NHS
North East London

Primary Care Contracts Sub-Committee

18 March 2024; 13:00-14:30; Venue MS teams

AGENDA

	Item	Time	Lead	Attached/ verbal	Action required
1.0 1.1. 1.2. 1.3	**Welcome, introductions and apologies** Declaration of conflicts of interest Minutes of the meeting held on 29 January 2024 Matters arising and actions log - APMS contract procurement programme - Lot 3	13:00	Chair	 Verbal Attached Attached Attached Verbal	 Note Note Approve Note Note
2.0	**Questions from members of the public**	13:05	Chair	Verbal	Note
3.0	**Special Allocation Scheme**	13:20	Gohar Choudhury	Attached	Approve
4.0 4.1.	**Dental, Optometry & Pharmacy Report** Dental recovery plan	13:35	Jeremy Wallman	Attached	Note
5.0	**Finance Report**	13:45	Rob Dickenson	Attached	Note
6.0	**Locum reimbursement protocol update**	13:55	Sarah See	Verbal	Note
7.0 7.1.	**Remedial Breach Notice approved by virtual sub-committee** Waltham Forest - Forest Surgery	14:05	 Alison Goodlad	 Verbal	 Note
8.0	**Any other business**	14:15	Chair	Verbal	Note
9.0 9.1. 9.2. 9.3. 9.4.	**Items for information only** GP contract report Risk register (top 5) Primary care access recovery plan Approved terms of reference	14:20	 Lorna Hutchinson Alison Goodlad Sarah See Chair	 Attached Attached Attached Attached	 Note Note Note Note
Date of next meeting: 21 May 2024					

- Declared Interests as at 26/02/2024

Name	Position/Relationship with ICB	Committees	Declared Interest	Name of the organisation/business	Nature of interest	Valid From	Valid To	Action taken to mitigate risk
Alison Goodlad	Deputy Director of Primary Care	Primary care contracts sub-committee	Indirect Interest	Northamptonshire NHS Foundation Trust	Sister is Mental Health Practitioner	0022-01-08		Declarations to be made at the beginning of meetings
Benjamin Molyneux	Associate Medical Director, NEL ICB	Clinical Advisory Group Primary Care Collaborative sub-committee Primary care contracts sub-committee	Financial Interest	Locum GP	I work as an ad hoc self-employed GP at GP practices in NEL	2023-05-01		Declarations to be made at the beginning of meetings
Diane Jones	Chief Nursing Officer	Clinical Advisory Group ICB Board ICB Quality, Safety & Improvement Committee ICS Executive Committee Primary care contracts sub-committee	Non-Financial Professional Interest	Royal College of Nursing (RCN)	Professional membership	2020-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Royal College of Midwives (RCM)	Professional membership	1994-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Nursing & Midwifery Council (NMC)	Professional membership	1992-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	London Clinical Senate	Member	2017-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Homerton Hospital	Midwife (honorary contract)	2015-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	Group B Strep Support (GBSS)	Director and Trustee	2020-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	Sign Health	I am a Trustee of the charity	2023-05-01		
Dr Paul Francis Gilluley	Chief Medical Officer	Acute Provider Collaborative Joint Committee Clinical Advisory Group ICB Board ICB Population, Health & Integration Committee ICB Quality, Safety & Improvement Committee ICP Committee ICS Executive Committee Primary care contracts sub-committee	Non-Financial Professional Interest	British Medical Association	I am a member of the organisation.	2022-07-01		
			Non-Financial Professional Interest	Royal College of Psychiatrists	Fellow of the College	2022-07-01		
			Non-Financial Professional Interest	Medical Defence Union	Member	2022-07-01		
			Non-Financial Professional Interest	General Medical Council	Member	2022-07-01		
			Non-Financial Personal Interest	Stonewall	Member	2022-07-01		
			Non-Financial Personal Interest	National Opera Studio	Trustee on the Board	2023-08-01		

Raliat Onatade	Chief Pharmacist and Director of Medicines and Pharmacy	Clinical Advisory Group Formulary & Pathways Group (FPG) Primary care contracts sub-committee	Non-Financial Professional Interest	North Thames Genomic Medicine Service Alliance	I am also Chief Pharmacist for North Thames Genomic Medicine Service Alliance, which is an NHS organisation hosted by UCL Partners. North East London is part of the North Thames region for Genomic Medicines, therefore the role is complementary, rather than in conflict.	2021-04-01		
			Indirect Interest	Roche	I have signed a Consultancy Agreement with Roche to attend a meeting designed to improve Roche's understanding of the recent changes to the NHS in England, the opportunities and challenges with the new Integrated Care System (ICS) structure and the delegation of specialised commissioning. Roche will apply these insights to be a more constructive industry partner. My role (in accordance with all applicable clauses of the ABPI Code of Practice) will entail a single 1 hour virtual speaker session at the Roche Policy, Value and Access Chapter meeting on 15 November 2023. I will be paid £220 per hour, and payment will be for 1 hour preparation time and 1 hour meeting (the actual session).	2023-10-24	2023-11-15	
Richard Bull	Programme Director - Primary Care	Primary care contracts sub-committee	Non-Financial Personal Interest	St Mary's Secret Garden charity	Chair of St Mary's Secret Garden charity	2021-09-30		
Sarah See	Managing Director of Primary Care	ICS Executive Committee Primary Care Collaborative sub-committee Primary care contracts sub-committee	Indirect Interest	NELFT; CAMHS Havering	Husband is an employee	1998-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	GP - Waltham Forest	Registered with a GP practice in Waltham Forest; members of the practice team works with the NHS NEL, LW LMC and NHSE/I	2001-01-01		Declarations to be made at the beginning of meetings
			Indirect Interest	Old Church Surgery (Chingford)	Niece works for GP practice	2022-06-05		Declarations to be made at the beginning of meetings

Shilpa Shah	LPC CEO attend meetings as a guest	Formulary & Pathways Group (FPG) Primary Care Collaborative sub-committee Primary care contracts sub-committee	Non-Financial Personal Interest	Samaritans	Director of Branch Operations at Samaritans National voluntary role.	2022-10-01		
			Non-Financial Personal Interest	Waltham Forest Samaritans	Listening volunteer at Waltham Forest Samaritans	2015-07-15		
			Financial Interest	Pharmacy Services Partnership	I am a consultant manager to the Pharmacy Services Partnership which is a Pharmacy Provider Company	2023-04-01		
Sue Evans	Associate Non Executive Member	ICB Audit and Risk Committee ICB Workforce & Remuneration Committee Primary care contracts sub-committee	Non-Financial Professional Interest	Worshipful Company of Glass Sellers' of London (City Livery Company) Charity Fund	Company Secretary / Clerk to the Trustees'	2014-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	North East London NHS	Self and family users of healthcare services in NEL	2017-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	St Aubyn's School Charitable Trust	Trustee and Director of Company Ltd by Guarantee	2013-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	NHS Health Research Authority	Member of Research Ethics Committee	2023-07-01		Declarations to be made at the beginning of meetings

- Nil Interests Declared as of 26/02/2024

Name	Position/Relationship with ICB	Committees	Declared Interest
Gohar Choudhury	Assistant Head of Primary Care	Primary care contracts sub-committee	Indicated No Conflicts To Declare.
William Cunningham-Davis	Director of Primary Care Delivery	Newham Health and Care Partnership Newham ICB Sub-committee Primary care contracts sub-committee Waltham Forest Health and Care Partnership Board Waltham Forest ICB Sub-committee	Indicated No Conflicts To Declare.
Lorna Hutchinson	Assistant Head of Primary Care	Primary care contracts sub-committee	Indicated No Conflicts To Declare.
Abdul Rawkib	Senior Primary Care Commissioning Manager	Primary care contracts sub-committee	Indicated No Conflicts To Declare.
Jane Lindo	Director of Primary Care	Primary care contracts sub-committee	Indicated No Conflicts To Declare.
Rob Dickenson	Senior Finance Manager - Primary Care	Primary Care Collaborative sub-committee Primary care contracts sub-committee	Indicated No Conflicts To Declare.
Jeremy Wallman	Head of Primary Care Commissioning; Dentistry, Optometry and Pharmacy	Primary care contracts sub-committee	Indicated No Conflicts To Declare.
Kate Hudson	Observer of Primary Care Contracts Sub Committee	Primary care contracts sub-committee	Indicated No Conflicts To Declare.
Amy Wilkinson	Director of Partnerships, Impact and Delivery	City & Hackney ICB Sub-committee City & Hackney Partnership Board Primary care contracts sub-committee	Indicated No Conflicts To Declare.

NHS
North East London

DRAFT
Minutes of the Primary Care Contracts Sub-Committee
29 January 2024; 13:00-15:00; Via MS teams

Members:	
Ahmet Koray (AK) Chair	Interim Director of Finance, NHS North East London
Sarah See (SS)	Managing Director of Primary Care, NHS North East London
Sue Evans (SE)	Non-Executive Member, NHS North East London
Diane Jones (DJ)	Chief Nursing Officer, NHS North East London
Attendees:	
Ben Molyneux (BM)	Assistant Medical Director, NHS North East London
Jane Lindo (JL)	Director of Primary Care, NHS North East London
William Cunningham-Davis (WCD)	Director of Primary Care, NHS North East London
Richard Bull (RB)	Director of Primary Care (C&H), NHS North East London
Alison Goodlad (AG)	Deputy Director of Primary Care, NHS North East London
Lorna Hutchinson (LH)	Assistant Head of Primary Care, NHS North East London
Gohar Choudhury (GC)	Assistant Head of Primary Care, NHS North East London
Jeremy Wallman (JW)	Head of Primary Care Commissioning; Dentistry, Optometry and Pharmacy, NHS North East London
Rob Dickenson (RD)	Senior Finance Manager, NHS North East London
Raliat Onatade (RO)	Chief Pharmacist and Director of Medicines and Pharmacy
Kate Hudson (KH)	LLMC Director of Primary Care (for NEL, SEL & SWL)
Ian Williamson (IW)	London Wide LMC
Jignasa Joshi (JJ)	Chair, North East London Local Optical Committee
Shilpa Shar (SSh)	CEO, North East London Pharmaceutical Committee
Asif Imran (AI)	Barking, Dagenham and Havering LMC
Natalie Keefe (NK)	Head of Primary Care Delivery, NHS North East London
Keely Horton (KHo)	Minute taker, Governance Officer, NHS North East London
Apologies:	
Paul Gilluley (PG)	Chief Medical Officer, NHS North East London
Tam Bekele (TB)	Secretary, East London and City Local Dental Committee

Item No.	Item title	Action
1.0	**Welcome, introductions and apologies**	
	The Chair welcomed members and participants to the meeting of the primary care contracts sub-committee and apologies were noted.	
1.1.	**Declaration of conflicts of interest**	
	The Chair reminded members of their obligation to declare any interest they may have on any issues arising at the meeting which might conflict with the business of the committee. No additional conflicts were declared. Declarations made by members of the committee are listed on the register of interests. The register is included in the pack of papers and available from the secretary of the committee.	

1.2	**Minutes of the meeting held on 27 November 2023 and 12 December 2023**	
	The minutes of the meeting held on 27 November 2023 and 12 December 2023 were accepted as an accurate record.	
1.3	**Matters arising/action log**	
	The action log was reviewed and the following update was noted: • Locum Reimbursement Policy – legal advice is being sought and an update will be brought back to the next meeting. • Merger proposal white house surgery - West One PCN has agreed the move and Seven Kings are meeting on 23 January. The merger target date is 1 April 2024. • Dental, Optometry and Pharmacy update – JW has been in contact with the designated nurses for looked after children (LAC) to ensure information on access to services is cascaded through the necessary teams.	
2.0	**NEL Wide – Change of Control for Operose Health**	
	Alison Goodlad (AG) presented to the Committee the proposed change of control for Operose Health. The following key points were noted: • NHS NEL has received an application from Operose Health seeking consent for a change of control from its current owner Centene Corporation to T20 Osprey Midco Ltd. • Operose Health operates approximately 60 GP practices nationally via providers including AT Medics. AT Medics Ltd holds seven APMS contracts in NEL. • Due diligence process is being undertaken as a London wide process with legal support. • Patients registered at these seven practices, and relevant local stakeholders, have been informed of the application and have been notified of the steps being taken and they will have the opportunity to provide comments and ask questions via a questionnaire on the ICB website. • Information has been provided on the ICB website along with a link to a survey to provide comments and to join a webinar. • Updates have been provided to the NEL ICB Board and the inner and outer NEL Health Overview and Scrutiny committees. • The decision to grant consent, or not to grant consent, to the change of control will then be made at a meeting of this committee to be held in public and papers will be shared on the ICB website. Discussion points were: • A wide range of engagement has taken place with stakeholders and organisations involved. This has been discussed at local scrutiny committees and with local councils. • Services that are currently offered to patients will not be affected. • The LMC have received a number of queries from practices. The Primary Care Contracts sub-committee thanked AG for her presentation and noted the contents of the report and noted the next steps of the decision to consent to proposed change of control will be made at a future meeting of the sub-committee.	

3.0	**Payment to PCNs for the Investment and Impact Fund (IFF) 22/23 Indicator AC-02**	
	Alison Goodlad (AG) briefed members on payments to Primary Care Networks (PCNs) for the Investment and Impact Fund (IFF) 22/23 indicator AC-02 (Ambulatory Care Sensitive Conditions). The sub-committee is asked to approve the recommendation: • To recognise the effort the PCNs have made in proactively providing interventions in Primary Care and an alternative approach for paying PCNs for this indicator, based on provision of information outlining their approach to this. Key highlights included: • There has been a national issue with indicator AC-02 due to no baseline or in-year achievement data was made available to PCNs and data on achievement was not made available nationally to PCNs following year-end. • There were 36 IIF indicators for 22/23. • The aim of AC-02 is, through joint work with other system partners, PCNs improve outcomes for patients with these conditions to achieve a reduction in the rate of Ambulatory Care Sensitive Condition admissions. • Based on an approach taken in NHS South West London, supported by Londonwide LMC, the proposal is that PCNs will be asked to provide information on their approach to pro-actively identify patients at risk of admission for ambulatory care sensitive conditions and to put in place interventions to address this. If PCNs provide a sufficiently robust response, the full value of AC-02 will be paid (or topped up) to each PCN. • There is sufficient funding from funds set aside for accruals to pay the 22/23 IIF. • There is a risk of PCNs becoming disengaged with any future specification that requires collaboration with wider ICS if full payment is not made for AC-02. • The IIF for 2023/24 has been significantly redesigned to focus on five indicators only and the Indicator AC-02 has been retired. The remaining IIF-committed funding for 2023/24 has been recycled into the Access and Capacity Improvement Fund. Discussion points were: • There was agreement that the data is not accurate and not provided in a timely way which impacted practices delivering the indicator. • This is a welcome approach to support practices. The Primary Care Contracts sub-committee approved the proposal.	
4.0	**NEL Wide – Procurement update**	
	Alison Goodlad (AG) provided a verbal update to the sub-committee on the NEL wide procurement. The following key points were noted: • NEL APMS contracts procurement programme entails the procurement of six APMS practices, including one zero list procurement. • The committee had previously agreed on the preferred bidders.	

	• Successful bidders can now be made public as the stand still period has ended. However, Lot 3 is still in the standstill period due to the decision previously made to delay. • Lot 1 & 2: Successful bidder is ELFT. • Lot 4, 5 & 6: Successful bidder is Addison Road Medical Centre. • Planned go live date is 1 April 2024. Discussion points were: • Acknowledgment of the large amount of work involved. • All those involved in the process will be asked to complete a survey as part of a learning review. The Primary Care Contracts sub-committee thanked AG for her verbal update and the work which had gone into the successful procurement.	
5.0	**Extension of NEL-wide Local Incentive Schemes (LISs) for the PCN Supplementary Care Homes Service and Safeguarding (General Practice Reporting)**	
	Alison Goodlad (AG) provided an update on the NEL-wide Local Incentive Schemes (LISs) for the PCN Supplementary Care Homes Service and Safeguarding (General Practice Reporting). The Sub-Committee is asked to approve an extension for a maximum of nine months under the existing specifications for these schemes to allow sufficient time to review. Key updates from the papers include: • Extending these schemes will allow sufficient time to review performance against the requirements of these schemes, consider changes to the specifications and the way these schemes operate and undertake engagement. • The care homes service focuses support on older people living in care homes, working in partnership with other providers to ensure that the needs of the residents are proactively met and avoid unnecessary emergency admissions. • The supplementary care homes service is funded recurrently from delegated funding in Barking and Dagenham, Redbridge and Havering and from non-delegated funding in Newham, Waltham Forest and Tower Hamlets. • The safeguarding LIS pays practices for reports submitted to Local Authorities that provide information to address safeguarding concerns in relation to children and adults. • The safeguarding LIS is funded recurrently and the estimated expenditure for NEL for 23/24 is £504k. Discussion points included: • The decision made to extend for 9 months and not 12 months. • The funding is recurrent through a mixture of delegated and non-delegated. Non-delegated funding should be looked at separately. • Quality indicators for the safeguarding LIS is important and was a suggestion to explore more with support from the Quality team. • Length of tender for LISs in general should be reviewed and should have the ability to change specifications within year when changes in guidance is received.	

	• It would be helpful to look at and include indicators around vision and sight loss. The Local Optometry Committee (LOC) can provide support with this. Members supported the proposal in principle but would like to see additional work on extending for 12 months as well as 9 months and to confirm the funding streams for both options. • Contact is to be made with the Quality Team to support quality indicators. • The Care Home LIS will be discussed further to determine funding source and length of proposal. • The Safeguarding LIS is agreed in principle, pending confirmation of funding source and to be extended to 12 months. **ACTION**: Meeting to be arranged to explore the Care Home LIS and Safeguarding LIS further and confirm funding streams. **ACTION**: Liaise with the Quality Team to support with quality indicators.	**AG/AK / SS** **AG/DJ**
6.0	**Redbridge – Additional Space Request for Forest Edge Practice**	
	Natalie Keefe (NK) presented the additional space request for Forest Edge Practice. Key highlights include: • Forest Edge Practice moved to Hainault Health Centre in 2005 and the practice list continues to grow year on year. In April 2005 the practice list size was 7619 and in April 2023 it has increased to 13,666. • The limited space is impacting on expanding capacity to meet the increase in demand for services. • The practice currently has 9 consultation rooms for 17 clinical staff and 2 small admin offices for 16 non-clinical staff plus medical notes. • The practice provides face to face and telephone appointments but would like to offer more face to face appointments. • Clinical sessions are held throughout the day to ensure the rooms are used to full capacity. • The practice is requesting additional consultation rooms and admin space, this will enable them to increase capacity to meet ongoing patient health needs. • It is also a training practice and the additional space will allow them to take on an additional registrars to help improve overall access to services but also support the workforce issues Redbridge Borough has with recruiting GPs. Discussion points included: • There is no outstanding debt with property services. • The continuing practice growth was acknowledged. • There is a cost pressure but is void cost. The sub-committee approved the additional space and associated rent reimbursement and the cost of the additional IT cabling and equipment.	
7.0	**Dental, Optometry & Pharmacy Report**	
	Jeremy Wallman (JW) provided a verbal update to the sub-committee.	

