Improving lives together
Norfolk and Waveney Integrated Care System

Meeting of the Norfolk and Waveney ICB Primary Care Commissioning Committee
Tuesday 7 February 2023, 9am-10am Part 1
Meeting to be held via video conferencing and You Tube

Item	Time	Agenda Item	Lead
1.	09:00	**Chair's introduction and report on any Chair's action**	Chair
2.		**Apologies for absence**	Chair
3.		**Declarations of Interest** To declare any interests specific to agenda items. Declarations made by members of the Primary Care Committee are listed in the ICB's Register of Interests. *For Noting*	Chair
4. Pg 5 Pg 18		**Review of Minutes and Action Log from the January 2023 meeting** *For approval* **Matters arising** Primary Care Committee Terms of Reference – *For Noting*	Chair
5. Pg 31		**Forward Planner** *For Noting*	SP
		Service Development	
6. Pg 32		**Providing General Practice Services in Norwich – Public Consultation** *For Noting*	SP
7. Pg 56		**Learning Disability Health Checks** *For Noting*	SN
8. Pg 62		**Estates Quarterly Update** *For Noting*	PH
9. Pg 71		**CQC Reports** *For Noting* • Heacham	SN
10. Pg 78		**SMI Health Checks** *For Noting*	JD
		Finance & Governance	
11. Pg 82		**Primary Care Commissioning Committee Self-Assessment** *For Approval*	SP
12. Pg 86		**Prescribing Report** *For Noting*	MD
13. Pg 93		**Finance Report** *For Noting*	JG
		Any Other Business	
14.		**Questions from the Public**	Chair
Date, time and venue of next meeting **Tuesday 14 March 2023, 13:30 – 16:30 – ICB PCCC** **To be held by videoconference and You Tube**			
Any queries or items for the next agenda please contact: **sarah.webb7@nhs.net**			
Questions are welcomed from the public. **Please send by email: nwicb.contactus@nhs.net** **For a link to the meeting in real-time** **Please email: nwicb.communications@nhs.net** **Glossary of Terms** **https://improvinglivesnw.org.uk/about-us/website-glossary-of-terms/**			

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

Declared interests of the Primary Care Commissioning Committee

Name	Role	Declared Interest- (Name of the organisation and nature of business)	Type of Interest			Is the interest direct or indirect?	Nature of Interest	Date of Interest		Action taken to mitigate risk
			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests			From	To	
James Bullion	Partner Member - Local Authority (Norfolk), Norfolk and Waveney ICB	Norfolk County Council		X		Direct	Executive Director Adult Social Services, Norfolk County Council	Ongoing		In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		Skills for Care		X		Direct	Trustee of Skills for Care	Ongoing		Member prepared to leave any meeting where training and development provision might be likely awarded or recommended to be provided by skills for care
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	
		South Norfolk PCN				Indirect	Clinical Director of SNHIP Primary Care Network	2022	Present	
Steven Course	Executive 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	Executive Director of Nursing, Norfolk and Waveney ICB	Royal College of Nursing		X		Direct	Member of Royal College of Nursing	Ongoing		Inform Chair and will not take part in any discussions or decisions relating to RCN
Hein van den Wildenberg	Non-Executive Member, Norfolk and Waveney ICB	Lakenham Surgery			X	Direct	Registered patient at 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	Executive Director of Patients and Communities, Norfolk and	Drayton Medical Practice			X	Direct	Registered patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice

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	Waveney ICB	Castle Partnership				Indirect	Partner is a practice nurse at Castle Partnership	Ongoing		might have an interest
Shepherd Ncube	Head of Delegated Commissioning	Nothing to Declare	N/A			N/A	N/A	N/A		N/A
Sadie Parker	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 Joint Chief Executive	N&W 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.
		N&W ICB				Indirect	Close relative is an employee of N&W ICB	Ongoing		Will not take part in any discussion or decisions relating to the declared interests
		Windmill Surgery				Direct	Registered patient at 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	Registered patient at 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	
Rosemary Moore	Member Practice Representative	Norfolk and Waveney ICB	X			Direct	Employed by Norfolk and Waveney ICB as Senior Primary Care Resilience Manager	2020	Present	Will not take part in any discussion or decisions relating to the declared interests.
		Blofield Medical Practice			X	Direct	Registered patient at 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	2022	
		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	Registered patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice
		Norfolk County Council	X			Direct	Elected Member of Norfolk County Council, Elmham and Mattishall Division	Ongoing		Low risk. In attendance as a representative of the Local Authority. Chair will have overall responsibility for deciding whether I be excluded from any particular decision or discussion.
		Norfolk County Council	X			Direct	Cabinet Member for Adult Social Care and Public Health	Ongoing		
		Norfolk County Council	X			Direct	Chair of Norfolk Health and Wellbeing Board	Ongoing		
		Breckland District Council	X			Direct	Elected Member of Breckland District Council, Upper Wensum Ward	Ongoing		

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		Norfolk County Council	X			Direct	Chair of Governance and Audit Committee	Ongoing		
		Manor Farm	X			Direct	Farmer within Dereham patch	Ongoing		Low risk. If there is an issue it will be raised at the time.
James Reeder	Suffolk Health and Wellbeing Board	Suffolk County Council	X			Direct	Cabinet Member for Children and Young People's Services	Ongoing		
		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		
		Norfolk and Suffolk NHS Foundation Trust	X			Direct	Norfolk and Suffolk Foundation Mental Health Trust – Governors Council	Ongoing		
		Suffolk and North East Essex Integrated Care Partnership	X			Direct	Suffolk County Council representative for Suffolk and North East Essex Integrated Care Partnership	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		
Healthwatch Attendees (Norfolk and Suffolk)										
Andrew Hayward	HealthWatch Norfolk Trustee	East Harling GP Practice			X	Direct	Registered patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
		HealthWatch Norfolk	X			Direct	Trustee and board member HeathWatch Norfolk	2020	Present	Will not take part in any discussion or decisions relating to the declared interests.
		East Harling Parish Council			X	Direct	Member, East Harling Parish Council	2020	Present	
		NHS England		X		Direct	GP appraiser, NHSE	2015	Present	
Sue Merton	HealthWatch Suffolk	Nothing to Declare	N/A				N/A	N/A		N/A

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Improving lives together
Norfolk and Waveney Integrated Care System

Norfolk and Waveney Primary Care Commissioning Committee

Part One

Minutes of the Meeting held on Tuesday 10 January 2023 via video conferencing & YouTube

Voting Members - Attendees

Name	Initials	Position and Organisation
Hein Van Den Wildenberg	HW	Non Executive Member, Norfolk and Waveney ICB (Deputy Chair)
Steven Course	SC	Executive Director of Finance, Norfolk and Waveney ICB
Chris Turner	CT	Associate Director of Nursing and Quality, Patient Safety Specialist, Norfolk and Waveney ICB, deputising for Tricia D'Orsi, Executive Director of Nursing

In attendance

Name	Initials	Position and Organisation
Mel Benfell	MBe	Joint Chief Executive Officer, Norfolk & Waveney Local Medical Committee
Mark Burgis	MB	Executive Director of Patients and Communities, Norfolk & Waveney ICB
Cllr Bill Borrett	BB	Chair of the ICP and Partner Member of the ICB
Michael Dennis	MD	Associate Director of Medicines Optimisation, Norfolk and Waveney ICB
James Foster	JF	Practice Manager Committee Attendee
Carl Gosling	CG	Senior Delegated Commissioning Manager Primary Care, Norfolk & Waveney ICB
James Grainger	JG	Senior Finance Manager – Primary Care, Norfolk & Waveney ICB
Sarah Harvey	SH	Head of Primary and Community Strategic Planning, Norfolk and Waveney ICB
Andrew Hayward	AH	Trustee of Healthwatch Norfolk
Sue Merton	SM	Healthwatch Suffolk
Rosemary Moore	RM	Practice Manager Committee Attendee
Shepherd Ncube	SN	Associate Director of Delegated Commissioning, Norfolk and Waveney ICB
Sadie Parker	SP	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
Sarah Webb	SW	Primary Care Administrator (minute taker) Norfolk & Waveney ICB

Apologies

Name	Initials	Position and Organisation

James Bullion	JB	Chair, Partner Member – Local Authority (Norfolk) Norfolk & Waveney ICB
Dr Hilary Byrne	HB	ICB Board Partner Member – Providers of Primary Medical Services, Norfolk & Waveney ICB
Patricia D'Orsi	PDO	Executive Director of Nursing, Norfolk & Waveney ICB

Attendees to support the meeting

Amanda Brown	AB	Head of Corporate Governance, Norfolk & Waveney ICB
Tony Dean	TD	Chief Officer, Norfolk Local Pharmaceutical Committee
Jayde Robinson	JRo	Head of Primary Care Workforce Transformation Norfolk & Waveney ICB

No	Item	Action owner
1	**Chair's introduction**	**Chair**
	HW welcomed everyone to the meeting. HW was chairing on behalf of JB.	
2	**Apologies for absence**	**Chair**
	Noted above.	
3.	**Declarations of Interest** *For Noting*	**Chair**
	RM declared she was now working as Senior Primary Care Resilience Manager, Norfolk and Waveney ICB on an interim basis.	
4.	**Review of Minutes and Action Log from the December 2022 Committee** *For Approval*	**Chair**
	The minutes were agreed to be an accurate reflection of the December 2022 Committee. **ACTION:** SW to send to JB for signing **Action Log** ACTION 126 MB updated members. Activity had been focused on debunking myths and appointment data to demonstrate work done in primary care had been shared. Work had been done with EDP and Look East and the social media campaign and this would continue.	**SW**
5.	**Forward Planner** *For Noting*	**SP**
	The planner was noted.	
6.	**Risk Register** *For Noting*	**SP**
	SP focused on one RED risk. **Resilience of General Practice** The update included discussion with the LMC prior to Christmas about support provided to general practice to enable them to clinically prioritise patients. The system remained very challenged in urgent and emergency care and January was an exceptionally business month. Practices had been written to, to confirm	

	assurances over what support would be provided to them to be able to clinically prioritise patients where that may impact them in other areas. In addition, funding had recently been approved which equated to about £150,000 for each of the 5 localities specifically to support winter resilience in general practice. Discussions about potential further support continued with the LMC and as MB had highlighted, some of the work that had been undertaken with communications. SP paused to allow MBe to comment. MBe highlighted a discussion that was held at last month's Committee which followed on comments made by the LMC prior to the December meeting which asked that the significant risk to general practice associated with secondary care interface issues remained recorded. This was agreed by the Chair and has been documented within the December minutes but was not reflected within the risk register. MBe felt that as this is a major cause of risk factor to general practice and work had been done between the ICB and LMC where an action plan had been pulled together and sent to secondary care providers before Christmas to mitigate risks (in acknowledgement that they exist) therefore MBe questioned why this also had not been reflected within the risk register update. SP responded by saying that in November 2022 there had been an agreement to close the risk as the infrastructure had been put in place to support the work around the secondary and primary care interface. A discussion took place, and it was agreed to reference the secondary care interface risk and action plan within PC14 going forward. **ACTION: SP to include reference to interface risks within risk PC14 and share with the LMC.** SP went on to highlight PC10 – gabapentanoids – SP confirmed MD would refer to this in his later report and SP felt that the risk summary showed trends were quite positive for the system. MD expected that he may be able to reduce the score on this at the next update. If this trend continued there would be a recommendation to close in line with its individual target date at the end of March 2023. MD highlighted that the score on the summary sheet was incorrect and showed it had moved from 9 – 12 when it should show 9 and MD would amend this. MD agreed that if the trend remained below top quartile to retire the risk and monitor this through his monthly update. SP went on to discuss SMI – severe mental illness health checks. There was a paper on the agenda today. SP pointed out that the ICB target date was the end of March 2023 and SP felt it was unlikely the target would be met and recommended that the risk would be extended and this would be reported on separately. HW thanked SP for the update.	**SP**

7.	**Learning Disability Health Checks** *For Noting*	**SN**
	SN provided an update to Committee which demonstrated the progress made since last month. SN highlighted the 6% increase in activity from last month and compared to the same period last year there was an 11% increase. At the end of November, it would be 44% and was expected to reach over 50% by end of December. SN confirmed the good position against national target and local ambition. Regular delivery meetings continued with localities to ensure we remained on track. Practices with low uptake had been contacted with a view to provide additional support. Information continued to flow to PCNs and to practices ensuring that regular conversations were held on progress made. SN would continue to report on progress made monthly. The final point was around the risks and feedback received from practices around healthchecks slowing down in December partly due to weather. SN gave an example where within a practice 7 DNAs occurred on one day due to bad weather and so reflection on what could be done to respond to changing conditions may be useful. A reduction had also been seen during the festive season. SN spoke about the focus on the year end position and the plans to reach out to as many people as possible. MB noted the good progress and the variation across Norfolk and Waveney and asked about comparisons regionally and nationally. SN confirmed that comparative data had been part of the monthly reporting and unfortunately this data was not yet available this month. This information would be included in future reports when it was available. SN confirmed that the ICB had been leading in the region but recognised that more could be done. SC referred to the next steps which SN had outlined and the additional bid for funding and asked whether it was a bid for this financial year or for the longer term. SN confirmed it was for the current year. 75% uptake was the national target, but the local ambition was beyond that, and the additional funding was requested to help meet the target and to reach more people. JR referred to a comment he had read in the paper where it was stated there were a lot more people registered with severe learning difficulties in our region and wanted to know who and why and whether these were measured any differently. SN felt that register had improved over the time and that was a consistent pattern across the country where the registers had grown. MBe felt it was pertinent that Norfolk was one of the original pilot sites for the learning disability health check DES meaning practices are well used to working with partners to identify specific patient cohorts and general practice also does well at delivering this service, most recently with the support of the ICB. HW thanked MBe for the historical context and there being no further questions thanked SN for his report.	

8.	**SMI Health Checks** *For Noting*	**JD**
	JD took the paper as read and provided the SMI update to Committee for noting. JD acknowledged the local trajectory was split into quarters and one of the risks to delivery was winter and the pressure felt in general practice. JD referred to a meeting which had been held earlier in the day with locality colleagues who had relayed concerns from GP practices who were experiencing high workload. It was hoped activity would catch up in quarter 4. JD would indicate a clear benchmarking position for Norfolk and Waveney for his next report. JD wanted to update on some of the learning from the overall health check meeting that he attended which addressed SMI, LD, diabetes etc which JD felt had been positive and outlined what outcomes he hoped to achieve from this meeting, which included launching a roadshow in each of the main localities in Norfolk and Waveney. JD offered to take questions. BB was interested to see the benchmarking data and thanked JD for including that. He wanted to pick up on the meeting about health checks and was also pleased to hear about the roadshow and the options available to patients. If the long-term ambition was more prevention and patients becoming empowered to care for themselves to make the necessary adjustments to their lives, BB gave his support to this as he felt it would be a key piece of work going forward and part of the ICB 5-year plan. BB asked that once a quarter there could be a focus on data and in between months updates on SMI health checks. HW felt this could be framed as an action point and some thought given to how it would shape into the forward planner **ACTION: JD to set this out in the forward planner.** JR fully supported both JD and BB comments. Talking about health checks more generally, JR referred to his experience of getting health checks and gave examples of what was taking place at Suffolk County Council. This had included patients that would not normally attend a health check appointment and referenced the idea of working out in the community. JD felt it would be beneficial to include the ambitions in the next report. A starting point would be to communicate a message out first and to raise the profile of health checks before a launch. He felt that there had been support from patients' groups for this and felt that patients receiving health checks in a community setting might remove some of the fears of having a health check. JR referred to a personal experience of being invited for his own NHS health check and asked if this was best use of general practice time as JR felt that hosting these in the community would be the answer. BB picked up that he had been challenging the public health team in his role as a cabinet member, to invest more in the NHS health check programme and to look at the performance as some had been delivered by general practice but	**JD**

	not enough. One of the things considered was to bring in alternative outside providers to help increase the provision of the NHS health check outside general practice. BB would like to see health checks more embedded as a key delivery priority of general practice, albeit noted the impact amongst all the other pressures. MBe felt there was some confusion around the terminology being used and raised the need for the Committee to be explicitly clear on who was meant when using the term 'primary care' and what was meant by 'health check'. There are various types of health checks that are commissioned by different organisations, from different providers that are only deliverable to specific patient cohorts. These are all enhanced services, so general practice has the option to deliver them. The NHS Health Check, which JR was referring is commissioned by County Council Public Health teams from both general practice and pharmacies, as well as Reed Wellbeing and the County Council itself in Norfolk. These are only available to specific cohorts of patients. NHS Health Checks are therefore not within the ICB remit. The LD Health Check DES is commissioned by contracting directly with individual general practices to deliver this check to their own patients on a specific register. The SMI Health Check is an LCS commissioned by the ICB directly with general practices to deliver to their own patients on a specific register. Secondary care providers are also responsible for providing this health check to some patients on the register. MBe referenced recent collaborative work the LMC Executive had done with Norfolk County Council public health team to onboard general practice and the public with changes in the wider delivery of NHS Health Checks and offered to work with JD on the messaging to general practice and the public if wider uptake up of health checks was something that the ICB wanted to promote. HW thanked MBe for the offer of support working with JD. AH updated Committee that Healthwatch Norfolk had carried out surveys commissioned by the County Council in relation to NHS health checks and would be able to provide an update at a future meeting. AH felt that due to the limitations of the health checks available managing patient/public expectation was important. HW thanked JD for the update and reflected on the discussion and asked officers to consider how this could be incorporated in a future update. **ACTION: SN to engage with partners and consider how and when to provide an update on NHS Health checks.**	**SN**
9.	**Workforce and Training Update** *For Noting*	**JRo**
	JRo took the paper as read and guided the Committee through the main points and highlights. HW thanked JR for the update and opened for questions.	

	MBe clarified that the LMC had sent a number of comments on this report and the paper in part 2 and asked that the situation with the ARRS funding was clarified as there appeared to be a contradiction in the information provided. JRo confirmed that ARRS funds budget utilisation sat at 87% across the PCNs and this was the position as of the end of November. Work was continuing with the PCNs and their succession planning within the recruitment plans. Rotational roles and joint roles were being considered with the introduction of some pharmacy work in particular. There were a number of ways that we are working with PCNs directly in order to utilise the full budget within this financial year. MBe continued to press on the spend as the paper stated there was no underspend however the next agenda item stated there was a significant underspend and the LMC wished to understand which it was. HW felt that the update from JG later on the agenda may help. BB thanked JRo for the update and was pleased to see this being presented to Committee. He asked how the change of governance for this workstream would fit with the ICB workforce and primary care strategies and how joined up it would be across the different parts of health and social care. JRo confirmed that she, along with her team, sat under the ICB workforce team, having been previously aligned to primary care. JRo confirmed that they were in a different directorate under workforce but were all aligned. The strategy was in line with the ICB strategy and JRo provided some examples. Primary care workforce funding continued to flow through the primary care committee. BB confirmed he had supported job fairs for health and social care and JRo confirmed these were part of the wider workforce recruitment plans and gave examples of recruitment drives. There being no further questions, HW thanked JRo for the report.	
10.	**Primary Care Networks Direct Enhanced Services** *For Noting*	**SH**
	SH took the paper as read and outlined highlights to Committee for noting. SH apologised for the confusion around the ARRS budget as this had been data which was received at the end of November when there was a forecast underspend but there were plans to ensure that the funding was used by the end of the year. There being no further questions, HW thanked SH for the report.	
11.	**CQC Reports** *For Noting*	**SN**
	Wensum Valley Medical Practice SN outlined highlights in the report. CT thanked SN for the update and advised that the newly appointment ICB patient safety nurse fellow had linked in with Wensum to support them with the governance around incident reporting. Progress had been made and work continued to help embed some of what had already been achieved. CT felt this was positive, and the practice was fully engaged.	

	JR noted the speed in which assistance had been provided to move the rating, asked if that was correct and offered congratulations. SN thanked JR and confirmed that work had been underway for a long time and accelerated recently and close working had been undertaken by the CQC and they had been supporting the practice. There being no further comments or questions HW thanked SN for the report.	
12.	**Terms of Reference Review** *For Approval*	**AB**
	AB provided an update to Committee on the Terms of Reference and took the paper as read. MBe confirmed that comments and questions had been made by the LMC and responses were awaited, along with the final draft. MBe raised concerns around the governance of proposing a document for PCCC approval when it was not the final version and there were outstanding issues. AB appreciated the LMC comments and that the LMC had not seen a final version that showed the comments had been accepted. The document would be shared after this meeting, once all comments had been considered. MBe clarified that the LMC concerns included that, along with the LMC, other attendees and the voting members had not seen the version that they were being asked to vote on because this was on the agenda for approval, not for noting. HW agreed it was for the ICB Board to approve the Terms of Reference. HW took the LMC's point and asked SP to clarify. SP confirmed that due to meeting times it was not possible to wait until the February PCCC meeting to bring the final version of the TOR as they need to be approved at the February ICB Board meeting. As a result of the feedback and comments from members and attendees today these would be taken on board and combined with the feedback from all the Local Representative Committees, then recommended to the Board for approval. SP would ensure that comments were responded to and an updated version circulated virtually outside of the meeting, which Members can then support. This would be brought back to February PCCC for noting at the next meeting in public. HW felt this was a pragmatic approach and would give JB the opportunity to review the updated version. RM stated she couldn't find anywhere in there the length of term for members and didn't know whether it should be included. RM felt that it would clarify for both members and the wider audience AB confirmed it was not something that was usually set out in the Terms of Reference, but felt it was a good point and perhaps could be added to another document, she would consider the most appropriate location. BB welcomed these Terms of Reference. BB felt it would be a change of role to the Committee as it would be more strategic and more assurance driven especially as there would be delivery groups underneath with general practice and dentistry.	

