Improving lives together
Norfolk and Waveney Integrated Care System

Meeting of the Norfolk and Waveney ICB Primary Care Commissioning Committee
Tuesday 12 July 2022, 13:30 – 15:00/15:30 Part 1
Meeting to be held via video conferencing and You Tube

Item	Time	Agenda Item	Lead
1.	13:30	**Chair's introduction and report on any Chair's action**	Chair
2.		**Apologies for absence**	Chair
3.		**Declarations of Interest** To declare any interests specific to agenda items. Declarations made by members of the Primary Care Committee are listed in the ICB's Register of Interests. *For noting*	Chair
4.		**Review of Minutes and Action Log from the June 2022 meeting (CCG)** *For approval*	Chair
5.		**Terms of Reference** *For Noting*	AB
6.		**Forward Planner** *For Noting*	SN
7.	13:40	**Risk Register** *For Noting*	SN
		Service Development	
8.	14:00	**Severe Mental Illness Health Checks** *For Noting*	JD
9.	14:10	**Learning Disability Health Checks** *For Noting*	SN
10.	14:20	**Interface Update** *For Noting*	MB
11.	14:30	**Locally Commissioned Services** *For Noting*	GC
12.	14:40	**Wave 4b Primary Care Hubs Programme Business Case** *For Approval*	PH
13.	14:50	**CQC Reports** • **Cromer Practice** *For Noting*	SN
		Finance & Governance	
14.	15:00	**Prescribing Report** *For Noting*	MD
15.	15:10	**Finance Report** *For Noting*	JG
		Any Other Business	
16.	15:20	**Questions from the Public**	Chair

Date, time and venue of next meeting
Tuesday 9 August 2022, 13:30 – 16:30 – ICB PCCC
To be held by videoconference and You Tube

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

Questions are welcomed from the public.
Please send by email: nwicb.contactus@nhs.net
For a link to the meeting in real-time
Please email: nwicb.communications@nhs.net

NHS Norfolk and Waveney Integrated Care Board (ICB)
Register of Interests

Declared interests of the Primary Care Commissioning Committee

Name	Role	Declared Interest- (Name of the organisation and nature of business)	Type of Interest			Is the interest direct or indirect?	Nature of Interest	Date of Interest		Action taken to mitigate risk
			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests			From	To	
James Bullion	Partner Member - Local Authority (Norfolk), Norfolk and Waveney ICB	Norfolk County Council		X		Direct	Executive Director Adult Social Services, Norfolk County Council	Ongoing		In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
Steven Course	Director of Finance, Norfolk and Waveney ICB	March Physiotherapy Clinic Limited				Indirect	Wife is a Physiotherapist for March Physiotherapy Clinic Limited	2015	Present	Will not have an active role in any decision or discussion relating to activity, delivery of services or future provision of services in regards March Physiotherapy Clinic Limited
Tricia D'Orsi	Director of Nursing, Norfolk and Waveney ICB	Nothing to Declare	N/A				N/A	N/A		N/A
Hein van den Wildenberg	Non-Executive Member, Norfolk and Waveney ICB	Lakenham Surgery			X	Direct	Member of a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
		College of West Anglia			X	Direct	Governor at College of West Anglia (Note: the College hosts the School of Nursing, in partnership with QEHKL and borough council)	2021	Present	Low risk. If there is an issue it will be raised at the time.
Norfolk and Waveney ICB Attendees										
Mark Burgis	Director of Patients and Communities, Norfolk and Waveney ICB	Drayton Medical Practice			X	Direct	Member of a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
		Castle Partnership				Indirect	Partner is a practice nurse at Castle Partnership	Ongoing		
Shepherd Ncube	Head of Delegated Commissioning	Nothing to Declare	N/A			N/A	N/A	N/A		N/A
Sadie Parker	Associate Director of Primary Care, Norfolk and Waveney ICB	Active Norfolk		X		Direct	Represent N&WCCG as a member of the Active Norfolk Board	2019	Ongoing	Low risk. If there is an issue it will be raised at the time
NHS England and NHS Improvement Attendee										
Fiona Theadom	Contracts Manager, NHS England and NHS Improvement	Nothing to Declare	N/A				N/A	N/A		N/A
Local Medical Committee Attendees										
Mel Benfell	Norfolk & Waveney Local Medical Committee Executive Officer	NHS Norfolk and Waveney ICB				Indirect	Personal friend of an employee of the ICB	2015	Present	Will not take part in any discussion or decisions relating to the declared interests.

		Windmill Surgery				Indirect	Member of a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
Naomi Woodhouse	Norfolk & Waveney Local Medical Committee Joint Chief Executive	Long Stratton Medical Practice			X	Direct	Member of a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
Practice Managers drawn from General Practice Attendees										
James Foster	Member Practice Representative	St. Stephens Gate Medical Practice	X			Direct	Partner at St. Stephens Gate Medical Practice	2019	Present	Will not take part in any discussion or decisions relating to the declared interests.
		One Norwich	X			Direct	Director, One Norwich Practices Ltd (GPPO/PCN)	2019	Present	
		N2S	X			Direct	Director, N2S, Provider of day surgery in a primary care setting	2014	Present	
		Orchard Surgery	X			Direct	Spouse is Partner at Orchard Surgery	2020	Present	
Rosemary Moore	Member Practice Representative	Humbleyard Practice	X			Direct	Employee of Humbleyard Practice	2020	Present	Will not take part in any discussion or decisions relating to the declared interests.
		Blofield Medical Practice			X	Direct	Member of a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
		Norfolk and Norwich University Hospitals NHS FT (NNUHFT)			X	Direct	Chair of NNUHFT Patient Panel	2018	Present	
Health and Wellbeing Board Attendees (Norfolk and Suffolk)										
Bill Borrett	Norfolk Health & Wellbeing Board Chair	North Elmham Surgery			X	Direct	Member of a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice
		Norfolk County Council	X			Direct	Elected Member of Norfolk County Council, Elmham and Mattishall Division	Ongoing		Low risk. In attendance as a representative of the Local Authority. Chair will have overall responsibility for deciding whether I be excluded from any particular decision or discussion.
		Norfolk County Council	X			Direct	Cabinet Member for Adult Social Care and Public Health	Ongoing		
		Norfolk County Council	X			Direct	Chair of Norfolk Health and Wellbeing Board	Ongoing		
		Breckland District Council	X			Direct	Elected Member of Breckland District Council, Upper Wensum Ward	Ongoing		
		Norfolk County Council	X			Direct	Chair of Governance and Audit Committee	Ongoing		
		Manor Farm	X			Direct	Farmer within Dereham patch	Ongoing		Low risk. If there is an issue it will be raised at the time.
Healthwatch Attendees (Norfolk and Suffolk)										
Andrew Hayward	HealthWatch Norfolk Trustee	East Harling GP Practice			X	Direct	Member of a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and
		HealthWatch Norfolk	X			Direct	Trustee and board member HeathWatch Norfolk	2020	Present	Will not take part in any discussion or decisions relating to the declared interests.
		East Harling Parish Council			X	Direct	Member, East Harling Parish Council	2020	Present	
		NHS England		X		Direct	GP appraiser, NHSE	2015	Present	
Sue Merton	HealthWatch Suffolk	Nothing to Declare	N/A				N/A	N/A		N/A

NHS
Norfolk and Waveney
Clinical Commissioning Group

Norfolk and Waveney CCG Primary Care Commissioning Committee

Part One

Minutes of the Meeting held on

Tuesday 14th June 2022 13:30
via video conferencing & YouTube

Present:
Doris Jamieson (DJ) – Primary Care Committee Chair, Norfolk & Waveney CCG
Kathy Branson (KB) – Registered Nurse
John Ingham (JI) – Chief Finance Officer, Norfolk & Waveney CCG
Hein Van Den Wildenberg (HW) - Lay Member for Financial Performance

In attendance:
Michael Dennis (MD) - Head of Medicines Optimisation, Norfolk & Waveney CCG
James Foster (PF) - Practice Manager Committee Member
Andrew Hayward (AH) – Trustee of Healthwatch Norfolk
Rosemary Moore (RM) – Practice Manager Committee Member
Shepherd Ncube (SN) – Head of Delegated Commissioning, Norfolk & Waveney CCG
Sadie Parker (SP) – Associate Director of Primary Care, Norfolk & Waveney CCG
Peter Taylor (PT) - Assistant Director, Public Health Commissioning, Norfolk County Council
Fiona Theadom (FT) - Deputy Head of Delegated Primary Care Commissioning / Interim Head of Primary Care Workforce and Training, Norfolk & Waveney CCG
Karen Watts (KW) Associate Director of Nursing and Quality, Norfolk & Waveney CCG
Tracy Williams (TW) – Clinical Governing Body Member, Norfolk & Waveney CCG

Attending to support meeting:
Gina Cooper (GC) – Senior Manager – GP Resilience, Norfolk and Waveney CCG
Sarah Webb (SW) – Primary Care Administrator (Minute taker), Norfolk & Waveney CCG

1.	**Chair's introduction and report on any Chair's action**	**Action**
	Chair welcomed everyone to the Norfolk and Waveney CCG Primary Care Commissioning Committee meeting which continued to be held virtually via MS Teams and streamed on You Tube.	
2.	**Apologies for Absence**	
	Mel Benfell (MBe) - Joint Chief Executive Officer, Norfolk & Waveney Local Medical Committee (LMC) Cllr Bill Borrett (BB) – Chair Health and Wellbeing Board at Norfolk County Council Mark Burgis (MB) - Director of Primary and Community Care, Norfolk & Waveney CCG Carl Gosling (CG) – Senior Delegated Commissioning Manager Primary Care, Norfolk & Waveney CCG Sue Merton (SM) Community Development Officer, Healthwatch Suffolk Naomi Woodhouse (NW) - Joint Chief Executive Officer, Norfolk & Waveney Local Medical Committee	

3.	**Declarations of Interest**	
	Chair encouraged Committee members to check and update their Declarations of Interest forms in respect of all interests (including those of close family members) where applicable.	
4.	**Review of Minutes and Action Log from the May 2022 meeting**	**DJ**
	The minutes of the May 2022 meeting were agreed to be a true and accurate record and would be sent to Chair for signature. **ACTION: SW to send DJ signed minutes.** There were no matters arising. <u>Action Log</u> JI requested an action be added in respect of the financial implications for the SMI Healthchecks as this action would need to be resolved. **ACTION: SW to add onto action log**	**SW** **SW**
5.	**Forward Planner**	**SP**
	Proposed draft forward planner in respect of ICB PCCC, which had been circulated to Committee members on 13 June 2022. SP provided a brief overview to Committee members. SP reflected on work done previously and what work would be needed in the future. A suggestion was to bring the risk register bi-monthly which would fall in line with the new "Governing Body" as that would also meet bi-monthly. Locally commissioned services had been removed as this had become business as usual. A date needed to be confirmed around the report on delegation which would fit in with timelines of NHSE/I. DJ queried the feedback from localities and asked if the Committee wished to hear this in the future. SP indicated that within the Governance of the new ICB there would be a People and Communities Committee which would focus on the development of primary and community provision . The new Primary and Community Development board would also be established as part of the ICB. SP felt PCN development reporting would be heard there. PCCC would focus on the contractual side of delegated commissioning. DJ felt that it was important that updates from localities were heard in the future. TW supported DJ comments and agreed Place would become much more significant. TW reflected on the risks and agreed it was right to hear these bi-monthly however it would be useful to hear if any risks escalated in between time. In respect of QOF actuals, TW felt that these were helpful around the immunisations and vaccinations and asked if these needed to be considered and felt it would be useful to have some oversight. JI noted that the Learning Disability and Autism Healthchecks would be moved to bi-monthly reporting going forward. JI felt this needed to be heard monthly to ensure this remained a priority. JI was unsure if the remit of delegated commissioning primary care would be for this Committee but felt it would be useful for the future.	

	KB supported JI comments regarding the LD HealthChecks. KB reflected on the fact that there was a risk dashboard presented to the Quality and Performance Committee and felt that this would be useful going forward. DJ agreed it would be useful to resurrect this. SP thanked members for their comments. A performance report would be needed in respect of immunisations and vaccinations and all other areas. SP went on to say that the BI team continued to work on the data needed to develop the primary care reports. The committee terms of referency would be reviewed again in December 2022 and that provided us with an opportunity to refine the work plans further. In respect of leaning disability healthchecks, the risk score remained the same. There was a robust structure in place for this programme of work and SP asked SN to provide an update to Committee today. SP felt the greater focus needed to be on SMI healthchecks going forward, where performance had been particularly low. The final point around the risk register summary, SN had dedicated resource to improve the risk register and SP hoped to implement this in time for the first ICB Committee. DJ asked if the forward planner could be finalised in time for the July 2022 Committee. **ACTION: SP/SW to finalise forward planner for July 2022**	**SW**
6.	**Risk Register**	**SP**
	SP advised that a comprehensive review had been undertaken in respect of each risk with its owner and drew Committees' attention to these. PC1 Workforce Risk Error with an arrow – should not be upwards. This would be resolved. The recommendation within the action log was to create two risks. The risks around GPs and nurses were different to the rest of the workforce particularly in respect of the Additional Roles. SP felt that these needed to be separated out. PC2 Estates Strategic Plan Recommendation was to close this risk as it had significantly reduced, had met the tolerated risk and due date. A rationale had been provided by Paul Higham within the risk update. PC9 Hypnotics and Anxiolytics A comprehensive update indicated positive progress had been made on this risk. Teams were starting to work with the mental health provider trust. PC11 Interface An update would be provided at July 2022 Committee. A change to the target date had been proposed due to staffing issues. Progress was underway within a new task and finish group. PC14 (GBAF)	

	This would transfer to the ICB Board Assurance Framework. Risk had been slightly reduced and had met target score. SP suggested that this remained under review for another one or two months given some case rises had been seen in other areas of the country. PC15 Wave 4B hubs A significant reduction in score on the risk rating. The update reflected the work being done within the estates team and there was confidence around progress. This would continue to be monitored at new Committee due to the target date being 2024. PC16 Severe Mental Illness Healthchecks New risk agreed at Committee in May 2022. Information had been captured and an update had been provided for June 2022. HW thanked SP for the update. HW asked if the risk PC15 could await approval from NHSE/I in September 2022 and remain a RED risk. JI was in agreement as it would not be unusual for the circumstances to change at the last minute. DJ was also in agreement. TW was in agreement with the General Practice workforce differences and separating the ARRS roles and felt the wider primary care workforce would be impacted along with supporting services going forward. DJ questioned the closure of PC2 – there was a comment in the paper around the development of the PCN strategy and DJ asked why the risk was lower. JI reflected the work done around strategic view of primary care estates and JI felt there was a good overview of the estates as PCNs may not have their own views. JI was in agreement with the risk content. SP confirmed the LMC had raised the same queries. The work done had enabled the risk score to be reduced and SP felt the team and infrastructure in place would meet the target as originally raised. The work would continue. JI referred to PC14 and the proposal to close this. JI referred to increase in unpleasant behaviours impacting on retention and recruitment. JI felt it important not to lose sight of this. SP felt this linked in with PC1. PC14 risk was around the impact of the Covid19 pandemic and linked in with resilience and workforce and these would continue to be monitored. Communications and engagement were in support with a campaign and it was raised at HOSC and councillors were supportive. NHSE/I had included a section on managing appropriate behaviour within policy guidance manual along with template documents such as a standard letter which could be sent to patients who were rude or abusive. There was a patient template agreement which outlined behaviours expected and what patients would expect in return to enable patients to remain with their practices.	
7.	**Learning Disability Health Checks**	**SN**

	SN outlined that this was a summary report for Committee where delivery against the year-end target had been outlined. SN took the opportunity to confirm the position with Committee and outlined that Norfolk and Waveney performance was now consistent with the regional performance. SN outlined the priorities for the next 2 quarters and the work being done to reach out to patients and practices which needed additional support. SN went on to talk about the work with ProtectNow and the peripatetic team, the focus on the team in West Norfolk and the additional resources in South Norfolk. The LD Champions channel had been opened to all colleagues and SN reflected on the work that Open Doors were doing to help understand the feedback and engagement with people that had their healthchecks and SN welcomed the report which was due. SN offered to take questions. DJ had a question around data and referred to the link to the risk register where patients were encouraged to have checks who had not had checks before, whereby DJ then referred to NHSE/I guidance. DJ asked whether the data would split out and identify new uptake to enable monitoring to ensure patients who had not received a healthcheck in the last year that these were prioritised. SN responded by saying the funding arrangements in place would allow identification of who had not received healthchecks and there was an awareness of numbers and work was being done with practices on this. DJ asked if there would be a separate line which could report where patients had not had a healthcheck before. SN responded by saying that as a system there was no data available. NHSE/I monthly reporting would be available in arrears and this would identify those who had not had healthchecks. DJ asked if this could be separated out to provide assurance to the Committee for the future. KW thanked SN for the report and noted progress made. KW had comments around the engagement which had taken place and how ProtectNow would be able to identify patients who had not taken up healthchecks. KW referenced people had attended Governing Body previously where they had the opportunity to speak, and what would make it easier for patients to attend healthchecks. TW had comments similar to KW along with the focus on the missing 30%. TW felt that there needed to be a cultural change and suggested to use the insight gained from the data provided. TW felt some individuals would struggle to attend some settings and felt a bespoke offer may be appropriate to meet patient needs. JI continued the theme of the focus on people who had not had a healthcheck and felt that there may be a need to report on longest waits for a healthcheck,	

	or the longest time since a patient had received a healthcheck and to focus on these. SN reflected on early feedback from Early Doors and how patients would like to be contacted. SP was aware that 30% of patients had not been reached in 2020/21 and reflected on the work SN and his team were doing, and the recommendations to the Committee for commissioning. SP reflected on the work the peripatetic team had done and the intensive resources some patients required. SP added to the comments with regard to the longest waits. The reliance on this data sat with practices and may not be accessible. SP hoped that work with the data sharing with individual practices would enable this in the future. DJ thanked SN for the report.	
8.	**CQC Reports**	**SN**
	SN gave an update on CQC inspection reports for this month. Two inspection reports had been published by the CQC since last month: Manor Farm Medical Centre, Swaffham. Wensum Park Medical Practice, Norwich. Both practices had been assessed by CQC as inadequate in their overall rating and in the leadership and safe domains. Both practices had been rated good in caring and responsiveness and requires improvement in the effectiveness domain. SN reflected on a previous challenge from the members of the Committee on the proactive support for practices in order to avoid poor service delivery. Work was underway around learning, leadership and cultural change issues and the CQC had agreed to support the CCG with leadership and cultural change. Sessions would be available to practices to support them to drive improvements in medicines management and governance. TW thanked SN for the reports and reflected on the similarities within the practices and the demographics and felt the patient population needed focus. JI had 2 questions. JI referred to the two reports where safety was rated inadequate and wanted assurance on patient safety. JI felt that it would be useful to see the reports as a whole overall picture in order to keep a view on themes and the actions which had been taken to provide context and assurance. SN confirmed that there were no patient safety issues which needed to be raised as these had been assessed by the CQC through the practice action plans. DJ reflected on JI's comments on themes and the regular communications to practices and asked if there was a place where emerging themes could be highlighted to enable practices to be more proactive. SN would give thought	

	to which platform would be suitable to share good practice and the lessons learned would be a focus. PT had two points. One theme may be around geography and the benefit of the overall view of Norfolk and Waveney. The other point was the slight difference between the two inspections. There was a warning notice served in terms of Manor Park Medical Centre as they were actively in breach of a recommendation and PT wanted to highlight governance was the theme that often suffered as a result of staffing. The practice would want the warning notice removed as soon as possible and PT queried whether the CQC could visit again. SP referenced that the CQC were part of the team where the action plans were reviewed. Where a notice had been applied, the CQC had prioritised another visit. SP referred to DJ comments about being proactive in support and refenced videos of training and the work being done within medicines team. SP also noted Manor Farm had not been inspected since around 2016, when CQC had a different inspection regime, and work with practices would be ongoing to support practices going forward.	
9.	**Locally Commissioned Services**	**GC**
	GC provided a high level update to Committee. • Phlebotomy was live within General Practice across the entire system. • Spirometry toolkit had now been developed and rolled out. The impact of a delayed release would be seen once quarter one figures are received. It was anticipated that quarter two would see an upturn in activity. • Proactive Healthcare – an internal meeting would take place to sign off the submissions from practices by the deadline of 30 June. • Searches and reports – work had been done with General Practice and Ardens reports had been created which enabled consistent reporting. In respect of commissioning, searches had been identified which would inform understanding of where activity was taking place. • Patient Survey Report – a response was being worked upon – this was delayed due to the significant amount of data which had been received which had highlighted the lack of understanding of practices' core services and this would be further reviewed to enable a more comprehensive response. • Warfarin mobilisation – the project had been delayed due to the need to ensure a smooth transfer of data from acute to primary care. The transfer was more in depth due to the need to undertake data validation. The mobilisation had been delayed by one month to enable this. GC offered to take questions.	

	There being no questions DJ thanked GC for the report and the work done. GC thanked the Committee for their challenge and support and felt this had enabled successful roll out of the LCS.	
10.	**Prescribing Report**	**MD**
	MD provided highlights to Committee. MD outlined March 2022 data received in detail to Committee. Dependence forming medicines – an improvement was noted within all 3 areas. Work had started with NSFT around the initial response to the over prescribing review and mental health was a key area of work going forward. MD would include a section on this within future reports. MD went on to antibiotics and the work being done around this, which included focused work being done with outliers. MD welcomed comments. TW referred to the antibiotic prescribing, the trends and to a time when she would have her own prescribing data. MD commented that data down to individual prescriber level would come with significant health warnings, for example trainee doctors' prescribing data would sit under their trainer. TW felt that this prescribing data, with caveats needed to be highlighted to individuals. The data was available from the national portal and TW felt that this would be a good idea. DJ thanked MD for the update.	
11.	**Any Other Business – Questions from the Public**	**Chair**
	There being no other business or questions from the public the Committee closed at 14:50	
	Date, time and venue of next meeting **Tuesday 12th July 2022, 13:30** **Via MSTeams Live & You Tube**	
	Any queries or items for the next agenda please contact: **Sarah Webb – sarah.webb7@nhs.net**	

Minutes agreed as accurate record of meeting:

Signed: …….. Date: ……..
Chair

Code
RED Overdue
AMBER Update due for next Committee
GREEN Update given
BLUE Action Closed

Improving lives together
Norfolk and Waveney Integrated Care System

Norfolk & Waveney IBC Primary Care Commissioning Committee - Part One
Action Log 12 July 2022

No	Meeting date added	Agenda Item	Owner	Action Required	Action Undertaken / Progress	Due date	Status	Date Closed
0106	12th April 2022	12	SW	Interface Update - schedule an update on July 2022 agenda	Added to forward planner, recommend close action	12th July 2022		14th June 2022
0109	14th June 2022 (10th May 2022 meeting)	8	JD	Added on in June 2022, should have been May 2022 - SMI Healthchecks Item - Financial Implications need resolution		12th July 2022		
0110	14th June 2022	4		Minutes - to add signature and send to Chair	Signed minutes sent to Chair	12th July 2022		14th June 2022
0111	14th June 2022	5	SP/SW	Forward plan to be reviewed in advance of implementation of ICB in July 2022	Forward plan updated and included in papers	12th July 2022		14th June 2022

APPENDIX F

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

1 Constitution

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

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

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

2 Authority

2.1 The Committee is authorised by the Board to:

- Investigate any activity within its terms of reference.
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these terms of reference.
- Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's constitution, standing orders and Scheme of Reservation and Delegation (SoRD) but may not delegate any decisions to such groups.

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

3 Purpose

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

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

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

4 Membership and attendance

Membership

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

Constitution.

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

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

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

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

Chair and Vice Chair

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

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

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

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

Attendees

4.9 Only members of the Committee have the right to attend Committee meetings. The following individuals, who are attendees and not members of the Committee, will be invited to attend Part 1 and Part 2 meetings:

- NHS England and NHS Improvement
- ICB Board Partner Member – Providers of Primary Medical Services
- Local Medical Committee Representative
- Director of Patients and Communities
- Associate Director of Primary Care
- Two Practice Managers drawn from general practice

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

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

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

4.11 Other individuals may be invited to attend all or part of any meeting as and when appropriate to

assist it with its discussions on any particular matter including representatives from the Health and Wellbeing Boards, Secondary and Community Providers.

Attendance

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

5 Meetings Quoracy and Decisions

5.1 The Committee will meet at least 4 times a year in public subject to the application of 5.4 below. The Committee will operate in accordance with the CCG's Standing Orders. The Secretary to the Committee will be responsible (or delegate where appropriate) for giving notice of meetings. This will be accompanied by an agenda and supporting papers and sent to each voting member and non-voting attendee no later than 5 days before the date of the meeting. When the Chair of the Committee deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as s/he/they shall specify. Additional meetings may take place as required in public or private as appropriate for the nature of the business to be transacted.

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

5.3 In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

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

Quorum

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

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

5.6 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken. If an urgent decision is required, the process set out at 5.10 and 5.11 may be followed.

Decision making and voting

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

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

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

Urgent Decisions

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

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

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

6 Responsibilities of the Committee

6.1 NHS England has delegated to the ICB authority to exercise the primary care commissioning functions set out in Schedule 2 in accordance with section 13Z of the NHS Act.

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

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

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

6.4 The role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act.

6.5 This includes the following:

a. decisions in relation to the commissioning, procurement and management of Primary Medical Services Contracts and other primary medical care services under other appropriate contracting arrangements, including but not limited to the following activities:

    I. decisions in relation to Enhanced Services, including in relation to the PCN Network DES;

II. decisions in relation to Local Incentive Schemes (including the design of such schemes);

III. decisions in relation to the establishment of new GP practices (including branch surgeries) and closure of GP practices;

b. decisions about 'discretionary' payments;

c. decisions about commissioning urgent care (including home visits as required) for out of area registered patients;

d. the approval of practice mergers;

e. planning primary medical care services in the Area, including carrying out needs assessments;

f. review reports of primary medical care services in the Area;

g. decisions in relation to the management of poorly performing GP practices and including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the performers list);

h. management of the Delegated Funds in the Area;

i. Premises Costs Directions functions;

j. co-ordinating a common approach to the commissioning of primary care services with other commissioners in the Area where appropriate;

k. such other ancillary activities as are necessary in order to exercise the Delegated Functions;

l. approval of the investment of PMS Monies.

m. review, redesign and decommissioning of existing Local Enhanced Services;

n. review and design of primary care dashboard; and

o. review and monitoring of the primary care risk register;

p. Approve arrangements for shared care commissioning

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

a) The recommendations of the clinical executive, the executive management team and other Board committees;

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

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

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

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

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

7 Behaviours and Conduct

ICB values

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

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

Equality and diversity

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

Conflicts of Interest

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

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

Confidentiality

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

8 Accountability and reporting

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

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

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

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

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

9 Secretariat and Administration

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

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Committee Chair with the support of the relevant executive lead.
- Attendance of those invited to each meeting is monitored, highlighting to the Chair those that

do not meet the minimum requirements.

- Good quality minutes are taken in accordance with the Standing Orders and agreed with the Chair and that a record of matters arising, action points and issues to be carried forward are kept.
- The Chair is supported to prepare and deliver reports to the Board.
- The Committee is updated on pertinent issues/ areas of interest/ policy developments.
- Action points are taken forward between meetings and progress against those actions is monitored.

10 Review

10.1 The Committee will review its effectiveness annually.

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

Date of approval:

Date of review:

Norfolk and Waveney ICB – Primary Care Committee – 2022/23 PART ONE

	Proposed date:	July 12th	August 9th	September 13th	October 11th	November 8th	December 13th	Jan 10th	Feb 14th	March 14th			
Standing items:	Risk Register	Y		Y		Y		Y		Y			
	Monthly Finance Report	Y	Y	Y	Y	Y	Y	Y	Y	Y			
	Estates Quarterly		Y			Y			Y				
	Digital Quarterly		Y			Y			Y				
	Prescribing Report	Y	Y	Y	Y	Y	Y	Y	Y	Y			
	Workforce and Training			Y				Y					
	PCN DES			Y				Y					
	CQC Inspections Report	Y	Y	Y	Y	Y	Y	Y	Y	Y			
	Director of Primary Care Report		Y		Y		Y		Y				
Spotlight items:	Annual or Bi Annual Report on Delegation	TBC											
	Terms of Reference Review	Y					Y						
	Learning Disability /Autism Health check monthly	Y	Y	Y	Y	Y	Y	Y	Y	Y			
	PCCC Self Assessment									Y			
	Severe Mental Illness Health checks	Y	Y	Y	Y	Y	Y	Y	Y	Y			
	Enhanced Access			Y			Y			Y			
Items noted without a date:													

NHS Norfolk and Waveney CCG – Primary Care Commissioning Committee Assurance Framework

PC1	
Risk Title	General Practice – Workforce (GPs and Nurses)
Risk Description	Lack of general practice GPs and Nurse workforce due to vacancies and impending staff retirements. The impact on the service delivery to patients.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Sadie Parker	Primary Care Committee Commissioning (PCC)	Fiona Theadom	01.06.2020	31.03.2025

Risk Scores								
Unmitigated			**Mitigated**			**Tolerated**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	3	4	12	2	4	8

Controls	Assurances on controls
• Workforce plans in place at system level. • Primary Care Workforce Transformation team being expanded and recruited to support workforce development with integrated working with ICS workforce team. • Training hub supported by clinical leadership with two roles recruited to support Placement and Quality of Learning Organisations and Educators • Primary Care Networks (PCNs) supported to develop and implement workforce trajectories in support of the Additional Roles Recruitment Scheme (ARRS) to provide a multi-disciplinary approach to patient care • National workforce reporting service - Practices report monthly, PCNs report quarterly, contractual requirement as part of General Medical Services (GMS) and PCN Directed Enhanced Services (DES).	**Internal:** Reporting to Primary Care Commissioning Committee (PCCC). Training Hub and Workforce Implementation Group meets two-monthly **External**: NHSEI returns monthly as part of the General Practice Transformation implementation and quarterly assurance meetings with Health Education England (HEE) and NHSE/I

Gaps in controls or assurances

- System approach for paramedic rotational roles agreed approach subject to national review.
- General Practice workforce plans need to be refreshed and updated,
- Understanding general practice resilience as work refocuses from pandemic response towards business as usual may lead to higher numbers of the workforce leaving/retiring during 2022 and 2023
- Ability to attract new workforce to Norfolk and Waveney and can be mitigated by system level action

Updates on actions and progress

Date	Action	RAG	Target completion
May 2022	New ICS Level Training Hub contract requires submission of 4 documents relating to primary care workforce planning to HEE by end Sept 2022: • Workforce Strategy (3 years) • Stakeholder Engagement Strategy and Plan (3 years) • Operational Delivery Plan (1-3 years) • Financial Plan (yearly) To be approved by new Oversight Board by end Sept 2022.		30 September 2022 (amended)

	A placement capacity expansion strategy is due to be published and number of learning organisations is increasing with targeted intervention and support. The recruitment to PCN Additional Roles Recruitment Scheme to support general practice faces challenges in some geographical areas also facing GP and Nurse recruitment difficulties. Primary care has joined the ICS led initiative looking at how to improve recruitment in rural and isolated coastal areas and other ICS task and finish groups to consider system wide approach to recruitment & retention for N&W. Recommended change to target date.		
June 2022	Recommendation to create two risks related to workforce, one for GPs and Nurses and a second risk for other healthcare professionals and ARRS. GPs and Nursing workforce facing differing pressures from Allied Health Professionals; primary care nursing workforce different pressures from secondary care and therefore recommend separate from ICS People risk register. Actions and further details to be described in the Training Hub Strategy and Delivery Plan being developed.		August 2022
July 2022	This risk reflects risks to GPs and Nurse workforce only. Refer to PCxx for Allied Health Professionals and ARRS in general practice. Further details relating to Nurse recruitment and retention will be included next month.		August 2022

Visual Risk Score Tracker (ICB July 2022 onwards)												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score												
change	→	→	→	→								

PC6	
Risk Title	Learning Disability Annual Physical Health Checks
Risk Description	The CCG is at risk of failing to meet its commitment to improve health and wellbeing for people with a learning disability if the quality and uptake of the annual physical health checks are not completed in line with the NHS national guidance. A minimum requirement of 75% in uptake numbers is required under the National Directed Enhanced Service (DES) and a different and targeted approach is required for the CCG to meet this commitment for this group of people. There is a risk that people living with a learning disability will experience significant health inequalities. Access to an annual physical health check is intended to help reduce this risk, however, there are variable rates of uptake across Norfolk & Waveney GP practices. The CCG will not be able to fully meet its commitment to transform the lives of people with Learning Disabilities.
CCG priority	

Risk Owner	**Responsible Committee**	**Operational Lead**	**Date Risk Identified**	**Target Delivery Date**
Sadie Parker	Primary Care Commissioning Committee	Shepherd Ncube	01.06.2020	31.03.2023

Risk Scores

Unmitigated			**Mitigated**			**Tolerated**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	3	4	12	2	3	6

Controls	**Assurances on controls**
• Plan in place to increase uptake of LD health checks across practices • All practices signed up to the LD DES (bar 1 - UEA as they feel their student population does not meet the criteria) • Regular monitoring by Norfolk Health Overview and Scrutiny Committee • CQC inspections usually include review of LD health checks performance • Application to be regional exemplar site was successful - BAME outreach worker in post. • Transformation funding secured for a small peripatetic team, this will help support practices that are behind their trajectory. • Peripatetic team and GP with a special interest are now in post and their first pilot area to improve LD health checks was in the Norwich PCN, with south Norfolk next. • Regular assurance reports to NHSE/I & PCCC	**Internal:** Primary Care Commissioning Committee **External**: NHSE Checkpoint and Assurance Framework, Health Overview and Scrutiny Committee Reports to NHSE/I

Gaps in controls or assurances

LDAHCs are now being undertaken face to face

Updates on actions and progress

Date	**Action**	**RAG**	**Target completion**
June 2022	NHS England has issued a communication to all practices confirming the priority for Q1 and Q2 is to offer a health check to all people who didn't engage in 2021—22. The Delegated Commissioning team to send out a further communication outlining additional short-term support for practices to achieve this and requesting confirmation that practices are able to meet the national request – if not, to outline any support required to ensure prioritisation of this cohort by end September.		30/06/22

July 2022	Steady progress is being in prioritising, reaching and carrying out health checks for people who did not have it done in 21-22 in Q1 and Q2. We have received positive engagement from the majority of practices confirming they have plans in place or requesting further support to achieve this. Locality teams to confirm local plans in support of this initiative. Data streams are in the process of being established in order to monitor progress and highlight further areas where support may be required. Excellent progress was made in the update and quality of the reviews and the risk score has been reviewed by the LD delivery group and the risk of failing to meet the national and local commitment for this population has reduced. The recommendation is to revise the score to 12		31/07/2022

Visual Risk Score Tracker												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score												
change	→	→	→	→								

PC9	
Risk Title	Hypnotics and anxiolytics prescribing
Risk Description	High prescribing rate of hypnotics and anxiolytics in primary care - 3rd nationally on volume per 1,000 patients. These medications have negative side effects on patients and should not routinely be used long term.
CCG priority	

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Dr Frankie Swords	Primary Care Commissioning Committee (PCCC)	Michael Dennis	28.07.2020	31.3.2023

Risk Scores

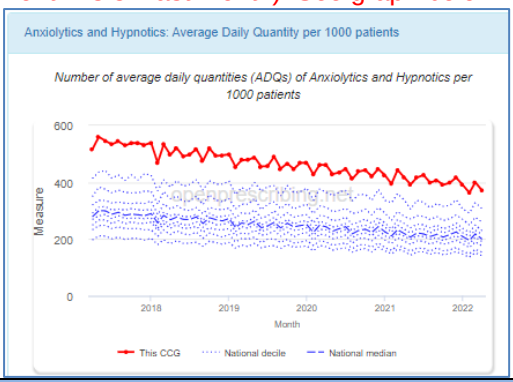
Unmitigated			Mitigated			Tolerated		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	4	4	16	3	4	12

Controls	Assurances on controls
Practices have been encouraged to review their use of hypnotics/anxiolytics however not all practices have taken decisive action to reduce this. This years' Prescribing Quality Scheme (PQS) incentivises work to reduce prescribing.	**Internal:** Review Open Prescribing data each month, report progress to PCCC. Identify practices with the highest prescribing rates. **External**: NHS England

Gaps in controls or assurances

The Prescribing Team are moving back to Quality Innovation Productivity and Prevention (QIPP) delivery and Business As Usual (BAU) alongside ongoing Covid vaccination work. The CSU team is now joining the CCG team on 1st July and we are seeking to recruit to vacancies.

Updates on actions and progress

Date	Action	RAG	Target completion
May 2022	February 22 data = ADQ/1000 patients = 363.143 98th percentile. Outlier practices will be offered further support with audit and action planning. The new PQS is being launched and incentivises improvement in this area. Practice data is showing a more marked decline for N&W practices overall than other areas, which is positive.		30.6.2022
Jun 2022	March 22 data = ADQ/1000 patients = 399.991 98th percentile (a longer month 31 days vs 28) We are now working on a longer-term project around deprescribing with NSFT, this will aim to change the prescribing culture within the organisation and reduce the use of all sedatives by clearer prescribing guidelines.		30.11.2022
Jul 2022	April 22 data = ADQ/1000 patients = 371.297 98th percentile (30 days in this month vs 31 last month). See graph below. 		30.11.2022

Month	1	2	3	4	5	6	7	8	9	10	11	12

Score												
change	→	→	→	→								

PC10	
Risk Title	Gabapentinoids prescribing in primary care
Risk Description	High prescribing of gabapentinoids in primary care - 28th nationally on volume per 1,000 patients. These medications have negative side effects on patients, their use should be regularly reviewed and they should be used in caution with opioids/hypnotics.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Dr Frankie Swords	Primary Care Commissioning Committee (PCCC)	Michael Dennis	28.07.2020	31.03.2023

Risk Scores

Unmitigated			Mitigated			Tolerated		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	3	12	3	3	9	2	3	6

Controls	Assurances on controls
Practices have been encouraged to review their use of gabapentinoids however not all practices have taken decisive action to reduce this. Outlier practices are encouraged to audit their use of all DFM's	**Internal:** Review Open Prescribing data each month, report progress to PCCC. Identify practices with the highest prescribing rates. **External**: NHS England

Gaps in controls or assurances

The CSU team are being in housed by the CCG and vacancies that they have been carrying will be advertised to improve team resilience. Practice engagement is occasionally an issue.

Updates on actions and progress

Date	Action	RAG	Target completion
May 2022	Outlier practices will be offered support to audit prescribing and development of an action plan. Now 25th (74th percentile). Recommend change to target date of delivery.		30.6.22
Jun 2022	Outlier practices are being offered support. The CCG is now 28th nationally (a decrease in comparative prescribing). Joint meetings between prescribing and quality team are resuming to discuss plans and support for practices.		30.6.22
Jul 2022	April ePact data shows Norfolk and Waveney has stayed at 28th position and 74th percentile. Outlier practices have been offered support and we will be following this up.		31.7.22

Visual Risk Score Tracker

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score												
change	→	→	→	→								

PC11	
Risk Title	Primary Care/Other Providers Interface
Risk Description	There is a risk to interface issues in relation to reinstating routine care and stepping back up services as part of Phase 3, use of virtual appointments has resulted in some diagnostics being pushed to primary care unfunded. If these risks happen this could lead to other issues at the interface which also result in increased workload for primary care. These are not driven by virtual appointments in secondary care but more likely lack of communication, understanding, awareness of the responsibilities of the Provider. There is often no particular department that causes an issue, just a range of individuals. Increased workload for primary care, increasing frustration at the passing of unfunded activity from secondary care to primary care, risk that some practices will refuse to pick up any additional workload from secondary care leaving patients in a very difficult position.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Dr Frankie Swords	Primary Care Commissioning Committee	Kate Lewis	26/08/2020	30.9.2022

Risk Scores								
Unmitigated			**Mitigated**			**Tolerated**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	3	3	12	3	4	12

Controls	Assurances on controls
The risk has been flagged to EMT, steps being taken to address the issues include; • Establishment of a system wide Interface Group, with representation from all system partners, the aim of the group is to discuss and agree actions to resolve key interface issues. • All providers have approved and are implementing the interface policy which clarifies contractual roles and responsibilities in secondary care. • Review and update the current process for all system partners to report interface issues for escalation. • Practices can escalate interface issues into the PID inbox currently. These are flagged to the relevant provider for investigation. • To set out plans to scope specific projects and pieces of work to identify issues in relation to this risk and to quantify the extent of the issue.	**Internal:** EMT (Executive Management Team), Interface Group **External**: Local Medical Committee (LMC)

Gaps in controls or assurances
Dedicated resource to progress project pieces including administrative support remains a barrier to investigating issues and implementation of mitigating actions.

Updates on actions and progress			
Date	**Action**	**RAG**	**Target completion**

July 2022	• Clinical Interface Group continues to meet on a monthly basis. • Task and Finish Group 1: Repeat x-ray requests met on 7th June. Actions agreed and fed back to Clinical Interface Group for approval. Full written report by 16/08/22. • Task and Finish Group 2: Private Referrals requests to meet on 7th July. • Clinical Interface Group agreed to establish Task and Finish Group 3: ICE user requests – meeting tbc.		16.08.22

Visual Risk Score Tracker

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score												
change	New	→	→	←								
ICB 2022/23												

PC13	
Risk Title	Resilience of General Practice
Risk Description	There is a risk to the resilience of general practice due to a number of factors including workforce and workload – if this happens individual practices could see their ability to deliver care to patients impacted through lack of capacity or the quality of care provided. This will have a wider impact as neighbouring practices pick up additional workload which in turn affects their resilience.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Sadie Parker	Primary Care Commissioning Committee	Sadie Parker	02/11/2020	30/09/2022

Risk Scores

Unmitigated			Mitigated			Tolerated		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
3	4	12	3	4	12	2	4	8

Controls	Assurances on controls
• Locality teams support for practices in their areas • PCN development support • Workforce support through Additional Roles Reimbursement Scheme and training • CCG working with NHSE to develop supportive framework for improving primary care quality	**Internal:** PCCC, locality teams, development of primary care quality supportive framework **External**: Complaints, CQC

Gaps in controls or assurances

- Process for quality framework not yet fully developed.

Updates on actions and progress

Date	Action	RAG	Target completion
06.06.22	No change reported in resilience issues this month. The WAF programme has been concluded and the resilience programme has been agreed and published to practices. Some practices have been registering significant numbers of Ukrainian guests and others have had significant numbers of asylum seekers registering, both of which have impacted on their capacity. The CCG has provided support to practices where it can by providing guidance and facilitating registration, working with the People from Abroad team at Norfolk County Council. The delegated team is planning to develop a more proactive approach to supporting the registration of asylum seekers.		30.6.22
01.07.22	Practices are beginning to see increased staff sickness again, with high levels of demand remaining. There is a current shortage of needles for blood collecting in the supply chain, this is being managed by the pathology alliance however is leading to cancellation of non-urgent blood testing. We have been directed by the national team to commission a locally commissioned service for health checks for Ukrainian nationals, and this is currently in development. The panel for assessing applications for resilience funding is meeting on 6 July.		31.7.22

Visual Risk Score Tracker

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score												
change	→	→	→	→								

PC 14 BAF06	
Risk Title	Impact on general practice from the Covid-19 pandemic
Risk Description	There is a risk services provided by general practice across Norfolk and Waveney system may be impacted by Covid 19 due to the impact of staff testing positive, staff isolating, increased demand from patients that have put off accessing services during the pandemic, and the delivery of the PCN Covid vaccination campaign. If this happens, significant pressures will be placed on practices and other primary care services, as well as urgent and emergency care and community services. Staff absences will increase and the infrastructure to provide safe and responsive services will be compromised. This may lead to delays in accessing care, increased clinical harm as a result of delays in accessing services, failure to deliver the recovery of services adversely affected, and poor outcomes for patients due to pressured Primary Care services
CCG priority	To deliver the Covid vaccination programme to all eligible residents. To make sure that people can live as healthy a life as possible & To make sure that you only have to tell your story once.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Mark Burgis	Primary Care	Sadie Parker	01/09/2020	30/09/2022

Risk Scores								
Unmitigated			**Mitigated**			**Tolerated**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	4	20	3	4	12	3	4	12

Controls	Assurances on controls
• Locality teams and strategic primary care teams prioritised around supporting the resilience of general practice and the Covid vaccination programme. All practices have been supported to review business continuity plans • £2.94m supporting primary care funding invested in all 105 practices to ensure additional capacity can be maximised. Further £2.3m invested in May 2021. PCN ARRS (additional roles reimbursement scheme) may be used to support the covid vaccination campaign. Extended hours and improved access schemes can be repurposed by PCNs to provide additional capacity. Locally commissioned services commissioned on block basis in Q2-4 to enable flexibility to support recovery of services • Primary care workforce and training team working closely with locality teams to identify clinical and volunteer workforce and to ensure training available to support practices and PCNs in setting up and maintaining services • Winter Access Funding bid submitted to NHSE&I for £4.8m in November • National contract temporary changes implemented in December to free up capacity until the end of March 2022	**Internal:** EMT, Strategic Command, SMT, workforce steering group, primary care cell **External**: Primary Care Commissioning Committee, NHS England via delegation agreement, Health Education England, Norfolk and Waveney Local Medical Committee

Gaps in controls or assurances

- Practice visits, CQC inspections focused on where there is a significant risk or concern
- Unplanned risk associated with outbreaks, self-isolation requirements or positive cases
- Impact of ambulance delays diverting practice teams from routine and urgent care to respond to emergencies

Updates on actions and progress			
Date	**Action**	**RAG**	**Target completion**
06.06.22	We are receiving fewer reports of staff absences due to Covid, usual workforce pressures apply and an increase in turnover of reception staff is being reported widely, due to the increase in unpleasant and abusive behaviours from some patients. WAF programme has concluded. Resilience programme has been published to practices, with panels due to be held to assess applications in July. Target score has been met for this risk, suggest keeping under review for at least a further month.		
01.07.22	We are seeing some impact from increasing cases of Covid leading to staff sickness, this is being closely monitored with the locality teams supporting around business continuity planning where they can. It is recommended this risk is combined with and monitored through the practice resilience risk (PC13) under the 'living with Covid' approach .		31.7.22

Visual Risk Score Tracker												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score												
change	→	→	↓	→								

PC15	
Risk Title	Wave 4B Primary Care Hubs – loss of capital funding
Risk Description	There is a risk that there could be a loss of £25m capital funding if the 5 Wave 4B Primary Care Hubs are not operational by March 2024. Programme Business Case approved by December 2021. Full Business Case approved by March-June 2022.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Sadie Parker	Primary Care Commissioning Committee (PCCC)	Paul Higham	31.03.2021	31.03.2024

Risk Scores								
Unmitigated			**Mitigated**			**Tolerated**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	2	4	8	2	2	4

Controls	Assurances on controls
CCG have appointed NorLife to project manage and write the Programme Business Case and NorLife are in the process of engaging with various stakeholders across the 5 projects. Wave 4B Programme Board established - 5 workstreams also established as support. Meet with NorLife fortnightly to review progress and outstanding actions.	INTERNAL: Wave 4B Programme Board, Primary Care Estates Team, PCN Teams, PCCC, CCG EMT. EXTERNAL: NHSE/I, LMC, Provider Trusts, Third Party developers (tbd), County, City and District Councils

Gaps in controls or assurances

Programme plan monitored by Programme Board.
Feedback awaited from NHSE/I around approval process which could be put the delivery of the programme at risk.

Updates on actions and progress

Date	Action	RAG	Target completion
June 2022	Internal work on the revised PBC is on track for the internal deadline of 10th June and submission to NHSE/I on 22nd June. Upon submission to NHSE/I the approval process is expected to take 3 months. During this period work will continue to develop the FBCs for each scheme at risk. A report from NHSPS on their proposed approach to the 2 new build schemes which will inform FBC development is expected w/c 6 June. Overall risk likelihood has been significantly reduced due to the progress made, meaning a reduction from a risk score of 16 to 8.		22.6.22 (NHSE/I PBC Submission)
July 2022	PBC was submitted to NHSE on 22nd June 2022 in advance of formal ICB approval. The PBC is presented to the PCCC in July 2022 to obtain formal ICB approval. No feedback from NHSE regarding the PBC submission has yet been received. Queries are due to be received by 26th July 2022.		31.7.22

Score	1	2	3	4	5	6	7	8	9	10	11	12
change												
	→	→	↓	→								

PC16	
Risk Title	Severe Mental Illness (SMI) Annual Physical Health Checks
Risk Description	1. The CCG is at risk of failing to meet its commissioning commitment to meet the needs of its SMI population which leads to a **clinical risk** that patients with SMI will experience significant health inequalities and a 15-20% higher mortality when compared to their peers. 2. There is also a **performance risk** identified with regards to delivering the national target of the Norfolk and Waveney system delivering 60% of SMI health checks. 3. Out of a total of 9,463 patients, 3,398 checks were done or 35.9% (according to Q4 2021-22 data). 4. Access to a SMI annual health check is recommended to reduce this risk, however there are variable rates of patient uptake across GP practices.
CCG priority	Tackling Health Inequalities

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Sadie Parker	Primary Care Commissioning Committee	Shepherd Ncube	10/05/2022	31.03.2023

Risk Scores								
Unmitigated			**Mitigated**			**Tolerated**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	3	4	12	2	3	6

Controls	Assurances on controls
• Plan in place to increase uptake of SMI checks across N&W reviewed by PCCC and MH boards. • A 2-year improvement trajectory has been agreed with NHS England. • Monthly steering group has been established with input from Mental Health and Locality colleagues. • All practices signed up to the SMI LCS; letter to be sent to practices highlighting end of year position and plan for improvement by June 2022. • Funding from Mental health for additional clinical capacity has been secured to trial a small clinical team to provide checks across a PCN. The resource is expected to start from Quarter 3. This will help support practices that are behind their trajectory. • Regular assurance reports to NHSE/I & PCCC	**Internal:** Primary Care Commissioning Committee, monthly steering group **External**: NHSE Checkpoint and Assurance Framework, Health Overview and Scrutiny Committee Reports to NHSE/I.

Gaps in controls or assurances
• Planned additional resources are not expected to have an impact until Quarter 3 (22-23).

Updates on actions and progress			
Date	**Action**	**RAG**	**Target completion**
June 2022	• Progress shows an overall increase in delivery at year end to just under 40% of completed SMI checks across the system. 10% increase compared to Q3 Data. • Competing demands and priorities in primary care is impacting on the delivery of checks, it is recognised that additional resource is required to achieve the 60% national target for our system. • Plan to launch the pilot concept in the Norwich locality for clinical team from Q3 is being developed.		31/07/22

July 2022	• Draft letter to GPs outlining end of year position, resources available and aims for this year drafted and awaiting internal approval before sending out. Target date of w/c 18/07 to complete. • Meetings with clinical directors in the West Locality (w/c 4/07) to undertake point of care testing pilot. • Briefing report also drafted for HOSC due 14/07/2022		31/07/2002

Visual Risk Score Tracker

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score												
change			New	➔								

NHS Norfolk and Waveney CCG – Primary Care Commissioning Committee Assurance Framework

PC17	
Risk Title	General Practice – Allied Health Professionals Workforce (PCN Additional Roles and Direct Patient Care)
Risk Description	Lack of general practice (GP) Additional Roles (ARRS) and Direct Patient Care roles in the workforce due to vacancies and recruitment and retention challenges. The impact on the service delivery to patients.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Sadie Parker	Primary Care Committee (PCC)	Fiona Theadom	30.06.2022	31.03.2024

Risk Scores								
Unmitigated			**Mitigated**			**Tolerated**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	3	4	12	2	4	8

Controls	Assurances on controls
• Workforce team recruited in ICB structure. • Training hub supported by clinical leadership via 5 Ambassador roles. • Primary Care Networks (PCNs) supported to develop and implement workforce trajectories in support of the Additional Roles Recruitment Scheme (ARRS). • PCN ARRS Workforce Templates – online portal for 2022/23 for PCNs to update to NHSE to inform Training Hub spending. • National workforce reporting service - Practices report monthly, PCNs report quarterly, contractual requirement as part of General Medical Services (GMS) and PCN Directed Enhanced Services (DES).	**Internal:** Reporting to Primary Care Commissioning Committee (PCC). Training Hub and Workforce Implementation Group meets two-monthly **External**: NHSEI returns monthly as part of the General Practice Transformation implementation and quarterly assurance meetings with Health Education England (HEE) and NHSE

Gaps in controls or assurances

- Workforce strategy requires review and refresh to reflect PCN development updates and post pandemic environment
- Recruitment of community pharmacists and technicians remains challenging. Similar roles recruited into PCNs from community pharmacy
- System approach for paramedic rotational roles agreed approach subject to regional review.
- Understanding general practice resilience as work refocuses from pandemic response towards business as usual may lead to higher numbers of the workforce leaving/retiring during 2022 and 2023
- Ability to attract new workforce to Norfolk and Waveney and can be mitigated by system level action
- Some geographical areas facing greater challenges in recruitment, e.g. West and East

Updates on actions and progress

Date	Action	RAG	Target completion
July 2022	New ICS Level Training Hub contract requires submission of 4 documents relating to primary care workforce planning to HEE by end July 2022 for socialising with primary care during August: • Workforce Strategy (3 years) • Stakeholder Engagement Strategy and Plan (3 years) • Operational Delivery Plan (1-3 years) • Financial Plan (yearly)		30 Sept 2022

	Plans to be approved by new Oversight Board by 30 Sept 2022. Need to include targeted plans in areas facing greatest challenges in recruitment and retention. A placement capacity expansion strategy is due to be published and number of learning organisations is increasing with targeted intervention and support. The impact of ARRS recruitment on other system partners is of concern and discussions continue as to how to mitigate this risk. Primary care has joined the ICS led initiative looking at how to improve recruitment in rural and isolated coastal areas and other ICS task and finish groups to consider system wide approach to recruitment & retention for N&W.		

Visual Risk Score Tracker												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	--	--	--									
change	--	--	--	New								

Agenda Item 8

Subject:	**Severe Mental Illness Health Checks**
Presented by:	**Shepherd Ncube, Head of Delegated Commissioning, Primary Care**
Prepared by:	**Julian Dias, Deputy Senior Delegated Commissioning Paper**
Submitted to:	**ICB Primary Care Commissioning Committee**
Date:	**12 July 2022**

Purpose of paper:

To update the Board on plans and progress to-date to around patients with Severe Mental Illness (SMI) as well as end of year performance position and uptake of checks

1. Background

NHS England set out the ambition for annual physical health checks for those living with an SMI in the NHS Long Term Plan. The national metric for CCG performance is set by NHSE/I, and was previously given as a percentage of the SMI population, given in table 1:

Table 1: SMI PHC ambition for Norfolk and Waveney	2021/22	2022/23	2023/24
NHSE/I set minimum number of people with SMI receiving APHC	5,184	5,939	6,695
% of the SMI population (based on 21/22 Q4 QOF register size (9,134) (note QOF register size varies each quarter)	57%	65%	73%

Note: QOF is the Quality and Outcomes Framework, which is a voluntary framework that incentivises practices to deliver care according to nationally negotiated indicators.

2. Activity to-date

- All people with SMI are eligible to receive an annual health check inclusive of all ages. As of March 2022, this represents a population in Norfolk & Waveney of 9,134 people. Responsibility for the delivery of SMI checks is shared amongst 2 main groups (Primary care and Secondary Care) and is supported by voluntary sector.
- As a system, at the end of Quarter 4 2021/22, N&W providers had completed 3,548 SMI checks, against an ambition (nationally set) of 5,184 – this is 38.9% delivery compared against the national target previously expressed as 60%.
- On average using 2019-20 activity figures, the system carried out 2,389 checks per year. The impact of COVID-19 is highlighted when reviewing the figures for

2020/21; where 1,985 checks were done, a reduction of 404 SMI checks. This showed the impact patient access, relocation of resource to support the booster programme etc.

- The system shows good signs of recovery post COVID-19, carrying out 3,548 checks in 2021-22; however, the national target has not been met.
- The local trajectory across 2022-2023 follows the uptake seen in checks performed at the end of 2021-22.
- SMI report to HOSC will be delivered on the 14th of July 2022 via Appendix A

3. Opportunities to drive service improvement:

Opportunity	Action being taken:
a) System wide recognition of inequalities, raised through Covid19 and Core20Plus5 This heightened awareness provides an 'open door'	• Monthly meetings re-established to monitor progress and support delivery. • Regular agenda item in our meetings with locality teams • NSFT will be focusing on the quality of checks; specifically, what happens once the checks are done (smoking cessation, dietary management etc.)
b) In year funding to support new approaches and capacity	• Proof of concept to test out a dedicated resource to deliver SMI checks within a Primary Care Network. • This will be to trial a peripatetic team approach for the hardest to reach individuals following the model of a successful scheme for Learning Disability health checks.
c) Ensuring the full SMI PHC is completed Ensuring all core elements of health checks are completed when the patient attends the practice will result in a higher completion rate and help to make every patient visit count.	• Liaise with GP practices, understand the data streams and how these searches can be access on SYSTM-One • Point of Care testing pilot
a) Data There are ongoing challenges to ensure all activity is correctly coded and able to be shared across the system.	• Use of multiple channels to share guidance to enable operational colleagues to pinpoint and find data to then carry out checks. • NSFT internal capacity resource for leadership • Digital colleagues are working with us to scope potential solutions – this will improve clinical care, future data reporting and efficiencies.

4. Recommendation to the Board:

Primary Care Committee members are invited to note the update, progress and current challenges. Additionally, the board is requested to note Appendix A (SMI HOSC report).

Key Risks	
Clinical and Quality:	Increasing the rate of SMI health checks should improve clinical care for people with an SMI. The quality of checks is a key focus for this work.
Finance and Performance:	An increase in the uptake of health checks will increase pressure on budgets
Impact Assessment (environmental and equalities):	N/A
Reputation:	The Health Overview and Scrutiny Committee is overseeing the system's work in the area.
Legal:	N/A
Information Governance:	N/A
Resource Required:	ICS teams
Reference document(s):	SMI health check locally commissioned service
NHS Constitution:	N/A
Conflicts of Interest:	None identified
Reference to relevant risk on the Board Assurance Framework	PCCC risk register

Governance

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

Appendix A- SMI HOSC Report:

Briefing for Norfolk Health Overview and Scrutiny Committee

Annual health checks for adults with Severe Mental Illness in Norfolk & Waveney (Update and Assurance plan)

1. Executive summary:

This briefing paper has been prepared for the members of the Norfolk Health Overview and Scrutiny Committee (NHOSC) to provide an overview of the Severe Mental Illness (SMI) annual health check programme work.

Recognising the health inequalities for people living with an SMI, NHS England has made a commitment to improve the quality of care and treatment of people living with a severe mental illness and has set national performance targets for all Clinical Commissioning Group (CCGs) in England. There are currently 9,126 adults living in Norfolk and Waveney (N&W) with SMI and a total of 3,548 people received a physical health check in 2021/22.
Delivery was significantly impacted by the restrictions associated with COVID-19, particularly in primary care where there was a national focus on the vaccination programme. This paper will provide background information, local routes of delivery, progress on delivery against the national targets and our plan to improve the uptake and quality of annual health checks.

2. Introduction and Background:

NHS England set out the ambition for annual physical health checks for those living with an SMI in the NHS Long Term Plan. The CCG data collection for people with SMI receiving a full physical health check data contains information on the number of people on the General Practice SMI register at the end of each quarter, and of these how many received a comprehensive physical health check in the 12-months to the end of the reporting period.

The national metric for CCG performance is set by NHSE/I, and was previously given as a percentage of the SMI population, given in table 1:

Table 1: SMI PHC ambition for Norfolk and Waveney	2021/22	2022/23	2023/24
NHSE/I set minimum number of people with SMI receiving APHC	5,184	5,939	6,695
% of the SMI population (based on 21/22 Q4 QOF register size (9,134) (note QOF register size varies each quarter)	57%	65%	73%

Note: QOF is the Quality and Outcomes Framework, which is a voluntary framework that incentivises practices to deliver care according to nationally negotiated indicators.

Severe Mental Illness (SMI) is defined in this instance as all individuals who have received a diagnosis of schizophrenia or bipolar affective disorder, or who have experienced an episode of non-organic psychosis.

To achieve the full completion of a SMI annual check, table 2 outlines the elements that need to be completed and accurately recorded by the patient's GP practice.

Table 2 – elements of the annual physical health check for SMI	
Core Physical Health Checks	**Additional elements, screening, and interventions**

1. BMI or Waist Circumference. 2. BP recorded. 3. QRISK or Cholesterol. 4. Blood Glucose or HbA1c recorded. 5. Alcohol Consumption recorded. 6. Smoking status recorded.	7. An assessment of nutritional status, diet and level of physical activity. 8. An assessment of use of illicit substance/non prescribed drugs. 9. Medicine's reconciliation or review. 10. Follow-up interventions for: weight management; blood pressure; blood glucose; alcohol consumption; smoking; substance misuse; blood lipids. 11. Access to national cancer screening for: cervical cancer; breast cancer; bowel cancer.

For monitoring, NHSE measures the system against delivery of the core 6 physical checks; however, all 11 elements need to be recorded as part of the complete annual health check.

3. Health Inequality and Impact:

3.1 Health Inequalities

People living with SMI face stark health inequalities and are less likely to have their physical health needs met, both in terms of identification of physical health concerns and delivery of the appropriate, timely screening and treatment.

Compared to the general population, people living with SMI:

- Face a shorter life expectancy by an average of 15 – 20 years, however this life expectancy gap is worse in Norfolk and Waveney with a life expectancy gap of 16.5-20.5 years.
- Are three times more likely to smoke.
- Are at double the risk of obesity and diabetes, three times the risk of hypertension and metabolic syndrome, and five times the risk of dyslipidaemia (imbalance of lipids in the bloodstream).
- Research have also shown this cohort of patients have been disproportionately adversely impacted by COVID-19.

The SMI physical health check was introduced to reduce this inequality and enable people with SMI to have their physical health needs met by increasing early detection and expanding access to evidence based physical care assessment and interventions.

3.2 National Policy:

The Five Year Forward View for Mental Health started the focus on SMI physical health checks, growing the delivery of health checks for this group from 30% (or 140,000 people) in 2017/18, to 60% (or 280,000 people) from 2018/19.

The more recent NHS Long Term Plan (LTP) and associated NHS Mental Health Implementation Plan 2019/20-2023/24, have identified that NHS England should ensure that SMI physical health checks are received by 280,000 people in 2020/21, 280,000, building to 390,000 people in 2023/24.

Additionally, the Core20PLUS5 NHSE/I programme to support the reduction of health inequalities at both national and system level identified the SMI cohort of patients as 1 of 5 focus clinical areas that requires accelerated improvement. Best practice evidence indicates that where primary care teams deliver care collaboratively with secondary care services outcomes are improved.

4. Overview of 2021-2022

All people with SMI are eligible to receive an annual health check inclusive of all ages. As of March 2022, this represents a population in Norfolk & Waveney of 9,134 people. Responsibility for the delivery of SMI checks is shared amongst 2 main groups (Primary care and Secondary Care) and is supported by voluntary sector. This is demonstrated further by **Appendix A**.

Throughout 2021-22, Covid-19 as well as the subsequent vaccination booster programme continued to place significant pressure on healthcare providers across N&W. The competing challenges of high levels of staff sickness and absence across general practice and people worried about attending general practices have had a significant impact on the planned delivery and uptake of SMI health checks.

Despite the considerable challenges presented by Covid-19, colleagues in general practice, supported by the CCG team and in conjunction with secondary care mental health teams, continued to work hard to support the health and care needs of people living with SMI. However, despite the sustained hard work and efforts, the national target has not been met.

5. Delivery position in N&W and nationally:

As a system, at the end of Quarter 4 21/22, N&W had completed 3,548 SMI checks, against an ambition (nationally set) of 5,184 – this is 38.9% delivery compared against the national target previously expressed as 60%.

The number of SMI annual health checks carried out historically from 2019/20 to 2021/22 across Norfolk and Waveney is shown in figure 1, with the national ambition and local trajectory outlined for comparative purposes. **Appendix B** also provides further detail into the quarterly activity figures.

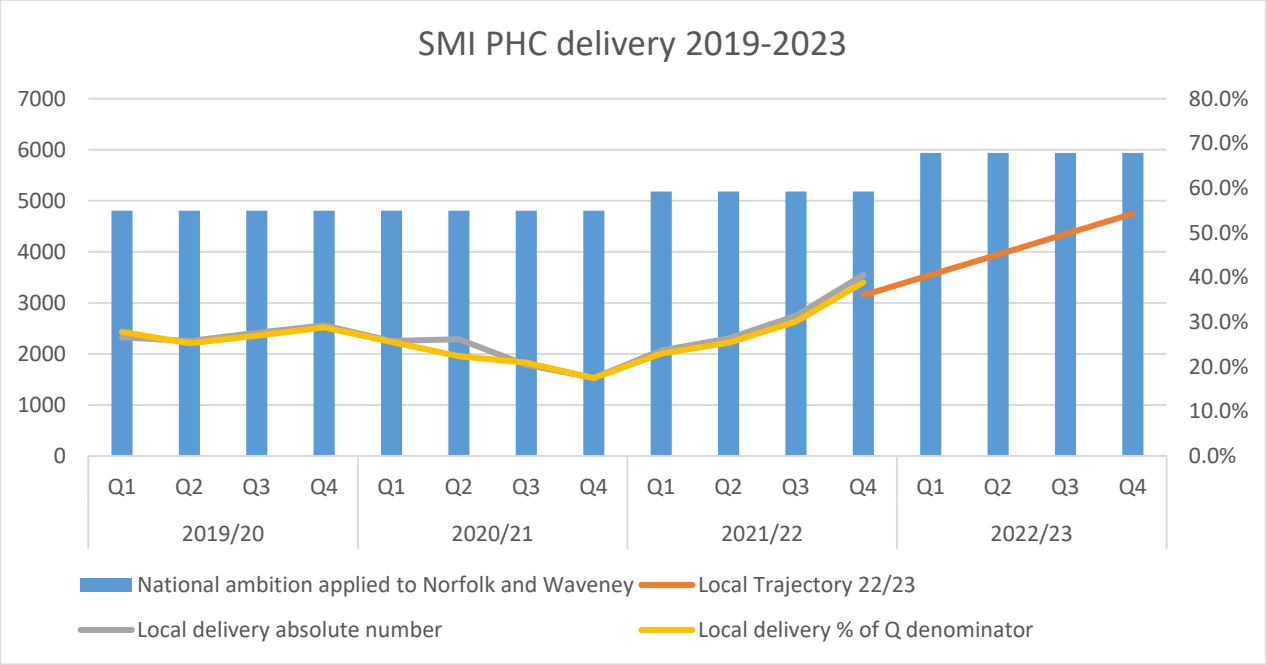


Figure 1

Source: [Statistics » Physical Health Checks for people with Severe Mental Illness (england.nhs.uk)]

For further context and benchmarking, the regional and national delivery are mapped below (percentages have been used to provide comparative data):

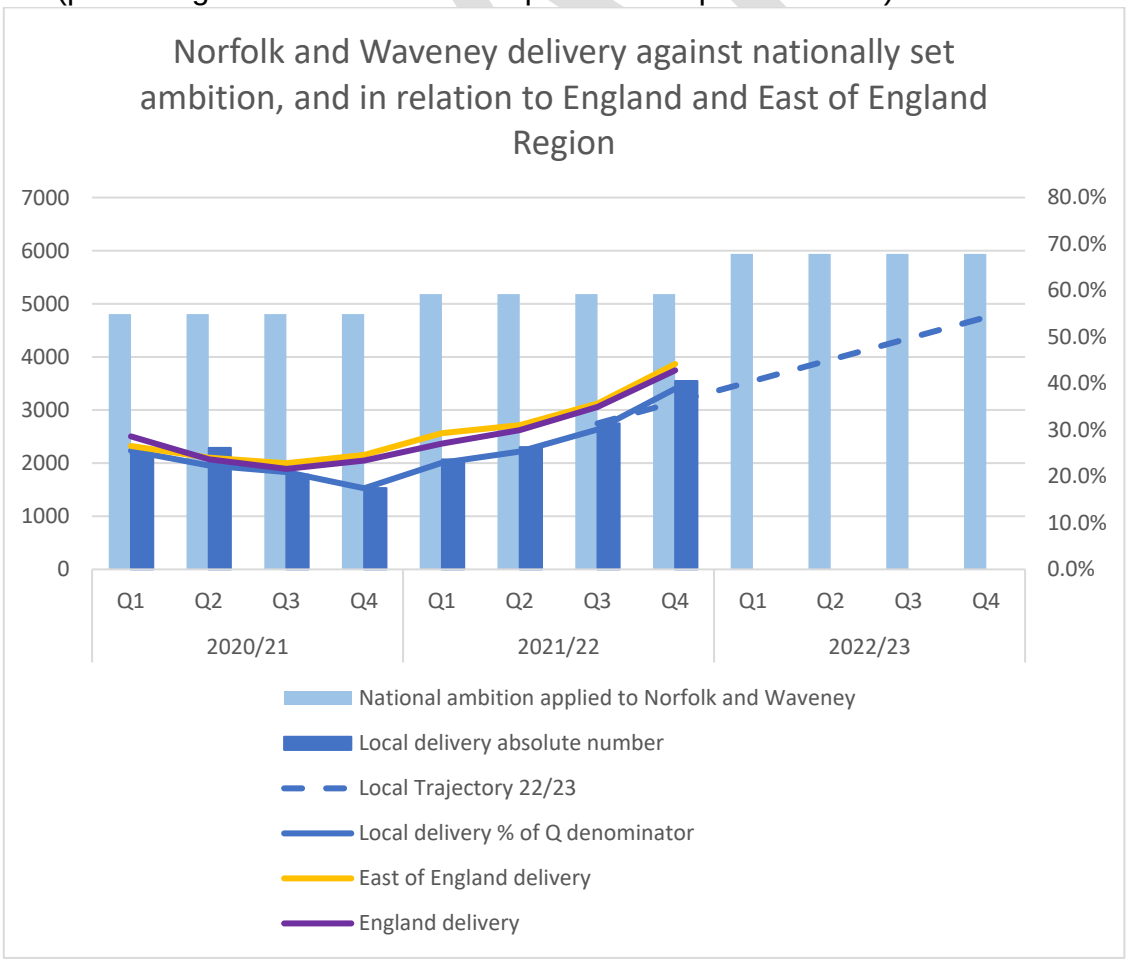


Figure 2

From the above, the following observations can be drawn out:

- The pattern of delivery follow regional and national metrics, with a downturn through 20/21 and upturn through 21/22.
- N&W has recovered to the pre-Covid19 delivery position.
- On average using 2019-20 activity figures, the system carried out 2,389 checks per year. The impact of COVID-19 is highlighted when reviewing the figures for 2020/21; where 1,985 checks were done, a reduction of 404 SMI checks. This showed the impact patient access, relocation of resource to support the booster programme etc.
- The system shows good signs of recovery post COVID-19, carrying out 3,548 checks in 2021-22; however, the national target has not been met.
- The local trajectory across 2022-2023 follows the uptake seen in checks performed at the end of 2021-22.
- Compared against the East of England and National delivery, the N&W are underdelivering in terms of health checks provided.
- The project group is working with colleagues to understand the reasons for this performance; however, it appears to be multi-faceted including:
- Prioritising patients who have not had their health checks; sufficient allocation of resource, booking and coding practices and finally focusing on those patients who are missing individual checks.

Utilising the end point baseline performance position for 2021-22; the table 3 shows the delivery of annual health checks across the 5 localities in Norfolk and Waveney:

Table 3

Locality	**Number of checks carried out:**	**Local Delivery Percentage:**
Great Yarmouth and Waveney	871	33.9%
North Norfolk	557	37.5%
Norwich	960	36%
South Norfolk	577	36%
West Norfolk	413	35%
Year-end Position	3,548 (including NSFT-)	38.9%

Figure 3 shows the delivery of each of the individual ‘core 6’ elements of the health check (referenced in table 2). This demonstrates that many people living with an SMI do access healthcare services but are having only some of the health check elements completed. With further engagement, both with system providers and our SMI population, we are confident that completion of full health checks will continue to improve through approaches such as *Making Every Contact Count.*

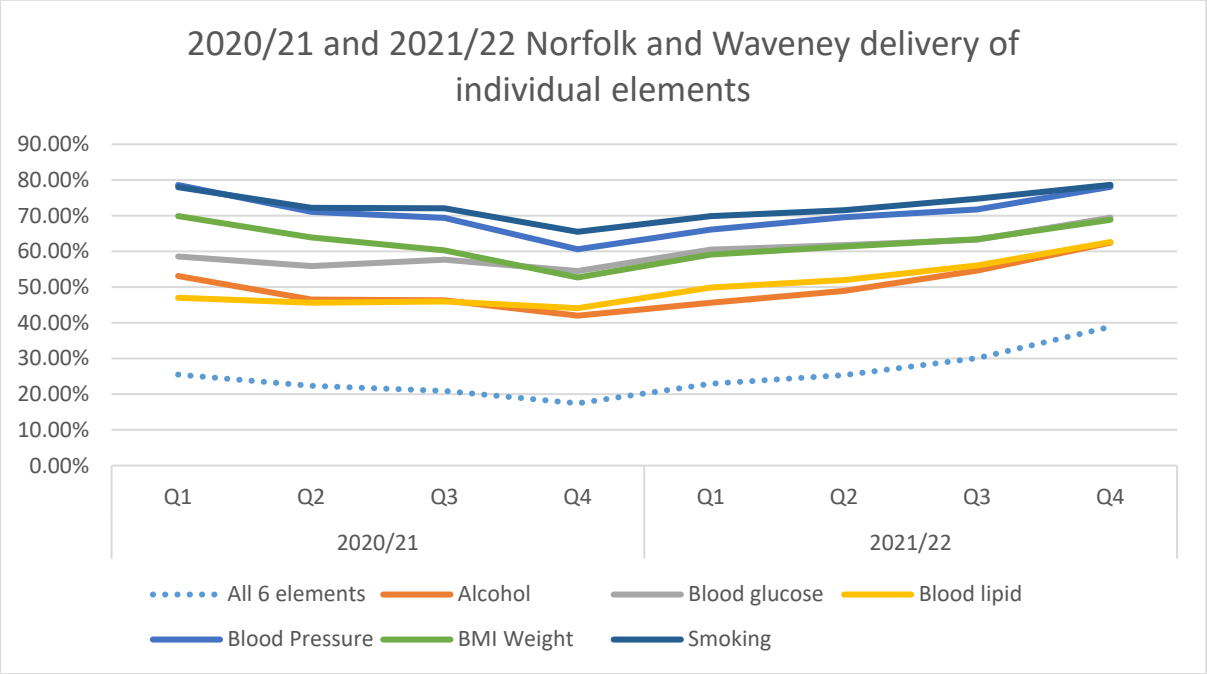


Figure 3

6. Governance and escalation

The system provides assurance to NHSE/I through the Mental Health Commissioning team within the CCG, including a recovery action plan submitted to NHES/I as part of planning for 2022/23. The mental health team provide assurance to the Norfolk and Waveney system through the Mental Health Partnership Board, and SMI PHC is viewed monthly.

Simultaneously, the uptake and quality of SMI annual health checks has been identified as a risk and will be monitored by the Primary Care Commissioning Committee's (PCCC) risk register during the monthly meetings which are held in public. Mitigation has been supplied in the risk assessment for oversight and assurance with progress update reports to be submitted to PCCC on a quarterly basis.

7. Opportunities & Translation of good practice:

Opportunity	Action being taken:
d) System wide recognition of inequalities, raised through Covid19 and Core20Plus5 This heightened awareness provides an 'open door'	• Monthly meetings re-established to monitor progress and support delivery. • Regular agenda item in our meetings with locality teams • NSFT will be focusing on the quality of checks; specifically, what happens once the checks are done (smoking cessation, dietary management etc.)
e) In year funding to support new approaches and capacity	• Proof of concept to test out a dedicated resource to deliver SMI checks within a Primary Care Network.

	• This will be to trial a peripatetic team approach for the hardest to reach individuals following the model of a successful scheme for Learning Disability health checks.
f) Ensuring the full SMI PHC is completed Ensuring all core elements of health checks are completed when the patient attends the practice will result in a higher completion rate and help to make every patient visit count.	• Liaise with GP practices, understand the data streams and how these searches can be access on SYSTM-One • Point of Care testing pilot

The SMI working group engages with experts by experience, to inform improvement work. Work is underway to collate patient stories and feedback from SMI service users across N&W.

8. Risk and Challenges:

Risk	Mitigation / action
b) Workforce Workforce training in some areas remain unclear on training and upskilling opportunities; with not all staff being trained to the required level.	• Workforce capacity and recruitment is being reviewed • We are using multiple channels to share SMI PHC training and upskilling resources e.g. practice letters, online channels.
c) Engagement Work to drive up engagement in this patient cohort; targeting the hardest to reach patients.	• Empowering people to ask for their health check through enducation and drive up patient self care. • Continuation of the Outreach service in 2022/23 • Close work with experts by experience. • The new SMI locally commissioned service incentivises practices to dedicate increased resource to engagement with this patient group and the nomination of a SMI champion.
d) Quality The health checks will only have impact on people that are supported to alter their lifestyle as a result. Not all intervention services currently have offers that suit those living with SMI	• A pilot of dedicated weight loss support for people with an SMI • National early implementor status (one identified per region nationally) of tobacco cessation for people living with an SMI • Work with the Health Intervention Transformation Group to meet the 'so what' aspect once the health check is carried out. • Work with experts by experience.

e) Data There are ongoing challenges to ensure all activity is correctly coded and able to be shared across the system.	• Use of multiple channels to share guidance to enable operational colleagues to pinpoint and find data to then carry out checks. • NSFT internal capacity resource for leadership • Digital colleagues are working with us to scope potential solutions – this will improve clinical care, future data reporting and efficiencies.

9. Delivery and Improvement Plans for 2022-2023

A key focus for 2022-23 is to assist practices by undertaking proof of concepts that will lead to increases in patients accessing their SMI check. Several initiatives are planned to boost performance through 2022/23 are outlined as follows:

9.1 NSFT clinical / operational manager new role:

- The creation of a post to strengthen the links between NSFT and primary care teams and provide leadership to support system solutions from within.

9.2 Continue Outreach project through 22/23:

- The charity 'Together' has been commissioned support the uptake of checks for people with SMI through 2021/22 and 2022/23. The team supports practices by organizing and scheduling the SMI checks. Communications are ongoing to promote this service.

9.3 Dedicated SMI & Eating Disorder nursing Proof of Concept:

- Discussions have taken place about testing the above dedicated resource via funding from the Mental health commissioning teams for 1 year.
- The proposed concept of nursing/HCAs will work closely with a PCN to deliver SMI checks as well as advise on eating disorders.
- Modelling outlines that this would result in circa 420 additional SMI checks per year. If successful, these posts could be scaled up across PCNs / localities.

In addition, the team are still developing the below 2 interventions which will serve to further improve the current position for SMI in Norfolk & Waveney:

9.4 Resiliency Primary Care Liaison and Learning post:

- The initial scoping work done has exposed the potential need for a primary care liaison and learning post to be piloted.
- This post could provide practices with expert advice on clinical systems, how to ensure their SMI registers are up to date, scheduling and coding and translation of good practices across primary care networks

9.5 Dedicated SMI resource web resource:

- We are also scoping plans to develop a purpose-built web resource that the system can utilise to help support in the uptake and delivery of SMI checks.

Recognising the importance of learning across programmes and maximising the opportunities to engage with people in our communities, we have brought together teams which are working on supporting the physical health of those living with an SMI, Learning Disabilities, Neurodiversity and Autism to share good practice and address challenges collectively.

10. Conclusion

This report acknowledges the hard work done to recover from the impact of COVID-19 on the delivery of SMI health checks. However, there still remains work to do to improve the uptake and the impact of the SMI health checks and ensure this is sustainable over time.

Learning taken from across our own system and through networks across the Region have helped inform the current plan for improvement. The uptake and quality of SMI annual health checks has been identified as a risk and will be monitored by the Primary Care Commissioning Committee's (PCCC) risk register during the monthly meetings held in public, to ensure patients with SMI have access to their annual health checks.

Appendix A- Roles and responsibilities in delivering SMI Health Checks:

Primary Care:

General Practice colleagues carry out annual physical health assessments and follow-up care for: patients with SMI who are not in contact with secondary mental health services and patients with SMI who have been in contact with secondary care mental health teams (with shared care arrangements in place) for more than 12 months and / or whose condition has stabilised. In Norfolk and Waveney this is commissioned as a Locally Commissioned Service (LCS) which complements the quality and outcomes framework and was revised for 2022/23 to support practices in being able to invest more time to build relationships with individuals.

Secondary Care

Mental Health teams are responsible for carrying out physical health assessments and checks for patients with SMI under the care of a mental health team for less than 12 months and/or whose condition has not yet stabilised. In Norfolk and Waveney our secondary care mental health provider, Norfolk and Suffolk Foundation Trust (NSFT) has been commissioned to provide additional support staff to enable the health checks to be undertaken.

Voluntary Sector

The VCSE provider Together have been commissioned to provide an outreach service in conjunction with Primary Care. Together are very experienced in working with people with an SMI and have robust networks to support people living in the community. The service supports GP practices to contact people on their quality and outcomes framework register who have not had a complete SMI physical health check and enables conversations and practical help to support uptake of assessments and intervention

Agenda Item 9

Subject:	**Learning Disability Annual Health Checks progress update**
Presented by:	**Shepherd Ncube, Head of Delegated Commissioning, Primary Care**
Prepared by:	**Sarah Collingwood, Delegated Commissioning Manager**
Submitted to:	**ICB Primary Care Committee**
Date:	**July 2022**

Purpose of paper:

To update the Committee on plans and progress to-date to prioritise offering learning disability health checks to all people who did not receive one in 2021/22 during the first two quarters of 2022/23.

The Committee is also asked to note the learning disability annual health check briefing for the Health Overview and Scrutiny Committee on 14 July 2022 included in Appendix A with this paper.

1. Background

NHS England has issued a request to all GP practices that they prioritise offering learning disability health checks to all people who did not receive one in 2021/22 during the first two quarters of 2022/23.

In Norfolk and Waveney this amounts to **1686** as at the end of March 2022, as confirmed by NHS England in June 2022.

NHS Norfolk & Waveney LD health checks 2021- 2022				
Total LD register 14+	**Total health checks completed**	**Total health checks declined**	**Total patients not had an AHC**	**% total AHC**
6,812	4,799	327	1,686	70.4%

2. Activity to-date

- A communication has gone out to all practices re-iterating the request from NHS England and requesting assurances that practices prioritise offering a health check to anyone who did not have one in 2021/22 by 30 September.
- Recognising that this cohort includes some of the hardest to reach patients, a menu of short-term support has been offered to all GP practices across Norfolk and Waveney to help them meet this challenge, including:

- ProtectNow call handling team resource to reach out to patients and facilitate attendance at health check appointments
- Guidance from the Peripatetic team on quality, coding and data cleansing
- Additional nursing resource to support practices with booking appointments, LD register cleansing and physical health checks
- Additional clinical resource to support with physical health checks via an independent clinical provider
- The LD Champions Teams Channel offering access to best practice, resources, training and peer support

- To-date, **48%** practices have responded to confirm that a plan is in place to complete this work by 30 September. **11** practices have requested additional support.

3. Next steps

- Going forward, a series of meetings will take place with each of the five localities to discuss individual localised plans to support this work and review performance data to identify any individual practices requiring assistance.
- From the baseline data provided by NHS England in April 2022, performance and trajectories will be monitored on a monthly basis using clinical systems (non-PID) to drill down and understand the patients who have not had a health check to-date.
- Patients who have not responded to invitations to attend health checks or who have declined will be reviewed in September.

4. Schedule of implementation

June	• Issue a communication to practices • Seek assurances practices will prioritise these checks by 30/09 • Offer of short-term support to practices
July	• Locality meetings to confirm local plans and identify further areas of support • Performance tracking • Roll out of additional support
August	• Performance tracking • Roll out of additional support
September	• Performance tracking • Roll out of additional support • Review uptake and implement next stage

5. Learning disability annual health check briefing for the Health Overview and Scrutiny Committee

The Board is asked to note the learning disability annual health check briefing for the Health Overview and Scrutiny Committee on 14 July 2022 included as Appendix A in this paper.

6. Recommendation to the Board:

Board members are invited to note the update, progress and current challenges. Further progress reports will be brought to future meetings in line with the forward plan

Key Risks	
Clinical and Quality:	Provision of increased numbers of health checks is intended to identify clinical issues early. Quality of health checks is a key focus of the work being undertaken.
Finance and Performance:	Increased take up of health checks will lead to increased pressure on budgets
Impact Assessment (environmental and equalities):	N/A
Reputation:	The Health Overview and Scrutiny Committee is monitoring our work in this area
Legal:	N/A
Information Governance:	N/A
Resource Required:	Teams throughout the ICS
Reference document(s):	LD health checks DES
NHS Constitution:	N/A
Conflicts of Interest:	None noted.
Reference to relevant risk on the Board Assurance Framework	PCCC risk register

Governance

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

Appendix A: Learning disability annual health check briefing for the Health Overview and Scrutiny Committee

Briefing for Health Overview and Scrutiny Committee

Annual health checks for people over the age of 14 with learning disabilities in Norfolk and Waveney

1. Introduction

This paper is to provide an update to members of the Health Overview and Scrutiny Committee (HOSC) on the learning disability (LD) annual health check programme for people aged 14 and over with a learning disability in Norfolk and Waveney.

This follows on from the previous update in the March 2021 HOSC Briefing.

2. Background

All people aged 14 years and over with a learning disability are eligible to receive an annual health check and there is a nationally negotiated enhanced service contract available to GP practices to fund this work. As of March 2022, this represents a population of just over 6,800 people across 105 GP practices in Norfolk and Waveney. There is a national requirement for clinical commissioning groups to ensure they commission for a 75% uptake among the eligible population.

Throughout 2021-22, Covid-19 continued to place significant pressure on healthcare providers across Norfolk and Waveney. The competing challenges of high levels of staff sickness and absence across general practice, along with people with a learning disability being worried about coming into general practices, had a significant impact on the planned delivery and uptake of learning disability health checks.

In addition, December's national prioritisation of the Covid-19 booster programme in response to the new Omicron variant and subsequent diversion of clinical staff also affected practices' ability to deliver health checks at a time when the majority of health checks are usually scheduled.

Despite the considerable challenges presented by Covid-19, colleagues in general practice, supported by the CCG team, continued to work hard to support the health and care needs of their patients with a learning disability. All GP practices signed up to provide LD health checks in 2021-22 and all appointments reverted to face-to-face after having moved online during the previous year.

3. Overview of 2021-22

Achievements

In 2021-22 the Norfolk and Waveney system completed annual health checks for 4,799 people with a learning disability, which is the equivalent of 70.4% of people on a learning disability register.

Reviewed in the context of the significant ongoing pressures placed on GP practices and the wider health and care system by Covid-19, this serves to demonstrate the drive and determination of our health and care colleagues to continue to support people with a learning disability.

This success was supported by a number of innovative workstreams aiming to improve both the quality and uptake of learning disability health checks across the system.

- **Peripatetic Team pilot**

Having secured Transformation funding, a new team was established to support the provision of learning disability health checks within general practice. The pilot focused on the Norwich locality, which had historically poor performance with LD health checks. The pilot involved offering targeted training and guidance for GP practice teams, support with identifying and focusing on patients who had not had a health check in the last 12-18 months, LD register data cleansing and developing more personalised communications tools and reasonable adjustments.18 out of 22 practices took up the offer of support and the uptake increased 17% in 2021-22 and was 5% higher than before the pandemic.

Cumulative and comparative performance data – Norwich Locality					
Year	LD register	Q1	Q2	Q3	Q4
19/20	1325	109 (8.2%)	290 (21.8%)	509 (38.4%)	842 (63.5%)
20/21	1511	37 (2.4%)	135 (8.9%)	349 (23.1%)	789 (51.5%)
21/22	1488	166 (11.0%)	450 (30.0%)	683 (45.2%)	1017 (68.3%)

- **Exemplar project**

As a result of an innovative bid, Norfolk & Waveney CCG was selected to be the exemplar site for the eastern region by NHS England. Outreach learning disability workers were recruited to promote the importance of a learning disability annual health check and provide appropriate support access particularly amongst ethnic minority groups, Traveller, Roma and Gypsy families, Asylum Seekers and Refugees community groups.

- **Additional resource – West and South Norfolk**

Further to NHS England's request to all systems nationally to increase support to improve the uptake of health checks, in February 2022 a short-term externally staffed model was commissioned to provide additional resource that could be rapidly mobilised to carry out annual health checks by a registered learning disability nurse. This resource was initially focused on the CCG's West Norfolk locality where the lowest uptake of health checks was reported.

The provision of dedicated specialist resource has allowed for more than 150 additional and high-quality health checks, with nurses able to undertake a full and holistic patient consultation and onward referral to additional services where

necessary. This service has typically targeted harder to reach cohorts requiring additional time and input to facilitate engagement within the health check process.

Positive feedback has been received, both from people with a learning disability in terms of experience and quality of care, and practice teams in terms of provision of specialist guidance and support

The success of the initiative triggered an interest among practices in the CCG's South Norfolk locality and further resource has been secured to support the delivery of annual health checks into Quarter 1 and 2. This also supports our ambition to move away from delivery of health checks in Quarter 4 to a more balanced distribution across all four quarters.

Opening Doors peer-led workshops
Norfolk and Waveney CCG commissioned Opening Doors, a user-led organisation run by people with learning disabilities, to develop a workshop to support people with a learning disability, their families and carers to gain a better awareness and understanding of the benefits of annual health checks.

A mixture of virtual and face-to-face workshops ran through January and February 2022. During this time, Opening Doors engaged with 47 people with a learning disability as well as paid and family carers. Feedback was overwhelmingly positive, with the majority of respondents confirming they found the training useful in increasing knowledge and confidence about annual health checks. The workshops also proved helpful in collecting information on potential barriers to people attending a health check, the types of reasonable adjustments people would find useful and how best to share invitations to health checks.

Learnings and outcomes will be shared with GP practices and learning disability champions.

Challenges

There are several key challenges that continue to be addressed:

- Complex needs:
  Whilst the system as a whole delivered health checks to almost 5,000 people with a learning disability, this means there remained around 2,000 people who did not receive a health check in the last year. It is recognised that this cohort of people may be amongst the hardest to reach and therefore, more difficult to engage using traditional methods of contact. Plans are progressing to secure additional capacity to support practices to engage with this cohort within the health check programme.

- Quality:
  It is recognised that the quality of health checks is inconsistent across the system, which may have been further exacerbated through the move to remote service provision during the pandemic. Evidence shows us that good quality annual health checks are important in early identification and treatment of unmet health needs. We have identified a need for additional training to support GP practice teams –

from administrative to clinical staff – and we have plans through our in-house training hub to make this available.

- Data:
  The CCG's Business Intelligence team developed a report in 2021-22 extracting available monthly performance data from the national reporting system much earlier than the release of nationally validated data to give a monthly snapshot of LD register numbers and uptake broken down by practice, Primary Care Networks and the five CCG localities. Whilst the aim was to enable identification of potential discrepancies between practice data and what was reported via the national portal to be reviewed much more quickly, anecdotal evidence suggests that historical coding anomalies remain an issue for many practices and that actual uptake figures at practice-level are much higher than the nationally extracted data reporting. Whilst data continues to improve, further work is underway with the CCG's Business Intelligence team and other stakeholders to align different coding and systems and achieve one version of the truth.

  Workforce:
  Recruitment for additional workforce to support with LD health checks has been a challenge for many PCNs and practices. PCNs are working closely with the CCG to explore other ways to support workforce-related issues.

- 14–17-year-olds:
  An initial review of uptake of 14–17-year-olds in 2021-22 indicates low participation in the annual health check programme. The CCG's Children's and Young People team is working with schools, families and carers and GP practices to raise awareness and understanding of the benefits of annual health checks and to improve participation within the programme.

4. Delivery and uptake

In 2021-22 NHS England asked CCGs to ensure 75% of all people with a learning disability aged 14 and over had an annual health check.

The table below shows 2021-22 performance across Norfolk and Waveney based on data received from NHSE&I with an overall achievement of 70.4%%.

All practices within Norfolk & Waveney CCG signed up to deliver learning disability health checks and confirmed their aim to deliver a minimum of 75% of health checks in 2021-22. However, as previously noted, the unplanned diversion of staff to deliver the Covid-19 booster programme in December 2021/ January 2022 and the increased prevalence of Covid-19 in the community in January – March 2022 had a significant impact on planned delivery. However, despite this the system delivered an increase of 2.7% on 2020-21 performance.

Uptake of learning disability annual health checks 2021-22		
	Total uptake 2021-22	Previous year comparison 2020-21

Locality	Register (Mar 22)	Total AHC	% AHC	Register (Mar 21)	Total AHC	% AHC
Norfolk & Waveney	**6812**	**4,799**	**70.4%**	**6,810**	**4,607**	**67.7%**
East of England	33,255	23,292	70.0%	31,921	22,224	69.6%
England	300,818	214,622	71.3%	284,755	209,433	73.5%

Uptake of learning disability annual health checks NWCCG 2021-22						
Locality	**Register (Mar 22)**	**Q1**	**Q2**	**Q3**	**Q4**	**Total checks**
GYW	1778	171 (9.6%)	257 (14.5%)	348 (19.6%)	420 (23.6%)	**1196 (67.3%)**
N Norfolk	1197	72 (6.0%)	149 (12.4%)	242 (20.2%)	419 (35.0%)	**882 (73.7%**
Norwich	1488	166 (11.2%)	284 (19.1%)	233 (15.7%)	334 (22.4%)	**1017 (68.3%)**
S Norfolk	1360	109 (8.0%)	103 (7.6%)	217 (16.0%)	474 (34.9%)	**903 (66.4%)**
W Norfolk	989	71 (244.8%)	93 (320.7%	176 (17.8%)	362 (36.6%)	**702 (71%)**
N&W	**6812**	**589 (8.6%)**	**886 (13.0%)**	**1216 (17.9%)**	**2009 (29.5%)**	**4700 (69.0%)**

5. Patient stories

A piece of work is underway to collate patient stories and feedback from the CCG's Peripatetic team and additional LD nursing initiative in West Norfolk to share vital learning with the wider system. Some examples of the Peripatetic team's work are highlighted below:

Patient 1 – male, late-forties 48-years old, had never had an annual health check before. The team at the patient's GP practice explained that, despite many attempts, they had never been able to get in touch with him to arrange an annual health check appointment. The Peripatetic team decided to try a different approach and sent the patient a letter explaining the health check process, followed up with a visit to his home. The patient agreed to talk to the team about health checks and, upon running through the process and what to expect, it was discovered that the patient didn't like to visit his doctor's surgery. The team explained the purpose and benefits of the health

check and showed the patient what would happen by completing basic observations such as blood pressure, oxygen saturation and pulse rate. This helped the patient to better understand the process and he agreed to book an appointment for his health check which he attended as planned. The appointment went well and it is hoped that this intervention will enable the patient's continued engagement in the annual health check programme.

Patient 2 – male, mid-twenties. Whilst happy to book annual health checks with his GP surgery, the patient had failed to attend any of his previously booked appointments. The Peripatetic Team got in touch with the patient's mum on the morning of his next scheduled appointment to make sure they were still planning to come along for the health check. It turned out the patient was feeling really anxious about his health check and the family was having a really stressful morning trying to get him to the surgery on time. The Peripatetic team offered to visit the family at home to provide some additional support to the patient's mum and accompany them to the surgery. With some more reassurance, the patient was able to get to his health check appointment on time, where routine checks identified high blood sugars and a likely diagnosis of diabetes. the patient was referred to the local hospital's diabetic centre and the Peripatetic Team again accompanied him to the appointment and helped the patient and his family to understand his new diagnosis.

Patient 3 – female, early-fifties, had no record of ever attending her GP practice. It was noted that her parents had routinely declined a health check on her behalf due to her significant anxieties that had prevented her from leaving her home for many years. The Peripatetic Team wrote to the patient and her family again, following up with a telephone call to her mother who agreed to work with the team. The team is in the process of slowly building up a relationship with the patient with the aim of helping her to complete the first step in the health check progress – a pre-health check questionnaire. Progress so far is positive, and the patient's mother has commented that this is the first time she's seen her daughter communicate with anyone outside of the family for many years. Work continues to support the patient to overcome her anxiety and take the first steps towards her health check.

Patients 4 and 5 – male, early-twenties. These brothers were contacted by the Peripatetic Team and given further information about the purpose and benefits of the annual health check. As a result, one brother successfully went on to attend his annual health check appointment whilst the second brother was removed from the practice's learning disability register further to clinical review.

6. Plans for 2022-23

Improving the health and wellbeing of people with a learning disability is a priority for the CCG and – increasingly – to the Care Quality Commission (CQC) as they begin to roll out their practice inspection programme once again.

NHS England has confirmed a national target of 75% delivery of annual health checks for people with a learning disability in 2022-23, with a commitment that health checks for people with a learning disability that were not completed during 2021/22 should be prioritised for the first two quarters of 2022-23.

Plans have been submitted as part of the CCG's operational planning setting out the aim to deliver health checks to 85% of the eligible population in Norfolk & Waveney in 2022-23 (with the aim that 100% of people will be invited). Planned delivery is based on the assumption that there will be fewer checks completed in Quarter 1 due to recovery work and the Spring Covid booster programme. There is also a need to account for widespread annual leave during Quarter 2.

Work is planned over the longer-term to encourage practices to increase activity in the first two quarters of the year. However, this year – in line with NHS England's request to prioritise health checks for all those who didn't receive one in 2021-22, the CCG will focus on supporting practices with this initiative in Quarters 1 and 2.

Whilst increasing uptake is key, improving the accuracy of the data held by practices and the quality of physical health checks are also priorities.

As such, this year the CCG has plans in place to progress the following initiatives:

- developing a programme of learning for practice staff to support the increased quality of health checks in partnership with the Training Hub.
- providing support to practices to improve the accuracy of their coding and cleansing of learning disability registers
- exploring other, innovative, ways in which to support the delivery annual health checks and engage with people with learning disabilities
- undertaking a system-wide peer review - *Building the right support* – looking at transforming care for people with learning disabilities and autism, led by Norfolk County Council
- supporting practices to engage with more complex, harder to reach people on their learning disability registers
- targeting awareness and uptake of health checks amongst 14-17-year-olds

Agenda item:

Subject:	**Primary and Secondary Care Interface**
Presented by:	**Mark Burgis, Director of Patients and Communities**
Prepared by:	**Kate Lewis, Head of Primary Care Strategic Planning**
Submitted to:	**PCCC**
Date:	**12th July 2022**

Purpose of paper:

To update PCCC on progress made by the Clinical Interface Group.

Executive Summary:

As previously reported to PCCC, progress to address issues between the clinical interface of primary and community care continues primarily via the Clinical Interface Group. However, while there has been intermittent gaps in CCG management support to the group, the Clinical Interface Group has now moved under the strategic direction of the Primary and Community Care Directorate to assist with the progression of issues.

Three key issues which are now being led and coordinated by the Strategic Primary Care Team are:

1. Repeat chest X-ray requests
2. Private referrals
3. ICE user registration

These pieces of work are being progressed via time-limited Task and Finish groups which report back to the Clinical Interface Group.

The Clinical Interface Group remains the focal point for ensuring that the Interface Policy is adhered to by all partner organisations. The PCCC are asked to note the associated risks identified by the Clinical Interface Group, specifically the ICB's ability to appropriately resource the investigation of issues/ complaints raised and mitigating action plans.

Recommendation to PCCC

To note the update and associated risk and gap in risk control/ assurances

1. Background

1.1 The Clinical Interface Group was established in 2021/22 to address critical issues arising between the clinical interface of primary and secondary care. The majority of pressing issues have occurred as a result of Phase 3 recovery and pressure on all parts of the system to address the patient backlog.

1.2 The specific issues the Clinical Interface Group was convened to address include the shift of unfunded patient activity to general practice from secondary care. In addition, all partner organisations are encouraged to table agenda items where a partnership approach may work to resolve and support service improvements and patient care.

2. Priority Areas

2.1 Secondary care adherence to interface contractual requirements – this area is monitored via contractual and quality issues raised by general practice. The mechanism for CCG oversight is via monitoring of the PID inbox however, General Practice is advised to continue to raise QIRs with providers directly and unresolved queries continues to be provided via the ICB Planned Care, Quality and Primary Care Teams as necessary.

2.2 Development of collaborative, supportive relationships across the system- One of the underlying principles of the interface group was recognition that all system partners are equals and that all providers are able to raise issues for discussion and action. The Clinical Interface Group continues to focus on the relationship development piece, building new networks and identifying individuals across organisations to make connections with the shared aim of delivering improved patient care.

2.3 Priority Projects via Task and Finish:

(i) Task and Finish 1: Repeat X-ray requests – a task and finish group has been set up to investigate and scope the extent of repeat x-ray requests being initiated in secondary care emergency departments, then passed to general practice with an instruction to make a referral in 4-6 weeks.

(ii) Task and Finish 2: Private referrals – to agree what is in scope and the process for private referral activity to be referred directly to secondary care, rather than via general practice.

(iii) Task and Finish 3: ICE User registration – to consider expanding the list of professionals to enable direct request of pathology and imaging via the ICE system, rather than through a doctor – this is an issue for community trusts as well as general practice.

3 Challenges and risks

3.1 Ongoing confusion regarding roles and responsibilities at the interface can result in patients falling through the net and not receiving the care and follow up they should be getting. Successful adherence to contractual requirements is crucial in supporting good patient care across the interface.

3.2 Identifying what is business as usual and can be picked up through existing mechanisms to reduce unnecessary duplication, ensuring that activity picked up by the Clinical Interface Group is timely and appropriate.

3.3 Progress of the Interface Group is slow in resolving and moving forward many of the issues raised due to.

- staff involved not having time to dedicate to this work
- many other competing priorities
- the complexity of some of the issues
- multiple steps needed to resolve
- differing views from providers
- lack of time to discuss some of the very complex issues in detail

3.1 Recognising that due to the reasons highlighted in 3.4, relationships between partners can breakdown and that the Clinical Interface Group has an important role to play in bridging relationships also through non-contractual means.

4. Next steps

4.1 Progress with the priority areas above continue via the Clinical Interface Group.

4.2 The risk relating to gaps in dedicated resource to support the Clinical Interface Group will be raised through the executive leadership team.

5. Recommendation

5.1 Members are invited to note this report. A further update will be provided in October.

Key Risks	
Clinical and Quality:	Patients at risk as a result of interface issues not being addressed and confusion not being resolved to clarify each parties role and responsibilities.
Finance and Performance:	N/A
Impact Assessment (environmental and equalities):	Not applicable
Reputation:	There is a reputational risk to the ICB if significant interface issues are not addressed.
Legal:	Not applicable
Information Governance:	Further work underway to explore IG requirements for ICB
Resource Required:	Capacity constraints are impacting progress
Reference document(s):	NHS standard contract
NHS Constitution:	N/A
Conflicts of Interest:	Practice partners and staff will have direct experience of interface issues.
Reference to relevant risk on the Governing Body Assurance Framework	N/A

GOVERNANCE

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

Norfolk and Waveney
Integrated Care Board

Agenda item: 11

Subject:	**Locally Commissioned Services**
Presented by:	**Gina Cooper, Senior Manager - GP Resilience**
Prepared by:	**Gina Cooper, Senior Manager - GP Resilience**
Submitted to:	**Primary Care Commissioning Committee**
Date:	**12th July 2022**

Purpose of paper:

To update on the progress to date.
To wrap up project and revisit milestones.

Executive Summary:

Following correspondence from the Local Medical Committee in August 2017, the CCG has completed a programme to review Locally Commissioned Services from GP practices. This paper provides a brief update on the progress of the review and asks committee to note the update and next steps.

Recommendation to Governing Body/ Committee:

To note the progress to date.
To accept this final paper for the LCS Review Programme.

1. Introduction

The purpose of this paper is to update Committee on progress of the Locally Commissioned Services (LCS) Review.

It should be noted that GP practice partners and staff on the committee are directly affected by the proposals in this paper and therefore, despite the meeting being held in public, should not participate in the discussion.

2. Programme Overview - Original Position

- Total of 38 Locally Commissioned Services (LCS) across Norfolk & Waveney;
- Total spend of approximately £14.6million;
- Five former commissioning bodies;
- Inconsistent funding for similar services, depending on geographic location of practice;
- Varying contractual details – some services not reviewed, some out of contract, little consistent monitoring;

3. Process

- To propose a robust programme governance structure enabling clear delivery based on 6 key principles:

1. Patients can access a **consistent range of services** delivered in general practice, regardless of where they are registered in N&W
2. The overall level of **investment** in general practice in N&W is **maintained**
3. The outcomes of the review should **provide stability to general practice** and reduce unnecessary bureaucracy involved in delivering services
4. The review will be undertaken **transparently**, fairly and will be **guided by clinicians**
5. **Funding of commissioned services will be fair** and will reflect the cost of delivering the service specification
6. Any **transitional period** (ie changes in overall funding for individual practices) will be managed sensitively and fairly

- To devise an approach to enable each service to be analysed and stratified based on impact on patients, practice and system;
- All services to include Quality, Equality and Data Impact Assessments;
- To engage with patients to capture views on proposed changes and service delivery;
- To commission consistent services to all patients across N&W, offered to all General Practice;
- To ensure the financial envelope is maintained, with practices funded consistently and equitably on actual cost of service delivery;
- To agree and implement a system for submission of reporting which is light on bureaucracy yet effective for monitoring;
- To deliver the programme for commencement in April 2022.

4. Current position

- 12 LCS have been commissioned from practices across Norfolk and Waveney:
  - Care Homes Local Enhancement
  - Diabetes
  - Monitoring Eating Disorders
  - Inclusion Health
  - Phlebotomy
  - Proactive Healthcare PMS
  - PSA Monitoring
  - Shared Care
  - Spirometry
  - Supporting SMI Health checks
  - Treatment Room'
  - Warfarin Monitoring
- All patients have access to all services across N&W, provided either by their registered practice or an agreed alternate primary care provider;
- Practices have clear consistent specifications, including funding, reporting and training details;
- All services were commissioned from 1st April 2022 with varying contract lengths of 1-5 years, recognising that a longer contract introduces increased stability to general practice;
- A patient engagement survey was undertaken which highlighted the lack of understanding of the general public with regard their General Practice service provision – an enhanced patient communication plan has been proposed to improve understanding of local healthcare services;
- Data quality enhancements have been introduced through clinical system templates and area wide reporting elements – reporting was reduced from monthly to quarterly to increase efficiencies;
- The Local Calculating Quality and Reporting System was introduced for ease of evidence upload, tracking and payments across the system, negating the need for practices to create additional invoices through different platforms;

- Those practices whose income reduced through the LCS Review programme are supported for a period of 12 months transition funding to enable them to review their delivery structures and reorganise where required;
- The £14.6 million financial envelope was maintained with all services funded fairly and consistently;
- The practices are funded partly on an item of service and partly on an activity block basis to support business planning – any funding identified as unspent towards the second half of the financial year will support a short term commissioned service to ensure all finances are invested in patients and general practice;
- Practices were fully engaged throughout the programme to ensure transparency, with clinicians leading the service review, practice managers being engaged in understanding current service provision, and then regular, N&W wide engagement sessions throughout the lead up to service commencement and regularly thereafter.

5. Learnings

- It became evident during the early phases of the review that the former commissioning bodies had very different priorities when commissioning their local services, often dependent on their local community provision and rurality of services. It was not possible to mitigate all elements of this during the review as the contracts of wider services did not align. However, the review recognised the challenges and enabled the Proactive Healthcare PMS LCS to be utilised flexibly to support an element of wrap around community-based services to support patients.
- The patient engagement exercise demonstrated a lack of understanding about services delivered in general practice and were compounded by frustrations (perceived and real) endured during the pandemic. It is recommended that future reviews of this type could benefit from a patient education session prior to engagement on the particular subject, to support a more targeted output.
- Engagement with the Local Medical Committee was particularly beneficial; weekly operational meetings enabled the review to retain pace and focus and it is recommended that future programmes continue with targeted meetings enabling full discussion of concepts prior to proposals.
- The programme management and governance were both challenged and benefitted from such a small management team; an agile project management approach was adopted with light-touch tracking and monitoring of milestones; however, a dedicated project management support officer for a programme of this nature would have reduced the pressures on the programme management. It would also have mitigated the risk of a single point of failure had the programme manager been absent.

