity limitations	01/04/23	31/03/25
			Expanding Student Placement Capacity	Hannah Baker Kirsty Shanley	AMBER (At Risk)	Digital Nurse Student Placement excellent engagement & evaluation - looking to expand to other professions - challenge capacity to roll out. PCNs working with education providers to develop new placement models.	01/04/23	31/03/25
	4. AHP Roadmap Development		Support to FCPs & PCNs with Roadmap navigation	Hannah Baker / Tom McNally / Matt Cooper	GREEN (On-Track)	FCP practitioners identified, engagement improving across AHPs professions at practice & PCN level	01/04/23	31/03/24
RETAIN - Recruitment, Retention, Career Development, Equality, Diversity & Inclusion	1. Wellbeing, coaching & mentoring support	90k	Health & Wellbeing Pilot	Lydia Jacks / Rajiv Nandha / Janet Thornley	GREEN (On-Track)	Resources created and embedded Programme of 121 sessions delivered Developing network of H&WB Champions to undergo training programme for long term sustainability along with repository of resources on SharePoint site	01/04/22	31/03/24
		450k	Shine Programme	Janet Thornley	RED (Off-Track)	30 Practices participated in programme with excellent outcomes retention & patient care - non-recurrent funding no further funding identified	01/04/23	31/12/23
			Coaching & Mentorship Training	Helen Worthington-Smith	BLUE (Complete)	Contract with Akeso to provide coaching sessions.	01/04/23	31/03/24
			Peer support network development	Janet Thornley / Kirsty Shanley / Tom McNally / Matt Cooper / Mehreen Shafiq / Rajiv Nandha	GREEN (On-Track)	All Clinical Workforce Leads established peer support networks & regular development sessions	01/04/23	31/03/24
	2. Flexible / Portfolio working		BLMK Local Fellowships	Helen Worthington-Smith	BLUE (Complete)	4th GP Educator recruited - developed pipeline of GP Educators from trainees	Complete	Complete
		65K	Flexible Pool Scheme	Susi Clarke	AMBER (At Risk)	Contract with Lantum renewal Feb 24, funding for 2024/25 TBC. 71% practices signed up, 107 clinicians onboarded, further 83 under approval. ANP & GPN increasing numbers	01/02/23	30/01/24
			International Medical Graduates	Hannah Baker	GREEN (On-Track)	Support to IMGs with identifying sponsoring practices, challenge Primary Care School not identifying those requiring visas earlier in training. Expansion of practices registered as visa sponsors maximising, NHSE funding	Ongoing	Ongoing
			GP Retention Scheme (Retainer)	Hannah Baker	GREEN (On-Track)	Challenge to locate GP Retainers, practices not reporting via NWRS. GP Retention Lead supporting with identifying employing practices	Ongoing	Ongoing
		41k	Supporting Mentors Programme	Helen Worthington-Smith	GREEN (On-Track)	8 GPs recruited, completed / undergoing ILM 5 or 7 Coaching, mentoring GP Fellows. Contract being arranged with Akeso to undertake management of process. Funding for mentoring activity for those on N2PFP will be provided from April 2024.	01/04/2023	31/03/2024
			International GPs	Hannah Baker	BLUE (Complete)	8 GP successfully embedded with BLMK	Complete	Complete

STRATEGIC WORKSTREAM	DELIVERABLE	ALLOCATION / INVESTMENT	TASK DESCRIPTION	ASSIGNED TO	STATUS OF TASK	PROGRESS/ UPDATES	PLAN START	PLAN END
			Portfolio Career Opportunities	Helen Worthington-Smith	RED (Off-Track)	No capacity / funding to progress		
	3. Career Development, Work Experience & Legacy opportunities		**Mid-late career package**	Raj Venugopal	GREEN (On-Track)	Support to mid career GPs, Phoenix Leadership Programme, GP Symposiums, Peer support networks & scoping VCSE opportunities	Ongoing	Ongoing
			Coaching Faculty Development	Helen Worthington-Smith / Shankari Maha	AMBER (At Risk)	Capacity to support limited		
			Quality & Differential Attainment programme	Hannah Baker / Kirsty Shanley / Sadaf Javed	AMBER (At Risk)	Ongoing programme of work to expand student placement capacity & differential attainment. Challenge - capacity to meet all demands	Ongoing	Ongoing
			Clinical Pharmacist Network development	Rajiv Nandha / Lydia Jacks	GREEN (On-Track)	Support to PCNs & practices to create Clinical Pharmacist career pathways & attractive career options	01/04/2023	31/03/2025
Reform - Leadership Development, new ways of working, integrated team working, organisational development	**1. Leadership Development**		**Phoenix GP Leadership Programme**	Helen Worthington-Smith, Raj Venugopal	BLUE (Complete)	Programme complete. Evaluation presented at December Workforce Leads meeting. Considering wider in-house leadership programme development, capacity permitting	Complete	Complete
			Primary Care Clinical Leads Development Programme	Susi Clarke, Jay Willett	GREEN (On-Track)	First event complete, developing bespoke leadership programme, lunch & learn, development opportunities	01/09/2023	31/03/2024
	2. New Ways of Working	**30k**	**Personalised Care**	Helen Worthington-Smith, Karen Duggan	GREEN (On-Track)	Support to Personalised Care roles, peer support networks, education & training advice	Ongoing	Ongoing
			Video Group Consultations	Helen Worthington-Smith / Janet Thornley / Karen Duggan	GREEN (On-Track)	4 Personalised Care groups identified to undertake VGC training. Training dates planned	01/04/2023	31/03/2025
	3. Digital Workforce Strategy		**Review of Primary Care opportunities**	Susi Clarke, Jay Willett	AMBER (At Risk)	Link in with ICB strategy development & scoping re RPA opportunities	Not started	Not started
	2. Support to recruitment, induction & embedding		**GP Recruitment Fairs & job signposting**	Helen Worthington-Smith	GREEN (On-Track)	Support to practices & GP trainees, alignment to system recruitment activities	Ongoing	Ongoing
			Support to PCNs & Practices with advert writing & recruitment	Helen Worthington-Smith	GREEN (On-Track)	Working with Primary Care Careers to refine adverts & attraction strategy	Ongoing	Ongoing
			Support to PCNs with Workforce Plans & data analysis	Susi Clarke / Place-based leads	GREEN (On-Track)	Ongoing review of ARRS recruitment against plan, affordability & retention of staff	Ongoing	Ongoing
		300K	**New to Practice Programme**	Helen Worthington-Smith / Shankari Maha / Janet Thornley / Kirsty Shanley	GREEN (On-Track)	Excellent evaluation of GP programme to data, GPN programme ready to launch end March 2024. New GPN Early Careers role now appointed to.	Ongoing	Ongoing
			In reach schools & HEIs	Janet Thornley / Kirsty Shanley / Mehreen Shafiq	AMBER (At Risk)	Capacity to progress limited, need to align to system approach	On pause	On pause
			Digital Student Nurse Placements	Kirsty Shanley / Hannah Baker	GREEN (On-Track)	Excellent evaluation of placements to date, expanding for 2024 opportunities for other professions	01/03/2024	01/09/2024
			Pipeline into Nursing	Kirsty Shanley / Janet Thornley	GREEN (On-Track)	Working with HEIs to attract nurses into PC	Ongoing	Ongoing
		£50k	**Primary Care Careers - recruitment platform**	Helen Worthington-Smith, Marie Lehane	GREEN (On-Track)	Practices & PCNs utilising the platform, need to encourage further sign up. Survey out with users currently to understand usage and value to inform future investment decisions	Ongoing	Ongoing
	3. Flexible & rotational opportunities		**Student Nurse Associate Project**	Kirsty Shanley / Jay Willett	GREEN (On-Track)	Numbers increasing, with several NAs now graduated, 6 graduates from 2023 progressing to Registered Nurse Degree Apprenticeship. 2 Trainee Nurse Associates commenced programme Feb 2024. Ongoing work to support pipeline of TNAs.	Ongoing	Ongoing
	4. Apprenticeships		**ACP development & scoping**	Hannah Baker	AMBER (At Risk)	Capacity to progress limited, need to align to system approach. Improving planning and numbers of ACP apprentices, key challenge is capacity to adopt apprenticeship models in practice.	Ongoing	Ongoing
			Supporting practices with clinical & non-clinical apprenticeships	Jay Willett	AMBER (At Risk)	Limited capacity to progress as desired. System level Apprenticeship group being reestablished through WDA which will include PCTH representation		
	5. Team & Organisation Development		**Targeted support to practices & PCNs**	Lydia Jacks, Janet Thornley, Rajiv Nandha, Helen Worthington-Smith	GREEN (On-Track)	Ongoing programme of work to embed culture change and improve working environment - link to wider system approach. Challenge long term sustainability - need to adopt train the trainer approach. Culture and OD has been identified as a key priority for 2024/25 and is a key theme for Festival of Learning 29th Feb. Work likely to build on foundations set through Health and Wellbeing work	01/04/2023	31/03/2025
			EDI strategy	Lydia Jacks	AMBER (At Risk)	Development of EDI strategy and implementation programme - linked to ICB & wider system approach	30/11/2023	31/03/2024

