Improving lives together
Norfolk and Waveney Integrated Care System

Meeting of the Norfolk and Waveney ICB Primary Care Commissioning Committee
Tuesday 11 October 2022, 13:30 – 15:00/15:30 Part 1
Meeting to be held via video conferencing and You Tube

Item	Time	Agenda Item	Lead
1.	13:30	**Chair's introduction and report on any Chair's action**	Chair
2.		**Apologies for absence**	Chair
3.		**Declarations of Interest** To declare any interests specific to agenda items. Declarations made by members of the Primary Care Committee are listed in the ICB's Register of Interests. *For noting*	Chair
4. Pg 5		**Review of Minutes and Action Log from the August and September 2022 meetings** *For approval*	Chair
5. Pg 23		**Forward Planner** *For Noting*	SP
6. Pg 25	13:35	**Risk Register – Carried forward from September 2022** *For Noting*	SP
7. Pg 38	13:45	**Director of Patients and Communities Report** *For Noting*	SP
		Service Development	
8. Pg 41	13:55	**Items carried forward from September 2022 Committee** **GP Patient Survey Results** *For Approval* **Resilience Funding** *For Noting*	KL SN
9. Pg 52	14:05	**Learning Disability Health Checks** *For Noting*	SN
10. Pg 57	14:15	**CQC Reports** • Andaman Surgery *For Noting*	SN
		Finance & Governance	
11. Pg 63	14:25	**Prescribing Report** *For Noting*	MD
12. Pg 74	14:35	**Finance Report** *For Noting*	JG
		Any Other Business	
13.	14:45	**Questions from the Public**	Chair

Date, time and venue of next meeting
Tuesday 8 November 2022, 13:30 – 16:30 – ICB PCCC
To be held by videoconference and You Tube

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

Questions are welcomed from the public.
Please send by email: nwicb.contactus@nhs.net
For a link to the meeting in real-time
Please email: nwicb.communications@nhs.net
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.
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	
Steven Course	Director of Finance, Norfolk and Waveney ICB	March Physiotherapy Clinic Limited				Indirect	Wife is a Physiotherapist for March Physiotherapy Clinic Limited	2015	Present	Will not have an active role in any decision or discussion relating to activity, delivery of services or future provision of services in regards March Physiotherapy Clinic Limited
Tricia D'Orsi	Director of Nursing, Norfolk and Waveney ICB	Nothing to Declare	N/A				N/A	N/A		N/A
Hein van den Wildenberg	Non-Executive Member, Norfolk and Waveney ICB	Lakenham Surgery			X	Direct	Member of a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
		College of West Anglia			X	Direct	Governor at College of West Anglia (Note: the College hosts the School of Nursing, in partnership with QEHKL and borough council)	2021	Present	Low risk. If there is an issue it will be raised at the time.
Norfolk and Waveney ICB Attendees										
Mark Burgis	Director of Patients and Communities, Norfolk and Waveney ICB	Drayton Medical Practice			X	Direct	Member of a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
		Castle Partnership				Indirect	Partner is a practice nurse at Castle Partnership	Ongoing		
Shepherd Ncube	Head of Delegated Commissioning	Nothing to Declare	N/A			N/A	N/A	N/A		N/A
Sadie Parker	Associate Director of Primary Care, Norfolk and Waveney ICB	Active Norfolk		X		Direct	Represent N&WCCG as a member of the Active Norfolk Board	2019	Ongoing	Low risk. If there is an issue it will be raised at the time

2

NHS England and NHS Improvement Attendee										
Fiona Theadom	Contracts Manager, NHS England and NHS Improvement	Nothing to Declare	N/A				N/A		N/A	N/A
Local Medical Committee Attendees										
Mel Benfell	Norfolk & Waveney Local Medical Committee Executive Officer	NHS Norfolk and Waveney ICB				Indirect	Personal friend of an employee of the ICB	2015	Present	Will not take part in any discussion or decisions relating to the declared interests.
		Windmill Surgery				Indirect	Member of a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
Naomi Woodhouse	Norfolk & Waveney Local Medical Committee Joint Chief Executive	Long Stratton Medical Practice			X	Direct	Member of a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
Practice Managers drawn from General Practice Attendees										
James Foster	Member Practice Representative	St. Stephens Gate Medical Practice	X			Direct	Partner at St. Stephens Gate Medical Practice	2019	Present	Will not take part in any discussion or decisions relating to the declared interests.
		One Norwich	X			Direct	Director, One Norwich Practices Ltd (GPPO/PCN)	2019	Present	
		N2S	X			Direct	Director, N2S, Provider of day surgery in a primary care setting	2014	Present	
Rosemary Moore	Member Practice Representative	Humbleyard Practice	X			Direct	Previous Employee of Humbleyard Practice	2020	2022	Will not take part in any discussion or decisions relating to the declared interests.
		Blofield Medical Practice			X	Direct	Member of a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
		Acle Surgery	X			Direct	Supporting the newly appointed practice manager at Acle Surgery	2022	Present	
		Norfolk and Norwich University Hospitals NHS FT (NNUHFT)			X	Direct	Chair of NNUHFT Patient Panel	2018	Present	
Health and Wellbeing Board Attendees (Norfolk and Suffolk)										
Bill Borrett	Norfolk Health & Wellbeing Board Chair	North Elmham Surgery			X	Direct	Member of a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice
		Norfolk County Council	X			Direct	Elected Member of Norfolk County Council, Elmham and Mattishall Division	Ongoing		Low risk. In attendance as a representative of the Local Authority. Chair will have overall responsibility for deciding whether I be excluded from any particular decision or discussion.
		Norfolk County Council	X			Direct	Cabinet Member for Adult Social Care and Public Health	Ongoing		
		Norfolk County Council	X			Direct	Chair of Norfolk Health and Wellbeing Board	Ongoing		
		Breckland District Council	X			Direct	Elected Member of Breckland District Council, Upper Wensum Ward	Ongoing		
		Norfolk County Council	X			Direct	Chair of Governance and Audit Committee	Ongoing		
		Manor Farm	X			Direct	Farmer within Dereham patch	Ongoing		Low risk. If there is an issue it will be raised at the time.
James Reeder	Suffolk Health and Wellbeing Board	Suffolk County Council	X			Direct	Cabinet Member for Children and Young People's Services	Ongoing		Will not take part in any discussion or decisions relating to the declared interests.
		Suffolk County Council	X			Direct	Children's Services and Education Lead Members Network	Ongoing		

3

		East of England Government Association	X			Direct	East of England Government Association	Ongoing		
		James Paget University Hospital Trust	X			Direct	James Paget Healthcare NHS Foundation Trust Governors Council	Ongoing		
		Suffolk County Council	X			Direct	Suffolk Safeguarding Children Board	Ongoing		
		Suffolk Chamber of Commerce	X			Direct	Member of the Lowestoft and Waveney Chamber of Commerce board part of Suffolk Chamber of Commerce	Ongoing		
		Northfields St Nicholas Primary Academy			X	Direct	Governor of Northfields St Nicholas Primary Academy part of the Reach2 Academy Trust.	Ongoing		
Healthwatch Attendees (Norfolk and Suffolk)										
Andrew Hayward	HealthWatch Norfolk Trustee	East Harling GP Practice			X	Direct	Member of a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and
		HealthWatch Norfolk	X			Direct	Trustee and board member HeathWatch Norfolk	2020	Present	Will not take part in any discussion or decisions relating to the declared interests.
		East Harling Parish Council			X	Direct	Member, East Harling Parish Council	2020	Present	
		NHS England		X		Direct	GP appraiser, NHSE	2015	Present	
Sue Merton	HealthWatch Suffolk	Nothing to Declare	N/A				N/A	N/A		N/A

4

Norfolk and Waveney Primary Care Commissioning Committee

Part One

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

Voting Members - Attendees

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

In attendance

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

Guest Speakers

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

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

Apologies

Name	Initials	Position and Organisation
Mel Benfell	MBe	Joint Chief Executive Officer, Norfolk & Waveney Local Medical Committee (LMC)
Cllr Bill Borrett	BB	Chair Health and Wellbeing Board at Norfolk County Council
James Bullion	JB	Chair, Partner Member – Local Authority (Norfolk) Norfolk and Waveney ICB
Steven Course	SC	Director of Finance, Norfolk and Waveney ICB
Particia D'Orsi	PDO	Director of Nursing, Norfolk and Waveney ICB
Andrew Hayward	AH	Trustee of Healthwatch Norfolk
Sue Merton	SM	Healthwatch Suffolk

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

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

	MB agreed with VCJ on the last point and clarified she was referencing elective care. MB felt it was important that work was being done in the system and reflected on the Gold calls that had taken place. MB agreed that there was more work to be done and was confident that the system would survive the winter if the elective position was recovered. MB reflected the position of the reduction in treatment times, especially long waits but recognised that there was more work to be done. VCJ reference a discussion she had heard in the news that morning about the elective waiting list reduction and wondered if there were any comparative figures for Norfolk & Waveney and how the electives were performing and what the waiting list situation was. MB confirmed that the position was not just locally but regionally and nationally, and MB would include that information at a report at a future Committee. HW thanked MB for the report and welcomed a future update on Place.	
7	**Learning Disability Health Checks** *For Noting*	**SN**
	SN provided an update on progress made. A meeting had been held with the LMC regarding contractual position for delivering annual health checks for people with a learning disability. A standard form of words had been agreed for inclusion in the LD PCCC update report. SN gave an update on progress made since last month • April and May data had been received from NHS England and good progress had been made. • SN attended the Norfolk Health Overview Scrutiny Committee last month and the overall feedback was positive. The committee acknowledged the significant progress and investment made to improve the ICB position in relation to uptake and quality of annual health checks. It was acknowledged that the impact of the additional clinical resources in West Norfolk had made, and the work the peripatetic team had done in Norwich. There were some challenges set in terms of how to demonstrate and sustain the progress made and discussions were underway to put in place long term delivery plans • Deep dive meetings with ICB locality colleagues had been arranged to strengthen the grip and understanding of the local plans, opportunities and challenges. Two meetings had been held so far with Norwich and Great Yarmouth and Waveney. LD annual health checks were being prioritised within localities and some of the challenges that localities were facing were outlined. • A meeting had taken place with NHS England colleagues to review last year's and this year's Q1 performance. As a system we now lead in the East of England in terms of the uptake of annual health checks and action plans. SN reported the position was strong but needed to continue to work on our long-term plans to build resilience and sustainability. SN drew Committee's attention to the activity in April and May and noted the improvements made. The additional resource in West Norfolk had made a significant impact within 8 weeks and SN reflected the Norwich position as he felt this needed to be addressed, however no major concerns were noted. SN concluded by acknowledging the challenge from Norfolk HOSC on sustainable plans	

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

	uptake of SMI health checks, the quality of the check and made it worthwhile for the patient. Once checks were done, work would continue to address some of the inequalities. It was acknowledged in the report that only 40% of the checks were completed last year and that there was a need to improve and strengthen the current delivery plans to target patients who had not had their checks and to ensure no one missed out. Norfolk HOSC challenged the ICB to put in place a long term and sustainable plan to improve the current position and Patricia D'Orsi agreed to lead this piece of work. JD felt that this would strengthen the position in terms of performance and quarter one. Validation of final performance from last year was still awaited. It appeared from local intelligence that 734 health checks for SMI had been completed so far in quarter one and JD was planning to benchmark compared to last year. JD felt that there was a need to raise the profile of the work done and provided feedback on a meeting he had attended in the West Locality. JD committed to provide an update on the outcome of this meeting at a later Committee. JD opened for questions. VCJ wanted to understand the voluntary sector involvement and how patients were identified and how the rationale and participation was explained. JD reflected on the work done in the team and the work in participation with the charity Together. GP practices had their register size for SMI where they could undertake searches on their systems. These are often hard to reach, complex patients. Together had contacted the hard-to-reach patients and there had been some positive uptake. JD would produce a small section on the work that Together had done which would identify contact rates for hard-to-reach patients and if there had been any difference in uptake as a result. There had been collaboration with Mind and user experts by experience and user groups which informated some of the main collaboration work. JD felt that there needed to be a change in mindset as it was a patient's right to the health check. JD would use next month's report to focus on the work that the voluntary sector had done as well as patients. VCJ followed up on community connectors and social prescribing elements of local government and asked how these were communicated with. JD reflected on a third meeting that was held today of an annual health check group. Not just for SMI, focus was also on LD, diabetes etc. Social prescribing would be a focus and JD felt that there was an opportunity there amongst other opportunities discussed within the group. HW thanked JD for the report.	
9	**Estates Quarterly Update** *For Noting*	**PH/CMcW**
	PH picked out the key highlights for Committee. • Appendix 3 – showed premises capacity, surplus and deficit across Norfolk and Waveney as at June 2022 – state perspective based on GMS services only. • Predictions regarding new demand from housing developments for the next 15 years. • Wave 4b scheme in Kings Lynn.	