	BB was concerned that dentistry needed support and that the Committee should have a clear idea of current performance and the trajectory over the last year so that there was a realistic starting place when the ICB took over responsibility. BB explained that he sits on the ICB, as does the Chair James and Hein and if there were any issues that should be raised at that meeting, he would be happy to do so. BB was broadly in favour of the principle of two new delivery groups that sat underneath this Committee, as this would give the Committee more time to consider strategic matters. HW agreed that he supported the addition of the delivery groups and was looking forward to a strategic shift for PCCC and the assurance that afforded this change. AH asked for clarity over the membership of the delivery groups as it indicated a question mark by the side of Healthwatch and asked if they were welcome to attend. AB referred to FT for confirmation. FT confirmed that Healthwatch were very welcome but very conscious that the creation of two more groups would add more to Healthwatch's workload. FT would try and manage the workload and confirmed that she wanted to have a conversation with both Healthwatch organisations to ensure they were happy to support both groups. MBe wanted to clarify to those who hadn't seen the LMC comments that their concerns did not relate to the formation of the delivery groups. The queries were in relation to terminology, wording and attendees and so if the ask was of voting members to support the progression and formation of the delivery groups and the proposed structure of what is decided where then that would be different to the actual approval of the ToR. The LMC understood BB's comments and supported AH's comments. HW finished by saying that a final version would be circulated to voting members ahead of submission to the Board.	
13.	**Prescribing Report** • **Community Pharmacy Strategy** *For Noting*	**MD** **TD**
	MB provided his prescribing report to Committee and the report was taken as read. There being no questions TD was invited to the meeting to update on the Community Pharmacy Strategy for Committee to note. TD then went on to provide a briefing to Committee. HW thanked TD for the update and welcomed this and noted how clearly this had been laid out. SP agreed that the plan on the page was clear and SP recognised the hard work that had been put in place and thought needed to the infrastructure around delivery past April. While the commissioning was being hosted by another ICB, this ICB would be responsible for strategy and development locally. SP reported that work was being done on the primary and community development approach and it was the ICB's intention to set up a board, which	

	would include the LPC as members. The strategy would be an early agenda item to enable us to consider delivery against strategy and workforce. HW thanked SP and asked if there were any other questions of comments along with what the plan was for April. TD welcomed the fact that community pharmacy would sit squarely within primary care with a dotted lined to other providers as there was interaction with community care, medicines optimisation and many others. MB noted it was an integral part and played a vital role. MB acknowledged the schemes being worked on and felt that integrating services would bring real opportunity. MB went on to say he welcomed working together. TD noted that in the Northeast of England they had introduced a regionally commissioned pharmacy first scheme where pharmacies provided funded consultations and supply. While these were not necessarily the preferred models for our system, there were innovations that could be explored to relieve the pressure in the system. TD felt there needed to be ambition, as though pharmacies were not necessarily in a "good place" overall, there were a large number that could do more given adequately commissioned service developments. JF wondered, if a home medicine preauthorisation scheme which might ease pressure on GP surgeries was something to explore, which pharmacies could easily deliver? TD confirmed that something similar was being introduced in the Northeast of England. MD confirmed that over the counter provision was being addressed, particularly in respect of asylum seekers, and would be interested to explore the model that the Northeast had set out. Consideration was being given to moving oral antivirals into key pharmacies rather than in hospital settings and that work should be going live soon. MD looked forward to working on this and thanked TD. There being no further comments HW thanked MD and TD for their respective updates.	
14.	**Finance Report** *For Noting*	
	JG provided the finance report to Committee for noting. **Executive Summary** The position at M8 for primary care and prescribing budgets were £1.6m adverse to budget for the ICB, which represented Q2-Q4 of this financial year. This did not include a £3.5m payment due from NHSE for the additional ARRS spend. When this was received in full around M10 the underlying position would be £1.9m favourable. This position included an efficiency target of just over £7.3m built into the budget. This formed part of the full year efficiency requirement of £8.4m. Through continued monitoring of the efficiency projects, current forecast was to deliver slightly below plan. The project with the highest potential underspend being the Low-Risk Cost effective switching project. **Financial Summary**	

	GP prescribing was £0.6m adverse to plan as at M8. With the figures being 2 months in arears, this showed the April to September estimated cumulatively were undervalued. Efficiency savings had materialised in this period which allowed the forecast to be delivered and these efficiency expectations were within budget. Of the £7.3m requirement for the 9 months, 6 months of actual achievement had been received. There were also prior year benefits within GP Prescribing. These were critical to the 2023/24 plan being developed, as these benefits were non-recurrent to 2022/23 and would not be available in 2023/24. There was a prior year benefit and other positive variances within delegated primary care that had crystalised worth £2.0m year to date. **Detailed Finance Analysis** This showed the key drivers behind the prescribing spend being on plan however there were still some key areas of risk around Continuous Glucose Monitoring and SGLT2. There was a high degree of uncertainty over the financial implications of these factors. We received additional EPACT figures for DOACS, CGM and SGLT2 which showed large year on year increases up to M8. **Delegated Commissioning** The underspend was predominantly due to the way in which PMS and GMS budgets were ring fenced to delegated primary care and prior year credits from 2021/22 most specifically around the accruals for QOF. **GP and Other Prescribing** Variances within Prescribing lead to the overall 9 month adverse forecast of £1.1m which had moved significantly from M7 to M8 as some of the prescribing cost pressures materialised. There remained a large degree of uncertainty and risk within prescribing. The finance and medicines management teams worked closely together to monitor the EPACT data for the key areas of risk DOACS, Continuous Glucose Monitoring and SGLT2 which continued to grow considerably more than the growth built into our budgets. There was a high degree of pressure coming from No Cheaper Stock Obtainable (NCSO) items and some high increases in prices had been seen which would begin to materialise in M8 onwards and look to stabilise M9 to M10. There being no questions HW thanked JG for his report.	
15.	**Any Other Business** **Questions from the Public**	**Chair**
	Haniya Chaudhary asked a question around plans for addressing domestic violence and abuse within a healthcare setting and where this sat in current priorities and plans. As mentioned today, prevention and early intervention was a priority as the health issues that were connected to domestic violence and abuse in Norfolk. Haniya asked what the plans were to improve general practice and their training around identifying domestic abuse at an earlier stage.	

	MB thanked Haniya for her question and felt that it would be a suggestion to use the Contact Us option in order to provide a full and comprehensive answer and committed to doing so. The meeting then concluded at 15:05	

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

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

Norfolk & Waveney IBC Primary Care Commissioning Committee - Part One
Action Log 07 February 2023

No	Meeting date added	Agenda Item	Owner	Action Required	Action Undertaken / Progress	Due date	Status	Date Closed
0126	13-Dec-22	6	MB	Director of Patient and Communities Report - MB to action further communications to be produced for patients in support of primary care.	MB confirmed that this was underway and continued to progress through various channels.	07-Feb-23		10-Jan-23
0127	13-Dec-22	7	SN	SN to complete deep dive into declines and provide more context within his next Learning Disabilities Health Checks update.	Underway, propose to bring to February 2023 meeting	07-Feb-23		
0128	13-Dec-22	8	JD	JD to provide information on benchmarking within his next Severe Mental Illness health checks report and provide Committee with oversight of the learning from the annual health checks meeting (that look at SMI, LD, Diabetes etc.)	Benchmarking included in the report.	10-Jan-23		10-Jan-23
0129	10-Jan-23	4	SW	Signed December 2022 minutes to chair	Signed minutes sent to chair	07-Feb-23		10-Jan-23
0130	10-Jan-23	6	SP	Risk register - SP to reference Interface updates within PC14 going forward and share with the LMC.		14-Mar-23		
0131	10-Jan-23	8	JD	JD to set out focus on data and updates on SMI in the forward planner		07-Feb-23		
0132	10-Jan-23	8	SN	SN to engage with partners and consider how and when to provide an update on NHS Health checks		TBC		

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APPENDIX F

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

1 Constitution

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

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

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

2 Authority

2.1 The Committee is authorised by the Board to:

- Investigate any activity within its terms of reference.
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these terms of reference.
- Create a Primary Medical Services Delivery Group and a Dental Services Delivery Group that will undertake specific agreed tasks and decision making as set out in the ICB Scheme of Reservation and Delegation as delegated to the appropriate director (SoRD). The Committee shall appoint the Chair and agree the membership and terms of reference of these groups in accordance with the ICB's constitution, standing orders and SoRD.

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

3 Purpose

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

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

3.3 The Committee has no executive powers, other than those delegated in the SoRD and

specified in these terms of reference.

4 Membership and attendance

Membership

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

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

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

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

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

Chair and Vice Chair

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

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

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

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

Attendees

4.9 Only members of the Committee have the right to attend Committee meetings. The following individuals, who are attendees and not members of the Committee, will be invited to attend Part 1 and Part 2 meetings subject to s.4.10:

- ICB Board Partner Member – Providers of Primary Medical Services
- Local Representative Committee members – Local Medical Committee, Local Dental Committee, Local Pharmacy Committee and Local Optical Committee
- Director of Patients and Communities
- Director of Primary Care
  One practice manager (or other suitably experienced individual) from primary medical services and one from (NHS) primary dental

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

- Healthwatch Norfolk

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

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

4.11 Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter including representatives from the Health and Wellbeing Boards, Secondary and Community Providers.

Attendance

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

5 Meetings Quoracy and Decisions

5.1 The Committee will meet at least 4 times a year in public subject to the application of 5.4 below. The Committee will operate in accordance with the ICB's Standing Orders. The Secretary to the Committee will be responsible (or delegate where appropriate) for giving notice of meetings. This will be accompanied by an agenda and supporting papers and sent to each voting member and non-voting attendee at least 7 calendar days before the date of the meeting. When the Chair of the Committee deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as s/he/they shall specify. Additional meetings may take place as required in public or private as appropriate for the nature of the business to be transacted.

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

5.3 In accordance with the Standing Orders, the Committee will normally meet virtually unless a face to face meeting is deemed necessary.

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

Quorum

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

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

5.6 If the quorum has not been reached, then the meeting may proceed if those attending

agree, but no decisions may be taken. If an urgent decision is required, the process set out at 5.10 and 5.11 may be followed.

Decision making and voting

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

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

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

Urgent Decisions

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

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

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

6 Responsibilities of the Committee

6.1 NHS England has delegated to the ICB authority to exercise the primary care commissioning and dental functions in accordance with section 13Z of the NHS Act and as set out in Schedule 2 of the Delegation Agreement as follows:

Schedule 2A: Primary medical services

- decisions in relation to the commissioning and management of Primary Medical Services;
- planning Primary Medical Services in the Area, including carrying out needs assessments;
- undertaking reviews of Primary Medical Services in respect of the Area;
- management of the Delegated Funds in the Area;
- co-ordinating a common approach to the commissioning and delivery of Primary Medical Services with other health and social care bodies in respect of the Area where appropriate; and
- such other ancillary activities that are necessary in order to exercise the Delegated Functions.

Schedule 2B: Primary dental services and prescribed dental services

- decisions in relation to the commissioning and management of Primary Dental, Services; for clarity this includes primary care, community care/special care dental services and secondary care dental services;
- planning Primary Dental Services in the Area, including carrying out needs assessments;
- undertaking reviews of Primary Dental Services in the Area;
- management of the Delegated Funds in the Area;
- co-ordinating a common approach to the commissioning and delivery of Primary Dental Services with other health and social care bodies in respect of the Area where appropriate; and
- such other ancillary activities that are necessary in order to exercise the Delegated Functions.

Schedule 2C: Primary ophthalmic services

Ophthalmic services are hosted by Hertfordshire and West Essex Integrated Care Board (H&WE ICB) on behalf of the ICB. In accordance with the Memorandum of Understanding with HWE ICB and other ICBs in the East of England region H&WE ICB will report general optometry services matters to the Committee including information to support decision making as and when matters arise. The ICB remains responsible and accountable for the provision of this service.

- decisions in relation to the management of Primary Ophthalmic Services;
- undertaking reviews of Primary Ophthalmic Services in the Area;
- management of the Delegated Funds in the Area;
- co-ordinating a common approach to the commissioning of Primary Ophthalmic Services with other commissioners in the Area where appropriate; and
- such other ancillary activities that are necessary in order to exercise the Delegated Functions.

Schedule 2D: Pharmaceutical services and local pharmaceutical services

Pharmaceutical services are hosted by HWE ICB on behalf of the ICB.

NHS England has established mandated local committees to be known as Pharmaceutical Services Regulations Committees (PSRC). The PSRC is an ICB committee with representatives from all East of England ICBs attending. NHS England has delegated decision making to each PSRC in relation to matters under the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 as amended.

H&WE ICB will coordinate and host the PSRC to agreed Terms of Reference as set out in the NHS England Pharmacy Manual (https://www.england.nhs.uk/primary-care/pharmacy/pharmacy-manual/).

In accordance with the Memorandum of Understanding with HWE ICB and other ICBs in the East of England region H&WE ICB will provide quarterly reports to the Committee on decisions made at the PSRC.

Applications and Notifications will be made by H&WE ICB on behalf of the ICB to the PSRC for determination.

The ICB remains responsible and accountable for the provision of this service.

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

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

- Duty as to patient choice (section 14V);
- Duty as to promoting integration (section 14Z1);
- Public involvement and consultation (section 14Z2).

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

6.4 The role of the Committee shall be to carry out the functions relating to the commissioning of primary services under the NHS Act and detailed in the Delegation Agreement with NHS England.

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

a) The recommendations of the executive management team, the relevant Delivery Group and other Board committees;

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

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

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

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

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

7 Behaviours and Conduct

ICB values

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

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

Equality and diversity

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

Conflicts of Interest

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

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

Confidentiality

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

8 Accountability and reporting

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

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

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

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

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

9 Secretariat and Administration

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

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Committee Chair with the support of the relevant executive lead.
- Attendance of those invited to each meeting is monitored, highlighting to the Chair those that do not meet the minimum requirements.
- Good quality minutes are taken in accordance with the Standing Orders and agreed with the Chair and that a record of matters arising, action points and issues to be carried forward are kept.
- The Chair is supported to prepare and deliver reports to the Board.
- The Committee is updated on pertinent issues/ areas of interest/ policy developments.
- Action points are taken forward between meetings and progress against those actions is monitored.

10 Review

10.1 The Committee will review its effectiveness annually.

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

Date of approval:

Date of review:

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NORFOLK AND WAVENEY ICB - PRIMARY CARE COMMISSIONING COMMITTEE

Primary Care Commissioning Committee Scheme of Delegation (Interim) for Dental Services and Primary Medical Services

This Scheme of Delegation should be considered in conjunction with the Terms of Reference for the Primary Care Commissioning Committee. It will be reviewed in September 2023 to determine its effectiveness and fitness for purpose.

Purpose

The Primary Care Commissioning Committee ("PCCC") have agreed the establishment of a Primary Medical Services Delivery Group and a Dental Services Delivery Group that will undertake specific agreed tasks and decision making as set out in the Scheme of Reservation and delegation as delegated to the appropriate director. The Committee shall determine the membership and terms of reference of these groups in accordance with the ICB's constitution, standing orders and Scheme of Reservation and Delegation (SoRD).

The purpose of the Delivery Groups is to provide a framework for effective decision making in relation to certain contractual matters for general practice and dental services under delegated authority from the ICB's Primary Care Commissioning Committee. The PCCC Scheme of Delegation also allows for certain decisions to be made by an appropriate member of the Primary Care Commissioning Team as outlined in detail in Appendix A.

This PCCC Scheme of Delegation does not remove the ICB's obligations for engagement and consultation with patients and key stakeholders under 13Z of the Act. Decision making of each Delivery Group will be informed by appropriate and proportionate engagement and consultation with patients and communities and will also be evidence based making effective use of all available data and business intelligence as necessary.

Membership

The members of each Delivery Group will be agreed by the Primary Care Commissioning Committee.

The Chair of PCCC will appoint a Chair of each Delivery Group who has the specific knowledge, skills and experience making them suitable to chair the Group.

The voting members for each Delivery Group will be:

- Chair – Executive Director of Patients and Communities
- Director – Primary Care (Deputy Chair)
- Associate Director - Primary Care Commissioning
- Finance – Head of Finance
- Associate Director of Nursing and Quality

The following attendees may be invited to attend each of the Delivery Groups as described below:

General Practice Delivery Group	Dental Services Delivery Group
• Head of Primary Care Commissioning	• Head of Primary Care Commissioning
• Head of Primary and Community Care Strategic Planning	• Head of Primary and Community Care Strategic Planning
• Senior Primary Care Commissioning Manager (General Practice)	• Senior Primary Care Commissioning Manager (Dental)
• Representative of the Local Medical Committee	• Representative of the Local Dental Committee
• Healthwatch Norfolk and Healthwatch Suffolk	• Healthwatch Norfolk and Healthwatch Suffolk
• Representative from the ICB's BI team	• Representation from general dental practice team or community dental services
	• Representative of the Local Dental Professional Network
	• Consultant in Dental Public Health

The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters. Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter

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

Quoracy of Group meetings and decisions

Each Delivery Group will meet at least 4 times a year or more often to meet business needs. Each Group will operate in accordance with the ICB's Standing Orders and Detailed Delegated Financial Limits. The Secretary to each Group will be responsible (or delegate where appropriate) for giving notice of meetings. This will be accompanied by an agenda and supporting papers and sent to each voting member and non-voting attendee at least 7 calendar days before the date of the meeting. When the Chair of the Group deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as s/he/they shall specify. Additional meetings may take place as required as appropriate for the nature of the business to be transacted.

In accordance with the Standing Orders, the Group will normally meet virtually unless a face to face meeting is deemed necessary.

For a meeting to be quorate a minimum of three (3) Members of the Group are required

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

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

Decision making and voting

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

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

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

Urgent Decisions

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

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

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

General Responsibilities of the Delivery Groups

There will be two Delivery Groups directly reporting to PCCC:

- General Practice Operational Delivery Group
- Dental Services Operational Delivery Group

The responsibilities of each Delivery Group are described in section 6 of the Primary Care Commissioning Committee's Terms of Reference as set out in Schedule 2 of the Delegation Agreements with NHS England.

The Primary Care Commissioning Committee will provide assurance and oversight of all decisions made by the Delivery Groups of the Committee. Each Group will prepare an integrated assurance report that details the work of the Group. Frequency will be determined annually by PCCC and set out in the work plan of the PCCC. As a minimum, the integrated assurance report will include:

- Activities and decisions made by each Group since the last meeting
- Changes/updates to national policy/strategy
- Quality and Safety – emergent issues and thematic review and response
- Risk and finance assessment
- Forward plan
- Recommendations to PCCC (where required)

In addition to the two Delivery Groups acting as sub-groups of PCCC, the ICB may form other groups for primary care matters as required reporting to the People and Communities Board or to PCCC. For example, a Dental Taskforce to focus on dental transformation and strategy, or a community pharmacy strategy group. If established, each group will prepare a report to PCCC four times per year.

Phased introduction to Scheme of Delegation

It is envisaged that some decisions may be made by an appropriate member of the Primary Care Commissioning Team in the future, as described below, however initially the Primary Care Commissioning team will make a recommendation to the appropriate Delivery Group in a phased introduction to the Scheme of Delegation. This approach will be reviewed in September 2023 alongside review of the Scheme of Delegation with the intention of moving decision making for specified contractual matters to the Primary Care Commissioning Team. Individual roles within the Primary Care Commissioning Team empowered to make decisions will be set out in detail and agreed with the PCCC in advance.