6. Recommendation

Members are invited to:

- Note the progress to date of the programme team
- To accept this as the final paper for the LCS programme, now that the programme has been implemented.

Key Risks	
Clinical and Quality:	Pace of programme may result in key elements being overlooked. Quality team were engaged to undertake Equality Impact Assessment and Quality Impact Assessments to minimize risk.
Finance and Performance:	The financial envelope is fixed and service stratification will be applied to manage allocation. Risk of inaccurate historic activity data may result in cost pressures. A contingency to be held back to manage this.

Impact Assessment (environmental and equalities):	None identified
Reputation:	Non-delivery of the programme will result in a lack of trust from practices and patients alike.
Legal:	Part of CCG's local budget and responsibilities
Information Governance:	N/A
Resource Required:	Primary care directorate and PCN locality teams, medicines, quality and planned care teams, CCG clinical leads, LMC officers and elected members
Reference document(s):	N/A
NHS Constitution:	N/A
Conflicts of Interest:	Managed as per CCG policy and with reference to declarations of interest register. GP practice partners and staff are conflicted
Reference to relevant risk on the Governing Body Assurance Framework	LCS risk was monitored through PCCC and formally closed at April 2022 meeting.

GOVERNANCE

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

Agenda item: 12

Subject:	**Wave 4b Programme Business Case Approval**
Presented by:	**Paul Higham, Associate Director, Primary Care Estates**
Prepared by:	**Paul Higham, Associate Director, Primary Care Estates**
Submitted to:	**Primary Care Commissioning Committee (PCCC)**
Date:	**12th July 2022**

Purpose of paper:

To seek PCCC approval of the revised Programme Business Case (PBC) for the Wave 4b Primary Care Hub Programme.

Executive Summary:

In 2019 the CCG were awarded, subject to business case approval, £25.2m capital for the development of 5 primary care hubs across Norfolk & Waveney. A requirement of the capital award was that all sites needed to be operational by March 2024.

Progress on the programme stalled during 2020 due to the covid-19 pandemic but regained traction in 2021.

A Programme Business Case (PBC) was submitted to NHSE/I on the 1 Dec 2021 with total capital cost of £47m (including third party funding). The CCG responded to a series of questions from NHSE/I January-March 2022.

In April 2022, NHSE/I clarified "Red lines" which meant that the Programme Business Case as submitted would not be approved and that changes were required:

- To preserve the benefit of NHS capital investment, ideally no third party or private capital can be used, and
- Procurement cannot take place via the LIFT company and therefore the proposed procurement model is invalid, and
- March 2024 completion.

This has resulted in a revised proposal which delivers four Primary Care Hubs instead of five:

Two of the original schemes withdrawn due to capital cost / construction timeline and are seeking alternative routes of funding/delivery, supported by the CCG (Attleborough and Shrublands, Gorleston).

One substitute replacement scheme included (Thetford Healthy Living Centre reconfiguration).

All schemes to be delivered within £25.2m capital funding allocation.

The proposal is for NHS Property Services to develop two new build schemes (Rackheath and King's Lynn) and for the CCG to work with existing landlords to develop two existing buildings (Aslake Close, Sprowston and Thetford Healthy Living Centre).

- The revised proposals have been reviewed by the Wave 4b Programme Board but the board does not have decision making authority.
- A revised PBC has been completed and was submitted to EMT for sign-off for onward submission to NHSE/I on 22nd June. EMT approved the onward submission but noted that the PBC needed to go to a formal committee for ICB approval. The first NHSE meeting where the PBC will be formally reviewed is due to held on the 25th August. In order for the PBC to be reviewed at this meeting formal ICB approval is required in advance.
- NHSE/I have advised that the outcome of the approval process for the PBC will be known by 19th September 2022. There are a number of gateways the PBC needs to pass before final approval is issued. The full approval timeline for the PBC is shown below.
- Upon approval of the PBC the 4 x individual Full Business Cases (FBC) will be brought through the new ICB governance process which is in development. It is expected the first completed FBC will be completed in the Autumn 2022 and presented to PCCC for formal approval.

September JISC - submission by 22 June
Programme business case review and approvals timeline

Task Name	Duration	Start	Finish
CCG submits Board approved PBC to Region by this date	**0 days**	**Wed 22/06/22**	**Wed 22/06/22**
Fundamental criteria review	10 days	Wed 22/06/22	Tue 05/07/22
Fundamental criteria review meeting with Capital & Cash	0 days	Tue 05/07/22	Tue 05/07/22
PBC detailed review by Region, C&C and DHSC	15 days	Wed 06/07/22	Tue 26/07/22
Detailed review queries issued to CCG	0 days	Tue 26/07/22	Tue 26/07/22
CCG responds to detailed review queries	6 days	Wed 27/07/22	Wed 03/08/22
Clear CCG responses and draft recommendation report	10 days	Thu 04/08/22	Wed 17/08/22
Issue recommendation report to C&C	0 days	Wed 17/08/22	Wed 17/08/22
C&C review recommendation report	11 days	Thu 18/08/22	Thu 01/09/22
Capital Investment Oversight Group Meeting	**0 days**	**Thu 25/08/22**	**Thu 25/08/22**
Final recommendation report cleared with C&C	5 days	Fri 02/09/22	Thu 08/09/22
Regional Strategic Development Committee meeting	**0 days**	**Thu 08/09/22**	**Thu 08/09/22**
Recommendation report signed by Regional Directors	2 days	Fri 09/09/22	Mon 12/09/22
Report submitted to JISC	0 days	Tue 13/09/22	Mon 19/09/22
JISC	**0 days**	**Mon 19/09/22**	**Mon 19/09/22**

- Due to the timeframe for the projects, the CCG has decided to proceed at risk with the development of combined Outline Business Cases/Full Business Cases.
- The schemes of greatest risk of delivery to the March ’24 deadline are the new build schemes at King’s Lynn and Rackheath. Current programme drafted by NHSPS has forecast completion of July ’24. Work continues to attempt to reduce programme duration with NHSE/I being supportive of approach being undertaken.
- Revised Capital and Recurrent Revenue requirements of the programme are shown below.
- CCG/ICB revenue liability from the revised programme falls from £1.5m to £0.4m. Mainly driven by reduced rental values due to changes in ownership model.
- Although now not part of the Wave 4b programme alternative options for Attleborough and Shrublands are being developed. These alternative delivery options will have revenue consequences which will be funded from the revenue reduction in the Wave 4b programme.

	Capital Requirement							Funding Source	
Project Name	Land £'000	Construction £'000	Fees £'000	Optimisum Bias £'000	IT £'000	Contingency £'000	Total Capital £'000	Wave 4b Capital £'000	3PD Capital £'000
Rackheath	250	4,775	573	1,609	466	1,470	9,143	9,143	
King's Lynn	350	5,677	731	1,923	485	1,760	10,926	10,926	
Sprowston	-	1,181	159	402	157	362	2,261	1,669	592
Thetford	150	1,999	183	446	236	448	3,462	3,462	
Total	**750**	**13,632**	**1,646**	**4,380**	**1,344**	**4,040**	**25,792**	**25,200**	**592**

	Increase In Recurrent Revenue Costs							Funding Source	
Project Name	Rent £'000	Rates £'000	Water £'000	Clinical Waste £'000	IT £'000	Maintenance Fund £'000	Total £'000	CCG £'000	NHS Trust £'000
Rackheath	-	50	5	5	104	35	199	125	74
King's Lynn	-	50	5	5	106	35	201	91	110
Sprowston	40	17	1	1	3	-	62	62	-
Thetford	102	-	5	5	44	-	156	156	-
Total	**142**	**117**	**16**	**16**	**257**	**70**	**618**	**433**	**185**

Report

Recommendation to the Board:

Key Risks	
Clinical and Quality:	N/A
Finance and Performance:	N/A
Impact Assessment (environmental and equalities):	N/A
Reputation:	
Legal:	
Information Governance:	N/A
Resource Required:	N/A
Reference document(s):	N/A
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	N/A

Governance

Process/Committee approval with date(s) (as appropriate)	Wave 4b Programme Board 15th June 2022 EMT 22nd June 2022

Improving lives **together**
Norfolk and Waveney Integrated Care System

ICB PCCC 12 July 2022
Item 12

Norfolk and Waveney
Integrated Care System

Primary Care Capital (Wave 4b) Programme Business Case

June 2022

Contents

1 Programme Business Case Review Criteria – navigation for reviewers

This section provides signposting to the Key Review Criteria for colleagues reviewing this Programme Business Case (PBC).

Key Review Criteria	Main Evidence Required	Location in PBC
Strategic Case		
Is the proposed programme an integral part of the organisation's business strategy?	Extracts from business and other relevant strategies Reference to relevant government and organisational policies	Executive Summary 3.3.8 Norfolk and Waveney CCG Strategic Direction 3.7 The Case for Change
Is the proposed investment sufficiently stand alone to form a programme or could it be more sensibly undertaken as part of another programme or project?	Relevant extracts from business and other strategies Reference to scoping documentation	3.4 Estates Strategic Context 3.7 The Case for Change 3.8 Programme Objectives 3.9 Investment Objectives 4.10 Options Framework
Are the spending objectives and underpinning business needs defined clearly and supported by the key stakeholders and customers?	SMART spending objectives (specific, measurable, achievable, relevant, timebound) Evidence of stakeholder and customer involvement and support	3.8 Programme Objectives 5.1 Purpose 5.2 Programme Objectives
Is the scope for potential change to current services and business processes clearly defined?	Clear statement of business outcomes and service outputs Statement of any security and confidentiality issues	3.19 Outcomes and Key Activities
Have the main benefits been clearly defined by key stakeholders and customers, alongside arrangements for management?	Benefits realisation plan/register	3.20 Programme Benefits 4.4 Benefits Realisation 4.11.8 Benefits Realisation Plan 4.12 Benefits Methodology 6.6 Benefits for each scheme 7.8 Post Implementation and Evaluation Arrangements Appendix 3: Benefits Realisation Plan
Have the main risks been identified, alongside arrangements for their management and control?	Risk management plan/register	3.22 Programme Risks 5.15 Commercial Risk 7.5 Risk Management Process Appendix 5: Risk Register
Economic Case		
Have the Critical Success Factors (CSFs) for options appraisal been identified?	Prioritised CSFs (high, medium, low) Relevant performance measures	4.2 Critical Success Factors 4.10 Options Framework 4.12.4 Critical Success Factors (Benefits Methodology)
Has a sufficiently wide range of options been identified and assessed?	Use of any feasibility study 10 to 12 main options – full description Use of the options framework • for scope • for service solutions • for service delivery • for implementation • for funding	4.10 Options Framework 4.11.3 Site options appraisal methodology 4.11.6 Site options appraisal results
Has a preferred option for the delivery of the programme been identified following robust	Analysis of options against • spending objectives • Critical Success Factors	4.10 Options Framework 4.11 The Proposed Schemes 4.11.3 Site options appraisal methodology

Key Review Criteria	Main Evidence Required	Location in PBC
analysis of the available options?	• evidence of likely support from key stakeholders Blueprint (MSP®) Project dossier (MSP®)	4.11.6 Site options appraisal results
Commercial Case		
Has a high-level assessment of the potential Deal(s) and its likely acceptability to potential suppliers been undertaken?	Description of potential Deal Market soundings and engagement Existing suppliers	5.3 Commercial Approach 5.3.2 Funding Routes 5.4 Contractual Process and Milestones 5.14 Proposed Procurement Route
Financial Case		
Has a high-level assessment of affordability and funding source(s) been undertaken?	Indicative capital and revenue costs (£) Whole life costs Likely sources of organisational funding	6.3 Financial Costs 6.4 Recurrent Revenue Costs 6.9 Financial Affordability 6.10 System Affordability
Management Case		
Has a high-level assessment of the achievability and deliverability of the programme been undertaken?	Indicative time-scales Use of special advisers Feasibility study Peer review	5.3 Commercial Approach 7.3.1 Norfolk and Waveney ICS Estates Governance 7.4.2 Use of Specialist Advisers 7.4.3 Programme Delivery and Methodology 7.4.6 Programme Plan 7.4.7 Programme key milestones
Are all the necessary arrangements in place for the successful completion of the next phase?	Senior Responsible Owner Programme Board and team Governance and reporting arrangements Programme plan and agreed deliverables Programme assurance and evaluation	7.2 Governance and Programme Management 7.3.2 Wave 4b Programme Board 7.4.1 Programme Team 7.4.6 Programme Plan 7.4.7 Programme key milestones 7.4.9 Project monitoring and escalation and Change Control 7.8 Post Implementation and Evaluation Arrangements 7.8.5 Monitoring arrangements with NHS England & NHS Improvement 7.8.6 Project Review Process 7.10.4 Project Approval Requirements

If a different format of the document or its sections is required, please contact the Norfolk and Waveney Primary Care Estates Team via nwccg.pcestates@nhs.net

2 Executive Summary

Context

The Business Case provides details of four proposed Hub schemes which support the Primary Care Estates Strategy and the broader Norfolk and Waveney ICS Estates Strategy.

These proposed Hubs are in:

- Rackheath, a village on the outskirts of Norwich
- Sprowston, a suburb of Norwich
- King's Lynn and Thetford, market towns which are amongst the highest density populations in the area and with significant deprivation.

This follows the successful 2019 bid for STP capital (also known as "Wave 4b funding") which originally proposed five Primary Care Hub schemes. Following submission of the original Programme Business Case and review with NHS England & NHS Improvement, this case now proposes four schemes which will make optimal use of the £25.2 million NHS capital funding available, as well as fulfilling the original intentions of the bid. Schemes which have been part of the assessment process, but which are not being taken forward using this source of capital funding, remain a priority and form part of the ICS Estates and Primary Care Estates Strategies, with alternative approaches being taken to progressing these schemes.

Demographics

Norfolk and Waveney is a large rural area, with significant urban settlements and many smaller market towns and villages. The area's population is generally older and projected to increase at a greater rate than the rest of England. By 2040 our population is expected to increase by over 110,000 with older age groups growing faster than younger age groups. The demographics across the area are extremely variable, with life expectancy being lower than national averages in the most deprived areas and not increasing as fast as the rest of England. Please see Section 3.6.1 Population Health Overview.

The healthcare estate has the potential to support the planning and commissioning of services which are adaptable to meet the diversity of needs across these different areas. The Hubs proposed in this business case will form part of this modern, adaptable estate.

Vision and challenges

The ICS Estates Strategy drives a vision of an estate that allows delivery of the right care in the right place, enables better patient outcomes, and empowers health, social care and third sector staff to provide the best possible care.

Our estate will be accessible, safe, sustainable, digitally enabled, functionally optimized, and promote wellbeing. The ICS Estates Team leads a strong and well-established partnership approach with colleagues working across the healthcare estate in Norfolk and Waveney, which provides a solid basis for collaboration to ensure the enabling function of the healthcare estate can flourish as the ICS develops. We aim to maximise opportunities to enhance primary and community-based care, through the development of hub and spoke models to enable better integration of services and a net shift of care from hospitals into community settings, closer to where people live.

Primary care estate is a key part of the community-based healthcare estate which needs to support new ways of working, promote prevention and personalisation of care – through nurturing links to other services, both community based, whether statutory or voluntary, together with secondary care – and tackle variations in health outcomes through a focussed "place-based" approach to addressing health inequalities.

There are challenges identified for the healthcare estate in Norfolk and Waveney, including demand and capacity gaps in both primary care and other services, lack of functionally suitable primary and community estate to support care closer to home, variation in ownership, age and condition of estate, increasing waiting lists, the lack of digital maturity of the ICS, responding to the "Green" agenda and workforce recruitment and retention issues.

The proposals in this business case – described in more detail below – are a key part of the primary care estate response to these challenges and support to the vision for the healthcare estate.

Through these proposed schemes, modern facilities will be provided where services can work together and which act as a "Hub" for the areas they serve, providing a focus not just for the services located at the Hubs, but for patients, staff and service providers to use, to move towards joined up ways of working and approaches to health and care provision. The buildings provide the base to the clinical and service models which will develop alongside them, enabling the change in ways of working.

Current estate provision and strategy progress

The information below is drawn from the Primary Care Data Gathering exercise, as at April 2022.

There are 159 premises in Norfolk and Waveney from which GMS services are provided, with 55 of these premises being branch sites.

Both practice list sizes and premises vary widely – which could be expected for an area which is largely rural with some concentrations of population around the main city and market towns. Practice list sizes (registered patients – weighting not applied) vary from over 30,000 to just over 2,000 and building sizes from 1600m² to 111m². Almost half of these premises are owned by contractor partnerships (47.2%) and third parties or "private" owners making up just over a quarter (25.8%) with the remainder being in NHS or other statutory sector ownership.

Six Facet Surveys were undertaken in 2021 for 80 of these premises (the intention is for the remainder of the surveys to be completed in the near future) and 42.8% of premises were reported as being "Satisfactory" in terms of condition and having an Amber RAG rating in terms of overall functionality (24.5% rated B and 18.9% rated C for functionality).

This situation has been aided by over £4m of NHS Estates Technology and Transformation Fund investment in the area since 2019, supporting 11 schemes delivering proposed and completed new builds, extensions and refurbishments as well as a number of smaller scale schemes.

The CCG is in the process of reviewing the Primary Care Estates Strategy with some PCNs already having commenced the development of Estate Strategies. The work being facilitated by NHS England & NHS Improvement to determine the "state of readiness" of areas to engage with the PCN Service and Estate Strategy Toolkit will support the development of these strategies.

These strategies will build on the work already completed – as described in this business case – to determine future and support existing priority primary care schemes and to address the work identified in the Six Facet Surveys to bring premises up to a satisfactory condition (valued at £863,288) and the forward maintenance work required (£1,599,037), not all of which would be eligible for NHS capital funding.

Proposed schemes and approach

Each proposed scheme is supported by a Steering Group which includes stakeholders and prospective tenants. These Steering Groups have shaped the choice of the sites for each proposed scheme.

See Sections 4.10 and 4.11 for details of the long and short list of options and the options appraisal events. Partner Letters of Support are included at Appendix 7. As the business cases for each scheme are progressed, further letters of commitment will be sought, to ensure continued project support and particularly from those parties who will be tenants within the premises, to ensure a shared understand of liability and pre-commitments.

The proposals are:

Scheme name	North Norfolk – Rackheath	Norwich – Sprowston

Type	New build at Halsbury Homes site on Broad Lane, Rackheath	Expansion of existing healthcare premises at Aslake Close, Sprowston, Norwich
Ownership	NHS Property Services	Primary Health Properties PLC
Locality	North Norfolk	Norwich
Why these options have been chosen	• Strategic importance to estates strategy: The Rackheath and Sprowston schemes form a strategic joint approach to meeting existing and anticipated healthcare demand from Greater Norwich Neighbourhood Plan – which indicates significant population growth • Anticipated growth would see registered list sizes across these PCN areas increase by around 30,000 • Clinically important to: o Local Maternity and Neonatal Service supporting provision of continuity of carer and services in the community o Expansion of community services wrap-around integration with PCNs, focussed on preventative response to identified population healthcare and risk stratification o Support to extend community provision and MDT opportunities to manage Long Term Conditions, Mental Health, Public Health initiatives and voluntary sector services • Local political and patient interest and support for the Rackheath development established for more than 5 years • Makes optimal use of existing, underutilised estate in an area which will need to ensure healthcare facilities are able to offer flexible space for a range of service provision.	

Scheme name	**King's Lynn – Nar Ouse Way**
Type	New build at Nar Ouse Way site, south King's Lynn
Ownership	NHS Property Services
Locality	West Norfolk
Why this option has been chosen	• Strategic importance to estates strategy: Addresses significant existing premises constraint in an area of population growth and health inequalities (one of the most deprived areas in the ICS) • Local political and patient interest and support for the development established for more than 5 years • Anticipated growth would see registered list sizes across King's Lynn PCN increase by an estimated 8,000.

Scheme name	**South Norfolk – Thetford Healthy Living Centre**
Type	Refurbishment of existing healthcare premises at Thetford Healthy Living Centre, Croxton Road, Thetford
Ownership	NHS Local Improvement Finance Trust (Community Health Partnerships head lease holder)
Locality	South Norfolk
Why this option has been chosen	• Strategic importance to estates strategy: Addresses significant existing premises constraint in an area of population growth and health inequalities (one of the most deprived areas in the ICS) • Local political and patient interest and support for the development established for more than 5 years • Anticipated growth would see registered list sizes across King's Lynn PCN increase by an estimated 7,000 • Makes optimal use of existing, underutilised estate in an area which will need to ensure healthcare facilities are able to offer flexible space for a range of service provision.

Section 3.7, the Case for Change, provides more detail on the Hubs including the initial and developing service model for the Hubs.

The focus of the bid and of the proposals in this business case is to support the primary care improvement strategy across the ICS, providing a key part of the necessary infrastructure to deliver

integrated health and social care, within the community, increasing the capacity for a growing population and supporting the necessary activity shift into the community setting. This will be achieved by:

a. Better integration: through the buildings helping to enable clinical and service models which support improved planning between services, promote more personal involvement of patients and facilitate access to good information – which can also support prevention and self-care.

b. Care closer to home: through providing capacity for acute providers to have outreach services and outpatient services in the Hubs, enabling care pathways to be improved and providing capacity for community services, to improve patient access to these services.

c. An increase in capacity which will meet significant demand from population growth, driven by substantial housing developments in the areas in which these Hubs are proposed. See Section 3.12 for an overview of the registered list sizes for the PCNs where the proposed Hubs will be based, and the anticipated and annual growth per site from housing developments.

The Programme is overseen by a multi-agency Programme Board, which together with Steering Groups for each proposed scheme have been involved throughout the development of this business case, made up of organisations who will provide services from the buildings, the Local Medical Committee, and patient representatives. There has also been engagement from local politicians.

The Steering Groups evaluated the options for the proposed schemes and provided invaluable input and support from the communities these proposals will serve. With their agreement, these Groups will continue to support the development of these proposals throughout the approval process, as the buildings are brought into operation and beyond.

Alignment to Strategic Goals and Capital Schemes

The Primary Care Hubs will be buildings where a range of services can work side-by-side keeping people well and helping to prevent hospital admissions. The needs of communities have changed and can be much greater particularly where there are health inequalities and where populations have complex, long term conditions.

The Hubs support the approach of shifting the focus on treating those who are unwell to preventing ill health and tackling health inequalities. The Hubs support this through accommodating multi-disciplinary teams, made up of the additional roles which are supporting PCNs as well as the opportunity for other services to base staff at the Hubs.

This will look different at each of the proposed Hubs initially, but the plan is for each Hub to expand this approach as they are developed, working with local community services and responding to the needs of their local populations.

The proposed Hubs will move the local health and social care economy towards the achievement of its strategic goals. Specifically:

Promoting prevention through more opportunities to engage people in healthy behaviours before health problems arise – improving outcomes in population health and healthcare.

Enabling better access for marginalised groups to help tackle inequalities, through ensuring place-based partnerships are aware of the potential for these Hubs to offer flexible, bookable space for service specific interventions.

Closer integration with other services, which will support joint working, promoting better results for patients and an improvement in service quality in terms of improved access to health services for patients and the increased satisfaction of patients. This will also help our system enhance productivity and value for money.

Providing a base for an increasing range of Primary Care Network staff, including access to their services for all patients in the network.

Increasing system capacity through the provision of two new and two refurbished fully compliant modern health care facilities – helping to ensure capacity and capability requirements for primary care to meet current and increased demand for GMS services and to extend and sustain primary care support to the healthcare system.

Supporting the **achievement of workforce goals** through providing training facilities, supporting skill mix through the accommodation of Primary Care Network (PCN) Additional Roles Reimbursement Scheme (ARRS) staff and providing more attractive and compliant workspaces.

Acting as **exemplars of digital technologies**, through implementing digital solutions to support better ways of working

Supporting environmental targets through more efficient building design and building services, energy efficiency and use of renewable technologies.

As these proposed Hubs are developed – and as other primary care developments planned in Norfolk and Waveney progress – the CCG will look towards the potential of replicating the approach being developed in Cavell Centres as models where:

- Co-location of community services, outpatients, diagnostics and other health services, alongside the third sector and local authority services (e.g. social care and housing support) come together under one roof and help support the system response to challenges identified by Population Health Management.
- Premises occupation is informed by Primary Care Networks and local system priorities, based on population health data and demographics – helping to support the expanding primary care workforce and the increased delivery of services in a community setting.
- Buildings are system owned and managed – this is a change focussed on new build premises, which would be achieved over time and learning from models elsewhere. This approach could additionally enable a different employment model for GMS providers, removing the liability of the estate from contractors and supporting recruitment and retention.

The potential capital investment in the New Hospital Programme in Norfolk and Waveney, alongside the proposed investment Primary Care Hubs, needs to align to ensure the healthcare system achieves the best outcomes in terms of managing demand on services and reducing waiting times, through the estate supporting the optimal delivery of services. This alignment is overseen by the ICS Estates Programme Board. Please see Section 3.3.6 Secondary Care.

The Norfolk and Waveney system is employing a diagnostic hub and spoke model – with Diagnostic Assessment Centres (DACs) providing hub locations at each of our three acute sites, and the Community Diagnostic Centres providing spoke sites in the community. Mobile diagnostic services will also operate, providing services to hard-to-reach locations.

These proposed Primary Care Hubs will support this model through signposting (where the Community Diagnostic Centre is not co-located) and information provision (e.g. where a diagnostic hook up means provision is available at the Hub).

The proposed Hubs will utilise £25.2m of NHS Capital to provide more flexible operational models, with bookable rooms and shared resources, able to meet the changing requirements of the NHS and promote closer integration.

All the Hubs will include community and/or outpatient provision alongside GPs and PCN services. Bookable clinical, meeting and training rooms will act as a flexible resource for the wider health and social care community, improving the utilisation of the NHS estate as well as accessibility for patients and visitors.

As a predominantly rural area, with less well-developed digital infrastructure, Norfolk and Waveney has not been at the forefront of the Digital revolution. The proposed Hubs offer the opportunity to implement new technologies and address digital deprivation across the CCG, acting as exemplars for other services within each locality in developing the fundamental digital infrastructure foundations as a platform for further transformation and change.

Five Case Model

The Business Case includes the following sections which demonstrate a transactable, affordable and deliverable Programme:

The **Strategic Case** sets out the strategic context of the proposed investment, in terms of national and local services, setting out the case for change and business need for the investment – analysing the existing service provision and demands and the need for improvement that the proposed Hubs will support.

The **Economic Case** demonstrates a systematic place-based approach to finding the right solution in each of the chosen localities. Designs have been led by a series of local steering groups that included patients and elected members alongside NHS stakeholders. High level economic appraisals have been completed for several options in each locality. Shortlisted options have been assessed following Treasury best practice guidelines with an appropriately constituted panel. Preferred ways forwards have been endorsed by all stakeholders. The ICS Estates Programme is strongly focussed on stakeholder engagement and this Programme has sought active input from stakeholders in the

planning, design, process and decision making of the Programme. The Programme approach to stakeholder engagement is set out in the Management Case.

The **Commercial Case** describes how the programme will be taken forwards and how success will be recognised through a set of objectives. It describes how the proposed Hub services and construction works will be procured working with NHS Property Services and existing landlords. It details how development risks will be allocated and shared minimising the risk to the NHS. It proposes contractual arrangements to underpin this and how the costs will be treated in the accounts of the public sector stakeholders.

The **Financial Case** has tested the value for money represented by the proposed investment and confirmed a cost benefit ratio of 5.4. It has identified the development of the Integrated Care Hubs as the preferred option and proved that the programme is affordable with an annual recurrent revenue impact across the schemes of £0.4m.

The **Management Case** details the structured and accountable approach to the development of the Programme, including the management of key risks and the realisation of identified benefits. It identifies the resources required to deliver the schemes going forwards and the CCG/ICS's ability to deliver them. It recognises the potential negative environmental impacts of the buildings and commits the CCG to a sustainable approach: Be lean: Use less energy (efficient building design and building services); Be clean: Supply energy efficiently (utilise combined heat and power plant (CHP) or district heating and cooling); Be green: Use renewable technologies.

The healthcare system continues to change rapidly, driving opportunities for innovation and transformation across clinical models, digital approaches, workforce deployment and the use of estate.

The Norfolk and Waveney Integrated Care System is ready to support the delivery of these proposed Hubs, which are a key element of the focus on the healthcare estate as an enabler of change.

This Programme Business Case and proposed approach has already generated discussions about other similar opportunities to meet needs and demands across the ICS Partnership and the ICS welcome the discussions which have already taken place with NHS England & NHS Improvement and look forward to developing the proposed Hubs.

Please note – at the time of reviewing this Programme Business Case, Norfolk and Waveney Clinical Commissioning Group was preparing for the transition of its statutory functions to become the Norfolk and Waveney Integrated Care Board, from 1 July 2022. This Programme Business Case document still refers to the Clinical Commissioning Group and "CCG" – these references will be updated as the Programme Business Case is refreshed.

3 Strategic Case

This chapter sets the strategic context, summarising the plans and priorities of the key health and social care stakeholders. It considers the geographic, demographic, and epidemiological characteristics that make the Norfolk and Waveney system unique. It considers the current capacity in primary care and the likely demand to arise from population growth and health need, summarising proposals already underway to address them. Finally, it concludes where gaps exist in current and planned provision and how the proposals will address them.

3.1 The Norfolk and Waveney Integrated Care System

Our mission is to help the people of Norfolk and Waveney live longer, healthier and happier lives.

From July 2022, our Integrated Care System will include:

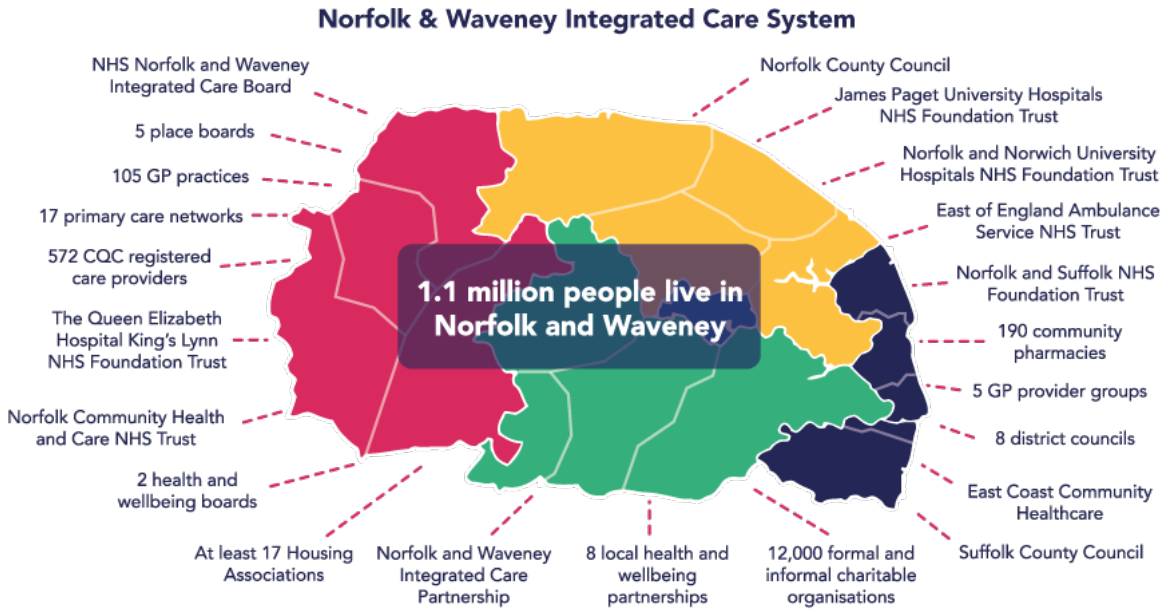


Figure 1: Norfolk and Waveney Integrated Care System

Over and above everything else we want to achieve, we've set ourselves three goals:

1. To make sure that people can live as healthy a life as possible.

This means preventing avoidable illness and tackling the root causes of poor health. We know the health and wellbeing of people living in some parts of Norfolk and Waveney is significantly poorer – how healthy you are should not depend on where you live. This is something we must change.

2. To make sure that you only have to tell your story once.

Too often people have to explain to different health and care professionals what has happened in their lives, why they need help, the health conditions they have and which medication they are on. Services have to work better together.

3. To make Norfolk and Waveney the best place to work in health and care.

Having the best staff, and supporting them to work well together, will improve the working lives of our staff, and mean people get high quality, personalised and compassionate care.

Like all Integrated Care Systems in England, we will work to:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development.

The Health and Care Act will put ICSs on a statutory footing, comprised of an Integrated Care Partnership and an Integrated Care Board:

Integrated Care Boards (ICBs)

- ICBs will be new statutory organisations bringing the NHS and partners together locally to improve population health and care. The ICB will be responsible for the day-to-day running of the NHS in Norfolk and Waveney, including planning and buying healthcare services.
- The functions of NHS Norfolk and Waveney Clinical Commissioning Group (CCG) will be transferred to NHS Norfolk and Waveney Integrated Care Board by July 2022, following their closure.
- The ICB will have a very different role to the existing CCG – helping to bring organisations together, working collaboratively, removing traditional barriers and more.

Integrated Care Partnerships (ICPs)

- ICPs will be responsible for agreeing an integrated care strategy for improving the health care, social care and public health across the whole population. They will work to address the wider determinants of health, such as employment and housing.
- The partnership will be established locally and jointly by Suffolk and Norfolk county councils and the ICB.

Our Integrated Care Partnership (ICP)

The Norfolk and Waveney system is well-placed to develop a strong Integrated Care Partnership. There is a sound track record of system-wide partnership working and the essential foundations are already in place to meet the vision and outcomes described in the guidance to date.

Given the cross-over of statutory duties, priorities, membership and scope, we have agreed the Norfolk and Waveney ICP will be established with the same membership as the Norfolk Health and Wellbeing Board (including Waveney/Suffolk members) and that they will hold streamlined meeting arrangements.

The ICP met in 'shadow' form for the first time on 28 April and discussed governance, including terms of reference, principles and the Integrated Care Strategy. A task and finish group has been established to co-ordinate the development of the Integrated Care Strategy. The ICP will be formally established following the first meeting of the ICB on 1 July 2022.

Our local working arrangements

This diagram sets-out how we will work at a local level in our ICS:

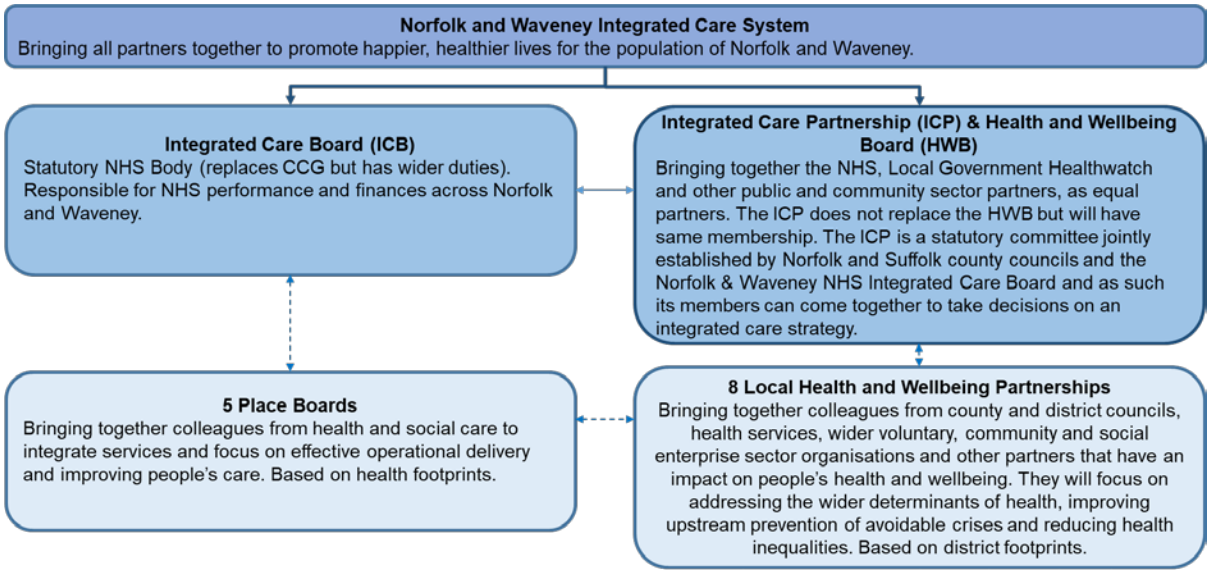


Figure 2: Norfolk and Waveney ICS Local Working Arrangements

This approach was developed by our cross-system Place Steering Group, which brings together Primary Care Networks, district and county councils, health and care service providers and the CCG. Here is an explanation of our rationale:

- It was clear from national guidance and our engagement that our local partnership arrangements will need to support both the operational integration of health and care services and our work to address the wider determinants of health. It was recognised that both functions should be considered of equal importance. Creating distinct arrangements for both of these important areas of work will mean that they each get the focus they need, and the right partners will be involved in the work.

- By continuing to join-up health and social care services on our existing health footprints, we will be able to build on the real progress we've made, particularly towards integrating primary, community, mental health and adult social care services around our Primary Care Networks

(PCNs). Importantly, given the significant demands on these services, adopting this approach will minimise disruption and enable frontline colleagues to focus on caring for people.

- By establishing local arrangements to focus on the wider determinants of health, not only does this signal our intent as a system about the importance of preventing ill-health and tackling the causes of health inequalities, but it will also give us the ability to develop much more ambitious, integrated local strategic plans. This approach will therefore enable us to integrate our local public sector more effectively beyond just health and social care services.

- The approach is also in line with national policy, which highlights the importance of forging closer working relationships between the NHS and partner organisations involved in addressing the wider determinants of health, such as district councils, the voluntary, community and social enterprise sector, housing associations and the criminal justice system, as well as the principle of subsidiarity.

It is our intention to create five Place Boards, based on our current health footprints. The Place Boards will bring colleagues from health and social care together to integrate services, with a focus on effective operational delivery and improving people's care. The Place Boards will remain aligned to our local Health and Wellbeing Partnerships.

The findings from our engagement and further discussions are helping us to determine the governance and reporting frameworks for the Place Boards and the Partnerships. This work is being led by our Place Accountability Framework Task and Finish Group, whose remit and responsibilities are to:

- Propose an approach for identifying outcomes for delivery by Place Boards and Partnerships.
- Identify the support needed for Place Boards and Partnerships to enable them to deliver agreed outcomes.
- Consider the various governance models for our Place Boards and propose an approach for Norfolk and Waveney (to include documentation such as Partnership Agreements and local leadership arrangements).
- Consider the concept of a maturity matrix to support delegation from the ICB to Place Boards.
- Consider the interactions between Place Boards and strategic ICB structures.
- Consider approaches to financial delegation and propose a model for Norfolk and Waveney.
- Encapsulate the above issues in a Place Accountability Framework document.

Here is a summary of the progress and decisions we have made about defining priorities for our Place Boards, delegation to place, and the size, membership, leadership and functions of our Boards and Partnerships:

Defining priorities

In line with the Government's 'Health and social care integration: joining up care for people, places and populations' white paper, the Task and Finish Group has agreed the following approach to defining priorities for delivery by each Place Board:

- Identify national and strategic priorities for our ICS.
- Test resonance of proposed ICS priorities with system partners.
- Set appropriate outcome measures from ICS priorities.
- Identify what is driving the gaps locally using data and intelligence.
- Agree review period for short/long-term ICS and local priorities.

Size and membership of our Place Boards

We will build on our existing arrangements to create five Place Boards based on the current health localities, replacing our current local delivery groups. It's important to note that while these alliances will be built-up from PCNs and will match the areas covered by our five GP provider organisations, they will not just focus on general practice or primary care.

This map shows our 17 primary care networks, five Place Boards and our whole system:

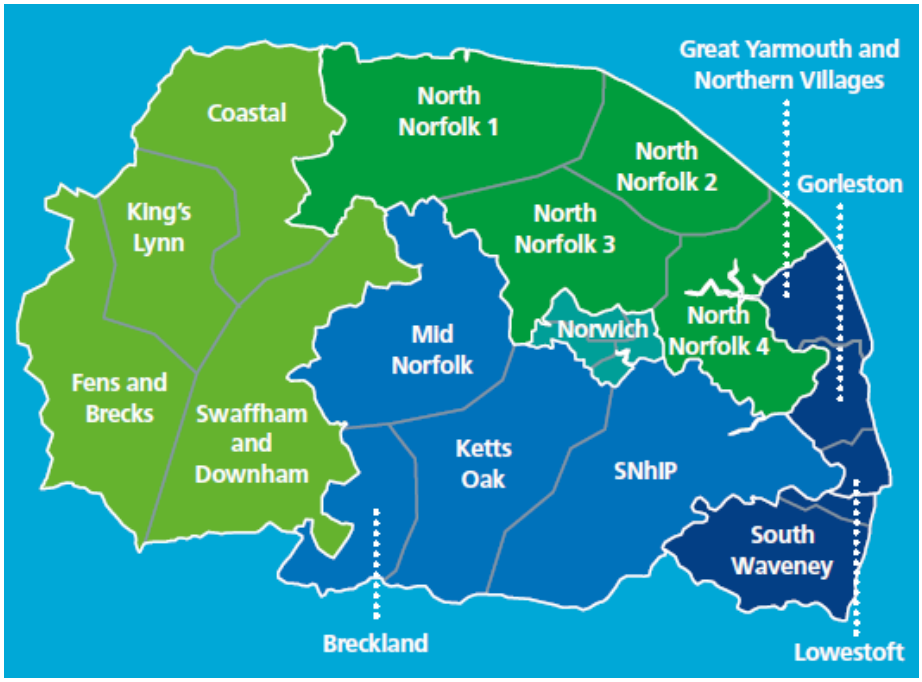


Figure 3: Norfolk and Waveney Primary Care Networks

Here is the population of each Place Board:

Place Board	Population (based on size of practice lists)
North Norfolk	176,627
Norwich	239,182
South Norfolk	237,424
West Norfolk	179,099
Great Yarmouth and Waveney	241,574

Further work is currently being done to finalise the leadership and membership of our five Place Boards, but in order to deliver a set of functions to join-up health and social care services, membership will need to include Executive Level representation from:

- General practice
- NHS trusts (acute, community and mental health services)
- Adult social care and children's services
- Public Health
- District councils

Representatives from:

- Locality teams for the Integrated Care Board
- Local health and wellbeing partnerships; and
- Place VCSE Network(s) Lead

Size and membership of our local Health and Wellbeing Partnerships

We have done further work with our district councils, Primary Care Networks, our health and wellbeing boards and other stakeholders locally about the formation of the new partnerships. We have finalised the number of partnerships as eight, based on the district council footprints within our ICS (although recognising that East Suffolk District Council covers a larger area than just Waveney).

Further work is also being done to agree the leadership and membership of these partnerships, but the membership will need to include Senior Leadership from:

- Strategic and operational teams of district councils
- Locality teams for the Integrated Care Board

- NHS providers (acute, community, primary care and mental health services)
- Commissioning teams for adult social care and children's services
- Social care providers (NORCA/SAICP)
- Public Health
- Place VCSE Network
- Other partners that have an impact on people's health and wellbeing
- and representatives from the local Place Board(s).

'Neighbourhood' level working

There will continue to be times when we need to work at an even more local or 'neighbourhood' level. At this level there is a real opportunity to continue to, amongst other things, improve people's care by developing multidisciplinary community teams. So as is the case now, our Primary Care Networks will continue to operate at the very local 'neighbourhood' level. Similarly, our Health and Wellbeing Partnerships would also focus on specific, smaller geographic areas when needed.

Working together

Flexibility will be key to making all of our partnership working effective. So equally partners from across Norfolk and Waveney will work across 'place' boundaries when necessary in order to meet the needs of either particular geographic areas or communities of interest.

It is important to emphasise that the three elements of our ICS will not be a hierarchy. We are building our ICS on the principles of distributed leadership - leadership at every level - and that of subsidiarity. The experience of working together during the Covid 19 pandemic has been very helpful in this respect; people have worked together in teams to do their best for individuals, families and communities, regardless of which organisation each individual works for. That spirit of team working and common purpose is what we seek to embrace as an ICS.

Fundamentally, the key to making any partnership arrangements work effectively is building strong, trusting relationships between colleagues and organisations that are prepared to be flexible. There will be times when to resolve a 'wicked issue' we will need to involve colleagues from our Integrated Care Board and Integrated Care Partnership, and when we will need to take action at neighbourhood, place and system levels.

As we transition to becoming an Integrated Care System we will be as clear as we can about functions, governance and accountability because these are important, but when solving complex problems relationships will always matter more than lines on a map or how we choose to structure how we work together.

Financial position

The Norfolk and Waveney ICS is in SOF4, and one of the four exit criteria relates to finance: "Delivery of the H2 financial plan and improvement in the underlying financial deficit in line with NHSE/I agreed medium term financial plan." The underlying deficit as at March 2022 is significantly lower than that at March 2021, although still represents a challenge for the system. This will be further explored and addressed via the development of an ICS Medium Term Financial Plan by July 2022.

3.2 National Strategic Context

The schemes proposed in this Programme Business Case originate from an analysis of local Place based needs and have been designed in collaboration with local providers and patient groups. However, they will also respond to the Strategic direction of the emerging Integrated Care System (CCG) and align to NHS national policy.

Strategic Context	How this business case delivers the vision of national and local policy
Delivering National Priorities.	The proposals will support several national policy objectives, including levelling up services in two areas of significant deprivation. In addition,

	learning the lessons of the pandemic, replacing existing non-compliant facilities and providing new service hubs that are pandemic safe.
NHS Long Term Plan	Promoting integration, offering digital innovation, shifting outpatient appointments.
Climate Change Act	By providing BREEAM Excellent rated buildings.
Carbon Reduction	By replacing unsustainable infrastructure and through the utilisation of brownfields sites.
Carter Review	Through investment into deprived and under resourced communities
Naylor Review	By reducing backlog maintenance and non-compliance in the existing estate. By including proposals to utilise vacant or redundant public sector land.
Local Government Policy Alignment	Housing – The proposals are driven by planned housing growth and addressing deprivation. Travel – The chosen locations are at the heart of the communities they will serve, minimising travel, ensuring good patient choice, and bringing new services into areas of deprivation. Town Planning – The proposals have been developed in collaboration with local authority partners. They facilitate a series of planned strategic urban extensions that are critical to local land use plans.
Integrated Care System	Moving the local system towards a more integrated model of care that improves outcomes, addresses inequality, improves the efficiency of the primary care estate and contributes to wider social objectives
Place Based Partnerships	The proposals will move the local Primary Care Networks forwards, whose ambitions to offer a wider range of clinical and social interventions, are currently limited by infrastructure constraints.

3.2.1 NHS Long Term Plan

The 10-year plan for the NHS could not have anticipated the pandemic or the impact it would have on the NHS. It remains a key strategic document and key aims relevant to our proposals include:

That the NHS will move to a new service model in which patients get more options, better support, and properly joined-up care at the right time in the optimal care setting.

- Groups of GP practices – typically covering 30-50,000 people – will be funded to work together to deal with pressures in primary care and extend the range of convenient local services, creating genuinely integrated teams of GPs, community health and social care staff.
- Every patient will have the right to online ‘digital’ GP consultations.
- Redesigned hospital support will be able to avoid up to a third of outpatient appointments.
- The NHS will take actions to strengthen its contribution to prevention and health inequalities, including:
- Doubling enrolment in the successful Type 2 NHS Diabetes Prevention Programme.
- Cut smoking in pregnancy.
- Current workforce pressures will be tackled, and staff supported.
- Introducing new roles and flexible working options into primary care.
- Increasing the number of trainees and training placements.
- To upgrade technology and facilitate digitally enabled care across the NHS, including:
- Integrated care records.
- Decision support systems.

- Empowering patients to manage their own care.

3.2.2 The Health Infrastructure Plan

The Health Infrastructure Plan of October 2019 highlights the clear interdependency between estates and patient care. Well-designed facilities can speed up recovery, ensure patients are appropriately treated and that medication is provided on time. In contrast, poor quality facilities can lead to poor quality of patient care affecting patient safety, increasing waiting times and leading to inefficient working practices for staff. The plan highlights the significant unmet demand for capital in the system, with the value of NHS backlog maintenance up 37% between 2014-15 and 2017-18. The highest risk category- significant- is the fastest growing.

3.2.3 Climate Change Act

The UK Government introduced the Climate Change Act with a target to cut carbon emissions by at least 80% by 2050, with a minimum reduction of 26% by 2020 across the UK. As the health sector is the largest public sector emitter of carbon emissions, the NHS and Trusts have a legislated responsibility to meet these targets.

3.2.4 NHS Carbon Reduction Strategy

The NHS Carbon Reduction Strategy for England sets an ambition for the NHS to help drive change towards a low carbon society. The strategy shows the scale of reduction in carbon required for the NHS to progress towards the Climate Change Act requirements and recommends key actions for the NHS to become a leading sustainable and low carbon organisation. NHS buildings and estates are very significant and visible consumers of energy and generators of carbon emissions.

To reduce carbon emissions by 2050, the NHS will need to put carbon management at the core of its thinking. When building new health estate, sustainable buildings with less energy intensive processes will be key and a change in staff behaviour will be fundamental.

Delivering a 'Net Zero' NHS (2020) estimates the Primary Care estate accounts for around 167 kilo tonnes of CO^2 a year from 7,000 GP facilities. It proposes a range of intervention required to reduce that to zero.

Both the ICS and CCG have developed Green Plans to respond to these challenges and support the NHS net zero targets and ambitions. The CCG Plan and actions will form the basis for the ICB Green Plan.

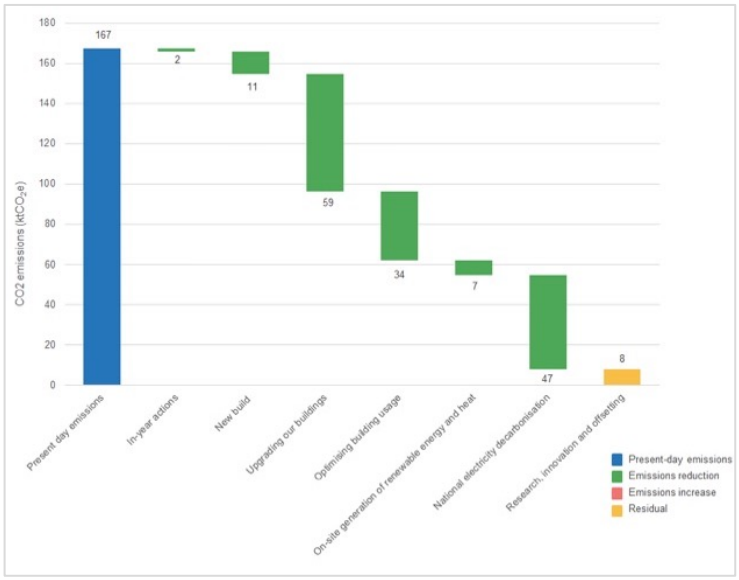


Figure 4: Interventions to reduce emissions in the primary care estate

3.2.5 The Carter Review[1]

Independent report for the Department of Health with the aim to reduce unwarranted variation in health outcomes and to increase efficiency in support areas such as procurement & estates. The proposals are cognisant of its requirements.

3.2.6 Naylor Review[2]

Acknowledges CCG/ICS process as the way forward; the proposals in this PBC are closely aligned with the CCG/ICS, described below. Identifies surplus land and backlog maintenance as major issues for the NHS and proposes a solution to improve health buildings, provide land for housing and funds to resolve backlog.

3.3 Local Strategic Context

3.3.1 The Emerging Integrated Care System

Please see Section 3.1 for details of the Norfolk and Waveney Integrated Care System.

[1] Unwarranted variation: A review of operational productivity and performance in English NHS acute hospitals; Lord Carter of Coles; Department of Health; Crown copyright 2016
[2] NHS Property and Estates: Why the estate matters for patients, an independent report by Sir Robert Naylor; Department of Health, Crown Copyright 2017

3.3.2 Place Based Partnerships

Please see Section 3.1 for details of the place-based partnerships in Norfolk and Waveney.

The NHS Plan proposed that from July 2019 all patients in England would be covered by a PCN. Networks are typically groups of practices with a combined list of between 30-50,000 patients, ideally with geographically contiguous practice areas. It is anticipated increasing funding will flow into the local health economy via the PCN rising to over £1m per PCN by 2023/24. Funds will be directed into a single shared bank account via a Directed Enhanced Service within the GP Contract.

There are 17 Primary Care Networks (PCNs) in Norfolk and Waveney, with the Norwich PCN further divided into four neighbourhoods.

PCNs will be able to make shared appointments under an Additional Roles Reimbursement Scheme (ARRS) including a PCN Clinical Director. Reimbursement will meet 70% of the appointment cost.

The PCN Service specification identifies a range of provision that might be resourced these include:

- Medication Review
- Enhanced health in care homes
- Anticipatory care
- Personalised care
- Supporting early Cancer diagnosis
- Cardiovascular prevention and diagnosis
- Tackling neighbourhood inequalities.

PCNs are able to hire into any of the following roles under the ARRS scheme and Mental Health Practitioners can be employed on a 50:50 shared reimbursement model with mental health providers.

- Care Coordinator
- Clinical Pharmacist
- Pharmacy Technician
- Dietitian
- First Contact Physiotherapist
- General Practice Assistant
- Health and Wellbeing Coach
- Mental Health Practitioner.
- Nursing Associate
- Occupational Therapist
- Community Paramedic
- Podiatrist
- Social Prescribing Link Worker
- Physician Associate
- Advanced Practitioner (level of practice)

For a PCN with a combined list of 50,000 this reimbursement could rise to over £720k per annum by 2023. Further resources will become available as improved access appointments, which are currently paid to individual practice, will in future flow through PCNs. The table below shows the funding for a PCN with a weighted population of 50,000 for 2021/22, 2022/23 and 2023/24 – using average costs for a role and potential head count.

For the weighted populations for the PCNs where these roles will be based and anticipated population growth please see Section 3.12.

	Weighted Population	2021/22	2022/23	2023/24
Total ARRS funding	50,000	£615,738	£834,802	£1,148,042
Average Norfolk and Waveney ARRS salary (April 2022)		£39,542	£39,542	£39,542
Potential Head County (WTE)		15.6	21.1	29.0

PCNs were established with three key areas of focus:

1. **Addressing workforce challenges:** By changing the skill mix in general practice to ease problems with GP and nurse recruitment.

2. **Consolidating General Practice into the wider health system:** With the aim of better integration between primary, intermediate, and secondary care. PCNs will support the commissioning role of the CCG with access to key performance data.
3. **Improving Population Health:** By finding and offering services to people at risk of deteriorating ill-health, as well as prevention of illness.

With premises constraints in each of the localities, the Hub proposals are essential to achieving these aims.

3.3.3 Service Demand and Capacity Review

In 2018 the STP commissioned a demand and capacity review to consider the 'Service' pressures on the Norfolk and Waveney system over the period 2018-2023. This highlighted some significant challenges and made proposals to address them. Its key findings were:

- Fragmented commissioning landscape (5 CCGs, 2 County Councils).
- Primary Care under increasing service demand and recruitment pressure, it also recognised immaturity in Primary Care Network provision at that time.
- Struggling and fragmented acute sector. Workforce issues at QEH, financial pressures at the Norfolk & Norwich.
- Insufficient Community and social care support leading to delayed discharge from hospital.
- Lack of long-term strategic planning.

Proposed Acute Services Interventions

- A forecast 500 bed deficit by 2023 if shortages in out of hospital care were not addressed.
- A sustainable solution would require joint planning and interventions.
- In primary care reducing A&E demand by 20%. The proposed Hubs will support primary care capacity to manage A&E demand, by ensuring they can maintain (in the face of rising demand/population growth) their existing approach of offering same/next day appointments in response to urgent care needs.
- In intermediate care facilitating discharge releasing 130 acute beds.
- Normalising acute lengths of stay across all providers.
- Broader integration and standardisation across the system to reduce costs.
- Even with all proposals implemented there will still be a 120-bed deficit by 2023.

Proposed Primary Care Interventions

Developing Primary care Networks to address rising inappropriate A&E attendances.

PCNs need to address differing demographics and workforce challenges.

Integrating estates and digital strategies across the STP area.

Proposed Intermediate and Social Care Interventions

Addressing delayed discharge of those who are medically fit.

Investing in intermediate care should result in a net saving to the health economy.

3.3.4 Secondary Care

The ICS are encouraging more joint working and integration between the three acute providers in Norfolk: The Norfolk and Norwich University Hospitals NHS Foundation Trust (Norwich), the James Paget University Hospitals NHS Foundation Trust (Gorleston) and the Queen Elizabeth Hospital King's Lynn NHS Foundation Trust (King Lynn).

There is also a significant infrastructure investment programme proposed including Diagnostic and Assessment Centres supported by a new training facility in Norwich.

The James Paget Hospital is earmarked for complete replacement after 2025 and significant improvements are being proposed at the Queen Elizabeth Hospital. The proposed Hub in King's Lynn (see Section 4.11.12) is supporting the Queen Elizabeth Hospital's estate plans through provision of space to allow for outpatient activity to take place on a site away from the main campus. These first four proposed Hubs for Norfolk and Waveney – and all future developments – will have an objective of supporting the acute providers and wider health and social care system with the appropriate

provision of more services in the community, through provision of dedicated space where required and flexible/bookable space.

Since the original Hub proposals, commissioning reforms have moved the local acute providers away from tariff-based reimbursement to block contracts. This will impact on the original activity assumptions used to offset the costs of the proposed Hubs. As such the change in commissioning model will provide additional clinical capacity to support acute services rather than deliver a reduction in acute spend.

3.3.5 The Norfolk and Waveney People Plan

The CCG/ICS have published their workforce strategy recognising the significant challenges facing all areas of the country including Norfolk and Waveney. They have identified four key challenges:

Creating new opportunities, roles, and new ways of working with evolving services and with greater effective use of technology as a system.

Promoting good health and wellbeing for our people, so they remain in their current roles, improving retention, and develop into future roles to support the system.

Maximising and valuing the skills of our workforce, developing, and implementing new roles across the whole system to allow them to work to the top of their license and registration, allowing for other functions to be delivered by supporting roles.

Creating a positive and inclusive culture and developing strong leadership at all levels that works collectively for the good of patients and service users across all of health and care in Norfolk and Waveney.

The Plan recognises the double hit from the ageing Norfolk and Waveney population as more services are required to support older people, those of working age reduce in numbers. In addition, there will be a higher proportion of people reaching retirement age, including health and social care staff. Figure 4 shows data for the Norfolk and Waveney population.

Figure 5: Changing age profile Norfolk and Waveney

The Plan identifies the urgency of attracting and retaining new employees into the workforce including the increasing challenges of recruiting abroad. There are an estimated 3,000 (5.5%) vacancies in the Norfolk and Waveney health and social care work force of 55,000.

The plan sets strategic workforce goals for health and care to 2025, they are to:

- Adopt system wide positive new ways of working following the Covid 19 pandemic.
- Develop staff to support the increased provision of intermediate care to slow down demand at acute and specialist care.
- Reduce agency or locum usage by 10% and replace them on a 1:1 basis with bank or substantive staff.
- Review skills mix with ongoing service transformation, implementing a number of new associate level roles to broaden the skill mix ratio. Including within PCN's.

- Reduce system wide vacancy level to less than 5% by 2025.
- Changes to skill mix for certain areas with consistent supervision models.
- Reduce sickness rates by 1%.
- Increase rotational posts/positions across the system areas.
- Increase measurable collaborative workforce processes for equality, diversity, and inclusion, supporting recruitment and retention.
- Increase and target system level support for the workforce with initiatives such as coaching, system wide health and wellbeing training.
- Develop leadership capabilities across the system.
- Increase awareness and engagement of the People Plan.

The proposed Hubs will have an important role in facilitating the Workforce Strategy objectives including:

Providing training facilities.

Supporting skill mix through the accommodation of PCN ARRS staff.

Providing more attractive and compliant workspaces.

3.3.6 Norfolk and Waveney CCG Strategic Direction

The CCG's responsibilities will transfer to the Integrated Care Board. The CCG is a partner on the Health and Wellbeing Board assisting the closer integration of policy and priorities as this transition takes place. It retains responsibility for commissioning health services on behalf of the population across Norfolk and Waveney and the CCG's Commissioning Strategy mirrors many of the priorities of the CCG with a single vision for primary care.

"We will empower people to understand and manage their health and wellbeing through coordinated care and support networks and improve population health and wellbeing in the longer term throughout Norfolk and Waveney". [3]

The CCGs commissioning focus has been at the five localities level working closely with the PCNs and individual practices within them.

The key commissioning priorities are:

Reducing pressures on Urgent and Emergency Care by transforming out of hospital and integrating it with community services. This includes initiatives such as crisis response, the provision of primary care streaming at the door to A&E services and implementing a 'Home First' model to reduce discharge delays.

Population Health Management by building on the findings of a series of pilot projects. These include Medicines optimisation through a digital technology innovation and use of the 'Bridges to Health'[4] pathway model to avoid non elective admissions. A separate technology innovation will deliver an integrated care record assisting clinical decision making and appropriate data sharing.

Implementing a Digital Strategy by ensuring digital innovation forms part of all investment decisions. The ICS is reported as the least digitally mature in England.[5] The Digital Strategy has five objectives summarised in the diagram below.

The initial focus of the Digital Strategy will be: Ensuring a common patient record system across the three acute providers; Primary Care system integration; Developing the Integrated Care Record; Establishing an ICS level digital team to push forwards and champion innovation.

[3] Norfolk and Waveney CCG (Jan 2020) Strategic Commissioning Strategy.
[4] Lynn J, Straube BM, Bell KM, et al. Using population segmentation to provide better health care for all: the "Bridges to Health" model. The Milbank Quarterly 2007; 85(2): 185-208
[5] NHS Innovation (2019)

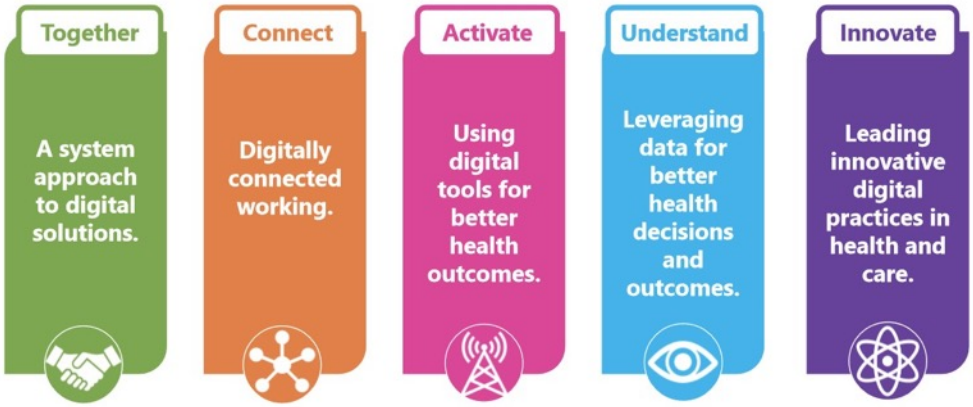


Figure 6: Norfolk and Waveney CCG Digital Strategy Objectives

Planned Care Formerly, an STP level Planned Care Board was in place with a focus on ensuring system wide pathway reforms. Initial projects included, Neurology, Gynaecology, Dermatology and Gastroenterology, with the aim to ensure more consistent, efficient, and effective referral practices. A second area of work sought to reform outpatient appointments, and cross sector working groups reviewing other clinical areas were in place including primary, community and acute colleagues. As part of the transition to the ICS, this Board has been replaced by an Elective Recovery & Transformation Board, chaired by the Chief Executive of the Queen Elizabeth Hospital Foundation Trust and with representation from NHS England & NHS Improvement. This Board has a specific workstream for outpatient transformation, which is focussed on national targets, alongside specialty groups which will feed into the outpatient transformation workstream. Cross cutting workstreams are performance, single patient waiting list, theatre capacity and workforce. Priority areas at present are in keeping with national guidance: Dermatology, Ophthalmology and Musculoskeletal conditions. The expectation is that the Hubs proposed in this business case – and the wider Primary Care Estates Strategy – will support this work as it develops, and in line with workforce developments, by helping the expansion of pathways into community settings.

Mental Health by moving forwards the strategic goals of promoting prevention and wellbeing, improving access, increasing provision in primary care, providing effective crisis support, effective inpatient care and ensuring better integration with other services. Mental Health Practitioners and Recovery Workers are embedded in primary care and the focus of the IAPT (Improving Access to Psychological Therapies) service is also moving towards PCNs. As well as providing space for these roles, the Primary Care Hubs will need to provide space for clinics to take place and this could extend to offering space to the Community Mental Health Team for clinics. This provides opportunities for specialist clinics to be held in a community setting and for work supporting (for example) dementia and Serious Mental Illness to link up.

There are new Mental Health Wellbeing Hubs, which are CCG specified and funded services provided by the voluntary sector. These are non-clinical services which have a Café, crisis sanctuary and therapeutic environment. The intention of the Wellbeing Hubs is for anyone to be able to drop into the Café and, for someone needing support, for this to be normalised. The Wellbeing Hubs are based in town centre “High Street” locations and are staffed by Mental Health Practitioners able to provide support as required. Co-location of the Wellbeing Hubs and Primary Care Hubs was considered, but due to the timing of the services and the specification for the Wellbeing Hubs it was not considered appropriate. Following the establishment of the Wellbeing Hubs, the pathways and relationships between those and other services – including the Primary Care Hubs – will be formed. The expectation is that the Mental Health Practitioners within PCNs and those within the Wellbeing Hubs will provide the key links and support. See Section 3.6.6 for more information on the Wellbeing Hubs.

The proposed Hubs will move the local health and social care economy towards the achievement of its strategic goals. Specifically:

Promoting prevention through more opportunities to engage people in healthy behaviours before health problems arise – improving outcomes in population health and healthcare.

Enabling better access for marginalised groups to help tackle inequalities, through ensuring place-based partnerships are aware of the potential for these Hubs to offer flexible, bookable space for service specific interventions.

Closer integration with other services, which will support joint working, promoting better results for patients and an improvement in service quality in terms of improved access to health services for patients and the increased satisfaction of patients. This will also help our system enhance productivity and value for money.

Providing a base for an increasing range of Primary Care Network staff, including access to their services for all patients in the network.

Increasing system capacity through the provision of two new and two refurbished fully compliant modern health care facilities – helping to ensure capacity and capability requirements for primary care to meet current and increased demand for GMS services and to extend and sustain primary care support to the healthcare system.

Supporting the **achievement of workforce goals** through providing training facilities, supporting skill mix through the accommodation of Primary Care Network (PCN) Additional Roles Reimbursement Scheme (ARRS) staff and providing more attractive and compliant workspaces.

Acting as **exemplars of digital technologies**, through implementing digital solutions to support better ways of working

Research and Evidence The CCG is committed to promoting research and ensuring commissioning decisions are based on best available evidence when addressing the healthcare priorities of the population.

Quality Measures and structures are in place to ensure commissioned services deliver the requirements of their specifications, safely and to the specified standards. Where providers are in special measures or deemed inadequate by regulators, commissioners will work to support struggling providers or place contracts with alternative providers.

3.4 Estates – Strategic Context

Our ICS Estate Strategy lays out how we will support and enable our system to deliver upon its visions and meet national drivers and local priorities. It seeks to show how the NHS estate in Norfolk and Waveney will be transformed to support new models of care, deliver better outcomes to patients, and provide best value for money. It has been developed in partnership with commissioners and providers across the system.

Our 2022 Estate Strategy builds on and renews our focus following on from the 2018 strategy workbook, rated ‘good’ by NHS England & NHS Improvement, and the subsequent 2019 checkpoint.

National Drivers

The NHS Long Term Plan sets out how the NHS will tackle the pressure its staff are facing while making extra funding go as far as possible. As it does so, it must accelerate the redesign of patient care to future proof the NHS for the decade ahead.

Our estates response to the long-term plan, and overarching programmes of work that we are focusing on over the next five years are:

- Investing to improve the quality and condition of primary care premises to support delivery of high-quality primary care
- Exploring opportunities to deliver hub and spoke models for the delivery of services, where appropriate
- Focussing on prevention and provision of integrated primary, community, and mental health services

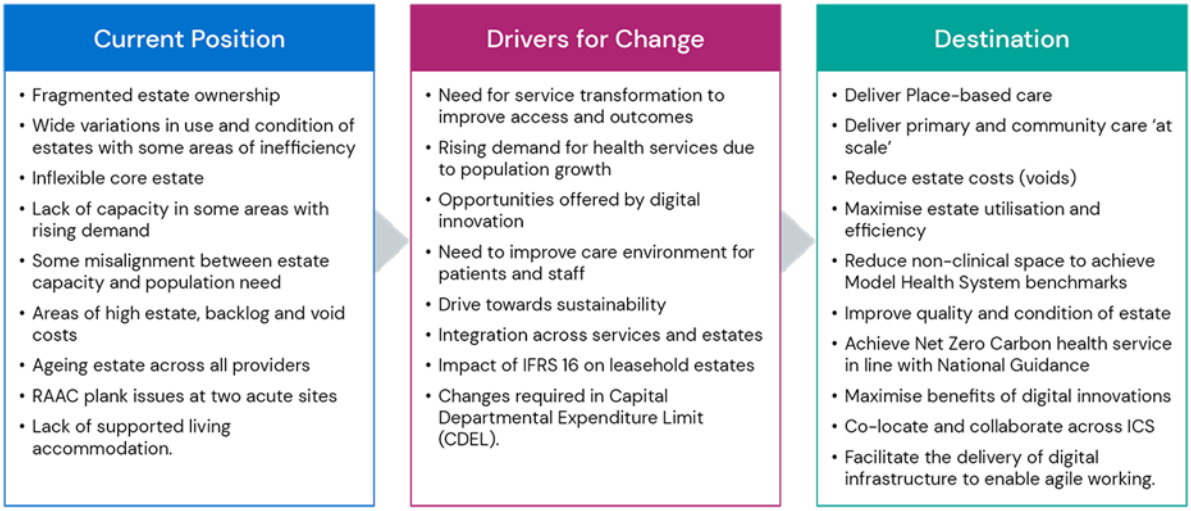
- Consolidating and redeveloping our acute services – including re-location of appropriate acute services into the community
- Optimise property costs by improving utilisation and increasing tech-enabled delivery of care
- Transformation of estates service support and delivery through our development programme
- Support Trust's to remain below or meet their respective benchmark values as per the Model Health System.

Local Drivers

Our ICS Estate Strategy is integral to supporting the 5-year clinical plan and we will aim to enable the ICS Clinical Strategy by:

- Ensuring that estates support provision on preventative models of care
- Supporting delivery of care locally and closer to home e.g., in the community and PCNs
- Enabling re-location of services closer to areas of high need where clinically appropriate
- Ensuring that estate supports access to services for all of our population
- Reducing the negative impact of wider determinants of health by providing equitable access to care
- Supporting integration of physical, mental health, community and social care by co-locating services and providing shared spaces.

In developing our ICS Estate Strategy, we have adopted a methodical approach to review our current position for key estates metrices, identified the drivers for change in our health system and our estate to develop plans for future changes required in service delivery and estates. The below graphic illustrates key considerations for future estates planning.



Our ICS estates vision is to provide estate that allows delivery of the right care in the right place, enables better patient outcomes, and empowers health, social care and third sector staff to provide the best possible care. Our estate will be accessible, safe, sustainable, digitally enabled, functionally optimized, and promote wellbeing.

In order to achieve our estates vision, we will:

- Ensure that the right services are delivered in the right place – matching demand and capacity, delivering multi-disciplinary working in Places/neighbourhoods
- Implement operational hub & spoke models to deliver integrated, multidisciplinary working and support care closer to home, enabling and supporting the clinical strategy of the ICS
- Develop a resilient and digitised estate to support remote consultations, separation of flows and to sustain elective services which maybe otherwise impacted by a business continuity event such as a pandemic
- Maximise the benefit of investing in and developing our staff well-being and ability to build patient welfare
- Provide fit for purpose estate that offers an improved working environment for the workforce, promotes wellbeing for all patients and contributes to successful recruitment and retention programmes that sustain our workforce
- Provide safe, sustainable, and efficient estate, specifically resolving capacity and RAAC plank roof issues at two of our acute hospitals

- Deliver value for money in terms of service benefit, operating costs, financial return and contribute to the sustainability 'agenda', achieve Net Zero Carbon targets by reducing combined carbon footprint.

Prioritised Investment

NHS capital continues to be constrained and funding for large scale reconfiguration projects and new builds can be difficult to secure. As an ICS, we have developed a prioritised capital pipeline that is kept live and up to date through the Strategic ICS Estates Group. It is prioritised in the context of the national drivers, ICS's clinical strategy and priorities, estate strategy principles, tackling growing demand and population, and sustainability. The pipeline spans all developments for primary; community; mental health; acute health; and community providers. The pipeline is prioritised for recommendation by the ICS Strategic Capital Board by early Q3 in each financial year.

The ICS Strategy and capital pipeline recognises and has prioritised the need for investment in these four schemes, and in addition, commits to determining additional locations and property requirements that help further deliver and achieve national and local drivers and priorities.

Delivery of these schemes is a priority project within our ICS Estate Strategy, they underpin the direction of travel and are fundamental to us realising our vision and the 'how do we get there' element of our strategy.

This investment will help us:

- Deliver new estate using modern methods of construction, helping to meet the sustainability agenda and work towards carbon 'net zero'
- Support the 'levelling up' of access to services and reduce health inequalities, at scale and pace
- Build estate that provides flexible occupation supporting diversification of services under one roof, allowing for specialised and focused sectors
- Create an estate that makes co-location of health, community, social care, and 3rd sector organisations a reality to support new ways of working, PCN and preventative healthcare agendas
- Provide flexibility of service delivery, partnership working and driving cost savings within the system
- Provide additional floorspace to accommodate new PCN staff, and create an attractive workplace to promote and sustain staff recruitment and retention making GP partnership more attractive
- Respond to the significant shift towards out-of-hospital appointments and care closer to home, and support the secondary care improvement plans and the HIP programme
- Transition from dated, constrained estate to modern fit-for-purpose healthcare facilities
- Respond to and provide additional capacity for the increasing demand and growing population.

The map below shows the Estate Strategy journey as proposed in 2018/19 to 2021/22 when the work to develop the current Estates Strategy was initiated.

Figure 7: 2018 Estate Strategy Journey

3.5 Data, digital transformation and information governance

The success of our ICS will be underpinned and enabled by modern, efficient digital and data services which support system transformation and sustainability. Our new ICS Digital and Data Strategy, co-created with key partners and stakeholders across the system, sets out our ambitions for the next three years. This strategy will become the foundations of our ICS Digital Transformation Plan which will be based on further increasing our digital maturity in line with, 'What Good Looks Like'.

Norfolk and Waveney is amongst the least digitally mature ICS nationally and will benefit from the NHS England "levelling up" agenda. There has been great progress in the last three years, with digital leads across the system working closely together. Primary Care has always been at the forefront of digital initiatives in the area. In recent years, there has been a major investment in mobile working, with over 1,500 devices deployed across the estate. All GP Practice data has been migrated to the cloud, bringing instant benefits to multi-site practices. The majority of practices have deployed an online consultation system and the population of Norfolk and Waveney ranks as the second highest users of these systems in the country. Funding from NHSX has seen a cloud telephony platform procured for Primary Care which allows transfer of calls between practices and can be used from any internet connected device.

Digital Strategy for Primary Care has the following key themes:

a. Infrastructure and operational IT – developing our fundamental digital infrastructure foundations as a platform for further transformation and change

b. Collaborative working – co-operative working across the CCG, ICS and other settings, sharing data, best practice and enabling continuity of care

c. Digitisation and optimisation – implementing digital solutions to bring better ways of working and developing our existing solution to ensure maximum value

d. Outcomes and Data – managing and controlling data to improve data quality and standardisation, utilising data for clinical support and proactive care

e. Supporting people, digital access and self-care – ensuring quality of care, empowering citizens and digital inclusion, improving access to care and promoting self-care

f. Clinical safety, assurance and Information Governance – ensuring the rigorous application of safety standards and Information Governance protocols across all technology deployed in primary care.

Whilst progress in many ambitions is held back by the lack of an electronic patient record in any of the three acute Trusts, the Norfolk and Waveney Shared Care Record project will increase cohesion between the organisations in our Integrated Care System, improving the efficiency of the health and

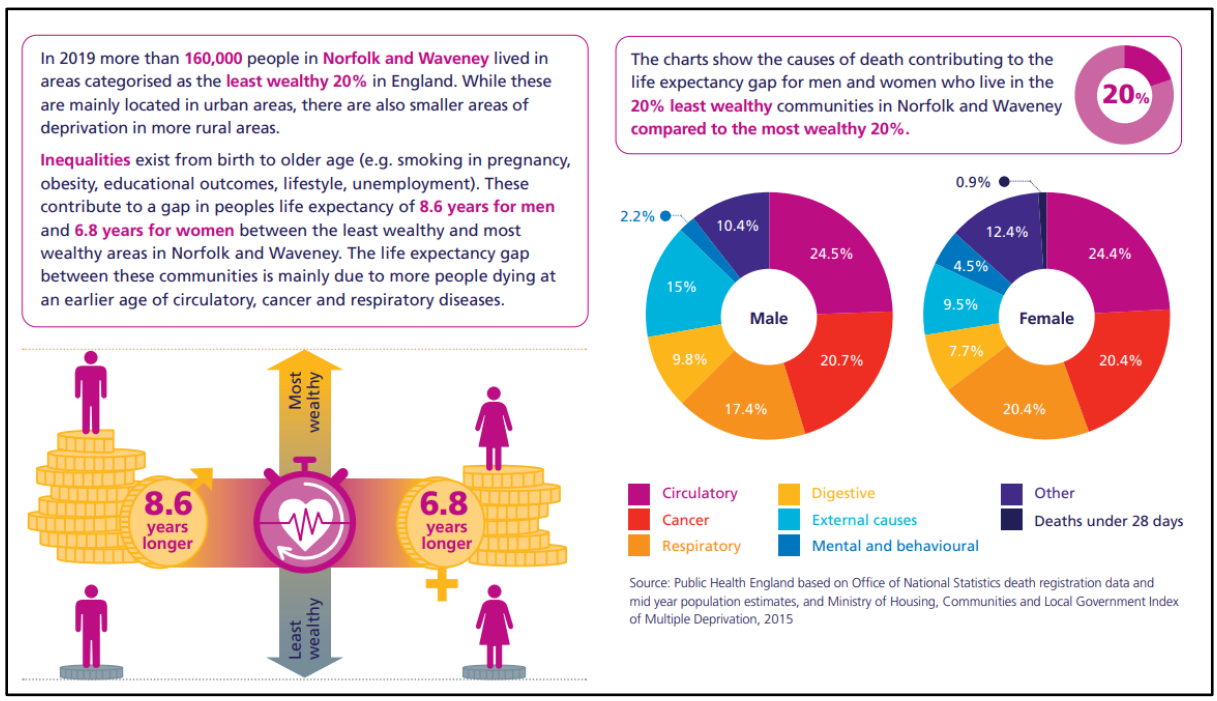
care machine. Reducing duplication, helping achieve faster and clearer care journeys, and freeing resources to be better deployed elsewhere, the Shared Care Record will help us overcome challenges we currently face as a system.

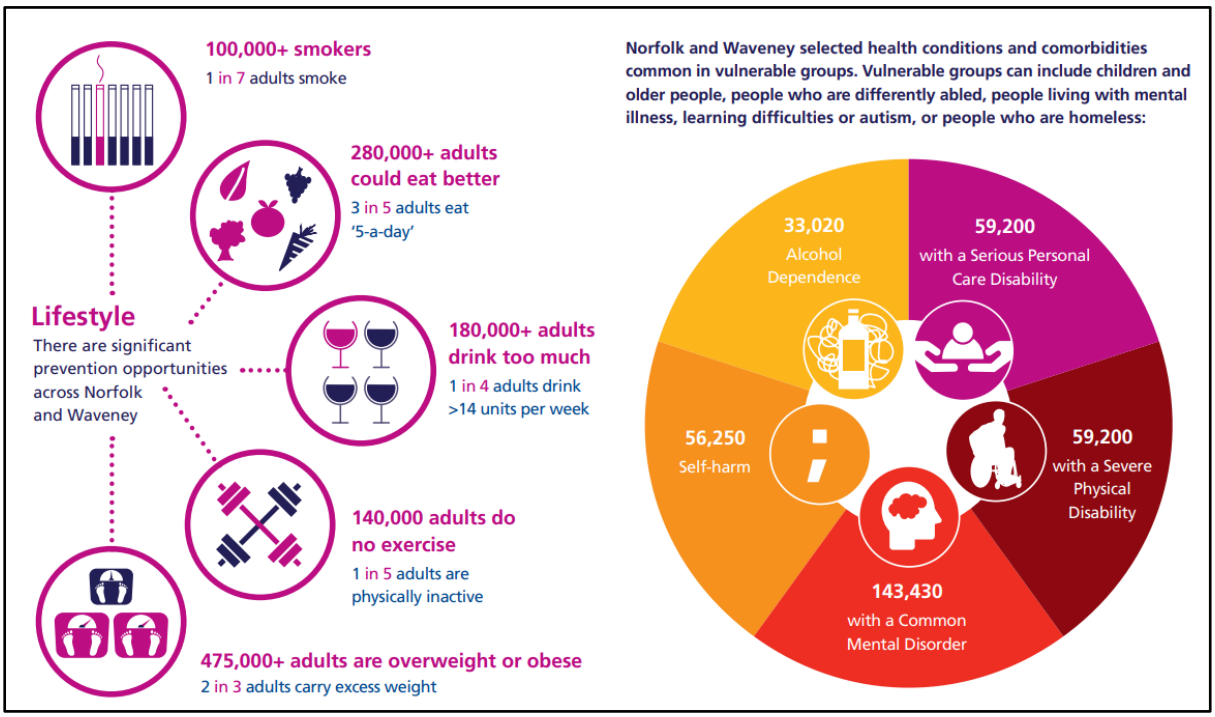
More importantly, at the human level, this efficiency and easier access to shared information will give our staff more time to care. They will also have more confidence in making the right decision for a citizen, knowing the detail of previous wishes and our colleagues' existing plans. Empowering our staff in this way will help us to achieve our goal of making Norfolk and Waveney the best place to work in health and care.

3.6 Clinical Strategy and Public Health

3.6.1 Population Health Overview

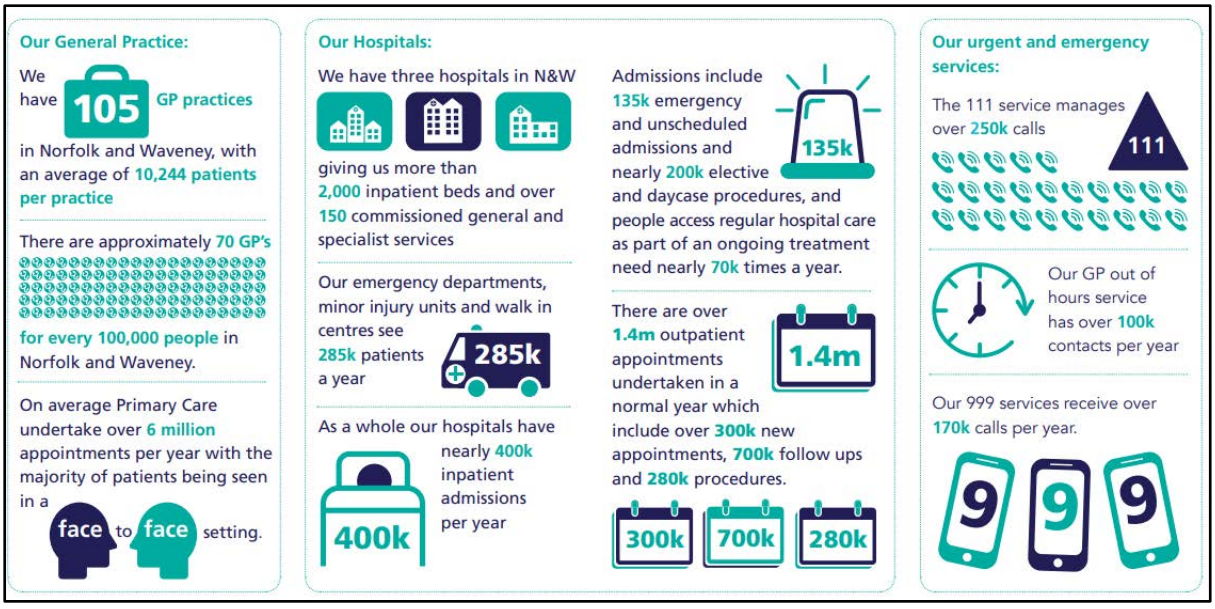
The following information is derived from: Integrating NHS Services: Our System Clinical Strategy for the next five years the new strategy for Norfolk and Waveney ICS.





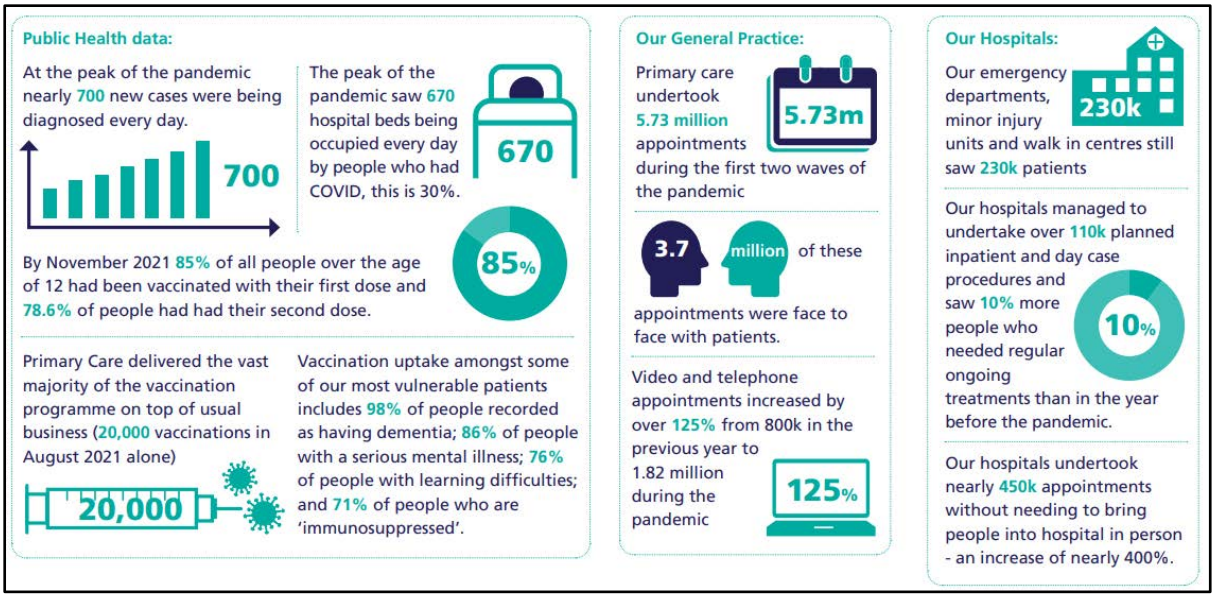
Summary of healthcare services

Here are some key facts about how people who live in Norfolk and Waveney are cared for in a normal year:



How our services managed in the pandemic and the challenges that lie ahead

The information below shows how the system coped in the first two waves of the pandemic and the challenges we now face.



3.6.2 Health and Wellbeing

Public health data summarised in Appendix 1 illustrates the area generally reports better health when compared with the England averages.

However there remain a number of public health issues of concern which are key to planning health needs within the Hubs described in this Programme:

- 15.1% (21,670) children live in low-income families.
- Life expectancy for both men and women is higher than the England average but there is significant variation; 7.1 years for men and for 4.7 years for women, between the best and worst performing areas.
- The suicide rate is above the national and regional averages and is increasing.
- Similarly, the numbers of those killed or seriously injured in road traffic accidents is higher than national averages.
- Smoking levels are higher than national averages with a particular issue for those smoking during pregnancy.
- Educational attainment remains below national averages.
- Statutory homelessness figures are also above national averages.

3.6.3 Deprivation

The 2019 index of multiple deprivation considers seven domains of deprivation including Income, Employment, Education, Crime, Housing and the Environment in addition to Health Deprivation. It ranks each small area's (LOSA[6]) score nationally to provide a measure of relative deprivation.

Higher deprivation is concentrated in Lowestoft, Great Yarmouth and to a lesser extent in Norwich and Kings Lynn, with a few pockets of deprivation in the smaller towns as illustrated in the map below, from SHAPE: the darker areas represent higher levels of deprivation, as per the Index of Multiple Deprivation (IMD). The Norfolk and Waveney Index of Multiple Deprivation average score is 21.73.

The locations of the proposed Hub schemes in this Programme are shown by the "GP" markers:

King's Lynn IMD score: 45.65

Breckland (Thetford) IMD score: 45.59

North Norfolk (Rackheath) IMD score: 23.15

[6] Lower Layer Super Output Areas (LSOA) are a geographic hierarchy designed to improve the reporting of small area statistics in England and Wales.

Norwich (Sprowston) IMD score: 8.66 (but note proximity to locations with higher scores of 48.27, 34.62 and 36.47 – see smaller map)

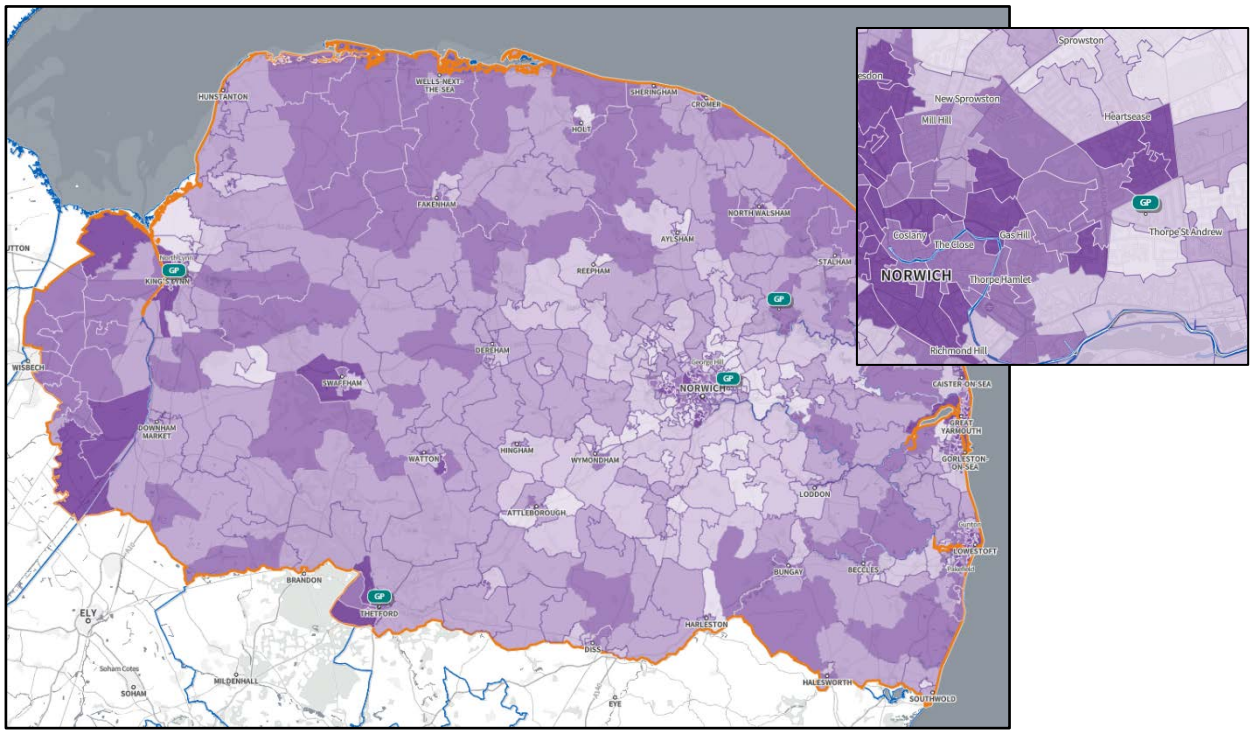


Figure 8: Norfolk and Waveney - Index of Multiple Deprivation

Deprivation impacts on the demand and delivery of health care services. Evidence shows that populations from deprived communities may access primary care more often and require longer consultation times. They may also disproportionally access secondary care through unplanned routes such as emergency departments. Between 2008 and 2017 across England, the number of GPs working in areas containing the most deprived quintile of the population fell by 511, while 134 additional GPs were recruited to the areas containing the most affluent quintile[7].

3.6.4 Joint working and integration

Local health and care providers in Norfolk and Waveney have been working jointly as a Sustainability and Transformation Partnership for a number of years. This partnership includes GP practices, the three local acute trusts, community services, mental health and social care.

The CCG are encouraging more joint working and integration between the three acute providers in Norfolk. Significant infrastructure investment has been proposed including:

- Diagnostic and Assessment Centres supported by a new training facility in Norwich.
- The James Paget Hospital is earmarked for complete replacement after 2025.
- A business case is in preparation for significant infrastructure improvements at the Queen Elizabeth Hospital.

As noted above, the proposed Hub in King's Lynn (see also Section 4.11.12) is supporting the Queen Elizabeth Hospital's estate plans through provision of space to allow for outpatient activity to take place on a site away from the main campus. These first four proposed Hubs for Norfolk and Waveney – and all future developments – will have an objective of supporting the acute providers and wider health and social care system with the appropriate provision of more services in the community, through provision of dedicated space where required and flexible/bookable space.

The Norfolk and Waveney system is employing a diagnostic hub and spoke model – with Diagnostic Assessment Centres (DACs) providing hub locations at each of our three acute sites, and the Community Diagnostic Centres providing spoke sites in the community. Mobile diagnostic services will also operate, providing services to hard to reach locations.

The proposed Community Diagnostic Centres provide tests and services in community locations, supporting the rapid diagnosis and management of common medical conditions, helping to improve

[7] Campbell D. Poor lose doctors as wealthy gain them; new figures reveal. *Guardian*; 20 May 2018.

patient outcomes, benefit the healthcare system, relieve pressure on acute settings and improve the patient experience. Patient expectations are increasing, and delivery of these services must make effective and efficient use of funding available. Both the Hubs and Community Diagnostic Centres will be meeting the needs of a rural population and will be planned to ensure those with mobility issues or transport concerns can be met. The ICS recognises the importance of considering how the clinical teams are available to manage the services. A recognised challenge will be ensuring the right patients attend the Centres instead of seeking care at emergency departments. The role of the Hubs will be one of signposting (where the Community Diagnostic Centre is not co-located) and information provision (e.g. where a diagnostic hook up means provision is available at the Hub).

Mental Health Practitioners are embedded within primary care as part of the ARRS roles, alongside Social Prescribing for Mental Health and Recovery Workers. They work locally to respond to the nationally led transformation of community mental health services that will implement the integrated models of primary care and community mental health care.

An enhanced health programme in care homes has strengthened care quality in several care homes across Norfolk. An example of this is taking place in North Norfolk where the enhanced Care Home Team is supporting care homes and general practices. The service is reducing admissions to hospitals and reducing the number of GP visits needed, by offering a more tailored and organised service for care homes.

In Great Yarmouth and Waveney, integrated care delivery between East Coast Community Healthcare (ECCH), St Elizabeth Hospice and James Paget University NHS Hospital Trust provides specialist led palliative care and day service provision. The service is working closely with Primary Care Networks. This is supported by a 24/7 advice line for patients and their families, as well as health and care professionals.

A range of initiatives are underway across Norfolk and Waveney to support patients to stay well in their own homes and prevent avoidable admissions to hospitals. PCNs are also developing their approach to population health management.

The Department of Health and Social Care has published new proposals to streamline and update the legal framework for Health and Social Care.[8]

The paper sets out their legislative proposals for a Health and Care Bill and aims to build upon the Collaborations seen through the pandemic and shape a system that is better able to serve people in a fast-changing world. This Bill introduces Integrated Care Systems and Integrated Care Boards.

3.6.5 ICS Clinical Strategy

The clinical service strategy for this Programme will align to and support the wider ICS clinical strategy.

The ICS System Clinical Strategy clinical objectives set out what the public, patients and staff should expect from their NHS:

The statements describe what the plan will try to achieve and have three key aims:

They describe the expectations that patients and staff have told the ICS they want from the NHS in Norfolk and Waveney

They explain how the ICS plans to help improve certain areas of health within the population

They detail how NHS services will work together to achieve the goals of the ICS.

The CCG wants to ensure health and social care can operate in a more integrated way. The digital, estates and workforce strategies underpin how the CCG want to deliver healthcare over the next 10 –

[8] Working together to improve health and social care for all - GOV.UK (www.gov.uk)

15 years. The CCG's Wave 4b Hub Model is based on a single infrastructure principle meaning clinical and social care teams can work together and share information. The integration of health and social care services will ensure that personalised care packages can be delivered in a seamless way to patients.

Providers are already aligning their services to the Primary Care Networks (PCNs) and moving away from the locality models that were previously in operation. The foundation of the clinical strategy for CCG, and throughout the transition to the ICB, will be 'Place Based Care'. The design of the Wave 4b Hubs will underpin this methodology by providing flexible use areas that can be used 365 days a year and 24 hours a day. They will include bookable rooms and areas that can be used for health and wellbeing service as well as providing space for the wider community to use for health and wellbeing events.

3.6.6 Clinical Focus for the Hubs

The ICS and CCG wants to ensure that it learns from its experiences during the pandemic and work together to ensure that they have high levels of preparedness in place for future waves of coronavirus or similar events. The development of the Wave 4b Hubs will provide them with centres that have the modern flexible space needed to deliver the services during such events in the future. The design of the Wave 4b Hubs will include flexible space that is easy to reconfigure to meet future needs as well as the current clinical requirements of the CCG.

The pandemic has demonstrated how well different teams can work together and in a variety of ways. One focus of the ICS over the next two years will be to enact shared care and active management of people on waiting lists, whilst developing an understanding and focus within the population of preventative care. The use of data and population health management is essential to stratify risks for specific demographics, communities, and workplaces. By developing a population health management and inequalities 'levelling up' strategy it will allow the CCG to target collective resources where evidence shows there are the most significant issues and greatest impacts.

There will also be a need for the coordination of long-term resource and capacity planning to minimise and mitigate the wider adverse effects of increased health inequalities arising from the unequal impacts of Covid 19. Please see Section 3.18 Ensuring the Hubs are Pandemic Safe.

Part of the clinical model for the Wave 4b Hubs will be to develop resilient primary care services with the Primary Care Networks, that can focus on the needs of the local population and putting patients in control of their care. Many services are already designed around the principles of 111, by defining what planned care and unplanned care is within Primary Care, this will help define how the Wave 4b Hubs will need to operate. The Hubs will provide the accommodation needed to deliver outpatient care in the community and allow for a standardised approach to integrating secondary care into primary care settings for treatments, procedures, and the management of long-term conditions, frailty and multi morbidities wherever it is appropriate and safe.

Described in the digital model for the Wave 4b Hubs is putting patients in control of their own care which is key to reduce chronic diseases in the future.

The Case for Change describes the Norfolk and Waveney Primary Care Hub model and how the services to be provided from each Hub have been determined. It is envisaged that this will be an evolving model, drawing on national best practice (e.g. the developing Cavell Centres), as well as local operational experience and place-based partnership focus and feedback. The business cases for each Hub will explore in more detail the focus of the clinical model for the population being served.

To ensure that the Primary Care Hubs can meet current and future demand or service need the CCG will ensure the right estate solutions can underpin effective service integration.

The business cases for each Hub will explore in more detail the focus of the clinical model for the population being served. The four key service design characteristics all will share are:

- **An integrated workforce**, with a strong focus on partnerships spanning primary, secondary, and social care.
- **A combined focus on personalisation of care** with improvements in population health outcomes.
- Aligned clinical and financial drivers
- Provision of care to a defined, registered population of between 30,000 and 50,000.

The main service delivery considerations that have been made in arriving at a model for the Primary Care Hubs are:

- **Access** – ensuring extended hours are available.
- **Workforce** – ensuring Hubs have a broader workforce and skill set.
- **Care shift** – out of hospital and into community and self-care.
- **Transformation -** new ways of working and demand management.
- **Population health management** - targeting collective resources to where evidence shows there is the biggest problem and that they will have the greatest impact.

Within the proposed Hubs health organisations and social care providers, supported by the community and voluntary sector, will work closely together, to deliver joined-up services to defined groups of the population. In this way, preventing, reducing, or delaying a healthcare need before it escalates; and preventing people with complex needs from reaching crisis points.

Carers and Family Involvement

For many people living with long-term conditions or ongoing care needs, carers and family members play a key role in supporting them to stay healthy and well. There is evidence that greater involvement of families and carers can improve outcomes and experience for patients, carers and staff. The Hubs will endeavour to support carers to develop knowledge and skills in their caring role and to create closer partnerships between carers and health professionals.

Focus on Mental Health

Nine out of ten adults with mental health problems are supported in primary care. The Improving Access to Psychological Therapies (IAPT) programme to treat common mental health conditions is world leading. Mental illness is a leading cause of disability in the UK. Stress, anxiety, and depression were the leading cause of lost workdays in 2017/18. As well as the significant cost of poor mental health to the economy, it is also known that mental health problems can exacerbate physical illness, affecting outcomes and the cost of treatment. Reducing the impact of common mental illness can also increase our national income and productivity.

The Five Year Forward View for Mental Health set out plans for expanding IAPT services so at least 1.5 million people can access care each year by 2020/21. The NHS will continue to expand access to IAPT services for adults and older adults with common mental health problems, with a focus on those with long-term conditions.

The Five Year Forward View for Mental Health also sets new waiting time standards covering the NHS IAPT services, early intervention in psychosis and children and young people's eating disorders.

Mental Health in Norfolk and Waveney

More information can be found in the Mental Health Transformation Programme. The Mental Health Programme is closely linked with the development of the Clinical Strategy.

Mental Health Well-Being Hubs are being developed in the following areas:

Service	Location	Provider
STEAM House Café **S**upport, **T**ransform, **E**at and **E**ducate, **A**spire, **M**otivate	High Street, Gorleston	Access Community Trust
STEAM House Café	High Street, King's Lynn	Access Community Trust
REST Café **R**ecover, **E**at, **S**upport, **T**alk	Churchman House, Norwich	MIND
REST Café	High Street, Aylsham	MIND
REST Café	TBC, South Norfolk	MIND

The Mental Health Wellbeing Hubs are CCG specified and funded services provided by the voluntary sector. These are non-clinical services which have a Café, crisis sanctuary and therapeutic environment. The intention of the Wellbeing Hubs is for anyone to be able to drop into the Café and, for someone needing support, for this to be normalised. The Wellbeing Hubs are based in town centre "High Street" locations and are staffed by Mental Health Practitioners able to provide support as required. The West, East and Norwich Wellbeing Hubs are running, with the North Hub due to be in operation around June 2022 and the South Hub working as a "spoke" model until permanent premises are finalised. Co-location of the Wellbeing Hubs and Primary Care Hubs was considered, but due to the timing of the services and the specification for the Wellbeing Hubs it was not

considered appropriate. Following the establishment of the Wellbeing Hubs, the pathways and relationships between those and other services – including the Primary Care Hubs – will be formed. The expectation is that the Mental Health Practitioners within PCNs and those within the Wellbeing Hubs will provide the key links and support.

Mental Health Practitioners are embedded within primary care as part of the ARRS roles, alongside Social Prescribing for Mental Health and Recovery Workers. The work locally to respond to the nationally led transformation of community mental health services will implement the integrated models of primary care and community mental health care.

Voluntary Sector

The voluntary sector will play a pivotal role in the delivery of the Hubs. The voluntary sector has a unique and vital role to play in offering both complementary services and alternative support options to provide the best "fit" for patients' needs and preferences. The voluntary sector will have a key role within the place-based partnerships as part of the ICS, working collaboratively to improve population health issues.

As an initial principle there is an understanding that the voluntary sector will support navigation of patients and the provision of information and support. Each Hub premises will be supported by an operational agreement, which will set out expectations about how the building will be used. These will include the need for the flexible, bookable space to be used by voluntary sector organisations, so they can be supported in their role within each Place.

As the CCG and Practices move through the Business Case process there will be stakeholder engagement and consultation sessions. All Hubs will have additional capacity earmarked for future growth and the operational policy will ensure both clinical and training resources can be booked by the voluntary sector for health and wellbeing services.

Other Services

Long Term Conditions

The Primary Care Hubs will link with ongoing work to consider how joint approaches can take place in primary and community settings to facilitate MDT approaches to Long Term Conditions. Using the Population Health Management approach of risk stratification, enabled by the Eclipse system, high risk patients will be identified, and MDT meetings will review and determine support. The conditions focussed on initially are respiratory, diabetes, coronary heart disease and CYP asthma.

Physiotherapy and musculoskeletal (MSK) Services

The NHS Long Term Plan identified that, "Low back and neck pain is the greatest cause of years lost to disability, with chronic joint pain or osteoarthritis affecting over 8.75 million people in the UK. Over 30 million working days are lost due to musculoskeletal (MSK) conditions every year in the UK and they account for 30% of GP consultations in England. The NHS will build on work already undertaken to ensure patients will have direct access to MSK First Contact Practitioners (FCP). 98% of STPs have confirmed pilot sites for FCP and 55% of pilots are already underway. The NHS will expand the number of physiotherapists working in primary care networks, enabling people to see the right professional first time, without needing a GP referral. We will also expand access to support such as the online version of ESCAPE-pain (Enabling Self-management and Coping with Arthritic Pain through Exercise), a digital version of the well-established, face-to-face group programme."

Wave 4b Hubs will have larger group and clinical rooms to facilitate therapy sessions.

Facilitating other Key Services

Part of the design of the Hubs will be the flexibility of the rooms with a no names on doors principle. There will be touch down areas and bookable rooms (both clinical and non-clinical) that can be accessed by health and social care workers and voluntary groups. Community, Maternity, Social Care and Children's Services (as examples) already work with some of the practices but currently space is limited within their current estate and not all clinical services can be provided within the Practices.

Each organisation has or are developing strategies which are based on the Hub model (integrating with Primary Care). Working with the practices the individual organisations will be able to book rooms for certain sessions providing clinics, drop-in or group sessions. As the model develops the various organisations will be able to work together to provide end to end pathways. These pathways will involve the Voluntary Sector, Citizens Advice and other Local Authority Services (via signposting).

Secondary Care services will be provided within some of the Hubs please see Section 3.7 The Case for Change.

Delivering the shift of care

Promotion of self-care and long-term condition self-management will be promoted and will form the basis of educational packages for the population around primary care Hubs.

18-20% of a GP workload is treating minor ailments, a large proportion of which could be self-treated. Annually, this is around a £2 billion cost to the NHS. There have also been many published articles that demonstrate that the use of self-care training for people with long-term health conditions is effective both in terms of increasing quality of life and increasing efficiencies in the system.

To increase patients' ability to self-care we plan to:

- Empower people who use services to be more informed of how to manage their condition and recognise the signs of when increased support may be required.
- Ensure consistency in staff communication, to develop and gain confidence in people's self-care skills whether they access health or social care services.
- Enable and support people to use technology in supporting self-care.
- Self-Care is the actions that individuals take for themselves to maintain and improve their health, and wellbeing. The Hub model will play an important role in the promotion of self-care. Supporting a shift to self-care will be an important factor in managing overall demand and focussing expensive medical resources on those who genuinely need them.

Benefits of self-care could include:

- Changes in patient behaviour, with patients managing and making informed decisions about their own health and care, that is, engaging in healthier behaviours such as those correlated to smoking, obesity and adherence to medication.
- Improved health and wellbeing, with better health outcomes and increased patient safety.
- Improved patient and clinician experience.
- Reduced demand on services including unplanned care admissions and A&E visits.

