

Meeting of the Norfolk and Waveney ICB Primary Care Commissioning Committee
Tuesday 13 September 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. <i>For noting</i> | Chair |
| 4. Page 5 | | Review of Minutes and Action Log from the August 2022 meeting <i>For approval</i> | Chair |
| 5. Page 19 | 13:35 | Forward Planner <i>For Noting</i> | SP |
| 6. Page 20 | 13:40 | Risk Register <i>For Noting</i> | SP |
| Service Development | | | |
| 7. Page 37 | 13:45 | Branch closures – Advice Note <i>For Approval</i> | MT |
| 8. Page 45 | 13:55 | Learning Disability Health Checks <i>For Noting</i> | SN |
| 9. Page 49 | 14:05 | Severe Mental Illness Health Checks <i>For Noting</i> | SN/JD |
| 10. Page 52 | 14:15 | Resilience Funding <i>For Noting</i> | SN |
| 11. Page 55 | 14:20 | Primary Care Network overview and update and progress on the Additional Roles Reimbursement Scheme <i>For Approval</i> | KL |
| 12. Page 63 | 14:35 | Enhanced Access <i>For Approval</i> | FT |
| 13. Page 68 | 14:45 | GP Patient Survey Results <i>For Approval</i> | FT/KL |
| Finance & Governance | | | |
| 14. Page 76 | 14:55 | Prescribing Report <i>For Noting</i> | MD |
| 15. Page 87 | 15:05 | Finance Report <i>For Noting</i> | JG |
| Any Other Business | | | |
| 16. | 15:15 | Questions from the Public | Chair |
| <p>Date, time and venue of next meeting Tuesday 11 October 2022, 13:30 – 16:30 – ICB PCCC To be held by videoconference and You Tube</p> | | | |
| <p>Any queries or items for the next agenda please contact: sarah.webb7@nhs.net</p> | | | |
| <p>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</p> | | | |

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. |
| Dr Hilary Byrne | Partner Member - Primary Medical Services | Attleborough Surgeries | X | | | Direct | GP Partner at Attleborough Surgeries | 2001 | Present | To be raised at all meetings to discuss prescribing or similar subject. Risk to be discussed on an individual basis. Individual to be prepared to leave the meeting if necessary. |
| | | MPT Healthcare Ltd | X | | | Direct | Director of MPT Healthcare Ltd | 2020 | Present | 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. |
| | | Norfolk Community Health and Care Trust (NCH&C) | | | | Indirect | Spouse is employee of NCH&C (Improvement Manager) | 2021 | Present | 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 | 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 | 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 was Partner at Orchard Surgery | 2020 | 2021 | | |
| Rosemary Moore | Member Practice Representative | Humbleyard Practice | X | | | Direct | Previous Employee of Humbleyard Practice | 2020 | 2022 | 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 |
| | | Acle Surgery | X | | | Direct | Supporting the newly appointed practice manager at Acle Surgery | 2022 | Present | | |
| | | 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 might have an interest. | |
| | | 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 | | | |
| 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 | |

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| | | 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 |
| James Reeder | Suffolk Health and Wellbeing Board | Suffolk County Council | X | | | Direct | Cabinet Member for Children and Young People's Services | | Ongoing | Will not take part in any discussion or decisions relating to the declared interests. |
| | | Suffolk County Council | X | | | Direct | Children's Services and Education Lead Members Network | | Ongoing | |
| | | East of England Government Association | X | | | Direct | East of England Government Association | | Ongoing | |
| | | James Paget University Hospital Trust | X | | | Direct | James Paget Healthcare NHS Foundation Trust Governors Council | | Ongoing | |
| | | Suffolk County Council | X | | | Direct | Suffolk Safeguarding Children Board | | Ongoing | |
| | | Suffolk Chamber of Commerce | X | | | Direct | Member of the Lowestoft and Waveney Chamber of Commerce board part of Suffolk Chamber of Commerce | | Ongoing | |
| | | Northfields St Nicholas Primary Academy | | | X | Direct | Governor of Northfields St Nicholas Primary Academy part of the Reach2 Academy Trust. | | Ongoing | |

Norfolk and Waveney Primary Care Commissioning Committee

Part One

**Minutes of the Meeting held on
 Tuesday 9 August 2022 13:30
 via video conferencing & YouTube**

Voting Members - Attendees

| Name | Initials | Position and Organisation |
|-------------------------|----------|--|
| Hein Van Den Wildenberg | HW | Non Executive Member, Norfolk and Waveney ICB, deputising for the Chair |
| James Grainger | JG | Senior Finance Manager – Primary Care, Norfolk & Waveney ICB, deputising for Steven Course, Director of Finance |
| Chris Turner | CT | Head of Nursing and Quality, Patient Safety Specialist, Norfolk and Waveney ICB, deputising for Tricia D’Orsi, Director of Nursing |

In attendance

| Name | Initials | Position and Organisation |
|---------------------------|----------|--|
| Mark Burgis | MB | Director of Primary and Community Care, Norfolk & Waveney ICB (attending part time) |
| Dr Hilary Byrne | HB | ICB Board Partner Member – Providers of Primary Medical Services, Norfolk & Waveney ICB |
| Vivienne Clifford Jackson | VCJ | Trustee, Healthwatch Norfolk |
| Michael Dennis | MD | Head of Medicines Optimisation, Norfolk and Waveney ICB |
| James Foster | JF | Practice Manager Committee Member |
| Carl Gosling | CG | Senior Delegated Commissioning Manager Primary Care, Norfolk & Waveney ICB |
| Rosemary Moore | RM | Practice Manager Committee Member |
| Shepherd Ncube | SN | Head of Delegated Commissioning, Norfolk and Waveney ICB |
| Sadie Parker | SP | Associated Director of Primary Care, Norfolk and Waveney ICB |
| Cllr James Reeder | JR | Cabinet Member for Children and Young People’s Services, Suffolk County Council |
| Fiona Theadom | FT | Deputy Head of Delegated Primary Care Commissioning/Interim Head of Primary Care Workforce and Training, Norfolk and Waveney ICB |
| Sarah Webb | SW | Primary Care Administrator (minute taker) Norfolk and Waveney ICB |

Guest Speakers

| Name | Initials | Position and Organisation |
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| Julian Dias | JD | Deputy Senior Delegated Commissioning Manager Primary Care, Norfolk and Waveney ICB |
| Anne Heath | AH | Head of Digital, Norfolk and Waveney ICB |

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| Paul Higham | PH | Associate Director Primary Care Estates, Norfolk and Waveney ICB |
| Cath McWalter | CMcW | Senior Primary Care Estates Manager, Norfolk and Waveney ICB |

Apologies

| Name | Initials | Position and Organisation |
|-------------------|----------|--|
| 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 |
| James Bullion | JB | Chair, Partner Member – Local Authority (Norfolk) Norfolk and Waveney ICB |
| Steven Course | SC | Director of Finance, Norfolk and Waveney ICB |
| Particia D’Orsi | PDO | Director of Nursing, Norfolk and Waveney ICB |
| Andrew Hayward | AH | Trustee of Healthwatch Norfolk |
| Sue Merton | SM | Healthwatch Suffolk |

| No | Item | Action owner |
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| 1 | Chair’s introduction and report on any Chair’s action | Chair |
| | HW confirmed he was chairing in JB absence. HW welcomed Cllr James Reeder from Suffolk County Council and Vivienne Clifford Jackson (representing Healthwatch Norfolk). | |
| 2 | Apologies for absence | Chair |
| | Noted above. | |
| 3 | Declarations of Interest <i>For noting</i> | Chair |
| | 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 Interest It was noted that JF’s DoI has not been amended to reflect that his wife was no longer a working partner at Orchard Surgery (with effect from 30 September 2021). RM declared she was no longer an employee of Humbleyard Practice. The register would be updated. | |
| 4 | Review of the Minutes and Action Log from the July 2022 meeting <i>For Approval</i> | Chair |
| | Minutes of the last meeting – comments from the LMC had been received outside the meeting and would be reviewed. JB had reviewed the minutes, the grammar and contextual changes would be made and circulated outside of the meeting. The members agreed the minutes to be an accurate description of the July 2022 Committee. ACTION: Minutes would be sent to Chair for signing. There were no matters arising. Action Log 109 – circulated outside meeting – closed. | |

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| | <p>113 – ongoing discussion – HW suggested this point was included in the next Interface update.</p> <p>114 – on agenda – closed.</p> <p>115/116 MD to provide an update within agenda item 12 – closed.</p> <p>117/118 completed – closed.</p> | |
| 5 | <p>Forward Planner <i>For Noting</i></p> | SP |
| | <p>SP confirmed the forward planner was for information.</p> | |
| 6 | <p>Director of Patients and Communities Report <i>For Noting</i></p> | MB |
| | <p>[Note: this agenda item was discussed during the meeting, after agenda item 13 on the agenda]</p> <p>MB requested the report was taken as read.</p> <p>MB focused on a few key highlights.</p> <p>The system was under intense urgent and emergency care pressure and MB reminded colleagues in the system that ca. 80% of urgent care was dealt with in primary care. MB expected additional funding from the region to support the system over the winter and reflected that the current system demand was akin to what would normally be experienced in the winter. Work would need to be focused on what could be done to make the system more resilient and it was noted there were also resilience challenges within general practice.</p> <p>MB reported the work being done at place level with general practice working with system colleagues, district councils, and mental health colleagues. There was a need to have a strong system in Norfolk and Waveney and there was scope to work at place to support many areas. MB confirmed he would share further details around place development at a future meeting as he felt that it would be useful to obtain a Committee perspective.</p> <p>MB reported that Dr Frankie Swords had joined the ICB. Within the report there was an outline of the work that Frankie intended to do to support general practice and a first engagement session had been held with clinical directors. Frankie had been shadowing and had spent a day in a couple of practices where she had experienced some of the pressures and seen some of the great work that was being undertaken.</p> <p>Frankie's background was acute. She was keen to support the work of the group and support general practice more generally to work with HB and others.</p> <p>MB paused to take questions.</p> <p>VCJ commented that there was no mention of Kings Lynn. VCJ reflected the impact on people in West Norfolk who cannot have their surgery and wondered what the plans were to ease the pressures in West Norfolk, and whether the other Trusts were getting involved, and how the whole situation was being dealt with as she felt this was about patients, communications and communities which sat in Healthwatch's remit. Healthwatch welcomed the new Medical Director and asked if Healthwatch could be mentioned to her and an arrangement could be made for her to attend a Healthwatch meeting to hear about the work being done. VCJ expressed surprise that the report had marked the risk relating to the NHS constitution as non-applicable.</p> | |

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| | <p>MB agreed with VCJ on the last point and clarified she was referencing elective care. MB felt it was important that work was being done in the system and reflected on the Gold calls that had taken place. MB agreed that there was more work to be done and was confident that the system would survive the winter if the elective position was recovered. MB reflected the position of the reduction in treatment times, especially long waits but recognised that there was more work to be done.</p> <p>VCJ reference a discussion she had heard in the news that morning about the elective waiting list reduction and wondered if there were any comparative figures for Norfolk & Waveney and how the electives were performing and what the waiting list situation was. MB confirmed that the position was not just locally but regionally and nationally, and MB would include that information at a report at a future Committee.</p> <p>HW thanked MB for the report and welcomed a future update on Place.</p> | |
| 7 | <p>Learning Disability Health Checks <i>For Noting</i></p> | SN |
| | <p>SN provided an update on progress made.</p> <p>A meeting had been held with the LMC regarding contractual position for delivering annual health checks for people with a learning disability. A standard form of words had been agreed for inclusion in the LD PCCC update report.</p> <p>SN gave an update on progress made since last month</p> <ul style="list-style-type: none"> • April and May data had been received from NHS England and good progress had been made. • SN attended the Norfolk Health Overview Scrutiny Committee last month and the overall feedback was positive. The committee acknowledged the significant progress and investment made to improve the ICB position in relation to uptake and quality of annual health checks. It was acknowledged that the impact of the additional clinical resources in West Norfolk had made, and the work the peripatetic team had done in Norwich. There were some challenges set in terms of how to demonstrate and sustain the progress made and discussions were underway to put in place long term delivery plans • Deep dive meetings with ICB locality colleagues had been arranged to strengthen the grip and understanding of the local plans, opportunities and challenges. Two meetings had been held so far with Norwich and Great Yarmouth and Waveney. LD annual health checks were being prioritised within localities and some of the challenges that localities were facing were outlined. • A meeting had taken place with NHS England colleagues to review last year's and this year's Q1 performance. As a system we now lead in the East of England in terms of the uptake of annual health checks and action plans. SN reported the position was strong but needed to continue to work on our long-term plans to build resilience and sustainability. SN drew Committee's attention to the activity in April and May and noted the improvements made. The additional resource in West Norfolk had made a significant impact within 8 weeks and SN reflected the Norwich position as he felt this needed to be addressed, however no major concerns were noted. SN concluded by acknowledging the challenge from Norfolk HOSC on sustainable plans | |

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| | <p>and concerns from LMC colleagues on equity of resources to general practices.</p> <p>SN offered to take questions.</p> <p>VCJ thanked Committee for allowing her to attend. VCJ reflected she was new to the meeting and was unable to determine from previous notes what the purpose of the health checks were. VCJ did not understand how only 256 health checks had been undertaken against a target of 6000 and whether this was criterion referencing or norm referencing. She asked what involvement the voluntary sector had and if there were other ways of communicating with people with LD, as the language used by the NHS was not always accessible. VCJ asked if patients understood why they were having the health check, the purpose of this, and what outcomes would benefit them as she felt patients may not be compliant if they were not able to understand this.</p> <p>SN agreed that commissioning of services in relation to patients with LD had needed improvement. More patients were in hospital with LD and had not received the appropriate care that they need. In respect of primary care SN felt it was important that the needs were identified at the earliest opportunity and patients with LD have their health checks completed and action plans put in place. Plans were developed and communicated through all parts of the system. SN highlighted that the data show that patients with LD die prematurely. SN believed having quality health checks would allow the identification of underlying causes.</p> <p>Emerging themes identified so far had been around dental care, diabetes and long-term condition access. Work was being done with several organisations and it was helpful to see how the cohort of people had integrated into the community and SN referenced the charity Open Doors as they had been helpful with their support to understand the needs of the communities. They had undertaken a survey and written a report on engagement for consulting with families and provided some feedback on how people with LD like to be engaged.</p> <p>SN responded that the figures being reported were for 2 months only and were consistent with our Q1 plans. Norfolk and Waveney led in the region, however there was a need to maintain this position.</p> <p>HW said it was important we have a view on timeliness of health checks for all people with LD. The reporting currently starts each year from zero, creating a risk that some patients may never be seen, and the committee would not be able to tell. HW therefore requested that we are able to see how many unique LD patients had been seen in (say) the last 18-24 months, in addition to the current reporting of stats in the current year. SN said he would introduce such reporting.</p> <p>HW thanked SN for his report.</p> | <p>SN</p> |
| <p>8</p> | <p>Severe Mental Illness Health Checks <i>For Noting</i></p> | <p>JD</p> |
| | <p>JD outlined some highlights to Committee.</p> <p>The feedback from Norfolk HOSC on 14 July 2022 around SMI Improvement work and plans for the system was positive; the Committee members from</p> | |

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| | <p>Norfolk HOSC appeared satisfied that the plans submitted addressed the uptake of SMI health checks, the quality of the check and made it worthwhile for the patient. Once checks were done, work would continue to address some of the inequalities. It was acknowledged in the report that only 40% of the checks were completed last year and that there was a need to improve and strengthen the current delivery plans to target patients who had not had their checks and to ensure no one missed out. Norfolk HOSC challenged the ICB to put in place a long term and sustainable plan to improve the current position and Patricia D’Orsi agreed to lead this piece of work.</p> <p>JD felt that this would strengthen the position in terms of performance and quarter one. Validation of final performance from last year was still awaited. It appeared from local intelligence that 734 health checks for SMI had been completed so far in quarter one and JD was planning to benchmark compared to last year. JD felt that there was a need to raise the profile of the work done and provided feedback on a meeting he had attended in the West Locality. JD committed to provide an update on the outcome of this meeting at a later Committee.</p> <p>JD opened for questions.</p> <p>VCJ wanted to understand the voluntary sector involvement and how patients were identified and how the rationale and participation was explained.</p> <p>JD reflected on the work done in the team and the work in participation with the charity Together. GP practices had their register size for SMI where they could undertake searches on their systems. These are often hard to reach, complex patients. Together had contacted the hard-to-reach patients and there had been some positive uptake. JD would produce a small section on the work that Together had done which would identify contact rates for hard-to-reach patients and if there had been any difference in uptake as a result. There had been collaboration with Mind and user experts by experience and user groups which informed some of the main collaboration work. JD felt that there needed to be a change in mindset as it was a patient’s right to the health check. JD would use next month’s report to focus on the work that the voluntary sector had done as well as patients.</p> <p>VCJ followed up on community connectors and social prescribing elements of local government and asked how these were communicated with.</p> <p>JD reflected on a third meeting that was held today of an annual health check group. Not just for SMI, focus was also on LD, diabetes etc. Social prescribing would be a focus and JD felt that there was an opportunity there amongst other opportunities discussed within the group.</p> <p>HW thanked JD for the report.</p> | |
| 9 | <p>Estates Quarterly Update <i>For Noting</i></p> | PH/CMcW |
| | <p>PH picked out the key highlights for Committee.</p> <ul style="list-style-type: none"> • Appendix 3 – showed premises capacity, surplus and deficit across Norfolk and Waveney as at June 2022 – state perspective based on GMS services only. • Predictions regarding new demand from housing developments for the next 15 years. | |

- Wave 4b scheme in Kings Lynn.
- Full business case would be presented to private part of Committee for proposed move of St James Medical Practice.
- Wave 4b proposal for Thetford. Further update on Attleborough awaited and would be shared at a later Committee.
- Existing capacity issues at Humbleyard Surgery, schemes in various stages of development in Drayton and Taverham.
- North Norwich scheme as part of Wave 4b.
- East – Lowestoft – Bridge Road surgery use of a section 106 arrangement there and practice had engaged third party developer.
- PCN estates strategies would help demonstrate issues with capacity and demand.

CMcW joined the meeting to provide an update on national policy development and estates strategies.

NHS England commissioned a program of support – this was a national program to help PCNs use the PCN service and estates toolkit to develop clinical and estates strategy and provided summary details.

PH reported that NHS England confirmed that if there was a slippage in the funding to March 2023 it would not be an issue for funding to be carried forward to 2024 and funding sat with NHS England.

HW opened for questions.

VCJ asked about patient involvement in procurement.

PH responded by saying it depended on the scheme and its size and gave an example of a new build facility and a potential relocation needing a consultation. If there was an extension to an existing premises, it would normally be expected that a patient participation group would be involved in that. For the Wave 4b schemes there was active patient engagement and patient representation.