APPENDIX A – Primary Care Commissioning Committee Scheme of Delegation

PRIMARY AND COMMUNITY CARE DENTAL SERVICES (For clarity, this includes Primary Dental Services commissioned under GDS or PDS contracts, special care dental services (community dental) and Level 2 specialist dental services, Out of Hours services and any other dental services commissioned by the ICB)	**Primary Care Commissioning Team (in line with Finance delegated budget authority) from September 2023**	**Dental Services Delivery Group**	**Primary Care Commissioning Committee**	**Financial impact, risk or cost pressure**
Change to hours of service delivery				
Sub-contracting				
Relocations				
Request to convert from PDS(+) *(time limited contract) to GDS (only if providing mandatory services) (changing to in perpetuity, the value of contract is likely to exceed £1m)*				
Managing Disputes – Informal Process				
Managing Disputes – (Local Dispute Resolution)				
Claims for Financial support (ex contract funding)				
Permanent re-basing by reducing contract value				
Incorporations/Dis-incorporation				
Force Majeure				
Contract Sanctions				
Contract Termination (initiated by provider)				
Contract Termination (initiated by ICB)				
Remedial notices				
Breach notices				
Managing Disputes – Informal Process				
Managing Disputes – (Local Dispute Resolution)				
Commission service intentions (<£100k)				
Commission service intentions (<£1m)				
Contract Award (<£1m over lifetime of contract)				
Commission service intentions (>£1m)				
Contract Award (>£1m over lifetime of contract)				
SECONDARY CARE DENTAL	**Primary Care Commissioning Team (in line with ICB Finance delegated budget authority) from September 2023**	**Dental Services Delivery Group**	**Primary Care Commissioning Committee**	**Financial risk or cost pressure**
Commission intentions (<£100k)				
Commission intentions (<£1m)				
Contract Award (<£1m over life time of contract)				

Commission intentions (>£1m)				
Contract Award (>£1m over life time of contract)				

PRIMARY MEDICAL SERVICES (For clarity, this includes general practice services commissioned under GMS, PMS and APMS contracts and Locally Commissioned Services)	**Primary Care Commissioning Team (in line with ICB Finance delegated budget authority) from September 2023**	**Primary Medical Services Delivery Group**	**Primary Care Commissioning Committee**	**Financial impact, risk or cost pressure**
Change to hours of service delivery (temporary)				
Changes to services (contractual) e.g. branch site closures, opening hours, services				
Local Enhanced Services				
Sub-contracting arrangements				
Practice relocation *(note: responsibility for dispensing relocation/changes is PSRC)*				
Managing Disputes – Informal Process				
Managing Disputes – (Local Dispute Resolution)				
Claims for Financial Support				
Practice Merger				
Incorporations/Dis-incorporation				
PCN DES contractual changes				
Force Majeure				
Contract Sanctions				
Contract Termination (initiated by provider)				
Contract Termination (initiated by ICB)				
Remedial notices				
Breach notices				
Change of practice boundary (increasing)				
Change of practice boundary (decreasing)				
Commission intentions (<£100k)				
Commission intentions (<£1m)				
Contract Award (<£1m over life time of contract)				
Commission intentions (>£1m)				
Contract Award (>£1m over life time of contract)				

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 7th	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	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			
	Restoring Diabetes Care								Y				
	GP resilience - Primary Care Multi Profressional Forum (CT)									Y			
Items noted without a date:													
Notes:													
01.08.22 - GP Patient Survey results report to September committee				Y									
05.09.22 Workforce and Training deferred to October committee													
05.09.2022 No CQC inspections published since the last committee													
13.09.2022 Following the death of Her Majesty the Queen, the public session of the primary care committee was cancelled in line with national mourning guidance received. A small number of time critical items were heard by voting members. 1) Branch closures advice note. 2) Additional roles and PCN DES appendix and PCN development funding focussed. 3) Enhanced access.													
11.10.22 workforce plans going to part 2 meeting													
11.10.22 SMI - No changes to update from previous month													
08.11.22 SMI will be a verbal update													
06.12.2022 Revised timeline for TORs review - now due in New Year to align with NHSE transition and other committees													
06.12.2022 Enhanced access paper, no new information to report													
07.02.2023 3 non-urgent items postponed due to time limits from rearranging meeting													

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Norfolk and Waveney
Integrated Care Board

Agenda item: 06

Subject:	**Providing general practice services in Norwich – public consultation**
Presented by:	**Sadie Parker, Director of Primary Care**
Prepared by:	**Sadie Parker, Director of Primary Care**
Submitted to:	**Primary Care Commissioning Committee**
Date:	**7 February 2022**

Purpose of paper:

This paper is for noting.

1. Background

Following approval by primary care committee members in private at the last meeting, the ICB has launched a public consultation on the provision of general practice services in Norwich.

The APMS contract covering the registered practice and walk in centre based at Rouen Road, Norwich, and the vulnerable adults service inclusion health hub comes to an end on 31 March 2024. A walk-in centre has been in place for many years in Norwich, and this particular contract hasn't changed since it was let as part of national policy in 2009.

It should be noted that GP practice attendees are likely to be conflicted by this report.

2. Consultation

The ICB is considering the options for how general practice services are delivered in the greater Norwich area when the current contracts come to an end in spring 2024. The consultation period commenced on 24th January and will run to 26th March.

The consultation document is attached. This is available online via our website and has been shared with health and care partners for them to promote. Hard copies of the survey are available in the walk-in centre. In addition to the survey, we have also engaged a company to do some in depth direct engagement, both running sessions within the walk-in centre itself, and to engage with various voluntary sector groups representing client groups, with the aim of including the views of groups and communities whose health needs may not always be met.

This consultation is an opportunity to look at the investment currently being made in these healthcare services and think about what the best option for these services might look like in the future. Is it to keep what we have, or make changes? If we make changes, where and how would people like to see services provided?

The consultation we have launched is a vital part of the commissioning process. We want to provide services that best meet patients' needs, are best value for taxpayer's money, and which create equity of access to care for everyone, including communities whose health needs are not always being met.

These considerations are important to make sure that general practice services are meeting the needs of local people now, and in the future.

Public feedback is important at this early stage to help us plan and design services that meet people's needs and support the health and wellbeing of people across all our communities. We will be listening very carefully to what local people are saying and are encouraging everyone to get involved and have their say.

Once the consultation process has been completed and we have analysed the responses, we will be taking a report on our proposals to the Norfolk County Council Health Overview and Scrutiny Committee, as well as bring proposals back to the primary care commissioning committee.

3. Recommendation to the Committee:

Committee members are invited to note the update.

Key Risks	
Clinical and Quality:	The survey will enable us to have a greater understanding of services important to patients.
Finance and Performance:	The survey will enable us to understand how to provide best value for money
Impact Assessment (environmental and equalities):	An equality impact assessment has been drafted and published with the survey document.
Reputation:	ICB is responsible for delegated commissioning as per its delegation agreement and in line with NHS Constitution and the national drive to address health inequalities within systems.
Legal:	ICB is responsible for delegated commissioning as per its delegation agreement and in line with NHS Constitution. The ICB is responsible to the Health Overview and Scrutiny Committee for demonstrating proposals are in line with the outcome of the consultation.
Information Governance:	The survey feedback is anonymous.

Resource Required:	ICB officers, company commissioned to undertake the in depth interviews
Reference document(s):	Delegation agreement and NHS Constitution
NHS Constitution:	
Conflicts of Interest:	GP practice attendees are likely to be conflicted.
Reference to relevant risk on the Board Assurance Framework	N/A

Governance

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

NHS
Norfolk and Waveney

Providing general practice services in Norwich

Norwich Walk-in Centre, Vulnerable Adults Service – Inclusion Health Hub, and GP Practice on Rouen Road

Public Consultation and Engagement

January 24th to March 26th 2023

If you would like this information in large print or in an alternative version, please contact NHS Norfolk and Waveney and we will do our best to provide it.

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communication for all

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Contents

What is the purpose of this document?

This document is published by NHS Norfolk and Waveney Integrated Care Board (**NHS Norfolk and Waveney**). It sets out some details on our proposed vision for how general medical services may be provided in Norwich when the contract for the Norwich Walk-in Centre (**WiC**), the GP Practice on Rouen Road, and the Vulnerable Adults Service – Inclusion Health Hub (**VAS**) expires on 31 March 2024. The Vulnerable Adults Service consists of three elements: Inclusion Health Hub, Inclusion Health practices, and Mainstream Primary Medical Services. Only the Inclusion Health Hub is within the scope of this document.

This document is the basis of the consultation process run by NHS Norfolk and Waveney to gather people's views from 24 January and 26 March 2023. It sets out:

- NHS Norfolk and Waveney's objectives
- The case for change with supporting evidence
- Several options considered by NHS Norfolk and Waveney that were developed during extensive engagement work and conversations with local people and clinicians
- The consultation process and how to have your say
- Opportunities for you to help shape what future services look like

Our objective

NHS Norfolk and Waveney seeks to work in partnership with people and communities. We have what is known as “Triple Aim” duty so when making decisions we need to consider all likely effects on:

- Health and wellbeing for people, including its effects in relation to inequalities
- Quality of health services for all individuals, including the effects of inequalities in relation to the benefits that people can obtain from those services
- The sustainable use of NHS resources

For further details of our statutory duties in respect of patient and public involvement please see NHS Norfolk and Waveney Integrated Care Board Governance Handbook on our website.

The objective of this consultation is to continue to find ways to provide good quality general practice services for people living in Norwich and surrounding area after the contract for the WiC, the GP Practice on Rouen Road, and the VAS expires on 31 March 2024.

When we are considering making changes to how we provide general practice services for patients we want to make sure we understand what impact they would have. We know that making decisions about changing how we provide care for people is important and we take these decisions seriously. So, we would like you to:

- Tell us what you think of the changes that NHS Norfolk and Waveney is proposing.
- Help us understand what the impact would be on patients using the Norwich WiC and the GP Practice on Rouen Road.
- Share your thoughts on how the healthcare capacity currently associated with the Norwich WiC could be reshaped to increase equity of access for all Norwich residents, help meet growing demand for general practice services, and support resilience of general practices in Norwich.
- Share your thoughts about any other options for reviewing provision of services that we might not have considered that would help us meet our objective of providing good quality general practice services for people in the greater Norwich area.

Setting the scene

The NHS introduced a policy in 2009 which saw every Primary Care Trust receive funding to commission (buy) an Alternative Provider Medical Services (APMS) centre with a registered list and walk-in centre across England with the aim of:

- Improving patients' access to general practice services - particularly when some patients have difficulties getting timely or convenient appointments with a GP practice or accessing primary care more generally
- Modernising the NHS to be more responsive to patients' busy lifestyles
- Offering patients more choice
- Accessing care from a GP or a nurse with no need to register or to pre-book an appointment
- Opening for longer hours than the typical GP practice

Norwich WiC

The WiC on Rouen Road, Norwich provides general practice services under that policy. This includes treatment of minor illness and injury to those who need it in Norwich and the surrounding area, whether registered with the health centre, another practice, or not registered with the NHS at all.

Patients don't need to make an appointment at the WiC, they don't need to be registered with a GP practice, and the opening hours are longer than those in other practices (7am – 9pm). It also provides access to vulnerable adults when the VAS is closed.

Currently the Norwich WiC provides approximately 5,666 appointments every month. To put that in context of overall general practice appointment activity, during the 12 months September 2021 to August 2022, there was an average of 557,000 appointments across Norfolk and Waveney.

The usage of the WiC is highest during normal business hours, with peak usage between lunchtime 12 – 1pm, and with a high amount of use during the early morning (7am – 9am). Usage is lowest during the last opening hours (7pm – 9pm). The busiest day is Monday.

The largest proportion of patients using the WiC are patients that are already registered with one of the 22 Norwich GP practices (66%). Seven percent (7%) are registered with the Rouen Road GP practice. The majority of patients seek treatment at the WiC for same-day general practice services rather than minor injury treatment.

General feedback from Norwich GP practices has highlighted that the WiC can help to improve patient access to healthcare by providing a safety net to help them meet on-the-day demand. It can help to improve resilience in general practice by providing additional capacity to practices experiencing sickness absence or other workforce pressures. It also helps to address health inequalities by providing access to healthcare for those who may be leading chaotic lives, who aren't registered with a GP practice, or who struggle to book appointments.

The WiC provides open access to general practice services for many people. This includes refugees and asylum seekers for whom English is not their first language, those who live chaotic lives, those who are not registered with the local health and

care system, and those who otherwise struggle to make or attend pre-booked appointments. These groups may be served by the VAS and associated services, and the WiC provides additional capacity for these patient groups outside of the VAS opening hours. More information about the VAS is provided below.

In addition to the WiC, a GP Out of Hours service is operational across Norfolk and Waveney. This provides patients with urgent access to general practice services outside of core working hours (6.30pm – 8am, Monday – Friday, and all day Saturdays, Sundays and public holidays). This is accessed by calling NHS 111.

GP Practice at Rouen Road

The GP practice at Rouen Road is open from 8am to 8pm every day, including public holidays.

There are 6 GPs who work within the service, 2 nurse practitioners, and 2 nurses. They are supported by 3 members of the healthcare team, 2 pharmacists, 4 members of the prescription team, practice management, and an administrative and reception team.

The service provides general practice services to around 10,300 registered patients and the practice boundary serves the whole of Norwich.

The VAS - Inclusion Health Hub

The VAS is based at Under One Roof on Westwick Street in Norwich. It provides enhanced primary medical support to people with a complex range of needs between 9am – 5pm, Monday to Friday.

The VAS aims to address health inequalities by bringing together specialist healthcare professionals to provide inclusion health services and an asylum seeker and refugee service.

Inclusion health services are for people who are socially excluded and likely to experience stigma and discrimination, live chaotic lives, typically experience multiple overlapping risk factors for poor health, and are not consistently accounted for in electronic records. These experiences frequently lead to barriers in access to healthcare and extremely poor health outcomes.

The VAS provides targeted inclusion health services on a short-term basis, usually up to 6 months. Users are then integrated into general practice within the Norwich Primary Care Network (**PCN**) to one of the Inclusion Health Practices to ensure a supported transition and to plan for their ongoing needs.

The current healthcare landscape - why do things need to change?

General practice services encompass lots of services – including primary medical care, preventative screening, mental health, and vaccinations. We want services to be responsive to the patients and communities they serve.

Since 2009, the healthcare landscape and national policy has changed greatly – in no small part more recently due to the impacts of the COVID-19 pandemic. We have learned a lot about the importance of reaching out to people who aren't accessing general practice services, and about the unequal access to healthcare that has been heightened by the pandemic.

There are some big challenges facing the health service today that must be factored into how services are planned, designed, and commissioned. These include:

- Meeting the increasing needs of patients;
- Improving and increasing equity of access to general practice services;
- Improving outcomes and the quality of care;
- Using the limited workforce in the most appropriate way and ensuring general practice services are resilient; and
- Achieving value for money.

Other factors influencing the need for change include:

- There are now more ways for people to access health services that didn't exist when walk-in centres like the one in Norwich were established. General practice now offers more appointments earlier and later in the day through Enhanced Access, and community pharmacies offer more services than they used to such as helping to treat minor illness and supporting medicines use reviews. Not only are these services open at similar times to the Walk-in Centre, they are also available across Norfolk and Waveney, reducing the need for people to travel to the one walk-in centre in Norwich. These services have been developed as a result of feedback from patients about how, when and where they would like to be able to access services.
- Improving access to care, providing more joined-up care, and reducing health inequalities are key pillars of the NHS Long Term Plan. The strategic direction of the NHS has moved away from providing walk-in centres towards improving flexibility and access to healthcare professionals through access to other services as described above.
- Other national policies which relate to the introduction of digital solutions and clinical triaging patients, many of which were accelerated as a result of COVID-19, are further impacting on how patients access general practice services.
- The demand for healthcare services is increasing as our population grows and ages, and as the demographics of our population changes. General practice tends to act as a first point of contact for most people accessing the NHS and provides an ongoing relationship to those who need it. This connection to people is what makes general practice so valued by the communities it serves. Despite this, there are real signs of genuine and growing dissatisfaction, and access to urgent care is having a direct impact on general practices' ability to provide continuity of care to those patients who need it most.

Recognising this pressure has led NHS England to commission a review of Primary Care, which includes general practice, and forming recommendations for the future. These have been set out in: Next Steps for Primary Care: Fuller Stocktake Report, May 2022. This document outlines the steps that decision makers and services should take to arrange, join-up and deliver services to improve outcomes for local people.

- There is now an increased focus on addressing health inequalities and a better understanding about how we can do this. We have learned a lot about the importance of reaching out to people who aren't accessing general practice services, and about the unequal access to healthcare that has been heightened by the pandemic. In the greater Norwich area there are areas of significant deprivation, whose residents experience poorer health outcomes, as set-out in **Appendix 1**.

- Our health is determined by complex interactions between individual characteristics, lifestyle, and the physical, social, and economic environment. Inequalities in health and access to healthcare have deepened since COVID-19. National NHS requirements set out in the Network Contract DES requirements for Tackling Neighbourhood Health Inequalities (TNHI) outline how equity of access for local people in underserved communities with unmet health needs must be increased in order to improve their outcomes.

- Norfolk and Waveney Integrated Care System (**ICS**)'s Integrated Care Strategy and Clinical Strategy reinforce this, too. Seldom heard communities, the most vulnerable, and those that are socially excluded experience additional difficulties accessing services, which results in poorer health outcomes. Preventing ill health and care needs from arising in the first place and targeting high risk groups to help address and reduce health inequalities are key priorities for the organisations within our ICS that are working together to provide health and care. Systematic planning and proactive management are essential to help improve access to healthcare and health outcomes for all residents across our communities.

All these factors must be taken into consideration when current healthcare contracts expire and new service contracts are developed. That is why we need your help to identify and help shape the future of healthcare services within the Norwich area.

What patient and stakeholder engagement has there been so far?

To understand what local people think about the walk-in services in Norwich, a period of engagement was undertaken in June 2022 with current WiC users and local clinicians.

The data was captured via an online survey. Engagement with the survey was made possible using a variety of channels including digital, face-to-face, and qualitative interviews to support engagement across a wide range of audiences. The key themes that emerged from the pre-engagement were:

• **A view that this is an essential service –** Feedback indicates that many respondents report either struggling or not trying to book an appointment at the GP surgery where they are registered and turn to the WiC instead.

• **Convenient location –** on the whole, the WiC is thought to be in an accessible location. However, noting the high likelihood of travelling by car, and the lack of designated and / or free parking available for visitors.

• **I can 'just walk-in' –** not having to make an appointment is the most influential factor when making the decision to visit the WiC. Indeed, when asked whether they would prefer to be able to book an appointment, respondents are most likely to say 'no' (42%) (however noting that a further 27% are unable to give a view).

• **Broad satisfaction with opening hours –** current opening hours meet expectations and needs for most, although some would like to see a 24/7 service.

• **Long waiting times –** there are some complaints of having to wait a long time to be seen, although this does appear to be an expectation of many visitors.

• **Issues with waiting outside –** there are also some complaints of having to wait outside, and with no shelter or seating provided for when weather is bad or waiting times are long (and when feeling ill).

• **Room for improvement** – although many are satisfied (to some degree) with aspects of the service they receive, there is room for improvement to achieve top ratings, in areas such as the treatment of visitors by staff (clinical expertise, dignity and respect, friendliness and attentiveness), as well as the cleanliness and comfort of facilities.

• **Communications and clarity** – are key for inclusive engagement, ensuring that everyone is able to access the information they need to use the WiC. Communications and clarity can also help to make it feel safe for diverse participants to engage with the centre.

Additional targeted engagement was undertaken in November 2022 to seek qualitative feedback from vulnerable adults and adults with additional needs to supplement the results of the initial programme of pre-engagement. This was achieved through engagement with a range of 'advocates' – representatives of Voluntary Community and Social Enterprise (**VCSE**) organisations and groups working with and supporting these populations.

A number of recurring themes were highlighted between the two pre-engagement programmes, including:

- Improving communications to be more inclusive;
- A lack of clarity around the role of the WiC either as an overspill for GP surgeries or an emergency centre;
- The need to create a person-centred approach to services which supports the creation of a safe space for all service users.

What are the options for the possible future of the Norwich WiC, VAS, and GP Practice at Rouen Road?

Considering all the information provided above, NHS Norfolk and Waveney has produced the following options, which take into account a service that:

- Provides good value for money and reduces duplication of funded services - we are not looking to save money, but to use our resources more effectively
- Works collectively for all partners involved, including patients, Norwich-based GP practices, NHS Norfolk and Waveney and NHS England
- Is in line with national policy and local priorities, including the NHS strategies for addressing health inequalities and improving access to healthcare services, as well as our local Integrated Care Strategy and Clinical Strategy.

Option 1

No Change. Reprocure (buy again) all three services

Summary of proposal: this option would mean that the current WiC service, VAS, and GP practice would be reprocured (bought again) as they currently are, under one contract. This would mean the current location and services provided would not change. This would:

- Not support GP practices to improve resilience
- Not support improvements to patient access to healthcare services or address health inequalities
- Not deliver value for money as it duplicates other funded services such as Enhanced Access and GP Out of Hours

Additionally, as described above, the way that we access healthcare is changing. Through the creation of PCNs, the NHS is encouraging practices to work together to share provision of healthcare activity including appointments, screening, and vaccinations. Providing a walk-in facility is no longer a key feature of NHS policy. Based on a review of national policies as described above and local healthcare needs, we do not think this is the most appropriate option.

Advantages

- There would be no disruption to the services at the GP practice, VAS, or WiC, and no uncertainty for staff currently working in these services.
- It would continue to provide a level of support for GP practices experiencing capacity issues.
- There would be an opportunity to review the services and their opening hours following feedback from the consultation.