Phlebotomy

Like other practices in Norfolk, it is anticipated phlebotomy will be provided for registered patients at each Hub. There is also the opportunity for more extended services to be operated in support of patients from other practices within the local Network.

Workforce Education and Training

The CCG is committed to the extensive training of the workforce of the future. For each of the Schemes there will be a focus on Education on Training for both NHS Staff and Patients. Each of the Hubs will have the space to facilitate the training of GPs, Nurses, and other health professional. At least two of the Hubs will host Training Practices the others will provide placements for clinical trainees associated with other training practices within the PCN.

Each of the Hubs will also provide patients and the general public with the opportunity for self-care and health education.

Communication and Education

One of the biggest challenges facing the NHS is cultural. Specifically, the relationship between the public and the NHS, and between patients and the staff who care for them, needs to be transformed. As well as ensuring that the resources (funding and workforce) needed to deliver care are available, the Hubs will work to fully engage patients and the public in improving health and care. There will be a greater emphasis on shared responsibility for improving health between patients and the NHS.

Patients will need help and support to understand the new approach to healthcare. They will need to understand how to navigate the system, adapting to Self-Care and the move to joint 'ownership' of their own healthcare.

People living with long-term conditions need not only the right knowledge and information to effectively manage their health, but they also require confidence and a sense of empowerment to do so. There is evidence that health coaching can support self-management and behaviour change (Health Education England and the Evidence Centre 2014).

In addition, there will be a review of current treatment pathways – showing how patient pathways can be improved to reduce confusion for the patients and their carers by using technology and clear care navigation.

3.7 The Case for Change

The Norfolk and Waveney Primary Care Hub Model

The Primary Care Hubs will be buildings where a range of services can work side-by-side keeping people well and helping to prevent hospital admissions. The needs of communities have changed and can be much greater particularly where there are health inequalities and where populations have complex, long term conditions. The Hubs support the approach of shifting the focus on treating those who are unwell to preventing ill health and tackling health inequalities. The Hubs support this through accommodating multi-disciplinary teams, made up of the additional roles which are supporting PCNs as well as the opportunity for other community and voluntary services to base staff at the Hubs. This will look different at each of the proposed Hubs initially, but the plan is for each Hub to expand this approach as they are developed, working with local community services and responding to the needs of their local populations.

The services to be provided initially from the first four hubs were determined through:

- Capacity and capability requirements for primary care to meet current and increased demand for GMS services and to extend and sustain primary care support to the healthcare system. In the absence of this increased capacity – which is focussed on areas of intense housing growth and in two of the schemes, on areas of significant deprivation – there is a high probability that demand will divert to other parts of the healthcare system, impacting on the timeliness and quality of patient care.
- Supporting Community Services by providing purpose-built spaces where community teams can join up with GP services, to improve patient outcomes by introducing more proactive and co-ordinated care, including through MDT agreed interventions that support people where possible to remain at home.
- Supporting Acute Services through provision of capacity for services to transfer into a community setting and align with primary care, supporting integrated service delivery and encouraging expectations that conditions can be managed in community settings. Research has shown that accessible primary care may help reduce rates of emergency department use. In Norfolk and Waveney a large proportion of urgent care requests are met by the offer of same or next day appointments in primary care.
- The need for support to the Norfolk and Waveney Local Maternity System to respond to the Better Births Vision, including:
    - Continuity of Carer which requires Midwifery Hubs to deliver community-based care to women and their families. Midwives must be localised in order to deliver the requirements of Continuity of Carer.
    - Provision of perinatal mental health services in the community ensuring women have access to their midwife as they require, after having had their baby.
    - Working across boundaries to provide maternity services to support personalisation, safety and choice, where maternity services, particularly ante- and postnatally are provided alongside other family-orientated health and social services. Collaboration with GPs is considered vital to delivering effective and safe care during a woman's pregnancy.

The ICS will support these developments through the Steering Groups for each project as their business cases are developed and then beyond through organisational development workshops for clinical leads and teams to support the achievement of integrated working – moving towards a collective vision and leadership behaviours in each Hub.

As these proposed Hubs are developed – and as other primary care developments planned in Norfolk and Waveney progress – the CCG will look towards the potential of replicating the approach being developed in Cavell Centres as models where:

- Co-location of community services, outpatients, diagnostics and other health services, alongside the third sector and local authority services (e.g. social care and housing support) come together under one roof and help support the system response to challenges identified by Population Health Management.
- Premises occupation is currently informed by developing Primary Care Networks and local system priorities, based on population health data and demographics – helping to support the expanding primary care workforce and the increased delivery of services in a community setting. Further development of the local structures will bring commissioning and care at a Neighbourhood and Place level.

- Buildings are system owned and managed – this is a change focussed on new build premises, which would be achieved over time and learning from models elsewhere. This approach could additionally enable a different employment model for GMS providers, removing the liability of the estate from contractors and supporting recruitment and retention.

The developing Hub model for Norfolk and Waveney:

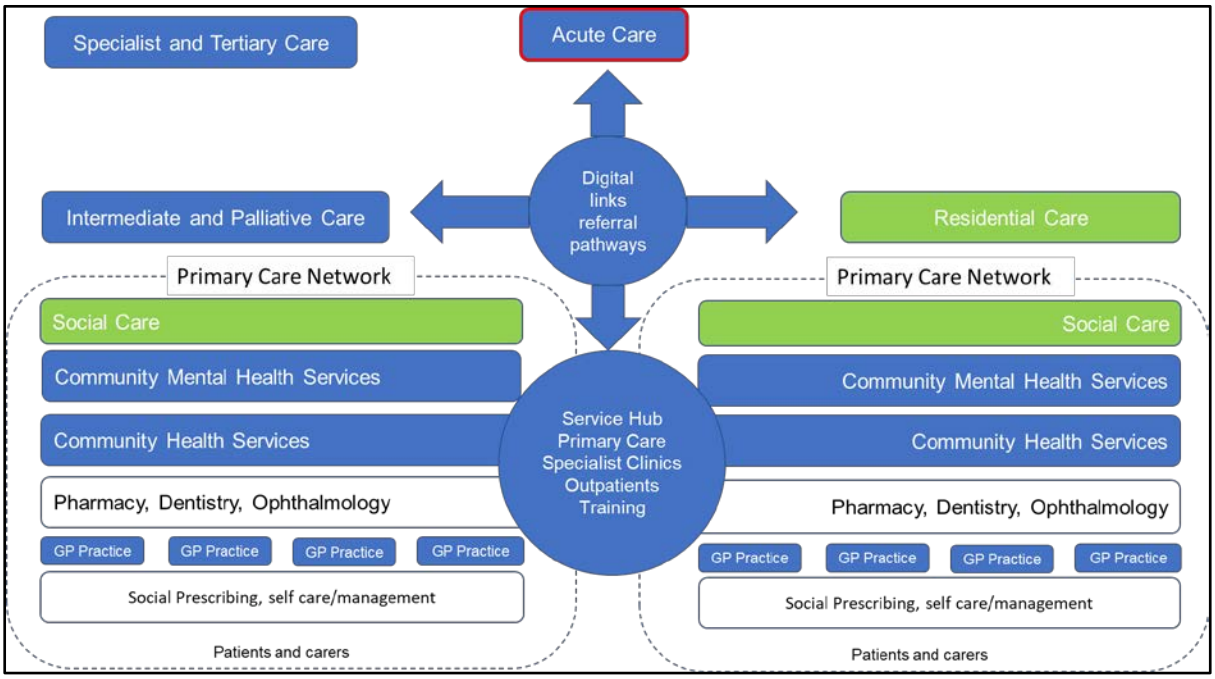


Figure 9: Developing Primary Care Hub model for Norfolk and Waveney

What the Hub model will support:

Population Health Management Population Health Management (PHM) is an approach used to improve the current and future health and well-being of people within a defined area and reduce the health inequalities experienced by patients and service users. It includes action to: • Reduce ill health • Plan and deliver the health and care services people need • Address the wider issues that affect people's health outcomes	**How?** Bringing services together to support those people identified at most at risk of ill health, including information and guidance to support self-care and prevention. Promoting an MDT approach and provide capacity and capability to continue and increase the management of Long-Term Conditions in settings which are community based and easier to access for patients, so reducing demand on acute services. The proposed Hub sites in King's Lynn and Thetford will serve two of the areas with highest levels of deprivation in Norfolk and Waveney and will help to address health inequalities in these areas.
Health and Care Alliances As part of the creation of the ICS, the five new alliances will work alongside the ICB bringing together colleagues from health and social care to integrate services	**How?** The ICB Estates Teams will work alongside the landlords of the Hubs to ensure that the buildings are flexible and adaptable in their design and efficient in how the space is used through tenancy agreements which promote

	increased collaboration among providers and wider coordination of care.
Public Health Strategy Public Health vision for Norfolk: *Help the people of Norfolk live in healthy places, promote healthy lifestyles, prevent ill-health and reduce health inequalities."* Public Health is prioritising public health actions which will: • Promote healthy living and healthy places • Protect communities and individuals from harm • Provide services that meet community needs • Work in partnership to transform the way we deliver services.	**How?** Provision of a modern, positive working environment which can enable primary care to take the lead in improvement and providing public health and, as the Hubs develop, space for other services supportive of promoting public health. Services such as weight management require regular access to spaces and the Hubs will be ideally placed to support this need. The Hubs need to help support: • Early intervention • Development of self-care • Health promotion activities • Links to social care, housing advice and the voluntary sector.
Hospital Restructuring With two of the three acute trusts in Norfolk and Waveney planning new hospitals, and all acute trusts (including those close to the borders of the ICS) seeking to provide some services in community settings – these proposed Hubs and the Primary Care Estate Strategy – needs to support this approach as part of integrated, place based care.	**How?** The Hubs will enable the relocation of appropriate acute services into the community. This will help the acute trusts in planning their capacity for new hospital buildings. Initially this will be focussed on maternity services, supporting continuity of carer for women and their families as well as services identified by colleagues from secondary care where outpatient services can be transferred into these settings. As well as providing dedicated spaces in the community for services usually provided in a secondary care setting, providing all the benefits for patients in receiving care closer to home, this also frees up space for other specialities in the main hospital buildings. This will contribute to more patients being able to receive care and treatment more quickly – and the increased capacity in the system will help to respond to the increasing demand for services.
Reduction in demand on acute services including A&E Primary care provides a response to urgent care need through the provision of same or next day appointments.	**How?** Through the provision of modern facilities, the capacity for primary care to support responses to urgent care will be made more resilient. The Hubs will support primary care capacity to manage A&E demand, by ensuring they can maintain (in the face of rising demand/population growth) their existing approach of offering same/next day appointments in response to urgent care needs. Over time, the Hubs have the potential to offer an increased response to urgent care needs.

The Norfolk and Waveney Hubs
At the time of opening in March 2024, the four Hubs will support the following services:

North Norfolk – Rackheath	**Norwich – Sprowston**	**King's Lynn – Nar Ouse Way**	**South Norfolk – Thetford Healthy Living Centre**
All Hub buildings will provide flexible, bookable space for health and social care services, supported by building specific operational agreements/tenants agreements for how the space will be used. Quarterly "house committee" meetings will be encouraged, where building, operational and management issues can be discussed. Users of these flexible spaces will include: • Community services e.g. weight management • Public Health initiatives • Active Norfolk • Third sector			
General Medical Services	General Medical Services	General Medical Services	General Medical Services
Community Services (Norfolk Community Health and Care NHS Trust)	Pharmacy	Maternity and Neo Natal Services (Queen Elizabeth Hospital King's Lynn NHS Foundation Trust)	Outpatient Services (West Suffolk NHS Foundation Trust)
Maternity and Neo Natal Services (Norfolk and Norwich University Hospitals NHS Foundation Trust)		Outpatient Services (Queen Elizabeth Hospital King's Lynn NHS Foundation Trust)	Community Services (Norfolk Community Health and Care NHS Trust and Suffolk Community Services)
			Norfolk and Suffolk NHS (Mental Health) Foundation Trust
			Community Dental Services (Community Dental Services – Community Interest Company)
			Pharmacy

Some Hubs will begin with a zero or small patient list (Kings Lynn) and others with an existing practice transferring into the new facilities (Rackheath, Sprowston). Interim plans will be agreed with the practices to include the temporary use of the space while the growth in their list sizes takes place. All will require organisational development plans that are sensitive to the experience and expectations of the patient list to be covered. Each Hub premises will be supported by an operational agreement, which will set out expectations about how the building will be used. These will include the need for the flexible, bookable space to be used by voluntary sector organisations, so they can be supported in their role within each Place.

How will we know if the Hub model is working?

Please see the Management Case for details of post project evaluation and the Programme Benefits.

Activity metrics for the Locality GP registered population:
- Rate of non-elective admissions per 1000 population

- Rate of A&E attendances per 1000 population
- Rate of readmissions to hospital within 31 days of discharge per 100 spells.

Operational performance metrics:
- Appointment waiting times
- Appointments offered per GP per day
- Staff satisfaction rates
- Patient satisfaction / friends and family test
- GP survey metrics relating to availability of appointments.
- No. of appointments per GP – average vs. actual.

The ICS Estates Team and Primary Care Estates Team will review how the success of the estates model can be assessed, looking at information sources such as Model Hospital.

How the Hubs will evolve

The Hubs will not be standalone premises but will work alongside the developing Community Diagnostic capability and Urgent Treatment Centres – as well as being premises which will offer bookable, flexible space for a range of health and social care organisations, including the third sector, to support the developing "Places" as part of the ICS. The ICS does not rule out these premises accommodating other services or developing to offer walk-in services, if this is not planned for the initial phase.

The Hubs will form a key part of the strategic core estate for primary care and the healthcare system in Norfolk and Waveney. The developing Primary Care Hub model, and the service model and ways of working in the Hubs, will inform the wider system approaches to service integration and supporting patient care at place level.

3.8 Programme Objectives

The overall aim of the programme is to support the delivery of the CCG/ICS strategic ambitions by providing a modern fit for purpose estate that facilitates the delivery of new models of out of hospital care. The estate is a key enabler, which alongside digital technology can transform the delivery of care and realise the ambitions to improve the health and wellbeing of the population. The investment objectives for Primary Care Hub model are detailed below and are aligned to the key drivers of, improved efficiency, effectiveness, economy and compliance.

(Click here to see the SMART summary of the objectives)

Modernising the Primary Care Estate Over 50% of Norfolk's primary care estate is owned by independent contractors, whilst most were purpose built, less than 10% were constructed in the last 10 years. Many have been extended and improved over the years, but few can achieve the high standards of compliance now required of health buildings.	Follow this link to read more about the GP Estate and a summary of the Primary Care Data Gathering programme information for Norfolk and Waveney
Creating Capacity In 2020 the CCG commissioned a comprehensive Capacity Planning exercise to evaluate current premises capacity in Primary Care. This exercise has identified the facilities and services with the highest current utilisation.	Follow this link to read more about capacity, demand from new housing and the anticipated/assumed registration growth where the proposed Hubs will be based
Meeting Workforce Challenges Physical capacity in itself is not enough, and the proposals seek to promote the plans captured in the local workforce strategy.	Follow this link to read more about the workforce challenges and plans
Meeting the Demand from Planned Housing	Follow this link to read more about capacity, demand from new housing and the

Local planning policies have sought to concentrate new development in and around existing settlements through a series of Strategic Urban Extensions (SUEs). These bring significant further service demand pressure into areas already struggling after many years of growth.	anticipated/assumed registration growth where the proposed Hubs will be based
Promoting Closer Integration and a Wider Range of Services As premises come under more space pressure the first savings tend to be made in the wrap around services, that add value to patients experience of care. Currently Primary Care Networks are being encouraged to recruit additional health and social care posts to realise the national vision for a more integrated care.	Follow this link to read about PCN Place based care plans
Addressing Service Deprivation Deprivation is concentrated in the urban areas of Lowestoft, Great Yarmouth, Kings Lynn and parts of Norwich. In many cases these are the same areas earmarked for the most growth and whose services are currently under most pressure.	Follow this link to read more about Deprivation and Health need Follow this link to read about Accessibility
Learning from the Pandemic The Covid 19 pandemic has highlighted the problems an aging estate has, in being flexible to meet unexpected demands. Many of the existing premises were unsafe to continue providing services at the height of the lockdown, some smaller branch surgeries were temporarily closed. Few practices were able to deliver vaccinations within their buildings looking to larger and more modern community facilities to help.	Follow this link to read about the system Covid 19 response

3.9 Investment Objectives

The objectives for the proposed investment, how they link to the Key Drivers, are enabled by the programme and quantified for delivery in the Benefits Realisation Plan are summarised in the table below.

Investment Objective	Key Driver	Enabled by the programme	Measures from the Benefits Plan
Improve outcomes in population health and healthcare	Modernising Primary Care	Improved local access to sustainable primary and community care services	1) Preventing illness and promoting well being
	Creating capacity	Sized to accommodate planned growth	2) Providing care closer to home.
	Promoting Closer Integration and a Wider Range of Services	Multi-Agency Hubs wide catchment Trust and PCN services on site	3) Promoting Integrated Working

Investment Objective	Key Driver	Enabled by the programme	Measures from the Benefits Plan
	Learning from the pandemic	Sustainable design, wide corridors, one-way routes, large waiting areas.	1.4) Demand Management b) Vaccination programmes f) Workplace health
Tackle inequalities in outcomes, experience, and access	Modernising Primary Care	Extended hours Shift of acute services into the community.	1.4) Demand Management 2) Providing care closer to home.
	Addressing Service Deprivation	Two of the Hubs will be located in areas of high deprivation. See also Section 4.9 Accessibility and Section 3.6.3 Deprivation.	1.3) Reducing A&E attendances 2) Providing care closer to home.
Enhance **productivity and value for money**	Modernising Primary Care	New or expanded fit for purpose facilities. Better utilisation of existing facility. Enabling revenue cost discounts across whole lease.	4/5 Sustainable and Cost-effective Services.
Help the NHS support broader **social and economic development**.	Modernising Primary Care	Hosting PCN social care services Incorporating bookable public health spaces.	2) Providing care closer to home. 2.3 Extended range of services. 2.4) Spaces for public health.
		Meeting the highest environmental criteria	4.3) Contributing to environmental targets.
	Meeting Workforce Challenges	Registered as a training facility Workplace health and wellbeing initiative Nurse training Wider skills training	3) Promoting Integrated Working.

3.10 The Current Estate

This section considers the current primary care premises capacity across the Norfolk and Waveney area, within the Localities, at the PCN and Practice level.

3.10.1 NHS and statutory standards

The required standards for health buildings are set by statutory and best practice guidelines such as Statutory Building Regulations and Health Building Notes. These are constantly updated based on evidence and major health and safety alerts. All landlords are responsible for ensuring statutory compliance is met undertaking appropriate testing as required.

NHS Guidance and best practice are not mandatory and consequently most health buildings that are more than a few years old are unlikely to be fully compliant with the latest NHS best practice

guidance. This does not mean they are unsafe simply they were not designed to the standards of current best practice.

Ideally commissioners would wish to see all services commissioned from providers operating in accessible and fully compliant facilities at the heart of the communities they serve. Whilst they provide funding that includes an element or reimbursement for premises costs, securing appropriate premises is a Providers responsibility. It is also their responsibility (or that of their landlord) to ensure those premises are safe and well maintained.

There are a number of reasons why continuing to invest in non-compliant buildings may be a poor use of scarce NHS resources:

- Service delivery and quality compromises.
- Poor access for those with disability or cognitive impairment.
- Poor service integration and efficiency.
- A lack of sustainability.
- An adverse impact on recruitment and retention of staff.
- They may be in the wrong location or being delivered by a failing provider.

In many cases the cost of replacement is unaffordable to the provider or commissioner. For facilities in private ownership, particularly where the alternate use for their current building is limited, landlords may be financially locked into the current facility.

If we consider the available floorspace for services, the impact of full compliance is normally a significant increase in the size of buildings. For example, in the last few years the compliant size a standard GP consultation room has increased from 12 to 16 m^2 (25%).

3.10.2 The GP Estate in Norfolk and Waveney

Local general practice is the mainstay and focus for out of hospital care in England it is one of the aspects of the NHS that makes it unique.

Across Norfolk and Waveney there are 102 practices working from 159 premises. GPs are ‘independent contractors’, which means they are private businesses that contract with the NHS to provide services to patients.

Over recent years the size and maintenance costs of modern health buildings have led to increasing numbers being built by or sold to and leased back from specialist private sector landlords. This approach allows the Practice to concentrate of providing healthcare and pushes the maintenance and development of the estate to professional organisations – meaning these premises are often in a better state of repair. In other areas the GP owned estate has been seen to have more significant maintenance and compliance issues than that leased from third parties. In collaboration with Community Health Partnerships, and as part of the Primary Care Data Gathering Exercise, the CCG commissioned a Six-Facet condition survey of most GP premises in Norfolk and Waveney. This will inform both the Wave 4b schemes and the wider investment decisions in the GP estate moving forwards and the results of these surveys are detailed below.

It suggests that around 50% of the current GP estate is over 30 years old. Many of these buildings have been updated over the years but have significant compliance issues when compared to current best practice in the design of health buildings.

Less than 10% of buildings have been constructed or substantially converted in the last 10 years.

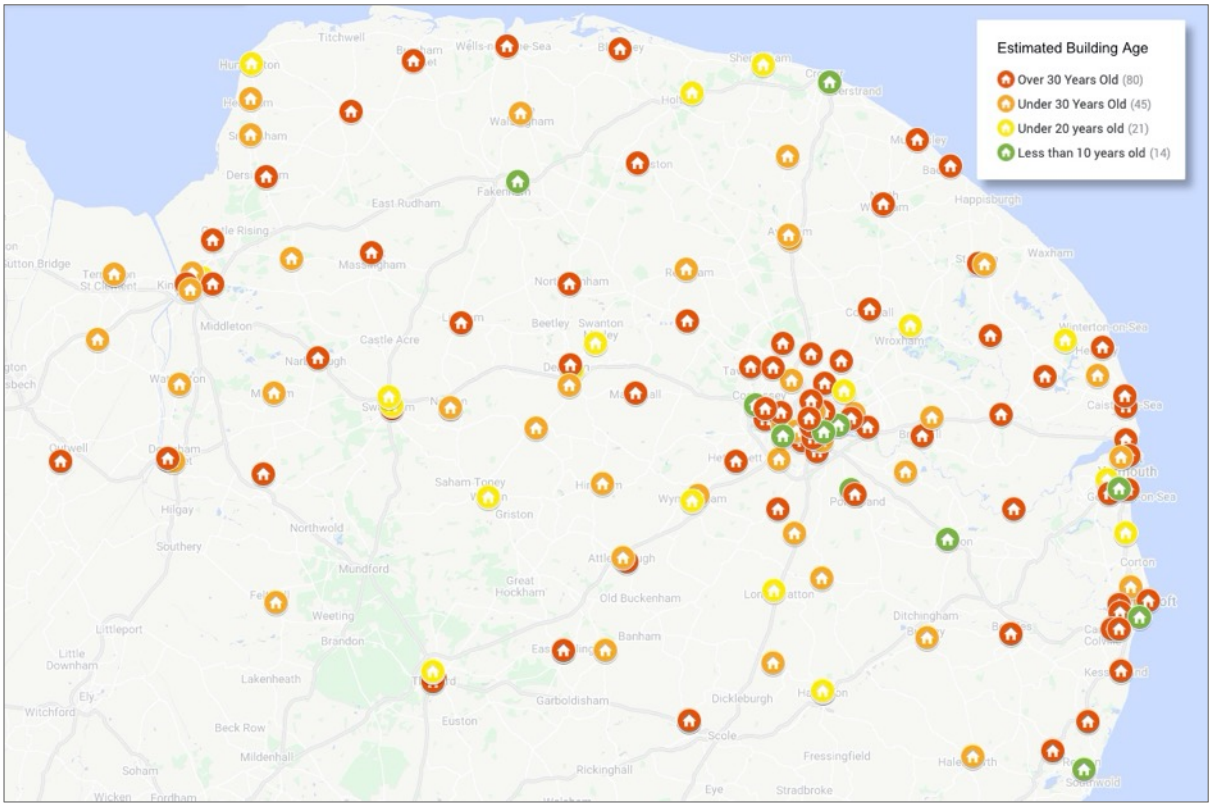


Figure 10: General Practice Premises by Age Norfolk and Waveney

Primary Care Data Gathering and Six Facet Surveys

Norfolk and Waveney was a pilot area for the national Primary Care Data Gathering exercise, which aimed to learn more about GP practice premises, enabling the NHS to better understand the condition of general practice estates and provide evidence and identify opportunities for investment, as well as supporting Primary Care Networks to demonstrate cases for change as part of the developing ICS Estate Strategy. Three Facet Surveys formed part of the exercise and the CCG chose to fund the additional Facets, leading to eighty premises (about half the primary care estate) having a Six Facet Survey report completed. The remaining Six Facet Surveys will be undertaken in the near future.

The Primary Care Data Gathering exercise outcomes (as at April 2022) are included below and the CCG will continue to work on maintaining and improving this data to drive future investment opportunities and decisions for the ICS.

There 159 primary care premises in Norfolk and Waveney, of which 55 are branch sites providing services to 1,076,509 registered patients (1,128,996 total average weighted patients).

GP Contract

- List sizes range from 31,049 (36,788 weighted) to 2,015 (2,415 weighted). The average list size of 10,351 (10,856 weighted) is a little above the England average of 9,479 (9,151 weighted).

Workforce

- 780 GPs work in the area (619.1 full time equivalent total), the largest practice having 18.4 GPs and the smallest having 1. The average across practices of 6.1 GPs compares to the England average of 5.4.
- Across all staff – GPs, Nurses, Direct Patient Care and Admin – the full time equivalent total is 3,215.8, the largest practice having 110.3 staff and the smallest 8.5.
- Practices have to accommodate an average of 31.8 staff, versus the England average of 21.9.

CQC

- The majority of practices, 89, are rated “Good” by CQC (87.3%). 7 practices are rated outstanding (6.9%), with 5 requiring improvement (4.9%) and 1 rated inadequate.

Property tenure (based on 86% data completion)

- 47.2% of premises are GP owned and third parties or “private” owners make up 25.8% - with the remainder being in NHS or other statutory sector ownership.

- This is a high percentage of premises which are not GP owned (compared nationally) and the majority of these will be purpose built rather than converted for use as a medical facility. This is reflected in the reasonably good condition and functionality ratings achieved in the Six Facet Surveys as detailed below (nb. not all premises have yet been surveyed).

Occupation (92% data completion)

- The average size of premises (NIA) is 448m² which compares to the England average of 378m².

Rooms (38-47% data completion)

- The largest premises reporting data has 23 consultation/examination rooms and the average room numbers (across 69 premises) is 8.
- Four premises reported having one consultation/examination room.
- Across the premises reporting, the average sessions delivered in consultation/examination rooms was 73, which compares to the England average of 79.

Building age (84% data completion)

- The majority of the estate (31.4%) is at least 28 years old, but a significant amount (29.6%) is over 38 years old.
- 80 premises who responded reported that there was potential to redevelop or expand the existing practice.

Revenue implications (97% data completion)

- £11,355,331 rent reimbursement is funded annually by the CCG, representing an average of £73,260 across 155 premises, compared to an England average of £79,340.

Six Facet Surveys

Eighty surveys have been undertaken, the majority of which were completed in 2021.

These surveys identify:

A Forward Maintenance Value of £863,288 to bring all premises up to a satisfactory condition, with this averaging £10,791 across the premises, compared to an England average of £19,640. This is broken down by:

- £20,218 High Risk Forward Maintenance Value
- £128,311 Significant Risk Forward Maintenance Value
- £319,001 Moderate Risk Forward Maintenance Value
- £448,558 Low Risk Forward Maintenance Value

A total forward maintenance value across these premises for the next two to five years of £1,599,037, with this averaging £19,987 across the premises, compared to an England average of £31,087.

Overall Condition RAG			
Green	68	42.8%	England average 59.4%
Amber	12	7.5%	England average 39.4%
Red	0		England average 1.2%
Overall Condition rating			
B	68	42.8%	
B/C	9	5.7%	
C	3	1.9%	
Overall Functionality RAG			
Green	10	6.3%	England average 60.5%
Amber	68	42.8%	England average 37.4%

Red	2	1.3%	England average 2.1%	
Overall Functionality rating				
A	9	5.7%		
B	39	24.5%		
C	30	18.9%		
D	2	1.3%		
Statutory Compliance		Yes	78	49.1%
		No	2	1.3%
Contractual Compliance		Yes	78	49.1%
		No	1	0.6%

3.10.3 Pharmacies and Dentists

Pharmacies

Across Norfolk and Waveney there are over 160 pharmacies, most are contractors opening for 40 hours per week with around 20 opening under 100-hour contracts. In addition, there are a handful of distance selling pharmacies working via the internet.

Pharmacies are seen as a key resource in enabling patients to manage their own minor health problems and long-term conditions without recourse to NHS services. Many now have consultation rooms enabling them to offer a wider range of advice, support, and medication review services.

There are already a range of enhanced services offered by some pharmacies including:

- Needle and syringe exchange.
- Screening services such as chlamydia screening.
- Stop smoking, cessation services.
- Supervised drug administration service.
- Emergency hormonal contraception services.

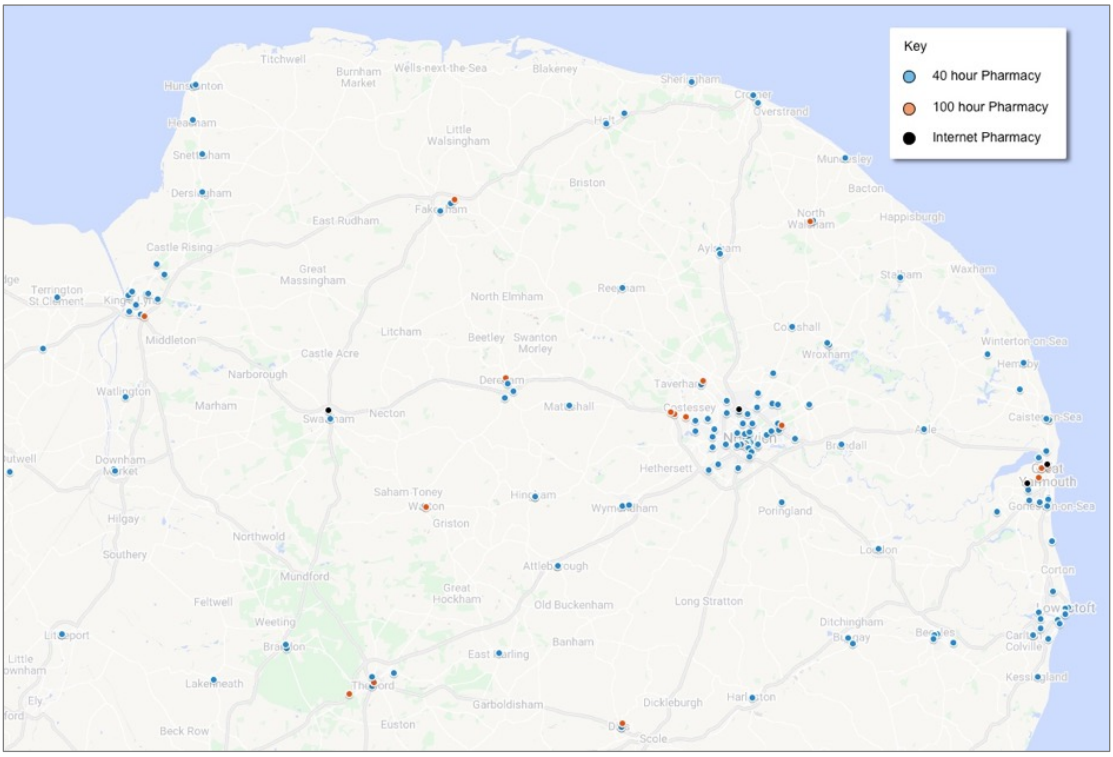


Figure 11: Pharmacies Norfolk and Waveney

Pharmaceutical Needs Assessment (2018)

The PNA guides pharmacy developments in the area concluded that there was 'adequate' pharmacy provision across Norfolk and Waveney but that there was additional work required to fully integrate them into the local primary care team, fully utilise the resources they offer and realise the vision in the Pharmacy Forward View[9] for Pharmacies:

- As the facilitator of personalised care for people with long-term conditions.
- As the trusted, convenient first port of call for episodic healthcare advice and treatment.
- As the neighbourhood health and wellbeing Hub.

The distribution of pharmacies closely matches the population spread across Norfolk and Waveney, in the less populated more rural areas patients may have access to dispensing Practices: over 50% of Norfolk's practices are able to dispense to some or all of their patients.

The following indicates the pharmacy developments/arrangements expected at the four proposed Primary Care Hub sites.

Scheme name	Locality	PCN	Pharmacy
Rackheath	North Norfolk	NN4	In operation – close to site
Sprowston	Norwich	East Norwich Neighbourhood	In operation – co-located
King's Lynn	West Norfolk	King's Lynn	In operation – close to site
Thetford	South Norfolk	Breckland	In operation – co-located

Dental Practices

Unlike GPs, General Dental practitioners (GDPs) are far more reliant on private work to augment their income. Funding for NHS work is tariff based, controlling costs and the CCG contract will also specify

[9] http://psnc.org.uk/wp-content/uploads/2016/08/CPFV-Aug-2016.pdf

a volume of activity. Two main types of contracts are used General Dental Services (GDS) and Personal Dental Services (PDS) where a time limited contract is required. Patients pay a proportion of the cost even under NHS care plans. The specificity of GDS and PDS dental contracts means there are fewer opportunities to more closely integrate services with other primary care providers.

NHS Dentistry plays a vital role in preventing those suffering dental pain from inappropriately seeking support from General Practice or Accident and Emergency departments.

Dental services are commissioned by NHS England and NHS Improvement. As part of the planning for the proposed Hubs, the dental commissioners were contacted and invited to consider whether dental services could be included. Commissioners had committed to tender new dental services across Norfolk, to begin operation in 2022 and there was no requirement identified for additional provision.

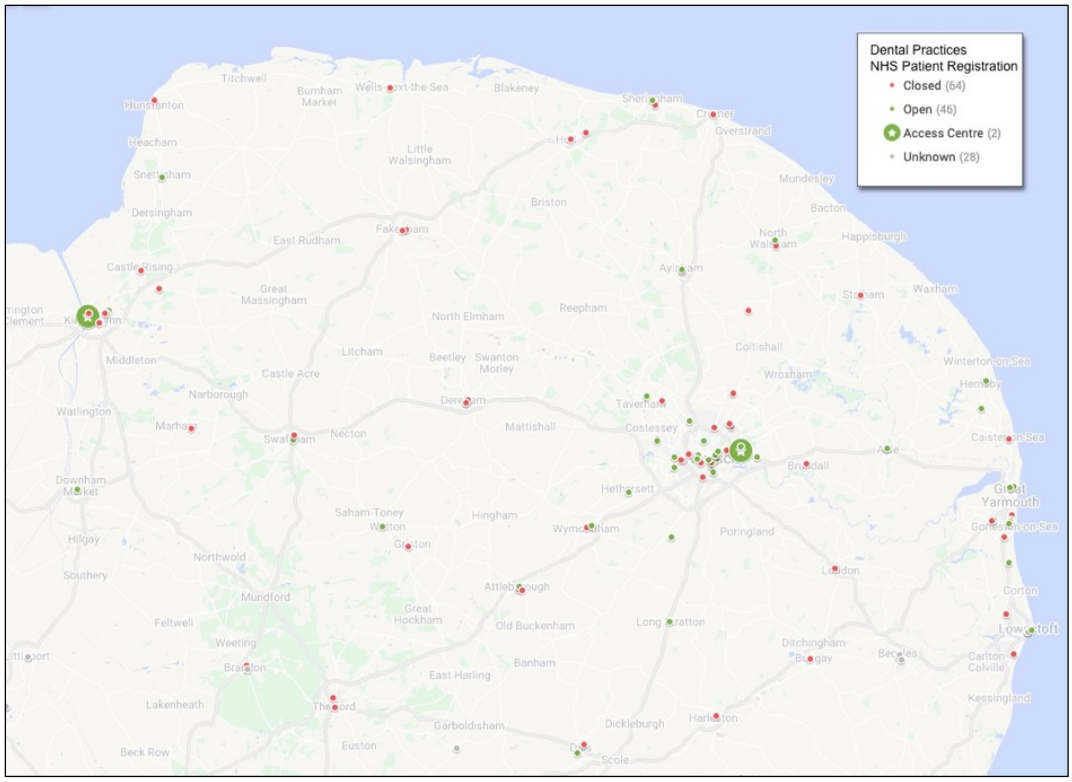


Figure 12: Dental Practices and NHS Patient Registration Status Norfolk and Waveney 2019

3.10.4 Community Estate

There are three main Community Providers in Norfolk, Norfolk Community Health and Care (NCH&C), East Coast Community Healthcare (ECCH) and Cambridge Community Services (CCS). Of these NCH&C have the largest owned and leased estate. The other providers operate largely from rented or touchdown space in other providers premises.

Community providers operate from several venues including GP practices and Health Centres some of which are sublet from NHS property services. Equally they may act as landlords for GPs and other providers. Nationally the trend has been for community providers to rationalise the number of bases they hold often retrenching back to premises they own or have a long-term lease for. Many of the services are peripatetic working in patients own homes and so require less access to clinical rooms.

Unlike GPs their contracts do not normally include a specific allocation for premises costs. Most hold block contracts to provide a range of services to an identified population. In addition to these they may hold specific contracts for named services. The contract form for community services often makes it hard for a commissioner to specify geographical locations for service delivery, although commissioners can mandate specific premises from which the service must be delivered. These factors may also make it problematic to persuade community services to engage in Hub proposals where the impact may be an increased premises cost.

It used to be commonplace for community teams to have rooms or touchdown spaces in GP practices. This is now increasingly less likely for the reasons summarised above particularly following the pandemic restrictions. In the east of the CCG area the ECCH community teams have aligned

themselves to match the PCNs and are supporting the delivery of the 'Primary Care Home' concept developed by the National Association of Primary Care[10]

Going forwards it seems more likely that PCNs will begin to employ their own staff, duplicating or replacing some of the services previously provided by the community team. This may require some updating of the current Premises Directions that govern what can be reimbursed to GPs. Currently they limit the extent to which areas outside of those required to deliver core GMS can be considered and valued for reimbursement.

As PCNs expand their workforce under the Additional Roles Reimbursement Scheme (ARRS), it is likely that some of these staff will require a base or clinical space to deliver services. The Premises Directions will require the space to be subject to approval by the Commissioners and be included as part of GMS space in order to secure premises reimbursement.

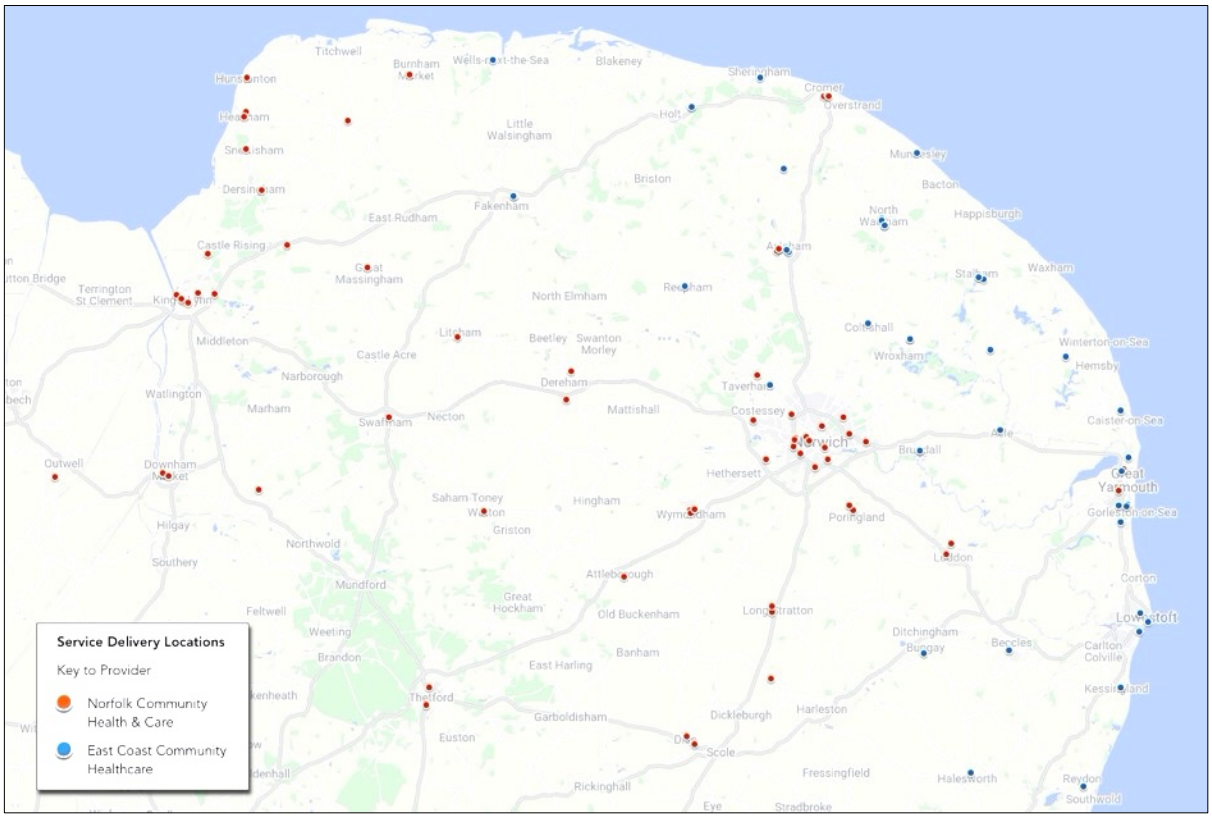


Figure 13: Main pre Covid Community Services Delivery Locations

3.11 Current Capacity

Following on from the observations above that capacity is multifaceted this section will examine three aspects.

Contractual Capacity: A shortage of capacity may be down to no contract for a service being in place. This may not be an omission but due to financial pressures, policy constraints or commissioning plans.

Workforce Capacity: Alternatively, a lack of capacity may be due to problems recruiting and retaining sufficient staff to deliver a service.

Premises Capacity: Finally, there may be insufficient premises capacity to physically deliver the services that are commissioned.

3.11.1 Contractual Capacity

NHS Commissioning was established principally to prioritise where the finite NHS budget should be spent. Through publicly accountable bodies with clear strategic goals taxpayers' money is spent to secure health and social care services. By necessity this means a level of 'Rationing' is required setting a threshold below which care will not be publicly funded. This is a

The proposed Hubs will utilise NHS Capital to provide more flexible operational models with bookable rooms and shared resources able to meet the changing requirements of the NHS and promote closer integration.

Most of the Hubs will include community services alongside GP and Outpatients provision. Where this isn't the case from the outset, the expectation will be that this is developed as part of the operational plan for the Hub.

[10] https://napc.co.uk/primary-care-home/

contentious process, and many believe the demand for healthcare is infinite and there will always be a view that capacity is insufficient.

Nationally and locally, there is a strong emphasis on 'evidence based' care, ensuring that resources are invested in services that are proven to be effective and good value for money. Commissioners are assisted by national bodies like The National Institute for Health and Care Excellence and locally by Public Health colleagues based with local authorities. In addition, through research undertaken in our universities and teaching hospitals.

We expect the contracts health service providers currently hold to evolve to support longer term, outcomes-based agreements, with less transactional monitoring and greater dialogue on how shared objectives are achieved. However, in the interim there will continue to be several different forms of contract used by commissioners to secure services.

Block Contracts: Define a broad service to be delivered for a set sum but leave the methods of delivery and the balance between various elements to providers. They often have few key performance indicators and consequently are comparatively easy to administer. Prices are paid annually, fixed and predictable but inflexible if there are unexpected demands or savings. These contracts are expected to become more common with NHS Trusts as the ICS develops.

Capitation Payments: Regular payments are awarded for a defined set of services based on the number of patients registered with the provider or in a target group. The payment is not dependent on the numbers seen. This form is often used with 'independent contractors' such as GPs where there is a requirement to provide a universal service to a population. The provider must manage the demand for services in order to stay within budget.

Tariff Based Payments: Payments are made with reference to an agreed rate for each intervention or procedure. Providers submit details of the work undertaken and once validated commissioners make an appropriate reimbursement. This encourages providers to be more efficient and increase the volume of the service they provide. It also encourages them to improve the efficiency of their record keeping and coding to ensure payments are maximised. Tariff based systems require significant administrative resources on both sides. This form contract is expected to decline.

Cost and Volume: A locally negotiated form of the Tariff payment where a price and volume of service is negotiated. This is often used for time limited campaigns like immunisations.

NHS Service Contracts: There are a suite of model contracts available for commissioners to adapt for procuring bespoke local services. These include the Alternate Provider Medical Services (APMS) contract used to secure a time limited General Practice provider. The national standardised documentation ensures these contracts are robust both in law and in terms of performance monitoring.

Many NHS providers may receive income from more than one of these contract types. For example, general practice under the national General Medical Service (GMS) contract receives:

- Capitation Payments for their core income based on the number of patients on their list.
- Tariff based payments for Directed, National and Local Enhanced Services.
- Cost and Volume Payments

Indicators of poor contract capacity might include:

- In year emergency payments to providers who have exceeded agreed volumes.
- Significant variations in performance quality, or patient volume against key performance indicators.
- Providers reporting significant underspends or reporting large cost efficiency savings.
- Providers reporting significant deficit positions related to just one contract area.
- Service inequity for patients covered by the same service contract.
- Large variations in per capita expenditure for patients in the same health economy.

Consideration of these contracting indicators should be made alongside proposals for investment in infrastructure. Taking the final one for example there are data sets publicly available and more detailed information available to commissioners to examine variation in per capita payments.

NHS reimbursements to practices will vary based on list size, weighting based on their patients – a formula is applied to account for different levels of patients' needs) and premises payments.

GP income for this data set includes all clinical services payments, premises reimbursements and dispensing income. Dispensing services are offered largely from rural practices where patients do not have access to a pharmacy. All but one of those practices earning over £201 per patient are dispensing practices.

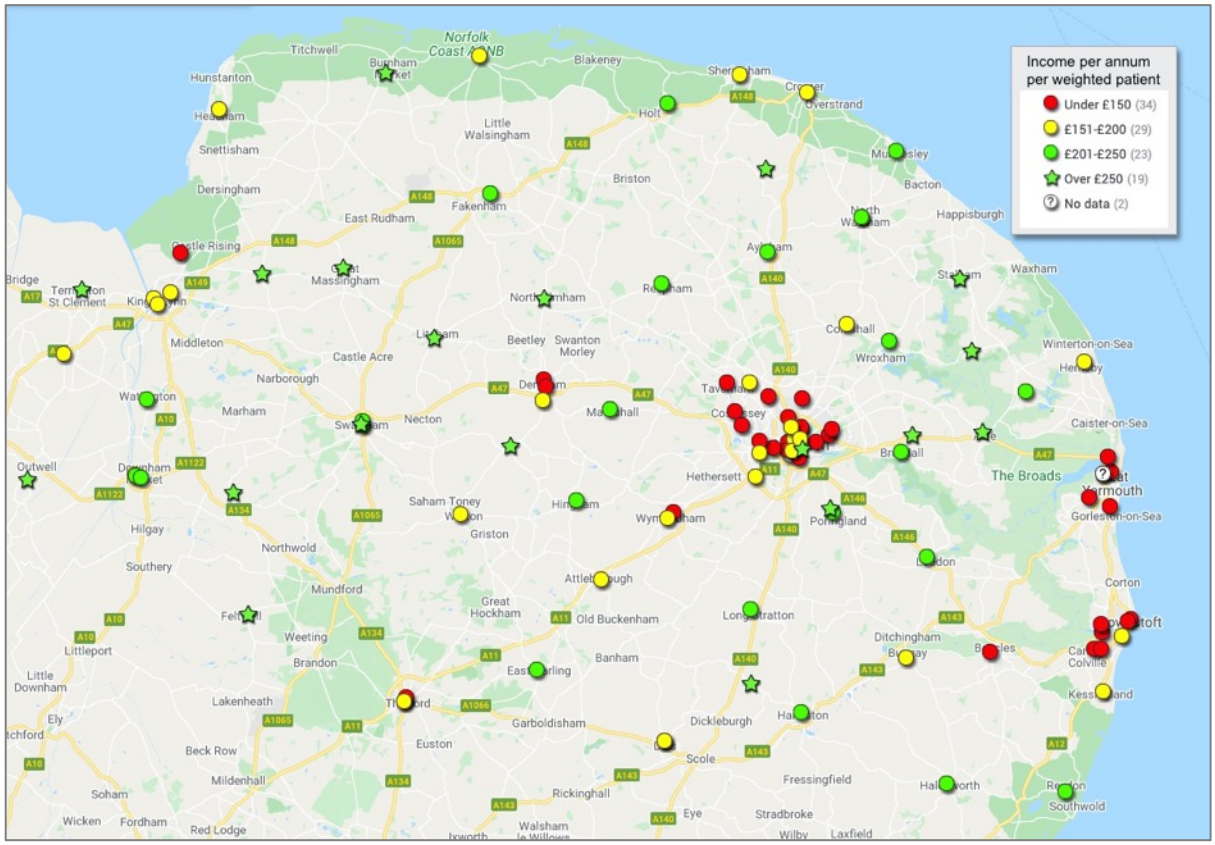


Figure 14: Annual Income per Weighted Patient Norfolk and Waveney 2019/20

The changing contracting environment and increased focus on provider collaboratives will offer opportunities to work differently within the proposed Hubs. Locating Hub services in urban areas will help to address some of the current inequity in primary care health resources allocated to those communities.

3.11.2 Workforce Capacity

The Workforce Plan summarised the current recruitment and retention challenges facing Norfolk and Waveney and the NHS more generally. There are initiatives underway to help address these issues. Increasingly primary care is moving away from doctors being the first point of contact for patients. Staff or digital triage systems try to target patients to the most appropriate and quickest solution to meet their needs.

For a number of years Practice Nurses have been upskilling themselves to take on more of the roles within general practice, Nurse Practitioners are now common in most larger practices. Others have undertaken further training to be able to prescribe predetermined medications, a task that otherwise takes up a significant amount of a doctor's time. Other nurses have specialised in certain areas to become 'advanced practitioners' supporting the needs of those with long-term conditions.

More recently a series of new roles have been introduced into general practice to help manage core General Medical Services (GMS) and expand the range of services available from the practice, these help relieve demand in the practice and avoid patients care breaking down increasing the risk of an unplanned visit to hospital. From 2022, this includes fifteen roles now being funded through Primary Care Networks and shared across several practices.

There is a national data set submitted regularly by each practice giving details of their current workforce. It offers the chance to compare the relative levels of staffing at a group practice level. The Primary Care Data Gathering programme will also help to establish a baseline of more accurate data.

GP Workforce

Despite the changes to skill mix identified above a key workforce capacity metric is Registered Patients per Full Time Equivalent (FTE)[11] GP. Particularly in a largely rural area like Norfolk, the GP remains the key workforce asset in primary care. By comparing the number of patients each GP has to support on the practices list we get a relative position of workforce capacity or constraint.

The map below summarises this data for Norfolk and Waveney in September 2020 using the practices workforce return and the unweighted patient list. We have coloured the markers to reflect relative capacity.

Detailed consideration of this data is included in the locality level analysis below alongside the premises capacity information. In many cases what is reported as a premises issue may have its root in workforce problems. Whilst a poor working environment may impact on a practices ability to recruit and retain staff, where providers have sufficient space in an existing building, they need to demonstrate an ability to fully utilise it before considering expansion.

Similarly, where a proposal is brought forwards to meet planned expansion in an area, the practices' historical ability to fully staff its current services may need to be considered.

In addition, a commitment, and an ability to staff extended hours can generate significant additional capacity without the need to expand premises.

- Green Markers indicate practices where the patient to FTE GP ratio is below 1,750 and there is capacity to support additional patients and grow the list without recruitment.
- Red Markers indicate practices where the patient to FTE GP ratio is already above 2,000 suggesting they will need to recruit additional Doctors or consider other skill mix or triage measures to manage the existing list.
- Amber Markers indicate practices who are at recommended GP staffing levels and will only need to recruit if they are impacted by significant growth.

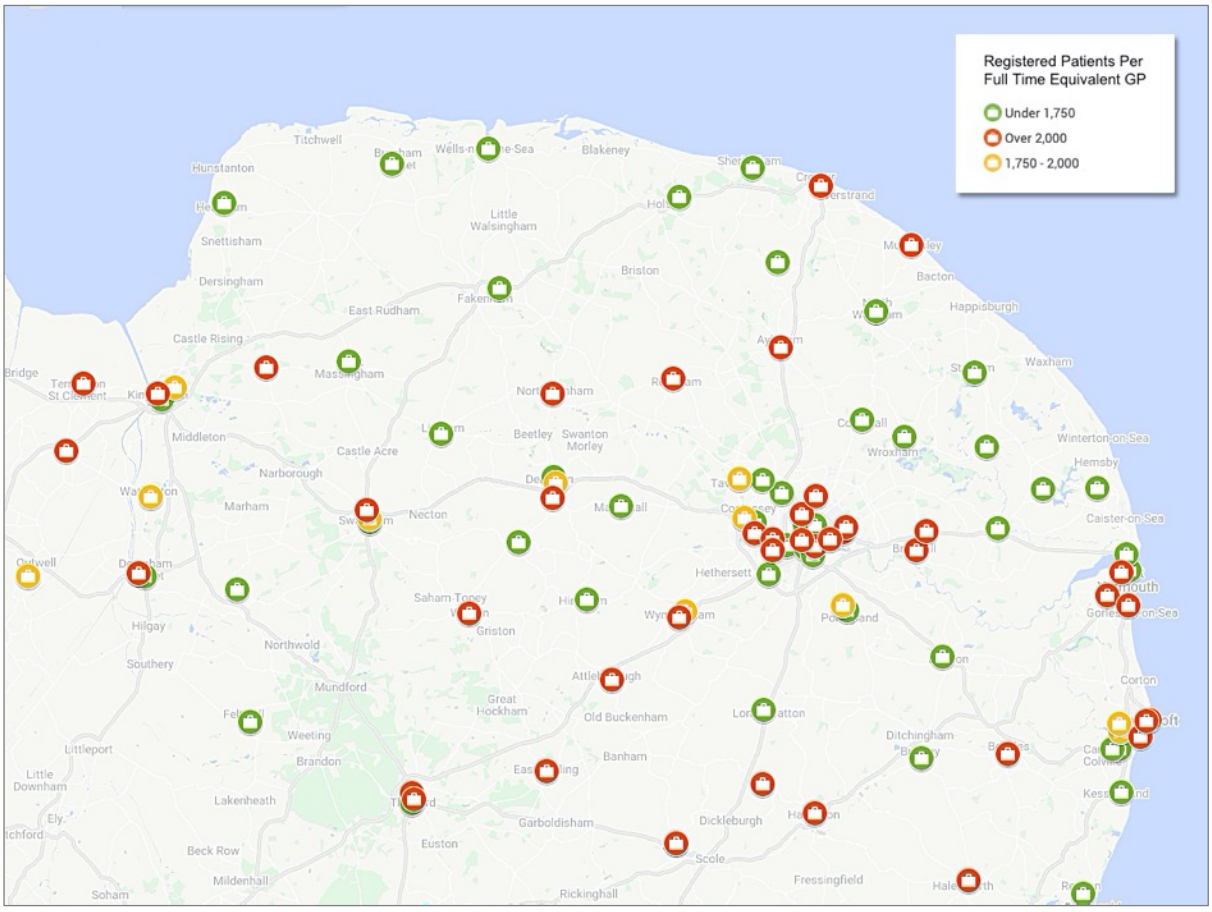


Figure 15: GP Workforce Capacity Norfolk and Waveney to 1,750 patients per FTE

[11] FTE is calculated by combining all the full and part-time hours worked and dividing it by the number of hours in a fulltime week.

Nursing Workforce

Unlike the GP workforce there is no benchmark or target ratio of nursing staff to patients. As identified above there are also an increasing range of qualified nursing roles within general practice. Practices may also employ Health Care Assistants to undertake some of the more routine duties previously undertaken by Nurses.

In considering the national dataset we can see a summary figure for full time equivalent qualified nurses regardless of their role. Across the Norfolk and Waveney area there is on average just over 2,500 patients on the list per full time Nurse.

The map below summarises this information indicating:

Green: Those practices whose nursing workforce to patient ratio is currently at least 10% below average.

Amber: Those at or around average ratio.

Red: Those who are more than 10% above average.

The introduction of the new and expanded workforce under the Additional Roles Reimbursement Scheme should see a positive impact on overall workforce capacity.

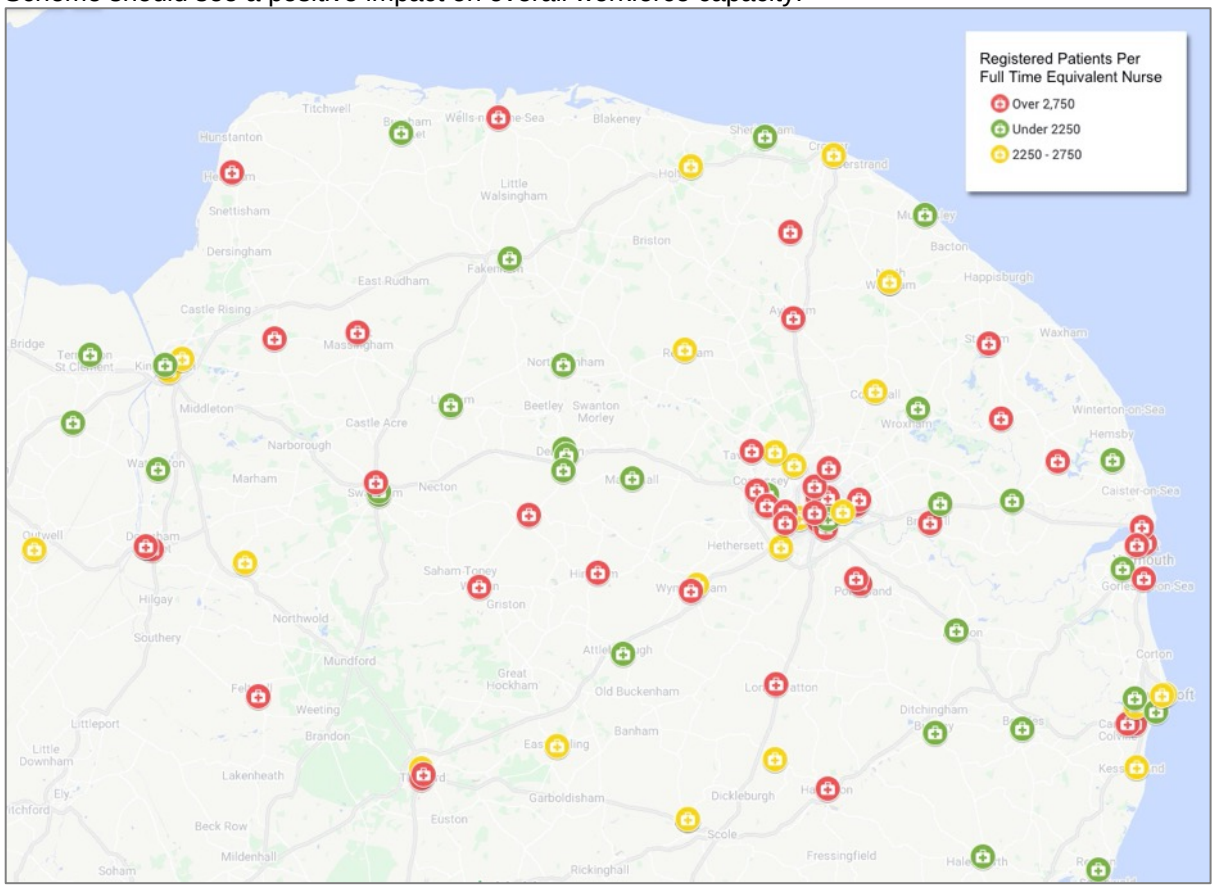


Figure 16: Nurse Workforce Capacity Norfolk and Waveney to average demand.

It is not by chance that this data mirrors the income analysis in the previous section. Doctors considering entering into partnership will be mindful of the assets, income and liabilities of a practice. They and salaried staff may also consider the relative deprivation of the area, in terms of the workload it places on a practice and the resources available to address those demands. Clinicians are motivated to be able to offer their patients an excellent service that meets their needs and helps maintain their health. This is inevitably more challenging where resources are limited.

For the employed staff within a practice including nurses, the total income of the partnership will determine the number of staff that can be retained, the hours they work and rate of pay, before considering workforce skill shortages.

The graph below illustrates that the Norfolk GP workforce, when compared to England is older with 38% over the age of 50. This suggests succession planning may be an issue in some areas as GPs look to retire.

The age of shareholding partners can have a significant impact on the estate, as those close to retirement are less likely to want to take on a new liability or risk. More importantly their retirement plans may rest on realising the value of their current share in the estate by selling it on to an incoming partner.

In many more deprived areas, the alternate use value of a GP surgery (for example as a dwelling) may be lower than its current clinical use value, this can be an effective block to moving to upgraded premises which may be owned by a third party and leased back to the GPs. Younger GPs may find themselves unable to pay off the loan they took on to buy into the premises, older GPs may find their retirement plans unaffordable.

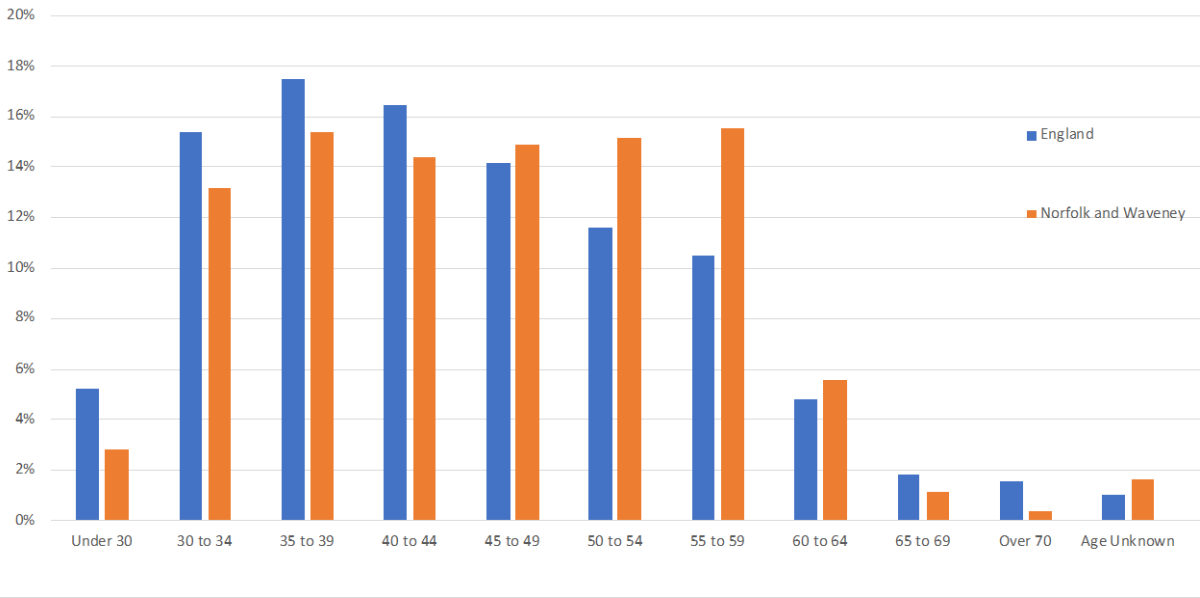


Figure 17: GP Headcount (Sept 2020) by age England and Norfolk and Waveney

At a PCN level the GP age profile is fairly consistent across all networks but there are particular issues in Swaffham & Downham where over half the workforce (55%) is aged over 50. In the Breckland PCN the figure is (47%), in North Norfolk 4 (44%), in West Norfolk Coastal (42%) and in the Norwich PCN (40%) of the workforce are in the over 50 age ranges.

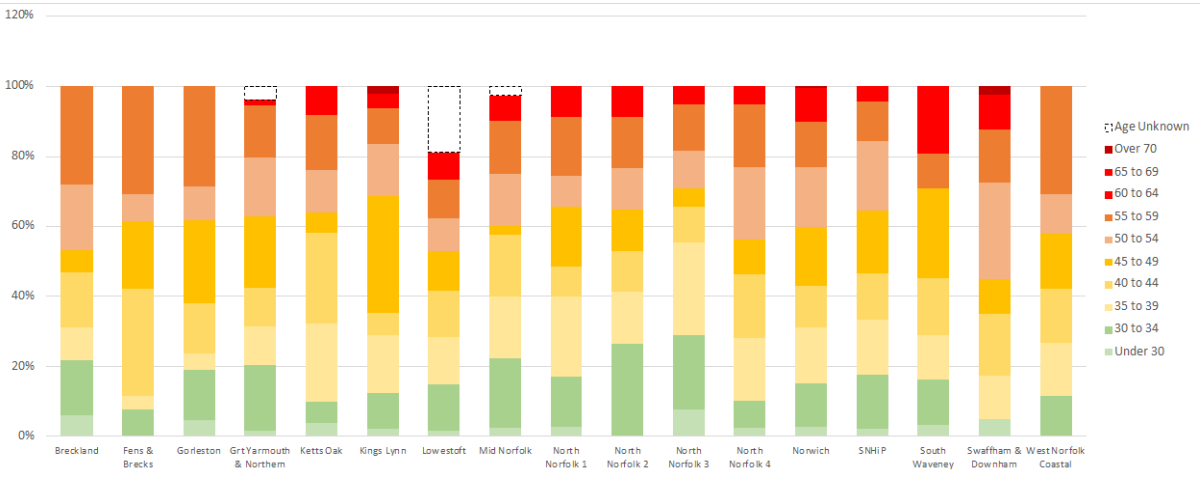


Figure 18: GP Headcount (Sept 2020) by PCN and age band

Hubs are ideal locations to offer enhanced career choices for staff, as a wider range of services are offered, often over extended hours to patients from across the locality. Including education and training facilities within Hubs can assist the recruitment and retention effort for the whole locality. Providing clinical placements for trainees can introduce them to the rewards of working in more challenging localities once they qualify.

Whilst significant progress is now being made through PCN appointments to address skill shortages and diversify the primary care workforce, the data summarised above suggests the area will face significant challenges over the next decade as key staff reach retirement age.

Hubs are likely to be modern leased facilities, removing the financial barriers to some younger GPs joining owned premises, where they would need to take out a mortgage.

3.11.3 Premises Capacity

Having sufficient space, that meets the minimum standards required and is accessible to patients, is a fundamental element in meeting service demand. As discussed earlier in this chapter minimum standards are not the same as current NHS best practice standards for new premises.

This analysis looks at physical space regardless of its condition. Six Facet Surveys were undertaken in 2021 for 80 GP practice premises (the intention is for the remainder of the surveys to be completed) and 42.8% of premises were reported as being “Satisfactory” in terms of condition and having an Amber RAG rating in terms of overall functionality (24.5% rated B and 18.9% rated C for functionality).

This section provides a brief overview of the localities in which each of the proposed Hubs are to be based:

North Norfolk – Rackheath	**Norwich – Sprowston**	**King’s Lynn – Nar Ouse Way**	**South Norfolk – Thetford Healthy Living Centre**
The Rackheath and Sprowston schemes form a strategic joint approach to meeting existing and anticipated healthcare demand from Greater Norwich Neighbourhood Plan			
New build at Halsbury Homes site on Broad Lane, Rackheath	Expansion of existing healthcare premises at Aslake Close, Sprowston, Norwich	New build at Nar Ouse Way site, south King’s Lynn	Refurbishment of existing healthcare premises at Thetford Healthy Living Centre, Croxton Road, Thetford

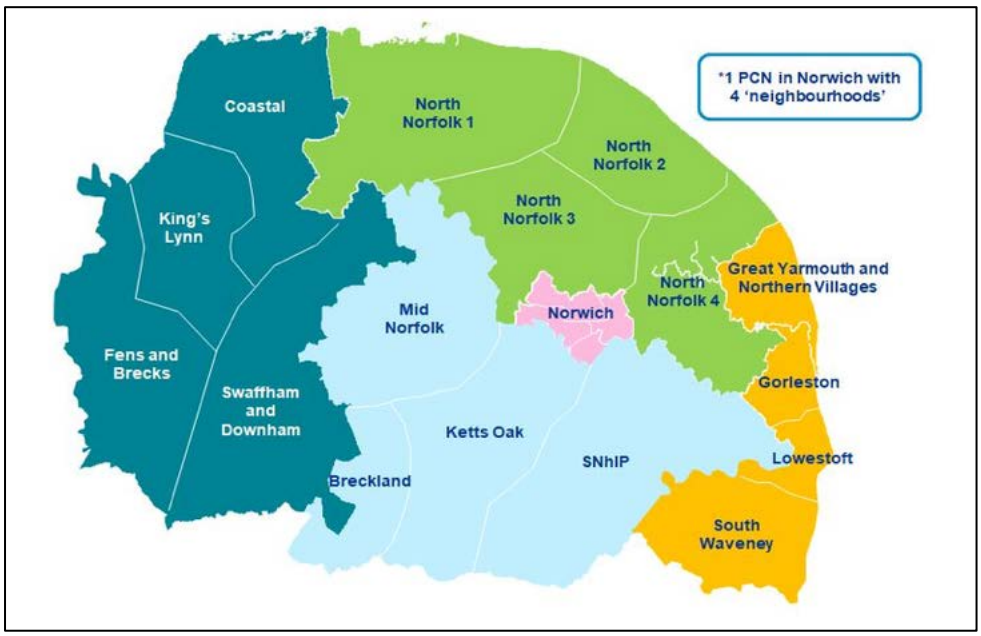


Figure 19: Norfolk and Waveney PCNs

Table 2, below, details the actual registered list sizes for the PCNs where the proposed Primary Care Hubs will be based, and the anticipated and assumed growth per site arising from housing.

North Norfolk and Norwich

The two proposals which would be located in these localities form a strategic joint approach to meeting existing and future demand from the Greater Norwich Neighbourhood Plan:

- North Norfolk – Rackheath
- Norwich – Sprowston

Over the next 15 years the developments in the area which it is proposed these Hubs will serve will create a demand for almost 30,000 additional registrations. Figures 19 and 20 show the impact of the growth with and without the proposed developments.

There are two Primary Care Networks (PCNs) whose practice areas to some extent cover the Growth Triangle:

- East Norwich Neighbourhood – Sprowston and Old Catton
- North Norfolk 4 (NN4) – Hoveton and Wroxham Practice

There is currently no primary care health facility in Rackheath. The nearest is the East Norwich Medical Practice (ENMP) at Sprowston. This facility is the focus of the Norwich – Sprowston Wave 4b Hub proposal (which would see an extension and improvements to the premises) to meet the demand arising from other development in the growth area.

Closer into Norwich, the Thorpewood Medical Practice and ENMP's Thorpe Surgeries both have limited capacity, between them they are able to register an additional 3,000 patients. However the proposed housing developments between Thorpe and Rackheath will exceed that capacity.

There was previously a small part time branch of the Hoveton and Wroxham Medical Centre in Rackheath. This closed in 2017 having become significantly non-compliant and, consequently, underutilised. Subsequently there have been several proposals to replace this capacity in the light of the housing growth planned for the area. Most of the local population continue to be registered with the Hoveton and Wroxham Medical Centre[12]. The main site for the practice is in Hoveton which is 9km away and not easy to access for patients, particularly during the summer months when Wroxham becomes very busy with holidaymakers.

The East Norwich PCN records good levels of registration capacity, largely due to the recently constructed Lionwood Surgery. That facility is located close to Norwich City centre and approximately 4/5 miles from parts of the Growth Triangle and facing significant demand from developments in Central Norwich.

The East Norwich Medical Practice (ENMP) site at Sprowston is ideally located to serve the growth Triangle. Old Catton is also on the fringe of the development, but their premises are already constrained.

Although the NN4 PCN do not have a facility close to the growth area, the Hoveton and Wroxham Practice cover the Rackheath area having previously had a branch in the town. The Thorpewood Medical Group also have Rackheath within their practice area. The next closest PCN is Norwich North Neighbourhood whose practices are least able to respond with constraint across all practices.

The Rackheath area does not have a current facility close by and its historical alignment to Hoveton and Wroxham 9km away, may make it difficult to sustain significant levels of growth. Although delayed by the pandemic, demand from new housing is expected to increase significantly over the next 15 years (please see Table 2, below).

As already noted above – over the next 15 years the developments in the area which it is proposed these Hubs will serve (Rackheath and Sprowston) will create a demand for almost 30,000 additional registrations. At the predicted growth rate current capacity will be exhausted within 3 years.

West Norfolk

[12] Rackheath Population 1,972 (2011) practice registrations in the town reported as 1,500 (2021)

This locality will house the King's Lynn – Nar Ouse Way proposed Hub. The Hub will be located in the King's Lynn PCN but is also anticipated to serve patients from some parts of the Fens and Brecks PCN. As shown in Table 2, the practices in these areas have limited existing capacity to meet the expected growth of around 8,000 registrations and even after this proposed development – and other developments in the King's Lynn area – capacity will remain a challenge.

The Locality covers most of the West Norfolk and Kings Lynn local planning area and part of the Breckland Local Planning Authority. The locality is divided into four PCNs (see Figure 18).

The Kings Lynn urban area gives most rise for concern: the St James Medical Practice and Southgate's Surgical and Medical Centre are two of the top five most constrained practices in the area. There is significant unmet demand in the Kings Lynn PCN area and additional demand will arise from new housing to the north and south of the town. There is a well-developed proposal to replace the St James premises, which has planning approval and Final Business Case awaited, which will be essential to easing some of the pressure.

However, demand for additional registrations is likely to arise from housing proposals at West Winch and North Runcton, and in the town centre – totalling around 8,000 – and there is currently no provision to meet this demand. Registration pressure is likely to fall on the Southgates Medical and Surgical Centre, which is not currently in a position to respond.

There are significant deprivation issues in the urban area of Kings Lynn (South, Central and North Lynn) but the remainder of the locality records only small pockets of deprivation. Deprivation may lead to additional demands on primary care from patients with more complex needs.

Across Norfolk and in the West Norfolk Locality there is a general trend for rural (dispensing) practices to have larger less constrained premises than non-dispensing practices in urban areas.

South Norfolk

There are four Primary Care Networks (PCNs) in the South Norfolk locality: SNhIP, Mid Norfolk, Ketts Oak and the Breckland Alliance.

The Breckland Alliance records the highest levels of constraint in the locality due to significant overcrowding in Thetford.

The southern areas of the locality show considerable constraint in Attleborough, East Harling and Kenninghall and in Thetford itself. Thetford and Attleborough are experiencing significant demand from new housing. As indicted in Table 2, growth of around 7,000 registrations is expected over the next 15 years. This pattern reflects the Breckland local planning authority's historical concentration of growth at Attleborough and Thetford.

Across Norfolk and in this locality, there is a general trend for rural (dispensing) practices to have larger less constrained premises than non-dispensing practices in urban areas. As a locality South Norfolk is has a reasonable level of capacity in some of its practices. However, as the analysis demonstrates there are significant pockets of constraint where new patients may struggle to register in the future without further investment in new estate.

3.12 Demand from New Housing

The ICS estates team are a statutory consultee with local planning authorities and provide a central contact for planners to engage with the healthcare system on planning matters. An engagement protocol between local planning authorities and the ICS is in place, stipulating the process on how and when health is consulted on local plans, neighbourhood plans, planning consultations and the like.

This approach provides the opportunity for the ICS to benefit from contributions via the Community Infrastructure Levy (CIL) or Section 106 agreements (s.106). To date we have responded to 140 planning applications, requesting contributions of up to £22,077,380 and have been successful in agreeing and/or obtaining capital contributions in the region of £3,685,325 – alongside agreements securing land for health care developments.

This work supports our ICS Investment Pipeline, as we ensure all mitigation and contributions sought are aligned to prioritised projects. CIL and S106 payments generally help facilitate smaller schemes in conjunction with other funding routes.

The following indicates the CIL and S106 contributions sought/secured in the vicinity of the four proposed Primary Care Hub sites. It should be noted the contributions sought/secured are for healthcare in the area and not specific to primary care. Historically, health has not been on the "123"

list for the Greater Norwich area, so the chances of securing CIL which might support the Rackheath or Sprowston proposals are low. The ICS Estates Team is working with planning authorities to develop the framework around health infrastructure requirements.

Scheme name	Locality	PCN	S106/CIL	
Rackheath	North Norfolk	NN4	Land off Green Lane West 322 dwellings CIL £TBC – requested Land adjacent Mahoney Green Up to 205 dwellings CIL £74,451 – requested	Land at Green Lane East Up to 165 dwellings and 16 supported living bungalows CIL £332,627 – requested Land East of Wroxham Road Up to 350 dwellings CIL £903,672 - requested
			Please see Section 4.11.10 for details of an existing S106 agreement relating to land availability.	
Sprowston	Norwich	East Norwich Neighbourhood	White House Farm Up to 516 dwellings CIL £801,973 – requested	
King's Lynn	West Norfolk	King's Lynn	Land West of Constitution Hill Up to 1110 dwellings CIL £3,037,439 – requested	Land at West Winch Up to 500 dwellings CIL £1,221,590 + £220,320 (EEAST)
Thetford	South Norfolk	Breckland	Thetford Urban Expansion S106 £2,253,000 – secured Trigger 2030 (£178K) Trigger 2036 (£2.175m)	

Table 1: Section 106 and CIL contributions

In addition, there is an existing Section 106 agreement relating to the planning permission at Green Lane East (Rackheath), which contains provision for land for a medical centre. Please see Section 4.11.10 Proposed Scheme: North Norfolk, Rackheath for more details.

The population in the CCG area is growing, with migration into Norfolk and Waveney exceeding those moving out of area, in addition births expected to exceed deaths. As identified elsewhere in this chapter other factors such as deprivation and the age of a population may generate additional service demand. Some of this is addressed through the 'weighting' of practice lists.

Estimating capacity

A significant proportion of service need arises from planned new housing. To meet this projected population growth this section examines that demand. New housing has been identified from local plans and the five-year land availability assessments required from local planning authorities – alongside the housing data available via SHAPE (Public Health England's Strategic Health Asset Planning and Evaluation tool).

To convert these into registrations we have used the registration data in SHAPE to determine the dwellings and expected registration numbers. This has been mapped to GP practices, using the distribution of existing patient registrations by LSOA. It should be recognised that some people move between practice lists and other households will divide as children leave home, that many patients will stay locally and not re-register with no net gain in registrations. An adjustment was made to the calculation to account for the Greater Norwich Neighbourhood Plan, which is not yet fully reflected in SHAPE.

The table on the next page details the actual registered list sizes for the PCNs where the proposed Primary Care Hubs will be based, and the anticipated and assumed growth per site arising from housing.

Site Details - Sprowston and Rackheath				Population					NIA (m2)					
Locality	PCN	Practice Code	Practice	Current Weighted Patient Population	Growth 1 to 5 years	Growth 6 to 10 years	Growth 11 to 15 years	Total Population To Serve	NIA Required For Forecast Population	Current NIA	Proposed Developments	Combined NIA	NIA Variance Surplus / (Deficit)	NIA % Variance
North Norfolk	NN3	D82062	Coltishall Medical Practice (Spixworth)	1,275	64	1	0	1,340	88	93	0	93	5	5.4%
North Norfolk	NN3	D82062	Coltishall Medical Practice (Coltishall)	8,510	428	5	1	8,944	590	622	0	622	32	5.4%
North Norfolk	NN4	D82025	Hoveton & Wroxham Medical Centre	11,486	1,121	7,067	6,670	26,344	1,348	990	0	990	(358)	-26.6%
Norwich	East Norwich	D82071	East Norwich Medical Partnership (Sprowston)	12,604	2,628	3,657	3,225	22,113	1,136	981	145	1,126	(10)	-0.9%
Norwich	East Norwich	D82013	Old Catton Medical Practice	6,696	907	2,241	2,201	12,045	752	449	0	449	(303)	-40.3%
North Norfolk	NN4	D82025	Hoveton & Wroxham Medical Centre (Rackheath)	0	0	0	0	0	0	0	714	714	714	0.0%
Total				30,786	4,655	12,964	12,096	60,501	3,914	3,135	859	3,994	80	2.0%

Site Details - Kings Lynn				Population					NIA (m2)					
Locality	PCN	Practice Code	Practice	Current Weighted Patient Population	Growth 1 to 5 years	Growth 6 to 10 years	Growth 11 to 15 years	Total Population To Serve	NIA Required For Forecast Population	Current NIA	Proposed Developments	Combined NIA	NIA Variance Surplus / (Deficit)	NIA Variance
West Norfolk	Fens and Brecks	D82105	St Clements Surgery (Terrington)	7,499	320	9	0	7,829	564	685	0	685	121	21.5%
West Norfolk	Fens and Brecks	Y03222	St John's (Terrington St Clements)	644	19	4	0	667	50	35	0	35	(15)	-30.0%
West Norfolk	Fens and Brecks	Y03222	St John's (Terrington St John)	6,611	196	38	0	6,844	513	359	0	359	(154)	-30.0%
West Norfolk	Coastal	D82010	Grimston Medical Centre	6,240	176	1	0	6,417	517	349	0	349	(168)	-32.5%
West Norfolk	King's Lynn	D82099	Southgates and the Woottons (Southgates)	16,815	1,401	608	0	18,823	1,034	624	0	624	(410)	-39.6%
West Norfolk	King's Lynn	D82618	Southgates and the Woottons (Woottons)	5,929	1,367	90	0	7,386	558	285	0	285	(273)	-48.9%
West Norfolk	King's Lynn	D82051	St James Medical Practice (Kings Lynn)	19,021	1,561	497	0	21,080	1,128	695	592	1,287	159	14.1%
West Norfolk	King's Lynn	D82044	Vida (Fairstead Surgery)	2,690	173	44	0	2,908	140	198	0	198	58	41.6%
West Norfolk	King's Lynn	D82044	Vida (Gayton Road Health Centre)	13,105	777	199	0	14,081	677	965	0	965	288	42.5%
West Norfolk	King's Lynn	D82044	Vida (St Augustine's)	2,746	177	45	0	2,968	143	202	0	202	59	41.6%
West Norfolk	King's Lynn	D82099	Southgates and the Woottons (Nar Ouse Way)	0	0	0	0	0	0	0	486	486	486	0.0%
Total				81,301	6,168	1,536	0	89,004	5,324	4,397	1,078	5,475	151	2.8%

Site Details - Thetford				Population					NIA (m2)					
Locality	PCN	Practice Code	Practice	Current Weighted Patient Population	Growth 1 to 5 years	Growth 6 to 10 years	Growth 11 to 15 years	Total Population To Serve	NIA Required For Forecast Population	Current NIA	Proposed Developments	Combined NIA	NIA Variance Surplus / (Deficit)	NIA Variance
South Norfolk	Breckland	D82002	Grove Surgery	11,960	2,579	1,498	1,144	17,181	956	580	0	580	(376)	-39.3%
South Norfolk	Breckland	D82002	Grove Surgery (THLC)	619	36	21	16	691	38	30	477	507	469	1218.0%
South Norfolk	Breckland	Y01690	School Lane Surgery	9,290	168	97	74	9,629	547	480	0	480	(67)	-12.3%
South Norfolk	Breckland	Y01690	School Lane Surgery (THLC)	6,638	120	70	53	6,881	391	343	0	343	(48)	-12.3%
South Norfolk	Breckland	D82063	Watton Medical Practice	14,351	999	2	1	15,353	890	924	0	924	34	3.8%
Total				42,858	3,902	1,688	1,288	49,736	2,822	2,357	477	2,834	12	0.4%

NIA Requirement = 500m2 for first 6,000 patients plus 250m2 per subsequent 6,000 patients (as per PCN Toolkit methodology). Model assumes space required is the same if operating from a single or multiple sites.
Expected Growth = Shape Housing Data plus GNLP Adjustment. Adjustment reflects planned 13,507 homes by 2038 not fully included in Shape analysis.

Table 2: Proposed Hub sites - list sizes and anticipated growth

The maps below show the anticipated registration capacity, which has been determined by the methodology used by the PCN Service and Estates Toolkit: Capacity (m²) modelling based on NHSE Current Space Standard: 500m² for every 6,000 patients, plus 250m² for every 6,000 patients thereafter, regardless of how many sites a practice has.

This map shows projected registration capacity (blue circles) and registration constraint (white circles) up to 15 years' time, excluding the Primary Care Hubs proposed in this Programme:

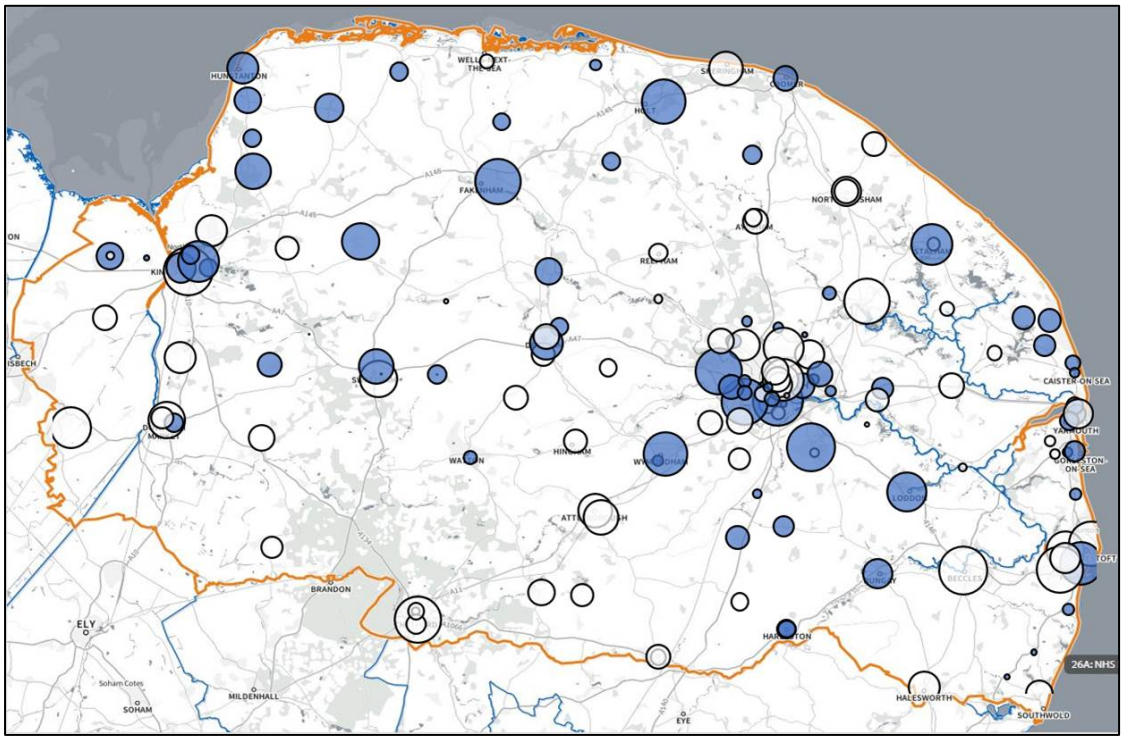


Figure 20: Projected registration capacity and constraint, excluding Hub proposals

This map shows projected registration capacity (blue circles) and registration constraint (white circles) after the development and with the additional capacity provided by the Primary Care Hubs proposed in this Programme, up to 15 years' time. Note the additional capacity in King's Lynn (West), Thetford (South) and to the north of Norwich indicated by the red circles.

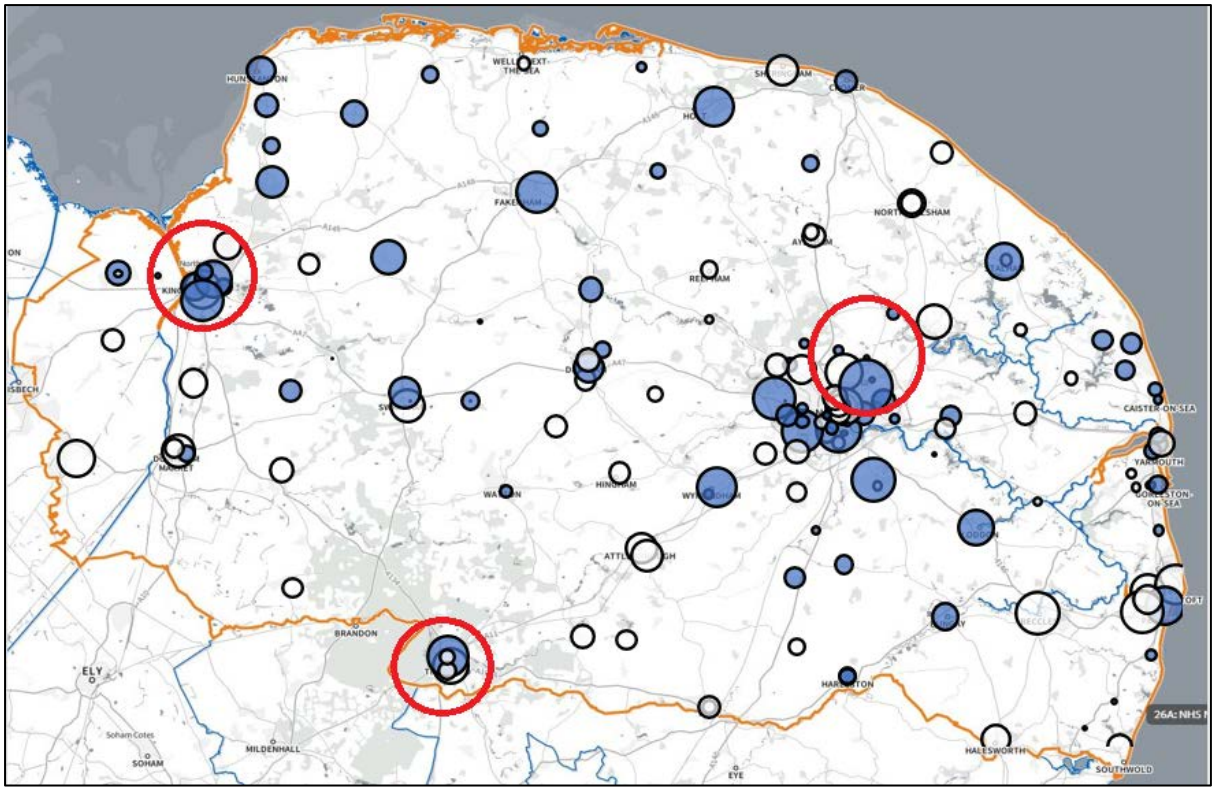


Figure 21: Projected registration capacity and constraint, including Hub proposals

3.13 Gap Analysis

The analysis at an CCG level has identified several areas where the expected demand for registrations is unlikely to be met by current service providers. Either due to the constraints of premises that are now too small to accommodate the additional staff required, or that they are not able to recruit and retain sufficient staff to meet current demand and in a small number of cases because there is no contract holder with capacity located close enough.

Some of these are more urgent than others, for example where an area already has constrained practices and is facing significant housing developments that have already started on site.

The development of Primary Care Networks and their ability to make joint appointments offers the prospect of the greater sharing of resources. This might allow integrated proposals to serve a wider population and potentially meet demand from more than one area.

Solutions are likely to arise through two main routes:

Firstly, for large strategic schemes impacting on more than one practice or site the CCG may work with locality and PCN leadership to develop a specification for a service and facility. They may seek support from NHS Property Services, LIFT Company, Local authority, NHS Trusts or external advisers to develop a business case. If applicable look to commissioning colleagues to tender for a service provider.

For smaller single site schemes the CCG may look to GP practices or contractors to bring forwards proposals through the normal business case process. These may be for existing premises improvements or replacement.

1. Kings Lynn: A mixed approach may be required to resolve the significant constraint and demand in the town.

The St James practice scheme will create an appropriately sized building for its current list, addressing constraint and creating an additional capacity for 4,500 registrations. This will meet demand arising from housing proposals to the north of the town.

A strategic approach may be required to reduce constraint at the Southgates Practice, address deprivation challenges, progress workforce objectives and meet the demand from housing developments to the south of the town.

Addressing constraint and demand issues in Kings Lynn is one of the Wave 4b capital proposals. The CCG have worked with the Locality and PCN leadership to design an integrated proposal that can benefit the wider locality. The capacity planning proposed a facility could be sized to serve a population equivalent to a 12-14,000 list, meeting existing constraint in addition to new housing demand on a single site. However, the consultation with local providers has proposed a new practice just meeting the growth needs.

2. Norwich North/Broadland: The magnitude of growth in the areas north of Norwich City will require a range of interventions but demand far exceeds any current capacity. Provision needs to be made for 30-40,000 additional registrations over an extended period. A robust response will need to include a range of premises improvements, expansions, replacements and potentially the tendering of new services.

A planning application was submitted during 2021 for the large site north of Rackheath and if supported, health should seek developer contributions for the provision of a new branch surgery to support a list of at least 8,800 registrations within the development.

Discussions should continue with planners to ensure appropriate new provision within the Beeston Park SUE's to meet the expected registration demand of 21,200 (excluding Rackheath) with appropriate phasing.

In the interim premises improvements or expansion at Sprowston, Taverham, Hellesdon, Spixworth, St Faiths and Old Catton may be required to support growth across the wider area and the first stages of the SUE development.

3. Attleborough: There is an unmet demand for 5,800 additional registrations along with considerable constraint in the existing practice. The CCG, Locality and PCN may help to facilitate a proposal that could be led by the current provider through a traditional business case process. If their proposal is to utilise the existing Station Road site, the CCG may have a role in facilitating a more integrated scheme with the Community Trust and Connaught Hall Trustees.

4. Thetford: There is considerable constraint in the two main Thetford practices sites who are facing a demand for 11,000 new registrations from proposed housing.

Outline proposals have already been developed to convert void administrative areas in the Thetford Healthy Living Centre into clinical rooms for the expansion of primary care. This would generate sufficient capacity to ease current constraint and meet demand from the first phases of the planned housing in the area over the next 10 years.

The CCG, Locality and PCN should ensure discussions continue with the Breckland District Council and that appropriate developer contributions are sought to offset the cost of meeting the demand being generated from the development. See Table 1 and Section 4.11.13.

In the longer term a site for health has been identified in the master plan to come on stream after 2030 should it be required.

5. Hethersett/Cringleford: All sites of the Humbleyard Practice are constrained and there is planned housing that will generate demand for an additional 6,800 registrations.

6. Great Yarmouth: South of the river Yare the need to redevelop the Shrublands site offers the opportunity not only to meet demand in the area but to provide higher quality modern facilities that could support all the Gorleston PCN practices and target some of the key deprivation issues in the area. The inclusion of training and education facilities enhanced, or extended roles may assist in meeting workforce targets, recruitment, and retention of staff.

7. North Walsham: There is a demand for 4,700 registrations that cannot be met from current provision as both practices are above capacity. The CCG may wish to explore the potential for a joint proposal from the two local practices. If the preferred option is a single practice relocation or expansion, that should be led by the practice through a traditional business case approach. The Paston surgery is unlikely to be able to expand further on its current site. The CCG and Locality should work closely with the North Norfolk Council to ensure all opportunities for developer contributions are accessed.

8. Beccles: A demand for a further 3,600 registrations from approved housing cannot be met by the current practice which reports considerable constraint. Further work is required to examine the current resources allocated to the practice and primary care on the hospital and adjacent sites. There has been considerable investment on the site over the last few years. The CCG may wish to work with NHS Property Services to review opportunities for further integration and efficiencies along with the potential to expand the GP facility on the NHSPS site if required.

9. Lowestoft: The town is planned to require around 12,500 additional registrations with an estimated capacity of 8,700. The shortfall might be accommodated by further expansion or reconfiguration of the Kirkley Mill facility. It is well located and already provides multi agency/hub services. However, most of the other facilities in the PCN are already constrained and some very outdated so an additional scheme may be desirable north of the river.

10.Diss: The scale of demand planned for Diss is moderate at 1,635. The practices share the same health centre and have expanded into areas vacated by community services. There have been a number of proposals to expand or replace the facility over the years.

11.Aylsham/Reepham: A moderate demand for 2,000 additional registrations arising in the Aylsham, Reepham area will push the two practices into a higher level of constraint. Either practice might be encouraged to being forwards proposals to expand existing premises. The CCG should ensure any section 106/CIL opportunities are realised as this has been an area of considerable growth over the last few years.

Investment proposals being promoted by commissioners will be targeted at these identified areas of capacity shortfall. Proposals outside of these areas will need to identify, the strategic and local priorities they are seeking to address, before progressing them through the business case process.

12. Sheringham: Only moderate growth (300 registrations) is planned for the town but the practice reports considerable constraint. The health centre is already a multi-agency Hub and there may be opportunities for greater efficiencies, perhaps through more bookable spaces.

13. Halesworth: There is an unmet demand for just over 1,500 registrations from planned housing. The surgery is already constrained but shares its' NHS Property services site with other services. It is a large site perhaps offering the prospect for moderate expansion.

3.14 Business Needs – current and future

The following table looks at the Investment Objectives being targeted and what is currently happening within the system and what needs to change to improve outcomes and realise benefits.

Objective	Current Situation	Business Need
Improve outcomes	Integrated Teams, in some areas of the CCG, can only operate in virtual mode due to lack of suitable accommodation in primary and community estate. Insufficient primary care workforce to meet growing need. The opportunity for physical integration of services is variable across the CCG due to limited capacity and suitability of the primary and community estate in some areas. Health and local authority estate strategies are not aligned to maximise integration opportunities for the delivery of health and wellbeing services.	To fully implement the integrated model and to be able to work where necessary within the same building to enable joint assessment and treatment/care planning. To reduce the variation in primary and community estate across the CCG and provide sufficient capacity and functionally suitable accommodation to maximise the opportunities for service integration. Increase the primary care workforce, to include PCN roles, and provide sufficient and suitable accommodation. To continue to develop digital platforms for staff and patients providing access to a Shared Care

Objective	Current Situation	Business Need
	Digital capabilities have improved during the pandemic, but some areas still lack the infrastructure to deliver objectives. Variable access to suitable accommodation to integrate physical and mental health services. Insufficient capacity in the primary care estate to accommodate staff to focus on prevention and wellbeing. Face to face and virtual social prescribing in place but patchy.	Record and self-help applications to support education and self-management. Partnership working with local authority and voluntary sector to maximise access to wellbeing services. Create community assets that are easily accessible and locally "owned". Ability to bring together patients and carers for joint health education programmes and self-help groups. Access to opportunities for physical activity.
Tackle inequality	Current services and estate constraints are more acute in the areas of highest deprivation. Investment in premises and workforce is lower in the urban areas and the deprivation areas of Yarmouth and Waveney. Primary care premises in rural areas benefit from additional resources generated from GP prescribing and dispensing that are not available to those in the areas of deprivation. Practice income is higher in rural areas enabling them to compete more effectively for limited workforce resources. Digital deprivation is aligned to the wider measures of deprivation.	Providing significant investment and a more integrated offer within the deprivation and urban areas. Providing extended primary care hours to improve access for marginalised groups. Providing access to acute outpatient's services in community settings. Providing accessible digital resources on site to those who do not have access to technology at home. Providing additional face to face appointments for those not able to utilise or afford digital of phone-based services.
Enhance productivity	Poor condition of some of the existing primary and community estate. Clinical functionality of buildings no longer meets the needs of new models of care and ways of working – not fit for purpose. Lack of capacity in primary care estate to support current and future growth (population and housing). Limited capacity in some areas is hampering the implementation of integrated working. Poor working conditions for staff having an impact on recruitment and retention.	To provide fit for purpose primary and community estate which facilitates the implementation of the CCG strategy with regard to service integration. Sufficient high-quality estate to meet current demand and future growth. Flexible accommodation able to adapt to future change. Digitally enabled facilities to implement new ways of working and to maximise utilisation of the available estate. To improve the working environment to support recruitment and retention. Create neighbourhood assets that are accessible and valued by the community.

Objective	Current Situation	Business Need
	Poor patient experience – DDA compliance an issue in many premises. Many of the current facilities do not have sufficient capacity or are not suitably designed to allow for the adapted patient flows needed to meet infection prevention and control (IPC) measures to deal with an epidemic. Primary care working practices do not maximise utilisation of clinical space by undertaking administrative functions in clinical rooms. Due to capacity constraints and lease structures the GP estate portfolio is not integrated with other primary care services. Available public sector land for redevelopment Variable utilisation of community estate resulting in some void costs alongside constraint for other providers. Dispersed void spaces across public sector and NHS funded properties. Surplus land and substandard buildings being retained.	Improve the patient experience – Access for All. Improved design to allow for ease of implementation of IPC measures in the event of a pandemic. Modernise ways of working to maximise utilisation of clinical space, prioritising face-to- face contacts. Purpose designed, efficient and sustainable facilities to maximise space utilisation and reduce running costs. Where appropriate, centralisation of appropriate administrative functions in non-clinical settings. Reduce void space and maximise the investment of these savings in improving the quality and integration of the estate.
Support broader social and economic development.	Variation across the CCG in the implementation of the integrated care models resulting in inconsistent co-ordination of a rapid response to support patients in the community. Quality of pro-active and crisis care planning for frail and/or vulnerable patients with complex conditions is variable across the CCG. Acute hospitals are used as a place of safety when community support cannot immediately be put in place for patients who are not well enough to be left on their own. If the ambulance service is not aware of how to access local support conveyance to hospital often takes place. **(Prior to Covid 19)** Patients are often in hospital longer than their 'fit for discharge' date as co-ordinated community support is not always in place.	Full implementation of the integrated model to proactively manage frail and complex patients in the community. Provision of Hubs to allow for integrated teams to assess and treat patients in a functionally suitable community facility. Improved access to urgent primary care – same day appointments and extended hours. Local Access Point (virtual) – for simplicity of referral. Multidisciplinary community approach to proactively manage discharge from acute setting and reduce the length of stay. More integrated approach to the management of residents in care homes to reduce non-elective admissions. Embed change in practice due to Covid 19 as business as usual.

Objective	Current Situation	Business Need
	Patients remaining in hospital when appropriate admission to care home is unable to take place due to availability of care home beds, or due to delays in decisions on responsibility for funding.	Please see Section 3.7 Case for Change for details of how we are moving towards this model.

3.15 Embedding the Service Model in the Proposed Hubs

The following table shows the foundation principles that the Primary Care Hub model will be built on.

ID	Foundation principle	Requirement Met	Evidence of compliance
1	To deliver care/ support in the right place, by the right person, at the right time	✓	Implementation of the Wave 4b Primary Care Hub Transformation Strategy will deliver: **Access** – ensuring extended hours are available **Workforce** – ensuring a broader workforce and skills set **Care shift** – out of hospital and into community and self-care **Transformation** – new ways of working – demand management Each of these four initiatives will ensure that integrated Primary Care, Community, IAPT, Mental Health Services, Social Care and Secondary Care services are available to the local population. They will ensure that care and support is delivered in the right place, by the right person and at the right time. Extended hours will improve access and choice for patients. A skilled workforce will mean that patients can be seen by a range of healthcare professionals. The shift of care to self-care will free up capacity of more highly skilled clinicians, and initiatives to manage demand will be introduced.
2	To manage demand	✓	Demand on Primary care has increased continuously over recent years, and the situation in Norfolk has been particularly difficult due the long distances patients need to travel and the high level of elderly residents in the area. Norfolk has previously been a blackspot for GP recruitment, but this is improving. The CCG has recognised these difficulties, and this is why the Wave 4 bid was submitted, to meet the increased demand and provide capacity within Hubs which would support different workforce models. The aim is to create a workforce with a skill mix which allows clinicians to work at the upper end of their licence, maximising the contribution of a wider range of support staff. The ambition of these Hubs is to increase both the GP and non-GP workforce according to the patterns of demand, and to work with colleagues in mental health and community services to integrate the clinical offer, thus making most effective use of clinical skills, reducing duplication and gaps, and deliver effective and efficient primary care-based services. The objective is to manage more patients within a primary care setting and reduce recourse to

ID	Foundation principle	Requirement Met	Evidence of compliance
			emergency and secondary care. In doing so, the Hubs will explore technology-based solutions as well as more traditional approaches.
3	To deliver a shift of care from acute, to community, to Primary and self-care	✓	The CCG is already working with its partner organisations developing a clinical model that moves to an out of hospital care focus, providing care closer to the patient's home.
4	To utilise a workforce with appropriate skills, to improve recruitment and retention of staff	✓	PCNs have already begun to expand their workforce through the appointment of Mental Health Practitioners Social Prescribers Community Coordinators Minor illness (Prescribing) nurses Pharmacist and Pharmacy technicians Plans for workforce include: Support and employ new primary care roles, e.g. pharmacists, community co-ordinators, physiotherapists and physician associates Develop clinical and non-clinical leadership structures through the super-partnership Develop bespoke GP portfolio careers The PCNs also have ambitions to expand training. In addition to taking GP registrars and medical students (which it has done for many years), Hubs also aim to provide Practice Nurse, Pre-registration Pharmacist and Social Prescriber training and support. Developing a strong ethos on training and development, with several nurses trained as prescribers and mentors.
5	To support the vision for providing care closer to home wherever possible	✓	The Wave 4b Primary Care model, with emphasis on supporting General Practice, will provide General Practice at scale in Norfolk. This bid is for the development of four Hubs within the Norfolk and Waveney CCG, to support integrated primary care. They will provide a range of community and secondary care services giving improved access close to people's homes.
6	Maximise utilisation of estate and service	✓	The Wave 4b Hubs will be designed to meet current and future capacity (20 years) based on current capacity and demand data. The Hubs will be designed to be compliant, flexible, and welcoming community buildings.
7	Provide additional / extended hours for services	✓	Extended hours services will be provided from the Wave 4b Hubs. With services being available in the evenings Monday to Friday and additional services at weekends.
8	Reduce and remove duplication and complexity of service pathways	✓	The CCG wish to reduce the use of "pathways" in preference for a co-production model supported by MDT. Where pathways are needed the Practice will work with secondary and community services to simplify communications and processes.
9	Promote and support self-care and self-management	✓	Within the Hubs, self-care and Long-Term Condition self-management will be promoted and will form the basis of educational packages for the population around the Hubs. Central to this strategy is the work of the Social Prescribers and the Community Co-ordinators who

ID	Foundation principle	Requirement Met	Evidence of compliance
			will support patients with mild to moderate needs to evaluate what it is they want to achieve, and support them to do so, capitalising on the breadth of community resources available locally.
10	Educating the population on how to access services	✓	The Hub model launch will require a communications plan to support and educate the population on how to access services. Communications will play a vital role in the roll out / mobilisation of the Hub model.
11	Improved patient experience	✓	An improved patient experience will be realised through the Primary Care Hub model because: Maternity Services will be provided 7 days a week, supporting the ongoing implementation of the national Maternity Transformation Programme, in particular supporting the continuity of care. Please see Case for Change – Section 3.7. Same day/urgent care services will be provided in conjunction with mental health services to ensure that mental health conditions have parity with physical health Education resources and the promotion of self-care will result in patients understanding how they can help themselves and will, in time, reduce reliance on more expensive healthcare resources. Patients will benefit from services provided by the wider integrated multi-disciplinary team approach.
12	Promotion and support in the management of Long-Term Conditions	✓	The Clinical Hub model aims to support patients via the most appropriately qualified clinician. Most long-term conditions are managed by nurses who have additional training. It is envisaged an integrated programme (one stop shop approach) which enables patients to access several services in one visit from a variety of providers. The design of the building will consider the benefit of multi-disciplinary teams working together and combined with opportunistic education of patients.
13	Promotion and support in delivering the 'Prevention agenda'	✓	Social Prescribers and Community Co-ordinators will support patients to identify their priorities and will assist them to achieve their goals through a range of services and activities. The design of the building will help to deliver new models of care for prevention. Group work facilities are essential for some services and will be present in all hubs.
14	Supporting the concept of 'every contact counts'	✓	Making Every Contact Count (MECC) requires health professionals to use all opportunities presented to them to maximise health promotion messages. It is recognised that patients tend to be more receptive to advice from a medical professional than other groups. As an integrated team, staff will confidently give health promotion messages as the opportunity arises and can promote both in-house services and health promotion as well as signposting to external services or using the auspices of the Social Prescriber or Community Co-ordinator to assist the patient in accessing support services.

