Primary Care Commissioning Committee Part One

Tue 13 February 2024, 13:30 - 16:30

Agenda

13:30 - 13:30 (0 min)

Agenda

Debbie Bartlett

2024 02 13 Item 00 ICB Primary Care Committee Agenda Pt 1.pdf (1 pages)

13:30 - 13:30 (0 min)

1. Chair's introduction and report on any Chair's action

Information *Debbie Bartlett*

13:30 - 13:30 (0 min)

2. Apologies for absence

Information *Debbie Bartlett*

13:30 - 13:30 (0 min)

3. Declarations of Interest

Information *Debbie Bartlett*

2024 02 13 Item 03 Declarations of Interest.pdf (5 pages)

13:30 - 13:30 (0 min)

4. Review of Minutes and Action Log from the December 2023 meeting

Decision *Debbie Bartlett*

2023 12 12 Item 04 NWICB PCCC Minutes Part One.pdf (10 pages)
2024 02 13 Item 04 PCCC Action Log Part One.pdf (1 pages)

13:30 - 13:30 (0 min)

5. Forward Planner

Decision *Sadie Parker*

2024 02 13 Item 05 ICB PCCC Forward Planner 2023-2024 P1.pdf (1 pages)

13:30 - 13:30 (0 min)

6. Risk Register

Decision *Sadie Parker*

2024 02 13 Item 06 Monthly risk ratings combined.pdf (8 pages)

13:30 - 13:30 (0 min)

Service Development

13:30 - 13:30

7. Holt Medical Practice – Application to close Blakeney branch surgery

0 min

Decision *Sadie Parker*

Item format:

- Presentation of report
- Questions from committee
- Questions from the public

Committee discussion and decision

2024 02 13 Item 07 HMP application to close Blakeney branch surgery.pdf (10 pages)
2024 02 13 Item 07 Final submission HMP.pdf (38 pages)

13:30 - 13:30
0 min

8. Joint Forward Plan – Primary Care

Information *Oliver Loveless*

2024 02 13 Item 08 Joint Forward Plan.pdf (4 pages)

13:30 - 13:30
0 min

9. Advice Note for Branch Surgeries seeking to change their service provision or opening hours

Decision *Fiona Theadom*

2024 02 13 Item 09 Branch Surgery Advice Note PCCC report.pdf (7 pages)
2024 02 13 Item 09 Advice Note for Branch Surgeries seeking to change their service provision or opening hours.pdf (12 pages)

13:30 - 13:30
0 min

Finance & Governance

13:30 - 13:30
0 min

10. Operational Delivery Group Report• General Practice• Dental Services

Information *Sadie Parker / Fiona Theadom*

2024 02 13 Item 10 General Practice Operational Delivery Group Report.pdf (5 pages)
2024 02 13 Item 10 Dental Services Operational Delivery Group Report.pdf (3 pages)

13:30 - 13:30
0 min

11. Finance Report

Information *James Grainger*

2024 02 13 Item 11 M9 Finance Report.pdf (15 pages)

13:30 - 13:30
0 min

Any Other Business

13:30 - 13:30
0 min

12. Questions from the Public

Discussion *Debbie Bartlett*

NHS
Norfolk and Waveney
Integrated Care Board

Meeting of the Norfolk and Waveney ICB Primary Care Commissioning Committee
Tuesday 13 February 2024, 13:30 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.		**Review of Minutes and Action Log from the December 2023 meeting** *For Approval*	Chair
5.		**Forward Planner** *For Approval*	SP
6.		**Risk Register** *For Approval*	SP
		Service Development	
7.	13:50	**Holt Medical Practice – Application to close Blakeney branch surgery** *For Approval* Item format: • Presentation of report • Questions from committee • Questions from the public • Committee discussion and decision	SP
8.	14:35	**Joint Forward Plan – Primary Care** *For Noting*	OL
9.	14:45	**Advice Note for Branch Surgeries seeking to change their service provision or opening hours** *For Approval*	FT
		Finance & Governance	
10.	14:55	**Operational Delivery Group Report** • **General Practice** • **Dental Services** *For Noting*	SP/FT
11.	15:05	**Finance Report** *For Noting*	JG
		Any Other Business	
12.	15:15	**Questions from the Public**	Chair

Date, time and venue of next meeting
Tuesday 12 March 2024 13:30 – 16:30 – ICB PCCC
To be held by videoconference and You Tube

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

Questions are welcomed from the public.
Please send by email: nwicb.contactus@nhs.net
For a link to the meeting in real-time
Please email: nwicb.communications@nhs.net
Glossary of Terms
https://improvinglivesnw.org.uk/about-us/website-glossary-of-terms/

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

Declared interests of the Primary Care Commissioning Committee

Name	Role	Declared Interest- (Name of the organisation and nature of business)	Type of Interest			Is the interest direct or indirect?	Nature of Interest	Date of Interest		Action taken to mitigate risk
			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests			From	To	
Debbie Bartlett	Partner Member - Local Authority (Norfolk), Norfolk and Waveney ICB	Norfolk County Council		X		Direct	Interim 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.
		Diss Parish Fields			X	Direct	Patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an 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	
		South Norfolk PCN				Indirect	Clinical Director of SNHIP Primary Care Network	2022	Present	
Steven Course	Executive Director of Finance, Norfolk and Waveney ICB	March Physiotherapy Clinic Limited				Indirect	Wife is a Physiotherapist for March Physiotherapy Clinic Limited	2015	Present	Will not have an active role in any decision or discussion relating to activity, delivery of services or future provision of services in regards March Physiotherapy Clinic Limited
Patricia D'Orsi	Executive Director of Nursing, Norfolk and Waveney ICB	Royal College of Nursing		X		Direct	Member of Royal College of Nursing	Ongoing		Inform Chair and will not take part in any discussions or decisions relating to RCN
		In Essex	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.
Hein van den Wildenberg	Non-Executive Member, Norfolk and Waveney ICB	Lakenham Surgery			X	Direct	Registered patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
		College of West Anglia			X	Direct	Governor at College of West Anglia (Note: the College hosts the School of Nursing, in partnership with QEHKL and borough council)	2021	Present	Low risk. If there is an issue it will be raised at the time.
Norfolk and Waveney ICB Attendees										
Mark Burgis	Executive Director of Patients and Communities, Norfolk and	Drayton Medical Practice			X	Direct	Registered patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice

	Waveney ICB	Lakenham Surgery				Indirect	Partner is Locum Practice Nurse at Lakenham Surgery	Ongoing		might have an interest
		Castle Partnership				Indirect	Partner was a practice nurse at Castle Partnership (to be removed Jan 2024)	2020	2023	
Shepherd Ncube	Head of Delegated Commissioning	Nothing to Declare	N/A			N/A	N/A	N/A		N/A
Sadie Parker	Director of Primary Care, Norfolk and Waveney ICB	Active Norfolk		X		Direct	Represent N&WCCG as a member of the Active Norfolk Board	2019	Ongoing	Low risk. If there is an issue it will be raised at the time
		Director of One Norwich Practices Ltd				Indirect	Close personal friendship with Dr Jeanine Smirl, Director of One Norwich Practices Ltd	Ongoing		Risks to be managed as they arise. Professional integrity will be maintained at all times and decisions ran by Executive Director of Patients and Communities where necessary. In situations where risks cannot be tolerated, prepared to not take part in discussions/decisions
NHS England and NHS Improvement Attendee										
Fiona Theadom	Contracts Manager, NHS England and NHS Improvement	Windmill Surgery			X	Direct	Registered patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
Local Medical Committee Attendees										
Mel Benfell	Norfolk & Waveney Local Medical Committee Joint Chief Executive	N&W ICB				Indirect	Personal friend of an employee of the ICB	2015	Present	Will not take part in any discussion or decisions relating to the declared interests.
		N&W ICB				Indirect	Close relative is an employee of N&W ICB	Ongoing		Will not take part in any discussion or decisions relating to the declared interests
		Windmill Surgery			X	Direct	Registered patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
Lisa Drewry	Executive Officer, Norfolk & Waveney LMC	Burnham Market			X	Direct	Registered patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
Ian Wilson	Executive Officer with Norfolk & Waveney Local Medical Committee	National Health Service England				Indirect	Father-in-Law is member of national NHSE Sounding Board	Ongoing		
		Norfolk and Waveney Enterprise Services				Indirect	Brother – Senior employee (non-Board member) – Norfolk and Waveney Enterprise Services	Ongoing		
		Drayton & St Faiths Medical Practice			X	Direct	Registered patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
Naomi Woodhouse	Norfolk & Waveney Local Medical Committee Joint Chief Executive	Long Stratton Medical Practice			X	Direct	Registered patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
Health and Wellbeing Board Attendees (Norfolk and Suffolk)										
Bill Borrett	Norfolk Health & Wellbeing Board Chair	North Elmham Surgery			X	Direct	Registered patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice
		Norfolk County Council	X			Direct	Elected Member of Norfolk County Council, Elmham and Mattishall Division	Ongoing		Low risk. In attendance as a representative of the Local Authority. Chair will have overall responsibility for deciding whether I be excluded from any particular decision or discussion.
		Norfolk County Council	X			Direct	Cabinet Member for Adult Social Care and Public Health	Ongoing		
		Norfolk County Council	X			Direct	Chair of Norfolk Health and Wellbeing Board	Ongoing		