STRATEGIC WORKSTREAM	DELIVERABLE	ALLOCATION / INVESTMENT	TASK DESCRIPTION	ASSIGNED TO	STATUS OF TASK	PROGRESS/ UPDATES	PLAN START	PLAN END
	6. Integrated Working		**Personalised Care Conference**	Karen Duggan	GREEN (On-Track)	4 x conferences delivered since March 2023 with significant increase in attendance throughout the year. Plan to run 3 x conferences per year going forward, funding permitting	30/11/2023	31/03/2025
			Clinical Lead Strategy Development Programme	Susi Clarke	GREEN (On-Track)	As above		
			Festival of Learning	Lydia Jacks / Helen Worthington-Smith / Janet Thornley	GREEN (On-Track)	Confirmed for 29th Feb. Core focus of event is on integrated team working with range of speakers and interactive table discussions, informative posters and share/learn ethos planned for the day	30/09/2023	01/03/2024
			Community Pharmacy Support	Jay Willett	GREEN (On-Track)	Community Pharmacists Leads completed Leadership Programme. Support to Community Pharmacy Lead with ICB networking event, identifying DSP and supervision capacity	Ongoing	Ongoing
	7. Communications Strategy		**Development of Share Point site, Social Media & Comms**	Helen Worthington-Smith, Lydia Jacks, Nahim Wahid	GREEN (On-Track)	Linking with AHP Faculty to learn from their social media campaign. SharePoint site up and running, regular updates posted via LinkedIn.	Ongoing	Ongoing
	8. Knowledge & Library Services		**Support to Primary Care with evidence searches, summaries & research**	Beth Thompson	GREEN (On-Track)	Ongoing support to individuals, practices & PCNs. Linked with Research & Innovation Network to support with translation of Research opportunities within PC	Ongoing	Ongoing

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Report to the Primary Care Commissioning & Assurance Committee - 15 March 2024
10. Primary Care Estates

Vision: "For everyone in our towns, villages and communities to live a longer, healthier life"	
Please state which strategic priority and / or enabler this report relates to	
Strategic priorities	
☐	**Start Well:** Every child has a strong, healthy start to life: from maternal health, through the first thousand days to reaching adulthood.
☐	**Live Well:** People are supported to engage with and manage their health and wellbeing.
☐	**Age Well:** People age well, with proactive interventions to stay healthy, independent and active as long as possible.
☐	**Growth:** We work together to help build the economy and support sustainable growth.
☐	**Reducing Inequalities:** In everything we do we promote equalities in the health and wellbeing of our population.

Enablers			
Data and Digital ☐	Workforce ☐	Ways of working ☐	Estates ☒
Communications ☐	Finance ☐	Operational and Clinical Excellence ☐	Governance and Compliance ☐
Other ☐(please advise):			

Report Author	Nikki Barnes Associate Director of System & ICB Estates
Date to which the information this report is based on was accurate	29th February 2024
Senior Responsible Owner	Dean Westcott, Chief Finance Officer Nicky Poulain, Chief Primary Care Officer

The following individuals were consulted and involved in the development of this report:
Estates Team and Primary Care Team.
This report has been presented to the following board/committee/group:
Estates Working Group. Primary Care Delivery Group.
Purpose of this report - what are members being asked to do?
The members are asked to **note** the key primary care estates activities/developments.

Executive Summary Report

1. Brief background / introduction:

This report provides a summary of activities and developments relating to Primary Care Estates since the last meeting. The report includes an overview of key projects, estates risks, an update on the Primary Care Estates Strategy Refresh, and a brief update regarding S106 funding for primary care.

Members of the Primary Care Commissioning & Assurance Committee are asked to note the report.

2. Summary of key points:

2.1 Good progress across a range of schemes, no significant change to risks for projects. Key highlights include commencement of the construction works at the ESC for the De Parys Reprovision project.

2.2 Work on refreshing the Primary Care Estates Strategy is underway, feeding into the wider system Infrastructure Strategy which is due for sign-off by the ICB Board in September 2024.

2.3 £1.8m S106 funding has been used to support primary care estates schemes in 2023/24. Significant further sums are available with circa £3m already identified against priority projects. The remaining funding will be factored into the Estates Strategy refresh.

3. Are there any options?

Not applicable.

4. Key Risks and Issues

See Section 4.0

The current key risks have previously been highlighted:

- Risks to delivery of Biddenham new surgery scheme, due to financial viability issues. Mitigating actions underway in partnership with NHSE, the Valuation Office Agency (District Valuer Service) and with Bedford Borough Council.
- As a result of practice delays with progressing the Lower Stondon extension scheme, there is a risk that there will be insufficient S106 funding to deliver the full project. Work on the project has resumed, and an updated Cost Plan is expected soon.

Have you recorded the risk/s on the Risk Management system? Click to access system	Yes ☒	No ☐

E2, E7, E8

5. Are there any financial implications or other resourcing implications, including workforce?

No new financial implications.

6. How will / does this work help to address the Green Plan Commitments? Click to view Green Plan

Replacement of poor-quality old buildings with modern compliant premises, which will result in improved energy efficiency.
Travel planning for each scheme, with a focus on sustainable transport modes as far as possible.
Energy efficiency assessments completed last year will support some practices to identify options for reducing energy usage (and potential for cost savings for practices).

7. How will / does this work help to address inequalities?

Supports delivery of the primary care strategy, which includes greater focus on prevention, targeting reductions in inequalities, targeted Population Health Management approaches.

8. Next steps:
Continued delivery of the prioritised primary care Estates schemes within BLMK, and continued work on the Primary Care Estates Strategy refresh.
9. Appendices
Not applicable.
10. Background reading
Not applicable.

PRIMARY CARE ESTATES

March 2024

HIGHLIGHT REPORT

1.0 INTRODUCTION

This report provides a summary of key activities and developments relating to Primary Care Estates this period. Members of the Primary Care Commissioning & Assurance Committee are asked to note the report.

2.0 BLMK-WIDE DEVELOPMENTS

2.1 RAAC Assessments Update

Seven further premises were surveyed in January 2024, so the ICB has now received assurance that there is no RAAC present in all of the BLMK primary care premises constructed since 1950, (RAAC was not used prior to this date). One final exercise is being conducted to contact the owners of seven of the older primary care premises to check that there have not been any significant extensions to any of these buildings since 1950.

The Regional team are conducting a desktop exercise to prioritise which of the POD premises (Pharmacy, Optometry and Dentistry practices) may require site surveys. The approach to these surveys, and any ICB involvement, will be agreed when this list has been finalised.

2.2 Sustainability/Green Plan Initiatives

Estates team working with ICB partners on the creation of a “re-use” furniture and equipment database to avoid waste and measure impact on Net Zero through savings made through re-provision.

3.0 PLACE UPDATES

3.1 Bedford Borough

3.1.1 North Bedford Programme / Reprovision of The De Parys Group (DPG) – The contract for the refurbishment works in the ESC building has been awarded to ASHE Construction. Hoarding was erected around the building from 12 February 2024 and the construction work commenced on 19 February 2024. The work is scheduled to be complete in Autumn 2024.

The relocation to the ESC means that patients will be seen in modern, purpose-designed accommodation which will provide additional capacity and continue to improve access to a range of appointments. The practice hope to offer more specialist clinics in their new home, such as cardiology, dermatology and family planning. Patients with conditions such as diabetes, heart failure, respiratory illnesses and coronary heart disease will benefit from plans to hold multi-disciplinary clinics, with the aim of reducing the need for patients to visit hospital.

The De Parys Group is also one of the largest training practices and the new and improved premises will ensure that Trainee (and student) GPs, Nurses, Clinical Pharmacists, Nurse Associates and Health Care Assistants are retained for the population of Bedford.

In response to feedback from the patient consultation on the relocation of services to the ESC, the ICB is working with partners to improve the parking provision on the Bedford Health Village site. Work is underway with partners to establish a transport plan for the site as a whole, including provision of an additional 11 car parking spaces in the shorter term, and business case in development to propose the creation of 45 additional car parking spaces in the short/medium term.

There is a risk that works will not complete in Kempston Clinic in time for the CCS Community Eye Service to move out of the ESC, in order for work to start in that area of the building. The project team are seeking a contingency solution to ensure this does not delay the works.

3.1.2 King Street – Kempston Health Centre Scheme – The works for reconfiguring the Halsey Road Health Centre in Kempston for King Street Surgery are now out to tender. The programme plan indicates a target date for completion of the works by the beginning of July, although there are a number of risks which could cause small delays, including finalising the legal documentation for the release of the capital funding from NHS England to NHS Property Services (NHS PS).
The project will now take place in 2024/25 and other smaller enabling projects have been brought forward. This approach reduces the risk of any of the capital funding being lost to the BLMK system. It enables all schemes to progress as planned, it has no impact on our prioritised Estates programme, and does not adversely impact the GP IT budget.

The broader project to re-assess the feasibility of relocating King Street Surgery from their current three premises into a consolidated single facility is a joint scheme in partnership with Bedford Borough Council. The Council are procuring the expert external support for this project, with a detailed programme plan and timeline to be agreed thereafter.

3.1.3 Great Barford – A Feasibility Study is underway regarding the proposed relocation of the practice to the nearby empty school building (Council-owned). The Study is expected to be complete by the beginning of April, and the next steps will be agreed in partnership with Bedford Borough Council and the practice.

