Improving lives together
Norfolk and Waveney Integrated Care System

Meeting of the Norfolk and Waveney ICB Primary Care Commissioning Committee
Tuesday 9 August 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 7		**Review of Minutes and Action Log from the July 2022 meeting** *For approval*	Chair
5. Pg 24	13:35	**Forward Planner** *For Noting*	SP
		Service Development	
6. Pg 25	13:40	**Director of Patients and Communities Report** *For Noting*	MB
7. Pg 29	13:50	**Learning Disability Health Checks** *For Noting*	SN
8. Pg 34	14:00	**Severe Mental Illness Health Checks** *For Noting*	SN/JD
9. Pg 37	14:15	**Estates Quarterly Update** *For Noting*	PH
10. Pg 46	14:25	**Digital Quarterly Update** *For Noting*	AH
11. Pg49	14:35	**CQC Reports** • Heacham Practice • Orchard Surgery • Manor Farm *For Noting*	SN
		Finance & Governance	
12. Pg 65	14:50	**Prescribing Report** *For Noting*	MD
13. Pg 84	15:00	**Finance Report** *For Noting*	JG
		Any Other Business	
14.	15:10	**Questions from the Public**	Chair
Date, time and venue of next meeting **Tuesday 9 August 2022, 13:30 – 16:30 – ICB PCCC** **To be held by videoconference and You Tube**			
Any queries or items for the next agenda please contact: **sarah.webb7@nhs.net**			
Questions are welcomed from the public. **Please send by email: nwicb.contactus@nhs.net** **For a link to the meeting in real-time** **Please email: nwicb.communications@nhs.net**			

ICB PCCC

Voting Members

- Chair - James Bullion – Norfolk County Council
- Non-Executive Director Hein Van Wildenberg - ICB
- Director of Nursing Patricia D'Orsi - ICB
- Director of Finance Steven Course - ICB

1.1 Only members of the Committee have the right to attend Committee meetings. The following individuals, who are attendees and not members of the Committee, will be invited to attend

Part 1 and Part 2 meetings:

- NHS England and NHS Improvement Fiona Theodom - ICB
- ICB Board Partner Member – Providers of Primary Medical Services Hilary Byrne - ICB
- Local Medical Committee Representative Mel Benfell & Naomi Woodhouse
- Director of Patients and Communities Mark Burgis - ICB
- Associate Director of Primary Care Sadie Parker - ICB
- Two Practice Managers drawn from general practice
  James Foster – Partner St Stephensgate Medical Practice
  Rosemary Moore – Consultant at Acle Surgery

Part 1 meetings only:

- Healthwatch Norfolk - Andrew Hayward
- Healthwatch Suffolk - Sue Merton
- Health and Wellbeing Board representative – Norfolk County Council - Bill Borrett
- Health and Wellbeing Board representative – Suffolk County Council – James Reeder

Email addresses to form distribution list Part 1 – voting members and members who are attendees
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Other Attendees – all ICB – may attend regularly or one off
Karen Watts – Associate Director of Nursing and Quality (deputise for Patricia D'Orsi)

Chris Turner – Head of Nursing and Quality, Patient Safety Specialist (deputise for Patricia D'Orsi)
Tracey Rogers - Senior Nurse for Primary Care – will attend Part 2 for either PD'O/KW/CT
Jason Hollidge - Director of Commissioning Finance – Deputise for Steven Course
Paul Higham – Associate Director of Estates
Catherine McWalter – Senior Primary Care Estates Manager – (deputise for Paul Higham)
Shepherd Ncube – Head of Delegated Primary Care Commissioning
Carl Gosling – Senior Delegated Commissioning Manager – (deputise for Shepherd Ncube)
Julian Dias – Deputy Senior Delegated Commissioning Manager
Fiona Theodom - Deputy Head of Delegated Primary Care Commissioning/Interim Head of Primary Care Workforce and Training
Keri Robinson – (deputise for Fiona Theodom)
James Grainger - Senior Finance Manager – Primary Care
Michael Dennis - Head of Medicines Optimisation
Jess Adcock – Advanced Medicines Optimisation Pharmacist (deputise for Michael Dennis)
Anne Heath – Associate Director of Digital
Peter Ward – Head of Digital (deputise for Anne Heath)
Sarah Webb – Primary Care Administrator / minute taker

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

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NHS England and NHS Improvement Attendee										
Fiona Theadom	Contracts Manager, NHS England and NHS Improvement	Nothing to Declare	N/A				N/A	N/A		N/A
Local Medical Committee Attendees										
Mel Benfell	Norfolk & Waveney Local Medical Committee Executive Officer	NHS Norfolk and Waveney ICB				Indirect	Personal friend of an employee of the ICB	2015	Present	Will not take part in any discussion or decisions relating to the declared interests.
		Windmill Surgery				Indirect	Member of a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
Naomi Woodhouse	Norfolk & Waveney Local Medical Committee Joint Chief Executive	Long Stratton Medical Practice			X	Direct	Member of a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
Practice Managers drawn from General Practice Attendees										
James Foster	Member Practice Representative	St. Stephens Gate Medical Practice	X			Direct	Partner at St. Stephens Gate Medical Practice	2019	Present	Will not take part in any discussion or decisions relating to the declared interests.
		One Norwich	X			Direct	Director, One Norwich Practices Ltd (GPPO/PCN)	2019	Present	
		N2S	X			Direct	Director, N2S, Provider of day surgery in a primary care setting	2014	Present	
		Orchard Surgery	X			Direct	Spouse is Partner at Orchard Surgery	2020	Present	
Rosemary Moore	Member Practice Representative	Humbleyard Practice	X			Direct	Employee of Humbleyard Practice	2020	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.
Healthwatch Attendees (Norfolk and Suffolk)										
Andrew Hayward	HealthWatch Norfolk Trustee	East Harling GP Practice			X	Direct	Member of a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and

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		HealthWatch Norfolk	X			Direct	Trustee and board member HeathWatch Norfolk	2020	Present	Will not take part in any discussion or decisions relating to the declared interests.
		East Harling Parish Council			X	Direct	Member, East Harling Parish Council	2020	Present	
		NHS England		X		Direct	GP appraiser, NHSE	2015	Present	
Sue Merton	HealthWatch Suffolk	Nothing to Declare	N/A				N/A	N/A		N/A

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Improving lives together
Norfolk and Waveney Integrated Care System

Norfolk and Waveney Primary Care Commissioning Committee

Part One

Minutes of the Meeting held on
Tuesday 12 July 2022 13:30
via video conferencing & YouTube

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
Hein Van Den Wildenberg	HW	Non Executive Director, Norfolk and Waveney ICB

In attendance

Name	Initials	Position and Organisation
Mel Benfell	MBe	Joint Chief Executive Officer, Norfolk & Waveney Local Medical Committee (LMC)
Bill Borrett	BB	Chair Health and Wellbeing Board at Norfolk County Council
Mark Burgis	MB	Director of Primary and Community Care, Norfolk & Waveney ICB
Hilary Byrne	HB	ICB Board Partner Member – Providers of Primary Medical Services, Norfolk & Waveney ICB
James Foster	JF	Practice Manager Committee Member
Carl Gosling	CG	Senior Delegated Commissioning Manager Primary Care, Norfolk & Waveney ICB
James Grainger	JG	Senior Finance Manager – Primary Care, Norfolk & Waveney ICB
Andrew Hayward	AH	Trustee of Healthwatch Norfolk
Sue Merton	SM	Healthwatch Suffolk
Rosemary Moore	RM	Practice Manager Committee Member
Shepherd Ncube	SN	Head of Delegated Commissioning, Norfolk and Waveney ICB
Fiona Theodom	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
Jessica Adcock	JA	Deputy Head of Medicines Optimisation, Medicines Optimisation Locality Lead (GYW) Norfolk and Waveney ICB

Amanda Brown	AB	Head of Corporate Governance, NHS Norfolk and Waveney ICB
Gina Cooper	GC	Senior Manager, GP Resilience, Norfolk and Waveney ICB
Julian Dias	JD	Deputy Senior Delegated Commissioning Manager Primary Care, Norfolk and Waveney ICB
Paul Higham	PH	Associate Director Primary Care Estates, Norfolk and Waveney ICB

Apologies

Name	Initials	Position and Organisation
Michael Dennis	MD	Head of Medicines Optimisation, Norfolk and Waveney ICB
Particia D'Orsi	PDO	Director of Nursing, Norfolk and Waveney ICB
Sadie Parker	SP	Associated Director of Primary Care, Norfolk and Waveney ICB

No	Item	Action owner
1	**Chair's introduction and report on any Chair's action**	**Chair**
	JB introduced himself to the Committee as the new Chair with effect from 1 July 2022. JB went on to explain that he is Partner Member – Local Authority (Norfolk) and Director of Adult Social Services for Norfolk.	
2	**Apologies for absence**	**Chair**
	Noted above.	
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 Interest *For Noting*	**Chair**
	Rosemary Moore – an addition was noted and would be reflected within the next DoI Consultant at Acle Surgery. DR Hilary Byrne – would be added onto the next DoI GP in Attleborough.	
4	**Review of the Minutes and Action Log from the June 2022 meeting (CCG)** *For Approval*	**Chair**
	Minutes of the last meeting were agreed subject to a small change on the CQC report item whereby it should be noted as Wensum Valley and not Wensum Park. **ACTION:** Signed minutes would be sent to Chair. There were no matters arising. **Action Log** All items closed. 0109 remained outstanding – in progress.	**SW**
5	**Terms of Reference** *For Noting*	**AB**
	AB presented Terms of Reference (ToR) to the Committee for noting, having been approved at the Board on 1 July 2022.	

	Committee would be given some time to familiarise themselves with them and these would be bought back to January 2023 Committee to discuss whether any amendments would be needed. The Terms of Reference would be set out in the Governance Handbook which would be published on the website. MBe advised additional comments had been submitted from the LMC which remained outstanding. MB felt the change for 7 working days for submission of papers to 5 working days may not be enough given the size of the Agenda Pack. Committee noted the Terms of Reference.	
6	**Forward Planner** *For Noting*	**Chair**
	No comments received.	
7	**Risk Register** *For Noting*	**SN**
	SN highlighted specific key areas of concern. 10 risks on the register. One RAG rated RED PC11 - Previously reported as RED. This had reduced to an Amber rating – a paper would be presented later on within the agenda. PC13 – Resilience of General Practice. Feedback continued to be received around staff sickness and this would continue to be monitored. A recommendation had been made to combine PC13 and PC14 as they were related in terms of staffing. PC9 – Hypnotics and anxiolytics. Remained RED rated, however a positive downward trend had been noted. The final change was around LD and autism and the risk had reduced to Amber and remained on track. HW had 2 comments. One on PC15 – it had been agreed at the last CCG PCCC for this to remain RED RAG until approval from NHSE in September. HW had a comment on PC16 – the SMI healthchecks. HW felt the risk score needed to be increased and asked if this would be discussed within Item 8 within the agenda. HB had a comment on PC1 in respect of lack of General Practice GP and nurse workforce and the controls referred to workforce plans, training hubs etc which related to the nurse workforce and had concerns over the amount of GPs who planned to retire in the future and felt enough was not being done about this. MBe had some significant comments on PC1 MBe referred to work being done with practices to identify actual GP numbers working in General Practice in Norfolk. The LMC holds data which could be shared. MBe made a comment on PC11 with regard to primary care and other providers interface and the paper could be read that the shift of work was being accepted by GPs and that is not actually the case. MBe felt the risk was already in train and felt that this needed to be amended slightly.	

	FT responded to HB comments in respect of the workforce risks. Until June 2022 there was only one risk in place for the whole of the workforce and it had been recognised that there were very different challenges for GPs and nurses verses the AHPs and the ARRS roles. The risks had been separated out this month and work would need to be done to enter more detail into both risks. SN would have further conversations with internal colleagues and other colleagues to better streamline the process for reporting. JB felt that if the risks were merged JB would like the detail captured in respect of COVID issues reflected accurately. Committee agreed that PC13 and PC14 could be merged with an agreement that these would continually be monitored.	
8	**Severe Mental Illness Health Checks** *For Noting*	**JD**
	JD presented the paper to Committee to note latest updates. Improvement had been noted in a similar vein to LD, although there was a long way to go. Some of the lessons learned have been inputted along with some of the feedback received from practices along with locality teams reflected the improvement could be reflected in SMI. There are 9134 patients with SMI across N&W. Q4 data received for 21-22, Q1 data for 22-23 awaited. 3548 SMI were delivered across the system against the national ambition of 5184 which equated to the old performance ranking as a system of 38.% against 60% national target. JD felt this was an achievement for the system at it showed the largest amount of health checks for SMI delivered in the last 3 years. The system was recovering slowly however the was more work to do to ensure that this vulnerable group of patients access their SMI health checks. Work within the project team had given an opportunity to reflect on the impact of COVID and health inequalities. This was shown within the review of the 2020-21 figures as only 1985 health checks were completed however the system does need some extra resource to counterbalance pressures within primary care practices. JD reflected MBe comments. There were a lot of cross- challenges that could be covered by LD and SMI and wanted to draw attention to Section 3 of the paper where the focus was to drive service improvement which would make a difference and work was being done in close collaboration with locality colleagues and primary care colleagues. There needed to be an acknowledgement that work was needed to reach out to localities, systems and health case to test new approaches to better understand what was being done and why their performance was better than Norfolk and Waveney. The most common trends – make every patient visit count and the “so what behind the check” – once the healthcare check was delivered what was being done to ensure quality of care to patients and whether anti-smoking cessation advice, dietary and lifestyle advice and whether patient and peer engagement support was being driven up and the answers were varied across the system. Recognition was needed across the system in respect of inequalities and an action plan would be developed. Work was being done with partners in NSFT and	

	secondary care to ensure the entire patient pathway was recognised. There was a need to test new methods of delivery and JD would welcome a discussion with SN and the LMC to address SMI as a whole to effectively address lessons learned within the LD project and reflect upon how the position has improved. The view of the team was that primary care could use some additional support to deliver concepts to trial a peripatetic team that would be in addition to primary care practice staff who would deliver checks. There would be an issue around funding as previously highlighted and the second one would be around point of care testing which would drive up obtaining bloods outside of hours for patients and who may struggle to reach a GP practice. JD had two further points. There needed to be an acknowledgement that there was some way to go to achieving national target and the pressure on primary care. To achieve the highest performance of checks done across the system was testament to how much primary care was working. Help had been given to understand the data and coordination, booking and work alongside some partnership charities. By enabling some pilots this year JD felt hopeful that SMI healthchecks would have a similar success story to LD. JB thanked JD for the update and reflected on the degree of ambition needed and the challenges presented around the numbers. Given the context for mental health services JB felt it was even more critical what was happening in primary care verses the referral into secondary services. MBe agreed with the reference to NSFT and the LD comments and wanted to mention the risk paper as it was not clear from the figures and data used whether it was purely general practice data and whether the papers lacked information on secondary care provider data which MBe appreciated given it was a PCCC but cannot look at the targets which were not reflected as there was no target within the LCS for general practice to deliver. MBe did not want to detract from the ambition but felt an opportunity had been missed without putting a target within the LCS. MBe felt it would be really helpful if more information was provided within the paper to give a clearer indication of where both types of provider were on delivery as MBe felt it was unclear where the real issues were. MBe provided an example where a secondary care provider ceased annual reviews throughout 2021 and felt it this had applied to SMI then it may be had affected data and asked for more detail within both the risks and papers going forward. MBe again reiterated the need for equity. MBe referred to a letter that has been written around the risk paper and the response awaited on that JD responded by committing to provide a response to MBe and agreed to ensure that detail was clear around resources and JD committed to take an action to review the risk and paper to ensure clarity on data and where the information was coming from. HW thanked JD for the paper. HW agreed that there was learning to be taken from the LD approach. HW had a few points namely the target and how to achieve it and reaching everyone whilst it may appear that everyone had been reached. Funding was mentioned previously whereby the Committee had asked for more detail and asked when JD would have the detail for the funding detail. HW felt the risk needed higher emphasis. CT observed that the focus on the quality of the check and noted the positives of the opportunity of following up with the cohort and the actual outcomes.	