		Breckland District Council	X			Direct	Elected Member of Breckland District Council, Upper Wensum Ward	Ongoing		
		Norfolk County Council	X			Direct	Chair of Governance and Audit Committee	Ongoing		
		Manor Farm	X			Direct	Farmer within Dereham patch	Ongoing		Low risk. If there is an issue it will be raised at the time.
James Reeder	Suffolk Health and Wellbeing Board	Suffolk County Council	X			Direct	Cabinet Member for Children and Young People's Services	Ongoing		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.
		Suffolk County Council	X			Direct	Children's Services and Education Lead Members Network	Ongoing		
		East of England Government Association	X			Direct	East of England Government Association	Ongoing		
		James Paget University Hospital Trust	X			Direct	James Paget Healthcare NHS Foundation Trust Governors Council	Ongoing		
		Suffolk County Council	X			Direct	Suffolk Safeguarding Children Board	Ongoing		
		Norfolk and Suffolk NHS Foundation Trust	X			Direct	Norfolk and Suffolk Foundation Mental Health Trust – Governors Council	Ongoing		
		Suffolk and North East Essex Integrated Care Partnership	X			Direct	Suffolk County Council representative for Suffolk and North East Essex Integrated Care Partnership	Ongoing		
		Suffolk Chamber of Commerce	X			Direct	Member of the Lowestoft and Waveney Chamber of Commerce board part of Suffolk Chamber of Commerce	Ongoing		
		High Street Surgery, Lowestoft			X	Direct	Patient at a Norfolk and Waveney GP Surgery	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
		Northfields St Nicholas Primary Academy			X	Direct	Governor of Northfields St Nicholas Primary Academy part of the Reach2 Academy Trust.	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	Registered patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
		HealthWatch Norfolk	X			Direct	Trustee and board member HeathWatch Norfolk	2020	Present	Will not take part in any discussion or decisions relating to the declared interests.
		East Harling Parish Council			X	Direct	Member, East Harling Parish Council	2020	Present	
		NHS England		X		Direct	GP appraiser, NHSE	2015	Present	
Sally Watson	Healthwatch Suffolk (Community & Engagement Manager)	Nothing to Declare	N/A				N/A	N/A		N/A
Other Primary Care Members										
Andrew Bell	Vice-Chairman Norfolk Local Dental Committee General Dental Practitioner in Norfolk and Waveney	Dental Practices	X			Direct	Partner within a group of Dental Practices within Norfolk and Waveney (John G Plummer and Associates)	Ongoing		Non-voting member - risks will be taken in accordance with COI Policy
		General Dental Practice Committee		X		Direct	Vice-Chair Norfolk LDC, General Dental Practice Committee (BDA) Representative for Norfolk	Ongoing		
		Bridge Road Surgery			X	Direct	Registered patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest

Deborah Daplyn	Chair, Norfolk & Waveney Local Optical Committee Optical Contractor working within ICB boundaries	Integrated Care Board	X			Direct	Receipt of fees and honorarium for attendance at meetings with ICB and other interested parties	Apr-23	Onoing	Non-voting member - risks will be taken in accordance with COI Policy
		General Optical Services	X			Direct	Own a practice which works within primary care and receives money under a General Optical Services Contract	Apr-23	Ongoing	
		Sheringham Medical Practice			X	Direct	Registered patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
Tony Dean	Chief Officer, Norfolk Local Pharmaceutical Committee (now known as "Community Pharmacy Norfolk"	CO of the LPC		x		Direct	CO of the LPC- the statutory representative body for community pharmacy Contractors	2005	Present	Non-voting member - risks will be taken in accordance with COI Policy
		Docking & Great Massingham Surgeries			X	Direct	Registered patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
Tania Farrow	Chief Officer of Community Pharmacy Suffolk representing Waveney contractors	Community Pharmacies		X		Direct	Local Representative body for Community Pharmacies involved in negotiation and support for local Community Pharmacy services	Nov-15	Present	Non-voting member - risks will be taken in accordance with COI Policy
Lauren Seamons	Deputy Chief Officer, Norfolk LPC (Community Pharmacy Norfolk)	Norfolk LPC	X			Direct	Employed by Norfolk LPC	Ongoing		Non-voting member - risks will be taken in accordance with COI Policy
		The Hollies, Downham Market			X	Direct	Registered patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
Jason Stokes	Secretary Norfolk Local Dental Committee (LDC)	National Health Service	X				I have an NHS GDS Contract	2007	Present	I would exclude myself from any discussions particular to my own GDS contract. I would exclude myself from any section of a meeting that ICB members
		British Dental Association		X			I am a member of the British Dental Association (BDA) Principal Executive Committee (PEC) – board of directors	2015	Present	This is unlikely to impact on working with the ICB. I would exclude myself from any section of a meeting that ICB members felt appropriate.
		Associate Dental Postgraduate		X			I am Associate Dental Postgraduate Dean for Early Years (Health Education England)	2022	Present	This is unlikely to impact on working with the ICB. I would exclude myself from any section of a meeting that ICB members felt appropriate.
		St Stephens Gate, Norwich			X	Direct	Registered patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
Karen Watts	Director of Nursing and Quality, Norfolk and Waveney ICB	Norfolk and Norwich University Hospitals NHS FT	N/A			Indirect	Son in Law Senior Registrar Cardiology rotational role NNUHFT	Ongoing		I always make the chair aware and leave the meeting if cardiology at the NNUH is discussed in terms of benefiting the service.

		Royal College of Nursing		X		Direct	Member of Royal College of Nursing	1980	Present	Inform Chair and will not take part in any discussions or decisions relating to RCN
		Coltishall			X	Direct	Patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest

NHS
Norfolk and Waveney
Integrated Care Board

Norfolk and Waveney Primary Care Commissioning Committee

Part One

Minutes of the Meeting held on
Tuesday 12 December 2023
via video conferencing & YouTube

Voting Members - Attendees

Name	Initials	Position and Organisation
Debbie Bartlett	DB	Chair, Partner Member – Local Authority (Norfolk) Norfolk and Waveney ICB
Steven Course	SC	Executive Director of Finance, Norfolk and Waveney ICB
Karen Watts	KW	Director of Nursing and Quality, Norfolk and Waveney ICB (Deputising for PD'O)
Hein Van Den Wildenberg	HW	Non Executive Member, Norfolk and Waveney ICB (deputy Chair)

In attendance

Name	Initials	Position and Organisation
Andrew Bell	AB	Vice Chairman, Norfolk Local Dental Committee, General Dental Practitioner in Norfolk and Waveney
Dr Hilary Byrne	HB	ICB Board Partner Member – Providers of Primary Medical Services, Norfolk & Waveney ICB
Tony Dean	TD	Chief Officer, Community Pharmacy Norfolk
Lisa Drewry	LD	Executive Officer, Norfolk & Waveney Local Medical Committee
Michael Dennis	MD	Associate Director of Medicines Optimisation, Norfolk and Waveney ICB
Sharon Gardner	SG	Community Pharmacy Clinical Lead, Norfolk & Waveney ICB
Carl Gosling	CG	Senior Delegated Commissioning Manager – Primary Care, Norfolk and Waveney ICB
Joni Graham	JGr	Executive Officer (Estates, Digital, Pharmacy & Prescribing) Norfolk & Waveney Local Medical Committee
James Grainger	JG	Head of Finance Primary Care & Corporate, Norfolk and Waveney ICB
Andrew Hayward	AH	Trustee of Healthwatch Norfolk
Oliver Loveless	OL	Head of Primary Care Strategic Planning, Norfolk and Waveney ICB
Shepherd Ncube	SN	Associate Director of Delegated Commissioning, Norfolk and Waveney ICB
Sadie Parker	SP	Director of Primary Care, Norfolk and Waveney ICB
Jon Punt	JP	Complaints and Enquiries Manager, NHS Norfolk and Waveney Integrated Care Board
Peter Taylor	PT	Assistant Director, Public Health Commissioning Norfolk County Council, Public Health
Fiona Theadom	FT	Head of Primary Care Commissioning, Norfolk and Waveney ICB
Sarah Webb	SW	Primary Care Administrator, Minute Taker

Apologies

Name	Initials	Position and Organisation
Cllr Bill Borrett	BB	Chair of the ICP and Partner Member of the ICB
Mark Burgis	MB	Executive Director of Patients and Communities, Norfolk & Waveney ICB
Deborah Daplyn	DD	Chair, Norfolk & Waveney Local Optical Committee Optical Contractor working within ICB boundaries
Patricia D'Orsi	PD'O	Executive Director of Nursing & Quality, Norfolk & Waveney ICB
James Reeder	JR	Cabinet Member for Children and Young People's Services, Suffolk County Council
Jason Stokes	JS	Secretary Norfolk Local Dental Committee (LDC)

No	Item	Action owner
1.	**Chair's introduction** DB welcomed members to the December 2023 Primary Care Commissioning Committee.	**Chair**
	Matters Arising There were no matters arising.	
2.	**Apologies for absence**	**Chair**
	Noted above.	
3.	**Declarations of Interest** *For Noting*	**Chair**
	None received.	
4.	**Review of Minutes and Action Log from the October 2023 Committee** *For Approval*	**Chair**
	The minutes were agreed to be an accurate reflection of the October 2023 Committee and minutes would be sent to the Chair for signing. **ACTION SW to send Chair signed minutes for safekeeping.** **<u>Action Log</u>** **0169 Closed** **0170 Workforce and Training – SP to link in for resources available and direct marketing.** SP updated she had linked in with the comms lead. Key points included the distribution of a campaign toolkit, creation of a newsletter template, and efforts to promote different roles in general practice. Progress had been made in providing resources, such as a campaign toolkit and newsletter template, to practices for promoting different roles in primary care. The challenge now was to assess how effectively these resources were being used and to gather feedback. There was consideration of involving local councils and parish councils in future engagement plans, to emphasise the long-term nature of this initiative for education and information change in the community. The item could now be closed.	**SW**
5.	**Forward Planner** *For Approval*	**SP**

	SP confirmed that work continued on the forward plan. Two committee meetings had been removed as agreed. A refined version would be brought to the next Committee along with a draft plan for the next financial year for consideration. DB thanked SP for the update and the forward planner was approved.	
6.	**Risk Register** *For Approval*	**SP**
	SP presented the Risk Register to Committee for approval. The update covered the risk register and highlighted no changes in scores. There was a proposal to manage risks within the two operational delivery groups. Two critical risks, the resilience of general practice and dental services, would still be monitored by the Committee. The update on the resilience of general practice noted additional winter funding for capacity, and two further practices had been identified as risks. There remained capacity issues within the primary care team due to vacancy controls and the organisational change process. The head of strategic planning role had been filled on a temporary basis and capacity issues were expected to improve in time, once the organisational change process concludes. Mitigating action to improve the dental risks, including the short term dental plan and workforce initiatives, were progressing. A review of units of dental activity (UDAs) was underway to address feedback received from the profession. HB commented about the additional funding offered to primary care for resilience over winter. Whilst this was welcomed, this would only equate to about 4 days of a GPs time in total over the whole winter and HB would welcome any additional funding for general practice should it become available. HW was happy with the proposal for presentation of the risks to Committee to highlight the critical risks in more detail, and he asked to continue to include the first page summary dashboard as an overview. HW commented that the dental service resilience risk indicated on the detail sheet aimed for a score of 6 in 2 months, however this seemed too optimistic and asked if this would be addressed with the team to propose a more realistic forecast. **Action – FT would consider the score and timeframe for the dental risk.** DB also reassured Committee that these risks were discussed at the ICB Board. Committee agreed with the suggestion to review the dental risk and the prospect score and the risk register was approved.	**FT**
7.	**Optometry Update ad General Optical Services (GOS) Contract Variations** *For Noting*	**CH**
	CH presented the Optometry Update and General Optical Services (GOS) Contract Variations to Committee for noting.	

The ICB aimed to understand challenges and implement local solutions to enhance resilience and stability in primary care optometry.