HB had a question around the funding through NHS England to support the development of the clinical strategy and the estates strategy. Was that just to develop the strategy? What happened if every PCN came back and said we have a strategy where does the money come from for that building or work.

PH agreed that this was a good challenge and had been relayed back to NHS England in terms of it was good to have a strategy however if the revenue and capital do not adjust there was questions on how to deliver strategies. There was no planned increase for capital for primary care therefore there is no answer for that.

HB asked how a strategy could be developed if there was no idea of funding to support this.

PH responded by saying that the ICB was not alone with this and feedback had been given to NHS England as NHS England would push for better utilisation of assets.

CMcW felt NHS England may begin to assess what the scale of ask was across primary care.

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| | <p>HW asked if all 17 PCNs were engaged and had their support to engage.</p> <p>PH confirmed that no communications had been done with the PCNs as the program had changed and was likely to change in the future. The program had been set and funded by NHS England and it would be expected that ICBs and PCNs take part. The launch event was planned to take place in September.</p> <p>HW thanked PH and CMcW for the update.</p> | |
| 10 | <p>Digital Quarterly Update <i>For Noting</i></p> | AH |
| | <p>AH joined the meeting.</p> <p>AH provided an update on the cyber incident which was currently being experienced by Advanced Health and Care. Advanced Health and Care products Adastra, CareSys, Odyssey, Carenotes, Crosscare and Staffplan were all affected by a cyber security incident caused by ransomware on their infrastructure. None of the products were in use in this area. Adastra was a prominent system within the 111 and out of hours market and was widely used across the country but not in this area. Carenotes was widely used in mental health systems but again, not in this area.</p> <p>Two products from Advanced were used in Norfolk & Waveney - one of them was Docman. Advanced acquired Docman a couple of years ago and have not assimilated the product onto their main infrastructure, so the two companies were run separately. There was an online consultation system provided by Advanced called PATCHS and no practices run this live however a couple were trailing it and there had been assurances that this was on a completely different infrastructure.</p> <p>The national cyber team were leading the response to this and working closely with Advanced. Organisations affected were suffering significant issues due to the lack of access to the systems. There will be regular updates because there were some systems by Advance used in the area.</p> <p>HW referenced the Shared Care Record and suggested that once it had been operating for a few months, then the committee would like to hear how it was working in practice from both an IT perspective as well a health care professional viewpoint, to understand if benefits were being realised. HW felt that AH could advise on suitable timing. AH confirmed the project was progressing well.</p> <p>HW thanked AH for the update.</p> | |
| 11 | <p>CQC Reports</p> <ul style="list-style-type: none"> • Heacham Practice • Orchard Summary • Manor Farm <p><i>For Noting</i></p> | SN |
| | <p>SN confirmed that 3 formal reports had been published since the last meeting. It should be noted that some of the inspections had been carried out in March 2022.</p> <ul style="list-style-type: none"> • Heacham Practice • Orchard Summary • Manor Farm | |

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| | <p>All 3 practices had been rated inadequate. There were common areas for all practices. Caring had been rated good. There had been issues within the well led domain and responsiveness areas. SN was pleased to note the work that had gone into supporting these services to turn around and there were no immediate concerns to be raised. All practices had an action plan in place and these were being monitored on a regular basis with the CQC, with the localities and ICB colleagues with the practices. Good progress had been made across all practices.</p> <p>SN invited questions:</p> <p>VCJ asked how the learning was shared about the causes of the problems, the resolution of these and the ongoing plan, and how were the communications to the public and wider patients' groups managed, given these issues may have given rise to anxieties for patients of these practices.</p> <p>SN referred to CT to provide some input. CT agreed that the teams had worked closely together, and progress had been made. The challenge of the pandemic and the pressure that primary care was under cannot be underestimated. There had been a move to a mixed programme or blended option of support, not only to provide reactive support when practices had been inspected and the inspection had not gone well, but to try and take a more proactive approach. Regular training was provided monthly on some of the key areas that were identified within the CQC reports.</p> <p>SN agreed that the sessions to support practices to learn from some of the turnaround work seemed to be working well and had been focussed on leadership, organisational culture, long term conditions, staff, and wellbeing. SN felt it was helpful that the CQC were leading on sessions on the leadership of practices. Strengths that sit within the system had been identified in terms of providing the sessions and the quality team were leading on the quality aspect. SN felt positive about the gradual development of the system in terms of learning however recognised more needed to be done.</p> <p>HB had a question and a comment. HB referred to the learning meetings and asked how much attendance there was from practices. HB mentioned the learning to some practice manager colleagues who had not been aware however it had featured in a newsletter that had been circulated. HB asked if it was worth communicating to practices with the heading CQC to draw their attention to the information and the meetings and this in turn could increase attendance.</p> <p>CT responded by saying that there was a session next week, which would be the third session since re-launch and the sessions had tried to be kept to the same day and time in order that it becomes a regular meeting. CT thought that around 30 attended the first session and there were around 40 plus who had indicated their intention to attend the next session. CT confirmed these sessions were cascaded within the GP newsletter and it might be worthwhile asking the LMC to support as part of their newsletter and CT offered to take that forward.</p> <p>HW thanked SN and CT.</p> | |
| 12 | <p>Prescribing Report <i>For Noting</i></p> | MD |

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| | <p>MD provided an update to Committee for noting.</p> <p>MD was happy to receive feedback on any special items for future reporting.</p> <p>MD provided an update on CSU team colleagues who had now merged with the ICB Team as the service was brought in house.</p> <p>In respect of the actions:</p> <p>With reference to EMIS and Optimize RX, part of the PQS was that practices enable Optimize RX which the former CCG had funded for all practices. The database of recommendations mostly consisted of clinical safety and quality algorithms. 13 EMIS practices currently use Optimize RX and only 7 practices do not use Optimize RX, 5 of which are EMIS. Two of those are due to change to Systmone and have indicated they may then enable it. There were no new issues with EMIS and Optimize RX.</p> <p>MD highlighted that papers had been sent to the LMC (MD apologised for lateness) in respect of low-risk cost effective prescribing QIPP scheme and arrangements had been made to meet on a regular basis with LMC to discuss these.</p> <p>MD invited questions</p> <p>VCJ asked how patients were involved in understanding their medication and the interaction as well as what was necessary and what things cost. VCJ felt people were unaware of issues and the fact there might be a letter which outlined two drugs might be unhelpful in the long run. VCJ asked what work was being done with partner organisations and asked if there was a plan to reach all patients that had difficulties and whether there may be a more cost-effective outcome. VCJ felt there was enormous waste as patients reorder all drugs and they do not necessarily understand what the drug does, what was important and what was not.</p> <p>MD confirmed that there was ongoing work in respect of waste however it was difficult without managing every interaction and every order of a patient and felt it would be impossible to address this. There was a service available for some practices called prescription ordering direct (POD), where patients phone in for their medication which allows the checking of supplies. PCN clinical pharmacists and GP practices were part of the solution and they could look at complex patients who have been prescribed different medication and may need more help. There was a structured medication review service in the PCN Directed Enhanced Service where conversations were held with patients about the medication in some detail and where patients were asked to stop medications that were no longer needed or chose not to take any longer. In some cases, patients did not understand why they were on medication and sometimes medication made them feel worse or they did not understand the benefits of continuing with medication. MD confirmed he would be happy to talk to patient groups. Prior to COVID, MD attended PPGs and other various forums to listen to patient issues. Work was being done to roll out POD to practices and there was a national review of repeat medication order systems and audits would be offered to practices once this has been published.</p> <p>HW asked SW to close the two actions and thanked MD for the report.</p> | |
| 13. | Finance Report | JG |

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| | <i>For Noting</i> | |
| | <p>JG highlighted the key points to Committee.</p> <p>Executive Summary This report was produced in arrears due to the timing of the CCG and now ICB month ends and reporting the final M3 accounts for the legacy CCG.</p> <p>The final position at M3 for primary care and prescribing budgets were £2.88m favourable to budget for Q1. This position included an efficiency target of just over £1m built into the budget. This formed part of the full year efficiency requirement of £8.4m. These efficiencies were not phased in a linear fashion and built up over the year.</p> <p>Financial Summary GP prescribing was £1.1m favourable to budget as at M3. With the figures being 2 months in arrears, this was an over-valuation of the April-22 and May-22 estimates. Efficiency savings had materialised in this period which allowed the forecast to be delivered (and in some schemes over delivered). These efficiency expectations were within budget. Of the £1.026m requirement for the quarter, 1 month of actual achievement had been received and this over-delivered. Given the lack of data at M3 this could change further into the financial year. There were also prior year benefits within GP Prescribing.</p> <p>There was a prior year benefit for delegated primary care that had crystallised of £1.8m.</p> <p>Detailed Finance Analysis Key drivers behind the prescribing underspend of £1.1m against budget were shown and described some of the key areas of risk around continuous glucose monitoring and SGLT2. There was a high degree of uncertainty over the financial implications of these factors these had been provided for within M3.</p> <p>System Development Fund This showed as an overspend due to the Transformation costs and ambiguity over the funding. The organisation had committed spend with GPIT staff costs and an historic commitment to transformation spend, both have been provided for creating the overspend.</p> <p>Delegated Co-Commissioning The positive variance due to a prior year crystallisation of benefits due to slippage within QOF from 2021/22.</p> <p>GP and Other Prescribing Detailed variances with Prescribing led to the £1.1m underspend, the differences stem from prior year benefits which flowed into GP Prescribing (some of these benefits have been absorbed by the risks around CGM, SGL2T, NCSO and DOACS) and realised a £0.6m benefit after this absorption. Other benefits came from historic vacancies within the legacy CSU Medicines Management team which have been repaid from the original SLA.</p> <p>HW highlighted the importance of some of the underlying cost pressures, described in the report. It was good to see these are being closely monitored.</p> <p>There being no questions for JG, HW thanked JG for the update.</p> | |

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| 14. | Any Other Business – Questions from the Public | Chair |
| | <p>There were no questions from the public or public members present at Committee.</p> <p>There being no other business HW thanked participants for their attendance and the meeting then closed at 15:00.</p> | |

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| Name: | Signature: | Date: |
| Signed on behalf of NHS Norfolk and Waveney Integrated Care System | | |

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



Norfolk & Waveney IBC Primary Care Commissioning Committee - Part One
 Action Log 13 September 2022

| No | Meeting date added | Agenda Item | Owner | Action Required | Action Undertaken / Progress | Due date | Status | Date Closed |
|------|--------------------|-------------|-------|-------------------------|------------------------------|-----------|--------|-------------|
| 0119 | 09-Aug-22 | 4 | SW | Signed minutes to chair | Signed minutes sent to chair | 13-Sep-22 | | 25-Aug-22 |
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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 | | | Y | | | | | |
| | PCN DES | | | Y | | | | Y | | | | | |
| | CQC Inspections Report | Y | Y | Y | Y | Y | Y | Y | Y | Y | | | |
| | Director of Patients and Communities 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 checks | 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: | | | | | | | | | | | | | |

Notes:
01.08.22 - GP Patient Survey results report to September committee

Y

NHS Norfolk and Waveney ICB – 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 (PCCC) | | | 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 | | | | |
| <ul style="list-style-type: none"> Workforce plans in place at system level. Primary Care Workforce Transformation team expanded to support workforce development working within ICS workforce team. Training hub supported by clinical leadership with two clinical 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). Wide range of initiatives in place to support GP retention Advanced Practice Forum established | | | | | <p>Internal: Reporting to Primary Care Commissioning Committee (PCCC) and the People Board. Training Hub and Workforce Implementation Group meets two-monthly Workforce Strategy (in development for approval by end Q2)</p> <p>External: NHSEI returns monthly as part of the General Practice Transformation implementation and assurance meetings with Health Education England (HEE) and NHSE/I</p> | | | | |
| Gaps in controls or assurances | | | | | | | | | |
| <ul style="list-style-type: none"> Lack of national or regional plans to increase GPs and Nurses in training ICS level working required to support Nurse recruitment and retention throughout their career pathway from Trainee Nurse Associates to senior level roles. General Practice workforce plans need to be refreshed and updated at local level 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. Cost of Living crisis impact on workforce yet to be fully understood. Ability to attract new workforce to Norfolk and Waveney and can be mitigated by system level action Vacancy for Expansion Lead to support Quality Lead roles | | | | | | | | | |
| Updates on actions and progress | | | | | | | | | |
| Date | Action | | | | | RAG | Target completion | | |

| | | | |
|-----------|--|--|-----------------------------|
| May 2022 | <p>New ICS Level Training Hub contract requires submission of 4 documents relating to primary care workforce planning to HEE by end Sept 2022:</p> <ul style="list-style-type: none"> • Workforce Strategy (3 years) • Stakeholder Engagement Strategy and Plan (3 years) • Operational Delivery Plan (1-3 years) • Financial Plan (yearly) <p>To be approved by new Oversight Board by end Sept 2022. 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.</p> | | 30 September 2022 (amended) |
| July 2022 | <p>This risk reflects risks to GPs and Nurse workforce only. Refer to PC17 for Allied Health Professionals and ARRS in general practice. Further details relating to Nurse recruitment and retention will be included next month.</p> | | August 2022 |
| Sept 2022 | <p>To support retention: Wide range of initiatives in place. Continue to increase Schwartz Rounds participation and to develop system wide round with the ICS workforce team. Outline CPD plan for 2022-23 submitted; further engagement sought within Norfolk and Waveney to finalise by September. Education Plan submitted to HEE.</p> <p>To increase placement capacity, continue to increase the number of Learning Organisations and educators through active engagement by Quality Leads. The Deep End Project launched on 29/7/2022: aims to support GP practices within the most deprived communities, reduce health inequalities and support 12 sites to become learning organisations. Evaluation of project to be undertaken.</p> <p>Quality leads to link in with ICB workforce team regarding placement expansion work across the system</p> <p>To develop system level approach to Nurse recruitment and retention.</p> <p>To continue to expand the newly established Advanced Practice forum</p> | | March 2023 |

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

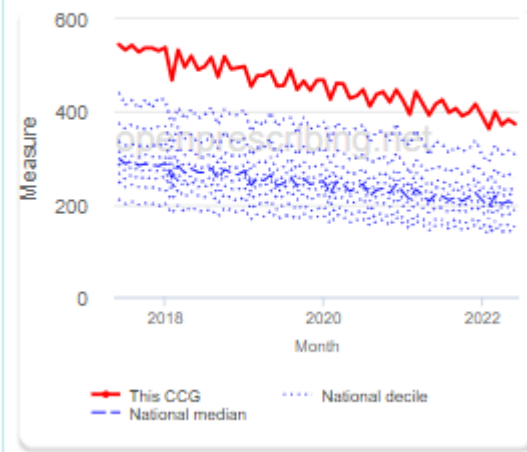
| PC6 | | | | | | | | | |
|---|--|--|------------|------------------|--|----------------------|-------------|----------------------|--|
| Risk Title | | Learning Disability Annual Physical Health Checks | | | | | | | |
| Risk Description | | <p>The ICB is at risk of failing to meet its commitment to 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. 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 ICB will not be able to fully meet its commitment to transform the lives of people with Learning Disabilities.</p> <p>National delivery targets to improve the uptake and quality of annual health checks for people aged 14 and over with a learning disability have been set for commissioners. All GP practices in Norfolk and Waveney have voluntarily signed up to the national Directed Enhanced Service (DES) which does not set a target for achievement, but requires practices to identify all registered patients, aged 14 years and over, with a learning disability, with the aim of reducing their health inequalities. The contract specification requires the practice to 'invite patients on the health check learning disabilities register for an annual health check.' Practices may resign from the DES at any time by giving not less than 1 months' notice.</p> | | | | | | | |
| ICB priority | | | | | | | | | |
| Risk Owner | | Responsible Committee | | Operational Lead | | Date Risk Identified | | Target Delivery Date | |
| Sadie Parker | | Primary Care Commissioning Committee | | Shepherd Ncube | | 01.07.2022 | | 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 | | | | |
| <ul style="list-style-type: none"> 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 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, moving on to South Norfolk in 2022/23. Regular assurance reports to NHSE/I & PCCC | | | | | <p>Internal: Primary Care Commissioning Committee</p> <p>External: NHSE Checkpoint and Assurance Framework, Health Overview and Scrutiny Committee Reports to NHSE/I</p> | | | | |
| Gaps in controls or assurances | | | | | | | | | |
| LDAHs are now being undertaken face to face. | | | | | | | | | |
| Updates on actions and progress | | | | | | | | | |
| Date | Action | | | | | | RAG | Target completion | |
| August 2022 | NHS England has released validated uptake data for April and May 2022. Norfolk and Waveney has reported 4.2% uptake, representing the highest performance in the East of England region and above the regional average of 3.6%. However, it should be noted that several practices have not been included within this data | | | | | | | 31/08/2022 | |

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| | <p>set so it is expected that the register size and completed checks will increase once this information is pulled through to CQRS.</p> <p>Focussed meetings to understand local plans, review uptake and identify practices requiring further input and support continue between the Delegated Commissioning, Quality and Locality teams.</p> | | |
| Sept 2022 | <p>Good progress has been made since the last meeting. NHS England has released validated uptake data to June 2022. Norfolk and Waveney has reported a 13.7% uptake which is amongst the highest performing areas within the East of England. All practices have now been included within the data set.</p> <p>Focussed meetings to understand local plans, review uptake and identify practices requiring further input and support continue between the Delegated Commissioning, Quality and Locality teams.</p> <p>Practices will be asked to provide an update on progress against the Q1/Q2 prioritisation, as well as any challenges and successes.</p> | | 30/09/2022 |

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|---|----|----|----|----|----|----|----|----|----|
| Visual Risk Score Tracker | | | | | | | | | |
| ICB 2022/23 (months July 2022 – March 2023) | | | | | | | | | |
| Month | 07 | 08 | 09 | 10 | 11 | 12 | 01 | 02 | 03 |
| 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. | | | | | | |
| ICB 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 joined the ICB team on 1 st July 2022 and we are seeking to recruit to vacancies. | | | | | | | | |
| Updates on actions and progress | | | | | | | | |
| Date | Action | | | | | RAG | Target completion | |
| Jun 2022 | March 22 data = ADQ/1000 patients = 399.991 98 th 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. Rate per day = 12.903 | | | | | | 30.11.2022 | |
| Jul 2022 | April 22 data = ADQ/1000 patients = 371.297 98 th percentile (30 days in this month vs 31 last month). Rate per day = 12.377 | | | | | | 30.11.2022 | |
| Aug 2022 | May 22 data = ADQ/1000 patients = 383.362 98 th percentile (31 days this month) Rate per day = 12.367 | | | | | | 30.11.2022 | |
| Sep 2022 | June 22 data = ADQ/1000 patients = 373.690 98 th percentile (30 days this month) Rate per day = 12.456, overall trend is downwards and at a rate greater than national average. | | | | | | 30.11.2022 | |