	JB highlighted the fact that is was the CoChair of the Mental Health Programme Board and referred to MBe point and felt that the Programme Board had some sight on the work that was being done and felt that this was a useful link. JD committed to talking to Diane Smith around the funding and would ensure the PCCC would have oversight. SN thanked JD for the insight and that there could be improvement going forward. JB thanked JD for the update.	
9	**Learning Disability Health Checks** *For Noting*	**SN**
	SN presented the LD progress update for this month. Committee members were invited to note the priority for Q1-Q2 to all the individuals that did not receive the annual health checks and content of the HOSC paper within the Appendix. Good progress continued to be made around the annual health checks for people with a learning disability and progress remained on track towards local and national ambition for this year. Additional resources were in place. ProtectNow was supporting practices until 1 July 2022 and this had been paused whilst the information governance arrangements were being reviewed and the expectation is that this arrangement would start again soon. SN gave a brief update on the work done by the Peripetetic team led by the quality team who are supporting practices and the focus of resources was on the South. SN extended appreciation to Fens and Breks PCN who were hosting a clinical resource. Work had started with a clinical independent advisor and the first surgery had been completed. Regarding Q1 and Q2 prioritisation, SN confirmed that all practices had been written to in terms of prioritisation for quarter 1 and quarter 2 and whether any additional support was needed. In addition, work was being done with ICB localities on the remaining outstanding healthchecks and meetings had taken place to focus on these. JB felt that it was a positive move in the right direction. JB invited comments and questions. MBe supportive of the work done however felt it was important to support general practice and top ensure that practices are not being asked to do anything outside of their contracts. MBe was pleased to note that the ProtectNow project had been paused until the issues had been rectified. MBe highlighted that the PCCC need to be mindful that any targets referenced are former CCG and ICS targets and not practice targets and practices were trying to achieve these targets. Any achievement within QOF or the DES are voluntary for practices and MBe was not sure where the reference was within the paper setting out the 75% target under the DES or it seemed to infer that the target was for practices under the DES and MBe requested that papers related to LD were amended to ensure that this was made clear. The was reference to additional support for some practices but at this was a contract there needed to be equity of access to any additional resources that the ICS and former CGG were providing to practices under any DES, LCS or any other contract and MBe was unclear why this had not been discussed with the	

	LMC and unclear as to how this would ensure equity of access and equity of funding because where practices receive additional resources and their achievement increased the funding would increase and that appeared to be inequitable and there was a need to ensure equity across 105 practices. JB posed the questions to SN to answer. SN wanted to emphasis the commitment for the outcome of the people with LD and recognised the tensions that exist because of that focus and wanted to see a change of the quality of life for the families and would use the contract for that. For the practice it was voluntary for them and they were exercising that option. Some practices have said they do not need any additional support. The offer was there for practices that were willing to improve the outcome of their population. They would have to work with additional resources. It was a voluntary exercise rather than imposed. SN appreciated the paperwork submitted may have been read as this had been forced on practices. The contract was that of equal partners between the CCG and practices and this provided an opportunity for equal partners for practices to have a conversation with the ICB. More importantly there was further work to do with the LMC colleagues to either agree or disagree on issues before these issues are brought to the Committee. MBe agreed that there had been a discussion in weekly meetings around LD delivery but felt that the issue remained around lack of equity of access and if practices were doing the work themselves any practice received additional support this may not have been evidenced as to why this was needed. A further discussion was needed where the ICB was going to provide additional resources to deliver something that was under a contract that needed a prior discussion with the LMC before returning to the meting as there cannot be any inequity across 105 practices. MBe reiterated the want for quality health checks for all patients regardless of what the type is and the issue was how these were undertaken and how resources were used to support practices with this to ensure that there was equity in access. JB thanked MBe for the input and there needed to be an agreement of a conversation prior to returning to Committee to understand the nature of what had been agreed to and what the expectations were. BB reflected the conversation and felt that the extra focus was because of the statistics and some practices were undertaking more health checks than others and the system was not doing enough. BB appreciated the contractual discussions however he felt it was important not to lose sight on the fact that the health checks were not being undertaken and they needed to happen and there were not as many being done as others in the system. BB felt SN needed to be congratulated and the team for the work done as the indicator had been dramatically different. BB felt that the performance was not equal across practices and thought that extra help would increase their performance and BB emphasised the importance of the vulnerable group getting these health checks. CT agreed with BB comments and asked about the additional nursing and clinical support which was in place until end of September 2022. SN had pre-empted this and was preparing a paper for EMT to understand if these resources could be extended. JB noted the progress and further discussions would take place with the LMC.	
10	**Interface Update**	**MB**

	For Noting	
	MB provided an update to the Committee. MB outlined the importance of the work being undertaken by the group, which was established in 2021, which is to highlight and address clinical issues between primary and secondary care. Most of the pressing issues have occurred as a result of phase three recovery and pressure on all parts of the system to address the patient backlog. MB recognised the close involvement of the LMC, in particular Dr Wendy Outwin. MB took the paper as read and highlighted a few key issues to Committee: • Lois Taylor, who had been instrumental in establishing the group, had recently left the ICB; Kate Lewis is now leading the interface work • Membership of the group was strong, with representation from the LMC, medical directors and clinical leads from most providers across Norfolk and Waveney • The group is currently focussing on chest xrays, private referrals and ICE user registrations MB advised that Task and Finish groups had been established; one group was focussed on private referrals, looking at streamlining pathways and preventing unnecessary work. MB reflected on the risks highlighted and raised a couple of points. First was around pace, in particular the agreement of changing pathways and the process that sits behind this, and trying to reach agreement with providers, primary care and the LMC. MB acknowledged that whilst some progress had been made, there was a need to ensure that patients did not fall through the gap between primary and secondary care. The final point was linked to the membership of the Interface Group; recognising the seniority of members and ensuring effective use of their time. MB advised that the group discuss key issues and any actions identified are assigned to specific task and finish groups to take forward. MB felt the update paper did highlight the risks and that steps were being taken to address them. JB asked colleagues if they had any questions. MBe asked about an email the LMC had sent querying a QIR. MB committed to providing a response. **ACTION: MB to provide a response to the LMC around the QIR query.** JB thanked MB for the update.	**MB**
11	**Locally Commissioned Services** *For Noting*	**GC**
	GC proposed that this was an opportunity to wrap up the programme and reflect on what had gone well and what could be learnt from the programme for the future. GC felt that programme had been a huge achievement over the last 10 months given this work had been tried to be undertaken for 5 years.	

	Work had been completed to streamline 38 locally commissioned services across 105 practices to ensure consistency for patients and that patients in different areas were able to access the same services. GC felt it was no longer a postcode lottery and that practices were now remunerated in the same way for the same specifications. GC reflected on the learning from the programme taking 5 CCGs commissioning to make one consistent approach had meant a number of assumptions had been made; addressing this in relative isolation without consideration that differing areas had invested differing amounts into other services, such as mental health / community, meant there was still a variation across the area. However, although this was recognised, it was deemed that the LCS review programme should continue based on the 6 key principles agreed by committee. GC felt that one development point would be to revisit the areas where particular services had been decommissioned and reflect on the investment in the community services and mental health where there had been huge changes made. GC also addressed good patient engagement which was one of the actions which was outstanding. GC felt this may be difficult if patients were not educated as to what *should* be provided from a GP surgery on a contractual basis. The patient survey showed that patients had used the survey as a way of highlighting their frustration around perceived limited access to practices during the pandemic, and access to dental provision, and the links to hospitals. There was a need to better support patients to understand what should be delivered from a GP surgery. Work was planned with the Communications team to develop a campaign to educate patients. GC felt another key learning point was the close collaboration work with the LMC and felt that this had helped the programme to achieve the results it had. GC finished by saying that that the achievement of the LCS programme is that all patients across Norfolk and Waveney are able to access the same services, with the exception of the warfarin monitoring go-live in GYW which was commencing transfer out of the James Paget on 18 July 2022. JB sought comments. HB felt a look back would be useful as some of the services that were decommissioned were believed to be useful services, for example preventing admissions, admission avoidance. Given the state of the pressures on the system HB felt this counterintuitive. HB felt that there had been a clinical administrative burden with the introduction of these LCS and felt she was spending more time doing administrative work than before. HB felt the coding templates used were incorrect and felt that it would be useful to review in future to see whether practices were still engaged or not and whether they had carried on providing the services. MBe wanted to reiterate GC comments on the complexity of the programme and felt the work involved should not be underestimated. GC had completely glossed over the level of work this programme has taken and the LMC were in no doubt about the effort required to get to this point. Whilst it was never going to perfect GC deserved all the recognition for this piece of work as without GC the outcome would never have been achieved. MBe referred to HB point and asked if HB was finding issues with administration, then she would like to hear about this along with	

	the issues with the templates then they would work with the ICB to get these changed. MBe would welcome feedback from practices whether they were facing similar issues. MBe thanked GC on behalf of the 105 practices and patients in Norfolk and Waveney. BB felt it was important not to have different services in different parts and that they should be equitable and that was important as some services may be stopped as they may not be available elsewhere. BB felt he was not an expert in the area but thought moving forward with the ICS would have more local variation through PLACE boards and the health and well-being partnerships because there would be local solutions with primary care solutions at the centre of it and BB questioned whether this was going to be lost and heading in a different direction as if that was the case then BB had concerns. MB echoed MBe comments around the work done. LCSs were not the only route to deliver different ways of working. MB was a supporter of place but felt that there was work that could be done to tailor work locally which would include work with local providers including primary care. MB referred to a conversation that had taken place with the Ambulance Trust and a PCN around how things could be done differently. There was a need to ensure that patients get the right level of care and support for the population not just for PLACE but for the Norfolk and Waveney system and community. MB felt that it wouldn't be done once in all areas and this work was trying to ensure that with the services that patients receive there was equality and plenty of opportunity for local design. MB felt there might be an opportunity to look back in 6-12 months. JB thanked MB and referred to the fact this was the first ICB PCCC that PLACE boards were starting to emerge now. GC wanted to take a couple of points. GC referred to HB's point on templates. During the first quarter of the year these had been challenging to undertake for both SystemOne and EMIS. GC felt the templates should now be stable and it was the first time the CCG had put out templates to share across the board and support consistency. GC felt that these should not be more clinically or administratively heavy and asked for feedback and examples. GC referred to the comment around equalisation and locality. One key point to note was PCCC had agreed six key principles to underpin the programme and one of them was a consistent range of services across all areas. There was a need to fund this fairly and GC went on to explain this in further detail. JB thanked GC and deferred to MBe. MBe supported MB and GC and the fact that there had to be a basis where there was equity in provision for patients across Norfolk & Waveney in certain areas and there was no disparity. There was a need to ensure that all practices were being paid appropriately for the work they were doing and there were some significant issues that were addressed. There had been local innovation and there needs to be the funding available and the budget was not able to be increased for the review. MBE felt there needed to be a review of funding streams and any future funding that may allow innovation and allow for local differences. MBe felt important to note that practices got what they had asked for.	

	SM raised a point around the enhanced patient communication plan to improve patient understanding of local health care services. SM felt there was a need to remember that Healthwatch in Suffolk and Norfolk would provide help promoting things going forward. HB did not want to antagonise GC and recognised the challenge around the funding envelope and that it had to be fixed. HB referred to a number of services that had been stopped because of the review and they were predominantly around admissions avoidance. Given how much money is spend in primary care this may save considerably more in secondary care and HB felt it counterintuitive, as the services would not be restored and felt that this would add to pressure on the acutes. GC commented that practices were still able to undertake local projects as a result of the Proactive Healthcare LCS which enabled projects to capture key data to test their effectiveness. MB felt the points HB raised were valid and would need to be considered going forward. As it was GC's last meeting MB wanted to thank GC for the work done as MBe had done previously. JB thanked GC for the work done on behalf of the Committee.	
12	**Wave 4b Primary Care Hubs Programme Business Case** *For Approval*	**PH**
	PH presented a Business Case to Committee for approval. PH provided a brief overview and an update to Committee on the latest position. PH offered to take questions on the business case. JB wanted to check whether the Committee were being asked to comment on the business case but seeking a formal approval as it had been approved already by the ICS. The CCG Executive approved the document for submission but they were not formally an approving body therefore PH seeking approval today. HW outlined he had sent questions and comments offline, none of which stand in the way of the support of this approval. HW requested that PH and he touch base offline. HW felt that one area was downplayed was the overall programme made more sense to previous variants and de-risked however felt that was a significant risk given the spend on this and whether it will be achieved on schedule. HB felt that the Committee needed to be aware of issues in Attleborough and other practices. Attleborough were identified as the highest need area within South Norfolk. 5000 plus houses were scheduled to be built, some of which built already. The population growth was potentially in excess of 15000 which was not the numbers quoted in the report. It should be 5800 which was considerably less than expected. The practice was one and the area identified as some of the greatest need and therefore was going to have a new building and then it became apparent that this would not be going ahead due to funding. HB felt that there was no plan for Attleborough and felt there was a concern for primary care services. HB felt that she did not recognise the numbers within the report given she worked within	

	Attleborough. HB felt the Committee needed to be aware of challenges of delivering services and HB went into these in detail with Committee as she felt there was no other solution currently. PH responded to HB comments and referred to pressures on other practices and it was known that Humbleyard and Attleborough were know pressure points in terms of being constrained in future housing development over the next 15 years. The difference between the numbers may potentially be down to time scales however these can be checked. PH recognised there was a problem for Attleborough in terms of capacity and the reason this was withdrawn because of costs and timescales. Both Kings Lynn and Rackheath showed similar spend and were effectively Greenfield sites therefore it was a lot easier to build something within the timeframe. PH reported that he was committed to work with the practices. Humbleyard were in discussion with Broadland council regarding new builds however these discussions were at an early stage. HB reported that she had no visits from NHS Property Services and her understanding was about a modular building being put and the back of the practice that would have a lifespan of 3 years with planning consent fort that time and HB expressed concerns around this. PH responded by saying NHS Property had been on site but may not have spoken to the practice on the day they visited but had been on site and PH would provide an update to the Practice Manager and had offered some time to meet with her. JB wanted confirmation that PH would return to Committee with further detail on Attleborough and Shrublands and whether these issues would be bought back. PH confirmed he would include an update on Attleborough and the additional pressures on practices across the county. BB understood that it was a specific project to spend capital within a certain timeframe but felt that ambitions were wider than one public estate BB felt this was an important project that would be key to this where all public sector organisations were making their property assets available to each other in order that a more efficient public estate could be designed by working together using land and buildings that would be more needed by one part of the public sector than the other. BB felt that it would be a key part of any strategy to deliver care settings across the county and would need to be referred to going forward. Breckland would publish their sites later in the week. BB felt there should be some indicative timeframes in respect of future demand for places like Attleborough which was a centre for growth. BB hoped that there would be funding available for developers and that other assets of the public sector could be used as leverage to support ambitions in the future. JB thanked BB for his comments and asked PH if he had any comment of the One Public Estate aspect. PH responded by saying that Wave 4b programme updated was presented regularly to The One Public State Board and members of the board were part of the project and work was being done to exploit public estate opportunities across the patch and gave an example around a new facility in Taverham. There is a dedicated post to respond to planning applications within the ICS estates team and PH recognised that there was more work to be done.	

	JB felt it was the role of the PCC to track progress and PH said that he reported quarterly however given frustrations and interface issues it may be a more regular update was needed. **ACTION: PH to provide another update at August 2022 Committee.** JB asked if the Committee would support the proposal with reservations given by HB and HW and there was agreement for Committee to approve this business case.	
13.	**CQC Reports – Cromer Practice** *For Noting*	**SN**
	SN wanted to highlight that Cromer Practice had featured on the practices at risk summary and they now had a good rating. The feedback from the CQC had been positive. JB duly noted the update.	
14	**Prescribing Report** *For Noting*	**JA**
	JA asked for the report to be noted. MBe highlighted the end of the report the section around the QIPP scheme low risk, cost effective prescribing QIPP support which is an incentive scheme. This does not appear to have been raised anywhere and the LMC had emailed MD directly and no response had been received. JA committed to providing a response to the LMC. MBe highlighted the fact that any incentive scheme development had to be consulted with the LMC and the LMC were not aware of this however it seemed to have been implemented. The LMC were not able to see this had been discussed on any previous PCCC agenda and asked if this could be bought back to the next meeting. **ACTION: JA to provide an update to the LMC around the QUIPP scheme.** RM had a comment as she felt take up was low. 29 out of 105 practices. If this had not gone through proper governance RM asked if there would be an extension and could potentially be signed up to it. JA confirmed this and the figure was taken a week before the deadline for completion and there had been more take up since and the deadline for the completion of the work was end of August 2022 for the first bracket of payment and this would be bought back to the next meeting. JA confirmed practices would be made aware. HB reported there had been concerns as in order for practices to sign up they had to accept some additional software called OptimiseRx and there were concerns around this slowing down speed and there were challenges around speed of IT and systems crashing. If this part of the scheme was not signed up to then practices were not able to access any other components of the scheme. JA clarified that the Section 5 of report was being referred to which was the PQS. The ICS do ask practices to sign up to OptimiseRx which alerts prescribers to risks of prescribing. There was awareness of the issues with OptimiseRx and	**JA**

	EMIS and there would be a representative from OptimiseRx to meet with one of the practices to demonstrate the system and JA offered to report back to HB. **ACTION: Update on PQS to Committee within next Prescribing Update.**	**JA**
15.	**Finance Report** *For Noting*	**JG**
	JG asked the report taken as read but highlighted key points. **Executive Summary** M2 accounts for the legacy CCG which also included a Quarter 1 forecast. Report produced in arrears due to month end. Forecast position at M2 for primary care prescribing budgets were £0.1m 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 would build up over the year. **Financial Summary** GP prescribing is £0.1m favourable to budget as at M2 and forecasted to be the same for the quarter. With the figures being 2 months in arears, this was a marginal over-valuation of the April-22 estimate. In addition, efficiency savings had materialised in this period allowing the forecast to be delivered. These efficiency expectations were within the budget. Of the £1.026m requirement for the quarter 1 months of actual achievement had been received, and this over-delivered, given the lack of data at M2 this could change. There was a difference between delegated primary care and the system development fund of £0.5m. All other areas are on plan. **Detailed Finance Analysis** This showed the key drivers behind the prescribing underspend of £0.1m against budget 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. **System Development Fund** This key area of investment was shown as an underspend as it had been unable to move budget at M2 due to NHSE/I restrictions. This would be corrected at a later date. **Delegated Co-Commissioning** The adverse variance was due to the budget movement issue just described in the system development fund and would be corrected at a later date. **GP and Other Prescribing** Outline detailed variances with prescribing led to the slight underspend, the differences were all immaterial, and showed predominately on plan. **Financial Risk**	

	These had been refreshed for the new financial year, and the largest areas which could lead to a financial deterioration identified as. 1) Impacts of NICE guidance 2) Non-Delivery of efficiencies 3) Impact of nationally mandated expenditure JG offered to take questions. JB felt the removal of the health and social car levy may well impact of the overall budget position for the NHS let alone primary care. JG asked if there were national uncertainties at the moment and JG agreed there were. JB thanked JG for the update.	
16.	**Any Other Business – Questions from the Public** BB requested a list of attendees and organisations that they represent. BB requested the Agenda and pack had page numbers. **ACTION:** **SW to produce list of attendees and organisations they represent.** **ACTION:** **SW to ensure pack was numbered appropriately in future.** **There being no further business, the meeting then closed at 15:20**	**Chair** **SW** **SW**

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

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

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

Norfolk & Waveney IBC Primary Care Commissioning Committee - Part One
Action Log 9 August 2022

No	Meeting date added	Agenda Item	Owner	Action Required	Action Undertaken / Progress	Due date	Status	Date Closed
0109	14th June 2022 (10th May 2022 meeting)	8	JD	Added on in June 2022, should have been May 2022 - SMI Healthchecks Item - Financial Implications need resolution	JD provided finance modelling by email to SW on 19th July 2022. SW forwarded to Part One members 20th July 2022	12th July 2022 9th August 2022		20th July 2022
0113	12th July 2022	10	MB	Interface Update - MBe asked about an email the LMC had sent querying a QIR and MB committed to responding to it.		9th August 2022		
0114	12th July 2022	12	PH	Wave 4b Primary Care Hubs Programme Business Case - PH committed to providing an update within his regular quarterly update at August 2022 Committee.	Scheduled update on August 2022 Agenda	9th August 2022		19th July 2022
0115	12th July 2022	14	JA/MD	Prescribing Report Mbe had a query around the QIPP scheme - JA to provide an update	The QIPP scheme had been clinically signed off by CEC and financially by EMT, it will be included as an appendix in the August Prescribing report for information	9th August 2022		
0116	12th July 2022	14	JA/MD	JA to provude an update to Committee on the PQS	Meeting with OptimiseRx and EMIS practice to be held on Mon 1 August, a verbal update will be included with the Prescribing report at the August meeting	9th August 2022		
0117	12th July 2022	16	SW	Committee requested a list of Committee attendees and organisations they work for in light of new Membership for ICB PCCC.		9th August 2022		
0118	12th July 2022	16	SW	SW to ensure Agenda Pack had page numbers in future		9th August 2022		

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

	Proposed date:	July 12th	August 9th	September 13th	October 11th	November 8th	December 13th	Jan 10th	Feb 14th	March 14th			
Standing items:	Risk Register	Y		Y		Y		Y		Y			
	Monthly Finance Report	Y	Y	Y	Y	Y	Y	Y	Y	Y			
	Estates Quarterly		Y			Y			Y				
	Digital Quarterly		Y			Y			Y				
	Prescribing Report	Y	Y	Y	Y	Y	Y	Y	Y	Y			
	Workforce and Training			Y				Y					
	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

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Norfolk and Waveney
Integrated Care Board

Agenda item: 6

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:	**9 August 2022**

Purpose of paper:

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

Executive Summary:

A. Clinical Interface Group update
B. Urgent and Emergency Care update
C. Launch of the Place boards
D. Medical director engagement sessions with PCN clinical directors and medical staff to discuss priorities for the ICS

Report

A: Clinical Interface Group – update for PCCC

The Clinical Interface Group continues to meet under the leadership of strategic primary care. The priority focus for this group has been uncontracted activity falling on general practice. Three Task and Finish Groups are in the process of being set up to explore discrete pieces of work related to this area.