DB commented that this was not an area she knew about and sought clarification on whether the number of tests, particularly community visits, aligned with the local population's needs, especially given the rural context. DB was interested in understanding whether the 2% figure for community visits was considered appropriate.

CH responded by saying that she had access to data and would also be able to make comparisons to other ICBs and that this was something that was just underway within optometry. There was an opportunity to look in more depth about health inequalities and how that worked for our specific region.

KW thanked CB for a good paper and had an interest in those patients within residential care and people at risks of falls, if they had not had some support to be able to access their eye tests. KW asked if CB knew whether support was available as there was an elderly demographic. KW highlighted that it was important to prevent mechanical falls.

CH agreed that this was a good point and the importance of sight tests to prevent falls and would be exploring the domiciliary services available in Norfolk and Waveney and if they were meeting the needs of the elderly and rural populations.

AH asked whether Community Opticians carry out an emergency service and asked if there was an idea of what proportion offered that service. CH did not have any figures to hand but knew that it was sign posted from general practices. AH commented on a personal experience and was unsure why this resource was not being used. CH agreed this was a useful point and it would be good to make the people of Norfolk & Waveney aware of this.

DB thought this might be one of the potential benefits of the local devolution of the services to the ICB level to allow us to influence and shape the services to meet the needs of our population.

SP asked about the figures. The Norfolk and Waveney population was 1.1 million and it was recommended that people had a sight test every two years. If everyone had tests done this was equate to 600,000 tests. There were around 11,000 care home beds in Norfolk and Waveney plus people who were housebound. The 8,000 tests provided by domiciliary providers seemed a small proportion of providers. These points would be taken away and considered in developing our strategic approach in future.

CH clarified not everyone was entitled to NHS sight tests and the majority of sight tests were private. DB asked for some of the comparative figures.

HB noted GP practices see many patients who had not had an eye test in many years and the cost was often a disincentive. HB referenced a personal experience whereby the cost was £48.50 which may be significant to many.

DB considered how we could help people to connect with a sight test.

CH agreed and noted people who fall often had the wrong glasses - it was vital the glasses they were wearing were the right ones. Elderly people at risks of

	falls often had the wrong prescription / type of lens, for example varifocals, when separate pairs may reduce falls. PT highlighted one of the exempted groups was diabetics and there was information that could be gathered and collectively used to get an idea of what proportion were eligible for free eye testing. PT asked if the providers for fall services and those responding to falls were aware and checking if people had the right glasses. KW signposted Paul Benton to link into as he was the lead on the system wide work. Given what CH had said around the preventative options, she noted people do not realise they have glaucoma and had lost their peripheral vision. There was more we could do to promote eye health. KW also went on to state people can start developing cataracts as they get older. DB thanked CH for the report and recognised this was a starting point and there would be more work done and brought back in due course. The report was duly noted.	
8.	**Complaints and Contacts** *For Noting*	**JP**
	JP presented the Complaints and Contacts report for noting and provided an update on contacts received during quarters one and two. JP highlighted the full delegation of primary care complaints to the ICB took place on 1 July 2023. The report covered 3 months of data and indicated a notable increase in contacts, mainly concerning dentistry and general practice, which revealed challenges related to access. JP emphasised that these findings aligned with known issues addressed in the access plan. The report included appendices with specific numbers per provider or practice and offered insights for teams working with providers. DB thanked JP for the report and it was helpful to explain the transition phased. HW noted it captured the charts and themes and the format worked. HW asked to receive the report twice a year at Committee going forward and had a question on what feedback was received from people who had complained or been in contact – and did they generally feel they have been listened to and addressed. JP responded by saying that the complaints team would in the first instance, if someone was dissatisfied, see if there were other ways in to resolve this, for example by offering a virtual or face to meeting. JP agreed it was a useful prompt to consider and he would raise it at regional and local forums to see if there was any learning which could be replicated or adopted. KW acknowledged how busy it had been in dentistry, as quite often complaints went to her team too. KW mentioned the need for effective communication about the team's efforts to be included. KW acknowledged it was good to work together to achieve the best outcome and ask the "so what" question, what had changed as a consequence and how we could recognise the work which resulted. JP acknowledged this was a challenge as he reported to the Patient and Communities Committee as well. When the ICB finalises its restructure the remit of the team would shift somewhat and become more of a patient	

	experience team. The aspiration was to not just look at complaints but try to join up what the providers were being told and to bring some kind of leadership around the “so what”. OL commented that he had worked with JP whilst OL was in his previous role and in regard to the access and capacity plans the PCNs had worked hard on this. OL would be interested to see if there was any correlation to the complaints were coming through against these milestones. SN commented how this data would be used to track improvement in the capacity and access plan and to try and work on whether this connected with other pieces of work. JP agreed as he had requests for the data from ICB teams and PCNs and wanted to ensure a common understanding of the data. DB acknowledged that there was work to do and thanked JP for the report which was duly noted.	
9.	**Pharmacy First** *For Noting*	**SG**
	SG presented the Pharmacy First report to Committee for noting. SG provided a detailed overview. The launch of the Pharmacy First service was a significant development which involved clinical pathways and additional services. There was a need to ensure effective communication, clinical upskilling, and digital infrastructure integration would be crucial for the success of this. Coordination between general pharmacies, along with management of patient expectations would be key. The ICB would work with stakeholders to ensure the service was a positive experience for patients and there was a need to understand and accept there were capacity issues with some pharmacies, and these would need to be worked through as the service launched. HB commented whilst this was very welcome, she thought the amount of work created in general practice would be quite significant. HB gave an example around the impact of a patient presenting in a pharmacy with high blood pressure, the work this created and the consequences not fully thought through. Whilst this is a national concept, HB thought that there was an opportunity lost as capacity was diverted away it would have been more useful to manage many more communications around blood pressure. SN echoed the point HB made and drew a parallel on the work done with LD annual health checks. There was a campaign and health promotion which created demand in general practice which they struggled to cope with and agreed there needed to be thought about the impact of this. PT had some points that he wanted to acknowledge. As the commissioner responsible for contraceptive services, he asked to continue to be involved and he supported widened access. SG agreed she had spoken mainly about the Pharmacy First service and there was an expansion of the blood pressure and oral contraception services. SG went on to say she was linked in with oral contraception because that was the model for the independent prescriber pathfinder programme as well so had linked in with ICASH. SG believed pharmacies would focus on the Pharmacy First element to begin with and as the services progressed, they would tie in	

	with other services to obtain the fixed monthly fee and pharmacies would have to provide all the services. SG agreed that as the year went on, she would continue to carefully monitor progress. PT also wanted to emphasise the great work that happened in the general practice setting. The LARC rates were some of the best in England and the backbone of this was the provision by practices. There was a need to think about the pathway and if this was appropriate as ICASH would struggle if they started to see a significant increase in activity. SG confirmed it was more the referrals from ICASH into pharmacy and it was a separate process with the pathfinder sites yet to be confirmed. Once this had happened the work would link up with local general practice. TD noted the opportunity as pharmacies would focus on Pharmacy First and to stop patients going back to the GP practice when they could be treated in Community Pharmacy. The impact would not be seen quickly but given this was new funding there was an incentive for pharmacies to take this up and hopefully take some appointments off general practice. The hypertension service was an opportunity to move some routine monitoring to community pharmacy. TD agreed there should be conversations about preparedness, capacity and the usage of services. DB acknowledged the report was for noting and asked for the Committee to be updated when SG felt it was appropriate. SG agreed to monitor and evaluate this and the key would be the communication between the stakeholders. She would bring a report back to PCCC in due course. Committee noted the report.	
10.	**Operational Delivery Group Report** • **General Practice** • **Dental** *For Noting*	**SP/FT**
	SP presented the General Practice Operational Group report to Committee for noting. SP highlighted some key areas for information, including the monitoring of the e-declaration action plan and the efforts to improve the uptake of learning disability and severe mental illness health checks. The independent prescribing pathfinder programme mentioned by SG in the previous item was approved and there was an application from a practice to proceed with a project to convert from an owner occupier model to a landlord owned a lease model which was a key part of resilience for many practices. FT introduced the Dental Operational Group report. FT confirmed that this report was an update from 2 meetings, as the one in September 2023 had been cancelled. FT provided the highlights to note were that the approval of workforce recruitment and retention plans. The group received a report on the impact of patient experience and reflected back on the conversation held earlier and the importance of joining this up. FT highlighted the risk whereby many of the practices were forecast to underachieve on their activity and this was likely to be the case until the end of	

	the year. This was largely due to workforce recruitment and retention challenges. DB was pleased to hear the ODG supported the workforce plan. DB agreed it would take time for the workforce initiatives to embed and improve dental activity. DB confirmed Committee were happy to note the report and updates.	
11.	**Reports from the Pharmaceutical Service Regulations Committee** *For Noting*	**CH**
	CH presented the Pharmaceutical Service Regulations Committee report to Committee for noting. CH highlighted the Committee was hosted and chaired by NHS Hertfordshire and West Essex ICB who worked on behalf of the six ICBs in East of England. For this quarter there were no market entry applications and there were no breach or remedial notices issued for Norfolk and Waveney market entry applications under appeal. There was one fitness application granted on appeal for new inclusions on the pharmaceutical list and one not approved due to incomplete information. There was also a change of Superintendent approval. Reporting would occur on a quarterly basis and members and colleagues in the ICB were welcome to attend any future meetings should they wish to. DB thought it might be useful to listen in and it would be helpful to have that background. DB wanted to be clear that nobody had applied to open a pharmacy in Norfolk and Waveney during this period. CH confirmed this and that since April, seven community pharmacies had closed during that time. PT thanked CH and as they had not met thought it would be useful to catch up outside of the meeting as NCC commission public health services directly from pharmacy. PT had noted the impact of closures, not least where they were in some of our more rural or disparate communities. PT thought it would be helpful to have some intelligence from CH on the use of the PGD (patient group direction) model that was being developed. DB asked how the ICB compared with the other ICBs covered by the Committee and whether we were out of step or if it was a national trend. SG confirmed the ICB were inline and one of the biggest impacts was Lloyds Pharmacy had completely withdrawn from the bricks and mortar market. Their online operation had been sold to Pharmacy2U and in effect they have left the pharmacy market. We had 5 Lloyds Pharmacies within Sainsbury's and these were large ones and others were lost in other areas which had a big impact. Boots announced that they were going to close 300 branches nationwide and 2 of these additional closures will impact further in the future. TD provided further context. Nationally, there were just over 12000 pharmacies with over 2000 lost in the last 2-3 years and there would be further losses. This was not just permanent pharmacy closures. Opening hours had been lost as pharmacies had reduced their hours to contractual minimum. The fundamental	