	Key points included: • Pharmacy First will launch on 31 January 2024. Once data becomes available it will be shared at future meetings. • NEL is the highest performing ICB in terms of the dentistry contract performance. • The difference in underspend will come back into the ICB once the year end process has been completed as a non-recurrent resource. • Delivery across dental access has improved. Discussion points included: • The performance metrics refer to contracts and includes delivery of dental access. They have national contracts and breach in contract is reported to the ICB. • Local LMCs are engaging with practices and pharmaceutical committees around Pharmacy First. The sub-committee thanked JW for his verbal update and welcomed a detailed update at a future meeting once further data is available.	
8.0	**Finance Report**	
	Rob Dickenson (RD) briefed the sub-committee on the month 9 position, noting that the circulated paper provides more details. Key points noted were: • NHS NEL has reported an overspend of £21.5m year to date with a forecast overspend of £28.3m (excluding Additional Roles Reimbursement Scheme (ARRS) which will be refunded by NHS E/I). • The recently delegated Dentistry, Optometry and Pharmacy services are forecast to underspend by £10.6m. • There is an ongoing review of financial commitments against available resources. • The main risks to the position include prescribing and demographic growth. • The Prescribing position is overspent by £20.6m, with a forecast overspend of £27.5m. The available prescribing data is two months in arrears therefore the reported position is based upon data from April to October. • The month 9 reported position reflected a forecast ARRS spend of £46.5m (89% utilisation). This would allow a drawdown of £13.5m from NHSE. The ICB has been working closely with PCNs to fully understand their recruitment intentions up to the end of March 2024. This has resulted in a month on month increase in the forecast spend. • Dental budgets were ring-fenced but since month 8, national guidance has changed, allowing ICBs to retain any underspend. Discussion points included: • ARRS funding and why some networks have not used their full utilisation, creating outliers. • A discussion on ARRS roles and pharmacy should be held, and what support can be provided to help to control prescribing spend and efficiency. • Prescribing costs and improvements in wound care spend should be shared with the NEL wound care group. • Equalisation of schemes has been paused.	

	• ARRS is ring-fenced funding for PCNs to recruit additional staff. As this is a national scheme it comes under the PCN contract. There are quality aspects to these roles to ensure value for money and how to measure performance but it is difficult for the ICB to monitor as this is not funding that is held locally. • The 24/25 operating plan guidance has not been received. Work has started on drafting the financial planning process for 24/25 with some high level indicative numbers. A deficit is expected at the end of the 23/24 financial year. **ACTION**: Meeting to be arranged to discuss ARRS and pharmacy recruitment to explore developing a business case to support utilising the funding source. **ACTION**: RO and DJ to discuss wound care and improvement on spend. The Primary Care Contracts sub-committee noted the primary care finance report from month 9.	**RO/SS / BM** **RO/DJ**
9.0	**Updated Risk Register**	
	Alison Goodlad provided an update on the risk register. Key highlights include: • Earlier in 2023 a Commissioning, Strategy and Transformation Department Risk Register was produced. • Following risks identified, new corporate and organisational risks were included in the Primary Care section of the risk register. Previously identified NEL-level risks were reviewed and added. • A meeting was held with the NEL ICB Primary Care representatives and was further reviewed by the Primary Care Directorate Senior Managers and a refreshed register was produced. • The risks were also reviewed at the meeting of the Primary Care Delivery Group and the Primary Care Collaborative sub-committee. • Eight risks are rated over 12. These include primary care resilience and sustainability, access to routine NHS dentistry and primary care workforce. Key discussions included: • Operational risks need to be managed appropriately rather than mitigated. • It was suggested that risks are peer reviewed looking at scoring and how these are determined. • The impact of risks was noted and how risk ratings can be improved, especially risks where they are impacted by the current financial position. **ACTION**: Primary care team to meet with the Quality team to look at risks and level of scoring. The sub-committee approved the refreshed risk register.	**AG/DJ**
10.0	**AOB**	
10.1	**BHR Homelessness Outreach: Outcome of virtual approval**	
	The Committee approved by virtual request an extension of the current BHR homeless outreach contract delivered by Partnership of East London Cooperatives (PELC) for a period of nine months.	
	Date of Next meeting – 18 March 2024	

NHS North East London

Primary Care Contracts Sub-Committee – Actions Log

OPEN ACTIONS					
Action ref:	**Date of meeting**	**Action required**	**Lead**	**When**	**Status**
2.0	27/11/23	Locum Reimbursement Policy The Locum Reimbursement paper is to be presented to the Financial Recovery Board for final decision and internal legal advice should be sought.	LH	Mar 2024	Update to be brought back to next meeting. On agenda
4.0	27/11/23	Merger Proposal White House Surgery (B&D) and Castleton Road Surgery (Redbridge) TC to provide the Committee with assurance that the management team will be delivering an effective merger of the White House Surgery and Castleton Road Surgery following final meetings with PCNs.	TC	Dec 2023	West One PCN has agreed the move and Seven Kings are meeting on the 23/01 to agree. Merger target date is 1st April.
5.0	27/11/23	Dental, Optometry and Pharmacy Update JW to liaise with the Designated Nurses for LAC to ensure information on access to services is cascaded through the necessary teams.	JW	Dec 2023	Jeremy has touched base with the designated nurses for LAC. **Action closed**
5.0	29/01/24	Extension of NEL-wide LISs for the PCN Supplementary Care Homes Service and Safeguarding (General Practice Reporting) Meeting to be arranged to explore the Care Home LIS and Safeguarding LIS further and confirm funding streams. Liaise with the Quality Team to support with quality indicators.	AG/AK/ SS AG/DJ	Mar 24 Mar 24	
8.0	29/01/24	Finance report Meeting to be arranged to discuss ARRS and pharmacy recruitment to explore developing a business case to support utilising the funding source. RO and DJ to discuss wound care and improvement on spend.	RO/SS/ BM RO/DJ	Mar 24 Mar 24	
9.0	29/01/24	Risk register Primary care to meet with the Quality team to review risks and level of scoring.	AG/DJ	Mar 24	

NHS
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Primary Care Contracts sub-committee

18 March 2024

Title of report	NEL Special Allocation Scheme ((SAS) (Y06592)) Review of NEL-wide Special Allocation Service and Future Commissioning Intentions
Author	Gohar Choudhury, Head of Primary Care Commissioning
Presented by	Gohar Choudhury, Head of Primary Care Commissioning
Contact for further information	gohar.choudhury@nhs.net
Executive summary	Statutory provisions are set out in GP contract regulations for the immediate removal of violent or aggressive patients. ICBs are required to commission primary medical services to these patients in a secure environment. This service was previously known as the violent patient scheme and is now called the Special Allocation Service (SAS). The North East London Special Allocation Scheme was procured and an APMS contract was awarded to One Health Lewisham (OHL) from 1 February 2020. The contract is now due for review and renewal as the initial five-year term ends on 31 January 2025. NHS England has undertaken a national review of the commissioning and management of Special Allocation Services and published its report in August 2023. The purpose of this report was to support improvements in the commissioning and management of SAS services where appropriate. We have reviewed our commissioning arrangements to ensure that we are compliant with the recommendations of the report. This paper presents an overview of contract performance and commissioning options for SAS. OHL is performing well and providing a good service to this cohort of patients. Our review recommends that the APMS contract is extended for the further period of 5 years under the current terms.
Action / recommendation	The Committee is asked to approve the recommendation of option 2 – extend the contract for a further term of five years till 31 January 2030.
Previous reporting	N/A
Next steps/ onward reporting	When approved, this report will be shared with the local primary care groups for information.
Conflicts of interest	Any conflicts of interest to be managed in line with the Terms of Reference (ToR) of the Committee.

Strategic fit	Which of the ICS aims does this report align with? • To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access • To support broader social and economic development
Impact on local people, health inequalities and sustainability	Extending this contract will ensure continuity of primary medical services in a secure environment for patients that have been removed for violent or aggressive acts from mainstream general practice within North East London in line with national regulations. This service can target the needs of these potentially vulnerable patients, thereby helping to address health inequalities related to socio-economic deprivation. Additionally, it plays a vital role in narrowing the gaps in physical health outcomes among a population characterised by a high incidence of mental illness and other social factors.
Impact on finance, performance and quality	Extending the existing contract will continue to commit £265,035 revenue expenditure per annum from the delegated primary care budget. This is not a new cost pressure and is already accounted for in the budget.
Risks	**Risk** / **Mitigation** **Option 1**: Patient care will be disrupted if the contract is terminated on January 2025. / To go through a procurement process and issue the contract to a new provider. **Option 2:** Patient care will be disrupted if the contract is terminated on January 2025. / The commissioner to extend the contract as the option within the contract for a further five years until 31 January 2030. **Option 3:** The contractor does not wish to extend the contract after its expiry date on 31 January 2025 / To go through a procurement process and issue the contract to a new provider.

1.0 Introduction

Statutory provisions are set out in GP contract regulations for the immediate removal of violent or aggressive patients and all ICBs are required to commission a violent patient scheme known as the Special Allocation Service (SAS) to provide primary medical services in a secure environment to these patients. This SAS allows Commissioners to balance the rights of patients to receive services from GPs with the need to ensure that specified persons, including GPs, their staff, patients and others on the premises, deliver and receive those services without actual or threatened violence or other reasonable fear for their safety.

Under the violent patient regulations, once satisfied that a patient's behaviour warrants removal from the practice list, in order to remove a patient immediately, the practice is required to notify the police and complete an online form via the PCSE website.

After removal, all patients must be allocated to and accepted by the ICB commissioned SAS. Subsequently, all patients allocated to SAS should be regularly reviewed to monitor the ongoing appropriateness of the patients continued registration with the SAS and their rehabilitation. This is with a view to safely returning choice to the patient in timely way and reintegration to mainstream Primary Care.

2.0 Background - Local situation

Historically, there were a range of different SAS services in different boroughs within NEL and across London. In order to ensure the commissioning of consistent, fit for purpose Special Allocation Services in 2019, a procurement for new SAS services took place covering North East, South East and North Central London.

One Heath Lewisham was the successful bidder and provide SAS services to both North East and South East London under separate contractual arrangements. The service went live on 1 February 2020 and was commissioned on a five year basis with provision to extend for a further five years.

3.0 National Review of the Commissioning and management of Special Allocation Services

Over the past year, NHSE has undertaken a national review of the Commissioning and management of Special Allocation Services. This was published in August 2023 (see Appendix 1). The purpose of this report was to support improvements in the commissioning and management of SAS services where appropriate.

We have reviewed our commissioning arrangements to ensure that we are compliant with the recommendations for Integrated Care Boards as commissioners of SAS and our responses are summarised below:

Recommendation	Response
a. Consider how support and resources to SAS providers (current and prospective) could be enhanced or put in place. b. Increasing local support could include a range of options such as: establishing a community of practice, professional support networks and collaborative working, developing specialist training, learning and development opportunities on key items such as: continuous risk assessment, personal safety and clinical training on trauma informed practice, substance misuse, mental health. These interventions may help to support an increase in interest in providers to enter the market	The Clinical Lead for the Special Allocation Scheme, Dr Davies regularly meets with other SAS leads in areas such as East Kent and Nottingham to share ideas, have on-going discussions. He is trying to setup a WhatsApp Group or similar mechanism to share ideas and queries with other providers. One Health Lewisham (OHL) also provide SAS to South East London ICB so this means that issues that arise can then be dealt with together. Dr Davies has indicated that he is more than happy to support practices with training sessions/webinars and discussions about potential referrals to the service. Communications will be going out to practices with details about contacting the

	service if they have any queries around referring and a webinar.
c. All commissioned SAS services should have an Equality and Health Inequality Impact Assessment which considers the challenges and mitigations of significantly increased travel distance where applicable. Possible mitigations include contribution to travel costs, patient transport and/or mobile unit outreach services (safety risks assessments supporting).	An EQIA was undertaken at the time of procuring the service and this has been reviewed and refreshed. OHL arranges transport required for a patient who needs their service but has difficulty in getting to a site.
d. If not already in place, all new patients accepted by the commissioned SAS provider should receive a welcome letter.	OHL send all new patients am introduction and welcome letter with information about the service and contact details.
2. Risk assessments (commissioners should ensure): a. SAS providers initial risks assessment of new patients' needs are inclusive of a) the level of security and safety measures required, b) patients care plan, and c) assessment of rehabilitation needs to enable discharge.	OHL conduct a risk assessment on every new patient and this is shared within the service. OHL use 5 internal parameters to assess a patient and look at the reason to why they have been placed on the scheme. The templates of these assessments are appended to this document.
b. Should be continually updated after each patient encounter.	This is generally done when the encounter is long enough to review a patient.
3. Services (commissioners should ensure) a. All SAS call handling services are updated to support access to digital first offers if not already in place.	OHL offer online consultations and the use of NHS app to SAS patients and has a dedicated website for patients
b. Ensure there are pathways to support equitable access needs when patients are managed by a SAS provider out of area e.g. access to PCN services, diagnostics, maternity, district nursing.	Patients are offered services/pathways as they would be in a main stream practice.
c. There is a comprehensive discharge summary in place and completed at the end after a final risk assessment with the patient. The discharge summary should include information on any outstanding referrals in process, consideration to provision of prescription medication to cover the interval of time prior to re-registering (normally 3-4 weeks supply). A copy of the discharge could be saved in the medical records so	OHL provide a comprehensive discharge summary with all clinical information such as an ongoing treatment, referrals and medication highlighted and a supply of medication to ensure they are covered until they register with another GP Practice. This information is saved in the medical records.

available to the receiving practice.	
4. Protecting staff (commissioners should ensure) a. All SAS providers should have access to or arrange enhanced security if risk assessments identify the need.	There is regular contact with OHL about the service and risk assessments have been done for sites that are used. In addition, the service has a security present at the sites.
b. In circumstances where SAS providers risk assessment identify risk to other staff, appropriate local information sharing with other NHS organisations e.g. OOH, community pharmacy should be enabled.	This forms part of the ongoing risk assessment.

4.0 Commissioning Intentions for One Health Lewisham SAS

The service went live on 1 February 2020 and the current contract end date is 31 January 25 with the option to extend until 31 January 2030. A strategic commissioning review has been undertaken to inform a decision around the future commissioning of this service and this is outlined below.

GP Contract Strategic Commissioning Review (Special Allocation Service) – One Health Lewisham

Place:	**PCN:**
North East London Wide Service	**N/A**
Practice name:	**Practice code:**
Special Allocation Scheme	Y06592
Raw list size:	**Weighted list:**
160 (January 2024)	N/A
Current provider:	
One Health Lewisham	
Contract Start Date:	**Contract End date:**
1 February 2020	31 January 2025
Contract Term Provision for Extension/Break Clause:	
Option to extend contract by a further five years until 31 January 2030	
Reason for contract review:	
Expiry of the initial five-year term at the end of January 2025. The contract requires the provider to be notified of its commissioning intentions nine months prior to the expiry date (31 April 2024)	
Practice website:	
https://www.sasnel.nhs.uk/	
Report Completed by:	
Safdar Raffiq – Senior Primary Care Commissioning Manager	
Summary of Recommendation:	
The initial five-year term of the Special Allocation Scheme contract ends on 31 January 2025. As detailed in section 8.1 the preferred option is in favour of extending the contract for an initial term of five years (31 January 2030). This minimises risk and ensures the seamless continuity of patient services, avoiding any disruptions.	

1.0 Contract Overview / History

1.1 The North East London Special allocation Service (SAS) was awarded to One Health Lewisham in 2019 and the contract started on 1 February 2020.

Historically, there had been no national detailed guidance for the SAS which had led to variances and inconsistencies in the schemes across London as well as nationally. The SAS arrangements previously commissioned in London were considered to be not fit for purpose. It was proposed that new compliant services be procured across London by developing a framework for the former CCGs to standardise the various schemes to ensure that patients that have been removed by a practice due to an incident where there has been a reported incident of violence or threatened violence can then have access to Primary Medical Care Services in a controlled, secure and safe environment. The ultimate aim of such a scheme is to rehabilitate the patient back into "mainstream" primary care.

The London leads proposed to develop, as far as possible, a common approach to contract pricing across the CCGs.

The grounds on which a contractor may request that a person be removed from its list of patients with immediate effect are that due to an act of violence and aggression which can be take the form of physical and non-physical assault. The NHS defines non-physical assault as 'the use of inappropriate words or behaviours causing distress and/or constituting harassment'.

The Special Allocation Service replaced the three formerly separate services across North East London with one NEL-wide service.

i. A specialist GP practice with a list of registered patients who have been removed from their GP Practice due to an encounter that warranted a police crime reference number.

ii. The service has three sites across North East London that patients can access (in Hackney, Waltham Forest and Redbridge)

iii. Patients are able to appeal being placed on the scheme and if applicable can appeal if they stay on longer than 12 months.

iv. The scheme is setup to support patients with their medical needs and to discharge them back into a main stream Primary Care Setting.

1.2 The commissioned service model aspires to deliver a North East London wide service characterised by accessibility, proactivity, holistic care, coordination and integrated care. The service is designed to rehabilitate patients back into a normal GP setting whilst ensuring their medical needs are addressed thereby achieving better health outcomes and addressing the needs of this cohort.

Key elements of the current service model are:

- Provision of primary medical services to the registered practice list

- A clinically lead service that support patients registered at the practice across North East London providing them with access to Primary Care Services, and
- A primary care service to support the rehabilitation of patients back into a GP Setting.

The service headquarters are in Lewisham where all the back-office duties and responsibilities and telephone consultations take place and these premises also host the South East London SAS. There are three satellite services across North East London where NEL patients can be seen for face to face consultations.

2.0 Practice Specific Information

2.1 Patient List

2.1.1 The contract provides primary care service to a list of around 200 patients who have been removed from their GP practice for violent and aggressive behaviours. Whilst it is not possible to provide a comprehensive list of these types of incidents, some examples are below:

- Offensive language, verbal abuse and swearing
- Racist or homophobic comments
- Unwanted or abusive remarks
- Negative, malicious or stereotypical comments
- Invasion of personal space
- Brandishing of objects or weapons
- Near misses i. unsuccessful physical assaults
- Offensive gestures
- Threats or risk of serious injury to staff
- Intimidation
- Stalking
- Alcohol and/or drug substances misuse
- Incitement of others and/or disruptive behaviour
- Unreasonable behaviour and non-cooperation, and
- Any of the above linked to destruction of or damage to property.

2.1.2 The patient list size has remained 200 or below with growth relatively stable over the last three years (see figure 1.0 below). In 2020/21 there was a 14% reduction in the patient list size, attributed to the impact of COVID-19.

Figure 1.0

Date	Raw list size
Feb-24	184
Feb-23	200
Feb-22	195
Feb-21	166
Feb-20	124

2.1.3 The patient list consists largely of a male population, who mainly fall within the 30-44 age group. This is depicted in figure 2.0 below.

Figure 2.0 (August 2023)

Age group	Number
10 to 19	0
20 to 24	7
25 to 29	15
30 to 34	22
35 to 39	25
40 to 44	29
45 to 49	32
50 to 54	23
55 to 59	16
60 to 64	9
65 to 69	4
70 to 74	2
75 to 79	2
80 to 84	0
85 to 89	0
TOTAL	**186**

2.1.4 The service is made up mainly of white British male patients as shown in figures 3 below and 4 below.

Figure 3.0 (August 2023)

Sex	Number
Male	142
Female	44

Figure 4.0 (August 2023)

Ethnicity	Number	Code
British	47	WB
Irish	6	WI
Other	19	WO
Indian	7	AI
Pakistani	9	AP
Bangladeshi	23	AB
Other Asian	7	AO
Chinese	1	OEC
Any Other	6	OEO
White/Black African	0	WBA
White/Black Caribbean	11	WBC
White/Asian	0	WA
Other Background	0	MOB
Caribbean	7	BC
African	20	BA
Other Background	2	BOB
NK or not willing	21	N
TOTAL	**186**	

Figure 5.0 (August 2023)

Area	Number of practices in area	Number of practices referring	Total number of referrals made	% of practices referring
Tower Hamlets	35	23	77	66%
Barking and Dagenham	41	15	41	37%
Redbridge	43	20	46	47%
City and Hackney	40	23	50	58%
Waltham Forest	41	23	46	56%
Newham	48	28	52	58%

Across the areas, we have had 1 practice in Tower Hamlets (Health E1 (Homeless)) refer 14 times, 1 practice in Barking and Dagenham refer 10 times and 23 practices refer between 5 and 8 times. Contacts are being made with practices who have high referrals to see if there is a specific reason for this and if any other routes can be considered. We are also in the process of arranging a webinar to support practices on any queries they may have.

Figure 5.1 and 5.2 (August 2023)

Below are the number of patients who have/had been on the scheme longer than 12 months and for those on the scheme over 36 months, the reasons for these have been provided in Figure 5.2. This information has been taken since the scheme began. Each of the 5 risk categories can be scored 0-3 giving a maximum risk of 15.