Through the Action Log and standing agenda items, monitoring progress and troubleshooting issues takes place. Noted in the risk log for PCCC, managerial and administrative capacity to support the Clinical Interface Group remains the main barrier to progressing key pieces of work.

B: Urgent and Emergency Care update

Our health and care system, like others across the country, continues to see very high demand for health and care services. Our emergency departments and

ambulance service are currently extremely busy with pressure at levels we would more typically expect to see during the winter months. This is sometimes leading to patients having to wait longer times for ambulances to arrive and for admission to hospital should this be required.

It is really important that we work together to address these challenges collectively and support each other to help reduce pressure across the system.

The flow of patients across the system remains a challenge and work is underway to urgently review discharge pathways, encourage successful discharge and ask patients and their families to be safely supported at home where possible.

A 100-day challenge is currently taking place in Norfolk and Waveney to drive improvement and innovation in discharge, and a number of initiatives have been set up to improve patient flow.

The 'Happy Healthy Holidays' communications campaign is also underway to encourage locals and holidaymakers to choose health services wisely and promote the use of self-care, pharmacies and NHS111.

C: Launch of the Place boards

As part the local working arrangements of our ICS (Integrated Care System), we have established five Place Boards (Great Yarmouth & Waveney, North Norfolk, Norwich, South Norfolk, and West Norfolk) based on the current health footprints. They bring together colleagues from health and care and aim to integrate services with a focus on effective operational delivery and improving people's care. They are part of the governance structure of the ICS and accountable to the ICB (Integrated Care Board) and aligned to the local Health and Wellbeing Partnerships in each Place.

They are launching within a developmental phase at the end of July and beginning of August. The purpose of the developmental Place Boards is to;

a) Identify local health and care priorities and deliverables, using data and intelligence, that focus on addressing the health and wellbeing needs of the Place population together with local Health and Wellbeing Partnerships.
b) Consistently use a system-wide perspective when considering how to integrate health and care services; including VCSE and independent sector agencies.
c) Provide oversight and assurance to the ICB; developing a shared Place Plan made up of the ICS strategic objectives/ICS strategy and local need.
d) Ensure effective operational delivery within existing local resources to improve people's care at Place.
e) Support delivery of national and system priorities and commitments.

D: Medical Director engagement sessions with PCN clinical directors and medical staff to discuss priorities for the ICS

Dr. Frankie Swords, ICB Medical Director, has set up a series of formal engagement events with the wider community of clinical and care professional (CCP) leaders, to listen to and harness the voice of clinical (NHS) and care (social care, VCSE and other care providers) professionals. The aim will be to build the CCP voice into every decision made as an ICB.

There will also be planned monthly meetings – open to all medical staff who would like to attend – but particularly aimed at GPs, consultants and specialists. The time will be used flexibly and as an opportunity to share the specific priorities of the ICB, the progress made that month and current areas of focus or concern. It will also be a chance to raise any specific issues needing attention.

Dr. Swords will be working closely with senior medical leaders to provide them with direct support on the pressures faced by each area.

Recommendation to the Board:

To note the report.

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

Governance

Process/Committee approval with date(s) (as appropriate)	Audit Committee for information.

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Norfolk and Waveney
Integrated Care Board

Agenda item: 7

Subject:	**Learning Disability Annual Health Checks progress update**
Presented by:	**Shepherd Ncube, Head of Delegated Commissioning, Primary Care**
Prepared by:	**Sarah Collingwood, Delegated Commissioning Manager**
Submitted to:	**ICB Primary Care Commissioning Committee**
Date:	**August 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 (except UEA practice due local population needs-separate commissioning arrangements will be put in place if this is required) 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 initial data from the Central Quality Reporting System (CQRS) showing delivery of learning disability health checks in April and May 2022.
- Reporting usually takes place on a monthly basis, however changes in the way the data has been collected by NHS Digital has delayed publication until July 2022.

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2. Key highlights events since last month

- A progress delivery report was shared and presented at Norfolk Health Overview and Scrutiny committee (HOSC) last month-14 July 2022 as planned. The overall feedback was positive, and the excellent progress made in Norwich and West Norfolk was observed and acknowledged by the committee.

- The impact of the additional clinical resources in West Norfolk and the Peripatetic team was recognised and the committee was keen that long term funding arrangements/plans are put in place to maintain and sustain the progress made so far.

- Norfolk and Waveney ICB Annual Health Check delivery and implementation group in July agreed to carry out 'deep dive' meeting to challenge and support local delivery plans.

- Deep dive meetings have now been set up will the 5 ICB Locality teams. We have held two meetings so far with colleagues from Norwich and Great Yarmouth and Waveney. Good progress has been made this quarter and follow up actions were agreed with challenged practices. Workforce challenges and pressures due to Covid and sickness and fatigue in general practice was a key feature across in our discussion.

- A Meeting with NHSE colleagues to discuss Q1 data was held on 18/07/2022. Good progress was noted. Discussed the challenges associated with current contractual arrangements for delivering this programme and possible ways to manage this including the possibility of subcontracting arrangements. We also agreed a targeted approach to reach out and offer additional support to practices that struggled to reach 50% in uptake last year.

3. Learning disability AHC activity to-date

Learning disability health check uptake April-May 2022				
Region	**LD register**	**Completed**	**Declined**	**% uptake**
Beds, Luton, M Keynes	4214	148	2	3.5%
Cambs & Peterboro	3985	141	0	3.5%
Herts & West Essex	6694	227	4	3.4%
Mid & South Essex	4669	145	6	3.2%
Norfolk & Waveney	**6156**	**256**	**4**	**4.2%**
Suffolk & NE Essex	5117	203	8	4.0%
East of England	**30835**	**1120**	**24**	**3.6%**

- Norfolk and Waveney has reported 4.2% uptake via the national CQRS portal. This is currently the highest performance in the East of England region and above the East of England average of 3.6%. However, it should be noted that several practices have not been included within this data set so it is expected that the register size and completed checks will increase once this information is pulled through to CQRS.

Learning disability health check uptake April-May 2022				
Locality	**LD register**	**Completed**	**Declined**	**% uptake**
Great Yarmouth & Waveney	1670	66	1	4.0%
North Norfolk	1173	37	2	3.2%
Norwich	1151	21	0	1.8%
South Norfolk	1179	53	1	4.5%
West Norfolk	983	79	0	8.0%
Norfolk & Waveney	**6156**	**256**	**4**	**4.2%**

4. Next steps

The Delegated Commissioning and Quality teams are conducting 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.

Validated data will be shared with PCNs and practices to enable situational analysis at a local level.

5. Recommendation to the Board:

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

Key Risks	
Clinical and Quality:	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)	

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Norfolk and Waveney
Integrated Care Board

Agenda item: 8

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

Purpose of paper:

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

1. Background

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

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

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

2. Activity to-date

- As of March 2022, the total population of patients on a SMI register represents 9,134 people across Norfolk & Waveney. Responsibility for the delivery of SMI checks is shared amongst 2 main groups (Primary care and Secondary Care) and is supported by voluntary sector.
- As a system, at the end of Quarter 4 21/22, N&W had completed 3,548 SMI checks, against an ambition (nationally set) of 5,184 – this is 38.9% delivery compared against the national target previously expressed as 60%.

- We are still awaiting the finalised performance data for Q1 to detect the most up to date version of performance in these checks.
- A report was provided to HOSC on the 14th of July 2022 around the SMI improvement work and plans for system working within the new ICS.
- Committee members were satisfied with the ICB efforts and plans to improve the uptake and quality of annual health check. However, it was noted that only 40% of the checks were completed last year and there was a need to improve and strengthen the current delivery plans so that more people can be checked.
- The ICB was challenged and encouraged to put in place long term and sustainable arrangements to improve the current position and Tricia D'orsi- ICB Director of Nursing agreed to lead on this piece of work.

3. Improvement plans in pipeline:

- Delegated representatives have attended PCN Clinical Director meetings in the West Locality to raise profile of SMI checks and offer support to work collaboratively to undertake proof of concepts for additional staffing.
- The uptake has been quite positive; the plan for August is to repeat this across other localities if appropriate.
- We will also be focusing on our SMI information resource website that could be used for training, accuracy of coding, and any other FAQs that arise.
- We will also review Q1 performance data for this year and ensure this is shared and analysed.

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:	Improving the care and treatment of people with a serious mental illness is one of the top clinical priorities in the NHS Long term plan. The clinical risk is that if the annual health checks are not completed, the risk of premature death for this population group remains high.
Finance and Performance:	long term clinical additional resources will be required to be able to make significant and sustainable improvements with the uptake and quality of checks.
Impact Assessment (environmental and equalities):	N/A
Reputation:	ICB is at risk of failing to meet its commissioning responsibility in line with NHS Constitution and the national drive to address health inequalities within systems.
Legal:	N/A

Information Governance:	N/A
Resource Required:	Business Intelligence team Delegated Commissioning team Locality teams Quality in Care team NSFT Mental Health Commissioning team
Reference document(s):	The NHS Long Term Plan
NHS Constitution:	1. The NHS provides a comprehensive service, available to all 3. The NHS aspires to the highest standards of excellence and professionalism 4. The patient will be at the heart of everything the NHS does 5. The NHS works across organisational boundaries 7. The NHS is accountable to the public, communities and patients that it serves
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	PC16

Governance

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

Norfolk and Waveney
Integrated Care Board

Agenda item: 09

Subject:	**Primary Care Estates – quarterly update**
Prepared by:	**Primary Care Estates Team**
Submitted to:	**Norfolk & Waveney Primary Care Commissioning Committee**
Date:	**9 August 2022**

Purpose of paper:

Update on Primary Care Estates, for information.

Contents

Update:

Wave 4b Primary Care Hubs

The revised Wave 4b Primary Care Hub Programme Business Case (PBC) was submitted to NHS England (NHSE) in June 2022.

Following the initial review of the PBC submission, NHSE set out three key principles which the ICS need to work within, which required fundamental changes to the original Programme Business Case (PBC):

a. The total capital value of the scheme must fit within the £25.2m Wave 4b allocation with no third party / private capital to be used to top up the programme to fund new builds.

b. Procurement of the sites via a Strategic Partnering Agreement and LiftCo[1] was not a legally valid route for procurement (as per system letter from DHSC re. PFI/PPP approach being withdrawn).

c. There is no flexibility on the March 2024 deadline for completion of sites.

[1] LIFT – Local Improvement Finance Trusts: launched in 2001 as local joint ventures made up of local stakeholders, a private sector partner and Partnerships for Health (now Community Health Partnerships – a Department of Health owned company). The LIFTCo takes ownership of premises it builds or refurbishes and then leases the space to health and social care partners.

The ICB (then CCG) reassessed the Programme in line with the NHSE principles and have proposed a way forward which minimises the risk of the Wave 4b funding being lost to the Norfolk and Waveney health and care system. This proposal sees a reduction in the schemes being delivered from five to four, bringing in the substitute scheme for South Norfolk. The Attleborough (South Norfolk) and Shrublands (Great Yarmouth & Waveney) schemes have been removed from the programme due to a combination of the costs and expected build duration. These projects will not be abandoned, and the ICB will seek to deliver these via alternative means.

Over the Summer of 2022 the ICB intends to go to market for a Third Party Developer for the construction of the Shrublands scheme. A tender pack using NHSE material has been created and will be advertised for potential contractors to submit expressions of interest to the ICB for consideration.

A summary of the Wave 4b Primary Care Hubs is Appendix 1 to this report.

The initial "Fundamental Criteria Review" by NHSE of the revised PBC was positive. Detailed queries requiring an ICB response must be submitted early August. The NHSE and Department of Health and Social Care PBC review process will conclude in September 2022 at which point the ICB will know if the PBC has received approval.

The timetable for the programme and its completion deadline of March 2024 remains its biggest risk and the ICB is in regular discussions with NHSE about means of mitigating this risk. The ICB also chose to fund the development of the "Full Business Case" stages of each project (e.g. planning permission, tendering for contractors) concurrently, to help manage this risk. The monthly Wave 4b Programme Board is tracking progress against plan.

National policy developments and Estate Strategies

NHS England have commissioned Community Health Partnerships (CHP)[2] to support PCNs, nationally, to implement the PCN Service and Estates Toolkit in 2022/23. The Toolkit is clear that an estate strategy should be driven by a clinical strategy. As expected, the approach will see the optimisation of existing GP and wider estate through partnership working as being critical.

The specification from NHS England in the East Region was for CHP to ensure that 40% of the PCNs in the East of England had robust clinical and estates strategies in place. The focus was on PCNs with the highest levels of deprivation.

CHP and the Primary Care Estates Team have discussed the "state of readiness" of the ICS and PCNs to engage with the Toolkit. CHPs proposal (and available NHSE funding) was for support to be provided to 13 PCNs in Norfolk and Waveney.

The view of the Primary Care Estates Team is that the support should be available to all 17 PCNs (including the chance for those PCNs with full or partial existing strategies to benefit from an independent review, using the Toolkit). This would ensure an equity and consistency of approach and enable the ICS to have a solid basis for primary care estates strategic planning. The Estates Team had also heard, from individuals within NHSE, that future primary care estates proposals would only be considered if supported by an estate strategy: it therefore seemed unfair for only some PCNs to receive the NHSE commissioned support to develop strategies.

CHP describe the key outputs of their support as being as follows – see also an example outline delivery plan below:

a. Developed clinical plans and responsive estate plans

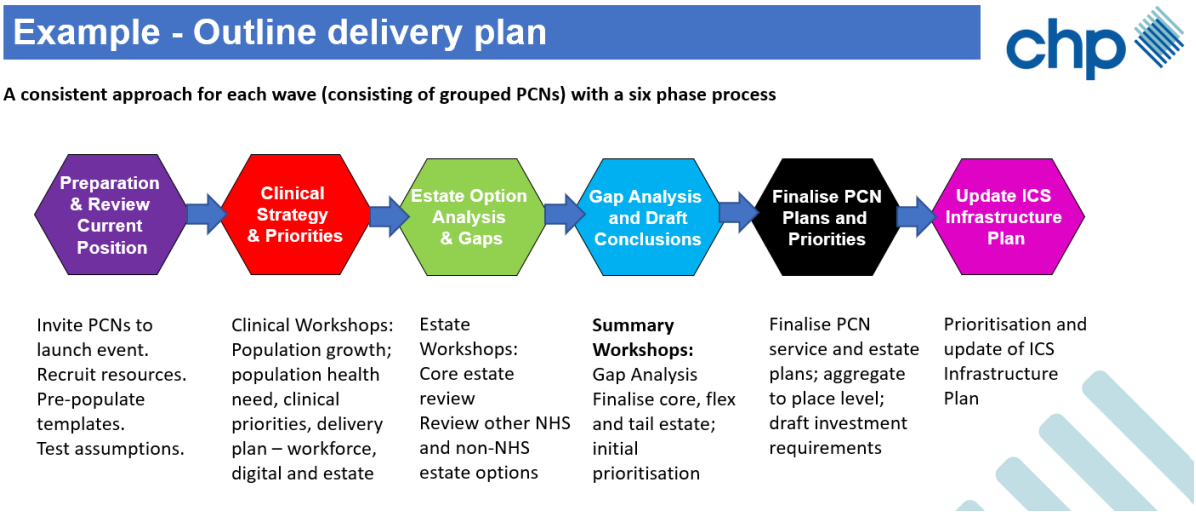
[2] Community Health Partnerships (CHP) is wholly owned by the Secretary of State for Health and Social Care. Incorporated in 2001, the focus was to improve the NHS estate via Public Private Partnerships. Since 2013, CHP have taken on the role of Head Tenant from the former Primary Care Trusts.

b. Completed toolkits per PCN, with ability to aggregate up to wider geographies (Place, ICB, etc.)

c. Prioritised short, medium, and long-term capital and revenue investment & disinvestment estimations

d. Updated Primary Care Data Gathering[3] dataset as data is refined and gaps are closed, including updated SHAPE[4] mapping

e. Aggregated summary reports at ICS level (and ICB if required) to feed into ICS strategy refresh and planning.