	core funding problem for community pharmacy remained and the new services, whilst helpful, do not address the core viability of community pharmacy and their dispensing functions. Outside the period of the report there were two distant selling pharmacies that were granted and due to open in Norwich. Since 2015, 20 pharmacies had been lost across Norfolk and Waveney and the majority of those had been in the last year. There had been a shift from multiple ownership to independent ownership of around 20%. TD offered information around the Pharmaceutical Needs Assessment group for consideration. SG asked Committee to note work was being done with stakeholders in the areas where there were closures as there was an impact on general practice. SG also worked closely with the quality assurance pharmacists within KW's team and offered quality support visits. DB thanked CH and SG for the helpful discussion. The report was duly noted.	
12.	**Finance Report** *For Noting*	**JG**
	JG presented the month 7 Finance Report to Committee for noting. JG ran through the slide pack in some detail for Committee's attention. HW thanked JG for the report and welcomed the linkage between what was discussed in other agenda items and the finances. He thought the comments around dental reserves were particularly striking as they had been for some time. Committee had heard previously about not being able to meet the and it was quite significant for the budget. HW wanted to check on optometry to ensure the eye tests referenced earlier were covered. JG agreed they were in the ledger. Month 8 had been completed and this showed some increase against budget in those areas. DB thanked JG for the report which was duly noted.	
13.	**Quarterly Prescribing Report** *For Noting*	**MD**
	MD presented the quality prescribing report to Committee for noting. The first table benchmarked the ICB across the six ICBs in the region. The ICB was consistent being third. This did not show the whole picture as it did not factor in deprivation scores or rebates. £1m was lost due to a discrepancy between the Department of Health and NHS England who were to provide the ICB with either a rebate or clawback profits from the pharmaceutical industry and this had not been forthcoming. MD then went through the report in some detail for Committee's attention. KW thanked MD for the report and commented on the work which correlated with the infection prevention and control team's work on addressing the rates of CDiff. MD finished by saying it was important the messages were right in Pharmacy First, particularly around the expectations of an antibiotic being prescribed at the end of a consultation.	

	DB thanked MD for the report and this was duly noted.	
14.	**Any Other Business**	**Chair**
	Questions from the Public There being no further business or questions from the public, the meeting then closed at 14:55	

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

NHS
Norfolk and Waveney
Integrated Care Board

Norfolk & Waveney IBC Primary Care Commissioning Committee - Part One Action Log
13 February 2024

No	Meeting date added	Agenda Item	Owner	Action Required	Action Undertaken / Progress	Due date	Status	Date Closed
0171	12-Dec-23	4	SW	Agree minutes, sign and send to Chair for safekeeping		13-Feb-24		
0172	12-Dec-23	6	FT	Risk Register - FT to consider the score and timeframe for the dental risk.		13-Feb-24		

Norfolk and Waveney ICB – Primary Care Committee – 2023/24 PART ONE

		April	May	June	July	August	September	October	December	February	March	Notes
	Proposed date:	21st	9th	12th	11th	8th	12th	11th	12th	13th	12th	
Standing items:	Risk Register		Y		Y		Y		Y	Y	Y	Nov & Jan updates moved to Dec and Feb respectively. Now BAF risks and summary brought to committee
	Monthly Finance Report	Y	Y	-	Y	Y	Y	Y	Y	Y	Y	
	Estates Quarterly		Y	Y			Y				Y	To move to 6-monthly, with operational detail discussed at GP ODG
	Digital Quarterly			Y			Y				Y	To move to 6-monthly, with operational detail discussed at GP ODG
	Prescribing Report	Y	Y	Y	Y	Y	Y		Y		Y	To move to quarterly strategic report with operational detail discussed a GP ODG
	CQC Inspections Report	Y	Y	Y	Y	Y	Y				Y	Individual inspections to move to GP ODG, and reported through their report. Six-monthly update on system picture to PCCC Will include dental report
	Primary Care Performance Report	TBC										Business intelligence work underway. Separate dental dashboard to be developed by end of March. A dental dashboard is also being developed by March 2024
	General Practice Delivery Group Report					Y	Y	Y	Y	Y	Y	
	Dental Delivery Group Report						Y	Y	Y	Y	Y	
	Primary Care Strategic Plan										Y	This item may be delayed due to vacancy controls affecting capacity
	Joint Forward Plan							Y		Y		
	Strategic Workforce Plan	TBC							TBC		Y	
	Report on annual changes to primary care contracts and impact analysis										Y	
	Optometry services – contractual changes and other matters	TBC					Y		Y		Y	Brought as and when required. Quarterly report from hosted team
	Reports from the Pharmaceutical Services Regulations Committee	TBC					Y		Y		Y	Brought as and when required. Quarterly report from hosted team
	Primary Care Resilience (strategic report)						Y				Y	
	Dental End of Year report							Y				
Spotlight Items	Terms of Reference Review							Y			Y	Annually
	Healthcheck Stocktake report					Y						Moved to GPODG
	Dental Strategy and Workforce Plan										Y	
	Oral Health Needs Assessment			Y					Y			
	Place development and interface with PCCC						Y		Y	Y		Postponed to post organisational change
	Delivery Plan for Recovering Access to Primary Care							Y		Y		Postponed to March
	Complaints and contacts (JP)				Y				Y			Nov update moved to Dec mtg,
Items noted without a date:												

Please note this is subject to change once the delivery groups are established and once pharmacy, optometry and dental commissioning has been transferred
As part of the transition, to stand down Nov and January PCCC meetings

2023 - 2024

Ref	Risk description	Month risk rating											
		1	2	3	4	5	6	7	8	9	10	11	12
PC1	General Practice – Workforce (GPs and nurses)	12	12	12	12	12	12	12	12	12	12	12	
PC6	Learning Disability Annual Physical Health Checks	12	9	9	9	9	9	9	9	9	9	9	
PC9	Hypnotics and anxiolytics prescribing	12	12	12	12	12	12	12	12	12	12	12	
PC 14 BAF16	The Resilience of General Practice	16	16	16	16	16	16	16	16	16	16	16	
PC15	Wave 4B Primary Care Hubs – loss of capital funding	8	8	8	8	6	6	6	6	6	6	6	
PC16	Severe Mental Illness (SMI) Annual Physical Health Checks	12	12	12	12	12	12	12	12	12	12	12	
PC17	General Practice – Allied Health Professionals Workforce including PCN Additional Roles	12	12	12	12	12	12	12	12	12	12	12	
PC18 BAF18	Dental Services Resilience	12	12	20	20	20	20	20	20	20	20	20	

Commentary

Risks PC1, PC6, PC9, PC15, PC16, PC17 were presented to January General Practice Operational Delivery Group.

2022 2023

Ref	Risk description	Month risk rating											
		1	2	3	4	5	6	7	8	9	10	11	12
PC1	General Practice – Workforce (GPs and nurses)				12	12	12	12	12	12	12	12	12
PC6	Learning Disability Annual Physical Health Checks				12	12	12	12	12	12	12	12	12
PC9	Hypnotics and anxiolytics prescribing				16	16	16	16	12	12	12	12	12
PC10	Gabapentinoids prescribing in primary care				9	9	9	9	9	9	9	9	6
PC 14 BAF16	The resilience of general practice				12	12	16	16	16	16	16	16	16
PC15	Wave 4B Primary Care Hubs – loss of capital funding				8	8	8	8	8	8	8	8	8
PC16	Severe Mental Illness (SMI) Annual Physical Health Checks				12	12	12	12	12	12	12	12	12
PC17	General Practice – Allied Health Professionals Workforce including PCN Additional Roles				12	12	12	12	12	12	12	12	12
PC18	Transition and delegation of Primary Care Services (Dentistry, Optometry and Community Pharmacy)								16	16	16	16	12

PC14 (BAF16)

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

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Mark Burgis	Primary Care	Sadie Parker	01/09/2020	31/03/2026

Risk Scores

Unmitigated			Mitigated			**Tolerated** (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	**4**	**20**	**4**	**4**	**16**	**3**	**4**	**12**

Controls

- Locality teams and strategic primary care teams prioritised around supporting the resilience of general practice~~.~~ All practices have previously been supported to review business continuity plans
- PCN ARRS (additional roles reimbursement scheme) funding has increased again in 2023/24
- Primary care workforce and training team working closely with locality teams to ensure training available to support practices and PCNs in setting up and maintaining services
- Interface group with representation from primary, community and secondary care system partners
- Standard contract requirements on interface – gap analysis and action plans, including monitoring being reviewed by contracts team
- Commencement of LMC General Practice Alert System sitreps

Assurances on controls

Internal: Executive Management Team, workforce steering group, primary care strategic planning meetings, establishment of new medical operational delivery group

External: Primary Care Commissioning Committee, NHS England via delegation agreement and assurance framework, Health Education England, Norfolk and Waveney Local Medical Committee

Gaps in controls or assurances

- Practice visit programme, CQC inspections focused on where there is a significant risk or concern
- Vacancies within primary care, workforce, quality and locality teams impacts the level of support which can be provided to practices. ~~Potential for~~ Organisational change ~~to also~~ is impacting on support available ~~going forward~~ due to vacancy controls.
- Continued reports of poor patient behaviour across practices, decrease in patient satisfaction with general practice through GP patient survey, consistent with national position.
- Progress on interface action planning process across Trusts impacted by ongoing pressures and national strike action.
- Reporting process for inappropriate transfers of workload from community and secondary care providers to general practice not yet fully utilised by practices, leading to under-reporting of issues.
- Workforce and capacity shortages across community pharmacy and dental practices, and ongoing drug shortages, are having an impact on general practice and the rest of the system.
- ~~Lack of clarity~~ Pressure on primary care budgets due to the ICB's financial position ~~leading to delays (or potential ceasing) of~~ impacting on our ability ~~work~~ to support resilience and transformation in general practice