ID	Foundation principle	Requirement Met	Evidence of compliance
15	Technological opportunities	✓	Technological opportunities in the service model include: Software Defined Wider Area Network technology: increasing application performance, increasing productivity and agility – and supporting flexible use of space Cloud technology for telephony and software Digital platforms supporting paperless approaches Use of analytics and machine learning Services driven by metrics and outcomes Promotion of self service tools, supported by social media and PCN websites providing advice Remote monitoring and observation tools. Please see Section 3.17 The Emerging Digital Strategy.

3.16 Design to Promote the Service Model

The Design Team have been working with Steering Groups and service providers to embed the clinical model into each of the schemes.

The aim of the Primary Care Hub Clinical and Digital Strategies is to give the opportunity for the different Hubs to offer services both in person and virtually, helping to enhance the local population's health and wellbeing. The different schemes will pilot different approaches to providing integrated services and self-care technologies. If they are proven to be successful with their patients and clinicians, the services and technologies can then be rolled out to other Hubs and practices.

One of the key principles of the Hubs is 'no names on doors' which will allow flexibility for service provision and allow maximum utilisation of the building. This design will facilitate clinical and medical staff to work together and consult with each other during the sessions.

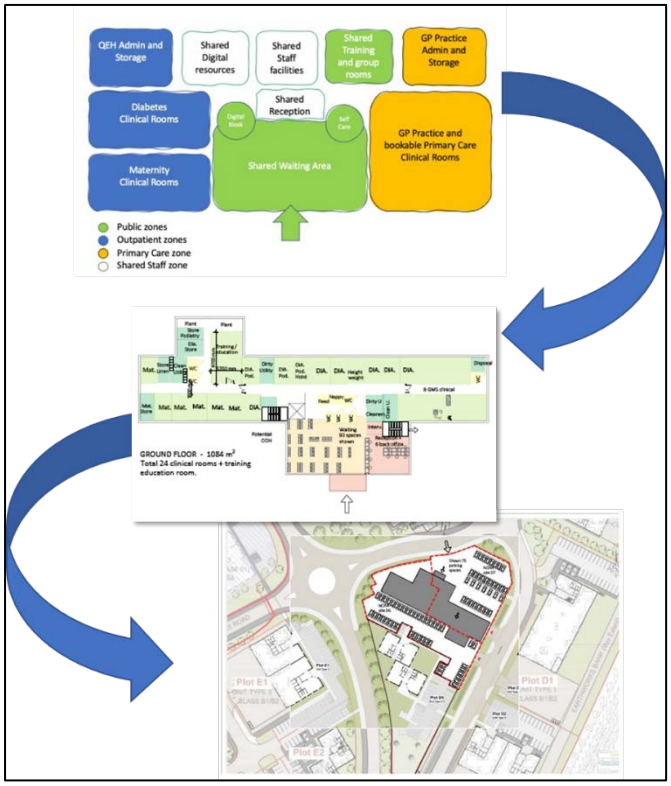


Figure 22: Example of Spatial Modelling Process (Kings Lynn)

The Primary Care Hub in King's Lynn has been identified by the Queen Elizabeth Hospital NHS Foundation Trust as a location for outpatient services for Diabetes and Maternity patients and this has been factored into estates, workforce and service planning. The space allocated for these services does not diminish the opportunity for the Hub to provide space for other services.

3.17 The Emerging Digital Strategy

Primary Care in Norfolk & Waveney has been shown to be an enthusiastic adopter of digital technology. All practices have a cloud hosted electronic record, and 100/105 GP Practices offer digital access through an online consultations system.

The emerging digital strategy for Primary Care in Norfolk and Waveney is based on 6 key areas:

- Infrastructure and Operational IT
- Collaborative Working
- Digitisation and Optimisation
- Outcomes and Data
- Supporting People, Digital Access and Self Care
- Clinical safety, assurance and IG

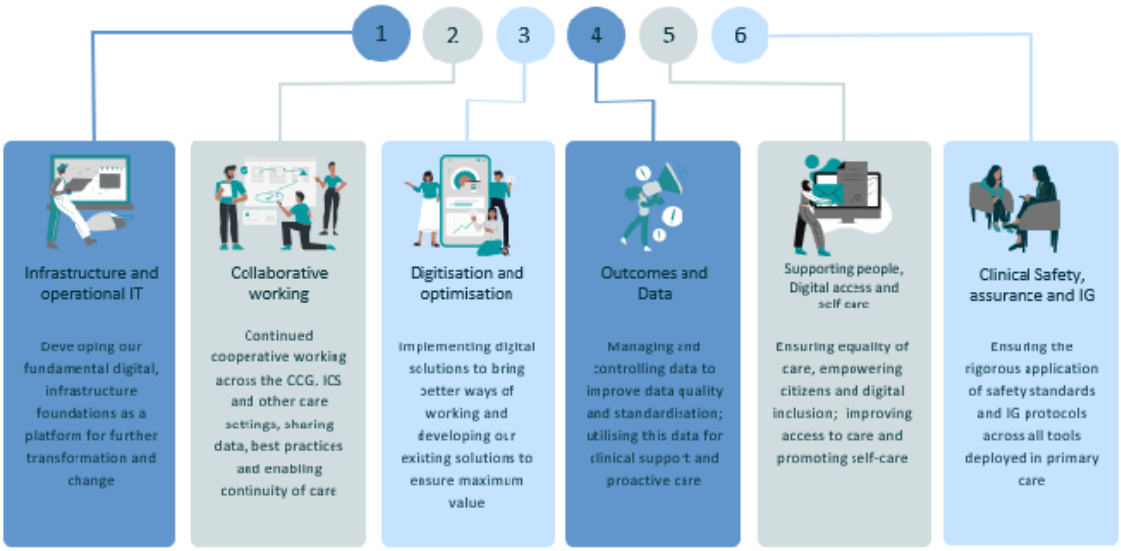


Figure 23: The Emerging Digital Strategy

3.17.1 Infrastructure and Operational IT

Traditionally, GP Practices have operated in data silos, with each premises having a local server and domain controller. This means multiple logons for staff who work in multi-premise practices or who are locums or who work at PCN level. Practice IT kit is often old and slow. The emerging digital strategy will move practices to cloud based technology and single sign on and take advantage of the investment in mobile technology that has been made in recent years.

The proposed Primary Care Hubs will be built with technology that supports this new model of working, with SD-WAN (Software Defined Wider Area Network) providing the reliability and resilience that is needed in Primary Care. SD-WAN increases application performance and delivers a high-quality user experience, which increases productivity and agility. This will support the plans to use all rooms and spaces within the hubs as flexible environments and not have rooms dedicated to people.

Cloud technology for telephony and software will further contribute to resilience and flexibility for staff.

3.17.2 Collaborative Working

Integrated services are supported by collaborative working at scale. Operational and infrastructure IT developments such as WiFi, single sign on and cloud telephony allow clinicians and support staff to work seamlessly across sites. Digital solutions will enable staff delivering PCN level services to use the Hubs, and versions of the clinical system and digital access that support PCN working will be in use, allowing patients to see the right person at the time that suits them, and the clinician to have the right information.

Hubs will have the right technology to enable collaboration with partners in the ICS, such as Community Pharmacy and the Acute sector – referral information can already be sent to pharmacies, and communication tools with the Acute sector will be developed as the hospitals grow in digital maturity. The Shared Care Record will provide early enablement of some collaboration through sharing of information.

3.17.3 Digitisation and Optimisation

The Hubs will be as paperless as possible, with all clinical notes available on a digital platform, and digital versions of information leaflets available for patients on a resource hub or sent by link. Suppliers will be asked to provide digital copies of any information and where this is not possible, originals will be scanned and destroyed. Beyond infrastructure and clinical benefits created by optimisation, there are positive environmental impacts.

3.17.4 Outcomes and Data

Patient flow will be optimised using data driven planning and processes for proactive care. As well as what goes into a patient record, the way that we manage the output can be equally impactful to patient care. Analytics and machine learning will be used to design and develop proactive models of health and care which will deliver better health outcomes and use resources in the best way. Services at the hub will driven by metrics and outcomes rather than demand and waiting times and first come first served.

3.17.5 Digital Access and Self Care

Digital access and triage allow patients to be directed to the right person first time. Patients of the Hubs will be encouraged to use services responsibly and self service tools will be promoted along with social media and PCN websites providing advice on resources available in the wider community. Remote monitoring and observation tools are becoming more prevalent and will be the norm for management of long term conditions when the Hubs open. By providing more engaging and meaningful tools aimed at patients, they can be empowered to take ownership of their health and care.

In order to develop and grow digital solutions, a “digital first” culture will be promoted, but not “digital only” – traditional accessibility options will remain available for those who need them. A series of “digital lessons” is being developed in collaboration with Healthwatch, providing easy to understand instructions on how to use the more common digital tools available, such as the NHS App and online consultation systems, for any citizens who care to access these.

3.17.6 Clinical Safety, Assurance and IG

With the development, innovation and creation of new tools, pathways and automation, there is an increased burden on safety and assurance.

Automated protocols respond to and can potentially add clinical information into patient records, so it is crucial that all tools and developments are rigorously screened and tested.

We will take a systematic approach to clinical risk management to the deployment of tools, working collaboratively with ICS partners, developing a wider risk approach.

Alongside clinical safety, it is crucial that the data we capture and process for the benefit of our patients is handled in a correct and legal way.

Adhering to the data protection impact assessment (DPIA) process means that we can be confident in the robustness of our solutions.

Adhering to the What Good Looks Like framework builds on established good practice to provide clear guidance to digitize, connect and transform services safely and securely. This will improve the outcomes, experience and safety for citizens.

3.18 Ensuring the Hubs are Pandemic Safe

The Covid 19 pandemic has thrown a sharp focus on the problems of an outdated and inflexible NHS estate responding to a new threat. As health systems looked for safe places to continue to treat or vaccinate large numbers many older buildings fell short of the specification required. In primary care much of this estate is owned or leased by GP's the historical arrangements for assessing, valuing, and reimbursing them have rightly come into focus and there has been a recognition that more flexible approaches that enable development and ensure ongoing compliance are required. The Norfolk and Waveney Primary Care Hubs will facilitate these changes across the ICS.

Local Response to Covid 19

The changes in the way in which GP practice appointments were provided in response to the Covid 19 pandemic during 2019/2020 represented an unprecedented speed of change and level of transformation not envisaged when the NHS Long-Term Plan was developed and written. The switch to a digital model with virtual consultations and a triage model had been expected to be implemented in a phased approach over a year or so but were implemented within a few weeks to protect both staff and patients.

Engagement with members of the public and patients was not possible, and this has led to some patient groups facing greater challenges when wishing to access primary care services, including digital exclusion and those in more deprived areas. However, some of these changes have been beneficial and in restoring services, it has been critical to retain the beneficial transformative elements in how appointments are provided. This will include a wider clinical skill mix, whilst ensuring an appropriate level of face-to-face appointments are available. Restoring appointment levels to appropriate pre-pandemic levels will therefore adopt a mixed approach between digital (including telephone) and face to face appointments that addresses the needs of the local practice populations whilst embedding total triage and cutting waiting times.

Having a stable, resilient, and adequate clinical skill mix is critical to improving access in primary care services. The way in which primary care medical services will be delivered in the future will be reliant on an appropriate staffing model to deliver a mixed digital/face-to-face model supported by increasing numbers of staff appointed under the Additional Roles Reimbursement Scheme (ARRS) planned to be employed each year.

Primary care estates plans need to continue to be reviewed with community partners to take account of the changing clinical skill mix, increase in workforce numbers and how appointments will be provided in the future alongside delivery of some services in the community. Where appropriate building in the flexibility to respond to different requirements through design and leasing and ownership models.

As activity returns to pre pandemic levels, the split of face-to-face appointments and remote appointments will be proportionate to the health and social needs of each practice population (including those requiring reasonable adjustments to be made).

PCNs have restarted the work to understand the impact of health inequalities created by the pandemic response, e.g. digital exclusion and ensure that health inequalities can be addressed to ensure equitable access for all individuals wishing to access primary care services, e.g., longer appointments for LD patients, making reasonable adjustments for deaf patients and ensure practices actively managing the backlog of care, including medication reviews, managing patients with long term conditions, screening and immunisations and cancer diagnosis. Ensure that screening and immunisations activity are restored to pre-pandemic levels and that any patient eligible for a screening programme or an immunisation receives it at the required time or age and that any backlog is addressed by end March 2022. The proposed Hubs will be operational towards the end of this period and are being designed to facilitate this new service model.

It is recognised that individual practices will recover at different speeds and in different ways and targeted support may be required to help them manage the risks and patient expectations. The Hubs

will have a mixture of new and existing patient lists and will implement different models of care. See Section 3.7 Case for Change for more information about list sizes and their growth at the Hubs.

Standard Operating Procedures (SOP)

The Hubs are expected to come online during 2024 and the design teams will track the developing best practice guidelines and SOPs to ensure they are pandemic safe and can assist the CCG and PCNs in ensuring their resilience the current and any future pandemic.

2020/2021 – Local Response to the Pandemic

Pandemic response operating under national SOP focused on safe patient care through clinical triage.

Income protection for GP practices to focus on pandemic response and vaccination programme for QOF, DES and LCS income.

2021/2022

Restoration and recovery of all services whilst still operating under the national SOP (Pandemic Response) and maintain a clinical triage model of care.

Delivery of booster programme and seasonal flu programme (over 50s and clinically vulnerable).

Review and PCN maturity assessment completed end June 21 demonstrated that despite the pandemic response, all PCNs have developed significantly in their individual maturity. Excellent progress has continued throughout 2021/22 as evidenced through the locality updates to the Primary Care Commissioning Committee. Good collaborative working and integrated care approach at locality level with system partners, e.g., community care, voluntary sector and councils benefitted significantly by the need to jointly respond to pandemic and vaccination programme, particularly in identifying health inequalities, which can be taken forward in the wider context of managing health inequalities.

PCN DES wider service development plans deferred until 2022 e.g., anticipatory care & personalised care.

Infection control measures

Primary care will follow the Infection control and social distancing measures set out nationally. Face coverings are required to be worn in healthcare settings unless the patient or member of staff is exempt.

Closer working with community pharmacy

The New Medicines Service, took effect from 1 Sept 2021.[13]

Previously the service is limited to four conditions (asthma and COPD, type 2 diabetes, antiplatelet/anticoagulant therapy, and hypertension) but expanded, from sept 2021, to include:

- Hypercholesterolaemia
- Osteoporosis
- Gout
- Glaucoma
- Epilepsy
- Parkinson's disease
- Urinary incontinence/retention
- Heart failure
- Acute coronary syndromes
- Atrial fibrillation
- Long term risks of venous thromboembolism/embolism
- Stroke / transient ischemic attack; and
- Coronary heart disease

This has the potential to redirect demand to appropriate provision within the system, but the practices need to be aware of it. The CCG is looking at digital solutions / developments to support integration in this way.

[13] https://www.nhs.uk/nhs-services/prescriptions-and-pharmacies/pharmacies/new-medicine-service-nms/

The proposed Hubs will seek to maximise digital links between providers on and off-site including Pharmacy.

3.19 Outcomes and Key activities

The identified business needs can be supported and addressed through this Primary Care Hub programme:

- Full PCN and Integrated Health & Care Teams in place.
- Presence of Community and/or acute services.
- Fit for purpose, digitally enabled, cost effective Integrated Care Hubs.
- Including capacity for planned growth.
- Improving the proportion of primary and community estate that is suitably sized and fit for purpose.
- Inclusion of PCN Prevention and Wellbeing services as part of the Integrated Teams.

Outcomes and Benefits

The outcomes and benefits ascribed in this PBC are aligned to those of the CCG given that the estate is an enabler to the delivery of this strategy rather than a strategic intention.

The outcomes identified for the scope of this programme are set out in the Benefits Realisation Plan and summarised in the following table.

Outcomes	Outputs and Key activities
New transformational models of working	Contractual variations or specifications. Working closely with PCNs. Incorporating digital spaces and infrastructure.
Primary Care Led	Rationalised schedules of accommodation. Specific service procurements. Availability of mixed tenures.
Reduction in A&E attendances	New models of care Closer integration improving access. Demand Management initiatives. Hub capacity and models of working will ensure primary care can maintain (in the face of rising demand/population growth) their existing approach of offering same/next day appointments in response to urgent care needs.
Demand Management	Additional capacity for: • General Medical Services • Community Services (NCH&C) • Maternity and Neo Natal Services (NNUH and QEHKL) • Outpatient Services (QEHKL and WSH) • Mental Health Services (NSFT). All Hub buildings will provide flexible, bookable space for health and social care services, supported by building specific operational agreements/ tenants agreements for how the space will be used. Users of these flexible spaces will include: • Community services e.g. weight management • Public Health initiatives • Active Norfolk • Third sector.
Incorporating acute services	Working with Acute providers. Providing suitable facilities which enable the Acute Trusts to size their main estate accordingly – ensuring best use is made of community-based

Outcomes	Outputs and Key activities
	estate to support services which can be appropriately delivered in that setting. Providing flexible leasing arrangements. Improve patient access to secondary care services closer to home.
Incorporating diagnostics	Working with acute and independent providers. Providing suitable facilities and infrastructure including mobile pads and hook-ups. Please see Section 3.6.4.
Extended range of community services	Working with Community providers and PCN. Ensuring facilities are able to be safely open to the public and voluntary sector organisations to optimise the benefit of a community facing, integrated facility. Providing suitable facilities. Providing flexible leasing arrangements.
Spaces for public health	Incorporating bookable public spaces. Incorporating self-testing/monitoring. Reducing digital inequality.
Digital links to other providers	Bespoke communications links to the nearest Acute provider overcoming. EPR compatibility issues.
Improved social care and wellbeing	Incorporation of shared PCN services within the facility including: Social Prescribing. Care Navigation.
Improved mental health care	Incorporation of suitable spaces and technology for IAPS and other mental health services.
Broad skill mix	PCN Workforce initiatives. Advanced Practitioners.
Improved Recruitment, retention	Registered as a training facility. Workplace health and wellbeing initiative. Nurse training. Wider skills training.
Digital Systems integration	Support to remote working, remote consultations where clinically appropriate. Support digital links to secondary and tertiary care. Support to digital multi-disciplinary meetings and support for patients. Access for patients to online support, information and advice. Roll out of SystmOne.
Promoting multidisciplinary care	MDT Meetings. Skill mix initiatives
Increased Capacity	New or expanded fit for purpose facilities.
Increased access	Wide catchment PCN/Outpatient services on site. See Section 4.9 Accessibility and Section 3.6.3 Deprivation.
Contributing to environmental Targets	BREEAM engagement.

Outcomes	Outputs and Key activities
Better Estate Utilisation	Occupation informed by PCN and local system priorities in response to population health needs and to reduce system pressure. Lease terms, principles of funding and operational agreement which supports how building will be used. Regular “house committee” meetings will be encouraged to bring building users together to discuss building, operational and management issues. These meetings should involve clinicians to ensure that the clinical aspects of building use is discussed. Where buildings are to be owned by NHS Property Services, they will manage the building from an operational perspective to ensure that premises are used to optimal capacity and that organisations can make best use of the assets, wherever the space in the building is located. Flexible use of space: “no names on doors”, bookable spaces, hot desks. Adaptability designed into the spaces to support services as they change in response to needs. Short term tenancies to support focussed and targeted responses to specific health needs in a locality e.g. smoking cessation, weight management. Flexible approaches to allow for ad hoc or annual use by services e.g. screening. Facilities for digital consultation, counselling, MDT – right service, right room, right time. Use of technology to monitor how space is used and can be flexed to respond to the building’s users e.g. sensors.

Outcomes and Key Activities

The benefits to be achieved from the investment objectives of this programme are detailed in the table below

These benefits are consistent with the overarching CCG/ICS Plan. A Benefits Register has been compiled based on the HM Treasury Green Book guidance and attached as Appendix 3.

Whilst all the benefits are important the cash releasing benefits are critical to the CCG/ICS overall financial position. Without the PCN and Integrated Hubs supporting the management of demand, the agreed activity plans with the acute trusts to contain activity are unlikely to be met. The societal benefits are also important to supporting the long-term sustainability of the CCG/ICS beyond the current 5-year plan.

3.20 Programme Benefits

Monetizable Benefits

Public Sector (Direct/Indirect), Social	Beneficiary	Cash, Non-cash releasing	Benefit Description
Public Sector Direct	CCG	Cash Releasing	Reduction in inappropriate Non elective admissions due to new Hub model of care and supporting estates enabler.
Public Sector Direct	CCG	Cash Releasing	Capital investment to achieve lower rental payments.
Public Sector Direct	LA	Cash Releasing	Reduction in Permanent Admissions to Care Homes. These Hubs – and future developments – need to ensure space is available to support the co-location of the joint social care/community services roles which

			support the assessment and discharge process. This will help support an MDT approach for patients.
Public Sector Direct	PCNs	Cash Releasing	Reduced Agency Costs due to Improving Recruitment & Retention.
Public Sector Direct	PCNs	Non-Cash Releasing	Improved workforce model enabled by improved estate.
Public Sector Direct	Ambulance Trust	Non-Cash Releasing	Reduced inappropriate A&E conveyances.
Public Sector Direct	Acute Trust	Non-Cash Releasing	Reduced inappropriate A&E attendances.

Societal Benefits

Benefit Category	Beneficiary	Benefit Class	Benefit Description
Social	System	Societal	Better management of patients with LTCs/Frailty.
Public Sector Direct	PCNs	Unmonetizable	Improved staff satisfaction – Primary Care.
Public Sector Direct	PCNs	Unmonetizable	Compliance with building standards within Primary Care.
Public Sector Direct	PCNs	Unmonetizable	Practices will be able to assist the system in meeting the 10 high impact changes and provide better quality service to patients.
Public Sector Direct	Community Trust	Unmonetizable	Improved staff satisfaction – Community& Mental Health.
	Patients	Unmonetizable	Improve patient outcomes – patients seen in right place, right time by right Person.
Social	Patients	Unmonetizable	Increased staff capacity supports patients to stay well and self-care.
Social	Patients	Unmonetizable	Future growth in list sizes catered for.

3.21 Progress to Date and Key Programme Milestones

Next Steps

The system has been challenged to deliver the schemes by April 2024 which will require a streamlined approvals process. The PBC document is intended to provide NHSE/I with reassurances as to the evidence underpinning the funding bid and demonstrate the capability of the Commissioner to deliver the programme.

3.22 Programme Risks

The Programme has used the ICS Project Management Office approach for the identification and management of risks. The process for determining and managing risks is described in the Management Case (Section 7) with specific commercial risks described in the Commercial Case (Section 5).

The Programme Risk register is overseen by the Programme Board and details all risks facing the Programme, including assessments of the impact and likelihood of the risk occurring. Appendix 5 is an extract from the Risk Register, showing the “live” risks being managed for the Programme. The Risk Management approach ensures that all risks are identified, analysed, evaluated, treated, monitored and managed appropriately.

3.23 Conclusion

The Norfolk and Waveney ICS needs to ensure it has a healthcare estate which allows the delivery of the right care, in the right place to enable better patient outcomes and empower health and social care staff to provide the best possible care.

This Strategic Case sets out the rationale and approach for these proposed schemes being a key part of the primary care estate response to the challenge of creating an accessible, safe, sustainable, digitally enabled, functionally optimised estate.

The Programme objectives demonstrate the requirements and anticipated outcomes from the approach of developing these proposed schemes. The Strategic Case places these proposals in the wider strategic context of both the ICS and its Places, alongside the national drivers which impact the Programme.

Local discussions and analysis have led to the development of the Investment Objectives, Critical Success Factors and Benefits which – along with the milestones and key risks – describe the elements of the Programme on which the Programme Board takes an overview, and which form the basis for the management and delivery of the Programme.

The Strategic Case also outlines the challenges to primary care estate arising from significant population growth and the requirement for primary care to provide modern facilities enabling the integrated framework where services can work together. These proposals will provide the blueprint for how the primary care estate in Norfolk and Waveney can act as an enabler, becoming Hubs for the areas they serve, driving the changes in the ways we work – including supporting digital, workforce and sustainability – towards the more joined up ways of working which are now required for effective health and care.

4 Economic Case

This chapter describes the approach to be taken in addressing identified gaps in service provision and the timeframe over which this might be delivered. It presents a series of long listed schemes that have been evaluated by the local health and social care economy and the shortlist of those schemes that appear to best address the Strategic Case.

4.1 Purpose of the Investment

The purpose of the proposed investment is to facilitate the delivery of four Primary Care Hubs across the Norfolk and Waveney area, in line with the ICS Estates Strategy, compliant with the capacity planning evidence and meeting the aims described in the Wave 4b funding application.

The economic case demonstrates that the Programme delivers social value to society, including wider social and environmental benefits.

At this Programme Business Case stage the aim is to ensure that the high-level proposals identify and quantify the system benefits required and that the critical success factors (CSFs) are achievable.

The methodology follows that as outlined in HM Treasury's Green Book (2018), utilising the options framework which provides a systematic approach to identifying and filtering a broad range of options for operational scope, service solutions, implementation timeframes and the funding mechanism for the project.

An appraisal of the options was undertaken evaluating each option against the programme investment objectives and critical success factors. A summary of the results of these appraisals is presented in Section 4.11 The Proposed Schemes. The preferred way forward is for the development of four Primary Care Hubs, consistent with the approach and objectives of the Wave 4b capital bid.

4.2 Critical Success Factors

The proposals will deliver a set of **Critical Success factors** common across all schemes, these are:

Has a Good Strategic Fit: with the agreed investment objectives, business, and service requirements of the emerging CCG.

Offers Value for Money: Optimising the social, economic, and environmental value against cost, benefit, and risk.

Provides Capacity and Capability: Provides an appropriately scaled and functional facility to meet the identified needs and is an attractive option for providers.

Can be Afforded: Its capital and revenue consequences can be funded by all stakeholders.

Is Achievable: Can be delivered by April 2024, can be staffed, and resourced by all stakeholders.

4.3 Programme Objectives

The objectives of the programme can be summarised as:

- Modernising the primary care estate
- Creating capacity
- Meeting workforce challenges
- Meeting the demand from planned housing
- Promoting closer integration and a wider range of services
- Addressing service deprivation
- Learning from the pandemic.

4.4 Benefits realisation

The schemes will deliver the benefits proposed in the wave 4b funding application. These are identified in the Benefits Realisation Plan (Appendix 3) and can be summarised as:

- **Enabling Transformational Care:** Through the provision of integrated facilities serving a registered list, the wider Primary Care Network, community service users and outpatients. Including services in the evening and at weekends. Proposals also include the provision of digital and physical resources that are bookable by staff, patients and the wider public.
- **Primary Care Led:** There will be a GP practice within the building, alongside PCN, Community and Acute outpatients.
- **Supporting demand management initiative**: The schemes facilitate the shift of maternity and other outpatient contacts from the Acute sites. Resources on site will support self-care. Maternity services, training and advice will contribute to a reduction in maternal smoking. The practice and PCN will also engage in demand management initiatives. Schemes target areas of high secondary care referral and avoidable admissions.
- **Incorporating Acute services:** In line with the national Maternity Transformation Programme two of the proposed Hubs (Rackheath and King's Lynn) will host an extended range of maternity services from the acute trust. This supports the Norfolk and Waveney Local Maternity System to respond to the Better Births vision, including continuity of carer and provision of services in the community. Two of the proposed Hubs (King's Lynn and Thetford) will support the provision of outpatient services from local acute Trusts.
- **Incorporating Diagnostics:** Each Hub will be suitably equipped to support the Norfolk and Waveney diagnostic hub and spoke model: either providing facilities for these services or a mobile diagnostic unit parking and hook up area. Each of the Hubs will have patient self-testing areas with resources to promote self-care including BP monitoring, weight, and the potential opportunity for near patient testing.
- **Extended range of PCN services:** The areas allocated for future GMS growth in each Hub will also be utilised by PCN ARRS appointees and services. As growth plans develop space utilisation in the Hubs will be kept under review alongside the PCNs, to ensure all available space is used optimally. All clinical rooms will be bookable by PCN partners or wrap around community services.
- **Spaces for public health:** The training and education rooms will be accessible out of hours and bookable by health and social care partners. In the main reception areas, there will be electronic kiosks offering curated health information. Digital rooms will be bookable for self-care packages such as Cognitive Behavioural Therapy (CBT).
- **Promoting multidisciplinary care:** Reception, waiting, training and staff facilities will all be shared. On and off-site multidisciplinary team meetings will be facilitated through digitally enabled, conference room facilities.
- **Supporting digital initiatives:** All clinical rooms will have universal docking stations to facilitate flexible use. The facilities will work towards system integration between all providers on site.
- **Improved mental health care:** Rooms will be available for PCN mental health services and appointments; self-directed CBT resources will be available on site. As well as providing space for the ARRS roles, the Primary Care Hubs will need to provide space for clinics to take place and this could extend to offering space to the Community Mental Health Team. Following the establishment of the Wellbeing Hubs, the pathways and relationships between those and other services – including the Primary Care Hubs – will be formed. The expectation is that the Mental Health Practitioners within PCNs and those within the Wellbeing Hubs will provide the key links and support.
- **Broad skill mix:** PCN ARRS health and social care appointments, advanced practitioners, secondary care staff and bookable spaces for voluntary groups will be present on site.
- **Improved recruitment and retention:** Teaching Practices will have access to teaching resources, and each facility is expected to offer trainee placements. The library, meeting room, training and digital resources will be available to other training practices in the PCN and other services on site.
- **Increased capacity:** Each facility is sized to meet all the currently planned growth in the area with future vertical or horizontal expansion space. The facilities will be open during evenings and weekends for selected services.

- **Contributing to environmental targets:** Each new facility will achieve the BREEAM excellent rating. BREEAM advisers have been appointed and will guide design decisions from the earliest point. Developers will be expected to monitor and work towards carbon neutrality during the build.
- **Better Estate Utilisation:** All rooms in the facilities will be multifunctional and bookable to maximise utilisation. The facilities will include hot desks for administrative task. Initial utilisation will be boosted by the location of PCN appointments into areas earmarked for future growth. One of the schemes will incorporate improved utilisation of an existing facility.

4.5 Process for Revision and Confirmation of Schemes

A systematic process has been followed to identify the preferred ways forward:

- Working with clinical evidence, local steering groups, patients, and key local stakeholders to define the need in each area.
- Developing an appropriate schedule of accommodation to meet that need.
- Considering a range of options to deliver each scheme.
- Estimating the financial impact of each scheme, in terms of the capital and ongoing revenue implications for the system.
- Evaluate the clinical, social, and economic benefit from each option using standardised methodologies such as the Comprehensive Investment Assessment (CIA) tool.
- Selecting a preferred way forward, that best meets these requirements.

The detailed proposals and process for each scheme are detailed in Section 4.11 The Proposed Schemes.

4.6 Approach to meeting the identified gaps in service provision

The key objective of the developing ICS estates strategy is to facilitate the strategic objectives summarised in the first chapter. The estate should be an enabler not a determinant of service policies, the existence of an historic facility will not in itself signify a commitment to a service at that location. Principally the CCG will commission services where there is the evidence of need.

- Need has been evidenced through detailed place-based approach.
- Define the population group and the system's boundaries.
- Identify the right partners and services.
- Develop a shared vision and objectives.

It is the role of providers to ensure the care provided is accessible to the population described in their contract and delivered from facilities that are safe and exceed the minimum standards required by the NHS.

This business case has moved forward the ICS prioritising of proposed schemes in primary care by addressing the gaps identified in the planning information available.

It gives priority to those proposals that:

Prioritise prevention:

- By presenting clinical and digital strategies within business cases that demonstrate how the investment will facilitate supporting registered patients to better manage their own health.
- By identifying and supporting those with long-term conditions that may be more vulnerable to unplanned emergency admissions.
- By offering within any facility access to education and self-help material to support patients and carers.
- Actively promoting and utilising digital technologies to improve patients' access and experience of care.

Address Inequalities:

- By targeting investment to those areas and populations with the greatest need and to areas of historical underinvestment.
- Utilising capacity and demand information to demonstrate the need for the investment and the appropriateness of its scale. Confirming a commitment to deliver the required capacity including the recruitment and retention of additional staff.
- By proposing alternative models of delivery for example, extended hours of opening, wider catchment areas, that are more accessible for hard-to-reach groups.
- Through the support and hosting of a wider range of services accessible to patients regardless of where registered.
- By incorporating a quantified benefits realisation plan within proposals.

Facilitate Integrated Working:

- Working with all providers in the locality to reduce barriers to integrated working whether, physical, administrative, or digital.
- Incorporating bookable areas within proposals for visiting clinical and social care services.
- Reviewing existing resources in the locality to prevent duplication and explore options to utilise or share resources.
- Incorporate proposals to ensure closer digital integration.

4.7 Spatial Strategy

The CCG is pursuing a Hub and spoke strategy, with a tiered approach to delivering care that seeks to ensure people are supported to live healthy lives as independently as possible.

In a large rural area such as Norfolk and Waveney it is not viable to deliver a comprehensive range of services at each tier within the limited resources available. Without sufficient referrals services become uneconomic to deliver and health professionals are unable to keep their skills and accreditation up to date.

Service Tiers

Much of the care and support required by the population will be delivered by family, friends, formal and informal carers, local groups, residential and care homes. They are supported by over-the-counter services from pharmacies and self-referral to dental practices, opticians, and other independent contractors. Increasingly the NHS are reaching into this tier to help the population manage its own health better, make better choices about lifestyle and more efficiently access the most appropriate service to meet their needs.

GP Practices are normally the first point of contact for planned NHS services. In Norfolk and Waveney, they have on average 7,000 registered patients supported at each site, though they range from less than a thousand in small part-time branch surgeries to over 20,000 in the largest single site (Beccles).

In order to generate sufficient referrals community mental health teams and community nursing normally support patients from a number of GP practices with a combined population of over 30,000.

Primary Care Networks in Norfolk and Waveney on average have populations of 54,000 although the smallest is just over 30,000 and the largest 82,000.

More specialist community services, outpatient clinics, remote diagnostics etc. require a larger catchment population to generate sufficient referrals, in the region of 50,000 to 100,000 depending on the service. The Hubs support this through the location of maternity and other outpatient services in their premises. Please see Case for Change, Section 3.7.

Intermediate and continuing NHS care beds cannot easily be delivered in very small numbers and therefore may need to draw patients from a larger population of over 100,000. There are successful models where this care is provided alongside nursing home services to smaller populations.

Acute hospitals require a catchment in excess of 300,000 to safely and efficiently offer a full range of District General Hospital services. There is a recognition that in rural areas smaller hospitals may

serve populations smaller than this[14] but this is likely to make service delivery more costly. There are moves within Norfolk and Waveney for the three acute providers to work more collaboratively.

For those requiring more specialist care there are tertiary centres drawing patients from a regional or national population.

4.8 Specifying the Hubs

As illustrated in the diagram below, the Hubs will bring a number of services together in a single accessible location, to serve a larger population, improving efficiency and effectiveness.

They will align with one or more primary care networks to address some of the contractual obstacles preventing the delivery of a more integrated experience for patients. With PCNs able to recruit staff, having a Hub location, equally accessible to all member practice patients, may help address capacity issues preventing constrained practices from utilising them.

All clinical rooms within Hub locations will be bookable and not demarked for named clinicians and (subject to leasing agreements) open to other providers to utilise. In areas experiencing significant constraint several clinical rooms will be made bookable for all PCN member practices to deliver core GMS/PMS services and ARRS services.

With a larger catchment area, a Hub will be an attractive location for NHS Trusts to deliver specialist and outpatient clinics. To maximise the opportunity for an extended range of services different models of sub-leasing will be explored.

Engagement with NHS Trusts, social care and independent contractors will be robust from the outset to prevent ambitious schemes that are over specified and risk subsequent void areas or prolonged underutilisation.

Proposals will not duplicate existing capacity and where appropriate facilitate the better utilisation of underutilised resources.

The Hubs will be delivered via NHS Property Services (new builds) or existing landlords (refurbishments/extensions) who will manage the necessary procurement of contractors.

Hubs will act as exemplars for digital integration, supporting the digital strategy for primary care by showcasing the benefits of collaborative working enabled by IT, demonstrating how digital solutions can support better ways of working – for example having digital platforms which support paperless working environments, development of referral and communication tools across organisational boundaries and promotion of self service tools, supported by social media and PCN websites providing advice.

Hubs will play a vital role in supporting demand management:

- Delivering prevention by pushing the boundaries and reducing variation.
- Supporting population and prevention approaches – e.g., Health Checks, identifying hypertension to ensure early treatment and improving the uptake of flu and coronavirus vaccination.
- Obesity and diabetes – rolling out the diabetes prevention programme and addressing obesity at scale, moving 10,000 adults from being obese to normal weight each year.
- Improved management of Diabetes in working age adults through patient activation and education in collaboration with PCN staff and better management in primary care.
- Smoking – Reduce prevalence, targeting pregnant women in areas of deprivation.
- Reduce maternal smoking prevalence 10% year on year.
- Reducing harmful drinking – identify those at risk from drinking and provide brief advice for 20,000 patients at next consultation and through the alcohol liaison team.
- Promoting and enabling workplace health and wellbeing (improving and enabling better health behaviour).
- Rolling out ‘Safe at Home’ accident prevention as part of the Healthy Child Programme.

[14] Monitor (2014) Facing the Future Smaller Acute Providers

- Improving access to mental health support as part of the Healthy Child Programme.
- Improved management of children and young people with Asthma, Diabetes and Epilepsy through patient and carer education and better management in primary care.
- Reduce acute admissions for ear nose and throat conditions for children and young people by patient education and better use of primary and community care.

4.9 Accessibility

As part of the design process the needs for patients with a wide range of needs will be addressed, including Dementia, Learning Disabilities and Neurodiversity. The Design team will take into account the varying impact of the hub's environment on the patient's sensory experience and will seek the input of experts by experience and Clinical Quality and Patient Safety colleagues to understand what is important to people in building design and in improving access.

Areas of special consideration will be:

- Ensuring provision of more "Changing Places" facilities
- Appropriate levels of glare-free controllable lighting
- Good quality acoustics
- Considering the needs of people with sensory impairments and/or communication and interaction needs
- Visual contrast and texture, which can be used for sensory wayfinding
- Low stimulus areas, clear signage, easy read text, reasonable adjustments
- Sensory elements - using colour, light, sound, texture and aroma therapeutically, in particular for patients with complex health needs
- Consideration of how the estate can be used to help support people to book and attend appointments.

4.10 Options Framework

A workshop approach was taken to review the available options for delivery of the Programme, taking into account the proposals in the original bid from 2019 and undertaking assessments of the potential projects against the Critical Success Factors and Investment Objectives identified for the overarching Programme, alongside capacity and demand considerations.

In preparing the Programme Business Case, the proposed schemes which formed part of the original bid were tested and assessed against the Investment Objectives and Critical Success Factors to ensure that they were appropriate for inclusion. This process itself was re-visited following the submission of the Programme Business Case in December 2021, resulting a final list of four proposed schemes. For reasons of achievability within the timescales required and within the £25.2m Wave 4b Capital funding available, the proposed schemes at Attleborough (South Norfolk) and Shrublands (Great Yarmouth and Waveney) were withdrawn from this Programme but remain a priority for the system and an alternative means of delivery for both schemes will be found.

Scheme name	Type	Locality	PCN
Rackheath	New build	North Norfolk	NN4
Sprowston	Refurbishment and extension	Norwich	East Norwich Neighbourhood
King's Lynn	New build	West Norfolk	King's Lynn
Thetford	Refurbishment and reconfiguration	South Norfolk	Breckland

It was not considered appropriate to develop an Options Framework which covered Scope, Service Solution, Service Delivery, Service Implementation and Funding for the Programme because of the steps taken to date in arriving at the final list of options:

a. The 2018 STP Estates Strategy identified and prioritised 17 primary care schemes which appeared as part of the "Prioritised Estate Projects Pipeline." This followed analysis across areas of demand, condition and service development and included a level of capital investment required for primary care premises. This is the origin of the long list of potential schemes for this programme.

b. The 2018 Estates Strategy was supported by STP-wide workshops which took place early in 2018 – at a locality level and led by the STP Estates Team – which focussed on the requirements for hubs and which considered outcomes at a locality level covering:

    - Service requirements for the hubs i.e. which services were important for inclusion taking into account locality specific need
    - Design considerations and service model
    - Potential locations – considering housing developments and areas of population growth/existing demand
    - Potential site opportunities
    - Key issues and risks.

c. The original bid for Wave 4b funding had identified the original five proposed projects following the above-mentioned Estates Strategy workshops and analysis. This was used as the short list for the Programme, alongside consideration of developments since the original bid was made, including analysis of the more recent Primary Care Capacity and Demand which identified areas under registration pressure from a combination of current constraint and future housing demand. This analysis supported the choice of this short list.

d. The development of a "business as usual" option retrospectively at Programme level would not add further value to the business case – the original bid had considered a "Do Nothing" option in preparation for submission.

e. There is no "do minimum" option at a Programme level – individual projects will be governed and managed by the programme.

f. Under the Programme Framework, each project will require an options appraisal at Full Business Case.

In developing the Programme Business Case and testing the options to be taken forward, Steering and Engagement Groups were held on a locality basis, allowing input and feedback from colleagues with specific knowledge of the varying requirements across the proposed Hubs – alongside representation from the programme team, who Chaired the Groups, to ensure consistency of consideration of proposed projects against the Investment Objectives and Critical Success Factors.

Option Appraisal events were held – one for each locality – which gave in-depth consideration to options at each proposed location for the Hubs, including business as usual, do minimum (without the benefit of Wave 4b funding in the locality) and further options including refurbishments and new build options, supported by a SWOT analysis. This is described further in Section 3.11. The exception to this approach was Shrublands, which had been subject to an Option Appraisal earlier in its project development history.

- Investment Objectives were discussed at Programme Board and at Group level to ensure shared understanding and clarity
- Critical Success Factors were subject to discussion to test, understand and ensure reasonable expectations at both Programme Board and during Option Appraisal events – an example of this was feedback from a participant concerned that the Critical Success Factors were financially driven – which led to a discussion about the quality component being a central theme for the Programme and within the strategic, value for money and capability factors.
- The reserve scheme at Thetford was also assessed against all criteria.

The Programme has been revised since the original Programme Business Case submission at the end of 2021 and the prioritisation of schemes has altered to reflect achievability in the timescales required and within the £25.2m Wave 4b Capital funding available. This has meant that the reserve scheme has been brought forward as part of the proposed final four options to be taken forward.

The table below shows the long list of potential primary care projects assessed against the Investment Objectives and Critical Success Factors alongside identifying – in the text – where the original short list has been changed. The long list of schemes included are derived from the 2018 STP Estate Strategy. The list of schemes does not reflect the 2022/23 primary care estates capital planning exercise, which was nearing conclusion at the time of drafting.

			Investment Objectives				**Critical Success Factors**				
W4B List	**Ref**	**Scheme name**	Population health outcomes	Tackle inequalities	Productivity and VFM	Social and economic development	Strategic Fit	VFM	Capacity Capability	Affordability	Achievability
Final	W4BN STP 5/10	Rackheath – new build	Y	Y	Y	Y	Y	Y	Y	Y	Y
Final	W4BNw STP 5/10	North Norwich (Sprowston) – refurbishment and extension	Y	Y	Y	Y	Y	Y	Y	Y	Y
Final	W4BW	King's Lynn – new build	Y	Y	Y	Y	Y	Y	Y	Y	Y
Final	W4BS(R) STP "High"	Thetford – refurbishment and extension[15]	Y	Y	Y	Y	Y	Y	Y	Y	Y
Short	W4BGYW STP 5/10 -1 STP 8/10 - 2	Shrublands Development Phases 1 and 2[16]	Y	Y	Y	Y	Y	Y	Y	Y (not via W4B)	Y (not via W4B)
Short	W4BS STP 5/10	Attleborough – new build[17]	Y	Y	Y	Y	Y	Y	Y	Y (not via W4B)	Y (not via W4B)
Long	STP 5/10	St James – new build *Proposal at FBC stage, taken forward with 3PD*	Y	Y	Y	Y	Y	Pending re-assessment	Y	Pending re-assessment	Y
Long	STP 8/10 STP 9/10	Dereham Health Hub / Hospital redevelopment	Not assessed: Revenue consequences of original proposal not affordable. Work ongoing with PCN to determine Estates Strategy and plan for the area.								
Long	STP 8/10	Hethersett Practice – new build	Business Case being progressed in discussion with local authority.								
Long	STP 8/10	Primary care development in Norwich	Not assessed: Discussions underway with PCN regarding potential replacement new build.								
Long	STP 8/10	North Lowestoft primary care development	Not assessed: Discussions underway with PCN regarding premises requirements in the area.								
Long	STP 8/10	Aylsham Market Surgery – additional	Not assessed: Practice have submitted an Expression of Interest for 2022/23 capital funding.								

[15] Reserve scheme brought forward due to revisions to programme after December 2021 Programme Business Case submission.
[16] Will be taken forward via alternative means: removed from final list re. W4B completion deadline and requirement for third party investment.
[17] Will be taken forward via alternative means: removed from final list re. W4B completion deadline and requirement for third party investment.

			Investment Objectives				Critical Success Factors				
W4B List	**Ref**	**Scheme name**	Population health outcomes	Tackle inequalities	Productivity and VFM	Social and economic development	Strategic Fit	VFM	Capacity Capability	Affordability	Achievability
		consulting rooms									
Long	STP 8/10	Birchwood Surgery – additional consulting rooms	Not assessed: Discussions underway with PCN and local planning authority for a potential new build for area.								
Long	STP 8/10	Burnham Market Surgery – new build *Completed early 2022*	Y	Y	Y	Y	Y	Y	Y	Y	Y
Long	STP 8/10	Campingland Surgery – new build	Not assessed: Discussions underway with practice and landlord re. potential development opportunities.								
Long	STP "High"	Primary Care Premises – proposals anticipated: GP led schemes	Not assessed: 2022/23 capital prioritisation underway, alongside Primary Care Estate Strategy and PCN Estate Strategy development.								

Table 3: 2018 Estates Strategy - long listed sites: Investment Objectives and CSFs

4.11 The Proposed Schemes – Norfolk and Waveney Primary Care Hubs

4.11.1 The Proposed Schemes – Norfolk and Waveney Primary Care Hubs

The section below sets out the site option appraisal methodology, economic analysis, clinical focus, option appraisals and economic appraisals for all four proposed schemes, as well as the benefits realisation plan. Following this, each of the four proposed schemes is separately considered in detail, including the process which led to the preferred way forward being selected for each.

Text in green boxes, like this one, indicate the preferred ways forward throughout the following sections.

4.11.2 The Case for Change

The Primary Care Hubs will be buildings where a range of services can work side-by-side keeping people well and helping to prevent hospital admissions. The needs of communities have changed and can be much greater particularly where there are health inequalities and where populations have complex, long term conditions. The Hubs support the approach of shifting the focus on treating those who are unwell to preventing ill health and tackling health inequalities. They do this through accommodating multi-disciplinary teams, made up of the additional roles which are supporting PCNs as well as the opportunity for other services to base staff at the Hubs. This will look different at each of the proposed Hubs initially, but the plan is for each Hub to expand this approach as they are developed, working with local community services and responding to the needs of their local populations. Please see the Case for Change Section 3.7 for further details.

The Options Framework at Section 4.10 details the background behind the requirement for these proposed Hubs.

The proposed Hubs are:

North Norfolk – Rackheath	**Norwich – Sprowston**	**King's Lynn – Nar Ouse Way**	**South Norfolk – Thetford Healthy Living Centre**

New build at Halsbury Homes site on Broad Lane, Rackheath	Expansion of existing healthcare premises at Aslake Close, Sprowston, Norwich	New build at Nar Ouse Way site, south King's Lynn	Refurbishment of existing healthcare premises at Thetford Healthy Living Centre, Croxton Road, Thetford
Please see Section 4.11.10	Please see Section 4.11.11	Please see Section 4.11.12	Please see Section 4.11.13

4.11.3 Description of the Preferred Ways Forward

Please see Sections for each proposal (linked in the table above) for more detailed information on the option appraisal process for each scheme. The preferred options are described briefly below, and a detailed financial impact is contained within the Financial Case later in this Programme Business Case.

North Norfolk – Rackheath

The preferred way forwards for the Norwich Growth Triangle included both the scheme at Sprowston and a new facility at Rackheath as this Growth Triangle area covers two localities and there is considerable growth is proposed, with and no current provider base.

The preferred way forwards will see a new purpose-built facility with a combined net internal area of 1,586 m^2 constructed alongside and extra care facility off Broad Lane. The land already has the benefit of an outline planning permission.

The site sits close to the existing village centre and is about 500m from current bus stops.

There are 66 parking spaces some providing charging points. In addition to dedicated disabled drop off points near the building there is an ambulance parking bay with charging point.

Close to the building is a mobile unit hard standing and electrical hook up point for mobile diagnostic units.

Figure 24: Rackheath – proposed Hub site plan

Figure 25: Rackheath – proposed Hub Ground Floor Plan

All clinical services will be located on the ground floor. A shared reception and interview room overlooks the single waiting area and WC facilities, nappy change and dedicated feeding rooms. In addition, there is a changing places facility.

There is staff access to the first floor from two stair cores and a lift.

In a wing that can be appropriately secured for safety reasons during out of hours is the GP provision of 10 Consultation/Examination and 2 Treatment rooms, plus supporting utility areas. This includes provision for trainee placements from within the PCN. Initial utilisation will be boosted by the location of PCN ARRS staff within the facility. All rooms will be bookable by PCN member practices ensuring flexible utilisation whilst the list builds up.

Utilising part of the waiting area are a suite of rooms that can be open 24/7 for maternity outpatient facilities and a bookable training and education room that can be utilised by any health and social care partner.

The maternity facility includes 2 consultation and examination rooms. This area also includes stores accessible 24/7 for peripatetic staff including midwives supporting home births.

A third area that can also be appropriately secured for safety reasons out of hours provides rooms for Community Nursing and Therapy. The area includes three clinic rooms and a large multifunction room alongside an MSK Physiotherapy area.

Figure 26: Rackheath – proposed Hub First Floor Plan

The partial first floor allows for future vertical expansion and the lift would allow clinical services to be delivered on the first floor if desired. At present only staff and digital resources are included upstairs. All staff rooms, changing and WC provision are shared. There are dedicated office areas for the three departments (GMS, Community, Maternity). There are bookable and digitally enabled, training and seminar/Multi-Disciplinary Team rooms. There is a bookable digital consultation room. These rooms will also be bookable by the PCN to support training and MDT meetings.

Norwich North

The preferred way forwards for Norwich north Growth Triangle was to remodel and extend an existing facility at Aslake Close Sprowston in addition to supporting a new build facility in Rackheath (see above).

Proposals at Sprowston would see a remodelling of the existing two practice facility into a single integrated building, combined with a single storey extension to the rear.

Existing carparking will be reconfigured to generate additional spaces and off-site options will be reviewed. Dedicated ambulance parking will be created with a charging point.

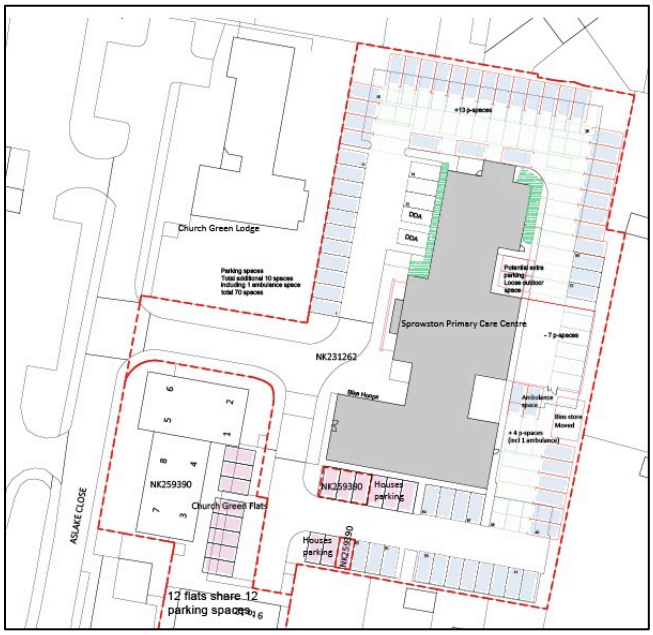


Figure 27: Sprowston – proposed Hub Site Plan

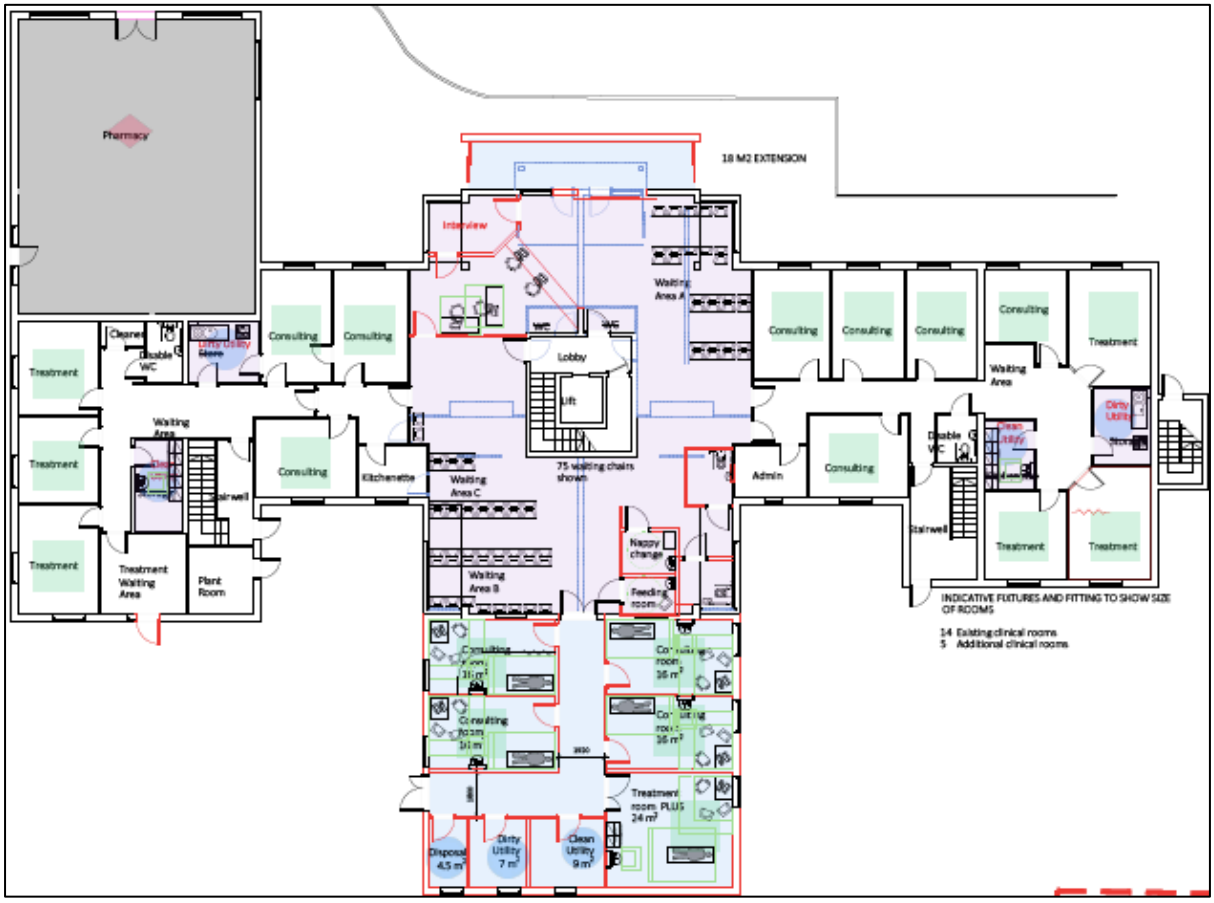


Figure 28: Sprowston – proposed Hub Ground Floor Plan

On the ground floor a new single reception and interview room will be created providing observation of waiting areas in current voids. New compliant WC facilities will be created and clean and dirty utility to current clinical areas addressing infection control requirements.

To the rear a new single storey extension will provide 4 consultation/examination rooms and 1 treatment room with supporting utility rooms.

The ground floor extension will be built to accommodate future upward expansion if required. This will include providing moderate alterations on the first floor to enable future access and capped off services to a potential sub wait/WC area (currently an office).

There is a commercial pharmacy on the ground floor outside of these proposals.

There are mental health and community rooms on the first floor that are unaffected by the proposed changes.

As an existing leased facility this scheme will proceed as tenants' improvements, with NHS capital abated for an agreed period of time as per the Premises Costs Directions and supported by a Grant Agreement. The landlord has already signalled their support to this approach.

Kings Lynn – Nar Ouse Way

The preferred way forwards for King's Lynn will see a new purpose-built facility with a combined net internal area of 1,574 m^2 constructed on Nar Ouse Way in the regeneration area. The land is owned by the Borough Council who have indicated their support for the scheme.

The site is adjacent to the two areas of high deprivation in South Lynn and the town centre.

It has good car access and is 300m from the nearest existing bus stop.

There are 75 parking spaces some providing charging points. In addition to dedicated disabled drop off points near the building there is an ambulance parking bay with charging point.

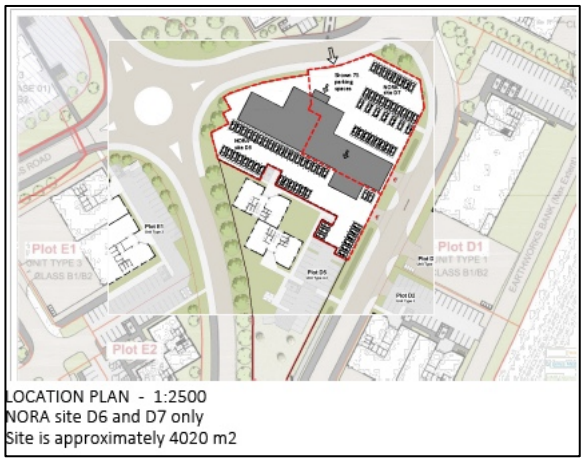


Figure 29: King's Lynn – proposed Hub Site Plan

Close to the building is a mobile unit hard standing and electrical hook up point for mobile diagnostic units.

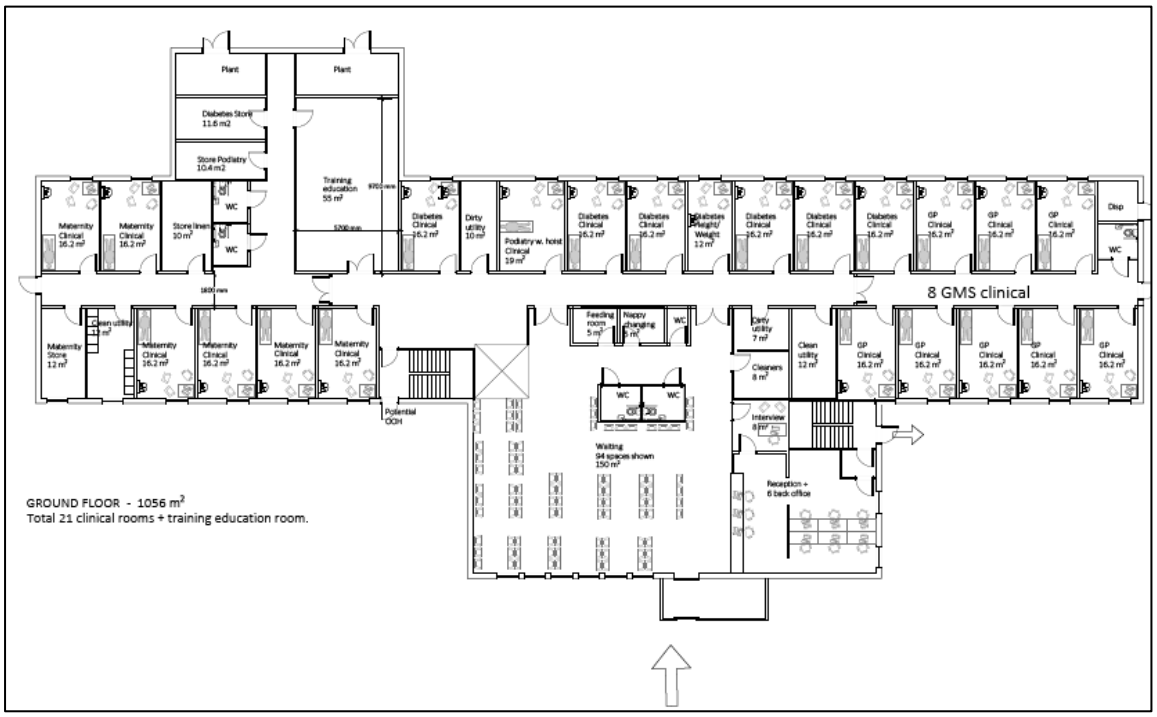


Figure 30: King's Lynn – proposed Hub Ground Floor Plan

All clinical services will be located on the ground floor. A shared reception and interview room overlooks the single waiting area and WC facilities, nappy change, and dedicated feeding rooms. There is staff access to the first floor from two stair cores and a lift.

In a wing, that can be appropriately secured for safety reasons out of hours is the GP provision of 6 Consultation/Examination and 2 Treatment rooms, plus supporting utility areas. This includes provision for trainee placements from within the PCN. Initial utilisation will be boosted by the location of PCN ARRS staff within the facility. All rooms will be bookable by PCN member practices ensuring flexible utilisation whilst the list builds up.

Close to the waiting area are a suite of rooms providing an outpatient clinic for the QEH Diabetes department. These include 6 general clinical rooms, 2 podiatric rooms and a bariatric clinical room with a hoist.

A second wing that can be open 24/7 are the maternity outpatient facilities and a bookable training and education room that can be utilised by any health and social care partner.

The maternity facility includes 4 consultation and examination rooms alongside 2 scanning rooms. This area also includes stores accessible 24/7 for peripatetic staff including midwives supporting home births.

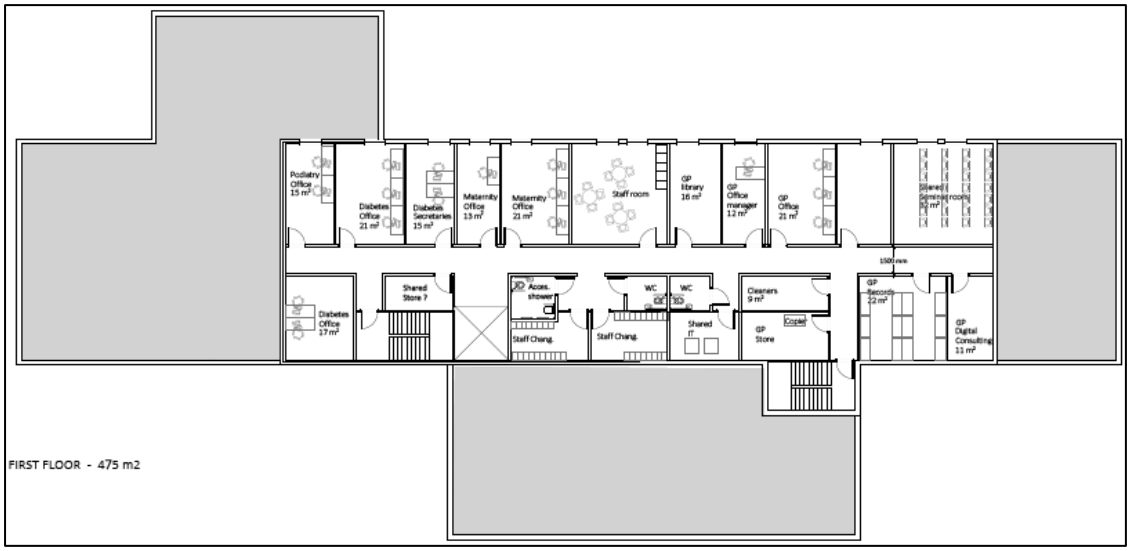


Figure 31: King's Lynn – proposed Hub First Floor Plan

The partial first floor allows for future vertical expansion and the lift would allow clinical services to be delivered on the first floor if desired. At present only staff and digital resources are included upstairs. All staff rooms, changing and WC provision is shared. While there are dedicated office areas for the three departments (GMS, Diabetics, Maternity), services will share other areas e.g. rest areas and reception to support integration. There are bookable and digitally enabled, training and seminar/Multi-Disciplinary Team rooms. There is a bookable digital consultation room. These rooms will also be bookable by the PCN to support training and MDT meetings.

South Norfolk – Thetford Healthy Living Centre

The preferred way forward for Thetford will be conversion works to the first and ground floors of Thetford Healthy Living Centre, creating 14 new consultation rooms, alongside creation of a second lift and an expansion to the car parking spaces. This approach will see all the areas currently occupied by PCN admin teams converted for clinical use, with the whole team being relocated off site, but to a facility nearby. It would create 13 compliant consultation rooms, sub waiting, office and storage (Clean utility) and dirty utility areas. It would reuse existing WC and reception areas. On the ground floor an additional consultation room would be created.

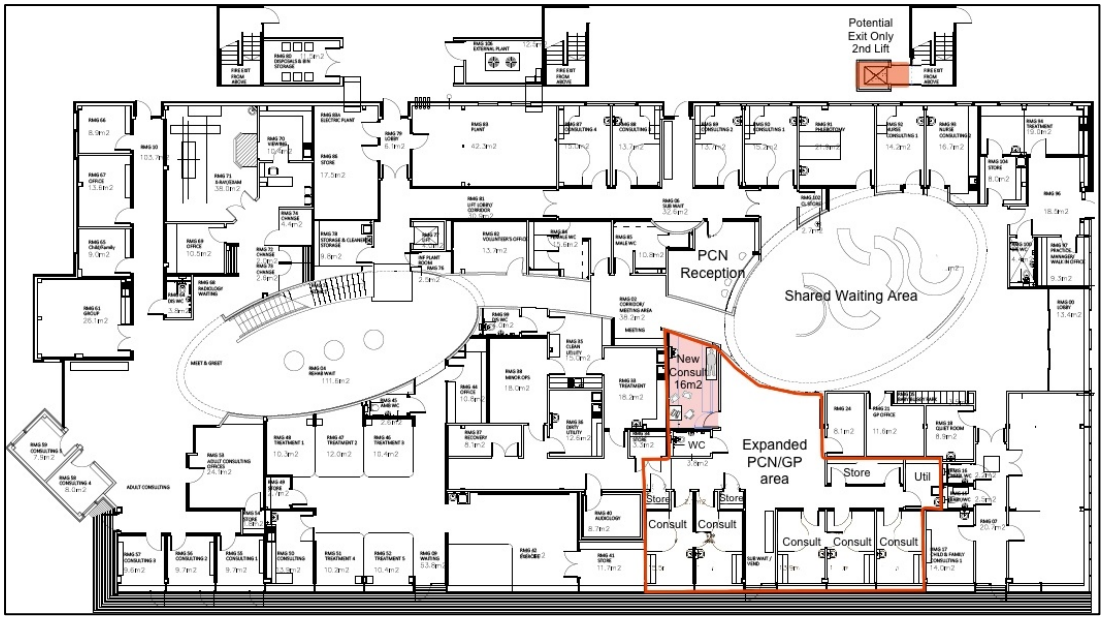


Figure 32: Thetford proposed Hub – Option 4 Ground Floor

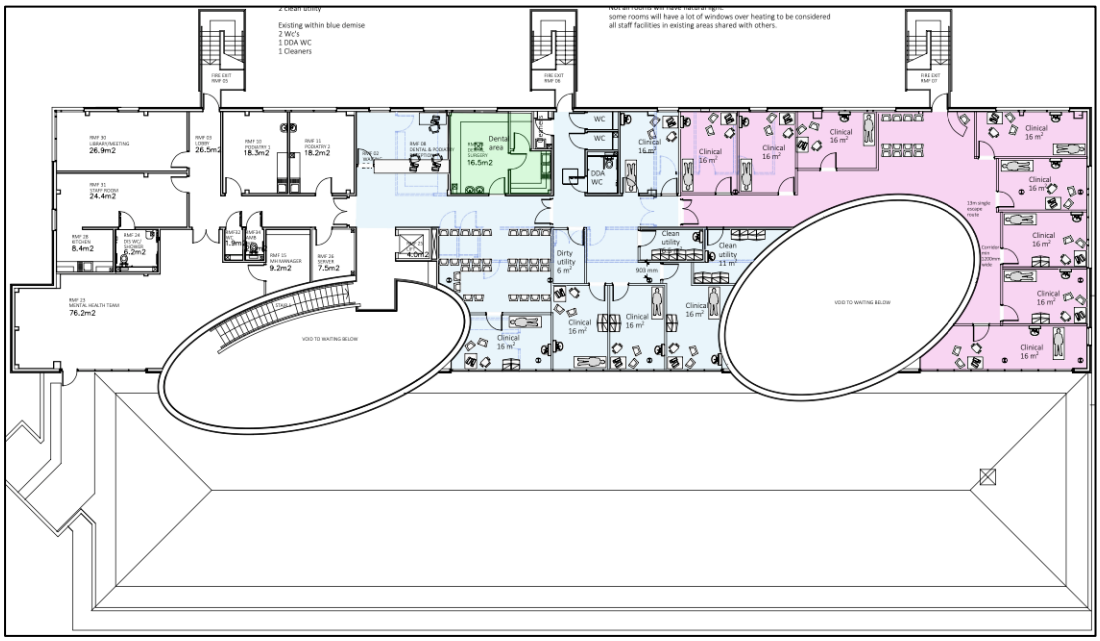


Figure 33: Thetford proposed Hub – Preferred Option First Floor

4.11.4 Site option appraisal methodology

Each of the shortlisted site options was assessed by a panel of provider and commissioner stakeholders. The panels also included patient representatives. The panel were provided with an appraisal pack of information prior to the appraisal event, which included:

- Programme overview
- Methodology explanation – including Critical Success Factors (CSFs)
- Summary of the proposed scheme – including demand and capacity, the status of existing primary care premises and other healthcare premises
- Site long list: details of potential options, risks and other considerations
- Site short list and overview reasons

- Options identified as feasible: Business As Usual, Do Minimum and at least two further options which included refurbishment and new build options
- SWOT analysis of options
- Financial appraisal of options
- Details of how voting would work, if required

The panel considered to what extent each option could meet the CSFs, deciding for each option if they should be:

Carried Forward	If the option could sufficiently meet the CSF requirements.
Discounted	If the option could not meet the requirements.
Preferred Way Forward	If a single option best met the CSF requirements.
Discounted but retained as a baseline	Where the option was included for comparison purposes for example 'Business as Usual'.

If there was disagreement or a tied result as to the rating of any CSF a panel voting scheme had been agreed and the majority decision would stand.

It was a requirement that the final Preferred Way Forward should be agreed by all stakeholders. In the event it was not, the panel were to agree what actions were required to be able to take a preferred option forward.

4.11.5 Economic analysis

The economic appraisal has been undertaken using the CIA model (See Appendix 10). This considers the overall discounted costs and benefits of the options being considered over the lifetime of each option. The key elements of this appraisal are as follows:

- It considers only net flows of money, not transfers between the different parts of the public sector. So, for example, it excludes rates and VAT.
- The appraisal period reflects the lifetime of the options. For new builds 25 years.
- Values are discounted by 3.5% per year to reflect the timing of the cash flows i.e., later cash flows having a lower value than earlier ones.
- Optimism Bias is included at 30%.
- The benefit achieved is from the discounted rent for investing Wave 4B capital funding.

Further benefits are currently being assessed and will be included in further CIA iterations. It is likely that those benefits will be similar across schemes where Integration and Innovation are key enablers.

The outcomes of the site option appraisal events are summarised in Tables 4, 5 and 6 below.

4.11.6 Clinical Focus

The focus of the ICS for these premises is to:

- Provide capacity and capability requirements for primary care to meet current and increased demand for GMS services, and to ensure primary care's support to the healthcare system can be extended and sustained;
- Support Community Services by providing purpose-built spaces supporting integrated service provision and more proactive and co-ordinated care;
- Support Acute Services through provision of capacity for services – where appropriate – to transfer into a community setting and encouraging this expectation of location of service provision;

- Support the Norfolk and Waveney Local Maternity System to respond to the Better Births Vision for continuity of carer and services in the community.

The proposals share the following strategic clinical focus:

a. Moving services from secondary care to community sectors including outpatient clinics, diagnostics, and urgent care.
b. Having close links with community health services including mental health services to foster an integrated MDT approach to care.
c. Reducing/stopping avoidable unplanned admissions for chronic ambulatory care sensitive conditions.
d. Supporting primary care to respond to urgent care and through this to help reduce A&E attendances.
e. Improving patient experience.
f. Supporting patients and carers to self-care and promoting healthy lifestyles.
g. Better access to services including initiatives such as extended opening hours and telehealth.
h. Involving patients, their families and carers in designing and developing the provision of services and care.
i. Improved choice.
j. Significantly improving training and education facilities and opportunities to attract and retain the next generation of GPs and healthcare professionals (including Nurses and other Healthcare Professionals).
k. Supporting the local PCN and positively engaging in its development.
l. Responding to Covid-19 including the opportunity to provide hot-hub facilities to separate patient flows and provide a vaccination base.
m. The preferred option has been chosen because it is able to deliver enough new space in line with NHS guidance and enables the Practice to provide sufficient and flexible accommodation to best meet the needs of their existing and new patients, taking into account underlying demographics.
n. Proposals enable providers to respond positively to the local vision and aims of the CCG and emerging ICS including Primary Care Networks, the NHS Five Year Forward View, including adopting and supporting clinically evidenced initiatives to reduce unplanned admissions and increasing access for patients.
o. In particular, the schemes will:
    - Ensure Primary Care in the area is sustainable and can respond to population growth.
    - Support training capacity.
    - Enable more community and out-of-hospital services to be provided in a community setting.
    - Support new initiatives such as tele-medicine in dedicated spaces.
    - Provide future flexibility including the potential to expand as population growth continues.

4.11.7 Site Option Appraisal results

The short list of options for the proposed new build Hubs (Rackheath/Sprowston and King's Lynn) followed a long list of potential sites which were investigated and appraised against the requirements for the proposed facilities. The details of the long list of sites can be found in the sections for the Rackheath and King's Lynn sections below.

	Rackheath					Sprowston				King's Lynn				Thetford			
	Option 1 Business as Usual	**Option 2** Sprowston (expansion)	**Option 3a** New build: Broad Lane "turnkey"	**Option 3b** New build: Broad Lane Site Only	**Option 4** New build: Mahoney Green	**Option 1** Business as Usual	**Option 2** Expansion of existing facilities	**Option 3** New build	**Option 4** New build (Rackheath) and expansion of existing facilities	**Option 1** Business as Usual	**Option 2** New build: Hardwick	**Option 3** New build: Nar Ouse	**Option 4** New build: West Winch	**Option 1** Business as Usual	**Option 2** Create 5 Consult/Exam rooms at THLC	**Option 3** Create 6 Consult/Exam rooms at THLC and associated infrastructure	**Option 4** Create 14 Consult/Exam rooms at THLC and associated infrastructure
Strategic Fit																	
Value for Money																	
Capacity and Capability																	
Affordability																	
Deliverability																	

Table 4: Site Option Appraisal results

4.11.8 Economic Appraisal results

	Rackheath					Sprowston				King's Lynn				Thetford			
	Option 1 Business As Usual	**Option 2** Sprowston	**Option 3** Broad Lane Turnkey	**Option 4** Broad Lane Site Only	**Option 5** Mahoney Green	**Option 1** Business As Usual	**Option 2** Expansion of existing facilities	**Option 3** New build	**Option 4** New build (Rackheath) and expansion of existing facilities	**Option 1** Business As Usual	**Option 2** New build: Hardwick	**Option 3** New build: Nar Ouse	**Option 4** New build: West Winch	**Option 1** Business as Usual	**Option 2** Create 5 Consult/Exam rooms at THLC	**Option 3** Create 6 Consult/Exam rooms at THLC and associated infrastructure	**Option 4** Create 14 Consult/Exam rooms at THLC and associated infrastructure
Total Incremental Discounted Costs **£000s**	0	-3,053	-20,094	-12,734	-14,340	0	-3,965	-23,567	-16,565	0	-14,646	-15,333	-14,213	0	-4,055	-3,500	-7,090
Total Incremental Discounted Cash Releasing Benefits **£000s**	0	13,608	63,723	63,723	63,723	0	18,461	63,104	77,332	0	61,172	65,635	59,989	0	22,574	27,089	63,207

	Rackheath					Sprowston				King's Lynn				Thetford			
	Option 1 Business As Usual	**Option 2** Sprowston	**Option 3** Broad Lane Turnkey	**Option 4** Broad Lane Site Only	**Option 5** Mahoney Green	**Option 1** Business As Usual	**Option 2** Expansion of existing facilities	**Option 3** New build	**Option 4** New build (Rackheath) and expansion of existing facilities	**Option 1** Business As Usual	**Option 2** New build: Hardwick	**Option 3** New build: Nar Ouse	**Option 4** New build: West Winch	**Option 1** Business as Usual	**Option 2** Create 5 Consult/Exam rooms at THLC	**Option 3** Create 6 Consult/Exam rooms at THLC and associated infrastructure	**Option 4** Create 14 Consult/Exam rooms at THLC and associated infrastructure
Net Present Social Value **£000s**	0	10,555	43,629	50,211	49,384	0	14,496	39,536	60,767	0	46,526	50,302	45,776	0	18,518	23,588	56.117
Cost/Benefit Ratio	0	4.46	3.17	4.72	4.44	0	4.66	2.68	4.67	0	4.18	4.28	4.22	0	5.57	7.74	8.91

Table 5: Economic Appraisal results

4.11.9 Benefits Realisation Plan – options appraisal summary

Benefit	Rackheath	Sprowston	King's Lynn	Thetford
New transformational models of working • Extended opening hours • Hosting shared services • Enhanced Digital facilities				
Primary Care Led • Independent Contractor presence on site • Multi agency • Bookable clinical and shared support areas				
Reduction in A&E attendances				
Demand Management				
Incorporating acute services				
Incorporating diagnostics				
Extended range of community/PCN services				
Spaces for public health				
Digital links to other providers				
Improved social care and wellbeing				
Improved mental health care				
Broad skill mix				
Improved recruitment and retention				
Digital Systems integration / Supporting Digital Initiatives				
Promoting multidisciplinary care				
Increased Capacity				

Benefit	Rackheath	Sprowston	King's Lynn	Thetford
• Meeting registration and service demand in Primary Care				
Increased access Improved access to seven-day services in each locality				
Contributing to environmental targets				
Better Estate Utilisation • Compliant buildings • Ensuring building sizes are robustly evidenced and let through flexible arrangements				

Table 6: Benefits Realisation Plan - options appraisal summary

The following four sections describe the proposed schemes and the options appraisal which led to the preferred way forward being identified in each case.

4.11.10 Proposed Scheme: North Norfolk, Rackheath

Scope

This proposal is seeking to develop a new-build integrated service Hub in Rackheath, bringing together GP services from the Hoveton and Wroxham Practice, community services from the Norfolk Community Health & Care NHS Trust (NCHC) and Maternity Services from the Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH)

The Hub will support a wider range of wrap around services including staff employed under the PCN's Additional Role Reimbursement Scheme (ARRS). The scheme is one of two proposed to address demand from the Norwich Growth Triangle and will be sized to meet the growth planned for Rackheath and the development areas between the town and Norwich.

There are four Primary Care Networks (PCNs) in the North Norfolk Locality which is a predominantly rural area with small market towns of North Walsham, Fakenham, Sheringham – see map below.

The location of the proposed scheme is shown by a red dot and the growth triangle in blue.

The area is covered by two Local Planning Authorities and is part of the Greater Norwich Development partnership.

Figure 34: North Norfolk: Rackheath – Proposed Hub location

Current Situation

At an earlier Option Appraisal event Commissioners confirmed their approach to meeting the considerable additional housing planned for the Norwich Growth Triangle would be to support bringing forward two schemes, both of which form part of this Programme.

- The first, through an expansion of the current East Norwich Medical Practice (ENMP) provision at Aslake Close in Sprowston to meet the initial demand arising from the Beeston Park development

- The second, through the development of a new facility in Rackheath to meet the needs of the current Hoveton and Wroxham patients in Rackheath and all the demand expected to arise from the new housing planned between the Wroxham Road and Plumstead Road.

Please see Section 3.12 for details of the actual registered list sizes for the PCNs where the proposed Primary Care Hubs will be based, and the anticipated and assumed growth per site arising from housing.

The proposed Primary Care Hub will be in the NN4 PCN in North Norfolk. The scheme name is Rackheath and its approximate proposed location is indicated on the map below by a red circle.

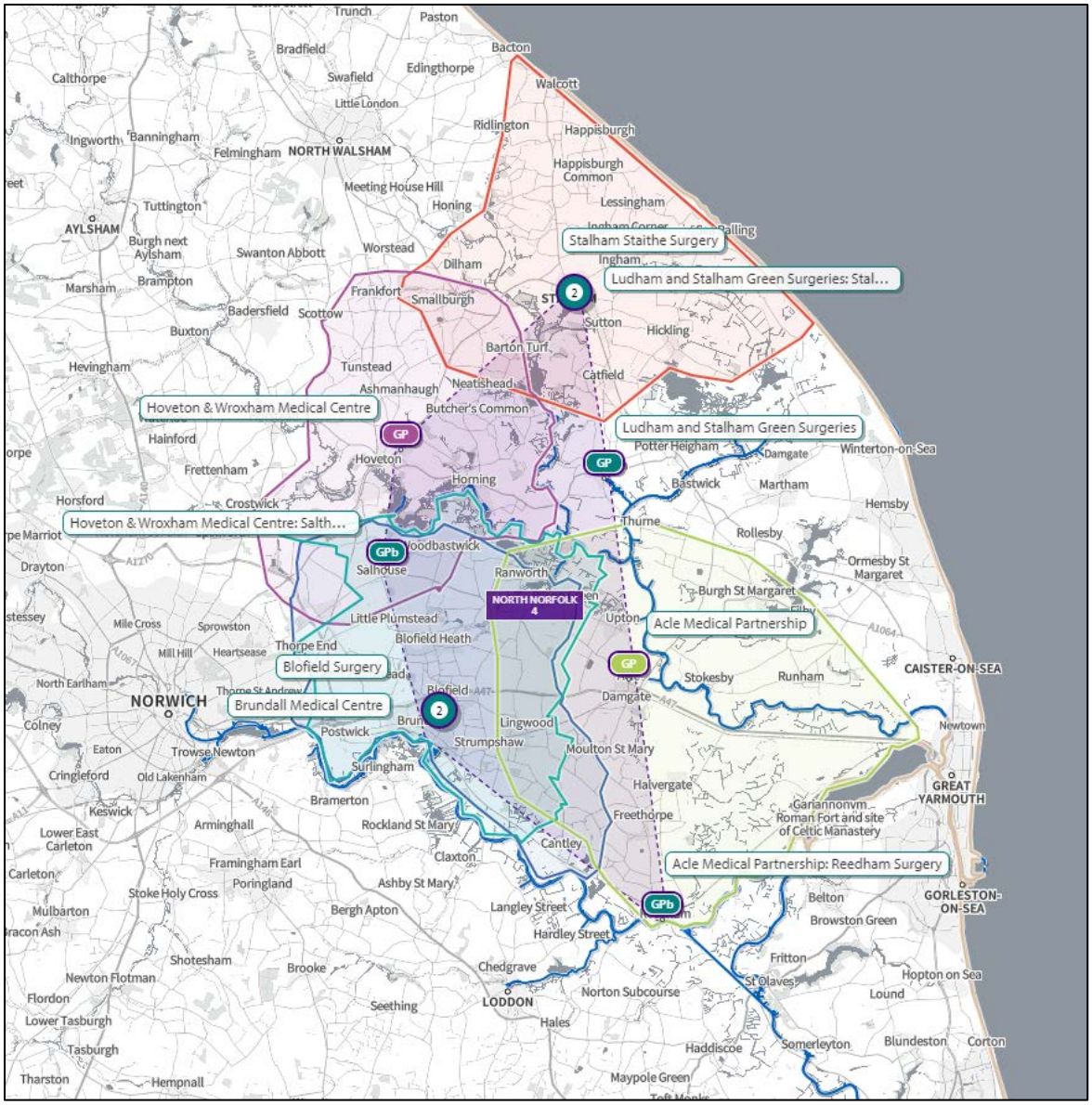


Figure 35: North Norfolk 4 Primary Care Network

Maternity Services

National Policy is driving more services away from acute hospitals where there is no clinical reason for them to be delivered there, providing services closer to people's homes in community settings.

The National Maternity Review (2021) has signalled a move towards more 'Personalised Care' with a 'Continuity of Carer' alongside better access to Postnatal and Perinatal support. It also charges departments with improving multi-professional and multi-agency working coming together in local maternity systems.

The Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH) is responding to the Review by increasing the size and scope of its midwifery services in the community. This creates a requirement for additional facilities for clinical contacts and educational sessions for groups. In addition, access to support spaces out of hours. The team's vehicles will also require bases near to the communities they will be serving.

For those accessing the service this will mean a continuity of care, close to home and more accessible post and perinatal groups increasing uptake. This will assist both in delivery of care and in promoting wider public health campaigns such as reducing maternal smoking.

Being part of this Hub will allow the service to more seamlessly blend with the users GP and community children's services.

Community Services

The Norfolk Community Health and Care NHS Trust (NCHC) is working closely with primary care and other community colleagues to deliver the NHS Long Term Plan commitments. NCHC want to develop more locally responsive services working as part of the PCNs. NCHC are working with Primary Care focusing on preventative management where possible. This will be one of the key focuses of the service provision from the Rackheath Integrated Care Hub. Another area of focus is on the delivery of Mental Health services and maintaining well-being for people to stay happy and healthy.

NCHC is already working with the PCN and throughout the wider health system on transforming acute hospital services. With the aim to improve the patient experience as well as making them more financially sustainable. As well as addressing urgent and emergency care services to enable good quality care for all.

NCHC is working with the ICS develop its Clinical Strategy as well as ensuring it delivers its own Clinical Strategy which includes:

- Working with primary care colleagues and other partners to support the development of primary care networks.
- Working with Norfolk and Suffolk NHS Foundation Trust (NSFT) on closer working around community physical and mental health services.
- Working within an alliance of community-based providers.
- Working within and leading on STP/ICS workstreams.

Primary Care Network Proposals

Hoveton and Wroxham Medical Partnership is part of the NN4 Primary Care Network and is already an improved access hub.

The new roles with the PCN are helping to deliver and contribute to an integrated work plan as per the ICS Primary Care Strategy whilst also building on the foundations of the NHS Long Term Plan and GP Forward View, supporting a more 'joined up' NHS with neighbourhood hubs and facilitating an integration between Primary and Social Care along with other community services. The new Hub will provide the space and flexibility to deliver these new services.

The multifunction room will allow more training of staff both in person and virtually. It will allow MDT sessions with the acute providers as well as interaction with specialise providers who are based further away (reducing time needed for traveling). This space can also be used for PCN activities.

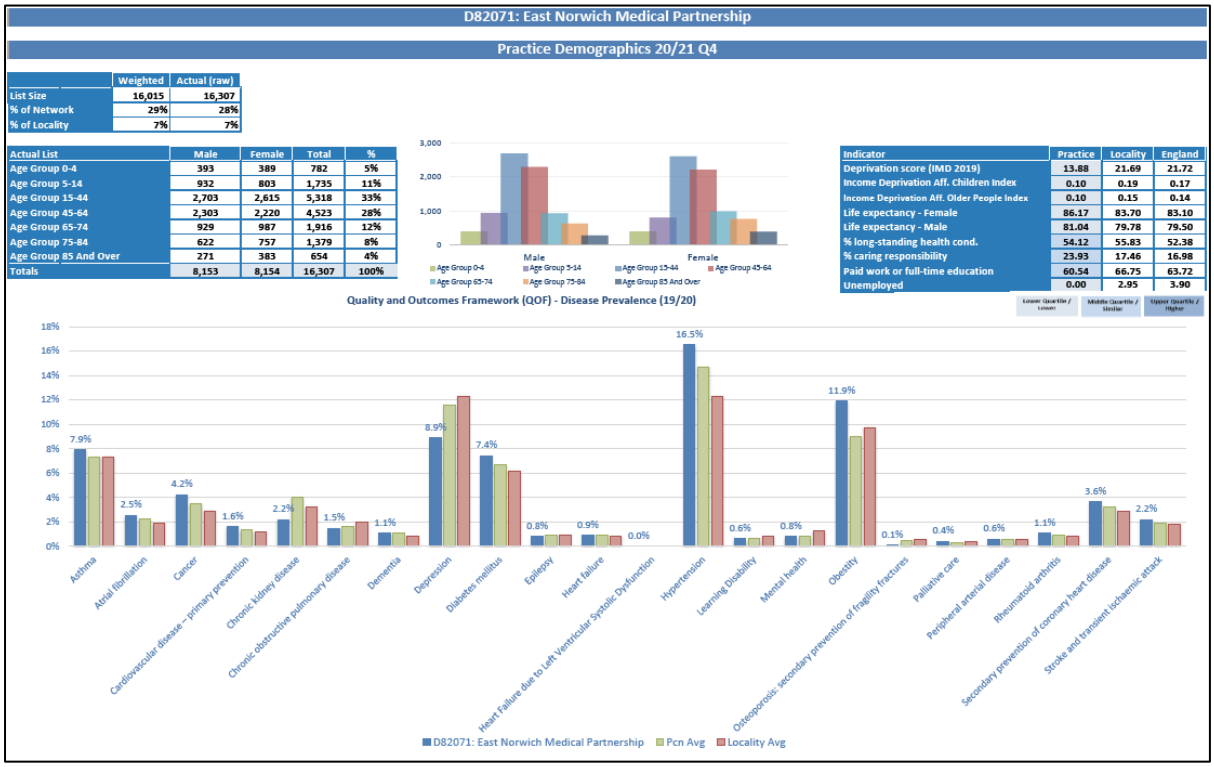
Place based care

The Hoveton and Wroxham Medical Partnership working with its PCN will work with the wider Health Economy providers and local government partners to develop their clinical model which will be detailed in the FBC. The model will be based on the population health needs of the Growth Triangle population. Some of this information is not known as not all of the housing has been planned.

Based on the population health needs of the growth triangle the following breakdown shows the health of the population of North Norfolk.

- Population in very bad health 1.4%.
- Life expectancy at birth for males (2020 – average number of years) 80.0

- Life expectancy at birth for females (2020 – average number of years) 83.2.



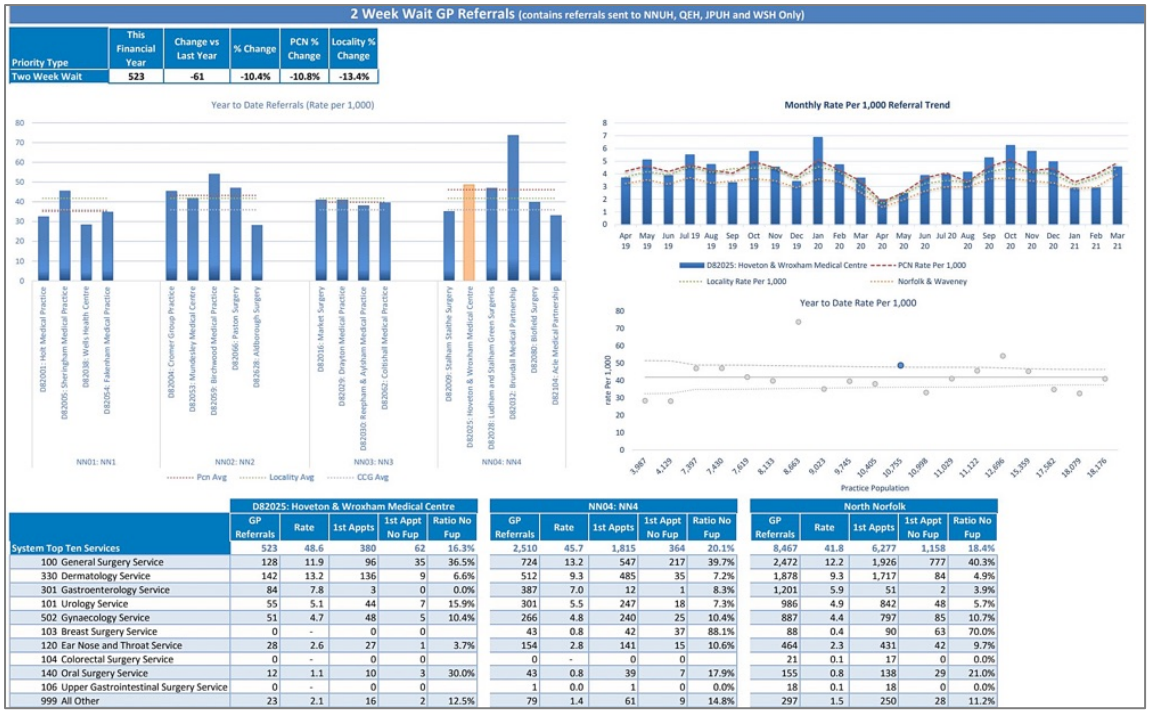
	Weighted	Actual (raw)
List Size	16,015	16,307
% of Network	29%	28%
% of Locality	7%	7%

Actual List	Male	Female	Total	%
Age Group 0-4	393	389	782	5%
Age Group 5-14	932	803	1,735	11%
Age Group 15-44	2,703	2,615	5,318	33%
Age Group 45-64	2,303	2,220	4,523	28%
Age Group 65-74	929	987	1,916	12%
Age Group 75-84	622	757	1,379	8%
Age Group 85 And Over	271	383	654	4%
Totals	8,153	8,154	16,307	100%

Indicator	Practice	Locality	England
Deprivation score (IMD 2019)	13.88	21.69	21.72
Income Deprivation Aff. Children Index	0.10	0.19	0.17
Income Deprivation Aff. Older People Index	0.10	0.15	0.14
Life expectancy - Female	86.17	83.70	83.10
Life expectancy - Male	81.04	79.78	79.50
% long-standing health cond.	54.12	55.83	52.38
% caring responsibility	23.93	17.46	16.98
Paid work or full-time education	60.54	66.75	63.72
Unemployed	0.00	2.95	3.90

Figure 36: Hoveton & Wroxham Medical Centre – demographics

Detailed above is the Q4 2020/2021 patient demographics for the Hoveton and Wroxham Medical Centre. The practice demographics is spread across age ranges, but the higher number being in the mid-range 15 – 64. It is envisaged that demand from new housing will continue this demographic trend. The Rackheath Hub with both Maternity and Community Nursing services on site will offer the opportunity for more focus on younger patients.

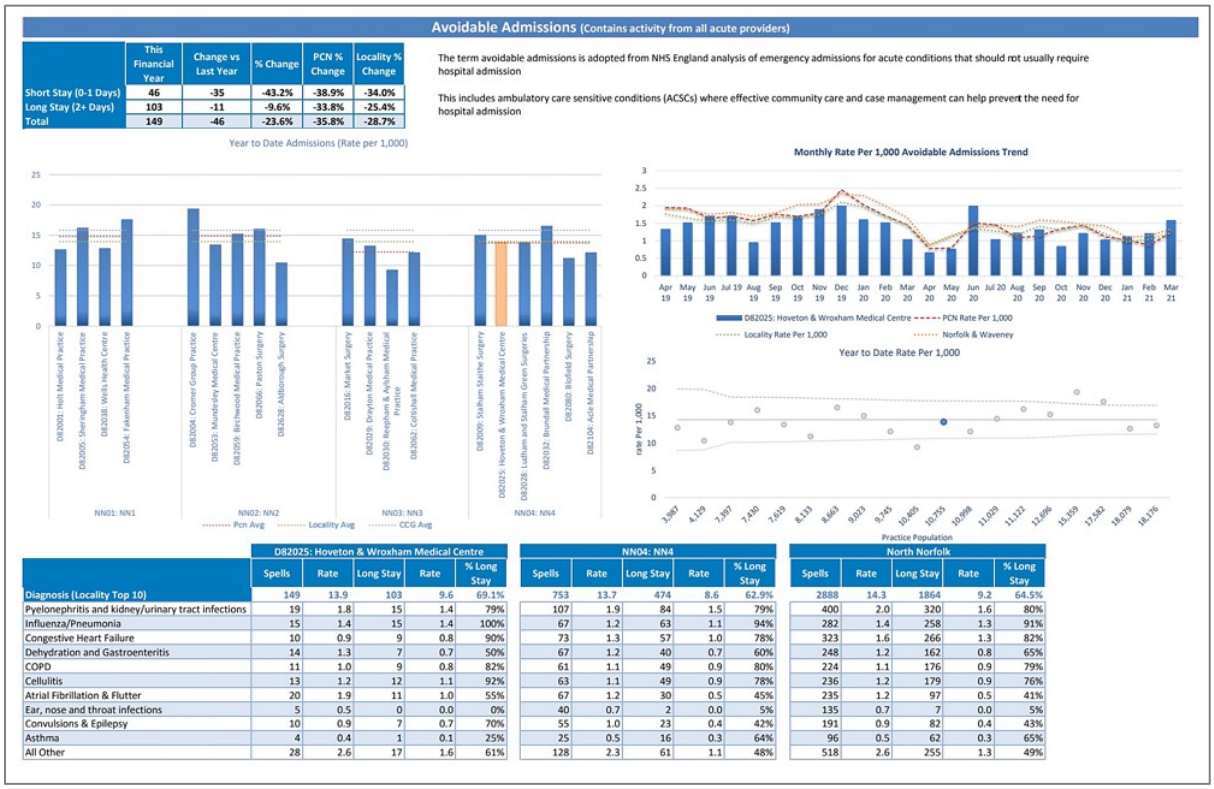


Priority Type	This Financial Year	Change vs Last Year	% Change	PCN % Change	Locality % Change
Two Week Wait	523	-61	-10.4%	-10.8%	-13.4%

	D82025: Hoveton & Wroxham Medical Centre					NN04: NN4					North Norfolk				
	GP Referrals	Rate	1st Appts	1st Appt No Fup	Ratio No Fup	GP Referrals	Rate	1st Appts	1st Appt No Fup	Ratio No Fup	GP Referrals	Rate	1st Appts	1st Appt No Fup	Ratio No Fup
System Top Ten Services	523	48.6	380	62	16.3%	2,510	45.7	1,815	364	20.1%	8,467	41.8	6,277	1,158	18.4%
100 General Surgery Service	128	11.9	96	35	36.5%	724	13.2	547	217	39.7%	2,472	12.2	1,926	777	40.3%
330 Dermatology Service	142	13.2	136	9	6.6%	512	9.3	485	35	7.2%	1,878	9.3	1,717	84	4.9%
301 Gastroenterology Service	84	7.8	3	0	0.0%	387	7.0	12	1	8.3%	1,201	5.9	51	2	3.9%
101 Urology Service	55	5.1	44	7	15.9%	301	5.5	247	18	7.3%	986	4.9	842	48	5.7%
502 Gynaecology Service	51	4.7	48	5	10.4%	266	4.8	240	25	10.4%	887	4.4	797	85	10.7%
103 Breast Surgery Service	0	-	0	0		43	0.8	42	37	88.1%	88	0.4	90	63	70.0%
120 Ear Nose and Throat Service	28	2.6	27	1	3.7%	154	2.8	141	15	10.6%	464	2.3	431	42	9.7%
104 Colorectal Surgery Service	0	-	0	0		0	-	0	0		21	0.1	17	0	0.0%
140 Oral Surgery Service	12	1.1	10	3	30.0%	43	0.8	39	7	17.9%	155	0.8	138	29	21.0%
106 Upper Gastrointestinal Surgery Service	0	-	0	0		1	0.0	1	0	0.0%	18	0.1	18	0	0.0%
999 All Other	23	2.1	16	2	12.5%	79	1.4	61	9	14.8%	297	1.5	250	28	11.2%

Figure 37: Hoveton & Wroxham Medical Centre – 2 week wait referrals

The diagram above shows the Hoveton and Wroxham Medical Centre 2 week wait referrals during 2020/2021 Q4. Clearly the pandemic has influenced the referral activity. The two highest referrals services are General Surgery and Dermatology. Working with the wider health economy the Practice and their PCN are looking at ways the new Integrated Hub could facilitate reducing the numbers of referrals especially in relation to developing a digital telemedicine solution which could reduce the number of direct referrals particularly for dermatological conditions. The hub proposals contain a fund to allow providers to plan for innovative approaches.



	This Financial Year	Change vs Last Year	% Change	PCN % Change	Locality % Change
Short Stay (0-1 Days)	46	-35	-43.2%	-38.9%	-34.0%
Long Stay (2+ Days)	103	-11	-9.6%	-33.8%	-25.4%
Total	149	-46	-23.6%	-35.8%	-28.7%

	D82025: Hoveton & Wroxham Medical Centre					NN04: NN4					North Norfolk				
	Spells	Rate	Long Stay	Rate	% Long Stay	Spells	Rate	Long Stay	Rate	% Long Stay	Spells	Rate	Long Stay	Rate	% Long Stay
Diagnosis (Locality Top 10)	149	13.9	103	9.6	69.1%	753	13.7	474	8.6	62.9%	2888	14.3	1864	9.2	64.5%
Pyelonephritis and kidney/urinary tract infections	19	1.8	15	1.4	79%	107	1.9	84	1.5	79%	400	2.0	320	1.6	80%
Influenza/Pneumonia	15	1.4	15	1.4	100%	67	1.2	63	1.1	94%	282	1.4	258	1.3	91%
Congestive Heart Failure	10	0.9	9	0.8	90%	73	1.3	57	1.0	78%	323	1.6	266	1.3	82%
Dehydration and Gastroenteritis	14	1.3	7	0.7	50%	67	1.2	40	0.7	60%	248	1.2	162	0.8	65%
COPD	11	1.0	9	0.8	82%	61	1.1	49	0.9	80%	224	1.1	176	0.9	79%
Cellulitis	13	1.2	12	1.1	92%	63	1.1	49	0.9	78%	236	1.2	179	0.9	76%
Atrial Fibrillation & Flutter	20	1.9	11	1.0	55%	67	1.2	30	0.5	45%	235	1.2	97	0.5	41%
Ear, nose and throat infections	5	0.5	0	0.0	0%	40	0.7	2	0.0	5%	135	0.7	7	0.0	5%
Convulsions & Epilepsy	10	0.9	7	0.7	70%	55	1.0	23	0.4	42%	191	0.9	82	0.4	43%
Asthma	4	0.4	1	0.1	25%	25	0.5	16	0.3	64%	96	0.5	62	0.3	65%
All Other	28	2.6	17	1.6	61%	128	2.3	61	1.1	48%	518	2.6	255	1.3	49%

Figure 38: Hoveton & Wroxham Medical Centre – avoidable admissions

The diagram above shows the reducing incidence of avoidable admissions for the Hoveton and Wroxham Medical Centre. One of the principal objectives of the ICS is reduce further the number of avoidable admissions and improve the patient experience through early intervention within primary and community care settings. As the ICS implement their Clinical Strategy the PCNs and Community Trusts will be working together and reviewing this data to see how the health system can reduce the number of avoidable admissions and how the new facilities can facilitate this.

Schedule of Accommodation

The schedule of accommodation meets the expected registration demand from new housing, provides the requirements for the proposed outpatient and community services and makes provision for PCN appointments.

The schedule of accommodation aims to deliver the service strategy and digital focus, to meet the expected registration demand, satisfy the requirements for the proposed outpatient services and PCN appointments. The “office accommodation” indicated is also intended to support non-clinical PCN work.

The schedule for the GMS element has been developed using standard modelling based on the proposed list size and operational hours. Maternity and Community services have based their requirements on existing provision and proposed activity.

The schedule has been refined with providers to meet both their requirements and the proposed operational model for the hubs and has been subject to further discussion as part of the Programme Business Case review and resubmission. Further definition will be required, in terms of use and adjacency, as part of the usual detailed design process, as this progresses.

The design team have utilised the latest HBN guidance, best practice considering lessons learned during the pandemic and changing consultation patterns.

	Main entry	m²	Number	Total
	Lobby	22.0 m²	1	22.0 m²
	Reception	10.0 m²	1	10.0 m²
	Back Office (per person)	8.0 m²	5	40.0 m²
	Sub total			72.0 m²

	Waiting Area			
	Waiting per clinical room	6.8 m²	13	88.4 m²
	Children's Play	6.0 m²	1	6.0 m²
	Buggy Area	8.0 m²	0	0.0 m²
	Nappy Change/Feed	4.0 m²	2	8.0 m²
	Accessible WC	4.5 m²	3	13.5 m²
	Changing Places	12.0 m²	1	12.0 m²
	Semi Ambulant WC	2.5 m²	0	0.0 m²
	Sub total			127.9 m²

	GP Clinical Areas			
	Consultation/Treatment	16.0 m²	10	160.0 m²
	Training	16.0 m²	2	32.0 m²
	25% Digital Consult /Counselling	12.0 m²	3	36.0 m²
	Bookable community consult	16.0 m²	2	32.0 m²
	Interview (off waiting)	8.0 m²	1	8.0 m²
	Clean Utility Store	12.0 m²	1	12.0 m²
	Dirty Utility	7.0 m²	1	7.0 m²
	Disposals	6.0 m²	1	6.0 m²
	Cleaner	6.0 m²	1	6.0 m²

	Accessible WC	4.5 m²	1	4.5 m²
	Sub total			303.5 m²

	Office Accommodation			
	Office - Manager	12.0 m²	1	12.0 m²
	Office Medium (per person)	7.0 m²	7	49.0 m²
	Store and Copier	8.0 m²	1	8.0 m²
	IT/Comms Room	10.0 m²	1	10.0 m²
	Sub total			79.0 m²

	Staff Accommodation			
	Staff Room w. kitchenette	20.0 m²	1	20.0 m²
	Ambulant WC	2.5 m²	3	7.5 m²
	Accessible WC	4.5 m²	0	0.0 m²
	Staff accessible WC/Shower	20.0 m²	1	20.0 m²
	Library/ doctor's working office	16.0 m²	1	16.0 m²
	Meeting/Seminar Room	20.0 m²	1	20.0 m²
	Record Store	18.0 m²	1	18.0 m²
	Plant Room	12.0 m²	1	12.0 m²
	Staff changing / lockers	18.0 m²	1	18.0 m²
	Sub total			131.5 m²

	Total Net internal area (NIA)			713.9 m²
	Planning allowance		6.0%	42.8 m²
	Engineering allowance		4.0%	28.6 m²
	Circulation allowance		30.0%	214.2 m²
	TOTAL GMS			**999.5 m²**

	Norfolk and Norwich Requirements (365 days PA)			
	Consult/exam	16.0 m²	2	32.0 m²
	Equipment store	8.0 m²	1	8.0 m²
	Office (per person)	7.0 m²	3	21.0 m²
	Accessible WC	4.5 m²	1	4.5 m²
	Waiting (per clinical room)	6.8 m²	3	20.4 m²
	Midwives store	12.0 m²	1	12.0 m²
	Access to training rooms OOH			
	Total Net internal area			97.9 m²
	Planning allowance		6.0%	5.9 m²
	Engineering allowance		4.0%	3.9 m²
	Circulation allowance		30.0%	29.4 m²
	TOTAL Norfolk and Norwich			137.1 m²

	NCH&C Norfolk Community Health and Care			
	Clinic 1, Leg ulcer	16.0 m²	1	16.0 m²

	Clinic 2, Catheter Clinic	16.0 m²	1	16.0 m²
	Clinic 3, Additional Clinics	16.0 m²	1	16.0 m²
	Physio Gym	45.0 m²	1	45.0 m²
	Health Education, Multi-functional	60.0 m²	1	60.0 m²
	Office 1; CN&T	60.0 m²	1	60.0 m²
	Office 2; CN&T	14.0 m²	1	14.0 m²
	Office 3; CN&T	14.0 m²	1	14.0 m²
	Store 1; Clean consumables	12.0 m²	1	12.0 m²
	Store 2; Clean equipment	12.0 m²	1	12.0 m²
	Store 3; Dirty equipment	12.0 m²	1	12.0 m²
	Store 4: Physio equipment store	12.0 m²	1	12.0 m²
	Staff Shower	5.0 m²	0	0.0 m²
	Staff Changing	16.0 m²	0	0.0 m²
	Access WC	4.5 m²	2	9.0 m²
	Shared Waiting pr no of clinical	6.8 m²	4	27.2 m²
	Total Net internal area			325.2 m²
	Planning allowance		6.0%	19.5 m²
	Engineering allowance		4.0%	13.0 m²
	Circulation allowance		30.0%	97.6 m²
	TOTAL NCHC			455.3 m²

	Rackheath Hub Total required area			
	TOTAL GMS			999.5 m²
	Norfolk and Norwich Requirements (365 days PA)			137.1 m²
	NCH&C Norfolk Community Health and Care			455.3 m²
	TOTAL Building GIA*			1591.8 m²

Service Solution

Recent Health Proposals in Rackheath

In 2020 there was an unsuccessful Outline Business Case submitted on behalf of the Hoveton and Wroxham Medical Centre on a site on Green Lane West. This proposal was part of a dual submission which, in addition to the phased implementation of a facility in Rackheath, sought to create additional capacity at the main site including some capacity to support Rackheath. The proposals at the Hoveton site were supported and are now complete.