The Primary Care Estates Team asked CHP to cost the provision of support to all 17 PCNs and, of the programme of support, to explore what the ICB may be able to deliver locally, thereby enabling the funding available to stretch to cover all 17 PCNs. An additional £85k has been quoted to increase the offer to all PCNs in Norfolk & Waveney. At the time of writing, discussions were ongoing with CHP as to how the programme could be delivered differently to fit within existing allocation.

CHP want to launch their programme of support in the Autumn of 2022, with the aim of having service and estate strategies drafted by April 2023. The Primary Care Estates Team will link with PCN Development Teams to make arrangements for the launch events (which will be virtual).

Appendix 2 to this report provides further information about the PCN Service and Estates Toolkit.

Funding to support General Practice Estate development

The Primary Care Estates Team is aware – formally or via informal enquiries – that 70% of practices are interested in funding to support an estates scheme. It is expected that this proportion will rise when the formal call for bids from practices interested in more space is made.

There is insufficient funding (capital and revenue) to undertake all the proposals.

Practices will come under continuing pressure in terms of:

a. The need to accommodate posts under the Additional Roles Reimbursement Scheme (ARRS);

[3] Community Health Partnerships were appointed by NHSE to lead the national Primary Care Data Gathering programme, which was intended to bring the information held on general practice premises in England up to a consistent baseline standard nationally. This information is linked to SHAPE.
[4] SHAPE is the Strategic Health Asset Planning and Evaluation tool is a web enabled application, provided by Public Health England, linking national data sets, clinical analysis, public health, primary care and demographic data with information on healthcare estates performance and facilities location.

b. Requests from other parts of the healthcare system to provide space in primary care settings for service delivery;

c. Registered list size growth from housing developments; and

d. The national call for PCN service and estate strategies to evidence and prioritise their ongoing estate requirements (see section above).

Capital:

a. Funding available to support bids for estates improvement grants is now solely the business as usual (BAU) capital funding allocated to the ICS. There is no replacement for the former national Estates Technology and Transformation Funding which practices could bid against.

b. The ICS will be reliant on BAU capital to fund primary care premises proposals or may wish in future to consider how the wider ICS capital allocation could support primary care, particularly if there is a continued drive towards outpatient services being provided in community/primary care settings.

c. The Primary Care Estates Team is waiting for confirmation of its share of the £1.9m BAU capital for 2022/23 which has to cover Digital and Estates projects and primary care estates. A prioritised list of schemes has been shared with the LMC and was submitted to the ICB (CCG) finance team in April 2022.

d. As PCCC will recall from the previous update, 61 Expressions of Interest have been received for proposed estates schemes in 2022/23 – from 50 individual practices. The schemes have been prioritised and feedback provided to individual practices if requested – a formal announcement about schemes for 2022/23 has not been made, pending confirmation of capital available.

e. As there are insufficient funds to undertake all the proposed schemes in 2022/23, the prioritisation is in effect a draft primary care estates programme for three years, which will be aligned to the Primary Care Estates Strategy. PCCC will receive a prioritised list of projects for information and review.

Revenue:

a. As PCCC know, a process has been drafted to address the increased interest from practices in securing additional reimbursable space (arising largely – but not wholly – from the need to accommodate ARRS roles).

b. To ensure an equitable approach, it is proposed that requests for such space are linked to the annual capital grants process from 2023/24.

c. The Primary Care Estates Team had intended, for 2022/23 that requests would be sought soon into the financial year. The new process, *Advice Note 1: Requests from practices for additional space and rent reimbursement,* was going to be released alongside details of the above-mentioned support for PCNs to use the Toolkit to develop service and estate strategies, but this announcement has not happened as quickly as anticipated.

d. ICB finance have confirmed there is limited budget available for additional estate related revenue costs beyond those schemes who have already received a level of approval. It is therefore expected that the majority of requests for additional space will be unable to be supported unless there is associated additional revenue funding available.

e. 17 practices have approached the Primary Care Estates Team to ask about applying for funding for additional space. The draft process has been shared with practices where they are keen to start assembling information – while making it clear that the process has not formally been released and that bids will need to be prioritised.

Rent reimbursement and rent reviews

Capacity within NHSE rent review team has been challenging for the primary care estates team.

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

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

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

2022/23 Reviews

Month	Number of rent review approvals	Rent increases
April	2	£ 7,120
May	7	£32,770
June	5	£23,875
	TOTAL TO DATE:	**£63,765**

Upcoming rent reviews

NHSE rent review team has indicated there are 4 upcoming rent reviews in July. Figures are not yet known.

Planning and new housing developments

The ICB Estates Team has been – in consultation with the Local Medical Committee – developing a template to support primary care in responding to consultations relating to planning. The Team receives a high level of correspondence including Local Plans, Neighbourhood Plans, Supplementary Planning Documents and of course planning consultations.

The following are areas where housing developments have prompted discussions about potential new primary care estates proposals:

a. Hethersett: discussions continue involving The Humbleyard Practice about potential solutions to the existing and future pressure on their capacity – the local planning authority are potentially interested in supporting a new build facility.

b. Taverham: discussions involving the local planning authority are quite advanced, with a multi-agency group meeting regularly: Taverham Communities & Health Hub Partnership, which is overseeing the design of the proposed building. The Taverham Partnership are proposing to move from their existing main site into the new premises.

c. Halesworth: developments include older people's housing and there is an opportunity to bid for Community Infrastructure Levy funding.

d. Lowestoft: there is an existing Section 106 agreement for land to be set aside as part of the Woods Meadow development. The Bridge Road Surgery have engaged a third party developer and work is underway to develop a business case for this scheme.

Primary Care Estate Capacity

Using NHSE guidelines (500m² per 6k patients + 250m² per subsequent 6k patients) the total primary care footprint in the ICB is in theory sufficient to deliver GMS services for our population as a whole. However, there is variation across the ICB with some PCNs having theoretical surplus capacity and some having theoretical deficit capacity. Using predicted population growth modelled from NHSE housing data the ICB is expecting an additional 125k patient registration between 2022 and 2037. This growth is not evenly distributed across the ICB footprint and therefore causes greater capacity differential across the county.

Appendix 3 displays current capacity in m² with blue circles representing practices with capacity and white circles representing those who are already seeing more patients than their building is designed for. Both coloured circles are scaled to show the size of the capacity or constraint. It's important to note that this calculation is based upon GMS services only and does not reflect any additional services such as the ARRS roles that primary care offers to patients. The NHSE formula also doesn't adjust for the age of buildings or for the condition of buildings. We generally find that older buildings can see more patients per m² due to changing standards over time with consultation rooms now at a standard 16m² when historically these would have been 12m². Although the formula isn't perfect it does provide a benchmark and assists the ICB in prioritising schemes and identifying sites which may be able to support additional services.

Norfolk and Waveney General Practice Estate: ongoing projects

The following estates projects are ongoing and due to complete over the next 12 months:

a. East Norfolk Medical Practice, The Lighthouse Surgery, Great Yarmouth – refurbishment to create new clinical rooms.

b. Blofield Surgery – 312m² extension to existing premises (subject to Grant Agreement conclusion).

c. Kirkley Mill Surgery, Lowestoft – internal reconfiguration and improvement works.

In addition to the above the ICB are working with practices to explore options for additional capacity in Attleborough and Toftwood. These options would be short term solutions with long-term solutions needing to be developed alongside system partners.

Longer terms schemes are progressing in Kings Lynn and Oulton Broad. The Full Business Case for a replacement surgery for St James Medical Practice, Kings Lynn is due to be reviewed by NHSE in August 2022. Bridge Road Surgery, Oulton Broad have engaged a developer for a replacement premises utilising a combination of Section 106, Community Infrastructure Levy Funding and private capital.

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

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

Scheme name	**North Norfolk – Rackheath**	**Norwich – Sprowston**
Type	New build at Halsbury Homes site on Broad Lane, Rackheath	Expansion of existing healthcare premises at Aslake Close, Sprowston, Norwich
Ownership	NHS Property Services	Primary Health Properties PLC
Locality	North Norfolk	Norwich
Why these options have been chosen	• Strategic importance to estates strategy: The Rackheath and Sprowston schemes form a strategic joint approach to meeting existing and anticipated healthcare demand from Greater Norwich Neighbourhood Plan – which indicates significant population growth • Anticipated growth would see registered list sizes across these PCN areas increase by around 30,000 • Clinically important to: o Local Maternity and Neonatal Service supporting provision of continuity of carer and services in the community o Expansion of community services wrap-around integration with PCNs, focussed on preventative response to identified population healthcare and risk stratification o Support to extend community provision and MDT opportunities to manage Long Term Conditions, Mental Health, Public Health initiatives and voluntary sector services	

	• Local political and patient interest and support for the Rackheath development established for more than 5 years • Makes optimal use of existing, underutilised estate in an area which will need to ensure healthcare facilities are able to offer flexible space for a range of service provision.

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

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

Appendix 2: PCN Service and Estates Toolkit

Community Health Partnerships and the National Association of Primary Care on behalf of NHS England, have produced a PCN Service and Estates Toolkit developed from the published guidance Primary Care Networks: Critical thinking in developing an estate strategy.

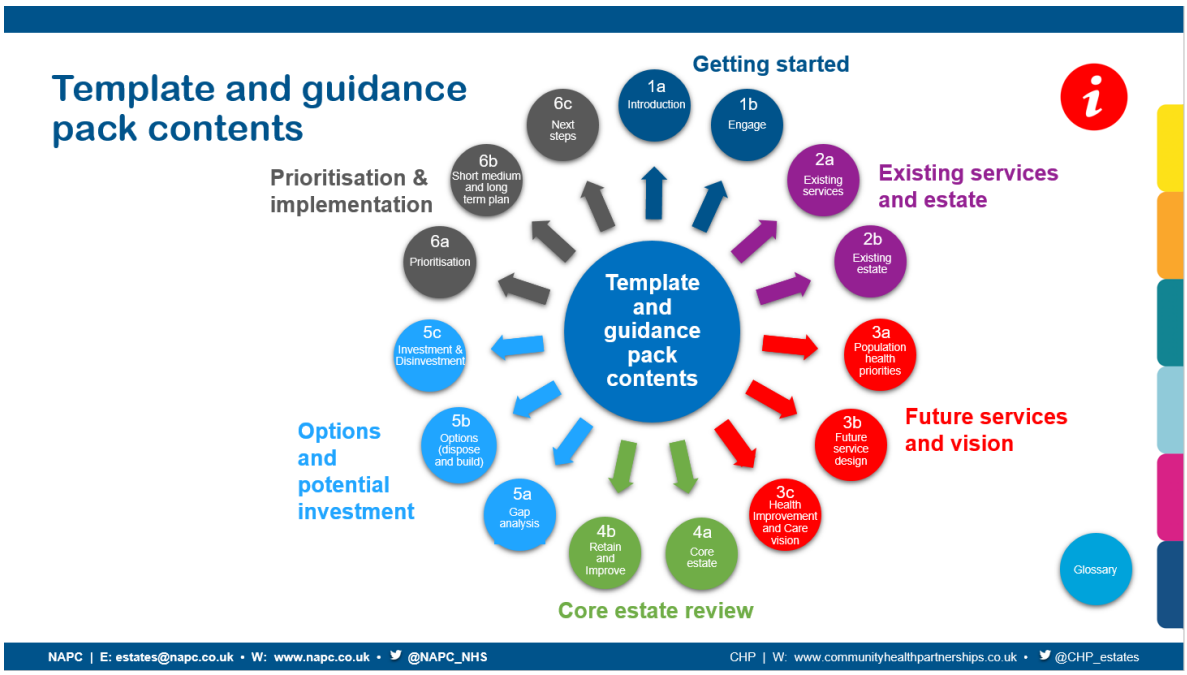
The benefits of the PCN Toolkit are to develop and articulate a standardised and consistent approach in identifying and delivering Prioritised short, medium, and long-term primary care capital investment & disinvestment plans and key challenges to delivery (e.g. negative equity)

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

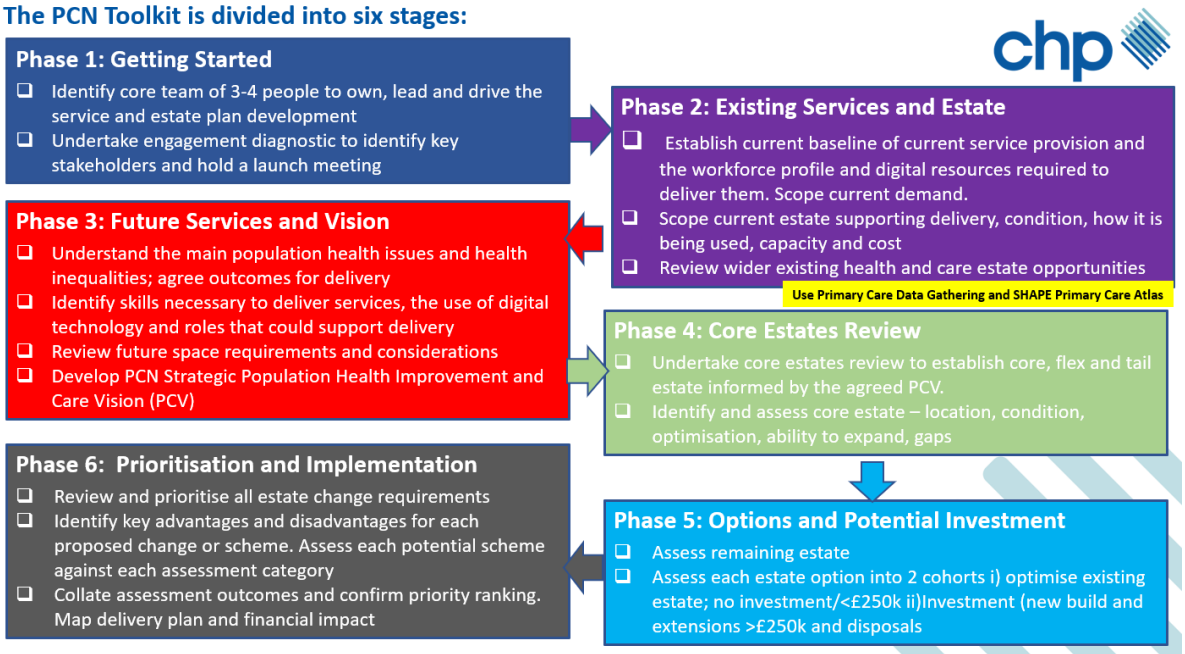
a. To enable each PCN to identify and prioritise their estate optimisation, disinvestment and any subsequent capital investment requirements to address population health priorities and future service needs.

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

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



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



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

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

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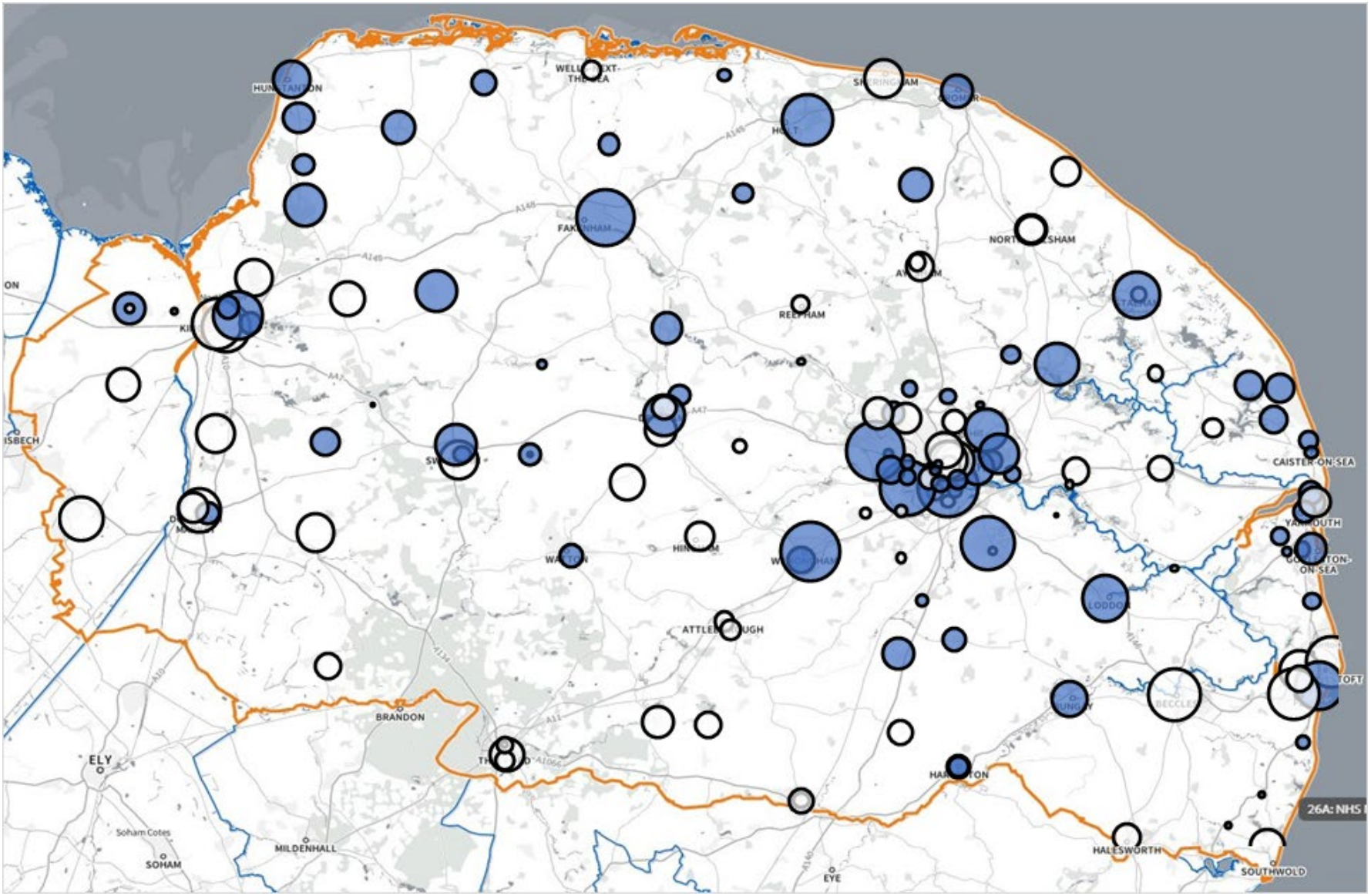
Appendix 3. Premises Capacity Surplus / Deficit: June 2022



Key Blue = Scaled Capacity White = Scaled Deficit

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Norfolk and Waveney
Integrated Care Board

Item 10

Subject:	Digital Update for Primary Care
Presented By:	Anne Heath, Head of Digital
Prepared By: **Date:**	Anne Heath 29th July 2022
Submitted To:	Primary Care Commissioning Committee
Purpose of Paper:	To provide an update on Digital projects and innovations
Executive summary Digital initiatives are going well, there is a lot of demand and involvement from practices.	
Clarification sought: **none**	

1.0 Current Position of Digital Projects and Initiatives

Clinical Systems

3 Practices in the area are currently changing their clinical system, from Emis to SystmOne. This has been driven by poor performance of Emis in one case, and PCN digital maturity in the other 2 cases, where convergence of systems will make for more effective working for staff in the Additional Roles and for initiatives such as enhanced access. A 4th practice has expressed interest in a switch. Currently, 19/105 practices use Emis, the rest SystmOne.