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion

Nov 2023	• 2 GP Practices have contacted the ICB stating that they are facing resilience issues, including workforce challenges, and are at risk. These practices have been contacted and supported by the ICB to ensure that patient services can continue to be provided. • Further GP Practice resilience issues have been identified through the LD Health Check programme and the completion of the annual practice E-Dec Declaration statement. • 62 Applications have been received from GP Practices applying for the £340k winter monies identified in November. Further funding may potentially be identified and released in the New Year • The CQC have advised they will be implementing their Transformational inspection programme from the 9th January 2024. • System primary care access and improvement plan has been received by ICB Board. Work continues on our interface processes. The ICB is linking with another ICB in England to learn from them and continually improve our processes. • A vacancy in the primary care team has been recruited to on a 3-month secondment, however, there remains concerns about capacity in the team. There is also no dedicated support for the interface programme in the ICB structure. It is expected these matters can be rectified once the ICB's organisational change process has completed. • In October 2023 a 12 month "Work Well Webinar Programme" launched which is based on the themes identified in the June 2023 Health and Wellbeing Survey. These include Burnout, Stress and Harassment) in the survey to support Health and Wellbeing for primary care. • Recruitment is pending for a Primary Care Health and Wellbeing Fellowship, which will help drive this agenda forward. • Primary Care Workforce (PC1 and PC17) has shown an 2% growth in general practice workforce across the system during 23/24. In addition, Primary Care Network Additional Roles Reimbursement Scheme has shown a 42% growth in workforce across the system during 23/24.		31.03.24
Jan 2024	• £750k further winter funding for general practice was released in January, along with a further investment of £750k in ARI (acute respiratory infection) hubs. This funding remains available for investment during quarter 4. • A significant number of practices have reported challenges with the annual health checks requirement for people with a learning disability and have requested additional support. Appropriate support has been agreed with respective practices. • The LMC has launched their General Practice Alert System, designed to monitor the resilience of general practice in a similar way to the Opel system. Anonymous sitreps are being provided to the primary care team. • Work remains underway to improve the issues caused at the interface between primary and secondary care. A new reporting form is proposed for implementation to automate the process and reduce administrative burden for all providers, LMC and the ICB. QEH has launched ICE requesting for pathology and radiology and a working group has been set up at the NNUH to seek to progress the project there, including colleagues from JPUH. A plan will be developed for 2024/25 and agreed through the interface group. The additional		31.03.24

	Interface task and finish groups continue and are reported against on a monthly basis in terms of progress. • The primary care and locality teams continue to work with individual practices at resilience risk to support them to stabilise.											
Visual Risk Score Tracker – 2023/24												
Month	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Score	16	16	16	16	16	16	16	16	16	16	16	
Change	→	→	→	→	→	→	→	→	→	→	→	

PC18 (BAF18)

Risk Title	**Resilience of NHS General Dental Services in Norfolk and Waveney**
Risk Description	Primary Care Services became the responsibility of the Integrated Care Board from 1st April 2023, the risk is the unknown resilience, stability and quality of dental services, and critical challenges relating to the recruitment and retention of dentists and dental care professionals and the limitations of the national dental contract, leading to a poor patient experience for our local population with a lack of access to NHS general dental services and Level 2 dental services.

Risk Owner	**Responsible Committee**	**Operational Lead**	**Date Risk Identified**	**Target Delivery Date**
Mark Burgis	Primary Care	Sadie Parker	01/04/2023	31/03/2026

Risk Scores

Unmitigated			**Mitigated**			**Tolerated** (Target in 36 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	**4**	**20**	**5**	**4**	**20**	**4**	**3**	**12**

Controls	**Assurances on controls**
• ICB primary care team recruited and in place working alongside newly recruited Quality Dental Nurse in Quality team and Finance colleagues, and Planned Care Team (for secondary care dental services) • Ring fenced dental budget for investment • Active engagement with dental contractors, LDC and Local Professional Network (and Managed Clinical Networks), regular dental newsletter in place • Dental Development Group established to engage with key stakeholders to agree short term plan by Sept 2023 • Dental Services Delivery Group established reporting to PCCC • Dental Strategy and local workforce plan to be in place by March 2024 • NHS England Long Term Workforce plan published June 2023 • NHS Business Services Authority performance/quality management reporting and quality framework in place with regular meetings established with the ICB. Access to eDen dental data management reports and dashboard for ICB staff. • Clinical expertise provided by NHSE through the LPN and Dental Advisor roles for 2023/2024 • Dental Data Review being updated to inform commissioning plans • Primary care workforce and training team working closely with delegated commissioning team to ensure workforce retention programmes and training support is linked to the Dental Delivery Plans	**Internal:** EMT, Primary Care Commissioning Committee, Dental Services Delivery Group **External:** NHS England, Norfolk and Waveney LDC, regional Local Professional Network and Managed Clinical Networks, Healthwatch Norfolk/Suffolk, NHS Business Services Authority

Gaps in controls or assurances

- The level of the unmet need for general dental services and the associated financial consequence of this once addressed (if possible) given the transfer for funds was based on 2022-23 current expenditure which are below budget required to meet population need

- Concern around the financial consequences due to dental contracts currently being returned or removed from providers, resulting in temporary and more expensive contracts with reduced activity and higher UDA (Unit of Dental Activity).
- Lack of access to NHS dentistry services is an area of quality concern. This impacts on some of our most vulnerable patient groups.
- Significant workforce shortfalls across general dental services, Level 2 services and secondary care dental services and a lack of comprehensive workforce data to support planning
- Lack of knowledge about the resilience and stability of existing dental services

Updates on actions and progress

Date opened	Action / Update	BRAG	Target completion
Sept 2023	The ICB has approved an Urgent Treatment Service pilot that is being mobilised and will be live during September for patients with an urgent dental need to receive urgent care. Nearly 30% of practices across Norfolk and Waveney have signed up to offer urgent treatment appointments. The pilot will be in place for 12 months with an option to extend for a further 6 months. A short-term initiative for 2023/2024 to support children's oral health education has also been agreed and providers have been invited to submit expressions of interest to the ICB. Other initiatives are under development as part of the ICB's short term plan. The Dental Development Group has supported the ICB's short term plan which will be published in September subject to final ICB approval by Primary Care Commissioning Committee and Executive Management Team. This includes identifying areas for access improvement in areas of greatest need using the Oral Health Needs Assessment as an evidence base to inform commissioning intentions, support to practices for quality improvement and workforce plans. Development of the ICB's long term dental plan is underway and subject to approval will be published in March 2024. All opportunities are being taken to actively engage with the dental profession which will help inform these plans in addition to a wider stakeholder engagement. Meetings of the ICB Dental Services Operational Delivery Group are taking place enabling the ICB and key stakeholders to take a deep dive when making decisions about important and urgent matters related to NHS dental services within the Scheme of Delegation of the Primary Care Commissioning Committee. The year end process for activity in 2022/2023 is underway which has identified a high level of underperformance largely due to difficulties in recruitment. The ICB is working with all providers to manage the financial impact of clawback. A lack of access to NHS dental services also has an impact on patient charge revenue		31/03/24
Dec 2023	The Mid Year Review of contracts achieving less than 30% by Sept has been completed by the ICB with NHS BSA to support. A number of practices at risk of achieving their activity by end of year have been contacted by the ICB to discuss how they can be supported. The key reason relates to recruitment challenges.		31/03/24

	The ICB has agreed a targeted reinvestment of monies freed up from contract terminations during 2023 to improve access and providers will be invited to bid for additional funding during Q4 2023/2024. Launch of Dental Workforce Retention Programmes and CPD training packages to support the upskilling and recruitment of the dental workforce supply. These are linked to the short-term dental workforce plans approved by the Primary Care Commissioning Committee in October 2023. To date the success of these incentives has increased N&W dental workforce by the following: • 3 x NHS Foundation Dentists - 2-year employment contract, once qualified. • 7 x NHS Dental Professionals – 1 year employment signed contracts • 3 x NHS Dental Professional - 1 year employment contract offered, awaiting signature. • 3 x NHS Dental Practices being supported with International Tier 2 Visa Sponsorship • 2x NHS Clinical Dental Fellowships in place to support with Children and Young People and Health Inequalities programmes The ICB has agreed in principle to supporting a review of UDA values. Practices with UDA values less than the current ICB average of £30 will be contacted individually during Q4 to agree their new contracts. The aim is to support recruitment and enable local providers to be more competitive in offers to dental performers.		
Feb 2024	A small number of practices have been identified as being at higher risk of instability due to historical decisions about commissioning. Potential support is being discussed with them. A risk register relating to dental matters is being developed for Dental Services Delivery Group. A four week engagement about the ICB's proposed Dental Long Term Plan proposals for next 2 years and beyond with members of the public and key stakeholders across Norfolk and Waveney, including the dental profession, was launched on 24 February 2024. Feedback will help inform ICB's plans due to be published Spring 2024.		31/3/2024

Visual Risk Score Tracker – 2023/24												
Month	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Score	16	16	20	20	20	20	20	20	20	20	20	
Change	→	→	↑	→	→	→	→	→	→	→	→	

Norfolk and Waveney
Integrated Care Board

Agenda item: 07

Subject:	**Holt Medical Practice Application to Close Blakeney Branch Surgery**
Presented by:	**Sadie Parker, Director – Primary Care**
Prepared by:	**Sadie Parker, Director – Primary Care**
Submitted to:	**Primary Care Commissioning Committee**
Date:	**13 February 2024**

Purpose of paper:

The purpose of this paper is to seek approval for a recommendation on Holt Medical Practice's (HMP) application to close their branch surgery in Blakeney, following an extensive period of engagement with their local registered population and wider stakeholders.

Introduction

In considering this paper, the Committee is invited to be mindful of the Board Assurance Framework (BAF) risk on the resilience of general practice, and our Joint Forward Plan commitments around this.

The ICB would like to acknowledge the efforts put into the engagement process by both the practice and the local community and stakeholders.

Background

HMP is a large practice (14,300 patients) in North Norfolk, covering a large rural area and operating out of three sites. The main surgery at Holt is large and purpose-built (1,186 m2), providing the full range of clinical services, all urgent/ duty services, a pharmacy and dispensing operation, and housing all the practice's back-office teams. It has been recently extended.

Melton Constable Surgery is a recently refurbished surgery with six consultation rooms (185 m2).

Blakeney Surgery is a small branch surgery with two consulting rooms (76 m2). Services from Blakeney Surgery reduced before the pandemic, in response to patient demand, and it was open for five mornings a week. For clarity, this was a decision supported by the commissioner of the time.

Like many branch surgeries, Blakeney temporarily closed on 20 March 2020, and face to face clinical services have not since been reinstated. The surgery is open five mornings a week (8am – 1pm) and staffed by a receptionist who provides administrative support to patients and a medicines collection service. For clarity, this temporary decision was also supported by the commissioner.

HMP has set out their rationale for closing Blakeney Surgery, and their application centres on the following points:

- Business viability and operational future-proofing – the costs of running three sites is prohibitive, and the cost of running Blakeney is more than the reimbursement received.
- Attracting new partners and reducing the buy-in required, with five of the seven clinical partners looking to retire in the next six years.
- The most efficient and effective use of a limited clinical and non-clinical workforce.
- The inability for a multi-disciplinary team to operate effectively in the Blakeney branch surgery means the workforce would be used inefficiently.
- The standard of the Blakeney building and the investment required to bring it up to modern standards, including the current poor infection control measures (for example, carpeted rooms, sinks and taps, sluice in the consulting room and no space to rehouse it, inability to access all sides of the examination couch).
- Future population growth mainly in Holt (including a new large care home) and also Melton Constable, with smaller growth in Blakeney.
- The majority of the practice's registered population being adequately served by Holt (Kelling) and Melton Constable surgeries.
- The historical usage of Blakeney appointments – HMP patients have tended to travel, from all over HMP's catchment area, to the site where a preferred appointment is available. Analysis by HMP shows that of the 3000 appointments offered at Blakeney in 2015-2019 (5% of the total appointments offered by HMP), 18% of patients were from Blakeney or Morston and 15% were from Melton Constable or Briston. (Note this doesn't take account of the numbers of appointments an individual had.)

