Norfolk and Waveney
Integrated Care Board

14 May 2025
Norfolk & Waveney Integrated Care Board
Primary Care Commissioning Committee

Questions received in relation to Item 13 on the agenda. The question related to the LCS Tracker of the financial report

Could you please give more detail on 'proactive healthcare'

a. *How is the ICB determining what should be funded?*
b. *What is this funding being spent on? For example, whether this is direct intervention (prescribed drugs), staffing costs, contracted out services and so on*
c. *What are the outcomes of this funding? How successful are the interventions?*
d. *How are interventions and/or success rates being measured and reported to the ICB and the public?*

Answers

Could you please give more detail on 'proactive healthcare'

a. **How is the ICB determining what should be funded?**

This LES provides the opportunity to address the needs of a specific patient population through proposing a flexible service which would promote proactive healthcare. The provider is encouraged to be innovative in its approach. Previous projects or initiatives can be submitted for continuation providing outcomes are measurable and demonstrate positive impacts on patient care and the wider health system.

The provider is asked to consider what target population needs are to be addressed; what it wishes to achieve and how that improvement will come about. They will need to submit a plan, and this will need to include as a minimum:

- what is the provider proposing to undertake
- why – what is the outcome that you wish to achieve?
- when – outline a clear timescale
- baseline – how will you capture your current position?
- measurement – what components will demonstrate that you have achieved your aim?

All Plans are reviewed and approved by Place Teams. Overall, the projects should be looking at reducing emergency and unplanned admissions by providers pro-actively addressing the needs of their population.

b. **What is this funding being spent on? For example, whether this is direct intervention (prescribed drugs), staffing costs, contracted out services and so on**

Each Place uses the funding differently and delivers the Pro-active health care LES as either a whole locality, PCN or individual practice.

Norwich Place:

All Norwich practices excluding the two detailed below use the funding to deliver the home visiting service for the Norwich area.

Thorpewood Medical	Diabetes Plus
UEA	72-hour Appointment service

South Place: Deliver individual projects by Practice

Attleborough Surgeries	Nurse Visiting and Education for homebound patients
Chet Valley Medical Practice	Maintaining Low Emergency Attendances
Church Hill Surgery	A&E & Admission Avoidance
East Harling & Kenninghall	Active Admission Avoidance Project
Elmham Surgery	Reducing Need for Emergency Care for the housebound
Grove Surgery	A&E & Admission Avoidance when English is a second language
Harleston Medical Practice	Avoiding Emergency Admission for deteriorating housebound patients
Heathgate Medical Practice	Avoiding Emergency Admissions - A Proactive Approach
Hingham Surgery	Active Admission Avoidance Project
Lawns Medical Practice	Outreach Nurse for housebound patients
Long Stratton Medical Partnership	Older Person's Admission Avoidance Scheme
Mattishall and Lenwade Surgeries	Mattishall Visiting Nurse Service
Old Mill & Millgates Medical Practice	Older Persons Admission Avoidance >75s with a focus on Respiratory
Orchard Surgery	Visiting Nurse
Parish Fields Practice	A&E & Admission Avoidance when English is a second language
School Lane Surgery Thetford	A&E & Admission Avoidance when English is a second language and improving the care of housebound patients
Shipdham Surgery	Outreach service improvement. Hospital Discharge Review Contact
Humbleyard Practice	Outreach Nurse for frail and vulnerable patients
Theatre Royal Surgery	Visiting Nurse
Toftwood Medical Centre	Reducing Need for Emergency Care for the housebound
Watton Medical Practice	A&E & Admission Avoidance when English is a second language
Windmill Surgery	Improving patient care and reducing frequent A&E attenders
Wymondham Medical Partnership	Reduction in emergency admissions for the 75 most frail patients and increase identification of frailty in rurally deprived patients over the age of 70

Great Yarmouth and Waveney Place: Deliver a mix of PCN and Practice delivery:

Lowestoft PCN	Design and deliver new model of care for impactable patients identified through PCN participation in the Optum Population Health Development Programme
Great Yarmouth & Northern Villages PCN	Home visiting service in partnership with ICS partners
Gorleston PCN	Gorleston Healthy Neighbourhood Programme

South Waveney PCN delivers individual projects by practice including:

Beccles Medical Centre	Empowering patients to manage their long term conditions - initial focus on diabetes, meds and including outreach LD support
Bungay Medical Practice	Proactively increase long term condition reviews and medication reviews
Cutlers Hill Surgery	Proactively identifying frequent attenders to A&E and minimising admissions with focus on patients with immediate risk of admission, Frequent flyers, Complex, Frailty vulnerable.
Longshore Surgeries	Target housebound for long term condition and medication reviews
Sole Bay Health Centre	Complex Care Team - care homes & housebound

West Norfolk Place: Deliver a mix of PCN and Practice delivery:

Fens & Brecks PCN	Frailty - Arthritis
Swaffham & Downham PCN	High Service User Optimisation Programme
Coastal PCN	Frailty – Arthritis

Kings Lynn PCN deliver as separate practices:

Southgates Medical practice	Practice matrons
St James Medical Practice	Focus on Housebound patients
The Hollies Surgery	Proactive Diabetes Management
Vida Healthcare	Proactive Diabetes Management
The Woottons Surgery	Practice matrons

North Norfolk Place: Deliver the project as a whole locality
Contact and follow up discharged patients to reduce the risk of readmissions - links with acute and community. The aim is for an holistic review, taking a What Matters to Me form for the patient. Each PCN also uses a Multi-Disciplinary Team approach

c. **What are the outcomes of this funding? How successful are the interventions?**

The aim is for a reduction in emergency and unplanned admissions by providers pro-actively addressing the needs of their local population. Full Evaluations and Case studies have been submitted by providers for each project for 2024-25, which will be reviewed by the ICB to optimise the future delivery of this service.

d. **How are interventions and/or success rates being measured and reported to the ICB and the public?**

Quarterly returns are submitted and reviewed and agreed by Place teams prior to payment being released. The overall investment in the service is reported via the Finance report to Primary Care Commissioning Committee.

Providers include in this report:

- Number of patient contacts/interventions
- Summary of activity outcomes
- Progress against agreed milestones.
- Provide evidence that the deliverables within the plan are being delivered.
- End of Q4 Full Evaluation of Scheme.