The client management (site/clinician/operational security) is stratified according to risk scoring. This gives opportunity to demonstrate a numerical risk reduction on discharge from SAS service.

Figure 5.1

> 12 months	> 24 months	> 36 months
98	39	14

Figure 5.2

Patients on the scheme after 36 months	Risk scores	Reason for still being registered
500128	5	Psychotic, dischargeable
500130	2	Failed discharge, Learning Disability, AIS
500140	2	Vulnerable
500142	8	Unstable MH and PD
500148	6	Alcoholism, indigence, oppositional
500084	2	Vulnerable, MH
500088	9	Safeguarding and acute MH ongoing
500112	7	Severe psychopathy, abuse history, PD
500113	3	High risk history, no contact
500007	8	MH and abuse history, vulnerable, no contact
500009	8	MH, personality disorder, complex, chaotic
500063	2	Cancer diagnosis while on NELSAS
500066	6	Severe paranoia, no contact
500126	5	Homeless, psychotic, itinerant, violent, no contact

2.2 Location

2.2.1 The service has three different sites across North East London that all patients on the scheme are able to attend with an appointment. As well as the below, patients are able to attend the main hub located at Novum Health Centre, Lewisham, if necessary and the provider One Health Lewisham can arrange for transport.

Kenworthy Road Health Centre (1st Floor) - Hackney

10 Kenworthy Rd, London E9 5TD

Mondays 09:00 – 13:00

Loxford Polyclinic - Redbrdige

417 Ilford Lane, Ilford IG1 2SN

Wednesdays 14:00 – 18:00

Forest Road Medical Centre – Waltham Forest

354-358 Forest Rd, Walthamstow, London E17 5JL

Fridays 09:00 – 13:00

2.3 Opening Hours

2.3.1 The practice operates in line with core opening hours, which is Monday – Friday, 8am to 6.30pm (excluding bank holidays and weekends).

2.4 Practice Workforce

2.4.1 The NEL SAS has appropriate GP and nurse availability to its patients during core hours.

2.5 Patient Participation Group (PPG)

2.5.1 Due to the nature of the service, a PPG is not appropriate however the service regularly asks for feedback from its patients to look at ways to improve its service. Summary of patient survey carried out in June 2023 enclosed as Appendix 6.

2.6 Contract Value

2.6.1 The annual contract value of £265,035 is paid as a block sum over 12 months for the delivery of core services.

3 Quality Performance

3.1
Figure 7 below shows all the encounters taken place at the scheme since the start of the contract. As you will see from the face to face encounters, these were low during the national lockdown but have gradually increased when sites were fully reopened.

Figure 7.0

NELSAS Encounters					
Month	Telephone	Face to Face	SMS/Email	H/Vis	V/Call
Feb-20	16	6	1		
Mar-20	33	5	3		
Apr-20	38	0	9		
May-20	43	1	11		
Jun-20	45	1	21		
Jul-20	50	6	18		
Aug-20	39	1	7		
Sep-20	49	6	10		
Oct-20	64	7	12	1	
Nov-20	54	0	4		
Dec-20	46	2	8		
Jan-21	46	2	4		
Feb-21	62	6	8		
Mar-21	64	4	17		
Apr-21	69	3	9		1
May-21	50	8	7	2	1
Jun-21	71	3	7		
Jul-21	55	0	11		
Aug-21	47	1	8		
Sep-21	59	2	25		
Oct-21	56	12	53		1
Nov-21	30	15	20		1
Dec-21	34	11	15		
Jan-22	30	13	17		
Feb-22	29	14	16		
Mar-22	48	16	12		
Apr-22	52	15	36		
May-22	35	17	8		
Jun-22	49	12	19		
Jul-22	61	19	5		
Aug-22	60	15	81		1
Sep-22	58	15	20		1
Oct-22	48	18	29		
Nov-22	64	13	27	1	
Dec-22	63	11	19		
Jan-23	51	14	13	3	
Feb-23	44	13	20	1	
Mar-23	68	14	42	1	
Apr-23	67	13	24		
May-23	64	18	13		
Jun-23	70	15	46	1	

4 Service Delivery Review

4.1 Service Delivery Aims

4.1.1 The aims of the service are to rehabilitate patients who have been placed on the Special Allocation Scheme back into mainstream primary care.

4.2 Appeals

4.2.1 Patients who have been placed on the scheme have the opportunity to appeal through the appeals process. Patients who remain on the scheme also have the opportunity to appeal if they have been on it for a minimum of 12 months and must have undergone at least 2 reviews. Where the provider's clinical lead thinks it appropriate to consider discharge before the minimum 12 months has elapsed, at least 3 reviews must have carried out in the previous 6 months.

Figure 8 below shows the number of appeals that have taken place since the service began. Patients who appealed and were out of area (i.e. they appealed to NEL when it should have been another area team) were informed of this.

	February 2020 - October 23
Appeal Upheld	9
Appeal Not Upheld	19
No further Action	19
Out of Area Patient	3
Pending	3
Total Appeals since contract started	**53**

5 Contract & Regulatory Compliance

5.1 CQC visited OHL as a provider in June and July 2023. The CQC report published in November 2023 refers to all services provided by OHL. Although the report recommendation was that the service Requires Improvement, there was very little referring to NEL SAS.

5.2 Downham Health & Leisure Centre - Care Quality Commission (cqc.org.uk)

5.3 The table below provides the final inspection report.

5.4 One Health Lewisham (OHL) have produced an action plan and submitted to the CQC and commissioners, which is appended to this report. It is worth noting the following:

i. The report applies to services provided by OHL in SEL and not just the SAS scheme
ii. The report is for services provided in the main to SEL SAS
iii. OHL informed NEL ICB of the outcome
iv. At the time of this report, South East London ICB have not yet met directly with the provider and there are no immediate plans for any contractual sanctions. We have reviewed the CQC report and OHL action plan with its relevance to NEL SAS.

The main areas that linked to the SAS that needed improvements were:

- Carry out an annual appraisal for all staff
- Train all staff who act as chaperones.
- Continue to ensure policies and procedures are followed, for example the appraisal policy

We will work closely with our SEL ICB colleagues to address anything further.
OHL have confirmed they have addressed these issues in the action plan and we will ensure this is an ongoing item in the contractual review meetings.

6.0 Commissioning Options

6.1 There are three options to consider for the future of this contract:

Option 1: Serve termination notice for the contract to end on 31 January 2025

The contract requires the contractor to be provided with nine-month notice of the contract expiry date (31 April 2024) - 31 January 2025. It is a statutory requirement for ICBs to commission a SAS, so dispersal of patients would not be an option. This option would involve going through a procurement process to secure a new provider.

Option 2: Extend the contract for five years (31 January 2030)

The contract provides for a five-year extension. This would provide continuity of services for the practice population. The Provider will need to be informed by 31 April 2024.

Option 3: Provider does not wish to extend the contract

This would mean a procurement process would need to be conducted, however the provider had indicated they would like to continue.

7.0 Risks

Risk	Mitigation
Option 1: Patient care will be disrupted if the contract is terminated on January 2025.	To go through a procurement process and issue the contract to a new provider.
Option 2: Patient care will be disrupted if the contract is terminated on January 2025.	The commissioner to extend the contract as the option within the contract for a further five years until 31 January 2030.
Option 3: The contractor does not wish to extend the contract after its expiry date on 31 January 2025	To go through a procurement process and issue the contract to a new provider.

8.0 Preferred Option

8.1 The preferred option would be to extend the contract for 5 years.

9.0 Next steps

- Inform service provider of contract extension by 31 April 2024.

10.0 Appendices (upon request to nelondonicb.corporate@nhs.net)

- Appendix 1 – Review of the commissioning and Management of Special Allocation Scheme
- Appendix 2 – SAS Initial Risk Assessment Template
- Appendix 3 – SAS Risk assessment Policy
- Appendix 4 – CQC plan
- Appendix 5 – Equality Impact Screening Tool
- Appendix 6 – Patient Survey Summary June 2023

NHS
North East London

Primary Care Contracts sub-committee

18 March 2024

Title of report	**Dental, Optometry & Pharmacy Update**
Author	Jeremy Wallman, Head of Primary Care Commissioning, Dentistry, Optometry and Pharmacy
Presented by	Jeremy Wallman, Head of Primary Care Commissioning, Dentistry, Optometry and Pharmacy
Contact for further information	jeremy.wallman@nhs.net
Executive summary	The report contains an update on performance of dental, optometry and pharmacy contracts as at month 11.
Action / recommendation	The primary care contracts sub-committee is asked to note the contents of the report.
Previous reporting	Commissioning Oversight Group (COG)
Next steps/ onward reporting	FPIC
Conflicts of interest	None
Strategic fit	To enhance productivity and value for money
Impact on local people, health inequalities and sustainability	To improve and stabilise the oral health of patients treated.
Impact on finance, performance and quality	As detailed in the report
Risks	Ongoing risks, identified in the report. Under delivery of Primary Care contracts previously referenced

Jeremy Wallman
Head of Primary Care Commissioning, Dentistry, Optometry and Pharmacy

6 March 2024

Primary, Secondary, Community and Specialist Dentistry NEL ICB Update 2023/24 Q3/M11

As London North West University Hospital, Guy's & St Thomas' and King's College all move to new software an exemption of PTL submissions has been granted. It is hoped that from April onwards figures will be reliable enough to submit. The absence of the two largest dental contracts and the fifth largest dental contract should be taken into consideration when viewing figures provided below. While the move to new software will have caused a reduction in productivity, GSTT and KCH were in a safe position to tolerate this.

There is little improvement to waiting times over the previous three months due to industrial action. Whilst undesirable, this is replicated at a national leave and in other medical specialties. The north south divide remains with NEL footprint disproportionately affected.

Due to the retention of medically simple paediatric patients by Community Dental Services (CDS) the mix of patients has altered for secondary care providers. Our neurodiverse paediatric patients often take longer to treat than neurotypical patients, meaning that productivity as defined by patient numbers will appear to reduce. Where six patients may have been seen per list previously, this number may have halved due to the complex needs of the patient and delays to treatment which have increased acuity. It must be remembered that when contracted activity is monitored a reduction in patient numbers does not necessarily equate to a reduction in clinical time and associated overheads. Chelsea and Westminster, UCLH and Barts have all reported this trend. A workstream for the five largest dental providers will begin shortly to review this trend, All findings and recommendations will be reported to the ICBs.

Primary Care

Primary Care performance at M11 is broadly in line with that recorded at M10, however it is likely that there will be an increase in delivery during March as contractor's close treatments down in time for them to be counted towards their 2023/24 contract delivery requirement. The forecast outturn in NEL of 90% will result in a potential 'claw-back', in respect of underperformance, of £9.7m. Any overperformance payment paid to dental contracts will result in the 'claw-back' being reduced. All under/over performance payments will be reconciled during the period June – September 2024 with the resultant clawback being deducted from contracts between October 2024 – March 2025. Overperformance payments will be paid as a 'one-off' transaction in October 2024.

YTD - LondonWide UDA Performance Summary

ICB Name	UDA Percentage	UDA Percentage	Expected UDA contract delivery FOT-M9	Overall (Over/Under) Expected Performance FOT-M9	Expected UDA contract delivery FOT-M10	Overall (Over/Under) Expected Performance FOT-M10	Expected UDA contract delivery FOT-M11	Overall (Over/Under) Expected Performance FOT-M11	FOT-UDA Projection with Working days - Central Team M8	FOT-UDA Projection with Working days - Central Team M9	FOT-UDA Projection with Working days - Central Team M10
	M11	M12	%	£'000	%	£'000	M11 %	'M11 £'000	%	%	%
North Central London ICB	85.8%		85%	(9,868)	87%	(8,711)	87%	(8,769)	96%	96%	95%
North East London ICB	88.7%		89%	(11,257)	90%	(9,727)	90%	(9,732)	98%	98%	98%
North West London ICB	88.2%		88%	(13,839)	89%	(12,344)	90%	(12,165)	98%	98%	98%
South East London ICB	86.4%		88%	(12,290)	89%	(11,197)	89%	(11,300)	94%	94%	94%
South West London ICB	87.4%		88%	(6,875)	89%	(6,055)	89%	(6,023)	97%	96%	97%
London Wide	**87.3%**	**0.0%**	**88%**	**(54,130)**	**89%**	**(48,036)**	**89%**	**(47,989)**	**97%**	**96%**	**96%**

Secondary Care

Generally, a satisfactory recovery for secondary dental care, however there is a clear north south divide in regards to patients waiting over 52 weeks. 1,583 patients waiting over 52 weeks in north London and 168 waiting over 52 weeks in south London. The recovery of dental specialties is restricted by reasons mentioned above. Paediatrics and maxillofacial are particularly affected by this and the current position for maxillofacial in particular may deteriorate as a result of strike action.

Barts is an outlier and in a very challenging position for all specialties, clarification is provided in the provider level information below.

Continued concern that there may be an increase in the number of patients from surrounding regions being referred into London. London has always been a net importer of patients but due to workforce issues there will be challenges in regions that may be less desirable to work in.

We are currently moving some Level 2 Oral Surgery (usually delivered in primary care) into Barts for undergraduates which will not affect activity levels on the acute contract. Once waiting lists in the Level 2 Oral Surgery service have been cleared, the transfer of patients will cease. As we move forward patients will be sourced from primary care practices rather than Level 2 Oral Surgery providers.

Barts Health

Unfortunately there is no sustained reduction in patients waiting over 65 weeks and this is unlikely to improve in the near future. The Trust is particularly affected by workforce shortages, the impact of industrial action and lack of access to theatres. There are currently over 30 dental nurses on sick leave.

- **Oral Surgery**, 339 patients waiting over 65 weeks of which 60% have an appointment booked, however, this is subject to change due to long term sickness within the department. 25 PAs are currently lost to long-term sickness and 10 PAs remain vacant. The 35 undelivered PAs are between maxillofacial and oral surgery clinicians. Oral surgery is a very challenging specialty at a national level and the position at Barts is likely to worsen. GSTT is providing mutual aid for the longest waiters.
- **Restorative**, 16 patients over 65 weeks the majority of which are special care and therefore more complex. Of the 16, all have an appointment booked. Some patients in the 52-64 week window will have treatment plans in place but dates have not yet been issued.
- **Paediatric**, 62 patients waiting over 65 weeks of which 73% have an appointment booked. There is one complex patient that has been waiting for 106 weeks. The Trust has focussed on non-admitted paediatric patients while a consultant is on maternity leave. Once the consultant returns the focus will shift to admitted patients.
- **Orthodontic**, 20 patients over 65 weeks of which 50% have an appointment booked. Workforce continues to be highly challenging with the two new orthodontic trainees on maternity leave.
- **Dental Medicine**, five patients waiting over 65 weeks all of which have an appointment booked. All five patients have Bechet's disease for which Barts is a centre. The only clinical consultant is now on maternity leave. Academics have been asked to deliver clinical time and mutual aid is being investigated but does not look promising.
- **Maxillofacial**, five patients over 65 weeks of which three have appointments booked. Some maxillofacial patients will be sitting under the oral surgery PTL. There is a patient at 104 weeks who requires bespoke prosthesis, arranging surgery is problematic. This specialty is affected by the workforce pressures mentioned under oral surgery.

Barts Health							
Specialty	Admitted / Non-admitted	October		November		December	
		52-64 weeks	65 weeks and over	52-64 weeks	65 weeks and over	52-64 weeks	65 weeks and over
Oral Surgery	Admitted	79	77	98	75	89	91
	Non-admitted	382	215	439	206	445	248
Restorative	Admitted	7	10	10	5	11	4
	Non-admitted	25	16	28	7	30	12
Paediatric	Admitted	36	67	65	50	76	49
	Non-admitted	80	35	41	29	29	13
Orthodontic	Admitted	23	14	25	16	20	17
	Non-admitted	86	5	74	6	37	3
Dental Medicine	Admitted	0	0	0	0	0	0
	Non-admitted	10	7	3	6	2	5
Maxillofacial	Admitted	8	3	9	3	9	5
	Non-admitted	1	0	2	1	2	0
Total		737	449	794	404	750	447

Barking, Havering & Redbridge University Trust

Three patients waiting over 65 weeks.

- **Orthodontic**, no patients over 52 weeks, BHRUT is receiving an increasing number of referrals from outside London. Where possible referrals are rejected due to low complexity but those meeting criteria have to be accepted. There is limited provision for orthodontics in surrounding regions.
- **Maxillofacial**, four patients waiting over 65 weeks of which only one has an appointment booked. Theatre lists regularly cancelled for higher priority / profile cases.

Barking, Havering & Redbridge University Trust							
Specialty	Admitted / Non-admitted	October		November		December	
		52-64 weeks	65 weeks and over	52-64 weeks	65 weeks and over	52-64 weeks	65 weeks and over
Orthodontic	Admitted	1	0	1	0	0	0
	Non-admitted	0	0	0	0	0	0
Maxillofacial	Admitted	54	4	55	1	53	2
	Non-admitted	17	2	22	1	28	2
Total		72	6	78	2	81	4

Homerton University Hospital

Two patients waiting over 65 weeks. Trust is concerned that they will have to assist Barts with its backlog and inherit the longest waiters which will be detrimental to their PTL position.

- **Maxillofacial**, one patient waiting over 65 weeks with an appointment booked. Trust face challenges with increasing referral numbers and the inability to match the overtime payments made by competing trusts.
- **Paediatric Maxillofacial**, zero patients over 65 weeks.

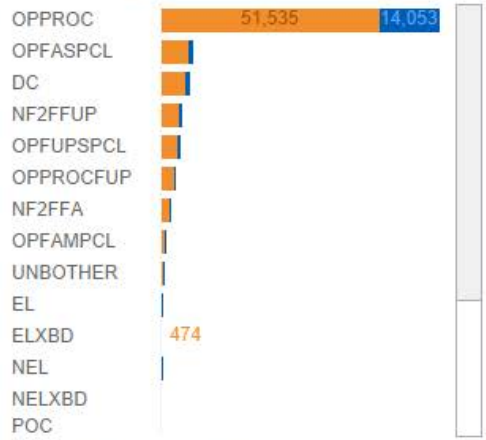
Homerton							
Specialty	Admitted / Non-admitted	October		November		December	
		52-64 weeks	65 weeks and over	52-64 weeks	65 weeks and over	52-64 weeks	65 weeks and over
Maxillofacial	Admitted	2	0	3	1	3	1
	Non-admitted	1	0	1	0	1	0
Paediatric Maxillofacial	Admitted	1	0	0	0	0	0
	Non-admitted	0	0	0	0	0	0
Total		4	0	4	1	4	1

ICB Secondary Dental Patient Flows - Provider Landing

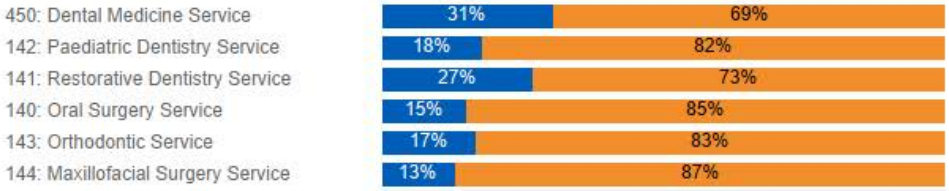
The map below displays Activity levels for NHS North East London Integrated Care Board providers, where patients accessing services within the ICB but are registered to a GP Practice outside of the ICB.