Please note more detailed information on the rationale and the feedback from the practice's extensive patient engagement is in the practice submission appended to this report.

As part of their application, HMP have noted that, if they are required to provide face-to-face services again at Blakeney Surgery, apart from their concerns about how the building would be refurbished and updated, this may require the practice to consider how services are provided across all of its sites to manage clinical and administrative resources effectively. With finite resources, they wish to use their resources as effectively as possible, focused where they can have the greatest benefit to meet the needs of their whole patient population.

HMP has confirmed it is committed to continuing to provide a medicines collection service, subject to discussion with potential local community sites.

Patient Engagement

HMP undertook a significant engagement exercise with the support of Healthwatch Norfolk from 1 August to 30 September 2023. This consisted of a survey, public meeting, five drop-in sessions and inviting written feedback by letter, email or comment card. HMP also regularly briefed their patient participation group.

- 675 surveys were completed.
- 60 letters/emails/online forms before the engagement phase commenced.
- 140 letters/emails/online forms during the engagement phase.
- 155 comments cards were completed across the three sites during the engagement phase.
    - Holt x44
    - Melton x38
    - Blakeney x53
- 200 people attended the public meeting.

Over half of the survey responses HMP received came from the Blakeney area, with a quarter coming from the Holt area and 12% from the Melton Constable area. From the survey the most important factors for people who responded were:

- Having a face-to-face appointment – 68.4%
- Being able to collect repeat medicines close to where they live – 52.9%
- Having healthcare services close to where you live – 50.6%

The key themes collected from all communication received by the practice were:

- Keep Blakeney Surgery open.
- Valued community asset.
- Wanting a return to pre-Covid services in Blakeney.
- Local medication collection.
- Concerns about transport for those that can't drive, and about carbon footprint.
- Concerns about vulnerable patients.
- Suggestions to crowd fund for the investment required.
- Concerns about Melton Constable Surgery being next.
- Wanting more engagement.
- Being positive about better understanding the proposals and rationale.
- Being positive about the quality of care provided by the practice.

Officers are satisfied the practice undertook significant and comprehensive patient engagement and this has been verified independently by Healthwatch Norfolk. In addition, the director of primary care was directly copied in to many of the letters received, and reviewed the communications received by the practice in person. We are satisfied that the report received from the practice is an accurate reflection of the patient feedback received.

Notwithstanding this, due to the community's principle wish for a return to consultations out of Blakeney Surgery, the public focus has remained strongly on this outcome. As a result, there was less detailed feedback collected relating to the

possibility of closure of Blakeney Surgery and mitigation (i.e., for an alternative medication collection service/ location). However, ICB officers believe this is an important part of the engagement process and would suggest further ICB public involvement with local stakeholders on this point in order to enable PCCC members to make an informed decision (this would be under our duty of public involvement and consultation (s.14Z45)).

Blakeney branch surgery estate

A site visit was organised to all three HMP facilities in January, kindly supported by the practice team. This included the chair and vice chair of the Committee, head of finance (representing the executive director of finance), the director of primary care and the associate director of primary care estates from the Integrated Care Board. Healthwatch Norfolk was also in attendance.

The associate director of primary care estates has provided information for inclusion in this paper.

Holt Medical Practice (Kelling)

Total reimbursable space for the practice demise within the building equals 1,186 m2 and is the sixth largest GP premises (out of 155) within Norfolk & Waveney. The site is owned by Primary Health Properties (PHP) and leased to the practice under a 21 year fully repairing and insuring lease which will end in 2043. At this point there is no reason to believe the lease will not be extended beyond this period and it is normal practice for primary care premises to be leased on a maximum of 20 to 25 year period. The wider site offers the ability for future expansion if required.

The building itself is in a good state of repair, has compliant clinical rooms and offers a flexible space for the practice to deliver services from. This site has benefited from recent investment from PHP and the NHS via capital works to extend the building. These works were completed in 2022 and in total cost £1.7m which was split approximately £1.0m NHS contribution and £0.7m PHP contribution. The partners have also invested in the building (not all costs are reimbursable by the NHS) and have seen increased ongoing running costs associated with the extended premises. This level of investment underlines the importance of the facility in the area.

Holt Medical Practice (Melton Constable)

Melton Constable site is owned by the GP partnership and has net internal area of 185 m2. This makes the site one of the smaller premises within the ICB but the premises was refurbished in 2021 and offers clinical rooms to higher specification compared to many other buildings of a similar age. The premises has also recently benefited from further investment from the GP partnership via a new roof. Although physically (and operationally) unable to offer the flexibility of the main practice site, the ability to offer six clinical rooms means the property still enables the practice to deliver a scale of service and outreach from the main site.

Holt Medical Practice (Blakeney)

Blakeney site is owned by the GP partnership, has net internal area of 76m2, houses two clinical rooms and is one of the smallest premises within the ICB. The consulting rooms are small when compared to modern standards, they don't meet infection prevention and control standards, and it is not possible to move around the couch, for example to perform adequate examinations or to perform cardiopulmonary resuscitation (CPR).

If the site is required for longer term use then the property would benefit from investment to improve the clinical rooms and general functionality of the building, noting it has been rated as Red for Functional Suitability when independently inspected in 2021. With only two clinical rooms, the site is not able to offer a high volume of appointments. The building does not lend itself to deliver modern general practice services where a range of clinicians deliver services. There is no space bordering the site that could be expanded onto nor is the local parking suitable to manage an increase in patients attending the facility.

With limitations of the existing building and the capacity available within other sites, then capital investment into the Blakeney site from the ICB would be unlikely, compared to alternative schemes across the ICB footprint where there is existing capacity shortfall.

Considerations in decision-making

PCCC has the authority to decide on the application. When the committee makes the decision, it does so following the NHSE Policy Guidance Manual, the ICB's Advice Note 3: Branch Closures, and with the ICB's statutory duties in mind.

- S.14Z35 – Duties as to reducing inequalities in access and outcomes.
- S.14Z43 – Duty to have regard to the wider effect of decisions (the triple aim)
- S.14Z44 – Duty to have regard to the need to comply with climate legislation. Consideration should be given to the guidance from NHS England.
- S.14Z45 – Duty of public involvement and consultation
- S.149 - Equality Act – Public sector equality duty

The General Medical Services (GMS) contract with HMP is for the services provided to its whole population, as such we need to bear in mind the impact of any decision on all patients registered with the practice, as well as the people living locally to Blakeney Surgery. In doing so we have to ensure the practice can continue to meet the reasonable needs of its patients.

Clauses 8.15.13 and 8.15.14 of the NHSE Policy Guidance Manual set out the considerations in assessing applications from practices to close a branch surgery:

- *financial viability;*
- *registered list size and patient demographics;*
- *condition, accessibility and compliance to required standards of the premises;*
- *accessibility of the main surgery premises including transport implications;*
- *the Commissioner's strategic plans for the area;*

- *other primary health care provision within the locality (including other providers and their current list provision, accessibility, dispensaries and rural issues);*
- *dispensing implications (if a dispensing practice);*
- *whether the contractor is currently in receipt of premises costs for the relevant premises;*
- *other payment amendments;*
- *possible co-location of services;*
- *rurality issues;*
- *patient feedback;*
- *any impact on groups protected by the Equality Act 2010 (for further detail see chapter 4 (General duties of NHS England);*
- *the impact on health and health inequalities; and*
- *any other relevant duties under Part 2 of the NHS Act (for further detail see chapter 4 (General duties of NHS England).*

Equality impact assessment

Both the practice and the ICB have undertaken an equality impact assessment (EIA) of the application to close the premises in Blakeney and the practice's proposal to provide a residual medicines collection service. In doing its EIA, the ICB is aware the practice's population is rural and many patients live in areas which make travel to one of the surgery sites more challenging. While the practice population is not deprived overall, the data may mask pockets of rural deprivation.

It is noted the practice already provides the following services to meet the reasonable needs of its population and seek to improve access:

- Dedicated early visits GP – a GP based at Holt which travels across the practice's area for patients who need to be seen face to face but are housebound.
- Online consultations and telephone consultations where clinically appropriate and to meet patient preference.
- Medicines home delivery for housebound dispensing and pharmacy patients, with the costs met by the practice.
- 2 duty GPs at all times for urgent clinical needs, and in order to clinically supervise the multi-displinary team.
- Online medication ordering facility, either via the NHS App or patient access.
- Certain vulnerable patients, who struggle with online access, are able to telephone to order their prescriptions.
- Texting patients when their medicines are ready for collection, to avoid wasted journeys.

The EIA identified a number of actions for the ICB and the practice in assessing the practice's registered patient population. These include ensuring staff are aware and trained as appropriate in areas such as those covered by the NHS Accessible Information Standard and understanding people's cultural needs.

In addition, the ICB's EIA suggested to us further work may be beneficial on the practice's proposed medication collection service to understand what might be needed for groups, such as those who are digitally excluded, or those who are carers. This ties in with the above patient engagement section, which suggests there was less detailed information collected on the practice's proposed mitigation. Working with local voluntary organisations, such as those who provide transport, was also highlighted as a potential action.

A clinical quality risk assessment (CQRA) has also been drafted. This highlights the issues with infection prevention and control, the issues around the size and configuration of the clinical rooms, and the proposals for medicines collection to remain in Blakeney.

ICB strategic plans

Our Joint Forward Plan commitment is to build the resilience of primary care. For general practice, the aim is to support the development of integrated neighbourhood working, something which our ongoing Community Services Review is designing in conjunction with our local clinicians and providers.

National policy for general practice centres on the following areas:

- The delivery plan for recovering access to primary care, specifically implementing the modern general practice access model, cloud-based telephony, Pharmacy First and Digital services through the NHS App.
- Developing services through the PCN (primary care network) and at scale services, such as providing enhanced care to care homes, enhanced access appointments through hubs in the evenings and on Saturdays, social prescribing and structured medication reviews.
- Each PCN has developed an access improvement plan, in line with national requirements. HMP is in a PCN along with Sheringham and Fakenham practices.
- The PCN plan includes ensuring cloud-based telephony is in place across all practices, reviewing online consultation systems, improving local feedback on access through the Friends and Family Test, and their patient participation groups.