3.1.4 Biddenham – The negotiations continue with the developer of the Biddenham scheme to try and find an affordable and value for money financial arrangement which considers the viability challenges previously raised by the developer. Further meetings took place in February with the national NHSE lead for Primary Care Estates and the Valuation Office Agency (DV) around a proposed Supplementary Rent mechanism. It continues to be emphasised to all stakeholders that this remains an important strategic project for the ICB.

3.1.5 Wixams – Discussions continue with partners, particularly the two Local Authorities in Bedfordshire, around partnership opportunities for improving access to healthcare in Wixams. The feasibility of an option for a temporary health facility is also being explored in partnership with the Wixams developer and NHS PS. It remains a clear ambition for the ICB to establish a primary care facility in the Wixams town centre. Success is reliant on partnership working and finding creative solutions, which the ICB is committed to, whilst recognising financial constraints. The ICB Board received a petition from the local community in December, and the ICB Chief Executive met with key local stakeholders including community representatives on 23rd February to continue discussions.

3.1.6 Queens Park Health Centre – the ICB Estates Team are exploring with the GP practice and PCN in this area about the best potential use of the void space in Queens Park Health Centre, and the capital works required to make this space fit for purpose. NHS PS have confirmed that a bid to their Healthy Places Programme for capital funding in 2024/25 has been successful (in principle, subject to detailed business case), which is likely to support re-configuration of the space to create additional clinical rooms and new admin space.

3.2 Central Bedfordshire

3.2.1 Grove View Integrated Health & Care Hub –The legal work is nearing completion to finalise the practice's lease for their occupation of the building. Costs for reimbursing the practice's Stamp Duty Land Tax (c.£55k) is being funded via S106 funding.

Section 106 funding has also been agreed for the next phase of detailed design work on the records room conversion to convert it into a large office for the PCN. This work is being led by Central Bedfordshire Council (CBC).

3.2.2 Ampthill Health Centre – Greensand Surgery/Oliver Street - works on the building commenced on 12th February 2024 and are due for completion in March. This work will create additional clinical space which will benefit the patients (and clinicians) of both practices based in the building and their respective PCNs.

3.2.3 Leighton Buzzard – The Outline Business Case (OBC) for delivering additional services in Leighton Buzzard is on track for completion in Spring 2024; once complete it will be presented to the Primary Care Delivery Group and subsequently the Primary Care Commissioning & Assurance Committee. We have duly informed the local community that findings will be shared by the end of May 2024.

The service model underpinning the OBC is based on enabling the PCN's vision for a same-day access service for the town, along with increased capacity for other PCN services and non-complex diagnostics (including phlebotomy, spirometry, 24hour BP monitoring).

In the meantime, the PCN has started using additional rooms at the Bassett Road Health Centre to enable increased provision of Musculoskeletal, phlebotomy and respiratory clinics, smoking cessation services and medication reviews amongst other PCN services.

3.2.4 Shefford Health Centre – The practice is being supported to develop proposals for converting part of their existing area of the building into additional clinical space. S106 funding has been secured in principle to fund these works, and contractor quotes are being obtained by the practice's landlord, NHS PS.

A separate options appraisal has commenced around the best future use of the void former dental area in this building. There is interest for this space from a number of providers, so the ICB Estates Team are supporting planning and negotiations around this to ensure maximum value for the local community and system.

3.2.5 Asplands – The construction work at both the main and branch surgeries for Asplands is now complete. Builders have worked hard with the practice to ensure minimum disruption and maximum number of clinicals rooms available at any one time, resulting in service delivery throughout the building programme. The doctors and staff are very happy with the improved accessibility, which was the main remit, and patients are providing positive feedback.

3.2.6 Hillton PCN – The former plans to convert part of Houghton Close Surgery's admin space into additional clinical space for the PCN have resumed. This project will be led by the practice, with support from the ICB and in close liaison with the landlord of the building. It is likely that this project will be eligible for S106 funding.

3.2.7 Lower Stondon – The practice has confirmed that the planning permission for their planned extension and reconfiguration project has now been renewed. The practice's professional advisors are obtaining an updated Cost Plan and have commenced work on an updated business case. The Practice have been made aware of the expiry dates for the relevant S106 funding, and there remains a risk that there are insufficient funds available to deliver the full project.. The ICB Estates Team will support the practice to consider any changes to their plans if required once the updated Cost Plan has been received.

3.2.8 Houghton Regis Health Centre – The recently vacated clinical space in the building has been offered to the local practice and PCN as additional primary care capacity. However, high Service/FM costs (non-reimbursable) are causing the PCN/Practice concern with taking on this void space. The costs have been benchmarked against similar buildings and are significantly higher. The ICB Estates Team are investigating the reasons for this with the landlord, NHS PS, with a view to considering opportunities for reducing these costs.

Once this information is available, next steps will be considered to ensure that this valuable clinical space in this growing community is used for the benefit of local services and their patients.

3.2.9 Sandy Health Centre/Sandhills PCN – A business case for the PCN to take on void space in the Sandy Health Centre building has been approved. Minor works are being carried out to the works prior to the PCN taking on the space, e.g., flooring repairs and IT connectivity.

3.2.10 Gooseberry Hill – Minor works are being carried out to create two additional clinical rooms in the void are of the building, and this space has been offered to Barton Surgery (who already use part of the building as a branch surgery). Awaiting the decision from the practice. Alternative options will be considered if the practice decline this opportunity, to ensure that this space is used for the benefit of local services and patients.

3.2.11 Cranfield new Surgery – construction work is moving at pace with building being transferred from the developer to the Council in early summer. Financial terms have now been agreed with the Council, and Heads of Terms are being drawn up. The Practice due to relocate to this new facility is not able to serve notice on their current premises until an Agreement for Lease is in place. Options to avoid the new surgery standing empty during the notice period are being explored.

3.3 Luton

3.3.1 Hatters PCN – Hatters are in occupation at Sundon Park Health Centre. Room Conversion and improvement works have been delayed due to Asbestos found in building but are now scheduled to commence on 22nd March.

The PCN Manager has growing concerns about the safety of the site due to local unsocial behaviour and have indicated that they would want to move out of Sundon in the longer term and explore the option of moving into empty space at Oakley Surgery, previously occupied by the pharmacy. Some early exploratory work has commenced to start assessing the feasibility of this longer-term option.

3.3.2 Medics and Phoenix PCNs - Estates Team supporting both PCNs to extend their occupation arrangements, as per approved business cases. Phoenix arrangements delayed in line with Bramingham procurement but now moving forward. Medics PCN exploring taking on additional space in Marsh Farm, to be PCN-funded.

3.3.3 Luton Town Centre Surgery – the provider of the practice/UTC/Out of hours services has raised continued concerns about the suitability and safety of the site, which could potentially impact on the future procurement of urgent care services operating from the building. Exploratory discussions are underway with partners to consider the feasibility of relocation of some or all of the services from the building.

3.3.4 Liverpool Road Health Centre – a recommendation to offer void space in the Health Centre for primary care use has been approved. Further detailed information is awaited from NHS PS to support these discussions with the practice/PCN.

3.4 Milton Keynes

3.4.1 East MK Scheme – The construction work is well underway on the Community/Health Hub, and colours, fixed furniture etc., is now being chosen. The construction of the access road has been delayed; therefore, it is not expected that the building will be operational until June-September 2025.

A steel signing ceremony took place on 15 February and was attended by the ICB Project lead.

The detailed planning for Expression of Interest process to confirm the primary care provided to operate from the building continues with the Primary Care Contracts team.

3.4.2 Stoney Medical Centre – Business case now approved for conversion of an admin room to clinical rooms using available S106 funding from West Northants Council. NHSPS have been requested to provide revised quotes and arrange the works. New quotes received and NHSPS have chosen preferred supplier. Once costs for minor IT have been finalised, application for S106 to be made for capital funding and start date for works to be confirmed.

3.4.3 Stonedean PCN – Stonedean have expressed an interest in the ground floor (GF) space originally looked at last year for Watling Vale PCN to occupy. Business case in development, possible funding available through West Northants S106 for capital works. Expected revenue savings for ICB through Service Charges and Facilities Management charges to be taken on by the PCN, whilst the ICB continues to reimburse rent and rates.

3.4.4 Water Eaton – Practice have agreed terms with NHS PS for taking on void space in building and will be finalised once wider discussions between NHS PS and the practice are fully resolved. The practice have been using the space since April 2023, so patients and clinicians are already benefiting from this additional capacity. S106 funding being sought for large meeting room conversion to two admin spaces.

3.4.3 Westfield Road Extension - Practice in liaison with Milton Keynes Council around available S106 funding, with support from the ICB, to potentially fund a significant extension to the premises. This is a scheme which was prioritised in 2023, but where delivery has been delayed.

4.0 ESTATES RISK REPORT

This section provides a summary of the key risks and issues relating to primary care premises and estates projects, and mitigating actions.

a. GP Premises constraints

Risk that some practices across BLMK will not have sufficient capacity to support delivery of the full range of face-to-face services and to enable them to keep their patient lists open to new registrations, and risk that PCNs will have insufficient capacity to maximise recruitment to ARRS roles.

Over 30 primary care estates projects underway to help alleviate constraints.