	• Full business case would be presented to private part of Committee for proposed move of St James Medical Practice. • Wave 4b proposal for Thetford. Further update on Attleborough awaited and would be shared at a later Committee. • Existing capacity issues at Humbleyard Surgery, schemes in various stages of development in Drayton and Taverham. • North Norwich scheme as part of Wave 4b. • East – Lowestoft – Bridge Road surgery use of a section 106 arrangement there and practice had engaged third party developer. • PCN estates strategies would help demonstrate issues with capacity and demand. CMcW joined the meeting to provide an update on national policy development and estates strategies. NHS England commissioned a program of support – this was a national program to help PCNs use the PCN service and estates toolkit to develop clinical and estates strategy and provided summary details. PH reported that NHS England confirmed that if there was a slippage in the funding to March 2023 it would not be an issue for funding to be carried forward to 2024 and funding sat with NHS England. HW opened for questions. VCJ asked about patient involvement in procurement. PH responded by saying it depended on the scheme and its size and gave an example of a new build facility and a potential relocation needing a consultation. If there was an extension to an existing premises, it would normally be expected that a patient participation group would be involved in that. For the Wave 4b schemes there was active patient engagement and patient representation. HB had a question around the funding though NHS England to support the development of the clinical strategy and the estates strategy. Was that just to develop the strategy? What happened if every PCN came back and said we have a strategy where does the money come from for that building or work. PH agreed that this was a good challenge and had been relayed back to NHS England in terms of it was good to have a strategy however if the revenue and capital do not adjust there was questions on how to deliver strategies. There was no planned increase for capital for primary care therefore there is no answer for that. HB asked how a strategy could be developed if there was no idea of funding to support this. PH responded by saying that the ICB was not alone with this and feedback had been given to NHS England as NHS England would push for better utilisation of assets. CMcW felt NHS England may begin to assess what the scale of ask was across primary care.	

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

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

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

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

	There were no questions from the public or public members present at Committee. There being no other business HW thanked participants for their attendance and the meeting then closed at 15:00.	

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

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 13 September 2022 14:30

Voting Members - Attendees

Name	Initials	Position and Organisation
James Bullion	JB	Chair, Partner Member – Local Authority (Norfolk) Norfolk and Waveney ICB
Steven Course	SC	Director of Finance, Norfolk and Waveney ICB
Patricia D'Orsi	PDO	Director of Nursing, Norfolk and Waveney ICB
Hein Van Den Wildenberg	HW	Non Executive Member, Norfolk and Waveney ICB

In attendance

Name	Initials	Position and Organisation
James Grainger	JG	Senior Finance Manager – Primary Care, Norfolk & Waveney ICB
Sadie Parker	SP	Associated Director of Primary Care, Norfolk and Waveney ICB
Fiona Theadom	FT	Deputy Head of Delegated Primary Care Commissioning/Interim Head of Primary Care Workforce and Training, Norfolk and Waveney ICB
Chris Turner	CT	Head of Nursing and Quality, Patient Safety Specialist, Norfolk and Waveney ICB
Sarah Webb	SW	Primary Care Administrator (minute taker) Norfolk and Waveney ICB

Guest Speakers

Name	Initials	Position and Organisation
Paul Higham	PH	Associate Director Primary Care Estates, Norfolk and Waveney ICB
Kate Lewis	KL	Head of Primary Care Strategic Planning Norfolk and Waveney ICB
Cath McWalter	CMcW	Senior Primary Care Estates Manager, Norfolk and Waveney ICB

Apologies

Name	Initials	Position and Organisation
Mel Benfell	MBe	Joint Chief Executive Officer, Norfolk & Waveney Local Medical Committee (LMC)

No	Item	Action owner
1	**Chair's introduction**	**Chair**

	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 as set out below. Notes of the decisions taken in the meeting would be taken to the meeting of the next Committee held in public and minutes would be made available online.	
2	**Apologies for absence**	**Chair**
	Noted above.	
3.	**Branch closures – Advice Note** *For Approval*	**CMcW**
	Item 7 from September 2022 Part One Agenda. CMcW requested members took the paper as read and highlighted pertinent points for members to consider before they made their decision. This was an Advice Note which set out the local procedure for requests to close GP branch surgeries and had followed discussions with the LMC. There had been 3 recent branch closure proposals which were at various stages of the process. CMcW outlined that the process followed nine stages and the majority of the activity took place within one or two stages. CMcW updated members on the progress of the 3 proposed branch closures and applications. Mundesley had a proposal to close its branch at Bacton and following the patient engagement period, feedback was now awaited from HOSC and the LMC before the application was finalised. These applications would be presented to a later PCCC. HW thanked CMcW for the note and wanted clarification whether the procedure should specify that proposals/applications would be presented to Part 2 of PCCC, in case of sensitive information. CMcW agreed to make that change. PD'O asked if, when closures of branch services were considered, within the decision were equality impact assessments completed to consider travel distance that individuals might experience. CMcW responded by saying that equality impact assessments were completed as part of the application and specifically outlined travel impacts and it would also be included as part of the patient engagement on the proposed branch closure. JB asked members to approve the advice note. Members agreed the proposal.	
4.	**Additional roles and PCN Direct Enhanced Service (DES)** *For Approval*	**KL**
	Item 11 from September Part One Agenda. The paper was taken as read. KL wanted to draw attention to the PCN transformation element which was within the appendix to the main paper. The PCN Transformation element of the PCN DES supported the continuous collaboration, leadership and maturity of the developing PCNs. In previous years, funding had been made available through the DES to support transformation, but this funding ceased in 2021. The ICB has some non-	

	recurrent monies for this year, which it was proposed that we use to continue to support the organisational development, to develop maturity and the leadership and collaboration of the PCNs. The appendix outlined a proposal and process to enable PCNs to bid for this money and put forward their plans and proposals for how they would solve shared problems and demonstrate their development within the aspects outlined. There was recognition of the pressures that practices and PCNs were under and therefore this this would be a light touch process. This process would facilitate PCNs to think more widely than general practice as a member of the PCNs and look to include all partners. The governance for the proposal would be through this Committee however the coordination and support for PCNs would be via the Primary Care Delivery Group. KL offered to take questions. CT noted the good progress and also the impact of the wider workforce across the health and social care system in particular the Ambulance Trust and reflected issues raised within a recent regional event that he had attended. CT felt that there needed to be consideration of the wider impact moving forward. KL responded by saying she had focused primarily on the transformation monies. The DES was segmented into four separate parts and how these would be bought together, a view of the development of PCNs and what this means. KL felt it fed into the development of the primary and community care strategy, how that linked into the wider ICS strategy and the workforce strategy. KL felt that this would be a discussion for another time and noted CT's point. KL wanted to demonstrate that ICB would have additional monies to support PCNs and the importance of the relationships between the practices and felt it was positive that the ICB wanted to support them in working collaboratively together. JB thanked KL and CT. JB felt the bids were meant to resolve what would be a critical issue particularly within the workforce. PD'O referred to section 4.3 and noted the good progress. PD'O felt it would be useful to include the detail around aspiration and overperformance in the report for context. PD'O commented on the recruitment and total numbers and felt a number of the roles were to support people with social and mental health requests into primary care. PD'O felt that the diagnostic capabilities and prescribing capabilities were not at the forefront of some of the roles and it was important to encourage more of these roles into primary care facilities. As there were no further comments the recommendations were outlined in Section 5. Clarification that the governance of this continued via this Committee and oversight through the primary and community care delivery group with updates to this Committee every four months. Members supported this approach. JB thanked KL and FT.	
5.	**Enhanced Access** *For Approval*	**FT**
	Item 12 from September Part One Agenda.	

	FT asked members to take the paper as read which set out the governance process which had been followed for enhanced access plans. FT explained that from 1st October 2022 PCNs would take responsibility for providing enhanced access across Norfolk and Waveney. This was a change from how it is currently provided though practices and third parties although PCNs can subcontract the services. The process was outlined in the paper and plans had been received from all PCNs and there was a level of confidence that from 1st October 2022 that each would comply with the minimum requirement for enhanced access which was Monday – Friday 6.30pm – 8pm and Saturday 9am – 5pm. Services would include a mix of general practice and hub provision. It had been a challenge for PCNs to mobilise within 6 months and therefore the ICB recognises that plans may evolve over the next 6 months; a process would need to be put in place to agree these changes. Conversations were ongoing with NHS 111 and IC24 (Integrated Care 24) around booking of appointments into enhanced access and FT felt confident they would be able to do this. Conversations were underway with the EPA (Eastern Pathology Alliance) around blood collections on Saturdays as practices would be providing the full range of general medical services then blood collections would be a requirement of that. FT advised that the cost of providing Saturday blood collections may raise a financial risk to the ICB and this needed to be quantified. This risk was highlighted to finance colleagues earlier in the process. FT offered to take questions. JB thanked FT for the clear and comprehensive process undertaken and asked if there were any questions or clarifications before members take the recommendation. JB was conscious that there were risks outlined and noted the IT and interoperability issues. PD'O raised a clinical governance question. PD'O asked if someone had bled in the extended hours on the Saturday and it was an abnormal result reported later in the evening or the next morning would that be picked up by 111 IC24. CG advised that there was a Standard Operating Procedure (SOP) in place for them to contact the patient. Any normal routine result would go back to the practice as normal. The patient would be contacted accordingly with the result. HW was curious to know how the population would know about the option of flexibility of appointment times and referenced the improved patient understanding of the services scope and thought about how to convey the message. FT confirmed there would be a system wide communication and plan with all patients and then each PCN would address their local population to explain local arrangements and that would be planned for the latter half of September. JB asked if there were any further comments or questions. SC asked if FT could provide more information around the financial risk described as he was keen to understand more.	

	FT confirmed that extending Saturday blood collections from Monday to Friday to include a Saturday would have a cost implication. Discussions were being held with the EPA to quantify the cost based on PCN plans and FT felt confident that this would be known in the next week or so. SC asked if he could be sighted on the risk once it had been quantified. JB thanked FT and as there were no further questions the members were asked to approve the governance process for the review and the approval of the plans. Members agreed the proposal.	**FT**
6.	**Any Other Business**	**Chair**
	There being no further business Part One concluded at 14:56.	