Shared Care Record

The Shared Care Record project is now in the implementation phase, with roll out planned around October 2022. Currently, the team to support the roll out is being recruited and the technical enablement work is underway.

Digitising Adult Social Care

NHS England has made funding available for a digital social care record (electronic care plan) for Care Homes and Domiciliary Care Providers, and also for Falls Prevention Technology in Care Homes. The digital social care record will integrate with the Shared Care Record and help in bringing a full view of information about the person to anyone in health and social care who is working with the individual, such as if a care home resident attends A&E.

Remote monitoring

Some GP Practices across Norfolk & Waveney, along with their aligned Care Homes, are undertaking a trial of remote monitoring technology. Staff in care homes will take observations remotely using Bluetooth enabled devices and the results can be seen on a dashboard at the GP Practice. NHS 111 will also make use of the observations in a trial of virtual ward rounds at the weekends.

SD-WAN

Software defined wider area network technology will be installed in all GP Practice premises towards the end of the year. This will bring better wi-fi and resilience to practices.

At the end of June, a number of practices suffered a network outage that was caused by a failure in both the primary and secondary HSCN (Health and Social Care Network) circuits. This should be a never event, but has happened twice on a wide scale now, and more often to some individual practices. The HSCN contract will expire in October 2023. Implementation of SD-WAN ahead of that will mean that a more resilient solution is in place by the time the contract expires.

Practice telephony

The NHSx funded cloud telephony platform for Norfolk & Waveney has been built and around 30 practices are currently live on the new system. The platform allows practice telephony to be used remotely from any internet connected device, so is great for home working and staff who work across multiple practices in a PCN. The system provides call transfer between any other practice on the platform free of charge so will support working at scale, such as for digital triage or enhanced access. The system comes with software that has direct integration with the clinical system. Costs are competitive. There is funding available for all practices to join the platform.

Technology refresh in GP Practice

The planned upgrade and replacement of IT kit in practices is underway, between 1 and 3 practices a week are being completed, depending on the number of PCs that need to be replaced, so the upgrade will go on for some time.

Cyber incidents

There has been an increase in the number of staff in primary care falling victim to phishing emails, which in themselves are on the increase. However, overall the proportion of staff is very small. The NHS Mail team have announced changes that are coming to better proactively identify phishing emails and warn users when they click onto sites or email addresses they have not previously used.

Digitisation of Lloyd George Notes

The programme to digitize paper notes at Emis practices is underway – the procurement is completed and a programme to uplift notes from practices and digitize them will shortly commence.

The work agreed by PCCC for some SystmOne practices is also progressing. The new national offer has been sent round for consultation, this looks like a good initiative which will benefit all practices.

Online Consultations market events

Practices were recently invited to view alternative online consultation systems at a market engagement event. Online consultation systems are contracted on an annual basis so practices are encouraged to consider their requirement for the year ahead around 3 or 4 months in advance of their contract ending, to plan for a smooth transition. Less than 5 practices have opted to move away from FootFall to date.

Digital Journey planner

An initiative by Redmoor Health, funded by NHS England, enables practices to measure their digital maturity and plan where they would like to develop or explore digital initiatives. A number of practices have currently signed up for this and are working through the toolkit.

Social Media

An independent study found that over half of all GP Practices in Norfolk and Waveney have unofficial social media accounts – this might be a Facebook or Twitter account set up in the name of the practice, but not by the practice. Where this has occurred, the intention is usually not good. Practices are being encouraged to have an official social media presence, and support is being provided to maintain and monitor this. Studies elsewhere have shown that it can be helpful in getting messages out to the public, whether these be health promotion or flu clinic information for example. Use of social media and push messaging via the NHS App may help to reduce the text message bill which has risen by 500% since the pandemic.

2.0 Development – national context, governance and finance

The technical strategies for cloud and wi-fi enablement that we have implemented here have garnered national interest which may lead to further investment.

Developments in the NHS App are in train, which will enable patients to receive messages from the practice, and to use online consultations via the app, as well as to view records.

3.0 Future Deliverables and Priorities

A re-draft of the Digital Strategy for Primary Care has been undertaken and will be shared with Primary Care for further input over the coming weeks.

4.0 Next steps

Continue with cloud strategy, wi-fi and other technology enablers for primary care and PCNs

5.0 Risks

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 Governing Body Assurance Framework	

Norfolk and Waveney
Integrated Care Board

Item 11

Subject:	**Briefing - Recent Care Quality Commission (CQC) inspection**
Presented by:	**Shepherd Ncube – Head of Delegated Primary Care Commissioning**
Prepared by:	**Sarah Collingwood – Delegated Commissioning Manager Primary Care**
Submitted to:	**NHS Norfolk and Waveney ICB Primary Care Commissioning Committee**
Date:	**28 July 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:

- **Heacham Group Practice**

Executive Summary:

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

The CQC inspects against five key areas as follows:

Safe
Effective
Caring
Responsive
Well Led

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

GP Practice	Locality	Date of Inspection/ Re-inspection	Previous Rating/Year	New Overall Rating
Heacham Group Practice (7,691 actual list size 1/4/2022)	West Norfolk	8 March 2022	Good	Inadequate

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Report

Background

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

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

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

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

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

Heacham Group Practice, West Norfolk Locality – Inspected: 5 July 2022 **Overall rating: Inadequate**					
	Are services safe?	**Are services effective?**	**Are services caring?**	**Are services responsive to people's needs?**	**Are services well-led?**
Rating	Inspected but not rated				

The CQC carried out an announced inspection of Heacham Group Practice on 8 March 2022. Overall, the practice was rated as inadequate. As a result of the concerns identified the CQC issued a Section 29 warning notice on 24 March 2022 in relation to a breach of Regulation 12 Safe Care and Treatment, requiring them to achieve compliance with the warning notice by 15 June 2022.

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Why this inspection was carried out:

The CQC undertook a focused inspection on 5 July 2022 to check that the practice had addressed the issues in the warning notice and now met the legal requirements. This report only covers the CQC's findings in relation to those requirements and will not change the ratings. At the inspection, the CQC found that the requirements of the warning notice had been met.

How the inspection was carried out:

Throughout the pandemic, the 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, they 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 all 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 site visit

Key findings:

- The CQC found the practice leadership had been improved. The practice had worked together with the CCG/ ICB and engaged other external support members such as experienced management to ensure necessary improvements were made. The practice had employed more staff and strengthened the management team. Although not all improvements had been completed in respect of concerns identified in the warning notice, they had a clear action plan enabling new systems and processes to be embedded and sustained.
- The systems and processes in place had been improved to support safe use of medicines. However, some of these actions had not had sufficient time to be fully completed and some patients were still awaiting review.
- There was an improved system to manage patient safety alerts. The CQC noted the practice had fully reviewed historic alerts to ensure they understood and incorporated the risks associated with the alert. The CQC found not all GPs were fully aware of the changes and the practice told the CQC they were improving the monitoring of clinical staff who held prescribing qualifications.

- The practice was in the process of reviewing patients to ensure that regular, appropriate and comprehensive medicine reviews were undertaken. In addition to reviewing the medicines, the practice was actively reviewing the patients summary care records and updating them accordingly.
- The systems and processes in place supported the safe recruitment of new staff.
- The practice had improved their oversight to ensure all staff had received appropriate training. The practice had increased training awareness for example, awareness and care for patients with a learning disability and for patients who were carers.
- A system to ensure competency checks were undertaken to ensure staff were competent to undertake their duties had been implemented.
- The practice had implemented a system and process to ensure that when things went wrong, learning was shared and actions taken to make improvements. This included greater involvement of staff and sharing findings through the use of the practice intranet.

The provider must:

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

In addition to the breach of regulations the provider should;

- Continue to review and monitor progress to ensure patients receive an appropriate structured medicine review in a timely manner

Download the full report:

Heacham Medical Group inspection report

Download the evidence table:

Heacham Medical Group evidence table

Next steps:

The Delegated Commissioning team continues to work closely with the Locality team, Medicines Management Team and the Quality Team to ensure that the Practice continues to make improvements in the areas identified within the CQC report.

Since the report has been published, the Practice has enlisted additional external clinical and managerial staff in order to support the practice turn around. The Delegated Team remains assured that sufficient progress is being made.

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.

Norfolk and Waveney
Integrated Care Board

Agenda item: 11

Subject:	**Briefing - Recent Care Quality Commission (CQC) inspection**
Presented by:	**Shepherd Ncube – Head of Delegated Primary Care Commissioning**
Prepared by:	**Sarah Collingwood – Delegated Commissioning Manager Primary Care**
Submitted to:	**NHS Norfolk and Waveney Primary Care Commissioning Committee**
Date:	**21 July 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:

- **Orchard 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
Orchard Surgery (11,152 actual list size 1/4/2022)	South Norfolk	14 June 2022	Good 2016	Inadequate

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Report

Background

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

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

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

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

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

Orchard Surgery, South Norfolk Locality – Inspected: 14 June 2022 **Overall rating: Inadequate**					
	Are services safe?	**Are services effective?**	**Are services caring?**	**Are services responsive to people's needs?**	**Are services well-led?**
Rating	Inadequate	Inadequate	Good	Requires Improvement	Inadequate

Following the CQC's previous comprehensive inspection in April 2016 the practice was rated at Good overall and Good in all domains.

The CQC carried out an announced inspection on Orchard Surgery on 14 June 2022. Overall, the practice was rated as Inadequate.

The ratings for each key question were:

- Safe - Inadequate

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

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 Inadequate overall.

CQC found that:

- The practice failed to demonstrate they delivered safe and effective care to all their patients.
- The practice systems and processes in place did not ensure good governance to protect patients and staff from the risk of harm.
- We found there was a lack of leadership and oversight from the provider to ensure services were delivered in a safe and effective way to patients.
- Staff dealt with patients with kindness and respect and involved them in decisions about their care.

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CQC found breaches of regulations. The provider must:

- Ensure care and treatment is provided in a safe way to patients
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

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

- Reduce the backlog of patient records awaiting full summarising
- Continue to encourage the uptake of cervical screening.
- Review the system and process to ensure all patients with a learning disability receive an annual review.
- Review and improve the opportunities for patients to access health checks.

The CQC has placed this service in special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, the CQC will take action in line with their enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement, the CQC will move to close the service by adopting their proposal to remove this location or cancel the provider's registration.

Special measures will give people who use the service the reassurance that the care they get should improve.

As a result of the findings from the CQC's inspection, as to non-compliance, the CQC decided to issue a notice of decision to impose conditions on the provider's registration.

Background to Orchard Surgery

Orchard Surgery is located in Dereham at:

Commercial Road
East Dereham
Norfolk
NR19 1AE

The provider is registered with CQC to deliver the Regulated Activities; treatment of disease, disorder or injury, surgical procedures, diagnostic and screening procedures, maternity and midwifery services and family planning services.

The practice is situated within the Norfolk and Waveney Integrated Care System (ICS) and delivers General Medical Services (GMS) to a patient population of about 11300. This is part of a contract held with NHS England.

The practice is part of a wider network of GP practices which make up the Mid Norfolk Primary Care Network (PCN).

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

According to the latest available data, the ethnic make-up of the practice area is 99% White, 1% Asian and 1% Mixed. The age distribution of the practice population mirrors the local and national averages.

There is a team of four GP partners who provide cover at the practice. The practice has a team of two nurses who provide nurse led clinics. The GPs are supported at the practice by a team of reception/administration staff. The practice manager and deputy practice manager are based at the practice location to provide managerial oversight.

The practice is open between 8 am to 6 pm 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 by the practice with early morning appointments available on Thursdays. Out of hours services are provided by IC24 and accessed by calling the NHS111 service.

Download full report

Orchard Surgery CQC Report

Download evidence table

Orchard Surgery Evidence Table

Next steps:

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

Since the report has been published the practice has demonstrated engagement in the turnaround work and has sought additional managerial and clinical support from the South Norfolk General Practice Provider organisation, the Royal College of General Practitioners, an external experienced GP (who specialises in organisational development) and neighbouring practices.

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

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.

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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.

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Norfolk and Waveney
Integrated Care Board

Agenda item: 11

Subject:	**Briefing - Recent Care Quality Commission (CQC) inspection**
Presented by:	**Shepherd Ncube – Head of Delegated Primary Care Commissioning**
Prepared by:	**Sarah Collingwood – Delegated Commissioning Manager Primary Care**
Submitted to:	**NHS Norfolk and Waveney Primary Care Commissioning Committee**
Date:	**28 July 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:

- **Manor Farm Medical Centre**

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/ Inspection	Previous Rating/Year	New Overall Rating
Manor Farm Medical Centre (7,493 actual list size 1/4/2022)	West Norfolk	31 March 2022	Good	Inadequate

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.

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Manor Farm Medical Centre, West Norfolk Locality – Inspected: 11 July 2022 Overall rating: Inadequate					
	Are services safe?	**Are services effective?**	**Are services caring?**	**Are services responsive to people's needs?**	**Are services well-led?**
Rating	Inspected but not rated				

The CQC previously carried out an announced comprehensive inspection at the practice on 31 March 2022. The practice was rated as inadequate overall and placed into special measures. As a result of the concerns identified, the CQC issued the practice with a warning notice relating to a breach of Regulation 12, Safe Care and Treatment, requiring them to achieve compliance with the regulation by 10 June 2022.

Why this review was carried out

The CQC undertook a focused review on 11 July 2022 to verify that the practice had addressed the issues in the warning notice and now met the legal requirements. This report only covers findings in relation to those requirements and will not change the ratings.

At the inspection, it was found that the provider had made improvements to mitigate the risks identified in the warning notice.

How this review was carried out

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, they have conducted our inspections differently.

This review was carried out without the need to make a site visit. This was with consent from the provider and in line with all 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

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The CQC's findings

The provider had made improvements to mitigate the risks identified in the warning notice.

For example:

- The CQC saw that medicines were prescribed safely to patients.
- The CQC saw that the dispensary was secure and improvements had been made.
- The CQC saw the practice had implemented a new policy to ensure that safety alerts were incorporated, reviewed and monitored by the practice.
- The CQC saw the practice had oversight of the immunisation status of staff who may be at risk of harm.
- The CQC saw that all members of staff had received a DBS check, in line with the practice's policy.

Whilst the CQC found no breaches of regulations, the provider should

- Continue to monitor and embed the new systems and processes which have been implemented to ensure they continue to be effective and are sustained.
- Continue to improve record keeping and document safety netting in patient records.
- Assess if asthmatic patients who had received two or more courses of steroids might benefit from receiving a steroid card.

Download the full report:

Manor Farm CQC Report

Download the evidence table:

Manor Farm Evidence Table

Next steps:

The Delegated, Locality, Quality and Medicines Management teams continue to work closely together with the Practice on their action plan. Teams are meeting regularly and the Delegated Team is assured that the Practice is engaged in embedding change within the action plan and working towards improvements within the Practice, focusing heavily on the areas within the warning notice and the domain areas of 'Safe', 'Effective' and 'Well-led'. The action plan illustrates the dedication within the Practice to address areas of concern to ensure that services are delivered in a safe and effective manner.

Since the report has been published excellent progress has been made with the action plan, and the Practice continues to enlist the support of additional management staff in order to support the practice turn around.

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

GOVERNANCE

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

Improving lives together
Norfolk and Waveney Integrated Care System

Agenda item: 12

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:	**9 August 2022**

Purpose of paper:

Information

Executive Summary:

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

1. Prescribing team focus areas

1.1 The newly merged prescribing teams are working on delivering or facilitating the delivery of the necessary efficiency savings. The team is however also supporting the vaccination programme, and practices at risk. The CSU and CCG teams have now joined to form the ICB medicines team as of 1st July. We are also working to fill the vacancies that the CSU have been carrying - all vacancies have been posted to TRAC and are awaiting authorisation.