Disadvantages

- It is not in line with NHS policy. National policy is to increase the number of appointments in general practice, including appointments that are earlier and later in the day, through the Enhanced Access policy. Providing a walk-in facility is no longer a key feature of NHS policy.
- This model of care no longer provides the best value for money. We are currently funding two services for people to receive general practice services, as they can get care from a local GP practice and from the walk-in centre, as well as the GP Out of Hours service. This duplication is inefficient. It made sense when walk-in centres were established as they provided longer opening hours than GP practices, however with the introduction of the Enhanced Access policy, people can now get appointments earlier and later in the day from GP practices around the Norwich PCN area.
- It wouldn't help to reduce health inequalities in the Norwich PCN area where we know there are people living with unmet health needs
- Feedback from the engagement undertaken showed us that the current role and use of the WiC isn't clear and delivering best value for patients and the wider community of Norwich
- It wouldn't be in line with the strategic direction of national policies outlined by NHS England or the ICS's Integrated Care Strategy and Clinical Strategy.

Option 2

Reprocure (buy again) the VAS and GP Practice at Rouen Road only (and allow the WiC service to expire)

Summary of proposal: This option would mean that the location and services provided at the GP Practice at Rouen Road would not change, and the VAS would continue to be provided from Under One Roof on Westwick Street. The WiC would close.

As explained above, the WiC is delivering general practice services by providing approximately 5,666 appointments monthly. This option would reduce available capacity across the healthcare system and reduce patient access to general practice services. Based on a review of national policies as described above and local healthcare needs, we do not think this is the most appropriate option.

Advantages

- No change to the patients registered at the GP Practice at Rouen Road or those who are receiving healthcare support via the VAS.

- There is an opportunity to review the service and opening hours following feedback from the consultation.
- It would remove the duplication of services provided by the Enhanced Access policy and GP Out of Hours service, as described above.

Disadvantages

- While the patients registered at the GP Practice at Rouen Road would continue to receive general practice services, and vulnerable adults would still be able to receive healthcare support via the VAS, there would be no additional local services provided in place of the WiC. This would reduce capacity and service within the Norwich area unless alternative provision was commissioned (bought).
- It would not help to improve the resilience of general practice in the greater Norwich area. Patients would no longer be able to access care from the walk-in centre when they couldn't get timely care from their GP practice, nor would practices be able to offer more appointments to replace the lost capacity without receiving greater investment.
- It wouldn't help to reduce health inequalities in the Norwich PCN area where we know there are people living with unmet health needs
- It wouldn't be in line with the strategic direction of national policies outlined by NHS England or the ICS's Integrated Care Strategy and Clinical Strategy.

Option 3

Reprocure (buy again) the GP practice and the Vulnerable Adults Service – Inclusion Health Hub under one contract. Redesign and commission (buy) the health service capacity that is provided at the Walk-in Centre in a different way to improve health outcomes in underserved communities across the Norwich area.

Summary of proposal: Based on a review of national policies as described above and local healthcare needs, we believe this is the most appropriate option. This option would mean that the location and services provided at the GP Practice at Rouen Road and the VAS would not change. The resources that are currently invested into the WiC would be redistributed across Norwich PCN to:

- Improve access to healthcare services for those with unmet health needs, seldom heard communities, the most vulnerable, and those that are socially excluded to help reduce health inequalities, in accordance with NHS guidance and Norfolk and Waveney ICS' Integrated Care Strategy and Clinical Strategy.
- Join-up services to better support increased demand for general practice services and provide care closer to home for people living in underserved communities. This will provide appropriate access to healthcare for people as

well as support resilience to GP practices in line with the Fuller Stocktake Report recommendations.

- Provide the foundations to support the local health and care system going forward to address increased demand arising from new service developments (both in the intermediate and long-term), local population changes, and growing complexity of needs. By reshaping how resources are allocated it will provide coverage across the whole of Norwich and help address some of the increased pressure arising from planned housing growth.

We have not finalised details of how this would operate in practice because feedback from patients, the public, and healthcare professionals is essential at this early stage to shape how services could be delivered to best meet local needs.

This option would not mean a reduction in spending. It would use the same amount of resource currently invested in the WiC and redesign services to widen coverage across the Norwich PCN area to be able to respond to people's needs.

We know there are underserved communities across the Norwich PCN area that have unmet health needs (see **Appendix 1**), and we want to improve access to general practice services for Norwich's diverse and growing population. Following NHS guidance and the principles of the NHS Long Term Plan, PCNs should prioritise equity of access to healthcare services to help drive down levels of health inequality in our communities and improve health outcomes for all.

This option would provide continued support and resilience to Norwich-based GP practices to help manage patient demand for general practice services by integrating capacity with other existing funded services. Examples could include Enhanced Access which offers same-day and pre-bookable appointments, GP Out of Hours, care home visiting, and home visiting. This supports the wider joined-up approach to integrated healthcare services in Norwich which will see neighbourhood teams working together to provide a range of integrated health and care services to help keep people well and out of hospital.

Patients who are registered with a GP practice within the Norwich PCN area would still be able to access same-day and pre-booked healthcare appointments through their own GP practices and onwards through Enhanced Access according to clinical need. For urgent problems outside of usual opening hours, patients would still be able to access the GP Out of Hours service by calling NHS111.

Public feedback from the consultation is essential in helping to shape what this looks like. Redesigning the WiC capacity would provide flexibility to adapt services and enable practices working together in Norwich PCN to manage current and future demand for healthcare. It would help to reduce health inequalities in our vulnerable and at-risk population groups, support resilience in GP practices, and follow guidelines set out in national and local strategies and policies. We believe this is the most appropriate option.

Advantages

- The patients registered at the GP Practice at Rouen Road would continue to receive general practice services, and vulnerable adults would still be able to receive healthcare support via the VAS.
- There is an opportunity to review the services and opening hours provided following feedback from the consultation.
- It would enable Norwich GP practices to develop services in their PCN that address health inequalities and provide equal access for vulnerable and at-risk population groups.
- It would remove the duplication of services outlined above yet maintain the overall capacity of services available in the greater Norwich area.
- It would enable capacity to be integrated with other existing funded services such as Enhanced Access, GP Out of Hours, care home visiting, and home visiting.
- The resources (money and workforce) associated with the WiC would be reshaped to address local needs across Norwich, build and strengthen services that improve outcomes for local people and provide resilience to practices in Norwich.
- This approach is in line with the strategic direction of national policies outlined by NHS England and the ICS's Integrated Care Strategy and Clinical Strategy.
- It builds on what people have said to us previously about how they want their health needs supported in Norwich. Previous feedback we've received has indicated that people want more services delivered closer to home, as well as for more integrated services, and better communication between services and the public.

Disadvantages

- While people would continue to be able to access general practice services from a local GP practice, the ability to walk-in without an appointment would be removed. This may be unpopular with people who prefer not to book or wait for an appointment.
- This option doesn't provide immediate resilience support for local practices experiencing capacity issues, although overall capacity in the healthcare system would be maintained.
- The location of where some staff work would likely change, and could require travel outside of Norwich city centre
- How patients access general practice services in Norwich would change as some patients may have to travel to a different location which could be outside of Norwich city centre.

What is Enhanced Access?

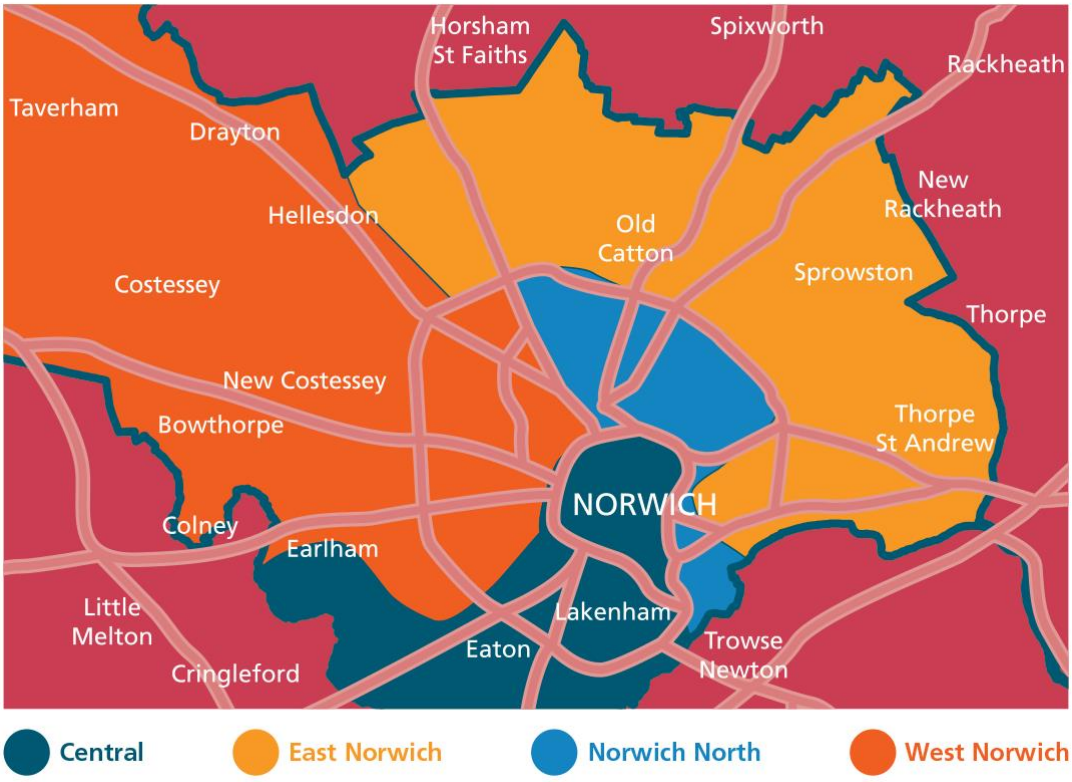
Under the national Enhanced Access policy that was introduced in October 2022, general practice now has appointments available 8am – 8pm Monday to Friday, and 9am – 5pm on Saturdays. These additional early morning, evening and weekend appointments are offered at various hubs across Norfolk and Waveney.

This means health professionals working in your area will have access to additional appointments to meet the needs of their patients. These additional early morning, evening, and weekend appointments will be offered at various surgery hubs across the greater Norwich area, which may be at your practice or one closer to you than the WiC in Norwich city centre. Enhanced Access appointments are accessed via GP practices. Read more about Enhanced Access here.

What is the Norwich PCN and what area does it cover?

PCNs are groups of practices that work together in a number of different ways to provide services that are responsive to patient needs in their area. PCNs build on existing general practice services and enable greater provision of proactive, personalised, coordinated, and more integrated health and social care for people close to home.

The Norwich PCN covers the below area:



Provide your feedback on the options outlined in this consultation

Using the information provided above and in combination with your own knowledge and views, we would like your feedback on the following questions:

1. Are you giving feedback as an individual or are you representing someone else (e.g., someone you care for, a friend, group, or organisation)?

    - ☐ As an individual
    - ☐ As a staff member at one of the services
    - ☐ I am representing someone else (please say who)

      _____

2. Please tell us your thoughts about Option 1

    _____

    _____

    _____

3. Please tell us your thoughts about Option 2.

    _____

    _____

4. Please tell us your thoughts about Option 3, which we think is most appropriate?

    _____

    _____

    _____

    What do you think are the advantages?

    _____

    _____

    What do you think are the disadvantages?

    _____

    _____

5. Do you understand how we intend to look after patients who are currently using the WiC? If No, what questions do you have?

- ☐ Yes
- ☐ No

If No, please let us know what questions you have:

_____

_____

6. Do you think that some individuals or groups are more likely to be more positively or negatively affected than others if Option 3 is taken forward? If yes, please say how?

- ☐ Yes
- ☐ No

If Yes, please say how:

_____

_____

_____

7. Do you have additional ideas or suggestions on how the healthcare capacity associated with the Norwich Walk-in Centre could be reshaped so that if offers more equal access for all Norwich residents, help meet growing local demand for general practice services, and support resilience of general practices in Norwich?

_____

_____

_____

8. Are there any other options you would like us to consider?

_____

_____

_____

Help us to shape how health services are delivered locally

We need your help in shaping where and how NHS Norfolk and Waveney and practices in Norwich PCN work to deliver healthcare to patients in the greater

Norwich area now and in the future. Please tell us about your experiences and preferences around general practice services through the questions below.

9. Have you used any of the services described above within the last 12 months? Please tick all that apply:

- ☐ The Walk-in Centre
- ☐ The GP practice at Rouen Road
- ☐ The Vulnerable Adults Service – Inclusion Health Hub
- ☐ None of the above
- ☐ I can't recall

10. How far would you be willing to travel for a pre-booked general practice service appointment?

- ☐ Less than 5 miles
- ☐ 5 - 9 miles
- ☐ 10 – 14 miles
- ☐ 15 – 19 miles
- ☐ 20+ miles

11. There are lots of important factors that influence your preferences for accessing general practice services. Please select the top 6 most important factors to you from the list below.

- ☐ Being able to book a same day appointment
- ☐ Being able to book an appointment in advance
- ☐ Being able to walk-in without an appointment
- ☐ Being able to get an early morning appointment
- ☐ Being able to get a lunchtime appointment
- ☐ Free car parking on site
- ☐ Close to public transport
- ☐ Being able to have a video or phone consultation to reduce travel for face-to-face appointments
- ☐ Having a face-to-face appointment
- ☐ Access to translation and interpreting services
- ☐ Having healthcare services close to where you live (within walking distance)
- ☐ Having healthcare services in a single centralised location (no matter the distance you have to travel)
- ☐ Other (please specify) _____

12. What is the most important consideration for you when you need to access general practice services, and why?

_____

_____

13. Are there any barriers that make it difficult for you to get general practice services when you need them?

_____

_____

14. Of the general practice services you have used before, what was it about them that worked well for you?

_____

_____

Opportunities to have your say

- **Online at https://www.smartsurvey.co.uk/s/GP_Norwich/.** You will be able to complete the survey online using an ipad that will be available at the WiC during the consultation period. In addition, engagement staff will be on hand over a number of days throughout the consultation period to help people complete the survey face-to-face.

- **Email**: nwicb.haveyoursay@nhs.net. You can fill in this consultation document and email it back to us. Please use the Subject Line: Providing general practice services in Norwich

- **Post**: Printed copies of this consultation document will be available at the WiC and GP Practice on Rouen Road. Completed copies can be posted back to us at the following address:

  FAO Communications and Engagement Team, NHS Norfolk and Waveney ICB, County Hall, Martineau Ln, Norwich, NR1 2DH.

Next steps

The consultation and engagement period will be open between 24 January and 26 March 2023.

NHS Norfolk and Waveney will then carefully consider the feedback received from patients, public, and wider stakeholders, and take into account all other considerations as outlined in this document. The outcome of this consultation and next steps will be communicated publicly on our website in due course.

Appendix 1 – Health Inequities data for Norwich area

The Norfolk Office of Data & Analytics (NODA) published Norwich Reducing Inequality Target Areas (**RITAs**) which provide analysis of indicators of multiple indices of deprivation (**IMD**) in October 2022. This report and the full set of Health Inequalities data for the Norwich area can be accessed online at [Norwich RITAs analysis of indicators (norfolkinsight.org.uk)]

IMD is a widely used indicator to rank relative deprivation, and includes seven different domains of deprivation: income, employment, education, health, crime, barriers to housing and services, and living environment.

To briefly summarise the key takeaways; when considering all indicators of multiple deprivation, the six worst performing (Middle Layer Super Output Areas) MSOA areas in order, relative to the Norwich average, are:

1. City Centre West
2. Mile Cross
3. Earlham
4. Lakenham & Tuckswood
5. Heartsease & Pilling Park
6. Bowthorpe & West Earlham

Heat map showing neighbourhood index across deprivation indicators

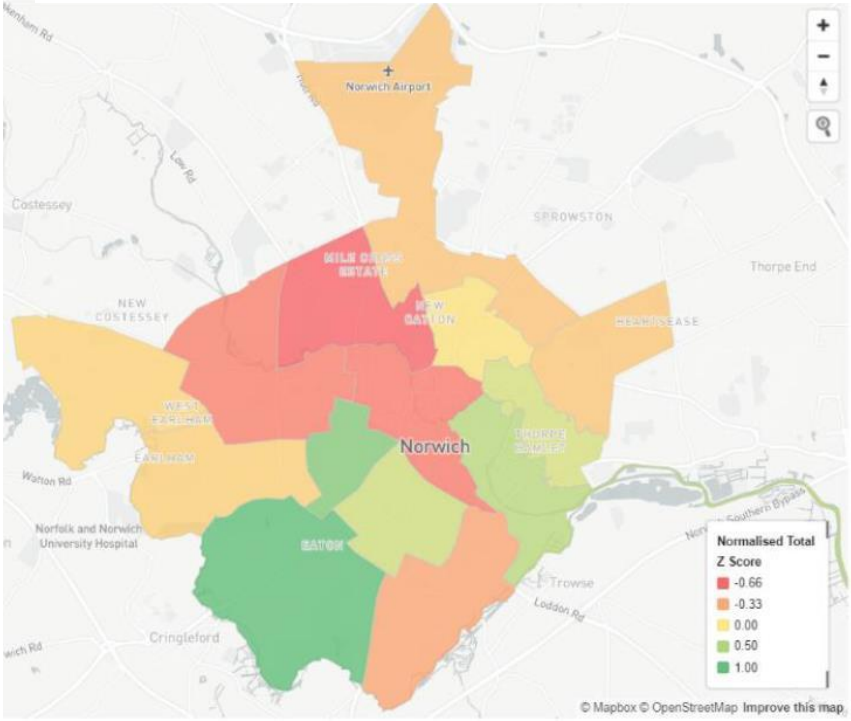
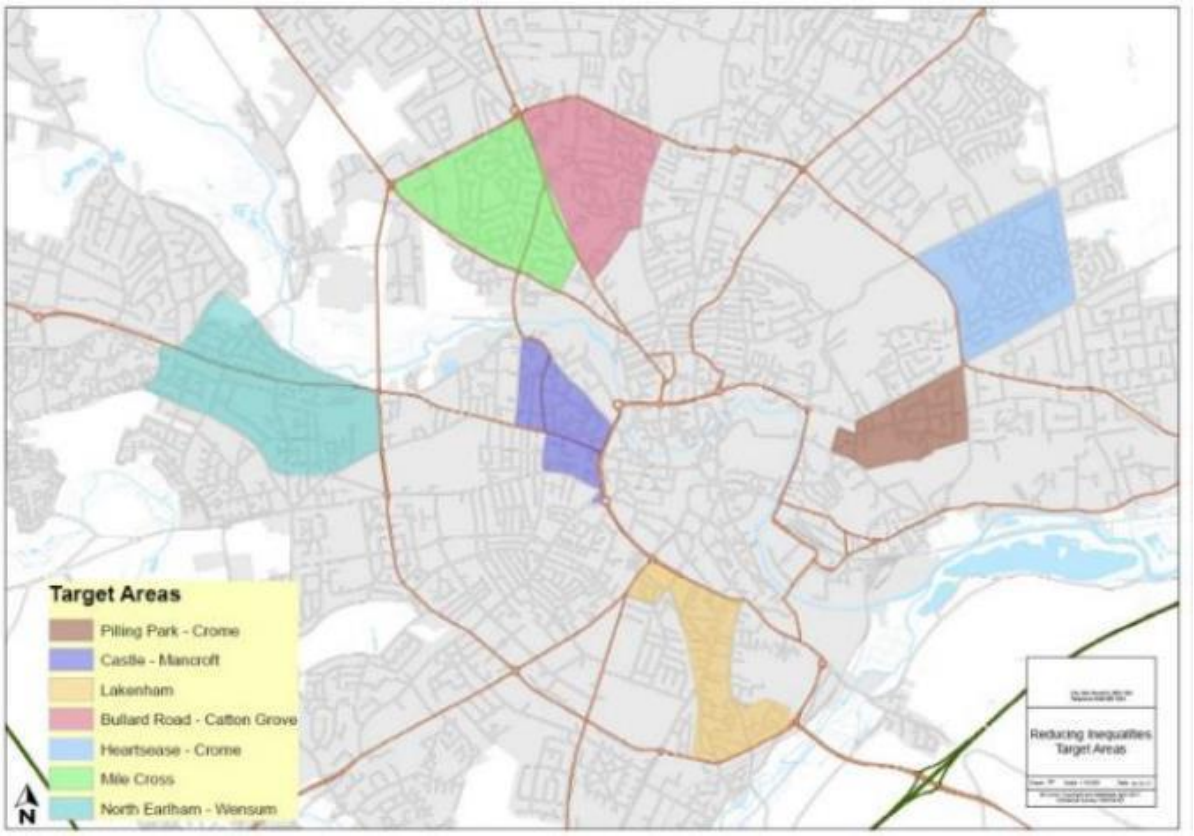


Figure 2.0: The seven local areas identified in 2015 RITAs analysis

The analysis conducted by NODA demonstrates differences in the particular issues faced by each MSOA.



Appendix 2 – Glossary

Alternative Provider Medical Services (APMS)	A form of GP contract which is time-limited.
Clinical triage	GP practices receive requests for medical help or advice. For each patient request, the practice needs to work out: • Why they have sought help from their GP • What kind of help the patient needs • How quickly the patient needs help • Who is the best person to help this patient • Where and when the patient should be seen The answers to these questions help the practice to sort patients based on their clinical needs.
GP Out of Hours	This service provides access to GP services during the out-of-hours period from 6.30pm to 8am on weekdays and all day at weekends and on bank holidays.