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

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Norfolk & Waveney IBC Primary Care Commissioning Committee - Part One
Action Log 11 October 2022

No	Meeting date added	Agenda Item	Owner	Action Required	Action Undertaken / Progress	Due date	Status	Date Closed
0119	09-Aug-22	4	SW	Signed minutes to chair	Signed minutes sent to chair	13-Sep-22		25-Aug-22
0119	13-Sep-22	5	FT	Enhanced Access - SC requested he could be fully sighted on the financial risk		11-Oct-22		

22

Norfolk and Waveney CCG – Primary Care Committee – 2021/22 PART ONE

		April	May	June	July	August	September	October	November	December	January	February	March
	Proposed date:	13th	11th	8th	13th	10th	14th	12th	9th	14th	11th	8th	8th
Standing items:	Risk Register	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	PCN Development and Locality Update	Y	Y	GYW	North	Norwich	South	West	GYW	North	Norwich	South	West
	Monthly Finance Report	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Estates Quarterly	Y			Y			Y			Y		
	Digital Quarterly			Y			Y			Y	Y		Y
	Prescribing Report	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Workforce and Training		Y			Y			Y			Y	
	CQC Inspections Report												
	Director of Primary Care Report							Y	Y	Y	Y	Y	Y
	Primary Care Planning												
Spotlight items:	Annual or Bi Annual Report on Delegation	Y						Y		Y			
	Terms of Reference Review						Y		Y				Y
	Learning Disability /Autism Health check monthly	Y						Y	Y	Y	Y	Y	Y
	PCCC Self Assessment				Y	Y							
	Committee training			Y									
Comms and Engagement							Y			Y			
Spotlight items: without a date	Local Commissioned Services				YPt2	Y	Y			Y			
	Severe Mental Illness Health checks								Y	Y	Y		
	Improved Access								Y	Y			
Items noted without a date:	CQC new reports by exception									Y			
	Bowthorpe Care Village Locally Commissioned Service					Y							
	QOF Actuals - tbc				YPT2								
	Audit Report												
Items in RED	Deferred due to pandemic/ToR deferred/Improved Access deferred due to team capacity following the new winter access fund planning requirements SMI deferred until February 2022. Work underway with the Mental Health Team and localities.												Essential items only for this PCCC
Notes	May and June Committee heard PCN Development Update, focused locality updates will recommence once workload and capacity allows Digital Report December 21 deferred to Jan 22 due to staff absence Comms and Engagement. Improved Access and Flexible Staff Pooling Update will be incorporated into the Director of Primary Care Report December 21									Digital update deferred to January '22 to accommodate other items on the agenda			Terms of reference review not included due to move to ICB
	PCCC Self Assessment Template circulated in June 2021, results to come to August committee in private									SMI report deferred to January '22 due to primary care team's capacity			
	Primary and Secondary Care Interface						Y	Y	N	Y			
Additional Item	Flexible Staff Pooling Update for noting								Y	Y			

23

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

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

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

Y

24

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

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

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

Risk Scores

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

Controls	Assurances on controls
• Workforce plans in place at system level. • Primary Care Workforce Transformation team expanded to support workforce development working within ICS workforce team. • Training hub supported by clinical leadership with two clinical roles recruited to support Placement and Quality of Learning Organisations and Educators. • Primary Care Networks (PCNs) supported to develop and implement workforce trajectories in support of the Additional Roles Recruitment Scheme (ARRS) to provide a multi-disciplinary approach to patient care • National workforce reporting service - Practices report monthly, PCNs report quarterly, contractual requirement as part of General Medical Services (GMS) and PCN Directed Enhanced Services (DES). • Wide range of initiatives in place to support GP retention • Advanced Practice Forum established	**Internal:** Reporting to Primary Care Commissioning Committee (PCCC) and the People Board. Training Hub and Workforce Implementation Group meets two-monthly Workforce Strategy (in development for approval by end Q2) **External**: NHSEI returns monthly as part of the General Practice Transformation implementation and assurance meetings with Health Education England (HEE) and NHSE/I

Gaps in controls or assurances

- Lack of national or regional plans to increase GPs and Nurses in training
- ICS level working required to support Nurse recruitment and retention throughout their career pathway from Trainee Nurse Associates to senior level roles.
- General Practice workforce plans need to be refreshed and updated at local level
- Understanding general practice resilience as work refocuses from pandemic response towards business as usual may lead to higher numbers of the workforce leaving/retiring during 2022 and 2023.
- Cost of Living crisis impact on workforce yet to be fully understood.
- Ability to attract new workforce to Norfolk and Waveney and can be mitigated by system level action
- Vacancy for Expansion Lead to support Quality Lead roles

Updates on actions and progress

Date	Action	RAG	Target completion

May 2022	New ICS Level Training Hub contract requires submission of 4 documents relating to primary care workforce planning to HEE by end Sept 2022: • Workforce Strategy (3 years) • Stakeholder Engagement Strategy and Plan (3 years) • Operational Delivery Plan (1-3 years) • Financial Plan (yearly) To be approved by new Oversight Board by end Sept 2022. A placement capacity expansion strategy is due to be published and number of learning organisations is increasing with targeted intervention and support. The recruitment to PCN Additional Roles Recruitment Scheme to support general practice faces challenges in some geographical areas also facing GP and Nurse recruitment difficulties. Primary care has joined the ICS led initiative looking at how to improve recruitment in rural and isolated coastal areas and other ICS task and finish groups to consider system wide approach to recruitment & retention for N&W. Recommended change to target date.		30 September 2022 (amended)
July 2022	This risk reflects risks to GPs and Nurse workforce only. Refer to PC17 for Allied Health Professionals and ARRS in general practice. Further details relating to Nurse recruitment and retention will be included next month.		August 2022
Sept 2022	To support retention: Wide range of initiatives in place. Continue to increase Schwartz Rounds participation and to develop system wide round with the ICS workforce team. Outline CPD plan for 2022-23 submitted; further engagement sought within Norfolk and Waveney to finalise by September. Education Plan submitted to HEE. To increase placement capacity, continue to increase the number of Learning Organisations and educators through active engagement by Quality Leads. The Deep End Project launched on 29/7/2022: aims to support GP practices within the most deprived communities, reduce health inequalities and support 12 sites to become learning organisations. Evaluation of project to be undertaken. Quality leads to link in with ICB workforce team regarding placement expansion work across the system To develop system level approach to Nurse recruitment and retention. To continue to expand the newly established Advanced Practice forum		March 2023

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

26

	PC6
Risk Title	Learning Disability Annual Physical Health Checks
Risk Description	The ICB is at risk of failing to meet its commitment to improve health and wellbeing for people with a learning disability if the quality and uptake of the annual physical health checks are not completed in line with the NHS national guidance. Access to an annual physical health check is intended to help reduce this risk, however, there are variable rates of uptake across Norfolk & Waveney GP practices. The ICB will not be able to fully meet its commitment to transform the lives of people with Learning Disabilities. 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.
ICB priority	

Risk Owner	**Responsible Committee**	**Operational Lead**	**Date Risk Identified**	**Target Delivery Date**
Sadie Parker	Primary Care Commissioning Committee	Shepherd Ncube	01.07.2022	31.03.2023

Risk Scores

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

Controls	**Assurances on controls**
• Plan in place to increase uptake of LD health checks across practices • All practices signed up to the LD DES (bar 1 - UEA as they feel their student population does not meet the criteria) • Regular monitoring by Norfolk Health Overview and Scrutiny Committee • CQC inspections usually include review of LD health checks performance • Transformation funding secured for a small peripatetic team, this will help support practices that are behind their trajectory. • Peripatetic team and GP with a special interest are now in post and their first pilot area to improve LD health checks was in the Norwich PCN, moving on to South Norfolk in 2022/23. • Regular assurance reports to NHSE/I & PCCC	**Internal:** Primary Care Commissioning Committee **External**: NHSE Checkpoint and Assurance Framework, Health Overview and Scrutiny Committee Reports to NHSE/I

Gaps in controls or assurances

LDAHCs are now being undertaken face to face.

Updates on actions and progress

Date	**Action**	**RAG**	**Target completion**
August 2022	NHS England has released validated uptake data for April and May 2022. Norfolk and Waveney has reported 4.2% uptake, representing the highest performance in the East of England region and above the regional average of 3.6%. However, it should be noted that several practices have not been included within this data		31/08/2022

27

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

Visual Risk Score Tracker									
ICB 2022/23 (months July 2022 – March 2023)									
Month	07	08	09	10	11	12	01	02	03
Score									
Change	→	→	→						

28

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

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

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

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

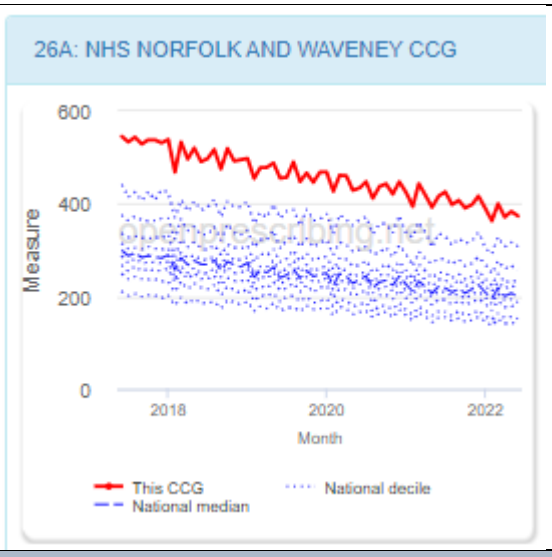
Gaps in controls or assurances

The Prescribing Team are moving back to Quality Innovation Productivity and Prevention (QIPP) delivery and Business As Usual (BAU) alongside ongoing Covid vaccination work. The CSU team joined the ICB team on 1st July 2022 and we are seeking to recruit to vacancies.

Updates on actions and progress

Date	Action	RAG	Target completion
Jun 2022	March 22 data = ADQ/1000 patients = 399.991 98th percentile (a longer month 31 days vs 28) We are now working on a longer-term project around deprescribing with NSFT, this will aim to change the prescribing culture within the organisation and reduce the use of all sedatives by clearer prescribing guidelines. Rate per day = 12.903		30.11.2022
Jul 2022	April 22 data = ADQ/1000 patients = 371.297 98th percentile (30 days in this month vs 31 last month). Rate per day = 12.377		30.11.2022
Aug 2022	May 22 data = ADQ/1000 patients = 383.362 98th percentile (31 days this month) Rate per day = 12.367		30.11.2022
Sep 2022	June 22 data = ADQ/1000 patients = 373.690 98th percentile (30 days this month) Rate per day = 12.456, overall trend is downwards and at a rate greater than national average.		30.11.2022

29



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

30

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

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

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

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

Gaps in controls or assurances
The CSU team have been in-housed by the ICB and vacancies that they have been carrying will be advertised to improve team resilience. Practice engagement is occasionally an issue.