Refresh of Primary Care Estates Strategy underway, including consideration of further tactical project opportunities.

b. Loss of S106 Funding

As a result of not being able to prioritise at this stage some of the schemes where S106 is available to support, (due to the S106 funding being insufficient to prevent a significant revenue consequence to the ICB), there is a risk that S106 funding will expire and be lost to the system.

Ongoing discussions with specific providers about alternative potential use of S106 funding.

Regular monitoring of available S106 funding, and liaison with Planning Leads at the Local Authorities.

c. Biddenham New Surgery

As a result of national economic circumstances, there is a risk that it will not be financially viable for the developer of Biddenham new surgery to proceed with construction of the building and/or it may not be affordable for the ICB to supplement the originally agreed rental value, which may result in the project being delayed/terminated.

Ongoing negotiations with developer, with support from national leads at NHSE and national and local DV office.

d. King Street Surgery

As a result of multiple premises challenges, there is a risk that the practice could lose premises capacity which is essential to the safe operation of their service, and which could result in the practice handing back their NHS contract.

Project underway to relocate Cater Street to Kempston Health Centre.

Practice being supported to take forward a sale and leaseback arrangement.

Joint project with Bedford Borough Council to develop OBC for a long-term solution.

e. Cranfield New Surgery

As a result of the GP practice provider being unable to serve notice on their current premises until they have an Agreement for Lease in place for their new building, there is a risk that the new premises will be empty for a period of time and unavailable for the benefit of patients.

Ongoing negotiations with CBC and planned negotiations with current landlord.

f. Void NHS Space

As a result of high increases in service charge costs in recent years, there is a risk that primary care providers will be unable to afford to take on void space for the benefit of primary care delivery.

To be reviewed on a case-by-case basis.

g. Lower Stondon

As a result of practice delays with progressing the scheme, there is a risk that there will be insufficient S106 funding to deliver the full project.

To be reviewed with practice once updated Cost Plan has been completed.

h. Sundon Park Health Centre

As a result of frequent security and anti-social behaviour incidents at the site, there is a risk that this will not be a viable location for the PCN for the longer-term.

Starting to explore alternative long-term options, particularly around the PCN taking on alternative space at Oakley Surgery.

i. Luton Town Centre Surgery

As a result of frequent security and anti-social behaviour incidents at the site, there is a risk that this will not be a viable location for the practice, UTC and Out of Hours Service for the longer-term. This may impact on the Urgent Care procurement.

Starting to explore alternative long-term options.

5.0 ESTATES STRATEGY REFRESH

A timeline for completion of the BLMK Infrastructure Strategy has been agreed – this is expected to be signed off by the ICB Board in September 2024. Primary care estates will be a key component of this strategy, as part of the total out of hospital estate within each Place.

The Strategy work is at the data gathering stage. To support this, the Business Intelligence team are supporting the development of the Primary Care Estates Heatmap. The Heatmap will include the following information, and a first draft is expected to be available by mid-March:

5.1 LEVEL OF NEED

- Capacity – patients per m², clinical rooms per 1,000 patients, housing growth impact in next 5 years
- Condition – key metrics from completed Facet Surveys, e.g., Condition Rating, Backlog Maintenance, Functional Suitability Rating, Age of Building
- Efficiency – appointments per 1,000 population, appointments per m²
- Quality – Patient Access Survey summary score, CQC rating, Equality Act compliance
- Value for Money – cost per m²
- Health Need/Inequalities – IMD score
- Energy Efficiency – EPC / DEC score
- Workforce Development – Training practice, if practice would take more training placements if had more space, practice not filling vacancies due to space constraints, part of a PCN not recruiting to ARRS roles due to space constraints.

5.2 DELIVERY PLANS / OPPORTUNITIES

- Existing premises improvements programmes.
- PCN Estates Plans – including assessment of each building as Core, Tail & Flex.
- Strategic Estates ambitions.

(NB – for all of the information above, where available.)

We are also exploring how best to cross-reference to available S106 funding for each Parish.

Regular updates on this work will be provided to the Primary Care Delivery Group and this Committee.

6.0 S106 FUNDING

A total of £1.8 million of S106 funding will be spent on primary care estates projects in 2023/24, in line with the prioritised Estates Programme and void projects.

Further S106 is available as follows:

Bedford Borough	£396,300.29
Central Bedfordshire	£4,939,915.70
Milton Keynes	£6,666,577.72

Some smaller sums are also available from neighbouring Local Authorities. Luton Borough Council does not hold any S106 funding for health.

There are plans being explored with a number of practices around opportunities to use some of the larger sums of S106 funding available, and circa £3m of this funding has already been committed in principle against identified projects.

Following initial analysis of the Primary Care Estates Heatmap, it is suggested that communication around available S106 funding will be shared with primary care providers.

Whilst it is important for providers to be aware of this funding and have the opportunity to use it to support premises projects, the ICB has an important strategic estates planning role to play in supporting this funding to be used to achieve maximum value (strategic and transformational projects wherever possible). It is also important to note that supporting practices through the governance and due diligence of applying for and drawing down S106 funding can have significant capacity impact for the ICB Estates Team, so it is important to try and manage the programme around this in line with identified priorities – whilst taking into account S106 expiry dates and not holding back proactive providers.

7.0 CONCLUSION

Significant progress is being made with delivery of the Primary Care Estates Programme. The refresh of the Estates Strategy (as part of the broader BLMK Infrastructure Strategy) will be an opportunity to assess how well the current programme is helping to mitigate pressures in primary care and to consider what further tactical and strategic projects are required going forwards, and potential funding sources/challenges.

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Report to the Primary Care Commissioning & Assurance Committee - 15 March 2024
11. Terms of Reference for the Primary Care Commissioning and Assurance Committee and the Executive Led Primary Care Delivery Group

Vision: "For everyone in our towns, villages and communities to live a longer, healthier life"	
Please state which strategic priority and / or enabler this report relates to	
Strategic priorities	
☒	**Start Well:** Every child has a strong, healthy start to life: from maternal health, through the first thousand days to reaching adulthood.
☒	**Live Well:** People are supported to engage with and manage their health and wellbeing.
☒	**Age Well:** People age well, with proactive interventions to stay healthy, independent and active as long as possible.
☒	**Growth:** We work together to help build the economy and support sustainable growth.
☒	**Reducing Inequalities:** In everything we do we promote equalities in the health and wellbeing of our population.

Enablers			
Data and Digital ☒	Workforce ☒	Ways of working ☒	Estates ☒
Communications ☒	Finance ☒	Operational and Clinical Excellence ☒	Governance and Compliance ☒
Other ☐(please advise):			

Report Author	Lynn Dalton, Associate Director of Primary Contracting and Development
Date to which the information this report is based on was accurate	06/03/2024
Senior Responsible Owner	Nicky Poulain, Chief Primary Care Officer

The following individuals were consulted and involved in the development of this report:
Michelle Evans-Riches, Head of Corporate Governance.
This report has been presented to the following board/committee/group:
Primary Care Medical Services Delivery Group.

Purpose of this report - what are members being asked to do?

The members are asked to **discuss and approve** the following:
A) The Terms of Reference for the Primary Care Commissioning & Assurance Committee (PCCAC)
B) The Terms of Reference for the (Executive Led) Primary Care Delivery Group (PCDG)

Executive Summary Report

The Terms of Refence have been developed to ensure there is robust governance arrangements in place for the commissioning of NHS England delegated statutory functions of Primary Care Medical (GP) Services, Community Pharmacy, Optometry and Dental Services. The Terms of reference also support the ICB wider primary care strategic objectives.

Under the Terms of NHS England delegation agreement, the ICB is required to establish a Primary Care Commissioning Committee, a sub-committee of the ICB Board to oversee the commissioning of primary care services. The national agreement was refreshed in June 2022 to facilitate what is commonly known as double delegation, which enables the Primary Care Commissioning and Assurance Committee to delegate a range of its operational functions to other groups as it sees appropriate.

1. Brief background / introduction:

In April 2023, the Primary Care Commissioning and Assurance Committee (PCCAC) was established. The PCCAC superseded the previous Primary Care Commissioning Committee that was in place prior to changes to NHS England delegation agreement specifically for Primary Medical Services. The change also reflected the delegation by NHS England of Community Pharmacy, Optometry and Dental services to ICBs.

The change in the delegation agreement enabled the ICB Primary Care Commissioning and Assurance Committee the ability to establish the Primary Care (Medical Services (GP)) Group and Primary Care (Community Pharmacy, Optometry and Dental Group) in April 2023. These are underpinned by a range of other operational groups to ensure the ICB is meeting its statutory and strategic functions.

In 2023 the two delivery groups were established for a one-year period to support the development of the new functions and build relationships with the contractors and their representatives. It was agreed this would be for a period of one year only and from April 2024 the two groups would merge to form one (Executive Led) Primary Care Delivery Group and new terms of reference would be developed for the merged groups.

2. Summary of key points:

2.1 The Terms of Reference for the Primary Care Commissioning and Assurance Committee have been reviewed and updated.

2.2 The Terms of reference for the merged and newly established single Executive led Primary Care Delivery Group.

3. Are there any options?

No.