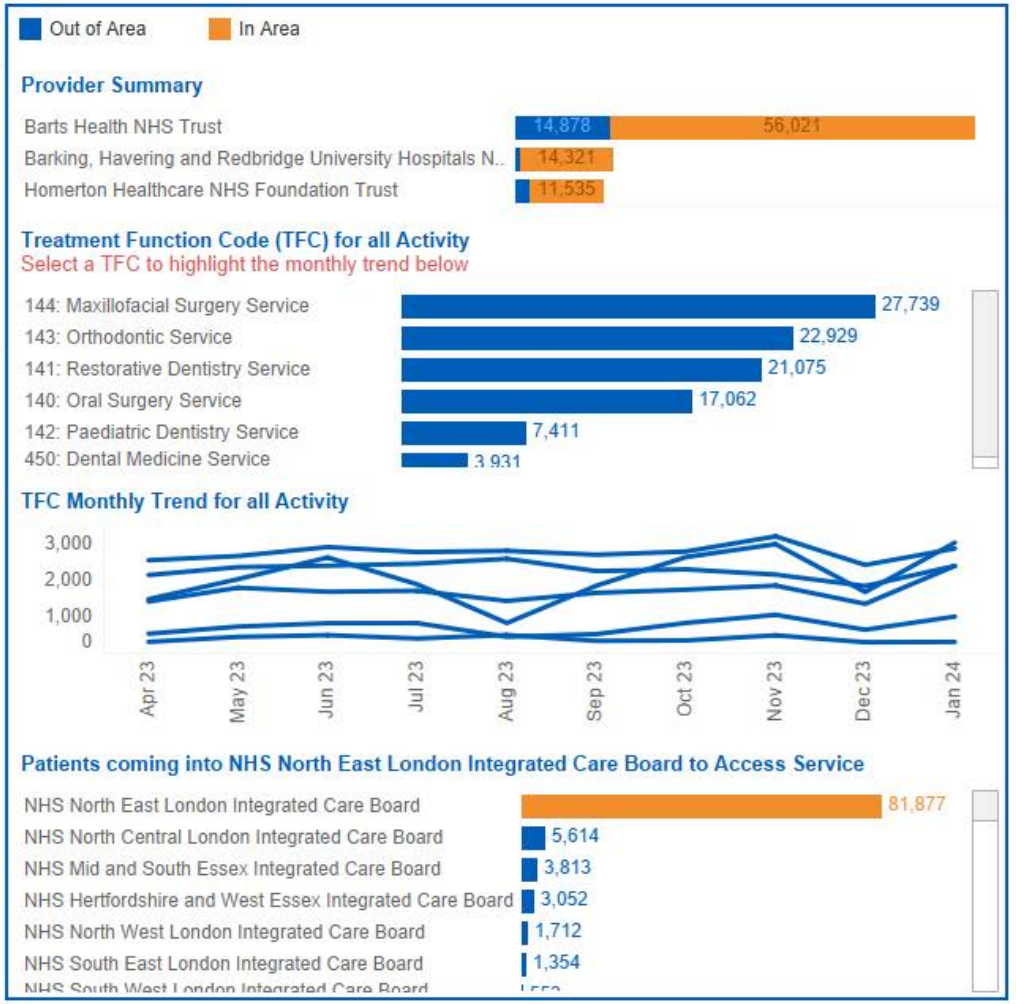
Total Provider flow for NHS North East London Integrated Care Board: All

Attendance Type Summary



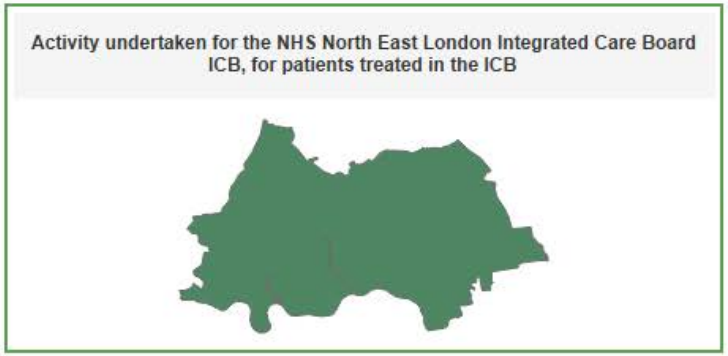
Percentage of activity undertaken for in area patients vs out of area patients

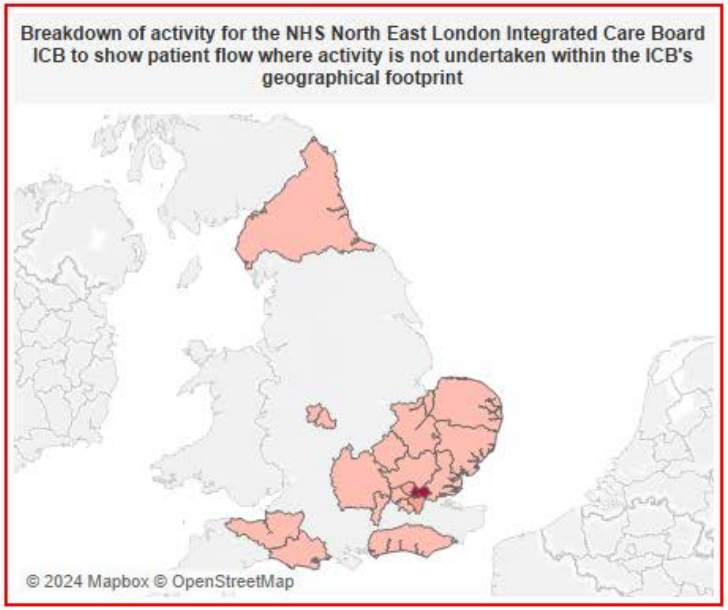




- 56,021 NEL patient attendances at Barts, 14,321 NEL patient attendances at BHRUT, 11,535 NEL patient attendances at Homerton, 81,877 in total
- 5,614 attendances for NCL patients
- 3,813 attendances for Mid and South Essex patients
- 3,052 attendances for Hertfordshire and West Essex
- Total of 18,270 attendances for patients outside NEL ICB

ICB Secondary Dental Patient Flows - ICB of Patient





In Area | Out of Area

Total Number of Activity undertaken by NHS North East London Integrated Care Board	Total Activity within the NHS North East London Integrated Care Board	Total Activity for patients from the NHS North East London Integrated Care Board, treated in other ICB's
104,722	81,877	22,845

Percentage of activity within the NHS North East London Integrated Care Board

78% | 22%

Breakdown of total activity for patients from the NHS North East London Integrated Care Board, treated in other ICB's

NHS North East London Integrated Care Board	81,877
NHS South East London Integrated Care Board	13,898
NHS North Central London Integrated Care Board	8,114
NHS Mid and South Essex Integrated Care Board	429
NHS North West London Integrated Care Board	119
NHS Sussex Integrated Care Board	110
NHS South West London Integrated Care Board	75
NHS Birmingham and Solihull Integrated Care Board	25

Provider Summary for all NHS North East London Integrated Care Board Activity

Barts Health NHS Trust	56,021
Barking, Havering and Redbridge University Hospitals NHS..	14,321
Guy's and St Thomas' NHS Foundation Trust	12,564
Homerton Healthcare NHS Foundation Trust	11,535
University College London Hospitals NHS Foundation Trust	7,607
King's College Hospital NHS Foundation Trust	1,334
Mid and South Essex NHS Foundation Trust	429

- 104,722 attendances for NEL patients
- 81,877 of which delivered in ICB
- 22,845 delivered in alternative ICBs
- 12,564 attendances delivered by GSTT, 7,607 attendances delivered by UCLH, etc
- 639 attendences provided by ICBs outside London Region

Community Dental Services

- CDS serves the following patient groups, paediatric, special care, elderly and homeless and provides oral health promotion (OHP) on behalf of the local authorities that commission it.
- Number of referrals increasing, particularly paediatric.
- **Paediatrics**, increase in oral decay due to poor diet and reduced supervised brushing. To combat the increase in referrals and prevent onwards referrals to secondary care oral health promotion is a focus for local authorities and the DOP team is liaising with them and CDS providers.
- **Special care**, Public Health working on a needs assessment to review the demands of this patient cohort
- **Elderly**, care and nursing home residents' oral health needs have evolved since the creation of domiciliary services which are no longer the most suitable method of treatment. National review of domiciliary due to start shortly with a local review already underway. Demand driven by deteriorating oral health in population though lack of nursing staff and therefore brushing of residents' teeth.
- **Rough sleeping homeless** numbers have increased and the location of rough sleepers has changed since the procurement of CDS. DOP team is working with local authorities and advocates to review need and service provision. Pilots proposed for Bromley, Haringey and Barnet

DGAS

Dental GA Suites (DGAS) is the Project Tooth Fairy legacy to utilise one of the three GA procedure rooms at The Royal London.

NEL, NCL, NWL and SEL ICBs have committed funding for two days, one day, one day and one day per week respectively.

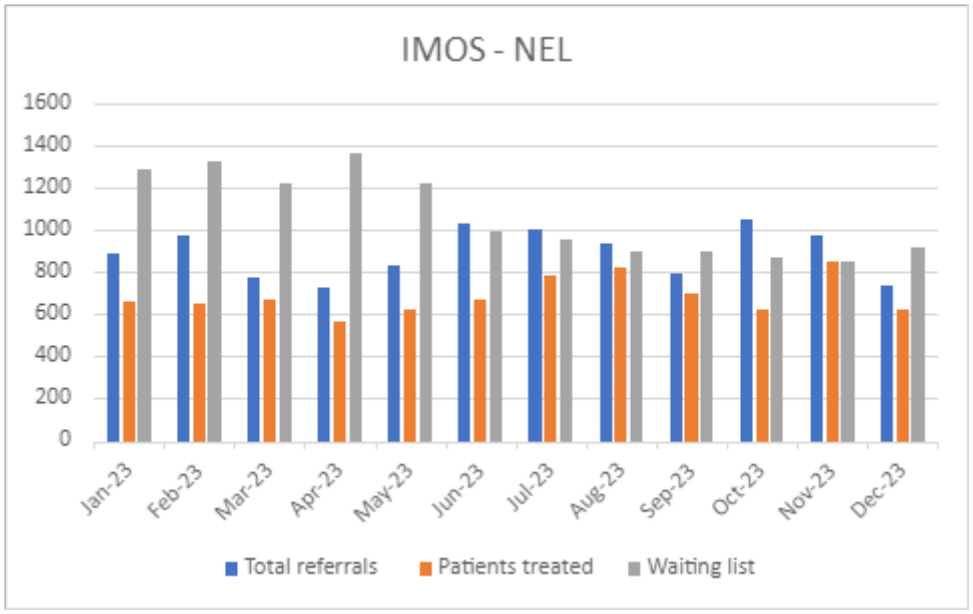
CFDP

Child Friendly Dental Practices (CFDP) is a pilot set up by Eastman Dental Hospitals (NCL) in conjunction with London Dental Commissioners to improve the oral health of children in London. The pilot targets children that have been referred to Community Dental Services for treatment for dental decay. These children could be treated in high street practices where the clinicians have been given the appropriate resources. Ten practices in north west London have been provided with clinical equipment, training and regular support sessions to enable them to deliver the prescribed treatment. In addition to reducing pressure on the Community Dental Service by moving the patient to a different setting, this innovative pathway also reduces the time the patient waits for treatment and the costs incurred by the NHS.

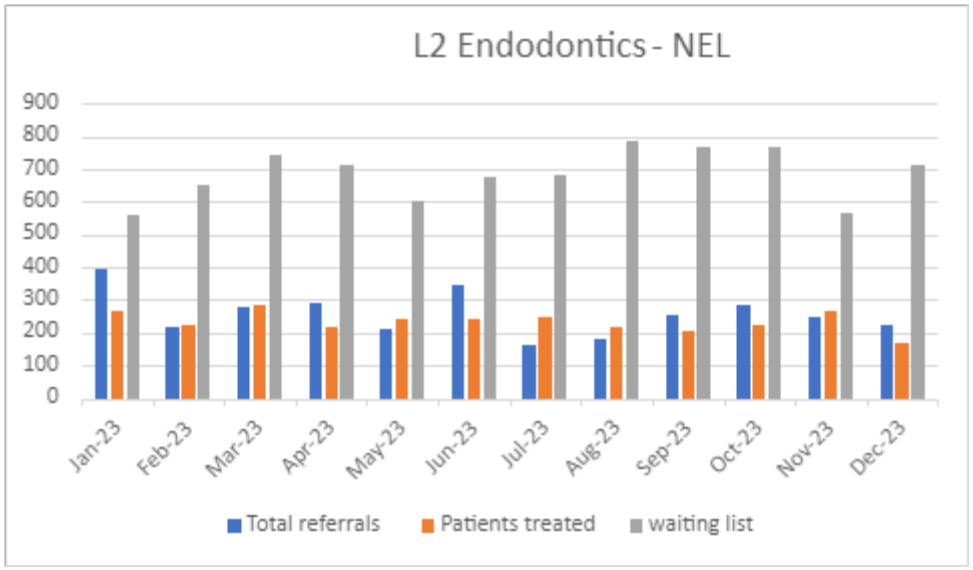
The pilot has closed and a report on the findings is being complied. In its current format, CFDP is not suitable for roll out but the learning will inform decisions on future commissioning for children.

Intermediate Oral Surgery Services and Level 2 Complexity Endodontics

- Increase in demand for both services and workforce and funding is restricitng capacity.
- To increase workforce we are working with Managed Clinical Networks, Local Accreditation Panels and the Office of the Chief Dental Officer to create accreditation of performers with conditions. These condituions would mean an applicant who is not quite suitable for full accreditation would be supervised when in parctice until they are deemed competant to work in isolation. This is an innovative pathway being created by London to address waiting times.
- Transfer of IMOS patients to Barts undergarduates starts in August.
- IMOS consistently receiving higher volume of referrals than system capacity.
- L2 Endo showing trend to higher volume of referrals than system capacity.



Current waiting list for NEL ICB IMOS providers 920. Similar to previous quarter and an acceptable number.



Current waiting list for NEL ICB L2 Endo providers 711. Waiting list is too high and generating considerable waiting times.

Briefing Paper to NEL ICB EMT – Dental Recovery Plan

1. Introduction

The Governments Dental Recovery plan; Faster, simpler and fairer: our plan to recover and reform NHS dentistry, was published on 7th February 2024 and the key strategic commitments made in the plan are:

a) In 2024, 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. Introduction of mobile dental vans to take dentists and surgeries to isolated under-served communities.
b) 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. The introduction of dental outreach to primary schools in under-served areas in addition to taking forward a consultation on expanding fluoridation of water to the north-east of England - a highly effective public health measure.
c) 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 committed to in the NHS Long Term Workforce Plan, reducing bureaucracy and setting the trajectory for longer-term reforms of the NHS dental contract.

2. Summary of Key NHS Commissioning Commitments

The significant NHS aspects of the plan in respect of dental commissioning are:

a) Increase in the minimum UDA value to £28.00.
b) Introduction of a new patient premium for 2024/25. This will pay an additional £50 for a new patient receiving a band 2 or 3, and an extra £15 for a new patient receiving a Band 1 in addition to the funding the practice would already receive.
c) Roll out of dental vans in certain underserved ICBs. This is focused on isolated rural and coastal communities *NOT APPLICABLE IN LONDON*
d) Introduction of a 'golden hello' scheme (£20k per dentists, split over 3 years, available for posts agreed by regions / ICBs to be priorities for access) to encourage dentists into under-served areas and supporting those practices with the lowest rates of payment for their work. *NOT APPLICABLE IN LONDON

The plan commits to bringing forward proposals for reform, however there is no specific detail around this, as they are subject to further work up and will require consultation.

3. ICB Specific Actions

a) Introduction of a minimum indicative £28 UDA value

The process for implementing the minimum indicative £28 UDA value can be achieved by either:

- A reduction to the number of a contractor's commissioned UDAs; or
- An increase to a contractors Negotiated Annual Contract Value (NACV).

Work has been undertaken to review the data held and identify affected contracts within NEL. These are detailed in table below:

Provider Name	2023-24 Total Contract Value	UDA Performance Target	Current Cost per UDA	2023-24 UDA Delivered - Financial Year To Date:	Year end activity projections	Projected UDA Over/Under (-) Performance	Projected Overage/Clawback Value	Option 1: New Annual Contracted Activity if UDAs reduced to achieve £28 per UDA	Option 2: Revised Contract Value based on existing contracted UDAs if uplifted to £28	2023-24 additional in year cost of UDA uplift in March 2024	Full Year Effect of UDA Uplift 2024-25 excluding DDRB uplift
Nilesh Patel	£481,860.00	18,000	£26.77	15,709.6	19,394.5	1,394.5	39,045.7	17,209	£504,000	£22,140	£504,000
St Johns Dental Practice Limited	£246,442.54	8,847	£27.86	6,377.4	7,873.3	-973.7	-27,263.6	8,801	£247,716	£1,273	£247,716
Mohsin Ali	£394,763.74	15,101	£26.14	11,867.2	14,650.8	-450.2	-12,605.5	14,098	£422,828	£28,064	£422,828
Denise Walters-Payne	£48,170.71	1,900	£25.35	968.6	1,195.8	-704.2	-19,717.7	1,720	£53,200	£5,029	£53,200
MRS A BROGAN	£399,572.64	15,436	£25.89	11,003.0	13,583.9	-1,852.1	-51,858.9	14,270	£432,208	£32,635	£432,208
Wanstead Village Dental & Health Centre	£601,674.72	22,644	£26.57	17,760.0	21,925.8	-718.2	-20,108.6	21,488	£634,032	£32,357	£634,032
Total	**£2,172,484.35**	**81,928**	**£158.58**	**63,685.8**	**78,624.1**	**-3,303.9**	**-92,508.5**	**77,586.0**	**£2,293,984**	**£121,500**	**£2,293,984**

The table includes the revised activity figures, the cost of continuing to contract at the same level of activity and details of projected 2023/24 performance to help ICBs determine whether they wish to reduce the number of commissioned UDAs or increase the contractors contract value.

The DOP Commissioning Hub, on behalf of the ICB, will undertake the following tasks:

- Validating and making decisions on eligible contracts
- Management and administration of the contract variation process
- Provide details of changes relating to commissioned UDAs or to the Contract Values to the NHS BSA

Decision making process for eligible contracts

The DOP hub has confirmed that the contracts identified are eligible to receive a change to their commissioned UDAs or their contract value due to an indicative UDA value of below £28.

Following a review of these contracts, the default position is that they will be subject to an adjustment to their Contract Value and receive an additional in-year uplift to increase their UDA value to £28. The consensus across the London ICBs is that a reduction in contracted UDAs to achieve the minimum UDA value of £28 will simply result in less commissioned activity and a reduction in access for patients.

Process for agreeing and documenting the change

The deadline for determining the relevant change to a contract is 01/03/2024. This has been actioned and discussed with the relevant contractors, the outcome of those discussions and agreement will form the basis of contract variation notice, following receipt of said document from the NHSE National Team.

To ensure good governance the DOP hub is keeping a log of each variation to assure NHS England that all agreements are in place and properly recorded before 31st March 2024.

Changes to commissioned UDAs or to the Contract Value on Compass

The DOP hub will ensure that the contractor has signed the contract variation by 08/03/2024 and that the contract variation has been countersigned and returned to the contactor by 15/03/2024.

The DOP hub will make the necessary changes needed on Compass by 15/03/2024 and ensure these have been implemented by 22nd March 2024 to ensure all arrangements are finalised before 31st March 2024.

A flow chart providing details and timescales for each step in the process is attached as Appendix 1.

b) New Patient Premium

As part of the NHS and government's dental recovery plan, it is introducing a new patient premium scheme starting on 1st March 2024 to run for 13 months until 31st March 2025. Participating practices will receive a nominal credit of UDAs equivalent to:

- £15 for each eligible new patient requiring only band 1 care,
- £50 for each eligible new patient requiring a band 2 or 3 treatment

This will be in addition to the UDAs a practice would already be deemed to have delivered for this care. In practice this means the new patient premium value for seeing a new patient would be translated into the equivalent UDA rate for each contractor.

For example, in a case where a band 2 or 3 treatment has been completed (£50 new patient premium):

- Where a contractor has a UDA rate of £30, they will receive a 1.67 UDA credit, and
- Where their UDA rate is £40, they will receive a 1.25 UDA credit.

Patient eligibility

The two-year patient eligibility period is defined as the time between the completion date for the patient's most recent course of treatment, and the acceptance date for the patient's current course of treatment.