Updates on actions and progress			
Date	**Action**	**RAG**	**Target completion**
May 2022	Outlier practices will be offered support to audit prescribing and development of an action plan. Now 25th (74th percentile). Recommend change to target date of delivery.		30.6.22
Jun 2022	Outlier practices are being offered support. The CCG is now 28th nationally (a decrease in comparative prescribing). Joint meetings between prescribing and quality team are resuming to discuss plans and support for practices.		30.6.22
Jul 2022	April ePact data shows Norfolk and Waveney has stayed at 28th position and 74th percentile. Outlier practices have been offered support and we will be following this up.		31.7.22
Aug 2022	May ePact data shows no change in national ranked position.		31.8.22
Sept 2022	June ePact data shows no change in national ranked position		31.9.22

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

PC11	
Risk Title	Primary Care/Other Providers Interface

31

Risk Description	There is a risk that patients will not be able to access optimal care from primary care teams due to Insufficient capacity of primary care to meet additional workload outside current contracted activity Poor morale and disenfranchisement exacerbating primary care workforce challenges

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

Risk Scores

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

Controls	Assurances on controls
Through the Primary, Community and Secondary Care Interface Group, the ICS is developing a three-pronged approach to support the relief of pressure on general practice and to improve working relationships between primary and other providers. This includes; • Quality and non-contract activity raised by practices via PID inbox; • Non-contracted Activity (shift in workload to general practice) • Changes to existing pathways/ services and subsequent impact on general practice The Interface Group provides oversight to these approaches while the contractual mechanism is through the System Contracting Development Group led by the ICB Contracting Team.	**Internal:** • Interface policy has been agreed by all providers, supported by LMC • The Clinical Interface Group has reviewed all outstanding actions relating to non-contracted activity. These have either been added to the agenda as substantive items for discussion OR are the subject of in-depth review via Task and Finish groups. • Backlog of open PID queries fully cleared August 2022 • All providers now have a single point of contact for primary care to liaise with directly **External**: Local Medical Committee (LMC)

Gaps in controls or assurances

- Identified resource on Commissioner and Provider side for continuity and to progress project pieces.
- Project and coordinating support remains a barrier to investigating issues and implementation of mitigating actions.
- Standing agenda items to review progress against T&F 1 which is looking into non-contracted activity.
- On-going piece of work with the LMC to consider the effectiveness of the PID process and to identify new areas for further discussion or T&F groups.
- Compliance with interface policy not yet audited and action plan for each provider against their analysis against standard contract not yet shared with LMC
- Governance of Interface Group to be considered when reviewing ToR. Currently reports to CCTG

Updates on actions and progress

Date	Action	RAG	Target completion

September 2022	• Clinical Interface Group continues to meet on a monthly basis. • Progress against the Task and Finish Groups continue within the constraints identified. • Further clarity on three-pronged approach as recognised by members of the Interface Group, as standing agenda items for updates and discussion.		20.09.22

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

33

PC 14 BAF06 (PC13 integrated into this risk from September 2022)	
Risk Title	The resilience of general practice
Risk Description	There is a risk to the resilience of general practice due to several factors including the ongoing Covid-19 pandemic, workforce pressures and increasing workload. There is also some evidence of increasing poor behaviour from patients towards practice staff. Individual practices could see their ability to deliver care to patients impacted through lack of capacity and the infrastructure to provide safe and responsive services will be compromised. This will have a wider impact as neighbouring practices and other health services take on additional workload which in turn affects their resilience. This may lead to delays in accessing care, increased clinical harm because of delays in accessing services, failure to deliver the recovery of services adversely affected, and poor outcomes for patients due to pressured general practice services.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Mark Burgis	Primary Care	Sadie Parker	01/09/2020	31/03/2023

Risk Scores

Unmitigated			Mitigated			Tolerated		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	4	20	4	4	16	3	4	12

Controls	Assurances on controls
• Locality teams and strategic primary care teams prioritised around supporting the resilience of general practice, dedicated resource to support the Covid vaccination programme. All practices have been supported to review business continuity plans • PCN ARRS (additional roles reimbursement scheme) funding has increased again in 2022/23 • Primary care workforce and training team working closely with locality teams to identify clinical and volunteer workforce and to ensure training available to support practices and PCNs in setting up and maintaining services • Resilience funding process has been completed earlier this year (Q2) to provide practices with more opportunity to bid and respond	**Internal:** Executive Management Team, Senior Management Team, workforce steering group, primary care strategic planning meetings **External**: Primary Care Commissioning Committee, NHS England via delegation agreement, Health Education England, Norfolk and Waveney Local Medical Committee

Gaps in controls or assurances

- Practice visit programme, CQC inspections focused on where there is a significant risk or concern
- Unplanned risk associated with outbreaks or positive cases
- Impact of ambulance delays diverting practice teams from routine and urgent care to respond to emergencies
- Continued reports of poor patient behaviour across practices, decrease in patient satisfaction with general practice through GP patient survey, consistent with national position

Updates on actions and progress

Date	Action	RAG	Target completion
01.07.22	We are seeing some impact from increasing cases of Covid leading to staff sickness, this is being closely monitored with the locality teams supporting around business continuity planning where they can. It is recommended this risk is combined with and monitored through the practice resilience risk (PC13) under the 'living with Covid' approach.		31.7.22

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

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

35

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

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

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

Risk Scores

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

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

Gaps in controls or assurances

- Workforce strategy requires review and refresh to reflect PCN development updates and post pandemic environment
- HEE workforce data for Allied Health Professionals not split out between different roles
- Recruitment of community pharmacists and technicians remains challenging. Similar roles recruited into PCNs from community pharmacy
- System approach for paramedic rotational roles agreed approach subject to national and regional review.
- Understanding general practice resilience as work challenges increase may lead to higher numbers of the workforce leaving/retiring during 2022 and 2023
- Ability to attract new workforce to Norfolk and Waveney and may be mitigated by system level action
- Some geographical areas facing greater challenges in recruitment, e.g. West and East
- Challenges of recruitment, retention and integration can only be addressed if PCNs and commissioning bodies can understand the huge values the additional roles can bring.

Updates on actions and progress

Date	Action	RAG	Target completion

July 2022	New ICS Level Training Hub contract requires submission of 4 documents relating to primary care workforce planning to HEE by end July 2022 for socialising with primary care during August: • Workforce Strategy (3 years) • Stakeholder Engagement Strategy and Plan (3 years) • Operational Delivery Plan (1-3 years) • Financial Plan (yearly) Plans to be approved by new Oversight Board by 30 Sept 2022. Need to include targeted plans in areas facing greatest challenges in recruitment and retention. A placement capacity expansion strategy is due to be published and number of learning organisations is increasing with targeted intervention and support. The impact of ARRS recruitment on other system partners is of concern and discussions continue as to how to mitigate this risk. Primary care has joined the ICS led initiative looking at how to improve recruitment in rural and isolated coastal areas and other ICS task and finish groups to consider system wide approach to recruitment & retention for N&W.		30 Sept 2022
Sept 2022	The new Ambassadors to build upon early work in acting as a point of contact to support new staff working in primary care, creating peer support groups for questions, dissemination of key information and understanding training and development needs. Physicians Associate careers fair planned August. Clinical Pharmacy Ambassadors developing an online forum for pharmacy professionals within primary care to highlight development opportunities as well creating a space for networking and peer support. A support pack has been developed for pharmacy professionals new to primary care to communicate key information which will be useful to them in their new roles. Work has also been done around providing guidance on clinical supervision for pharmacy professionals recruited through ARRS. The Newly Qualified Pharmacist (NQPh) pathway is established in community pharmacy and the NHS managed sector. N&W hoping to pilot a developmental role [band 6 to band 7 AFC] model to introduce a NQPh - GP pathway to attract a pipeline of newly qualified ARRS pharmacists into general practice to compliment or reduce recruitment from other pharmacy sectors. Discussions ongoing with HEI about nursing placements. The aim is to map placements and to share information on the quality of the learning environments. Slow engagement from HEIs. restructures.		November 2022

Visual Risk Score Tracker			
ICB 2022/23 (July 2022 onwards)			
Month	1	2	3
Score			
Change	New	→	

37

Norfolk and Waveney
Integrated Care Board

Agenda item: 07

Subject:	**Director of Patients and Communities Update**
Presented by:	**Mark Burgis, Director of Patients and Communities**
Prepared by:	**Paul Martin, Communications and Engagement Lead**
Submitted to:	**ICB Primary Care Committee**
Date:	**11 October 2022**

Purpose of paper:

To provide a general update on work being carried out by the ICB since the last meeting.

Executive Summary:

A. Urgent and Emergency Care update
B. Meeting the BSL Community
C. Abuse from patients towards primary care staff

Report

A: Urgent and Emergency Care update

The pressure on our health and care system has continued to increase over the last month. Pressures predominantly appear as ambulance hospital handover delays and long community response times as a result of poor patient flow through hospitals and delays through discharge pathways.

Work continues to support EEAST to transfer low acuity calls from their control centre to other providers and to assist ambulance crews to access alternative community support to reduce avoidable conveyances to hospital.

ICB discharge teams are busy mobilising a series of measures to increase availability of home support and increase community bedded capacity to meet demand and improve patient flow ahead of winter. Mobilisation of planned virtual ward facilities have been brought forward to provide additional capacity earlier.

Planning has started for an integrated winter ICS communications campaign supporting the national ‘Keep Warm, Keep Well’ messaging this winter. The main message will be around preparing homes for winter, steps to improve and safeguard health and where to find support if injured or unwell.

38

There are also significant urgent care demands on general practice and we know that around 80% of urgent care is delivered in primary care; latest July data still show that general practice is offering more appointments than pre-pandemic with 70% on average being delivered face to face (compared to 62% nationally) and around 40% being delivered on the day of request.

Over the coming months, UEC priorities include:

- Reduction in ambulance hospital handover delays
- Improved ambulance response to emergency calls, (specifically C2 response times)
- Increase availability, access to and utilisation of SDEC (Same Day Emergency Care) facilities to decompress EDs
- Creation of additional capacity to accommodate winter surge (community beds, virtual wards and homecare)
- Increase available community care to avoid admissions and support hospital discharge

B: Meeting the Blind Sign Language (BSL) Community

Sadie Parker and Fiona Theadom again met with the BSL Community and Deaf Connections in August to hear from several participants regarding their experiences with the current provision and access. The general feedback seemed to be that some improvements to General Practice experiences had been seen since the change of non-spoken languages contract in October 2021.

However, there still existed experiences which exposed some of the challenges needing to be addressed, particularly regarding those who are profoundly deaf when accessing healthcare. This included a lack of interpreters and the unreliability of booking interpreters for patients with an urgent need. The group were keen for regular continued engagement with the ICB team.

We will continue to work with practices and also with colleagues across the system to tackle difficulties across multiple providers. Sadie will attend the ICS Health Inequality Oversight group in October to raise this work with senior colleagues across the system and agree a way forward.

C: Abuse from patients towards primary care staff

Unfortunately, we are seeing a sustained increase in negative behaviour from patients towards health and care staff across Norfolk and Waveney (N&W), which seems to be contributing to high turnover in roles within General Practice.

Although recognising national workforce pressures, our practices have provided more face-to-face appointments than before the pandemic. We are working to address this issue through a variety of different communication channels to make it absolutely clear that any abuse will not be tolerated.

One example of where we have provided support to practices is how the ICB communications and engagement team have been in contact with the South Norfolk Locality to attend their Practice Managers meeting. We heard their experiences and co-produced revised materials from the N&W Primary Care campaign. These include communication

assets regarding Zero Tolerance to abuse, providing information for the population on General Practice roles and profiling services offered in N&W. Discussions will also centre on how we can get this new information out, not only in practices, but also within Patient Participation Groups, Parish newsletters and supermarkets to manage wider patient expectations. This work will then continue across the other localities for their support.

This will be sighted with Healthwatch and the LMC to ensure a uniformity of messaging that addresses patient feedback.

Recommendation to the Board:

To note the report.

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

Governance

Process/Committee approval with date(s) (as appropriate)	As set out in forward plan.

Norfolk and Waveney
Integrated Care Board

Agenda item: 08

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

Purpose of paper:

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

Executive Summary:

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

1.0 Background

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

The results of the survey are published by Ipsos MORI on behalf of NHS England on the GP Patient Survey publication website

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

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

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

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

2.0 The Survey – An Overview

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

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

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

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

3.0 The Results

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

Headlines:

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

Detail:

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

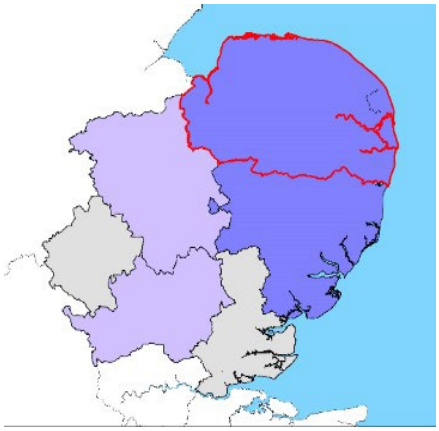
If we take a PCN view of the answers to this question NN2 are the best performing PCN whereas on the other end of the scale Gorleston PCN is the lowest performing. Having the ability to view survey results at a PCN level is helpful in that we can make some comparisons and consider how practices might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

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

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

GP PATIENT SURVEY

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



July 2022 Overall experience of GP practice
% Good

- 78.0 up to 80.9
- 75.0 up to 78.0
- 72.0 up to 75.0
- 70.0 up to 72.0
- 63.4 up to 70.0

Results range from

64%

to

77%

The ICS represented by this pack is highlighted in red

Comparisons are indicative only: differences may not be statistically significant

%Good = %Very good + %Fairly good

Base: All those completing a questionnaire: ICS bases range from 6,015 to 44,352

10

Ipsos

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

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

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

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

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

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

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

44

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

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

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

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

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

Potential factors influencing outcomes?