4. Key Risks and Issues		
The key risk is not having the governance arrangements in place for NHS delegated statutory functions.		
Have you recorded the risk/s on the Risk Management system? Click to access system	Yes ☐	No ☒
5. Are there any financial implications or other resourcing implications, including workforce?		
Ensuring the ICB commissions Primary Medical Services, Community Pharmacy, Optometry and Dental services within the ICB delegated budget.		
6. How will / does this work help to address the Green Plan Commitments? Click to view Green Plan		
7. How will / does this work help to address inequalities?		
Primary Care plays a key role in commissioning and supporting services that meet the needs of the population, ensuring integration and supporting variation.		
8. Next steps:		
The Committee is asked to approve the Terms of Reference.		
9. Appendices		
Appendix A – Primary Care Commissioning and Assurance Committee (PCCAC) Terms of Reference Appendix B - Primary Care Delivery Group (PCDG) Terms of Reference.		
10. Background reading		

DRAFT 2023/25

Governance Handbook Appendix F Primary Care Commissioning and Assurance Committee Terms of Reference

1.0 Constitution

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

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

1.3 The Committee is a non-executive chaired committee of the Board, and its members are bound by the Standing Orders and other policies of the ICB.

2.0 Authority

2.1 The Primary Care Commissioning and Assurance Committee is accountable to the ICB Board and shall report to the Board on how it discharges its delegated primary care commissioning functions for primary medical services from July 2022 and primary community pharmacy, optometry and dental services from April 2023.

2.2 The ICB holds only those powers as delegated in these Terms of Reference as determined by the NHS England Commissioning Board.

2.3 The Committee is authorised by the Board to:

a) Investigate any activity within its terms of reference.
b) Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) as outlined in these terms of reference.
c) Commission any reports it deems necessary to help fulfil its obligations.
d) Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice.
e) 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 with the

ICB's Constitution, Standing Orders and Scheme of Reservation and Delegation but may not delegate any decisions to such groups.

2.4 For the avoidance of doubt, the Committee will comply with, the ICB Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation.

3.0 Purpose

3.1 The Committee exists to scrutinise and provide assurance to the ICB Board that there is an effective system of primary care services including medical, community pharmacy, optometry and dental services commissioning that supports it to effectively deliver its statutory and strategic objectives and provide sustainable, high quality primary care.

3.1.1 The Committee acknowledges in exercising the ICB's functions (including those delegated to it), it must comply with the statutory duties as set out in the NHS Act 2006 (as amended by the Health and Care Act 2022), including:

a) Management of conflicts of interest (section 14O).
b) Duty to promote the NHS Constitution (section 14P).
c) Duty to exercise its functions effectively, efficiently and economically. (Section 14Q).
d) Duty as to improvement in quality of services (section 14R).
e) Duty in relation to quality of primary medical services (section 14S).
f) Duties as to reducing inequalities (section 14T).
g) Duty to promote the involvement of each patient (section 14U).
h) Duty as to patient choice (section 14V).
i) Duty as to promoting integration (section 14Z1).
j) Public involvement and consultation (section 14Z2).
k) Delivery of the ICB & Health & Care Partnership strategic objectives for primary care commissioning.

3.1.2 The Committee acknowledges that it is subject to any directions made by NHS England or the Secretary of State to the ICB.

3.2 Role of the Committee

3.2.1 The Committee has been established in accordance with the above statutory provisions to enable the members to make collective decisions on the review, planning and procurement of primary medical services, community dental services. The Committee will receive assurance reports on community pharmacy market entry requests through the regionally established ICBs Pharmaceutical Services Regulatory Committee (PSRC) which includes BLMK under delegated authority from NHS England, and Optometry reports

to provide the committee with assurance from the hosted ICB that Optometry services are being commissioned in line with statutory functions.

3.2.2 The role of the Committee shall be to carry out the functions relating to the commissioning of primary care services including primary medical, community pharmacy, optometry and dental services under section 83 of the NHS Act 2006 (as amended by the Health and Care Act 2006).

3.2.3 In performing its role the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and Bedfordshire Luton and Milton Keynes ICB which will sit alongside the Scheme of Reservation and Delegation and these terms of reference.

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

3.2.5 NHS Bedfordshire Luton and Milton Keynes to receive assurance from the regional Pharmaceutical Services Regulatory Committee (PSRC) in relation to community pharmacy services including market entry requests.

4.0 Membership and attendance

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

4.2 The Board will appoint nine members of the Committee including two who are Non-Executive Members of the ICB Board. Other attendees of the Committee need not be members of the Board, but they may be.

4.3 When determining the membership of the Committee, active consideration will be made to equality, diversity and inclusion.

4.4 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 matters.

Chair and Deputy Chair

4.5 The Committee shall satisfy itself that the ICB's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the ICB policy and procedures relating to conflicts of interest.

4.6 If the Chair has a conflict of interest, then the Deputy Chair or, if necessary, another member of the Committee will be responsible for deciding the appropriate course of action.

4.7 Members with Voting rights:

a) Non-Executive Member (Chair)
b) Non-Executive Member
c) ICB Chief Primary Care Officer
d) ICB Chief Finance Officer
e) ICB Chief Nursing Director
f) ICB Chief Medical Director
g) Three Clinical Representatives who have primary care leadership experience delivering either primary medical, primary dental and primary ophthalmic services or services that may be provided as pharmaceutical services, following appointment of the ICB Partner Members or clinical lead roles. One of these members will be the Deputy Chair of the Committee.

4.8 Other attendees – non-voting.

The following non-voting attendees will be invited to attend the meetings of the Primary Care Commissioning and Assurance Committee, as subject area specialists and as pertinent to Agenda items:

a) Deputy Chief Primary Care Officer
b) Associate Director of Primary Care Contracting and Development
c) Associate Director of Primary Care and Prevention
d) Associate Director of Pharmacy & Medicines Optimisation
e) Non-Executive Member
f) One representative from each Healthwatch in BLMK (4)
g) One representative from each Local Medical Committee (2)
h) One representative from the Local Pharmaceutical Committee
i) One representative from each Local Optometry Committees (2)
j) One representative from each Local Dental Committees (2)
k) One representative from each Health and Wellbeing Board in BLMK (4)
l) One Public Health representative for each Local Authority area (2)

5.0 Meeting Quoracy and Decisions

5.1 The Primary Care Commissioning and Assurance Committee shall meet in private quarterly. Additional meetings may be convened on an exceptional basis at the discretion of the Committee Chair.

Quorum

5.2 For a meeting to be quorate the following four members need to be present: one non-executive member (Chair for the meeting), ICB Chief Primary Care Officer or ICB Chief Medical Director, ICB Chief Finance Officer plus one other ICB Executive Board Member.

5.3 Where members are required for quoracy but unable to attend, they should ensure that a named and briefed deputy is in attendance who is able to participate and vote on their behalf. No other deputies are permissible.

Decision making and voting

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

5.5 Only voting members of the Committee, or deputies for members required for quoracy, may vote. Each voting member is allowed one vote and a majority will be conclusive on any matter.

5.6 Where there is no clear majority, the Chair of the Committee will hold the casting vote. The result of the vote will be recorded in the minutes.

6.0 Responsibilities of the Committee

6.1 The responsibilities of the Primary Care Commissioning and Assurance Committee are authorised by the Board of the ICB. The Committee is responsible for providing the ICB Board with assurance in relation to its decisions for the commissioning, procurement and management of Primary Care contracts including primary medical (GP), community pharmacy, optometry and dental services including but not limited to the following activities:

a) Review and approve recommendations made by the Primary Care (Medical services (GP), Community Pharmacy, Optometry and Dental) Delivery Group to ensure the ICB is meeting its statutory responsibility for commissioning and overseeing delegated primary care services and functions to include:
   i. General Medical Services (GMS) and Alternative Provider of Medical Services (APMS) contracts (including the design of APMS contracts, performance of contracts, appropriate contractual action such as issuing breach/remedial notices and removing a contract) has been applied.

ii. Assurance on contractual compliance and decision making in relation to the management of poorly performing medical, (GP), community pharmacy, optometry and dental practices and including, without limitation, decisions and liaison with the Care Quality Commission where the Care Quality Commission has reported non-compliance with standards (but excluding any decisions in relation to the performers list).
iii. Receive Optometry reports to provide the committee with assurance from the hosted ICB that Optometry services are being commissioned in line with statutory functions.
iv. Receive Pharmaceutical Services Regulatory Committee (PSRC) reports to provide the committee with assurance the PSRC is implementing the requirements of the community pharmacy regulatory framework.
v. Approve the development (subject to financial authorisation) of newly designed services for all contractor groups and implementation of financial services or local incentive schemes and other ancillary activities as appropriate.
vi. Decision making on whether to establish new GP and community dental practices (including branch surgeries) and closures of GP and dental practices.
vii. Agree the Primary Care procurement plans and approve the recommendations by the delivery group to award new contracts on completion of procurements.
viii. Ensure compliance with the Premises Cost Directions (2015) for primary medical services.
ix. Oversee the planning and preparedness for the delegation of NHS England Public Health (section 7a) services of vaccinations and immunisations with recommendation to the ICB Board for the services to be delegated to the ICB in 2025

b) Utilise local clinical knowledge to influence the development of and investment in primary care to improve access to all primary care commissioned services and taking a population health management approach.
c) Develop and commission end to end care and increased autonomy to shape future primary care services including medical services (GP), community pharmacy, optometry and dental services.
d) Take an active role in driving forward the NHS Long Term Plan.
e) Provide assurance on the delegated budget for commissioning of primary medical services including community pharmacy, optometry and dental services in Bedfordshire Luton and Milton Keynes.
f) Plan, primary medical care, community pharmacy, optometry and dental services in the BLMK area in response to population health assessments.