26A: NHS NORFOLK AND WAVENEY CCG



| 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 - 28 th 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 have been in-housed by the ICB 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 25 th (74 th percentile). Recommend change to target date of delivery. | | | | | | | 30.6.22 | | | | |
| Jun 2022 | Outlier practices are being offered support. The CCG is now 28 th 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 28 th position and 74 th percentile. Outlier practices have been offered support and we will be following this up. | | | | | | | 31.7.22 | | | | |
| Aug 2022 | May ePact data shows no change in national ranked position. | | | | | | | 31.8.22 | | | | |
| Sept 2022 | June ePact data shows no change in national ranked position | | | | | | | 31.9.22 | | | | |
| 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 that patients will not be able to access optimal care from primary care teams due to Insufficient capacity of primary care to meet additional workload outside current contracted activity Poor morale and disenfranchisement exacerbating primary care workforce challenges | | | | | | | |
| 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 | 4 | 12 | 2 | 4 | 8 | |
| Controls | | | | | Assurances on controls | | | | |
| <p>Through the Primary, Community and Secondary Care Interface Group, the ICS is developing a three-pronged approach to support the relief of pressure on general practice and to improve working relationships between primary and other providers. This includes;</p> <ul style="list-style-type: none"> Quality and non-contract activity raised by practices via PID inbox; Non-contracted Activity (shift in workload to general practice) Changes to existing pathways/ services and subsequent impact on general practice <p>The Interface Group provides oversight to these approaches while the contractual mechanism is through the System Contracting Development Group led by the ICB Contracting Team.</p> | | | | | <p>Internal:</p> <ul style="list-style-type: none"> Interface policy has been agreed by all providers, supported by LMC The Clinical Interface Group has reviewed all outstanding actions relating to non-contracted activity. These have either been added to the agenda as substantive items for discussion OR are the subject of in-depth review via Task and Finish groups. Backlog of open PID queries fully cleared August 2022 All providers now have a single point of contact for primary care to liaise with directly <p>External: Local Medical Committee (LMC)</p> | | | | |
| Gaps in controls or assurances | | | | | | | | | |
| <ul style="list-style-type: none"> Identified resource on Commissioner and Provider side for continuity and to progress project pieces. Project and coordinating support remains a barrier to investigating issues and implementation of mitigating actions. Standing agenda items to review progress against T&F 1 which is looking into non-contracted activity. On-going piece of work with the LMC to consider the effectiveness of the PID process and to identify new areas for further discussion or T&F groups. Compliance with interface policy not yet audited and action plan for each provider against their analysis against standard contract not yet shared with LMC Governance of Interface Group to be considered when reviewing ToR. Currently reports to CCTG | | | | | | | | | |
| Updates on actions and progress | | | | | | | | | |

| Date | Action | RAG | Target completion | | | | | | | | | |
|----------------------------------|--|-----|-------------------|---|---|---|---|---|---|----|----|----|
| September 2022 | <ul style="list-style-type: none"> Clinical Interface Group continues to meet on a monthly basis. Progress against the Task and Finish Groups continue within the constraints identified. Further clarity on three-pronged approach as recognised by members of the Interface Group, as standing agenda items for updates and discussion. | | 20.09.22 | | | | | | | | | |
| Visual Risk Score Tracker | | | | | | | | | | | | |
| Month | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| Score | | | | | | | | | | | | |
| change | New | → | → | ← | ← | ↑ | | | | | | |
| ICB 2022/23 | | | | | | | | | | | | |

| PC 14 BAF06 (PC13 integrated into this risk from September 2022) | | | | | | | | |
|---|---|---|------------|------------------|---|----------------------|----------------------|-------|
| Risk Title | | The resilience of general practice | | | | | | |
| Risk Description | | There is a risk to the resilience of general practice due to several factors including the ongoing Covid-19 pandemic, workforce pressures and increasing workload. There is also some evidence of increasing poor behaviour from patients towards practice staff. Individual practices could see their ability to deliver care to patients impacted through lack of capacity and the infrastructure to provide safe and responsive services will be compromised. This will have a wider impact as neighbouring practices and other health services take on additional workload which in turn affects their resilience. This may lead to delays in accessing care, increased clinical harm because of delays in accessing services, failure to deliver the recovery of services adversely affected, and poor outcomes for patients due to pressured general practice services. | | | | | | |
| Risk Owner | | Responsible Committee | | Operational Lead | | Date Risk Identified | Target Delivery Date | |
| Mark Burgis | | Primary Care | | Sadie Parker | | 01/09/2020 | 31/03/2023 | |
| Risk Scores | | | | | | | | |
| Unmitigated | | | Mitigated | | | Tolerated | | |
| Likelihood | Consequence | Total | Likelihood | Consequence | Total | Likelihood | Consequence | Total |
| 5 | 4 | 20 | 4 | 4 | 16 | 3 | 4 | 12 |
| Controls | | | | | Assurances on controls | | | |
| <ul style="list-style-type: none"> Locality teams and strategic primary care teams prioritised around supporting the resilience of general practice, dedicated resource to support the Covid vaccination programme. All practices have been supported to review business continuity plans PCN ARRS (additional roles reimbursement scheme) funding has increased again in 2022/23 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 Resilience funding process has been completed earlier this year (Q2) to provide practices with more opportunity to bid and respond | | | | | <p>Internal: Executive Management Team, Senior Management Team, workforce steering group, primary care strategic planning meetings</p> <p>External: Primary Care Commissioning Committee, NHS England via delegation agreement, Health Education England, Norfolk and Waveney Local Medical Committee</p> | | | |
| Gaps in controls or assurances | | | | | | | | |
| <ul style="list-style-type: none"> Practice visit programme, CQC inspections focused on where there is a significant risk or concern Unplanned risk associated with outbreaks or positive cases Impact of ambulance delays diverting practice teams from routine and urgent care to respond to emergencies Continued reports of poor patient behaviour across practices, decrease in patient satisfaction with general practice through GP patient survey, consistent with national position | | | | | | | | |
| Updates on actions and progress | | | | | | | | |
| Date | Action | | | | | RAG | Target completion | |
| 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 | |

| | | | |
|----------|---|--|----------|
| 01.09.22 | <p>This risk (resilience impact due to Covid-19 pandemic) has been combined with risk PC13 (general practice resilience) following agreement at the primary care commissioning committee in July. Resilience funding process has been completed with practices invoicing where funding has been awarded.</p> <p>It is expected there will be national funding for general practice for winter – discussions are taking place to determine how to invest this funding for best impact.</p> <p>There has been an unplanned influx of asylum seekers into our system in August and September, with several local hotels being procured as contingency accommodation. This is having an impact on practices local to the hotels, as well as on wider health and care partners. Work is underway to support both an immediate response and a longer-term system approach to the needs of asylum seekers.</p> <p>There are currently four practices rated as inadequate by the CQC, requiring increased support and development from multiple teams in the ICB, as well as the increased work and focus for the teams in the practices to respond. Training and learning are being shared with all practices on an ongoing basis.</p> | | 30.11.22 |
|----------|---|--|----------|

| 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 | | <p>There is a risk that there could be a loss of £25m capital funding if the Wave 4b Primary Care Hubs are not operational by March 2024. The Programme Business Case was revised and resubmitted June 2022, following NHSE feedback, reducing the programme from 5 schemes to 4.</p> <p>Programme Business Case due for approval September 2022, Full Business Cases approved by Spring 2023.</p> | | | | | | |
| 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 | | | |
| <p>The Wave 4b Primary Care Hub Programme is managed by the Wave 4b Programme Board which includes representatives from the ICB, NHSE, NHSPS, NorLife and the LMC.</p> <p>Below this:</p> <ol style="list-style-type: none"> NHSPS have teams in place to develop the FBCs for 2 of the 4 schemes. NorLife (existing landlord) are developing the FBC for 1 scheme. PHP (existing landlord) are developing the FBC for 1 scheme. <p>All schemes report into the programme board for ICB oversight.</p> | | | | | <p>INTERNAL: Wave 4B Programme Board, Primary Care Estates Team, PCN Teams, PCCC, ICB EMT.</p> <p>EXTERNAL: NHSE/I, LMC, Provider Trusts, Third Party developers (tbd), County, City and District Councils</p> | | | |
| Gaps in controls or assurances | | | | | | | | |
| Programme plan monitored by Programme Board. Feedback awaited from NHSE around approval process which could put the delivery of the programme at risk. | | | | | | | | |
| Updates on actions and progress | | | | | | | | |
| Date | Action | | | | | RAG | Target completion | |
| July 2022 | <p>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.</p> <p>No feedback from NHSE regarding the PBC submission has yet been received. Queries are due to be received by 26th July 2022.</p> | | | | | Blue | 31.7.22 | |
| August/ Sept 2022 | <p>Detailed review queries received from DHSC and NHSE late July and work continued to respond to these until mid-August. NHSE recommendation report was submitted to regional NHSE Business Case Review Meeting 25 August and was approved for submission to the NHSE Regional Strategic Development Committee on 8 September. If approved at that stage, it will then be presented at DHSC Joint Infrastructure Sub Committee on 16 September.</p> | | | | | | Yellow | 16.09.22 |

| Score | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
|--------|---|---|---|---|---|---|---|---|---|----|----|----|
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| PC16 | | | | | | | | |
|---|--|---|----------------------|----------------------|---|------------|--|-------|
| Risk Title | | Severe Mental Illness (SMI) Annual Physical Health Checks | | | | | | |
| Risk Description | | <ol style="list-style-type: none"> 1. The ICB 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. | | | | | | |
| 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 | | | |
| <ul style="list-style-type: none"> 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 | | | | | <p>Internal: Primary Care Commissioning Committee, monthly steering group</p> <p>External: NHSE Checkpoint and Assurance Framework, Health Overview and Scrutiny Committee Reports to NHSE/I.</p> | | | |
| Gaps in controls or assurances | | | | | | | | |
| <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> 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. | | | | | | 31/07/22 Action completed- Action completed- Meetings with locality | |

| | | | |
|-------------|--|--|--|
| | <ul style="list-style-type: none"> Plan to launch the pilot concept in the Norwich locality for clinical team from Q3 is being developed. | | PMs scheduled. |
| July 2022 | <ul style="list-style-type: none"> 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 | | 31/07/2022 Action completed, HOSC report delivered, west locality meeting done, x2 more scheduled in North and GY&W |
| August 2022 | <ul style="list-style-type: none"> Q1 (2022-23) performance data for SMI health checks has been released. Combined position is 38.2% which is a marginal change from Q4's position. Offer of support in the form of PM's meetings has been put out to practices, GY&W as well as West have accepted. Proof of concept with Swaffham & Downham PCN using AARS funds has been agreed (launch Oct 2022). SMI workshops led by Mental Health Team to commence 16/09 to provide increased collaborative work across ICB. | | 21/10/2022 |

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

**NHS Norfolk and Waveney ICB – Primary Care Commissioning
Committee Assurance Framework**

| PC17 | | | | | | | | | |
|---|-------------|--|------------|------------------|--|----------------------|-------------|----------------------|--|
| Risk Title | | General Practice – Allied Health Professionals Workforce including PCN Additional Roles | | | | | | | |
| 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 | | | | |
| <ul style="list-style-type: none"> 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). New ICS Social Prescribing Lead recruited | | | | | <p>Internal: Reporting to Primary Care Commissioning Committee (PCC). Training Hub and Workforce Implementation Group meets two-monthly</p> <p>External: NHSEI returns monthly as part of the General Practice Transformation implementation and quarterly assurance meetings with Health Education England (HEE) and NHSE</p> | | | | |
| Gaps in controls or assurances | | | | | | | | | |
| <ul style="list-style-type: none"> 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 national and regional review. Understanding general practice resilience as work challenges increase may lead to higher numbers of the workforce leaving/retiring during 2022 and 2023 Ability to attract new workforce to Norfolk and Waveney and may be mitigated by system level action Some geographical areas facing greater challenges in recruitment, e.g. West and East Challenges of recruitment, retention and integration can only be addressed if PCNs and commissioning bodies can understand the huge values the additional roles can bring. | | | | | | | | | |
| Updates on actions and progress | | | | | | | | | |
| Date | Action | | | | | | RAG | Target completion | |

| | | | |
|-----------|--|--|---------------|
| July 2022 | <p>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:</p> <ul style="list-style-type: none"> • Workforce Strategy (3 years) • Stakeholder Engagement Strategy and Plan (3 years) • Operational Delivery Plan (1-3 years) • Financial Plan (yearly) <p>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.</p> <p>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.</p> | | 30 Sept 2022 |
| Sept 2022 | <p>The new Ambassadors to build upon early work in acting as a point of contact to support new staff working in primary care, creating peer support groups for questions, dissemination of key information and understanding training and development needs. Physicians Associate careers fair planned August.</p> <p>Clinical Pharmacy Ambassadors developing an online forum for pharmacy professionals within primary care to highlight development opportunities as well creating a space for networking and peer support. A support pack has been developed for pharmacy professionals new to primary care to communicate key information which will be useful to them in their new roles. Work has also been done around providing guidance on clinical supervision for pharmacy professionals recruited through ARRS.</p> <p>The Newly Qualified Pharmacist (NQPh) pathway is established in community pharmacy and the NHS managed sector. N&W hoping to pilot a developmental role [band 6 to band 7 AFC] model to introduce a NQPh - GP pathway to attract a pipeline of newly qualified ARRS pharmacists into general practice to compliment or reduce recruitment from other pharmacy sectors.</p> <p>Discussions ongoing with HEI about nursing placements. The aim is to map placements and to share information on the quality of the learning environments. Slow engagement from HEIs. restructures.</p> | | November 2022 |

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

Agenda item: 7

| | |
|----------------------|--|
| Subject: | Procedure for requests to close GP branch surgeries |
| Presented by: | Michaela Trett, Primary Care Estates Manager and Shepherd Ncube, Associate Director Delegated Commissioning |
| Prepared by: | Michaela Trett, Primary Care Estates Manager |
| Submitted to: | Norfolk and Waveney ICB Primary Care Commissioning Committee [Part 1] |
| Date: | 13th September 2022 |

Purpose of paper:

To request that PCCC:

1. Approve a new Advice Note which aims to provide guidance for practices who want to apply to close a branch surgery.

Executive Summary:

1. Working with the Primary Care Team, Primary Care Estates has developed a new local process for GP practices wishing to close a branch surgery.
2. The attached Advice Note, which has been reviewed by the LMC has been drafted to support practices wanting to make a branch closure application.
3. The ICB has delegated authority in determining the applications.
4. Branch closures, whilst having a clear estates link, is a contractual function and should be overseen by the ICB Primary Care Team, supported by the Primary Care Estates Team in managing requests and the process.
5. Branch closure applications must be considered in accordance with the NHS England Primary Medical Care Policy and Guidance (PGM).
6. The attached Advice Note sets out the various stages of the application process.

Recommendation to PCCC:

PCCC are asked to:

1. Approve the attached Advice Note 3: Procedure for requests to close branch surgeries.

| Key Risks | |
|---|---|
| Clinical and Quality: | No risks are known, but the ICB would work closely with practices to identify anything arising on proposed branch closures. |
| Finance and Performance: | None known. |
| Impact Assessment (environmental and equalities): | No risks are known, but the ICB would work closely with practices to identify anything arising on proposed branch closures. |
| Reputation: | The ICB Communications and Engagement Team are aware of the proposed new procedure and will be kept informed of any new proposed branch closures. |
| Legal: | None known. |
| Information Governance: | None known. |
| Resource Required: | ICB officer time to support the practice and process. |
| Reference document(s): | N/A |
| NHS Constitution: | N/A |
| Conflicts of Interest: | None known. |
| Reference to relevant risk on the Governing Body Assurance Framework | N/A |

GOVERNANCE

| | |
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| Process/Committee approval with date(s) (as appropriate) | N/A |
|---|-----|

Item 7

| | |
|--|--|
| Norfolk & Waveney Primary Care Estates Team Advice Note 3: Procedure for requests to close branch surgeries | This advice note aims to provide guidance for practices who want to apply to close a branch surgery The Primary Care Estates Team are happy to discuss queries directly and can be contacted via nwpcb.pcestates@nhs.net |
|--|--|

Norfolk and Waveney Integrated Care Board (ICB) will work with practices to support them through the process for making applications for branch closures. The ICB has delegated authority in determining the applications.

All applications must be considered in accordance with NHS Regulations and NHS England policy.

Branch closure applications must be considered in accordance with the [NHS England Primary Medical Care Policy and Guidance \(PGM\)](#). Sections 8.15.10-8.15.29 apply, but reference to the live document must be made. For this reason, sections of the guidance are not replicated here. Adhering to the process ensures that any changes reflect and comply with national regulations and legislation to maintain robust contracts.

Please see the PGM for details of the process when closure is initiated by the commissioner – in these situations, the ICB will support the practice through the process.

The ICB will work with the contractor throughout the process offering support and guidance where appropriate and necessary.

The closure of a branch surgery is a contractual matter and the ICB Delegated Commissioning Team will lead the process, supported by the Primary Care Estates Team.

Stage 1 – Preliminary discussions

The contractor should have a preliminary discussion with the Delegated Commissioning Team and or Estates Team to include consideration of the areas outlined in the PGM Guidance (Section 8.15.12 & 8.15.13) and any other relevant issues. The ICB will make a record of the discussion. Practices are also encouraged to seek guidance from LMC, and either the contractor or the Commissioner may invite them to be party to discussions at any time.

Stage 2 – Initial Request

After the preliminary discussions, the contractor makes an initial request in writing to the ICB.

This letter should set out:

- The rationale for the closure request
- A short options appraisal demonstrating the options that the contractor has considered and who has been involved in the options appraisal – see template attached
- Patient feedback already received, for example, the Patient Participation Group.

The Primary Care Commissioning Committee (PCCC) will receive a paper from the Primary Care Team at this stage to indicate there will be an application to close asking them to note the request. The LMC will be informed of the application and receive a copy of the paper in advance of submission to PCCC.

Stage 3 – Involvement of patients and key stakeholders

The contractor is required to follow [The Patient and Public Participation Policy](#), The [Statement of](#)

[Arrangements & Guidance on Patient and Public Participation in Commissioning](#) (especially sections 3.2, 3.3 & 3.4, Appendix 3), and [The Framework for Patient and Public Participation in Primary Care Commissioning](#) (Section 4.3, 4.4, 5 & 6.2) . In addition the ICB has legal duties as set out in Section 14Z (2) NHS Act 2006 which must be adhered to.

The ICB Communications and Engagement Team will provide support and advice to the contractor as appropriate and if requested.