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

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

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

45

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

Dental outcomes

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

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

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

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

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

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

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

Recommendation to the Committee:

With the information provided in the Survey pack we can drill down to practice level to note the comparisons between practices in the range. However, it should be noted that results may not be statistically significant. It is recommended that the PCN Locality Leads support the PCNs to review individual area survey results, comparing with the ICS and national average and previous year's results, to raise awareness and encourage scrutiny. It will be important that each PCN review results within their own local context, as well as to look at practice variance across PCNs with the objective of sharing best

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

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

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

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

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

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

Governance

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

Norfolk and Waveney
Integrated Care Board

Agenda item: 08

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

Purpose of paper:

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

Executive summary:

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

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

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

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

1. Background information

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

49

2. Objective

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

3. Resilience funding process

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

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

4. Resilience funding overview and outcomes

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

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

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

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

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

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

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

5. Recommendation

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

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

GOVERNANCE

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

Norfolk and Waveney
Integrated Care Board

Agenda item: 09

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

Purpose of paper:

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

1. Background

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

52

2. Learning disability AHC activity to-date

April-June 2022

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

April - August 2022

Learning disability health check uptake up to August 2022					Trajectory Q2 (25%)
Locality	Register	Completed	Declined	%	Variance
GYW	1778	596	20	35%	+8.5%
North Norfolk	1224	201	8	16%	-8.6%
Norwich	1515	349	6	23%	-2%
South Norfolk	1402	349	5	25%	0
West Norfolk	981	247	10	25%	0
Norfolk & Waveney	**6900**	**1742**	**49**	**25%**	**+**

- Norfolk and Waveney have reported 25.2% uptake via the national CQRS portal. This is an increase of 675 checks year on year against uptake end of August 2021/22.
- Please refer to appendix 1 for a rolling total of health checks over the past year.

3. Next steps

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

53

- We are working with the ICB quality team to drive up the quality of annual health checks. Monthly meeting with LD nurses' network to support this work and share good practice remains in place.

54

4. Recommendation to the Board:

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

Key Risks	
Clinical and Quality:	Annual health checks are a proactive and evidence-based way of supporting people with a learning disability with new and existing health care requirements.
Finance and Performance:	Annual health checks for people with a learning disability are to be undertaken as per the specification within the national Directed Enhanced Service (DES) for GPs, the Quality Outcome Framework (QOF) and the Investment and Impact Fund (IIF).
Impact Assessment (environmental and equalities):	N/A
Reputation:	Health inequalities
Legal:	N/A
Information Governance:	N/A
Resource Required:	Business Intelligence team Children's and Young Peoples' team Delegated Commissioning team Locality teams Quality in Care team
Reference document(s):	The NHS Long Term Plan
NHS Constitution:	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)	

55

Appendix 1

Rolling total of annual health checks year-on-year

Locality	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	Total
Great Yarmouth and Waveney	34	53	73	78	77	99	107	113	124	106	125	189	66	135	106	148	141	**1,774**
North Norfolk	11	18	41	29	32	88	80	92	69	67	100	252	37	28	46	26	64	**1,080**
Norwich	30	38	95	88	80	115	78	71	84	89	103	142	21	63	84	82	99	**1,362**
South Norfolk	57	28	25	38	36	29	86	80	51	97	175	202	54	42	70	109	74	**1,253**
West Norfolk	10	24	11	28	33	32	55	58	62	61	133	168	79	54	56	43	15	**922**
Norfolk And Waveney	**142**	**161**	**245**	**261**	**258**	**363**	**406**	**414**	**390**	**420**	**636**	**953**	**257**	**322**	**362**	**408**	**393**	**6,391**

56

NHS
Norfolk and Waveney
Integrated Care Board

Agenda item: 10

Subject:	**Briefing - Recent Care Quality Commission (CQC) inspection**
Presented by:	**Shepherd Ncube – Head of Delegated Primary Care Commissioning**
Prepared by:	**Carl Gosling – Delegated Commissioning Manager Primary Care**
Submitted to:	**NHS Norfolk and Waveney ICB Primary Care Commissioning Committee**
Date:	**11th October 2022**

Purpose of paper:

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

- **Andaman Surgery**

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
Andaman Surgery (6,595 actual list size 1/7/2022)	Lowestoft	9th August 2022	Good/2015	Good

57

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.

Andaman Surgery, Lowestoft Locality – Inspected: 9 August 2022 **Overall rating: Good**					
	Are services safe?	**Are services effective?**	**Are services caring?**	**Are services responsive to people's needs?**	**Are services well-led?**
Rating	Requires Improvement	Good	Good	Good	Good

Following the CQC's previous comprehensive inspection in November 2015 the practice was rated at Good overall and Good in all domains.

The CQC carried out an announced inspection on Andaman Surgery on 9 August 2022. Overall, the practice was rated as Good.

58

The ratings for each key question were:

- Safe – Requires Improvement
- Effective – Good
- Caring - Good
- Responsive – Good
- Well-led - Good

Throughout the pandemic CQC has continued to regulate and respond to risk. However, taking into account the circumstances arising as a result of the pandemic, and in order to reduce risk, the CQC have conducted their inspections differently.

This inspection was carried out in a way which enabled the CQC to spend a minimum amount of time on site. This was with consent from the provider and in line with data protection and information governance requirements.

This included:

- Conducting staff interviews using video conferencing
- Completing clinical searches on the practice's patient records system and discussing findings with the provider
- Reviewing patient records to identify issues and clarify actions taken by the provider
- Requesting evidence from the provider
- A short site visit.

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 Good overall.

CQC found that:

• The practice had been responsive to the challenges that the COVID-19 restrictions had imposed. The practice had returned to offering all patients a face to face appointment, unless the patient requested telephone advice.

• The practice was addressing areas where backlogs had occurred, such as long-term condition review appointments.

• Patients told the CQC that the practice was led and managed in a way that promoted the delivery of person-centred care.

• The CQC found gaps in the practice system for the appropriate and safe use of medicines.

• The practice risk assessments had not fully identified and mitigated risks to ensure patients and staff were always kept safe from harm.

• Although the practice and staff told the CQC that there was clinical supervision, this was not always formally recorded for future and proactive learning.

• Staff treated patients with kindness and respect and involved them in decisions about their care.

• The practice sought feedback from patients from regular meetings, including those with their patient participation group.

The CQC found a breach of regulations.

The provider must:

• Ensure care and treatment is provided in a safe way to patients.

In addition, the provider should:

• Continue to improve the uptake of cervical screening.

• Continue to provide details of the Parliamentary and Health Service Ombudsman (PHSO) in all complaint responses.

• Continue to review and improve the prescribing of antibiotics in line with local and national guidelines.

• Embed the reviewed system for clinical oversight of managing pathology results in a timely manner.

Details of the CQC findings and the evidence supporting there ratings are set out in the evidence table

Background to Andaman Surgery

Andaman Surgery is located in Lowestoft at:

303 Long Rd,

Lowestoft

NR33 9DF

The provider is registered with the CQC to deliver the Regulated Activities; diagnostic and screening procedures, maternity and midwifery services, treatment of disease, disorder or injury and surgical procedures. These are delivered from this site.

The practice is situated within Norfolk and Waveney Integrated Care Systems (ICS) and delivers General Medical Services (GMS) to a patient population of about 6,600. This is part of a contract held with NHS England.

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

Information published by UK Health Security Agency (formerly Public Health England) shows that deprivation within the practice population group is in the fifth lowest decile (five 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 97.9% White, 0.7% Asian, 1% Black, 1% Mixed, and 0.1% Other.

The age distribution of the practice population closely mirrors the local and national averages. There are more female patients registered at the practice compared to males.

There is a team of three GPs who provide deliver services at the practice. The practice has a team of three nurses who provide nurse led clinics for long-term conditions.

The GPs are supported at the practice by a practice manager and a team of reception/administration staff.

The practice is open from 8am to 6.30pm Monday to Friday.

The practice offers a range of appointment types including book on the day, telephone consultations and advance appointments.

Extended access is provided locally by Suffolk GP+, where late evening and weekend appointments are available. Out of hours services are available through the NHS 111.

Download full report

Download full inspection report for Andaman Surgery - PDF - (opens in new window)

Download evidence table

Download evidence table for Andaman Surgery - PDF - (opens in new window)

Following the inspection and the new CQC rating of Good the ICB's Delegated Primary Care, Great Yarmouth and Waveney Locality, Quality and Medicines Optimisation teams will work closely to support the practice to develop an action plan to address the required improvement area of Safe Services and provide advice and guidance to support the work going forward.

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

61

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

GOVERNANCE

Process/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.

Improving lives together
Norfolk and Waveney Integrated Care System

Agenda item: 11

Subject:	**Prescribing team report**
Presented by:	**Michael Dennis Head of Medicines Optimisation**
Prepared by:	**Michael Dennis Head of Medicines Optimisation**
Submitted to:	**Primary Care Commissioning Committee**
Date:	**Oct 22**

Purpose of paper:

Information

Executive Summary:

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

1. Prescribing team focus areas

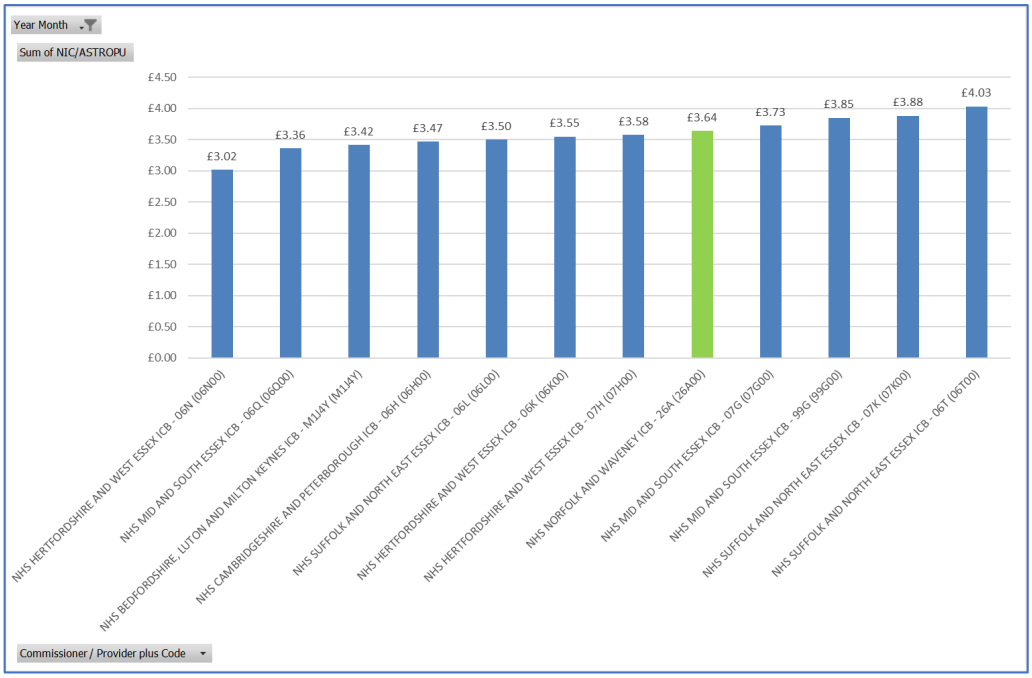
1.1 The newly merged prescribing teams are working on delivering or facilitating the delivery of the necessary efficiency savings.