For the purposes of this scheme, the definition of a 'new patient' is anyone who has:

1. Not received a Band 1, 2, or 3 course of treatment (excluding urgent care) from that Provider (e.g. the individual or business entity who holds the contract) in the previous 24 months, and
2. Not received a Band 1, 2, or 3 course of treatment (excluding urgent care) from that contract in the previous 24 months, and
3. Not received a Band 1, 2, or 3 course of treatment (excluding urgent care) from that clinician (a dentist or dental care professional) in the previous 24 months (this may be on contracts for different providers).

This is to ensure that all new patients have a fair chance of accessing the system. This criterion is based on the data held by NHS BSA. If a patient does not fit into this criterion a new patient incentive payment will not be made.

Contractor eligibility for credits under the New Patient Premium Scheme

- A contractor's participation in the new patient premium scheme is voluntary.
- This scheme is only for contractors providing mandatory services
- The contractor is only eligible to receive credits where such payments do not exceed the contractor's Negotiated Annual Contract Value or the total contracted units of dental activity.

Contractors who are ineligible for credits under the New Patient Premium Scheme

- A contract providing advanced mandatory services.
- A contract for a referral service where all patients will be 'new'.
- A contractor participating in a local scheme that incentivises seeing new patients.

National vs local schemes

Contractors providing mandatory services are legally entitled to participate in the national new patient premium scheme. However, these contractors cannot also participate in similar local schemes that incentivise seeing new patients, as this could result in the unacceptable situation where contractors are paid twice for the same initiative. If contractors opt to participate in a local scheme, as opposed to the national new patient premium scheme, contractors will be deemed to be opting themselves out of the national new patient premium scheme. In that scenario, commissioners must manually opt the contractor out of the national new patient premium scheme to prevent double payments from happening.

Checkbox on the contract details page in Compass

For the financial year 23/24, the Compass system has been programmed to allow a checkbox on the contract details page that will allow commissioners to exclude practices from the scheme. This page will go live on Compass on 27th February 2024. Please ensure that practices who are not eligible for the scheme are excluded on the system by midnight on 29th February 2024.

For the financial year 24/25, practices excluded from the scheme in 23/24 will have to be reviewed, and the checkbox updated, particularly where the practice may choose to participate in a new local scheme incentivising new patients or remove itself from an existing local scheme. (NHS BSA will provide guidance in due course on how to do this).

Credit for contractors

The start date for the scheme is 1st March 2024.

- Any treatment started in March 2024 and completed by 31st March 2024 will count towards the financial year 23/24.
- Any treatment started from 1st March 2024 and completed after 31st March 2024 will count towards the financial year 24/25 as long as that treatment is completed in that financial year 2024/25.
- The end date for the scheme will be 31st March 2025, Treatments of eligible patients not completed by 31st March 2025 will not be eligible for a new patient premium credit.
- Credits will be triggered by:
  - A New Patient credit will be made upon submission of an FP17 indicating that treatment has been completed, once patient eligibility has been confirmed by the data held by the BSA.

- If a patient fails to return for treatment, an incomplete treatment claim can be made. A New Patient credit would be made where activity relating to a Band 1, 2 or 3 treatment has taken place.

Reporting

Commissioners will receive a monthly report from NHS BSA containing data on:

• Number of UDAs on banded treatments (by contract).
• Number of eligible new patients seen (by contract).
• Number of UDAs resulting from the new patient premium (by contract).

Next steps for Commissioners (to be undertaken by the DOP Commissioning Hub on behalf of the London ICBs)

Commissioners will be required to:

1. [From 15/02/24] Communicate with contractors informing them about the scheme. Practices who have queries about their eligibility should raise these issues by 23/02/24.

2. [To be done between 27/02/24 and midnight 29/02/24 latest] Exclude practices from the scheme by completing the checkbox on the contract details page in Compass.
a. Contractors who are ineligible.
b. Contractors who have opted out.
c. Contractors who have opted to participate in a local scheme that incentivises seeing new patients.

3. Monitor practice behaviours and ensure that Negotiated Annual Contract Value or the total contracted units of dental activity is not exceeded.

4. Reassess practice eligibility as needed for financial year 2024/25 and update the checkbox on Compass. (NHS BSA will provide guidance on how to do this)

4. Finance

National sent Regions details of draft POD allocations on 9th February, and have included the dental 'ringfence' as part of this. Expenditure on the dental recovery plan will count as expenditure towards the 'dental ringfence' and this is reflected in the 'dental ringfence' allocations for 24/25.

The New Patient Premium is scheduled to launch on 1 March 2024, and so ICBs should expect additional expenditure that is not currently in their forecasts for this in 2023/24. National are adjusting allocations for the final month of 23/24; the North East London ICB allocation is £295k

Details of how payments will feature in dental reporting from the BSA are expected shortly

5. Recommendation

EMT is asked to acknowledge the detail of the dental recovery plan and endorse the work plan associated with its implementation across the ICB.

EMT is asked to acknowledge the volume of work undertaken by the DOP Commissioning Hub to implement the Dental Recovery Plan in extremely challenging timescales

Appendix 1

Flow chart process for adjusting commissioned UDAs or NACV, to reflect the minimum indicative UDA value to £28 from 1st April 2024

Action	Deadline (by when)
ICB review NHSBSA data to confirm contracts affected	23/02/2024
ICB to determine whether to reduce activity or invest more money in contract ie. by reviewing historic year end performance, local needs assessments and other local considerations. Records of decisions made must be kept to ensure consistency, fairness, and transparency	23/02/2024
ICB to discuss decision with the contractor and confirm agreement, complete appropriate contract variation notice, send to provider for signature and update ICB log	01/03/2024
Contractor returns signed variation notice to ICB. ICB to log returned documents to identify any missing	08/03/2024
ICB to countersign contract variation notice. ICB to log variations that have been countersigned to identify any outstanding	15/03/2024
Variation notice returned to provider and signed copy held and uploaded onto Compass for electronic storage. ICB to log to verify variation process complete	15/03/2024
ICB provides NHS BSA with details of changes to be made to Compass (UDAs or NACV adjusted)	15/03/2024
NHS BSA have completed changes to Compass (UDAs or NACV adjusted)	22/03/2024

NHS
North East London

Primary Care Contracts Sub-committee

18 March 2024

Title of report	Month 10 Primary Care Finance Report	
Author	Rob Dickenson – Deputy Director of Finance	
Presented by	Rob Dickenson – Deputy Director of Finance	
Contact for further information	r.dickenson@nhs.net	
Executive summary	• Summary of the Month 10 reported financial position.	
Action required	• Note the content of the report	
Practice Details (where applicable)	Practice name:	N/A
	Contract Type:	N/A
	Site address:	N/A
	List Size:	N/A
	No of partners:	N/A
	Current CQC Rating:	N/A
	PCN Details:	N/A
Previous reporting	N/A	
Next steps/ onward reporting	N/A	
Conflicts of interest	No decisions required therefore no conflicts to manage	
Strategic fit	• To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access • To enhance productivity and value for money	
Impact on local people, health inequalities and sustainability	Continual assessment of Value for Money (VfM) of current and future investments in order to reduce inequalities and provide a valuable service to the local people.	
Impact on finance, performance and quality	Ongoing review of financial commitments against available resources. The reported position (excluding DOPs) is £26.5m YTD overspend with a forecast overspend of £31.2m (excluding Additional Roles Reimbursement Scheme (ARRS) which will be refunded by NHS E/I). In addition, the recently delegated DOPs services are forecast to underspend by £10.2m (£7.5m YTD).	
Risks	The main risks to the position are Prescribing, Demographic Growth, ARRS, SDF and Same Day Access Funding.	

1.0 Introduction/ Context/ Background/ Purpose of the report

1.1 This report provides the Primary Care Contracts Sub-Committee with a summary of the financial position and associated risks, both at a high-level (NHS NEL) but also providing some information at a Place level.

1.2 The report is being presented to the Sub-Committee for information only.

2.0 Month 10 Financial Overview

2.1 At month 10, NHS NEL reported an overspend of £18.9m YTD and £21.0m FOT (as per the following table).

	YTD			Annual/Forecast		
Month 10	**Budget**	**Actual**	**Variance**	**Budget**	**FOT**	**Variance**
Area of spend	£m	£m	£m	£m	£m	£m
Delegated Primary Medical Services	341.8	341.8	(0.0)	400.1	400.1	(0.0)
Prescribing	213.9	239.1	25.2	255.8	286.1	30.2
Other ICB Funded Primary Care Services	55.5	56.7	1.3	66.8	67.7	1.0
Total ICB Funded Primary Care Services	**269.4**	**295.8**	**26.5**	**322.6**	**353.7**	**31.2**
SDF and other PC allocations	5.5	5.6	0.0	6.7	6.7	0.0
Total Primary Care Position (excl. DOPs)	**616.7**	**643.2**	**26.5**	**729.4**	**760.5**	**31.2**
Delegated Dentristry, Optometry and Pharmacy (DOPs)	186.8	179.2	(7.5)	224.1	213.9	(10.2)
Total Primary Care Position (incl. DOPs)	**803.5**	**822.4**	**18.9**	**953.5**	**974.4**	**21.0**

2.2 The delegated position is reported as a minor underspend (YTD and FOT). This excludes the planned drawdown of additional ARRS funding from NHSE.

2.3 ICB Funded overspend predominantly relates to Prescribing which is driven by a continuation of month on month pricing increases.

2.4 The DOPs reported position is a forecast underspend of £10.2m, which is predominantly in relation to Primary Dental Services.

2.5 The total Primary Care financial position is broken down by place in Appendix 1.

3.0 Month 10 Detailed Financial Position

3.1 The Primary Care budgets are funded from four sources. The first is the Delegated Primary Medical Services (Co-Commissioning) allocation. The second is from the overall ICB baseline allocation. The third is the System Development Fund (SDF) which includes Primary Care Transformation (PCT) funds. The fourth is the Delegated Dentistry, Optometry and Pharmacy allocation.

3.2 **Delegated Funding**

3.2.1 At Month 10, the Delegated Primary Care position is reflecting a minor underspend of £40k (YTD) and £42k (FOT) excluding ARRS drawdown. The table below provides a breakdown of the main categories of spend:

	YTD			Annual/Forecast		
Month 10	**Budget**	**Actual**	**Variance**	**Budget**	**FOT**	**Variance**
Spend Category	£m	£m	£m	£m	£m	£m
GMS/PMS/APMS Specific						
GP Contractual Service	201.9	201.1	(0.8)	241.5	241.6	0.0
Enhanced Services	1.7	1.7	0.0	2.0	2.0	0.0
Quality Outcomes Framework (QOF)	19.6	19.5	(0.1)	23.5	23.4	(0.1)
Premises Reimbursements	33.2	33.5	0.3	39.8	40.3	0.5
Other Administered Funds	2.9	3.0	0.2	3.5	3.7	0.2
Personally Administered Drugs	0.7	0.7	0.0	0.8	0.8	0.0
GMS/PMS/APMS Specific Total	**259.9**	**259.5**	**(0.4)**	**311.2**	**311.8**	**0.6**
Primary Care Networks (PCN)	69.3	69.3	0.0	73.1	73.1	0.0
Other	12.6	12.9	0.3	15.8	15.2	(0.7)
Total Delegated Primary Care Position	**341.8**	**341.8**	**(0.0)**	**400.1**	**400.1**	**(0.0)**

3.2.2 The position reported above assumed receipt of c.£13.6m from the centrally retained ARRS funding (c.£19m). This is based on a current forecast of c.£46.6m against c.£33.0m of ARRS funding within the allocation received.

3.2.3 Deep dive exercises were rolled out across all Primary Care budgets in all Places to ensure that the FOT was fully reflective of the current run rate of expenditure. The outcome of this exercise has been reflected in the reported FOT.

3.2.4 Of the underspends reflected under the 'Other Category' in the above table, the most notable are in Redbridge (c.£0.2m) and City & Hackney (£0.5m). These benefits are in contrast to the pressures seen in Premises and Locum reimbursements (c.£0.7m). The Locum pressures are predominantly associated with Tower Hamlets, with the Premises pressures being more distributed across places.

3.2.5 The forecast spend of c.£15.2m in the 'Other' category predominantly covers Local Commissioning Intentions in each of the boroughs, such as the schemes funded by the recycling of PMS Premium a number of years ago, as well as services such as the Care Home LIS, Phlebotomy, Homelessness, Interpreting and Practice Based Pro-active Care, to name a few.

3.2.6 The Delegated Primary Care financial position is broken down by place in Appendix 2.

3.3 ICB Baseline Funding (incl. Prescribing and SDF)

3.3.1 At Month 10, the ICB Funded Primary Care position is £26.5m YTD and £31.2m FOT. The table below provides a breakdown of the relative categories of spend.

	YTD			Annual/Forecast		
Month 10	**Budget**	**Actual**	**Variance**	**Budget**	**FOT**	**Variance**
Spend Category	£m	£m	£m	£m	£m	£m
Prescribing	213.9	239.1	25.2	255.8	286.1	30.2
Oxygen	2.1	2.0	(0.2)	2.6	2.3	(0.2)
Out of hours	1.2	1.4	0.1	1.5	1.6	0.1
LES and Other Commissioning Schemes	33.0	31.5	(1.5)	39.9	38.4	(1.5)
SDF - Primary Care Transformation	5.6	5.7	0.0	6.8	6.8	0.1
Access Hubs / Same Day Access	4.7	5.9	1.2	4.7	6.4	1.6
Primary Care - Other	0.9	1.3	0.4	2.0	1.4	(0.6)
GPIT & Meds Mgmt	13.5	14.7	1.3	16.1	17.7	1.5
ICB Funded Primary Care Services	**275.0**	**301.5**	**26.5**	**329.4**	**360.6**	**31.2**

3.3.2 The main reason for the overspend is due to a continuation of Prescribing pressures, which were seen throughout 2022-23 financial year, as well as anticipated slippage of efficiency targets built into the Prescribing budgets.

3.3.4 There are additional pressures in the Primary Care Corporate budgets, as well as the well documented pressure as a result of extending the Same Day Access service. These are both reported at a NEL level.

3.3.5 In contrast projected underspends against LES and other Commissioning Schemes are associated with current and expected activity and performance trends against a range of contracts.

3.3.5 The ICB Funded Primary Care financial position is broken down by place in Appendix 3.

3.4 Delegated Dentistry, Optometry and Pharmacy Services

3.4.1 From July 2023, the commissioning of Dentistry, Optometry and Pharmacy services was transferred from NHSE to ICBs. The table below reflects the month 10 financials associated with these services:

	YTD			Annual/Forecast		
Month 10	**Budget**	**Actual**	**Variance**	**Budget**	**FOT**	**Variance**
Spend Category	£m	£m	£m	£m	£m	£m
Delegated Dental	120.2	113.1	(7.0)	160.2	150.6	(9.6)
Delegated Optometry	16.2	17.4	1.2	21.6	22.7	1.0
Delegated Pharmacy	30.2	29.7	(0.4)	40.2	39.6	(0.6)
Delegated Property Costs	1.5	0.7	(0.8)	2.0	0.9	(1.0)
DOPs Total	**168.0**	**161.0**	**(7.0)**	**224.0**	**213.8**	**(10.2)**

3.4.2 Dental budgets were previously ring-fenced but since month 8, the national guidance has changed, allowing ICBs to retain any underspends in 2023-24. The latest performance to month 10 suggests a year-end FOT of c.£9.6m underspend, net of patient charge revenue and performance adjustments. This is a consistent picture across London, and is also consistent with 22-23.

3.4.3 The Optometry overspend is consistent with the increase in activity being seen throughout the year. The numbers of sight tests have increased plus a small increase in Repairs and Replacements, which may be a backlog following the COVID period.

3.4.4 Closure of some Pharmacies may be contributing to the Pharmacy underspend. The data is always two months in arrears, therefore there is some risk in accurate forecasts but the forecast is consistent with the YTD.

4.0 Risks and mitigations

4.1 In addition to risks mentioned above, there are a number of key risks inherent within the Primary Care budgets. This report highlights three of the main risks and the mitigations that are in place.

4.2 Demographic Growth

4.2.1 The forecast presented within this report is based on patient list growth seen up to 1st January 2024. As this is the final update before year-end, we now know what the core contract values will be for the remainder of the year. There is therefore no risk of variance in the last two months.

4.2.2 The growth seen in the last 12 months is higher than was seen in the previous period, however half of that growth was seen in the final quarter, which mitigated any cost pressures.

4.2.3 The table below compares growth in the corresponding two 12 month periods, split by place:

	Actual Growth Q4 21-22 - Q4 22-23		Actual Growth Q4 22-23 - Q4 23-24	
Places	**Weighted**	**Raw**	**Weighted**	**Raw**
Barking & Dagenham	2.2%	2.1%	3.4%	2.8%
City & Hackney	0.5%	1.0%	1.8%	2.2%
Havering	1.2%	1.3%	2.4%	1.9%
Newham	3.1%	3.9%	2.5%	2.9%
Redbridge	3.0%	2.8%	2.8%	3.0%
Tower Hamlets	0.7%	2.6%	1.4%	1.9%
Waltham Forest	0.4%	0.7%	1.6%	1.5%
NEL Total	**1.6%**	**2.2%**	**2.2%**	**2.4%**

4.3 Additional Roles Reimbursement Scheme (ARRS)

4.3.1 The Additional Roles Reimbursement Scheme (ARRS) is reimbursed on a claims basis. PCNs recruit additional staff, submit claims to the ICB and, once verified, will be paid (subject to the maximum pay bandings set out by NHSE).

4.3.2 For the last 3 years, NHSE have only given ICBs (Formerly CCGs) part of the ARRS allocation (c.63%) within the baseline funding received at the start of the financial year.

4.3.3 The remaining c.37% is available to draw down against, if and when the total quantum of PCN claims exceed the initial c.63%.

4.3.4 Over the last few months, the ICB have been working closely with PCNs to fully understand their recruitment intentions up to the end of March 2024. This has resulted in a month on month increase in the forecast spend.

4.3.5 The month 10 reported position reflected a forecast ARRS spend of £46.6m (89% utilisation) giving rise to a drawdown request of £13.6m from NHSE.

4.3.6 NHSE have been reviewing the forecast over the previous months and since month 10 reporting period have now agreed with our forecast and will be allocating the £13.6m to the ICB in month 11.

4.3.7 Whilst we have assurance of the full funding to cover the forecast of £46.6m, there is still the risk that final claims relating to 23-24 (some of which won't be received until after year-end) will exceed this figure and therefore cause a cost pressure for the ICB.

4.3.8 The utilisation of total allocation, at a borough level, ranges from 97% in Newham to 72% in Havering. These percentages have increased in the last few months which emphasises the risk set out above. The table below gives an indication of network utilisation, reflecting that 40% of the networks are forecast to spend their full allocation, and almost three quarters are forecast to utilise at least 90%:

Utilisation rate	**No of PCNs**
Utilisation 100%	19
Utilisation 90 - 99%	15
Utilisation 80 - 89%	4
Utilisation 70 - 79%	7
Utilisation 60 - 69%	2
Utilisation 50 - 59%	0
	47

4.3.9 Further detail is shown in Appendices 4 & 5.

4.4 Prescribing

4.4.1 At Month 10, the Prescribing position is £25.2m overspend YTD, with a forecast overspend of £30.2m.

4.4.2 The available prescribing data is always 2 months in arrears. The reported position is therefore based upon data from April to November.

4.4.3 The forecast is made of a combination of factors, which include an assumed shortfall in efficiency target (c.£5m), an increase in volume of prescribing (c.£12m) and an increase in price (c.£12m).

4.4.4 The Pharmacy and Medicines Optimisation team have worked hard to identify and mobilise initiatives to deliver against their £17m efficiency target, however there are number of factors driving the increased prescribing spend:

- Volume of prescribing items is up **5.3%**
- Registered list size up **2.3%**
- NICE TA impacts / More costlier evidence based medicines used across all sectors (**8.3%** increase in Actual Cost per 1000 pts)
- Temporary monthly price concessions
- Inflated Drug Tariff Prices

4.4.5 The latest data suggests that although NEL ICB spend (marginally) more per 1,000 patients than any of the London ICBs (£9,689 per 1,000 patients), it is one of the lowest in the country (national average £13,657 per 1,000 patients).