The preferred approach to patient engagement will be discussed and agreed between the contractor and the ICB; in some circumstances it may be appropriate for the ICB to offer support. The contractor remains responsible for informing the registered patients and key stakeholders of the proposed changes. It is the ICB's responsibility to ensure that involvement activities have met legal requirements.

The ICB, if requested, will help the practice develop an engagement and communications plan, including identifying key stakeholders and key dates within the consultation/engagement period. The standard period for public engagement is four to six weeks, but there may be circumstances where this period should be extended.

The following describes who must be engaged with and the lead for each group:

| | |
|---|---|
| a. Patients of both the main and branch surgery | Contractor |
| b. Neighbouring practices (both in terms of geography and overlapping catchment areas and those within the PCN) | Contractor |
| c. Neighbouring ICBs (where affected) | ICB – Delegated Commissioning Team |
| d. Patient Participation Group | Contractor |
| e. Local Medical Committee (LMC) | ICB – Delegated Commissioning Team (if not already contacted by contractor) |
| f. Healthwatch | ICB – Delegated Commissioning Team |
| g. Local Pharmaceutical Committee (LPC) | ICB – Delegated Commissioning Team |
| h. Local Community Groups e.g. Parish Councils | Contractor |
| i. Any identified groups within the community that may be particularly affected by the proposals | Contractor |
| j. Other NHS providers who use the branch site or who may be affected by services transferring out of the site. | Contractor |
| k. Health Overview and Scrutiny Committee | ICB – Delegated Commissioning Team |
| l. Local MPs and local Councillors | ICB – Delegated Commissioning Team |
| m. Internal ICB Teams e.g. Digital Team | ICB – Delegated Commissioning Team |

The practice must be able to demonstrate that everyone affected has had sight of information on the consultation. The methods of communication and approach taken should be proportionate to the change in delivery of medical services to patients and may include:

- a. Letters to each household
- b. Texts/email
- c. Practice led drop in sessions
- d. Practice led consultation/engagement meetings which vary in times to ensure access for all groups
- e. Information included on prescriptions
- f. Website – including ICB website if appropriate
- g. Posters
- h. 'Seldom heard' patients – including information in alternative formats or identifying groups and ensuring efforts are made to engage in ways which are appropriate for that group
- i. Attendance at local Community Forum(s).

Results of the consultation should be provided to the ICB.

It may be helpful for some groups (e.g. LMC, HOSC) to review the outcomes of the patient and practice engagement consultation. The engagement with these groups should be timed to take place after the patient consultation process has been completed.

The ICB is committed to fulfil its obligations under the Equality Act 2010, and to ensure services commissioned by the ICB are non-discriminatory on the grounds of any protected characteristics. The practice will be required to take health inequalities into consideration such as transport, rurality, site accessibility, whether any reasonable adjustments need to be made, vulnerable patients, health inclusion, etc and carry out an Equality Impact Assessment, which includes consideration of health inequalities. The ICB will be able to offer guidance on the completion of the Equality Impact Assessment. It may be helpful to consider drafting the Equality Impact Assessment at the outset and then adding to/revising it throughout the engagement.

The ICB will offer advice and guidance to the contractor in respect of any media interest.

The contractor will meet all reasonable costs associated with the consultation and application, for example, postage costs.

If the site is a dispensing site then consideration should be given to the [Pharmaceutical Regulations](#), & guidance notes [Chapter 15](#) (see PGM 8.15.26 & 8.15.27) depending if dispensing rights need to be relocated or if the main site is already a dispensing site (see [PCSE guide](#)).

Stage 4 – Formal Application

Once the consultation period comes to an end the contractor may submit a formal application to close the branch surgery.

The application form at appendix Annex 14A of the NHS England Primary Medical Care Policy and Guidance (Template Application Notice to Close Branch Premises) must be used and can be requested from the ICB nwicb.pcestates@nhs.net or [found online](#).

As much detail as possible should be included and it must include an analysis of the consultation feedback, the Equality Impact Assessment along with copies of the information sent or used to communicate the proposed closure to all key stakeholders.

Stage 5 – Assessment of the application by the ICB

The Delegated Commissioning Team will assess the application (including considering the relevant factors listed in 8.15.13 of the PGM) and will make a recommendation via a report to the Primary Care Commissioning Committee (PCCC) whether to approve or reject the branch closure request. The report will be shared with the LMC prior to submission to PCCC.

PCCC may request any additional information and a practice representative from the practice may be requested to attend.

Stage 6 – Primary Care Commissioning Committee (PCCC)

The application will be presented to the next available meeting of PCCC and will include a recommendation from the Delegated Commissioning Team.

The Delegated Commissioning Team, supported by the Estates Team, will draft all papers to Committee providing sufficient information for a decision to be made. The commissioner should document how it has taken the various factors into account.

If PCCC approves the branch closure then the ICB Delegated Commissioning Team will agree a final date for closure with the contractor.

If PCCC refuses the application the contractor will be notified within 28 days. The contractor has the right to appeal and should refer to the NHS Dispute Resolution Process.

Stage 7 – Notification

The contractor will be responsible for notifying all registered patients of the closure to include details of how to re-register elsewhere if a patient did not wish to access care at the practice's alternative premises. This can be done in several ways, which should be proportionate depending on the size of practice, the number of patients affected and the likelihood of patients wishing to register elsewhere. It could be via a letter to each household, text message, email message, posters, ringing households etc. The contractor will be responsible for all costs incurred.

The contractor should provide patients with a telephone number (and other suitable alternative means) to contact the practice with queries. The contractor must also make sure they notify external organisations such as CQC, Primary Care Support England. They must amend their website, NHS Choices and practice leaflet and cancel any contracts such as telephony, waste collections, blood collection services, PCSE and Trust deliveries. The ICB will ensure relevant internal teams (e.g. digital) are aware of the closure.

The contractor will consider how best to engage with vulnerable patients, those with complex needs and other patients who may require more support in understanding the change in service provision.

Stage 8 - Varying the GMS Contract

The ICB Primary Care Team will issue a variation to the GMS/PMS/APMS contract to remove the registered address of the branch surgery, effective from the agreed date.

Where the contractor has previously been granted with premises consent to dispense, and these rights are only associated to the closing premises in question (that is also listed on NHS England dispensing contractor list), the contractor's consent to dispense will cease, unless an application to relocate dispensing rights has been made.

Stage 9 – Additional steps

The contractor remains responsible for ensuring the transfer of patient records (electronic and paper Lloyd George notes) and confidential information to the main surgery, having full regard to confidentiality and data protection requirements, Records Management: NHS Code of Practice guidance and any relevant guidance from the Health & Social Care Information Centre or the Information Commissioner's Office. Where a third-party contractor is being used to handle records,

they must be vetted and appropriate contractual arrangements put in place.

The ICB will retrieve all NHS owned assets from the premises and will de-commission the branch link. The contractor will make arrangements with the landlord to admit the ICB within a reasonable amount of time after the provision of medical services ceases.

Rent reimbursement payments in respect of branch surgery will cease on the agreed closure date.

DRAFT

| OPTIONS APPRAISAL | Option 1 | Option 2 | Option 3 | Option 4 |
|---|------------|---|--|---|
| | Do nothing | Maintain current premises but re-configure services This could include consideration of the site being used by another practice, the PCN or another provider | Consolidate to 1 site (existing main site) | Consolidate to alternative site (existing branch) |
| ENVIRONMENT Sufficient space | | | | |
| ENVIRONMENT Patient safety services Accessibility Digital considerations CQC and legislation requirements Backlog maintenance | | | | |
| Workforce | | | | |
| Financial considerations | | | | |
| Lease position | | | | |
| Overall rating | | | | |

Agenda item: 8

| | |
|----------------------|--|
| 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 Commissioning Committee |
| Date: | September 2022 |

Purpose of paper:

To update the Committee on progress made to improve the uptake of learning disability annual health checks (AHC) across Norfolk and Waveney for 2022/23. The report is based on data taken from the national Central Quality Reporting System (CQRS) data.

1. Background

- National delivery targets to improve the uptake and quality of annual health checks for people aged 14 and over with a learning disability have been set for commissioners. All GP practices in Norfolk and Waveney have voluntarily signed up to the national Directed Enhanced Service (DES) which does not set a target for achievement, but requires practices to identify all registered patients, aged 14 years and over, with a learning disability, with the aim of reducing their health inequalities. The contract specification requires the practice to 'invite patients on the health check learning disabilities register for an annual health check.' Practices may resign from the DES at any time by giving not less than 1 months' notice.
- NHS England has shared uptake data from the Central Quality Reporting System (CQRS) showing delivery of learning disability health checks from April-June 2022.

2. Learning disability AHC activity to-date

| Learning disability health check uptake April-June 2022 | | | | | Comparative 21/22 | |
|---|--------------|-------------|-----------|--------------|-------------------|-------------|
| Region | Register | Completed | Declined | % | Completed | % |
| Beds, Luton, M Keynes | 4603 | 490 | 8 | 10.6% | 286 | 6.2% |
| Cambs & Peterboro | 4311 | 469 | 12 | 10.9% | 332 | 8.0% |
| Herts & West Essex | 7224 | 840 | 12 | 11.6% | 592 | 8.5% |
| Mid & South Essex | 5361 | 523 | 9 | 9.8% | 459 | 8.8% |
| Norfolk & Waveney | 6889 | 941 | 24 | 13.7% | 516 | 7.5% |
| Suffolk & NE Essex | 5429 | 781 | 18 | 14.4% | 510 | 9.4% |
| East of England | 33817 | 4044 | 83 | 9.9% | 2695 | 8.1% |

- Norfolk and Waveney has reported 13.7% uptake via the national CQRS portal. This is 3.8% higher than the East of England average performance and represents the highest number of health checks completed at present. This is a significant improvement year-on-year against uptake end of Q1 2021/22.
- Please refer to appendix 1 for a rolling total of health checks over the past year.

| Learning disability health check uptake April-June 2022 | | | | | Trajectory Q1 (10%) |
|---|-------------|------------|-----------|--------------|---------------------|
| Locality | Register | Completed | Declined | % | Variance |
| GYW | 1800 | 307 | 11 | 17.1% | + 7.1% |
| North Norfolk | 1229 | 111 | 5 | 9.0% | -1.0% |
| Norwich | 1492 | 168 | 3 | 11.3% | +1.3% |
| South Norfolk | 1375 | 166 | 1 | 12.1% | +2.1% |
| West Norfolk | 992 | 189 | 4 | 19.1% | +9.1% |
| Norfolk & Waveney | 6888 | 941 | 24 | 13.7% | +3.7% |

3. Next steps

- The Delegated Commissioning and Quality team continues to conduct a series of focussed meetings with Locality teams to review the previous year's performance, discuss local plans and identify any practices requiring specific support or input.
- A follow-up communication will be sent to all practices in early September to request an update on Q1/Q2 prioritisation and details of challenges and successes.
- Validated data will continue to be shared with PCNs and practices to enable situational analysis at a local level.

4. 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: | Annual health checks are a proactive and evidence-based way of supporting people with a learning disability with new and existing health care requirements. |
| Finance and Performance: | Annual health checks for people with a learning disability are to be undertaken as per the specification within the national Directed Enhanced Service (DES) for GPs, the Quality Outcome Framework (QOF) and the Investment and Impact Fund (IIF). |
| Impact Assessment (environmental and equalities): | N/A |
| Reputation: | Health inequalities |
| Legal: | N/A |
| Information Governance: | N/A |
| Resource Required: | Business Intelligence team Children's and Young Peoples' team Delegated Commissioning team Locality teams Quality in Care team |
| Reference document(s): | The NHS Long Term Plan |
| NHS Constitution: | <ol style="list-style-type: none"> 1. The NHS provides a comprehensive service, available to all 3. The NHS aspires to the highest standards of excellence and professionalism 4. The patient will be at the heart of everything the NHS does 5. The NHS works across organisational boundaries 7. The NHS is accountable to the public, communities and patients that it serves |
| Conflicts of Interest: | N/A |
| Reference to relevant risk on the Board Assurance Framework | PC6 |

Governance

| | |
|---|--|
| Process/Board approval with date(s) (as appropriate) | |
|---|--|

Appendix 1

Cumulative total of annual health checks year-on-year

| CUMULATIVE | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Apr-22* | May-22 | Jun-22 |
|------------------------------|------------|------------|------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|----------|-------------|-------------|
| GY&W | 78 | 158 | 235 | 335 | 443 | 559 | 683 | 789 | 914 | 1103 | 0 | 1304 | 1611 |
| NN | 41 | 70 | 102 | 190 | 271 | 363 | 432 | 499 | 599 | 851 | 0 | 916 | 1027 |
| NOR | 95 | 183 | 264 | 379 | 457 | 528 | 612 | 701 | 804 | 946 | 0 | 1030 | 1198 |
| SN | 25 | 63 | 99 | 128 | 214 | 294 | 345 | 442 | 617 | 819 | 0 | 915 | 1081 |
| WN | 12 | 40 | 73 | 105 | 161 | 219 | 281 | 342 | 475 | 643 | 0 | 776 | 965 |
| NORFOLK & WAVENEY | 251 | 514 | 773 | 1137 | 1546 | 1963 | 2353 | 2773 | 3409 | 4362 | 0 | 4941 | 5882 |

*Data not available and incorporated into May's figures.

Agenda item: 9

| | |
|----------------------|--|
| Subject: | SMI Health Checks- Monthly Update |
| Presented by: | Shepherd Ncube, Head of Delegated Commissioning, Primary Care |
| Prepared by: | Julian Dias, Deputy Senior Delegated Commissioning Paper |
| Submitted to: | ICB Board |
| Date: | September 2022 |

Purpose of paper:

To update the Board on plans and progress to-date to around patients with Severe Mental Illness (SMI) for September 2022.

1. Background

The Delegated Commissioning and Mental health teams have been working with localities to ensure that patients have increased access to SMI health checks. The SMI working group have offered support sessions to practice managers to cover any issues or challenges, but also what support tools are available.

2. Activity to-date

The Q1 performance position for SMI health checks in 2022-23 has been released. In summary for all x6 core SMI checks:

1. N&W carried out 3,341 from a possible 9,381 = 35.6%
2. NSFT carried out 247 from a possible 3,345 = 7.4%
3. Combined 3,588 from a possible 9,381 = 38.2%

These performance figures show a marginal decrease when compared to Q4 of last year (38.9%) but still shows the system outperform last year's Q1 position which is encouraging, but still with a lot of work left to do.

To address this, work has commenced with Swaffham and Downham PCN to make use of their AARs budget to introduce new clinical capacity from October 2022; as well as within Norwich. It is hoped that this will lead to an increase in the number of checks carried out within these PCNS and soon the locality as a whole.

4. Improvement plans in pipeline:

- Monthly planning and set up meetings with PCN development team in Swaffham & Downham to provide additional capacity and administration for SMI health checks commencing 12/09/2022
- SMI collaborative workshops led by Mental health team (comprising representation from locality and NSFT) to see how best to increase SMI checks uptake commencing from 16th September to 21st October 2022.
- We will also be focusing on our SMI information resource website that could be used for training, accuracy of coding, and any other FAQs that arise.

5. 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: | Improving the care and treatment of people with a serious mental illness is one of the top clinical priorities in the NHS Long term plan. The clinical risk is that if the annual health checks are not completed, the risk of premature death for this population group remains high. |
| Finance and Performance: | long term clinical additional resources will be required to be able to make significant and sustainable improvements with the uptake and quality of checks. |
| Impact Assessment (environmental and equalities): | N/A |
| Reputation: | ICB is at risk of failing to meet its commissioning responsibility in line with NHS Constitution and the national drive to address health inequalities within systems. |
| Legal: | N/A |
| Information Governance: | N/A |
| Resource Required: | Business Intelligence team Delegated Commissioning team Locality teams Quality in Care team NSFT Mental Health Commissioning team |
| Reference document(s): | The NHS Long Term Plan |
| NHS Constitution: | 1. The NHS provides a comprehensive service, available to all 3. The NHS aspires to the highest standards of excellence and professionalism |

| | |
|--|---|
| | <ul style="list-style-type: none"> 4. The patient will be at the heart of everything the NHS does 5. The NHS works across organisational boundaries 7. The NHS is accountable to the public, communities and patients that it serves |
| Conflicts of Interest: | N/A |
| Reference to relevant risk on the Board Assurance Framework | PC16 |

Governance

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

Agenda item: 10

| | |
|----------------------|---|
| Subject: | GP Resilience Funding Allocations for 2022/23 |
| Presented by: | Shepherd Ncube, Head of Delegated Commissioning, Primary Care |
| Prepared by: | Sarah Collingwood, Delegated Commissioning Manager |
| Submitted to: | ICB Primary Care Commissioning Committee |
| Date: | September 2022 |

Purpose of paper:

To update the Committee on the GP Resilience Funding process and funding allocations for 22/23

Executive summary:

For the last few years, CCGs have received funding to support practice resilience as part of the General Practice Forward View memorandum of understanding with NHS England & Improvement (NHSE/I). The funding amount for 2022/23 was £143K, to be allocated by year-end.

This year, GP practices were invited to submit bids for funding amounts in a similar way to the previous year, however the process was moved from Q4 to Q1/2 in order to avoid winter pressures.

A Funding Panel convened to review applications in July 2022 as per the agreed Terms of Reference; out of £143K funding, £141,944 has been allocated to 14 practices. A discussion with the LMC around investment of the surplus will be scheduled in due course.

The Committee is asked to note the update on GP resilience funding allocations for 2022/23.

1. Background information

For the last few years, CCGs have received funding to support practice resilience as part of the General Practice Forward View memorandum of understanding (M.O.U) with NHSE&I. In line with the M.O.U, funding has been allocated to different practices on a yearly basis to support the operational and functional needs of GP practices based on a bidding process. In 2022/23 the funding allocation made available was £143K, to be allocated by year-end.

2. Objective

This paper seeks to provide an update to the Committee on the GP Resilience Funding process and funding allocations for 2022/23.

3. Resilience funding process

Following feedback received from Panel members and GP practices in 2021/22 a number of changes were implemented to streamline the bidding process and allocation of funds in 2022/23:

- To avoid the busy winter period and potential clashes with other funding streams such as the Winter Access Fund, the application process began in Q1 and concluded early in Q2
- Practices requested more time to prepare their bids; as such, the application period was extended from four to six weeks.
- The application form was reviewed and shortened and included example answers and prompts to assist practices in its completion.
- More detailed guidance was provided to practices, setting out what could (and could not) be applied for.
- Additional online Q&A sessions were scheduled – these were well-attended again and proved useful platforms for additional questions and queries.
- In order to maximise Panel members' time, an initial, structured review of applications took place ahead of the Panel meeting to ensure additional queries and alternative potential funding sources could be clarified before the meeting took place.
- As recommended by TIAA, in addition to the national matrix scoring, further weighting was made available for practices fulfilling certain criteria (practices at risk register, low CQC rating, closed list) and to allow for local intelligence. This meant that final funding decisions were based on scores.