g) Undertake reviews of primary care services in the BLMK area, including primary medical services, community pharmacy, optometry and dental services.
h) Co-ordinate a common approach to the commissioning of primary care services.
i) Ensure collaborative working on monitoring and addressing issues of quality in primary care based on the principle of continuous improvement.
j) Recommend the key primary care priorities that are included within the ICB strategy/annual plan, including priorities to address variation/inequalities in care.
k) Oversee and monitor delivery of primary care related ICB key statutory requirements.
l) Review and monitor those risks on the Board Assurance Framework and Corporate Risk Register which relate to primary care, and high-risk operational risks which could impact on care. Ensure the Board is kept informed of significant risks and mitigation plans, in a timely manner.
m) Oversee and scrutinise the ICB's response to all relevant (as applicable to primary care) Directives, Regulations, national standards, policies, reports, reviews and best practice as issued by the Department of Health and Social Care, NHS England and other regulatory bodies / external agencies (e.g., Care Quality Commission, National Institute of Clinical Excellence), to gain assurance that they are appropriately reviewed and actions are being undertaken, embedded and sustained.
n) Maintain an overview of changes in the methodology employed by regulators and changes in legislation/regulation and assure the Board that these are disseminated and implemented across all sites.
o) Ensure that mechanisms are in place to review and monitor the effectiveness of the quality of care delivered by providers and place.
p) Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for equality and diversity as it applies to people drawing on services.
q) Oversee the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for medicines optimisation and safety.
r) Have oversight of and recommend approval of the terms of reference and approve work programmes for the groups reporting into the Primary Care Commissioning and Assurance Committee.
s) Provide assurance on the transformation and integration programme for primary care which includes the ambitions in the NHSE 'Fuller Stocktake Report' (May 2022), the NHSE 'Delivery Plan for Improving Access to Primary Care' (May 2023) and the ICBs 'Delivery Plan for Prevention in Primary Care Settings` (January 2024).

t) The Committee will provide regular assurance updates to the Board in relation to activities and items within its remit.

6.2 Delegation of functions and decisions to the Primary Care Delivery Group

The following operational functions and decisions in relation to General Practice, community pharmacy, optometry and dental services are delegated to the Executive led Primary Care Delivery Group, from the Primary Care Commissioning and Assurance Committee and these are:

i. Oversee commissioning and operational delivery of primary care contracts including the design of Alternative Provider of Medical Services and Personal Dental Service contracts.
ii. Monitoring of contracts taking contractual action such as issuing remedial and breach of contract notices and or termination of contracts in line with the terms of the contracts and national policy guidance manuals.
iii. Oversee the programme of Alternative Provider of Medical Services and Personal Dental Service and other procurements and make recommendations to the PCCAC for contract award.
iv. Oversee the development (subject to financial authorisation) of newly designed enhanced services “Local Enhanced Services” and implementation of “Directed Enhanced Services” and “Local Incentive Schemes
v. Approving practice mergers.
vi. Approving contractors change of boundary requests and relocation requests.
vii. Approve dental contractors change of hours of service delivery.
viii. Approving requests to convert General Dental contracts to Personal Dental contracts.
ix. Approving primary care medical and dental incorporation applications
x. Oversee and approve the rebasing of dental contracts.
xi. Making decisions on discretionary payments including Section 96 emergency financial support, within the Chief Primary Care Officer Executives SFO authorisation limits
xii. Making decisions relating to Primary Care Estates issues.
xiii. Making decisions relating to Primary Care Digital issues.
xiv. Making decisions relating to Primary Care Workforce.

6.2.1 The Primary Care Delivery Group will report decisions it has made to the Primary Care Commissioning and Assurance Committee at each meeting to provide oversight and assurance.

7.0 Behaviours and Conduct

ICB Values

7.1 Members will be expected to conduct business in line with the ICB values and objectives. Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality and Diversity

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

Declarations of Interest

7.3 All members, ex-officio members and those in attendance must declare any actual or potential conflicts of interest which will be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration will be excluded from the discussion at the discretion of the Committee Chair.

8.0 Accountability and reporting

8.1 The Primary Care Commissioning and Assurance Committee is directly accountable to the Board. The minutes of meetings shall be formally recorded. The Chair of the Committee shall report to the Board after each meeting and provide a report on assurances received, escalating any concerns where necessary.

8.2 The Committee will advise the Audit and Risk Assurance Committee on the adequacy of assurances available and contribute to the Annual Governance Statement.

8.3 The Committee will receive scheduled assurance report from its delegated group the Executive led Primary Care Delivery Group which will include quarterly assurance reports from the Primary Care Workforce & Education Network Training Hub Steering Group, the Estates Working Group the region wide Secondary Care Dental Steering Group and the region wide Pharmaceutical Services Regulatory Committee. Any delegated groups would need to be agreed by the ICB Board.

9.0 Secretariat and Administration

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

i. The agenda and papers are prepared and distributed at least five working days before each meeting in accordance with the Standing Orders having

been agreed by the Chair with the support of the relevant executive lead.

ii. Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not attend at least 75% of meetings.

iii. Records of members' appointments and renewal dates are reviewed and the Board is prompted to renew membership and identify new members where necessary.

iv. Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept.

v. The Chair is supported to prepare and deliver reports to the Board.

vi. The Committee is updated on pertinent issues/ areas of interest/ policy developments.

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

10.0 Review

10.1 The Committee will review its effectiveness at least annually.

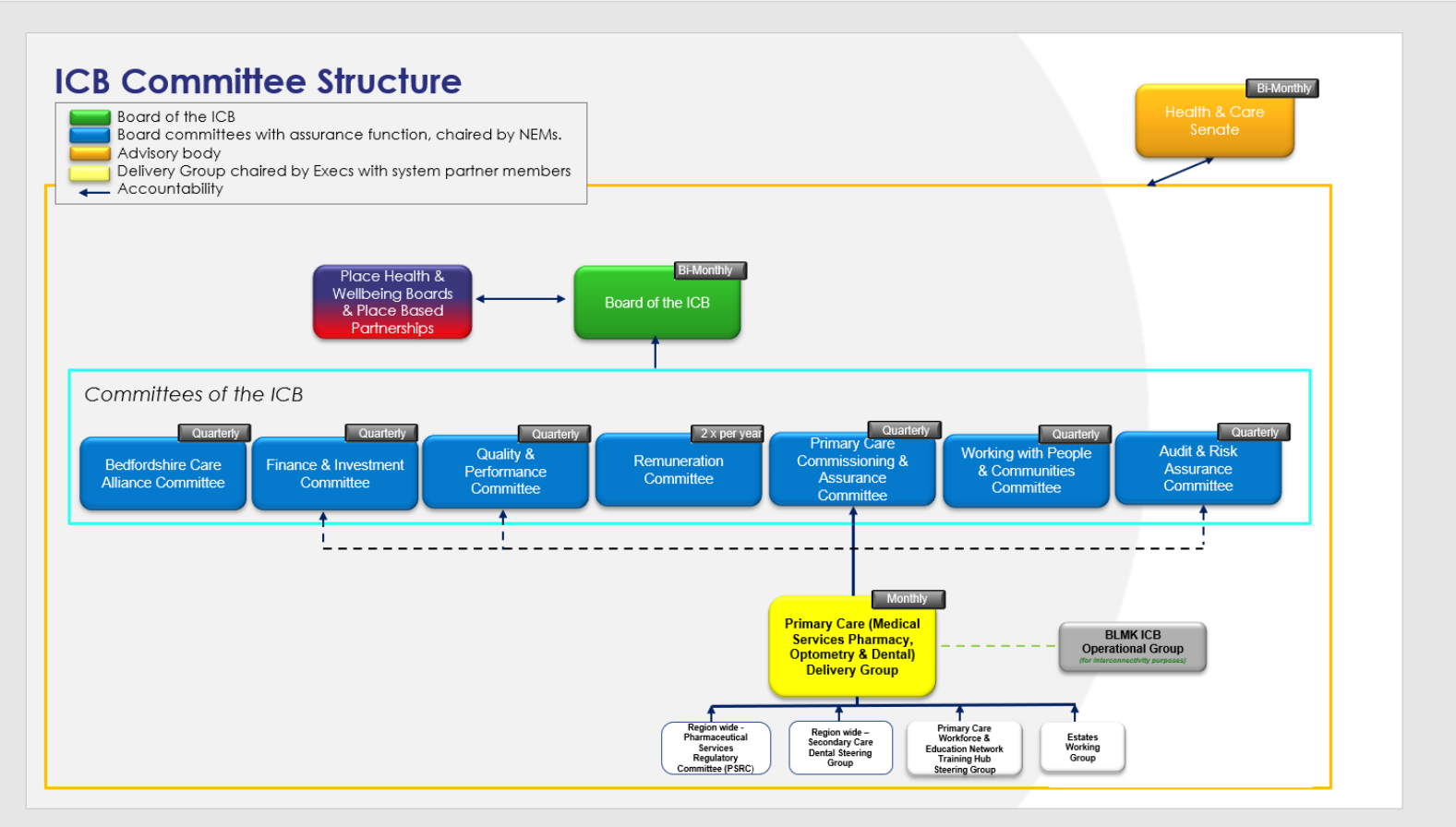
10.2 These Terms of Reference will be reviewed at least every two years and more frequently if required. Any proposed amendments to the Terms of Reference will be submitted to the Board for approval.