There is an existing Section 106 agreement dated 29 June 2021 relating to the outline planning permission (granted on the same date) for the proposed development of land at Green Lane East, Little Plumstead, Norfolk. The proposed development is to comprise residential dwellings (including market and affordable dwellings), an extra care independent living facility and a medical centre. It is the land available for the medical centre which is the site chosen for the proposed Hub at Rackheath – this is marked as the Halsbury Homes site on Figure 36.

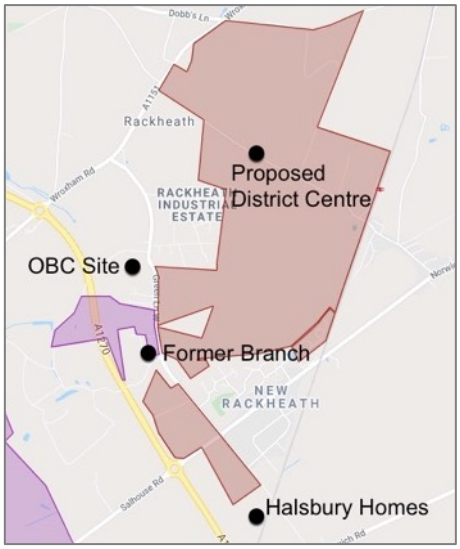


Figure 39: Rackheath proposed Hub – Identified Sites

The CCG and NHS Property Services are working together to understand and manage risks arising from this agreement:

- Owner obligation/liabilities – the S106 agreement contains provisions which mean that the NHS, in purchasing part of the site, could become liable for a wider set of "owner" planning obligations in the agreement. The proposed mitigation (NHS Property Services sought planning law advice) is a condition to completion of sale contract for deed of variation to S106, limiting NHS liability to the development of the Medical Centre Land only
- Reserved matters (Medical Centre Land) application timing – the planning authority need to assess Nutrient Neutrality impacts, which will delay the wider residential site development and the submission of the reserved matters application (the Medical Centre Land and extra care facility – latter facility separate from the Hub proposal). The proposed mitigation is that a full planning application for the development of the health centre only is submitted.

The site allocated for health currently stands in open countryside without access to public transport or pedestrian routes to the town.

Long List of Sites

In total nine sites have been investigated as potential options for a new facility.

The table below lists them and how well they fitted with the requirements for the new facility.

Of these, two were confirmed by the Steering Group as having more potential for the proposed scheme and shortlisted for this option appraisal.

The chosen sites sit in the middle of the proposed catchment area, to serve both existing and new populations.

They are located close to or on bus routes.

They are within easy access of the current village and its amenities.

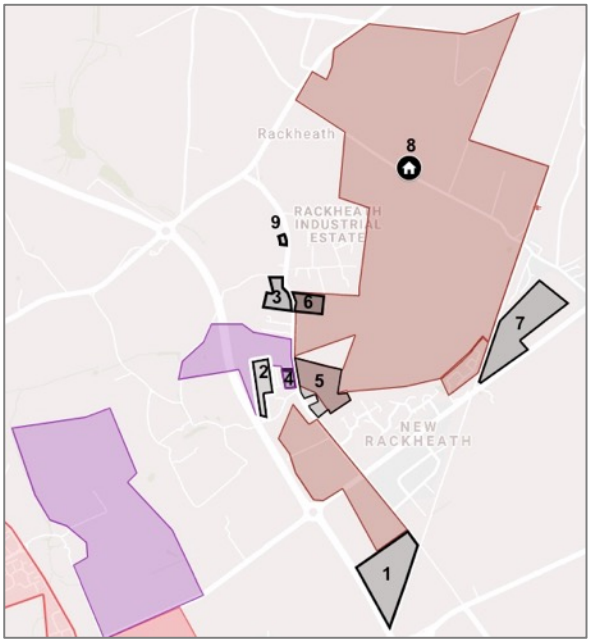


Figure 40: Rackheath proposed Hub – Long List Sites

Ref	Description	Fit	Shortlist
1	Halsbury Homes site Broad Lane	Current planning permission	Yes
2	Mahoney Green	Health use on site, central location	Yes
3	Previous OBC Site Green Lane West	No longer available	No
4	Former Church Mahoney Green	Removed from market	No
5	Building Partnerships Green Ln West	Timing Housing site	No
6	Adjacent to industrial estate	No longer available	No
7	East of Salhouse Road	Infrastructure problems	No
8	North of Rackheath Muck Lane	Masterplan site, Timing	No
9	Rackheath Village Hall/sports park	Too small.	No

Short Listed Options

Five options are shortlisted. In addition to the two new development options, a 'Business as Usual' option where no investment is made and a 'Do Minimum' option that involves the least additional

investment. Option 3 has an additional variation, in that the landowner has a developer lined up able to deliver a turn-key solution should that be required.

Option 1	**Business As Usual**	Making no investment and leaving existing resources in place to meet the demand.
Option 2	**Do minimum**	Sprowston (expansion) Expanding the existing facility at Aslake Close, Sprowston to meet some of the demand.
Option 3a	**New Build Broad Lane "turnkey"**	A new facility on the Halsbury Homes site on Broad Lane developed by the landlord's partner Medical Centres using £1.5m NHS Capital to meet all the anticipated demand.
Option 3b	**New build: Broad Lane Site Only**	A new facility on the Halsbury Homes site on Broad Lane to meet all the anticipated demand. Developed by a 3rd party using £5m of the available NHS capital
Option 4	**New build: Mahoney Green**	Develop a new facility on the Mahoney Green site to meet all the anticipated demand.

OPTION 1: Business as Usual

Description: This option would see no new investment, leaving the patients in Rackheath to travel to Sprowston, Wroxham or Thorpe to access GP Services. It is estimated that existing capacity at these sites will be taken up with the registration demand from the Growth Triangle within 7 years. Not all patients would find it easy to travel further to access services.

Figure 41: Hoveton and Wroxham Medical Practice

Designs: Not Applicable

SWOT Analysis

Strengths

This option involves no immediate cost to the NHS.

Weaknesses

The existing capacity at Sprowston, Thorpe and Wroxham equate to around 7,300 registrations. Registration demand from all the sites across the Growth Triangle is expected to total around 1,000 per annum. This suggests even if we ignore growth from outside of the triangle and the inconvenience to patients who would have to travel for a service, current capacity will be used up in about 7 years. Wroxham and Thorpe practices will face additional registration demand from outside the Growth Triangle reducing that period to perhaps just 5 years.

Leaving the situation "as is" may also compromise PCN development, meaning the local population would not have the full benefit from the services provided under the Additional Roles

Reimbursement Scheme. The requirement for capacity to house these additional roles may mean that existing capacity comes under pressure earlier than the estimated 7 years.

Opportunities

This option does not preclude negotiations to secure Section 106 developer contribution to offset the cost of provision at a later point.

Threats

The Wave 4b capital and current site on Broad Lane would be lost.

Programme: Not applicable to this option.

Benefits: This option will not deliver any of the benefits identified in the Realisation Plan of the Programme Business Case.

OPTION 2: Do Minimum (Sprowston – expansion)

Description: This would see a moderate expansion of the East Norwich Medical Practice facility in Sprowston to provide five new clinical rooms and improve the internal layout. This scheme has already been identified as a preferred option in the Wave 4b Programme for the Norwich Locality on the assumption a scheme would also come forwards in Rackheath.

Figure 42: East Norwich Medical Partnership, Sprowston

Designs: Proposals on the ground floor of the existing building would see reconfiguration of the reception, waiting and entrance areas. In addition, there would be the provision of fully compliant WC facilities as well as clean and dirty utility rooms to both existing clinical areas.

To the rear a new single-storey extension would provide four new fully compliant clinical rooms, clean and dirty utility rooms on the ground floor and one Treatment 'plus' room. The improvements to the waiting areas will ensure the current void areas are fully utilised and that staff have good observation of both these areas and access to the first floor.

On the first floor, moderate alterations will allow future vertical expansion if required.

Externally, redesign of the parking area could create an additional 10-15 parking spaces.

The existing Pharmacy, Mental Health and Community areas within the building will not be altered.

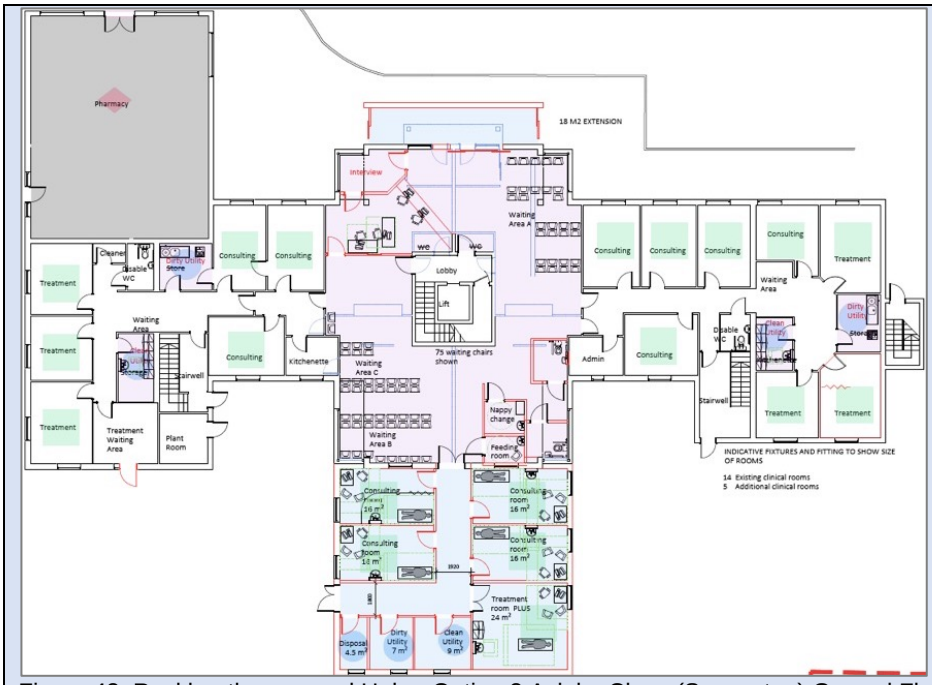


Figure 43: Rackheath proposed Hub – Option 2 Aslake Close (Sprowston) Ground Floor

SWOT Analysis

Strengths

The proposal enables the current facility to be fully utilised. This would enable the multi-agency hub to offer a wider range of services including PCN ARRS appointments, in addition to creating capacity for further registrations. As a group practice, East Norwich Medical Partnership have been able to recruit and retain staff from all disciplines. With two sites the practice is able to realise economies of scale in back-office staffing, releasing administration rooms for digital initiatives. Their landlord (PHP) has indicated a willingness to support and part fund improvements to the building.

Weaknesses

The additional 145m^2 of floor space proposed will not generate sufficient capacity to meet all the demand proposed in the growth triangle. Consequently, an additional new build facility is likely to be required within 5 years of completion. As a refurbishment and extension, it may not achieve environmental targets. Sprowston will not be easily accessible for all residents of the new housing developments proposed north of Rackheath.

Opportunities

The Landlord PHP is happy to fund at least 34% of the development costs, enabling the scheme to progress as a Premises Improvement. The offsetting of costs with the available NHS Capital would lead to a reduced rent over an extended period. The range of services within the building and in neighbouring buildings, including the Community Hub, can facilitate further integration of health and social care services. The surgery can use its other site to ease pressure on services during the refurbishment and extension.

Threats

It is likely that planners will require more than 15 new parking spaces to support the proposed 4,500 additional registrations, and options on site are limited. There would be significant disruption to services during the construction.

Programme

- Once identified as the preferred option, formal agreement can be quickly reached with the Landlord.

- Planning permission would be gained as part of the combined OBC/FBC for the scheme expected to be submitted Q4 2022.
- Start on site is expected Q1 2023 with a 10-month construction period.
- Completion Q1 2024
- Operational Q1 2024

Benefits

The proposals enable the realisation of a number of the identified benefits expected to follow from Wave 4b capital funding, specifically

- Enabling transformational care
- Primary Care Led
- Supporting demand management initiative
- Extended range of community services
- Spaces for public health
- Promoting multidisciplinary care
- Digital initiatives
- Improved mental health care
- Broad skill mix
- Improved recruitment and retention
- Increased capacity
- Improved utilisation of the estate.

OPTION 3a: New Build Broad Lane "turnkey"

Description: This option would see a partial two storey, new facility, sized to meet all the planned demand arising in the Wroxham Road to Plumstead Road corridor, on a site with a current planning permission. It will integrate under one roof, a GP Practice, community services from Norfolk Community Health & Care Trust and Maternity services from the Norfolk and Norwich Hospital Trust. Option 3a would see the development completed by the landowner and developer Medical Centres.

Designs

The design would see services divided over a partial two storey building with joint reception and waiting areas.

It would be fully compliant with latest NHS guidance and aim to achieve a BREEAM Excellent rating and zero carbon targets.

All patient facing services would be on the ground floor.

All staff, training and digital resources would be shared.

Clinical rooms earmarked for future growth would be bookable by tenants

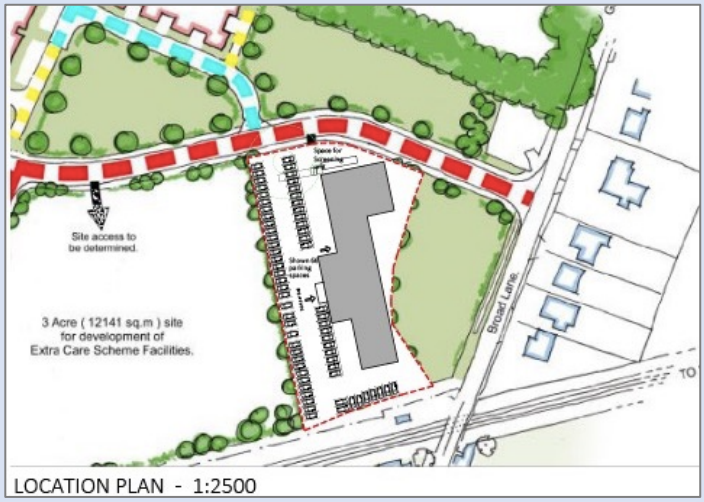


Figure 44: Rackheath proposed Hub – Option 3 Site Plan

and related health and social care providers in the area.

Clinical rooms in each providers' domain would be unallocated and multi-functional to achieve the best utilisation.

A Changing Places facility would be included on the ground floor providing a resource for the local community in addition to hub users.

The facility is designed to be in use 365 days per year and out of hours.

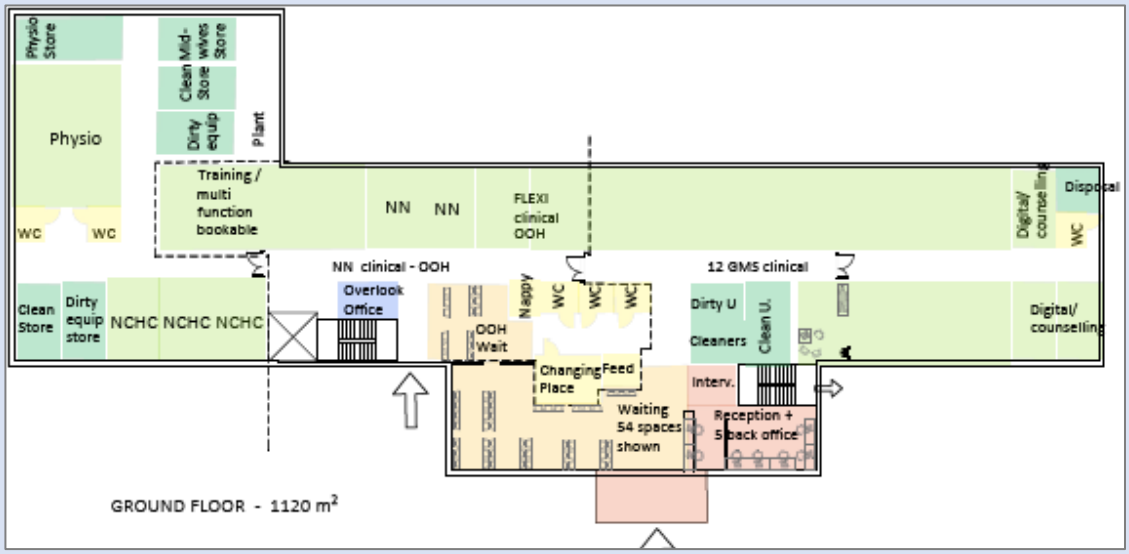


Figure 45: Rackheath proposed Hub – Option 3 Proposed Ground floor plan

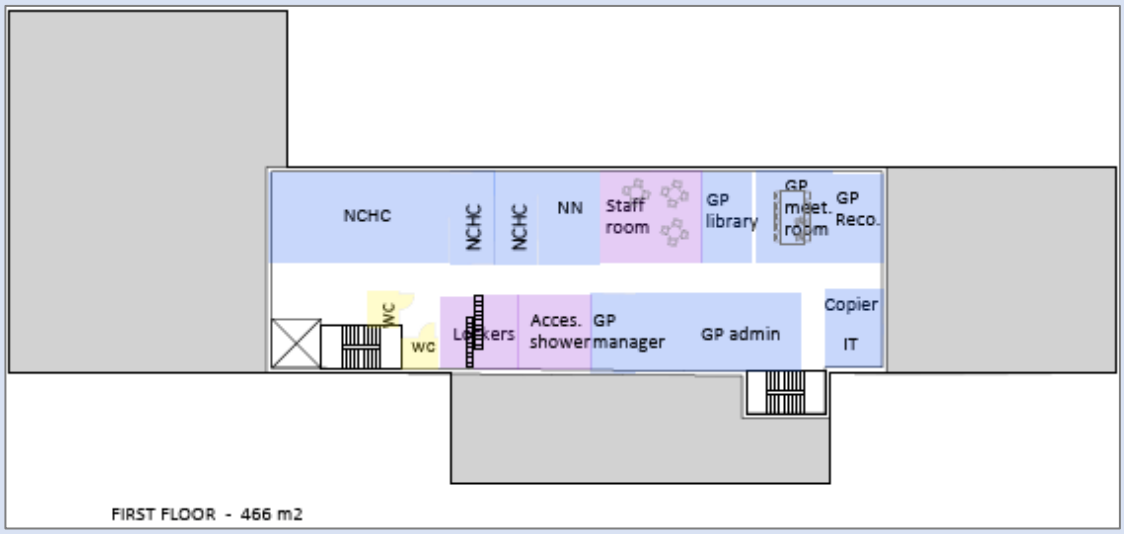


Figure 46: Rackheath proposed Hub – Option 3 Proposed First floor plan

SWOT Analysis

Strengths

The site is large enough, well situated and has the benefit of a current planning permission. It is close to the current village, the existing pharmacy and bus stops.

The building would be fully compliant, sized to accommodate the expected growth and meet the highest environmental credentials. It would facilitate the required benefits identified in the Programme Business Case.

Weaknesses

Progressing the health facility before the main housing sites are developed at Rackheath North may lose the opportunity for developer contributions.

Opportunities

The site and design would allow future vertical or horizontal expansion if required. The proposals will not impede continued discussions with Planning Authorities and developers for future additional provision elsewhere in the growth area if required.

The landlord has suggested they would endeavour to co-locate a pharmacy to help offset costs (this would be subject to a pharmacy licence being granted or a minor relocation of the existing pharmacy).

Threats

Option 3a: The landowner has a developer already identified for the scheme and only wishes to utilise a maximum of £1.5m of the £5m NHS Capital available. This could increase the revenue liability of the scheme (see financial analysis below).

If this prevents the scheme proceeding, on the basis of affordability, the landowner will consider an outright purchase of the site for the NHS to develop. This is summarised below as Option 3b.

Programme: Planning permission would be gained as part of the combined OBC/FBC's for the schemes expected to be submitted Q4 2022

- Start on site is expected Q2 with a 15-month construction period.
- Completion Q2 2024
- Operational Q2 2024

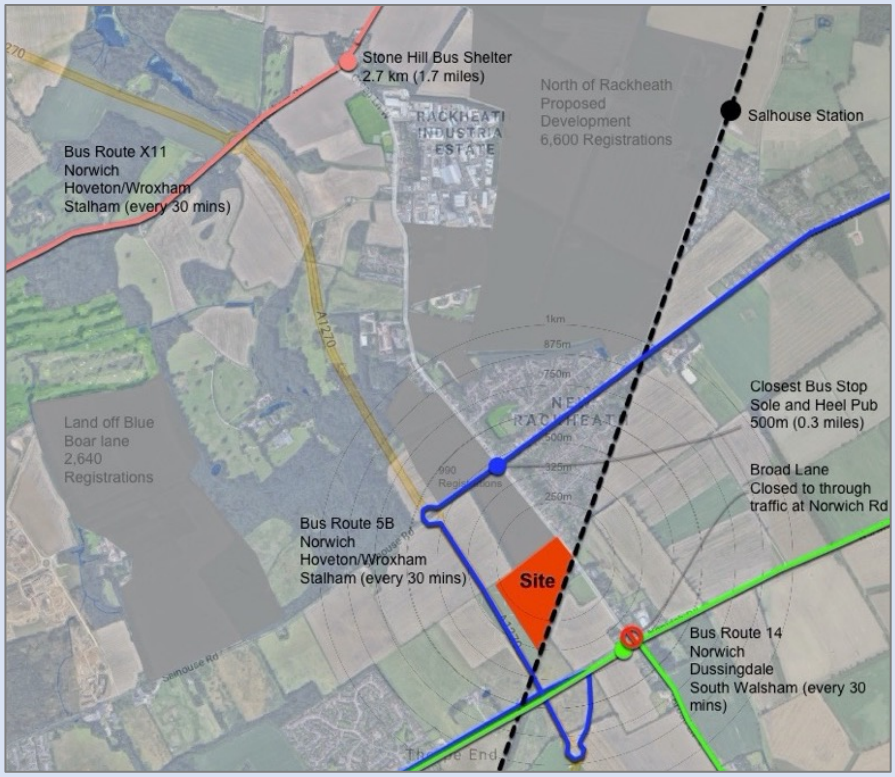


Figure 47: Rackheath proposed Hub – Option 3 Public Transport Routes

Benefits

The proposals enable the realisation of a number of the identified benefits expected to follow from Wave 4b capital funding, specifically

- Enabling transformational care

- Primary Care Led
- Supporting demand management initiative
- Incorporating acute services
- Extended range of community services
- Spaces for public health
- Promoting multidisciplinary care
- Digital initiatives
- Improved mental health care
- Broad skill mix
- Improved recruitment and retention
- Increased capacity
- Improved utilisation of the estate.

OPTION 3b: New Build Broad Lane Site Only

Description: This option would exactly match Option 3a, but, via NHS Property Services, the NHS would proceed with site purchase only**.**

Figure 48: Rackheath proposed Hub – Option 3a and 3b Wider Site Plan

Designs: Would match those already described in Options 3a.

SWOT Analysis: The relative benefits of each site would be the same as identified for Options 3a, apart from any that would have been outside of the NHS funded elements.

The principal difference would be the ability to gain the largest advantage from the utilisation of the full £5m of NHS capital that is available to reduce the ongoing costs of the facility to the NHS.

Programme

- Planning permission would be gained as part of the combined OBC/FBC's for the schemes expected to be submitted Q4 2022
- Start on site is expected Q2 2023 with a 36-week construction period (NHSPS proposed solution of 2-stage approach using a nationally approved modular contractor).
- Completion Q2 2024
- Operational Q2 2024

As part of the OBC/FBC the programme will be further defined.

Benefits: The non-financial benefits would match those in option 3a. The financial benefits are discussed in the financial assessment below.

OPTION 4: New build Mahoney Green

Description: This option would use the site of a former wartime RAF facility, most recently used as a builder's yard on Mahoney Green.

The building would be fully compliant, sized to accommodate the expected growth and meet the highest environmental credentials. It would facilitate the required benefits identified in the Programme Business Case.

Designs

The design would be the same and have the same benefits as Option 3. The layout is mirrored to fit this site better.

A partial two storey building, with all patient facing services on the ground floor with a joint reception and waiting areas.

It would be fully compliant with latest NHS guidance and aim to achieve a BREEAM Excellent rating and zero carbon targets.

All Staff, training and digital resources would be shared.

Clinical rooms earmarked for future growth would be bookable by tenants and related health and social care providers in the area.

Clinical rooms in each providers' domain would be unallocated and multi-functional to achieve the best utilisation.

A Changing Places facility would be included on the ground floor providing a resource for the local community in addition to hub users.

The facility is designed to be in use 365 days per year and out of hours.

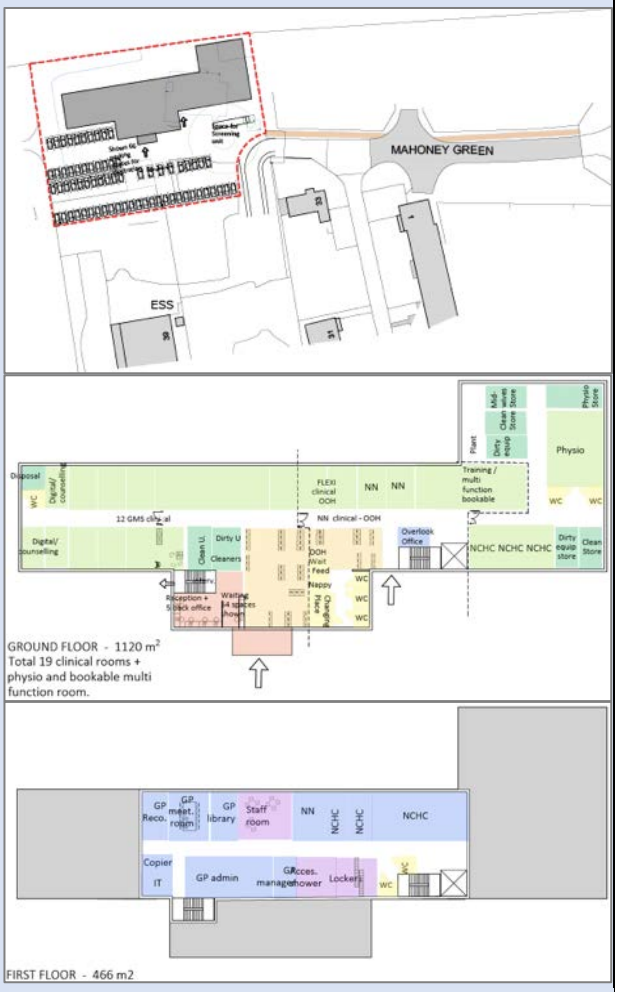


Figure 49: Rackheath proposed Hub – Option 4 Site and Floor Plans

SWOT Analysis

Strengths

The site is large enough, close to the original branch surgery and village hall.

The building would be fully compliant, sized to accommodate the expected growth and meet the highest environmental credentials. It would facilitate the required benefits identified in the Programme Business Case.

Weaknesses

Progressing the health facility before the main housing sites are developed at Rackheath North may lose the opportunity for developer contributions.

Opportunities

The landowner is a pharmacist who also runs the town's pharmacy, and he would explore bringing a pharmacy to site. Additionally, the landowner has indicated having had discussions with a private dental practice and podiatrist. These elements would be separate to the Business Case and cannot be guaranteed, although they could be incorporated into the overall design as independent commercial ventures. The site and design would allow future vertical or horizontal expansion if required as a larger area is in the landowner's demise. The proposals will not impede continued discussions with Planning Authorities and developers for future additional provision elsewhere in the growth area if required.

Threats

The landowner would like to own and lease the building back to the NHS but when offered the opportunity to provide high level costs to deliver a turnkey solution was only able to provide a price for a building shell for NHS fit out. As a consequence, we are not able to consider that as an option. He would be prepared to sell the site at a premium cost of £1m if the NHS wished to develop the scheme through an alternate route.

Programme

- Once identified as the Preferred Option, further discussions would be held with the landlord to negotiate purchase of the site.
- A developer would be identified, and planning permission would be gained as part of the combined OBC/FBC's for the schemes expected to be submitted Q4 2022.
- Start on site is expected Q2 2023 with a 15-month construction period.
- Completion Q2 2024
- Operational Q2 2024

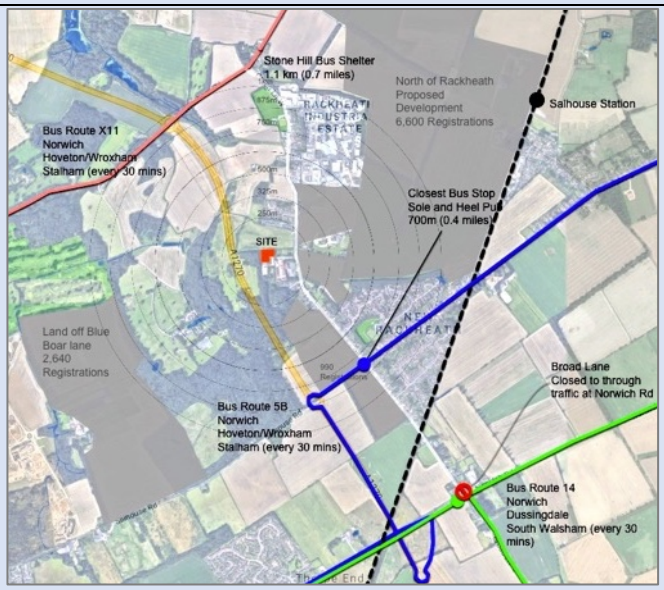


Figure 50: Rackheath proposed Hub – Option 4 Public Transport Routes

Benefits

- Enabling transformational care
- Primary Care Led
- Supporting demand management initiative
- Incorporating acute services
- Extended range of community services

- Spaces for public health
- Promoting multidisciplinary care
- Digital initiatives
- Improved mental health care
- Broad skill mix
- Improved recruitment and retention
- Increased capacity
- Contributing to environmental targets.

North Norfolk – Rackheath: Financial Appraisal

Capital and Revenue implications have been estimated using the best available information, but actual costs may vary when the schemes finally come to market. The indicative figures were all calculated on the same basis to allow comparison at the Options Appraisal event.

Capital Costs

The following outlines the estimated capital costs of each option, with a split of source of capital. Additional contingency of 21% has been added to options 3a to 4. The contingency is to provide further mitigation against current market conditions.

		Capital Requirement							Funding Source	
Project Name	GIA	Land	Construction	Fees	Optimisum Bias	Contingency	IT	Total Capital	Wave 4b Capital	3PD Capital
	m2	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Option 1 - BAU		-	-	-	-	-	-	-	-	-
Option 2 - Do Minimum (Expansion at Aslake Close)	145	-	1,181	159	402	244	157	2,143	1,551	592
Option 3a - Broad Lane Halsbury Homes	1586	-	5,700	480	1,854	1,698	466	10,198	1,966	8,232
Option 3b - Broad Lane Site (NHSPS)	1586	250	4,775	573	1,609	1,470	466	9,143	9,143	-
Option 4 - Mahoney Green Site (NHSPS)	1586	####	5,222	677	1,770	1,620	466	10,755	10,755	-

Recurrent Revenue Costs

Estimated recurrent costs for each option with estimated liability of where costs will need to be met.

	Increase in recurrent revenue costs						Funding Source	
Project Name	Rent	Rates	Water	Clinical Waste	IT	Total	CCG	NHS Trust
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Option 1 - BAU	-	-	-	-	-	-	-	-
Option 2 - Do Minimum (Expansion at Aslake Close)	40	17	1	1	3	62	62	-
Option 3a - Broad Lane Halsbury Homes	283	50	5	5	104	447	281	166
Option 3b - Broad Lane Site (NHSPS)	-	50	5	5	104	164	103	61
Option 4 - Mahoney Green Site (NHSPS)	-	50	5	5	104	164	103	61

Assumptions:

- Abated rent increase based on estimated cost once STP funding applied.
- For Option 3a the amount of capital offsetting the rent is only £1.5m (Ex VAT) at request of the developer.
- For the new build Option 3b and 4 an assumption is made that Wave 4b allocation fully funds the build and therefore no rent will be due on the premises.
- For the extension in Option 2 it is assumed that the existing GP landlord contributes 34% of capital. An additional contingency has been added to the CCG liability.
- Estimated additional IT revenue costs based on additional IT workstations needed.

- Excludes operational expenses, electric, etc.

Non-Recurrent Revenue

Estimated non-recurrent revenue consequences for each scheme:

	Non Recurrent Revenue		
Project Name	SDLT	Proj Mgmt	Total NR Revenue
Scheme	£k	£k	£k
Option 1 - BAU			-
Option 2 -Do Minimum (Expansion at Aslake Close Surgery)			
Option 3a - Broad Lane Halsbury Homes	70	40	110
Option 3b - Broad Lane Site/Norlife calc rent	97	40	137
Option 4 - Mahoney Green Site/Norlife calc rent	126	40	166

Assumptions:

- SDLT based on full value of annual rental, not the abated rent.
- Additional project management needed from the ICS, if no existing capacity.

Option 2 generates the best cost/benefit ratio, however, this option is also considered as a separate investment against the North Norfolk Growth Triangle and it was discounted by the panel as a single investment. The next best cost/benefit ratio are Options 3b and 4.

The NPSV of the Options was fed into the Option Appraisal Process.

Preferred Option

After having considered the designs, SWOT analysis, indicative programme and benefits realised, Option 3b had received the highest rankings.

Preferred Way Forward: North Norfolk – Rackheath

Option 3b: New build – Broad Lane Site Only

A new facility on the Halsbury Homes site on Broad Lane to meet all the anticipated demand. Developed by NHS Property Services using £5m of the available NHS capital was consequently agreed as the preferred way forwards.

Preferred Option – Detailed Costing and Benefits

Capital

The overall capital cost for the preferred option is £9.14m which will be fully funded from the Wave 4b allocation. The capital costs identified here are based on estimated costs but includes significant contingency, a robust tender process will be undertaken at FBC stage.

Recurrent Revenue

The estimated recurrent revenue implications of the preferred option is an annual increase in revenue costs of £164k per annum across all tenants. This is split by tenant as follows: Primary Care (CCG Reimbursable) £103k, NCHC £49k and NNUH £12k.

Non-Recurrent Revenue

The estimated cost of non-recurrent revenue funding needed is £137k which consists of £97k for SDLT and £40k for project management.

Benefits

The results of the economic appraisal to 2073 are summarised below:

	Option 0 - Business as Usual	Option 1 - Aslake - Single Storey extension and refurb	Option 2 - New Build - Broad Lane/Halsbury Homes	Option 3 - New Build - Broad Lane/3PD Full Capital offset	Option 4 - New Build - Mahony Green/3PD Full Capital offset
Incremental costs - total	£0.00	-£3,053	-£20,094	-£13,512	-£14,340
Incremental benefits - total	£0.00	£13,608	£63,723	£63,723	£63,723
Risk-adjusted Net Present Social Value	£0.00	£10,555	£43,629	£50,211	£49,384
Benefit-cost ratio		4.46	3.17	4.72	4.44

Option 3 has the best Cost to Benefit ratio (4.72) of the options being reviewed once the costs and benefits are discounted over the lifetime of each option.

Detailed Design and Planning Commentary

The preferred way forwards for will see a new purpose-built facility with a combined net internal area of 1,586m^2 constructed alongside an extra care facility off Broad Lane. The land already has the benefit of an outline planning permission.

The site sits close to the existing village centre and is about 500m from current bus stops.

There will be 66 parking spaces some providing charging points. In addition to dedicated disabled drop off points near the building there is an ambulance parking bay with charging point.

Close to the building is a mobile unit hard standing and electrical hook up point for mobile diagnostic units.

Figure 51: Rackheath proposed Hub – Site Plan in Context

Figure 52: Rackheath proposed Hub – Preferred Option Ground Floor Plan

All clinical services will be located on the ground floor. A shared reception and interview room overlooks the single waiting area and WC facilities, nappy change and dedicated feeding rooms. In addition, there is a changing places facility.

There is staff access to the first floor from two stair cores and a lift.

In a wing that can be locked out of hours is the GP provision of 10 Consultation/Examination and 2 Treatment rooms, 3 Digital consultation rooms, plus supporting utility areas. This includes provision for trainee placements from within the PCN. Initial utilisation will be boosted by the location of PCN ARRS staff within the facility. All rooms will be bookable by PCN member practices ensuring flexible utilisation whilst the list builds up.

Utilising part of the waiting area are a suite of rooms that can be open 24/7 for maternity outpatient facilities and a bookable training and education room that can be utilised by any health and social care partner.

The maternity facility includes 4 consultation and examination rooms. This wing also includes stores accessible 24/7 for peripatetic staff including midwives supporting home births. The adjacent clinical area that can also be locked out of hours, provides rooms for Community Nursing and Therapy. The area includes three clinic rooms and a large multifunction room alongside an MSK Physiotherapy area.

The NHS will want to encourage use of the site by the local community out of hours and the design of the building will take into account the need for multifunctional rooms in an area of the building where access will be possible.

Figure 53: Rackheath proposed Hub – Preferred Option First Floor Plan

The partial first floor allows for future vertical expansion and the lift would allow clinical services to be delivered on the first floor if desired. At present only staff and meeting resources are included upstairs. All staff rooms, changing and WC provision are shared. There are dedicated office areas for the three departments (GMS, Community, Maternity). There is a bookable and digitally enabled, meeting/Multi-Disciplinary Team rooms. These rooms will also be bookable by the PCN to support training and MDT meetings.

4.11.11 Proposed Scheme: Norwich, Sprowston

Scope

This proposal is seeking to refurbish and extend an existing integrated service Hub in Sprowston. It includes GP services from the East Norwich Medical Practice, community mental health services from Cambridge & Peterborough NHS Foundation Trust and a commercial pharmacy. It will support a wider range of wrap around services including staff employed under the PCN's Additional Role Reimbursement Scheme (ARRS). The scheme is one of two proposed to address demand from the Norwich Growth Triangle, the second at Rackheath will be a new build facility.

There are four 'neighbourhoods' in the Norwich PCN which cover the urban area of Norwich the largest population centre in the Norfolk and Waveney ICS area – see map below.

Figure 54: Sprowston proposed Hub – location

The area is covered by the Norwich City Council and is part of the Greater Norwich Development partnership.

The location of the proposed scheme is shown by a red dot and the growth triangle in blue.

Current Situation

The Growth Triangle is an area to the north of Norwich that has been identified to take a large share of the city's growth over the next 15-20 years. Significant housing will be developed through a series of strategic urban extensions. The two largest proposals are located north of Sprowston at Beeston Park and north of the small settlement of Rackheath. Development is already underway on some of the smaller sites in Norwich and Rackheath.

There are currently three primary care facilities close to the proposed development. Marked on the map with green and red dots on Figure 52.

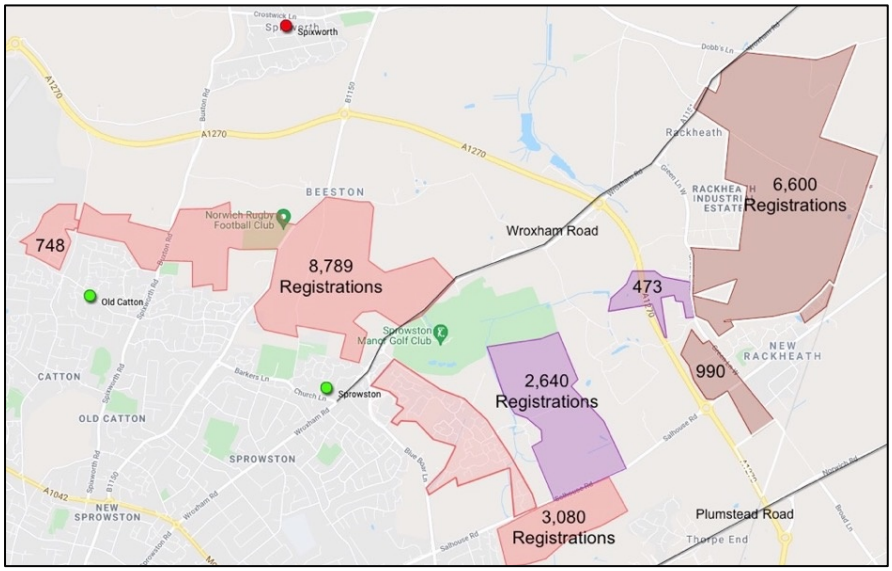


Figure 55: Norwich Growth Triangle showing Registration Demand

This section considers the best approach to meeting that demand, testing the original proposals submitted in the bid for Wave 4b funding that looked to develop two new facilities in the Growth Triangle to ensure they best meet the objectives of the programme.

Since the bid was submitted the CCG commissioned a primary care premises capacity planning exercise to ensure its proposals were robust. That information has suggested a mixed approach seeking to ensure full utilisation of existing capacity alongside investing in new facilities might be considered. Please see Section 3.12 for details of the actual registered list sizes for the PCNs where the proposed Primary Care Hubs will be based, and the anticipated and assumed growth per site arising from housing.

The proposed Primary Care Hub will be in the East Norwich Neighbourhood. The scheme name is Sprowston and its approximate proposed location is indicated on the map below by a red circle.

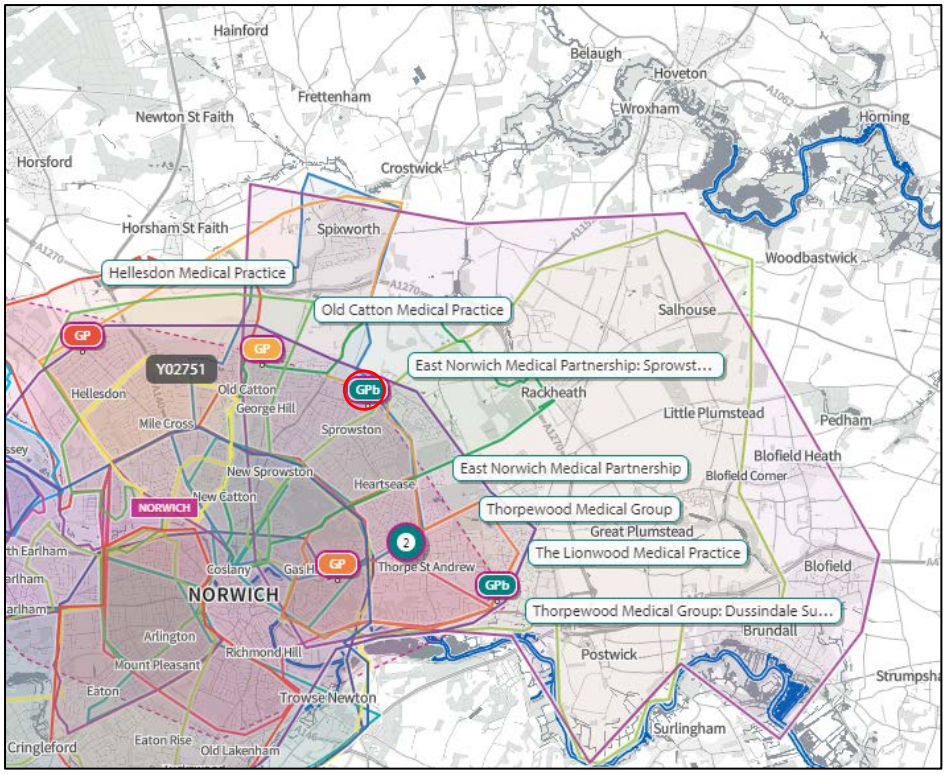


Figure 56: East Norwich Neighbourhood Primary Care Network

East Norwich Medical Practice (ENMP) Sprowston

Figure 57: East Norwich Medical Practice Aslake Close (Sprowston) premises and location

This modern, purpose-built, leased facility originally hosted two practices but is now utilised by a single provider. GMS are delivered alongside mental health, community and learning disability services. At 981m² net internal area (NIA), the GP facility currently serves a registered population of around 11,200. A recent survey of the facility shows that its configuration for two practices leaves several areas void and the building is problematic for use by a single provider: for example, unobserved access to clinical areas. Whilst there is a lift, there are currently no clinical services on the first floor and some admin rooms are unused. Car parking areas surround the building and there is the potential to extend the existing building to the rear and create clinical areas to the first floor.

Figure 58: East Norwich Medical Practice Aslake Close (Sprowston) Ground Floor

Old Catton Medical Practice

Figure 59: Old Catton Medical Practice Location

The Old Catton Practice is a purpose build, older GP owned facility that has been extended in recent years. With a net internal area of 435m^2 it has limited capacity. The facility has a partial second storey for administrative teams, there is no lift. Parking is adequate, there are no additional services on site.

Figure 60: Old Catton Surgery Floor Plan

Spixworth Branch Surgery

Spixworth is a small branch surgery of the Coltishall Practice and is on a very constrained plot with only limited parking. At only 93m^2 NIA it is already constrained with limited registration capacity. They are members of the North Norfolk 3 (NN3) PCN.

Figure 61: Spixworth Surgery

Other Primary Care Proposals in the Growth Area

Rackheath

There have been several proposals to replace a branch surgery that closed a few years ago in Rackheath. This included an unsuccessful Outline Business Case submitted in 2020 on behalf of the Hoveton and Wroxham Medical Centre. The practice has most of the current residents of Rackheath on their lists as they previously ran the part time branch surgery in the village.

In 2021 a planning application by Halsbury Homes was approved which includes a site for a proposed health facility on Broad Lane, Rackheath. This proposal was submitted prospectively by the developer although the CCG were consulted by planners.

Provision in Master Plans

The master plan for the North of Rackheath development included provision for health in the proposed District Centre. This was expected to be in the third and final phase of development. This development is now expected to start on site during 2022 growing at 200 dwellings PA to 3,000 in total. The identified location is currently in open countryside, remote from the current settlement and the housing sites under construction. These are in the strip next to the Halsbury Homes site. Also marked on the plan below are the previous unsuccessful OBC site and the location of the former branch surgery.

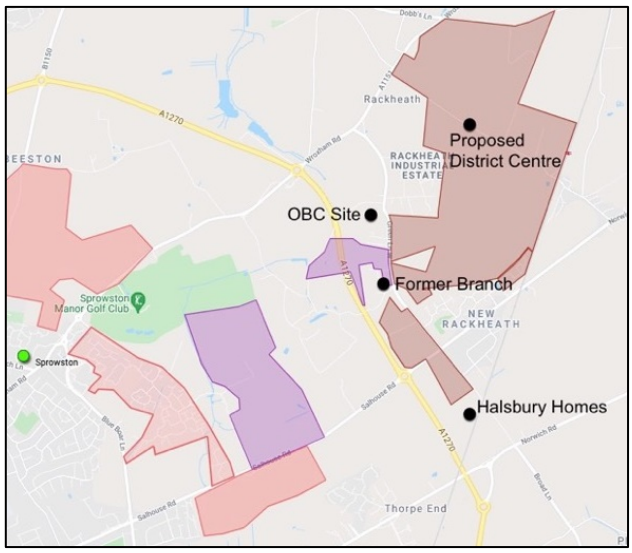


Figure 62: Rackheath proposed Hub – sites

Beeston Park Development

The master plan for the Beeston Park development, that forms the largest housing allocation North of Sprowston, makes provision for up to 2,000m^2 for a range of community uses including health, library, and a community hall.

The Health Impact Assessment plans for this provision in Phase 3 – or year 5/6 from start on site. This was based on the capacity that existed within local practices back in 2012 when it was completed. This development is just in its preparation stages now, so the site identified for health is unlikely to be available until 2027/28 at the earliest.

The health allocation will be triggered after 2,233 dwellings are completed, that level of housing will have generated a demand for 5,000 registrations, which would need to be managed within existing provision in the area.

Neither of the two large sites have a Section 106 or CIL commitment in place to provide for health infrastructure, although there have been discussions between health and planners.

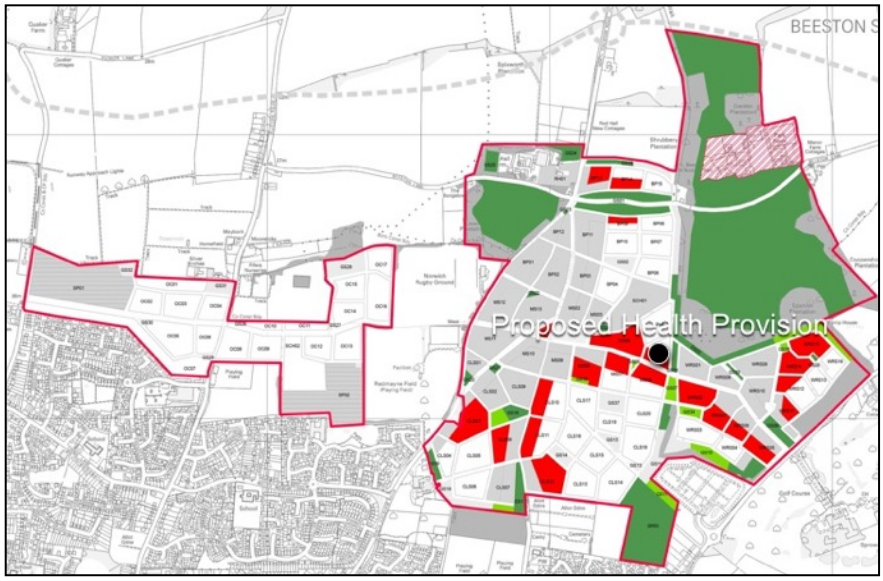


Figure 63: Phase 3 Beeston Park Master Plan

Place Based Care

The East Norwich Medical Partnership, working with its PCN will work with the wider Health Economy providers and local government partners to develop their clinical model which will be detailed in the

FBC. The model will be based on the population health needs of the Growth Triangle population. Some of this information is not known as not all of the housing has been planned.

The following breakdown shows the health of the population in the area that the proposed scheme will serve. This can be placed within an overview of population health in the Norwich area:

Population in very bad health 1.2%.

Life expectancy at birth for males (2020 – average number of years) 77.2

Life expectancy at birth for females (2020 – average number of years) 81.7

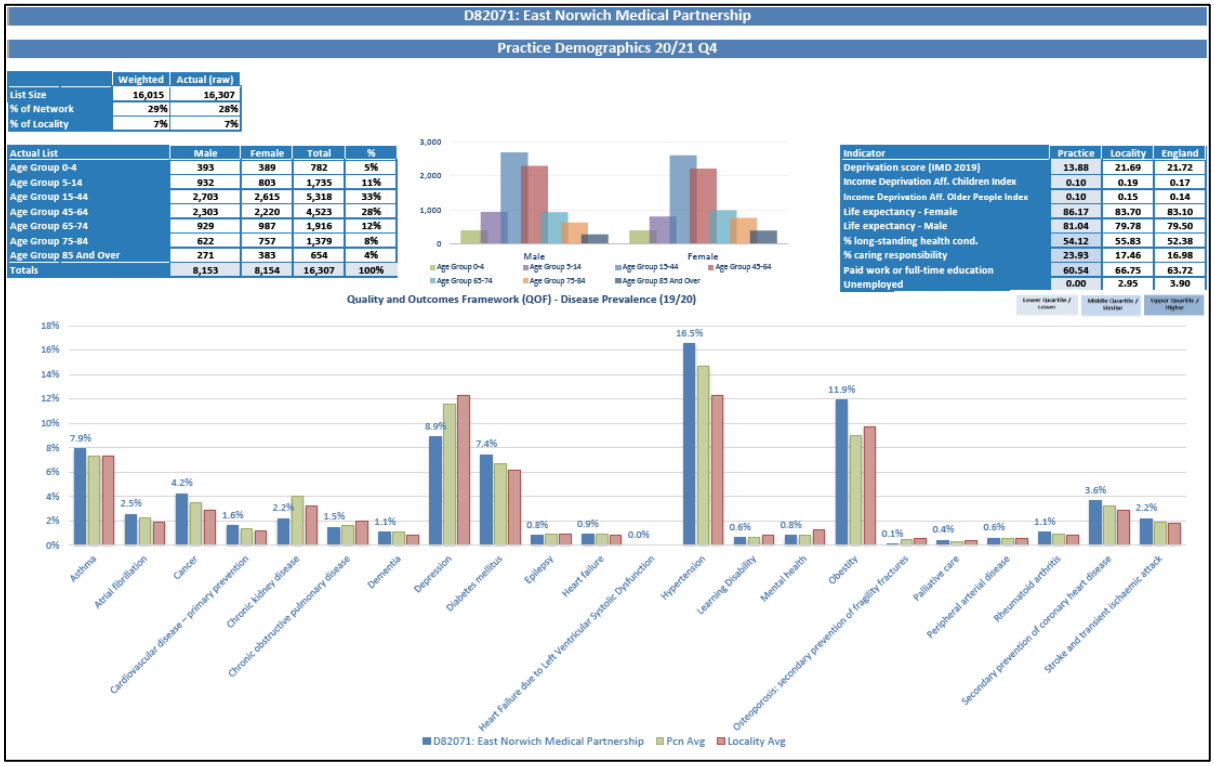


Figure 64: East Norwich Medical Practice – Demography

The diagram above provides a profile a demographic profile of the practices current list. The deprivation indices indicate the area is less deprived than the wider locality in Norwich and England as a whole with commensurate higher life expectancies. The population is on average older than that of the England which may go some way to explaining the diseases whose prevalence is higher in the Practice population. They are an outlier in respect of obesity and hypertension and to a lesser extent Diabetes. All of these suggest lifestyle and public health messaging will be a focus for the hub. There are a number of PCN ARRS roles that will assist in addressing these needs.

The practices referral rates for all disciplines are lower than PCN and CCG averages suggesting they are effective at managing long-term conditions locally.

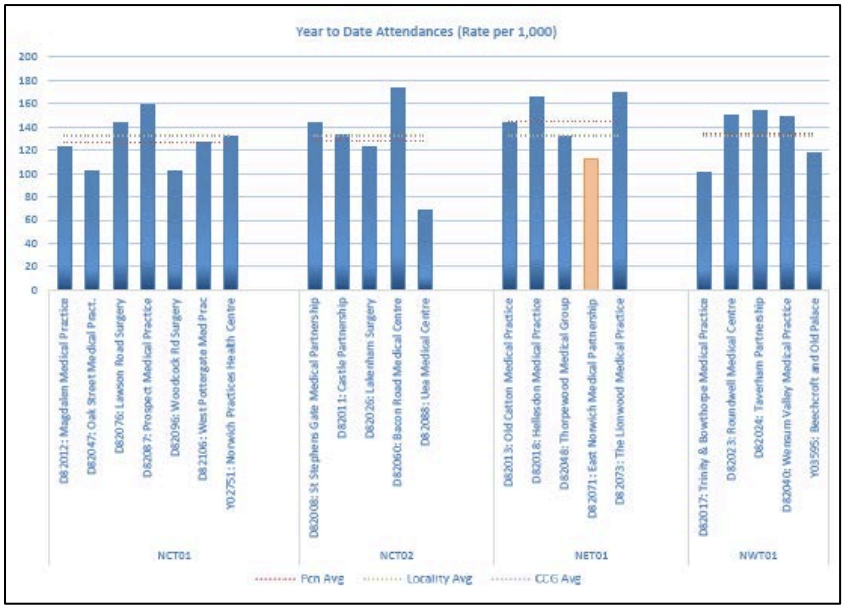


Figure 65: East Norwich Medical Practice – Year to date acute attendances

The only area where the PCN are an outlier is the pathology testing rate which may be in support of managing patients out of hospital care. The practice's patients are also less likely to attend A&E than other PCNs in Norwich or across the CCG, with a lower rate of those that do being deemed 'Avoidable Admissions'.

	This Financial Year	Change vs Last Year	% Change	PCN % Change	Locality % Change
Pathology Tests	116,191	-8,277	-6.6%	-16.3%	-15.9%

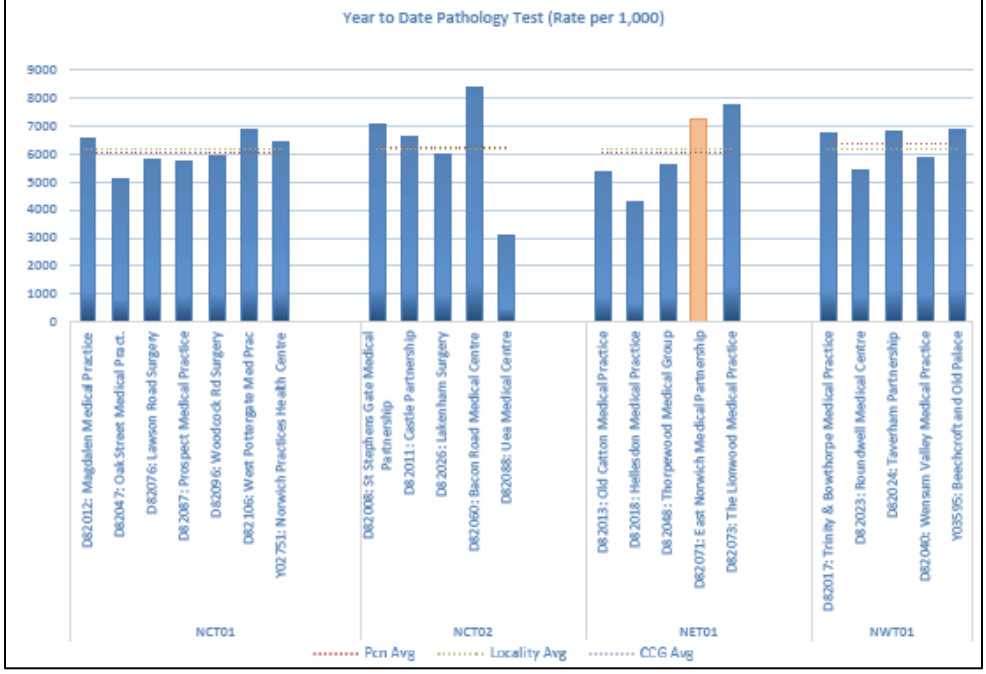


Figure 66: East Norwich Medical Practice – Pathology Testing Rate per 1000 patients

The current clinical model seems to be working well and the PCN will provide an excellent foundation on which to build an expanded service to meet the needs of the Growth Triangle. The provision of additional fully compliant clinical areas will greatly enhance their ability to expand the range of core and wrap around services offered.

A key aim of the Hub programme is to encourage patients and service users to take a greater personal responsibility for their health and wellbeing especially in relation to preventative measures as well as providing better signposting for services. The new health hub will provide education and training to promote preventative care and self-care.

The move to integrating services has already started with Community, Primary Care and Secondary Care services working together. As the PCN develops the clinical model in line with the wider ICS Clinical Strategy, the aim facilitated by the premises improvements will be for wider integration across the teams who will use all the available insights to anticipate and intervene early, to prevent poor heath and avoidable unplanned admissions.

This new facility will allow full health integration and facilitate multi-disciplinary management of long-term conditions as well as working with patients to manage their own condition.

With the use of digital technology and shared resources with local authority colleagues and the third sector, the use of sign posting to ensure both health and social economic issues can be addressed.

Schedule of Accommodation

The schedule of accommodation aims to deliver the service strategy and digital focus, to meet the expected registration demand, satisfy the requirements for the proposed outpatient services and PCN appointments.

The schedule for the GMS element has been developed using standard modelling based on the proposed list size and operational hours.

The schedule has been refined with providers to meet both their requirements and the proposed operational model for the hubs.

The design team have utilised the latest HBN guidance, best practice considering lessons learned during the pandemic and changing consultation patterns.

The proposals at Sprowston will see some improvements made to void areas within the existing building and a single storey extension to provide additional fully compliant clinical rooms.

Refurbishments to the 205m^2 of the existing facility:

- Relocation of reception.
- Remodelling of waiting areas.
- Provision of compliant WC, feeding and changing rooms.

Infection control improvements 29m^2

- Clean and Dirty Utility rooms.

Future proofing

- Minor alteration to the first floor including capped services to facilitate future first floor expansion. 59m^2

Extension

	GP Clinical Areas			
	Consultation	16.0 m²	4	64.0 m²
	Treatment Plus Room	24.0 m²	1	24.0 m²
	Clean Utility Store	9.0 m²	1	9.0 m²
	Dirty Utility	7.0 m²	1	7.0 m²
	Disposals	4.5 m²	1	4.5 m²
	Sub total			**108.5 m²**
	Covered Lobby area with automatic doors			18 m²
	Circulation			33.5 m²
	TOTAL New Build			**160.0 m²**

Short Listed Options

Four options are shortlisted.

Option 1	**Business As Usual**	Making no investment and leaving existing resources in place to meet the demand.
Option 2	**Expansion**	Sprowston (expansion) Expanding the existing facility at Aslake Close, Sprowston to meet all the anticipated demand in the Growth Triangle.
Option 3	**New Build**	Develop a new facility to meet all the anticipated demand.
Option 4	**New Build and Expansion**	Develop a new facility and expand an existing facility that will between them meet the identified growth. *This option brings together this Sprowston scheme and the separate Wave 4b North Norfolk, Rackheath scheme to meet the anticipated demand in the Norwich Growth Triangle i.e.* • *New Build = Rackheath* • *Expansion = Sprowston*

OPTION 1: Business as Usual

Description: This option would make no additional provision and leave the current practices and services neighbouring the proposed development, to meet the registration demand. ENMP Sprowston are in discussions with their landlord to renew their lease and incorporate minor changes to improve functionality. These would be funded by their landlord and the cost recovered through a new lease agreement.

Designs:

Figure 67: Sprowston proposed Hub – Landlords Proposals

SWOT Analysis

Strengths

This option would have no immediate cost to the local health economy and would not require Wave 4b funding. Existing facilities would be better utilised.

Weaknesses

Existing capacity at Sprowston and Old Catton would be used up within three years, after which an alternative solution would still be required. The opportunity for NHS capital would have passed. The current building configuration at Sprowston does not allow them to deliver an optimum service or fully utilise the building. The landlord's proposed improvements to the internal layout are moderate and may still not achieve the full capacity of the building. None of the service benefits and increased integration that is proposed in the Wave 4b bids will be achieved.

Opportunities

This option might allow health and social care to benefit, at a later point, from proposed allocations in the Master Plans for the Growth Triangle, through Section 106 agreements. These are still subject to negotiation.

Threats

The East Norfolk Medical Practice are currently in negotiations with their landlord as a breakpoint in their lease at Sprowston approaches and improvements to the building have yet to be agreed.

Programme: Not applicable to this option.

Benefits: This option will not deliver any of the benefits identified in the Realisation Plan of the Programme Business Case.

OPTION 2: Sprowston – expansion

Description: This option would look to expand existing premises to meet a significant share of the expected increase in demand and deliver the benefits proposed as part of the Wave 4b funding application. Of the three sites near the Growth Area, ENMP at Aslake Close, Sprowston represents the best opportunity for expansion. The proposals would also see internal reconfiguration of the existing premises to enable the whole facility to be fully utilised. To the rear of the existing premises a 290m^2 NIA, two-storey extension would create 10 additional fully compliant clinical rooms.

Figure 68: Sprowston proposed Hub – Option 2 Concept Image

Designs: Proposals on the ground floor of the existing building would see reconfiguration of the reception, waiting and entrance areas. In addition, there would be the provision of fully compliant WC facilities as well as clean and dirty utility rooms to both existing clinical areas.

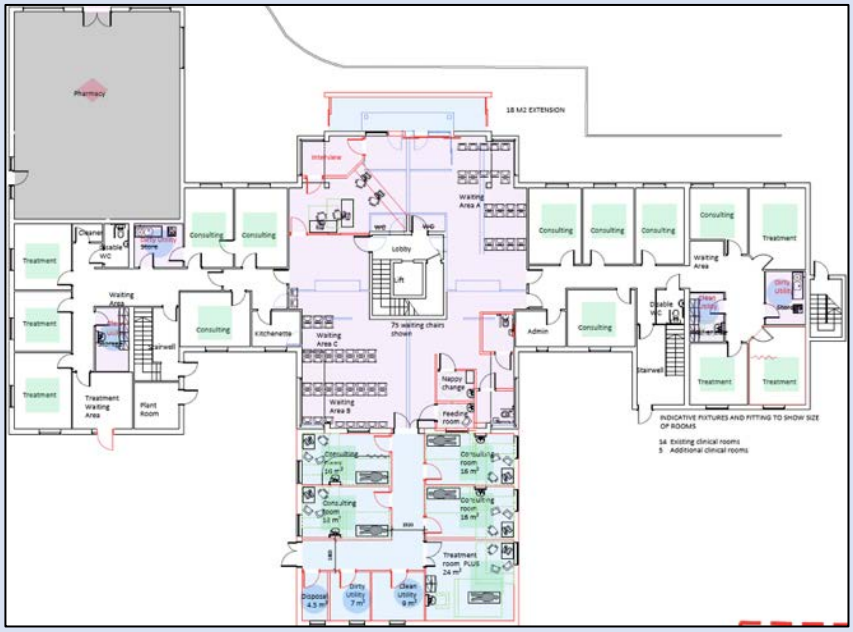
To the rear a new single-storey extension would provide four new fully compliant clinical rooms, clean and dirty utility rooms on the ground floor and one Treatment 'plus' room. The improvements to the waiting areas will ensure the current void areas are fully utilised and that staff have good observation of both these areas and access to the first floor.

On the first floor the proposed alterations to the existing facility will create a sub-waiting area and fully compliant WC facilities. Provision of a staff office will allow supervision of the sub-wait area.

On the first floor of the proposed extension there are a further five fully compliant clinical rooms. One of which could be subdivided to form two digital consultation rooms.

Externally, redesign of the parking area could create an additional 10-15 parking spaces.

The existing Pharmacy, Mental health and Community areas within the building will not be altered.



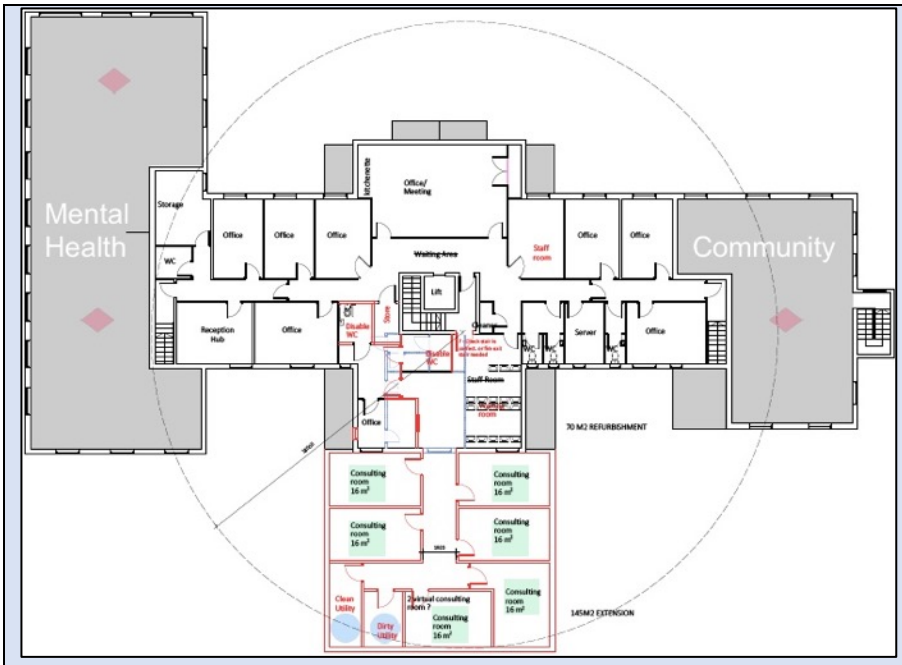


Figure 69: Sprowston proposed Hub – Option 2 Aslake Close Ground and First Floors

SWOT Analysis

Strengths

The proposals enable the current facility to be fully utilised, including provision of clinical services on the first floor via the existing lift. The proposals enable the multi-agency hub to offer a wider range of services including PCN ARRS appointments, in addition to creating capacity for an additional 9,136 registrations. As a group practice, East Norwich Medical Practice have been able to recruit and retain staff from all disciplines. With two sites the practice is able to realise economies of scale in back-office staffing, releasing administration rooms for digital initiatives. Their landlord (PHP) has indicated a willingness to support and part fund improvements to the building.

Weaknesses

The additional 290m^2 proposed will not generate sufficient capacity to meet all the demand proposed in the growth triangle. Consequently, an additional new build facility is likely to be required within 7 years of completion. As a refurbishment and extension, it may not achieve environmental targets.

Opportunities

The Landlord PHP are happy to fund at least 34% of the development costs, enabling the scheme to progress as a Premises Improvement. The offsetting of costs with the available NHS Capital would lead to a reduced rent over an extended period. The range of services within the building and in neighbouring buildings, including the Community Hub, can facilitate further integration of health and social care services. The surgery can use its other site to ease pressure on services during the refurbishment and extension.

Threats

It is likely that planners will require more than 15 new parking spaces to support the proposed 9,000 additional registrations, and options on site are limited. There would be significant disruption to services during the construction.

Programme

Once identified as the preferred option, formal agreement can be quickly reached with the Landlord.

Planning permission would be gained as part of the combined OBC/FBC for the scheme expected to be submitted Q4 2022.

Start on site is expected Q1 2023 with a 10-month construction period.

Completion Q3 2023

Operational Q3 2023

Benefits

The proposals enable the realisation of a number of the identified benefits expected to follow from Wave 4b capital funding, specifically

- Enabling transformational care
- Primary Care Led
- Supporting demand management initiative
- Extended range of community services
- Spaces for public health
- Promoting multidisciplinary care
- Digital initiatives
- Improved mental health care
- Broad skill mix
- Improved recruitment and retention
- Increased capacity
- Improved utilisation of the estate.

OPTION 3: New build

Description: This option would see a single large Hub facility built within the Growth Area to meet all the expected demand. The GP practice would start with a zero list and grow over the next decade to serve a registered population of up to 28,000. It would be fully compliant with the latest guidance and achieve the highest environmental criteria. The facility would offer space for additional wrap around services from other providers and the Primary Care network. The practice area would extend to 1,400m^2 with an additional 485m^2 for Community services and 120m^2 Acute services, in total 2,005m^2.

Of the identified sites in Master Plans the Beeston Park location is best placed to serve all of the Growth Area. The North of Rackheath site is more remote from the most quickly growing areas, north of Norwich and access is hindered by the new northern bypass.

Designs: The final detailed site plans for Beeston Park are not yet available.

The proposed location lies north of the Sprowston Park and Ride, but currently is open farmland.

The proposed allocation of 2,000m^2 (floorspace) will be insufficient for the hub and the other services envisioned in the masterplan. With its associated parking the hub is likely to require a minimum site size of 6,000m2.

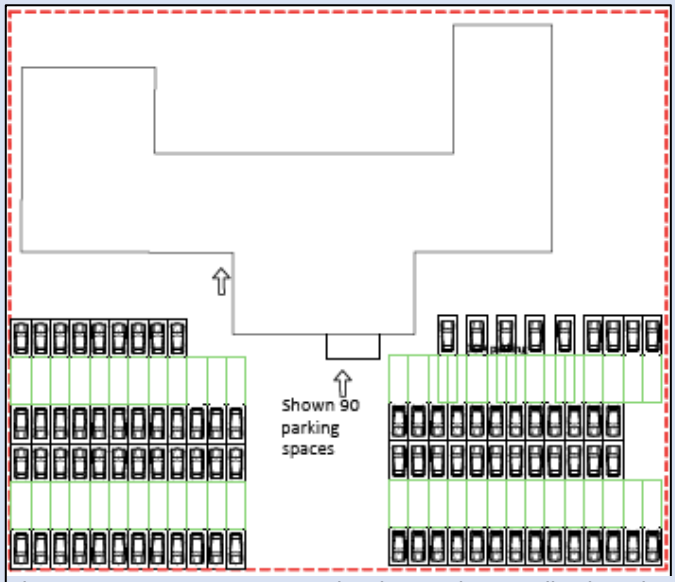


Figure 70: Sprowston proposed Hub – Option 3 Indicative Site Plan

The proposal would see services divided over a partial two storey building with a joint reception and waiting area.

It would be fully compliant with latest NHS Guidance, aim to achieve a BREEAM Excellent rating and respond to Carbon Neutral targets.

All patient facing services would be on the ground floor.

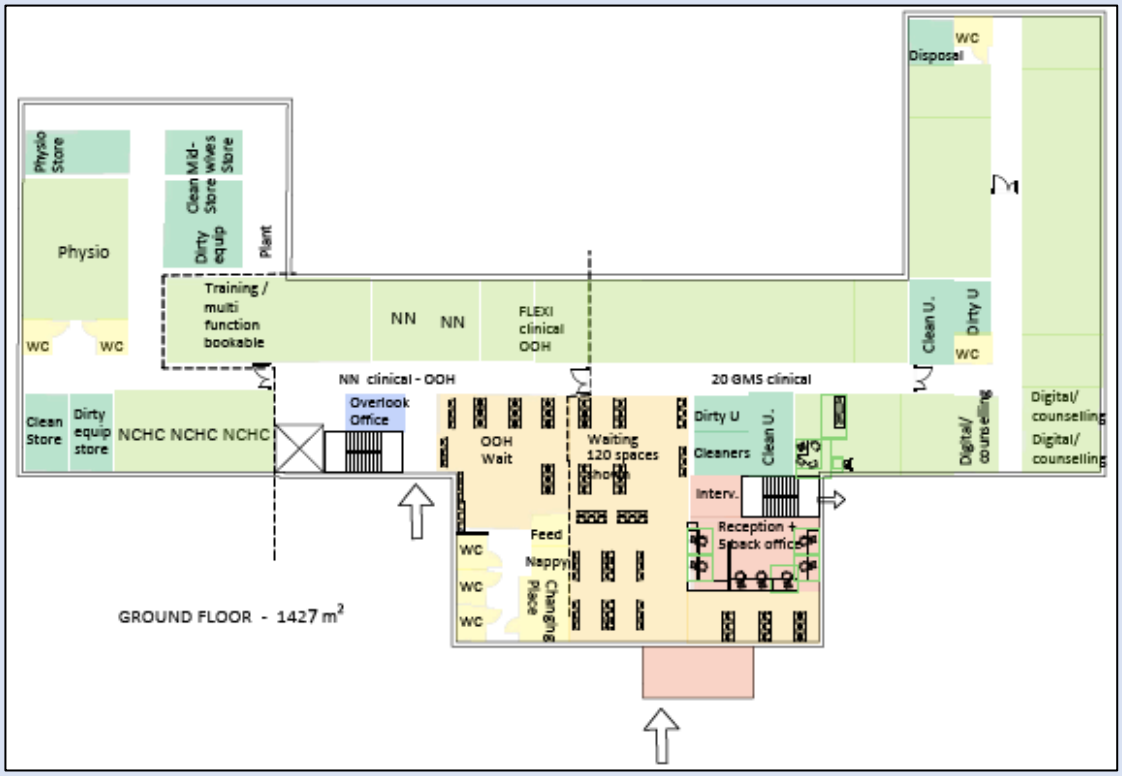


Figure 71: Sprowston proposed Hub – Option 3 Indicative Ground Floor Plans

Staff, training, and digital resources would be shared.

Clinical rooms earmarked for future growth would be bookable by tenants and related health and social care providers in the area.

Clinical rooms in each providers' domain would be unallocated and multi-functional to achieve the best utilisation.

A changing places facility would be included on the ground floor providing a resource for the local community in addition to hub users.

The facility is designed to be in use 365 days per year including out of hours.

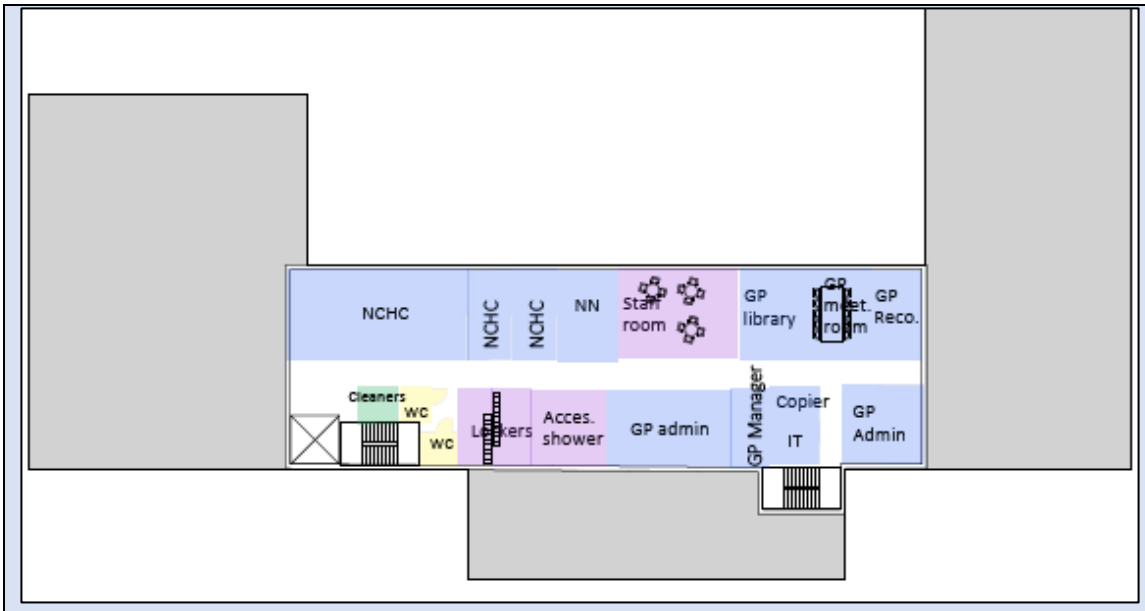


Figure 72: Sprowston proposed Hub – Option 3 Indicative First Floor Plan

SWOT Analysis

Strengths

The building would be fully compliant, sized to meet the expected growth and meet the highest environmental credentials. It would facilitate the required benefits identified in the Programme Business Case.

Weaknesses

The proposed site, its size and phasing, means an alternative location in phase 1 of the development needs to be identified. This will need to be developed ahead of the proposed phase in the housing masterplan when the health facility was promised, which may place into doubt any Section 106 benefits.

Opportunities

Delaying the scheme for a number of years might allow the NHS to benefit from developer contributions to offset the cost of the scheme but this would rule out accessing Wave 4b capital.

Threats

The current proposed phasing of the housing would mean the scheme will not attract Wave 4b funding unless a site can be brought forward more quickly. There is insufficient existing capacity to bridge the gap if the scheme is delayed. As a green field site there is a risk that road and service infrastructure will not be in place in time.

Programme

Once identified as the preferred option further discussions will take place with the Local Planning Authority and Developers to identify and bring forward an alternative site in Phase 1 of the development.

Planning permission would be gained as part of the combined OBC/FBC for the scheme expected to be submitted Q4 2022.

Start on site is expected Q2 2023 with a 15-month construction period.

Completion Q2 2024

Operational Q2 2024

Benefits

The proposals enable the realisation of a number of the identified benefits expected to follow from Wave 4b capital funding, specifically

- Enabling transformational care
- Primary Care Led
- Supporting demand management initiative
- Incorporating acute services
- Extended range of community services
- Spaces for public health
- Promoting multidisciplinary care
- Digital initiatives
- Improved mental health care
- Broad skill mix
- Improved recruitment and retention
- Increased capacity
- Improved utilisation of the estate.

OPTION 4: New build and Expansion

Description: This option would combine a new build in the Rackheath Area with a moderate expansion of the East Norwich Medical Practice (ENMP) Sprowston Facility.

With sites already identified in Rackheath, and practice support in place at Sprowston, this proposal can move forward quickly.

Proposals would see a 145m^2 single storey extension and internal reconfiguration at the ENMP Sprowston facility. This would be constructed to allow a second storey to be added at a future date if required.

At Rackheath a 1,586m^2 partial two storey new build facility will accommodate a branch of the Hoveton and Wroxham practice, community services and acute midwifery.

Designs: Proposals at ENMP Sprowston would match the ground floor plan (Figure 12 in Option 2 above).

Proposals on the existing ground floor would see reconfiguration of the reception, waiting and entrance areas. In the addition to the provision of fully compliant WC facilities, clean and dirty utility rooms to both existing clinical areas.

To the rear a single-story extension would house five new fully compliant clinical rooms including one treatment ‘plus’ room. The improvements to the waiting areas will ensure the current void areas are fully utilised.

On the first floor of the existing building. moderate improvements would be made to enable future access to a vertical extension.

The design for Rackheath would see services divided over a partial two storey building with joint reception and waiting areas.

It would be fully compliant with latest NHS guidance and aim to achieve a BREEAM Excellent rating and zero carbon targets.

All patient facing services would be on the ground floor.

All staff, training and digital resources would be shared.

Clinical rooms earmarked for future growth would be bookable by tenants and related health and social care providers in the area.

Clinical rooms in each providers' domain would be unallocated and multi-functional to achieve the best utilisation.

A changing places facility would be included on the ground floor providing a resource for the local community in addition to hub users.

The facility is designed to be in use 365 days per year and out of hours.

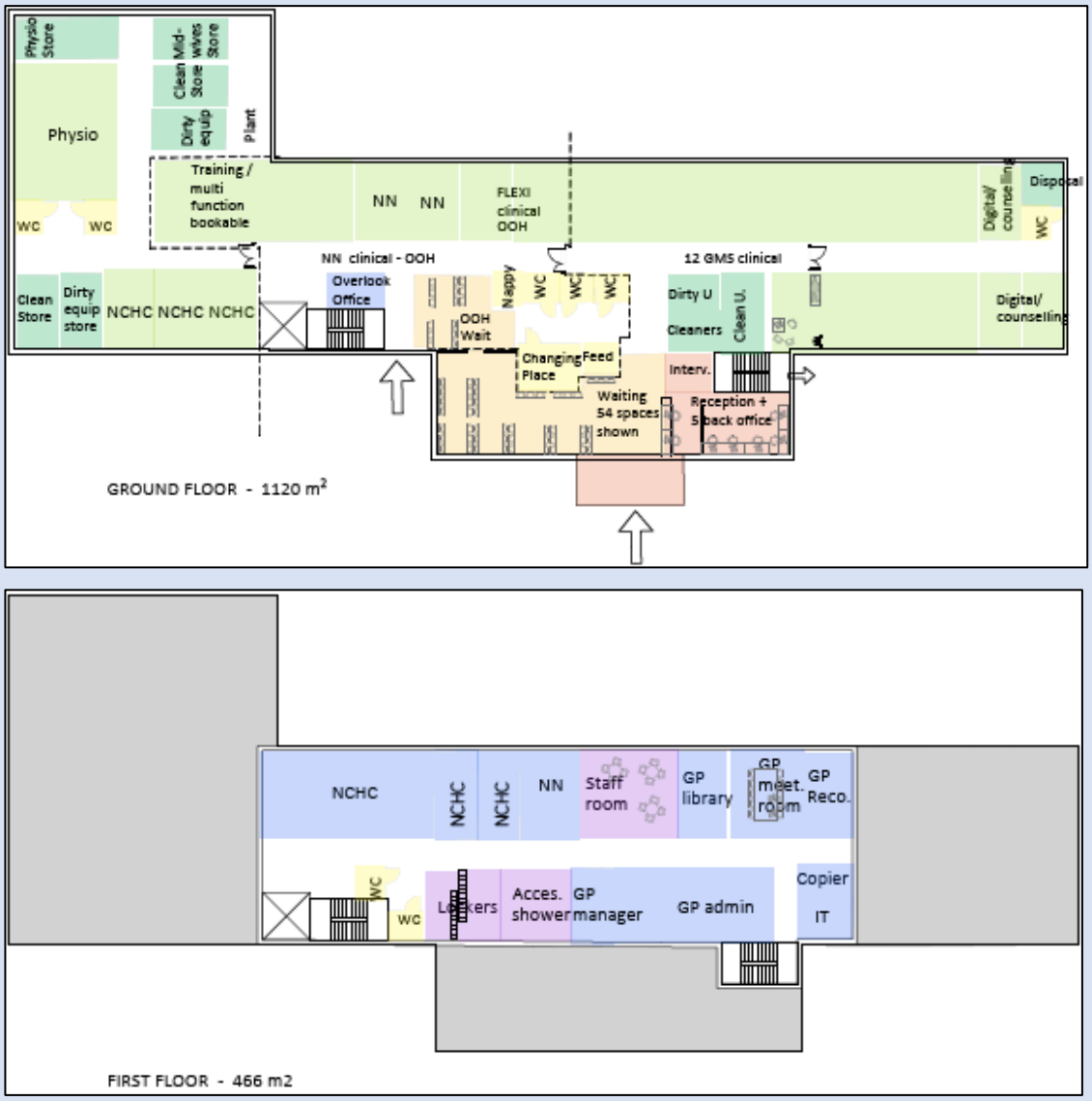


Figure 73: Sprowston proposed Hub – Option 4 Indicative Floorplan (Rackheath)

SWOT Analysis

Strengths

This proposal facilitates additional capacity north and south in the Growth Area, meeting the current identified demand from strategic sites.

At Rackheath the building would be fully compliant, sized to accommodate the expected growth and meet the highest environmental credentials. It would facilitate the required benefits identified in the Programme Business Case.

The proposals at ENMP Sprowston will ensure the current building is more efficiently utilised and increases its capacity to register all the growth expected in the first two phases of the Beeston Park development.

Weaknesses

Progressing the developments before the main housing sites are developed at Beeston Park and Rackheath North may lose the opportunity for developer contributions.

Opportunities

The proposals will not impede continued discussions with Planning Authorities and the developer at Beeston Park around the proposed medical facility. If these discussions prove unfruitful Sprowston and/or Rackheath can be further expanded to meet demand.

Threats

Although halved, in comparison to the proposal for Option 2, the additional consultation spaces and registrations proposed at ENMP Sprowston may still require more parking than can be accommodated on-site and offsite mitigations may be required.

Programme

Once identified as the preferred option formal agreement can be quickly reached with the Landlord at ENMP Sprowston.

Rackheath will be the subject of a separate options appraisal to identify a preferred location from those already identified.

Planning permission would be gained as part of the combined OBC/FBC's for the schemes expected to be submitted by Q4 2022.

Start on site is expected Q1 2023 with a 10-month construction period at ENMP Sprowston and a 15 month construction period in Rackheath.

Completion ENMP Sprowston Q3 2023 and Q2 2024 in Rackheath.

Operational Q3 2023 at ENMP Sprowston and Q2 2024 Rackheath.

Benefits

The proposals enable the realisation of a number of the identified benefits expected to follow from Wave 4b capital funding, specifically

- Enabling transformational care
- Primary Care Led
- Supporting demand management initiative
- Incorporating acute services
- Extended range of community services
- Spaces for public health
- Promoting multidisciplinary care
- Digital initiatives
- Improved mental health care
- Broad skill mix
- Improved recruitment and retention
- Increased capacity
- Contributing to environmental targets.

Norwich – Sprowston: Financial Appraisal

Capital and Revenue implications have been estimated using the best available information, but actual costs may vary when the schemes finally come to market. The indicative figures are all calculated on the same basis to allow comparison at the option appraisal event. The preferred option once identified will be subject to a more rigorous financial assessment to accompany the submission version of the programme business case.

Capital Costs

The following outlines the estimated capital costs of each option, with a split of source of capital.

	Capital								Liability Split by	
Project Name	Size	Land	Construction	Fees	Optimisum Bias	Total Build Capital	IT	Total Capital	STP Capital	Other/3P D Capital
Scheme	SQM	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	
Option 1 - BAU	-	-	-	-	-	-	-	-	-	
Option 2 - Extension&Refurb	290	-	1,683	221	571	2,476	188	2,664	1,822	842
Option 3 - New Build	2,005	1,050	5,915	727	1,993	9,685	475	10,160	5,475	4,685
Option 4 - Extension&Refurb & New Build	1,731	505	6,037	756	2,038	9,337	439	9,776	6,589	3,188

Recurrent Revenue Costs

Estimated recurrent costs for each option with estimated liability of where costs will need to be met.

	Revenue				Liability Split by	
Project Name	Net Rent Incr	Maint/IT Chg Incr	VAT	Total Revenue Incr	CCG	Community /Acute
Scheme	£'000	£'000	£'000	£'000	£'000	£'000
Option 1 - BAU	-	-	-	-	-	
Option 2 - Extension&Refurb	85	52	20	157	157	
Option 3 - New Build	273	189	75	537	375	162
Option 4 - Extension&Refurb & New Build	194	168	56	418	304	114

Assumptions:

- Abated rent increase based on estimated cost once STP funding applied.
- For the new build element in Option 3 and Option 4 an assumption is made that £5m STP funding has been utilised to reduce rental payments.
- For the extension in Option 2 and Option 4, it is assumed that the existing landlord contributes 34% of capital.
- Estimated additional IT revenue costs based on additional IT workstations needed.
- There is no offset of existing primary care premises costs, as all existing premises remain in use for each option.
- Excludes operational expenses utilities, etc.

Non-Recurrent Revenue

Estimated non-recurrent revenue consequences for each scheme:

	Non Recurrent Revenue		
Project Name	SDLT	Proj Mgmt	Total NR Revenue
Scheme	£k	£k	£k
Option 1 - BAU			-
Option 2 - Extension&Refurb	25	30	55
Option 3 - New Build	122	50	172
Option 4 - Extension&Refurb & New Build	105	60	165

Assumptions:

- SDLT based on full value of annual rental, not the abated rent.

Preferred Option

The panels' unanimous view was that Option 4: Expansion of the ENMP Sprowston Hub and the development of a new Hub in the Rackheath area should be the preferred option.

Preferred Way Forward: Norwich – Sprowston

Option 4: New build and Expansion

This option would combine a new build in the Rackheath Area with a moderate expansion of the East Norwich Medical Practice (ENMP) Sprowston Facility.

Given the multiple tenants proposed, the complexity of site options, including an existing planning permission, it was agreed the new facility at Rackheath should be the subject of a second option appraisal (detailed in the section above).

The expansion at ENMP Sprowston would be developed under a premises improvement route part funded through Wave 4b Capital.

Preferred Option – Detailed Costing and Benefits

Capital

Post options appraisal and following work up of the Rackheath and other Wave 4b schemes in more detail a further contingency of £0.3m has been added to the scheme. The revised application of funds for the preferred option for £2.3m is now split as follows:

Item	£'000	
Land	-	
Construction	1,181	
Fees	159	
Optimism Bias	402	
IT	157	
Contingency	362	
Total Application of Funds		2,261
Wave 4b Capital	- 1,669	
3PD Capital	- 592	
Total Source of Funds		- 2,261

This option utilises £1.7m of the Wave 4b bid funding which totalled £25m. 3PD capital contribution of £0.6m is 34% of total costs excluding contingency and IT costs. If costs exceed estimates and the CCG contingency is required, it is expected that the 3PD contribution will also increase to maintain 3PD contribution at 34%.

The capital costs identified here are based on estimated costs, a robust tender process will be undertaken at FBC stage.

Recurrent Revenue

The estimated recurrent revenue implications of the preferred option are as follows:

The saving achieved through the benefit of the application of the Wave 4b funding is shown above as the Rent Abatement.

Rental calculations are based on a 66% rent reduction for capital input. Actual rental abatement will be dependent upon the rental negotiation with the existing 3PD developer. Total estimated rent for the extension is £117k per year with a rent abatement of £77k per year.

The amount of Wave 4b funding included in the preferred option for rental discount is £1.3m with the £0.2m held in contingency.

As this is an extension to an existing practice there are no existing revenue costs to offset against planned increases.

	Increase in recurrent revenue costs						Funding Source	
Project Name	Rent	Rates	Water	Clinical Waste	IT	Total	CCG	NHS Trust
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Sprowston	40	17	1	1	3	62	62	-

Cash Releasing Savings

The above rental is based on a 25-year lease which would equate to a saving of £1.9m over the lease lifetime. This produces a payback period of (£1.3m Wave 4b Capital Investment / £77k annual rent abatement) 17 years against the £1.3m Wave 4b capital deployed.

Item	Years	Annual	Total
		£'000	£'000
Rent	25	117	2,925
Rent Abatement	25	- 77	- 1,925
Net Rental Charge	**25**	**40**	**1,000**

Non-Recurrent Revenue

The estimated cost of non-recurrent revenue funding needed is £38k and is detailed below:

Non Recurrent Revenue Cost	BAU	Preferred Option
	£'000	£'000
SDLT	0	18
Project Management/Legal	0	20
Total Non Recurrent Revenue	0	38

SDLT costs are estimated on the full rental cost prior to abatement, until clarification obtained on treatment of abatement.

Benefits

The results of the economic appraisal to 2073 are summarised below:

Economic Summary (Discounted) - £'000					
	Option 1 - Business as Usual	Option 2 - Aslake Double Storey Extension and Refurbishment	Option 3 - New Build	Option 4 - Aslake Single Storey Extension and Refurbishment and New Build	Option 5 - Aslake Single Storey Extension Only
Incremental costs - total	£0.00	- 3,965	- 23,567	- 16,565	- 3,053
Incremental benefits - total	£0.00	18,461	63,104	77,332	13,608
Risk-adjusted Net Present Social Value	£0.00	14,496	39,536	60,767	10,555
Benefit-cost ratio		4.66	2.68	4.67	4.46

Option 4 has the best Cost to Benefit ratio (4.67) of the options being reviewed once the costs and benefits are discounted over the lifetime of each option. This is a combination of Option 5 plus Option 3 from the Rackheath scheme.

Detailed Design and Planning Commentary

The preferred way forwards for Norwich north Growth Triangle were to remodel and extend an existing facility at Aslake Close Sprowston in addition to supporting a new build facility in Rackheath

Proposals at Sprowston would see a remodelling of the existing two practice facility into a single integrated building, combined with a single storey extension to the rear.

Existing carparking will be reconfigured to generate additional spaces and off-site options will be reviewed. Dedicated ambulance parking will be created with a charging point.

Figure 74: Sprowston proposed Hub – Site Plan

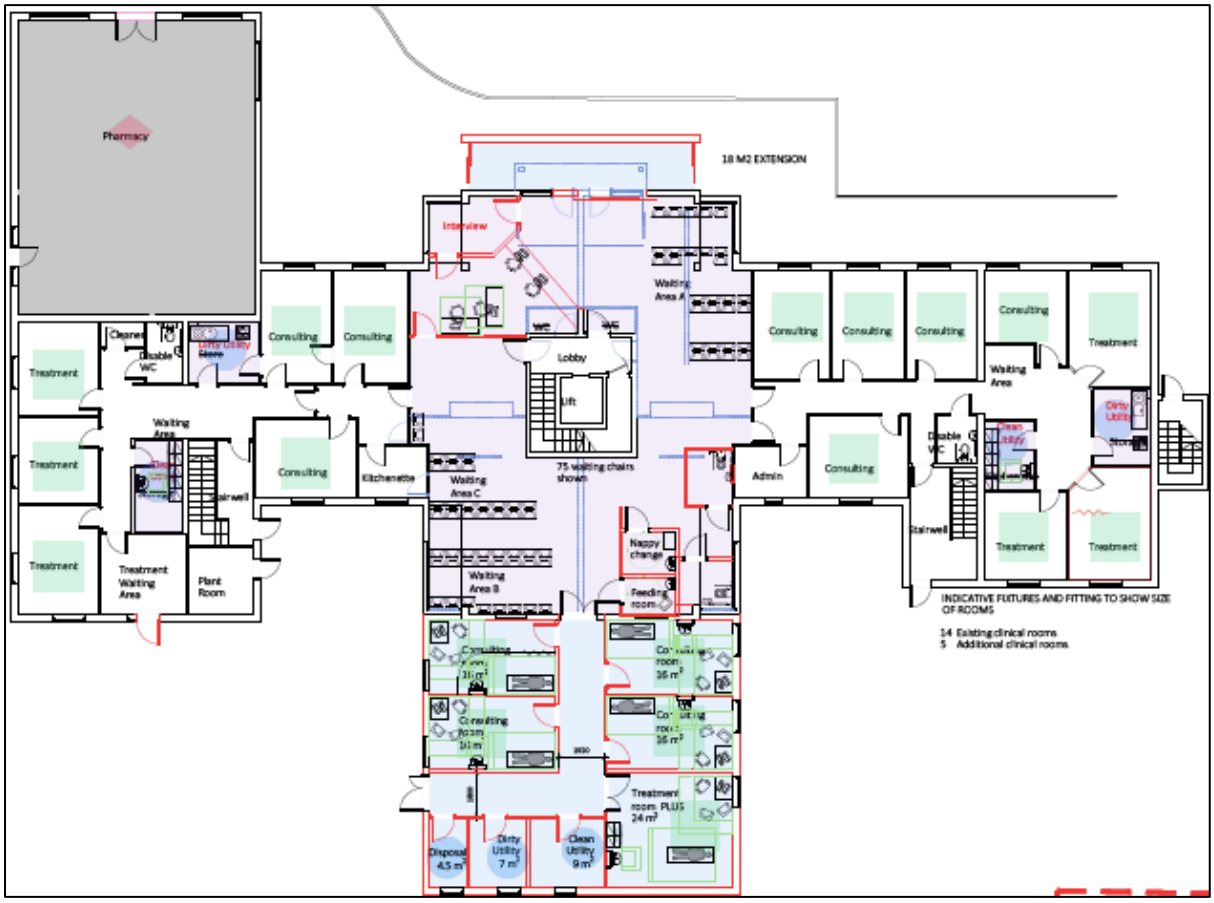


Figure 75: Sprowston proposed Hub – Ground Floor Plan

On the ground a new single reception and interview room will be created providing observation of waiting areas in current voids. New compliant WC facilities will be created and clean and dirty utility to current clinical areas addressing infection control requirements.

To the rear a new single storey extension will provide 4 consultation/examination rooms and 1 treatment room with supporting utility rooms.

The ground floor extension will be built to accommodate future upward expansion if required. This will include providing moderate alterations on the first floor to enable future access and capped off services to a potential sub wait/WC area (currently an office).

There is a commercial pharmacy on the ground floor outside of these proposals.

There are mental health and community rooms on the first floor that are unaffected by the proposed changes.

As an existing leased facility this scheme is expected to proceed as a landlord led premises improvement. The landlord has already signalled their support to this approach.

4.11.12 Proposed Scheme: King's Lynn – Nar Ouse Way

Scope

This proposal seeks to provide a new GP practice and location for Maternity and Diabetic outpatient services from the Queen Elizabeth Hospital King's Lynn NHS Foundation Trust (QEH) in the west Norfolk town of King's Lynn. In addition, it will provide a resource for the local Primary Care Network (PCN) and other health and social care providers. The facility will be sized and located to meet all the planned housing growth to the south of the town centre.

There are four PCNs in the West Norfolk Locality. Apart from King's Lynn, these PCNs cover predominantly rural areas.

The area is covered by two Local Planning Authorities, King's Lynn & West Norfolk, and Breckland.

The approximate location of the proposed scheme is shown by a red circle.

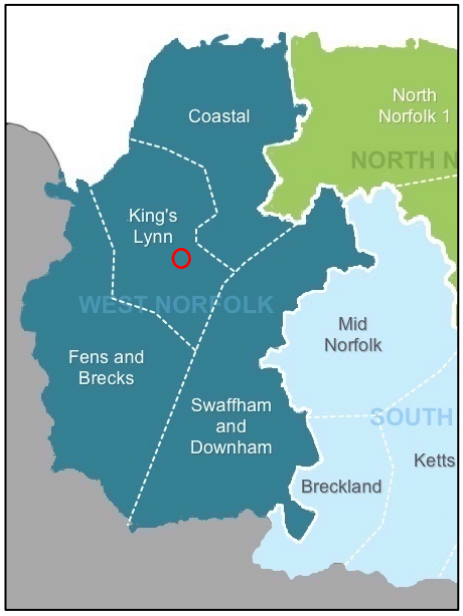


Figure 76: King's Lynn proposed Hub – proposed scheme location Nar Ouse Way

Current Situation

Within the West Norfolk locality, the King's Lynn PCN is the most constrained, faces the largest demand from new housing and has some of the most deprived communities in Norfolk and Waveney. Whilst there are well developed proposals to improve the situation there will still be significant unmet demand to the south of the town.

The QEH serves West Norfolk and surrounding areas. The Trust have an agreed Corporate Strategy and an agreed vision, 'to be the best rural District General Hospital for patient and staff experience.'

Underpinning delivery of the organisation's Corporate Strategy is Strategic Objective 4 which focuses on 'working with patients and system partners to improve patient pathways and ensure future sustainability.' The Trust is working proactively with key stakeholders to develop pathways of care at a Place level, with a clear focus on delivery of integrated pathways of care in locations which are convenient for their patients.

Figure 77: QEH Kings Lynn Corporate Objectives

Community Hubs within maternity services are well established within the locality and are recognised as enabling women to have better access to their midwives in line with national policy recommendations.

With regard to Diabetes services, there is a strong desire to develop a dedicated Diabetes outpatient setting which will provide place-based care and support. The aims of the service are to provide care for patients with newly diagnosed Type 1 Diabetes, care for patients with complex Type 2 Diabetes, provide specialist dietary advice for diabetic management and to provide structure education for patients with both Type 1 and Type 2 Diabetes. The provision of dedicated facilities within the Primary Care Hub will enable delivery of this vision.

The consequences of not having the investment associated with development of the Primary Care Hub would mean that services would remain as is and would not fulfil their true potential of delivery in a place-based, collaborative partnership.

The hospital currently has significant estate issues as the building is already 40 years past its expected life and critical problems have been identified with its roof. They are in the process of developing a business case to re-provide the ageing building, this includes reviewing which services might be more appropriately provided in the community rather than at the hospital site.

Since the bid was submitted the CCG commissioned a primary care premises capacity planning exercise to ensure its proposals were robust. Please see Section 3.12 for details of the actual registered list sizes for the PCNs where the proposed Primary Care Hubs will be based, and the anticipated and assumed growth per site arising from housing.

The proposed Primary Care Hub will be in the King's Lynn PCN. The scheme name is "King's Lynn" and its approximate proposed location is indicated on the map below by a red circle.

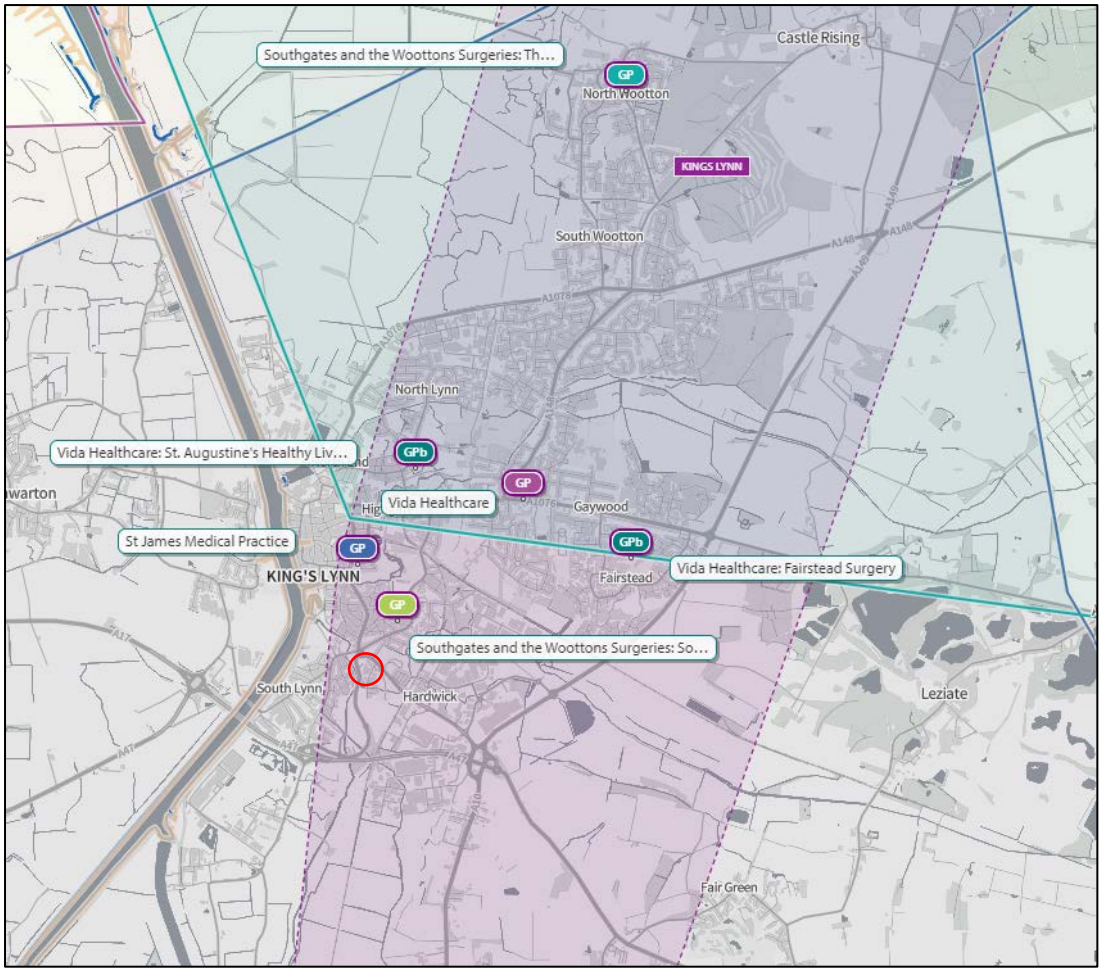


Figure 78: King's Lynn Primary Care Network (1)

The map below shows the PCN in the wider West Norfolk area – please note that the area extends north and south into other PCN areas as the Vida group have practices in Hunstanton and Downham Market – but these form part of other PCNs.