Considering the wider impact of decisions

ICB officers have written to a wide range of health and care service providers to understand the potential for impact on the services they provide to patients of the Holt Medical Practice, should the Blakeney branch surgery close. This included neighbouring practices, the PCN clinical director, Local Medical Committee, Local Pharmaceutical Committee, Norfolk County Council, Norfolk and Suffolk Foundation Trust, Norfolk and Norwich University Hospital Trust, Norfolk Community Health and Care Foundation Trust, North Norfolk Primary Care and North Norfolk District Council.

Not all responses have been received at the time of writing, therefore a verbal update will be provided in the meeting.

Duty to have regard to climate legislation

It should be noted that, following the temporary closure of the Blakeney branch surgery in March 2020, face to face appointments have not been resumed. The practice have stated that an average of 37 patients collected their medication from the site on a daily basis during February and March 2023. The practice has set out its intentions to seek to provide an ongoing medicines collection service local to Blakeney, should their application to close the branch surgery be approved.

HMP covers a very rural area in North Norfolk, and there are challenges for many of its rural communities in accessing public transport. There is a hopper bus serving Blakeney from neighbouring villages, however there is no direct bus journey from Blakeney to Kelling or Melton Constable, as reported in previous papers. There are local charities that provide volunteer drivers to transport people to appointments, as well as other settings, for a small charge.

Census data from 2021 compares vehicle ownership in North Norfolk to other areas in the UK and Norfolk. North Norfolk has the oldest average population at 50.1 years and has a vehicle ownership level of 85.4%. While this is not broken down to Blakeney, we have assumed similar levels. The Norfolk Joint Strategic Needs Assessment from April 2021 notes the average in Norfolk to be 67%, which is higher than the England average of 58%.

Patients have the option of contacting the practice online or by telephone, and appointments can also be offered remotely when clinically appropriate.

Options for committee to consider

1. To agree the application to close the Blakeney branch surgery.
2. To reject the application to close the Blakeney branch surgery.
3. To defer the decision and consider further public involvement by the ICB to understand patient views on the practice proposal to provide a residual medication collection service in Blakeney to inform the decision.

While the practice provided a comprehensive application, it is noted, due to the community's principle wish for a return to consultations out of Blakeney Surgery, the public focus has remained strongly on this outcome. As a result, there was less detailed feedback collected relating to the possibility of closure of Blakeney Surgery and mitigation (i.e., for the proposed medication collection service). However, ICB officers believe this is an important part of the engagement process and would suggest further ICB public involvement with local stakeholders on this point in order to support PCCC members in any decision.

Option 3 is the recommended option and would allow ICB officers, as commissioners, to collect further feedback from local people on the practice's proposed residual service of a medicines collection service.

If this is agreed, the practice would be offered an opportunity to refresh their submission before it is brought back to committee for decision, along with ICB officers' final recommendation.

The proposed timeline would be to commence engagement with local stakeholders following the Committee meeting to inform how the engagement is undertaken, with a view to undertake supplementary engagement work in early March. Then to bring the application back to committee for final decision on 23 April (with papers being published a week before).

Recommendation to Committee:

PCCC members are invited to approve a recommendation to:

- Defer a decision on the HMP application to close the branch surgery at Blakeney until 23 April
- To undertake further ICB public involvement under its duty of public involvement and consultation, to explore the practice's proposed mitigation to offer a medication collection service in Blakeney.

If this recommendation is approved, the intention is to list the application for decision at a committee meeting to be held on 23 April.

Key Risks	
Clinical and Quality:	Primary care resilience has a significant impact on service provision to patients across all parts of the system. HMP has highlighted their application is designed to maintain their resilience in future. There are no clinical or quality concerns about the services HMP provides to patients.
Finance and Performance:	The ICB has no concerns about the performance of HMP and patient feedback about their experience of using their services is good. There would be a negligible saving in rent and rates reimbursement should Blakeney surgery closure be approved, however this could be made available to support any residual service estates costs.
Impact Assessment (environmental and equalities):	Both the practice and the ICB has undertaken an EIA. Further engagement is recommended as set out in the paper before a final decision is made. Concern about carbon footprint was raised in the consultation. The NHS aim for delivering a net zero greener NHS was published in 2020 setting out aims over which the NHS has direct control and those it can influence. The ICB's EIA takes into consideration health inequalities particularly in regard to rural areas. The practice boundary covers a wide geographical rural area with many small villages where transport and travel are issues for the whole registered population if they have to

	travel to one of the practice sites. It is also an issue in North Norfolk generally. The practice already has a free medicines delivery service for housebound patients, which reduces patient travel for this reason. Community transport options could also be explored. The NHS net zero aim places responsibility on NHS to ensure primary care estates are energy efficient.
Reputation:	There is significant local interest in the practice's application.
Legal:	Formal delegation agreement with NHSE, delegation assurance framework, NHSE Policy Guidance Manual, Advice Note 3: Branch Closures
Information Governance:	Not identified
Resource Required:	Primary care, quality, finance, comms teams, noting the capacity issues being experienced due to vacancy controls.
Reference document(s):	Formal delegation agreement with NHSE, delegation assurance framework, NHSE Policy Guidance Manual, Advice Note 3: Branch Closures, primary care assurance framework
NHS Constitution:	None identified
Conflicts of Interest:	None identified
Reference to relevant risk on the Board Assurance Framework	BAF16 – the resilience of general practice

Governance

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

Holt Medical Practice – Application to Close a Branch Surgery: Blakeney Surgery

Introduction

Holt Medical Practice ("**HMP**") consists of 14,300 patients across a large practice area.[1] We have three sites: Holt, Melton, and Blakeney Surgeries. We are based in a very rural area.

Our patients are registered centrally with HMP and then access services or appointments from any of our sites where they are being offered. Many services are only offered at our main site, Holt Surgery.

We have always offered a more limited range of services from our branch sites. Since March 2020 there have been no appointments at all available from Blakeney Surgery ("**BS**"). Currently, BS operates as a drop in reception and medication collections hub only and patients travel to Melton or Holt for their appointments. There have been no appointments at BS since March 2020.

Over the last few years, we have seen a significant increase in demand for appointments and the complexity of the patients we are caring for has increased. This, running alongside workforce challenges and rising costs means our resources are more stretched.

The main funding, we receive from NHS England is per patient, not per site. It is unusual for a medical practice to run three sites as it costs significantly more money and carries with it many more operational challenges.

With our population on the rise, and a responsibility to plan for the future we feel we need to make certain our finite resources are working as hard as possible for the widest benefit of all our patients. Towards the end of 2022 we met with Blakeney Parish Council ("**BPC**") to discuss the future of BS. BPC informed us that there was a formal process we should follow if we were considering closing BS. We therefore held initial conversations with Norfolk & Waveney Integrated Care Board ("**ICB**") in January 2023 and formally applied to close BS in March 2023.

We understand our application to close one of our branch surgeries comes at a time when the number of similar applications across the country are at an all-time high as many services are feeling stretched and threatened by the uncertain landscape of healthcare. We are aware that two other branch surgeries have recently been permitted to close and there is currently one other active application within Norfolk and Waveney ICB.

By making this application we are trying to be responsibly proactive so we can preserve the good service that we provide for our patients and the future of HMP and the Partnership. We are committed to finding a suitable alternative local medications collection solution should BS close.

The purpose of this paper is to provide the ICB with a reminder of our reasons for this application, an update on the patient engagement activity and to present our conclusions.

Section A

Main Reasons why HMP applied to Close Blakeney Surgery

Most of these reasons have been discussed at length with the community. First through correspondence with local parishes back in 2021, then towards the end of 2022 with the assistance

[1] Practice Boundary | Holt Medical Practice (holt-practice.nhs.uk)

of Duncan Baker. This was then reinforced within our consultation document[2] and the presentation[3] we gave at the Public Meeting on 1st August 2023.

In summary:

1) <u>General HMP Misc</u>

a) **HMPs Catchment Area -** neighbours 7 other GP Surgery catchment areas.[4] There is some overlap in certain areas within our catchment meaning that some patients have a choice of where they are registered. The majority of our population live *only* within Holt Medical Practice's catchment area. However, for some Blakeney residents and those that live to the Northwest and West of BS (those that are furthest away from Melton or Holt Surgeries), there is overlap with Wells Surgery's catchment area and therefore a choice of which practice to register with.[5]

b) **Population Local to BS** – HMP has approximately 14,250 patients across a large practice area.[6] Postcode data from our clinical system shows that approximately 1950 patients live in Blakeney and the surrounding villages of Cley, Morston, Langham, Cockthorpe, Kelling, Wiveton and Salthouse.[7] This amounts to 14% of our population. 625 of these patients live in Blakeney, which is just 4.5% of our total practice population.

c) **Holt is purpose built –** Holt Surgery is by far the largest of our three sites, and was purpose built in 2003 to be a GP Surgery. It had a further extension in 2021 and now has 21 clinical rooms based off 4 waiting rooms.[8] It also houses our administration teams upstairs, along with our meeting/training rooms and staff room.[9] There is a dispensary and pharmacy on site and free parking for approx. 40 cars (plus the same for staff parking). It allows for a full healthcare service to be provided to patients in a safe, clean, and professional environment. Its layout lends itself to multidisciplinary team working. Melton is our next largest site with 6 consultation rooms,[10] and then BS with its 2 consultation rooms.[11]

d) **Historical Access -** Patients have always travelled to Holt Medical Practice for much of their care (even if they have not needed to attend any routine appts at our branch sites). Below are some of the reasons for this:

i) **The Duty Team** - urgent/acute on the day care has only ever been offered out of Holt Surgery (save for a handful of exceptional circumstances where, because of a power cut or a flu clinic, for example) we have temporarily moved it to Melton Surgery with its 6 clinical rooms. The duty team consists of 2 duty doctors, nurse practitioners,

[2] Appendix A1 – main consultation document
[3] Appendix A2 – public meeting presentation and notes
[4] Appendix A3 – neighbouring catchment areas
[5] Appendix A4 – catchment area overlaps - (between the red boundary line of HMP and the green boundary line of Wells)
[6] Appendix A5 – where our population lives
[7] Appendix A6 – split of the 14% local to Blakeney
[8] Appendix A7 – Holt Surgery Ground Floor Plan
[9] Appendix A8 – Holt Surgery First Floor Plan
[10] Appendix A9 –Melton Surgery Plan
[11] Appendix A10 – Blakeney Surgery Plan

paramedics, physician associates and a minor illness nurse. All of these on the day (or short notice, acute) appointments are only offered at Holt Surgery.