1.2 The prescribing quality scheme has facilitated some improvement in indicators (see below) and the data monitoring has been updated. The team continue to meet practices to facilitate implementation.

2. CCG/ICB Prescribing Performance

2.1 Net ingredient cost (NIC) per AstroPU (an attempt to normalise practice demographics) below is a proxy measure of relative cost-effectiveness. However, this does not take account of deprivation which is a key driver of prescribing spend. Norfolk and Waveney remain the 5th highest normalised raw spend of East of England CCGs at £3.64 with a downward trajectory in this spend (the mean spend is £3.58). 6 pence or 1.7% from average in July 22.

63



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

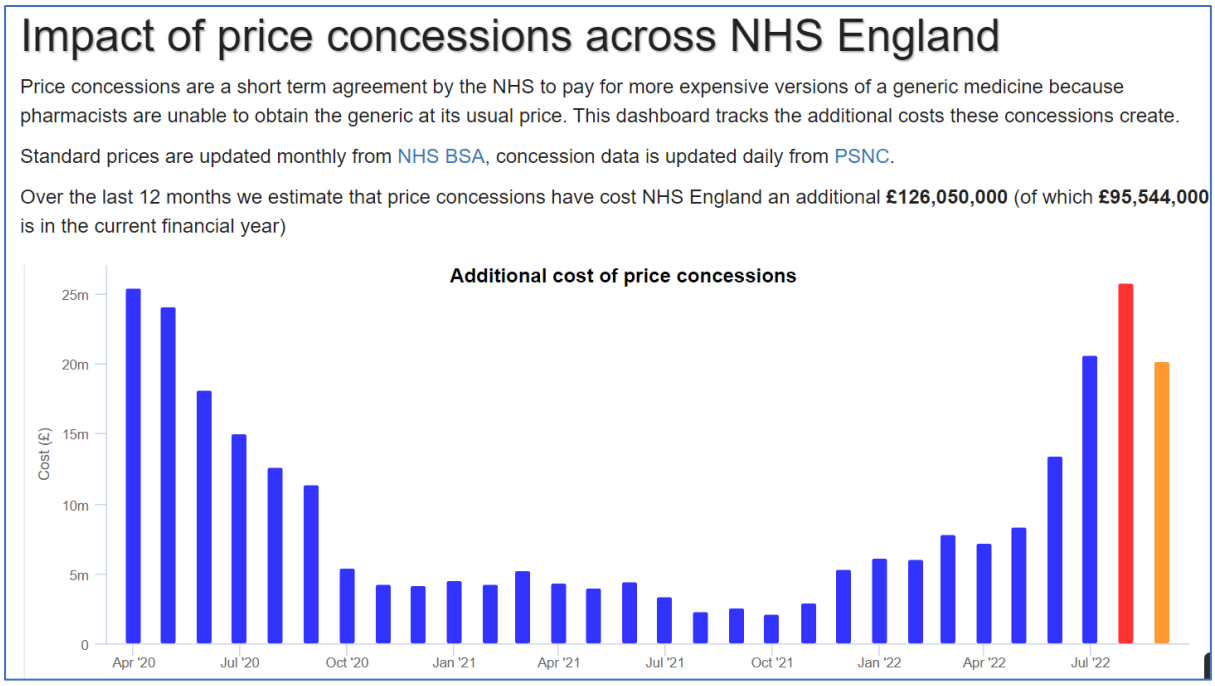
A price concession agreed by the department of Health when a product cannot be sourced at the drug tariff price
The impact of price concessions continues
There is a continued impact of price concessions since when they are no longer subject to the price concession, they tend to go back into the drug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

Table 1 Cost Pressure Report September 2022 July data

	YTD April-July	Projected August	Projected September
NCSO and other price concessions	£1,344,931	£701,107	£585,517
Back into DT at increased prices	£130,784	£103,091	£119,908
Total	£1,475,715	£804,98	£705,425

Projected figures are estimated but are based on price concessions announced

Table 2. Bar chart of NCSO additional costs over time



There is also significant inflation in category A prices for example ascorbic acid tablets 200mg and above now cost nearly £2 per tablet (August drug tariff) when prescribed but can be purchased for £1.99 for 30. Lower strengths are almost as expensive. Another example is Haloperidol 500mcg tablets, these are now £186 for 28. NSFT are now aware and are communicating with their teams to avoid this and other anomalies where possible.

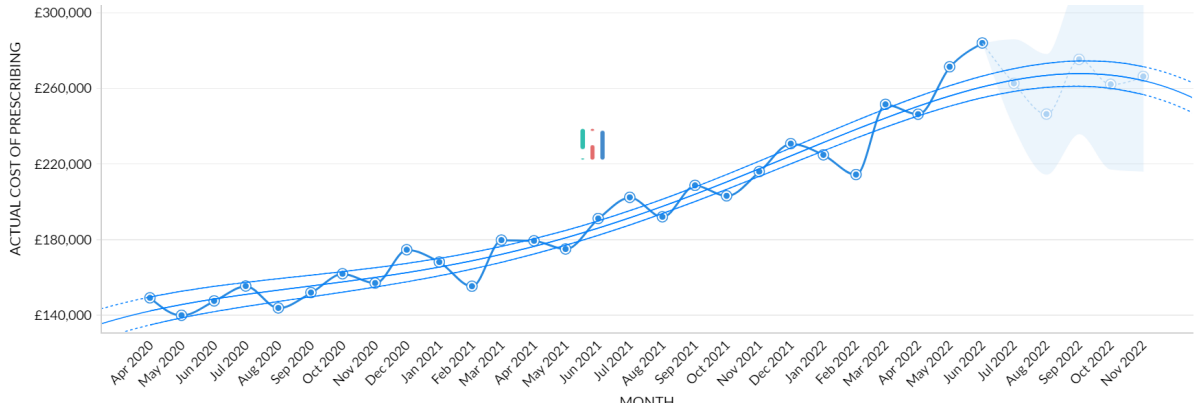
Some drugs have grown in costs due to an increase in the number of indications for their use e.g., SGLT 2's. This is expected to continue since whereas they had previously only been used in patients with diabetes they are now also used in patients with cardiovascular and renal disease. Others such as Famotidine have increased in volume due to the continuing global shortage of a commonly used alternative ranitidine. Others are increasing in use as awareness of their efficacy and active case finding continues to highlight the

65

growing number of people who would benefit from their use e.g., the DOACS, edoxaban, apixaban and rivaroxaban. The system was however down this month when this report was written.

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

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



3 Dependence forming medicines (DFMs)

3.1 As previously reported the CCG 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 July 22 are below. This was out of the 134 organisations on OpenPrescribing with position 1 being the highest (usually worst). Since April there are only 106 organisations listed due to further mergers of CCG's.

- **High dose opiates – a decrease in use to 85th (84th previously (out of 106 organisations) 20th percentile (previously 21st) on high dose opiate items as percentage of regular opiates**
- **Gabapentinoids – improved to 31st, 72nd percentile (previously 28th nationally 74th percentile) on defined daily doses of gabapentin and pregabalin**
- **Hypnotics and anxiolytics – improved 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)

66

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

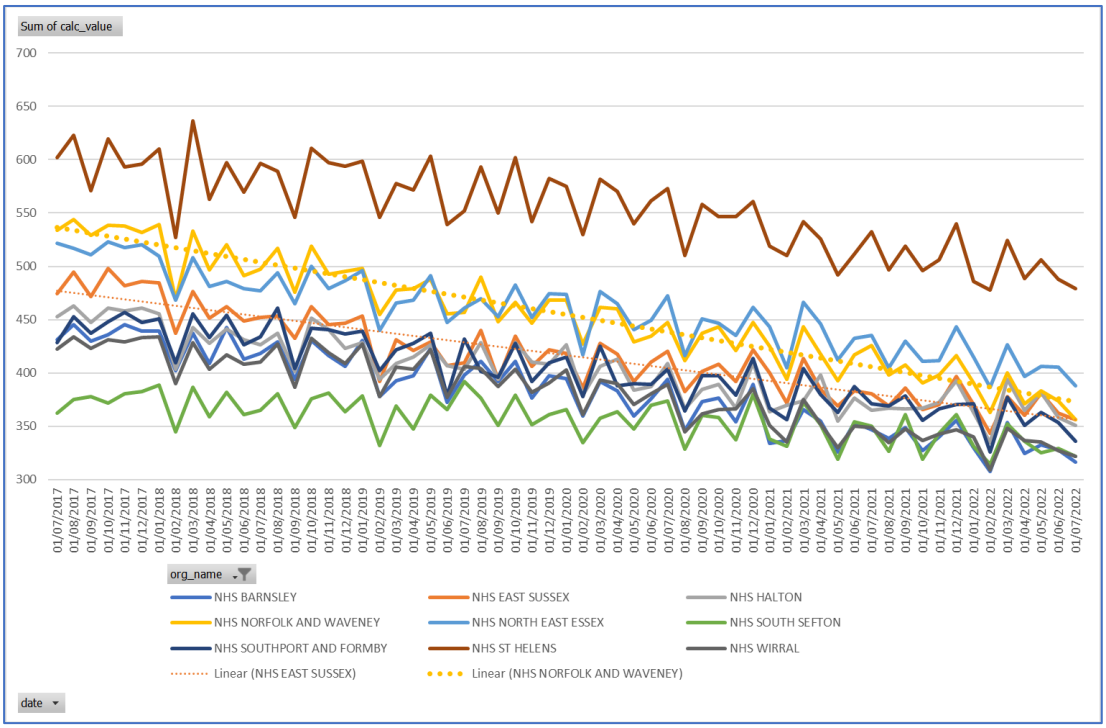
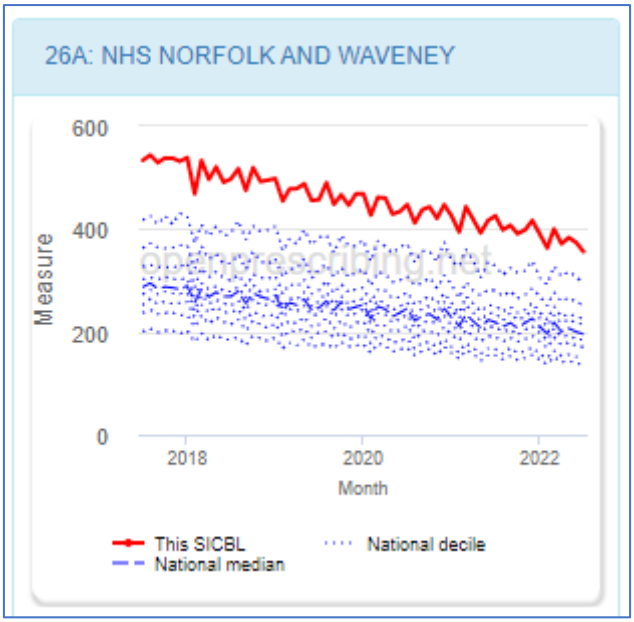


Table 5. Anxiolytics and hypnotics volume trend over time (red line is Norfolk and Waveney and darker blue line is national average)



3.3 We continue to work with the Academic and Health Science Network (AHSN) and UEA to develop and agree a standard pathway and SOP for deprescribing of DFM's with a particular focus on opioids initially. Next steps

67

include looking at aligning services and capacity, if possible, to facilitate delivery of aspects of the pathway.