10.3 The Committee will use a continuous improvement approach in its delegation and all members will be encouraged to review the effectiveness of the meeting at each sitting.

Date of Approval : March 2024

For review : March 2025

Appendix 1 Bedfordshire Luton & Milton Keynes – ICB Committee Structure



Primary Care Delivery Group (PCDG) Terms of Reference

The Primary Care Delivery Group is an Executive led sub-group of the Primary Care Commissioning and Assurance Committee (PCCAC). The PCCAC was established by Bedfordshire Luton and Milton Keynes Integrated Commissioning Board (BLMK ICB) in July 2022 and reports to the ICB in accordance with its constitution.

1.0 Authority

1.1 The Primary Care Commissioning and Assurance Committee has delegated authority to the Chief Primary Care Officer to oversee the executive led Primary Care Delivery Group as set out in the ICB committee structure Appendix 1.

2.0 Purpose

2.1 The Primary Care Delivery Group is to enable the Chief Primary Care Officer to focus and oversee the management and delivery of the entire primary medical (GP), community pharmacy, optometry and dental services programmes of work in the context of promoting increased quality, efficiency, productivity, value for money and reducing administration burden whilst providing assurance reports to the PCCAC at each meeting on the following functions.

a) Business as usual operational issues.
b) Oversee the implementation of primary care transformation adhering to the principle of subsidiarity.
c) Implementation and delivery on the transformation and integration programme for primary care which includes the ambitions in the NHSE 'Fuller Stocktake Report' (May 2022), the NHSE 'Delivery Plan for Improving Access to Primary Care' (May 2023) and the ICBs 'Delivery Plan for Prevention in Primary Care Settings` (January 2024).
d) Promotion of working collaboratively with the finance, quality and safeguarding and estates directorates and wider system health and care partners to support the delivery of primary medical services.
e) To give financial approval within the Chief Primary Care Officers financial authorisation level set out in the Statement of Financial Orders (SFOs).
f) Financial approval outside of the Chief Primary Care Officers financial authorisation, will be requested from the PCCAC.

3.0 Membership and attendance

3.1 The PCDG will meet on a **monthly** basis as convened by the Group Chair.

3.2 The core membership of the PCDG will include the following representation or their designate:

Members with voting rights:

a) ICB Chief Primary Care Officer (Chair)
b) ICB Deputy Chief Primary Care Officer (Vice Chair)
c) ICB Associate Director of Primary Care Contracting & Development
d) ICB Associate Director of Primary Care and Prevention.
e) ICB Associate Director of Finance
f) ICB Associate Director of Quality Improvement & Inequalities
g) ICB Associate Director System and ICB Estates.

3.3 Other attendees - non-voting

a) ICB Associate Director of Pharmacy and Medicines Optimisation
b) ICB Head of Primary Care Workforce Programme
c) ICB Head of Community and Primary Care Contracting
d) ICB Senior Contract Managers GP and Dental services
e) ICB Heads of Integrated Care
f) ICB Strategic Clinical Leads
g) ICB Community Pharmacy Integration Lead
h) ICB Associate Director People Transformation
i) One representative from each Local Medical Committee (2)
j) One representative from each Local Dental Committees (2)
k) One representative from the Local Pharmaceutical Committee
l) One representative from each Local Optometry Committees (2)
m) One representative from each Health and Wellbeing Board in BLMK (4)
n) One Public Health representative for each Local Authority area (2)

3.4 Other members will be co-opted as and when appropriate including, but not limited to:
a) Senior Finance Manager
b) Senior Public Health
c) Others to be agreed.

4.0 Meeting Quoracy and Decisions

Quorum

4.1 Quoracy will be a minimum **four** representatives - Chief Primary Care Officer (Chair) or Deputy Chief Primary Care Officer (Vice Chair), Associate Director of Primary Care Contracting and Development, Associate Director of Finance

and Associate Director of Quality Improvement & Inequalities or Associate Director System and ICB Estates.

4.2 Where members are required for quoracy but unable to attend, they should ensure that a named and briefed deputy is in attendance who can participate and vote on their behalf.

Decision making and voting

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

4.4 Only voting members of the group may vote. Each voting member is allowed one vote and a majority will be conclusive on any matter.

4.5 Voting members and responsible officers unable to attend the PCDG may appoint a deputy to attend and vote on their behalf. No other deputies are permissible.

4.6 Where there is a split vote, with no clear majority, the Chair of the Group will hold the casting vote. The result of the vote will be recorded in the minutes.

4.7 There may be times that decisions will need to be taken outside the meeting and subject to agreement with key representatives including the Chair of the Primary Care Commissioning & Assurance Committee or deputy. This will include contracting decisions e.g., list closure applications where a decision is required within 21 days of receipt of practice applications. Such decisions will be reported to the next PCCAC meeting.

5.0 Responsibilities of the Group

5.1 The responsibilities of the Primary Care Delivery Group will be delegated by the Primary Care Commissioning and Assurance Committee; it is expected these will be the focus areas:

5.1.1 Operational

i. Oversee commissioning and operational delivery of all primary care contracts including the design of Alternative Provider of Medical Services and Personal Dental Service contracts and Specialist Community Dental Services.

ii. Monitoring of contracts taking contractual action such as issuing remedial and breach of contract notices and or termination of contracts in line with the terms of the contracts and national policy guidance manuals.
iii. Oversee the programme of Alternative Provider of Medical Services and Personal Dental Service and other procurements and make recommendations to the PCCAC for contract award.
iv. Oversee the development (subject to financial authorisation) of newly designed enhanced services “Local Enhanced Services” and implementation of “Directed Enhanced Services” and “Local Incentive Schemes.”
v. Approving practice mergers.
vi. Approving changes to practice boundaries, relocation requests.
vii. Approving list closure applications.
viii. Approving requests to convert General Dental Services to Personal Dental Services contracts.
ix. Agree change of dental contractor hours.
x. Oversee and approve the rebasing of dental contracts.
xi. Approving primary care medical and dental services incorporation applications.
xii. Making decisions on discretionary payments including Section 96 emergency financial support, within the Chief Primary Care Officer Executives SFO authorisation limits.
xiii. Making decisions relating to Primary Care Estates.
xiv. Making decisions relating to Primary Care digital issues.
xv. Making decisions relating to Primary Care workforce.
xvi. Undertake reviews of primary medical and dental services in the BLMK area and co-ordinate a common approach to the commissioning of primary care services.
xvii. Utilise local clinical and management knowledge to influence the development of and investment in general practice to improve patient access to services and taking a population health management approach.
xviii. Develop and commission end to end care and shape future primary care services.
xix. Provide the PCCAC with an annual work plan outlining key committee dates to receive specific reports in addition to the quarterly assurance reports.
xx. Oversee the delivery of the ICB Vaccination strategy.

5.1.2 Strategic

i. Take an active role in driving forward the NHS Long Term Plan.
ii. Plan primary care services in the BLMK area in response to population health assessment.

iii. Oversee the planning and preparedness for the delegation of NHS England Public Health (section 7a) services, vaccinations and immunisations to the ICB in 2025.
iv. Promote collaborative working on monitoring and addressing issues of quality in primary care based on the principle of continuous improvement.
v. Make recommendations to the PCCAC on whether to establish new GP practices in an area subject to the Committee's agreement.
vi. Agree and put forward the key primary care priorities that are included within the ICB strategy/annual plan, including priorities to address variation/inequalities.
vii. Promote collaborative working and interconnectivity with the Quality and Safeguarding Group, Estates Working Group, Workforce & Education Network Training Hub Steering Group and Digital Group.
viii. Review and monitor primary care risks and mitigations to provide assurance to the PCCAC.
ix. Monitor, review risks on the Board Assurance Framework (BAF) and Corporate Risk Register which relate to primary care to include identifying new risks.
x. Ensure the Primary Care Commissioning and Assurance Committee is kept informed of significant risks and mitigation plans, in a timely manner.

5.1.3 Assurance reporting to the PCCAC

i. Provide assurance to the Committee to manage the overall budget for commissioning of primary medical, community pharmacy, optometry and dental services.
ii. Maintain an overview of changes in the methodology employed by regulators and changes in legislation/regulation and assure the PCCAC that these are disseminated and implemented across all sites and that they are appropriately reviewed, and actions are being undertaken, embedded, and sustained.
iii. Provide assurance that the mechanisms are in place to review and monitor the effectiveness of the quality of care delivered by primary care providers and place.
iv. Ensure risks both financial and operational are highlighted to the Committee with the appropriate mitigation plans.
v. Provide assurance on the transformation and integration programme for primary care which includes the ambitions in the NHSE 'Fuller Stocktake Report' (May 2022), the NHSE 'Delivery Plan for Improving Access to Primary Care' (May 2023) and the ICBs 'Delivery Plan for Prevention in Primary Care Settings` (January 2024).

6.0 Behaviours and Conduct

ICB Values

6.1 Members of the Primary Care Delivery Group will be expected to conduct business in line with the ICB values and objectives. Members of, and those attending, the Primary Care Delivery Group shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality and Diversity

6.2 Members of the Primary Care Delivery Group must consider the equality and diversity implications of decisions they make.