4. Resilience funding overview and outcomes

Practices were invited to submit applications for resilience funding between May and June 2022.

A total of 23 applications were received and a Funding Panel comprising representation from the ICB's Primary Care, Medicines Optimisation, Quality in Care and Finance teams, along with colleagues from NHS England and the LMC, convened to review applications as per the agreed Terms of Reference.

Before the review began, any conflicts of interest were declared and formal minutes were taken as a record of discussions.

Final funding decisions were communicated to relevant parties within 48-hours of the Panel's final decision.

Out of a total £143K funding, the Panel agreed to allocate £141,944 to 14 practices. Whilst successful bids were varied in their approach and requests, the majority fell into the following themes - support for significant turnaround work further to CQC inspection, training (clinical and non-clinical) and proactive initiatives looking at tackling issues before they impact upon practice resilience, such as staff wellbeing and organisational change.

Unsuccessful bids were signposted to alternative sources of support and assistance.

A discussion with the LMC around investment of the surplus will be scheduled in due course.

5. Recommendation

The Committee is asked to note the update on GP resilience funding allocations for 2022/23.

| Key Risks | |
|---|--|
| Clinical and Quality: | Failure to allocate resilience funding may result in poor clinical outcomes for patients |
| Finance and Performance: | Funding needs to be spent this financial year |
| Impact Assessment (environmental and equalities): | Improvements to GP operational resilience. |
| Reputation: | A poor CQC rating may affect the CCG and practice's reputation |
| Legal: | Practices unable to meet the needs of their population and contractual requirements |
| Information Governance: | N/A |
| Resource Required: | |
| Reference document(s): | TIAA audit report, national guidance |
| NHS Constitution: | Commitment to quality of care |
| Conflicts of Interest: | CCG Locality teams |
| Reference to relevant risk on the Governing Body Assurance Framework | N/A |

GOVERNANCE

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|--|--|
| Process/ Committee approval with date(s) (as appropriate) | A report on funding allocation and spend to the committee. |
|--|--|

Agenda item: 11

| | |
|----------------------|---|
| Subject: | PCN Transformation overview and update and progress on the ARRS roles. |
| Presented by: | Kate Lewis and Fiona Theadom |
| Prepared by: | Kate Lewis and Fiona Theadom |
| Submitted to: | Primary Care Commissioning Committee |
| Date: | 23/08/2022 |

Purpose of paper:

- The purpose of this paper is to provide an overview of the current status of the PCN DES and its component parts;
- To make a recommendation on plans to support PCN Transformation and associated funding and governance;
- To provide an update on the current status of the ARRS roles and clarification on reporting progress going forward.

Executive Summary:

The PCN DES has been in existence since 2019, although progress was delayed due to the pandemic, focus has been realigned to support reducing inequalities. Key components of the DES are also vital to supporting delivery of the Long Term Plan and recommendations laid out by the Fuller Report (May 2022). This paper recaps on the key components of the PCN DES with a specific highlight on PCN Transformation and ARRS roles.

1.0 Background

Across Norfolk and Waveney our 17 PCNs build on years of collaborative working between GP practices and community partners to improve care delivery for patients. We understand that in order to deliver more sustainable and personalised care, General Practice, through PCNs, will be the driver for developing integrated care delivery.

PCNs formed in 2019/20, during what is recognised as the Foundation Year, where PCNs were predominantly focused on organisation set-up. The years following, PCNs were required to develop their maturity as well as delivering against the DES service specifications. Some of the timescales for delivery and assurance shifted as a result of the pandemic, but as part of the Phase 3 recovery plan NHS England have looked to PCNs in response to some of the new emerging intel on widening inequalities.

2.0 The PCN DES Structure – An Overview

The PCN DES has multiple components to it:

A. Service Specification Delivery including:

- Enhanced Health in Care Homes
- Early Cancer Diagnosis
- Structured medication reviews and medicines optimisation

As part of re-phasing plans post recovery:

- Implementation of digitally enabled personalised care and support planning for care home residents by 31 March 2024.
- An extension to December 2022 for implementation of the **anticipatory care specification**.
- New Early Cancer Diagnosis service requirements.
- Enhanced Access from October 2022.

The Network Contract Directed Enhanced Service (DES) will be updated annually until at least 2023/24.

B. PCNs are also entitled to earn additional funding through – the [Investment and Impact Fund \(IIF\)](#).

For 2022/23, three new indicators focused on Direct Oral Anticoagulants (DOAC) prescribing and FIT testing for cancer referrals will be introduced.

C. What was previously referred to as [PCN Development](#) – funding centrally devolved to STPs to support the developing maturity and organisation of PCNs with the aim of greater collaboration from partner organisations. The last year of funding for this component was 2020/21 however, this paper goes on to propose plans for local PCN Transformation in its place.

D. [Additional Role Reimbursement Scheme \(ARRS\)](#) – Through the DES funding bigger teams of health professionals that will work across PCNs, as part of community teams, providing tailored care for patients and will allow GPs to focus more on patients with complex needs.

3.0 Governance

The DES contractual requirements are governed by the Primary Care Commissioning Committee (PCCC) and led by the Delegated Commissioning Team, this includes **A) Service Specification Delivery** and providing support for the **B) IIF**.

The **C) PCN Development programme** was previously run via the STP Primary and Community Care Programme Board but governed via PCCC. The CCG's PCCC agreed a rolling agenda item for PCN updates each month.

Assurance on the successful delivery and implementation of the **D) ARRS roles** was previously managed through the Training and Workforce Improvement Group but governed via PCCC and usually reported under a workforce update.

4.0 Updates

4.1 Service Specification Delivery and IIF

As the CCG has transitioned to ICB the roles and remit of the various committees and boards have naturally evolved. The Primary and Community Care Delivery Group (which is the interim forum for strategic primary and community care in lieu of a Programme Board) has temporarily held oversight of the development of PCNs. This includes identifying the support mechanisms and opportunities at a system level relating to the new service specifications. The Delivery Group has received updates from the Cancer and Medicines Management Team outlining their offer to support PCNs with the new requirements.

The Delivery Group has also received an update from the Business Intelligence Team on data analysis of IIF and system, locality and PCN level. Data packs have also been shared with PCNs directly.

4.2 PCN Development – referred to from this point as PCN Transformation

As previously noted, PCN development funding ceased in 2020/21. However, in order to support the continuing development and maturity of PCNs, the ICB has ring fenced funding, £400,000 for 2022/23.

Building on previous year's PCN Development planning process, we would like to invite PCNs to bid against the funding pot with ideas to support developing quality and leadership within their network. Appendix I details the proposal.

It is intended that the management of the programme continues via the Primary and Community Care Delivery Group and governance via PCCC.

4.3 ARRS Update

Following the ICB's successful bid for the Primary Care Training Hub Contract, the Primary Care Training Hub team has moved to align under the wider ICS workforce team allowing for closer working and integration. Under this team a new governance structure is being proposed to ensure continued oversight of the ARRS programme, managed through the new Primary Care Workforce Steering Group, formerly the TWIG and governed through PCCC.

The uptake of ARRS roles has increased in the last 12 months from 156.88 in April 2021 to 391 today. The table below shows the increase in each profession.

| Role | April 2021 | July 2022 |
|---------------------------------------|-------------------|------------------|
| <i>Advanced Practitioner</i> | - | 6.0 |
| <i>Care co-ordinator</i> | 16.07 | 94.0 |
| <i>Clinical Pharmacist</i> | 36.21 | 59.0 |
| <i>Dietician</i> | 1 | 1.0 |
| <i>Health and Wellbeing Coach</i> | 5.2 | 27.0 |
| <i>MHP B6</i> | 0 | 3.0 |
| <i>MHP B7</i> | 0 | 10.0 |
| <i>MHP B8a</i> | 0 | 2.0 |
| <i>Nurse associate</i> | 2 | 6.0 |
| <i>Occupational Therapist</i> | 1 | 2.0 |
| <i>Paramedic</i> | 0 | 16.0 |
| <i>Pharmacy technician</i> | 21.8 | 48.0 |
| <i>Physician associate</i> | 6.85 | 14.0 |
| <i>First Contact Physiotherapist</i> | 29.95 | 41.0 |
| <i>Social Prescribing Link Worker</i> | 36.8 | 62.0 |
| Grand Total | 156.88 | 391.0 |

5.0 Recommendation to Primary Care Commissioning Committee

- The governance of the DES continues via PCCC, acknowledging that the management of the various components maybe via differing ICB groups.
- Oversight of the developmental progress of PCNs is operationally managed via the Primary and Community Care Delivery Group with updates provided to PCCC every four months.

| Key Risks | |
|---------------------------------|--|
| Clinical and Quality: | <ul style="list-style-type: none"> • There is a risk that there is a widening gap between PCNs in terms of their development and ability to work collaboratively to deliver at scale. • There is a risk related to other providers' ability to engage and participate at PCN level. • There is a risk that PCNs will de-stabilise other providers by procuring staff in ARRS roles. |
| Finance and Performance: | <ul style="list-style-type: none"> • Consideration may need to be given to PCNs at the lower performing end of the metrics detailed in IIF and service specification metrics e.g. cancer early diagnosis - this information needs to be |

| | |
|--|--|
| | triangulated with other performance metrics such as QOF, prescribing, and any local resilience issues the ICB may be aware of. |
| Impact Assessment (environmental and equalities): | N/A |
| Reputation: | There may be an external stakeholder reputational impact if a PCN is unable to engage and participate in collaborative forum. |
| Legal: | N/A |
| Information Governance: | N/A |
| Resource Required: | N/A |
| Reference document(s): | PCN DES |
| NHS Constitution: | N/A |
| Conflicts of Interest: | GP practice colleagues - PCN members and Clinical Directors |
| Reference to relevant risk on the Board Assurance Framework | N/A |

Item 11

Appendix 1: Norfolk and Waveney PCN Transformation

Funding Proposal

In order to support the continuing development and maturity of PCNs, the ICB has ring fenced non-recurrent funding for 2022/23.

Building on previous year's PCN Development planning process, the ICB would like to invite PCNs to bid against the funding pot (now referred to as PCN Transformation) with ideas to support developing quality and leadership within their network.

Bids will be expected to address a shared issue/problem and or development need at the same time encouraging collaboration between all partners of the PCN.

We want to enable a light touch process however, bids must demonstrate intent, outlining the purpose and the maturity domains that it will help the PCN to progress against.

Process:

1. PCNs to submit bids against funding available (ball park £20k per PCN or per neighbourhood for Norwich);
2. Bids as a minimum must include:
 - Identified issue/ problem the funding will help to address;
 - The development opportunity by working collaboratively to resolve;
 - The identified domains from the maturity matrix which the project will support progress against;
 - Financial costing of the project.
3. Bids will be collated and summarised for the Primary and Community Care Delivery Group for approval.
4. PCNs to provide 6 month progress update for reporting via the Primary and Community Care Delivery Group, a summary overview to be reported via the governance route to Primary Care Commissioning Committee.
5. Following approval at the Primary and Community Care Delivery Group, PCNs will be notified of feedback, at which point each PCN may submit an invoice to:

NHS Norfolk and Waveney ICB
QMM Payables N185
Phoenix House
Topcliffe Lane
Wakefield
WF3 1WE
Email: sbs.apinvoicing@nhs.net

Or via Tradeshift.

Bids to be submitted to Kate Lewis: kate.lewis7@nhs.net **by 21st October 2022.**

PCN Transformation Bid Template

| | |
|--|---|
| Name of PCN: | |
| Title of bid: | |
| Outline of the issue/ problem that the PCN is trying to solve (max 250 words) | |
| Describe the key objectives of the bid (max 250 words) | |
| Describe in bullet points how the bid | <ul style="list-style-type: none">• |

| | |
|---|--|
| <p>supports the development of the PCN, relating back to the Maturity Matrix:</p> | <ul style="list-style-type: none"> • • • • • |
| <p>Outline the financial costing of the bid and describe how the funding will be utilised to achieve the objectives.</p> | |
| <p>Main contact for the bid (name and contact details)</p> | |
| <p>Commitment of PCN to provide six monthly progress report and final report detailing outcomes achieved.</p> | <p>All Practices in the PCN committed to deliver PCN Transformation component as detailed in this bid: YES/ NO (delete accordingly and confirm date of meeting/ email confirmation of agreement)</p> |

| | |
|----------------------|---|
| Subject: | Enhanced Access Service – Primary Care Network DES |
| Presented by: | Shepherd Ncube – Head of Delegated Primary Care Commissioning |
| Prepared by: | Carl Gosling – Senior Delegated Primary Care Commissioning Manager Fiona Theadom - Deputy Head of Delegated Primary Care Commissioning |
| Submitted to: | Delegated Primary Care Commissioning Committee |
| Date: | 13th September 2022 |

Purpose of paper:

To provide the ICB PCCC Committee with an update of the implementation of the Enhanced Access Service, contained with the Network Contract DES and to seek agreement to the process undertaken to approve the individual Primary Care Network Enhanced Access Service Plans.

Executive Summary:

Background

Following receipt of the letter B1375 “General Practice contract arrangements” dated 1st March 2022, NHS England (NHSE) confirmed, as previously agreed in 2019, that the two funding streams currently supporting enhanced access (Improved Access and Extended Hours) will be brought together to fund a single, combined and nationally consistent access offer with updated requirements, to be delivered by PCNs, under the Network Contract DES.

This will bring together the current £1.44 per head Network Contract DES extended hours funding and the current £6 per head ICB-commissioned extended/improved access services.

This transfer to PCNs was delayed as a result of the COVID-19 pandemic and delivery will now start from October 2022, with preparatory work from April 2022.

The new Enhanced Access arrangements aim to remove variability across the country and improve patient understanding of the service. The new offer is based on PCNs providing bookable appointments outside core hours within the Enhanced Access period of 6.30pm-8pm weekday evenings and 9am-5pm on Saturdays, utilising the full multi-disciplinary team, and offering a full range

of general practice services, including 'routine' services such as screening, vaccinations and health checks, in line with patient preference and need. PCNs will be able to provide a proportion of Enhanced Access outside of these hours, for example early morning or on a Sunday, where this is in line with patient need locally and it is agreed with the commissioner.

From 1 October 2022, PCNs will be required to provide Enhanced Access between the hours of 6.30pm and 8pm Mondays to Fridays and between 9am and 5pm on Saturdays.

To prepare for delivery of Enhanced Access from 1 October 2022, each PCN in Norfolk and Waveney has been working with the ICB to produce and agree an Enhanced Access Plan. Each Plan needs to set out how the PCN is planning to deliver Enhanced Access from October.

Full details of the requirements for Enhanced Access Service in the Primary Care Network Contract specification 2022/23 – PCN requirements and Entitlements can be found in section 8 at [NHS England » Network Contract Directed Enhanced Service – contract specification 2022/23 – primary care network requirements and entitlements](#) .

Current Position

To support and guide GP Practices, NHSE produced guidance, along with an Enhanced Access Service plan template for PCNs to complete and submit a draft plan to the ICB by the 31st July 2022.

All PCNs were encouraged to use the national template although it was not intended to replace detailed planning at PCN level and we expected templates to be supported by a series of service delivery plans setting out further details, for example, how the PCN is planning how to use its workforce and ensure some resilience, how patient engagement has been achieved and any communications plans informing patients of Enhanced Access arrangements.

In order to support GP Practices in the completion of the NHSE Enhanced Access Service template and answer any questions that GP Practices may have, Norfolk and Waveney ICB set up an Enhanced Access Service Task and Finish group. The Task & Finish group was made up of members from the Delegated Primary Care Team, Individual Locality Teams, the Primary Care Finance Team, Digital leads and representatives from the ICB's Urgent Care team. Other colleagues were invited to attend as appropriate, e.g. the Directory of Services team.

ICB Locality teams worked closely with individual PCNs to develop their plans providing guidance and clarification as necessary. The 17 individual Norfolk and Waveney PCNs have each submitted an Enhanced Service Plan, which must meet the core requirements as described in paragraphs 8.1.15 - 8.1.45 of the PCN DES specification "Contract specification 2022/23 – PCN Requirements and Entitlements".

Based on an ICB Primary Medical Care Weighted population of 1,120,324 a total of 67,245 Enhanced Access minutes are required to be contracted under the 2022/23 Primary Care Network Contract DES. Please see Appendix A for a full breakdown by individual PCN.

To approve the 17 individual Norfolk and Waveney Enhanced Service Plans and to provide feedback and seek amendments, if required, a Panel was set up in order to review the draft Primary Care Network (PCN) Enhanced Access Plans and agree a final iteration of individual PCN Enhanced Access Plans with the PCN's Core Network Practices by **31 August 2022**. The panel included colleagues from the Local Medical Committee and Healthwatch to ensure adequate independent oversight.

The role of the Panel:

In reviewing the PCNs' Enhanced Access Plans, the commissioner will need to ensure they form part of a cohesive ICS approach.

1. To work with all localities and teams in an ICS approach, to ensure that all PCN plans comply with the Contract Network DES.
2. To provide assurance to the system that PCNs are providing a safe and effective service to all patients.

The panel reviewed each PCN plan to ensure that each one was compliant with the core requirements of the PCN DES as described in PCN DES contract and summarised below.

1. Each PCN must provide a full range of general medical services during Network Standard Hours: Monday – Friday, 6.30 – 8.00 pm and Saturdays 9.00 am – 5.00 pm
2. Full range of general practice services to be made available;
3. All appointments within a PCN area must be available to all patients within the PCN;
4. Provide a mix of services provided during Network Standard Hours, including planned care appointments;
5. Advance booking and on the day booking available, and ability to cancel appointments on the day;
6. Enable NHS 111 to book into unused slots on the day.
7. Each plan has due regard to health inequalities, population health needs and demonstrates engagement with patients and other key stakeholders

The panel comprised:

| Project Role/Attendee | Organisation | Voting Member |
|---|---------------------|---------------|
| Associate Director of Primary Care | N&W ICB | YES |
| Head of Delegated Primary care Commissioning | N&W ICB | YES |
| Deputy Head of Delegated Primary Care Commissioning | N&W ICB | NO |
| Senior Delegated Commissioning Manager | N&W ICB | NO |
| North Locality Rep | N&W ICB | NO |
| South Locality Rep | N&W ICB | NO |
| Norwich Locality Rep | N&W ICB | NO |
| West Locality Rep | N&W ICB | NO |
| GYW Locality Rep | N&W ICB | NO |
| Integrated Urgent Care Rep | N&W ICB | YES |
| Finance Team Rep | N&W ICB | YES |
| Quality Team Rep | N&W ICB | YES |
| IT Team Rep | N&W ICB | NO |
| Norfolk & Waveney Local Medical Committee | LMC | NO |
| Healthwatch Norfolk | Healthwatch Norfolk | NO |
| Healthwatch Suffolk | Healthwatch Suffolk | NO |

In order to manage potential conflicts of interest, voting members were clearly identified.