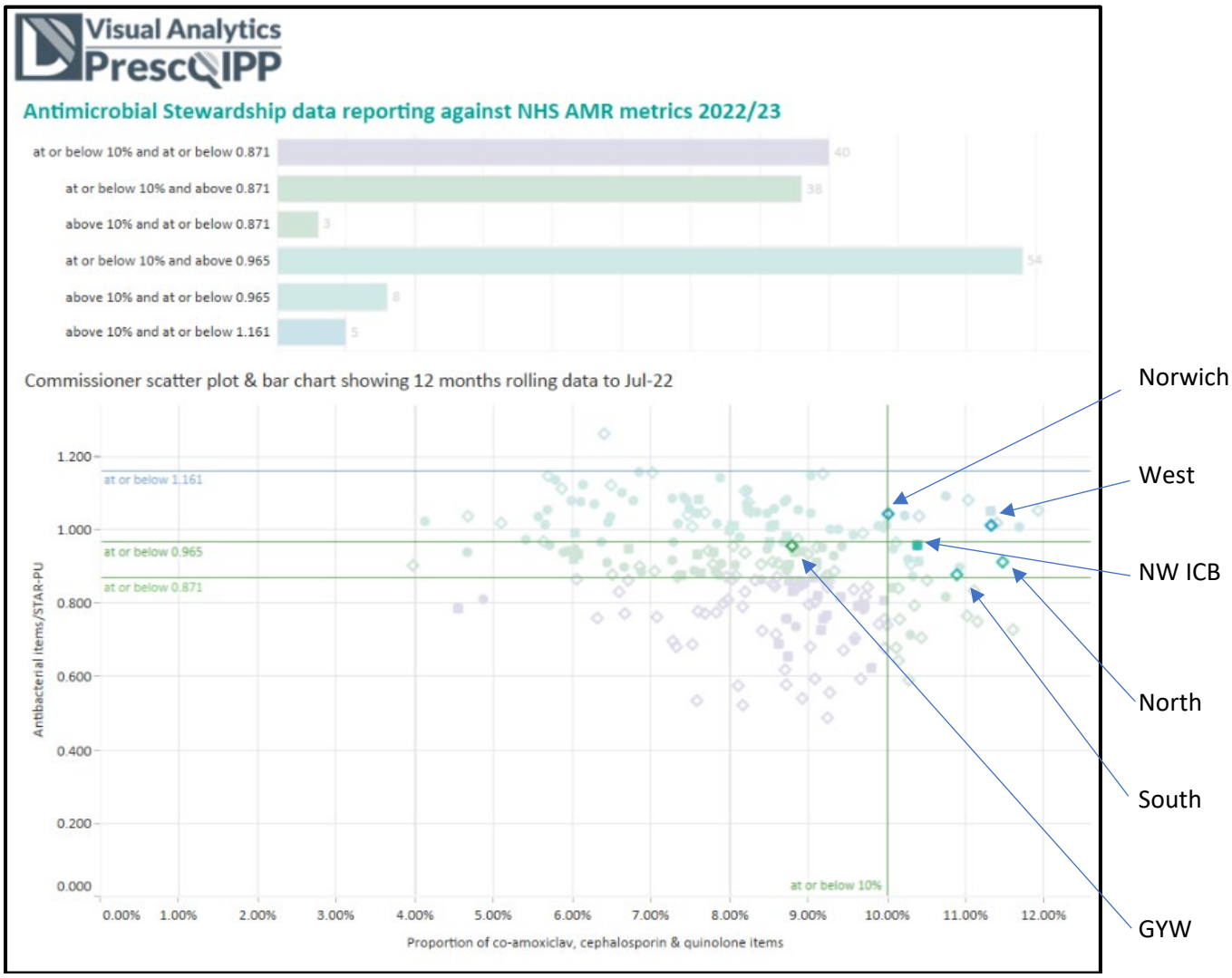
4 **Antibiotic Prescribing**

4.1.0 NHS System Oversight Framework (SOF) Antimicrobial Prescribing Metrics for 2021-22 have been updated. The antibiotic volumes target is now 0.871 or less antibacterial items per STAR-PU to align it with the UK AMR National Action Plan ambition to reduce community antibiotic prescribing by 25% by 2024. The national target for percentage of broad-spectrum antibiotic prescriptions as a total of overall antimicrobial prescriptions remains at 10%.

4.1.1 Antibiotic volumes, the bar chart on the left shows the volume of antibiotic prescribing by PCN's. Norfolk and Waveney is still above the new volume target of 0.871 with a value of 0.959 antibacterial items per STAR-PU in the 12 months to July 22. (Increase of 0.002 on June 2022) There is a trend of increasing antibacterial items per STAR/PU for Norfolk and Waveney. Ten PCNs are above this level, additionally there are now three PCNs, West Norfolk PCN and Fens & Brecks PCN and Kings Lynn PCN are above the second target of 0.965. It should be noted that Swaffham and Downham PCN have reduced their prescribing of antibacterial items and moved into the green section.

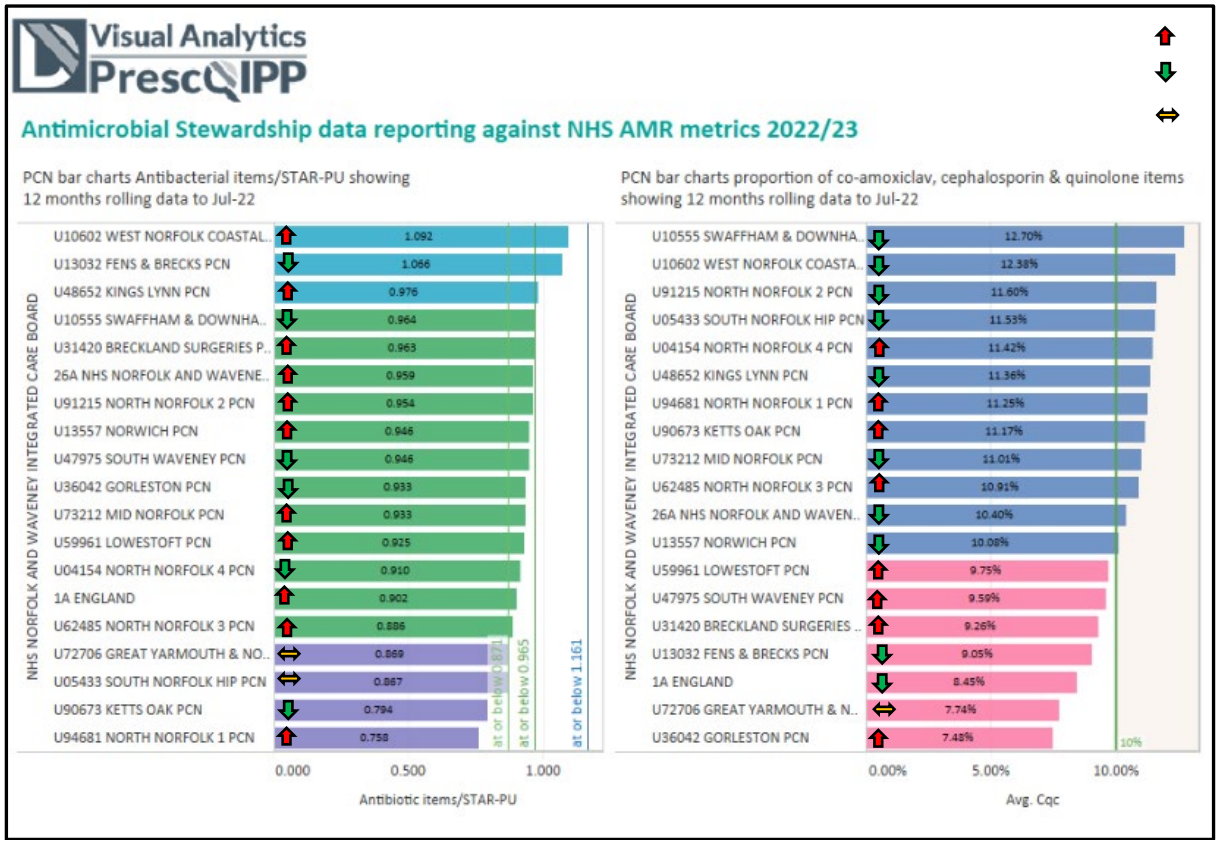
4.2 Percentage of broad-spectrum antibiotics, the bar chart on the right shows the percentage by PCN. Norfolk and Waveney CCG are currently above the national target of no more than 10% of all antibiotics at 10.40% in the 12 months to July 2022 (a decrease from 10.44% in June 2022). A reduction in the overall percent of broad-spectrum antibiotics is possibly linked to the increase in overall antimicrobial prescribing. All practices need to continue to focus on this area of prescribing, documenting the indication for an antibiotic, following the local antimicrobial guidelines and microbiology advice as appropriate.

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



69

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



4.3 Our outlier practices (above 14%) that are driving the higher percentage of Broad-spectrum antibiotics in June data are shown in Table 8.

Table 8: Outlier Practices for prescribing Broad Spectrum Antibiotics

Practice Name	% Broad Spectrum Antibiotics (July 2022)	Sum of percentile
ELMHAM SURGERY	18.38%	99.40
MUNDESLEY MEDICAL CENTRE	17.23%	99.09
BURNHAM SURGERY	16.60%	98.74
E HARLING & KENNINGHALL MEDICAL PRACTICE	16.33%	98.61
HOWDALE SURGERY	15.38%	97.95
WELLS HEALTH CENTRE	15.24%	97.80
REEPHAM & AYLSHAM MEDICAL PRACTICE	15.13%	97.63
OLD MILL AND MILLGATES MEDICAL PRACTICE	15.03%	97.55
THEATRE ROYAL SURGERY	14.95%	97.51
BRUNDALL MEDICAL PARTNERSHIP	14.75%	97.27
LUDHAM AND STALHAM GREEN SURGERIES	14.33%	96.67
TOFTWOOD MEDICAL CENTRE	14.19%	96.35