1.1.1 Current vacancies:
Band 4 Medicines Optimisation Administrator (x1)
Band 5 Medicines Optimisation Support Technician (x1)
Band 7 Medicines Optimisation Support Pharmacist (x3)
Band 8a Medicines Optimisation Pharmacist (x1)

Band 8c ICS Community Pharmacy Clinical Lead (x1) – funded by NHSE

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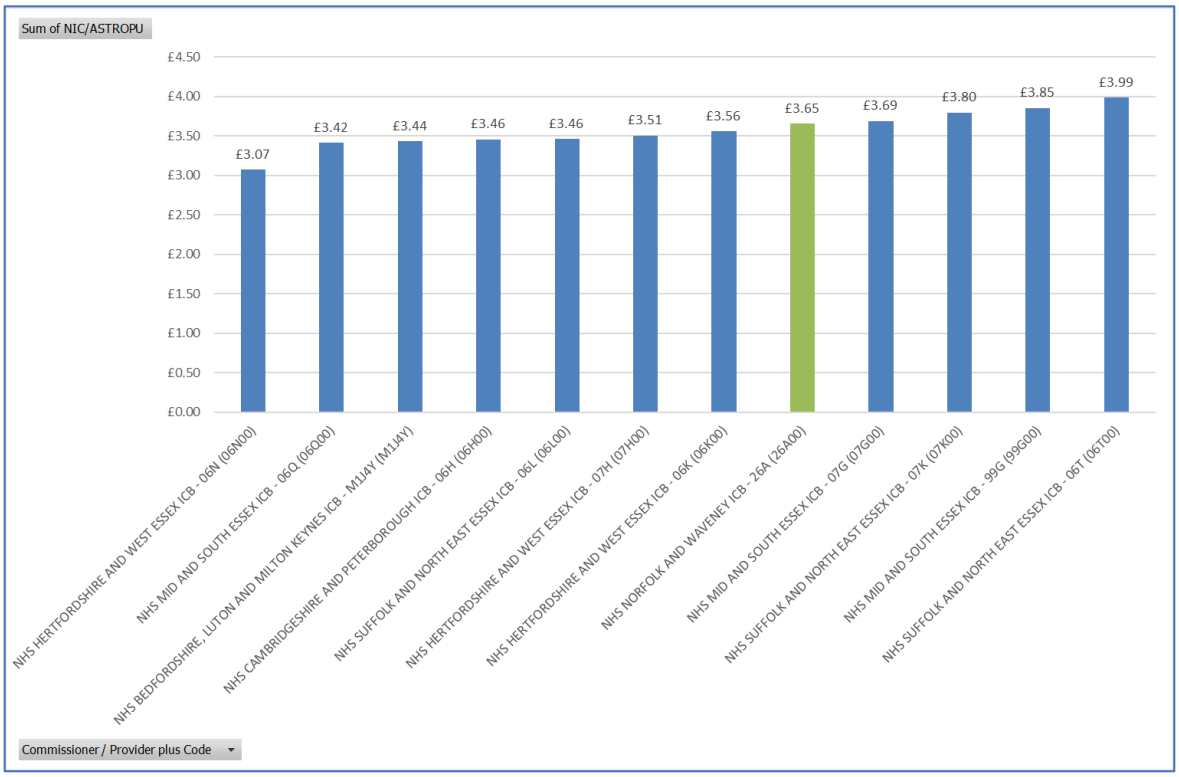
1.2 The prescribing quality scheme has been launched and the data monitoring has been finalised. The team are now meeting with practices to work on plans to implement the schemes.

1.3 The funded low risk cost effective switch programme has also been launched.

2. CCG/ICB Prescribing Performance

2.1 Net ingredient cost (NIC) per AstroPU (an attempt to normalise practice demographics) below is a proxy measure of relative cost-effectiveness. However, this does not take account of deprivation which is a key driver of prescribing spend. Norfolk and Waveney remain the 5th highest normalised raw spend of East of England CCGs at £3.65 with a downward trajectory in this spend (the mean spend is £3.575).



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.

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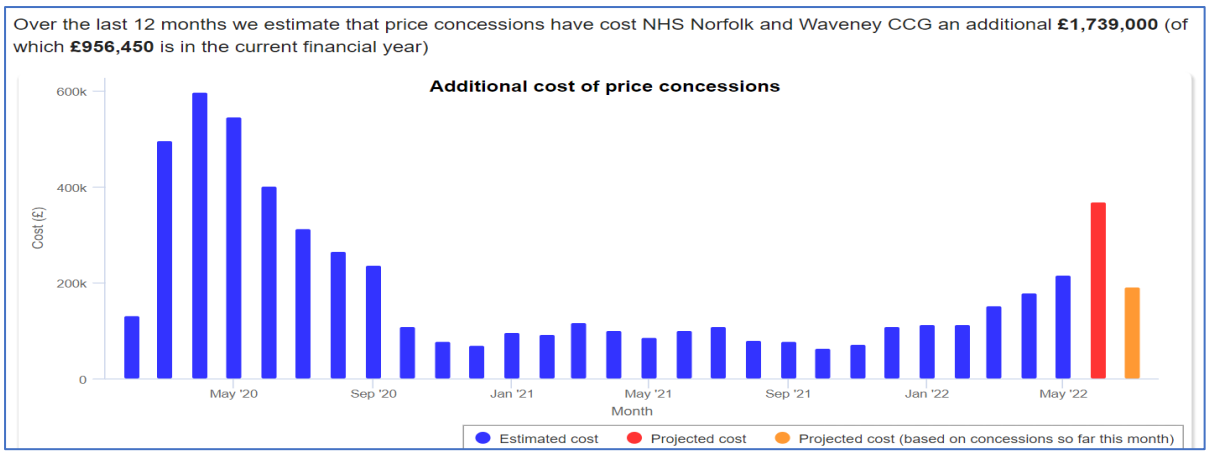
The £800m retained margin element is a target that the Department of Health and Social Care (DHSC) aim to deliver by adjusting the reimbursement prices of drugs in Category M of the Drug Tariff.

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

2.5 The cost of all prescribing year to date (as of March 2022 data) is £171,798,785 and an end of year underspend of £2.3m against our budget (-1.3%) after taking off recharges and rebates.

There are adjustments to Cat M prices in Q1, Q2, Q3 and Q4 which will have an impact on outturn. Category M prices are adjusted quarterly so that the community pharmacy contract remains within its overall financial envelope
In Q1 an increase of £3.47million per month in England (approx. £75,000 for N&W)
In Q2 a decrease of £16.3 million per month in England (approx. £347,000 for N&W)
InQ3 a decrease of £8.9 million per month in England (approx. £473,000 for N&W)
In Q4 a decrease of £16.4 million per month in England (approx. £837,000 for N&W)
NCSO
A price concession agreed by the department of Health when a product cannot be sourced at the drug tariff price
The impact of price concessions continues

Table 1. Bar chart of NCSO additional costs over time



Indications are that there will be no growth in Category M prices in April 2022

There is also significant inflation in category A prices for example ascorbic acid tablets 200mg and above now cost more than £1 per tablet when prescribed

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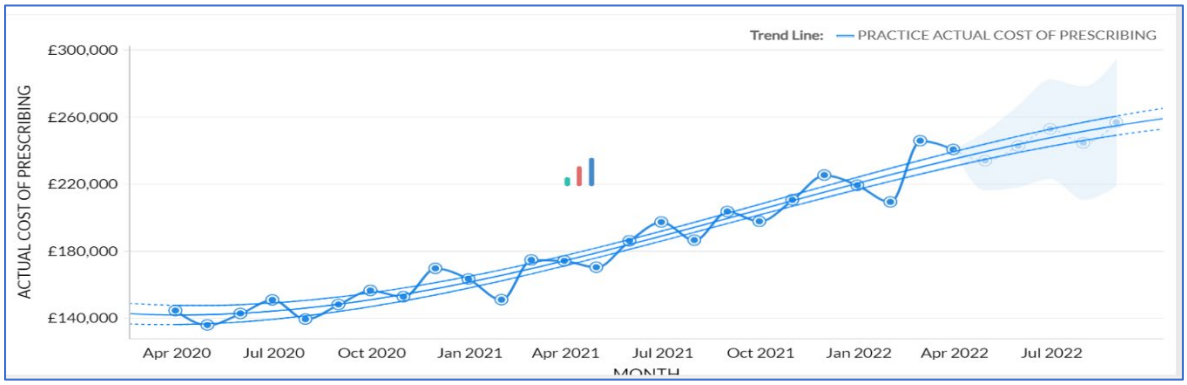
but can be purchased for £1.99 for 30. Lower strengths are almost as expensive.

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 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 2. 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 May 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 CCGs.

3.3 Practices identified to be the highest users (our top outliers) for hypnotics, anxiolytics and gabapentinoids will be offered audit and action plan development support.

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- **High dose opiates – a small increase in use to 76th (out of 106 organisations 28th percentile on high dose opiate items as percentage of regular opiates**
- **Gabapentinoids – stayed at 28th (previously 28th nationally (74th percentile) on defined daily doses of gabapentin and pregabalin**
- **Hypnotics and anxiolytics – remained at 3rd nationally (98th percentile) volume per 1000 patients – the trend (below) is however an improving one (yellow dotted line is Norfolk and Waveney performance and trend respectively)**

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

Table 3. Anxiolytics and hypnotics volume trend over time by top prescribing ICBs nationally

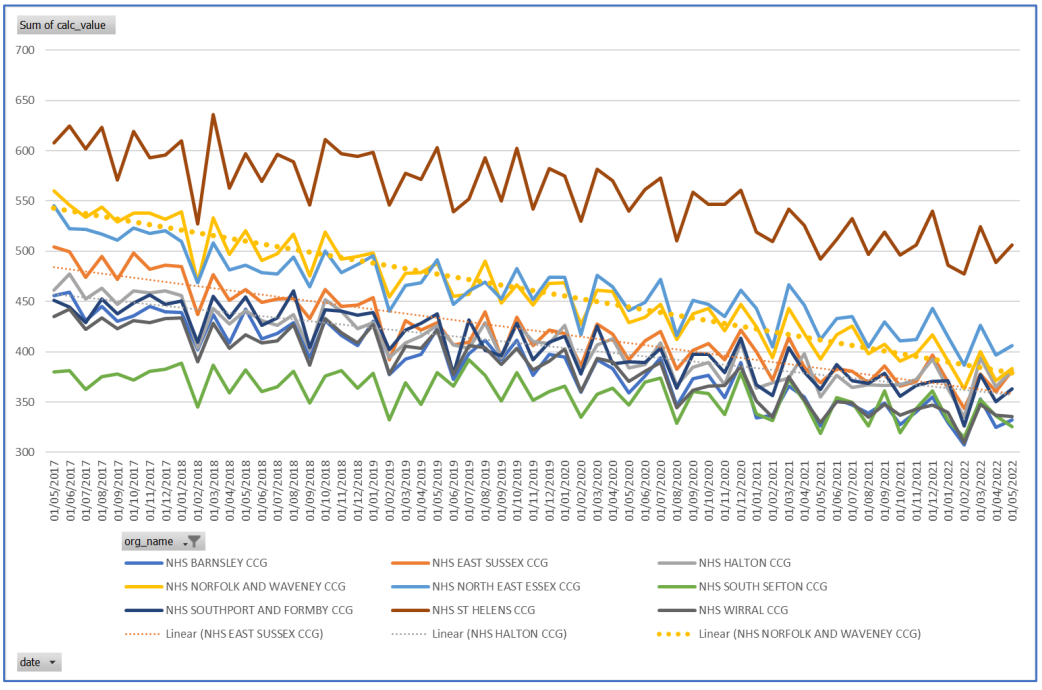

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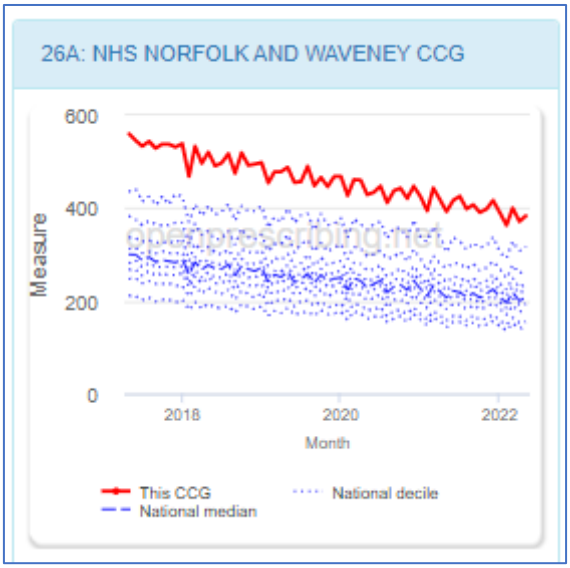
Table 4. Anxiolytics and hypnotics volume trend over time (red line is Norfolk and Waveney and darker blue line is national average)



3.4 We are 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 DFMs with a particular focus on opioids initially. Next steps include looking at aligning services and capacity, if possible to facilitate delivery of aspects of the pathway.

4 Antibiotic Prescribing

4.1.0 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 PCNs. Norfolk and Waveney is still above the new volume target of 0.871 with a value of 0.951 antibacterial items per STAR-PU in the 12 months to April 22. (Increase of 0.015 on March 2022) There is a trend of increasing antibacterial items per STAR/PU for Norfolk and Waveney. Nine PCNs are above this level, additionally there are now four PCNs, West Norfolk PCN and Fens & Brecks PCN, Kings Lynn PCN and Swaffham and Downham PCN, above the second target of 0.965.

4.2 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 10.48% in the 12

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months to May 2022 (a decrease from 10.52% in April 2022). A reduction in the overall percent of broad-spectrum antibiotics is possibly linked to the increase in overall antimicrobial prescribing. All practices need to continue to focus on this area of prescribing, documenting the indication for an antibiotic, following the local antimicrobial guidelines and microbiology advice as appropriate.

Table 5. CCG Position against NHS AMR metric 2021/22 – May 2022

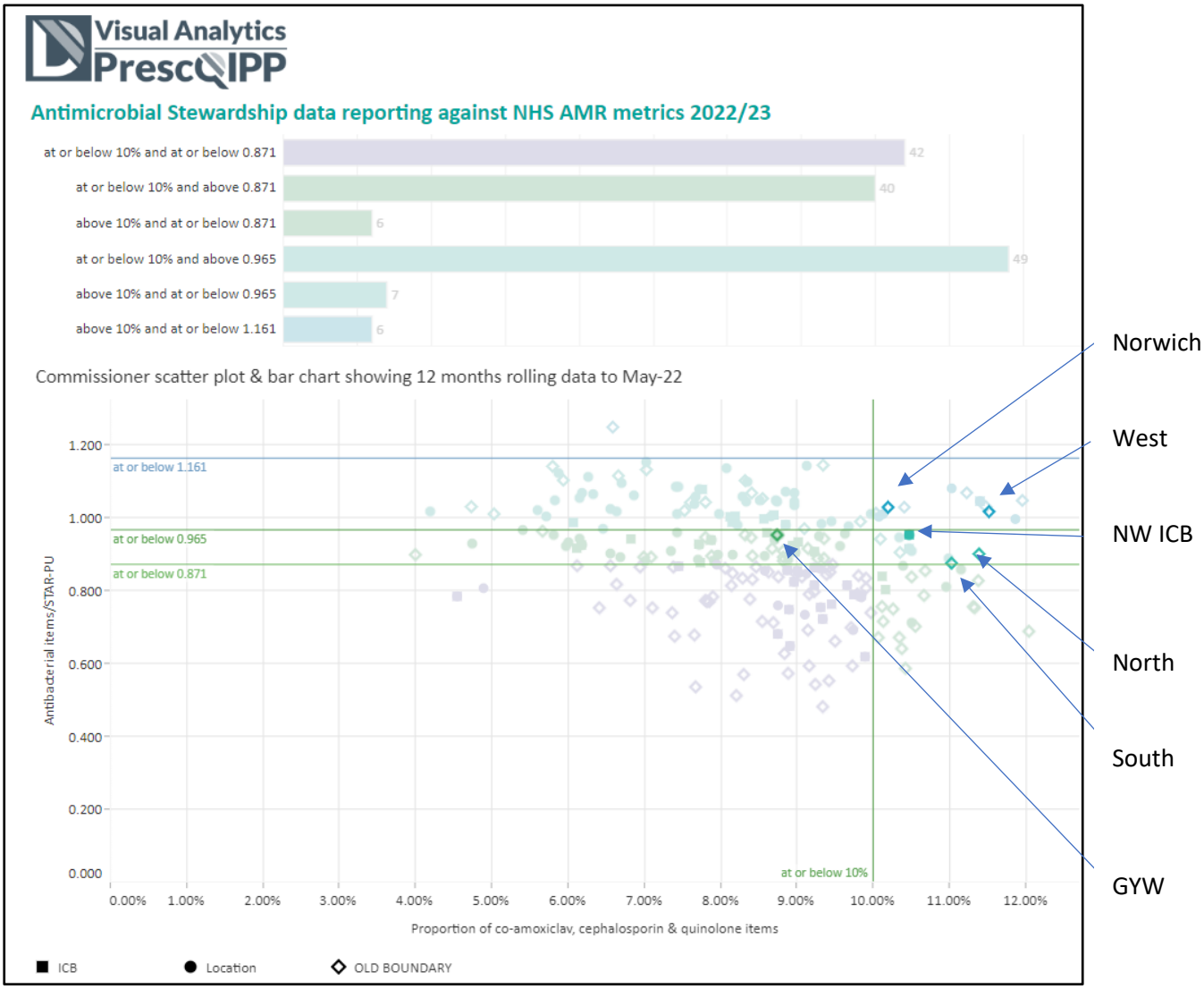

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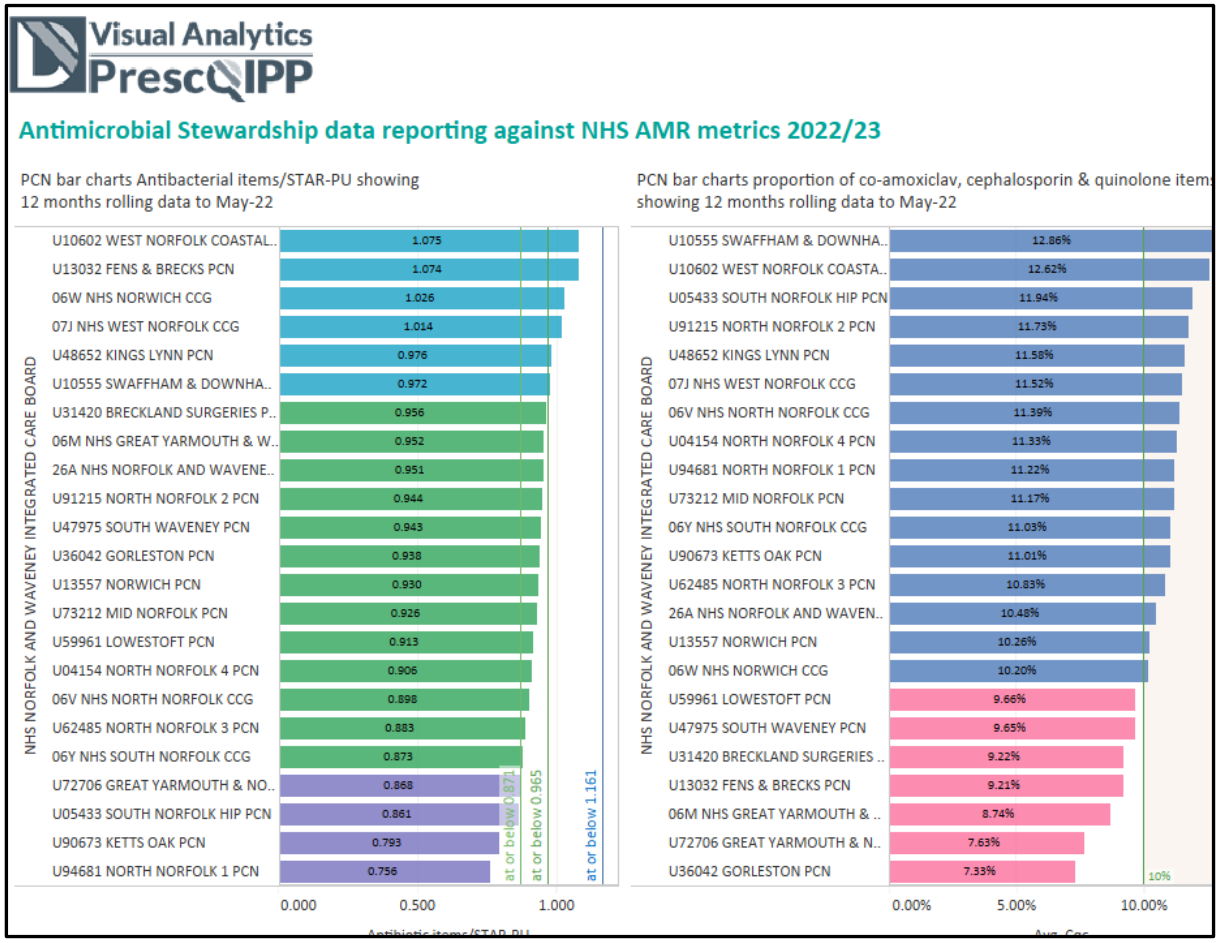
Table 6. PCN bar charts – Antimicrobial prescribing 12 months to end May 2022