A Review meeting for the Norfolk and Waveney Enhanced Access was held on the 10th August 2022 in order to review each PCN plan to ensure that each one was compliant with the core requirements as described in PCN DES contract. The Group approved PCN plans, in some cases subject to further information or areas of clarification being received by 31 August.

Since the review meeting on 10th August, PCNs have been submitting updated plans for final approval, which have been shared with all Panel members. The ICB delegated primary care team is confident that compliant plans will be in place by 1 October 2023 in all PCNs.

Risks

There are a small number of issues to be resolved to ensure all PCN services will be up and running effectively by 1 October 2022 however the team is assured that any mitigating actions will be in place.

There is a national IT interoperability issue which impacts how IT systems interface with each other to ensure the core requirements of the Enhanced Access service (para 8.29 refer) will operate. Pending the outcome and timeline for a national solution, interim arrangements may need to be put in place. All PCNs have detailed their workaround proposals.

A national sub-contract has been issued which PCNs may use when sub-contracting either all or elements of the service to other providers. This is currently being reviewed by relevant PCNs to determine its suitability.

It is recognised that some plans may evolve during the coming months and a process will be put in place to agree any significant changes to PCN plans.

Recommendation

Members of the PCCC are asked to consider and approve the governance process for the review and approval of the 17 individual Norfolk and Waveney PCN plans.

Appendix A

| PCN | Total PCN Pop (CCG Primary Medical Care weighted population) | Minutes per week | Contracted No of Hrs (to nearest 15mins) | Contracted Number of Minutes (to nearest 15 minutes) |
|--------------------------------------|--|------------------|---|--|
| Gorleston Primary Care Network | 47,123.98 | 2,827 | 47hrs | 2,820 |
| Gt. Yarmouth & Northern Villages PCN | 74,907.57 | 4,494 | 75hrs | 4,500 |
| Lowestoft Primary Care Network | 88,371.35 | 5,302 | 88hrs 15mins | 5,295 |
| SWAN | 58,096.13 | 3,486 | 58hrs 15mins | 3,495 |
| NN1 | 47,530.79 | 2,852 | 47hrs 30mins | 2,850 |
| NN2 | 44,486.94 | 2,669 | 44hrs 30mins | 2,670 |
| NN3 | 45,032.12 | 2,702 | 45hrs | 2,700 |
| NN4 | 50,886.54 | 3,053 | 51hrs | 3,060 |
| Norwich PCN | 235,404.08 | 14,124 | 235hrs 30mins | 14,130 |
| Breckland Surgeries | 43,808.53 | 2,629 | 43hrs 45mins | 2,625 |
| Ketts Oak Primary Care Network | 58,655.37 | 3,519 | 58hrs 45mins | 3,525 |
| Mid Norfolk | 47,212.51 | 2,833 | 47hrs 15mins | 2,835 |
| SNHiP | 82,900.35 | 4,974 | 83hrs | 4,980 |
| Coastal | 39,936.44 | 2,396 | 40 hrs | 2,400 |
| Fens and Brecks | 42,130.93 | 2,528 | 42hrs 15mins | 2,535 |
| Kings Lynn | 63,778.42 | 3,827 | 63hrs 45mins | 3,825 |
| Swaffham and Downham Market | 50,062.15 | 3,004 | 50hrs | 3,000 |
| Total | 1,120,324 | 67,219 | 1,120hrs 45mins | 67,245 |

Agenda item: 13

| | |
|----------------------|---|
| Subject: | GP Patient Survey Results 2022 |
| Presented by: | Fiona Theadom, Deputy Head of Delegated Primary Care Commissioning |
| Prepared by: | Kate Lewis, Head of Primary Care Strategic Planning and Fiona Theadom, Deputy Head of Delegated Primary Care Commissioning |
| Submitted to: | Primary Care Commissioning Committee |
| Date: | 13 September 2022 |

Purpose of paper:

- The purpose of this paper is to provide an overview of results for the GP Patient Survey and to compare results to national average performance.
- To also acknowledge the link between findings from the GP patient survey and patient demand, and how this feeds into the development of plans on demand and capacity for primary care.
- To outline next steps planned for approval by the Committee

Executive Summary:

This paper provides an overview of the purpose of the GP Survey and the metrics used across England to draw comparisons between practices and PCN areas. The paper summarises the key performance results for Norfolk and Waveney practices comparing the ICS performance with the national average. The later part of the paper describes some recommendations on taking the results forward.

1.0 Background

The GP Patient Survey assesses patients' experience of healthcare services provided by GP practices, including experience of access, making appointments, the quality of care received from healthcare professionals, patient health and experience of NHS services when their GP practice was closed. The survey also includes questions assessing patients' experience of NHS dental services.

The results of the survey are published by Ipsos MORI on behalf of NHS England on the [GP Patient Survey publication website](#)

The ICS Survey Results 2022 refers to field work 10 January – 11 April 2022 for practices across England.

Results for the survey are weighted and Ipsos MORI administers the survey on behalf of NHS England.

In Norfolk and Waveney Integrated Care System, 31,328 questionnaires were sent out, and 12,265 were returned completed. This represents a response rate of 39%. This is down from previous year's response rates.

The questionnaire (and past versions) can be found here: <https://gp-patient.co.uk/SurveysAndReports>

2.0 The Survey – An Overview

The GP Patient Survey measures patients' experiences across a range of topics, including:

- Your local GP services
- Making an appointment
- Your last appointment
- Overall experience
- COVID-19
- Your health
- When your GP practice is closed
- NHS Dentistry
- Some questions about you (including relevant protected characteristics and demographics)

The GP Patient Survey (GPPS) provides data at practice level using a consistent methodology, which means it is comparable across organisations. However, the survey has limitations:

- Sample sizes at practice level are relatively small.
- The survey does not include qualitative data, which limits the detail provided by the results.
- The data provide a snapshot of patient experience at a given time and are updated annually.
- There is variation in practice-level response rates, leading to variation in levels of uncertainty around practice-level results. Data users are encouraged to use insight from GPPS as one element of evidence when considering patients' experiences of general practice.

3.0 The Results

The full download of the ICS pack on the GP Survey can be found [here](#). Please refer to this pack to see the full detail. However, an overview is provided in the narrative below.

Headlines:

- Reports are available for the first time at PCN level in addition to ICS and general practice level.
- Taken across our ICS, our practices were above the national average in terms of rating positively across all categories.
- The survey revealed that three-quarters of participants said they would rate their overall experience as good.
- However this figure is a decrease on the 85% who gave this answer in 2021 and is reflective of overall experience nationally (83.0% in 2021 to 72.4% in 2022).
- There has been an increase in proportion of patients who think their overall experience is described as fairly or very poor from 6% in 2021 to 11% in 2022, in line with the national trend.
- Hingham Surgery is identified as the GP practice where patients are most satisfied with the level of care they receive with 98% of participants saying they rated their experience as good.
- There were just three practices where 50% of respondents or fewer did not rate the experience as good – Thorpewood in Norwich, High Street Surgery in Lowestoft and the East Norwich Medical Partnership.
- High Street Surgery in Lowestoft was also the practice which saw the largest drop in satisfaction year-on-year. In 2021, 84% of patients rated the service as good, compared with 48% in 2022.

Detail:

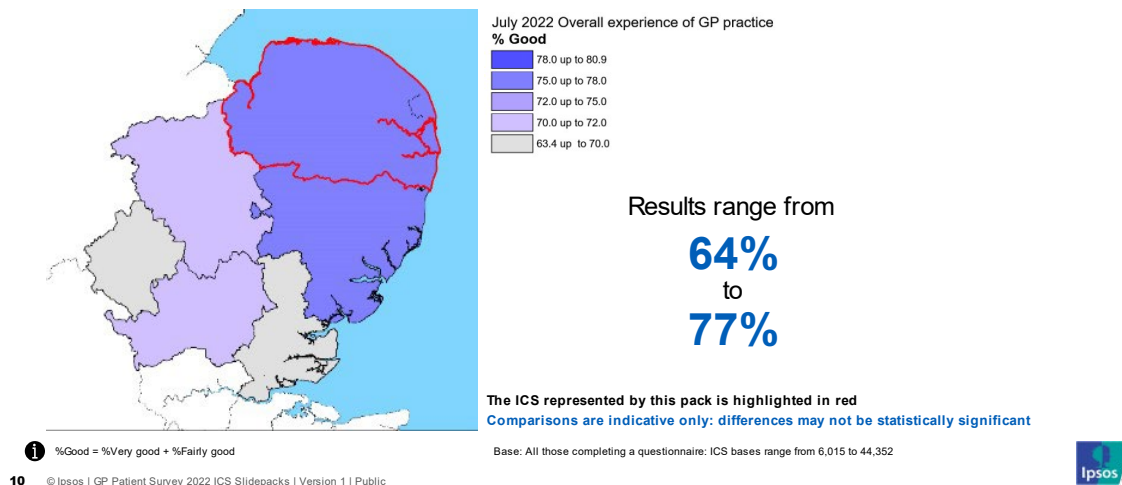
The first question, “Overall, how would you describe your experience of your GP practice?” the ICS performed better than the national average 76% vs 72%. With a practice range between 60% and 87%. However, this is a decrease from survey results from 2020, and 2021 which 85% of respondents confirmed as good.

If we take a PCN view of the answers to this question NN2 are the best performing PCN whereas on the other end of the scale Gorleston PCN is the lowest performing. Having the ability to view survey results at a PCN level is helpful in that we can make some comparisons and consider how practices might collaborate in response. It should however be acknowledged that each PCN has a different population who may respond to the survey in a different way.

The ICS result for this question compares favourably to other systems in East of England region, performing better along with Suffolk and North East Essex.

Overall experience: how the ICS result compares to other ICSs within the region

Q32. Overall, how would you describe your experience of your GP practice?



Patients were asked, “Generally, how easy is it to get through to someone at your GP practice on the phone?” the ICS performed better than the national average 59% vs 53% respondents stating ‘easy’. With a PCN range between 25% and 76%.

Patients were asked, “How helpful do you find the receptionists at your GP practice?” the ICS performed better than the national average 84% vs 82%. With a practice range between 71% and 94%.

It is worth noting that patients had to select from a range of descriptors, from very helpful to not at all helpful. The survey creators acknowledge that it does not account for qualitative feedback, which one might find useful in response to this question.

The Survey then moves on to ask patients about their awareness of online services. Please refer to the slide deck for the full break down of responses.

When asked, “How easy is it to use your GP practice’s website to look for information or access services?,” the ICS performed better than the national average, 73% vs 67% for easy, and better than the national average 27% vs 33% for not easy.

On the topic “Choice of appointment,” the ICS performed better than the national average when patients answered, “On this occasion (when you last tried to make a general practice appointment), were you offered a choice of appointment?” 62% said yes and 38% no.

When asked, “Were you satisfied with the type of appointment (or appointments) you were offered? The ICS performed better than the national average, 77% vs 72%. With a practice range between 68% and 82%.

Patients were then asked what they do "...when they are not satisfied with the appointment offered and do not take it." A range of descriptors are available to compare with national average.

When asked, "Overall, how would you describe your experience of making an appointment?," the ICS performed better than the national average, 62% vs 56% denoting 'good'. However, this is a decline from 2021 when 75% respondents said 'good'.

The next section on "Perceptions of care at patients' last appointment" provides a detailed breakdown of feedback from the patients' last appointment (please refer to slide deck).

Following which patients were asked a range of questions about their last interaction including 'enough time,' 'listening,' 'treating you with care and concern.' One of the questions we might want to pay particular attention to is about mental health: "During your last general practice appointment, did you feel that the healthcare professional recognised and/or understood any mental health needs that you might have had?," the ICS performed better than the national average, 86% vs 83% reporting yes and 4% vs 6% reporting no.

The last section of the Survey reports on 'Care and Concern' and can be used to look at how experience varies among different patient groups and factors such as age, gender, disability, religion, ethnicity, long term condition or deprivation.

Potential factors influencing outcomes?

It should be noted that the survey was undertaken at a time when general practice was facing numerous challenges nationally, regionally and in Norfolk and Waveney:

- Increase in patient expectations from general practice after the pandemic response and how practices operated during that time; increased patient satisfaction generally
- Workforce pressures due to sickness and vacancies resulting in lower numbers of staff available to see patients
- General practice still involved in the Covid vaccination programme as well as restoring services previously paused due to Covid response
- Winter pressures were significant across the system with general practice at the frontline of the urgent response for patients accessing healthcare and in supporting other system partners, e.g. enhanced support to care homes to reduce admissions and support discharge
- National media messaging helped raise patient expectations about access to general practice rather than managing expectations and helping to signpost patients to the right care. Local messaging required to inform and guide patients where to seek appropriate help
- Lack of understanding and awareness by patients about the different roles and responsibilities within general practice and how they support GPs to provide care.

It should be noted that Norfolk and Waveney provides a higher proportion of face-to-face appointments, 9% higher than the national average.

During July 2022, 535,254 appointments took place in general practice in Norfolk and Waveney, of which 74% were face to face and 22% by telephone.

Dental outcomes

With the transfer of responsibilities for dental services (primary, community and secondary care) to Norfolk and Waveney ICB from April 2023, subject to approval of the Delegated Commissioning arrangements by NHS England, the results from the dental survey questions (see below) will also be reviewed to help inform local commissioning intentions from 2023.

- When did you last try to get an NHS dental appointment for yourself?
- Last time you tried to get an NHS dental appointment, was it with a dental practice you had been to before for NHS dental care?
- Were you successful in getting an NHS dental appointment?
- Overall, how would you describe your experience of NHS dental services?

31,328 forms were sent out with a response rate of 39%.

22% had tried to get an appointment within the last 3 months, however 22% had not tried for over 2 years and 21% had never tried.

Of those who had tried to get an appointment, 66% were successful and 63% described their experience as good however 30% were not successful.

Reasons for not trying to get an appointment were varied from preferring a private dentist, not liking or not needing to go to the dentist, thinking NHS dental services not available or too expensive.

ICB staff are working closely with NHSE colleagues to understand the overall commissioning picture for primary and community care dental services, sharing soft intelligence and contract information prior to transfer of responsibilities in April 2023. The ICB is also involved in discussions with NHSE around future investment plans to help improve access in Norfolk and Waveney and tackle health inequalities.

Recommendation to the Committee:

With the information provided in the Survey pack we can drill down to practice level to note the comparisons between practices in the range. However, it should be noted that results may not be statistically significant.

It is recommended that the PCN Locality Leads support the PCNs to review individual area survey results, comparing with the ICS and national average and previous year's results, to raise awareness and encourage scrutiny.

It will be important that each PCN review results within their own local context, as well as to look at practice variance across PCNs with the objective of sharing best

practice and understand the factors influencing why there has been a drop in the percentage of patients regarding their overall experience as good and an increase in patients reporting their experience as poor.

Findings from the survey results should be used to inform PCN plans relating to Enhanced Access arrangements from 1 October 2022 and PCN DES requirements on reducing inequalities.

Following recent discussion with Healthwatch Norfolk and Healthwatch Suffolk and the ICB Quality team, the Delegated Primary Care Commissioning Team is developing a programme of work around improving access and further details will be reported to PCCC in November 2022. An analysis of the outcomes from the GP Access survey will be included as part of this project.

The findings of the GP Survey are also helpful in giving us a picture of demand and need. We will use this intelligence to feed into the new programme of work on Demand and Capacity for Primary Care.

| Key Risks | |
|--|--|
| Clinical and Quality: | <p>There is a risk that there is a widening gap between practices offer of high-quality services for patients if the survey is not considered by PCNs/ individual practices.</p> <p>It is suggested that PCNs view the survey within their own local context and share best practice with a view to closing the gap between practices.</p> |
| Finance and Performance: | <p>Consideration may need to be given to practices consistently seeing lower patient satisfaction – this information needs to be triangulated with other metrics such as QOF, prescribing, and any local resilience issues the ICB may be aware of.</p> |
| Impact Assessment (environmental and equalities): | <p>There is a risk of a widening gap in care provided if some patients face greater challenges in accessing general practice than others. It is suggested that PCNs view the survey within their own local context and share best practice with a view to closing the gap between different patient groups.</p> |
| Reputation: | <p>There has been significant national and local media interest in access to appointments in general practice</p> |
| Legal: | N/A |
| Information Governance: | N/A |
| Resource Required: | <p>Primary Care Directorate, Delegated Primary Care Commissioning and Quality teams. Locality teams, PCN and practice teams</p> |

| | |
|--|---|
| Reference document(s): | GPPS Survey (IPSOS) |
| NHS Constitution: | N/A |
| Conflicts of Interest: | GP practice colleagues - PCN members and Clinical Directors |
| Reference to relevant risk on the Board Assurance Framework | N/A |

Governance

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

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: | September 2022 |

Purpose of paper:

Information

Executive Summary:

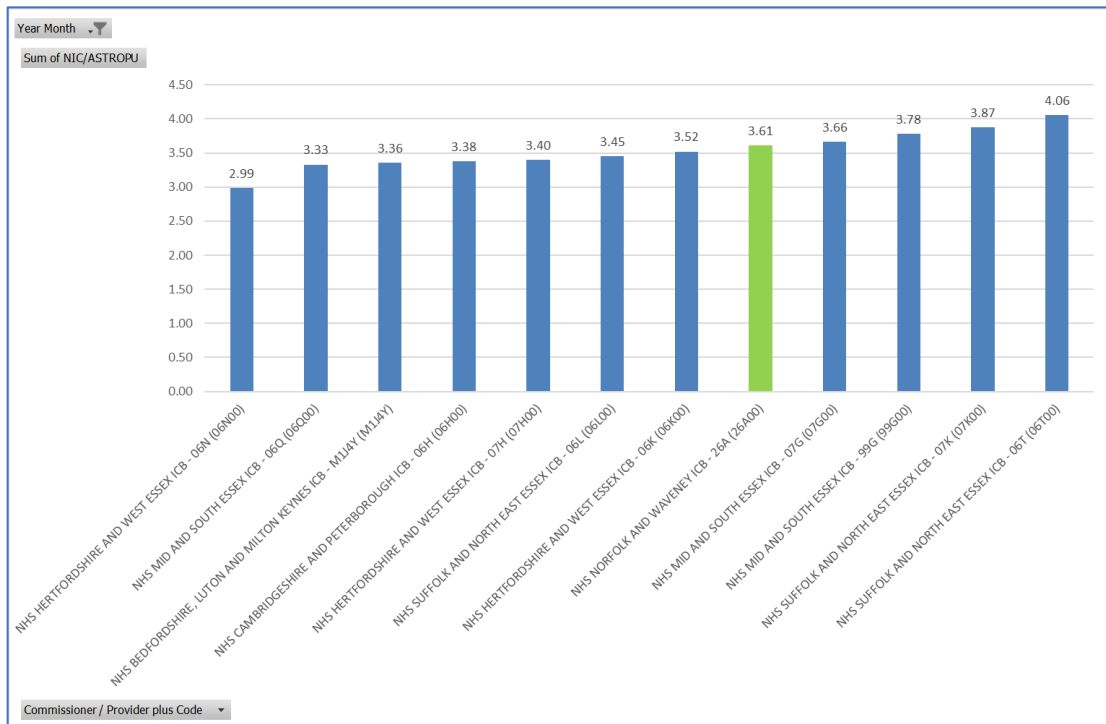
Progress on quality and spend indicators are outlined and some of our current projects are highlighted.