70

5 Primary Care Dietetic team update

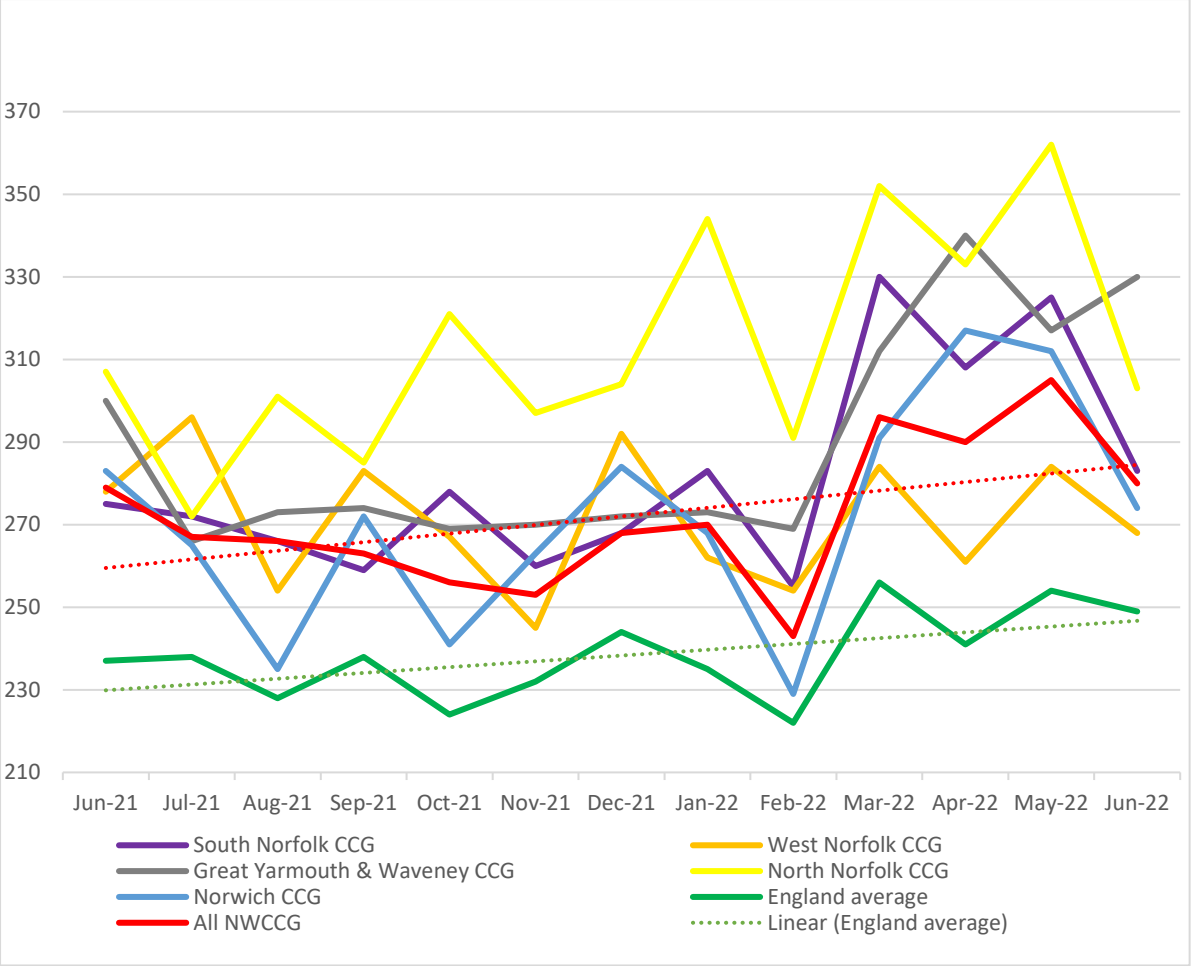
5.1 Oral Nutritional Supplements (ONS) are now an indicator for the 22/23 PQS aiming to reduce innappropriate prescribing of these products in N&W. prescribing of ONS has increased locally and nationally over the past 2 years (see table 9), possible reasons for this during the pandemic are: GP led prescribing, sometimes inappropriate prescribing by non dietitians in hospital, no weights/monitoring in primary care, pressures on local dietetic services, the need for healthcare professionals to 'do something'- not usually accompanied by appropriate food based advice.

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

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

Table 9: All Norfolk & Waveney Total ONS spend June 21 to June 22

71



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

72

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

73

Norfolk and Waveney
Integrated Care Board

Agenda item: 12

Subject:	**Primary Care Commissioning Committee (PCCC) 2022/23 Financial Report – August**
Presented by:	**James Grainger – Head of Finance Primary Care & Continuing Healthcare**
Prepared by:	**James Grainger – Head of Finance Primary Care & Continuing Healthcare**
Submitted to:	**Primary Care Commissioning Committee**
Date:	**11/10/2022**

Purpose of paper:

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

Executive Summary:

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

The 2022-23 budgets for ICB from July –March 2023 are based upon the draft financial plans as submitted in April 2022 for the CCG. These plans were not final, and the budgets have subsequently changed as submitted on the 20th June. These changes had a minimal impact on the budgets of Prescribing and Primary Care.

The current efficiency requirement within the Primary Care and Prescribing directorate is £7.3m this is within the GP Prescribing sub-directorate and for the 9 months from July-March 2023.

As at Month August, the 9 months forecast spend is £304.6m as against a plan of £307m leading to a total underspend of £2.4m for Primary Care and Prescribing in combination.

Report : Attached

Recommendation to the Board:

This report is presented for information only.

74

Key Risks	
Clinical and Quality:	None
Finance and Performance:	Achievement of Financial plan
Impact Assessment (environmental and equalities):	None
Reputation:	The achievement of the plan impacts the ICBs reputation with NHSE/I.
Legal:	None
Information Governance:	None
Resource Required:	None
Reference document(s):	NHSE/I guidance and communications
NHS Constitution:	None
Conflicts of Interest:	None
Reference to relevant risk on the Board Assurance Framework	Delivering Financial plan

Governance

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

75

Improving lives **together**

Norfolk and Waveney Integrated Care System

2022/23 Primary Care Commissioning Committee

Finance Report Norfolk & Waveney ICB

August 2022

Primary Care Commissioning Committee 11th October 2022

76

Contents

77

1.0 Executive Summary

- As the financial reporting for Primary Care and Prescribing is produced in arrears this report will relate to M5 (August-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.

- As at Month 5 (August), the 9 months forecast spend is £304.6m as against a plan of £306.9m leading to a total underspend of £2.4m for Primary Care and Prescribing in combination.

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

78

2.0 Financial Summary

Primary Care: Financial Summary	9 months ICB	Year to Date (August)			Forecast 9 Months (ICB)		Forecast at Month (July)		Comments on material Movement between July And August	*Detailed Variance Analysis*
	Budget	Budget	Actual	Variance (Fav)Adv	Actual	Variance (Fav) Adv	Actual	Movement (Fav) Adv		
	£m	£m	£ m	£m	£m	£m	£m	£m		
GP & Other Prescribing	141.7	30.9	31.1	0.2	141.7	0.0	141.8	(0.1)	immaterial difference	*3.1*
Primary Care										
System Development Fund	3.4	1.3	1.3	0.0	3.4	(0.0)	3.4	0.0		
Local Enhanced Services	12.4	2.8	2.8	0.0	12.3	(0.1)	12.4	(0.0)		
Other Primary Care	2.0	0.4	0.4	(0.0)	2.0	0.0	2.1	(0.0)		
Primary Care Delegated Co-Commissioning	143.5	32.1	31.5	(0.6)	141.1	(2.3)	141.1	0.0		*3.2*
Primary Care IT	3.9	0.8	0.8	0.0	3.9	(0.0)	3.9	(0.0)		
Total Primary Care	165.3	37.4	36.8	(0.6)	162.9	(2.4)	162.9	(0.0)		
Total Directorate	306.9	68.3	67.9	(0.4)	304.6	(2.4)	304.7	(0.1)		
Variance as a % of Budget				*-0.6%*		*-0.8%*		*0.0%*		
Total Primary Care	306.9	68.3	67.9	-0.4	304.6	-2.4				

Variance Signage: (Favourable)/Adverse

The detailed explanations are provided in 3.0 Detailed variance analysis.

79

3.0 Detailed Variance Analysis

Primary Care: Detailed Variance Analysis		9 months Budget ICB	Year to Date (August)			9 Months Forecast (ICB)			Narrative
		Budget	Budget	Actual	Variance (Fav)Adv	Actual	Variance	Variance (Fav)Adv	
		£m	£m	£ m	£m	£m	£m	%	
3.1	GP and Other Prescribing	141.7	30.9	31.1	0.2	141.7	0.0	0.0%	The GP Prescribing costs are reported nationally 2 months in arrears, so an estimate for July and August is considered in the Year to Date (YTD) position, and Forecast Outturn (FOT) considers estimates from July to March. The YTD is on plan and forecast is marginally overspent by £0.2m An efficiency target of £(7.3)m is included in the budget for the 9 months. It is assumed the efficiency savings are delivered as per plan and these are therefore included in the FOT expenditure position. Analysis of the savings achieved to date validates this position.
3.2	Primary Care Delegated Co-Commissioning	143.5	32.1	31.5	(0.6)	141.1	(2.3)	-1.6%	The undespend here is due to budgets held within Delegated Primary Care as per NHSE guidance costs shown in Locally Commissioned Services.

80

4.0 System Development Fund

Primary Care: System Development Fund	9months Budget ICB Budget £m	Year To Date(August) Budget £m	Actual £ m	Variance (Fav) Adv £m	9 months Forecast (ICB) Actual £m	Variance (Fav) Adv £m
GP Retention	0.0	0.0	0.0	0.0	0.0	0.0
Training Hubs	0.2	0.0	0.0	0.0	0.2	0.0
Online Consultation	0.2	0.0	0.0	(0.0)	0.2	0.0
Fellowship-Core Offer	(0.4)	-0.1	-0.1	0.0	-0.4	0.0
Infrastructure & Resilience	0.2	0.0	0.0	0.0	0.2	-0.0
Improved Access	5.5	1.2	1.2	0.0	5.5	0.0
Practice Resilience	0.1	0.0	0.0	0.0	0.1	0.0
Others	(2.4)	0.0	0.0	(0.0)	-2.4	0.0
	3.4	**1.3**	**1.3**	**0.0**	**3.4**	**(0.0)**
Variance as a % of Budget				*0.2%*		*-0.2%*

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.

81

5.0 Delegated Co Commissioning Analysis

Primary Care: Delegated Co Commissioning	9months Budget ICB £m	Year to Date (August) Budget £m	Actual £ m	Variance (Fav)Adv £m	9 Months Forecast (ICB) Actual £m	Variance (Fav) Adv £m
Contractual	94.0	20.9	20.9	0.0	94.7	0.7
QOF	11.9	2.6	2.7	0.0	11.9	0.0
Premises cost reimbursemen	11.1	2.5	2.6	0.1	11.2	0.1
Other - GP Services	10.7	2.5	1.9	(0.6)	10.1	(0.6)
Enhanced services	3.0	0.7	0.7	0.0	3.0	0.0
CCG Spend	0.3	0.1	0.1	(0.0)	0.3	(0.0)
PCN ARRS Staff	9.3	2.1	2.6	0.6	9.9	0.6
PMS to GMS	3.1	0.7	0.0	(0.7)	0.0	(3.1)
Prior Year	0.0	0.0	0.0	0.0	0.0	0.0
Total	**143.5**	**32.1**	**31.5**	**(0.6)**	**141.1**	**(2.3)**
Variance as a % of Budget				*-1.7%*		*-1.6%*

Variance Signage: (Favourable)/Adverse

The above table details the category of expenditure within Delegated Co Commissioning

Areas of material forecast variances:

- **Contractual:** The major overspend is due to the Impact and Investment Fund (IIF) not being funded to the full possible payment amount, our forecasts are prudently adjusted to reflect this.
- **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 (PCN's) using tranche 2 allocation which has not yet been received
- **Other GP Services:** This is the accrued income for the tranche 2 allocation not yet received.

82

6.0 GP And Other Prescribing

22/23 Primary Care: GP And Other Prescribing	9months Budget CCG	Year to Date(August)			9 months Forecast (ICB)		Forecast as at July		Comments on material Movement between July and August
	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	133.1	29.1	29.1	(0.0)	132.9	(0.2)	134.1	(1.3)	Recatagorisation of expense from GP Prescribing to Other Prescribing(Incentives)
Recharges to Local Authorities & NHS England	(3.9)	(0.8)	(0.5)	0.2	(3.9)	0.0	(3.9)	0.0	No Movement.
Rebates from pharmaceutical companies	(2.2)	(0.5)	(0.5)	(0.1)	(2.1)	0.0	(2.1)	0.0	No Movement.
GP Prescribing Subtotal	**127.0**	**27.8**	**28.0**	**0.2**	**126.8**	**(0.2)**	**128.1**	**(1.3)**	
Central Drugs	3.6	0.8	0.8	0.0	3.7	0.1	3.6	0.1	Marginal Difference
Dressings & wound care	4.4	1.0	1.0	(0.0)	4.4	0.0	4.4	0.0	Prior year benefit crystallisation
Others (Medicine Management, Oxygen, incentives etc.)	6.7	1.3	1.3	(0.0)	6.8	0.1	5.7	1.1	Recatagorisation of expense from GP Prescribing to Other Prescribing(Incentives)
Total Spend	**141.7**	**30.9**	**31.1**	**0.2**	**141.7**	**0.0**	**141.8**	**(0.1)**	
Variance as a % of Budget				*0.6%*		*0.0%*		*0.0%*	

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

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

83

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.

84

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.

85