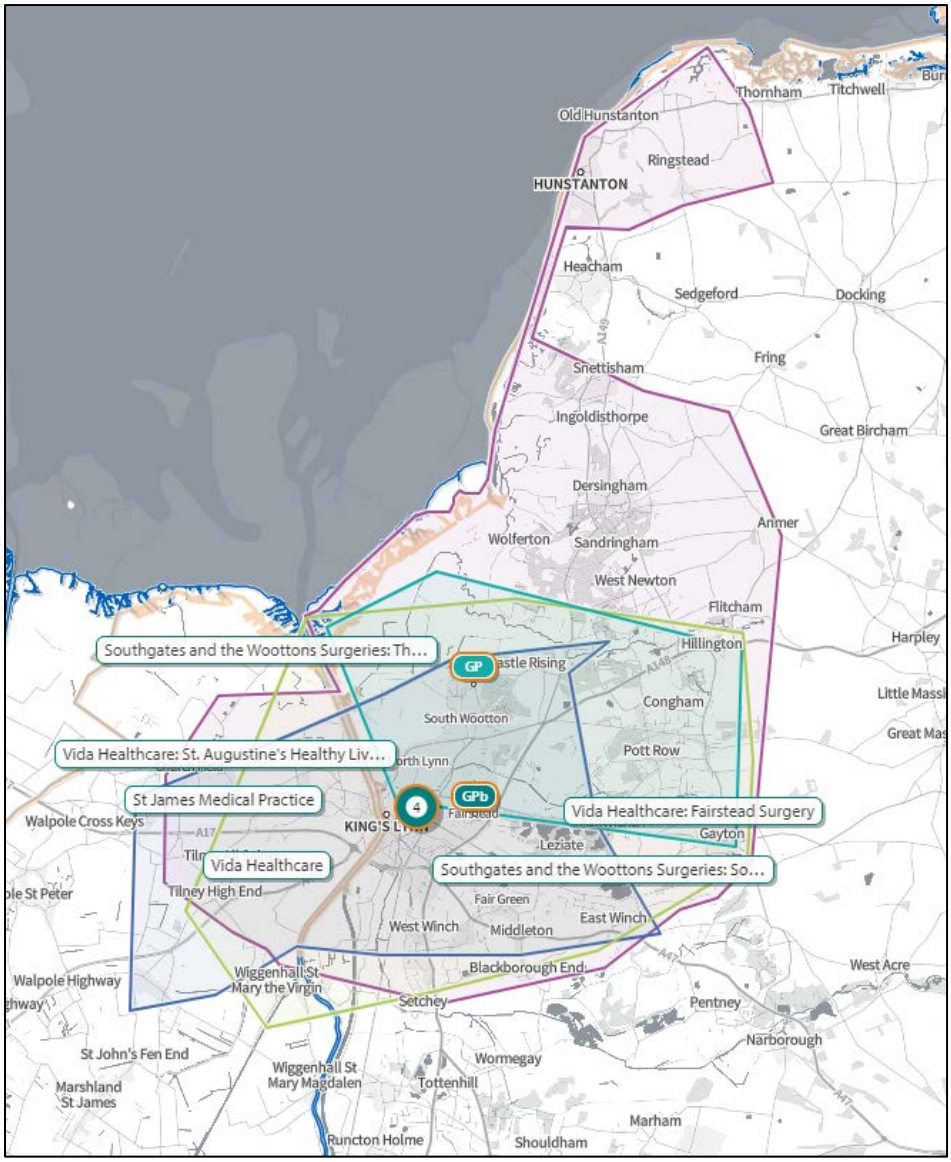


Figure 79: King's Lynn Primary Care Network (2)

Maternity Services

National Policy is also driving more services away from acute hospitals where there is no clinical reason for them to be delivered there. Providing services closer to people's homes in community settings.

The proposed Hub for King's Lynn will support The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust (QEHKL) in its preparation for major infrastructure changes to its estate through helping to create capacity at the main hospital site, allowing outpatient services to have facilities in a purpose built community setting.

The National Maternity Review (2021) has signalled a move towards more 'Personalised Care' with a 'Continuity of Carer' alongside better access to Postnatal and Perinatal support. It also charges departments with improving multi-professional and multi-agency working coming together in local maternity systems.

The Queen Elizabeth Hospital Trust is responding to the Review by increasing the size and scope of its midwifery services in the community. This creates a requirement for additional facilities for clinical contacts, scanning and educational sessions. In addition, the teams will require access to support spaces out of hours.

For those accessing the service these changes will mean a continuity of care, close to home and more accessible post and perinatal groups increasing uptake. This will assist both in delivery of care and in promoting wider public health campaigns such a reducing maternal smoking.

Being part of an integrated hub will allow the service to blend with the many users GP services more seamlessly.

Diabetic Services

The Trust recognises that many of the patients travelling regularly to the hospital site for follow-up Diabetic care, do not need to access other acute services. Space constraints and estates issues on the hospital site limit both the capacity and days of operation for the service.

By providing most outpatient services within the community the range and frequency can be increased alongside the benefits for patients, who may not have to travel so far. Many of those accessing the service have mobility issues and the availability of free parking close to the proposed facility will be an additional benefit.

The schedule of accommodation has been designed to support monthly contacts of between 400-500 (6,000 PA) but allows for growth as the current service has only limited access to clinical rooms.

Clinics are consultant, specialist nurse or multidisciplinary team led, requiring a variety of clinical room settings.

The multidisciplinary team may include:

- Diabetes Consultant
- Renal Consultant
- Diabetes Specialist Nurse
- Dietician
- Clinical Psychologist
- Paediatricians.

The service already provides virtual support for a wider group of patients during its clinical sessions. This can be increased and enhanced using the proposed digital technologies at the Hub.

Current clinical activity is summarised in the table below.

Frequency	Specialty	Held by	No.	Rooms	Hrs	Avg No. Patients	Type	% Virtual	Referral Condition
Weekly	General Diabetes	MDT	3	2	4	10	First & follow up	30% FUp	Type 1 & Type 2
Daily	General Diabetes	DSN	1	1 / 2	4	10	First & follow up	50%	Type 1 & Type 2
Monthly	Diabetic Pump	DSN	1	1 / 2	4	12	Follow ups	0%	Type 1 & Type 2
Weekly	Medical Obstetrics	MDT	1	2	4	12	First & follow up	0%	Type 1 & Type 2
Biweekly	Medical Obstetrics	MDT	1	2	4	12	First & follow up	0%	Type 1 & Type 2
Monthly	Young Persons Transitional	MDT	1	6	4	8	First & follow up	0%	Majority Type 1
Monthly	Diabetic Nephrology	MDT	1	3	4	10	First & follow up	50%	Type 1 & Type 2
2 x Monthly	Diabetic Pump	MDT	1	2	4	6	First & follow up	0%	Type 1 & Type 2
Weekly	Diabetes KLIFF	MDT	1	Meeting Room	4	10	First & follow up	0%	Type 1 & Type 2

Weekly	General Endocrine	Consultant	3	1	4	10	First & follow up	40% FUp	
3 x Monthly	General Endocrine	Consultant	1	1	4	9	First & follow up	40% FUp	

Figure 80: QEH King's Lynn – Current Diabetes Outpatient Activity

Place Based Care

This facility will allow full health integration and facilitate multi-disciplinary management of long-term conditions as well as working with patients to manage their own condition. It will provide a base for maternity and primary care to provide a wraparound service that support the pregnant person through their whole maternity journey as well proving the early years services key for all new-born babies.

With the use of digital technology and shared resources with local authority colleagues and the third sector the use of sign posting to ensure both health and social economic issues can be addressed.

The PCN may wish to look at providing a same day service with additional focus on children to align with the maternity services already located in the building. With the colocation of health visitors, school nurses and children's services within the primary care area of the building.

The King's Lynn Hub will largely be serving a new Primary Care population originating from proposed housing in West Winch and North Runcton. However, this is likely to share some of the characteristics of the current population in the area:

1. Population in very bad health 1.3%.
2. Life expectancy at birth for males (2020 – average number of years) 78.9
3. Life expectancy at birth for females (2020 – average number of years) 82.7

A key benefit identified for the Hubs is a reduction in referrals to secondary care. Latest information for the King's Lynn PCN shows them to be slightly higher referrers into secondary care than other PCNs or Practices in Norfolk and Waveney, being rank 7th highest referral out of the 21 PCNs.

	List Size		GP Referrals		Placement
	Weighted	Raw	2020/21	2019/20	
Norfolk & Waveney (system avg)	1,139,544	1,072,241	12.7	17.9	
WNKL01: Kings Lynn	**78,029**	**71,746**	**13.6**	**19.0**	**7**
D82044: Vida Healthcare	36,736	31,804	13.3	19.0	39
D82051: St James Medical Practice	18,804	16,937	12.9	18.4	48
D82099: Southgates Surgical & Medical Centre	16,732	17,160	13.3	18.0	41
D82618: The Woottons Surgery	5,757	5,845	17.5	24.5	6

Figure 81: King's Lynn Primary Care Network – Secondary Care Referrals March 2021

High referral rates may reflect population characteristics associated with areas of high deprivation. They may also be in part due to service pressures and premises constraints leading to delays in patients being able to access their GP or clinicians not being able to spend sufficient time supporting patients.

Where primary care services are under pressure attendances at Accident and Emergency departments often increase. This may be due to patients choosing to bypass primary care or where a poorly managed long-term condition leads to a crisis.

The table below looks at the total A&E attendances for the King's Lynn PCN, these rank them 3rd out of 21 PCNs with higher-than-average attendances for all the practice patients.

	List Size		A&E (Total)		Placement
	Weighted	Raw	2020/21	2019/20	
Norfolk & Waveney (system avg)	1,139,544	1,072,241	16.9	21.0	
WNKL01: Kings Lynn	**78,029**	**71,746**	**21.3**	**24.6**	**3**
D82044: Vida Healthcare	36,736	31,804	21.1	24.8	15
D82051: St James Medical Practice	18,804	16,937	22.0	25.6	10
D82099: Southgates Surgical & Medical Centre	16,732	17,160	21.6	22.9	12
D82618: The Woottons Surgery	5,757	5,845	19.2	24.6	22

Figure 82: King's Lynn Primary Care Network – Total A&E attendances March 2021

Of those who attend A&E and are admitted the hospital reviews whether in their opinion further health or social care support in primary care might have avoided that admission. That data along with total admissions is summarised below.

This information records that the King's Lynn PCN had the highest number of A&E admissions across the Norfolk and Waveney area in March 2021. The Vida and St James Practice were ranked first and second out of all practices in terms of the number admitted.

In the hospitals view the PCN also ranked highest in the numbers of those admission that could have been avoided with greater support in primary care.

	Emergency Admissions		Placement	Avoidable Admissions		Placement
	2020/21	2019/20		2020/21	2019/20	
Norfolk & Waveney (system avg)	7.0	8.4		1.3	1.9	
WNKL01: Kings Lynn	**10.1**	**11.9**	**1**	**1.8**	**2.7**	**1**
D82044: Vida Healthcare	10.4	13.1	1	1.9	3.1	5
D82051: St James Medical Practice	10.3	12.4	2	1.9	2.7	2
D82099: Southgates Surgical & Medical Centre	9.3	9.1	7	1.7	1.8	13
D82618: The Woottons Surgery	9.1	11.4	10	1.4	2.7	31

Figure 83: King's Lynn Primary Care Network – Emergency Admissions March 2021

The proposed Hub will play a vital role in delivering additional capacity and a different more accessible model of care that will support the PCN in improving avoidable and unplanned admissions into secondary care.

Schedule of Accommodation

The schedule of accommodation meets the expected registration demand from new housing, provides the requirements for the proposed outpatient and community services and makes provision for PCN appointments. The "office accommodation" indicated is also intended to support non-clinical PCN work.

The schedule has been refined with providers to meet both their requirements and the proposed operational model for the hubs and has been subject to further discussion as part of the Programme Business Case review and resubmission. Further definition will be required, in terms of use and adjacency, as part of the usual detailed design process, as this progresses.

	Main entry	m²	No.	Total
	Lobby	22.0 m²	1	22.0 m²
	Reception	10.0 m²	1	10.0 m²
	Back Office (per person)	8.0 m²	3	24.0 m²
	Sub total			56.0 m²

	Waiting Area			
	Waiting per clinical room	6.8 m²	8	54.4 m²
	Children's Play	6.0 m²	1	6.0 m²
	Buggy Area	8.0 m²	0	0.0 m²
	Nappy Change/Feed	4.0 m²	2	8.0 m²
	Accessible WC	4.5 m²	2	9.0 m²

	Changing Places	12.0 m²	TBC	0.0 m²
	Semi Ambulant WC	2.5 m²	1	2.5 m²
	Additional Staff DDA WC		1	
	Sub total			79.9 m²

	GP Clinical Areas			
	Consultation/Treatment	16.0 m²	6	96.0 m²
	Training	16.0 m²	2	32.0 m²
	Digital Consult	8.0 m²	1	8.0 m²
	Interview (off waiting)	8.0 m²	1	8.0 m²
	Clean Utility Store	12.0 m²	1	12.0 m²
	Dirty Utility	7.0 m²	1	7.0 m²
	Disposals	6.0 m²	1	6.0 m²
	Cleaner	6.0 m²	1	6.0 m²
	Accessible WC	4.5 m²	1	4.5 m²
	Sub total			179.5 m²

	GP Office Accommodation			
	Office - Manager	12.0 m²	1	12.0 m²
	Office Medium (per person)	7.0 m²	3	21.0 m²
	Store and Copier	8.0 m²	1	8.0 m²
	IT/Comms Room	10.0 m²	1	10.0 m²
	Sub total			51.0 m²
	Staff Accommodation			
	Staff Room w. kitchenette	16.0 m²	1	16.0 m²
	Accessible WC	4.5 m²	2	9.0 m²
	Staff accessible WC/Shower	7.0 m²	1	7.0 m²
	Library/ doctor's working office	16.0 m²	1	16.0 m²
	Meeting/Seminar Room pr seat	1.3 m²	24	31.2 m²
	Record Store	18.0 m²	1	18.0 m²
	Plant Room	12.0 m²	1	12.0 m²
	Staff changing / lockers	10.0 m²	1	10.0 m²
	Sub total			119.2 m²

	Total Net internal area			485.6 m²
	Planning allowance		6.0%	29.1 m²
	Engineering allowance		4.0%	19.4 m²
	Circulation allowance		30.0%	145.7 m²
	TOTAL GMS			**679.8 m²**

	QEH Maternity	Size m2	No	Total
	OP/Consultation	16.0 m²	4	64.0 m²
	Scanning Examination	16.0 m²	2	32.0 m²

	Single office	10.5 m²	1	10.5 m²
	Shared Office (Per person)	7.0 m²	3	21.0 m²
	Store	6.0 m²	1	6.0 m²
	Training/education/meeting per person	4.5 m²	12	54.0 m²
	OP Sub wait (per clinical room)	6.8 m²	6	40.8 m²
	Clean Utility	12.0 m²	1	12.0 m²
	Dirty Utility	7.0 m²	1	7.0 m²
	Cleaner	6.0 m²	1	6.0 m²
	Total Net internal area			253.3 m²
	Planning allowance		6.0%	15.2 m²
	Engineering allowance		4.0%	10.1 m²
	Circulation allowance		30.0%	76.0 m²
	TOTAL Maternity			**354.6 m²**

	QEH Diabetes Outpatients	Size	No	Total
	Reception 2 staff	12.0 m²	1	12.0 m²
	Waiting per clinical room	6.8 m²	9	61.2 m²
	Drinking Water Dispenser	0.5 m²		0.0 m²
	Download zone	1.5 m²		0.0 m²
	Height & weight room	8.0 m²	1	8.0 m²
	Dirty Utility	9.0 m²	1	9.0 m²
	Staff Changing – Unisex 10 places			0.0 m²
	Staff rest room incl. Beverages 10 person	8.0 m²		0.0 m²
	Staff WC	2.5 m²	1	2.5 m²
	Staff Shower	2.5 m²	1	2.5 m²
	Secretaries Office per person	7.0 m²	2	14.0 m²
	Clinic room	16.5 m²	6	99.0 m²
	Podiatry room	16.5 m²	2	33.0 m²
	Podiatry room incl. hoist	19.0 m²	1	19.0 m²
	Store; Podiatry	6.0 m²	1	6.0 m²

	Room	Size	No	Total
	Podiatry Office per Person	7.0 m²	2	14.0 m²
	Store: Linen	3.0 m²	1	3.0 m²
	Store: General	12.0 m²	1	12.0 m²
	Cleaners room	0.0 m²		0.0 m²
	External: Ambulance drop off	0.0 m²		0.0 m²
	Office 3 +2 people	7.0 m²	5	35.0 m²
	2 Patient WC DDA clinical area	4.5 m²	2	9.0 m²
	Total Net internal area			339.2 m²
	Planning allowance		6.0%	20.4 m²
	Engineering allowance		4.0%	13.6 m²

	Circulation allowance		30.0%	101.8 m²
	TOTAL Diabetes			**474.9 m²**

	Kings Lynn Total required area			
	TOTAL GMS			679.8 m²
	TOTAL Maternity			354.6 m²
	TOTAL Diabetes			474.9 m²
	TOTAL Building GIA			1509.3 m²

Site Long List

Whilst discussions continue with developers around the West Winch and North Runcton strategic sites, there are currently no Section 106 or Community Infrastructure Levy funds allocated. Nor are there any reservation sites identified for healthcare.

This may change as the masterplans develop. The Hopkins Homes site (Hardwick Green) is currently the most advanced and within the neighbourhood centre are potential sites. However, the developer advises these are unlikely to come forwards before the Wave 4b deadline of April 2024.

Figure 84: Hardwick Green Master Plan (Proposed Neighbourhood Centre)

Flood Risk and Land Contamination Issues in King's Lynn

Much of the areas to the south of the town centre are on reclaimed land that is susceptible to both flooding and/or has contamination issues. New planning applications may be asked to put in remedial measures to address such land issues which could add significantly to the cost of the scheme. This may include provision for flood risk if the current sea defences are breached.

Other Site Options Explored

The table below shows 17 of the sites that were investigated as potential options for the new health facility. Many of these were identified by local authority partners on the Engagement Group for the project, other sites had been shortlisted by the St James Medical Practice, some were commercially advertised. Of these, three were identified by the Steering Group as having more potential for the proposed scheme and were, therefore shortlisted to form the basis or this Options Appraisal.

	Site	Fit	Shortlist
1	Vacant commercial plot Campbells Meadow (rear of Tesco store)	Large site good price, Low Risk/Tidal Breach Flood areas	Yes
2	Triangle Site Nar Ouse Regeneration Area	Council owned on market, Low Risk/Tidal Breach Flood areas. Contamination risk	Yes
3	Former Winch Pub. Redevelopment site.	High cost, outside flood risk area, within housing development zone	Yes
4	Hardwick Green (Hopkins Homes)	Timing issues, outside flood risk area	No
5	Mill Lane Farm	Remote access/timing	No
6	Site adjacent to Morston Drift (NORA)	Size, shape, flood risk problematic	No
7	Various other sites NORA	Land contamination problems, flood risk	No
8	Morston Point various sites	Flood/drainage issues, timing, location	No

	Site	Fit	Shortlist
9	Gayton Parkway prospective housing application.	No Railway crossing, timing, remote location, breach flood risk	No
10	Kellard Place	Too small, flood risk	No
11	Vancouver Quarter vacant retail units	Access, building constraints, conversion compromises, breach flood risk	No
12	Plaxtole House site	Not available, breach flood risk	No
13	Southgates Medical Centre	Not available for redevelopment, breach flood risk	No
14	Car Park	Not large enough, breach flood risk	No
15	Former retail unit	Not large enough, breach flood risk	No
16	Former Tesco store Hardwick	High cost. Not on market for this type of use. Breach flood risk	No
17	Dragonfly hotel/Hardwick Roundabout sites	Not on market	No

Short Listed Options

There are four shortlisted options proposed to meet the demand from new housing in the area, provide outpatient services in the community and promote a greater integration between services. These options also include for comparison 'Business as Usual' not investing any of the Wave 4b capital.

As the proposals will involve a new GP practice and new outpatient provision from the hospital there is no 'Do Minimum' option. The agreed re provision to the St James Surgery and improvements at Gayton Road are incorporated into the Business as Usual Option.

Option 1	**Business as Usual**	Making no additional investment beyond those already committed and leaving the existing resources in place to meet the demand.
Option 2	**New Build/Campbells Meadow**	Develop a new integrated facility to support the QEH outpatients and meet all the anticipated registration demand.
Option 3	**New Build/Nar Ouse Way**	Develop a new integrated facility to support the QEH outpatients and meet all the anticipated registration demand.
Option 4	**New Build/Winch Pub Site**	Develop a new integrated facility to support the QEH outpatients and meet all the anticipated registration demand.

OPTION 1: Business as Usual
Description: This option would make no additional provision and leave the current practices and services in the town to meet the registration demand arising from the proposed new housing being developed to the south of King's Lynn
Designs: Not applicable to this option.
SWOT Analysis **Strengths** This option would have no immediate cost to the local health economy and would not require Wave 4b capital funding. Existing patients' established access routes to the current facilities would remain. **Weaknesses**

Outpatient services would remain on the hospital site.

There is no additional registration capacity at the Southgates Medical Centre the last remaining practice south of the centre. The Surgery would be increasingly impacted by the expected demand for 530 additional registrations per annum. As noted, they are already significantly above the national benchmark for the numbers of patients. This is likely to quickly lead to a list closure or temporary measures to create additional capacity.

This option will not facilitate integration or flexibility to work in different ways with the PCN and the health economy.

Opportunities

The Southgates Medical Centre may bring forwards plans to expand the current facility and some additional registration capacity may also be created.

Threats

Wave 4b funding could be lost from the wider programme.

Programme: Not applicable to this option

Benefits: There are no Programme Business Case benefits from this option. This option will not deliver any of the benefits identified in the Wave 4b Programme Business Case Benefits Realisation Plan (BRP).

OPTION 2: New Build/Campbells Meadow

Description: This option would see a new purpose-built facility constructed on a large vacant commercial plot to the rear of the Tesco store on the Hardwick retail park. It would provide all the accommodation required by the QEH and host a new GP practice sized to meet all the demand currently forecast for the southern part of the town, West Winch and East Runcton areas.

Designs:

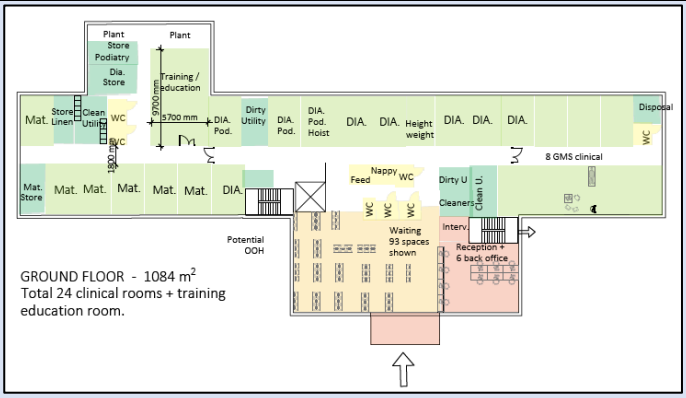
Figure 85: King's Lynn proposed Hub – Option 2 floor and site plans

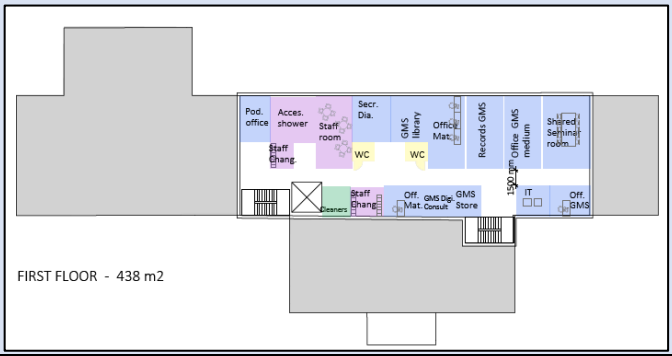
All patient facing services are on the ground floor. Accessed from a shared reception and waiting areas.

Diabetes services are located close to the seating to assist those with mobility problems. There will be a bariatric consultation room to assist patients requiring hoists.

The GP wing will take some time to reach full utilisation and in the interim rooms will be bookable by the PCN and other wrap around services.

The maternity wing will include a training and education room that will be bookable by any of the tenants or related health and social care users in the locality.





On the first floor served by a lift will be administrative, staff and meeting resources, including multidisciplinary team meetings. There will be a dedicated digital consultation room bookable by any tenant.

The maternity area will have 24/7 access 365 days per annum.

The facility would be fully compliant with latest NHS Guidance, aim to achieve a BREEAM Excellent rating and respond to Carbon Neutral targets (subject to site constraints)

The facility will have free on-site parking and a hard standing for mobile diagnostics units.

SWOT Analysis

Strengths

This option allows the QEH and GP services to come together in a fully integrated and compliant facility. For outpatients, the location is easily accessible from all areas of the town and locality, by public and private transport.

It is on the main route into King's Lynn from the communities planned in West Winch and North Runcton and more accessible than the Southgate's Medical Centre so may be the first choice for new registrations easing pressure for them.

Weaknesses

The site will require a change of use planning permission.

Opportunities

The site is much larger than required and additional land might be retained for future expansion or other priorities associated with the QEH's redevelopment plans.

Threats

This is a former industrial brownfield site and may be subject to some land contamination. It lies within a low-risk flood area but if the requirement of planners is to cater for the potential breach of existing flood defences it may need costly remedial works.

Programme

Once identified as the preferred option further discussions will take place to secure the site and undertake site surveys.

Planning permission would be gained as part of the combined OBC/FBC for the scheme expected to be submitted Q4 2022.

Start on site is expected Q1 2023 with a 15 month construction period.

Completion Q2 2024.

Operational Q2 2024.

Benefits

The proposals enable the realisation of a number of the identified benefits expected to follow from Wave 4b capital funding, specifically

- Enabling transformational care
- Primary Care Led

- Supporting demand management initiative
- Incorporating acute services
- Extended range of PCN services
- Spaces for public health
- Promoting multidisciplinary care
- Supporting digital initiatives
- Improved mental health care
- Broad skill mix
- Improved recruitment and retention
- Increased capacity
- Contributing to environmental targets.

OPTION 3: New Build/Nar Ouse Way

Description: This option would see a new purpose-built facility constructed in the proposed commercial area in the final phase of the Nar Ouse Regeneration Area. It would provide all the accommodation required by the QEH and host a new GP practice sized to meet all the demand currently forecast for the southern part of the town, West Winch and East Runcton areas.

Figure 86: King's Lynn proposed Hub – Option 3 Nar Ouse Way site

Designs: (The design is the same as option 2)

All patient facing services are on the ground floor. Accessed from a shared reception and waiting areas.

Diabetes services are located close to the seating to assist those with mobility problems. There will be a bariatric consultation room to assist patients requiring hoists.

The GP wing will take some time to reach full utilisation and in the interim rooms will be bookable by the PCN and other wrap around services.

The maternity wing will include a training and education room that will be bookable by any of the tenants or related health and social care users in the locality.

On the first floor served by a lift will be administrative, staff and meeting resources, including multidisciplinary team meetings. There will be a dedicated digital consultation room bookable by any tenant.

The maternity area will have 24/7 access 365 days per annum.

The facility would be fully compliant with latest NHS Guidance, aim to achieve a BREEAM Excellent rating and respond to Carbon Neutral targets (subject to site constraints).

The facility will have free on-site parking and a hard standing for mobile diagnostics units.

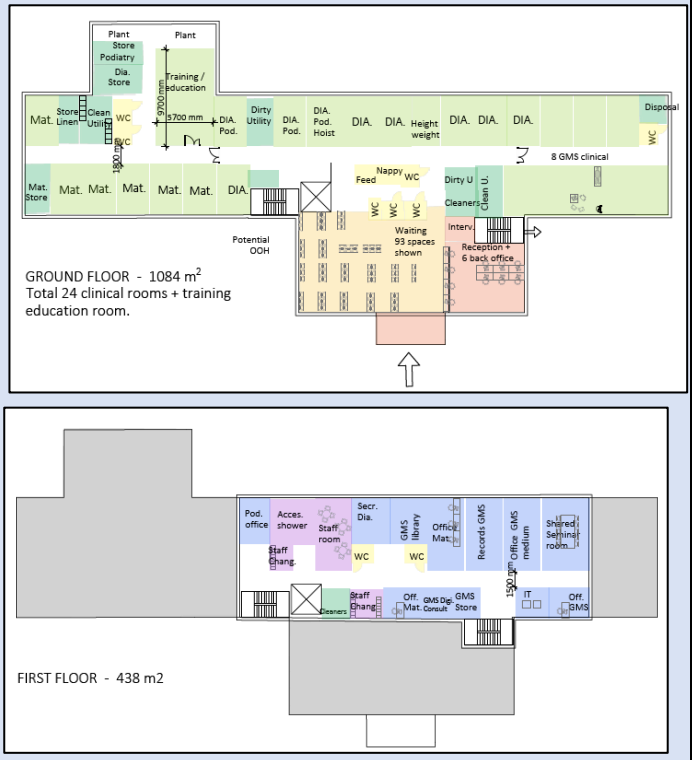


Figure 87: King's Lynn proposed Hub – Option 3 floor and site plans

SWOT Analysis

Strengths

This option allows the QEH and GP services to come together in a fully integrated and compliant facility. The facility will be close to the high deprivation areas of South Lynn and Central Lynn. The site is Council owned and available.

Weaknesses

The road infrastructure is not yet in place. The sites in this area are subject to known land contamination problems and remedial works are likely to be required. Public transport access may require two journeys from the largest proposed housing areas.

Opportunities

The proposals take up two of the identified plots but there are additional adjoining areas available should more land be required.

Threats

The site lies within a low-risk flood area but if the requirement of planners is to cater for the potential breach of existing flood defences it may need costly remedial works.

Programme

Once identified as the preferred option further discussions will take place to secure the site and undertake site surveys.

- Planning permission would be gained as part of the combined OBC/FBC's for the schemes expected to be submitted Q4 2022.
- Start on site is expected Q2 2023 with a 36-week construction period (NHSPS proposed solution of 2-stage approach using a nationally approved modular contractor).

- Completion Q2 2024
- Operational Q2 2024.

Benefits

The proposals enable the realisation of a number of the identified benefits expected to follow from Wave 4b capital funding, specifically

- Enabling transformational care
- Primary Care Led
- Supporting demand management initiative
- Incorporating acute services
- Extended range of PCN services
- Spaces for public health
- Promoting multidisciplinary care
- Supporting digital initiatives
- Improved mental health care
- Broad skill mix
- Improved recruitment and retention
- Increased capacity
- Contributing to environmental targets.

OPTION 4: New Build/Winch Pub Site

Description: This option would see a new purpose-built facility constructed on the site of the former Winch Pub on the A10 south of the Hardwick Roundabout. It would provide all the accommodation required by the QEH and host a new GP practice sized to meet all the demand currently forecast for the southern part of the town, West Winch and East Runcton areas.

Figure 88: King's Lynn proposed Hub – Option 4 Former Winch pub site

Designs:

All patient facing services are on the ground floor. Accessed from a shared reception and waiting areas.

Diabetes services are located close to the seating area to assist those with mobility problems. There will be a bariatric consultation room to assist patients requiring hoists.

The GP wing will take some time to reach full utilisation and in the interim rooms will be bookable by the PCN and other wrap around services.

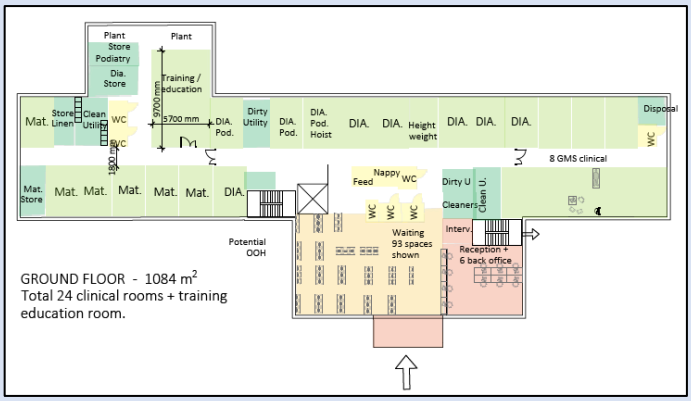
The maternity wing will include a training and education room that will be bookable by any of the tenants or related health and social care users in the locality.

On the first floor served by a lift will be administrative, staff and meeting resources, including multidisciplinary team meetings. There will be a dedicated digital consultation room bookable by any tenant.

The maternity area will have 24/7 access 365 days per annum.

The facility would be fully compliant with latest NHS Guidance, aim to achieve a BREEAM Excellent rating and respond to Carbon Neutral targets (subject to site constraints).

The facility will have free on-site parking and a hard standing for mobile diagnostics units.



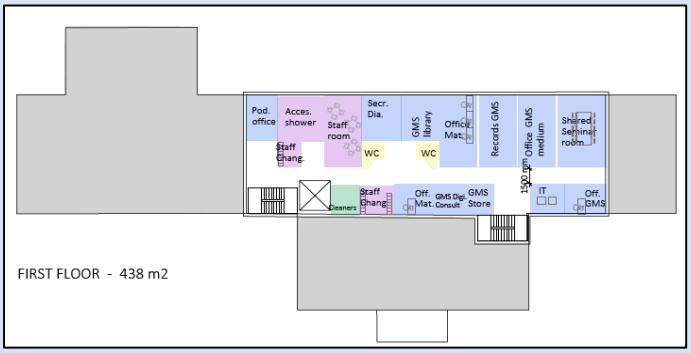


Figure 89: King's Lynn proposed Hub – Option 4 site plans (3 images)

SWOT Analysis

Strengths

This option allows the QEH and GP services to come together in a fully integrated and compliant facility. The site is in the heart of the new communities being created in West Winch/North Runcton. The site is outside of the flood risk areas.

Weaknesses

The site will require a change of use planning permission. It is less accessible to patients travelling by public transport from further afield. The site is expensive as it is being sold as a business. It will require demolition of the current structure.

Opportunities

Sitting outside of the flood zone and reclaimed areas this site should avoid the risk of abnormal cost or land contamination.

Threats

Planners may resist the loss of a community amenity site such as a pub. The site would only allow for future vertical expansion.

Programme

Once identified as the preferred option further discussions will take place to secure the site and undertake site surveys.

Planning permission would be gained as part of the combined OBC/FBC for the scheme expected to be submitted Q4 2022.

Start on site is expected Q1 2023 with a 15 month construction period.

Completion Q2 2024.

Operational Q2 2024.

Benefits

The proposals enable the realisation of a number of the identified benefits expected to follow from Wave 4b capital funding, specifically

- Enabling transformational care
- Primary Care Led
- Supporting demand management initiative
- Incorporating acute services
- Extended range of PCN services
- Spaces for public health
- Promoting multidisciplinary care
- Supporting digital initiatives
- Improved mental health care
- Broad skill mix
- Improved recruitment and retention
- Increased capacity
- Contributing to environmental targets.

Access

The main public transport routes serving the site options are shown below. The yellow routes link the proposed housing areas to the town centre via the Hardwick Road. There are several services provided by Lynx with at least one option hourly and more frequent services at peak times.

The blue routes link the centre of the town to the South Lynn area and are less frequent with a bus every two hours. Options 2 and 3 are divided by the railway line the nearest pedestrian crossing point is at Hardwick Road.

The nearest bus stop to Option 2 is indicated with a dotted yellow line showing the pedestrian route which is approximately 300m from the site. In addition to free parking proposed on site, there is ample public car parking across the retail park and fast access by car from the Hardwick Road. The site gives good direct access to the areas of proposed housing via a single bus journey.

There is a bus stop approximately 300m from the Option 3 site and footbridges across the River Nar that link it to the South Lynn area and the new housing being developed. Travelling to and from the proposed new housing in West Winch and North Runcton would currently require two bus journeys.

With a direct link to the main A47 from Nar Ouse Way car access is fast and convenient avoiding congestion on the Hardwick Road amble free parking would be provided on site.

The Option 4 site has a bus stop directly outside on the A10 with frequent buses to and from central King's Lynn. It is located within 1km of most of the proposed housing sites and adjacent to the Hardwick Green expected to be developed first. Journeys for outpatients travelling from wider afield would be more problematic, most likely involving two bus journeys via the central bus depot. The A10 and Hardwick Roundabout suffer considerable congestion at peak times. Free parking would be provided on site.

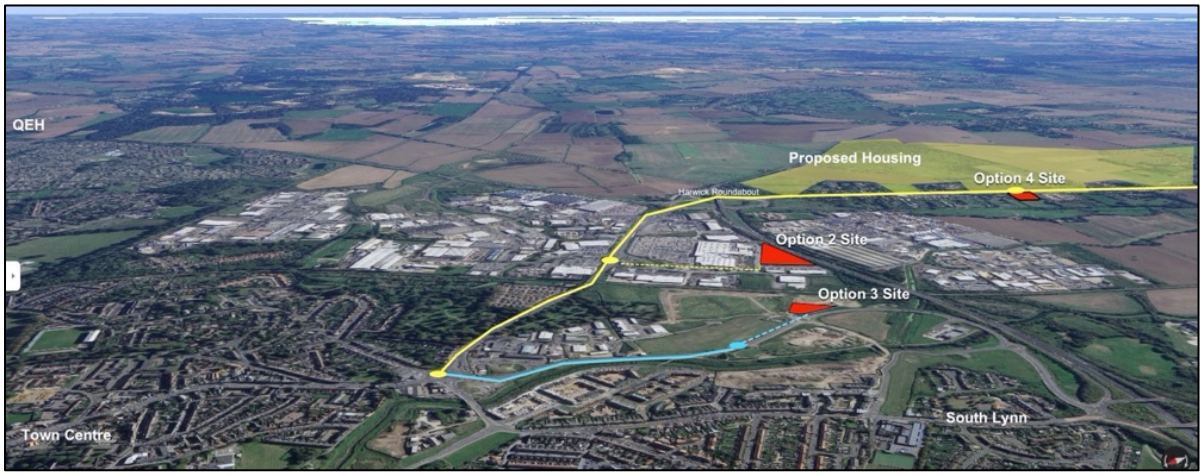


Figure 90: King's Lynn proposed Hub – Site locations and main bus routes

King's Lynn: Financial Appraisal

Capital and Revenue implications have been estimated using the best available information, but actual costs may vary when the schemes finally come to market. The indicative figures are all calculated on the same basis to allow comparison at the option appraisal event. The preferred option is subject to a more rigorous financial assessment below.

Capital Costs

The following outlines the estimated capital costs of each option, with a split of source of capital. Additional contingency of 27.5% has been added to provide further mitigation against current market conditions and mitigation for potential additional flood and site risks.

		Capital Requirement							Funding Source	
Project Name	GIA	Land	Construction	Fees	Optimisum Bias	Contingency	IT	Total Capital	Wave 4b Capital	3PD Capital
	m2	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Option 1 - BAU		-	-	-	-	-	-	-	-	-
Option 2 - New Build / Campbells Meadow	1574	100	5,369	694	1,819	1,665	485	10,133	10,133	-
Option 3 - New Build / Nar Ouse Way	1574	350	5,677	731	1,923	1,760	485	10,926	10,926	-
Option 4 - New Build / Winch Pub Site	1574	350	4,887	636	1,657	1,519	485	9,534	9,534	-

Recurrent Revenue Costs

Estimated recurrent costs for each option with the estimated liability by provider.

	Increase in recurrent revenue costs						Funding Source	
Project Name	Rent	Rates	Water	Clinical Waste	IT	Total	CCG	NHS Trust
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Option 1 - BAU	-	-	-	-	-	-	-	-
Option 2 - New Build / Campbells Meadow	-	50	5	5	106	166	77	89
Option 3 - New Build / Nar Ouse Way	-	50	5	5	106	166	77	89
Option 4 - New Build / Winch Pub Site	-	50	5	5	106	166	77	89

Assumptions:

- For the new build Option 2, 3 and 4 an assumption is made that Wave 4b Capital fully funding the build will mean occupancy will be rent free.

- Estimated additional IT revenue costs based on additional IT workstations needed. Also includes £72k per annum in relation to HSCN line rental based on upper end estimate from CCG (no assumption has been made of offsetting existing costs for current premises).
- Excludes Operational Expenses, service charges etc.

Non-Recurrent Revenue

For options 2 to 4. Stamp Duty Land Tax is estimated at £127k and project management at £50k.

Preferred Option

After having considered the designs, SWOT analysis, indicative programme and benefits realised Options 2 and 3 were equally ranked and the panel were asked to vote which should be the preferred option.

Preferences recorded were:

- Providers (3 votes) for Option 3.
- Commissioners (3 votes) for Option 3.
- Patient Representative (1 vote) for Option 2.

Option 3: **A New Facility on Nar Ouse Way** was consequently agreed as the preferred option. As the results were so evenly matched the Panel agreed that Option 2 might still be retained as a backup if for any reason the first choice could not proceed.

Preferred Way Forward: King's Lynn

Option 3: A New Facility on Nar Ouse Way

Preferred Option – Detailed Costing and Benefits

Capital

The overall capital cost for the preferred option is £10.93m which will be fully funded from the Wave 4b allocation. The capital costs identified here are based on estimated costs but includes significant contingency, a robust tender process will be undertaken at FBC stage.

Recurrent Revenue

The estimated recurrent revenue implications of the preferred option is an annual increase in revenue costs of £166k per annum across all tenants. This is split by tenant as follows: Primary Care (CCG Reimbursable) £77k and QEH £89k.

Non-Recurrent Revenue

The estimated cost of non-recurrent revenue funding needed is £177k which consists of £127k for SDLT and £50k for project management.

Benefits

The results of the economic appraisal to 2073 are summarised below:

	Option 0 - Business as Usual	Option 1 - New Build - Campbells Meadow	Option 2 - New Build - Nar Ouse Way	Option 3 - New Build - Winch Pub
Incremental costs - total	£0	-£14,646	-£15,333	-£14,213
Incremental benefits - total	£0	£61,172	£65,635	£59,989
Risk-adjusted Net Present Social Value (NPSV)	£0	£46,526	£50,303	£45,776
Benefit-cost ratio		4.18	4.28	4.22

Option 2 has the best Cost to Benefit ratio (4.28) of the options being reviewed once the costs and benefits are discounted over the lifetime of each option.

Detailed Design and Planning Commentary

The preferred way forwards for King's Lynn will see a new purpose-built facility with a combined net internal area of 1,574 m^2 constructed on Nar Ouse Way in the regeneration area. The land is owned by the Borough Council who have indicated their support for the scheme.

The site is adjacent to the two areas of high deprivation in South Lynn and the town centre.

It has good car access and is 300m from the nearest existing bus stop.

There are 80 parking spaces some providing charging points. In addition to dedicated disabled drop off points near the building there is an ambulance parking bay with charging point.

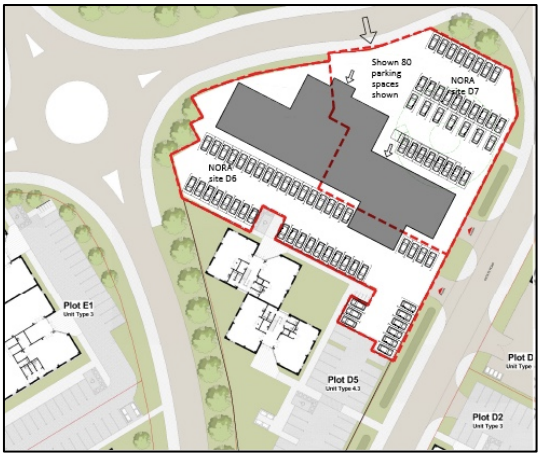


Figure 91: King's Lynn proposed Hub – Preferred Site

Close to the building is a mobile unit hard standing and electrical hook up point for mobile diagnostic units.

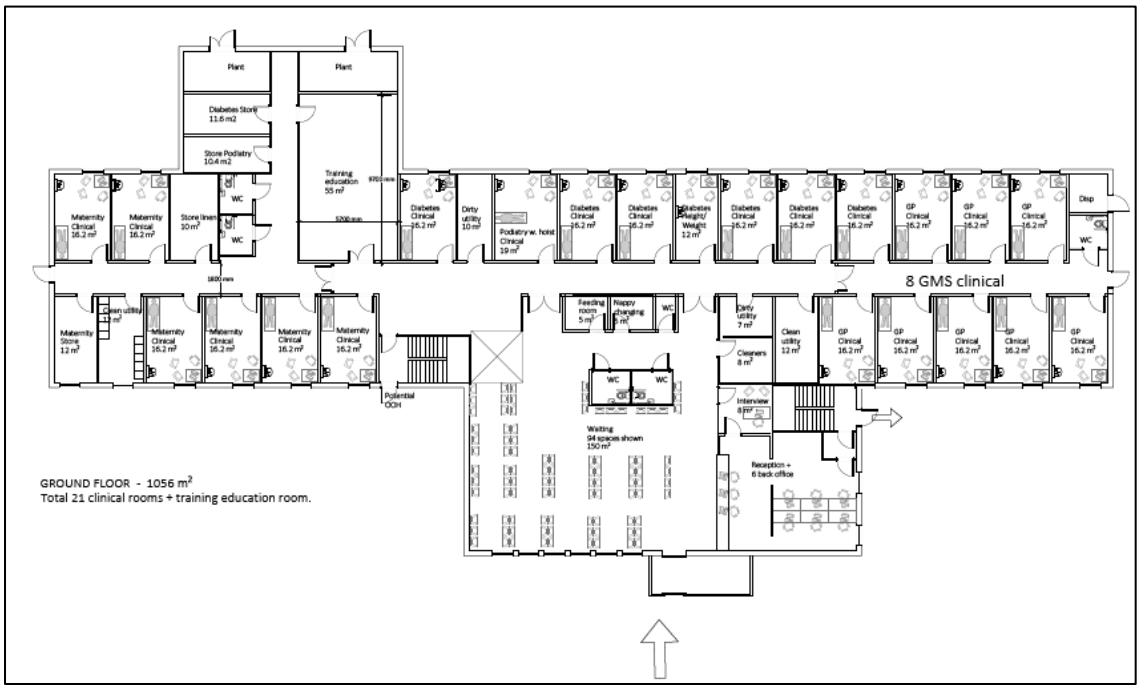


Figure 92: King's Lynn proposed Hub – Ground Floor Plan

All clinical services will be located on the ground floor. A shared reception and interview room overlooks the single waiting area and WC facilities, nappy change, and dedicated feeding rooms. There is staff access to the first floor from two stair cores and a lift.

In a wing that can be locked out of hours is the GP provision of 6 Consultation/Examination and 2 Treatment rooms, plus supporting utility areas. This includes provision for trainee placements from within the PCN. Initial utilisation will be boosted by the location of PCN AARS staff within the facility. All rooms will be bookable by PCN member practices ensuring flexible utilisation whilst the list builds up.

Close to the waiting area are a suite of rooms providing an outpatient clinic for the QEH Diabetes department. These include 6 general clinical rooms, 2 podiatric rooms and a bariatric clinical room with a hoist.

A second wing that can be open 24/7 are the maternity outpatient facilities and a bookable training and education room that can be utilised by any health and social care partner.

The maternity facility includes 4 consultation and examination rooms alongside 2 scanning rooms. This area also includes stores accessible 24/7 for peripatetic staff including midwives supporting home births.

Figure 93: King's Lynn proposed Hub – First Floor Plan

The partial first floor allows for future vertical expansion and the lift would allow clinical services to be delivered on the first floor if desired. At present only staff and digital resources are included upstairs. All staff rooms, changing and WC provision is shared. There are dedicated office areas for the three departments (GMS, Diabetics, Maternity). There are bookable and digitally enabled, training and seminar/Multi-Disciplinary Team rooms. There is a bookable digital consultation room. These rooms will also be bookable by the PCN to support training and MDT meetings.

4.11.13 Proposed Scheme: South Norfolk – Thetford Healthy Living Centre

This proposal is seeking to expand clinical services at the existing Thetford Healthy Living Centre.

The facility already provides GMS and PMS services for the Breckland Alliance Primary Care Network (PCN). It hosts outpatient services from the West Suffolk Hospital, Norfolk and Norwich and Papworth acute trusts. It is a base for Norfolk and Suffolk Mental Health Care Trust and community physiotherapy services from Norfolk Community Health and Care NHS Trust. It includes a plain film Xray unit, ultrasound, minor surgery and specialist audiology room.

Figure 94: South Norfolk Primary Care Networks

Scope and Content

A capital only scheme that will result in no increase to the current rental cost to the Commissioners but will bring much needed additional primary care clinical capacity in an area of high population growth and deprivation. The proposals will increase utilisation of the facility improving its value for money.

The proposal will enable an expansion of GMS services to meet increasing demand, a wider range of wrap around services including staff employed under the PCN's Additional Role Reimbursement Scheme (ARRS) and expanded outpatient provision.

There has been a longstanding need to expand primary care provision to meet the increased demand from historical housing developments. Local planners have approved a strategic urban extension that is now underway. It could ultimately generate demand for over 11,000 additional registrations which is supported by housing registration growth listed in Shape with 6,878 registrations expected within the next 15 years. Consequently, current facilities are no longer adequate for the size of the population being served.

Current Situation

There are three primary care health facilities in the town:

Grove Surgery

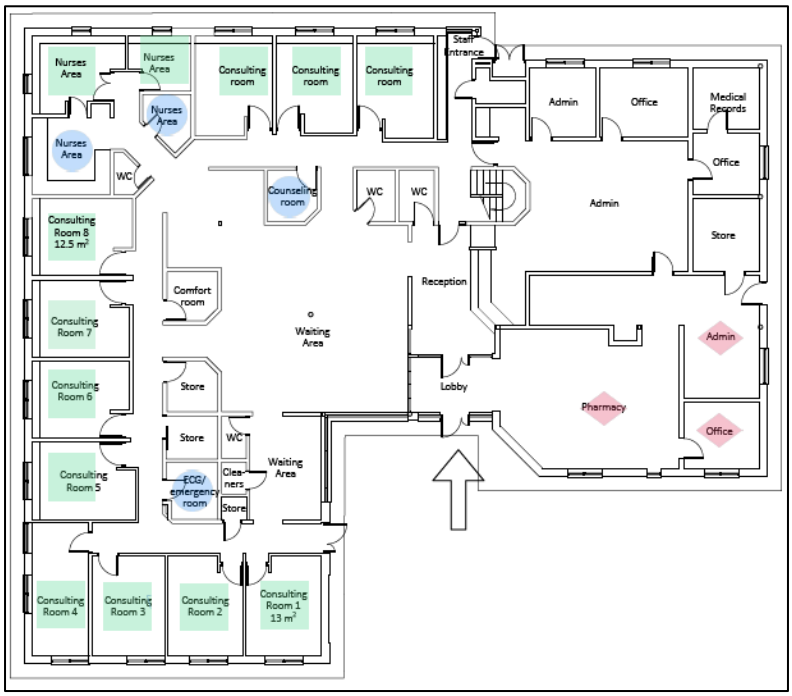
The Surgery is a purpose built, part two story, GP owned facility built in the 1980's with a moderate extension added in the 1990's. It is red brick under a tiled roof. There is a carpark for up to 40 cars including staff. There are ambulance and disabled parking spaces. The commercial Pharmacy within the building has a lease with a break point in 2036. The building is regarded as a Tail property by the PCN.

A recent (2021) six facet survey of the premises estimated the total cost to bring the surgery up to current minimum compliance would be in the region of £950,000 of which £100,000 will be required in the next 2-5 years in forward maintenance costs.

The reimbursed net internal area is 580 m^2 with a registered list of just under 12,000. This means utilisation is 20.67 patients per square metre, making it 19th most constrained practice in Norfolk and Waveney (2021).

It is significantly above the average levels of utilisation in Norfolk and Waveney. CCG analysis[18] suggests the building currently serves 4,000 more patients than would be expected for its size.

The position would have been worse if the CCG had not agreed to extend the temporary use of two clinical rooms at the Healthy Living Centre which has eased constraint over the last few years.



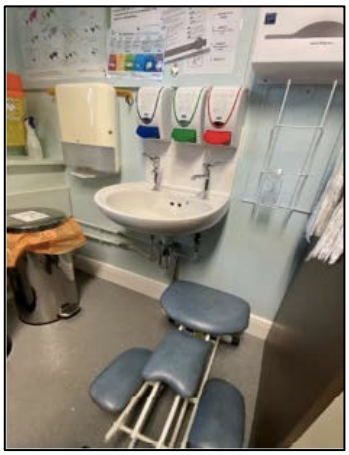


Figure 95: Grove Surgery Ground Floor

All clinical services are on the ground floor, there is an independent commercial pharmacy located within the building. There are 11 consultation/examination rooms none of which meet the HBN requirement of 16 m^2 most are 12-14m^2.

[18] PCN Service and Estates Strategy Toolkit methodology

The nurse treatment area gives most rise for concern with very small treatment and patients walk through preparation areas. Toilet facilities are undersized and inadequate. Corridors and waiting areas do not enable social distancing. There is a very small room identified for counselling which is not suitable for this use. There is no dedicated clean utility room as required by current infection control regulation. The Practice is not able to offer a private breast-feeding space. There is no lift to the first floor which accommodates office functions. A shortage of space has meant the staff room has been lost to an office. The meeting room now doubles as the staff rest area when not in use. The two small staff WCs do not facilitate staff changing now required for PPE. The Plant room is being used for storage due to lack of space which presents a fire risk.

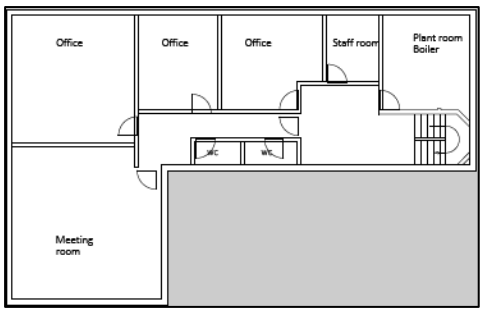


Figure 96: Grove Surgery First Floor

School Lane Surgery

The Surgery is a 480m2 purpose-built facility now over 25 years old but has been extended and improved during that period. It extends over two floors with mezzanine levels but no lift. The Surgery has no dedicated parking but there is a free public car park to the front of the building. The Surgery is leased with an 18-year term (2039).

With a weighted list of over 11,000 and a patient per square metre of 23.04 the Surgery is the most constrained in South Norfolk. CCG analysis suggests it is around 3,500 registrations above what would be expected for its size.

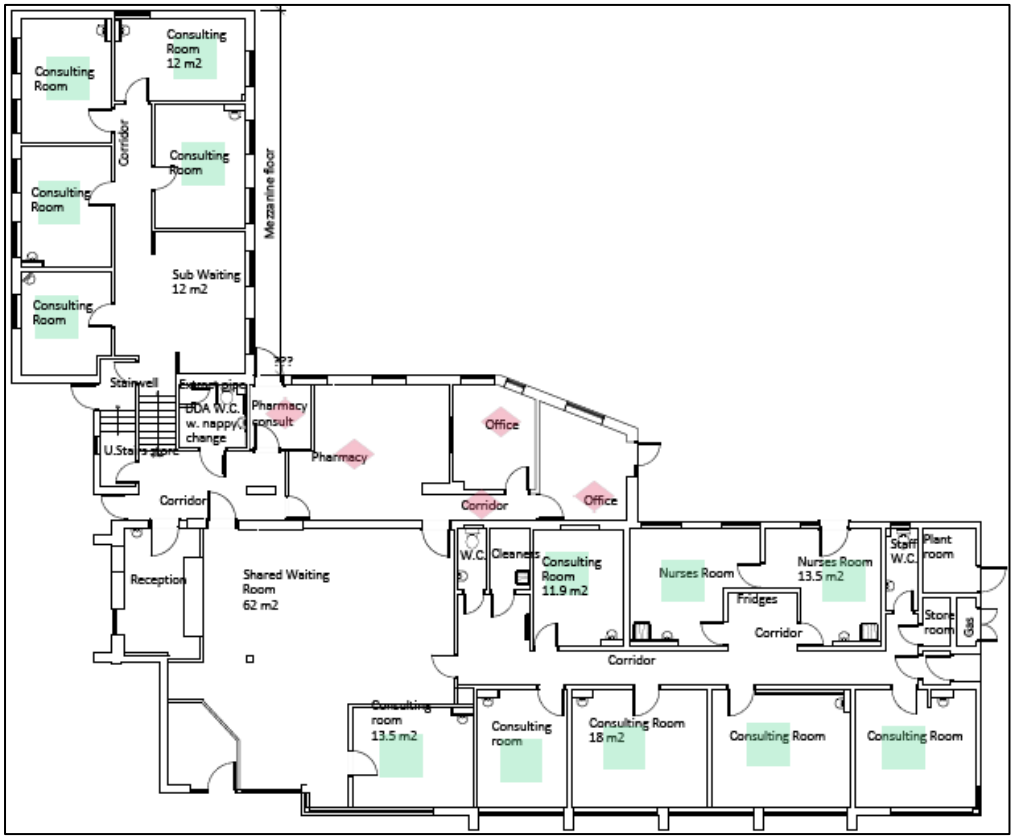


Figure 97: School Lane Ground Floor

The Surgery also run the PMS service at the Healthy Living Centre which has enabled them to keep their lists open as patients are able to access services from both sites.

Figure 98: School Lane Surgery

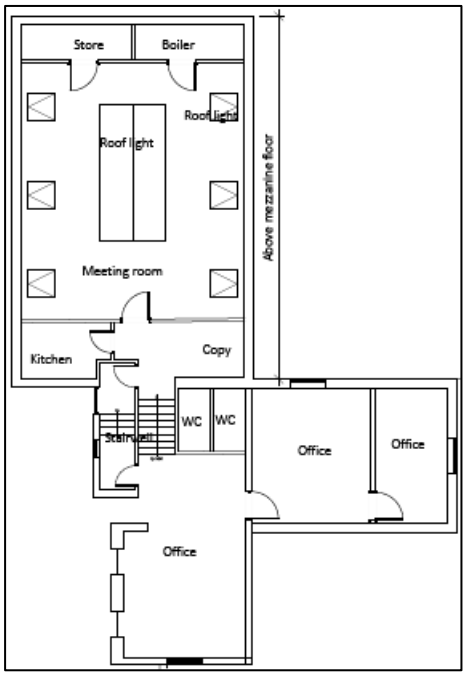


Figure 99: School Lane Surgery Upper Floors

The Surgery has 13 clinical rooms. In recent years the Practice has invested its own resources to improve the layout of the waiting and administrative areas on the ground floor. Five of the consultation rooms are up several steps not accessible to those with significant mobility problems. Several the consultation rooms are undersized, some of which are carpeted, and the nurse treatment rooms are non-compliant.

The sloping site is very constrained requiring several staircases and the upper floors are also split over two levels.

Demand has led to the gradual loss of staff areas to admin functions.

There is a very small kitchen area but no dedicated staff room or staff changing room.

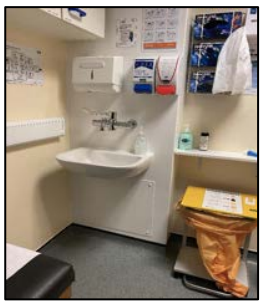


Figure 100: School Lane Surgery Non-Compliant Clinical Rooms

Thetford Community Healthy Living Centre

The Healthy Living Centre was built in 2006 as a multi-agency service Hub incorporating, community, mental health, outpatient, diagnostic services and a commercial pharmacy, alongside a PMS practice run by School Lane GPs. It was delivered under the NHSLift[19] initiative with Community Health Partnerships (CHP) holding a head lease on behalf of the NHS. The GP reimbursed area extends to 343m^2.

According to CCG analysis, at 6,638 the APMS list is 2,500 greater than would be expected for the reimbursed area.

The Primary Care Network have temporary use of other areas within the centre:

[19] Local Improvement Finance Trust

- Two consultation rooms to ease pressure at the Grove Surgery sharing waiting and reception areas with School Lane.
- PCN admin staff are currently based in unused areas on the first floor.

The Primary Care Network have a long history of working closely with Commissioners to better utilise the Healthy Living Centre. In 2015 the two Thetford Practice combined in a Community Interest Company to work with CHP to attract additional services into the building. They proved more responsive than commissioners in addressing underutilisation doubling the clinical services[20]. Clinical utilisation has continued to be high but successive changes to NHS Commissioner structures have made these improvements hard to maintain.

Figure 101: Thetford Healthy Living Centre ground floor utilisation

GP clinical services are located on the ground floor, there are 7 consultation/ examination rooms utilised by the PMS practice. All are modern, well equipped, and largely compliant with current NHS guidelines.

[20] Innovative Centre Management Doubles Patient Services: Focus on Thetford Healthy Living Centre (CHP 2016)

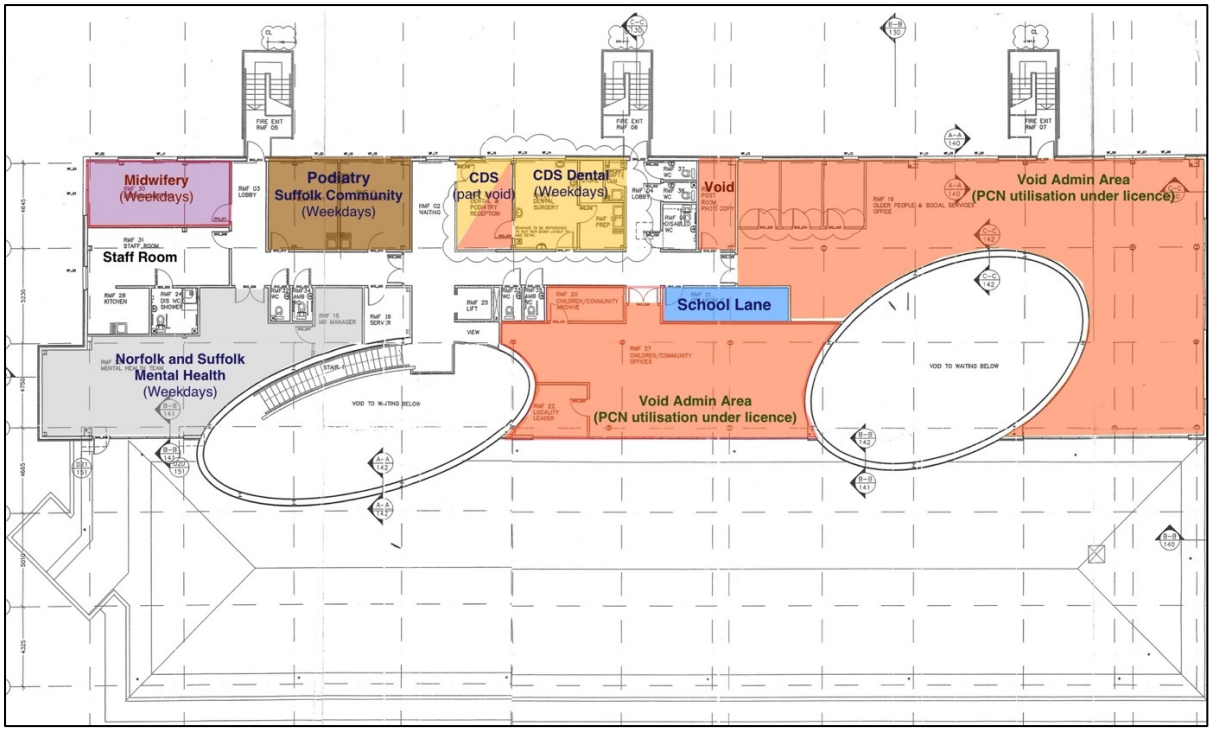


Figure 102: Thetford Healthy Living Centre first floor utilisation

There is lift access to the first floor where the PCN currently use void office areas. The building was the only Thetford facility suitable for supporting the Covid 19 vaccination campaign. The PCN were pleased to be supported by the CCG to offer patients a local vaccination venue. Support staff for the campaign currently occupy the void District Nursing office under licence.

Primary Care Network

The three practices forming the Breckland Alliance have worked together for many years, they now employ staff and other resources under a shared management Board and a jointly appointed managing partner.

PCN staff employed under the Additional Roles Reimbursement Scheme (ARRS) which the PCN are helping to deliver and contribute to an integrated work plan in line with the CCG' Primary Care Strategy whilst also building on the foundations of the NHS Long Term Plan (LTP), GP Forward View (GTFP) supporting a more 'joined up' NHS with neighbourhood hubs and facilitating an integration between Primary, Community and Social.

Outpatient Provision

Outpatient provision is already present at the Healthy Living Centre through a variety of providers:

- West Suffolk Hospital: various consultant led outpatient clinics, plain film Xray and ultrasound services.
- Addenbrookes Hospital: consultant led cardiology outpatients' clinics
- Norfolk and Norwich: Outpatients

The variety of provision has been helped by rooms being booked on an ad-hoc basis with none of the current services holding a long-term lease.

Community Services

There are a variety of community service providers present on the Healthy Living Centre including:

- Norfolk Community Health and Care: Physiotherapy
- Suffolk Community Services: Podiatry
- Community Dental Services: Specialist dental care

- Norfolk and Suffolk Mental Healthcare Trust: Community Team
- Anglia Community Services: Ophthalmology
- Hearing Care Centre: Audiology
- British Pregnancy Advice Service: Pregnancy advice and support.

Community Diagnostic Centres (CDC)

The Healthy Living Centre is one of two options being considered in the town as a 'spoke' CDC linked to the proposed Diagnostic Access Centres in Norwich, Gorleston and Kings Lynn. The project managers have been engaged in preparing this business case and the two proposals could be brought together at the FBC stage.

At the time of submitting the Programme Business Case the service requirements and schedule of accommodation for the CDC were not available. The generic model looks for standard consultation spaces alongside the diagnostic resources already available at the Healthy Living Centre. It is suggested up to 800m^2 might be required for stand-alone CDCs offering the full range of services.

Future Demand Thetford

The Breckland Adopted Local Plan (2019) makes a substantial new allocation in the form of a Strategic Urban Extension (SUE) to the north Thetford. Ultimately this is expected to include 5,000 new homes over 5 phases, the first phase is now well underway.

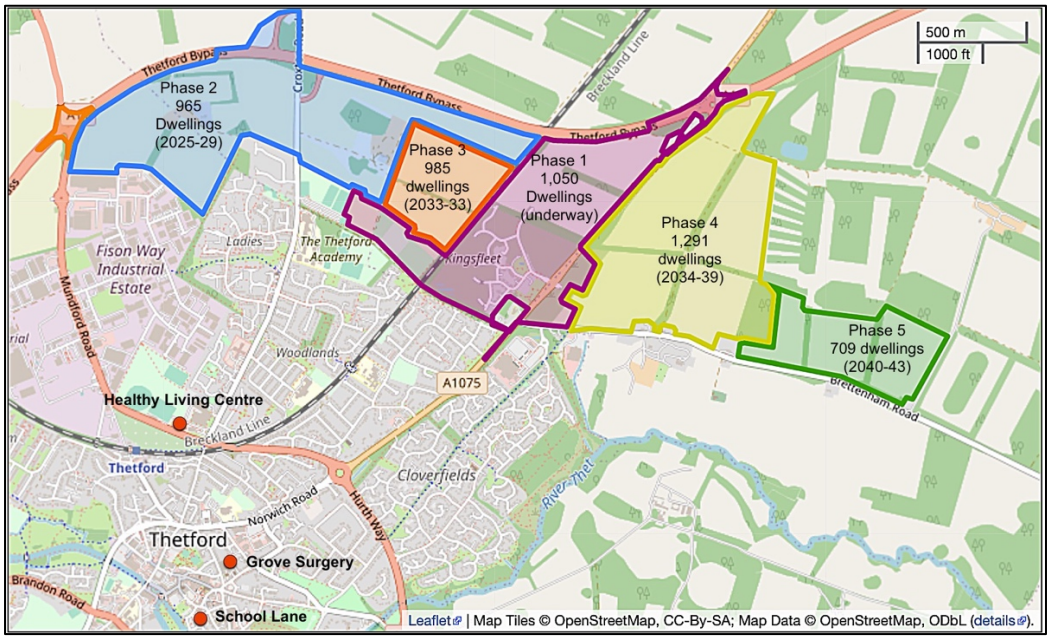


Figure 103: Thetford – current surgeries and proposed housing

The graph below shows the expected growth of registration demand, resulting from the phased development of the SUE. There are two Section 106 allocations whose likely trigger points are also indicated on the graph.

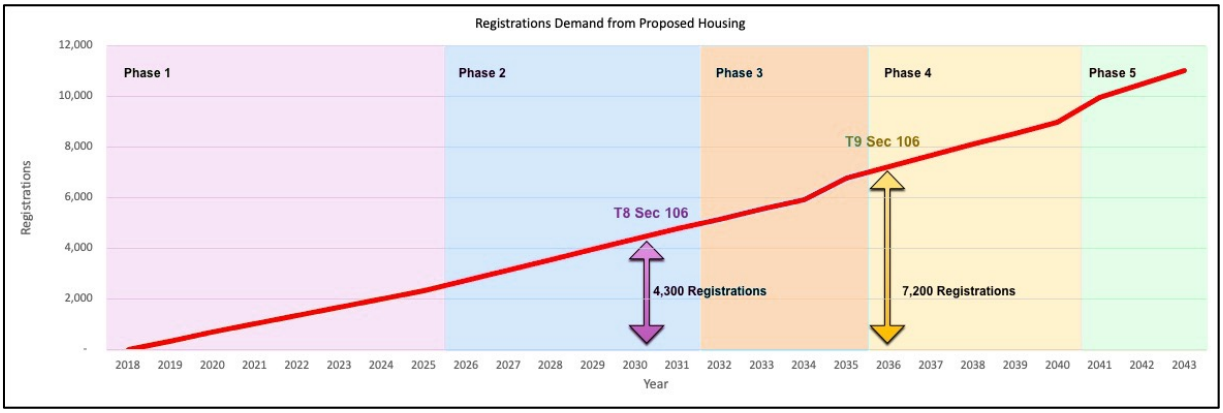


Figure 104: Thetford – cumulative registration growth

Although delayed by the pandemic, demand is now increasing rapidly and is expected to be 350-450 registrations per year over a 20-year period.

Section 106 Provision

An approved Section 106 agreement (27th November 2015) currently makes an allocation of £178k (Indexed Linked) marked T8 on the graph:

'to be used for the provision of primary care facilities at Thetford Healthy Living Centre, Grove Surgery or School Lane surgery or such other new facility on the Site or in the vicinity of the Site as may be required to serve the Development'.

This to be paid before 80% of the dwellings are completed in phase 2, which is not expected before 2030.

A second Section 106 agreement as part of the Master Plan makes provision for a 'Community Centre' and is triggered before 30% of the dwellings having been occupied in phase 4 of the development marked T9 on the graph above. Not expected before 2035/36. Uses may include a Doctors Surgery. The allocation is currently £2,175,000 (Index linked).

Looking at the proposed programme by 2030 demand for registrations will have risen to 4,300 and by 2035 to over 7,000[21]. Neither of these figures are sustainable without the proposed investment in infrastructure much earlier in the programme.

Primary Care now relies on a wide range of clinical staff to support patients and the use of GP appointments is an outdated measure of workforce capacity. However, the current practices do not have the physical capacity to accommodate any new staff within their reimbursed areas. They are only able to operate now because they have spilled into void areas at the Healthy Living Centre.

Therefore, they will not be able to support the proposed growth prior to the proposed developer contributions.

The situation is the same for the next nearest practices in East Harling and Kenninghall whose current utilisation is only slightly lower than the Thetford Practices. The nearest practices across the border in Suffolk are at least 10km away and currently exclude Thetford from their catchment areas.

The NHS no longer support stand-alone, single-handed practices. Unless it was a branch of an existing practice, a new facility within the SUE would not be viable until at least 2030 when demand exceeded 4,000 registrations. Pursuing this option Commissioners would be faced with subsidising an underutilised two GP practice with supporting nursing and administrative staff until the list increased.

The PCN's Watton Surgery has some capacity to grow, the majority of this will be required to meet the planned expansion of the town. Whilst patients were willing to travel to Thetford for more specialist services such as the C-19 vaccination campaign, it is not reasonable to expect Thetford patients to

[21] Assuming 2.2 registrations per dwelling.

travel routinely to Watton a two hour round trip by bus, for core GMS services, when there are three practices in the town.

Consequently, the PCN is not able to support the provision of core GMS services to the Thetford population in Watton as a solution to unmet demand.

Please see Section 3.12 for details of the actual registered list sizes for the PCNs where the proposed Primary Care Hubs will be based, and the anticipated and assumed growth per site arising from housing.

The proposed Primary Care Hub will be in the Breckland PCN. The scheme name is Thetford and its approximate proposed location is indicated on the map below by a red circle.

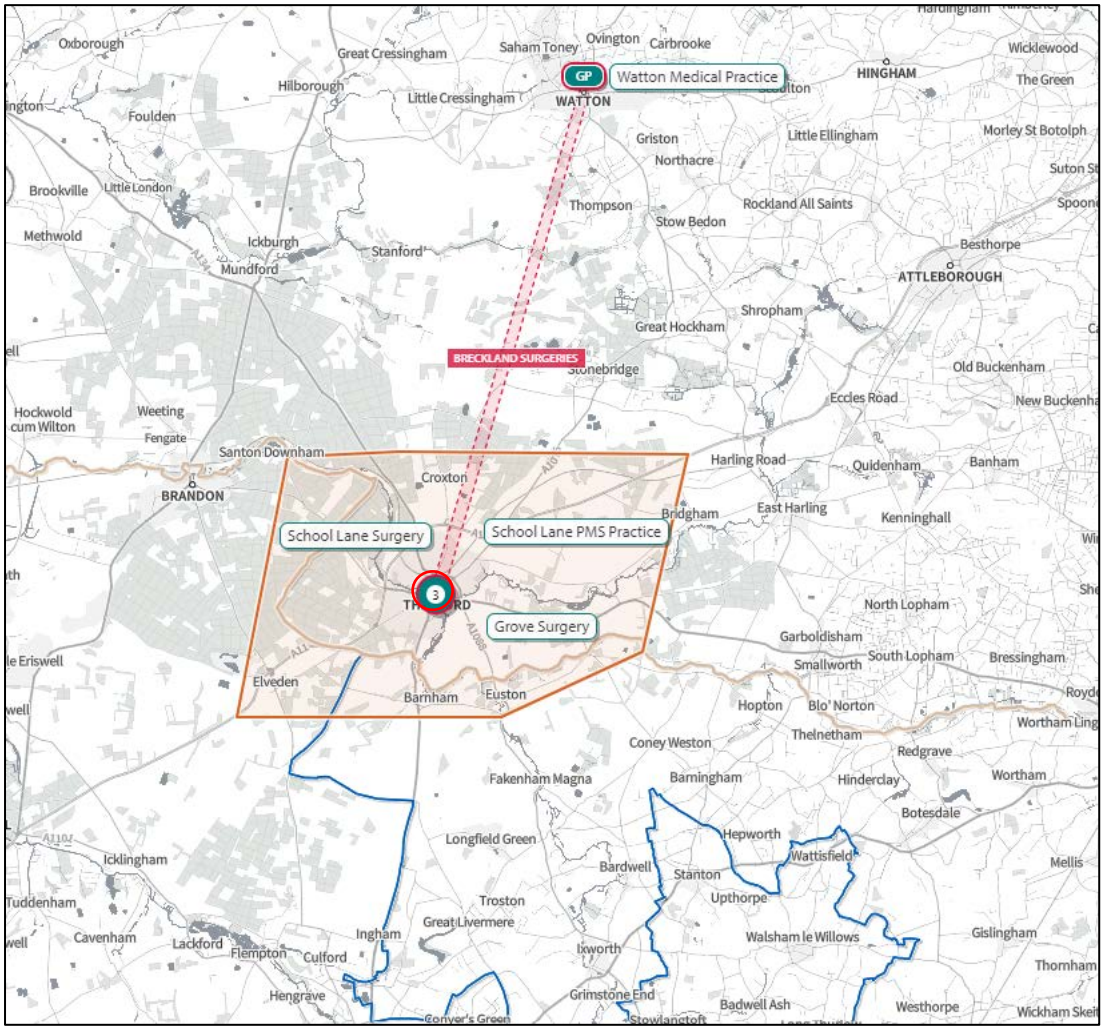


Figure 105: Breckland Alliance Primary Care Network

The current Primary Care Data Gathering information on Existing Estates and Services for the Breckland PCN is developing (as with all PCN data). A short summary of the information is shown below.

Workforce Gap

The expected demand from the SUE could require up to 9 additional whole time GPs (or similar extended clinical roles), along with the nursing and administrative staff required to deliver core GMS services.

In addition, the PCN's vision will require recruitment and accommodation for an additional 15 whole time equivalent ARRS roles in addition to a permanent facility identified for the current 15 WTE ARRS staff.

The main obstacle to these future appointments is the physical constraints of the Thetford practices. The current appointments are only able to operate in Thetford due to a temporary permission to use vacant areas in the Healthy Living Centre.

Unless permanent additional clinical and administrative rooms can be identified these services will not be available to PCN patients in Thetford. Whilst this may be acceptable for some specialist appointments, many of the ARRS roles will only be successful if they are accessible locally.

Place Based Care

1. Population in very bad health 1.2%.
2. Life expectancy at birth for males (2020 – average number of years) 80.1
3. Life expectancy at birth for females (2020 – average number of years) 83.8

Grove Surgery

The Grove Surgery, Thetford has a registered population of 13,500 patients representing 31% of the PCN. Selected communities within Thetford suffer significant deprivation. The Practices score from the Index of Multiple Deprivation (IMD) 2019 of 23.7 means it is one of the most deprived communities within the Norfolk and Waveney area.

Deprivation is concentrated in the urban areas of two wards within the town, Newton and Saxon.

Actual List	Male	Female	Total	%
Age Group 0-4	363	345	708	5%
Age Group 5-14	782	767	1,549	12%
Age Group 15-44	2,842	2,593	5,435	41%
Age Group 45-64	1,758	1,744	3,502	26%
Age Group 65-74	574	606	1,180	9%
Age Group 75-84	345	379	724	5%
Age Group 85 And Over	123	197	320	2%
Totals	6,787	6,631	13,418	100%

Indicator	Practice	Locality	England
Deprivation score (IMD 2019)	23.70	16.24	21.72
Income Deprivation Aff. Children Index	0.15	0.11	0.17
Income Deprivation Aff. Older People Index	0.15	0.10	0.14
Life expectancy - Female	83.06	84.14	83.10
Life expectancy - Male	80.11	80.93	79.50
% long-standing health cond.	48.64	54.79	52.38
% caring responsibility	25.20	18.80	16.98
Paid work or full-time education	69.78	62.17	63.72
Unemployed	4.04	0.99	3.90

Lower Quartile / Lower | Middle Quartile / Similar | Upper Quartile / Higher

Figure 106: Grove Surgery – Demographics

The Practice profile of disease prevalence reflects a comparatively younger list than other practices in the Southern Norfolk Locality. It reports levels of depression significantly higher than other PCN and Locality Practices. Asthma and Hypertension are also higher than other practices within the PCN.

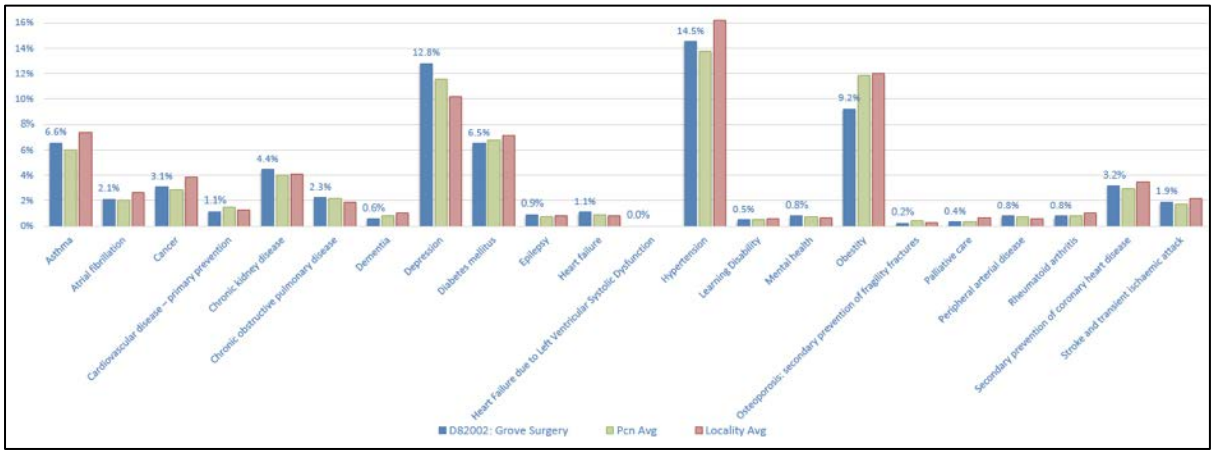


Figure 107: Grove Surgery – Disease Prevalence 2019/20 (QOF data)

The Grove Surgery look to the West Suffolk Hospital for acute services. When compared to other practices in the PCN, Locality and ICS they are a low referring practice.

Figure 108: Grove Surgery – Referral Rate per 1000 population

Despite this, there are a number of 'High Intensity Users' who regularly attend Accident and Emergency departments (more than 5 times in a year). These patients may with additional support be able to be supported within primary care.

The self-referrals to A&E result in the practice (and PCN) reporting a higher rate of 'Avoidable Admissions' than other PCNs in the locality and ICS. The Breckland Alliance is ranked 9th out of 20 PCNs for this measure.

Figure 109: Grove Surgery – High Intensity Users

School Lane Surgery

The Practice run two surgeries in Thetford, one in School Lane and a PMS branch at the Healthy Living Centre. With a combined list of 16,960 they represent 39% of the PCN. Like Grove Surgery their patients are drawn from several wards where there is significant deprivation. With an average IMD score of 24.12 they have the most deprived list in the locality.

Actual List	Male	Female	Total	%
Age Group 0-4	484	479	963	6%
Age Group 5-14	1,156	1,114	2,270	13%
Age Group 15-44	3,762	3,379	7,141	42%
Age Group 45-64	2,065	2,044	4,109	24%
Age Group 65-74	642	700	1,342	8%
Age Group 75-84	394	463	857	5%
Age Group 85 And Over	101	177	278	2%
Totals	8,604	8,356	16,960	100%

Indicator	Practice	Locality	England
Deprivation score (IMD 2019)	24.12	16.24	21.72
Income Deprivation Aff. Children Index	0.15	0.11	0.17
Income Deprivation Aff. Older People Index	0.15	0.10	0.14
Life expectancy - Female	83.19	84.14	83.10
Life expectancy - Male	80.04	80.93	79.50
% long-standing health cond.	54.52	54.79	52.38
% caring responsibility	19.35	18.80	16.98
Paid work or full-time education	64.09	62.17	63.72
Unemployed	0.00	0.99	3.90

Lower Quartile / Lower | Middle Quartile / Similar | Upper Quartile / Higher

Figure 110: School Lane Surgery – Demographics

The list has a relatively young demographic when compared to other practices in the Locality and ICS which may explain a lower average level of chronic disease. The practice does report higher levels of obesity, diabetes and kidney disease than other practices in the PCN and Locality.

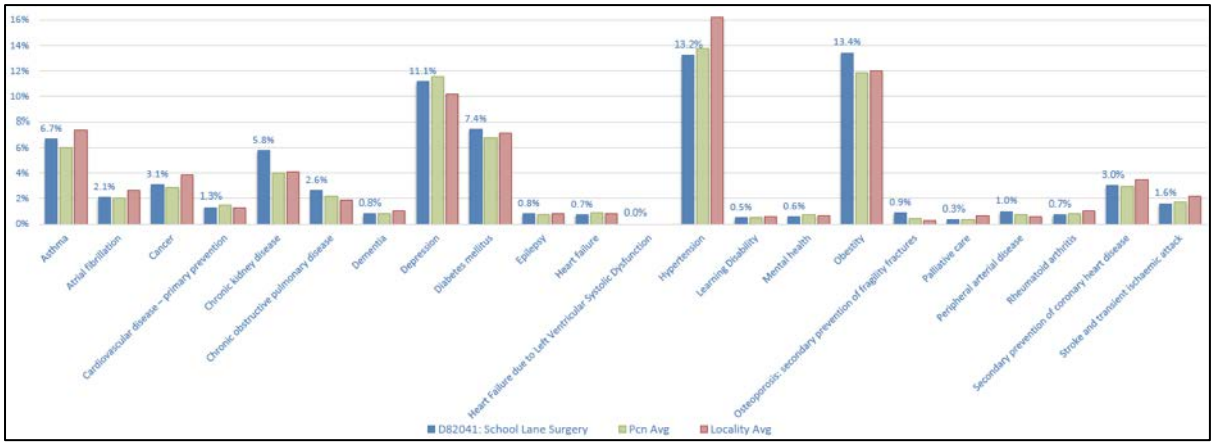


Figure 111: School Lane Surgery – Disease Prevalence 2019/20 (QOF data)

Like Grove Surgery the Practice refer into the West Suffolk Hospital and are a comparatively low referring practice. However, they also have a number of High Intensity Users making multiple visits to the A&E department in Bury.

Overall, their patient attendances at A&E are higher than other practices in the locality. Those that end up being admitted and are deemed avoidable are on average fewer than other practices in the PCN and ICS.

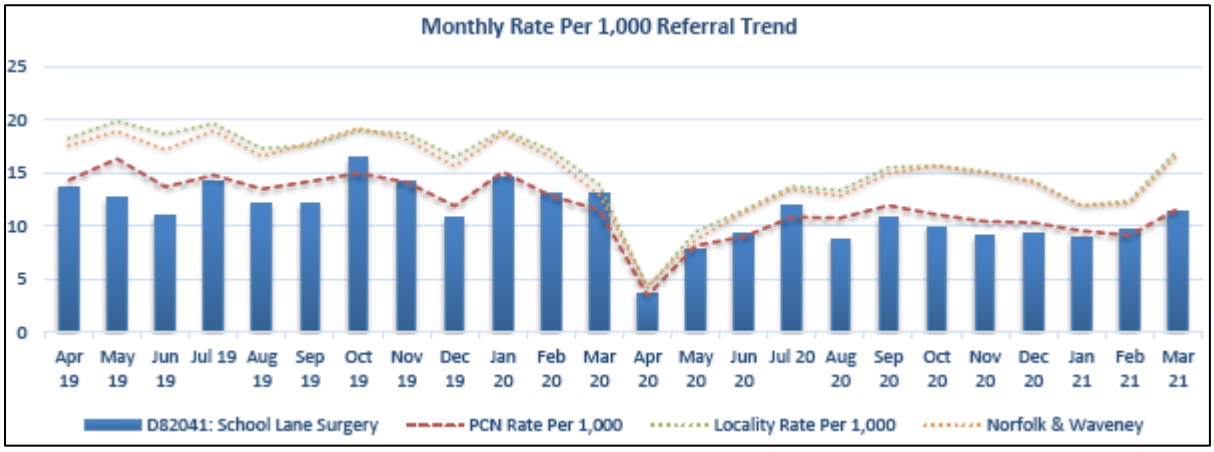


Figure 112: School Lane Surgery – Referral rates per 1000 patients

The PCN's patients are comparatively high users of A&E services when compared to the other practices in the South Norfolk Locality and are ranked 6th highest out of the 20 PCNs in Norfolk and Waveney.

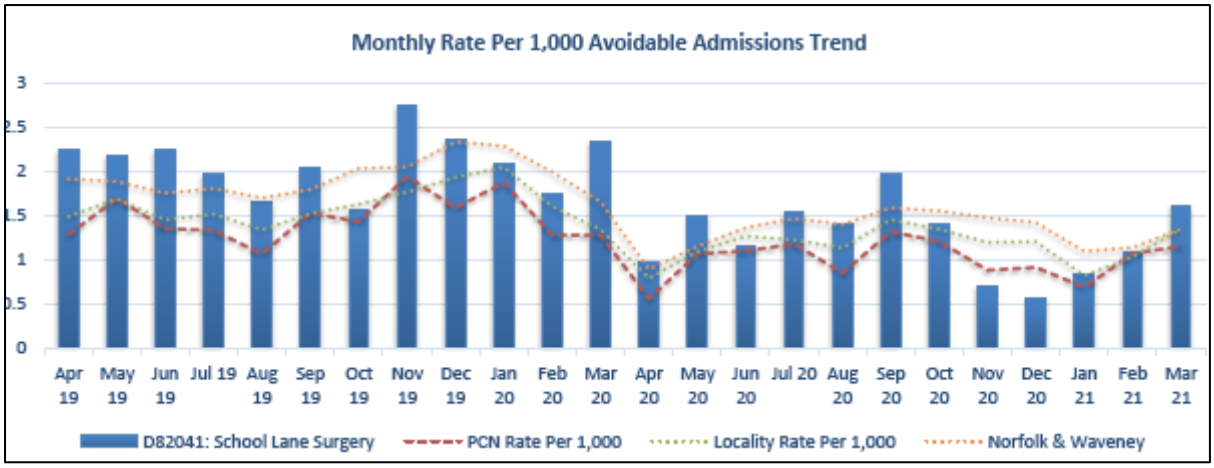


Figure 113: School Lane Surgery – Avoidable Admissions per 1000 population

Schedule of Accommodation

The schedule of accommodation aims to deliver the PCNs service strategy and digital focus, to meet the expected registration demand, satisfy the requirements of outpatient, dental and PCN appointments.

- Earlier option appraisal work has confirmed expansion of the existing Hub at the Healthy Living Centre as the desired location and most cost-effective solution. This will meet the long-term demand arising from phases 1-4 of the SUE, in addition to supporting ARRS and outpatient services in the interim.
- The schedule has been refined with providers to meet both their requirements and the proposed operational model for the hubs.
- The design team have utilised the latest HBN guidance, best practice considering lessons learned during the pandemic and changing consultation patterns.

Additional Accommodation Required

(The SOA assumes staff facilities, meeting rooms, admin and supporting infrastructure are already in place at the Healthy Living Centre other areas may also be shared. Additional administrative space will be found offsite for the displaced PCN administrative staff)

	Description	M2	Number	Total
	Reception	15	1	15.0
	Waiting/sub wait (per clinical room)	6.8	17	115.6
	Clinical Areas			
	Consultation Exam	16	13	208.0
	Treatment	16	1	16.0
	Clean Utility	12	1	12.0
	Dirty Utility	7	1	7.0
	Store	11	1	11.0
	Accessible WC	4.5	1	4.5
	WC	2	2	4.0
	Cleaner	6	1	6.0
	TOTAL			**399.1**

The PCN have recently published their Estates Strategy, which describes their Place Based clinical strategy and the ability of the current estate to deliver it. The Strategy also considered the growth proposed in the town and a long list of options to meet it.

Longlisted Options

Ref	Description	Fit	Shortlist
1	Expansion of Grove Lane Surgery	Short term solution only	No
2	Expansion of School Lane Surgery	Constrained site not feasible	No
3	Development of a new branch facility in the SUE	Costly and unsustainable for several years	No
4	Development of a new Practice and provider in the SUE	Provides no capacity in the short term	No
5	Expansion of the Thetford Healthy Living Centre	Does not address current underutilisation at THLC	No
6	Reconfiguration of the Healthy Living Centre to provide 5 new Consult/Exam	Short to medium term solution	Yes
7	Reconfiguration of the Healthy Living Centre to provide 6 new Consult/Exam	Medium term solution	Yes
8	Reconfiguration of the Healthy Living Centre to provide 14 new Consult/Exam	Long term solution until sec 106 funds become available	Yes

Short Listed Options

There are four shortlisted options proposed to resolve current overcrowding in the GP Practices; meet the proposed growth demand in the area; and promote a greater integration between services.

Those options are:

Option 1	**Business As Usual**	Making no investment and leaving existing resources in place to meet the demand.
Option 2	**Do Minimum: Create 5 Consult/Exam rooms Thetford Healthy Living Centre (THLC)**	Converting the former district nursing office and adjacent rooms into a 5 consultation room outpatients department. Expanding PCN services on the ground floor.
Option 3	**Create 6 Consult/Exam rooms and associated infrastructure THLC**	Converting the former district nursing office and adjacent rooms into a 5 consultation room outpatients department. Adding an additional consultation room on the ground floor for PCN expansion.
Option 4	**Create 14 Consult/Exam rooms and associated infrastructure THLC**	Converting the former District Nursing and Health Protection offices on the first floor to 12 Consult Exams and 1 Treatment Room. Adding an additional consultation room on the ground floor for PCN expansion.

OPTION 1: Business as Usual

Description: This Option would see no change to the current provision at the Healthy Living Centre with PCN staff continuing to occupy the vacant areas. The head lease holder (CHP) has already asked the PCN to seek a formal long-term lease to secure their position.

With a shortfall in capacity of 11,000 registrations to meet housing growth and no capacity in the current Thetford premises, business as usual is not a sustainable position.

Meeting the new demand will require up to 9 FTE GPs or equivalent advanced practitioners with supporting administrative staff. In addition, the PCN still has no permanent home for its 15 FTE ARRS appointments with a further 15 planned in the coming years.

Neither the ICS or local planning authority will be able to move forwards with its vision for the town and its clinical services without additional premises capacity. Without this investment the PCN would need to protect itself from unsustainable list growth.

Designs: See floorplans above.

SWOT Analysis

Strengths: This option does not have any strengths, save for it not requiring any investment.

Weaknesses: Existing practices will reach unsustainable levels of registration within a couple of years and will be forced to turn away patients seeking to register from the new communities. In the interim there will be a gradual erosion of wrap around community and ARRS services due to space constraints and a return to core GMS provision only.

Opportunities: There are no real opportunities with this option. Delaying the investment might allow sec 106 provision to be accessed to subsidise a future scheme. This option will not prevent the HLC being preferred option for Community Diagnostic Centre.

Threats: Further investment would be required in the other two premises in the town to ensure compliance and ease current operational pressures. This would not allow the demand from the new housing to be met. If the PCN face an onerous lease commitment at the HLC for its temporary admin areas, it may decide to vacate to more cost-effective premises.

Programme: Not applicable to this option.

Benefits: This option will not deliver any of the benefits identified in the Realisation Plan of the Programme Business Case.

OPTION 2: Do Minimum: Create 5 Consult/Exam rooms THLC

Description: This option would see the relocation of part of the PCN admin team off site. Followed by conversion of the former District Nurse's and adjacent rooms to 5 consultation/exam rooms with a small waiting area and reconfigured reception shared with Dental services. This area would be used to relocate the current outpatient services from the ground floor. They would utilise existing compliant WC facilities. There is lift access to the first floor.

The PCN would then utilise the vacated consultation rooms on the ground floor to provide an expanded, integrated service for PCN registered patients. The outpatient rooms would be accessible to any patient from the locality for more specialist services. The GP rooms would only need to be refreshed and re-equipped. The current practice reception will serve all the PCN consultation rooms.

Designs:

Proposed Floor Plans

First Floor

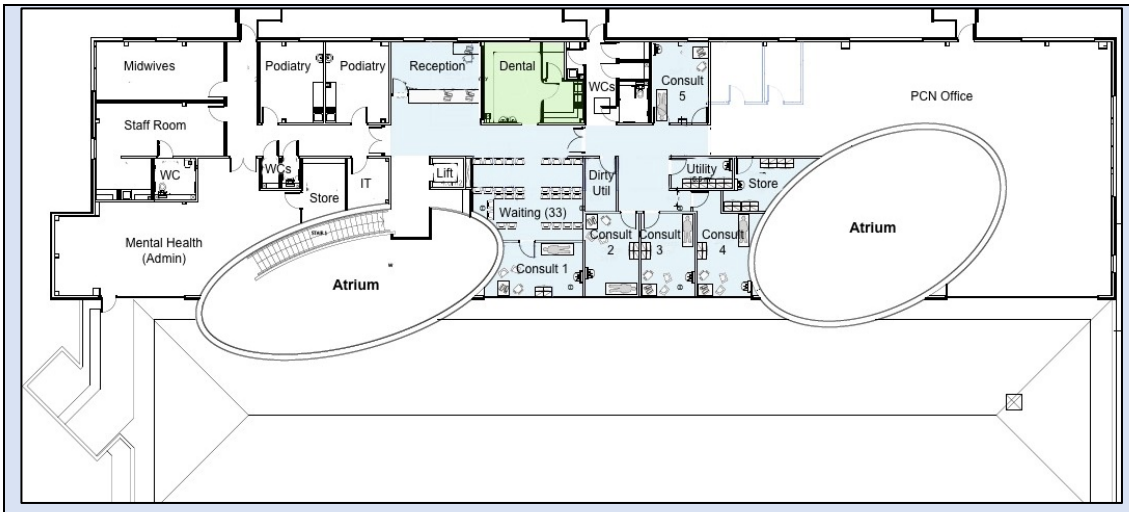


Figure 114: Thetford proposed Hub – Options 2 and 3 reconfiguration First Floor (blue)

SWOT Analysis

Strengths: This option would have the lowest conversion cost. It does not preclude further conversions in the future. It makes more efficient use of the existing facility.

Weaknesses: Given the current constraints within the Thetford estate and the proposed growth of the town, this conversion will only facilitate capacity to meet the first two of the five phases proposed for housing growth. It will not facilitate the desired growth in outpatients provision expressed by the West Suffolk Hospital. It will not enable further expansion of the ARRS programme. There will be a revenue consequence in moving PCN staff off site.

Opportunities: The scale of the conversion might not trigger the requirement for an expanded car park. This option will not prevent the HLC being preferred option for Community Diagnostic Centre.

Threats: If housing growth moves ahead of the planned programme, capacity may be used up more quickly.

Programme

Landlord and head leaseholder supportive. No planning permission required.

Start on site Q1 2023 – 4-month construction period (assuming car park expansion not required).

Completion Q2 2023.

Operational Q3 2023.

Benefits

The proposals enable the realisation of a number of the identified benefits expected to follow from Wave 4b capital funding, specifically

- Primary Care Led
- Digital initiatives
- Improved recruitment and retention
- Improved utilisation of the estate.

OPTION 3: Create 6 Consult/Exam rooms at THLC and associated infrastructure

Description: This option would see the same conversion on the first floor as Option 2 creating five new compliant consultation/exam rooms. In addition, the current outpatient's reception area on the

ground floor would be converted into a sixth compliant consultation room for use by the PCN. As in option 2 part of the PCN team would be relocated off site.

Designs: Please see Figure 103 for first floor conversion.

Ground Floor proposed new consultation room (pink) and expanded PCN area (red).

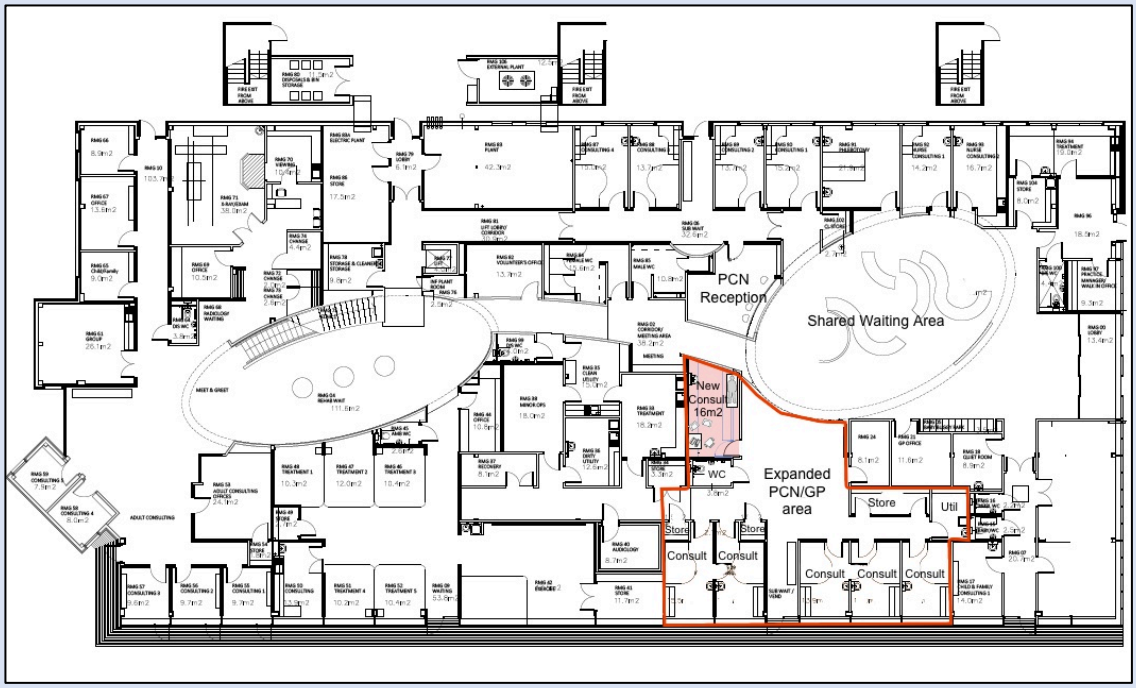


Figure 115: Thetford proposed Hub – Option 3 and 4 Ground Floor Proposed new consultation room

SWOT Analysis

Strengths: This option does not preclude further conversions in the future. It makes more efficient use of the existing facility and reuses the redundant reception area. All new clinical rooms on the first floor would be bookable.

Weaknesses: Given the current constraints within the Thetford estate and the proposed growth of the town, this conversion will only facilitate capacity to meet the first two of the five phases proposed for housing growth. It will not facilitate the desired growth in outpatients provision expressed by the West Suffolk Hospital. There will be a revenue consequence in moving PCN staff off site.

Opportunities: The scale of the conversion might not trigger the requirement for an expanded carpark. This option will not prevent the HLC being preferred option for Community Diagnostic Centre.

Threats: If housing growth moves ahead of the planned programme capacity may be used up more quickly. This option may make THLC less attractive as a potential Community Diagnostic Centre.

Programme

Landlord and head leaseholder supportive. No planning permission required.

Start on site Q1 2023 – 4-month construction period (assuming car park expansion not required).

Completion Q2 2023.

Operational Q3 2023.

Benefits

The proposals enable the realisation of a number of the identified benefits expected to follow from Wave 4b capital funding, specifically

- Primary Care Led
- Supporting demand management initiative
- Extended range of community services
- Digital initiatives
- Improved recruitment and retention
- Improved utilisation of the estate.

OPTION 4: Create 14 Consult/Exam rooms at THLC and associated infrastructure

Description: This option would see all the areas currently occupied by PCN admin teams converted for clinical use, the whole team would be relocated off site. It would create 13 compliant consultation rooms, sub waiting, office and storage (Clean utility) and dirty utility areas. It would reuse existing WC and reception areas. On the ground floor an additional consultation room would be created as in Option 3.

Designs: Please see Figure 112 for Ground Floor Plans

Figure 116: Thetford proposed Hub – Option 4 conversion of First Floor

Please see Figure 105 for proposed conversion of first floor into 13 consultation/exam rooms (blue and purple) and potential second lift if required (red).

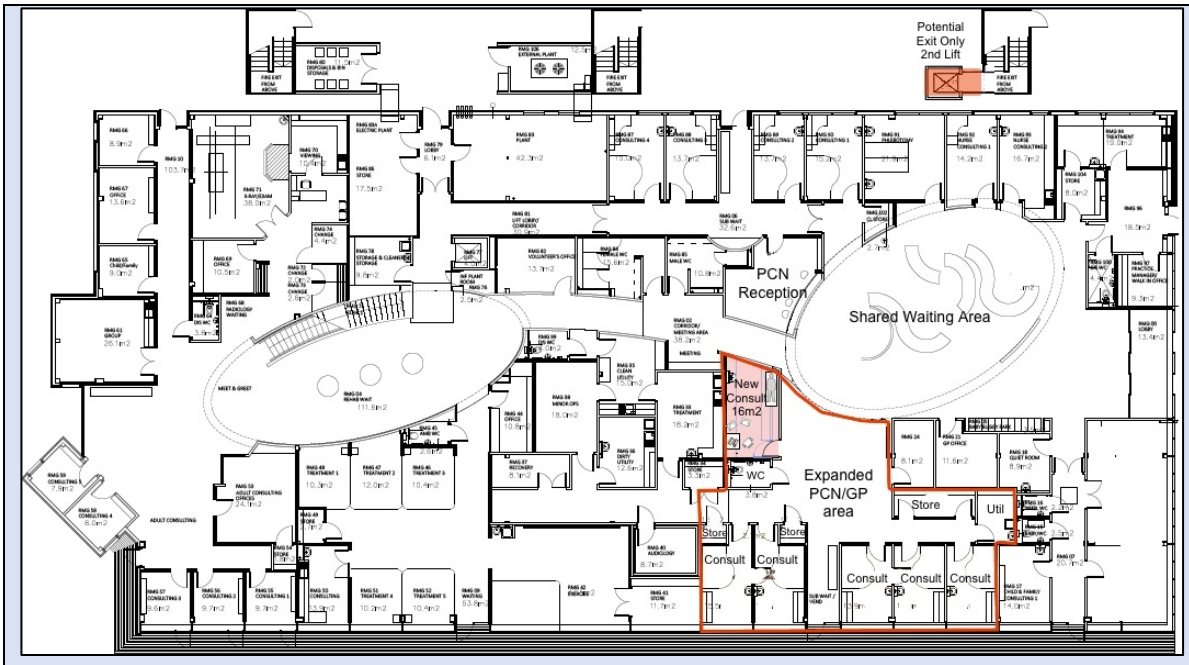


Figure 117: Thetford proposed Hub – Option 4 Ground Floor

Please see Figure 106 for proposed expansion of PCN area, new consultation room and potential lift.

This proposal may not require planning permission unless the additional lift is required. If permission is required planners may seek to expand parking which has been highlighted as a problem for some time. A planning application was approved previously for an expanded 91 spaces carpark although the scheme did not go ahead. Regardless of planning, current parking is likely to be inadequate for the additional clinical activity proposed.

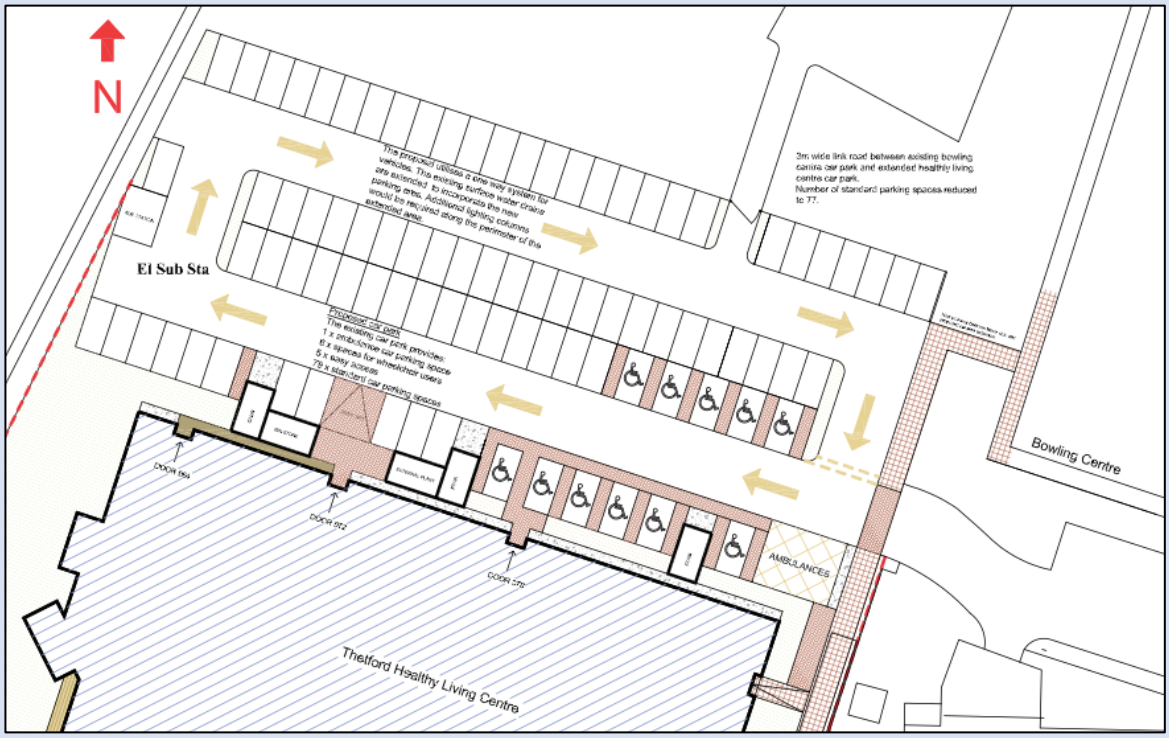


Figure 118: Thetford proposed Hub – car park expansion proposal (2018)

SWOT Analysis

Strengths: This option ensures sufficient capacity to relocate outpatient and provides the additional capacity to enable the PCN to meet the growth planned from the first four waves of the proposed housing. It provides capacity for PCN clinical Services to ease current registration pressure.

Weaknesses: This proposal is likely to trigger the requirement for increased permanent car parking. There will be a revenue consequence in moving PCN staff off site.

Opportunities: This option facilitates an increase in wrap around, ARRS, outpatient and diagnostic services in the short to medium term.

Threats: It is not clear if the West Suffolk Hospital will be able to sign a long-term lease. There may be a requirement to provide a second lift for high volume services. This option may make it less likely the HLC will be selected as the preferred option for the CDC if significant space and a long-term lease is required.

Programme

Landlord/head leaseholder supportive

Planning submitted prior to FBC

Start on site is Q1 2023

10-12 month construction period

Completion Q4 2023

Operational Q4 2023.

Benefits

The proposals enable the realisation of a number of the identified benefits expected to follow from Wave 4b capital funding, specifically

- Enabling transformational care
- Primary Care Led
- Supporting demand management initiatives
- Extended range of community services
- Spaces for public health
- Promoting multidisciplinary care
- Digital initiatives
- Improved mental health care
- Broad skill mix
- Improved recruitment and retention
- Increased capacity
- Contributing to environmental targets
- Improved utilisation of the estate.