1. Prescribing team focus areas

- 1.1 The newly merged prescribing teams are working on delivering or facilitating the delivery of the necessary efficiency savings. The team is however also supporting the vaccination programme, and practices at risk. The CSU and CCG teams have now joined to form the ICB medicines team as of 1st July. We are also working to fill the vacancies that the CSU have been carrying - all vacancies have been posted to the internal recruitment system and are awaiting authorisation.
- 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. However, this does not take account of deprivation which is a key driver of prescribing spend. Norfolk and Waveney remain the 5th highest normalised raw spend of the six East of England systems at £3.61 with a downward trajectory in this spend (the mean spend is £3.54). 7 pence or 2% from average in June 2022.



2.4 An explanation on retained margin (Category M) is below.

The community pharmacy sector nationally 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.

No cheaper stock obtainable (NCSO)

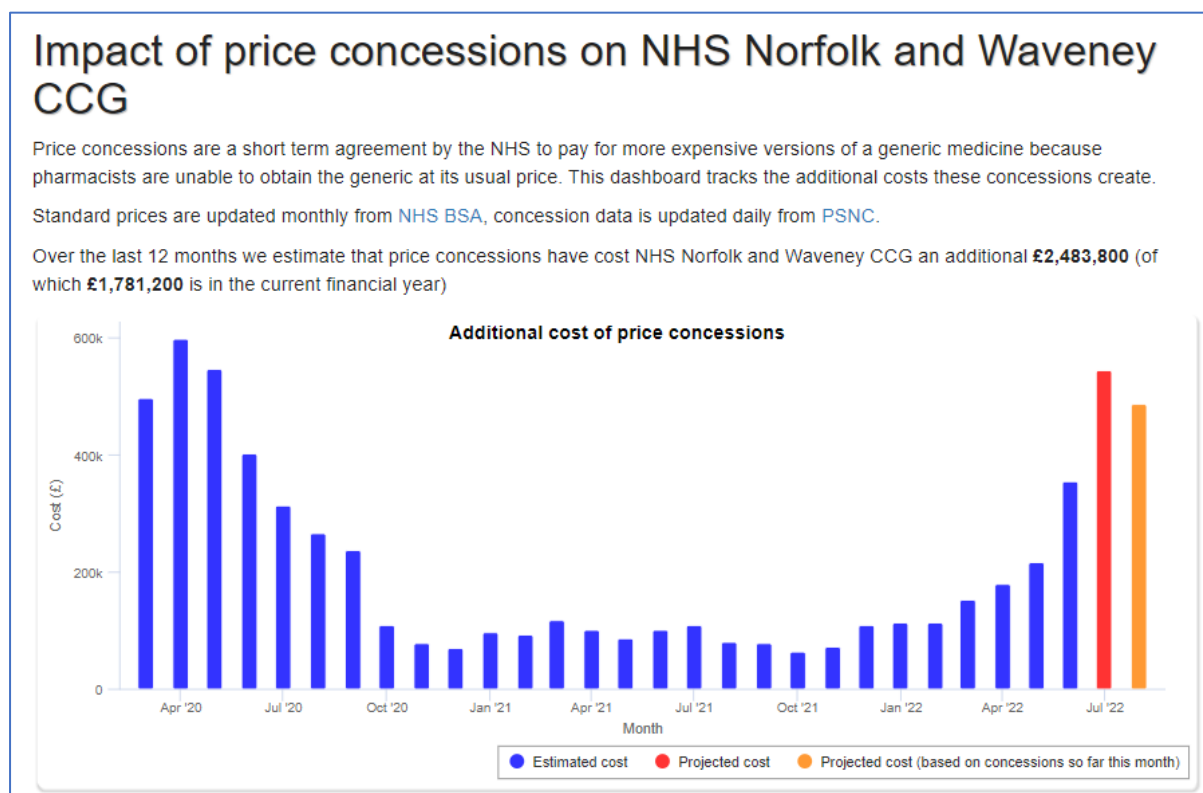
This is a price concession agreed by the Department of Health when a product cannot be sourced at the drug tariff (DT) price. The impact of price concessions continues since when they are no longer subject to the price concession, they tend to go back into the drug tariff at an increased price. The table below shows the impact year to date (YTD) and projected for the following 2 months.

Table 1 Cost Pressure Report September 2022 (June data)

| | YTD April-June | Projected July | Projected August |
|----------------------------------|----------------|----------------|------------------|
| NCSO and other price concessions | £766,048 | £631,692 | £642,421 |
| Back into DT at increased prices | £33,788 | £99,421 | £105,450 |
| Total | -£322,460 | -£251,195 | -£663,790 |

In Q4 will be £600,000 per month allowing for some fluctuations in NCSO
 Projected figures are estimated but are based on price concessions announced

Table 2. Bar chart of NCSO additional costs over time



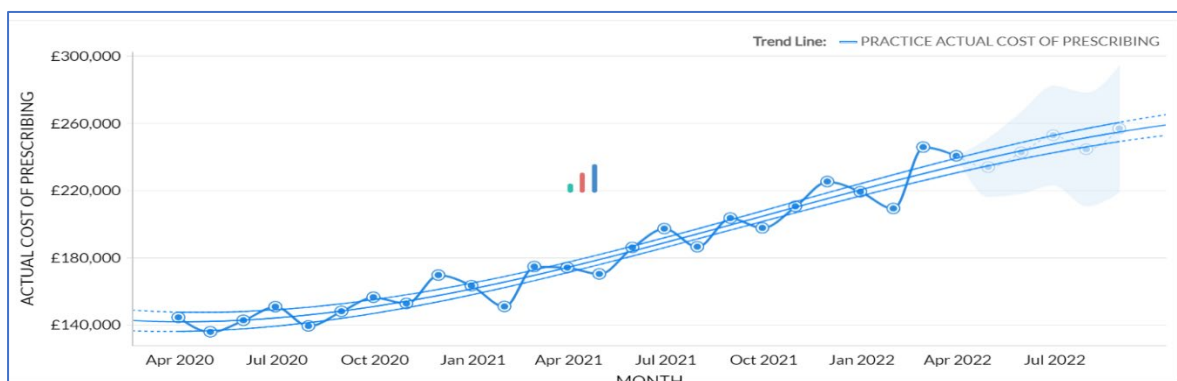
There is also significant inflation in category A prices, for example ascorbic acid tablets 200mg and above now cost nearly £2 per tablet ([August drug tariff](#)) when prescribed but can be purchased for £1.99 for 30. Lower strengths are almost as expensive. Another example is Haloperidol 500mcg tablets, these

are now £186 for 28. Norfolk and Suffolk Foundation Trust are now aware and are communicating with their teams to avoid this and other anomalies where possible.

Some drugs have grown in costs due to an increase in the number of indications for their use e.g., SGLT 2's. 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. Others such as Famotidine have increased in volume due to the continuing global shortage of a commonly used alternative ranitidine. Others are increasing in use as awareness of their efficacy, along with active case finding continues to highlight the growing number of people who would benefit from their use e.g., the DOACS, edoxaban, apixaban and rivaroxaban. The system was however down this month when this report was written.

The graph below shows the increase in spend. The increase is likely to accelerate.

Table 3. Monthly primary care spend on SGLT2i's over time



3 Dependence forming medicines (DFMs)

3.1 As previously reported the ICB has made marked improvements to its position as a national outlier on its use of high dose opiates in chronic pain. Our high use of hypnotics (and anxiolytics) is also improving, but remains a concern.

3.2 The national indicators for DFMs for June 2022 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 CCGs (now ICBs).

- High dose opiates – a decrease in use to 84th (76th previously (out of 106 organisations) 21st percentile (previously 28th) on [high dose opiate items as percentage of regular opiates](#)
- Gabapentinoids – stayed 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 Norfolk and Waveney performance with national percentiles (Norfolk and Waveney is the red line and national average is the blue line)

Table 4. Anxiolytics and hypnotics volume trend over time by top prescribing ICBs nationally

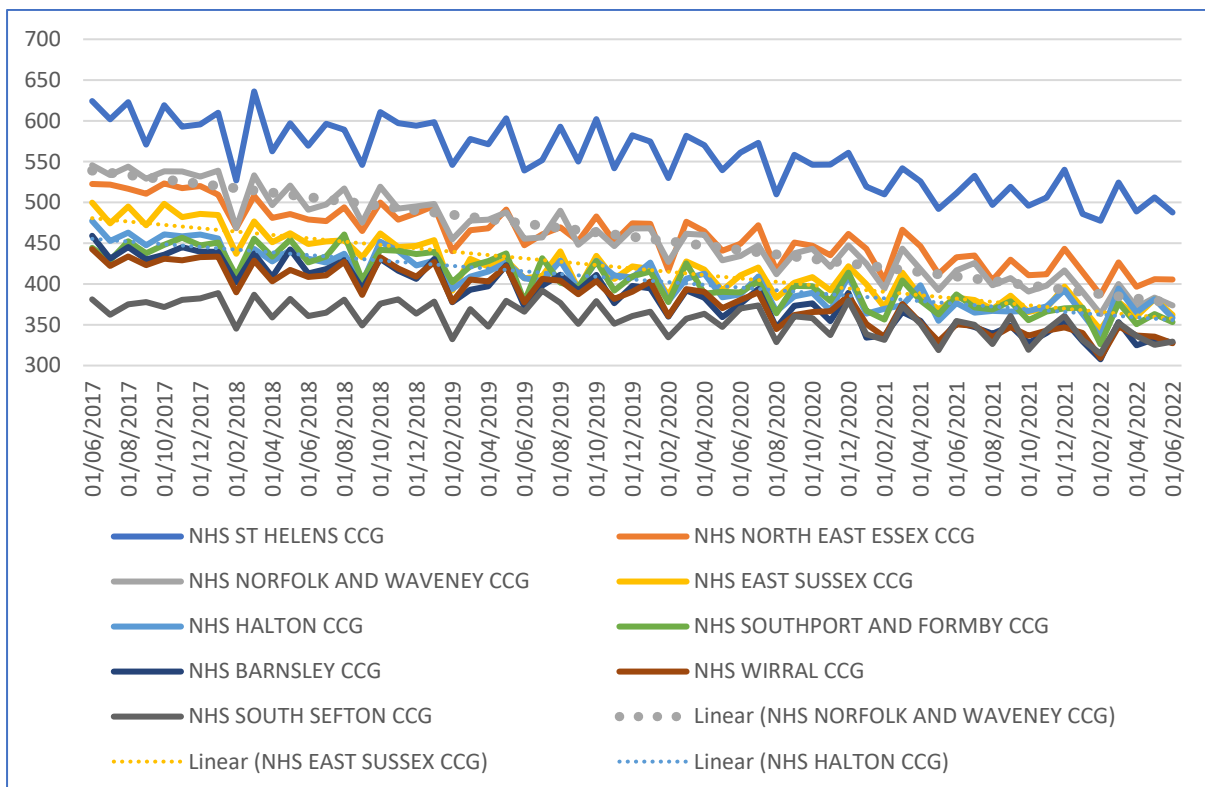
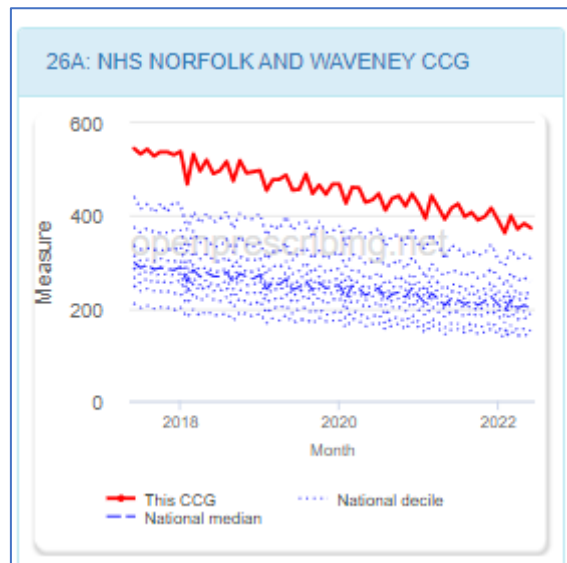


Table 5. Anxiolytics and hypnotics volume trend over time (red line is Norfolk and Waveney and darker blue line is national average)



3.3 We are continue to work with the Academic and Health Science Network (AHSN) and University of East Anglian (UEA) to develop and agree a standard pathway and SOP (standard operating procedure) for deprescribing of DFMs with a particular focus on opioids initially. Next steps include looking at aligning services and capacity, if possible to facilitate delivery of aspects of the pathway.

4 Antibiotic Prescribing

4.1 NHS System Oversight Framework (SOF) Antimicrobial Prescribing Metrics for 2021-22 have been updated. The antibiotic volumes target is now 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%.

4.2 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 0.957 antibacterial items per STAR-PU in the 12 months to April 2022. (Increase of 0.006 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 there are now four PCNs, West Norfolk PCN and Fens & Brecks PCN, Kings Lynn PCN and Swaffham and Downham PCN, above the second target of 0.965.

4.3 Percentage of broad-spectrum antibiotics, the bar chart on the right shows the percentage by PCN. Norfolk and Waveney practices are currently above the

national target of no more than 10% of all antibiotics at 10.44% in the 12 months to May 2022 (a decrease from 10.48% in April 2022). 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.

Table 6. CCG Position against NHS AMR metric 2021/22 – May 2022

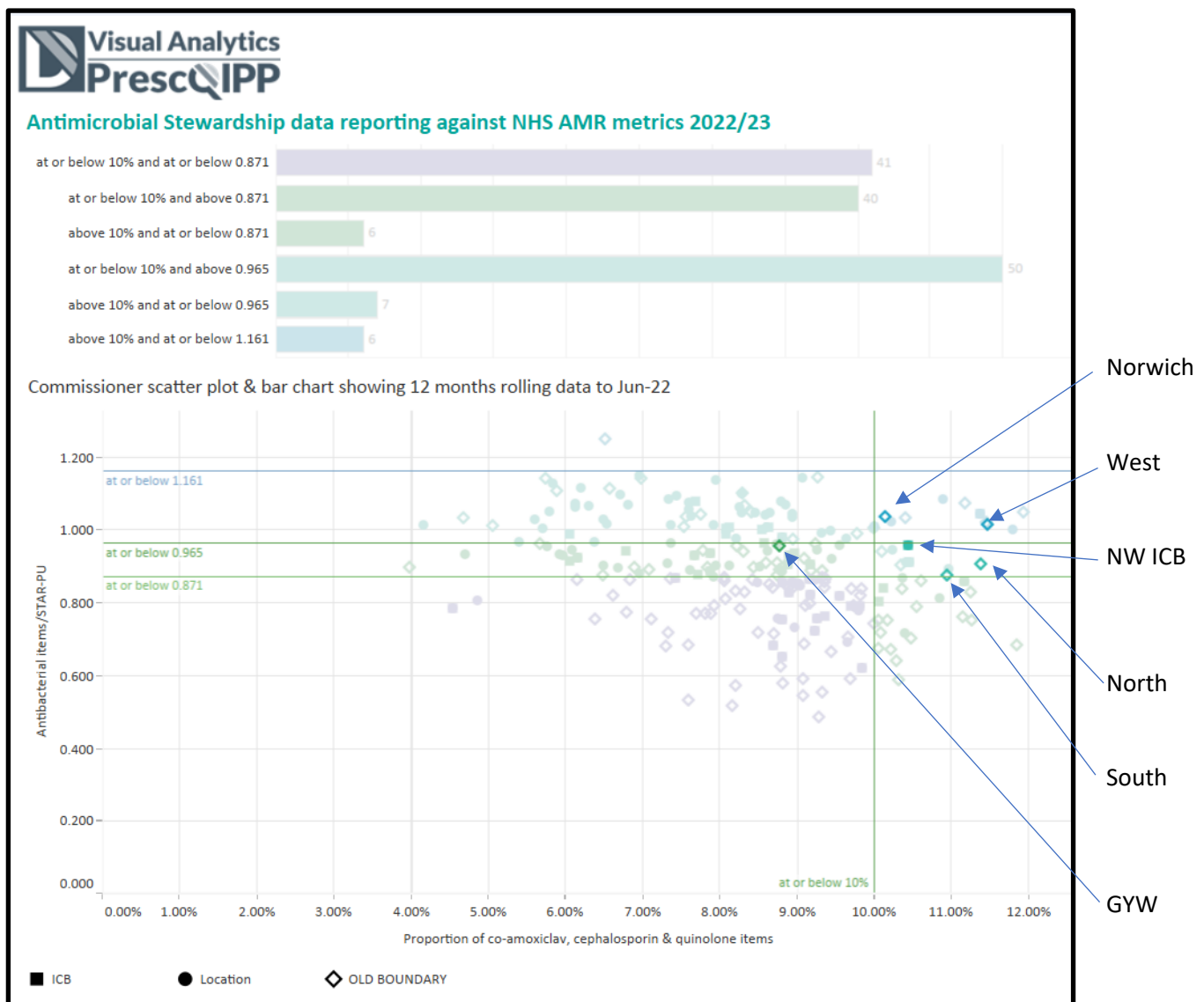
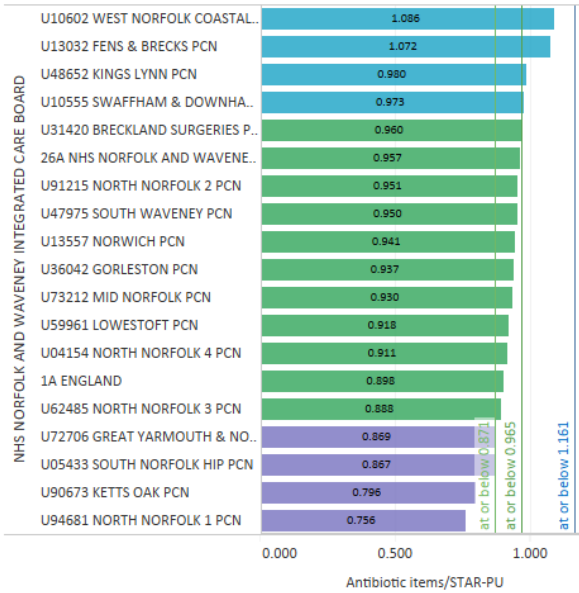


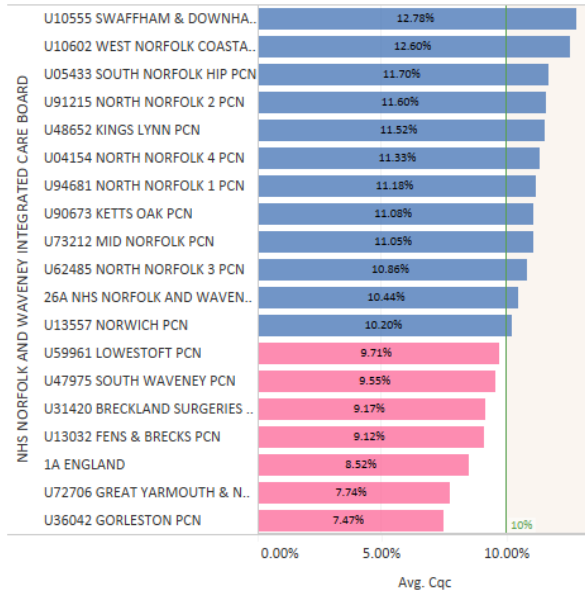
Table 7. PCN bar charts – Antimicrobial prescribing 12 months to end June 2022

Antimicrobial Stewardship data reporting against NHS AMR metrics 2022/23

PCN bar charts Antibacterial items/STAR-PU showing 12 months rolling data to Jun-22



PCN bar charts proportion of co-amoxiclav, cephalosporin & quinolone items showing 12 months rolling data to Jun-22



4.4 Our outlier practices (above 14%) that are driving the higher percentage of Broad-spectrum antibiotics in June data are.