	Outside normal surgery hours you can still phone your GP surgery, but you'll usually be directed to an out-of-hours service. GPs can choose whether to provide 24-hour care for their patients or to transfer responsibility for out-of-hours services to NHS England, which is responsible for providing a high-quality service for the local population. But this can mean different areas can have slightly different services.
Integrated care systems (ICSs)	ICSs are partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area. Find out more about the Norfolk and Waveney Integrated Care System at https://improvinglivesnw.org.uk/
Primary Care Trust (PCTs)	PCTs were part of the NHS in England from 2001 to 2013. PCTs were responsible for commissioning primary, community and secondary health services from providers. Primary care trusts were abolished on 31 March 2013 as part of the Health and Social Care Act 2012, with their work taken over by clinical commissioning groups (CCGs). Prior to July 1, 2022, NHS Norfolk and Waveney was Norfolk and Waveney CCG.
Primary Care Network (PCNs)	PCNs are groups of practices that work together in a number of different ways to provide services that are responsive to patient needs in their area. Through the creation of PCNs, the NHS is encouraging practices to work together to share provision of healthcare activity such as general practice appointments, screening, and vaccinations, to coordinate and provide more integrated health and social care for people close to home. Find out more about PCNs on the ICS website.
Urgent care	An illness or injury that requires urgent attention but is not a life-threatening situation. Urgent care services include a phone consultation through the NHS111 Clinical Assessment Service, pharmacy advice, out-of-hours GP appointments, and/or referral to an urgent treatment centre (UTC). If unsure what service is needed, NHS111 can help to assess and direct to the appropriate service/s.

Norfolk and Waveney
Integrated Care Board

Agenda item: 07

Subject:	**Learning Disability Annual Health Checks progress update**
Presented by:	**Shepherd Ncube Associate Director of Primary Care Commissioning.**
Prepared by:	**Thomas Araya, N&W ICB Contracts Manager, Primary Care**
Submitted to:	**ICB Primary Care Commissioning Committee**
Date:	**7 February 2023**

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 Clinical 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 Clinical Quality Reporting System (CQRS) showing delivery of learning disability health checks from April-Oct 2022.
- To support the implementation of Norfolk and Waveney system and primary care LD health check improvements, the below initiatives were put in place:
  - Implementation of LD Microsoft Teams channel. This has provided support to GP Practices and delivered a mechanism for practices to share best practice and support with issues around LD. This was also provided an avenue for the ICB LD leads to provide guidance and key comms to practices.
  - Implementation of 'LD Delivery and Improvement group'. This has enabled the group to meet monthly and to discuss issues, plans and areas of improvement.

- Additional clinical and or administrative support has been provided to boost uptake in South Norfolk, Norwich locality, West Norfolk and Great Yarmouth and Waveney Locality. We have been working with colleagues to agree suitable support for their locality, no support package has been agreed yet. This has been a big success with practices. This support was also offered to challenged practices going through CQC improvement plans.

Learning disability AHC activity to-date

April – October 2022

Learning disability health check uptake April – October 2022					Comparative 21/22	
Region	**Register**	**Completed**	**Declined**	**%**	**Completed**	**%**
Beds, Luton, M Keynes	**4,794**	**1,512**	**32**	**31.5%**	**933**	**20.8%**
Cambs & Peterboro	**4,359**	**1,117**	**30**	**25.6%**	**851**	**20.2%**
Herts & West Essex	**7,314**	**2,452**	**51**	**33.5%**	**1,870**	**26.8%**
Mid & South Essex	**5,561**	**1,720**	**47**	**30.9%**	**1,444**	**28.0%**
Norfolk & Waveney	**7,027**	**2,650**	**76**	**37.7%**	**1,791**	**26.1%**
Suffolk & NE Essex	**5,667**	**2,170**	**76**	**38.3%**	**1,929**	**36.5%**
East of England	**34,722**	**11,621**	**312**	**33.5%**	**8,818**	**26.7%**

Commentary

- There are delays with regional comparative data coming from NHS England.
- The table above shows that we have one of the largest LD registers in the region and we have completed more checks within East Anglia region.
- Approximately 700 more (12%) annual health checks have been completed until the end of October compared to the same period last year

April to December 2022

Learning disability health check uptake up to December 2022			
Locality	Register	Completed	%
GYW	1,798	1,010	56.2%
North Norfolk	1,190	548	46.1%
Norwich	1,490	734	49.3%
South Norfolk	1,449	653	45.1%
West Norfolk	979	455	46.5%
Norfolk & Waveney	**6,906**	**3,400**	**49.2%**

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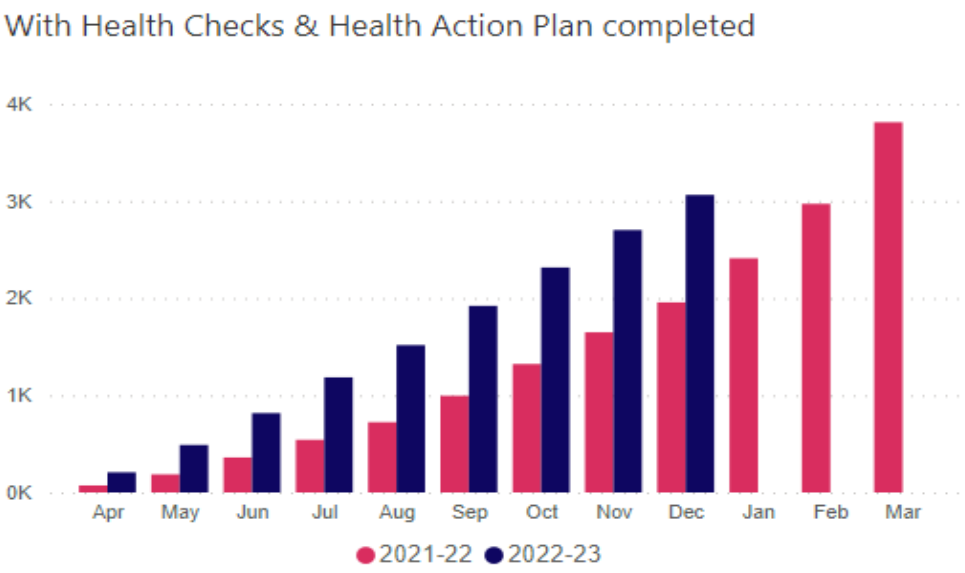
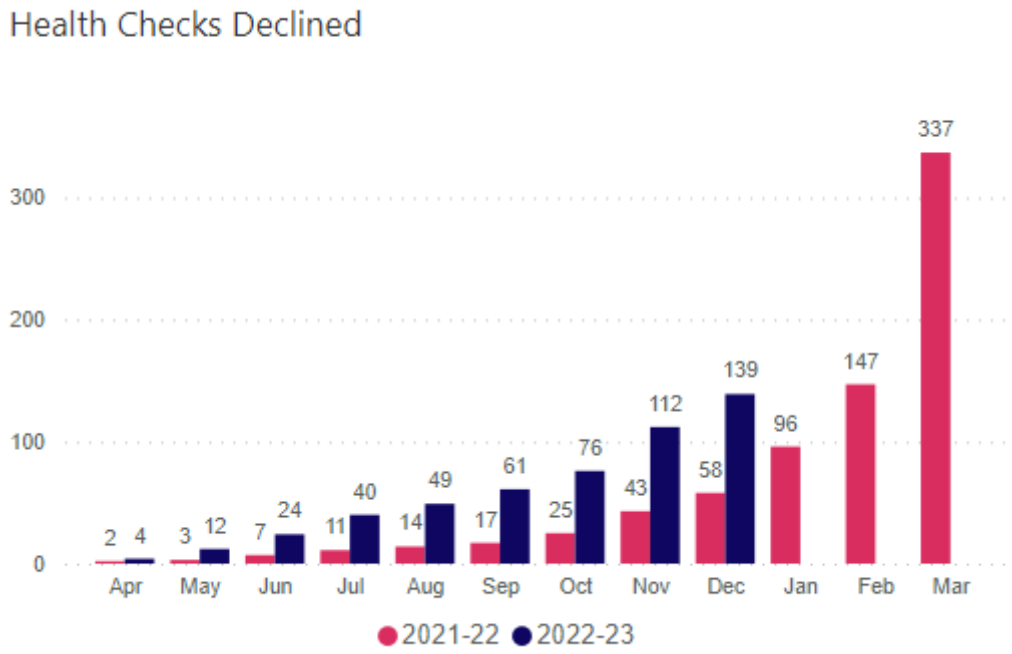


- Steady and positive progress has been made month on month, seeing 5% increase in activity from last month report.
- Significant improvement (10%) in performance compared to same period last year.
- Please refer to appendix 1 for a rolling total of health checks over the past year.



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- The number of checks declined have increased each month, we have started some qualitative work with practices in South Norfolk to target individuals who have not had checks in the past 18 months.
- A different approach is required to reach out to this group of people, further work is being done to explore ways to improve this position.

Key Opportunities and challenges

- The ICB submitted a funding bid to further improve the uptake and quality of LD/SMI annual health, and this request has been agreed in principle by NHS England. If approved, the plan is that this funding will be used to purchase Point of Care testing kits, administrative and clinical support for general practice.
- The equipment will reduce the time needed to wait blood tests and results; and the clinical and project management resources will help to increase the uptake and the quality of LD and SMI checks being completed.
- Capacity in general practice is not enough to reach out to all the people on our LD register. Performance data from last year and our forecast for this year shows that practices would require additional administrative and clinical support to support the ICB to meet its national target of 75% in annual health uptake and health action plans. The recommendations are that these resources should be embedded with practices or PCN arrangement. Third sector and voluntary sector organisation are critical in improving the uptake and the experience of people with a learning disability in relation to annual health checks.
- Winter pressures are likely to negatively impact on annual health check performance as practices deal with competing clinical priorities. Without additional clinical resources to support general practices the ICB is at risk of not meeting its commitment for annual health checks.

2. Next steps

- Continue to monitor progress and delivery risk via the Improvement and Delivery Group meeting every 2 weeks.
- Reach out to all practices via the GP newsletter to encourage, support and accelerate uptake in the next 12 weeks.
- Pro-actively contact practices with less than 50% uptake to check if additional support is required.
- ICB Quality team to continue working with South Norfolk practices to support with the process, making appointments, contacting patients, cleansing LD registers, and undertaking physical health checks worked well.
- Data will continue to be shared with PCNs and practices to enable situational analysis at a local level monthly basis.

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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:	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

Rolling total of annual health checks year-on-year

Sum of YearToDateValues	Column Labels																						
	2021												2022										Grand Total
Row Labels	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec		
Great Yarmouth and Waveney	34	87	160	238	315	414	521	634	758	864	989	1178	66	201	307	455	596	688	822	934	1010		11271
North Norfolk	11	29	70	99	131	219	299	391	460	527	627	879	37	65	111	137	201	298	370	437	548		5946
Norwich	30	68	163	251	331	446	524	595	679	768	871	1013	21	84	168	250	349	470	555	667	734		9037
South Norfolk	57	85	110	148	184	213	299	379	430	527	702	904	54	96	166	275	349	490	561	603	653		7285
West Norfolk	10	34	45	73	106	138	193	251	313	374	507	675	79	133	189	232	247	271	342	411	455		5078
Grand Total	**142**	**303**	**548**	**809**	**1067**	**1430**	**1836**	**2250**	**2640**	**3060**	**3696**	**4649**	**257**	**579**	**941**	**1349**	**1742**	**2217**	**2650**	**3052**	**3400**		**38617**

Actual HCs completed in month	Apr-21	May-21	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	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	
Great Yarmouth and Waveney	34	53	73	78	77	99	107	113	124	106	125	189	66	135	106	148	141	92	134	112	76	
North Norfolk	11	18	41	29	32	88	80	92	69	67	100	252	37	28	46	26	64	97	72	67	111	
Norwich	30	38	95	88	80	115	78	71	84	89	103	142	21	63	84	82	99	121	85	112	67	
South Norfolk	57	28	25	38	36	29	86	80	51	97	175	202	54	42	70	109	74	141	71	42	50	
West Norfolk	10	24	11	28	33	32	55	58	62	61	133	168	79	54	56	43	15	24	71	69	44	
Norfolk And Waveney	**142**	**161**	**245**	**261**	**258**	**363**	**406**	**414**	**390**	**420**	**636**	**953**	**257**	**322**	**362**	**408**	**393**	**475**	**433**	**402**	**348**	

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Norfolk and Waveney
Integrated Care Board

Agenda item: 08

Subject:	**Primary Care Estates – quarterly update**
Prepared by:	**Primary Care Estates Team**
Submitted to:	**Norfolk & Waveney Primary Care Commissioning Committee**
Date:	**7 February 2023**

Purpose of paper:

Update on Primary Care Estates, for information.

Contents

Update:

Wave 4b Primary Care Hubs

Since the approval of the Programme Business Case by NHS England and the Department of Health and Social Care, in September 2022, work has been progressing quickly to develop each of the four Hubs.

NHS Property Services have appointed a contractor to oversee the design and, subject to business case approval, build of the two new build schemes at Rackheath and King's Lynn. These schemes are supported by Steering and Engagement Groups.

The business case for the scheme to refurbish the Thetford Healthy Living Centre is due for consideration by NHS England in February 2023. Approval will mean this scheme can progress to construction.

The scheme at Sprowston is also expected to bring forward a business case for approval early in 2023, and this will see some changes to the proposal: to make better use of vacated space for provision of primary care, rather than the originally proposed extension.

A summary of the Wave 4b Primary Care Hubs is Appendix 1 to this report. Support is ongoing to facilitate the two schemes which formed part of the original programme, and which were withdrawn due to capital cost/construction timeline (Attleborough and Shrublands, Gorleston – please see ongoing projects section below).

The timetable for the programme and its completion deadline of March 2024 remains its biggest risk and the ICB is in regular discussions with NHS England about means of mitigating this risk. The monthly Wave 4b Programme Board is tracking progress against plan, as outlined in the table below.

Scheme	Development Partner	Short form Business Case submission	Construction Start	Construction Completion	Handover	Operational
Rackheath – North Norfolk	NHS Property Services	April 2023-June 2023	July 2023	March 2024	April 2024	May 2024
Sprowston – Norwich	Via landlord – Primary Health Properties	February 2023	March 2023	November 2023	December 2023	December 2023
King's Lynn – West Norfolk	NHS Property Services	April 2023-June 2023	July 2023	March 2024	April 2024	May 2024
Thetford – South Norfolk	Via landlord – Community Health Partnerships/ Norlife	February 2023	March 2023	November 2023	December 2023	December 2023

PCN Service and Estates Toolkit Programme

NHS England have commissioned Community Health Partnerships (CHP)[1] to support PCNs, nationally, to implement the PCN Service and Estates Toolkit in 2022/23. The Toolkit is clear that an estate strategy should be driven by a clinical strategy.

The Norfolk and Waveney launch date of this programme of support was 9 November.

Of the 17 PCNs in Norfolk and Waveney, 11 have so far engaged with Health Integration Partners (HIP) who are supporting the development of clinical strategies. Work is underway to engage the remaining 6 PCNs, but there is a deadline of end January 2023 for HIPs involvement (HIP are supporting the clinical strategy work nationally). Further support has started on the development of estate strategies. The programme is due to complete by April 2023. The ICB have queried with NHS England and CHP if there is an opportunity to use any financial underspend on the programme, caused by <100% coverage, to support remaining PCNs.

NHS England – in recent forums – have noted that primary care estates are central to discussions (e.g. Fuller stocktake report[2]) and that there was a need to use data to better understand and better utilise the estate, to create better environments for patients and workforce. However, there is also an acknowledged lack of NHS funding currently to build or refurbish premises.

Completion of the toolkit programme nationally will for the first time provide a consistent national view of the condition and demands on primary care estate. One of the aims of the programme is to use this evidence base to support future funding requirements in expenditure reviews.

Until completion of the programme the ICB continues to track premises capacity and demand for GMS services using a formula approach. The ICB approach only considers

[1] Community Health Partnerships (CHP) is wholly owned by the Secretary of State for Health and Social Care. Incorporated in 2001, the focus was to improve the NHS estate via Public Private Partnerships. Since 2013, CHP have taken on the role of Head Tenant from the former Primary Care Trusts.

[2] Next steps for integrating primary care: Fuller stocktake report

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GMS services and not any requirements for additional NHS or private services. This approach will need to be adjusted during 2023 to reflect the outcomes of the PCN Toolkit Programme. Appendix 3 presents the current ICB demand and capacity view in tabular form and Appendix 4 on a map. This data is presented in both tabular and map form because PCN boundaries sometimes make comparison at an aggregate level misleading. Presenting the data on a map helps to give context across boundary issues.

Funding to support General Practice Estate development

As noted previously, the Primary Care Estates Team is aware – formally or via informal enquiries – that around 70% of practices are interested in funding to support an estates scheme. It is expected that this proportion will rise when the formal call for bids, from practices interested in premises improvements and/or more space, is made. The Primary Care Estates Team had expected to make this formal call for bids before the end of 2022, but this date was changed to Spring 2023, to align with outcomes from the PCN Service and Estates Toolkit Programme.

The Primary Care Estates Team received confirmation in November 2022 of its share of the £1.9m BAU capital for 2022/23 which must cover Digital and Primary Care Estates projects: in 2022/23 primary care estates schemes have planned utilisation of £700k of this BAU capital. A prioritised list of schemes has been shared with the LMC and was submitted to the ICB (CCG) finance team in April 2022.

The schemes/proposals being supported by NHS business as usual capital and revenue funding to support increased rent reimbursement are:

Practice	Scheme	Capital	Fees	Revenue	Total	2022/23	2023/24
Elmham Group of Practices – Toftwood Medical Centre	Additional capacity	✓	✓	✓	£0.4m	£0.1m	£0.3m
Blofield Medical Centre	Extension	✓	✓	✓	£1.7m *with £1.2m from NHS capital*	£0.6m	£0.6m
St James Medical Practice	New build replacement premises	Third party funding	✓	✓	£8.2m *with £0.2m from NHS capital*	£0.0m	£0.2m
Long Stratton Medical Partnership	Extension	Third party funding	✓	✓	£1.6m *with £0.1m from NHS capital*	£0.0m	£0.1m
Drayton Medical Practice	Extension	Third party funding	✓	✓	£2.9m *with £0.1m from NHS capital*	£0.0m	£0.1m

There has been slippage against 2022/23 plan, with the Blofield extension scheme not yet underway due to protracted legal discussions**,** leading to increasing costs and viability issues for the partnership to consider. The ICB and practice are looking to maximise expenditure this financial year, but it will be mid-February before an accurate assessment can be made. Where possible expenditure on other schemes planned for 2023/24 has been brought forward into 2022/23 but this totals <£0.1m so has minimal impact on position. Replacement estate schemes to utilise any underspend against plan are not possible to put forward this late in the financial year, due to the time taken to complete legal agreements. If slippage against budget occurs in 2022/23 the ICB digital team are ready to submit digital bids against this allocation to ensure it is not lost to the system.

Norfolk and Waveney General Practice Estate: ongoing projects

Projects expected to complete in 2023:

Practice	Scheme
Blofield Surgery	312m² extension to existing premises (subject to Grant Agreement conclusion)
St James Medical Practice, King's Lynn	New (replacement) facility is due to open January 2024
Long Stratton Medical Partnership	153m² extension to existing premises.

Projects being scoped and/or prepared for approval:

Practice	Scheme
Toftwood Medical Centre (Elmham Group of Practices)	Additional capacity (modular building) and improvements.
Drayton Medical Practice	560m² extension to existing premises.
Attleborough Surgery	Additional capacity alongside development of long-term solution.
Bridge Road Surgery, Lowestoft	Practice have engaged a third-party developer for a replacement premises utilising a combination of Section 106, Community Infrastructure Levy Funding, and private capital.
Shrublands, Gorleston	The ICB went to market for a third-party developer for the construction of this scheme in Gorleston, which was originally one of the Wave 4b Primary Care Hubs. The ICB Chaired the stakeholder interviews of the third-party developers on 13 January.
Humbleyard Practice – Hethersett development	Discussions continue with The Humbleyard Practice about potential solutions to the existing and future pressure on their capacity – South Norfolk Council are undertaking some feasibility work towards supporting a new build facility.
Taverham Partnership	Discussions involving the local planning authority are quite advanced, with a multi-agency group meeting regularly: Taverham Communities & Health Hub Partnership, which is overseeing the design of the proposed building. The Taverham Partnership are proposing to move from their existing main site into the new premises.

In addition, there are housing related developments which may give rise to primary care estates scheme proposals (including, but not limited to):

a. Halesworth: developments include older people's housing and there is an opportunity to bid for Community Infrastructure Levy funding.
b. Lowestoft: there is an existing Section 106 agreement for land to be set aside as part of the Woods Meadow development. The Bridge Road Surgery have engaged a third-party developer and work is underway to develop a business case for this scheme.

The Primary Care Estates Team is also working with practices who are considering sale and leaseback proposals, who are proposing branch closures and where the ICB has been asked to join discussions in relation to leases.

Rent reimbursement and rent reviews

Capacity within NHS England rent review team remains challenging for the Primary Care Estates Team.