4.4.6 68% of the increase in the cost of prescribing in the first 8 months data can be attributed to the top 5 clinical areas (Endocrine, Cardiovascular, Central Nervous System, Respiratory, Nutrition and Blood). These 5 clinical areas also contribute to 72% of the total volume increase over the same period.

4.4.7 NEL Prescribing budgets are not set at Place level, which means traditional variance analysis is more difficult, however the Medicines Optimisation team have been reviewing practice and PCN level prescribing data using a range measures, such as comparing total spend in 22-23 compared with 23-24, spend per 1000 patients, cost per items prescribed, to name a few. This analysis identifies some outliers but the team want to analyse further in order to rule out any obvious reasons for the outliers.

4.4.8 To date £11.9m of the £17m Prescribing efficiency target has been identified, leaving a shortfall of c.£5m.

4.4.9 This includes a scoped stretch plan, which was originally targeting c.£1.8m but due to organisational delays in establishing the required Programme Support Team, is now only estimated at £0.5m. (further detail of this is provided in appendix 6).

5.0 Conclusion / Recommendations

5.1 The Primary Care Contracts Sub-Committee is asked to note the content of the report.

6.0 Attachments

6.1 Appendix 1 – Total Primary Care forecast by Place
Appendix 2 – Delegated Primary Care forecast by key spend category and by Place
Appendix 3 – ICB funded Primary Care forecast by key spend category and by Place
Appendix 4 – Summary of financial position for the ARRS
Appendix 5 – Graph representing utilisation of Place-level ARRS allocations
Appendix 6 – Identified Prescribing savings as at Month 10

Author: Rob Dickenson, Deputy Director of Finance
Date: 29th February 2024

Appendix 1 – Total Primary Care forecast by Place

	YTD			Annual/Forecast		
Month 10	**Budget**	**Actual**	**Variance**	**Budget**	**FOT**	**Variance**
Spend Category	£m	£m	£m	£m	£m	£m
Barking & Dagenham	35.5	35.5	0.1	42.3	42.3	0.1
City & Hackney	60.2	59.9	(0.3)	70.4	70.0	(0.4)
Havering	42.5	42.6	0.1	50.3	50.4	0.1
Newham	75.6	75.7	0.1	88.0	88.2	0.1
Redbridge	47.6	47.6	(0.0)	55.8	55.7	(0.0)
Tower Hamlets	64.6	64.3	(0.3)	76.2	75.8	(0.4)
Waltham Forest	50.7	50.0	(0.7)	59.1	58.2	(0.8)
Prescribing and other NEL-wide programmes	240.2	267.7	27.5	287.5	320.0	32.6
Total Primary Care Position	**616.8**	**643.3**	**26.5**	**729.5**	**760.7**	**31.2**

Appendix 2 – NEL Delegated Position by key spend category and by place

	Barking and Dagenham		Havering		Redbridge		Tower Hamlets		Newham		Waltham Forest		C&H	
Month 10	**Outturn**	**Variance**	**Outturn**	**Variance**	**Outturn**	**Variance**	**Outturn**	**Variance**	**Outturn**	**Variance**	**Outturn**	**Variance**	**Outturn**	**Variance**
Spend Category	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
GMS/PMS/APMS Specific														
GP Contractual Service	24.2	(0.0)	29.6	0.0	32.9	0.0	39.6	0.0	48.2	0.0	31.4	(0.0)	35.7	0.0
Enhanced Services	0.2	(0.0)	0.4	(0.0)	0.4	0.0	0.3	(0.0)	0.4	0.0	0.3	0.0	0.2	0.0
Quality Outcomes Framework (QOF)	2.3	0.0	3.3	(0.0)	3.7	(0.0)	3.1	(0.1)	4.5	0.0	3.1	(0.0)	3.3	(0.0)
Premises Reimbursements	4.8	0.1	4.3	0.1	3.5	0.0	8.3	0.1	7.6	0.0	4.7	0.1	7.0	0.1
Other Administered Funds	0.2	0.0	0.3	0.0	0.5	0.0	0.7	0.2	0.5	(0.0)	0.5	0.0	0.8	0.0
Personally Administered Drugs	0.0	0.0	0.2	0.0	0.1	0.0	0.1	0.0	0.1	0.0	0.1	0.0	0.1	0.0
GMS/PMS/APMS Specific Total	**31.8**	**0.1**	**38.1**	**0.1**	**41.1**	**0.0**	**52.1**	**0.2**	**61.3**	**0.1**	**40.0**	**0.1**	**47.1**	**0.1**
Primary Care Networks (PCN)	7.5	(0.0)	9.0	(0.0)	10.2	0.0	11.8	(0.0)	14.0	(0.0)	9.7	0.0	11.0	(0.0)
Other	1.7	(0.0)	1.7	(0.1)	2.7	(0.2)	0.0	0.0	4.2	(0.0)	3.5	0.1	1.3	(0.5)
Total Delegated Primary Care Position	**41.0**	**0.1**	**48.8**	**(0.0)**	**54.1**	**(0.1)**	**63.9**	**0.2**	**79.5**	**0.1**	**53.2**	**0.2**	**59.4**	**(0.4)**

- The forecast spend reflected against 'Other' predominantly covers Local Commissioning Intentions in each of the boroughs, such as the schemes funded by the recycling of PMS Premium a number of years ago, as well as services such as the Care Home LIS, Phlebotomy, Homelessness, Interpreting and Practice Based Pro-active Care, to name a few

Appendix 3 – ICB Funded Primary Care by key spend category and by place

	Barking and Dagenham		Havering		Redbridge		Tower Hamlets		Newham		Waltham Forest		C&H	
Month 10	FOT	Variance	FOT	Variance	FOT	Variance	FOT	Variance	FOT	Variance	FOT	Variance	FOT	Variance
Spend Category	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Out of hours	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.3	0.2	0.0	0.0	0.3	(0.0)
LES and Other Commissioning Schemes	1.0	(0.1)	1.2	0.1	1.3	0.1	11.9	(0.6)	7.4	(0.1)	5.0	(1.1)	10.3	0.1
Primary Care - Other	0.3	0.0	0.3	0.0	0.4	0.0	0.0	0.0	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)
ICB Funded Primary Care	**1.3**	**(0.0)**	**1.6**	**0.1**	**1.7**	**0.1**	**11.9**	**(0.6)**	**8.6**	**0.1**	**5.0**	**(1.1)**	**10.6**	**0.0**

- PC Other – This covers Simple Wound Care, CEG contracts, and PELC PTI cover.

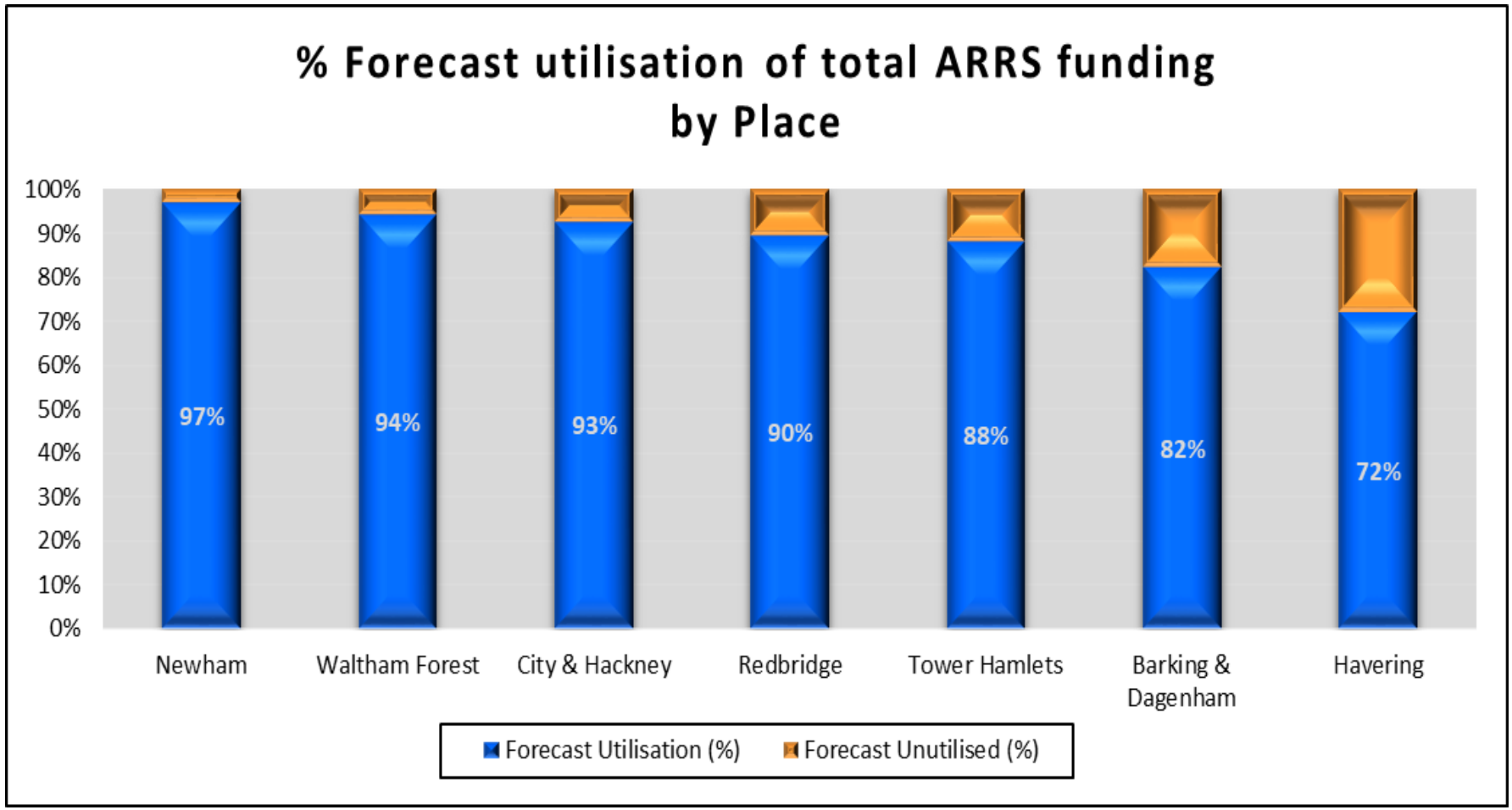
	Non Place	
Month 10	FOT	Variance
Spend Category	£m	£m
Prescribing	286.1	30.2
Oxygen	2.3	(0.2)
SDF - Primary Care Transformation	6.8	0.1
Access Hubs / Same Day Access	6.4	1.6
Primary Care - Other	0.4	(0.7)
GPIT & Meds Mgmt	17.7	1.5
ICB Funded Primary Care	**320.0**	**32.6**

Appendix 4 – Summary of financial position for the ARRS

	ICB ARRS Costs YTD M1-10	Forecast number of FTE in PCNs	Forecast ARRS spend Full year
Additional Roles	**£000's**	**FTE**	**£000's**
Clinical Pharmacist	7,009.3	276.7	14,219.4
Care Coordinator	3,020.4	206.6	6,545.1
Physiotherapist	2,637.0	101.3	5,214.8
Physician Associate	1,886.4	94.3	4,045.6
Social Prescribing	1,816.8	106.7	3,529.9
General Practice Assistant	1,237.1	135.4	3,124.0
Pharmacy technician	821.9	37.8	1,454.7
Health and Wellbeing Coach	741.4	44.8	1,335.4
Advanced Practice Nurse	307.7	32.1	1,236.7
Digital and Transformation Lead	504.1	22.6	1,135.2
CYP Mental Health Practitioner	384.1	34.8	989.1
Clinical Pharmacist Advanced Practitioner	443.9	10.5	858.9
Paramedic	295.9	20.3	779.6
Dietician	368.5	18.2	762.3
Trainee Nursing Associate	105.8	12.6	285.6
Podiatrist	143.5	5.0	270.2
Occupational Therapist	124.2	4.6	247.4
Nursing Associate	123.5	5.8	211.4
Physiotherapist Advanced	72.2	2.0	155.9
Podiatrist Advanced	29.8	1.0	49.6
	22,073.5	**1,173.1**	**46,450.8**

	Annual Budget	Forecast	Variance
	£000's	**£000's**	**£000's**
2023/24 ARRS allocation in ICB baseline - 12 months (63%)	**32,977.0**	**46,590.8**	**13,613.8**
2023/24 NHS E/I Retained - 12 months (37%)	**19,302.0**	**0.0**	**(19,302.0)**
Total 2023/24 ARRS funding available - 12 months (100%)	**52,279.0**	**46,590.8**	**(5,688.2)**
Utilisation of 100% funding	**89%**		

Appendix 5 – Graph representing utilisation of Place-level ARRS allocations



Appendix 6 – Identified Prescribing savings as at Month 10

M10 Primary Care Prescribing Efficiencies update

Savings Summary	Savings Target	£17,000,000	Savings YTD Actual	£5,767,178
			Forecast Savings	£11,929,342
Month 10	Planned savings	£11,625,931	Forecast variance vs plan	£303,412
			F'cast variance vs Target	-£5,070,658

Recovery Plan	Plan Savings (FY)			Plan Savings (YTD)			Actual Savings (YTD)			FOT Savings			Variance to Plan RAG
	Gross £000's	Investment £000's	Net £000's	Gross £000's	Investment £000's	Net £000's	Gross £000's	Investment £000's	Net £000's	Gross £000's	Investment £000's	Net £000's	
DOAC/Sitagliptin	4,594	0	4,594	2,459	0	2,459	2,311	0	2,311	4,554	0	4,554	
Rebate	1,035	0	1,035	516	0	516	594	0	594	1,045	0	1,045	
Optimise RX (M8)	2,452	0	2,452	1,733	0	1,733	2,153	0	2,153	2,804	0	2,804	
Prescribing Efficiency Scheme	1,147	(170)	977	472	0	472	275	0	275	1,129	(170)	959	
Meds Optimisation other areas	2,117	0	2,117	362	0	362	434	0	434	2,117	0	2,117	
Stretch - Scoped	1,800	0	1,800	0	0	0	0	0	0	450	0	450	
Stretch - Unscoped	4,024	0	4,024	0	0	0	0	0	0	0	0	0	
Total	**17,170**	**(170)**	**17,000**	**5,542**	**0**	**5,542**	**5,767**	**0**	**5,767**	**12,099**	**(170)**	**11,929**	

NHS
North East London

Primary Care Contracts Sub-Committee

18 March 2024

Title of report	GP Contract Update Report
Author	Abdul Rawkib
Presented by	For information only
Contact for further information	a.rawkib@nhs.net
Executive summary	The purpose of this report is to provide the Committee with updates on GP contract changes across NEL.
Action / recommendation	For noting
Previous reporting	N/A
Next steps/ onward reporting	N/A
Conflicts of interest	None
Strategic fit	N/A
Impact on local people, health inequalities and sustainability	N/A
Impact on finance, performance and quality	N/A
Risks	N/A
Appendices	N/A

1.0	**CQC Inspection Outcomes and Actions**
1.1	**City Square Medical Group (Tower Hamlets)** City Square Medical Group was issued with a Remedial Notice following the Inadequate CQC rating received in February: link to report The practice is being supported by leads from the Quality team and Medicines Optimisation team to make the necessary changes to improve the management and governance arrangements at the practice. The practice is required to submit an action plan to commissioners by 8 March 2024, which will be reviewed by the relevant Subject Matter Experts (SMEs) and further contractual action will be taken if required.
1.2	**Forest Surgery (Waltham Forest)** Forest Surgery was issued with a Remedial Notice following Requires Improvement CQC rating received in November 2023: link to report This was approved virtually by the sub-committee on 21 February 2024. The practice is being supported by leads from the Quality Team and Medicines Optimisation to make the necessary changes to improve the management and governance arrangements at the practice. The practice is required to submit its final action plan to commissioners by 31 March 2024, as their current APMS caretaker contract will expire. This will be reviewed by the relevant Subject Matter Experts (SMEs).
1.3	**Crawley Road Medical Centre (Waltham Forest)** Crawley Road Medical Centre was issued with a Remedial Notice following Requires Improvement CQC rating received in August 2023: link to report The practice is being supported by leads from the Quality team and Medicines Optimisation team to make the necessary changes to improve the management and governance arrangements at the practice. The practice submitted the final action plan to commissioners on 22 February 2024, which is being reviewed by the relevant Subject Matter Experts (SMEs) and further contractual action will be taken if required.
1.4	**Suttons Wharf Health Centre (Tower Hamlets)** Suttons Wharf Health Centre was rated Requires Improvement (RI) in January 2024: link to report The practice was rated Good across three of the five CQC domains, however was rated RI for Effective and Responsive. In line with the NHS England Standard Operation Procedure (SOP) for practices rated RI, it has been agreed by the TH local fora to not undertake any formal contractual action at this stage. However, for

	assurance purposes the practice will be required to submit an action plan addressing the improvement areas identified by the CQC. The practice response will be reviewed by the relevant SMEs. In the event the practice does not provide a satisfactory response, formal contractual action will be considered.
2.0	**Contract Extension**
2.1	**Porters Avenue (Barking & Dagenham)** Porters Avenue is an APMS contract that was originally procured in April 2019 on an initial term of 5 years, with the option to extend for another 5 years (5+5). It was agreed to enact contract clause 2.3 and extend the contact for the full duration until 31 March 2029. Extension Notice has been finalised and issued to the practice.

NHS
North East London

Primary Care Contracts Sub-committee

18 March 2024

Title of report	Risk Register
Author	Alison Goodlad, Deputy Director Primary Care
Presented by	Alison Goodlad, Deputy Director Primary Care
Contact for further information	alison.goodlad@nhs.net
Executive summary	Earlier in 2023, a Commissioning, Strategy and Transformation (CSTO) Department Risk Register was produced and submitted to the NEL ICB Governance Team. Each directorate within the CSTO Department had a separate tab for its risks. Following risks identified at rapid fire sessions, new corporate and organisational risks were included in the Primary Care Section of the risk register and previously identified NEL-level risks reviewed and added. In December 2023, the risks were reviewed and refreshed. A meeting has been held with Mark Rickets and Jagan John, the GP Primary Care Members of NEL ICB. It was then reviewed by the Primary Care Directorate Senior Managers at a meeting of the Primary Care SMT on 5 December. The risks were also reviewed at the meeting of the Primary Care Delivery Group on 21 December 23 and by the Primary Care Collaborative at its meeting on 10 January. The refreshed risks were presented to the January meeting of the Primary Care Contracts Sub Committee and as agreed, the ratings will be reviewed with the Quality Team.
Action required	To note the refreshed risk register
Previous reporting	The risks were reviewed at the meeting of the Primary Care Delivery Group on 21 December 2023 and by the Primary Care Collaborative at its meeting on 10 January 2024.
Next steps/ onward reporting	To be discussed
Conflicts of interest	None
Strategic fit	• To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access • To enhance productivity and value for money • To support broader social and economic development
Impact on local people, health inequalities and sustainability	The report sets out key risks within primary care in order to achieve our aims for the health and wellbeing of our population including health inequalities and sustainability.