Table 8: Outlier Practices for prescribing Broad Spectrum Antibiotics

| Practice Name | % Broad Spectrum Antibiotics (June 2022) | Sum of percentile |
|--|--|-------------------|
| TOFTWOOD MEDICAL CENTRE | 19.25% | 99.55 |
| BURNHAM SURGERY | 18.29% | 99.45 |
| ELMHAM SURGERY | 17.01% | 99.18 |
| GRIMSTON MEDICAL CENTRE | 16.55% | 98.88 |
| CHURCH HILL SURGERY | 16.16% | 98.60 |
| FELTWELL SURGERY | 16.11% | 98.54 |
| E HARLING & KENNINGHALL MEDICAL PRACTICE | 15.52% | 98.00 |
| MUNDESLEY MEDICAL CENTRE | 15.17% | 97.51 |
| HOVETON & WROXHAM MEDICAL CENTRE | 15.14% | 97.45 |
| BRUNDALL MEDICAL PARTNERSHIP | 14.75% | 96.82 |
| BRIDGE STREET SURGERY | 14.29% | 95.88 |
| OLD MILL AND MILLGATES MEDICAL PRACTICE | 14.04% | 95.51 |

5 Prescribing Quality Scheme (PQS)

5.1 96 out of 105 practices have signed up to take part in the scheme. Four practices have declined to take part.

6 Low risk, Cost-effective Prescribing QIPP Support Scheme

6.1 55 out of 105 practices have signed up to take part in the scheme

7 Primary Care Dietetic team update

7.1 Oral Nutritional Supplements (ONS) are now an indicator for the 22/23 PQS aiming to reduce inappropriate prescribing of these products in N&W. Prescribing of ONS has increased locally and nationally over the past 2 years (see table 9), possible reasons for this during the pandemic are:

GP led prescribing

Sometimes inappropriate prescribing by non dietitians in hospital

No weights/monitoring in primary care

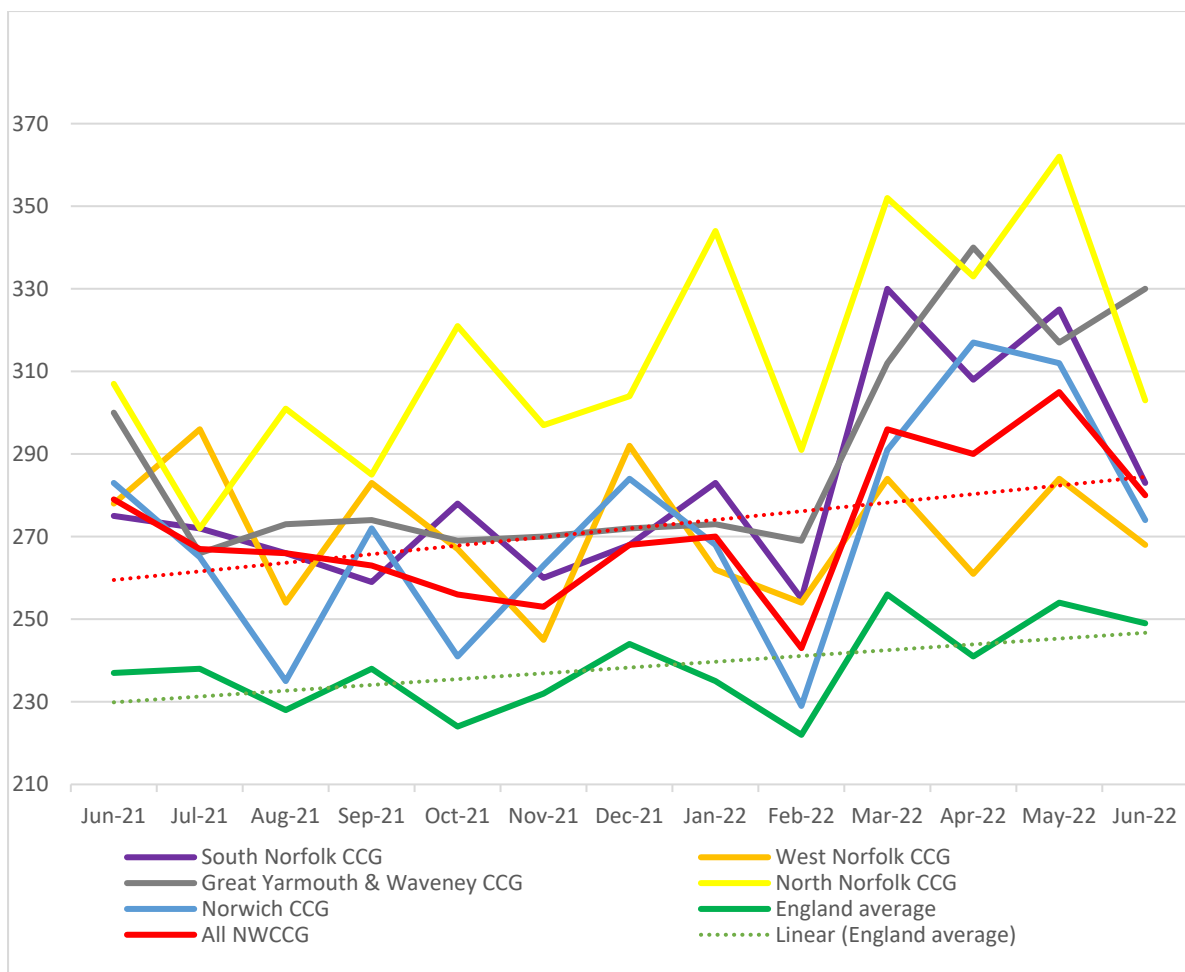
Pressures on local dietetic services

The need for healthcare professionals to 'do something'- not usually accompanied by appropriate food based advice.

7.2 Ability to tackle increased prescribing has been limited by nutrition contracting issues. This is due to be resolved imminently where the dietetic team can promote the new ONS prescribing guidelines and recommend cost effective switches.

7.3 The dietetic team continue to upskill and educate local healthcare professionals and care home staff by running virtual training events and smaller sessions to improve prescribing of nutritional products including ONS, infant formulae, thickeners, and vitamins/minerals.

Table 9: All Norfolk & Waveney Total ONS spend June 2021 to June 2022



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: | ICB practices remain 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 dispensing practices may be conflicted with competing financial interests associated with dispensing costs |
| 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 |
|---|------------------------|

Agenda item: 15

| | |
|----------------------|--|
| Subject: | Primary Care Commissioning Committee (PCCC) 2022/23 Financial Report – July |
| 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: | 13/09/2022 |

Purpose of paper:

To present the July 2022 Primary Care financial position for the Norfolk and Waveney Integrated Care Board to the Primary Care Commissioning Committee for information.

Executive Summary:

As the financial reporting for Primary Care and Prescribing is produced in arrears this report will relate to July of the ICB accounts. Since the ICB (Integrated Care Board) was formed from July 2022 hence the forecast for ICB would be 9 months from July-March 2023.

The 2022-23 budgets for ICB from July –March 2023 are based upon the draft financial plans as submitted in April 2022 for the CCG. 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 £7.3m this is within the GP Prescribing sub-directorate and for the 9 months from July-March 2023.

As at Month July, the 9 months forecast spend is £304.7m as against a plan of £307m leading to a total underspend of £2.3m for Primary Care and Prescribing in combination.

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 ICBs 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) | <i>n/a</i> |
|---|------------|



Improving lives **together**

Norfolk and Waveney Integrated Care System

2022/23 Primary Care Commissioning Committee Finance Report Norfolk & Waveney ICB

July 2022

Primary Care Commissioning Committee 13th September 2022

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1.0 Executive Summary

- As the financial reporting for Primary Care and Prescribing is produced in arrears this report will relate to M4 (July-22) of the ICB accounts. Since the ICB (Integrated Care Board) was formed from July 2022 hence the forecast for ICB would be 9 months from July-March 2023.
- The 2022-23 budgets for ICB from July –March 2023 are based upon the final financial plans as submitted on the 20th June 2022
- The current efficiency requirement within the Primary Care and Prescribing directorate is £7.3m this is within the GP Prescribing sub-directorate and for the 9 months from July-March 2023.
- As at Month 4, the 9 months forecast spend is £304.7m as against a plan of £307m leading to a total underspend of £2.3m for Primary Care and Prescribing in combination.
- Details of the major areas of variance for Primary Care are reported in section 3.0 Detailed Variance Analysis.

2.0 Financial Summary

| Primary Care: Financial Summary | 9 months ICB | Year to Date (July) | | | Forecast 9 Months (ICB) | | Detailed Variance Analysis |
|---|--------------|---------------------|-------------|----------------------|-------------------------|-----------------------|-------------------------------|
| | Budget | Budget | Actual | Variance (Fav)Adv | Actual | Variance (Fav) Adv | |
| | £m | £m | £ m | £m | £m | £m | |
| GP & Other Prescribing | 141.7 | 15.7 | 15.7 | (0.0) | 141.8 | 0.1 | 3.1 |
| Primary Care | | | | | | | |
| System Development Fund | 3.4 | 0.6 | 0.6 | (0.0) | 3.4 | (0.0) | |
| Local Enhanced Services | 12.4 | 1.4 | 1.4 | 0.0 | 12.4 | 0.0 | |
| Other Primary Care | 2.1 | 0.2 | 0.2 | 0.0 | 2.1 | 0.0 | |
| Primary Care Delegated Co-Commissioning | 143.5 | 16.1 | 15.8 | (0.3) | 141.1 | (2.4) | 3.2 |
| Primary Care IT | 3.9 | 0.4 | 0.4 | (0.0) | 3.9 | 0.0 | |
| Total Primary Care | 165.3 | 18.8 | 18.5 | (0.3) | 162.9 | (2.4) | |
| Total Directorate | 307.0 | 34.5 | 34.2 | (0.3) | 304.7 | (2.3) | |
| <i>Variance as a % of Budget</i> | | | | -1.0% | | -0.8% | |
| Total Primary Care | 307.0 | 34.5 | 34.2 | -0.3 | 304.7 | -2.3 | |

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 | 9 months Budget ICB | Year to Date (July) | | | 9 Months Forecast (ICB) | | | Narrative |
|---|------------------------|---------------------|--------|----------------------|-------------------------|----------|----------------------|--|
| | Budget | Budget | Actual | Variance (Fav)Adv | Actual | Variance | Variance (Fav)Adv | |
| | £m | £m | £ m | £m | £m | £m | % | |
| 3.1 GP and Other Prescribing | 141.7 | 15.7 | 15.7 | (0.0) | 141.8 | 0.1 | 0.0% | <p>The GP Prescribing costs are reported nationally 2 months in arrears so, estimate for July is considered in the Year to Date (YTD) position, and Forecast Outturn (FOT) considers estimate from July to March .</p> <p>The YTD is on plan and forecast is marginally overspent by £0.1m</p> <p>An efficiency target of £(7.3)m is included in the budget for the 9 months. It is assumed the efficiency savings are delivered as per plan and these are therefore included in the FOT expenditure position. Analysis of the savings acheived to date validates this position.</p> |
| 3.2 Primary Care Delegated Co-Commissioning | 143.5 | 16.1 | 15.8 | (0.3) | 141.1 | (2.4) | -1.6% | Budgets held within Delegated Primary Care as per NHSE guidance costs shown in Locally Commissioned Services. |

4.0 System Development Fund

| Primary Care: System Development Fund | 9months Budget ICB | Year To Date(July) | | | 9 months Forecast (ICB) | |
|--|--------------------------|--------------------|------------|--------------------|-------------------------|--------------------|
| | Budget | Budget | Actual | Variance (Fav) Adv | Actual | Variance (Fav) Adv |
| | £m | £m | £ m | £m | £m | £m |
| GP Retention | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Training Hubs | 0.2 | 0.0 | 0.0 | 0.0 | 0.2 | 0.0 |
| Online Consultation | 0.2 | 0.0 | 0.0 | (0.0) | 0.2 | 0.0 |
| Fellowship-Core Offer | (0.4) | -0.0 | -0.0 | (0.0) | -0.4 | 0.0 |
| Infrastructure & Resilience | 0.2 | 0.0 | 0.0 | 0.0 | 0.2 | -0.0 |
| Improved Access | 5.5 | 0.6 | 0.6 | (0.0) | 5.5 | 0.0 |
| Practice Resilience | 0.1 | 0.0 | 0.0 | 0.0 | 0.1 | 0.0 |
| Others | (2.4) | 0.0 | 0.0 | 0.0 | -2.4 | 0.0 |
| | 3.4 | 0.6 | 0.6 | (0.0) | 3.4 | (0.0) |
| Variance as a % of Budget | | | | 0.0% | | -0.3% |

Variance Signage: (Favourable)/Adverse

- The above table details the schemes within the System Development Fund (SDF). The Year to Date and Forecast spend matches the plan in all areas.

5.0 Delegated Co Commissioning Analysis

| Primary Care: Delegated Co Commissioning | 9months Budget ICB £m | Year to Date (July) | | | 9 Months Forecast (ICB) | |
|--|-----------------------------|---------------------|-------------|----------------------|-------------------------|-----------------------|
| | | Budget | Actual | Variance (Fav)Adv | Actual | Variance (Fav) Adv |
| | | £m | £ m | £m | £m | £m |
| Contractual | 94.0 | 10.4 | 10.4 | (0.0) | 94.7 | 0.7 |
| QOF | 11.9 | 1.3 | 1.3 | 0.0 | 11.9 | 0.0 |
| Premises cost reimbursemen | 11.1 | 1.2 | 1.2 | 0.0 | 11.1 | 0.0 |
| Other - GP Services | 10.7 | 1.3 | 1.3 | (0.0) | 10.7 | (0.0) |
| Enhanced services | 3.0 | 0.4 | 0.4 | 0.0 | 3.0 | 0.0 |
| CCG Spend | 0.3 | 0.0 | 0.0 | (0.0) | 0.3 | (0.0) |
| PCN ARRS Staff | 9.3 | 1.0 | 1.1 | 0.1 | 9.4 | 0.1 |
| PMS to GMS | 3.1 | 0.3 | 0.0 | (0.3) | 0.0 | (3.1) |
| Prior Year | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Total | 143.5 | 16.1 | 15.8 | (0.3) | 141.1 | (2.4) |
| <i>Variance as a % of Budget</i> | | | | <i>-2.0%</i> | | <i>-1.6%</i> |

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 the Impact and Investment Fund (IIF) not being funded to the full possible payment amount, which is prudently forecasted here.
- **PMS to GMS:** Budgets held within Delegated PC as per NHSE guidance costs shown in Locally Commissioned Scheme.

6.0 GP And Other Prescribing

| 22/23 Primary Care: GP And Other Prescribing | 9months Budget CCG | Year to Date(July) | | | 9 months Forecast (ICB) | |
|---|--------------------------|--------------------|-------------|-------------------|-------------------------|-------------------|
| | Budget | Budget | Actual | Variance (Fav)Adv | Actual | Variance (Fav)Adv |
| | £m | £m | £ m | £m | £ m | £m |
| GP Prescribing Costs | 134.1 | 14.9 | 14.9 | (0.0) | 134.1 | 0.1 |
| Recharges to Local Authorities & NHS England | (3.9) | (0.4) | (0.3) | 0.0 | (3.9) | 0.0 |
| Rebates from pharmaceutical companies | (2.2) | (0.2) | (0.3) | (0.0) | (2.1) | 0.0 |
| GP Prescribing Subtotal | 128.0 | 14.3 | 14.3 | 0.0 | 128.1 | 0.1 |
| Central Drugs | 3.6 | 0.4 | 0.4 | 0.0 | 3.6 | 0.0 |
| Dressings & wound care | 4.4 | 0.5 | 0.5 | (0.0) | 4.4 | (0.0) |
| Others (Medicine Management, Oxygen etc.) | 5.7 | 0.6 | 0.5 | (0.0) | 5.7 | (0.1) |
| Total Spend | 141.7 | 15.7 | 15.7 | (0.0) | 141.8 | 0.1 |
| <i>Variance as a % of Budget</i> | | | | <i>-0.2%</i> | | <i>0.0%</i> |

9 months budget is the 9 months plan for 22/23

Variance Signage: (Favourable)/Adverse

The above table details the categories of expenditure within GP and Other Prescribing.

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. There 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 |
|--|---|
| <p>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.</p> | <p>Robust management and oversight, through collaborative working between finance and medicines management to understand trends, variances and cost</p> |
| <p>Financially unstable practices</p> | <p>There are practices which are receiving resilience support from the ICB. 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".</p> |
| <p>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)</p> | <p>The ICB 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</p> |
| <p>Delegated financial position and the inability to control the spend within the ICB due to nationally mandated expenditure.</p> | <p>Negotiation with NHS England and Improvement and involvement in national allocation working groups. Look to cease or defer non mandated expenditure where possible.</p> |