The Primary Care Estates Team are in the early stages of discussion with NHS England about the ICB picking up the rent review function which they currently perform.

During a given financial year, there are several moving factors with rent reimbursements, with many back dated reviews in all months of the year. Therefore, the figures below are approximate.

- For the period 2020/21 total rent reimbursement was approximately £12,475,086
- For the period 2021/22 total rent reimbursement was approximately £12,763,163

This gives a rent reimbursement increase of £288,077 from 20/21 to 21/22. This figure does not include rent arrears paid and just takes actual reimbursement on all property as of March at the end of each financial year.

2022/23 Reviews

Month	**Number of rent review approvals**	**Rent increases**
April	2	£ 7,120
May	7	£32,770
June	5	£23,875
July	2	£ 9,900
August	2	£ 4,600
September	0	0
October	4	£24,650
November	1	-£21,100
December	5	£11,050
TOTAL TO DATE:		**£92,865**

Upcoming rent reviews

NHSE rent review team has indicated there are 2 upcoming rent reviews in January with a proposed increase of rent reimbursement by £1,750.

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Appendix 1: Wave 4b Primary Care Hub proposals – summary

Scheme name	North Norfolk – Rackheath	Norwich – Sprowston
Type	New build at Halsbury Homes site on Broad Lane, Rackheath	Expansion of existing healthcare premises at Aslake Close, Sprowston, Norwich
Ownership	NHS Property Services	Primary Health Properties PLC
Locality	North Norfolk	Norwich

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

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

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

Appendix 2: PCN Service and Estates Toolkit

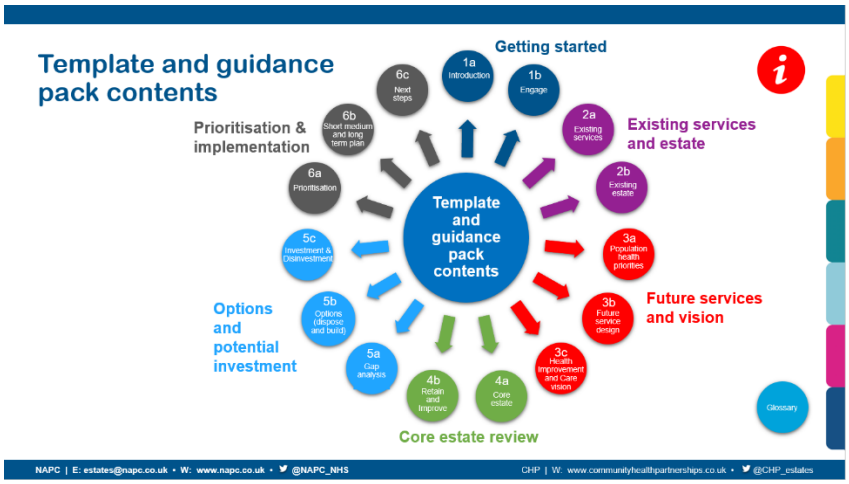
Community Health Partnerships and the National Association of Primary Care on behalf of NHS England, have produced a PCN Service and Estates Toolkit developed from the published guidance Primary Care Networks: Critical thinking in developing an estate strategy. The benefits of the PCN Toolkit are to develop and articulate a standardised and consistent approach in identifying and delivering Prioritised short, medium, and long-term primary care capital investment & disinvestment plans and key challenges to delivery (e.g. negative equity)

The purpose is to provide a national framework to support PCNs and systems to identify the future primary care estates investment requirements, whilst ensuring consistency in quality and outputs; to enable delivery of suitable, high quality estate provision for Primary Care, and to suitably support service development strategies across the wider health economy. The PCN Service and Estates Planning Toolkit provides practical tools for use and application and has two objectives:

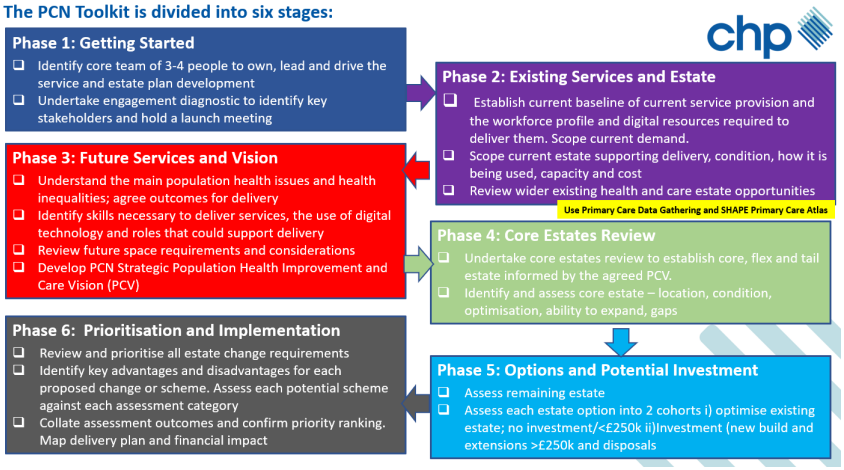
a. To enable each PCN to identify and prioritise their estate optimisation, disinvestment and any subsequent capital investment requirements to address population health priorities and future service needs.

b. To support the production of capital investment plans for PCNs and Places and help Integrated Care Systems (ICSs) to aggregate and prioritise local primary care investment requirements against other system demands for capital.

The image below reflects the 6 different stages of the PCN Toolkit:



The toolkit starts with a focus on key stakeholder engagement and consideration of priorities in line with a population health led approach to care model design.



It has been developed in line with other key national work streams, emerging policies and emergency planning requirements. This toolkit focuses on clinical vision and strategic estate planning, and we recommend reference to other relevant policies and guidance for wider considerations such as the net zero agenda, digital and health technologies, which should all be taken into consideration in completion of the toolkit.

The Toolkit should be used to further develop existing clinical and estate strategies and plans as opposed to replicating or replacing what has already been achieved and should be used flexibly to meet that objective. It has been developed to align with the Primary Care Data Gathering (PCDG) datasets and SHAPE PCDG Atlas analysis and reporting tools, minimising duplication of effort in establishing the initial baseline.

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Appendix 3: Demand and Capacity Table 2022 to 2037

Locality	PCN	Weighted list per site Jan 22	Current NIA (m2)	NIA Required for current population (m2)	Current NIA Surplus / (Deficit) (m2)	Expected Future Population 2037	Expected Future NIA (m2)	NIA Required for forecast population (m2)	Future NIA Surplus / (Deficit) (m2)
Great Yarmouth and Waveney	Gorleston	45,344	2,651	2,389	262	48,667	2,651	2,528	123
	Great Yarmouth and Northern Villages	72,394	4,570	4,109	461	81,565	4,570	4,649	(79)
	Lowestoft	83,023	4,496	5,209	(714)	91,790	4,496	5,575	(1,079)
	South Waveney	60,465	3,355	3,769	(415)	65,110	3,355	3,963	(608)
Great Yarmouth and Waveney Total		**261,226**	**15,071**	**15,477**	**(406)**	**287,133**	**15,071**	**16,714**	**(1,643)**
North Norfolk	NN1	51,408	3,736	3,048	689	56,722	3,736	3,272	464
	NN2	47,067	3,067	3,126	(59)	65,798	3,067	3,925	(858)
	NN3	49,838	3,078	3,077	2	54,094	3,550	3,254	296
	NN4	56,360	4,145	3,848	297	81,716	5,065	4,905	160
North Norfolk Total		**204,673**	**14,027**	**13,099**	**928**	**258,330**	**15,419**	**15,356**	**63**
Norwich	Central	63,359	4,682	3,820	862	69,899	4,682	4,162	520
	East Norwich	56,191	4,113	3,591	522	72,638	4,258	4,277	(19)
	Norwich North	43,105	2,260	3,046	(786)	46,421	2,260	3,184	(924)
	NPL	9,116	680	630	50	9,290	680	637	43
	West Norwich	53,921	4,191	3,667	524	63,089	4,341	4,069	273
Norwich Total		**225,692**	**15,927**	**14,755**	**1,172**	**261,337**	**16,222**	**16,329**	**(107)**
South Norfolk	Breckland	42,858	2,357	2,536	(179)	56,489	2,834	3,104	(270)
	Ketts Oak	65,093	4,144	3,962	182	73,135	4,144	4,297	(153)
	Mid Norfolk	50,402	3,443	3,438	5	52,861	3,443	3,571	(128)
	SNHIP	89,256	6,643	5,917	726	96,661	6,643	6,238	404
South Norfolk Total		**247,609**	**16,587**	**15,853**	**735**	**279,145**	**17,064**	**17,211**	**(147)**
West Norfolk	Coastal	30,620	2,753	2,247	506	33,040	2,753	2,377	377
	Fens and Brecks	46,065	2,548	3,333	(784)	51,414	2,548	3,608	(1,060)
	King's Lynn	77,938	4,267	4,225	42	79,822	5,345	4,326	1,019
	Swaffham and Downham	55,090	3,842	3,889	(48)	59,845	3,842	4,119	(278)
West Norfolk Total		**209,713**	**13,410**	**13,693**	**(283)**	**224,121**	**14,488**	**14,430**	**58**
Grand Total		**1,148,913**	**75,021**	**72,876**	**2,145**	**1,310,066**	**78,263**	**80,039**	**(1,776)**

Expected Future NIA (m²) assumes either future capital or revenue schemes will be completed at the below sites, based upon schemes with an existing level of approval. It is expected additional schemes will be added to this list in coming years.

- Wave 4b. East Norwich Medical Partnership (Sprowston)
- Wave 4b. King's Lynn PCN (Nar Ouse Way)
- Wave 4b. Hoveton & Wroxham Medical Centre (Rackheath)
- Wave 4b. Grove Surgery (THLC)
- Elmham Surgery (Toftwood)
- Drayton Medical Practice (Drayton)
- Blofield Surgery
- Lawson Road Surgery (Norwich)
- Taverham Partnership
- Sheringham Medical Practice (Sheringham)
- St James Medical Practice (Kings Lynn)

Future housing data is based upon NHS England commissioned housing growth information provided by Savills. This data currently only focuses on sites attached to planning permissions and excludes additional growth contained within local plans. This issue is being addressed within the PCN Toolkit Programme but currently growth presented is likely to be understated.

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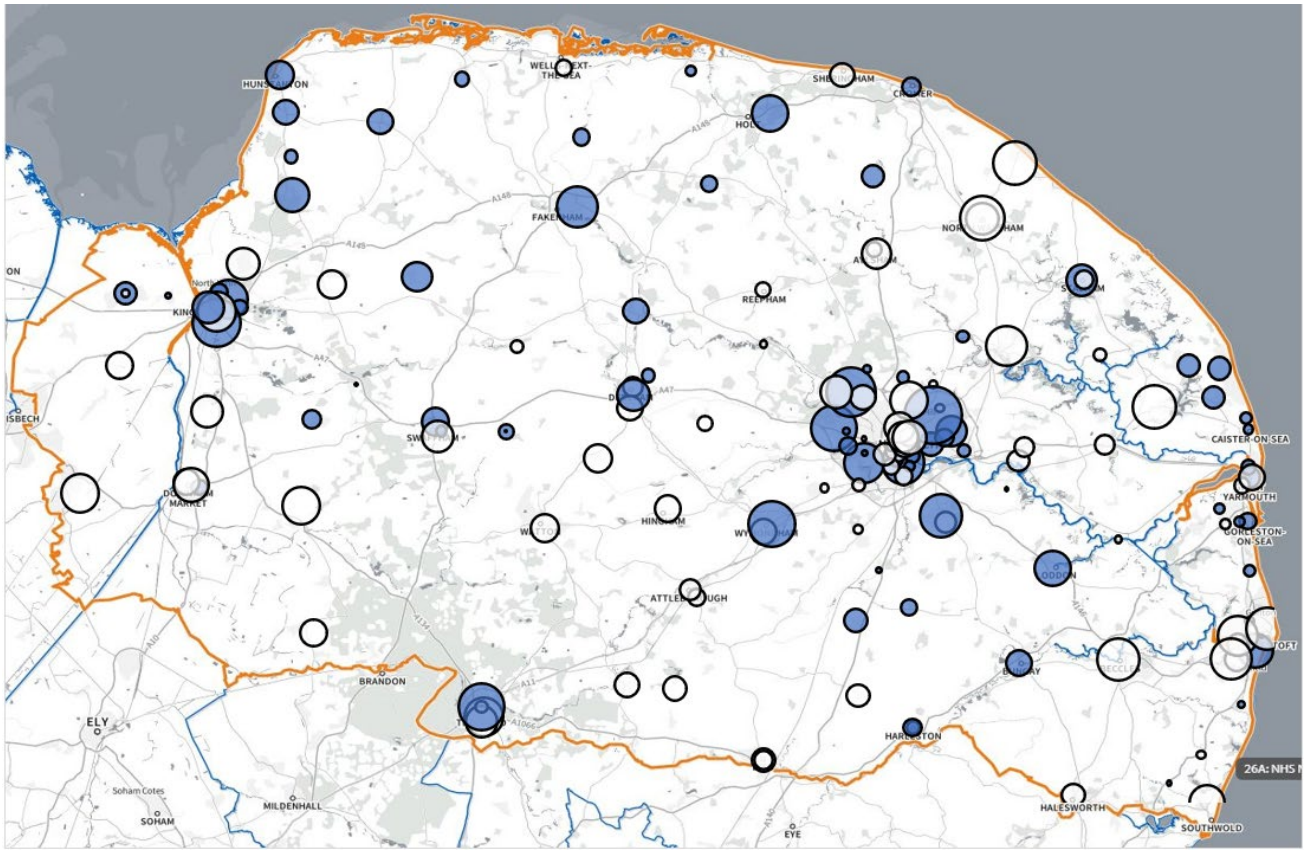
Appendix 4: Demand and Capacity Map 2037



Each circle represents a primary care site, with Blue circles showing sites predicted to have capacity and White circles predicted to have constraint. The circles are scaled to show the predicted capacity/constraint across the ICB footprint.

Please note that due to the scale of the map not all constraints are easily visible.

The ICB are working with practices across its footprint on schemes of varying levels of maturity to address predicted constraint. Completion of the PCN Toolkit Programme and associated estate strategies will highlight any gaps between need and potential schemes. Delivery of all future schemes are subject to capital and revenue affordability.

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Agenda item: 09

Subject:	**Briefing - Recent Care Quality Commission (CQC) inspection Heacham Group Practice**
Presented by:	**Shepherd Ncube – Associate Director of Primary Care Commissioning**
Prepared by:	**Gemma Claridge– Delegated Commissioning Manager – Primary Care**
Submitted to:	**NHS Norfolk and Waveney ICB Primary Care Commissioning Committee**
Date:	**7 February 2023**

Purpose of paper:

For Information - To provide an update to PCCC members on the Care Quality Commission inspection of the following practice who recently had a CQC inspection report published:

- Heacham Group Practice

Executive Summary:

PCCC members will be regularly updated with Care Quality Commission (CQC) inspection reports where the GP Practice has been rated or previously rated as Requires Improvement or Inadequate.

The CQC inspects against five key areas as follows:

Safe
Effective
Caring
Responsive
Well Led

The following practice was inspected, and the report findings are summarised below:

GP Practice	Locality	Date of Inspection/ Re-inspection	Previous Rating/Year	New Overall Rating
Heacham Group Practice 7673 actual list size 1/01/2023	West Norfolk	29th November 2022	Inadequate	Requires Improvement

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Report

Background

The Care Quality Commission (CQC) is the independent regulator of health and social care in England, this includes GP practices.

The CQC inspection is based on five key questions asked of all services being inspected. These are:

- **Is it safe?** Are you protected from abuse and avoidable harm?
- **Is it effective?** Does your care, treatment and support achieve good results and help you maintain your quality of life, and is it based on the best available evidence?
- **Is it caring?** Do staff involve you and treat you with compassion, kindness, dignity and respect?
- **Is it responsive?** Are services organised so that they can meet your needs?
- **Is it well-led?** Does the leadership of the organisation make sure that it's providing high-quality care that's based around your needs? And does it encourage learning and innovation and promote an open and fair culture?

The inspection and evidence obtained by the CQC against the five above questions will lead to an individual and an overall rating, which is either, **outstanding, good, requires improvement or inadequate.**

If practices fall short of the standards the CQC has the power to fine a practice, enforce an action plan or where there are very serious findings immediately close a practice.

Heacham Group Practice Norwich Locality – Inspected: 29 November 2022 **Overall rating: Requires Improvement**					
	Are services safe?	**Are services effective?**	**Are services caring?**	**Are services responsive to people's needs?**	**Are services well-led?**
Rating	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement

Following the CQC previous inspection on 8 March 2022, the practice was rated inadequate overall and for providing safe, effective and well-led services, requires improvement for providing responsive services and good for providing caring services. The practice was placed into special measures and issued with a warning notice relating to a breach of regulations. A subsequent focused review was carried

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out on 5 July 2022 where the CQC found that the practice was partially compliant with the warning notice and a requirement notice was issued. This inspection on 29 November 2022 was a comprehensive inspection to follow up on the concerns identified during the inspection in March 2022.

The CQC carried out an announced comprehensive inspection at Heacham Group Practice on 29 November 2022.

Overall, the practice is rated as **requires improvement**.

Safe Requires improvement

Effective Requires improvement

Caring Good

Responsive Requires improvement

Well-led Requires improvement

This inspection was to review in detail the actions taken by the provider to improve the quality of care and to confirm whether legal requirements were now being met.

The focus of this inspection included:

- The key questions of safe, effective, caring, responsive and well led.
- The follow up of areas where the provider ‘should’ improve identified in our previous inspection.

The follow up of areas where the provider ‘should’ improve identified in our previous inspection.

The inspection was carried out in a way which enabled the CQC to spend a minimum amount of time on site.

This included:

- Conducting staff interviews using video conferencing.
- Completing clinical searches on the practice’s patient records system (this was with consent from the provider and in line with all data protection and information governance requirements).
- Reviewing patient records to identify issues and clarify actions taken by the provider.
- Requesting evidence from the provider.
- A short site visit.
- Staff questionnaires.

CQC findings

The CQC based their judgement of the quality of care at this service on a combination of:

- What they found when they inspected
- Information from ongoing monitoring of data about services and
- Information from the provider, patients, the public and other organisations.

The CQC has rated this practice as Requires Improvement overall.

The CQC found that:

- The practice and leaders had been fully engaged with the external support provided by the Integrated Care Board. They had made clear improvements. These improvements had been newly established and required further time to be fully implemented, embedded and monitored to ensure improvements would be sustained.
- Overall, the clinical oversight and governance had been improved to ensure the service was safe and effective. However, there were some areas which required greater oversight.
- Not all patients received effective care and treatment that met their needs.
- Staff dealt with patients with kindness and respect and involved them in decisions about their care.
- Patients could access care and treatment in a timely way.

The CQC found a breach of regulations.

The provider must:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

In addition to the breach of regulations, the provider should:

- Continue to encourage uptake of cervical screening.
- Continue to monitor complaints to ensure policy is embedded.
- Continue to encourage the uptake of health checks.

The CQC are taking this service out of special measures. This recognises the improvements that have been made to the quality of care provided by this service.

Background to Heacham Group Practice

Heacham Group Practice is located in Heacham at:

45 Station Road
Heacham
King’s Lynn
PE31 7EX

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The practice has a branch surgery at:

Snettisham Surgery
Common Road
Snettisham
King's Lynn
PE31 7PE.

There is a dispensary on site at Heacham.

The provider is registered with CQC to deliver the Regulated Activities

- Treatment of disease, disorder or injury
- Surgical procedures
- Diagnostic and screening procedures
- Maternity and midwifery services
- Family planning services.

The practice is situated within the Norfolk and Waveney Integrated Care Board (ICB) and delivers General Medical Services (GMS) to a patient population of about 7720 patients. This is part of a contract held with NHS England.

The practice is part of a wider network of GP practices Coastal Primary Care Network (PCN).

Information published by Public Health England shows that deprivation within the practice population group is in the sixth highest decile (six of 10). The lower the decile, the more deprived the practice population is relative to others.

According to the latest available data, the ethnic make-up of the practice area is 99% White and 1% Asian.

The age distribution of the practice demonstrates that there is a higher than average older population as compared to local and national averages.

There is a team of GPs who provide cover at both practices. The practice has a team of nurses who provide nurse led clinics for long-term conditions of use of both the main and the branch locations. The GPs are supported at the practice by a team of reception/administration staff as well as dispensary staff. The practice manager and PA are based at the main location to provide managerial oversight.

Due to the enhanced infection prevention and control measures put in place since the pandemic and in line with the national guidance, most GP appointments were telephone consultations. If the GP needs to see a patient face-to-face then the patient is offered a choice of either the main GP location or the branch surgery.

Extended access is provided locally by the PCN, where late evening and weekend appointments are available. Out of hours services are provided by IC24.

Download full report

Download full inspection report for Heacham Group Practice - PDF - (opens in new window)

Download evidence table

Download evidence table for Heacham Group Practice - PDF - (opens in new window)

Following the inspection and the new CQC rating of Requires Improvement the ICB's Primary Care, West Norfolk Locality, Quality and Medicines Optimisation teams have been working closely to support the practice to develop an action plan to address the required improvements and provide advice and guidance to support the work going forward.