South Norfolk – Thetford Healthy Living Centre: Financial Appraisal

Capital and Revenue implications have been estimated using the best available information, but actual costs may vary when the schemes finally come to market.

Capital Costs

The following outlines the estimated capital costs of each option.

Project Name	GIA	Capital Requirement							Funding Source	
		Land	Construction	Fees	Optimisum Bias	Contingency	IT	Total Capital	Wave 4b Capital	3PD Capital
	m2	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Option 1 - BAU		-	-	-	-		-	-	-	-
Option 2 - 5 clinical rooms	245	-	683	96	234	156	144	1,313	1,313	-
Option 3 - 6 clinical rooms	261	-	734	103	251	167	147	1,402	1,966	-
Option 4 - 14 clinical rooms	477	150	1,999	183	446	448	236	3,462	3,462	-

Notes & Assumptions:

- Costs include VAT.
- Optimism Bias is included at 30% which is a NHSE requirement. Contingency is included at 20%.
- IT costs estimated – pending further detail. Options 2 and 3 include £100k for digital innovation and Option 4 includes £150k for digital innovation.
- Option 4 may require additional parking and a lift if this becomes a requirement. These additional costs have been included in capital estimates and consists of the following:
    - Additional land £150k
    - Car park construction works £450k
    - Additional lift and lobby area £245k

Recurrent Revenue

Project Name	Increase in recurrent revenue costs						Funding Source	
	Rent	Rates	Water	Clinical Waste	IT	Total	CCG	NHS Trust
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Option 1 - BAU	-	-	-	-	-	-	-	-
Option 2 - 5 clinical rooms	72	-	5	5	39	121	121	-
Option 3 - 6 clinical rooms	72	-	5	5	40	122	122	-
Option 4 - 14 clinical rooms	102	-	5	5	44	156	156	-

Notes & Assumptions:

- The overall rent for the Thetford Healthy Living Centre does not increase, however, the cost of Facilities Management and Lifecycle costs do increase as per Lease Plus terms. This cost has been included with the Rent heading above and ranges from £54k to £59k per year across options 2 and 4.
- There is an additional cost for Rent & Service charges due to the relocation of the PCN offices. These costs have been included with the Rent heading above and estimated at £28k per year for Options 2 to 3 and £54k per year for Option 4. Option increases in cost due to more PCN admin staff being relocated.
- Estimated additional IT revenue costs based on additional IT workstations needed, plus the ongoing cost of putting a NHS broad band line into the new office accommodation for the PCN team. This latter element based on £37k per annum pending confirmation from IT team.
- VAT has been applied as THLC is Opted to Tax. Also, the new office accommodation for the PCN team will also incur VAT. At this point it is assumed that additional VAT liability cannot be reclaimed.

Non-Recurrent Revenue

Estimated non-recurrent revenue consequences for each scheme:

	Non Recurrent Revenue		
Project Name	Proj Mgmt	FM Provider one off cost	Total NR Revenue
Scheme	£k	£k	£k
Option 1 - BAU			-
Option 2 - Refurbishment with 5 clinical rooms	50	5	55
Option 3 - Refurbishment with 6 clinical rooms	50	5	55
Option 4 - Refurbishment with 14 clinical rooms	50	5	55

Assumptions:

- It is assumed that there will not be any lease transactions that incur any Stamp Duty Land Tax.
- Additional project management needed from ICS if no existing capacity.
- The one-off costs from the FM provider are required for supporting the works, training staff on new areas, linking into current systems

Option Appraisal - Economic Analysis

The economic appraisal has been undertaken using the Treasury's Comprehensive Investment Assessment (CIA) model. This considers the overall discounted costs and benefits of the options being considered over the lifetime of each option. The key elements of this appraisal are as follows:

- It considers only net flows of money, not transfers between the different parts of the public sector. So, for example, it excludes VAT.
- The appraisal period reflects the lifetime of the options. Currently the assumption for appraisal period is for the remaining lease term of the Thetford Health Living Centre whose lease expires at the end of February 2032.
- Values are discounted by 3.5% per year to reflect the timing of the cash flows i.e., later cash flows having a lower value than earlier ones.
- Optimism Bias is included at 30%
- The analysis considers the benefits that are likely to accrue over the lifetime of the options. A number of benefits will be system benefits that accrue to different partners. Some of these benefits may be non-Cash releasing but benefit the system in some way. There are also some estimates in terms of Societal benefits which can relate to improved lifestyles for the element of the population who will benefit from more integrated care and wrap around services.
- The level of benefits is aligned to the amount of additional clinical space being created e.g., Option 4 with the additional 14 clinical & examination rooms is estimated to deliver the most benefits.

The results of the economic appraisal to 2073 are summarised below:

	Option 0 - Business as Usual	Option 1 - Refurbishment with 5 additional clinical rooms	Option 2 - Refurbishment with 6 additional clinical rooms	Option 3 - Refurbishment with 14 additional clinical rooms
Incremental costs - total	£0	-£4,056	-£3,500	-£7,090
Incremental benefits - total	£0	£22,574	£27,089	£63,207
Risk-adjusted Net Present Social Value	£0	£18,518	£23,588	£56,117
Benefit-cost ratio		5.57	7.74	8.91

Option 4 has the best Cost to Benefit ratio (8.9) of the options being reviewed once the costs and benefits are discounted over the lifetime of each option.

Although Option 4 costs the most, the potential benefits from having the additional clinical rooms should deliver more benefits to the system.

Preferred Option

After having considered each of the options, their relative strengths and weaknesses, the indicative programme, benefits and costs; Option 4 had received the highest ranking. It was not felt that the proposed addition of a second lift represented value for money however it was felt the additional parking proposed would be essential to the long-term expansion of services. Option 4: Conversion works to the first and ground floors of the Thetford Healthy Living Centre creating 14 new Consultation/Exam was agreed as the preferred way forwards in conjunction with proposals to expand the carparking.

Preferred Way Forward: South Norfolk – Thetford Healthy Living Centre

Option 4: Create 14 Consult/Exam rooms and associated infrastructure

Preferred Option – Detailed Costing and Benefits

Capital

The overall capital cost for the preferred option is £3.46m which will be fully funded from the Wave 4b allocation. The capital costs identified here are based on estimated costs but includes significant contingency, a robust tender process will be undertaken at FBC stage. For prudence VAT has been included at full cost but is expected to be reclaimable.

Recurrent Revenue

The estimated recurrent revenue implications of the preferred option is an annual increase in revenue costs of £156k per annum across all tenants. To free up space for the changes the PCN administration staff who are currently in the Thetford Healthy Living Centre will be relocated to nearby office accommodation which will incur an additional rental and service charge but at lower price per m2 than current cost within the Thetford Health Living Centre.

Non-Recurrent Revenue

The estimated cost of non-recurrent revenue funding needed is £55k for project management and Facilities Management non-recurrent costs. This includes the one-off costs from the Facilities Management provider are required for supporting the works, training staff on new areas and linking into current systems.

Detailed Design and Planning Commentary

The preferred option will see two offices on the first floor and a redundant reception area on the ground floor (total 477 m^2) of the Thetford Healthy Living Centre converted into 14 fully compliant consultation/exam rooms.

These works will be completed as a capital scheme with no impact on the current lease costs for the facility. There will be increased Facilities Management and Lifecycle charges to support the new clinical areas in line with the existing head lease terms.

To enable this redevelopment the PCN admin teams based in the offices will relocate to a neighbouring office block with a recurrent revenue implication for commissioners. There will also be non-recurrent revenue costs to facilitate the IT connections required for the move.

To support the increased activity the carpark will be expanded to create 91 spaces and a second external lift will be added.

First Floor

On the first floor the existing small sub waiting area and reception office will be converted into a larger open reception facing the stairs and lift. The reception area will overlook an enlarged waiting area with 33 seats. The existing dental clinical rooms (green) will be retained along with the adjacent WC facilities and cleaner's room. The remainder of the area will be converted into 13 compliant consult/exam rooms, clean and dirty utility, a storeroom and a sub waiting area with a further 12 seats and adjacent hot desk. A second external lift will be added accessed via the existing fire exit.

It is intended these areas will be used for current outpatient services and expanded Primary Care Network patient facing services.

Current outpatient services operate from the ground floor. By relocating them to the first floor, PCN services can expand around the existing ground floor reception and waiting areas, making it easier for patients to navigate services and more efficient to resource for the PCN.

Over time, in conjunction with conversion proposals on the ground floor, they will help the PCN meet the registration demands of the first 4 phases of the Strategic Urban Expansion of the town (circa 9,500 additional registrations).

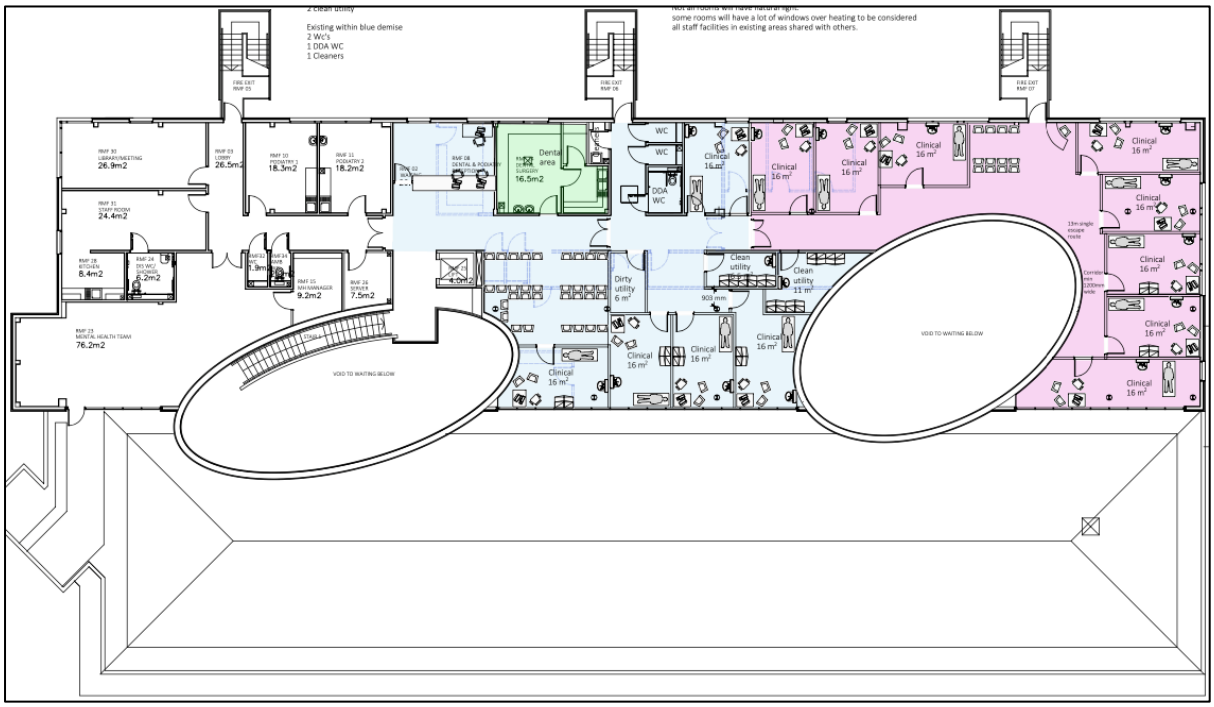


Figure 119: Thetford proposed Hub – Preferred Option First Floor

Ground Floor

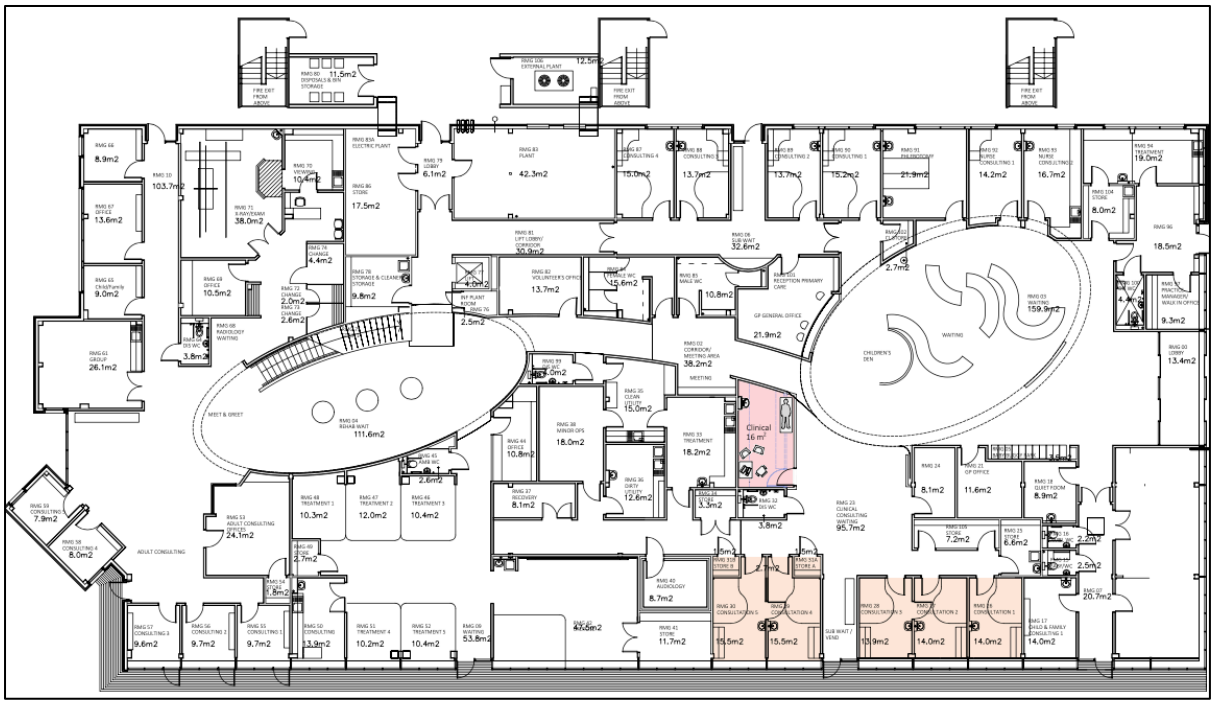


Figure 120: Thetford proposed Hub – Preferred Option Ground Floor

On the ground floor only minor works are proposed to convert the existing outpatients reception (pink area on Figure 117) to a compliant consult/exam room. The 5 current outpatient consultation rooms (orange are on Figure 117) will be utilised by the PCN. Adjoining doors in these rooms may need to be closed off to ensure acoustic privacy.

The PCN services will share the PMS practices' reception, waiting, WC, treatment, clean and dirty utility rooms.

The PMS reception will assist outpatient arrivals directing them to the new reception on the first floor. PCN patients will be directed to the most appropriate sub waiting areas.

External Works

The second lift (exit only) will discharge to the current car parking area.

Additional land will be purchased for a permanent replacement of the temporary overspill carpark, adjacent to the existing parking (40 spaces).

This will enable expansion up to 91 spaces, including 6 spaces for disabled visitors, 5 easy access for those with children and 79 standard bays. In addition there will be an ambulance parking bay next to the main entrance. A number of charging points will be provided including one to the ambulance bay in line with local planning guidance.

The centre currently hosts mobile (mammography) units, this facility will be retained occasionally utilising parking spaces to the northern corner of the building.

No other external works are proposed.

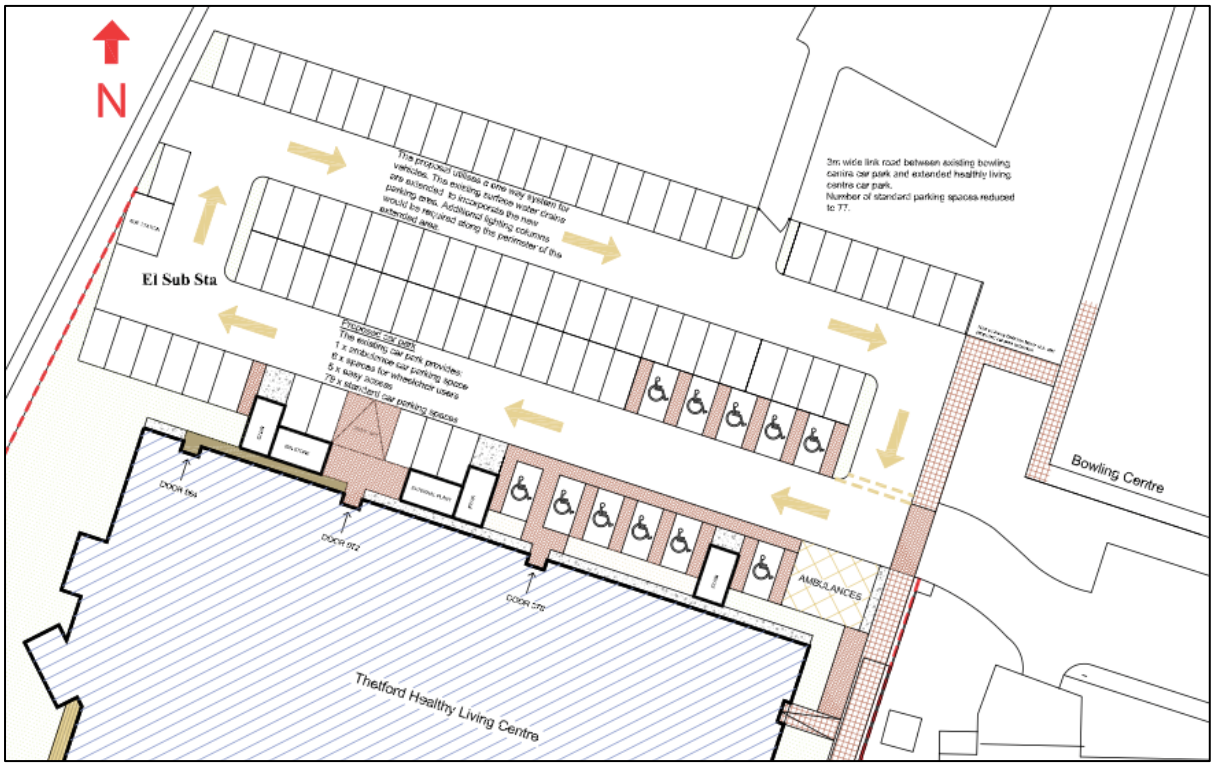


Figure 121: Thetford proposed Hub – Preferred Option Proposed Car Park Expansion

4.11.14 Facilitating other schemes

Local Estates Strategy work at PCN and ICS level will build on the work described above to establish an ongoing primary care premises programme of works. Immediate work is taking place to establish an alternative route for the two schemes which are no longer being taken forward via this Programme and Wave 4b Capital:

A Hub facility to serve the Gorleston area

Located on the Shrublands campus site, replacing the existing temporary facility, rehousing all the existing services, providing additional space for the replacement of a second surgery, space for East

Coast Community Healthcare community services and outpatient provision from the James Paget Hospital.

A Hub facility to serve the Attleborough Area.

Replacing both the existing practice sites and the health centre with a new single integrated facility, providing space for GP primary care facilities to serve an existing registered population of 20,000 and meet the expected growth of 10,000 registrations, Community and Nursing Therapy services and maternity services.

4.12 Benefits Methodology

4.12.1 Introduction to the benefits criteria

Those benefits that can be quantified financially are incorporated into the financial case whilst the benefits that are not financially quantifiable are incorporated into the Benefits Realisation Plan (Appendix 3). Each of the proposed schemes and the options considered to reach the preferred way forwards for that scheme, have been evaluated against the criteria. The detailed qualitative and quantitative assessments are contained within the proposed project sections below at Section 4.11.

4.12.2 Quantitative benefits appraisal

Activity and registration data, operational hours and service models has been used to inform the Schedules of Accommodation (SoA). Ensuring buildings are sized to meet the demand in the most efficient manner.

High level costs have been estimated for every option in each of the schemes to assist the local evaluation teams in deciding on the preferred way forwards. Those costs included:

Capital Costs:	*Recurrent Revenue Cost:*
Land	Indicative rents
Demolition/Construction	Maintenance costs
Fees	Ongoing IT costs
Optimism Bias at 30%	VAT
IT infrastructure	

The impact of any revenue offset from existing premises disposal has been incorporated. For the option appraisal exercise the revenue impact of Wave 4b capital funding up to £5 million for each scheme has been incorporated. A smaller amount where the scheme value is less than £5 million or the proposed procurement route did not offer the opportunity to utilise the full £5 million. For the purposes of the option appraisals capital costs above that covered by NHS Capital have been assumed to be raised by third party developers and the revenue consequences modelled.

In the financial case the CCG will seek to deploy the total capital resources available to provide the best value across all schemes, this will mean the more expensive schemes may attract a greater subsidy.

Non-Recurrent Revenue:

Stamp Duty Land Tax

Project Management cost to FBC

Temporary relocation

Removals Costs.

The costs have been reviewed in the quantitative Appraisal/CIA Model for the preferred way forwards in each of the schemes and the overall Programme Business Case.

4.12.3 Non-financial benefits

The full list of benefits described in the Benefits Realisation Plan have been reviewed against every option in each of the schemes. Those that are met by the proposals are listed in the option appraisals narratives in Section 4.11. These were considered by the Panel when reaching their decision as to

the preferred way forwards. Those options that were not able to deliver the required benefits or offered less benefit were discounted.

To assist the panels and simplify the process standardised designs were used for each of the schemes, with matching schedules of accommodation. These were run through the same cost models to enable delegates to focus on the qualitative aspects of the proposals in terms of access, location and strategic fit.

4.12.4 Critical Success Factors

To standardise the evaluation of options and ensure parity across different proposed sites the Programme Board agreed a common set of Critical Success Factors that could be applied to every option in all schemes. These captured both quantitative and qualitative outcomes.

- Has a Good Strategic Fit
- Offers Value for Money
- Provides Capacity and Capability
- Can be Afforded
- Is Achievable.

4.13 Economic Appraisal of Costs

Please see Section 4.10 for details of the Options Framework and long list of options.

The table below summarises each of the options considered for the schemes their Capital cost, proposed NHS 4b Capital contribution, Recurrent and Non recurrent revenue implications, programme, and non-financial benefits. Please see the detailed reports on the option appraisal process in Section 4.11.

Following the merger of the former CCGs and the capacity planning exercise, it was felt the proposed response to demand arising from the Norwich Growth Triangle, covering areas in Norwich and North Norfolk should be tested. This was to consider existing capacity and the impact of the delayed start to housing schemes. Consequently, an option appraisal took place ahead of the others to confirm the approach.

Scheme and option	Total Capital Cost (£'000)	Wave 4b capital (£'000)	Net Recurrent Revenue (£'000)	Non Recurrent Revenue (£'000)	Benefits Cost Ratio	Appraisal
Kings Lynn						
1: BAU	0	0	0	0	0	Benchmark
2: Campbells Meadow	10,133	10,133	166	175	4.18	Carried Fwd
3. Nar Ouse Way	10,926	10,926	166	175	4.28	Preferred
4: W Winch	9,534	9,534	166	175	4.22	Discounted
Norwich North						
1: BAU/Min	0	0	0	0	None	Benchmark
2: Large Extension	3,770	2,542	157	55	4.66	Discounted
3: New Build	10,160	5,475	537	172	2.68	Discounted
4a: Single Storey Extension At Sprowston	2,261	1,669	62	38	4.46	Preferred* In conjunction with larger scheme at Rackheath.
Rackheath						
1: BAU	0	0	0	0	None	Benchmark

2: Single Storey Extension At Sprowston	2,261	1,669	62	38	4.46	Preferred* in conjunction with Option 3b.
3a: Broad Ln	10,198	1,966	281	110	3.17	Carried Fwd
3b: Broad Ln (NHSPS)	9,143	9,143	103	137	4.72	Preferred
4: Mahoney (NHSPS)	10,755	10,755	103	166	4.44	Carried Fwd
Thetford						
1: BAU	0	0	0	0	0.00	Benchmark
2: 5 Clinical Rooms	1,313	1,313	121	55	5.57	Discounted
3: 6 Clinical Rooms	1,402	1,402	122	55	7.74	Discounted
4: 14 Clinical Rooms	3,462	3,462	156	55	8.91	Preferred

5 Commercial Case

5.1 Purpose

This chapter describes how the programme will be taken forwards and how success will be recognised though a set of SMART[22] objectives. It describes how services and works will be procured from within and outside of the public sector, specifically how development risks will be allocated. It proposes contractual arrangements to underpin this and how the costs will be treated in the accounts of the public sector stakeholders.

The Economic Case has identified the development of a series of Integrated Care Hubs as the preferred mechanism to facilitate the implementation of the Integrated Care model envisaged within the CCG strategy and operating plans. The full capital costs for the Programme make full use of the £25.2m Wave4b funding, with private sector capital (£0.6m) being used only to support the Norwich North scheme.

This chapter of the business case explores the commercial and procurement options available to the CCG to deliver the Programme and ensure that the identified benefits are realised.

It sets out the policy and principles, which will be adhered to in respect of the commercial approach, when developing the individual schemes and their Full Business Cases[23].

5.2 Programme Objectives

The objectives of the proposed programme are listed below and detailed in the Strategic Case.

Specific	Measure	Achievable	Relevant	Time constrained
Modernising the Primary Care estate	Integrated flexible multiagency spaces created	Validated programme	Aligned to CCG emerging strategy	Delivered by Quarter 2 2024
Creating Capacity	Provision of fully compliant and bookable clinical spaces	Commissioner and provider support.	Targeted to high demand, low capacity, and deprivation areas	Delivered by Quarter 2 2024
Meeting Workforce Challenges	Provision of bookable training and education suites.	Commissioner and provider support.	Compliant with the local workforce plan	Delivered by Quarter 2 2024
Meeting the demand from planned housing	Capacity created for 44,000 additional registrations	Commissioner and provider support.	Based on approved local plan allocations	Delivered over 15 -20 years
Promoting closer integration and a wider range of services	Services will be present from: 6 General Practices 1 Community Trust All 3 Acute Trusts 4 PCNs	Letters of Support are included in Appendix 7.	Core to the emerging clinical strategy	Delivered by Quarter 2 2024

[22] Specific, Measurable, Achievable, Relevant and Time constrained
[23] Projects will complete a combined OBC/FBC

Specific	Measure	Achievable	Relevant	Time constrained
Addressing Service Deprivation	Wide range of health and social care services proposed in the deprivation areas	Hubs are proposed in the deprivation areas of Gorleston and Kings Lynn	Key CCG strategic objective	Delivered by Quarter 2 2024
Learning from the pandemic	Creating bookable digital consultation rooms. Wide corridors, large waiting areas. Single route options.	All new Hubs will meet the highest standards for infection control. Users will be offered a range of in person and remote contact options.	Key CCG and national strategic objective	Delivered by Quarter 2 2024

Critical Success Factors

Option appraisals looked to find those proposals that were best able to deliver a set of Critical Success factors common across all schemes:

Has a Good Strategic Fit: with the agreed investment objectives, business, and service requirements of the emerging CCG.

Offers Value for Money: Optimising the social, economic, and environmental value against cost, benefit, and risk.

Provides Capacity and Capability: Provides an appropriately scaled and functional facility to meet the identified needs and is an attractive option for providers.

Can be Afforded: Its capital and revenue consequences can be funded by all stakeholders.

Is Achievable: Can be delivered by April 2024, can be staffed, and resourced by all stakeholders.

5.3 Commercial Approach

5.3.1 Programme Approach to Procurement

The scale of the project and availability of public capital will influence the procurement routes. The programme includes re-modelling and refurbishment schemes in addition to new build developments. The chosen locations include commercial sites, local authority land and stakeholder owned sites, which may also affect the procurement process.

Successful procurement of construction projects is dependent upon several factors. Best practice suggests that decisions regarding the most appropriate procurement route should be based on a VfM assessment of the whole life of the facility and not just the initial capital cost. Furthermore, it is recognised that integrated procurement routes and longer-term relationships or partnering will generally provide better value for money.

The Procurement Strategy should identify the best way of delivering the objectives of each scheme and value for money considering the risks and constraints. This should lead to the decisions about funding mechanisms and ownership of the completed asset. The procurement route that best delivers the procurement strategy can then be identified.

Key factors that will affect the procurement strategy will be:

- Project leadership and resources.
- Defined project objectives.
- Funding arrangements.
- Level of risk transfer.
- Speed of delivery.

- Complexity.

5.3.2 Funding Routes

In line with national guidance, schemes of less than £15m will be approved via the NHS England & NHS Improvement process under its existing scheme of delegation and Standing Financial Instructions (SFIs) for capital investment. The Programme is for four Primary Care Hubs – two new builds and two extensions/reconfigurations/refurbishments.

The two new builds will be delivered by NHS Property Services under Section 223 of the National Health Service Act 2006.

The two extensions/reconfigurations/refurbishments will be delivered via premises improvement grants to practices.

In establishing the preferred options, value for money testing (VfM) has been undertaken to ensure that best value is received for the NHS capital investment. Where the schemes are not 100% funded by NHS capital there will be an abatement of the rental charges over the full term of the lease, proportionate to the NHS capital invested.

Please see Section 4.10 for information about the site options appraisals.

VfM considerations as part of the local approval process will include:

- Alignment with commissioning intentions and developing estate strategies
- Alignment with guidance on space utilisation and sizing of Primary Care premises
- Use of formal option appraisal methodology where there are alternative options
- Benchmarking of costs
- Appointment of the District Valuer Service to assess the recurring premises costs implications of the scheme, heads of terms and VfM as appropriate.

In all cases there will be an expectation that any investment will, aside from the organisational change and societal benefits, offer a return on investment of more than 3.5%. Alternatively, an equivalent abatement against rental for the life of a long-term lease. An independent valuer will be used, or the District Valuer instructed as the arbiter of VfM in this respect. The Valuer will assess the VfM of each scheme before considering the impact of NHS Capital investment.

The table below summarises the expected capital requirements and the proposed funding routes. Please see the Financial Case for a detailed breakdown of costs.

Name/Location	Planning Permission	Capital	Contingency	NHS Capital	Non-NHS Capital	Total Capital	Expected Procurement Method
Rackheath - North Norfolk	Outline planning permission received	7.7	1.47	9.1	-	9.1	NHS Property Services via Section 223[24]
King's Lynn - West Norfolk	Planning permission required	9.2	1.76	10.9	-	10.9	NHS Property Services via Section 223
Sprowston - Norwich	Planning permission required	1.3	0.25	1.5	0.6	2.1	Via landlord: Primary Health Properties
Thetford - South Norfolk	May be required for new lift and will be required for car park	3.0	0.58	3.6	-	3.6	Via landlord: Community Health Partnerships
Total		**21.1**	**4.06**	**25.2**	**0.6**	**25.8**	

[24] Section 223 of the National Health Service Act 2006: NHS Property Services is a company formed under Section 223 to provide facilities or services under the Act and is wholly owned by the Secretary of State.

The ICS are in negotiation with local planning authorities to explore the potential to bring forwards Section 106 payments earmarked for health but unlikely to be triggered prior to the delivery of the proposed schemes.

5.3.3 Delivery

The CCG decided to proceed to develop business cases for each scheme at risk before national sign off the PBC, to ensure the Programme's tight deadlines can be achieved.

The Rackheath and King's Lynn schemes will be delivered by NHS Property Services via a Section 223 agreement.

The Sprowston scheme will be undertaken as an improvement scheme under the National Health Service (General Medical Services – Premises Costs) Directions 2013. Under the Directions the NHS supports the funding of General Practice premises for the purposes of development or improvement. Capital funding of projects is limited to between 33% and 66% of the total eligible cost and grants are conditional upon the contractor guaranteeing that the premises will remain in use for either 5,10 or 15 years, dependent on the value of the grant (15 years in this case). The NHS capital contribution will also be supported by a Grant Agreement between the contractor and the NHS. The landlord will be expected to run a limited tender as part of the combined OBC/FBC phase to identify a construction partner to complete the works. The Landlord will contribute 34% of the capital cost of the scheme.

The Thetford scheme will be undertaken via a Premises Improvement Grant. Premises Improvement Grants are determined by Section 8 of the Directions. Where projects are not contemplated by the standard provisions within the Directions, Direction 6 is considered for delivery, subject to the scheme being held on the National D6 register (these may be funded up to 100& of eligible cost depending on the nature of the scheme and appropriate VfM tests). The Thetford Healthy Living Centre is a LIFT Company building (LIFT Companies are Public Private Partnerships with 40% public 60% private ownership). Community Health Partnerships is the public shareholder for Thetford Healthy Living Centre.

Construction periods will vary by project please see Section 4.11 for details and the summary below. Where applicable, the Programme will assess the options for utilisation of modern methods of construction, where this will meet all requirements and benefits, and where this may impact positively on programme timeframes.

The critical path for all schemes has to deliver full commitment of the Wave 4b investment by March 2024.

The King's Lynn and Rackheath schemes will be delivered within the time frame by NHS Property Services under Section 223 of the National Health Service Act 2006 (NHS Property Services is a company formed under Section 223 to provide facilities or services under the Act and is wholly owned by the Secretary of State).

The improvement schemes route for the Sprowston and Thetford schemes can deliver within the time frame.

5.4 Contractual Process and Milestones

Dates have been approximated to the expected calendar quarter.

Name/Location	Development Partner Procurement	OBC/FBC submission inc Planning	Construction	Handover	Operational
Rackheath - North Norfolk	NHS Property Services	Q2 2022 Q3 2022	Q4 2022 Q1 2024	Q2 2024	Q2 2024
Sprowston - Norwich	Via landlord: Primary Health Properties	Q2 2022 Q3 2022	Q4 2022 Q2 2023	Q3 2023	Q3 2023
King's Lynn - West Norfolk	NHS Property Services	Q2 2022 Q3 2022	Q4 2022 Q1 2024	Q2 2024	Q2 2024
Thetford - South Norfolk	Via landlord: Community Health Partnerships	Q2 2022 Q3 2022	Q4 2022 Q2 2023	Q3 2023	Q3 2023

5.4.1 Market Supply

Construction sector in the East of England represents a larger share of all employment than any other UK region[25]. Since 2016 9.8% of all UK construction has occurred in the region but it accounts for only 9.6% of the UK population. Many of the locally based firms work in the neighbouring regions particularly greater London.

The post Brexit fall in international recruitment and the impact of the pandemic on the supply of labour and materials has led to a significant backlog in construction projects. Many major schemes are experiencing continuing delays but construction in the East remains exceptionally strong[26].

Figures from the Office for National Statistics have shown construction output fall by 0.2 per cent in August 2021 with output now 1.5 per cent below its pre-coronavirus (February 2020) level. New work remained stagnant in August (0.0 per cent) with repair and maintenance falling (0.6 per cent) on the month.

ONS provided anecdotal evidence from businesses suggesting that product shortages caused by supply chain issues and subsequent price rises were the main reasons for the decline.

The East has seen huge investment in windfarms and work is still running on Scottish Power Renewables £1.8 billion East Anglia One project. The firm has plans for more offshore windfarms in the area. Work has started on a £1 billion regeneration project at Purfleet, which will include 2,850 homes and a film and TV complex.

Cambridge continues to be a major Hub of activity in the region. The University of Cambridge is developing a new district on a 150-hectare site for about 8,500 people in northwest Cambridge, with phases of activity continuing through into the late 2020s. Among other major projects in the city is the £500 million AstraZeneca Cambridge Biomedical Campus was due to complete in 2020.

Small to medium sized construction projects have continued to recover lost time following the pandemic. The construction sector is comparatively high paying in the east and a number of smaller health schemes continue to make good progress.

In reviewing site options, the Programme team have been approached by a number of specialist healthcare developers hoping to be considered for the projects. All have indicated they are able to mobilise both the human resources and materials required to deliver the schemes.

The ICS have a pipeline of current schemes that are delivering to schedule these include:

- James Paget Hospital HIP2 redevelopment
- Norfolk and Waveney HIP2 Diagnostic Access Centres
- Hellesdon Hospital HIP2 Site redevelopment
- Hoveton and Wroxham (Main site) North Norfolk Extension – Completed
- Beccles Medical Centre Great Yarmouth & Waveney Improvements – Completed
- East Norfolk Medical Practice (Greyfriars) Great Yarmouth & Waveney Extension – in progress.
- Millwood Surgery Great Yarmouth & Waveney Extension – Completed.
- Kirkley Mill Surgery Great Yarmouth & Waveney Improvements – Completed.
- Blofield Surgery North Norfolk Extension – start on site expected Autumn 2022.
- Holt Medical Practice North Norfolk Extension and Improvements – Completed.
- Melton Constable Surgery North Norfolk Improvements – Completed.
- Mundesley Medical Centre North Norfolk Improvements (minor) – Completed.
- Coltishall Medical Practice North Norfolk Improvements (minor) – Completed.

[25] ONS *Annual survey - regional - ethnicity by industry, F: construction/All industry* (Jan - Dec 2018)
[26] CIOB (2020) The Real Face of Construction, Chartered Institute of Building, Bracknell

- Mile End Road Surgery Norwich Improvements – Completed.
- Parish Fields South Norfolk Improvements – Completed.
- Mattishall Surgery South Norfolk Improvements (minor) – Completed.
- Toftwood Surgery South Norfolk Temporary move – OBC/FBC expected Summer 2022.
- Gayton Road Surgery West Norfolk Extension – Completed.
- St James Surgery West Norfolk New build – FBC expected Summer 2022.
- The Burnhams Surgery West Norfolk New build – Completed.

5.5 Current Estate and Disposals

Three of the schemes proposed impact on the current NHS provider estate. Where there is an identified saving to commissioners this has been used to offset revenue costs.

Sprowston – Norwich: The Aslake Close facility is an existing leased multi agency building owned by a third party landlord. The proposals will improve the current utilisation and expand it. There will be no disposals associated with the scheme. The current lease is due for renewal and the CCG will ensure the new lease includes an appropriate long-term abatement, reflecting the NHS Capital improvement grant.

Thetford – South Norfolk: The Thetford Healthy Living Centre is an existing leased multi agency building owned by the Local Improvement Finance Trust Company. The proposals will improve the current utilisation through reconfiguration. There will be no disposals associated with the scheme.

5.6 Stakeholder Engagement and Support

The Programme has a Communications and Engagement Plan (please see Appendix 4) which identifies key stakeholders, their interest and methods of engagement. As the project develop, it is expected that Places will become more involved in engagement approaches for each project, while the Programme level approach continues to support this activity.

Letters of support from those stakeholders expected to sign leases to occupy each of the schemes are included in Appendix 7. The extent of each third parties' liability is summarised below. The financial impact is summarised in the Financial Case and detailed in the schedules of accommodation in each of the projects in Section 4.11.

It is recognised that there will be a requirement to ensure sign up and commitment to the projects by all key partners at OBC/FBC stage and this is being facilitated by the Programme Team and through the ongoing Project Steering Groups, as well as through direct discussions as required. These further letters of commitment will confirm their level of liability and the occupation terms (Heads of Terms).

Third Party Implications

Stakeholder	GIA m²	Estimated Revenue Impact to the CCG £'000s	Occupation Terms
Rackheath - North Norfolk			
GMS (Hoveton and Wroxham Medical Centre)	999	125	Long term lease
Community Services (NCH&C)	455		Long term lease
Maternity and Neonatal Services (NNUH)	137		Long term lease
Sprowston - Norwich			
GMS (East Norwich Medical Partnership)	145*	62	Renewal of long term lease
Pharmacy			Existing arrangements
King's Lynn - West Norfolk			
GMS	680	91	Long term lease
Maternity and Neonatal Services (QEH)	355		Long term lease
Outpatient Services (QEH)	475		Long term lease
Thetford - South Norfolk			
GMS (School Lane Surgery)	477	156	Renewal of long term lease
Outpatient Services (WSH)			Providers use bookable space
Community Services (NCH&C)			
Mental Health Services (NSFT)			

Community Dental Services (CDS-CIC)			
Pharmacy			Existing arrangements
Totals	3723	434	

*GIA of 145m² for Sprowston is size of extension only. Total size of premises will be 1,041 m²

5.7 Equipment Procurement

Responsibility for provision of fixed equipment (Groups 1 and 2) will be shared between the successful building contractor and the service provider organisations, while responsibility for provision of loose equipment items will lie with the individual service provider organisations. However, it is expected that there will be collective, Project Board-level oversight of the Equipment Strategy for each of the schemes and a process to ensure consistent provision of equipment, as this will enable safe, flexible use of the facilities.

The equipment requirements will be determined through the detailed design process and the development of the room data sheets at FBC. The Project Board will agree an equipment procurement strategy with the prospective service providers (tenants), including allocation of costs. Where appropriate, equipment may be transferred from the existing facilities, this will need to be approved by the Project Board as part of the Equipment Strategy.

5.8 Information and Communications Technology (ICT) Procurement

The provision of ICT services within the Norfolk and Waveney CCG will be based on the Emerging Digital Strategy (see Section 3.17): the digital design principles have underpinned the projected ICT requirements and costs. The process for procuring and managing the ICT services for the Norfolk and Waveney CCG will be followed for each of the schemes.

All projects must demonstrate at FBC submission stage how the latest technology will help create transformation as set out in national and local commissioning strategies.

The acceleration of the adoption of digital technology during the Covid 19 pandemic has resulted in significant investment in the ICT infrastructure. The individual projects will need to take this into consideration when scoping the ICT requirements for the new facilities.

5.9 Organisational Development

Simply providing new facilities does not in itself guarantee transformational change. Each stakeholder will need to implement a program of structured Organisational Development (OD) moving the system overall and partners individually from the current state to the desired Integrated Hub model.

For this reason, the OD programme needs to be co-ordinated by CCG and embedded into the benefits realisation requirements of the schemes.

Due to the level of anticipated integration and co-location in the integrated Hub model there will be impact on provider organisations in relation to the ways of working and model of care it is envisaged that the main provider organisation for each Hub will lead on the local change management strategy. The ongoing change management work will be fed back into the relevant steering group who then in turn will report to the Programme Board.

5.10 Programme Approach to Commercials

Employment Matters

Whilst it is not anticipated the proposals will have a significant impact on existing employees, each project will be required to identify at FBC submission stage any employment implications for staff. This will include:

- Any transfer of staff under the Transfer of Undertakings (Protection of Employment) (TUPE) regulations or, Retention of Employment (RoE).
- Any anticipated redundancies.
- The numbers of staff affected, and estimated costs involved.
- Any changes to working patterns, service delivery locations or staff bases.
- Any consultation that needs to be undertaken as part of the change.

- These issues will be addressed at FBC stage with the approach being consistent with the ICS Programme Management Office Change Management Policy.

Key Contractual Considerations

It is currently assumed that the procurement of the construction works associated with the schemes will be the responsibility of the developer or ultimate asset owner. As such the contract will be between the contractor and them not the NHS. For design and build contracts either the Joint Contracts Tribunal (JCT) or New Engineering Contract (NEC) Design and Build contracts could be utilised. These are recognised standard form contracts.

Where applicable all contracts will be formally tendered through the Find a Tender (FTS) (formerly known as OJEU).

Alternatively, the CCG and Stakeholders may choose to utilise an established framework agreement.

Whilst the contractual arrangements will be between the developer/owner and the contractor, the relevant partners will be fully involved in the development of the tender specifications and the selection of the preferred contractor.

It is assumed, as above, that all contracts will use a standard form of contract. If a non -standard form is proposed, then full due diligence and a report of the commercial terms of contract with legal advice will be required at FBC submission stage.

Change Management

Late client changes are one of the principle causes of delay and increased cost in construction projects. The risk is increased where multi agencies are involved and where there is not a clear scheme of delegated authority to agree changes.

The Change Management approach which will support the project monitoring and escalation process is that of the ICS Project Management Office, which will remain under review by the Wave 4b Programme Board to ensure it meets the needs of the Programme and projects and supports the delivery of the Programme – including identifying and agreeing the tolerances at which change in scope will be notified. Updates will be reported via the Wave 4b Programme Board, of which NHS England & NHS Improvement are members.

Day to day change management issues will be discussed at the Local Steering Committee and any resultant contract and/or cost changes will need to be approved by the relevant authorised decision-making group (where delegated) or within the approving organisation (where not delegated).

Lease Agreements

In line with current NHS policy, it is not currently intended that the CCG will enter into any lease agreements regarding the Integrated Care Hubs. The facilities will be multi tenanted and all leasing agreements will between the tenants and the landlord.

Commissioners will be requiring long occupancy periods in the region of 20 years or longer, with appropriate break clauses. Extension periods of circa 15 years, triggered by the tenant, may also apply. Where possible and especially where a significant proportion of the investment is made by the NHS capital contribution an in-perpetuity agreement will be sought.

All Leases should comply with the Landlord and Tenancy Act of 1954.

5.11 Ensuring Value for Money

Whilst desktop Value for Money assessments have been completed to assist the appraisal of options in the Programme Business Case, further Value for Money assessments will be carried out at the Full Business Case stage to demonstrate best value.

The District Valuer Service (or another independent Valuer) will be appointed to undertake a Value for Money and Current Market Value report following the initial design stage once estimated capital costs are available. This report is required to establish the affordability of each scheme and be the basis for negotiations on rental values. All parties will use the same Valuer during the lease rental and adjustment negotiation phase.

The DV will ensure lease agreements incorporate an appropriate long-term adjustment to reflect the level of public capital invested.

Lease adjustments will apply equally to Independent Contractors and NHS Trusts for the areas utilised for NHS services but will exclude any areas proposed for commercial or non-NHS uses.

Developers will provide valuation services at each stage of construction to evidence the drawdown of any resources prior to handover of the buildings. These valuations will be agreed jointly with the CCG prior to submission.

A contingency sum will be retained by the CCG in respect of final handover snagging and operational issues in the first 12 months of operation.

5.12 Safe Construction

The appointment of construction partners will be the responsibility of the selected developer in each scheme. They will be expected to ensure identified construction partners are fully accredited and experienced in delivering modern health facilities.

Full Health and safety compliance will be embedded into standard JCT/NEC contracts and supervised by developers who will follow Construction (Design and Management) Regulations. These require the formalised allocation of roles and responsibilities to ensure site safety. In most cases the projects will require formal HSE notification.

Several of the proposals are on live health sites and a management plan will need to be agreed with the NHS (and other stakeholders) to ensure staff and service users safety prior to permission to start on site is granted.

5.13 Economies of Scale

The Programme Team will ensure a standardisation of approach, design and appraisal and simplified reporting procedures to the Board. A single design team utilised a common approach to developing the schedules of accommodation and adjacency diagrams, while this has been reviewed as part of the resubmission of the Programme Business Case, learning has been shared across schemes and informed the final designs and draft operational policies.

The designs will be novated to the final FBC design teams for each scheme.

5.14 Proposed Procurement Route

Based on the analysis above the CCG has conclude the most cost effective and sustainable approaches to the procurement of the Primary Care Hubs will be:

- Norwich North and Thetford: for these refurbishment and extension projects, the CCG propose that the practices and landlords of the premises would tender for the works and include the tender analysis and the tender report in the Full Business Case.
- King's Lynn and Rackheath: for these new build projects, the CCG propose that NHS Property Services manage the developments and include the tender analysis and the tender report in the Full Business Case.

5.15 Commercial Risk

Please see Appendix 5 for the current Programme Risk Register and Section 5 for details of the Risk Management process.

Commercial risks will be transferred to the chosen developer(s) through the contractual or framework agreement. Those risks expected to be transferred include:

Construction and completion risks:	*Operational Risks:*
Time delays	Availability risk
Cost overruns	Demand risks lease defaults
Performance related	3rd party property damage.
Design risks	
Financing risks	
Supply risks	
Social and environmental risks	
Property damage	
Force majeure.	

5.16 Commercial Opportunities

Each of the Hubs offers the potential for co-location with compatible commercial providers. For example, pharmacies or dental practices. Whilst these will be subject to separate negotiations between the landlord and the prospective tenant, they offer the opportunity to enhance the users experience of integrated care.

The NHS will seek to ensure there is a clear definition between the NHS and commercial areas. Where possible the project team will seek to ensure only compatible, commercial services are supported.

5.17 Conclusion

This section of the Programme Business Case has described how the programme will be delivered and the objectives that will be used to determine the success of the proposed schemes.

The Commercial Case sets out the work completed to establish the Programme costs and deliverability and explains the Programme approach to contracting and procurement, and how best value will be delivered, along with proposed contractual arrangements to underpin this and how the costs will be treated in the accounts of the public sector stakeholders.

The Case explains how development risks are anticipated to be allocated and shared and provides confirmation of stakeholder support.

The CCG will continue to work closely alongside its partners to ensure that value for money is optimised across the four schemes, providing economies of scale where possible and consistency of approaches (where appropriate) and avoiding duplication.

The Commercial Case further demonstrates the benefits which this Programme will deliver for the patients, population and healthcare system in Norfolk and Waveney.

6 Financial Case

6.1 Purpose

The programme will include several sub projects each of which will require a costed Full Business Case. This chapter considers high level costs and overall affordability to the health and social care system, confirming these have been recognised by stakeholders and are considered affordable. The chapter will summarise a high-level evaluation of the financial benefits of the proposals using standardised HM Treasury tools[27]

A detailed financial assessment has been done for each of the schemes and for all the options considered for those schemes. These are contained in Section 4.11 and summarised in the Commercial Case.

The financial assessment includes the estimated capital and revenue costs and the financial and non-financial benefits that will be delivered through the investment. The realisation of these benefits is then risk adjusted resulting in a cost benefit ratio.

6.2 Financial Assumptions

Capital Grants

No additional Capital Grants have been identified. Discussion of potential future Section 106/CIL developer contributions are included in the descriptions of the proposals in Section 4.11.

Inflation

For the purposes of appraising options this has assumed a triannual 5% uplift. It is assumed that the investment of NHS capital will reduce ongoing CCG and NHS Trust revenue liabilities via reduced rents.

Optimism Bias

Bias has been applied at 30% to the construction costs.

6.3 Financial Costs

The following summary of costs are based on the preferred options of each of the 4 schemes.

Capital Costs

The estimated total capital is £25.2m which is the Wave 4b STP capital and £0.6m will come from existing premises landlords.

	Capital Requirement							Funding Source	
Project Name	Land £'000	Construction £'000	Fees £'000	Optimisum Bias £'000	IT £'000	Contingency £'000	Total Capital £'000	Wave 4b Capital £'000	3PD Capital £'000
Rackheath	250	4,775	573	1,609	466	1,470	9,143	9,143	
King's Lynn	350	5,677	731	1,923	485	1,760	10,926	10,926	
Sprowston	-	1,181	159	402	157	362	2,261	1,669	592
Thetford	150	1,999	183	446	236	448	3,462	3,462	
Total		**13,632**	**1,646**	**4,380**	**1,344**	**4,040**	**25,792**	**25,200**	**592**

Table 7: Capital Costs

Construction costs are based upon prudent assumptions. Optimism Bias has been included at 30% for this stage of the business case. This amounts to £4.4m of the total capital cost. Additional contingency of £4.0m has been added to the programme to provide contingency towards increasing constructions costs and market conditions.

IT costs include estimates for Health and Social Care Network (HSCN) line installation, cabling, Wi-Fi, PCs, IT installation/project management. There is also an amount of £200k included in each of the new builds for digital innovation, pending clarification from the tenants on final requirements.

[27] Comprehensive Investment Analysis (CIA) and Value for Money (VfM) assessments

In line with the original proposal for Wave 4b capital funding there is £25.2m allocated against schemes. The apportionment of NHS capital funding proposed is:

Rackheath - £9,143k

Kings Lynn - £10,926k

Sprowston - £1,669k

Thetford - £3,462k

All schemes other than the Sprowston scheme are to be fully funded by NHS Capital which will minimise the ongoing revenue costs for the CCG. The Sprowston scheme is an existing asset owned by Primary Health Properties (PHP). In order to make the scheme commercially viable for PHP it has not been possible to fully fund the scheme using NHS capital. However, the NHS contribution for the Sprowston scheme will reduce the revenue liability compared to fully funded landlord improvements.

Due to the time constraints of the programme the CCG is progressing at risk with the development of the individual scheme Full Business Cases (FBC). This means the CCG will incur costs before expected PBC and FBC approval of up to £1.5m. As such the CCG would like to request early draw down of the funding to support programme fees.

6.4 Recurrent Revenue Costs

Estimated Rental Costs

New rent calculations are based on total build costs including Optimism Bias but excluding Contingency. Rental values have been estimated assuming a 25 year TIR lease. Excluding Optimism Bias on a per m2 basis rental estimates are in line with recent District Valuer valuations for new schemes in the East of England.

The two new build schemes are expected to have nil rental impact for the CCG with NHSPS delivering the schemes via S223 transfer. A net increase of £40k is expected at Sprowston to reflect the capital contribution the landlord is making to the scheme.

The Thetford scheme is expected to have a net rental increase of £102k per year which consists of £54k for the relocation of admin space to a neighbouring facility and £48k for increased Facilities Management and Lifecycle costs chargeable under Lease Plus terms.

Estimated Recurrent Revenue Costs

The estimated increase in recurrent revenue costs for the new premises is £0.62m. Of which £0.43m relates to primary care space which is reimbursable by the CCG and £0.19m for NHS Trusts. The split between CCG and NHS Trust revenue costs has been calculated based upon each tenant's percentage split of the schemes planned GIA. The increase in revenue costs for NHS Trusts will be funded by each NHS Trust the CCG will not be increasing contract allocations to reflect these increased costs.

The expected terms of occupancy for the primary care hubs via TIR leases for 3 of the schemes and Lease Plus for the Thetford schemes will mean the charges applied cover expected whole life costs of the premises. Therefore further investment will not be required unless there are future changes to commissioning requirements.

	Increase in recurrent revenue costs							Funding Source	
Project Name	Rent £'000	Rates £'000	Water £'000	Clinical Waste £'000	IT £'000	Maintenance Fund £'000	Total £'000	CCG £'000	NHS Trust £'000
Rackheath	-	50	5	5	104	35	199	125	74
King's Lynn	-	50	5	5	106	35	201	91	110
Sprowston	40	17	1	1	3	-	62	62	-
Thetford	102	-	5	5	44	-	156	156	-
Total	**142**	**117**	**16**	**16**	**257**	**70**	**618**	**433**	**185**

Table 8: Estimated Recurrent Revenue Costs

6.5 Economic Appraisal

The total costs and benefits from the preferred options of individual schemes have been fed into the CIA model. This shows a cost to benefit ratio of 5.43 against the BAU scenario.

Option		Total Incremental Discounted Cost Incr £000s	Total Incremental Discounted Cash Releasing Benefits £000s	Net Present Social Value £000s	Cost/ Benefit Ratio
Option 1	BAU	0	0	0	0
Option 2 Total	Combined Preferred Options	-37,243	202,221	164,978	5.43

Table 9: Economic Appraisal

Benefits for each scheme

		Kings Lynn	Rackheath	Thetford	Sprowston
Cash Releasing	Reduction in Admissions to Care Homes	179	179	179	-
Cash Releasing	Reduced Agency Costs for Primary Care	53	53	54	-
Non Cash Releasing	Acute Demand Management	272	209	207	-
Non Cash Releasing	Increased GP appointments	91	76	55	-
Societal	Better management of people with Diabetes	691	691	691	138
Societal	Better management of people with Hypertension	178	178	178	36
Societal	Reduce smoking in pregnancy	8	8	8	2
Societal	Reducing harmful alcohol consumption	518	518	518	104
Societal	Reduce childhood accidents	40	40	40	8
Societal	Improving MH (social impact)	648	648	648	268
Equivalent Annual Benefit (£'000)		**2,680**	**2,601**	**2,580**	**556**
Incremental benefits - total (£'000)		65,635	63,723	63,207	13,608
Incremental costs - total (£'000)		- 15,333	- 13,512	- 7,090	- 3,053
Benefit-cost ratio		**4.3**	**4.7**	**8.9**	**4.5**

Table 10: Benefits for each scheme

6.6 Non-Recurrent Revenue

The following details the £0.4m non-recurrent revenue required.

Project Name	SDLT £'000	Project Mangement £'000	Total £'000
Rackheath	97	40	137
King's Lynn	127	50	177
Sprowston	18	20	38
Thetford	0	55	55
Total	**242**	**165**	**407**

Table 11: Non-Recurrent Revenue

Stamp duty land tax (SDLT) has been estimated based on the full estimated rent cost including Optimism Bias, pending clarification of ability to base on reduced rent.

6.7 Financial Affordability

The indicative costs shown in the financial appraisal have been reported to all stakeholders including the CCG. Each of the stakeholders has assessed these costs and confirmed that they are affordable and wish to proceed to the Full Business Case. Letters of support are included in Appendix 7.

The CCG has considered the overall affordability to the system and included an annual recurrent revenue budget of £1.45m for the Wave 4b Programme within its medium-term financial plan. This estimate was based upon costings assuming ownership of the assets sat outside of the NHS. With preferred options now looking to retain ownership within the NHS where possible the overall of expected revenue impact of £0.43m is affordable within planned values.

6.8 Sensitivity Analysis

This analysis looks at the change in cost required to bring the next best cost benefit result to match the preferred option.

Initial sensitivity analysis shows the following percentage changes in cost are required to move the ranking positions.

The Kings Lynn scheme has limited variation between site options with the cheapest site cost having lower predicted benefits due to its location within the town. Benefits have been calculated at a total level and distributed evenly across sites with the exception of Aslake Close which is a much smaller scheme. Benefit allocation methodology will be revised within the FBC submission to reflect scale of individual schemes.

	Cost Benefit Ratio of Preferred Option	Cost Benefit Ratio Next Best	Cost change % to move position	Benefit change % to move position
Sprowston*	4.67	4.66	0%	0%
Rackheath	4.72	4.44	13%	11%
Kings Lynn	4.28	4.22	1%	1%
Thetford	8.91	7.74	15%	13%

Table 12: Sensitivity Analysis

*Sprowston is output of combined impact of Rackheath and North Norwich as per 1st options appraisal held prior to Rackheath only event.

6.9 Conclusion

The Financial Case has taken a robust approach to estimating and evaluating the likely cost ceiling for each of the schemes.

Architects and quantity surveyors have estimated construction costs and fees in the light of current market conditions.

Consideration has been given to the challenges facing each of the sites, including land ownership, current use valuations, flood risks and land contamination.

Financial advisers have applied a high level of optimism bias to the construction costs.

Stakeholders and Commissioners have considered these revenue implications against their financial plans and agreed they are affordable.

Financial advisers have modelled and quantified high level economic and societal benefits for the local system and summarised the total cost and benefits utilising the Comprehensive Investment Appraisal model demonstrating a 4.97 return on investment.

7 Management Case

7.1 Introduction

The final chapter considers the delivery of the programme demonstrating that the system has sufficient resources in place to take it forwards in a timely manner. It demonstrates a recognition that sustainable change requires more than simply investment but also consensus from providers reinforced by commissioning decisions. It includes a benefits realisation plan demonstrating how progress will be recognised. It summarises a high-level risk assessment with proposed remedial

actions. Finally, it describes how post project evaluation will be undertaken and the contingencies that will be in place to ensure the plan is constantly updated to remain relevant.

7.2 Governance and Programme Management

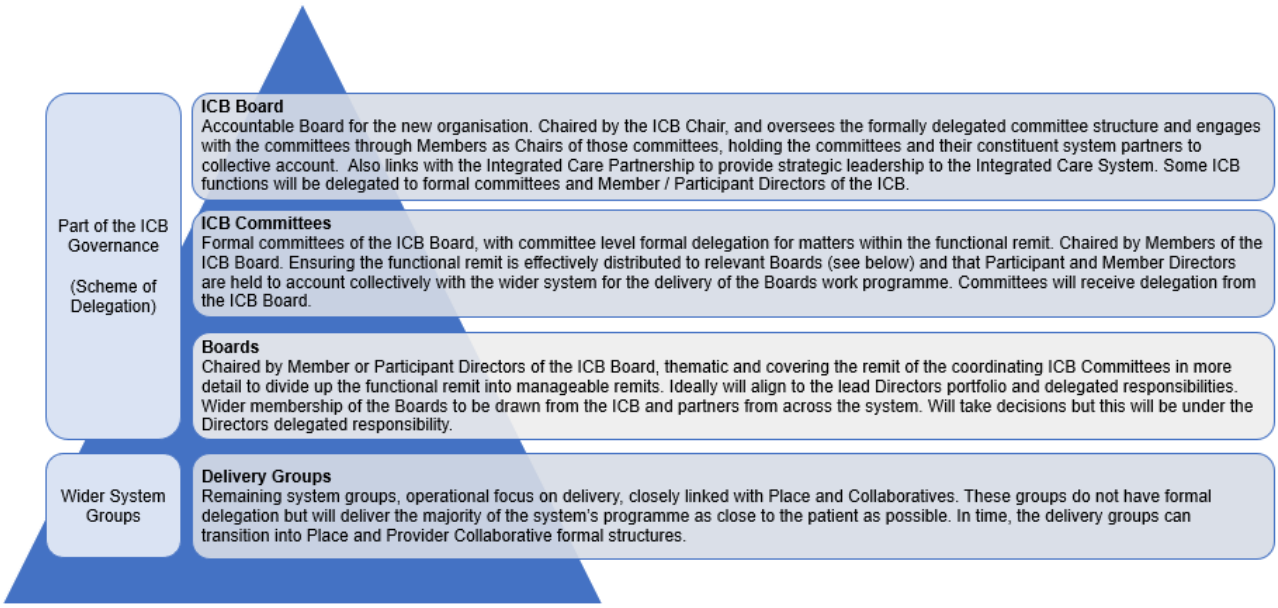
The Wave 4b Programme's governance arrangements have been positioned alongside existing governance structures in order to ensure an effective framework of strategic governance is in place. This is supported by the ICS PMO Team who form part of the Wave 4b Programme Board and the Programme Team.

7.3 Norfolk and Waveney ICS Governance

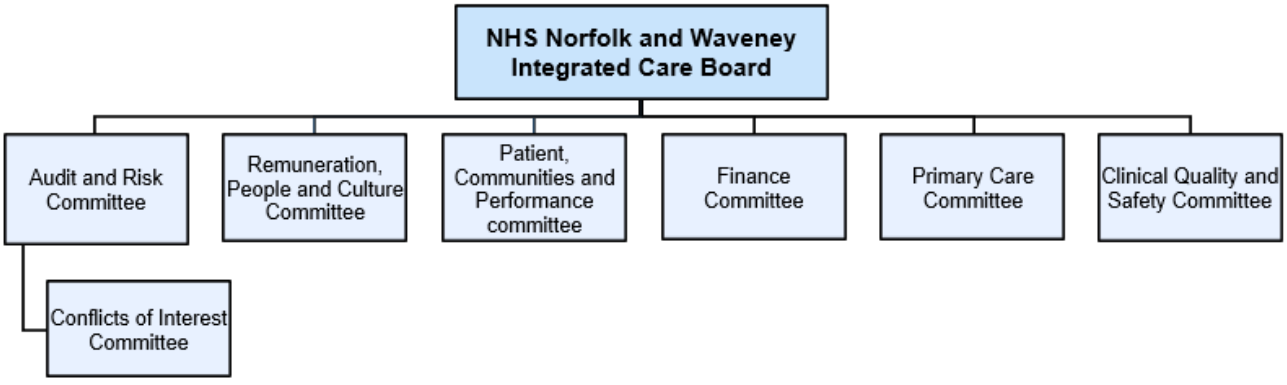
As part of the transition to the ICS, our governance working as a system has been reviewed and a new framework prepared to enable clear delegations and partnership working. It has been the case that many of our groups had been established over time and the new framework makes clear responsibility and accountability across the ICS.

Broadly the framework consists of four tiers. A further explanation of this can be found in our functions and decision map, but in summary:

A tiered delegation model is proposed, that will receive c200 functions from the CCG and NHS E/I but will preserve the partnership approach to delivery and improvement and form the basis of a model that can more easily evolve as our place-based and provider collaborative arrangements develop.



The Board of the Integrated Care Board will have several functions retained to it as set out in draft in the attached functions and decision map. The Committee structure which sits below this in the second tier will be as follows:



The third tier will include director delegation and boards, being developed as the new directors come into post and will include the ICS Estates Programme Board.

The system is currently working to distribute the functions of the ICB between the top three tiers. This will then enable the functions maps to be completed with the functions included and the Scheme of Delegation to be drafted to enact this. It is anticipated that this work will be completed by the end of May 2022.

The fourth tier has a set of operational groups and programme delivery groups that enable the system to work together effectively. These have and will continue to change over time in order to meet the needs of the system. These are action and delivery based and will continue to evolve with our ICS.

7.3.1 Norfolk and Waveney ICS Estates Governance

The ICS Estates Programme Board is one of several ICS Operational Groups within the Norfolk and Waveney Health and Care Partnership. Its main role is to bring key system partners together to develop and deliver the strategic estates vision and priorities, that support the Norfolk and Waveney Integrated Care System.

Our strategic vision is to provide a safe, functionally suitable and digitally enabled estate that allows for the delivery of the right care, in the right place, accessible to all and allowing better patient outcomes.

The Estates Group has been accountable to the System Planning and Transformation Group (SPTG) and will report into the ICS Strategic Capital Board for matters relating to our Capital Investment Pipeline.

Peer review and support of primary care estates plans – including but not limited to this Programme Business Case – is gained via the ICS Estates Programme Board, alongside support from colleagues in NHS England & NHS Improvement who provide advice and links to projects and programmes whose learning may be able to support this programme as it develops.

7.3.2 Wave 4b Programme Board

The Wave 4b Programme Business case has links and dependencies with other estates projects being conducted within the Norfolk and Waveney ICS. Consequently, oversight of the scheme is through the ICS Estates Programme Board which has executive and senior management membership from across CCG partners and NHSE/I. It conducts the oversight within the context of other projects, along with consideration from Executives who have responsibility for CCG wide funding and risk. The Programme Board unifies the governance and reporting arrangements of key ICS initiatives within which estates forms a key component. A Wave 4b Programme Board has been established as a sub-group to the ICS Estates Programme Board and the table below illustrates how the Programme Board has reported to the CCG Executive and ICS Estates Programme Board. The CCG Chief Finance Officer is also a member of the Wave 4b Programme Board.

Name	Role and organisation
Jason Hollidge (Chair)	Director of Commissioning Finance, Norfolk and Waveney CCG
John Ingham	Chief Finance Officer, Norfolk and Waveney CCG
Mark Flynn	Director of Strategic Projects, James Paget University Hospital
Paul Higham	Associate Director of Primary Care Estates, Norfolk and Waveney CCG
Paul Bird	Head of ETTF, NHS England and NHS Improvement, East
Steve Udberg	Strategic Estates Lead, Estates Delivery Team, NHS England and NHS Improvement
Jon Murphy	NHS England and NHS Improvement

Name	Role and organisation
Mark Page	Associate Director, ICS Estates, Norfolk and Waveney
Chris Philbedge	NHS Property Services
Barry Jenkins	Norlife Ltd
Duncan Butler	Norlife Ltd
Joni Graham	Norfolk & Waveney Local Medical Committee
Ben Hogston	Associate Director, Primary Care Network Development (GYW), Norfolk and Waveney CCG
Sarah Bird / Heather Farley	Acting Associate Director, Primary Care Network Development (North Norfolk), Norfolk and Waveney CCG
Fran O'Driscoll	Associate Director, Primary Care Network Development (South Norfolk), Norfolk and Waveney CCG
Emma Bugg	Associate Director, Primary Care Network Development (Norwich), Norfolk and Waveney CCG
Rebekah Mercer	Associate Director, Primary Care Network Development (West Norfolk), Norfolk and Waveney CCG
Cath McWalter	Senior Primary Care Estates Manager, Norfolk and Waveney CCG
To be confirmed	PMO Support, Norfolk and Waveney CCG
Shirley Chusonis	Primary Care Estates Support, Norfolk and Waveney CCG

As indicated in their Terms of Reference the Wave 4b Programme Board will:

a) Take overall responsibility for the effective running of the Wave 4b Programme:

b) Approve the:

- Programme Plan and milestones
- Budgetary expenditure
- Communications and engagement plan
- Critical Success Factors (CSF)
- Risk and Issue logs.

c) Recommend for Executive Board Approval

- Project Initiation Documents (PID)
- Programme Business Case (PBC) – including details of each scheme
- Full Business Cases (FBC).

d) Agree:

- Significant variations to the programme plan via a formal Change Request process
- Content of Business Cases required for investment.

e) Take necessary steps to expedite programme work streams, seeking external support when required.

f) Monitor and manage programme progress, including:

- Delivery of milestones & monitoring against programme plan

- Monitor expenditure against programme budget.

g) Provide visible leadership, direction, and commitment to the programme, promoting effective and positive communication of the programme goals and progress.

h) Ensure availability of essential programme resources.

i) Receive reports from individual work streams within the programme.

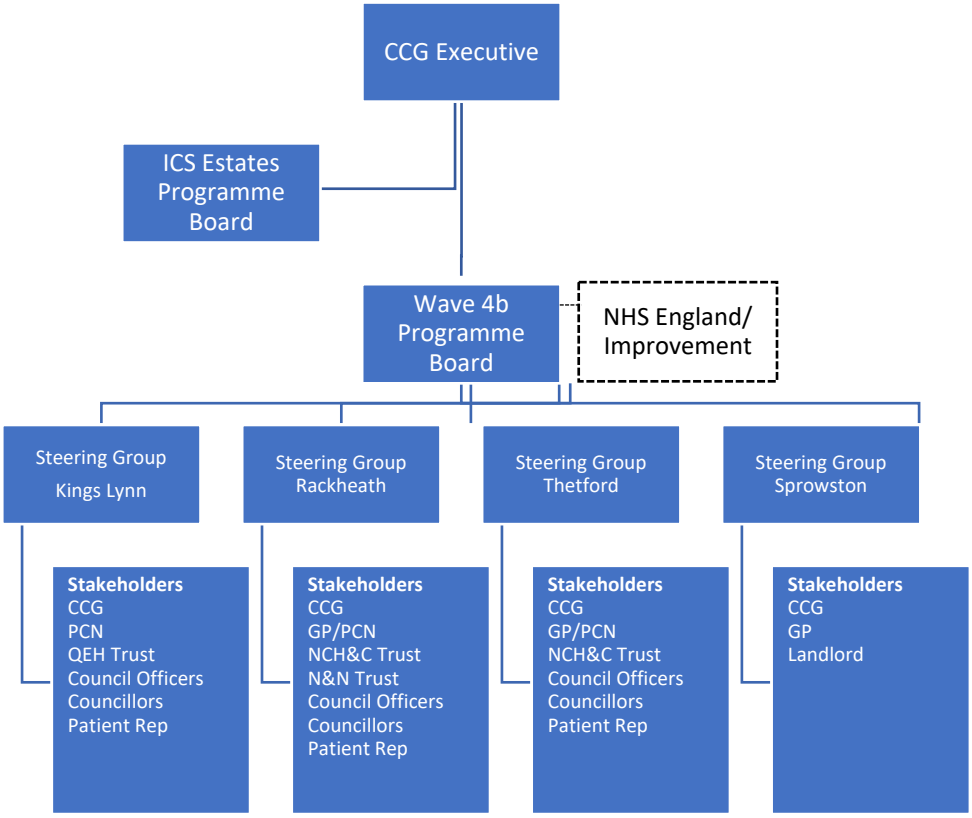


Figure 122: Programme Governance

7.4 Programme Management Office Arrangements

The Wave 4b Programme Board oversaw the availability of resource to support the design and delivery of the Programme and to ensure the Programme develops and runs effectively. The approach has been to use the ICS PMO to support the establishment of a Programme Team, ensuring consistency in approach, financial oversight, sharing of skills and good practice, Programme and project level monitoring and delivery, appropriate stakeholder engagement, risk mitigation and performance management.

7.4.1 Programme Team

Senior leaders approved the appointment of an external resource to assist the Programme Team: the Norfolk Local Improvement Finance Trust (LIFTCo) – Norlife, who can provide professional, estate and technical consultancy services as part of the Strategic Partnering Agreement (which is undergoing a review as part of the ICS development). LIFT Companies are public private partnerships, of which 60% is owned by the private sector and 40% owned by the public sector.

Project Management arrangements have been based on the CCG's governance structure and are reflective of national best practice, drawing on PRINCE2 and Managing Successful Programmes.

All staff employed to progress this scheme will be suitably experienced and qualified.

Day to day management of the programme is led by the programme team who are directly answerable to the Programme Board. The team provide links into each projects steering group, ensure they achieve the project timelines outlined in the master programme. They are responsible for

escalating significant risks to the programme Board, proposing, and implementing agreed remedial actions. The Programme Team will be supported by the experienced ICS PMO Team who provide the framework, documentation, advice and expertise to ensure effective project work across the ICS.

Programme Team details are set out in the table below.

Name	Designation	Employer	Role
John Ingham	Chief Finance Officer	NHS Norfolk and Waveney CCG	Executive and CCG Board Level lead
Jason Hollidge	Director of Commissioning Finance	NHS Norfolk and Waveney CCG	Senior Responsible Owner
Paul Higham	Associate Director Primary Care Estates	NHS Norfolk and Waveney CCG	Programme Director and Project Owner
Cath McWalter	Senior Primary Care Estates Manager	NHS Norfolk and Waveney CCG	Project Assurance
Phil Riedlinger	Senior PMO Manager	ICS PMO Team	Expert programme and project guidance

Place level representation is via the CCG Locality Leads from PCN Development Teams.

For clarify in respect of the terms used below:

- The Programme Team are supporting the Wave 4b Programme
- The PMO are the ICS system-wide resource who provide focussed guidance and support to programmes and projects across the system and who are providing expert project support to this Programme and to the individual projects within it.

Administrative resource is provided by the CCG.

7.4.2 Use of Specialist Advisers

The Programme Team identified to support the Programme is supplemented by access to appropriate specialist technical resources on an ad-hoc basis to support the establishment and delivery of key objectives for the Programme. This includes access to commercial, financial modelling, estates and health planning capabilities.

The Programme Team will access specialist legal advice as required to support understanding of commercial and legal implications.

The provision of this specialist support has been factored into the cost of delivering the Programme and has been/will be sourced through NHS Property Services and Norlife market tested supply chains where appropriate.

Name/s	Organisation	Area of expertise and role
Chris Philbedge	NHS Property Services	Business Case development and scheme development
Mark Nolan Gitte Kjeldsen	Chaplin Farrant	Architects Site search Surveying
Rebecca Trewinnard	Norlife	Health Planning and Business Case development
Duncan Butler	Norlife	Capacity planning and Business Case development
Barry Jenkins	Norlife	Commercial advice and support for Business Cases
Jane Hanvey	Norlife	Strategic financial planning and support

Name/s	Organisation	Area of expertise and role
	Melin Consultants	Sustainability and BREEAM

In addition, Place leads will add their capacity and capability through ad hoc engagement and representation on the Wave 4b Programme Board in order to ensure schemes are developed and delivered in line with agreed frameworks and expectations. The Programme Team will take an oversight role to ensure the expertise is shared across the programme maximising value for money.

7.4.3 Programme Delivery and Methodology

The Programme Team meet on a weekly basis to ensure effective management of the Programme, with the informal agenda covering project progress, risks and finance. Fortnightly, the Programme Team meet with Specialist Advisers to support the Programme Business Case development and this will continue, to help support scheme business cases and development. PRINCE2 has informed the methodologies of the programme management, including the risks, change, benefits and progress of the programme. This approach will also ensure the oversight of the feasibility of the projects, taking into account considerations covering economic, technical, legal and scheduling aspects – and advising on the logging and/or updating of risks and issues and their escalation, where appropriate.

7.4.4 Stakeholder Engagement

Led by the ICS Estates Programme, the Programme is strongly focussed on stakeholder engagement and has sought – and will continue to seek – active input from stakeholders in the planning, design, process and decision making of the Programme through to the schemes being completed. The Communications Plan will support consistent and effective methods to inform, engage and involve patients, the public, staff and all other stakeholders in taking the Programme forward.

The Communications Plan has been developed in accordance with CCG's Policy and is included as Appendix 4.

Each scheme has its own Steering Group. Membership includes:

- Prospective providers expected to commit to a lease in the facility.
- CCG Commissioners relevant to the scheme
- Patient representatives
- Local Authority Members/Parish Councillors
- Local Authority Members
- Local charitable groups.

Please see Appendix 4 for programme milestones and proposed Communications at each stage.

The Programme approach to stakeholder engagement will be adopted at project level, to ensure a consistent approach and so that collaboration continues to inform the design and development of the schemes. This approach recognises the need to factor in formal consultation on the plans for the new build schemes and the need for engagement with patients and stakeholders for the refurbishment and extension schemes. Effective engagement supports the Economic, Commercial and Financial elements of the Programme Business Case and the business cases for each of the schemes.

7.4.5 Programme Plan

The delivery of the high-level Programme Plan, which outlines the milestones and deliverables is overseen by the Wave 4b Programme Board. The Plan is updated on a regular basis and will provide an overview and framework as the projects within the Programme are delivered.

The key milestones in delivering the preferred options are set out below (more detailed project level programme plans can be found in the section for each scheme – please see Section 4.11).

7.4.6 Programme key milestones

The Programme Plan can be found at Appendix 2.

The Programme Plan included – and milestones summarised below – are for the overall Programme. Individual project plans for each of the four schemes are in production and will support the development and progress of the scheme OBC/FBCs. The individual project plans will be shared with NHS England & NHS Improvement as soon as they are available and will also form part of the monthly programme and project reporting to the Wave 4b Programme Board.

Milestones	Completed or Scheduled for Approval	Comments
CCG Wide Capacity Planning	January 2020	Completed – refreshed in May 2022 and included as part of the PBC resubmission
Project Governance in Place	Ongoing	Monthly Programme Board Meetings established 2020
Local Steering Groups	Ongoing	Monthly meetings
Confirmation of stakeholders	March 2021	Confirmed for each of the schemes
Schedules of Accommodation	June 2021	Produced for the schemes – refreshed in May 2022 and included as part of the PBC resubmission
Option appraisal events	September 2021	Completed for the schemes
Financial/Non-Financial Appraisal	October 2021	Completed for the schemes
Stakeholders sign off	Early November 2021	Completed for the schemes
Programme Board Sign Off	Late November 2021	Completed
Submission of Programme Business Case to NHS England & NHS Improvement	December 2021	Completed
Programme Business Case re-write	May-June 2022	Completed
Re-submission of Programme Business Case to NHS England & NHS Improvement	June 2022	On track
• NHS England & NHS Improvement submit recommendation report to "Capital and Cash" • Regional Business Case Review Meeting	August 2022	
• NHS England & NHS Improvement Regional Strategic Development Committee Meeting • Report submitted to Department of Health and Social Care Joint Infrastructure Sub Committee	September 2022	
Department of Health and Social Care Joint Infrastructure Sub Committee meeting	September 2022	
Department of Health and Social Care / NHS England & NHS Improvement approval	September 2022	
Combined OBC/FBCs for each proposed scheme developed	April – December 2022	
Business cases for each proposed scheme submitted to NHS England & NHS Improvement Regional Business Case Review Meeting • Short form business case review templates sent for information within NHS England & NHS Improvement and to Department of Health and Social Care • Updates to regional Capital Delivery Oversight Group	September – November 2022	
Scheme construction phases	January 2023 – March 2024	End stop date for all schemes as construction times will vary
Handover and completion checks.	Before May 1st 2024	End stop date for all schemes. Anticipated 1 month from practical completion
Services go live	On or before May 1st 2024	

7.4.7 Management of potential/perceived Conflicts of Interest

The Wave 4b Programme Board provides assurance in terms of the interests of those individuals or organisations associated with the Programme and projects, through standing agenda items at its monthly meetings and register of any declarations. The CCG (and ICB) will act under Conflicts of Interest guidance which requires detailed and stringent declarations to be in place to manage actual and perceived conflicts of interest. The CCG's approach and arrangements for managing Conflicts of Interest, as set out in its Standards of Business Conduct Policy and Constitution can be found online.

Norfolk & Waveney CCG Governance Handbook

Norfolk & Waveney CCG Constitution

The CCG/ICB will require any third-party organisations associated with the Programme and project delivery have robust Conflict of Interest policies.

7.4.8 Project monitoring and escalation and Change Control

The change control system to be used is in line with the best practice approach recommended by the ICS PMO, which recognises that projects and the context in which they take place change over time. The change control approach will ensure that proposed changes are identified, assessed and controlled in a structured way which allows for the project to remain responsive to stakeholders while remaining under control.

The Programme Board will continue working on the assumption that the capital award is fixed and projects will similarly work on this assumption. The change control process therefore is part of ensuring that plans remain within the allocated budget and regular reporting to the Programme Board on timeline, project progress and projected spend profile will be required.

7.4.9 Project monitoring and escalation

The Programme Team will be responsible for maintaining strong links between the projects and the Programme Board, including through monthly project reporting – which will facilitate the change management process.

Project Management will take place via NHS Property Services (King's Lynn and Rackheath schemes), CHP (landlord of Thetford scheme) and PHP (landlord of Sprowston scheme), with members of the Programme Team working in tandem with the Project Management for each scheme.

The measures to be in place in respect of project monitoring are in line with local guidance and best practice and include:

- Project Steering Groups will be embedded into Place level governance.
- Monthly reporting to the Wave 4b Programme Board including timeline, project progress, progress against actions identified, key risks and mitigations – with a particular focus on risks relating to the construction market and potential impact on timelines and cost.
- Ad hoc advice and support from the Programme Team (who will be represented on all Project Steering Groups) as required.

The Change Management approach which will support the project monitoring and escalation process is that of the ICS PMO, which will remain under review by the Programme Board to ensure it meets the needs of the Programme and projects and supports the delivery of the Programme – including identifying and agreeing the tolerances at which change in scope will be notified. Updates will be reported via the Wave 4b Programme Board, of which NHS England & NHS Improvement are members.

7.4.10 Change Control

Change Control is the process of handling proposed alterations to items that have been previously designated as fixed. This means that an item only becomes subject to change control once it has been signed-off and become part of the baseline specifications and cost.

The process will support the Programme to remain on track with its objectives and will support projects in working through challenges. The Wave 4b Programme Board – with advice and guidance

from the PMO and Programme Team – will keep the Change Control process under review in line with the requirements of the Programme.

The Programme Team – supported by the PMO – will maintain oversight and report to the Wave 4b Programme Board to provide assurance of progress in the development of projects against agreed baselines.

When initiating a request for change an agreed pro-forma will be completed detailing the proposed change and highlighting the impact of this change, with regard to cost, quality and programme.

The aim of change control is to ensure that if a signed-off item is changed then:

All stakeholders have an opportunity to participate and comment.

All recipients are made aware of the change if it is agreed.

That there is an audit trail which connects a change to the reason for its change, and which records the participation and authorisation of those people concerned with the change.

All issues and changes should be discussed between Project Managers with the Programme Team and a decision taken on which changes should be escalated through the Change Control process – which will activate the Change Control process. Activation may also take place through the Programme Team or Wave 4b Programme Board responding to monthly reporting or other issues raised.

The Change Control process will be required for (not exhaustive list):

Cost variance: where there is a variance in the estimated project costs of the agreed cost envelope for the project which may benefit from Programme level support and challenge.

- All projects will need to notify the Programme Team of any change control request and include such in the monthly reporting to the Wave 4b Programme Board.
- If additional funding is requested, information supporting additional costs will be provided.
- Due diligence will be provided by the Programme Team, supported by the Finance Team for either additional funding requests or a reduction in costing.
- The Programme Team will formally report to the Wave 4b Programme Board with a recommendation.
- The project programme plan will be adjusted as necessary.

Capital affordability: where the project has exceeded the capital cost envelope or a risk is indicated that this will occur.

- The project team – supported by the Programme Team – will attend an extraordinary Programme Board meeting to review next steps, which may include value-engineering, scope reduction or project withdrawal.

Deliverability: where there are risks to the project's deliverability due to circumstances which cannot be resolved within the Programme timeframe (e.g. revenue affordability, stakeholder support, planning and building timelines, business case deliverability).

Changes will be assessed by the Programme Team, consulting finance colleagues and the PMO before making recommendations to the Wave 4b Programme Board. The change may be accepted, accepted with conditions, rejected or deferred.

Change Management Planning will feature in the Full Business Case for each project and be included in their Project and Communication Plans. They will include provision for multi-provider events to facilitate the patient and service benefits expected through closer integration.

A Change Management approach for each project will develop a strategy towards the engagement of the client group, their advocates, and staff in the lead up to the move and, most crucially, the implementation of the new service strategy and work methods once the service goes live.

7.4.11 Programme Benefits Realisation Arrangements

The delivery of benefits will be managed though the Benefits Realisation Plan (please see Appendix 3). The delivery of these benefits will be measured using the proposed metrics within the plan and

monitored as part of commissioner's regular performance monitoring with the providers at each location.

The Plan recognises three levels of benefit, identified in line with the Investment Objectives:

Strategic

Operational

Task

Commissioner's response to performance shortfalls will vary depending on the level:

Where expected **Task** level service benefits are not being realised, where possible the CCG will put in place remedial measures with local providers to remove barriers to achievement and address the shortfall.

Where **Operational** level service benefits are not being realised the CCG will work with its partner organisations to remove organisational barriers to achievement. Alternatively, they may adjust the proposed benefits to reflect the operational planning context prevailing at the time.

The **Strategic** level benefits identified are related to national environmental challenges and better estate utilisation. Environmental performance targets will be agreed during the approval of full business case and delivered at the construction phase. Commissioners will work with occupying providers to ensure agreed levels of utilisation as specified in the plan. Occupancy terms will be flexible to enable underutilisation to be quickly addressed by temporary or additional uses.

Benefits Realisation Framework

The CCG has a Benefits Framework to support realisation of benefits. This is a key component of the overall CCG governance. The Framework sets out the rules on how to identify, design, monitor and review the benefits management cycle.

Each programme or project within the CCG follows this framework to ensure consistency of approach and reporting. The central CCG Programme Management Office collates individual programme and project benefits and maintains the overarching CCG Benefits Register.

Each programme's benefits register is required to show:

- A unique benefit number to enable tracking
- Benefit category and class
- Description of the benefit (including enabling project or activity)
- Service feature (which aspect of the programme will give rise to the benefit to facilitate monitoring)
- Potential costs incurred to deliver
- Activities required to secure benefit
- Responsible Officer
- Performance Measure/KPI
- Target improvement (expected level of change)
- Full year value of benefit
- Timescale to realise benefit
- All individual programme and project benefit registers will be assimilated into the CCG overarching Benefits Register. This is to ensure:
- Consistency in the way benefits are measured
- Avoidance of duplicating benefits
- Transparency and fairness where multiple programmes/projects are supporting the delivery of the same benefit e.g., Non-Elective Admissions
- Agreed methods and data sets to monitor achievement

- The totality of benefits across all programmes contributing towards achievement of CCG objectives.

The SRO and Programme Director are accountable for the effective identification, quantification, management, and communication of benefits throughout their programme.

Benefits will be reviewed regularly, and where necessary amended or changed where appropriate. The monitoring of benefits realisation will continue after programmes are implemented to ensure that the benefits continue to be realised once the changes have become business as usual.

The Programme Benefits Register for this programme is attached as Appendix 3. Due to the nature of this programme each individual project is responsible for delivering elements of those benefits.

The Programme Team will be responsible for ensuring that as each project develops, appropriate benefits are identified and captured as per the CCG Benefits Framework. The Programme Team will also ensure that targets for achieving those benefits are appropriately apportioned based on 'Place' metrics.

The Programme Team will collate the necessary benefits data and reporting for each project and consolidate into a regular report for the PMO. This data will also be captured in the regular reporting for the ICS Estates Programme Board.

Where achievement of benefits is reliant upon more than one Programme e.g., Primary Care Transformation etc., the Programme Leads will work closely together to ensure alignment of key deliverables are maintained to enable delivery of benefits overall. Where this becomes a challenge, this is escalated to the Wave 4b Programme Board for resolution.

Project Benefit Realisation

Each of the projects within this programme will be responsible for identification of benefits for their own projects in accordance with the CCG Benefits Framework. The Programme Director will support them with this to ensure alignment with the Programme Benefits.

Each project lead will be responsible for updating their benefits register and ensuring that the Wave 4b Programme Team is kept up to date. Any changes to benefits being achieved will be flagged to the Programme Team so that any interdependencies, or consequences, can be assessed by the Programme Team for resolution. Where resolution cannot be found, this will flagged to the PMO directly, for advice.

7.4.12 Risk Profile Assessment

The Programme Team and Board recognise the importance of understanding key risks associated with the delivery of the Programme and ensuring that appropriate mitigation is in place to address significant risks and provide assurance to key stakeholders. A key requirement associated with the delivery of Government funded projects is to undertake a Risk Profile Assessment (RPA), which provided a systematic process for understanding and assessing key criteria. The Programme Team have completed the RPA form, which, following review and discussion, has assessed the Programme as a Low Risk. The revisions to the Programme following the initial PBC submission will not alter this assessment.

7.5 Risk Management Process

7.5.1 Risks and risk management

Please see Appendix 5 for details of the Risk Register.

This Project follows the CCG's Risk Management Policy which is owned and overseen by the CCG Corporate Governance Team, with the Corporate Risk Register being reported to the CCG Executive Management Team.

The aim of risk management is to improve the likelihood of the Project or Programme achieving its stated objectives.

The risk management process is designed to:

- Focus the Programme Board and senior management team on the major risks that threaten programme/project delivery and objectives.

- Provide a clear picture of the major risks facing the programme/project, their nature, potential impact, and likelihood.
- Establish a shared and unambiguous understanding of what risks will be tolerated.
- Actively involve all those responsible for planning and delivery of the project's key deliverables and benefits.
- Embed risk awareness and management in planning and decision-making processes.
- Enable and empower managers to manage those risks within their area of responsibility.
- The objective of a risk management system is to ensure:
- Early identification and management of risks.
- Proper analysis, evaluation, and quantification of risks.
- Clear and consistent assignment of ownership and management of risks.
- Comprehensive identification, definition, and evaluation of appropriate mitigation routes.
- Clearly defined policy, standards, processes, and procedures.
- Robust documentation for audit purposes.

7.5.2 The Process

Risk analysis and management are on-going processes incorporated throughout the life of a programme/project and is the responsibility of all staff involved with a project. The responsible managers will keep partners informed of risks identified, action taken where appropriate and the success of those actions.

There are three parts to the risk management process:

1. **Analysis** - identification, definition, and assessment of probability and impact.
2. **Management** - risk mitigation strategy and plan, monitoring and control of actions employed to deal with the threat, and problems identified in analysis.
3. **Reporting** - all risks raised will be recorded on the project risk register and will be owned by the Project Director. Reporting of risks will be carried out on a regular basis in accordance with the agreed Governance structure and terms of reference.

7.5.3 CCG Risk Framework

The Risk Management Framework utilised for the CCG and any of its Programmes is based on a risk assessment matrix which looks at the likelihood of something happening and the consequences if it happens. This allocates a financial score which determines the level of risk being faced.

Risk Management is an integral part of programme management and allows for mitigating actions to be thought through and prepared for in case risks to achieving a programme or project come to fruition.

The programme team identified and assessed the potential risks to the programme and undertook scoring based on the likelihood of occurrence and the subsequent consequence to the deliverables or system if that risk happened. These are set out in the Strategic Case. The full risk register is attached at Appendix 5.

7.5.4 Risk Profile Assessment

Likelihood of (re) occurrence scoring matrix

LIKELIHOOD OF (RE) Occurrence		
Likelihood	Score	Description
Rare	1	Extremely unlikely or virtually impossible to (re)occur (0-5% chance)

Unlikely	2	Low possibility of (re) occurrence, but not impossible (6-20%chance)
Possible	3	Fairly likely to (re) occur (21-50% chance)
Likely	4	More likely to (re) occur than not (51-80% chance)
Almost Certain	5	Almost certainly will (re) occur (81-100% chance)

Consequence/Impact scoring matrix

Consequences / Impact		
Consequence	Score	Description – Examples
Negligible	1	**Injury** - Very minor injury or illness not requiring (medical)intervention **Loss of Production** - Negligible disruption (e.g., < 1 hour) **Financial cost / loss** - No effect on delivery of services **Reputation** - Unlikely media interest or loss of reputation **Quality** - Minor non-compliance, single local resolvable problem
Low	2	**Injury** - Minor injury or illness requiring limited intervention (e.g., First Aid) **Loss of Production** - Disruption of between 1 and 24 hours **Financial cost / loss** - Short term effect on delivery, not affecting partners **Reputation** - Low key media interest, very limited damage to reputation **Quality** - Single failure to meet single local standard
Medium	3	**Injury** - Medical intervention, hospital stay or longer lasting injury or illness **Loss of Production** - Disruption of between 1 and 6 days **Financial cost / loss** - Longer term effect on delivery, affects stakeholders **Reputation** - Multiple local media interest, some damage to reputation **Quality** - Multiple failures to meet local standards
High	4	**Injury** - Significant or permanent injury, major injury (RIDDOR reportable) **Loss of Production** - Disruption of between 7 and 27 days **Financial cost / loss** - Effects extending beyond one financial year **Reputation** - Significant media interest, significant damage to reputation **Quality** - Single failure to meet national standards
Extreme	5	**Injury** - Death or multiple permanent injuries **Loss of Production** - Disruption of 28 days or more **Financial cost / loss** – Long-term effects on financial viability of services or providers **Reputation** - National coverage in media, long term damage to reputation **Quality** - Multiple failures to meet national standards

The following shows the categorisation used based on the level of risk from the aggregate score.

Green	Score 1-4	Low	Generally regarded as acceptable
Yellow	Score 5-9	Moderate	Acceptable in the short term provided responsibility for control has been identified and is being implemented.
Amber	Score 10-15	Significant	Not acceptable – requires input to reduce risk
Red	Score16+	High	Not acceptable – requires urgent and immediate action to reduce risk to acceptable levels.

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

7.5.5 Mitigation Strategy and Monitoring

Based upon the level of concern and controllability for each risk, the Risk Owner will decide on the risk mitigation strategy and associated actions i.e. whether to accept, treat, or transfer the risk, and ensure those actions are carried out as required. The Risk Owner at least monthly (more frequently for red and amber/red risks), will review and monitor progress and consider the effect on the overall risk rating and report to the Programme Director so that those changes and updates are reflected in the risk register.

Where the risk has a high-risk rating (Red) contingency plans will need to be developed to address the consequences of the risk materialising.

Risks will need to be escalated to the next level of seniority (i.e. individual or group) and the escalation recorded in the risk register where:

- The risk is of high concern (red) – escalate to the Wave 4b Programme Board.
- The risk is outside the authority, responsibility, or control of the risk owner.
- The risk relates to more than one manager's area of responsibility.
- Actions to manage the risk require additional resources or the action requires approval elsewhere.

The escalation or transfer of the risk will be authorised by the Programme Board. If action is required in between Programme Board meetings the SRO will take on that responsibility.

When the risk actually happens, it becomes an issue and should be transferred to the 'Issues' log. If a risk affects the project but is outside the remit of the Programme/Project team or Programme Board it should be transferred to the most appropriate corporate governance body and managed therein. A watching brief within the programme/project will be required.

Each project within the Programme will have a risk register which will be reviewed by the Programme Team on a regular basis. The Programme Team will collate the individual risks and update the Programme Risk register for review and onward submission to the ICS Project Management Office.

Red risks will be flagged to the Programme Board in the Wave 4b Capital Programme update report.

Risk registers will be reviewed and updated monthly.

7.5.6 Programme Delivery Risk

The Risk Register for the Programme is included as Appendix 5.

The most significant risks to the Construction Programme delivery is approval delay.

Current material and workforce shortages are hampering many construction projects and these are expected to ease as the economy recovers from the effects of the pandemic and international travel eases.

The new regulatory frameworks impacting on construction following the departure from the European Union are not expected to have a significant impact on these schemes.

The most common construction programme risks with mitigations are identified in the table below.

Ref	Risk	Mitigation	Rating	Mitigated Rating
Design Risks				
	Errors and Omissions	Monthly design team meetings, staged sign off designs, Room Data Sheets, Planning documents.	Low	Low
	Delays	Contractual penalties. Monthly design team meetings early warning of delay.	Low	Low
	Stakeholder late changes	Formal stakeholders sign off followed by a design freeze. Commissioner approval of any variations.	Moderate	Low
	Contractual failures	Design risk will be transferred to 3rd Party developers protecting the NHS from liability.	Low	Low
External Risks				
	NHS Decision Delay	NHSE/I have been represented on the Programme Board and drafts of PBC documentation shared. There is also a national commitment to streamlining decision making. Discussions suggest the schemes may be subject to Gateway Reviews.	High	Significant
	New Stakeholders emerge	Following formal stakeholder sign off Commissioner approval will be required for additional stakeholder engagement.	Moderate	Low
	Public objections	Public engagement throughout the business case process including	Significant	Moderate

Ref	Risk	Mitigation	Rating	Mitigated Rating
		patient representation and local elected members.		
	Changes in law	Risk will be transferred to 3rd Party developers protecting the NHS from liability.	Moderate	Low
	Changes in Tax	NHS bodies will include mitigation for any changes in tax. Costs have been estimated with an assumption VAT will apply	Low	Low
Environmental Risks				
	Analysis of impact incomplete	BREEAM assessor engaged at PBC stage to ensure documentation and management is in place.	Moderate	Low
	New regulation or standards	Advisers will keep abreast of changing requirements projects will aim to achieve the highest ratings.	Moderate	Low
Organisational Risks				
	Workforce	Risk will be transferred to 3rd Party developers protecting the NHS from liability.	Significant	Low
	Materials delay	Contractual terms will include loss adjusted damages to ensure deadlines are met.	Significant	Low
	Health and Safety	Developers will appoint supervisors to oversee compliance with CDM regulations. Construction partners will have to be properly accredited and experienced	Moderate	Low
Project Management Risks				
	Quality failures	Construction risk will be transferred to 3rd Party developers protecting the NHS from liability. Staged payments will require independent completion certification. Contingency sums will be retained for practical completion and 12-month defects period.	Moderate	Low
	Contractor delay	Contractual terms will include loss adjusted damages to ensure deadlines are met.	Significant	Moderate

Ref	Risk	Mitigation	Rating	Mitigated Rating
	Stakeholder/Team conflicts	Project managers will be expected to address issues or escalate them to Commissioners where they cannot.	Low	Low
Rights of Way Risk				
	Expired permits	Permit and access risk will be transferred to 3rd Party developers protecting the NHS from liability	Low	Low
	3rd Party actions	Risk from 3rd Party actions will be transferred to Party developers who will need to demonstrate suitable liability cover before appointment protecting the NHS from liability	Moderate	Low
Construction Risks				
	Cost overruns	Contractual terms will agree a fixed Contractual Sum. Cost overruns not due to NHS variations or delays will be a developer liability.	Moderate	Low
	Technology changes	Developer liability.	Low	Low
	Contractual failure	Developers will need to demonstration sufficient insurance cover to protect the NHS from liability. NHSE/I will require a covenant protecting any staged payments already made in the event of liquidation.	Low	Low

7.5.7 Risk Register

The Programme Board reviews all the Risk Assessments on the Programme Risk Register. The open risks on the Programme risk register can be seen in Appendix 5. The Risk Assessments include all areas of risk identified by the Programme Team and stakeholders. These risks include the operational risks to clinical services to clinical services should the benefits not be delivered.

The Programme Risk Register is a live document and risks are amended, included, and assessed day by day by the Programme Team and monthly by the Programme Board to provide assurance that all risks are managed and mitigated as effectively as possible.

7.5.8 Risk Management Strategy

The CCG's Risk Management Strategy is in accordance with its Board Assurance Framework, the National Patient Safety Agency, and HM Treasury Green Book. It is designed to ensure that risks are identified, assessed, and mitigated with control and actions with associated review timescales in place. All risks have an owner and a lead.

7.6 Equality Impact Assessments

The CCG has conducted Equality Impact Assessments for the proposed Hubs using the locally mandated template. The Assessments were reviewed by a CCG Governing Body Member who is an Advanced Nurse Practitioner and Vice Chair for Norfolk's Health and Wellbeing Board as well as the Communications and Engagement Team. The overall impact for all four proposals will be the benefits

brought by increased capacity in primary care services in the relevant PCN area, provided from premises which are fit for purpose and sustainable to meet the needs of the population and demands in population growth over the coming decades. Primary care estate has a key role to play in accommodating the service provision which is required to meet the local population's health needs – helping to deliver multi-disciplinary services as well as primary care services. The Impact Assessments detail the positive and potential negative impacts and recommend mitigations which will be planned for appropriately either in the design of the premise and/or reflected in the operational agreements for the buildings.

7.7 Business Continuity Plan

Business continuity planning for each scheme will be considered in detail during the combined OBC/FBC and operational planning. High level current/construction impacts are summarised below.

Post construction continuity including change management, mobilisation, removals, and commissioning of the buildings will be detailed in the combined OBC/FBC for each scheme.

Rackheath:

Current

Following the closure of a non-compliant small branch facility several years ago, current residents of the town have to travel several miles to Hoveton or into Norwich for services. The rapid expansion of the town is increasing registration demand. The CCG has agreed minor improvements and expansion at the Hoveton and Wroxham Practice, to support growth elsewhere in the catchment area, and as an interim measure to support Rackheath whilst plans are delivered.

Community and maternity services are located across several sites locally, some of which are now looking for additional space to house extended PCN services.

Construction Phase

There is not expected to be any additional pressure on GP services during construction.

As a new facility the construction is not expected to impact on current community and midwifery services.

Sprowston:

Current

The current practices surrounding the proposed Growth Area north of Norwich have limited capacity that is quickly being taken up by new demand. The facility at Aslake close is relatively modern and in good repair. Having been designed for two practices it is inefficient for the single practice now in occupation, with several void areas. Consequently, much of the capacity is inaccessible. The provider has reached a break point in their lease.

The facility already hosts a range of services including mental health and a commercial pharmacy. It shares a campus site with learning disability and other community services.

Construction Phase

There is likely to be significant disruption to services and parking during the construction phase. It is proposed to phase the building beginning with a single storey extension to the rear this will allow the building to remain in operation through-out with internal relocations.

Community, Pharmacy, and other services on site will be unaffected by the proposed works and can operate normally.

The practice has a large nearby branch which can assist with business as usual.

King's Lynn:

Current

The GP service proposed is to serve a new patient list and ease pressure on existing practices. The three existing providers have several sites in the town all of which will continue to register and support patients.

As detailed in Section 3.12, there is significant demand from new housing anticipated alongside the need to address the requirement for improved healthcare facilities in one of the most deprived areas of Norfolk.

The Diabetic Outpatient services proposed for inclusion in the Hub currently operate from the Queen Elizabeth Hospital site which has significant estates issues that place key services at high risk.

The maternity services proposed have their administrative base on the hospital site but patient facing services are delivered across a range of other provider venues. Whilst there are significant capacity issues in primary care, these are not expected worsen during the delivery of the Wave 4b funded Hub.

Construction Phase

There is not expected to be any additional pressure on GP services during construction.

As a new facility the construction is not expected to impact on current outpatient services.

Thetford:

The current practices surrounding in Thetford are already constrained and facing pressure from new demand. As detailed in Section 3.12, there is significant demand from new housing anticipated alongside the need to address the requirement for improved healthcare facilities in another of the most deprived areas of Norfolk.

The Thetford Healthy Living Centre is modern and in good repair, but redesign and remodelling will ensure it is efficient for use as a multi-disciplinary Hub, addressing existing void areas and ensuring capacity can be optimally utilised.

The facility already hosts a range of services including community services, secondary care and a commercial pharmacy.

Construction Phase

There is likely to be some disruption to services and parking during the construction phase. It is proposed to phase the works to ensure the building can remain in operation through-out with internal relocations – meaning that all services on site will be able to continue operating.

The practice has sites within Thetford which can assist with business as usual to an extent.

7.8 Post Implementation and Evaluation Arrangements

The Wave 4b Programme Board will work alongside the ICS Estates Programme Board in ensuring that there are robust and effective means in place to track projects post completion and to evaluate the outputs, outcomes and benefits realised from these projects, as part of the wider Estates strategic context for the ICS and to ensure impact and learning – particularly from the Hub model approach to working and service provision – is captured and used to benefit future strategies and projects.

7.8.1 Post Programme and Project Evaluation

The Programme itself will undergo a post programme evaluation (PPE) to understand key learning in relation to the outcomes as well as the processes which were used to manage and deliver the Programme and its projects.

The PPE approach will include:

- Overall Programme Assessment: were all goals and objectives set out in the PBC met; was feedback from stakeholders on the deliverables favourable; was the programme delivered on time and to budget.
- Scope Management: were all items agreed upon in the scope delivered; were all change requests and outcomes documented; if required, were budgets and timelines appropriately adjusted?
- Quality of deliverables/benefits: was feedback from stakeholders on the quality of deliverables favourable; were anticipated benefits met; were any exceptional deliverables identified which added value; were any deliverables considered incomplete or below expected specification/acceptance criteria.
- Key accomplishments: identification of strengths or areas which stood out.

- Lessons Learned: identify positive lessons which should become embedded in the organisation's way of working; identify negative lessons and actions taken which can avoid these in future projects.
- Future considerations: determine activity required on the programme for the future including programme maintenance issues.
- Best practice: identify practices developed during the programme that would benefit the organisation if they were to be formalised.

The evaluation will be the responsibility of the SRO and will be led by the Programme Team, to include workshops with key stakeholders, patient/user feedback and review by the ICS PMO. The foundation of the PPE has already been laid, with lessons learned captured on an ongoing basis – as per ICS PMO guidance. The final report will be available 12 months after the programme has completed.

Commissioned by the ICS, each of the schemes will undertake a 12-month **post-delivery project evaluation**, in addition to the regular monitoring of services already in place. This will consider the projects, concept, planning, delivery intended and achieved benefits. It will also consider patients and staff members experience. The reports will be made publicly available to assist the local health and social care economy to learn lessons and improve the delivery of future schemes.

In line with best practice of investment programme sponsors evaluating and learning from projects which cost over of £1m, the ICS will use the existing PMO post-project evaluation process as the basis to understand what went well and what could have gone better in delivering the new facilities, to improve the management of future projects.

To ensure the value of the review process is maximised, the reviews will follow best practice including:

- Starting the planning for the post-project evaluation as an integral part of the project.
- Securing commitment to post-project evaluation from senior clinicians and managers, and an ICS/ICB director to champion the post-project evaluation.
- Involving all key stakeholders in planning and undertaking the post-project review.
- Developing relevant criteria and indicators to assess project outcomes from the outset of the project – see the benefits realisation section above.
- Putting in place project management mechanisms to enable monitoring and measurement of progress – see project management section above.
- Fostering a learning environment to ensure lessons are heeded.

7.8.2 Contingency Arrangements and Plans

The Programme Team and Programme Board will be closely monitoring the financial profile of each project as they develop towards OBC/FBC and will respond to the risks identified and commercial requirements which may have an impact.

For each proposal, the alternative to the Wave 4b capital funding could be to pursue the developments via third party development and this would have a revenue consequence for the NHS.

Section 4.11, detailing the scheme proposals, sets out the contingency allocated for each proposed scheme and the funding routes described in Section 5.3.2 the overall programme contingency.

7.8.3 Memorandum of Understanding for the Programme

A Memorandum of Understanding (MOU) will be developed to support Programme oversight, which will outline roles and responsibilities at ICS and Place level, including monitoring and control, financial, legal, commercial, governance and clinical oversight, together with communication and engagement and business case development and delivery.

The MOU also sets out expectations in relation to the sourcing of suitable resources both at ICS and Place to ensure the Programme and schemes are successfully delivered. This agreement, which will continue to be amended as the Programme progresses, will be agreed with NHS England & NHS Improvement colleagues.

The MOU may also be expanded to support the developing Primary Care Estate Strategy and PCN Estate Strategies and the proposed schemes at Place level – both setting the Wave 4b Programme in a longer-term context and helping to develop best practice in a different way of working in the Hubs.

7.8.4 Milestones for Initial Approvals and Six-Monthly Refresh

The key programme milestones are shown in Section 3.21 and Appendix 2 is the Programme Plan. As the projects are developed, this timeline will be updated accordingly.

The Programme Board agreed with NHS England & NHS Improvement that the Programme Business Case will be re-submitted June 2022, following discussion and review of the initial submission. Approval is anticipated during September 2022. The projects will be developed to combined OBC/FBC during this period, with anticipated approval by the end of December 2022.