Impact on finance, performance and quality	There are no additional resource implications/revenue or capital costs arising from this report
Risks	This paper notes the review of the risk management process for the CSTO Department and the current NEL Primary Care Risk Register, showing NEL wide risks rated over 12

1.0 Highest rated risks

The full version of the risk version is attached. Eight risks are rated over 12. These are:

- The risk that the financial constraints will impact on our ability to invest and therefore limits our delivery of GP services – **20**
- The risk that the financial constraints will impact on our ability to invest and therefore limits our delivery of Dental services – **20**
- Primary Care Resilience and Sustainability Quality and financial vulnerability - **16**
- Risk of limited or no access to routine NHS Dentistry – **15**
- Primary Care Workforce – Recruitment and Retention of GPs, nurses and other staff including ARRS staff – **15**
- GP Premises – Risk to sustainability and viability - **12**
- That national requirements and measurements don't meet our local ambition and strategy – **12**
- Risk that the reduction in capacity within the NEL ICB primary care team will lead to insufficient support to primary care - **12**

Primary Care Risk Register

ID no.	Date raised	Area Raised by	Initial risk score	Corporate objective	Risk description	Previous rating	Current rating			Target rating	Target completion date	Completed mitigating actions	Mitigating actions in progress	Risk owner	Action Owner	Responsible committee or group	Escalation required (Y/N)	Escalation Details	Updates/ comments	Close Down Status
							Likelihood	Impact	Risk Score (1-25)											
PC01	13 March 2023	Primary Care Directorate	9	To tackle inequalities in outcomes, experience and access	There is a risk to primary care that lack of clarity around prioritisation processes and how/where funding and resources are allocated, will result in making investment decisions that don't align with local priorities by supporting primary care and improving population health, particularly where priorities might be conflicting eg NEL vs Place. Additionally,a lack of clarity around prioritisation could delay the allocation of resources effectively to deliver our priorities.	9	3	3	9	6	Sep-24		Ensure that the future prioritisation process and associated funding allocation to support any programme of work reflects the agreements set out in the Finance Strategy and principles and objectives of the ICS. Identifying and supporting informed discussions where priorities conflict. Prioritisation process to be transparent and supporting the allocation of resources. Review of 23/24 primary care budgets, as part of the Financial Recovery Process. Work being undertaken to firm up priorities and objectives and ensure alignment with place teams.	Sarah See	Sarah See	Primary Care Contracting Sub Committee	N			
PC19	20 December 2023	Primary Care Directorate	15	To tackle inequalities in outcomes, experience and access	There is an ongoing risk associated to the local population with limited, or no access, to routine NHS dentistry for both adults and children which will lead to a deterioration in the oral health of the population with wider consequences in terms of chronic health issues for adults and impact on children's education. There is significant eveidence to suggest that those in the most deprived groups are the most adversely affected.	N/A	4	5	15	12	Mar-25	Investment of £3.1m to deliver additional routine NHS dental access for the period Oct -2023 - March 2024, signed off by the ICB in August 2023; Urgent Care Procurement completed, new permanent delivery in place from April 2024	Development of DOP specific provider groups; Inclusion of Dentistry as part of place based discussions within NEL. Ongoing work with Dental Public Health Consultants and LAs to formulate Oral Health approaches/strategies that can increase the opportunity for the population to access Oral Health advice and promote the delivery of 'supervised tooth brushing in schools and other community settings	Sarah See	Jane Lindo/ Jeremy Wallman	Primary Care Contracting Sub Committee and Commissiong Oversight Group (COG)	Y			
PC02	13 March 2023	Primary Care Directorate	12	Develop our NEL integrated care system	There is a risk to the development of primary care in NEL and the ability to meet the needs of the local people that national measures and requirements (often requested at short notice) do not align/meet our local ambition and are not consistent with our ICS strategy which will impact on our ability to develop comprehensive plans and strategies and/or impact on our resources and ability to deliver against local priorities. For example - national operating plan targets on GP appointment numbers, constraints on the ways that national investments can be spent	12	4	3	12	9	Sep-24			Sarah See	Jane Lindo	Primary Care Collaborative	N			
PC04	13 March 2023	Primary Care Directorate	12	To enhance productivity and value for money	There is a risk that the financial constraints will impact on existing GP Primary care services and investment in new services and that this will make an impact on local people. Risk that of inadequate investment in primary care services beyond core GMS/PMS, APMS services . There is a risk that disinvestment in primary care services destablises them and residents lose the accessibility and continuity provided by primary care. This could also lead to reputational risks for the ICB, particularly for the LIS equalisation programme that the ICB have committed to and has been delayed.	12	4	5	20	9	Mar-25		Prioritisation process to be transparent and support the allocation of resources. Phasing of workstreams. Business cases to demonstrate value and good outcomes and ability of primary care to react quickly, be acessible to the local population, have a strong impact and provide continuity of care. Ensure this is backed up with good data. Communication with stakeholders to manage expectations. Ensure maximum efficiencies and value for money and assess any opportunities to release funding to where efficiencies can be made. Use technology to maximise productivity. Review of 23/24 primary care budgets.	Sarah See	Sarah See	Primary Care Contracts Sub Committee	Y			
PC20	20 December 2023	Primary Care Directorate	20	To enhance productivity and value for money	There is a risk that the financial constraints will impact on investment in new dental services and that this will have an impact on local people's access to dentistry and the oral health of the local population. Risk that the available recurrent underspend in GDS is used as a contribution towards the ICBs FRP, therefore no scope to commission additional access. This could also become a reputational risk to the ICB we are unable to repeat additional investment during 24-25 or fund other OH schemes	N/A	4	5	20	9	Sep-25	Additional Investment secured, non-recurrently, in 23-24	Review spend in 24/25, and deliver viable proposal to re-invest recurrnt resource (unspent)	Sarah See	Jane Lindo/ Jeremy Wallman	Primary Care Contracts Sub Committee; FPIC, COG	Y			
PC05	13 March 2023	Primary Care Directorate	9	Develop our NEL integrated care system	There is a risk that PCNs are not yet mature enough/able to develop rapidly enough to work in an effective way with the Place Based Partnerships impacting on development and delivery of Transformation, especially where PCNs are delivery vehicle for transformation e.g Fuller and neighbourhood model. Risk of variability in PCN maturity and lack of accountability.	9	3	3	9	6	Mar-25	CD Development Programmes Support from Federations OD Programmes Regular PCN meetings PCN Strategic Infrastructure planning at NEL level completed and plans shared with PCNs All PCNs have Capacity and Access Plans agreed.	Ongoing PCN development and OD work being undertaken at place. PCNs have put in place Capacity and Access Plans and have received funding for this in order to work collectively to address issues around access and patient experience and share good practice and reduce variation. Places teams working with PCNs to review progress. Local dashboard is being used to highlight any issues with PCNs. System wide strategy and approach to be developed around role of PCNs and Federations.	William Cunningham Davis	Heads of Primary Care	Primary Care Collaborative	N			
PC07	13 March 2023	Primary Care Directorate	9	To enhance productivity and value for money	There is a risk that service pathways are fragmented and incompatible, not integrated and not effective due to services not working in a joined up way. This may result in services that do not deliver required outcomes eg the issue with Same day Access across the system where local people continue to go round the system with multiple contacts.	9	3	3	9	6	Sep-24	Completion of initial primary care goverance review.	Workstreams in place to address the various aspects of the Fuller Report. Representation from all parts of the systems involved and working in partnership, particularly at local place level. Goverance to be revisited in the light of the restructure and staffing capacity.	William Cunngham-Davis	Heads of Primary Care	Primary Care Collaborative	N			
PC08	13 March 2023	Primary Care Directorate	9	Develop our NEL integrated care system	There is a risk to primary care, in terms of ICB support and timely and acurate payments, caused by lack of investment in training and reduction to ICB staffing budgets, resulting in an insufficient amount of primary care staff with the right skills to support delivery. Primary Care depends on specialist skills and knowledge and there is a risk of being able to recuit and ensure sucession planning for the future. There is also the risk of loss of clinical leadership due to loss of funding for Clinical Lead roles. Finally, there is the risk that if the culture and OD is not mature enough, this will impact on the ability to work in a matrix way to support the development of primary care.	9	4	3	12	6	Sep-24	Primary Care Team Away Day planned for Dec 23 to focus on priorities, objectives and ways of working	OD Programmes in place to ICB staff in Primary Care Commissioning and Improvement and Place Based Teams. Prioritisation of workload, ensure staff are clear on roles and priorities. Ensure all staff have clear objectives and appraisals, automation of functions where appropriate, to free up capacity.	Sarah See	Sarah See	CSTO	N		The previous PC08 (primary care staff training), PC010 staff reduction and PC11 - staff restructure have been consolidated as one risk	
PC09	13 March 2023	Primary Care Directorate	9	To improve outcomes in population health and healthcare	There is a risk that the quality and variation of coding in practices is not of a sufficient standard and will result in loss of income for GP practices and the inability of the ICB to effectively monitor impact/outcomes or planning, which risks investing in services that are not delivering the required outcome.	9	3	3	9	6	Apr-23	All PCNs have produced plans to improve accuracy of recording in appt books as part of their capacity and access improvement plans	An incentive scheme has been developed to encourage practices to adopt standardised methods of clinical coding. As part of their Capacity and Access Improvement Plans, practices will be required to produce plans to improve acuracy of recording in appointment books.	William Cunningham Davis	Heads of Primary Care	Primary Care Contracts Sub Committee	N			
PC12	13 March 2023	Primary Care Directorate	16	Deliver High quality service for patients	The resilience, sustainability and viability of general practice and Primary Care is at risk due to reduced workforce, increased demand, quality issues and financial pressures which could result in morale deteriorating, premises becoming unaffordable/unviable and practices closing which will affect the ability of the wider Primary care system to deliver the Transformation required.	16	4	4	16	9	Mar-25	Surge planning guidance in place that can be applied by local systems to support their business continuity and preparedness plans. Expanded locum bank in place Additional access and capacity funding has been made available to PCNs. CPCS in place and well established.	Work is being undertaken to roll out cloud based telephony, increase the take up of online consultations, develop ehubs and move towards implementation of 'modern general practice'. This will help to improve efficiency and release capacity. Work is ongoing to ensure practices make optimal use of the CPCS and Pharmacy First to be rolled out. Suport offers through the Primary Care Recovery Plan to suport practices in managing demand and capacity. Support being given to practices identified as being most at risk, through SDF Resilence, workforce and Digital funding.	Sarah See	Deputy Directors of Primary Care	Primary Care Contracts Sub Committee	Y		Risk increased to 16	

PC13	13 March 2023	Primary Care Directorate	15	To tackle inequalities in outcomes, experience and access	Workforce risks. The risk that PCNs are not able to fully recruit to ARRS roles, and ensure that these are sustainable. There are also a number of GPs and nurses nearing the age of retirement and low GP and nurse patient ratios in most parts of NEL. There is a risk that workforce initiatives do not match the scale of the problem where recruitment and retention continues to be a challenge, leading to a continual reduction in capacity relative to growth and demand.	15	3	5	15	9	Mar-25	CD Development Programmes Support from Federations OD Programmes Regular PCN meetings PCN Strategic Infrastructure planning at NEL level completed and plans shared with PCNs Work taking place with the training hubs	NEL-wide GP Flexible Pools expanded GP Spin Programme continues GPN training and recruitment programme NEL Professional Development Framework Nursing - continued development and enhanced CPD GPN fellowships HCA training programme Hyper local plans in place to tackle areas of greatest workforce challenge.	Sarah See	Fiona Erne	Primary Care Collaborative	Y			
PC14	05-May-23	Primary Care Directorate	8	Develop our NEL integrated care system	Implementation of the contract changes/access recovery plans in 23/24 – Risk of capacity in the ICB primary care teams and general practice to deliver, Risk of buy-in and reception of changes by general practice and reputational risk.	8	2	4	8	4	Mar-24	Programme Plan for Access Recovery Plan in place with workstreams covering digital, interface, pharmacy, implementation of modern general practice etc	Task and Finish Group meeting regularly to oversee the implementation of the contract changes, with representation from central and place based primary care, digital, comms and Equip. Other Task and Finish Groups covering different workstreams such as Interface, prospective records access and direct referrals	Jane Lindo	Alison Goodlad	Primary Care Contracts Sub Committee	N			
PC15	05-May-23	Primary Care Directorate	12	To improve outcomes in population health and healthcare	NEL multi-lot APMS Procurement There is that 6 new practices do not become operational from April 24, due to insufficient capacity to be able to manage the NEL wide 6 lot procurement in a timely manner. This is particularly important for the new APMS zero list practices to ensure that once the new premises is completed a new practice can move in and serve the growing population of that area. It is also important to avoid risk of challenge where practices have been under caretaking arrangements for some time, following practice closures. There is also the risk that there won't be sufficient good quality bids to appoint to the 6 lots.	12	2	4	8	4	Mar-24	ITT has been issued and procurement has now completed. Approval of preferred bidders to take place in Dec with mobilisation from Jan to March. 'Go live' from 1 April. On track to meet procurement timeline.	Additional programme management capacity secured. Procurement team to provide procurement support. Task and Finish Group operational Group and Steering Group in place to manage and oversee process. Work programme in place.	Jane Lindo	Alison Goodlad	Primary Care Contracts Sub Committee	N			
PC18	30-Oct-23	Primary Care Directorate	12	Deliver High quality service for patients	GP Premises: The risk to the viability and sustainability of general practice and ability to provide patient care. Particular risk areas are in relation to service debt variability and practice debt and the impact on pratice viability, Planned increase in rents at NELFT properties, quality of property management and the impact on service provision and patient care, rent review backlog and impact on ICB finance, variation in support given to practices when relocating and having significant premises developments and moving to a standard NEL offer	12	3	4	12	8	Sep-25		Estates Steering Group set up to ensure robust oversight and management of the primary care estates premises budgets and ensure long term financial viability and resilience of practices in relation to premises costs and resolve issues relating to aged debt, appropriateness of service charge costs and quality of property maintenance. 4 workstreams have been established.: 1. Service charge variability. 2. Quality of property management 3. Rent review backlog 4. Standardisation of NEL offer to practices going through relocation or other developement	Sarah See	William Cunningham-Davies	Primary Care Delivery Group	Y			

North East London

Primary Care Contracts sub-committee

18 March 2024

Title of report	Update on the Delivery Plan for Recovering Access to Primary Care
Author	Alison Goodlad, Deputy Director Primary Care
Presented by	Jane Lindo
Contact for further information	sarahsee@nhs.net
Executive summary	The Fuller Stocktake built a broad consensus on the vision for integrated primary care services and in order to realise this, action is required to take the pressure off general practice. The Delivery Plan for Recovering Access to Primary Care was published on 9 May 2023. A two-year programme is in place to address the requirements of the plan, incorporating four key areas: implementing modern general practice access, empowering patients to manage their own health, building capacity and cutting bureaucracy. A paper was presented to the ICB Board in November 2023 which gave an overview of the national requirements of the plan and how we are working to implement the programme across North East London and the ICB gave assurance on our plans to deliver this. This update focusses on progress in three key areas: Expanding the role of community pharmacy, reducing bureaucracy at the interface between primary and secondary care and maximising use of digital telephony to enable practices to deliver modern general practice, along with a summary of progress against the Delivery Checklist for ICBs, risks and mitigations.
Action / recommendation	To note
Previous reporting	A paper giving an overview of the Delivery Plan for Recovering Access to Primary Care was presented to the NEL Executive Committee in November 2023. This report has been presented to the NEL primary care collaborative on 13 March 2024.
Next steps/ onward reporting	We will be presenting this paper to the March ICB Board meeting, as mandated by NHS England.
Conflicts of interest	N/A
Strategic fit	• To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access • To enhance productivity and value for money • To support broader social and economic development

Impact on local people, health inequalities and sustainability	North East London ICS has an ambition of working with and for the local people to create meaningful improvements in health, wellbeing and equity to the local population. Improvements to general practice in terms of access, experience and outcomes for local residents are central to this ambition. Our plan has been informed by resident insight and experience. An Equalities and Health Impact Assessment has been completed for delivery of this plan
Impact on finance, performance and quality	The paper provides an update on how work will be undertaken to implement the National Delivery Plan for Recovering Access to Primary Care. This plan will deliver a vision for improving access to primary care and enhancing quality and patient experience for local residents. National funding sources have been made available to the ICB to support general practices and PCNs to commence the early changes required to move towards modern general practice. In 23/24, we have received £1.6 million for transitional funding for practices to move towards the modern general practice and £2.5 million for cloud-based telephony.
Risks	• Risk of insufficient capacity to deliver a wide-ranging complex programme. Projects and actions are broken down into blocks with different leadership and ownership across the system, working to a timeline. This is being assessed as a part of the primary care portfolio review. • Individual risks and mitigations against each project are outlined in Appendix A. There are wider risks to the sustainability of primary care services which may impact on delivery at a practice level, caused by factors such as variations in funding, patient access, quality, performance, challenges in the recruitment and retention of staff, increasing rent and service charges, together with poor quality estate.

1.0 Background

1.1 The Delivery Plan for Recovering Access to Primary Care was published by NHS England (NHSE) on 9 May 2023. This sets out two central aims: to tackle the 8am rush and reduce the number of people struggling to contact their practice, and for patients to know on the day they contact their practice how their request will be managed.

1.2 A paper was presented to the ICB Board in November 2023 which gave an overview of the national requirements of the plan and how we are working to implement the programme across North East London.

1.3 This report gives an update on progress in line with the requirement from NHSE for ICBs to provide updates to their Boards in March 2024 on Recovering Access to Primary Care.

2.0 Introduction

2.1 Overall, we have been making good progress against the requirements of the plan. NHSE has developed a checklist of actions to enable ICBs to assess progress against the four plan commitments. Each action in the checklist has an owner and is attributed to a specific programme with leadership and progress captured within a programme report. The latest self-assessment for NEL ICB can be found in appendix A.

2.2 Particular areas of current focus that will enable a step change in access for patients include expanding pharmacy services, maximising use of digital telephony and moving to a modern general practice model and the freeing up of clinical capacity by reducing bureaucracy at the interface with secondary care. Plans and progress in these particular areas are covered in more detail in the sections below.

3.0 Expansion of Community Pharmacy Service

3.1 The new Pharmacy First scheme aims to make it easier for patients to access the care they need. Pharmacy First is an advanced service that will include seven new clinical pathways and will replace the Community Pharmacist Consultation Service (CPCS). The full service will consist of three elements:

Pharmacy First (Clinical pathways)	Pharmacy First (urgent repeat medicine supply)	Pharmacy First (NHS referrals for minor illness
Uncomplicated UTI Sinusitis Shingles Impetigo Infected insect bites Sore Throat Acute Otitis Media	previously commissioned as the CPCS	previously commissioned as the CPCS

3.2 Contractors will need to be able to provide all three elements (the only exception is Distance Selling Pharmacies who will not be required to do the otitis media pathway due to the need to use otoscopes). Remote consultations for six of the seven clinical pathways are permissible via high quality video and if clinically appropriate speed of access to medicines can be facilitated.

3.3 The existing referral routes for the CPCS will apply to the new clinical pathways' element, but patients will also be able to self-refer to a pharmacy for the seven clinical pathways (subject to the patient passing a clinically established gateway point in the relevant clinical pathway). A diagram illustrating the pathway for community pharmacy services is in appendix B.

3.4 The Community Pharmacy Consultation Service commenced in March 2022. There have been over 120,000 referrals from NEL GP surgeries for this service, which is the highest referral rate in England. This has been enabled by referrals from practices being made using EMIS clinical system integration. The Local Pharmacy Committee (LPC) were commissioned to train staff in practices and support the pharmacies to ensure delivery. In NEL 1% of referrals made to pharmacies are returned back to back to GP surgeries compared with a national average of 10%.

3.5 Under the Delivery Plan for Recovering Access to Primary Care it is a requirement of community pharmacy that blood pressure monitoring and oral contraception is

available from community pharmacies from 1 December 2023. NEL has a Hypertension Case Finding service through which GPs can refer for blood pressure checks and advanced monitoring. NEL has on boarded over 100 pharmacies which now provide improved access to contraceptive services.

3.6 NEL has commissioned the LPC to deliver training and support implementation for pharmacies and practices funded from the Service Development Funding (SDF) Investment. There is no data available as yet on additional activity. NEL ICB is also piloting a self-care scheme for eligible patients to get 'over the counter' products meaning they don't need to be referred back to the surgery for a prescription.