4.3 Our outlier practices that are driving the higher percentage of Broad-spectrum antibiotics in May data are.

Row Labels	% Broad Spectrum Antibiotics (May 2022)	Sum of percentile
BURNHAM SURGERY	0.19	99.32
ELMHAM SURGERY	0.18	99.25
MUNDESLEY MEDICAL CENTRE	0.17	99.03
LITCHAM HEALTH CENTRE	0.17	98.93
BRIDGE STREET SURGERY	0.17	98.86

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ALDBOROUGH SURGERY	0.17	98.63
PLOWRIGHT MEDICAL CENTRE	0.17	98.62
E HARLING & KENNINGHALL MEDICAL PRACTICE	0.17	98.45
GRIMSTON MEDICAL CENTRE	0.17	98.40
TOFTWOOD MEDICAL CENTRE	0.16	97.74
THE LIONWOOD MEDICAL PRACTICE	0.16	97.48
CHURCH HILL SURGERY	0.15	97.25

5 Prescribing Quality Scheme (PQS)

5.1 95 out of 105 practices have signed up to take part in the scheme. Three practices have declined to take part.

6 Low risk, Cost-effective Prescribing QIPP Support Scheme

6.1 In addition to the Prescribing Quality Scheme (PQS), there is also a QIPP scheme for General practice to implement low risk, cost effective drug switches in primary care

6.2 The scheme is open to all practices. Payment is based on staff time taken to complete the switch work. Extra money is available for those practices that complete the switches before 31 August 2022.

Practices will be able to claim up to their maximum allocation of 20p per patient. Each practice's maximum allocation can be found in Appendix 2 of the project document

- 20p per patient on list for performing all switches within 2 months.
- 10p per patient on list for completing the work in greater than 2 months
- 5p per patient if agreeing to take part but needing hands-on support from the medicines optimisation team.

6.3 51 out of 105 practices have signed up to take part in the scheme

6.4 The scheme was signed off by the Clinical Executive Committee and the finances were signed off by the Executive Management Team. The scheme document is in Appendix 1 for information.

Recommendation to Governing Body/ Committee:

The committee is asked to note this report

Key Risks

Clinical and Quality:	Some key quality areas need focus and outlier performance needs addressing. Mitigated through the prescribing quality scheme
Finance and Performance:	Risks highlighted in report
Impact Assessment (environmental and equalities):	Not applicable
Reputation:	ICB practices remain outliers for hypnotics and anxiolytics as highlighted in the report
Legal:	Not applicable
Information Governance:	Not applicable
Resource Required:	Medicines management team support to practices
Reference document(s):	Not applicable
NHS Constitution:	N/A
Conflicts of Interest:	GP dispensing practices may be conflicted with competing financial interests associated with dispensing costs
Reference to relevant risk on the Governing Body Assurance Framework	Prescribing cost risk noted on register

GOVERNANCE

Process/Committee approval with date(s) *(as appropriate)*	Monthly report to PCCC

Norfolk and Waveney
Clinical Commissioning Group

Low risk, Cost-effective Prescribing QIPP Support Scheme 1st July 2022 to 30th September 2022

FINAL v1.0

This scheme is open to all practices within Norfolk and Waveney CCG.

This scheme is **in addition** to the Prescribing Quality Scheme.

Queries

Please use the following email address nwccg.medsqueries@nhs.net for all queries relating to this scheme.

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1. Aim

The aim of this scheme is to provide reimbursement to practices for work done to achieve delivery of agreed low risk, cost effective prescribing QIPP projects carried out from 01 July 2022 to 30 September 2022.

2. How does this scheme work?

1. Practice to send an email to nwccg.pqs@nhs.net to confirm their participation in this scheme by 01 July 2022. Your practice will receive a confirmation email back from the CCG.

2. Practice to email the CCG monthly to inform them of the switches the practice has undertaken plus the number of hours to be charged using form in **Appendix 1**

3. Practices will be sent a letter in September 2022 informing them of the amount they will be paid by the CCG (ICB) for the staff time used. This will cover switches completed from 01 July - 31 August 2022.

4. Practices will be sent a letter in October 2022 informing them of the amount they will be paid by the CCG (ICB) for the staff time used for any further work completed after the end of 31 August 2022 and by 30 September 2022

3. What can my practice claim for?

Practices will be able to claim for pharmacist/administrator time needed to complete prescribing QIPP switches listed below based on the following hourly rates.

- Pharmacist work - £28.09 an hour (agenda for change mid-point band 7)
- Prescribing Clerk/administrative role - £14.09 (agenda for change band 3)

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Practices will be able to claim up to their maximum allocation of 20p per patient. Each practice's maximum allocation can be found in Appendix 2.

- 20p per patient on list for performing all switches within 2 months.
- 10p per patient on list for completing the work in greater than 2 months
- 5p per patient if agreeing to take part but needing hands-on support from the medicines optimisation team.

Practices will need to keep track of how much of their allocation they have used as they complete projects. If a practice is unsure how much allocation they have used they can contact the CCG Medicines Optimisation team via email NWCCG.pqs@nhs.net .

4. When can the practice claim for payment?

For work completed in the period 1 July 2022 to 31 August 2022
Each practice will be informed of the amount they will be paid by letter in September 2022.

For work completed in the period 01 September 2022 to 30 September 2022
Each practice will be informed of the amount they will be paid by letter in October 2022.

5. Pharmacist led QIPP projects

1. Buprenorphine 7-day patch generic & Butrans (5mcg, 10mcg,15mcg, 20mcg): change to Sevodyne or Reltrans

2. Concerta XL (& generic methylphenidate) XL 18mg, 27mg, 36mg, 54mg: change to branded Xaggitin XL – **currently out of stock so hold on doing this switch until stock is available.**

3. Fentanyl transdermal patch 12mcg 25mcg 50mcg 75mcg 100mcg: change to branded Matrifen

4. Longtec MR tablets 5mg 10mg 20mg 30mg 40mg 60mg 80mg: change to branded Oxypro

5. Oxycodone HCl MR tablets 5mg 10mg 15mg 20mg 30mg 40mg 60mg 80mg (generic and expensive brands): change to branded Oxypro

6. Administrator led QIPP switching projects (with supervision)

1. Abilify 10mg tablets: change to generic Aripiprazole
2. Adcal D3 chewable tablets: change to branded Calci D 1 daily
3. Arimidex 1mg tablets: change to generic Anastrozole
4. Azopt 10mg/ml eye drops: change to generic Brinzolamide
5. Cerazette 75mcg tablets: change to generic Desogestrel
6. Cialis 10mg, 20mg tablets: change to generic Tadalafil
7. Co-codamol 8/500mg,15/500mg capsules: change to Co-codamol tablets (not soluble) (Unless self-care is appropriate on the 8/500mg)
8. Colpermin EC 0.2ml MR capsules: Changeto generic Peppermint oil gastro-resistant capsules 0.2ml
9. Cosopt 20mg/ml 5mg/ml eye drop: change to generic Dorzolamide20mg/Timolol 5mg/ml
10. Diltiazem HCI 60mg MR tablets: change to branded Tildiem MR 60mg
11. Ezetrol 10mg tablets: change to generic Ezetimibe 10mg
12. Fluticasone/Salmeterol inhaler 125/25mcg, 250/25mcg 120D: changed to branded Sereflo
13. Hylo-forte Sod hyaluronate 0.2% PF eye drops 10ml: change to Hydramed 0.2% PF
14. Imigran 50mg,100mg tablets: change to generic Sumatriptan
15. Isosorbide mononitrate 60mg MR tablets: change to branded Monomil XL 60mg
16. Keppra 250mg, 500mg, 750mg 1gm tablets: change to generic Levetiracetam
17. Lyrica 25mg 50mg 75mg 100mg 150mg 200mg 225mg 300mg capsules: change to generic Pregabalin
18. Mirapexin 0.18mg tablets: change to generic Pramipexole 0.18mg
19. Movicol powder sachet 13.8gm(lem&lime):change to Cosmocol
20. Movicol plain powder sachet 13.7gm: change to Cosmocol

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21. Mucodyne 375mg capsules: change to generic Carbocisteine
22. Nasonex aqueous nasal spray 50mcg 140D: change to generic Mometasone
23. Nexium GR 20mg tablets: change to generic Esomperazole
24. Olanzapine orodispersible tablets 5mg 10mg 20mg: change to Olanzapine orodispersible tablets SF
25. Omeprazole 20mg tablets dispersible(EC pellets): change to Omeprazole capsules
26. Omeprazole EC 20mg 40mg tablets: change to Omeprazole capsules
27. Quetiapine MR 50mg 150mg 200mg 300mg 400mg tablets: change to branded Sondate XL MR tablets
28. Rivastigmine transdermal patch 4.6mg/24hrs: change to branded Alzest
29. Ropinorole HCI tablets MR 2mg 4mg 8mg: change to branded Ippinia XL tablets
30. Seretide evohaler 50mcg, 125mcg, 250mcg 120D: change to Sereflo
31. Singulair 10mg tablets: change to generic Montelukast
32. Sirdupla 125mcg/25mcg 250mcg/25mcg 120D inhaler: change to Sereflo
33. Tamsulosin 400mcg MR tablets : change to generic Tamsulosin 400mcg MR capsules
34. Topirimate 25mg 50mg capsules: change to Topirimate tablets
35. Travatan 40mcg/ml eye drops: change to generic Travoprost 40mcg/ml drops
36. Vesicare 5mg 10mg tablets: change to generic Solifenacin
37. Viagra 100mg tablets: change to generic Sildenafil
38. Xalacom eye drops: change to generic Latanoprost/Timolol 50mcg/ml +5mg/ml drops
39. Xalatan 50mcg/ml eye drops: change to generic Latanoprost

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7. Resources to support switching

Searches

All searches have been provided for S1

systm1 > reporting > clinical reporting > Norfolk and Waveney > Medicines Optimisation > QIPP Prescription searches

For EMIS searches please request via NWCCG.pqs@nhs.net

Switch Letters for Patients

A file of switch letters signed by Dr Mark Lim will be shared, these should be used for all switches performed. Any patient questions regarding this change, should be referred to Norfolk and Waveney CCG Contact Us team by phone on 01603 595857, or email: nwccg.contactus@nhs.net

8. Other points to note

- The CCG/ICB will review prescribing data (epact2 and Eclipse Live) throughout the year to validate claims.
- Practices cannot claim for a pharmacist to complete a piece of work which is appropriate for an administrative role and vice versa.
- **Claims cannot be made retrospectively for work that has already been completed.**

Appendix 1 – Template for submitting on completion of each agreed prescribing QIPP project

QIPP%20Submissio n%20Excel%20Sprea

Please email the completed Excel Spreadsheet to NWCCG.pqs@nhs.net by the 5th of the month following completion of the work.

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Appendix 2 - Practice allocation maximum payments (based on March 2022 list size)

Practice	List Size	20p/patient on list (work completed by 31 Aug 2022)	10p/patient on list (work completed after 31 August 2022)	5p/patient on list (work completed by CCG)
ACLE MEDICAL PARTNERSHIP	9,497	£1,899.40	£949.70	£474.85
ALDBOROUGH SURGERY	3,740	£748.00	£374.00	£187.00
ALEXANDRA & CRESTVIEW SURGERIES	14,886	£2,977.20	£1,488.60	£744.30
ANDAMAN SURGERY	6,600	£1,320.00	£660.00	£330.00
ATTLEBOROUGH SURGERY	18,752	£3,750.40	£1,875.20	£937.60
BACON ROAD MEDICAL CENTRE	4,678	£935.60	£467.80	£233.90
BEACHES MEDICAL CENTRE	24,987	£4,997.40	£2,498.70	£1,249.35
BECCLES MEDICAL CENTRE	19,659	£3,931.80	£1,965.90	£982.95
BEECHCROFT AND OLD PALACE	6,808	£1,361.60	£680.80	£340.40
BIRCHWOOD MEDICAL PRACTICE	11,770	£2,354.00	£1,177.00	£588.50
BLOFIELD SURGERY	7,867	£1,573.40	£786.70	£393.35
BOUGHTON SURGERY	3,228	£645.60	£322.80	£161.40
BRIDGE ROAD SURGERY	12,339	£2,467.80	£1,233.90	£616.95
BRIDGE STREET SURGERY	8,645	£1,729.00	£864.50	£432.25
BRUNDALL MEDICAL PARTNERSHIP	7,972	£1,594.40	£797.20	£398.60
BUNGAY MEDICAL CENTRE	11,398	£2,279.60	£1,139.80	£569.90
BURNHAM SURGERY	4,239	£847.80	£423.90	£211.95
CAMPINGLAND SURGERY	7,532	£1,506.40	£753.20	£376.60
CASTLE PARTNERSHIP	17,296	£3,459.20	£1,729.60	£864.80
CHET VALLEY MEDICAL PRACTICE	8,986	£1,797.20	£898.60	£449.30
CHURCH HILL SURGERY	4,508	£901.60	£450.80	£225.40
COASTAL VILLAGES PRACTICE	17,598	£3,519.60	£1,759.80	£879.90
COLTISHALL MEDICAL PRACTICE	8,808	£1,761.60	£880.80	£440.40
CROMER GROUP PRACTICE	12,321	£2,464.20	£1,232.10	£616.05
CUTLERS HILL SURGERY	10,472	£2,094.40	£1,047.20	£523.60
DRAYTON MEDICAL PRACTICE	18,322	£3,664.40	£1,832.20	£916.10
E HARLING & KENNINGHALL MEDICAL PRACTICE	8,657	£1,731.40	£865.70	£432.85
EAST NORFOLK MEDICAL PRACTICE	24,757	£4,951.40	£2,475.70	£1,237.85
EAST NORWICH MEDICAL PARTNERSHIP	15,493	£3,098.60	£1,549.30	£774.65
ELMHAM SURGERY	9,893	£1,978.60	£989.30	£494.65
FAKENHAM MEDICAL PRACTICE	15,547	£3,109.40	£1,554.70	£777.35
FELTWELL SURGERY	5,385	£1,077.00	£538.50	£269.25
FLEGGBURGH SURGERY	2,020	£404.00	£202.00	£101.00
GREAT MASSINGHAM SURGERY	6,409	£1,281.80	£640.90	£320.45
GRIMSTON MEDICAL CENTRE	5,179	£1,035.80	£517.90	£258.95