Following approval, at least six monthly refresh activities will form part of the programme timeline.

7.8.5 Monitoring Arrangements with NHS England & NHS Improvement

NHS England & NHS Improvement are members of the monthly Wave 4b Programme Board and this monitoring will be supplemented by informal meetings to check progress and provide a point of contact for ongoing queries or issues arising. This approach will be reviewed to ensure sufficient oversight takes place of the individual projects as they are developed and implemented.

7.8.6 Project Review Process

Initiated as part of the Programme Business Case review and resubmission, each of the four projects will be supported through a monthly formal review process which will provide a mechanism for updates on project progress and development, aiming to ensure projects ongoing viability. The outcomes of these reviews will be reported to the Wave 4b Programme Board using a RAG rating system and used to provide assurance to NHS England & NHS Improvement of the Programme's viability and deliverability.

Each project team will be asked to provide an update on activity in relation to the project focussing on:

- Progress since the last review against actions/milestones
- Building design and space utilisation
- Digital implications
- Timeline update
- Financials and costings
- Procurement/commercial aspects – including lease discussions
- Clinical and patient engagement
- Risk oversight and management
- Property specific issues e.g. planning
- Stakeholder engagement and communications.

7.9 Organisation of Programme

7.9.1 Project Sequencing and Interdependences

There is no requirement for project sequencing and each of the schemes can progress independently to allow the most rapid delivery and reduce project risks.

The Norwich North scheme (Sprowston) was agreed on the basis that the Rackheath scheme also progressed. The loss of either of these schemes will not prevent the other from progressing. It would require an alternative scheme to be identified in the Norwich Growth Triangle if the proposed benefits are to be realised. Please see Section 4.11 for more detailed information on these schemes, both have the potential for developer funding later in the housing schemes.

The expected build time for the two new build projects is approximately 15 months as they are of a similar scale and use of modern methods of construction may positively impact these timescales.

The refurbishment/extension schemes are expected to be completed within 10 months.

7.9.2 Reserve Schemes

Following discussion and review of the original Programme Business Case submission, the reserve scheme (Thetford) was brought forward to complete the revised programme of four schemes. The developing Primary Care Estate Strategy for Norfolk and Waveney – which will be informed by the development of PCN Estate Strategies, utilising the national PCN Service and Estate Strategy Toolkit – will build on the work already completed and described earlier in this document (Section 4.10) to identify priority capital projects for primary care. This work is in progress, but the ICS has identified current priority schemes for primary care. These are not suitable to stand as reserve schemes due to the timeline for the programme (completion required March 2024).

7.10 Individual Scheme Development and Delivery

Following submission of the Programme Business Case, preparation works will begin to enable a prompt start of the schemes once national support is confirmed. This will include putting in place the client-side monitoring arrangements.

Each scheme will have a Steering Group most likely constituted from the existing Steering Group membership.

The governance structure will match that of the PBC except that project management, design and planning will be delegated down to project level.

Commissioners' interests will be represented by members of the Programme Team and locality leads in each of the localities and overseen by the current project owner who will be accountable to the Programme Board for delivery of the schemes.

7.10.1 Full Business Case Development

The development of the business cases will be led by a Place based project team and overseen by the PBC Programme Director and Programme Board.

The combined OBC/FBCs will be developed using the five-case model and in line with any prevailing HM Treasury and NHS England & NHS Improvement guidance at the time of production. Early engagement with the NHS England & NHS Improvement Capital and Project Appraisal Unit will be encouraged through the Programme Board to socialise drafts and raise any key issues that could be detrimental to approval of the business cases.

The intention, supported by NHS England & NHS Improvement, is to allow for fast progression to a combined OBC/FBC. The benefit of this approach is that with limited time between the business cases there is less risk of any significant changes thus streamlining the development of the FBC and subsequent approvals. This approach will be essential to achieving the project time lines.

Each Place based project team will have access to business case writers and appropriate financial and non-financial modelling resources.

All organisations that have a financial or commercial interest within the project will be engaged in the process and approval will be required through their relevant governance structure. Evidence of such approval will be appended to the business cases.

All pre-project costs will be covered locally until all external approvals have been achieved.

Development costs will be covered either through the asset owner or development partner and recovered through ongoing lease payments for the duration of the contract term.

7.10.2 Key Milestones for individual schemes

Please see the detailed programme plan in Appendix 2 and Section 7.4.6.

Detailed project plans for each proposed scheme are in development and will be submitted as part of the combined OBC/FBCs.

Combined OBC/FBCs for each proposed scheme developed will be developed between April and December 2022. The proposed refurbishment schemes (Norwich – Sprowston and South Norfolk – Thetford Healthy Living Centre) are likely to proceed more swiftly.

The business cases for each proposed scheme will be submitted to NHS England & NHS Improvement for the governance process as described in Section 7.4.6 between September and November 2022.

Scheme construction phases are expected to commence early 2023 and have an end stop date of March 2024, although construction times for schemes will vary as noted above.

Handover and completion checks will take place before 1 May 2024 (this is the end stop date for all schemes, will individual scheme timelines varying). Services will go live in the new Hubs on or before 1 May 2024.

7.10.3 Project sponsor and Stakeholders Engagement, Sign Up and Regional Approvals Approach

Each project will have a Project Steering Group to ensure that schemes have leadership and to enable effective stakeholder engagement. The Programme Team will provide support and the Programme Director and Project Owner will act as sponsor for the four projects.

As described in Section 5.6, the Programme has a Stakeholder Engagement approach which recognises key Programme stakeholder relationships and their management. This approach will be adopted at project level. The business cases for each project will be required to include details of key stakeholder relationships. This will build on the work already established through project Steering/Engagement Groups which actively informed the proposed designs and the site options appraisals.

NHS England & NHS Improvement colleagues will receive project updates as members of the Programme Board and will have the opportunity to scrutinise, challenge and shape projects as they are developed. All four schemes will be subject to formal regional approval via the business case process under the Premises Costs Directions.

The Letters of support at Appendix 7 provide indication of stakeholder commitment to their support and engagement as the projects are developed. As part of the business cases for each project, confirmation will be required of the relevant stakeholders financial commitment to the schemes.

7.10.4 Project Approval Requirements

As agreed with national and regional NHS England & NHS Improvement colleagues:

All four projects will be required to submit separate combined OBC/FBC documentation to the Regional Team of NHS England & NHS Improvement, via the CCG (ICB);

The Regional Team will undertake a review against the Short Form Business Case Criteria – each case must demonstrate that it is viable on its own in terms of Value for Money and additional reviews may be required from specialist teams;

The cases will be formally reviewed at the regional Capital Investment Oversight Group meeting;

The Regional Team will send the business cases and short form business case review template to national NHS England & NHS Improvement colleagues for information and review;

As each business case is approved, updates will be made to the Regional Capital Delivery Oversight Group, confirming the case was within scope and financial envelope as detailed and described in the Programme Business Case, and to confirm the Programme is on track in terms of deliverability and affordability;

After all four project business cases have been submitted, an overall Programme update will be taken to the DHSC Joint Infrastructure Sub Committee in order to give assurance on affordability, delivery and timescales;

The Department of Health and Social Care will send a Memorandum of Understanding to the CCG (ICB).

7.10.5 Sustainability and Carbon Zero

The ICS are committed to reducing the carbon footprint across the whole health economy and are putting Green Plans in place at both system and organisation level to demonstrate a sound and proactive strategy to reaching ‘zero carbon’ to align with the wider NHS commitments. These plans are supported by an overarching Operational Plan which captures system wide as well as estates specific initiatives. Oversight of these Plans will take place at the ICS Green Plan Delivery Group, reporting to the ICS Net Zero Executive Group.

The Wave 4b Hubs will play a key role in helping the system move towards its Net Zero targets. These buildings will introduce highly serviced and improved clinical facilities and have the potential to decrease energy demand and carbon usage.

Recognising the potential negative impacts of highly serviced buildings, the CCG will adopt a sustainable approach in the design of the Hubs using the following energy strategies.

Be lean: Use less energy (efficient building design and building services)

Be clean: Supply energy efficiently (utilise combined heat and power plant (CHP) or district heating and cooling)

Be green: Use renewable technologies

Every effort will be made throughout the lifetime of the project to reduce energy demand as set out in the energy and sustainability policy document.

The design will implement high efficiency plant and U-values that aim to be better than current Building Regulations. However, the building will still have a significantly higher energy demand compared to other types of properties such as schools/hotels/offices etc. The project team will focus on the 'clean' aspects that could be applied to the project to address sustainable energy and heat policies. This strategy is based on current construction requirements. It is, however, anticipated that due to the rapid decarbonisation of the National Grid, lowering of carbon emission factors for electricity is imminent, and something already reflected for domestic buildings.

The 55% reduction in carbon emissions from electricity means direct electric heating systems will produce virtually the same CO2 emissions as gas, with heat pump systems being even more favourable. This will be closely monitored as the CCG move forward through the design process.

Another impact of lowering the carbon emission factors is the reduction in benefit it has on carbon reduction measures, such as combined heat and power.

Whilst the above changes have not yet been reflected in the Building Regulation assessments that apply to the redevelopment (non-domestic buildings), the two will be aligned as the design is progressed throughout the full business case (FBC) development.

At this stage, the CCG will continue to look for solutions that deliver and align with the current regulations.

Consideration to other 'green' renewable technologies such as photovoltaics, will be reviewed as part of the Low Zero Carbon report. Based on design team experiences elsewhere, it is predicted that any schemes introduced would generate approximately 1-2% renewable saving.

BREEAM

The four new build schemes will be expected to achieve BREEAM Excellent and aim for carbon neutrality in both construction and delivery.

To enable this the CCG have already appointed a BREEAM adviser whose initial observations and plan are included at Appendix 8. Where required Ecology surveys will be completed on each of the chosen sites prior to PBC approval, along with additional preparatory measures to ensure the highest achievement of BREEAM points.

The fifth scheme falls below the threshold for BREEAM as the new build extension is not large enough to impact on the existing buildings performance. However, the project will be expected to ensure the extension meets the highest environmental standards. It will take measures to improve the performance of the existing building through the proposed refurbishment of certain areas.

The detailed plan is at Appendix 8 but the key measures being taken to ensure achievement of the required BREEAM ratings are:

Energy: Specifying sustainable systems and energy efficient buildings

Health and Wellbeing: Encouraging healthy lifestyles and safe working environments

Innovation: Looking for opportunities to include exemplary new practices

Land Use: Looking to utilise brownfield sites and minimising ecological impact.

Choice of Materials: Responsibly sourced sustainable materials

Management Structures: Embedding sustainability monitoring at every stage including design, construction, commissioning, handover, and aftercare.

Pollution: Reducing the buildings impact on its immediate and wider environment through the use of sustainable systems.

Transport: Encourage and facilitate more sustainable transport choice including walking, cycling and public transport.

Waste management: Sustainable waste management including during construction.

Water utilisation: Minimising water utilisation and waste through leakage.

7.11 Conclusion

This Management Case has outlined the arrangements either in place or being established to support and ensure successful delivery of the Programme. This includes programme management measures, governance arrangements and expected approval routes. The Wave 4b Programme Board has recognised the need for capacity and capability at both Programme and project level to ensure that schemes develop and deliver as expected.

From the outset of the Programme, the identification and management of key risks has been recognised as being of vital importance, alongside mitigations. Mechanisms have been established to measure and report benefits as they are realised and this approach will be refined to a local Place level over the coming months, ensuring the Hubs – as they develop – can play their role in supporting the local population health based approaches as they are established. Evaluation arrangements have been identified and will be managed by the Programme Team and PMO in close collaboration with project teams.

The ICS has robust arrangements to ensure the effective management and delivery of the Programme, which include the mechanisms for review, adaptation and enhancement of these approaches as the Programme and projects progress – reporting in with the NHS England & NHS Improvement regional teams through the Capital Investment Oversight Group and Capital Delivery Oversight Group – and via programme updates to JISC.

8 Appendices

Appendix Number	Name
1	Health Profile Norfolk and Waveney
2	Programme Plan
3	Benefits Realisation Plan
4	Communications Plan
5	Risk Register (Extract – Open Risks)
6	Option Appraisal Event packs
7	Stakeholder Letters of Support
8	BREEAM and Environmental Overview
9	Flood Risk information and maps
10	Comprehensive Investment Analysis

Appendix 1: Health Profile Norfolk and Waveney

Indicator	Period	Norfolk			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Life expectancy at birth (Male)	2017 - 19	–	-	80.1	80.5	79.8	74.4		84.9
Life expectancy at birth (Female)	2017 - 19	–	-	84.1	83.9	83.4	79.5		87.2
Under 75 mortality rate from all causes	2016 - 18	–	8,405	309	302	330	544		223
Under 75 mortality rate from all cardiovascular diseases	2017 - 19	–	1,826	64.7	62.9	70.4	121.6		43.6
Under 75 mortality rate from cancer	2017 - 19	–	3,425	121.5	122.6	129.2	182.4		87.4
Suicide rate	2017 - 19	–	265	11.1	10.5	10.1	19.0		4.9
Killed and seriously injured (KSI) casualties on England's roads	2016 - 18	–	1,282	47.6	46.7	42.6*	97.4		17.7
Emergency Hospital Admissions for Intentional Self-Harm	2018/19	↓	1,400	164.1	173.1	193.4	433.4		51.6
Hip fractures in people aged 65 and over	2018/19	→	1,300	574	563	558	772		350
Cancer diagnosed at early stage (experimental statistics)	2017	→	2,287	54.2%	54.7%	52.2%	41.9%		57.7%
Estimated diabetes diagnosis rate	2018	–	-	75.5%	76.7%	78.0%	54.3%		97.5%
Estimated dementia diagnosis rate (aged 65 and over)	2020	–	9,116	63.4%	65.2%*	67.4%	51.3%		88.4%
Admission episodes for alcohol-specific conditions - Under 18s	2016/17 - 18/19	–	155	30.4	23.4	31.6	106.7		7.8
Admission episodes for alcohol-related conditions (Narrow)	2018/19	→	6,330	677	634	664	1,127		389
Smoking Prevalence in adults (18+) - current smokers (APS)	2019	–	106,518	14.5%	13.7%	13.9%	23.4%		8.0%
Percentage of physically active adults	2018/19	–	-	67.9%	66.9%	67.2%	46.7%		79.6%
Percentage of adults (aged 18+) classified as overweight or obese	2018/19	–	-	62.7%	63.3%	62.3%	75.9%		41.7%
Under 18s conception rate / 1,000	2018	→	222	17.1	14.4	16.7	39.4		3.6
Smoking status at time of delivery	2019/20	→	1,034	13.6%	9.5%*	10.4%	23.1%		2.1%
Breastfeeding initiation	2016/17	–	6,238	*	76.1%	74.5%	37.9%		96.7%
Infant mortality rate	2017 - 19	–	78	3.1	3.5	3.9	7.5		2.0
Year 6: Prevalence of obesity (including severe obesity)	2018/19	→	1,693	19.2%	18.0%	20.2%	29.6%		10.7%
Deprivation score (IMD 2015)	2015	–	-	21.2	-	21.8	42.0		5.7
Smoking Prevalence in adults in routine and manual occupations (18-64) - current smokers (APS)	2019	–	-	22.7%	25.1%	23.2%	36.8%		10.3%
Inequality in life expectancy at birth (Male)	2016 - 18	–	-	7.1	8.2	9.5	15.2		3.8
Inequality in life expectancy at birth (Female)	2016 - 18	–	-	4.7	6.1	7.5	13.8		1.8
Children in low income families (under 16s)	2016	↓	21,670	15.1%	14.1%	17.0%	31.8%		6.4%
Average Attainment 8 score	2018/19	–	345,004	45.3	47.0	46.9	39.0		57.5
Percentage of people aged 16-64 in employment	2019/20	→	409,400	78.0%	77.9%	76.2%	64.6%		84.1%
Statutory homelessness - Eligible homeless people not in priority need	2017/18	–	365	0.9	0.6	0.8	8.1		0.1
Violent crime - hospital admissions for violence (including sexual violence)	2016/17 - 18/19	–	560	22.4	33.6	44.9	127.6		12.1
Excess winter deaths index	Aug 2018 -Jul 2019	–	573	18.7%	16.4%	15.1%	28.5%		-2.4%
New STI diagnoses (exc chlamydia aged <25) / 100,000	2019	↑	3,515	651	637	900	4,418		383
TB incidence (three year average)	2017 - 19	–	106	3.9	5.9	8.6	45.0		0.2

Appendix 2: Programme Plan

Programme	Primary Care Wave 4b Programme
Project Reference	EST04

Start Date
16/09/2020

W	Scoping
G	Project / Programme on track to deliver and nothing to report
A	Project off track but plans in place to mitigate
R	Project Programme experiencing delay/non-delivery, require immediate support and intervention
B	Completed

Task Ref No	W/M/T	Description	RAG	W/M/T Start Date	Duration (weeks)	W/M/T End Date
	Workstream	ICS Estates Programme Board monthly meeting	G	01/09/2020	186.7	31/03/2024
	Workstream	Monthly meetings with NHS England & NHS Improvement	G	01/09/2020	186.7	31/03/2024
	Workstream	**Programme Business Case re-write creation, review, approvals**	G	08/04/2022	38.1	31/12/2022
	Milestone	Confirmation of PBC content requirements	B	21/04/2022	0.0	21/04/2022
	Task	PBC revision and redrafting	G	08/04/2022	9.0	10/06/2022
	Task	CCG/ICB governance and approvals	G	10/06/2022	1.4	20/06/2022
	Milestone	Submission to NHS England & NHS Improvement (NHSE/I)	G	22/06/2022	0.0	22/06/2022
	Task	Fundamental criteria review meeting with NHSE/I, DHSC Capital & Cash	G	22/06/2022	1.9	05/07/2022
	Task	PBC detailed review by NHSE/I Region, C&C and DHSC	G	06/07/2022	2.9	26/07/2022
	Task	Detailed review queries issued from NHSE/I to ICB	G	26/07/2022	0.0	26/07/2022
	Task	ICB responds to detailed review queries	G	27/07/2022	1.0	03/08/2022
	Task	NHSE/I clears ICB responses and drafts recommendation report	G	04/08/2022	1.9	17/08/2022
	Task	Recommendation report from NHSE/I to Capital & Cash	G	17/08/2022	0.0	17/08/2022
	Task	DHSC Capital & Cash review recommendation report	G	18/08/2022	2.0	01/09/2022
	Milestone	Regional "Capital Investment Oversight Meeting"	G	25/08/2022	0.0	25/08/2022
	Task	Final recommendation report from NHSE/I cleared with Capital & Cash	G	02/09/2022	0.9	08/09/2022
	Milestone	Regional NHSE/I Strategic Development Committee Meeting	G	08/09/2022	0.0	08/09/2022
	Task	Recommendation report signed by NHSE/I Regional Directors	G	09/09/2022	0.4	12/09/2022
	Milestone	Report submitted to DHSC Joint Infrastructure Sub Committee	G	13/09/2022	0.9	19/09/2022
	Milestone	DHSC Joint Infrastructure Sub Committee meeting	G	19/09/2022	0.0	19/09/2022
	Milestone	After submission of all four scheme cases, overall programme update to be taken to Joint Infrastructure Sub Committee for information and assurance on affordability, delivery and timelines	G	01/12/2022	4.3	31/12/2022
	Workstream	**Combined OBC/FBC development for each scheme: creation, review, approvals (nb. scheme timings may vary per scheme)**	G	08/04/2022	38.1	31/12/2022
	Milestone	Checkpoint meetings	G	08/04/2022	103.3	31/03/2024
	Milestone	Steering Group meetings for each scheme - monthly	G	08/04/2022	103.3	31/03/2024
	Milestone	Draft business cases reviewed by ICB	G	01/08/2022	8.6	30/09/2022
	Milestone	Draft business cases reviewed by Wave 4b Programme Board	G	01/08/2022	8.6	30/09/2022
	Milestone	Submission of business cases to Regional NHSE/I	G	01/09/2022	12.9	30/11/2022
	Milestone	NHSE/I Regional Team to send project business cases and completed short form business case review template to Capital & Cash for their information and to share to DHSC	G	01/09/2022	12.9	30/11/2022
	Milestone	As each case approved, updates made to regional Capital Delivery Oversight Group to confirm case within expcted scope and financial envelope and that overall programme still on plan in terms of both construction and financial delivery	G	01/09/2022	12.9	30/11/2022
	Workstream	**Scheme construction phase**	G	01/01/2023	65.0	31/03/2024

Months

01/09/2020 01/10/2020 01/11/2020 01/12/2020 01/01/2021 01/02/2021 01/03/2021 01/04/2021 01/05/2021 01/06/2021 01/07/2021 01/08/2021 01/09/2021 01/10/2021 01/11/2021 01/12/2021 01/01/2022 01/02/2022 01/03/2022 01/04/2022 01/05/2022 01/06/2022 01/07/2022 01/08/2022 01/09/2022 01/10/2022 01/11/2022 01/12/2022 01/01/2023 01/02/2023 01/03/2023 01/04/2023 01/05/2023 01/06/2023 01/07/2023 01/08/2023 01/09/2023 01/10/2023 01/11/2023 01/12/2023 01/01/2024 01/02/2024 01/03/2024 01/04/2024

Appendix 3: Benefits Realisation Plan

Benefits Realisation Plan (BRP) – Norfolk and Waveney Wave 4b Programme Business Case –

The BRP summarises the plans for securing the realisation of the benefits planned to be delivered as a result of the investment. It sets out each of the key benefits and tracks them back to the measures against the Investment Objectives set out in the business case:

- Preventing illness promoting wellbeing
- Providing care closer to home
- Promoting integrated working
- Delivering sustainable and effective services
- Ensuring cost effective services

The benefits have been classed using the following framework:

Class	£ Value	Timescale	Impact
Strategic	High	Long term	International National Fundamental to service across all providers in potentially many specialities
Operational	Medium	Medium term	Regional Local Improves service across all or many providers
Task	Low	Short term	Local Trust / service specific

The organisation responsible for the realisation of each benefit is identified. The measure to be used to determine the extent of realisation of each benefit, the baseline, target and the timescale for implementation are set out.

Investment Objective			1: Preventing Illness and promoting well being						
No.	**Benefit**	**Benefit Type**	**How this will be achieved**	**Risks / Constraints**	**Lead**	**Measure**	**Baseline**	**Target**	**Timescale**
1.1	**New transformational models of working** Extended opening hours Hosting shared services Enhanced Digital facilities	Task	Contractual variations or specifications. Working closely with PCNs. Incorporating digital spaces and infrastructure	• Revenue impact • PCN support • System integration	N&W CCG	Each Hub will meet these criteria: • Open evenings and/or weekends • Hosting PCN staff or services • Includes dedicated digital facilities for staff, patients and the wider public	Engagement set through APMS contract or variation to GMS/PMS contract	Measure met	April 2024
1.2	**Primary Care Led** Independent Contractor presence on site Multi agency Bookable clinical and shared support areas	Task	Rationalised schedules of accommodation. Specific service procurements. Availability of mixed tenures.	• Identifying head leaseholders • Managing void risks. • Prohibitive lease terms	N&W CCG	• A Practice and at least two other services are present	Leases or licences agreed prior to handover	Measure fully met	April 2024
1.3	**Reduction in A&E attendances**	Medium	New models of care Closer integration Demand Management measures below.	• Identifying a baseline figure for new services – using Emergency Care Data Set Activity Tracker.	Providers	• Comparative reduction in expected attendances	Benchmark rate per 1,000 on list for N&W	-20%	2030
1.4	**Demand Management**	Task	a) Supporting Prevention Health Checks, identifying hypertension to ensure early treatment	• Identifying a baseline figure for new services	Providers	• Hypertension check rate in target population	0%	Target %'s	
			b) Improving vaccination uptake	• Identifying a baseline figure for new services	Providers	• Target Vaccination rate for Flu and C-19		Target %'s Achieved or surpassed	
			c) Diabetes prevention programme	• Identifying a baseline figure for new services	Providers	• Reduction in obese adults on the list	??%	-10,000 across CCG	2030

Investment Objective			1: Preventing Illness and promoting well being						
No.	**Benefit**	**Benefit Type**	**How this will be achieved**	**Risks / Constraints**	**Lead**	**Measure**	**Baseline**	**Target**	**Times cale**
			d) Targeting Smoking Cessation to pregnant women and deprivation areas	• Identifying a baseline figure for new services	Providers	• Reduction in maternal smoking	Initial smoking status %	10% per year	
			e) Substance Misuse Identify those at risk of harmful drinking.	• Identifying a baseline figure for new services	Providers	• Provide brief targeted advice at next consultation	Identify target groups	Advice rate as % of list	
			f) Workplace Health Promoting and enabling workplace health and wellbeing	• Access to workplaces • Providing mixed use space including quiet work areas, staff and break out areas	Providers	• Improved retention and recruitment of staff • Improved sickness and absence numbers	Norfolk Benchmark rates of absence and turnover	% below benchmark	
			g) Childhood Accident Prevention Roll out of Safe at Home[28] Healthy Child Programme	• Dependent on a Multi-agency alliance	Providers	• Engage with the programme?	Benchmark rates for childhood accidents	Active engagement in the scheme Below average rates	
			h) Childhood mental health Healthy Child Programme[29]	• Dependent on a Multi-agency alliance	Providers	• Engage with the programme?	No engagement	Active engagement in the scheme Referrals made	
			i) Reducing childhood ENT admissions Pathway led referral models	• Identifying a baseline figure for new services	Providers	• Rate of referral lower than comparative services	N&W average referral rates	% Reduction	

[28] https://www.justonenorfolk.nhs.uk/staying-safe/staying-safe-in-the-home

[29] https://www.justonenorfolk.nhs.uk/healthylifestyles

Investment Objective			2: Providing Care Closer to Home						
No.	**Benefit**	**Benefit Type**	**How this will be achieved**	**Risks / Constraints**	**Lead**	**Measure**	**Baseline**	**Target**	**Timescale**
2.1	**Incorporating acute services**	Medium	Working with Acute providers Providing suitable facilities Providing flexible leasing arrangements	• Prohibitive lease terms • Cost of specialised infrastructure	N&W CCG	One or more of: • Outpatient clinics on site • Virtual outpatient clinics on site	Rate per list	17% saving in cost is assumed for remote outpatients.	
2.2	**Incorporating diagnostics**	Medium	Working with acute and independent providers Providing suitable facilities and infrastructure including mobile pads and hook-ups.	• Contracts for service • Prohibitive lease terms • Cost of specialised infrastructure	N&W CCG	One or more of: • Diagnostics on site • Mobile pad and hook-up included • Near Patient Testing on site • Self-testing area	No diagnostics	Infrastructure provided and/or services offered by provider.	
2.3	**Extended range of community services**	Task	Working with Community providers and PCN Providing suitable facilities Providing flexible leasing arrangements	• Contracts for service • Prohibitive lease terms	N&W CCG	One or more of the following provided on site • Community service • PCN service • Mental health service	No services	Active services on site	
2.4	**Spaces for public health**	Task	a) Incorporating bookable public spaces	• Void risk for unfunded spaces	N&W CCG	• Public Bookable rooms (Including out of hours) • Digital booking tool	Bookable rooms provided	Evidence of public health bookings	
			b) Incorporating self-testing/monitoring	• Provider supervision required	N&W CCG Providers	Self-testing area Health and Well Being Kiosks	No self - testing resources	Self-help resources are provided and used.	
			c) Reducing digital inequality	• Cost of specialised technology • Maintenance and updating • Support and training of the equipment	N&W CCG	Patient digital kiosks – for use of CBT, virtual consultations, selfcare and health education	Publicly accessible IT provided on site.	Evidence of patient access and utilisation of digital resources on site	

Investment Objective			2: Providing Care Closer to Home						
No.	**Benefit**	**Benefit Type**	**How this will be achieved**	**Risks / Constraints**	**Lead**	**Measure**	**Baseline**	**Target**	**Timescale**
2.5	**Digital links to other providers**	Medium	Bespoke communications links to the nearest Acute provider overcoming EPR compatibility issues.	• Availability of technology and high-speed links • Support of acute and primary care IT	N&W CCG Acute Trusts	At least one of: Installation of high-speed dedicated VPN in place to one or more acute providers to facilitate MDTs, virtual consultations, virtual ward / monitoring. Use of cloud-based solutions i.e., Office 365/One Drive Use of universal docking stations, full data sharing agreements, direct, single identifier, 'internet first'	No digital link to acute providers	VPN in place Cloud based solutions in place Full data sharing agreements in place	

Investment Objective			3: Promoting Integrated Working						
No.	**Benefit**	**Benefit Type**	**How this will be achieved**	**Risks / Constraints**	**Lead**	**Measure**	**Baseline**	**Target**	**Timescale**
3.1	**Improved social care and wellbeing**	Medium	Incorporation of shared PCN services within the facility including: Social Prescribing Care Navigation	• Void risk for unfunded spaces	PCNs Providers	One or more of: • PCN Social Care Service on site • Social worker on site • Voluntary services on site	Bookable or dedicated spaces available	Services based on site or providing weekly sessions.	
3.2	**Improved mental health care**	Medium	Incorporation of suitable spaces and technology for IAPS and other mental health services.	• Void risk for unfunded spaces • Ensure links with Mental Health Wellbeing Hubs: the expectation is that the Mental Health Practitioners within PCNs and those within the Wellbeing Hubs will provide the key links and support.	Mental Health Trusts	One or more of: • Drop in MH café on site • Mental health services/ • Mental health self-help resources on site	Bookable or dedicated spaces/resources available	Mental health services/resources on site and used.	

Investment Objective			3: Promoting Integrated Working						
No.	**Benefit**	**Benefit Type**	**How this will be achieved**	**Risks / Constraints**	**Lead**	**Measure**	**Baseline**	**Target**	**Timescale**
3.3	**Broad skill mix**	Medium	PCN Workforce initiatives Advanced Practitioners	• Recruitment • Employers' liabilities	Providers	One or more of: • PCN Clinical Service on site • Advanced Practitioners on site • Nurse led triage in operation • Inclusion of secondary care staff • Voluntary / 3rd sector		Broad skill mix of staff based on site.	
3.4	**Improved Recruitment, retention**	Medium	Registered as a training facility Workplace health and wellbeing initiative Nurse training Wider skills training	• Recruitment of trainers	Health Education England N&W CCG	At least two of: • Registered as a training practice (any profession) • Offering placements to trainees • Training rooms bookable by any health training organisation	Training spaces and resources provided	Medical Trainees in placement annually and/or Health training taking place at least annually	
3.5	**Digital Systems integration**	Medium	Roll out of SystmOne	• Legacy systems • Lack of a common acute EPR	N&W CCG	Providers incorporate compatible systems with community/ambulance and social care providers. Patient data is appropriately shared.	SystmOne in place	Data shared with other community and ambulance providers	
3.6	**Promoting multidisciplinary care**		MDT Meetings Skill mix initiatives	• Other agency engagement	Providers	Face to face or virtual multi-disciplinary/multi-agency meetings occur at least monthly	MDT physical and digital meeting spaces in place	MDT meetings happen at least monthly	

Investment Objective			4/5: Delivering sustainable and cost-effective services.						
No.	**Benefit**	**Benefit Type**	**How this will be achieved**	**Risks / Constraints**	**Responsible Organisation**	**Measure**	**Baseline**	**Target**	**Timescale**
4.1	**Increased Capacity** Meeting registration and service demand in Primary Care	Operational	New or expanded fit for purpose facilities	• Securing sites • Securing providers • Staff Recruitment	N&W CCG	Increased registration capacity	0	Registrations meeting demand profile	April 2024
4.2	**Increased access** Improved access to seven-day services in each locality.	Operational	Wide catchment Trust and PCN services on site	• Enabling safe operating out of hours.	N&W CCG	Extended hours and weekend services for patients other than those on the host practice list.	Bookable or dedicated spaces available	Weekly Evening and/or weekend clinical sessions taking place	
4.3	**Contributing to environmental Targets**	High	BREEAM engagement	• Brownfield sites • Partial refurbishment • Flood risks	N&W CCG	BREEAM Carbon impact ratings Sustainability targets	N/A	BREEAM Excellent achieved for new builds BREEAM Very Good for refurbishment Carbon Neutral achieved	
4.4	**Better Estate Utilisation** Ensuring building sizes are robustly evidenced and let through flexible arrangements.	Task	No names on doors Bookable clinical rooms Hot desks Interim tenants Expansion areas Digital booking tool	• Demand arising over a prolonged period. • Prohibitive lease terms • Active site management	Tenants	Each Hub specification will achieve initial utilisation of 50% and 80% utilisation within 5 years?	50%	80%	2029

Appendix 4: Communications and Engagement Plan

Overview

The Norfolk and Waveney STP submitted a bid in 2019 to NHSE/I for Capital Funding under the Wave 4b stream. This sought strategic funding to facilitate:

'Development of the Primary Care estate, across the new N&W STP footprint to develop and improve the delivery of integrated primary care.'

The single bid envisaged facilitating the proposed schemes to transform primary care across Norfolk and Waveney over a four-year period.

The vision for these facilities is that they will transform the delivery of primary care through better integration with social care, promoting self-care, providing venues for training and facilitating a further shift of services from other less appropriate settings. In addition, they will provide the focus of meeting increased service demand in areas with little current capacity and significant anticipated demand.

By concentrating services at a series of 'Hub' locations a larger number of patients and service users can be served.

The proposed Hubs are to be located in: Rackheath, Sprowston, Kings Lynn and Thetford

Objectives of the Wave 4b Programme

These are the objectives of the Wave 4b programme. They have been developed from the Norfolk and Waveney Health and Care Partnership 'in Good Health' Clinical Strategy.

Modernising the primary care estate Creating capacity Meeting workforce challenges Meeting demand from planned housing	Promoting closer integration and a wider range of services Addressing service deprivation Learning from the pandemic

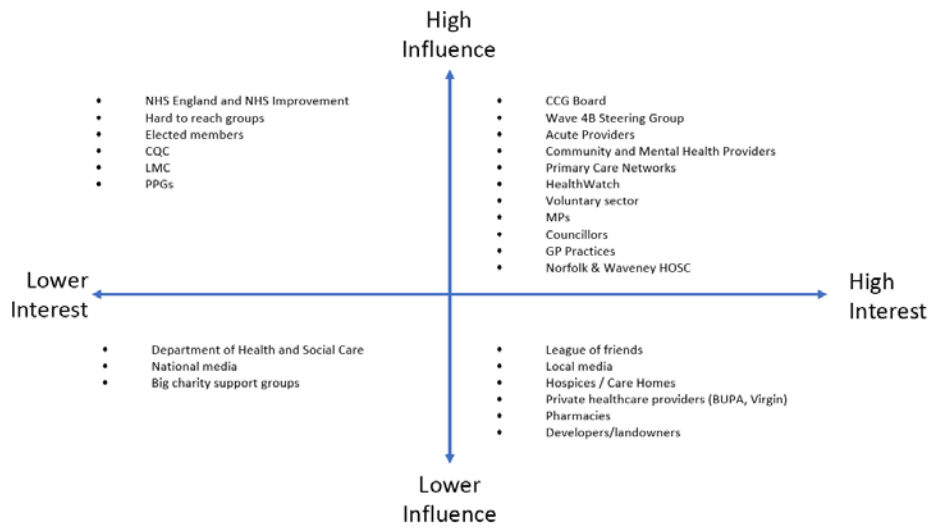
Objectives of the Communications Plan

To communicate effectively about the proposed schemes with patients and stakeholders throughout the Programme Business Case process.

To build engagement and satisfaction from our patients by focusing on benefits to them and keeping them fully informed.

To promote the benefits of the schemes and our commitment to providing leading services in facilities that are fit for purpose.

Stakeholders:



Key Messages

- To provide a transformational service in Primary Care
- To improve access to Primary Care Services
- To meet the increased demand
- To provide state of the art facilities for the delivery of integrated care for now and the future
- To provide a digitally enable facility which can provide virtual and on-site services
- A Service designed around the demographic and health needs of the local population
- To provide space for community and/or acute services and uses
- To act as an exemplar in each locality
- To provide an integrated model of care reflecting where possible non-medical models

Audience	Key information requirements / messages
Patients	Key facts regarding programme (inc. timescales and providers taking part,) and the rationale for the same. Specific benefits of the local scheme, more modern accommodation, service integration, digitally enabled Access to other services on site. Reassurance regarding standard and continuity of care Updates on progress as required Contact details for further information. Opportunities to be involved. Transport and access – recognition that relocating sites may disadvantage some
Public	General information on the programme and its objectives. The chosen broad locations for schemes, the programme and progress towards key stages of delivery.
Councils – County and District level	General information on the programme and its objectives. The chosen broad locations for schemes in their administrative area, The programme and progress towards key stages of delivery. Opportunities for involvement and key local contacts for further information.
NHS Property Services	Delivery partner for two proposed schemes.
Providers	Specific information on proposals and progress in each of the schemes. Opportunities for engagement or further information. Information on expected participants and where appropriate timescales for service procurement.
Social Care	General information on the programme and its objectives. The chosen broad locations for schemes in their administrative area, The programme and progress towards key stages of delivery. Opportunities for involvement and key local contacts for further information.
Private providers care homes, sheltered care	Opportunities for engagement or further information. Information on expected participants and where appropriate timescales for service procurement.
Other local services including providers and statutory agencies	General information on the programme and its objectives. The chosen broad locations for schemes in their administrative area, The programme and progress towards key stages of delivery. Opportunities for involvement and key local contacts for further information.
NHSE/I	Engagement will be through their membership of the Wave 4b Steering Group
DHSC	Engagement will come via NHSE/I

Audience	Key information requirements / messages
Wave 4b Steering Group / CCG/ICB	Monthly meetings
Media	Reactive management to any press interest. Programmed contact where public engagement events are planned. Prepared press release following submission of PBC. Ad-hoc opportunity for celebration of investment in primary care in Norfolk and Waveney through events and press releases

Communications and Engagement Plan

Milestone	Audience	Action	Outputs	Method	Timescale	Lead
Patient Engagement	Patient Participation Groups (PPGs) Engagement Forums CCG Staff Communities of interest and Public	Co-ordinate PPG meetings to inform audiences of latest developments	Help to shape services together. Provide assurance that patients will get the care they need.	PPG newsletter PPG conferences	2022 – 2024	CCG
PR Activity	All members of the public and stakeholders Councils, Local MPs	Generate proactive comms and PR Respond to media enquires	Generate good news stories across N&W	Media, Press Release	April 2023 – Mar 2024	CCG
Social Media Support	All stakeholders	Devise a Social Media Plan and Toolkit for all relevant social media channels	Update a wide demographic on latest the developments	Instagram Twitter Facebook	2022 – 2024	CCG
Community Partnerships and Engagement	Panel and Forum members CCG staff	Co-ordinate conferences and socialise updates	Ensure that engagement carried out around commissioning is fair and inclusive	Meetings and forums	2022 – 2023	CCG and NHSPS, Norlife, PHP
Events	All stakeholders Communities of interest	Support events at local community venues	Generate local enthusiasm and understanding	Event planning and scoping	Jan 2022 – Mar 2023	CCG
Marketing Materials	All stakeholders (generating materials that are accessible to all)	Develop a marketing campaign and brand guidelines	Content to inform members of the public and stakeholders	Website, posters, leaflets, newsletters	Jan 2022 – Mar 2023	CCG
Key dates						
PBC Submission					September 2022	CCG
Individual FBC Submission					By Dec 2022	CCG
NHS Sign off					By Dec 2022 – Jan 2023	CCG / NHSE/I

Milestone	Audience	Action	Outputs	Method	Timescale	Lead
Building Complete and opened					March 2024	Developers CCG

Communication Plan Risks

Risk/issue	Impact	Mitigation
Opposition from local people and/or elected members	Complaints and negative feedback through MPs, media etc Felt services don't meet their needs	Equalities Impact Assessment (EIA) – first version completed. EIAs required for each scheme. Engagement and briefing as early as possible highlighting the benefits of the new development
Delays in the process	Felt they are not listened to and complain via MPs, media etc Disengage from health services	Mitigate risk by keeping stakeholders engaged
Scheme/s do not progress	Local people become disillusioned with the project	Manage expectations – early indication at PBC should help highlight any issues

Appendix 5: Risk Register (Extract – Open Risks)

Likelihood score →	1: Rare	2: Unlikely	3: Possible	4: Likely	5: Almost Certain
Consequence score ↓					
5: Catastrophic	5	10	15	20	25
4: Major	4	8	12	16	20
3: Moderate	3	6	9	12	15
2: Minor	2	4	6	8	10
1: Negligible	1	2	3	4	5

Escalation Guidance (Mitigated RAG Rating)	
RED	Escalate via Exception Report to Local Operational Group or Programme Board
AMBER	Escalate to SRO
GREEN	Manage within the Project Team

Programme	Primary Care Estates Wave 4b

Date last reviewed by:	18.05.22 PC Estates Team

						Risk Management										
Project / Workstream	Reference Number	Owner	Date Risk Opened	Title	Risk / Issue Description	RAG Rating (Pre Mitigation)	Likelihood	Consequence	Pre Mitigated RAG Score	Mitigation Controls Established	RAG Rating (Post Mitigation)	Likelihood	Consequence	Mitigated RAG Score	Risk Status	Date Risk Closed
Primary Care Wave 4b Programme	EST04	Paul Higham		Planning Considerations	W4B6 Planning: There may be a large number of planning applications and design work associated with the schemes, to be achieved in a relatively short timeframe	High	3	4	12	Working with external expertise, identify at the earliest possible stage the requirements and engage with local planning authorities. Chaplin Farrant are engaged as architects for the Programme Business Case	Low	2	3	6	OPEN	
Primary Care Wave 4b Programme	EST04	Paul Higham		Programme timeframe	W4B9 Environmental: The requirement for schemes to achieve Net 0% carbon alongside BREEAM compliance and nutrient neutrality may increase costs and impact on the programme timeline. The construction and delivery phases need to deliver NHS Sustainability and Delivery Unit requirements of carbon reduction, improving air quality, single use plastics and procurement to ensure sustainable buildings	High	3	4	12	Involve BREEAM assessor at the stage of site selection: BREEAM assessor engaged Continue discussions with NHSE in respect of requirements and best practice.	Low	3	2	6	OPEN	
Primary Care Wave 4b Programme	EST04	Paul Higham	10/05/2021	Planning Considerations	W4B12 Section 106 availability: Agreement and stage release timescales for S106 monies	High	4	3	12	Early engagement with Planners and Landowners to ensure S106 will be released to benefit the Healthcare schemes	High	3	3	9	OPEN	
Primary Care Wave 4b Programme	EST04	Paul Higham	10/05/2021	ICS/Provider Agreement	W4B13 Affordability: BRP / Financial Targets have to be achieved as an ICS - CIA and Revenue impact (Benefits 4:1) has to be demostrated for PBC/OBCs being approved	Critical	4	5	20	Ensuring ICS Financial engagement as soon as possible. Ensuring the assumptions within the STP Bid are still applicable. Ensure need to demonstrate affordability is understood at CCG and scheme level.	High	3	4	12	OPEN	
Primary Care Wave 4b Programme	EST04	Paul Higham	10/05/2021	Planning Considerations	W4B14 Flood Risk: Applicable to Kings Lynn Flood Risk impact has to be mitigated or finding site outside the flood risk.	Critical	4	5	20	Working with planners and design team to mitigate risk. Also agreed approach with NHSE re flood risk: taking into consideration guidance from HBN00-07 and VOAQ gudfiance and requirements - plus potential onging impact on practice and CCG. Close working with Communications Team as required to formulate stakeholder communication plan.	Critical	4	4	16	OPEN	
Primary Care Wave 4b Programme	EST04	Paul Higham	10/05/2021	Stakeholder Engagement	W4B15 Reputation: Public objections to one or more of the projects. Potential impact on timeframe or failure to meet the deadlines. Non-delivery of proposals may lead to loss of confidence and non-delivery of investment objectives.	Low	2	3	6	Detailed enagement/comms plans, close working where applicable working with PPG and/or Healthwatch	Low	3	2	6	OPEN	
Primary Care Wave 4b Programme	EST04	Paul Higham	10/05/2021	Legals	W4B16 Commercial: Provider and/or Primary Care commitment to the schemes at PBC and to development of scheme to FBC and agreement of Head Lease/Lease	High	2	4	8	Ensuring continued engagement and agreement by the Steering Group/Board. Ensure Programme and scheme level understanding of funding requirements, approval expectations and Premises Costs Directions.	High	3	3	9	OPEN	Updated to replace W4B10 and W4B11
Primary Care Wave 4b Programme	EST04	Paul Higham	10/05/2021	DHSC/NHSEI	W4B17 Legislative environment: Potential change in legislation / policy change	High	3	3	9	Senior engagement with NHSEI to ensure policy alignment	Low	2	3	6	OPEN	

Primary Care Wave 4b Programme	EST04	Paul Higham	21/06/2021	Planning Considerations	W4B20 Technology: The digital elements of the projects need to be embedded. The delay to the national programme for the digitisation of Lloyd George notes may have an impact on optimising the space available for primary care services within the new Hubs.	Low	2	3	6	Ensure close links with CCG Digital Team to keep up to date on the national scheme and understand whether particular practices can/need to be prioritised when digitisation of notes is being planned.	Low	3	2	6	OPEN	
Primary Care Wave 4b Programme	EST04	Paul Higham	12/07/2021	Capacity to deliver projects	W4B22 Supply Chain: The budget may come under pressure due to the inflationary costs relating to construction industry/materials There may be insufficient market interest to deliver major projects.	High	3	3	9	Ensuring continued oversight by the Steering Group/Board and troubleshooting of specific issues as required/possible. Involvement of NHS Property Services will help to manage the market.	Low	3	2	6	OPEN	
Primary Care Wave 4b Programme	EST04	Paul Higham	12/07/2021	Programme timeframe	W4B23 Alignment: The required alignment of capital programmes (Wave 4b, CDHs, DACs) may pose a risk to timescales for programme/case development	High	3	3	9	Ensuring continued oversight by the Steering Group/Board and troubleshooting of specific issues as required/possible.	Low	3	2	6	OPEN	
Primary Care Wave 4b Programme	EST04	Paul Higham	08/04/2022	Programme timeframe	W4B29 Approvals: The approval process for the revised Programme Business Case has very little room for slippage. Any delays may lead to Programme and/or project slippage, loss of market interest and time-out on capital availability.	High	3	3	9	Clear guidance from NHSE received on expectations and timeframe and regular meetings with NHSE to review progress. Maintenance of detailed programme and scheme level project plans	Low	3	2	6	OPEN	
Primary Care Wave 4b Programme	EST04	Paul Higham	08/04/2022	Stakeholder Engagement	W4B30 Stakeholder Engagement and Communications: The Programme and Projects are operating in a complex and transitioning stakeholder environment (PCNs, GP Practices, Local Planning Authorities, Patients, Providers, Elected Representatives and local populations) – which means there are complexities in engagement and consulation which risk delays to delivery.	Low	2	3	6	Connections made at both Programme and Project level and oversight from CCG/ICB Communications and Engagement Team to ensure consistency of messaging. Development of robust Communications Plan to engage and involve key stakeholders. Programme Team attendance at project meetings to ensure delivery is on track and to support problem mitigation.	Low	3	2	6	OPEN	
Primary Care Wave 4b Programme	EST04	Paul Higham	08/04/2022	Transformation	W4B31 New ways of working and transformation: The Programme aims to deliver a service model change which will need a change to demand management approaches, workforce changes, pathway redesign and organisational development input. Without multiple system changes simultaneously, the opportunity to deliver transformational change may be lost.	High	3	3	9	Project governance in place to be able to deliver products to timelines – ensure that project governance remain consistent and current. Take Change Management advice from the ICS PMO and use Communications and Engagement Team expertise to ensure clear messaging across the system. The support of PCNs and Places within the ICS will be important to managing this approach and risk.	Low	3	2	6	OPEN	
Primary Care Wave 4b Programme	EST04	Paul Higham	08/04/2022	Capital	W4B32 Capital availability: A change of policy may lead to the removal or reprioritisation of capital available to Norfolk and Waveney leading to changes to the Programme.	Low	2	3	6	Maintain a detailed Programme Plan including NHSE/I level and DHSC level milestones Maintain liaison with internal and external stakeholders and to ensure Programme approval takes place within set timescales.	Low	2	3	6	OPEN	

Appendix 6: Option Appraisal Event packs

North Norfolk – Rackheath	Norwich – Sprowston	King's Lynn – Nar Ouse Way	South Norfolk – Thetford Healthy Living Centre
New build at Halsbury Homes site on Broad Lane, Rackheath	Expansion of existing healthcare premises at Aslake Close, Sprowston, Norwich	New build at Nar Ouse Way site, south King's Lynn	Refurbishment of existing healthcare premises at Thetford Healthy Living Centre, Croxton Road, Thetford
 Rackheath Option Appraisal Final.pdf	 Norwich Growth Triangle Option Appra	 Option Appraisal Kings Lynn Final.pdf	 Thetford Healthy Living Centre Option A

Appendix 7: Stakeholder Letters of Support

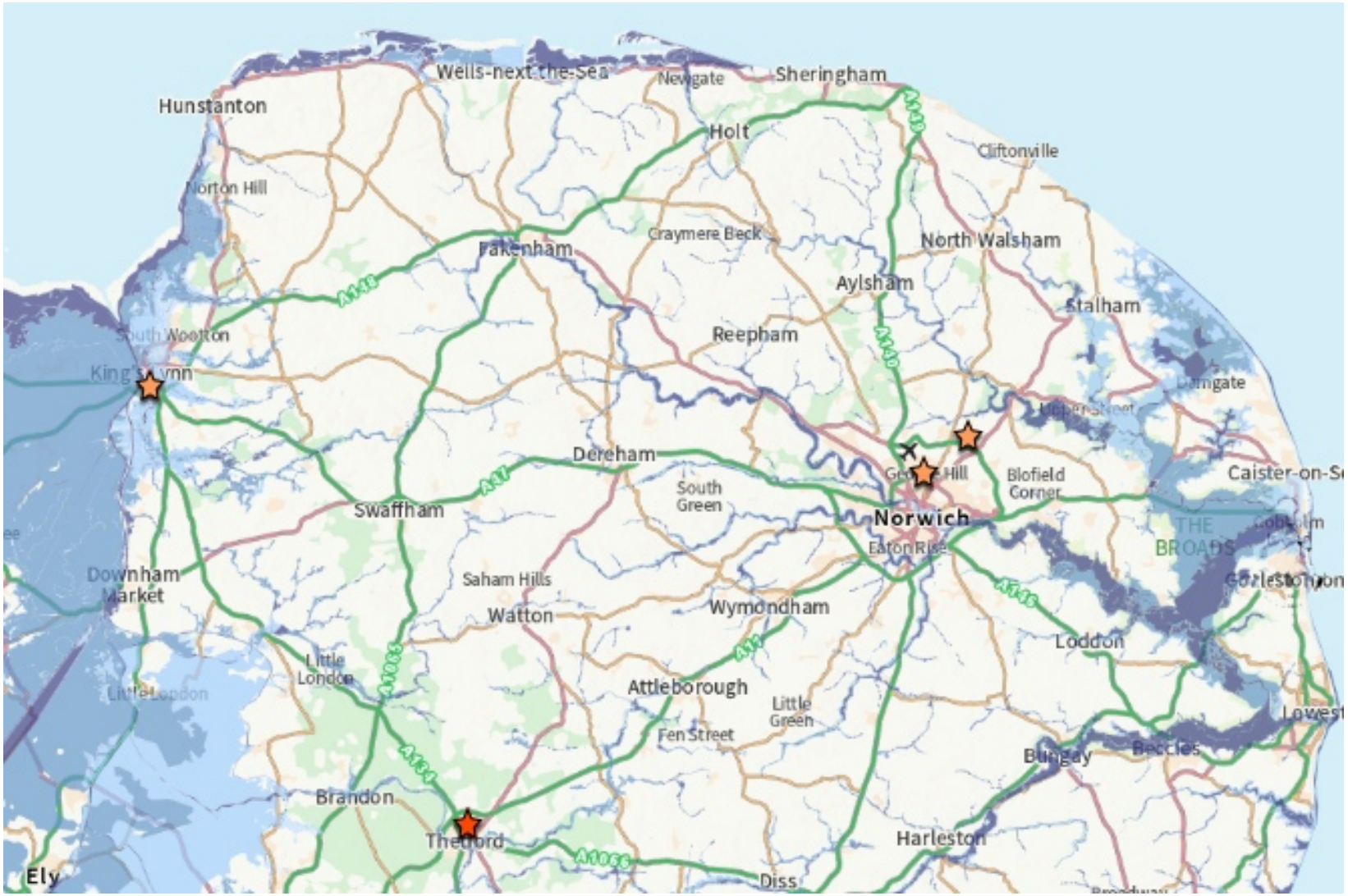
North Norfolk – Rackheath	Norwich – Sprowston	King's Lynn – Nar Ouse Way	South Norfolk – Thetford Healthy Living Centre
New build at Halsbury Homes site on Broad Lane, Rackheath	Expansion of existing healthcare premises at Aslake Close, Sprowston, Norwich	New build at Nar Ouse Way site, south King's Lynn	Refurbishment of existing healthcare premises at Thetford Healthy Living Centre, Croxton Road, Thetford
Hoveton and Wroxham.pdf NCHC.pdf NNUH.pdf	ENMP.pdf	QEHKL.pdf	Breckland Alliance.pdf CHP letter of support awaited

Appendix 8: BREEAM and Environmental Overview

BREEAM and Environmental Overvi

Appendix 9: Flood Risk information and maps

Norfolk flood risk map with sites indicated.



Preliminary Flood Risk Assessment report

Low lying coastal areas and reclaimed land mean that Norfolk and Waveney are ranked in the top 10 areas most at risk from flooding in the United Kingdom. In line with the recommendations of Health Building Note (HBN) 00-07 each of the schemes will, at the Full Business Case stage, include a resilience strategy not just against the risks of flooding but for:

- Sites, buildings and installations against a wide range of emergencies, hazards and threats and their impacts and consequences including resilience to the impacts of climate change.

At each stage of the process sites and designs will be shared with the CCGs nominated Accountable Emergency Officer to ensure resilience is at the heart of the choice of site, design and operational policies including business continuity management.

Given the high risk from flooding in the area it is appropriate at this early stage that a high level assessment of the proposed schemes and their locations is included below.

This annex utilises published, national and local data to consider the known risk from surface water, the sea and rivers.

The site most at risk in Rackheath has already had a comprehensive flood risk assessment completed by the landowner in order to gain the outline permission for the health facility. This concluded: the site is considered to be at a low risk of fluvial/tidal flooding. The EA Surface Water Flood Maps suggest that the majority of the Site is primarily at a 'very low' risk of surface water flooding from extreme rainfall. An area of the site towards the north associated with the boundary of the site and Broad Lane however, is shown to be subject to a surface water flood risk between 'High' to 'low' which is defined as having between a 1 in 30 (3.3%) and 1 in 1000 (0.1%) chance of flooding. Based on the above the risk of surface water flooding within the site is considered to be generally low given the position of the proposed buildings. Appropriate mitigation measures are however included in the site plan. These propose a green reserve area to the front of the site adjacent to the highest risk of surface water flooding on Broad Lane.

Whilst the proposed site in Kings Lynn is currently ranked as a 'Very Low Risk' from tidal flooding due to the sea defences in place, Local planners have indicated they may require some resilience measures to plan for over topping of those defences. The local authority has completed its own detailed Flood Risk Assessment which models the future impact of climate change. The design team will work with planners to incorporate what if any mitigation measures are required. A contingency sum has been included in the indicative costings to allow for these measures.

For other sites Norfolk County Council has prepared a Preliminary Flood Risk Assessment report (PFRA), which is a high level study aimed at highlighting areas of Norfolk susceptible to flooding from surface run-off.

The PFRA process provides a consistent high-level overview of the potential risk of flooding from local sources such as surface water, groundwater, and ordinary water courses.

Based on national surface water modelling approximately 37,000 properties are estimated to be at risk from flooding during a rainfall event with a 1 in 200 annual chance of occurring. Through this process, Norfolk was recognised as the 10th most at risk area out of 149 authorities.

Norwich was identified as having approximately 14,000 people at risk of flooding and was ranked 19th in a list of English settlements outside the national indicative Flood Risk Areas.

The Environment Agency provide a rating system for all areas of the UK the flooding risk for each of the proposed sites is summarised below.

Site	Flood risk from surface water	Flood risk from the Sea	Mitigation
Broad Lane, Rackheath	High Risk	Very Low Risk	A flood risk assessment has already been completed for this site. The risk from Broad Lane will be mitigated by a large green reserve area to the front of the site
Aslake Close, Sprowston	Medium Risk	Very Low Risk	Designs will allow for excess surface water to be drained from the site. There is no recent history of flooding on the site.
Nar Ouse Way, Kings Lynn	Very Low Risk	Very Low Risk	Local planners may require additional mitigation consequently an additional contingency sum has been included in the cost estimates for this scheme.
Thetford Healthy Living Centre, Croxton Road	Low Risk	Very Low Risk	No mitigation will be required: there are no additions proposed to the existing building.

A review of the flood risk assessments forms part of the NHS Property Services due diligence work on the Rackheath and King's Lynn proposals and sites. The outcomes of this will be reported as soon as they are known – and will form part of the OBC/FBC for these proposals.

Detailed Flood Risk Maps

North Norfolk – Rackheath (Broad Lane)

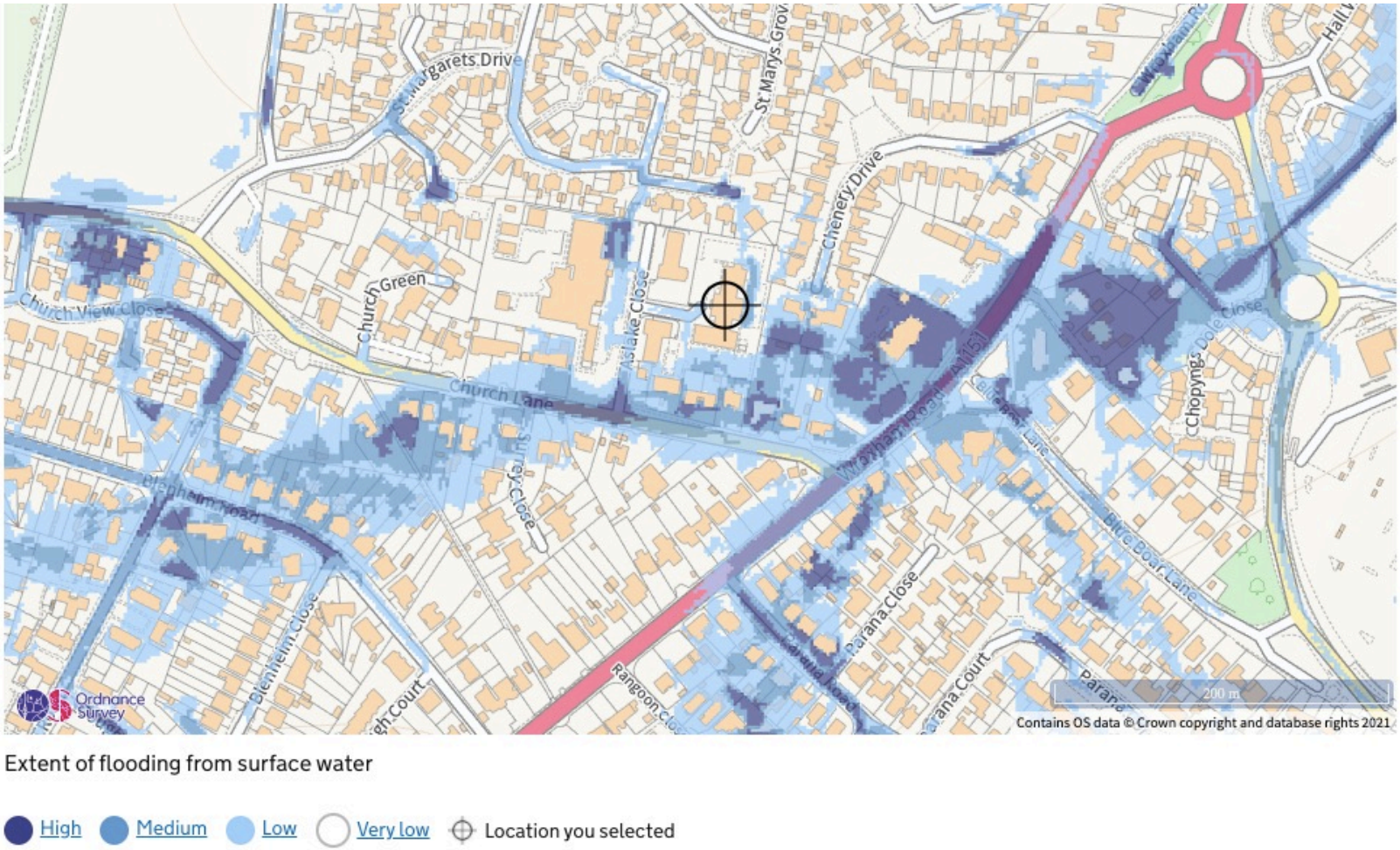
A flood risk assessment has already been completed for this development which now has outline permission. The site plan is superimposed over the flood risk map below. The green reserve to the front of the site provides a soak away for any surface water flooding in Broad Lane.

Extent of flooding from surface water

High Medium Low Very low Location you selected

Norwich – Sprowston (Aslake Close)

Surface water flooding risk, associated with run off from the onsite carparking area and local streets. The Full Business Case for the scheme will clarify any remaining risks, which are expected to be low.

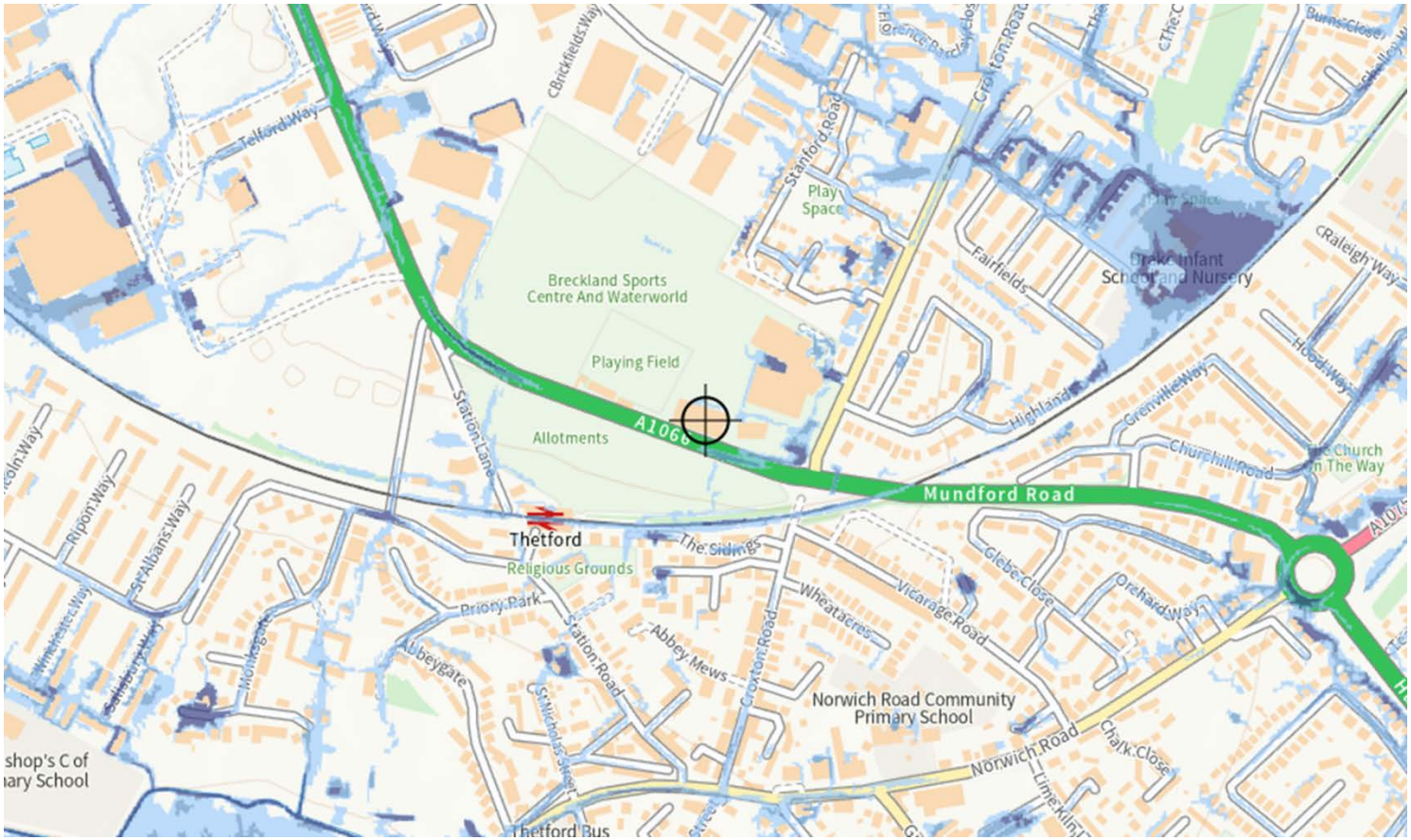


King's Lynn – Nar Ouse Way

Whilst the Environment Agencies assessment is 'Very Low Risk' initial discussions with planners suggest they may require mitigations in the case of sea defence failure or over-run. Consequently, a contingency sum has been included in the indicative costings. This will be a priority for the Full Business Case stage in terms of reviewing the risk level and the costs of mitigation, which were included as an indicative figure as part of the contingency costs for this Programme Business Case.

South Norfolk – Thetford Healthy Living Centre (Croxton Road)

The Environment Agencies assessment is ‘Low Risk’ for surface water and no mitigation is anticipated as being required: there are no additions proposed to the existing building.



Extent of flooding from surface water

High Medium Low Very low Location you selected

Appendix 10: Comprehensive Investment Analysis

Programme Level CIA Model Programme Level CIA Model			
North Norfolk – Rackheath	**Norwich – Sprowston**	**King's Lynn – Nar Ouse Way**	**South Norfolk – Thetford Healthy Living Centre**
New build at Halsbury Homes site on Broad Lane, Rackheath	Expansion of existing healthcare premises at Aslake Close, Sprowston, Norwich	New build at Nar Ouse Way site, south King's Lynn	Refurbishment of existing healthcare premises at Thetford Healthy Living Centre, Croxton Road, Thetford
Rackheath Proposal CIA Model	Sprowston Proposal CIA Model	Kings Lynn Proposal CIA Model	Thetford Proposal CIA Model

9 List of Tables and Figures

Improving lives together
Norfolk and Waveney Integrated Care System

Agenda item: 13

Subject:	**Briefing - Recent Care Quality Commission (CQC) inspection**
Presented by:	**Shepherd Ncube – Head of Delegated Primary Care Commissioning**
Prepared by:	**Jasmine Fisher – Delegated Commissioning Manager Primary Care**
Submitted to:	**NHS Norfolk and Waveney CCG Delegated Primary Care Commissioning Committee**
Date:	**10th June 2022**

Purpose of paper:

For Information - To provide an update to PCCC members on the Care Quality Commission inspection of the following practice who recently had a CQC inspection report published:

- Cromer Group Practice

Executive Summary:

PCCC members will be regularly updated with Care Quality Commission (CQC) inspection reports where the GP Practice has been rated or previously rated as Requires Improvement or Inadequate.

The CQC inspects against five key areas as follows:

Safe
Effective
Caring
Responsive
Well Led

The following practice was inspected, and the report findings are summarised below:

GP Practice	Locality	Date of Inspection/ Re-inspection	Previous Rating/Year	New Overall Rating
Cromer Group Practice (12,310 actual list size 1/4/2022)	North Norfolk	24th May 2022	Good	Good

Report

Background

The Care Quality Commission (CQC) is the independent regulator of health and social care in England, this includes GP practices.

The CQC inspection is based on five key questions asked of all services being inspected. These are: -

- **Is it safe?** Are you protected from abuse and avoidable harm?
- **Is it effective?** Does your care, treatment and support achieve good results and help you maintain your quality of life, and is it based on the best available evidence?
- **Is it caring?** Do staff involve you and treat you with compassion, kindness, dignity and respect?
- **Is it responsive?** Are services organised so that they can meet your needs?
- **Is it well-led?** Does the leadership of the organisation make sure that it's providing high-quality care that's based around your needs? And does it encourage learning and innovation and promote an open and fair culture?

The inspection and evidence obtained by the CQC against the five above questions will lead to an individual and an overall rating, which is either, **outstanding, good, requires improvement or inadequate.**

If practices fall short of the standards the CQC has the power to fine a practice, enforce an action plan or where there are very serious findings immediately close a practice.

Cromer Group Practice, North Norfolk Locality – Inspected: 24th May 2022 Overall rating: Good					
	Are services safe?	**Are services effective?**	**Are services caring?**	**Are services responsive to people's needs?**	**Are services well-led?**
Rating	Good	Good	Good	Good	Good

Following the CQCs previous inspection in July 2021 the Practice was rated as Good overall and for all key questions except for providing safe services.

The CQC carried out an announced desk-based review of Cromer Group Practice on 24 May 2022. Overall, the practice is rated as Good. This desk-based review was conducted without undertaking a site visit to follow up on the breach of regulation and areas where the provider 'should' improve which were identified in the previous inspection.

Throughout the pandemic CQC has continued to regulate and respond to risk. However, taking into account the circumstances arising as a result of the pandemic, and in order to reduce risk, CQC have conducted their inspections differently. This review was carried out in a way which did not require a site visit. This was with consent from the provider and in line with all data protection and information governance requirements.

The ratings for each key question are:

Safe - Good

Effective – Not Inspected

Caring - Not Inspected

Responsive - Not Inspected

Well-led - Not Inspected

This included:

- Conducting staff interviews using video conferencing
- Completing clinical searches on the practice's patient records system and discussing findings with the provider
- Reviewing patient records to identify issues and clarify actions taken by the provider
- Requesting evidence from the provider

CQC findings

The CQC based their judgement of the quality of care at this service on a combination of:

- What they found when they inspected
- information from ongoing monitoring of data about services and
- information from the provider, patients, the public and other organisations.

The Practice remains rated as Good overall:

CQC found that:

• The practice provided care in a way that kept patients safe and protected them from avoidable harm.
• The practice were carrying out structured medication reviews which were completed in a thorough and comprehensive manner.
• Staff communication and engagement had been improved. CQC received feedback from 16 members of staff and all staff members commented on the multiple positive changes which had taken place in the practice. They felt listened to and involved in the development of the practice's vision and values.
• The practice had recruited and trained a number of Health and Wellbeing coaches who carried out health checks. A Learning Disability nurse had recently been recruited to the practice whose role will include completing healthchecks for patients with a learning disability, whilst a specialist mental health nurse had been completing health checks for patients with serious mental illness.

In addition, CQC found the provider should:

• Continue to record weight measurements for the monitoring of patients on some medications.
• Continue to regularly review safety alerts.
• Continue to monitor and improve prescribing rates of Pregabalin and Gabapentin.
• Improve uptake for the national cervical screening programme.

Download full report

Cromer Group Practice CQC report

Download evidence table

Cromer Group Practice Evidence Table

Following the inspection and the improved rating of Good in Safe services, the CCG are assured that the North Norfolk Primary Care Locality team is working collaboratively with the Practice to ensure that the Practice continues to make improvements in the areas identified within the CQC report.

The Delegated Primary Care Team will liaise with the appropriate Primary care Locality team to ensure, that the areas highlighted by the CQC are addressed and continue.

Key Risks	
Clinical and Quality:	The concerns identified by the CQC which lead to a poor rating may put patients at risk
Finance and Performance:	Practice income could be affected as they invest in implementing identified improvements.
Impact Assessment (environmental and equalities):	Improving the health of the population
Reputation:	A poor rating may affect the practice's reputation
Legal:	GMS Contractual Obligations
Information Governance:	N/A
Resource Required:	This forms part of the delegated commissioning team's portfolio
Reference document(s):	CQC inspection framework and published reports
NHS Constitution:	N/A
Conflicts of Interest:	GP practice members may be conflicted
Reference to relevant risk on the Governing Body Assurance Framework	An interim risk register is currently being developed for the PCCC. CQC inspections will form part of a wider risk on the resilience of general practice

GOVERNANCE

Process/Committee approval with date(s) *(as appropriate)*	A regular report on CQC inspections is brought to PCCC for noting, along with reports as practice inspections are published.

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Norfolk and Waveney Integrated Care System

Agenda item: 14

Subject:	**Prescribing team report**
Presented by:	**Michael Dennis Head of Medicines Optimisation**
Prepared by:	**Michael Dennis Head of Medicines Optimisation**
Submitted to:	**Primary Care Commissioning Committee**
Date:	**July 22**

Purpose of paper:

Information

Executive Summary:

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

1. Prescribing team focus areas

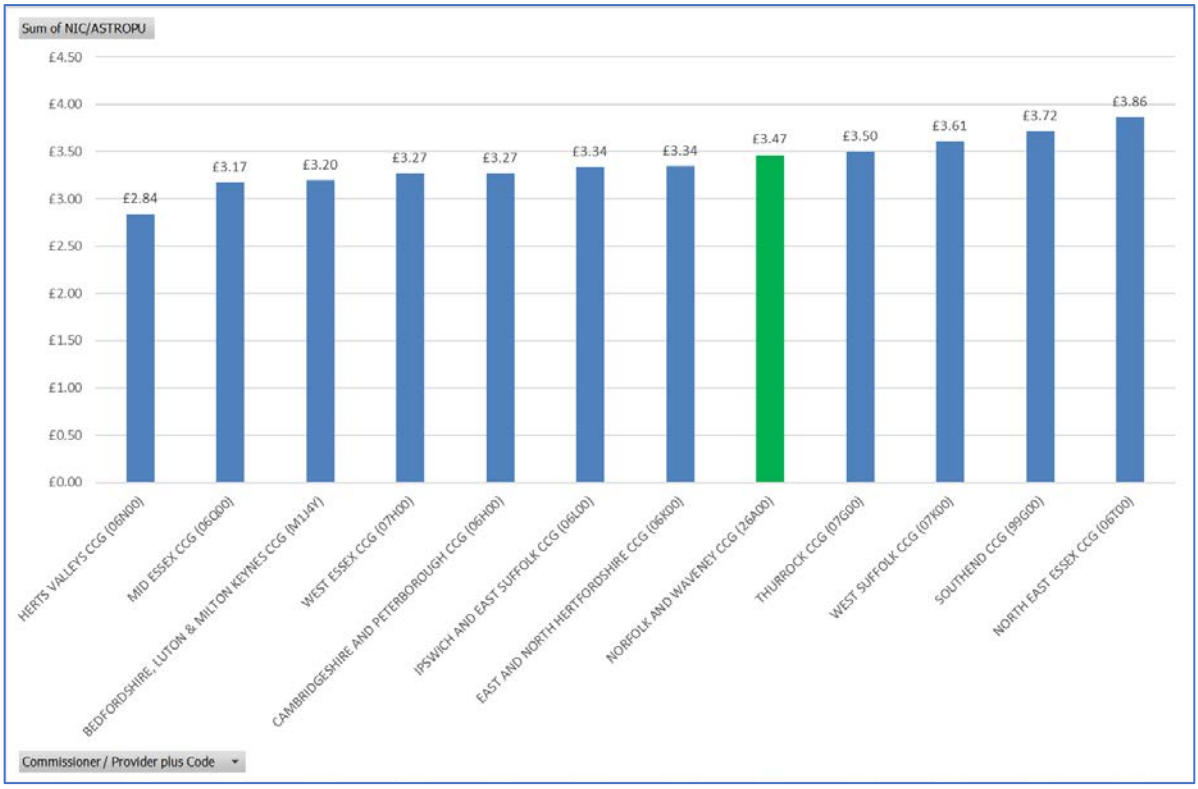
1.1 The newly formed prescribing teams are working on delivering or facilitating the delivery of the necessary efficiency savings. The team is however also supporting the vaccination programme, practices at risk. The CSU has now finally joined the CCG team on 1st July and are now the ICB medicines team. We are also working to fill the vacancies that the CSU have been carrying.

1.2 The prescribing quality scheme has been launched and the data monitoring has been finalised. The team are now meeting with practices to work on plans to implement the schemes.

1.3 The funded low risk cost effective switch programme has also been launched.

2. CCG/ICB Prescribing Performance

2.1 Net ingredient cost (NIC) per AstroPU (an attempt to normalise practice demographics) below is a proxy measure of relative cost-effectiveness, it doesn't however take account of deprivation which is a key driver of prescribing spend. Norfolk and Waveney has stayed as the 5th highest normalised raw spend of East of England CCGs at £3.47 in April.



2.4 An explanation on retained margin (Category M) is below.

The community pharmacy sector will receive £2.592bn per year from 2019/20 to 2023/24. Of the annual sum, £800m is to be delivered as retained buying margin i.e., the profit pharmacies can earn on dispensing drugs through cost effective purchasing.

The £800m retained margin element is a target that the Department of Health and Social Care (DHSC) aim to deliver by adjusting the reimbursement prices of drugs in Category M of the Drug Tariff.

Where the delivery rate of margin to community pharmacy will be under or over deliver on the £800m target, the DHSC will re-calibrate Category M Drug Tariff prices to bring the margin delivery rate back on track. This is the CAT-M reimbursement adjustments.

2.5 The cost of all prescribing YTD (as of March 2022 data) is £171,798,785 and an end of year underspend of £2.3m against our budget (-1.3%) after taking off recharges and rebates.

There are adjustments to Cat M prices in Q1, Q2, Q3 and Q4 which will have an impact on outturn. Category M prices are adjusted quarterly so that the community pharmacy contract remains within its overall financial envelope

In Q1 an increase of £3.47million per month in England (approx. £75,000 for N&W)
In Q2 a decrease of £16.3 million per month in England (approx. £347,000 for N&W)
InQ3 a decrease of £8.9 million per month in England (approx. £473,000 for N&W)
In Q4 a decrease of £16.4 million per month in England (approx. £837,000 for N&W)

NCSO

A price concession agreed by the department of Health when a product cannot be sourced at the drug tariff price
The impact of price concessions continues

Indications are that there will be no growth in Category M prices in April 2022

There is also significant inflation in category A prices for example ascorbic acid tablets 200mg and above now cost more than £1 per tablet when prescribed but can be purchased for £1.99 for 30. Lower strengths are almost as expensive.

The top drugs in terms of growth from April to February compared to last, are usually listed below. Some have grown in costs due to increased use e.g., DOACS, edoxaban, apixaban and rivaroxaban. Famotidine has increased in volume due to the continuing global shortage of ranitidine. The system was however down this month when this report was written.

Drugs known as SGLT 2's have grown significantly. This is expected to continue since whereas they had previously only been used in patients with diabetes they are now also used in patients with cardiovascular and renal disease.

3 Dependence forming medicines (DFMs)

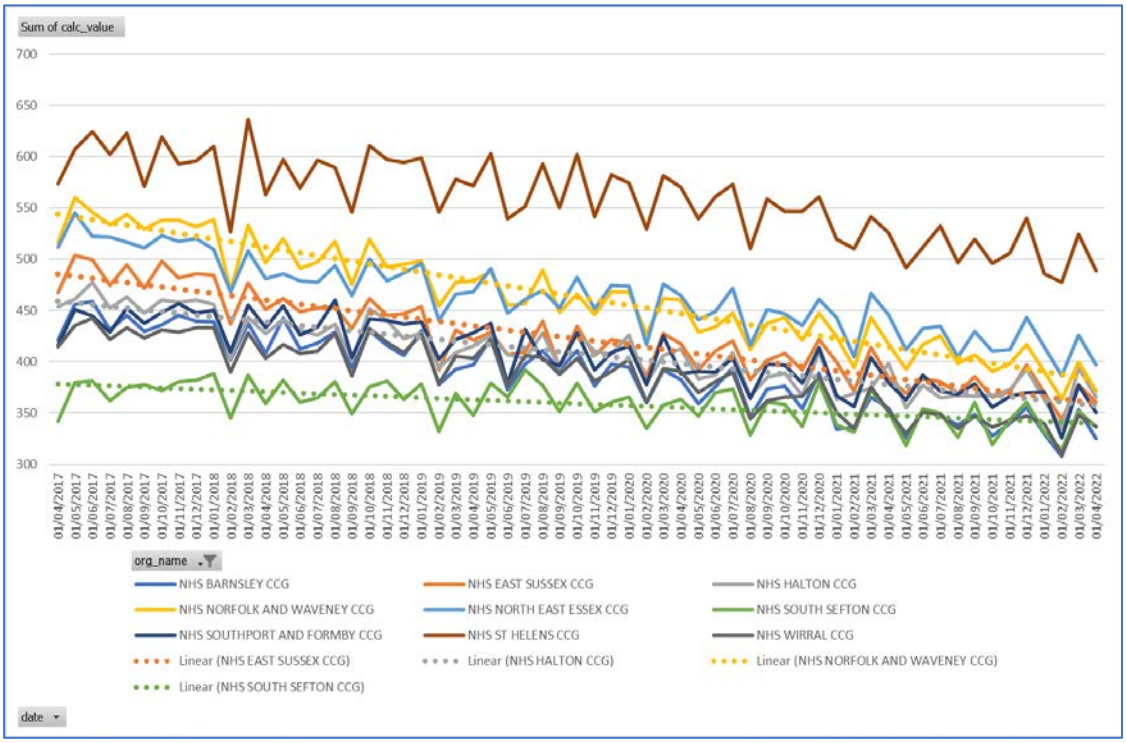
3.1 As previously reported the CCG has continued to improve from its position as a national outlier on its use of high dose opiates in chronic pain. Our high use of hypnotics (and anxiolytics) whilst improving, remains a concern however.

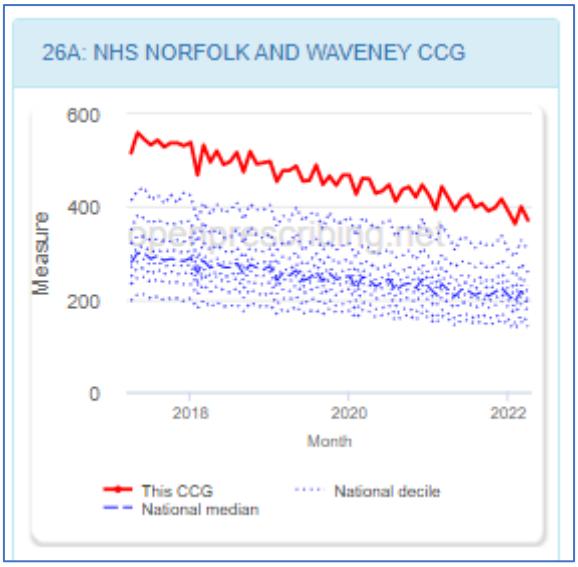
3.2 The national indicators for DFMs for March 22 are below. This was out of the 134 organisations on OpenPrescribing with position 1 being the highest (usually worst). Since April there are only 106 organisations listed due to further mergers of CCG's.

3.3 Top outlier practices on hypnotics and anxiolytics; gabapentinoids will be offered audit and action plan development support.

- **High dose opiates – improved to 83rd (87th previously) 22nd percentile (1th percentile previously) on high dose opiate items as percentage of regular opiates**
- **Gabapentinoids – at 28th (previously 28th nationally (74th percentile) on defined daily doses of gabapentin and pregabalin**
- **Hypnotics and anxiolytics – remained at 3rd nationally (98th percentile) volume per 1000 patients – the trend (below) is however an improving one (yellow dotted line is Norfolk and Waveney performance and trend respectively)**

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





3.4 We are currently working with the Academic and Health Science Network (AHSN) and UEA to develop and agree a standard pathway and SOP for deprescribing of DFM's with a particular focus on opioids initially. UEA have developed an opioid deprescribing toolkit and we ran a stakeholder event to collaborate on this. The event was on 26th April and included consultants, GP's, patients and a number of PCN pharmacists. We have further task and finish groups with relevant stakeholders to ensure we have a robust and plan with cohernet practice across the region. The outputs are being written up and will inform a next steps plan for further improvements. NHSE is already wanting to adopt this work regionally.

4 Antibiotic Prescribing

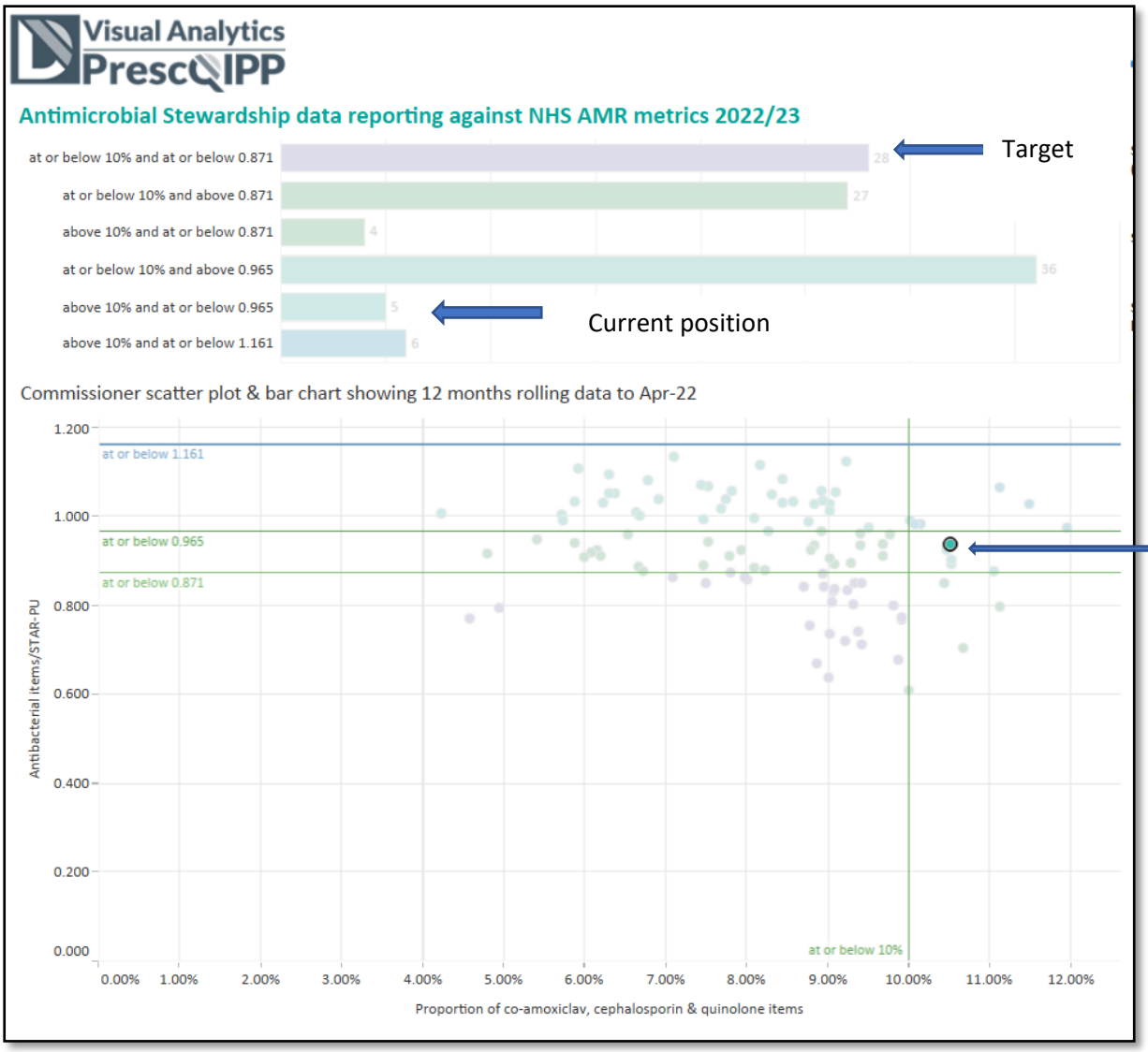
4.1.0 NHS System Oversight Framework (SOF) Antimicrobial Prescribing Metrics for 2021-22 have been updated the antibiotic volumes target to 0.871 or less antibacterial items per STAR-PU to align it with the UK AMR National Action Plan ambition to reduce community antibiotic prescribing by 25% by 2024. The national target for percentage of broad-spectrum antibiotic prescriptions as a total of overall antimicrobial prescriptions remains at 10%.

4.1.1 Antibiotic volumes, the bar chart on the left shows the volume of antibiotic prescribing by PCN's. Norfolk and Waveney is still above the new volume target of 0.871 with a value of 0.936 antibacterial items per STAR-PU in the 12 months to April 22. (Increase of 0.011 on March 2022) There is a trend of increasing antibacterial items per STAR/PU for Norfolk and Waveney. Nine PCNs are above this level, additionally West Norfolk PCN and Fens & Brecks PCN are above the second target of 0.965

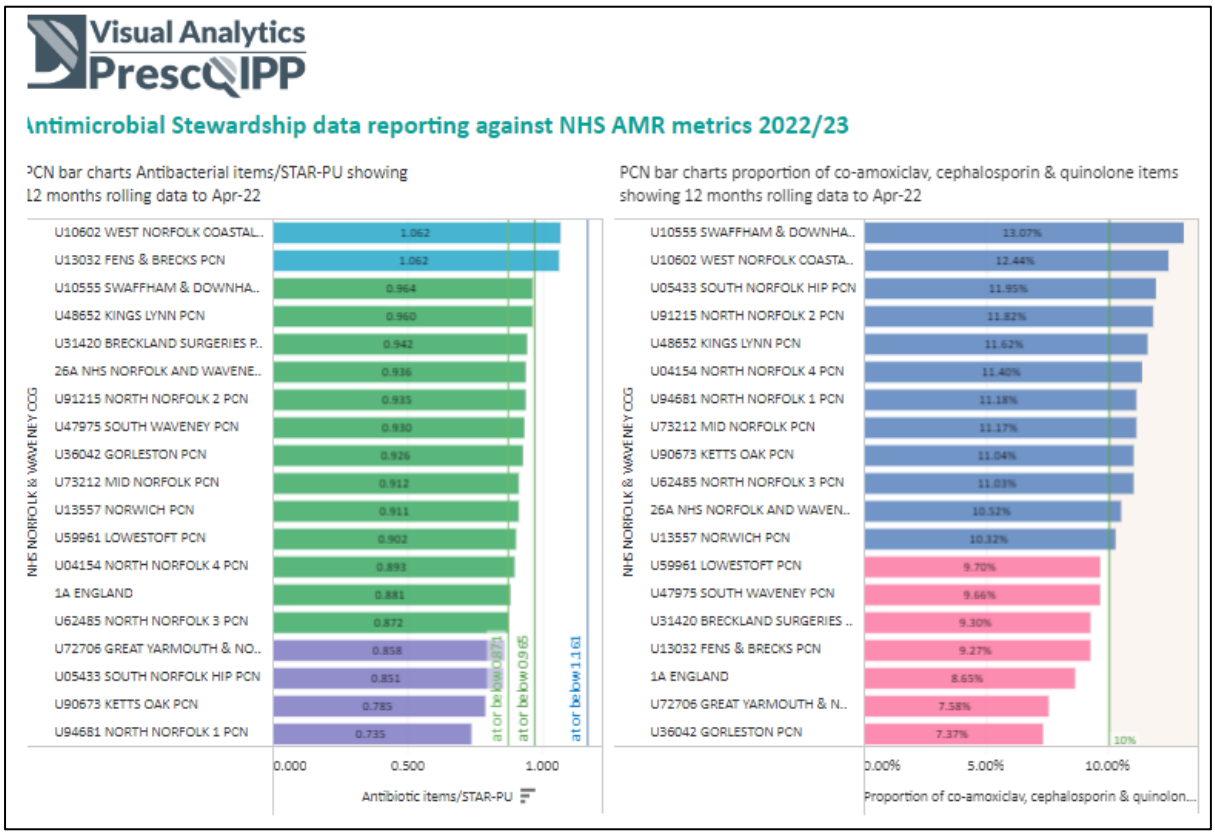
4.2 Percentage of broad-spectrum antibiotics, the bar chart on the right shows the percentage by PCN. Norfolk and Waveney CCG are currently above the

national target of no more than 10% of all antibiotics at 10.52% in the 12 months to April 2022 (a decrease from 10.60% in March 2021). A reduction in the overall percent of broad-spectrum antibiotics is possibly linked to the increase in overall antimicrobial prescribing. All practices need to continue to focus on this area of prescribing, documenting the indication for an antibiotic, following the local antimicrobial guidelines and microbiology advice as appropriate.

CCG Position against NHS AMR metric 2021/22 – April 2022



PCN bar charts – Antimicrobial prescribing 12 months to end April 2022



4.3 Our outlier practices that are driving the higher percentage of Broad-spectrum antibiotics in April data are.

Row Labels	% Broad Spectrum Antibiotics (April 2022)	Sum of percentile
BURNHAM SURGERY	18.98%	99.43
CHURCH HILL SURGERY	18.18%	99.26
LITCHAM HEALTH CENTRE	17.61%	99.09
E HARLING & KENNINGHALL MEDICAL PRACTICE	17.23%	98.94
HOWDALE SURGERY	16.06%	98.08
HELLESDON MEDICAL PRACTICE	15.62%	97.50
ELMHAM SURGERY	15.27%	97.16
ACLE MEDICAL PARTNERSHIP	15.03%	96.84
PLOWRIGHT MEDICAL CENTRE	14.81%	96.56
BRUNDALL MEDICAL PARTNERSHIP	14.79%	96.53
TOFTWOOD MEDICAL CENTRE	14.60%	96.32
BRIDGE STREET SURGERY	14.51%	96.16

5 Prescribing Quality Scheme (PQS)

5.1 The CCG has lauched the 2022-23 Prescribing Quality Scheme, all Practices are invited to take part

5.2 This year's scheme has entry criteria that the practice must meet to join the scheme. These entry criteria are to support safe and evidence based prescribing across Norfolk and Waveney Primary Care.

- Practices send a representative to at least 50% of prescribing leads meetings e.g., 3 per year
- Practices have Optimise Rx enabled and are using at a reasonable level agreed with the locality medicines lead.
- Practice pharmacists and technicians (PCN pharmacy teams) invite MMO representatives to their regular medicine's meetings, ideally all meetings but at least 50% of meetings e.g., 3-4 per year

5.3 95 out of 105 practices have signed up to take part in the scheme. Three practices have declined to take part.

6 Low risk, Cost-effective Prescribing QIPP Support Scheme

6.1 In addition to the Prescribing Quality Scheme (PQS), there is also a QIPP scheme for General practice to implement low risk, cost effective drug switches in primary care

6.2 The scheme is open to all practices. Payment is based on staff time taken to complete the switch work. Extra money is available for those practices that complete the switches before 31 August 2022.

Practices will be able to claim up to their maximum allocation of 20p per patient. Each practice's maximum allocation can be found in Appendix 2 of the project document

- 20p per patient on list for performing all switches within 2 months.
- 10p per patient on list for completing the work in greater than 2 months
- 5p per patient if agreeing to take part but needing hands-on support from the medicines optimisation team.

6.3 29 out of 105 practices have signed up to take part in the scheme

Recommendation to Governing Body/ Committee:

The committee is asked to note this report

Key Risks	
Clinical and Quality:	Some key quality areas need focus and outlier performance needs addressing. Mitigated through the prescribing quality scheme
Finance and Performance:	Risks highlighted in report
Impact Assessment (environmental and equalities):	Not applicable
Reputation:	CCG practices are outliers for hypnotics and anxiolytics as highlighted in the report
Legal:	Not applicable
Information Governance:	Not applicable
Resource Required:	Medicines management team support to practices
Reference document(s):	Not applicable
NHS Constitution:	N/A
Conflicts of Interest:	GP practice members may be conflicted
Reference to relevant risk on the Governing Body Assurance Framework	Prescribing cost risk noted on register

GOVERNANCE

Process/Committee approval with date(s) *(as appropriate)*	Monthly report to PCCC

Norfolk and Waveney
Integrated Care Board

Agenda item: 15

Subject:	**Primary Care Commissioning Committee (PCCC) 2022/23 Financial Report – Month 2**
Presented by:	**James Grainger – Head of Finance Primary Care & Continuing Healthcare**
Prepared by:	**James Grainger – Head of Finance Primary Care & Continuing Healthcare**
Submitted to:	**Primary Care Commissioning Committee**
Date:	**12/7/2022**

Purpose of paper:

To present the Month 2 (May 2022) Primary Care financial position for the Norfolk and Waveney CCG to the Primary Care Commissioning Committee for information.

Executive Summary:

The 2022-23 budgets to June 2022 are based upon the draft financial plans as submitted in April 2022. These plans are not final and whilst they are expected to change for the overall CCG and System, these changes are not anticipated to have an impact on the budgets of Primary Care.

The current efficiency requirement within this directorate is £1.026m for 3 months.

As at month 2 (May) the 3 months forecast spend is £**103.62m** as against plan of **£103.61m** leading to a marginal underspend of £0.1m. The two major components of Primary Care are Prescribing and Delegated Primary Care:

The forecast prescribing expenditure totals **£48m** as against 3 months plan of **£48m.**

The underspend in System Development Fund (SDF) is offset by overspend in Delegated Primary Care expenditure as the budgets are in SDF and spend in Delegated. The CCG was unable to move actuals and budgets as per NHSE instructions in M2.

Report : Attached

Recommendation to the Board:

This report is presented for information only.

Key Risks	
Clinical and Quality:	None
Finance and Performance:	Achievement of Financial plan
Impact Assessment (environmental and equalities):	None
Reputation:	The achievement of the plan impacts the CCGs reputation with NHSE/I.
Legal:	None
Information Governance:	None
Resource Required:	None
Reference document(s):	NHSE/I guidance and communications
NHS Constitution:	None
Conflicts of Interest:	None
Reference to relevant risk on the Board Assurance Framework	Delivering Financial plan

Governance

Process/Committee approval with date(s) (as appropriate)	*n/a*

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Norfolk and Waveney Integrated Care System

2022/23 Primary Care Commissioning Committee Finance Report

May 2022 (Month 2 reporting period)

Primary Care Commissioning Committee 12th July 2022

Contents

1.0 Executive Summary

- As the financial reporting for Primary Care and Prescribing is produced in arrears this report will relate to Month 2 of the legacy CCG accounts. The ICB (Integrated Care Board) accounts will be reported from Month 4 of 2022/23 financial year.

- The 2022-23 budgets to June 2022 are based upon the draft financial plans as submitted in April 2022. These plans were not final and the budgets have subsequently changed as submitted on the 20th June. These changes had a minimal impact on the budgets of Prescribing and Primary Care.

- The current efficiency requirement within the Primary Care and Prescribing directorate is £1.026m this is within GP Prescribing and for the 3 months from April-June 2022. The full year Efficiency Plan is £8.4m (plan is not linear). An additional efficiency requirement is built into the ICB budgets from M4 onwards.

- As at Month 2 (May) the 3 months forecast spend is £103.62m as against plan of £103.61m leading to a marginal underspend of £0.1m.

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

2.0 Financial Summary

Primary Care: Financial Summary	3 months CCG Budget £m	Year to Date (Month2) Budget £m	Actual £ m	Variance (Fav)Adv £m	Forecast 3 Months (CCG) Actual £m	Variance (Fav) Adv £m	*Detailed Variance Analysis*
GP & Other Prescribing	48.0	31.3	31.2	(0.1)	48.0	(0.1)	*3.1*
Primary Care							
System Development Fund	3.0	2.0	1.7	(0.3)	2.5	(0.5)	*3.2*
Local Enhanced Services	4.2	2.8	2.8	0.0	4.2	0.0	
Other Primary Care	0.8	0.5	0.5	(0.0)	0.8	(0.0)	
Primary Care Delegated Co-Commissioning	46.5	31.0	31.3	0.3	46.9	0.5	*3.3*
Primary Care IT	1.1	0.8	0.8	0.0	1.1	(0.0)	
Total Primary Care	55.6	37.0	37.0	(0.0)	55.6	0.0	
Total Directorate	103.6	68.3	68.3	(0.1)	103.6	(0.1)	
Variance as a % of Budget				*-0.1%*		*-0.1%*	
Total Corrected Primary Care	103.6	68.3	68.3	-0.1	103.6	-0.1	

Variance Signage: (Favourable)/Adverse

The detailed explanations are provided in 3.0 Detailed variance analysis.

3.0 Detailed Variance Analysis

Primary Care: Detailed Variance Analysis		3months Budget CCG	Year to Date (Month 2)			3 Months Forecast (CCG)			Narrative
		Budget	Budget	Actual	Variance (Fav)Adv	Actual	Variance	Variance (Fav)Adv	
		£m	£m	£ m	£m	£m	£m	%	
3.1	GP and Other Prescribing	48.0	31.3	31.2	(0.1)	48.0	(0.1)	-0.1%	The GP Prescribing costs are reported nationally 2 months in arrears so, estimates for April and May are considered in the Year to Date (YTD) position, and the same in the Forecast Outturn (FOT) as the CCG reports for the final 3 months before transferring to an Integrated Care Board (ICB). The YTD and FOT are broadly on plan with immaterial underspend variances to plan of £(0.1)m. An efficiency target of £(1.026)m is included in the budget for the three months.The full year planned efficiency target is £(8.4)m.(It is not phased linear). It is assumed the efficiency savings are delivered as per plan and these are therefore included in both the YTD and FOT expenditure position. Confirmation of these assumptions and savings values will be made in June when the April actual spend is received. Due to new NICE guidance which was published in March-22 there may be additional costs in the 2022/23 expenditure because of Continuous Glucose Monitoring (CGM) and prescribing of Sodium-glucose Cotransporter-2 (SGLT2) inhibitors. The exact financial implication is unknown as this guidance states that this prescribing is not suitable for all diabetic patients and the roll out will take time to implement, it is however thought to be considerable and may exceed £5m and if it does this will be an unfunded cost pressure. The Prescribing spend overall remains subject to significant volatility and the current macro-economic situation will increase this volatility further (e.g. high levels of inflation, supply issues which could have a potential cost impact). Surgeries are now seeing more patients than they did during the pandemic and this in turn may drive higher quantities of prescribed medicines. Due to this risk whilst we await final actual values, a prudent additional growth estimate of 1.5% on top of the demographic growth is included in the position.
3.2	System Development Fund	3.0	2.0	1.7	(0.3)	2.5	(0.5)	-15.1%	The budgets for the Impact and Investment Fund (IIF), Subject to Access and PCN Leadership are included in System Development Fund (SDF). However, actuals are recorded in Delegated Primary Care. The CCG was unable to move these budgets and actuals in M2 in order that the CCG complies with NHSE budget guidance. Hence there is a SDF underspend which is offset by a converse Delegated overspend.
3.3	Primary Care Delegated Co-Commissioning	46.5	31.0	31.3	0.3	46.9	0.5	1.0%	See above comment

4.0 System Development Fund

Primary Care: System Development Fund	3months Budget CCG Budget £m	Year To Date(Month2) Budget £m	Actual £ m	Variance (Fav) Adv £m	3 months Forecast (CCG) Actual £m	Variance (Fav) Adv £m
GP Retention	0.1	0.0	0.0	0.0	0.1	0.0
Training Hubs	0.1	0.0	0.0	0.0	0.1	0.0
Online Consultation	0.1	0.0	0.0	0.0	0.1	0.0
Fellowship-Core Offer	0.1	0.0	0.0	0.0	0.1	0.0
Supporting Mentor Scheme	0.0	0.0	0.0	0.0	0.0	0.0
Infrastructure & Resilience	0.1	0.0	0.0	0.0	0.1	0.0
Improved Access	1.8	1.2	1.2	0.0	1.8	0.0
Practice Resilience	0.0	0.0	0.0	0.0	0.0	0.0
PCT Transformation	0.4	0.2	0.2	0.0	0.4	0.0
Delegated System Development	0.5	0.3	0.0	(0.3)	0.0	(0.5)
	3.0	**2.0**	**1.7**	**(0.3)**	**2.5**	**(0.5)**
Variance as a % of Budget				*-15.0%*		*-15.1%*

Variance Signage: (Favourable)/Adverse

- The above table details the schemes within the System Development Fund (SDF).
- The Delegated System Development consists of budgets for Impact and Investment Fund, Subject to Access and PCN Leadership. The expenditure is incurred in Delegated Primary Care, the CCG was unable to move budgets and actuals in M2 to comply with NHSE/I guidance.

5.0 Delegated Co Commissioning Analysis

Primary Care: Delegated Co Commissioning	3months Budget CCG £m	Year to Date (Month 2) Budget £m	Actual £ m	Variance (Fav) Adv £m	3 Months Forecast (CCG) Actual £m	Variance (Fav) Adv £m
Contractual	30.8	20.6	21.0	0.4	31.4	0.6
QOF	4.0	2.6	2.7	0.0	4.0	0.0
Premises cost reimbursemen	3.7	2.5	2.5	0.0	3.7	0.0
Other - GP Services	3.5	2.3	2.3	(0.0)	3.5	0.0
Enhanced services	1.1	0.7	0.7	0.0	1.1	0.0
CCG Spend	0.1	0.1	0.1	(0.0)	0.1	(0.0)
PCN ARRS Staff	3.1	2.1	2.1	0.0	3.1	0.0
PMS to GMS	0.2	0.1	0.0	(0.1)	0.0	(0.2)
Total	**46.5**	**31.0**	**31.3**	**0.3**	**46.9**	**0.5**
Variance as a % of Budget				*0.9%*		*1.0%*

Variance Signage: (Favourable)/Adverse

The above table details the category of expenditure within Delegated Co Commissioning

Areas of material forecast variances:

- **Contractual:** The major overspend is due to Subject to access, Impact and Investment Fund and PCN Leadership whose budgets are in SDF area.

6.0 GP And Other Prescribing

22/23 Primary Care: GP And Other Prescribing	3months Budget CCG	Year to Date(Month2)			3 months Forecast (CCG)	
	Budget	Budget	Actual	Variance (Fav)Adv	Actual	Variance (Fav)Adv
	£m	£m	£ m	£m	£ m	£m
GP Prescribing Costs	44.9	29.2	29.2	(0.0)	44.9	(0.0)
Recharges to Local Authorities & NHS England	(0.7)	(0.5)	(0.4)	0.1	(0.6)	0.1
Rebates from pharmaceutical companies	(0.7)	(0.5)	(0.5)	(0.0)	(0.8)	(0.0)
GP Prescribing Subtotal	**43.5**	**28.3**	**28.3**	**(0.0)**	**43.5**	**(0.0)**
Central Drugs	1.2	0.8	0.8	0.0	1.2	0.0
Dressings & wound care	1.5	1.0	1.0	(0.0)	1.5	0.0
Others (Medicine Management, Oxygen etc.)	1.9	1.3	1.2	(0.1)	1.8	(0.1)
Total Spend	**48.0**	**31.3**	**31.2**	**(0.1)**	**48.0**	**(0.1)**
Variance as a % of Budget				*-0.2%*		*-0.1%*

3 months budget is the 3 months plan for 22/23

Variance Signage: (Favourable)/Adverse

The above table details the category of expenditure within GP and Other Prescribing, there are only immaterial variances to budget as at Month 2.

7.0 Financial risks

Risk	Mitigation
2022/23 outturn position deteriorates from the current forecast	There is robust management and oversight arrangements, detailed review of underlying position, via monthly review of actual expenditure compared to plan and specific mitigations agreed with budget managers.
New NICE Guidelines	Due to new NICE guidance which was published in March-22 there may be additional costs in the 2022/23 expenditure as a result of Continuous Glucose Monitoring (CGM) and prescribing of Sodium-glucose Cotransporter-2 (SGLT2) inhibitors. The potential mitigation is that these new drugs and therapies will not be suitable for all diabetic patients and will take time to roll out deferring the cost beyond 2022/23
Non delivery or under delivery of £1.026m Transformation Savings assumed in the financial position for Prescribing (Up to M3).	Practice Level Prescribing budgets, based on a scientific process to include deprivation, care home beds and list size has been calculated. Actual spend is being compared on a monthly basis to understand the outlying practices and take corrective steps. Theirs is an oversight group also setup to monitor and take corrective action.
Increased number of prescriptions for anti depressants and pain killers due to the large Elective surgery waiting list.	Regular monitoring by Prescribing Team should identify the trend and take corrective steps.

7.0 Financial risks (Continued)

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