4.0 Roll out of Digital telephony to support modern general practice access

4.1 Practice telephone systems play an important role in improving the experience of accessing general practice. NHSE has required all practices to have in place a digital telephone system that can perform certain key functions. This has the advantage of supporting practices to be able to provide patients with more holistic and personalised care with features such as automated booking, call recording and clinical systems integration. Modern digital systems allow for a much richer data collection regarding patient demand and the number of calls received to enable better management of the delivery of clinical services. Patients benefit from the option of receiving a call back, rather than waiting on hold.

4.2 Across NEL, 161 (61%) practices qualified for a funded upgrade, ranging from many requiring a complete change from an analogue system to a digital system, through to those being upgraded to a digital system with greater functionality. NEL practices are benefitting from a total investment of £2.5 million from NHSE for this purpose.

4.3 At present, 91 practices have a signed contract for a new digital telephone system, including all practices on old analogue systems. Implementation has been completed by some practices already, although most are awaiting implementation dates. Another 70 practices already had digital systems but without the full functionality required. Upgrades are expected to take place from March onwards. There is a requirement from NHSE to support practices once they have moved systems and the current proposal is to use the existing training hub digital facilitators to provide training to ensure that practices and their patients get maximum benefit from the new systems.

4.4 In order to facilitate working at scale NHS NEL has been encouraging all practices in a Primary Care Network (PCN) to use the same telephone system. Currently there are 20 PCNs where all practices either have or plan to have the same system, nine PCNs where it is possible that all practices will have the same system. The remaining PCNs have either not yet made a final decision or will continue to have a range of telephone systems across their practices. Although having a range of systems wont impact patient services in the short term, the PCN development programme will be aimed at helping practices to understand the longer-term benefits of moving onto one system to support collaboration and at scale working. Once practices do realise this benefit they can choose to change systems in 2027 at the latest.

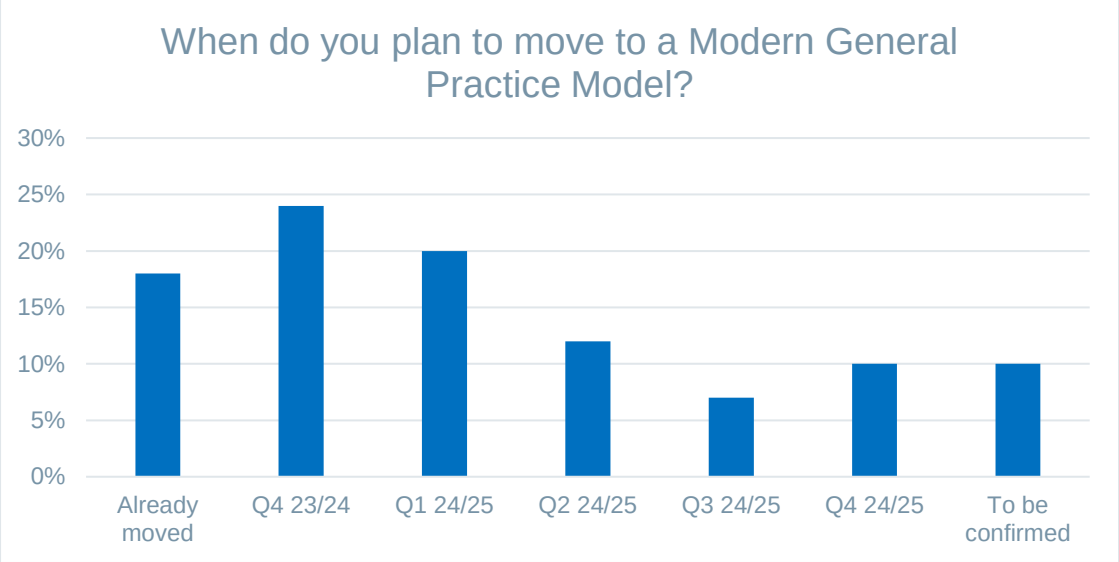
5.0 Moving to a modern general practice model of access

5.1 The modern general practice model moves away from the 8am phone call queue and 'first come, first served' process for allocating appointments. Instead, the model requires consistent structured information to be collected at the point of contact – to let the practice know about symptoms, ask a question, make a request or follow up

about something – with patients either providing this information via an online form or to reception staff who capture the information about their needs. Patients' needs can then be consistently assessed and triaged, allowing practices to provide patients with the most appropriate care or other response, from the right member of the practice team, including signposting or referring patients to other appropriate services.

5.2 To support implementation of the modern general practice aspirations as set out in the Access Recovery Plan, GP practices are entitled to receive funding to create capacity for change management and quality improvement within their teams**.** NEL ICB has been allocated £3.2 million for this, split equally between 23/24 and 24/25. All practices have submitted plans for how they will spend this funding and 95% of these plans have currently been approved with the expectation that all will be approved by the end of March. Further detail can be found in the checklist in Appendix A.

5.3 As part of the application process, all practices were required to indicate when they planned to move to a modern general practice model. The chart below shows planned progress by practices towards this model over the next year. By 1 April 24, 44% of practices will have implemented this model. We anticipate that all practices will have moved to this model by April 25.



6.0 Reducing bureaucracy at the interface with secondary care.

6.1 Reducing bureaucracy gives practices more time to focus on their patients' clinical needs. This workstream focusses on improving the interface between primary and secondary care, in order to enhance the experience for patients and staff as well as increasing efficiencies across all providers.

6.2 The ICS's Clinical Advisory Group (CAG) provides strategic oversight of NEL's work to improve the primary-secondary care interface, and will work with the acute and community collaboratives to enable this. Local interface groups have been established to ensure delivery at Place. CAG will identify and solve current and upcoming system interface challenges between primary and secondary care, strengthening relations, improving communication, developing new integrated pathways and ensuring interface processes meet the needs of all.

6.3 ICBs have been tasked with actions in four key areas: onward referrals; complete care (eFit notes and discharge/clinic letters); call & recall; and clear points of contact.

6.4 Most of the interface groups in NEL have completed a self-assessment tool in order to assess progress against the four areas, except for the BHR Group who are not yet in a position to report. (see Appendix C)

6.5 Place Based Partnerships have indicated that this is a resource intensive area of work, and Board recognition of this as a system priority would aid local discussions.

7.0 Key areas of focus going forwards into 24/25

7.1 As well as working to further develop the areas outlined above, we will be focussing on making further progress in the following areas:

- Working to increase the proportion of NEL practices with all four key functions of the NHS App enabled. This is currently 70% compared to the England average of 76%.
- Further progressing our GP registration campaign, encouraging continued use of our NEL online registration tool by local residents. There have been over 300,000 completed registrations since its launch with 90% of users reporting that it is easy/very easy to use.
- Working with the remaining 9% of practices to get 100% of NEL practices offering prospective records access.

7.2 All Primary Care Networks will be required to submit final reports demonstrating delivery against their Capacity and Access Improvement Plans in April 24 and these will be assessed to inform payments based on performance against their plans. This information will present an opportunity to assess progress in improving patient experience, demand management and accuracy of recording in appointment books.

7.3 It is expected that patients will report improved experience through national tools such as the Friends and Family test and annual GP-Patient Survey. We will also seek to understand progress through engagement with residents and Voluntary Sector partners such as Healthwatch. In addition, GP appointment data, primary care workforce data and data relevant to the uptake and use of digital tools will be used to assess progress.

Attachments

- A - Delivery Plan for Recovering Access to Primary Care – Progress against ICB Checklist
- B - Pharmacy First Pathway Overview
- C - Self-assessment against the four areas keys areas of improvement at the interface between primary and secondary care

Alison Goodlad
21 February 2024

North East London
Integrated Care Board

Primary Care Contracts Sub-Committee

TERMS OF REFERENCE

Status	1. The Board of the ICB has established the Finance Performance and Investment Committee (the "**FPIC**") and, in turn, the Primary Care Contracts Sub-Committee ("the **sub-committee**") has been formally established as a sub-committee of the FPIC. 2. These Terms of Reference set out the membership, the remit, responsibilities and reporting arrangements of the sub-committee and may only be changed with the approval of the FPIC and the Board. Additionally, the membership of the sub-committee must be approved by the Chair of the Board. 3. The sub-committee and all of its members are bound by the ICB's Constitution, Standing Orders, Standing Financial Instructions, policies and procedures of the ICB.
Authority	4. The sub-committee is authorised by the Board to take all necessary actions to fulfil the remit described within these terms of reference, including obtaining professional (including legal) advice, commissioning reports and creating groups. The sub-committee will follow the processes described by the Board for commissioning any professional advice. 5. The sub-committee does not have the authority to delegate any functions delegated to it. However, the sub-committee may establish groups (e.g. working, advisory or task and finish groups), which do not have any decision-making powers but may inform the work of the sub-committee. Such groups must operate under terms of reference approved by the sub-committee, and these must reflect appropriate arrangements for the management of conflicts of interest.
Purpose and responsibilities	6. The role of the sub-committee shall be to oversee the exercise of functions relating to primary care, primarily as relates to contracting and financial matters. 7. The specific matters delegated to the sub-committee are set out in the ICB's **Operational Scheme of Delegation for Primary Care**, which is in the Handbook and is available at this link. The sub-committee is authorised by the ICB to take decisions in relation to those matters described in the scheme of delegation and summarised below: (a) Oversight of all financial operations and decisions in relation to primary care services, within the ICB's area.

(b) Planning the Primary Medical Services Provider landscape in the ICB's area.

(c) Managing the Primary Medical Services contracts and the performance of Primary Medical Services Providers (including making decisions in relation to the management of those who are poorly performing).

(d) Planning and making decisions in relation to the commissioning and management of Primary Dental Services, including by carrying out needs assessments.

(e) Undertaking reviews of the Primary Dental Services in the ICB's area and planning the dental provider landscape.

(f) Making decisions in relation to the management of poorly performing Dental Services providers.

(g) Establishing appropriate contractual arrangements with acute providers to commission acute dental services.

(h) Awarding new contracts for prescribed dental services.

(i) Making decisions in relation to the management and provision of local Primary Ophthalmic Services, including by assuming responsibility for the award of new Primary Ophthalmic Services Contracts.

(j) Overseeing the performance of each of the relevant Primary Ophthalmic Services Contracts.

(k) Overseeing compliance of those who are party to Local Pharmaceutical Services Contracts with the terms of those contracts.

(l) Supporting the implementation and delivery of all elements of the Community Pharmacy Contractual Framework.

(m) Making decisions on how the ICB's individual allocation for PODs is spent.

8. Financial management in relation to primary care will be assured through the sub-committee, which may escalate matters to FPIC on the advice of the Chief Finance and Performance Officer. Where appropriate, the sub-committee may refer matters relating to Pharmacy, Ophthalmology and Dental services ('**POD**s') for discussion at the POD Commissioning Oversight Group ('**COG**').

9. The sub-committee's assurance responsibilities will be facilitated by:

   (a) Attendance of the Managing Director for Primary Care at meetings of the sub-committee.

   (b) Written summary reports from the Managing Director for Primary Care which shall be provided to the sub-committee on a quarterly basis. Such reports shall focus on areas of risk, and key points of debate, actions and decisions taken within the forum of COG or otherwise in relation to PODS.

   (c) Reports or other outputs which are shared with the sub-committee by COG.

Key duties relating the exercise of the sub-committee's functions

10. The ICB's responsibilities relating to primary care have been delegated to it by NHS England in reliance on section 65Z5 of the NHS Act 2006 and in accordance with the Primary Care Delegation Agreement. The sub-committee shall ensure that it adheres to the agreement at all times and the requirements of any assurance arrangements made by NHS England.

11. The Delegation Agreement imposes wide-ranging contractual obligations on the ICB and refers to relevant guidance documents, policy and expectations, and Mandated Guidance issued by NHS England from time-to-time.[1] In certain circumstances, decisions may require the approval of the ICB's Chief Executive Office or Chief Finance and Performance Officer and require approval of NHS England in accordance with the financial limits set out in the Delegation Agreement, which includes where a matter in relation to the Delegated Functions is *novel contentious or repercussive*[2]. The sub-committee will ensure that it takes advice on any matter where these requirements may apply and escalate matters as appropriate.

12. In relation to PODS, the sub-committee shall also take into account any advice, guidance or recommendations made by COG.

Collaboration and Alignment with Wider System Primary Care Governance

13. The sub-committee will work closely with:

   (a) The Primary Care Collaborative and any groups it establishes.

   (b) Governance structures in the seven places, which have a remit over primary care, in the context of the financial framework.

[1] See Schedule 9 of the Delegation Agreement.
[2] See Schedule 5 of the Delegation Agreement.

(c) COG and any other governance structures established for the purposes of PODS in London.

(d) The NEL Primary Care Quality Group.

(e) The Primary Care Delivery Group

This shall include the ability to ask those governance structures to support it in the exercise of its functions and to receive recommendations from them in order to inform decisions, as appropriate.

Chairing arrangements

14. The sub-committee will be chaired by the Independent Clinical Chair who is appointed on account of their specific knowledge, skills and experiences making them suitable to chair the sub-committee and will agree the sub-committee's agenda and ensure that its work and discussions meet the objectives set out in these terms of reference.

15. Sub-committee members may appoint a Vice Chair from amongst the members. If the Chair has a conflict of interest then the Vice Chair or, if necessary, another member of the sub-committee will be responsible for deciding the appropriate course of action.

Membership

16. The sub-committee members shall be appointed by the Board in accordance with the ICB Constitution and the Chair of the ICB will approve the membership of the sub-committee.

17. The sub-committee shall have 8 members as follows:

(a) Independent Clinical Chair **(Chair)**

(b) Non-Executive Member of the ICB Board **(Vice Chair)**

(c) Chief Finance and Performance Officer or nominated deputy

(d) Chief Medical Officer or nominated clinical deputy

(e) Chief Nursing Officer or nominated quality clinical deputy

(f) Managing Director of Primary Care

(g) Associate Medical Director of Primary Care

(h) A Place Director, on behalf of the Place Based Partnerships

Participants

18. Only members of the sub-committee have the right to attend meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the sub-committee.

19. The following will have a standing invitation to attend meetings of the sub-committee:

(a) Representatives from Healthwatch and the Local Medical Committee (London-wide and Barking & Dagenham and

	Havering), Local Dental Committee, Local Optical Committee and Local Pharmaceutical Committee. 20. The sub-committee may, invite others to attend meetings to support the sub-committee in discharging its responsibilities (e.g. Senior Managers, members of the POD Commissioning Team, members of COG).
Meetings Quoracy and Decisions	21. The sub-committee will operate in accordance with the ICB's governance framework, as set out in its Constitution and Handbook and wider ICB policies and procedures, except as otherwise provided below: *Scheduling meetings* 22. The sub-committee shall ordinarily meet on a bi-monthly basis, with six meetings each financial year. Additional meetings may be convened on an exceptional basis at the discretion of the Chair. 23. The Board, Chair, Chief Executive or FPIC may ask the sub-committee to convene further meetings to discuss particular issues on which they want the sub-committee's advice. *Quoracy* 24. For a meeting to be quorate there must be four members present, which must include: (a) Either the Chair or Vice Chair; (b) One Clinician 25. If any member of the sub-committee has been disqualified from participating on an item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum. 26. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken. *Voting* 27. Decisions will be taken in accordance with the Standing Orders. The sub-committee will ordinarily reach conclusions by consensus. When this is not possible, the Chair may call a vote. Only members of the sub-committee may vote. Each member is allowed one vote and a simple majority will be conclusive on any matter. Where there is a split vote, with no clear majority, the Chair of the sub-committee will hold the casting vote. The result of the vote will be recorded in the minutes. *Papers and notice* 28. A minimum of five clear working days' notice is required of the date and time of a meeting. Notice of all meetings shall comprise venue, time and date of the meeting, together with an agenda of items to be discussed.

Supporting papers must also be distributed at least five clear working days ahead of the meeting.

29. On occasion it may be necessary to arrange urgent meetings at shorter notice. In these circumstances the Chair will give as much notice as possible to members. Urgent virtual meeting by email or MS teams shall be permitted in exceptional circumstances (i.e. remedial action) at the discretion of the Chair.

Virtual attendance

30. It is for the Chair to decide whether or not the sub-committee will meet virtually by means of telephone, video or other electronic means. Where a meeting is not held virtually, the Chair may nevertheless agree that individual members may attend virtually. Participation in a meeting in this manner shall be deemed to constitute presence in person at such meeting. How a person has attended a meeting shall be specified in the meeting minutes.

Admissions of the public

31. The Chair shall determine, at their discretion, whether a meeting or part of a meeting shall be held in public or otherwise. It is anticipated that six meetings each year will be open to the public.

32. The Chair shall give such directions as they think fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the business shall be conducted without interruption and disruption.

33. A person may be invited by the Chair to contribute their views on a particular item or to ask questions in relation to agenda items. However, attendance shall not confer a right to speak at the meeting.

34. Matters to be dealt with by a meeting following the exclusion of representatives of the press and other members of the public shall be confidential to the members of the Sub-Committee and others in attendance.

35. There shall be a section on the agenda for public questions to the committee, which shall be in line with the ICB's agreed procedure as set out on our website here.

Recordings of meetings

36. Except with the permission of the Chair, no person admitted to a meeting of the sub-committee shall be permitted to record the proceedings in any manner whatsoever, other than in writing.

Confidential information

37. Where confidential information is presented to the sub-committee, all those who are present will ensure that they treat that information appropriately in light of any confidentiality requirements and information governance principles. This includes any information governance

	requirements expected of the ICB under the Delegation Agreement (e.g. clauses 17 and 21) and the MOU (e.g. clause 22). *Meeting minutes* 38. The minutes of a meeting will be formally taken in the form of key points of debate, actions and decisions and a draft copy circulated to the members of the sub-committee together with the action log as soon after the meeting as practicable. The minutes shall be submitted for agreement at the next meeting where they shall be signed by the Chair. *Governance support* 39. Governance support to the sub-committee will be provided by the ICB's governance team. *Conflicts of interest* 40. Conflicts of interest will be managed in accordance with the policies and procedures of the ICB and those contained in the Handbook and shall be consistent with the statutory duties contained in the National Health Service Act 2006 and any statutory guidance issued by NHS England. 41. The ICB acknowledges that it shall comply with sections 17 and 23 of the MOU which, in summary, requires the ICB to: (a) Openly declare conflicts of interest in any decision-making forum convened for the purposes of making a decision under the provisions of the MOU. (b) Comply with relevant guidance and maintain a publicly available register of interests in respect of all persons making decisions concerning the functions set out in the MOU.
Behaviours and Conduct	42. Members will be expected to behave and conduct business in accordance with: (a) The ICB's policies and procedures including its Constitution, Standing Orders and Standards of Business Conduct Policy; which sets out the expected behaviours that all members of the Board and its committees will uphold whilst undertaking ICB business; (b) The NHS Constitution; (c) The Nolan Principles; 43. Members must demonstrably consider equality diversity and inclusion implications of the decisions they make.
Accountability and Reporting	44. The sub-committee is accountable to the FPIC and shall report to the FPIC on how it discharges its responsibilities.

	45. The sub-committee will submit copies of its minutes and a report to the FPIC following each of its meetings. 46. The sub-committee will provide the FPIC with an annual report. The report will summarise its conclusions from the work it has done during the year.
Review	47. The sub-committee will review its effectiveness at least annually or more frequently if required. 48. These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the FPIC and the Board for approval.

Date of approval:	31 January 2024
Date of review	1 April 2025
Version:	2.0

Annex 1 – Key Documents

Delegation Agreement	https://northeastlondon.icb.nhs.uk/wp-content/uploads/2023/07/NEL-Primary-Care-and-Dental-Delegation-Agreement-FINAL.pdf
Memorandum of Understanding (PODS), including the Terms of Reference for the Commissioning Oversight Group	 MOU POD Services London.pdf  London POD Commissioning Ove
London Operating Model for PODS	[insert]
Link to the Operational Scheme of Delegation for Primary Care	https://intranet.northeastlondon.icb.nhs.uk/wp-content/uploads/2024/02/Appx-4.2-Operational-Scheme-of-Reservation-and-Delegation-for-Primary-Care.pdf