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Practice	List Size	20p/patient on list (work completed by 31 Aug 2022)	10p/patient on list (work completed after 31 August 2022)	5p/patient on list (work completed by CCG)
GROVE SURGERY	13,366	£2,673.20	£1,336.60	£668.30
HARLESTON MEDICAL PRACTICE	7,941	£1,588.20	£794.10	£397.05
HEACHAM GROUP PRACTICE	7,691	£1,538.20	£769.10	£384.55
HEATHGATE MEDICAL PRACTICE	9,808	£1,961.60	£980.80	£490.40
HELLESDON MEDICAL PRACTICE	10,756	£2,151.20	£1,075.60	£537.80
HIGH STREET SURGERY	12,484	£2,496.80	£1,248.40	£624.20
HINGHAM SURGERY	6,865	£1,373.00	£686.50	£343.25
HOLT MEDICAL PRACTICE	14,249	£2,849.80	£1,424.90	£712.45
HOVETON & WROXHAM MEDICAL CENTRE	9,719	£1,943.80	£971.90	£485.95
HOWDALE SURGERY	7,615	£1,523.00	£761.50	£380.75
HUMBLEYARD PRACTICE	21,761	£4,352.20	£2,176.10	£1,088.05
KIRKLEY MILL HEALTH CENTRE	6,717	£1,343.40	£671.70	£335.85
LAKENHAM SURGERY	8,635	£1,727.00	£863.50	£431.75
LAWNS PRACTICE	6,995	£1,399.00	£699.50	£349.75
LAWSON ROAD SURGERY	8,305	£1,661.00	£830.50	£415.25
LITCHAM HEALTH CENTRE	3,616	£723.20	£361.60	£180.80
LONG STRATTON MEDICAL PARTNERSHIP	11,262	£2,252.40	£1,126.20	£563.10
LONGSHORE SURGERIES	6,416	£1,283.20	£641.60	£320.80
LUDHAM AND STALHAM GREEN SURGERIES	5,842	£1,168.40	£584.20	£292.10
MAGDALEN MEDICAL PRACTICE	13,912	£2,782.40	£1,391.20	£695.60
MANOR FARM MEDICAL CENTRE	7,497	£1,499.40	£749.70	£374.85
MARKET SURGERY	10,016	£2,003.20	£1,001.60	£500.80
MATTISHALL SURGERY	8,582	£1,716.40	£858.20	£429.10
MUNDESLEY MEDICAL CENTRE	5,866	£1,173.20	£586.60	£293.30
NELSON MEDICAL CENTRE	6,226	£1,245.20	£622.60	£311.30
NORWICH PRACTICES HEALTH CENTRE	10,404	£2,080.80	£1,040.40	£520.20
OAK STREET MEDICAL PRACT.	7,776	£1,555.20	£777.60	£388.80
OLD CATTON MEDICAL PRACTICE	7,546	£1,509.20	£754.60	£377.30
OLD MILL AND MILLGATES MEDICAL PRACTICE	8,806	£1,761.20	£880.60	£440.30
ORCHARD SURGERY	11,154	£2,230.80	£1,115.40	£557.70
PARISH FIELDS PRACTICE	8,361	£1,672.20	£836.10	£418.05
PASTON SURGERY	6,722	£1,344.40	£672.20	£336.10
PLOWRIGHT MEDICAL CENTRE	6,055	£1,211.00	£605.50	£302.75
PROSPECT MEDICAL PRACTICE	6,814	£1,362.80	£681.40	£340.70
REEPHAM & AYLSHAM MEDICAL PRACTICE	9,120	£1,824.00	£912.00	£456.00
ROSEDALE SURGERY	15,392	£3,078.40	£1,539.20	£769.60
ROUNDWELL MEDICAL CENTRE	14,148	£2,829.60	£1,414.80	£707.40
SCHOOL LANE PMS PRACTICE	5,335	£1,067.00	£533.50	£266.75
SCHOOL LANE SURGERY	12,007	£2,401.40	£1,200.70	£600.35
SHERINGHAM MEDICAL PRACTICE	9,502	£1,900.40	£950.20	£475.10

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Practice	List Size	20p/patient on list (all work completed by 31 Aug 2022)	10p/patient on list (work completed after 31 August 2022)	5p/patient on list (work completed by CCG)
SHIPDHAM SURGERY	4,340	£868.00	£434.00	£217.00
SOLE BAY H/C	5,371	£1,074.20	£537.10	£268.55
SOUTHGATES SURGICAL & MEDICAL CENTRE	17,175	£3,435.00	£1,717.50	£858.75
ST CLEMENTS SURGERY	6,903	£1,380.60	£690.30	£345.15
ST JAMES MEDICAL PRACTICE	17,343	£3,468.60	£1,734.30	£867.15
ST JOHN'S SURGERY	6,288	£1,257.60	£628.80	£314.40
ST STEPHENS GATE MEDICAL PARTNERSHIP	18,478	£3,695.60	£1,847.80	£923.90
STALHAM STAITHE SURGERY	7,620	£1,524.00	£762.00	£381.00
TAVERHAM PARTNERSHIP	8,270	£1,654.00	£827.00	£413.50
THE HOLLIES SURGERY	4,788	£957.60	£478.80	£239.40
THE LIONWOOD MEDICAL PRACTICE	12,237	£2,447.40	£1,223.70	£611.85
THE MILLWOOD PARTNERSHIP	19,741	£3,948.20	£1,974.10	£987.05
THE PARK SURGERY	13,786	£2,757.20	£1,378.60	£689.30
THE WOOTTONS SURGERY	6,020	£1,204.00	£602.00	£301.00
THEATRE ROYAL SURGERY	8,730	£1,746.00	£873.00	£436.50
THORPEWOOD MEDICAL GROUP	12,679	£2,535.80	£1,267.90	£633.95
TOFTWOOD MEDICAL CENTRE	3,770	£754.00	£377.00	£188.50
TRINITY & BOWTHORPE MEDICAL PRACTICE	10,986	£2,197.20	£1,098.60	£549.30
UEA MEDICAL CENTRE	19,821	£3,964.20	£1,982.10	£991.05
UPWELL HEALTH CENTRE	10,773	£2,154.60	£1,077.30	£538.65
VICTORIA ROAD SURGERY	10,854	£2,170.80	£1,085.40	£542.70
VIDA HEALTHCARE	31,388	£6,277.60	£3,138.80	£1,569.40
WATLINGTON MEDICAL CENTRE	6,794	£1,358.80	£679.40	£339.70
WATTON MEDICAL PRACTICE	13,994	£2,798.80	£1,399.40	£699.70
WELLS HEALTH CENTRE	3,226	£645.20	£322.60	£161.30
WENSUM VALLEY MEDICAL PRACTICE	12,633	£2,526.60	£1,263.30	£631.65
WEST POTTERGATE MED PRAC	4,958	£991.60	£495.80	£247.90
WINDMILL SURGERY	6,997	£1,399.40	£699.70	£349.85
WOODCOCK RD SURGERY	8,166	£1,633.20	£816.60	£408.30
WYMONDHAM MEDICAL PARTNERSHIP	19,363	£3,872.60	£1,936.30	£968.15

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Norfolk and Waveney
Integrated Care Board

Agenda item: 13

Subject:	**Primary Care Commissioning Committee (PCCC) 2022/23 Financial Report – Month 3**
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:	**09/08/2022**

Purpose of paper:

To present the Month 3 (June 2022) Primary Care financial position for the Norfolk and Waveney CCG (Now 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 Month 3 of the legacy CCG accounts. The ICB (Integrated Care Board) accounts will be reported from Month 4 of 2022/23 financial year.

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

The current efficiency requirement within the Primary Care and Prescribing directorate is £1.026m this is within GP Prescribing and for the 3 months from April-June 2022. The full year Efficiency Plan is £8.4m (plan is not linear). An additional efficiency requirement is built into the ICB budgets from M4 onwards.

As at Month 3 (June) the 3 months forecast spend is £101.44m as against plan of £104.31m leading to an underspend of £2.88m.

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

Report : Attached

Recommendation to the Board:

This report is presented for information only.

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

Governance

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

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Improving lives **together**

Norfolk and Waveney Integrated Care System

2022/23 Primary Care Commissioning Committee Finance Report

June 2022 (Month 3 reporting period)

Primary Care Commissioning Committee 9th August 2022

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1.0 Executive Summary

- As the financial reporting for Primary Care and Prescribing is produced in arrears this report will relate to Month 3 of the legacy CCG accounts. The ICB (Integrated Care Board) accounts will be reported from Month 4 of the 2022/23 financial year.

- The 2022-23 budgets to June 2022 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 £1.026m this is within the GP Prescribing sub-directorate and for the 3 months from April-June 2022. The full year Efficiency Plan is £8.4m (plan is not linear). An additional efficiency requirement is built into the ICB (Integrated Care Board) budgets from M4 onwards.

- As at Month 3 (June) the 3 months forecast spend is £101.44m as against a plan of £104.31m leading to a total underspend of £2.88m 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.

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2.0 Financial Summary

Primary Care: Financial Summary	3 months CCG Budget £m	Year to Date (Month3) Budget £m	Actual £ m	Variance (Fav)Adv £m	Forecast 3 Months (CCG) Actual £m	Variance (Fav) Adv £m	Forecast at Month 2 Actual £m	Movement (Fav) Adv £m	Comments on material Movement between M2 and M3	*Detailed Variance Analysis*
GP & Other Prescribing	47.9	47.9	46.8	(1.1)	46.8	(1.1)	48.0	(1.2)	Prior Year Benefits crystallised	*3.1*
Primary Care										
System Development Fund	2.3	2.3	2.6	0.3	2.6	0.3	2.5	0.0		*3.2*
Local Enhanced Services	4.2	4.2	4.0	(0.3)	4.0	(0.3)	4.2	(0.3)		
Other Primary Care	0.7	0.7	0.8	0.1	0.8	0.1	0.8	0.0		
Primary Care Delegated Co-Commissioning	47.8	47.8	45.9	(1.8)	45.9	(1.8)	46.9	(1.0)	Prior Year Benefits crystallised	*3.3*
Primary Care IT	1.4	1.4	1.4	(0.0)	1.4	(0.0)	1.1	0.3		
Total Primary Care	56.4	56.4	54.7	(1.8)	54.7	(1.8)	55.6	(0.9)		
Total Directorate	104.3	104.3	101.4	(2.9)	101.4	(2.9)	103.6	(2.1)		
Variance as a % of Budget				*-2.8%*		*-2.8%*		*-2.1%*		
Total Primary Care	104.3	104.3	101.4	-2.9	101.4	-2.9				

The detailed explanations are provided in 3.0 Detailed variance analysis.

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3.0 Detailed Variance Analysis

Primary Care: Detailed Variance Analysis		3months Budget CCG	Year to Date (Month 3)			3 Months Forecast (CCG)			Narrative
		Budget	Budget	Actual	Variance (Fav)Adv	Actual	Variance	Variance (Fav)Adv	
		£m	£m	£ m	£m	£m	£m	%	
3.1	GP and Other Prescribing	47.9	47.9	46.8	(1.1)	46.8	(1.1)	-2.3%	The GP Prescribing costs are reported nationally 2 months in arrears so, estimates for May and June are considered in the Year to Date (YTD) position, and the same in the Forecast Outturn (FOT) as the CCG reports for the final 3 months before transferring to an Integrated Care Board (ICB). The YTD and FOT are underspent by £1.1m due to crystallisation on prior year benefits. An efficiency target of £(1.026)m is included in the budget for the three months.The full year planned efficiency target is £(8.4)m (the phasing is not linear). It is assumed the efficiency savings are delivered as per plan and these are therefore included in the FOT expenditure position. Analysis of the savings acheived to date validates this position. Due to new NICE guidance which was published in March-22 there may be additional costs in the 2022/23 expenditure because of Continuous Glucose Monitoring (CGM) and prescribing of Sodium-glucose Cotransporter-2 (SGLT2) inhibitors. The exact financial implication is unknown as this guidance states that this prescribing is not suitable for all diabetic patients and the roll out will take time to implement, it is however thought to be considerable and may exceed £5m and if it does this will be an unfunded cost pressure.Hence a provision for £1.8m for Q1 is created. The Prescribing spend overall remains subject to significant volatility and the current macro-economic situation will increase this volatility further (e.g. high levels of inflation, supply issues which could have a potential cost impact). Surgeries are now seeing more patients than they did during the pandemic and this in turn may drive higher quantities of prescribed medicines. Due to this risk whilst we await final actual values, a prudent additional growth estimate of 4% is included in the position.
3.2	System Development Fund	2.3	2.3	2.6	0.3	2.6	0.3	12.2%	There is ambiguity over Transformation funding and the purposes it can be used for, e.g. for PCN development and digital services. Hence and adverse variance of £0.3m has been created to provide for both
3.3	Primary Care Delegated Co-Commissioning	47.8	47.8	45.9	(1.8)	45.9	(1.8)	-3.8%	The YTD and FOT are underspent by £1.1m due to crystallisation of prior year benefits.

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4.0 System Development Fund

Primary Care: System Development Fund	3months Budget CCG Budget £m	Year To Date(Month3) Budget £m	Actual £ m	Variance (Fav) Adv £m	3 months Forecast (CCG) Actual £m	Variance (Fav) Adv £m
GP Retention	0.1	0.1	0.1	0.0	0.1	0.0
Training Hubs	0.1	0.1	0.1	0.0	0.1	0.0
Online Consultation	0.1	0.1	0.1	(0.0)	0.1	-0.0
Fellowship-Core Offer	0.1	0.1	0.1	0.0	0.1	0.0
Supporting Mentor Scheme	0.0	0.0	0.0	0.0	0.0	0.0
Infrastructure & Resilience	0.1	0.1	0.1	0.0	0.1	0.0
Improved Access	1.8	1.8	1.8	0.0	1.8	0.0
Practice Resilience	0.0	0.0	0.0	(0.0)	0.0	-0.0
PCT Transformation	0.1	0.1	0.4	0.3	0.4	0.3
	2.3	**2.3**	**2.6**	**0.3**	**2.6**	**0.3**
Variance as a % of Budget				*12.2%*		*12.2%*

- The above table details the schemes within the System Development Fund (SDF).
- As previously described there has been some ambiguity on the usage of Transformation funding between digital staff funding and PCN development so both have been provided for creating the variance against budget £0.3m.

5.0 Delegated Co Commissioning Analysis

Primary Care: Delegated Co Commissioning	3months Budget CCG £m	Year to Date (Month 3) Budget £m	Actual £ m	Variance (Fav)Adv £m	3 Months Forecast (CCG) Actual £m	Variance (Fav) Adv £m
Contractual	31.3	31.3	31.7	0.4	31.7	0.4
QOF	4.0	4.0	4.0	0.0	4.0	0.0
Premises cost reimbursemen	3.7	3.7	3.8	0.1	3.8	0.1
Other - GP Services	3.5	3.5	3.5	0.0	3.5	0.0
Enhanced services	1.1	1.1	1.2	0.1	1.2	0.1
CCG Spend	0.1	0.1	0.1	0.0	0.1	(0.0)
PCN ARRS Staff	3.1	3.1	3.2	0.1	3.2	0.1
PMS to GMS	1.0	1.0	0.0	(1.0)	0.0	(1.0)
Prior Year	0.0	0.0	-1.6	(1.6)	-1.6	(1.6)
Total	**47.8**	**47.8**	**45.9**	**(1.8)**	**45.9**	**(1.8)**
Variance as a % of Budget				*-3.8%*		*-3.8%*

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

Areas of material forecast variances:

- **Contractual:** The major overspend is due to Subject to access, Impact and Investment Fund and PCN Leadership whose budgets are in the SDF sub-directorate hence the adverse variance.
- **PMS to GMS:** Budgets held within Delegated PC as per NHSE guidance costs shown in LCS.
- **Prior Year:** Due to the crystalised benefits of Delegated Primary Care costs from 21/22.

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6.0 GP And Other Prescribing

22/23 Primary Care: GP And Other Prescribing	3months Budget CCG	Year to Date(Month3)			3 months Forecast (CCG)		Forecast as at M2		Comments on material Movement between M2 and M3
	Budget	Budget	Actual	Variance (Fav)Adv	Actual	Variance (Fav)Adv	Actual	Movement in FOT (Fav)Adv	
	£m	£m	£ m	£m	£ m	£m	£ m	£m	
GP Prescribing Costs	44.9	44.9	44.3	(0.6)	44.3	(0.6)	44.9	(0.5)	**Prior year benefit crystallisation**
Recharges to Local Authorities & NHS England	(0.7)	(0.7)	(0.6)	0.1	(0.6)	0.1	(0.6)	0.0	**No Movement.**
Rebates from pharmaceutical companies	(0.7)	(0.7)	(0.8)	(0.0)	(0.8)	(0.0)	(0.8)	0.0	**No Movement.**
GP Prescribing Subtotal	**43.5**	**43.5**	**42.9**	**(0.5)**	**42.9**	**(0.5)**	**43.5**	**(0.5)**	
Central Drugs	1.2	1.2	1.2	(0.0)	1.2	(0.0)	1.2	(0.0)	**No Movement.**
Dressings & wound care	1.5	1.5	1.2	(0.2)	1.2	(0.2)	1.5	(0.2)	**Prior year benefit crystallisation**
Others (Medicine Management, Oxygen etc.)	1.8	1.8	1.5	(0.3)	1.5	(0.3)	1.8	(0.4)	**Credits from CSU for Medicines**
Total Spend	**47.9**	**47.9**	**46.8**	**(1.1)**	**46.8**	**(1.1)**	**48.0**	**(1.2)**	
Variance as a % of Budget				*-2.3%*		*-2.3%*		*-2.5%*	

3 months budget is the 3 months plan for 22/23

Variance Signage: (Favourable)/Adverse

The above table details the categories of expenditure within GP and Other Prescribing. Benefits showing at M3 are derived mainly from the prior year crystalised benefits and additionally non-recurrent benefits from the CSU (Clinical Support Unit) for vacancies held within the Medicines Management team paid from the CCG/CSU contract.

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7.0 Financial risks

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

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7.0 Financial risks (Continued)

Risk	Mitigation
Volatile prescribing costs, that can fluctuate and are exacerbated by the macro-economic climate, supply issues and interest rates. In addition the CAT M and NCSO (No Cheaper Stock Obtainable) costs are inherently volatile.	Robust management and oversight, through collaborative working between finance and medicines management to understand trends, variances and cost
Financially unstable practices	There are practices which are receiving resilience support from the CCG. The mitigation of this potential risk is to ensure continued surveillance. We are also in receipt of allocation from NHSE/I which can be paid to practices “at risk”.
Additional costs due to existing estates costs, e.g. rent rate reviews, and new estates costs as a result of practice premises and expansion (e.g. additional revenue costs due to expansion of premises)	The CCG cannot mitigate existing establishment rates changes, but can look to be assured by close liaison with the District Valuer. Continued oversight so that estates growth is matched by annual increases in delegated budgets
Delegated financial position and the inability to control the spend within the CCG due to nationally mandated expenditure.	Negotiation with NHS England and Improvement and involvement in national allocation working groups. Look to cease or defer non mandated expenditure where possible.

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