Declarations of Interest

6.3 All members of the Primary Care Delivery Group and those in attendance declare any actual or potential conflicts of interest which will be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration will be excluded from the discussion at the discretion of the Chair.

7.0 Accountability and reporting

7.1 The Primary Care Delivery Group is directly accountable to the Primary Care Commissioning and Assurance Committee (Appendix 1). The minutes of meetings shall be formally recorded.

7.2 The Chair of the Group shall report to the Primary Care Commissioning and Assurance Committee and provide an assurance report to the committee on a quarterly basis and escalate concerns to the Chair of the PCCAC where necessary.

7.3 The Group will work collaboratively to ensure interconnectivity with other ICB Executive Led Groups including but not limited to finance and estates, quality and safeguarding and ICS system stakeholders.

7.4 The Primary Care Training Hub Steering Group and Estates Working Group will report into the Primary Care Delivery Group.

8.0 Secretariat and Administration

8.1 The Group shall be supported with a secretariat function which will include ensuring that:

i. The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant Associate Director.
ii. Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements.
iii. Records of members and conflicts of interest will be declared and recorded at each meeting.
iv. Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept.
v. The Chair is supported to prepare and deliver reports to the Primary Care Commissioning and Assurance Committee.
vi. The Group is updated on pertinent issues/ areas of interest/ policy developments.
vii. Action points are taken forward between meetings and progress against those actions is monitored.

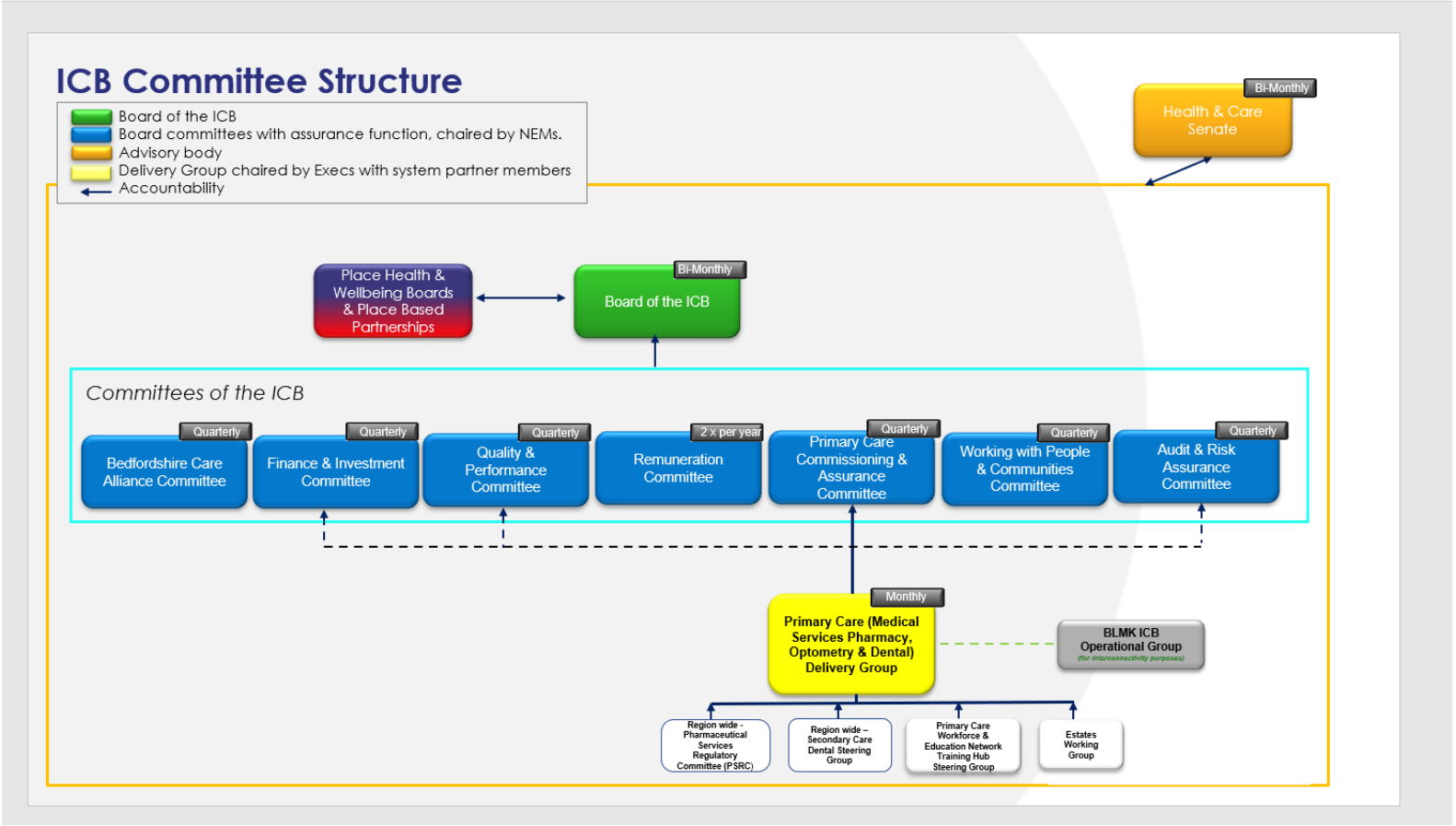
9.0 Review

9.1 The Terms of Reference will be reviewed at least annually and more frequently if required. The Terms of Reference and any proposed amendments will be submitted to the Primary Care Commissioning and Assurance Committee for approval.

Date of approval: March 2024

Date of review: March 2025

Appendix 1 Bedfordshire Luton & Milton Keynes – ICB Committee Structure



Item 14. Primary Care Commissioning & Assurance Committee (PCC&AC) - Meeting held in Public. Annual Cycle of Business 2023/24

	Accountable Person	Author/s	Date of meeting 15.03.24.
Agenda Item Title (or included as a section of another paper)	**Accountable Director and Lead for paper**	**Author/s**	
Opening Actions			
Welcome, Introductions and Apologies	Chair	Governance	✓
Relevant Persons Disclosure of Interests - Register of Interests	Chair	Governance	✓
Approval of Minutes and Matters Arising	Chair	Governance	✓
Review of Action Tracker	Chair	Governance	✓
Strategy & Integration - Assurance			
Integrating Primary Care in the ICS (Fuller Stocktake recommendations/BLMK Fuller Programme)	Deputy Chief Primary Care Officer	Amanda Flower	✓
Progress in BLMK - NHSE Delivery Plan for Recovering Access to Primary Care	Deputy Chief Primary Care Officer	Amanda Flower	✓
Prevention Plan	Associate Director Primary Care Transformation Prevention Lead, Covid and Flu Immunisation & Vaccination Strategy Lead	Craig Lister	✓
Primary Care Workforce Programme & Highlight Report	Head of Primary Care Workforce Programme / Associate Director People Transformation - Fuller	Marie Lehane / Susi Clarke	✓
Primary Care Estates Highlight Report/Estates Plan	Associate Director of System & ICB Estates	Nikki Barnes	✓
Periodic review of S106 tracker / S106 update	Associate Director of System & ICB Estates	Nikki Barnes	✓
Primary Care Digital Programme	Head of Digital Delivery	Mark Peedle	✓
Operational - Assurance			
APMS Contracts Re-procurement Plan	Associate Director of Primary Care Contracting and Development	Lynn Dalton	✓
Contractual assurance update (Medical Services)	Associate Director of Primary Care Contracting and Development	Lynn Dalton	✓
Contractual assurance update (Dental)	Associate Director of Primary Care Contracting and Development	Lynn Dalton	✓
Delegated Primary Care Medical Services Financial Report	Associate Director of Finance	Roger Hammond	✓
Delegated Primary Care Pharmacy, Optometry, Dental Services Financial Report	Associate Director of Finance	Roger Hammond	✓
Pharmaceutical Services Regulatory Committee Report (Quarterly)	Associate Director of Primary Care Contracting and Development	Lynn Dalton	✓
General Opthalmic Services (GOS) contracting report (Quarterly)	Associate Director of Primary Care Contracting and Development	Lynn Dalton	✓
Primary Care Directorate & Digital Risk Register	Deputy Chief Primary Care Officer	Amanda Flower	✓
Universal Offer & Enhanced Services Review	Deputy Chief Primary Care Officer	Amanda Flower	✓
Governance - Assurance			
Review Terms of Reference PCCAC and sub groups.	Chief Primary Care Officer / Associate Director of Primary Care Contracting and Development	Nicky Poulain / Lynn Dalton	✓
Audits 2023-24 - subject to agreement by Audit Committee (before March 2024)	Chief Primary Care Officer / Associate Director of Primary Care Contracting and Development	Nicky Poulain / Lynn Dalton	✓
Committee annual cycle of business	Chief Primary Care Officer / Associate Director of Primary Care Contracting and Development	Nicky Poulain / Lynn Dalton	✓
Communications from the meeting	Chair	Governance	✓
Committee Effectiveness	Chair	Governance	✓
Annual Review of Committee Effectiveness	Chair	Governance & Compliance Team	
Closing Actions			
Any Other Business	Chair	Governance	✓
Date and Time of Next Meeting	Chair	Governance	✓