Since the report has been published the practice has demonstrated engagement in the turnaround work and continues to engage with additional managerial and clinical support from a third party source.

Monthly meetings are currently in place between the practice, CQC and ICB support team to review progress to ensure that the areas highlighted by the CQC are addressed.

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Key Risks	
Clinical and Quality:	The concerns identified by the CQC which lead to a poor rating may put patients at risk
Finance and Performance:	Practice income could be affected as they invest in implementing identified improvements.
Impact Assessment (environmental and equalities):	Improving the health of the population
Reputation:	A poor rating may affect the practice's reputation
Legal:	GMS Contractual Obligations
Information Governance:	N/A
Resource Required:	This forms part of the delegated commissioning team's portfolio
Reference document(s):	CQC inspection framework and published reports
NHS Constitution:	N/A
Conflicts of Interest:	GP practice members may be conflicted
Reference to relevant risk on the Governing Body Assurance Framework	CQC inspections will form part of a wider risk on the resilience of general practice

GOVERNANCE

Process/Board approval with date(s) *(as appropriate)*	A regular report on CQC inspections is brought to PCCC for noting, along with reports as practice inspections are published.

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Norfolk and Waveney
Integrated Care Board

Agenda item: 10

Subject:	**SMI Health Checks- Monthly Update**
Presented by:	**Shepherd Ncube, Associate Director of Delegated Commissioning, Primary Care**
Prepared by:	**Julian Dias, Deputy Senior Delegated Commissioning Paper**
Submitted to:	**Primary Care Commissioning Committee**
Date:	**7 February 2022**

Purpose of paper:

To update the PCCC on plans and progress to-date to around patients with Severe Mental Illness (SMI) for February 2023.

1. Background

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

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

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

2. Quarter 3 Data:

The Quarter 3 data performance position for SMI annual checks has been released and vetted by the BI Team. In summary for all 6 core SMI checks:

- N&W carried out 4,051 from a possible 9,664 checks = **42.5% (427 checks more than Q2).**

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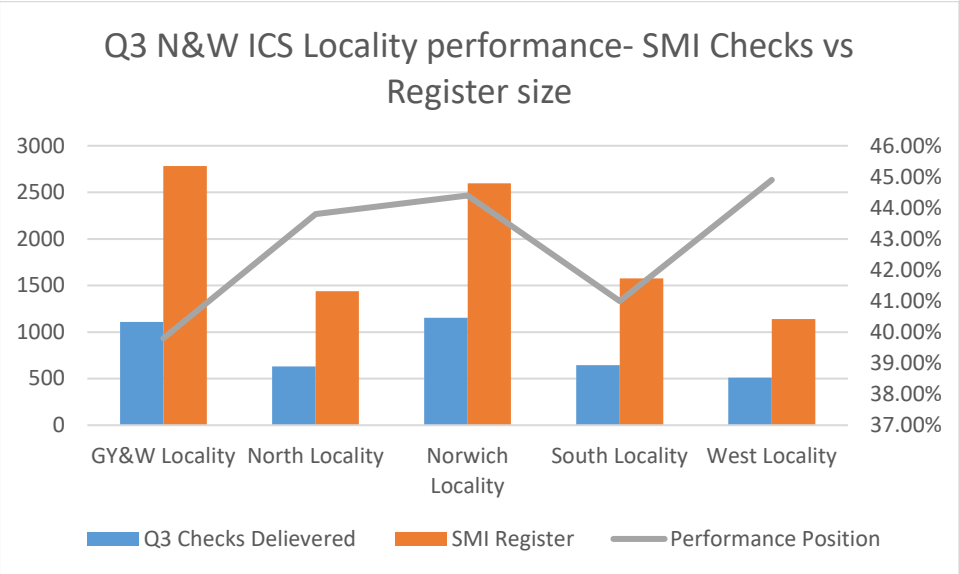
- NSFT carried out 342 from a possible 3,314 checks = **10.4% (42 checks more than Q2).**
- Combined 4,393 from a possible 9,664 checks = **46.1% (469 checks more than Q2).**
- This is further described in the locality splits across the ICB as below (the percentage position is against a national target of 60%):



	Q3 Checks Delievered	SMI Register	Performance Position
GY&W Locality	1109	2784	39.80%
North Locality	630	1439	43.80%
Norwich Localit	1154	2598	44.40%
South Locality	645	1575	41%
West Locality	512	1141	44.90%

3. Progress Plans Update since December 2022 report:

- The ICB has submitted a funding bid to increase frequency and quality of LD/SMI annual health checks carried out within general practice.
- This request has been agreed in principle by NHSE. Once fully approved, this funding will be used to purchase Point of Care testing kits, administrative and clinical support for general practice.
- The equipment will reduce the time needed to wait blood tests and results; potentially leading to an increase in system performance.

4. Benchmarking Performance Data:

- At the last Primary Care Commissioning Committee meeting, benchmarking of performance data was requested to see how the N&W ICB performs comparatively against other ICBs in the East of England region.

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	2020/21				2021/22				2022/23				Planning Trajectory			
ICB	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Bedfordshire, Luton & MK	1,547	1,535	1,371	1,520	1,992	2,195	2,494	3,621	3,944	4,239			3,800	4,300	4,800	5,392
Cambridgeshire & Peterborough	2,209	1,845	1,701	1,378	2,050	2,438	2,553	2,643	3,588	3,004			3,000	3,300	3,700	4,050
Herts & West Essex	3,493	3,215	2,850	3,530	3,591	3,119	3,388	4,573	4,054	4,715			4,700	5,000	5,350	6,050
Mid & South Essex	1,237	2,047	2,389	2,817	3,559	3,917	4,558	5,651	5,591	6,188			6,054	6,410	6,523	6,523
Norfolk & Waveney	2,254	2,288	1,785	1,530	2,069	2,302	2,748	3,548	3,588	3,924			3,548	3,948	4,348	4,748
Suffolk & North East Essex	2,353	2,125	1,720	1,991	2,014	2,551	3,319	3,955	3,995	4,233			4,072	4,826	5,387	5,564
East of England	13,093	13,055	11,816	12,766	15,275	16,522	19,060	23,991	24,760	26,303			25,174	27,784	30,108	32,327

- In terms of activity rankings, N&W ranks 5th in annual checks delivered (using Q2 data); however give or take are still delivering on our planning trajectory supplied to NHSE. Our trajectory is built around gradual yet sustainable improvement with any changes being embedded for the long term.

- Additionally, regarding uptake of COVID vaccinations within the SMI cohorts; Norfolk and Waveney have an uptake of 58.95%, which is the ***highest performer in the EOE region*** with the region itself performing ahead of the national average of 51.1%. This is down to the hard work being undertaken by GP practices.

5. Recommendation to the Committee:

Committee 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:	• Risk to delivery of service due to potential disruption caused by winter pressures. • 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 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

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

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Norfolk and Waveney
Integrated Care Board

Agenda item: 11

Subject:	**Committee self-assessment**
Presented by:	**Sadie Parker, Director of Primary Care**
Prepared by:	**Sadie Parker, Director of Primary Care**
Submitted to:	**Primary Care Commissioning Committee**
Date:	**7 February 2022**

Purpose of paper:

This paper is for approval.

1. Background

Each ICB committee is required to self-assess its performance on an annual basis. As the ICB only formed in July 2022, it was agreed a shortened self-assessment would be carried out in this first year. This means that the officer for each committee would complete the self-assessment, focusing only on the first section of the document

2. Self-assessment

Members are invited to review the self-assessment template attached and to approve the content.

There is one area marked as a 'no'; this is whether the committee prepares an annual report on its work for the Board. While the committee has provided a report every two months to Board, an annual report has not yet been requested. The primary care commissioning team does include its work in the ICB's (and formerly CCG's) annual report.

It is also noted there is not yet a single dashboard presented to committee members, however data is presented to members via the relevant reports, such as learning disability and severe mental illness health checks and the GP Patient Survey. Officers will continue to request the development of a dashboard internally, which will be provided once capacity allows.

Revised terms of reference will be presented to the ICB Board in February for approval. This recognises the change in responsibility for the committee as part of the national transition to full delegation of all four primary care services.

Training has already been provided for members on general medical services, dates are in the diary for further training on dental, community pharmacy and optometry services.

3. Recommendation to the Committee:

Committee members are invited to approve the self-assessment attached. This will then be reported to the Board

Key Risks	
Clinical and Quality:	This is reviewed at the committee through the reporting of Care Quality Commission inspections
Finance and Performance:	A monthly finance report is provided. A dashboard is not yet available to the committee
Impact Assessment (environmental and equalities):	N/A
Reputation:	ICB is responsible for delegated commissioning as per its delegation agreement and in line with NHS Constitution and the national drive to address health inequalities within systems.
Legal:	ICB is responsible for delegated commissioning as per its delegation agreement and in line with NHS Constitution.
Information Governance:	N/A
Resource Required:	ICB officers
Reference document(s):	Delegation agreement and NHS Constitution
NHS Constitution:	
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	N/A

Governance

Process/Committee approval with date(s) (as appropriate)	The self-assessment will be reported to the ICB Board along with other committee reports

Committee Review of Effectiveness – Part 1 Quantitative Self-Assessment			
	Yes	**No**	**Comments/ Action**
Composition, Establishment and Duties			
Does the Committee have written terms of reference that adequately define the Committee's role?	Y		TORs being reviewed for April 2023 to take account of the new PCCC responsibilities
Have terms of reference been approved by the Board?	Y		
Has the Committee been provided with effective: membership, authority and resources to perform its role effectively?	Y		
Does the Committee report to the Board in accordance with its ToR?	Y		Reports provided by chair every 2 months
Do Committee Members have sufficient knowledge to identify key risk areas and challenge management?	Y		Single dashboard development remains a gap, however data is brought separately for multiple areas, eg learning disability and severe mental illness health checks, GP patient survey
Does the Committee prepare an Annual Report on its work for the Board		N	This has not yet been requested, although primary care always forms part of the annual report
Has the Committee been quorate for each meeting this year?	Y		We were not quorate for one item in the January part 2 meeting due to redeployment of staff, February meeting rearranged to enable quorum
Administrative Arrangements			
Are agendas and reports circulated in good time for Committee Members to give them due consideration?	Y		
Are the minutes and actions circulated in good time for Committee Members to give them due consideration?	Y		
Has the Committee met the appropriate number of times this year?	Y		
Have all Committee Members attended meetings on a regular basis; is the level of attendance satisfactory and in line with the ToR's?	Y		
Governance, Scrutiny and Assurance			
Can the Committee demonstrate that it has provided the Board with assurance in respect of the Statutory Duties as per the ToRs?	Y		Report provided to each Board meeting, new template includes this
Can the Committee demonstrate that it has provided Board with assurance in respect of the BAF and Corporate Risks?	Y		Two Primary Care Committee risks now on the BAF. These are primary care resilience and transition of direct commissioning
Has the Committee sufficient time to give appropriate consideration and scrutiny to its business and agenda?	Y		
Does the Committee receive sufficient Reports to enable it to fulfil the ToRs?	Y		

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Do the reports presented to the Committee provide the quality and detail required to enable the Committee to provide assurance and carry out the ToR?	Y		
Does the Committee understand the risks / issues, make decisions and provide assurance	Y		
Has the Committee approved the ToR and work plans to support any sub-committee?			Not applicable, although new TORs from April will involve establishment of a medical and dental delivery group
Has the Committee received regular progress reports from any sub-committees and been advised of any significant issues / risks?			Not applicable
Has the Committee effectively managed Conflicts of Interest in line with the ICB's policy and the Committee's ToR?	Y		
Work Plan			
Has the Committee established a work plan for the year and has it been adhered to?	Y		Any amendments are captured in red and noted at each month
Does the Committee review its work plan at least quarterly?	Y		
Has the Committee achieved its agreed work plan?	Y		
Does the work plan reflect all of the duties and responsibilities set out in the ToR?	Y		
Are there any areas of the ToR which require additional focus or a change in approach? Have any necessary changes been made to the work plan to achieve this?	Y		Changes being proposed to reflect additional responsibilities from April 2023

Any other comments, areas for improvement?
Training has been provided for members on general medical services, further training planned for new areas from April 2023 – dentistry, community pharmacy and optometry services.

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Improving lives together
Norfolk and Waveney Integrated Care System

Agenda item: 12

Subject:	**Prescribing team report**
Presented by:	**Michael Dennis, Associate Director of Pharmacy and Medicines Optimisation**
Prepared by:	**Michael Dennis, Associate Director of Pharmacy and Medicines Optimisation**
Submitted to:	**Primary Care Commissioning Committee**
Date:	**7 February 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 prescribing team are working up ideas for next year's prescribing quality scheme and potentially an additional switch scheme.

1.2 The prescribing quality scheme has facilitated some improvement in indicators (see below). The team continue to meet practices to facilitate implementation.

2. 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. In the new ICB configurations Norfolk and Waveney have moved from 3rd out of 6 to 2nd out of 6 in October mainly due to very high flu costs, November data below puts the ICB closer to being back to 3rd.The available deprivation scores can be accessed here (registration required).

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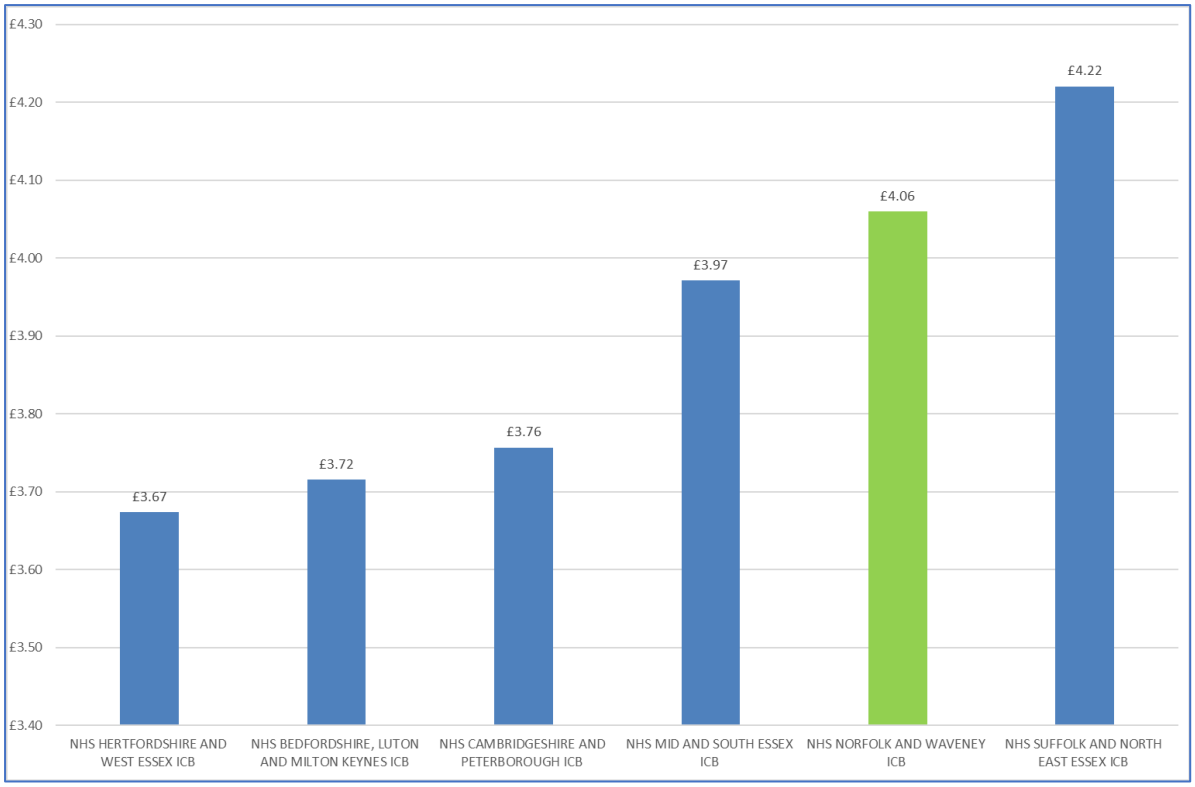

2.4 An explanation on retained margin (Category M) is below.

The community pharmacy sector will receive £2.592bn per year from 2019/20 to 2023/24. Of the annual sum, £800m is to be delivered as retained buying margin i.e., the profit pharmacies can earn on dispensing drugs through cost effective purchasing.

The £800m retained margin element is a target that the Department of Health and Social Care (DHSC) aim to deliver by adjusting the reimbursement prices of drugs in Category M of the Drug Tariff.

Where the delivery rate of margin to community pharmacy will be under or over deliver on the £800m target, the DHSC will re-calibrate Category M Drug Tariff prices to bring the margin delivery rate back on track. This is the CAT-M reimbursement adjustments.

NCSO (no cheaper stock obtainable)

NCSO is a price concession agreed by the Department of Health when a product cannot be sourced at the drug tariff (DT) price. There is a continued impact of price concessions 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 and projected for the following 2 months.

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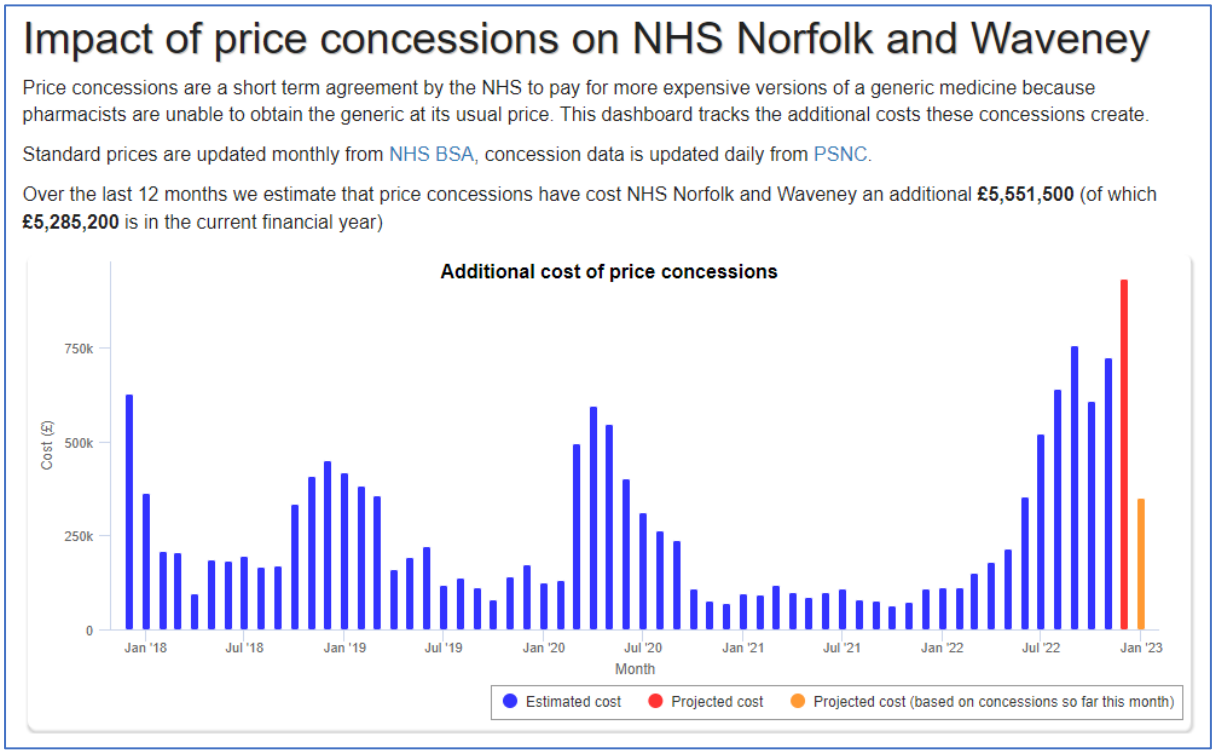
Table 1. Cost Pressure Report December 2022, October data

	YTD April-Nov	Projected Dec*	Projected Jan**
NCSO and other price concessions	£4,235,456	£985,541	£345,553 Minimum
Back into DT at increased prices	£745,486	£221,974	£403,734
Increase In cat M from Q3	£97,502	£188,888	£344,588***
Total	£5,078,444	£1,396,403	£1,094,142

* Projected figures are estimated but are based on price concessions announced
** based on price concessions announced to date, some are agreed after month end.
*** will continue at this level in Feb and March

Table 2. Bar chart of NCSO additional costs over time



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. Freestyle Libre 2 costs are increasing significantly due to the implementation of the NICE guidance.

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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 November 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 ICBs.

- High dose opiates – a small increase in use to 82nd (84th previously (out of 106 organisations) 22nd percentile (previously 21st) on high dose opiate items as percentage of regular opiates
- Gabapentinoids – improved to 30th ,72nd percentile (29th, 73rd percentile previously) on defined daily doses of gabapentin and pregabalin
- Hypnotics and anxiolytics – reverted back to 4th nationally 97th percentile (previously 3rd nationally 98th percentile) volume per 1000 patients – the trend (below) is however an improving one (yellow dotted line is Norfolk and Waveney performance and trend respectively)

The second chart compares NWCCG performance with national percentiles (NW is the red line and national average is the blue line)

Table 4. Anxiolytics and hypnotics volume trend over time by top prescribing ICB's nationally

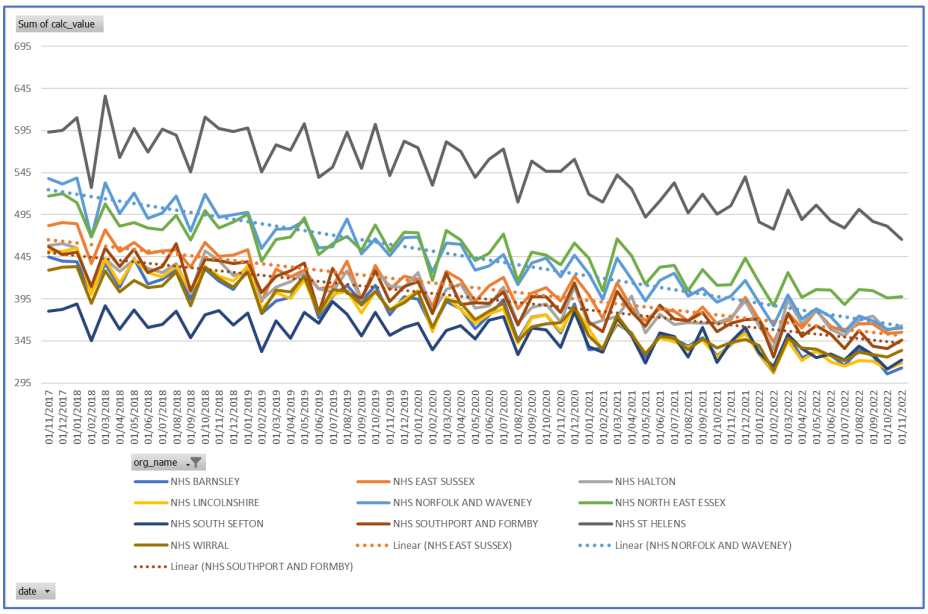

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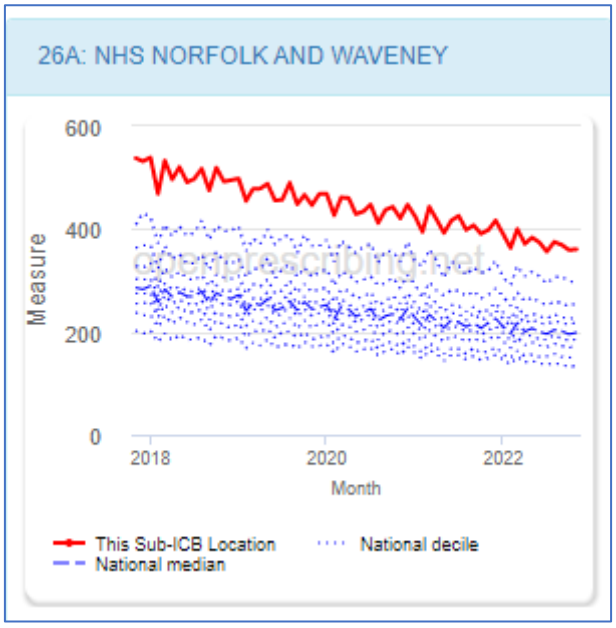
Table 5. Anxiolytics and hypnotics volume trend over time (red line is Norfolk and Waveney and darker blue line is national average)



3.3 We have secured regional funding for e-learning around deprescribing opioids along with virtual workshops. A bespoke CBT (cognitive behavioural therapy) e-learning package is also being developed. These will be launched as part of the offer to support practices to deliver the quality improvement within the forthcoming prescribing quality scheme.

4 Antibiotic Prescribing

4.1.0 NHS System Oversight Framework (SOF) Antimicrobial Prescribing Metrics for 2022-23 remain the same as 2021-22. The antibiotic volumes target is 0.871 or less antibacterial items per STAR-PU which aligns 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 is at or below 10%.

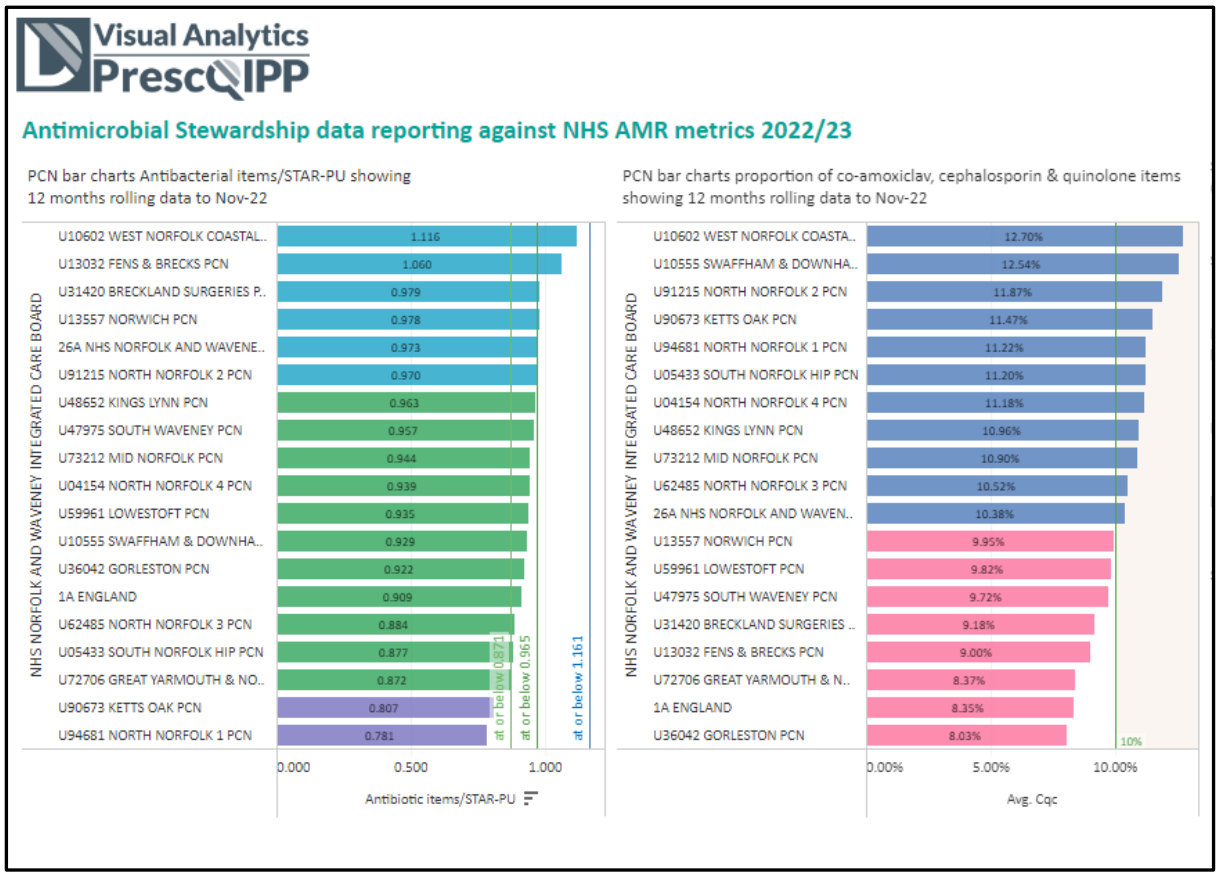
4.1.1 National AMS leads advise that targets will not be amended despite the recent uprise in antimicrobial prescribing, due to the National Action Plan ambition being a five-year plan from 2019-2024.

4.1.2 Antibiotic volumes, the bar chart on the left shows the volume of antibiotic prescribing by PCNs. Norfolk and Waveney are now above the second volume target of 0.965 with a value of 0.973 antibacterial items per STAR-PU in the 12 months to November 2022.

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

national target of no more than 10% of all antibiotics at 10.38% (reduction of 0.03%) in the 12 months to November 2022.

Table 6. PCN bar charts – Antimicrobial prescribing 12 months to end Nov 2022



4.3 Our outlier practices (above 14%) that are driving the higher percentage of Broad-spectrum antibiotics in November data are shown in Table 9. The number of practices above this threshold has reduced again significantly this month with only five practices above 14%.

Table 7: Outlier Practices for prescribing Broad Spectrum Antibiotics

Practice Name	Sum of percentile	Percentage of Broad-spectrum antibiotics (Nov 2022)
MUNDESLEY MEDICAL CENTRE	99.66	18.01%
BURNHAM SURGERY	99.63	17.85%
WELLS HEALTH CENTRE	99.32	16.04%
WINDMILL SURGERY	99.15	15.44%
E HARLING & KENNINGHALL MEDICAL PRACTICE	98.67	14.43%

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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

Norfolk and Waveney
Integrated Care Board

Agenda item: 13

Subject:	**Spotlight on Primary Care expenditure**
Presented by:	**James Grainger, Head of Finance**
Prepared by:	**Emma Kriehn-Morris, Associate Director of Finance** **James Grainger, Head of Finance**
Submitted to:	**Primary Care Commissioning Committee**
Date:	**7th February 2023**

Purpose of paper:

To present an update to the Primary Care Commissioning Committee on the financial, operational and efficiency performance within the Primary Care portfolio for December 2022.

Executive Summary:

Primary Care Financial Summary:

As at Month 8 (November), the 9 months forecast spend is £316.9m as against a plan of £313.6m leading to a total overspend of £3.3m for Primary Care and Prescribing in combination (excluding ARRS allocation due).

Details of the major areas of variance for Primary Care are reported in section 3.0 Detailed Variance Analysis.

The paper highlights the schemes currently identified and actions as a Prescribing Efficiencies Group that are being undertaken.

Co-working between finance and clinical Medicines Management colleagues continues and results are starting to be seen supporting governance, internal audit recommendations, project progression and efficiency delivery. Projects details and progress are shown within the report.

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 ICB's 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)	

Improving lives **together**

Norfolk and Waveney Integrated Care System

2022/23 Primary Care Commissioning Committee

Finance Report Norfolk & Waveney ICB

December 2022

Primary Care Commissioning Committee 7th February 2023

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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 M9 (December-22) of the ICB accounts. Since the ICB (Integrated Care Board) was formed July 2022 the forecast included is for the ICB for 9 months from July-March 2023.

- The 2022-23 budgets for the ICB are from July – March 2023 and 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. Efficiency target of £3.2m included in Forecast for remaining months from November –March.

- As at Month 9 (December), the 9 months forecast spend is £316.9m as against a plan of £313.6m leading to a total overspend of £3.3m for Primary Care and Prescribing in combination (excluding ARRS allocation due £4.5m if included then £1.2m underspend).

- Details of the major areas of variance for Primary Care are reported in section 3.0 Detailed Variance Analysis.

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2.0 Financial Summary

Primary Care: Financial Summary	9 months ICB Budget £m	Year to Date (December) Budget £m	Actual £ m	Variance (Fav)Adv £m	Forecast 9 Months (ICB) Actual £m	Variance (Fav) Adv £m	Forecast at Month (November) Actual £m	Movement (Fav) Adv £m	Comments on material Movement between October and November	*Detailed Variance Analysis*
GP & Other Prescribing	**143.1**	**95.7**	**97.8**	**2.1**	**146.8**	**3.7**	**144.3**	**2.5**	The No Cheaper Stock Obtainable (NCSO) cost pressures and increase in Sodium glucose cotransporter 2 (SGLT2) prescriptions have resulted in an increase in FOT at M9	*3.1*
Primary Care										
System Development Fund	**3.1**	**2.0**	**1.8**	**(0.2)**	**2.9**	**(0.2)**	**3.1**	**(0.3)**	Underspend in Improved Access	
Local Enhanced Services	**12.4**	**8.5**	**8.5**	**0.0**	**12.4**	**0.0**	**12.4**	**0.0**		
Other Primary Care	**2.2**	**1.3**	**1.1**	**(0.2)**	**1.9**	**(0.3)**	**2.1**	**(0.2)**	Release of accrual for RA smartcards, now covered in the GPIT contract with NCH&C	
Primary Care Delegated Co-Commissioning	**147.2**	**100.2**	**97.0**	**(3.2)**	**147.6**	**0.4**	**147.8**	**(0.2)**		*3.2*
Primary Care IT	**5.6**	**3.1**	**2.7**	**(0.3)**	**5.3**	**(0.3)**	**4.1**	**1.2**	FOT increased to match new allocation received in for Digital adult Social care and staff costs M9	
Total Primary Care	**170.4**	**115.1**	**111.2**	**(3.9)**	**170.0**	**(0.4)**	**169.5**	**0.5**		
Total Directorate	**313.6**	**210.8**	**209.0**	**(1.8)**	**316.9**	**3.3**	**313.8**	**3.0**		
Variance as a % of Budget				***-0.8%***		***1.1%***		***1.0%***		
Retrospective ARRS allocation to be received	**0.0**	**0.0**	**0.0**	**0.0**	**-4.5**	**-4.5**	**-3.5**	**(1.0)**		
Total Primary Care	**313.6**	**210.8**	**209.0**	**-1.8**	**312.4**	**-1.2**	**310.3**	**2.1**		

The detailed explanations are provided in 3.0 Detailed variance analysis.

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3.0 Detailed Variance Analysis

Primary Care: Detailed Variance Analysis		9 months Budget ICB	Year to Date (December)			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	143.1	95.7	97.8	2.1	146.8	3.7	2.6%	The GP Prescribing costs are reported nationally 2 months in arrears, hence actuals from July to October and estimates for November and December are considered in the Year to Date (YTD) position, and Forecast Outturn (FOT) considers July to October actuals and estimates from November to March. The YTD is is overspent by £2.1m and FOT is overspent by £3.7m.This is driven by cost pressures of No Cheaper Stock Obtainable (NCSO) due to supply chain issues and increase in SGLT2 prescriptions mitigated by prior year benefits. An efficiency target of £(3.2)m is included in the FOT position for remaining months. It is assumed the efficiency savings are delivered as per revised plan. Analysis of the savings achieved to date validates this position.
3.2	Primary Care Delegated Co-Commissioning	147.2	100.2	97.0	(3.2)	147.6	0.4	0.3%	The underspend here is due to prior year release.

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4.0 System Development Fund

Primary Care: System Development Fund	9months Budget ICB Budget £m	Year To Date(November) Budget £m	Actual £ m	Variance (Fav) Adv £m	9 months Forecast (ICB) Actual £m	Variance (Fav) Adv £m
GP Retention	0.1	0.0	0.0	0.0	0.1	0.0
Training Hubs	0.2	0.1	0.1	0.0	0.2	0.0
Online Consultation	0.2	0.1	0.1	0.0	0.2	-0.0
Flexible Pool	0.1	0.1	0.1	0.0	0.1	-0.0
Infrastructure & Resilience	0.2	0.1	0.1	0.0	0.2	0.0
GP Fellowship	0.5	0.0	-0.0	(0.0)	0.5	-0.0
Improved Access	1.8	1.8	1.8	(0.0)	1.8	-0.0
Practice Resilience	0.1	0.1	0.1	(0.0)	0.1	-0.0
Transformational Support	0.3	0.0	0.0	0.0	0.3	0.0
Supporting Mentor	0.0	0.0	0.0	0.0	0.0	0.0
Nurse Fellows	0.1	0.0	0.0	0.0	0.1	0.0
Others	(0.5)	-0.3	-0.3	(0.0)	-0.5	0.0
	3.2	**2.0**	**2.0**	**0.0**	**3.1**	**(0.0)**
Variance as a % of Budget				*0.1%*		*-0.1%*
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 bar some small immaterial differences.

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5.0 Delegated Co Commissioning Analysis

Primary Care: Delegated Co Commissioning	9months Budget ICB £m	Year to Date (December) Budget £m	Actual £ m	Variance (Fav)Adv £m	9 Months Forecast (ICB) Actual £m	Variance (Fav) Adv £m
Contractual	94.0	62.7	62.9	0.2	94.4	0.4
QOF	11.9	7.9	7.9	0.0	11.9	0.0
Premises cost reimbursemen	11.1	7.4	7.6	0.2	11.3	0.2
Other - GP Services	10.7	7.4	7.6	0.3	10.9	0.3
Enhanced services	6.6	3.9	3.9	0.0	6.7	0.0
CCG Spend	0.3	0.2	0.2	(0.0)	0.3	(0.0)
PCN ARRS Staff	9.3	8.6	8.6	0.0	13.8	4.5
PMS to GMS	3.1	2.1	0.0	(2.1)	0.0	(3.1)
Prior Year	0.0	0.0	-1.8	(1.8)	-1.8	(1.8)
Total	**147.2**	**100.2**	**97.0**	**(3.2)**	**147.6**	**0.4**
Variance as a % of Budget				*-3.2%*		*0.3%*

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), being funded to a level set by NHSE there is a prudent argument to increase this creating a cost pressure.
- **PMS to GMS:** Budgets held within Delegated PC as per NHSE guidance costs shown in Locally Commissioned Scheme.
- **PCN ARRS Staff:** This is due to Primary Care Networks (PCNs) using tranche 2 allocation which has not yet been received
- **Other GP Services:** This is due to overspend in Locum and Dispensing Fees.

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6.0 GP And Other Prescribing

22/23 Primary Care: GP And Other Prescribing	9months Budget CCG	Year to Date(December)			9 months Forecast (ICB)		Forecast as at November		Comments on material Movement in Forecast Outturn (FOT) between November and December
	Budget £m	Budget £m	Actual £ m	Variance (Fav)Adv £m	Actual £ m	Variance (Fav)Adv £m	Actual £ m	Movement in FOT (Fav)Adv £m	
GP Prescribing Costs	134.7	90.4	94.6	4.2	140.1	5.4	137.3	2.8	The difference between between the October actuals and estimate excluding flu recharges was £0.7m. The NCSO cost pressures and SGLT2 increased usage continue and hence the revised forecast is £2.8m more than previous month's forecast.
Recharges to Local Authorities & NHS England	(3.9)	(2.6)	(3.6)	(1.0)	(3.8)	0.1	(3.8)	0.0	October Flu Rebates higher than estimate
Rebates from pharmaceutical companies	(2.2)	(1.4)	(2.2)	(0.8)	(3.4)	(1.1)	(3.4)	0.0	An increase in Edoxaban Rebates.
GP Prescribing Subtotal	**128.6**	**86.4**	**88.8**	**2.4**	**132.9**	**4.4**	**130.1**	**2.8**	
Central Drugs	3.6	2.4	2.5	0.1	3.8	0.2	3.8	0.0	No Movement.
Dressings & wound care	4.4	2.9	2.9	(0.0)	4.3	(0.1)	4.3	(0.0)	
Others (Medicine Management, Oxygen, incentives etc.)	6.6	4.0	3.6	(0.4)	5.8	(0.8)	6.1	(0.3)	Release of additional staffing costs expected as POD project has a delayed start and other expenses which are lower than estimates
Total Spend	**143.1**	**95.7**	**97.8**	**2.1**	**146.8**	**3.7**	**144.3**	**2.5**	
Variance as a % of Budget				*2.2%*		*2.6%*		*1.7%*	

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.

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7.0 Financial risks

Risk	Mitigation
2022/23 outturn position deteriorates from the current forecast	There is robust management and oversight arrangements, detailed review of underlying position, via monthly review of actual expenditure compared to plan and specific mitigations agreed with budget managers.
New NICE Guidelines	Due to new NICE guidance which was published in March-22 there may be additional costs in the 2022/23 expenditure as a result of Continuous Glucose Monitoring (CGM) and prescribing of Sodium-glucose Cotransporter-2 (SGLT2) inhibitors. The potential mitigation is that these new drugs and therapies will not be suitable for all diabetic patients and will take time to roll out deferring the cost beyond 2022/23
Non delivery or under delivery of £1.026m Transformation Savings assumed in the financial position for Prescribing (Up to M3).	Practice Level Prescribing budgets, based on a scientific process to include deprivation, care home beds and list size has been calculated. Actual spend is being compared on a monthly basis to understand the outlying practices and take corrective steps. Theirs is an oversight group also setup to monitor and take corrective action.
Increased number of prescriptions for anti depressants and pain killers due to the large Elective surgery waiting list.	Regular monitoring by Prescribing Team should identify the trend and take corrective steps.

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7.0 Financial risks (Continued)

Risk	Mitigation
Volatile prescribing costs, that can fluctuate and are exacerbated by the macro-economic climate, supply issues and interest rates. In addition the CAT M and NCSO (No Cheaper Stock Obtainable) costs are inherently volatile.	Robust management and oversight, through collaborative working between finance and medicines management to understand trends, variances and cost
Financially unstable practices	There are practices which are receiving resilience support from the 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”.
Additional costs due to existing estates costs, e.g. rent rate reviews, and new estates costs as a result of practice premises and expansion (e.g. additional revenue costs due to expansion of premises)	The 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
Delegated financial position and the inability to control the spend within the ICB due to nationally mandated expenditure.	Negotiation with NHS England and Improvement and involvement in national allocation working groups. Look to cease or defer non mandated expenditure where possible.

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