- Demand for acute appointments has steadily increased over the last 5 years. In 2018, we offered 29000 acute appointments and in 2022 this has increased by nearly 3000 appointments to 31900.

- Historically duty used to be run by just 1 GP, now we need 2 doctors (3 on a Monday morning) all day. This creates a minimum of 80 acute, on the day appointments with a GP who simultaneously provides essential supervision to the wider duty and dispensing teams. This much needed, but location specific use of two GPs has reduced the number of GPs available to work from our branch surgeries. This allows us to meet the increased demand and the national access targets.

- We also have a dedicated Early Visits GP who is part of the Duty Team. They are also based out of Holt for centrality and ease of access to the whole catchment area. This effective, location specific use of another GP further reduced those available to work at branch surgeries. Given the demographics of our patients and the rurality of our area, this role is much valued and enhances our on the day care for our patients when they need it most.

ii) In addition to the Duty Team, there are **many other appointments and services that are only available at Holt Surgery** for a variety of reasons:

- Equipment – some equipment is only found at Holt – the spirometer, the ECG machine, the Doppler, the electronic health pod. Any patient requiring this equipment as part of their care will be required to attend Holt Surgery.

- Minor Operations – these are only performed at Holt where there is a dedicated room compliant with the corresponding infection control standards and where the specialist equipment and trolley are kept. An HCA assists the GP with these operations and so both staff must be located at Holt.

- Chronic Disease Management – these appointments have always predominantly been offered out of Holt Surgery (with small number of clinics run out of our branch sites).

- Pharmacist led services – our clinical pharmacists are based solely at Holt. Not only do they support the medicines management team (based entirely at Holt Surgery) but they provide additional on the day acute care, alongside the Duty Team and some access to routine services (such as smoking cessation, blood pressure monitoring, pill checks).

- PCN / Enhanced Access appointments – these are our late night, early morning, and Saturday appointments. These are only available from Holt due to supervisory, operational, and geographical reasons. Holt Surgery is the most central surgery to our PCN area.

- COVID and Flu clinics – a handful of flu clinics used to be held at our branch surgeries, but since the introduction of the COVID vaccination and the different clinical restrictions regarding its administration, these are always held at Holt Surgery where appropriate clinicians can work in a safe, socially distanced manner and parking and queue control can be efficiently managed.

iii) **Operationally** – much of our business function and non-clinical workforce are based at Holt Surgery. Holt Surgery houses our centralised business management team, IT function and support, our centralised telephones (all calls are directed to Holt) and is where the reception team, medical secretaries, nurse administrators, prescription and dispensing team and post room functions are based. These staff need to be grouped together, and able to access clinical support/supervision when needed.

This model exists not just due to HMP believing this is an efficient way to operate, but it is in line with the model of working that is recommended by the ICB and Arden & Gem – enabling better future functionality and joined up working as PCN work increases and technology advances. You cannot work out of branch sites in this way.

iv) **Third party services** – many other providers have relocated to central hubs, away from GP Surgeries. For example, maternity services – these used to visit Melton and Holt Surgeries and now are based solely out of Fakenham and Cromer, where this cohort of patients are expected to travel to.

2) <u>Historic Usage of Blakeney Surgery</u>

a) **Opening Times** – Holt Surgery is open 08.00 – 13.00 and 14.00 – 18.30, 5 days a week. Currently BS is open 08.00 – 13.00, five days a week.[12] The opening times of all our three sites have changed and evolved over time with the needs of the business. The opening times of Blakeney have never mirrored those of the main site at Holt Surgery.

b) **Range of Services -** There has been misunderstanding and often misrepresentation about the range of services that were provided from BS (or indeed from our other branch surgery at Melton). As you can see from the data[13], of the 20,000 appointments that were offered out of Blakeney between 2015 and 2019, 24% of them were with an HCA, and 72% were with a GP. This accounted for 96% of the total appointments available from Blakeney. It is worth noting the difference in the range of services provided from Holt Surgery to Blakeney Surgery.[14] This is the way that HMP has always operated.

c) **Frequency of Services** –the total number of BS appointments held during 2015 – 2019 consisted of only 5% if the total number of appointments offered across the whole of HMP.[15] This equates to an average of 2 or 3 clinical sessions per week held out of BS during this period.

d) **Dispensing at Blakeney** – historically each of our three sites stocked and dispensed a full range of medication. Back in April 2019 it was decided to relocate the routine medicines

[12] Opening Hours | Holt Medical Practice (holt-practice.nhs.uk)
[13] Appendix A11 – appt data H, M & B 2015 – 2019 (tab, Blakeney Jan 15 - 19)
[14] Appendix A11 – appt data H, M & B 2015 – 2019 (tab, Holt Appts Jan 15-Dec 19
[15] Appendix A11 – appt data H, M & B 2015 – 2019 (tab, Summary 15 – 19)

stock from BS to Melton Surgery. The Blakeney scripts were then prepared from the combined stock held in the better equipped and larger space at Melton Surgery and transported back to Blakeney for patients to collect. This assisted with efficiencies, quality and staffing. In 2021 all dispensing activity was moved from Melton Surgery to Holt Surgery where we now dispense medication for all of our patients and operate on a hub and spoke model. In February and March 2023, an average of 37 patients per day (Monday to Friday) collected their pre-prepared medication from BS.[16]

3) <u>Appointment Usage at BS</u>

We have investigated where patients had travelled from to access the appointments at our sites.

a) Between 2018 and 2019 there were approx. 6700 appointments in BS, 17,200 in Melton Surgery and 128,200 at Holt Surgery. We have analysed the postcode data of the patients that attended those appointments. You would expect the data to show that patients travelled from all over to attend the appointments at Holt Surgery, however, the data also shows that **patients travelled from all over the catchment area to attend the appointments at BS and Melton Surgery** as well.[17]

b) Between 2018 – 2019, **over 3,000 *different* patients attended the appointments available at BS**.[18] This is an average rate of 1 patient to 2 appointments.

- 545 of these patients (18%) were from Blakeney or Morston.
- 447 of these patients (15%) were from Melton Constable & Briston.

Many of these 3000 patients were only seen once, and some patients were seen over 10 times, however, the data supports the fact that there was a wide range of different patients, from a wide area, using the BS appointments. This search data contains patient identifiable data and so has not been included for review in our final report. It is available for inspection.

c) **Reintroduction of f2f appointments at BS** - If appointments were made available at BS in the future, there would be a **corresponding <u>reduction</u> in available services and appointments from Holt and Melton Surgeries**. Staff would need to be diverted from Holt and Melton Surgeries to provide for this; there are no additional staff ready and waiting to be placed at Blakeney.

d) **Conclusion** - Postcode data shows patients regularly travelled all over our catchment area, between sites, to attend appointments. Patients often followed their preferred clinician or were prepared to travel to secure an appointment. If appointments are reintroduced at BS, there will be less available to be offered at Melton and Holt Surgeries.

4) <u>Workforce – Current</u>

a) **National shortage of GPs & Modern Model of Primary Care** - this has led to a wider multidisciplinary team being utilised in primary care to meet patient demand, mandated by the Government, and tied to redirected funding, that cannot be used for the recruitment of

[16] Appendix B2 – Blakeney data capture – Activity from 09.02 – 31.03
[17] Appendix A12 – Map of postcodes of appts 2018 – 2019
[18] Appendix A11 – appt data H, M & B 2015 – 2019 (tab, All 3 Sites 18 - 19)

GPs. The profile of our clinical staffing has changed with a decreased proportion of our total appointments being GP appointments.

b) **Increased GP Led Clinical Supervision** - these additional, wider clinical roles are rarely independent practitioners and therefore need to work on site, alongside GPs who can supervise. Operationally, this means HMP has less flexibility about where GPs can be located during the working day as many of our wider clinical team cannot work independently. Remote supervision is not possible from Holt to either branch surgery. However, at Melton, with six clinical rooms, a single GP can supervise numerous members of staff. BS only has 2 clinical rooms.

c) **Increased Demand & Complexity of Appointments in Primary Care** – the demand for appointments has risen significantly in the last 5 years. The only way we have been able to meet this demand has been to recruit a wider clinical team (requiring more GP led supervision, based at Holt Surgery) and utilise another GP as our second Duty Doctor (meaning one less GP available to work flexibly).

d) **Other GP Led Commitments at Holt Surgery Reducing Operational Flexibility** – as an established training practice we continually host students from the UEA and GP Registrars. The student groups are large requiring access to the seminar rooms (exclusively located at Holt Surgery) and simultaneous use of 3 clinical rooms. GP Registrars are not allowed to work independently at any site.

e) **Staff Retention & Recruitment** – in the last five years HMP has seen a noticeable change in staff retention; 61 of our 93 staff have joined us since Jan 2019 – this equates to a 66% turnover. This is reflected nationally, with an exodus of staff from the NHS. In addition, our rurality is a challenge. We have less of a population pool to recruit from and staff we do recruit, need to travel longer distances to reach us. Most staff are reluctant to work over three different sites. It increases travel costs. BS is further away from most staff than Holt or Melton Surgery.

f) **Conclusion** – We are operationally stretched over 3 sites with less flexibility than we previously had. Considering the workforce issues, we would be safer and more resilient over 2 sites.

5) <u>BS Premises – Current Footprint</u>

a) **Estates** – Blakeney at 76m2 is one of the smallest premises within the Norfolk & Waveney ICB. There are only 5 (out of the total 155) other sites within Norfolk & Waveney which are smaller than the BS, and all of these operate on part-time hours.[19] Of the 5 that are smaller, only 3 still function as branch sites. We are unsure of the range or frequency of services provided from these sites during their opening times. It is very unusual to run a GP Practice across all three sites. We understand from the ICB Estates Team that there are only 11 practices that have more than 2 sites.[20]

b) **Surveyors Report** - The ICB asked Chaplain Farrant to undertake a survey of all branch surgeries in 2021.[21] The report on BS identified the need for £41,000 + VAT to be spent on

[19] Appendix A13 – Sites in N&W Smaller than BS
[20] Appendix A14 – N&W Surgeries with 2 or More Sites
[21] Appendix A15 - Chaplin Farrant Report on BS

physical improvements to the bricks and mortar (to bring the building up to RAG rating B) and £75,000 + VAT internally, to make it "*functionally suitable*" and "*to comply with minimum building standards*" for a GP site. As the report was compiled in 2021, these estimated costs will since have increased. The report highlighted the need for investment in a building that is not currently deemed fit for purpose.

c) **Investment** – the above Report suggested a minimum investment of £116,000 was needed to bring BS (on its existing footprint) up to acceptable standards. We have enquired of the ICB estates team whether or not there would be any NHS England funding available towards future improvements at BS. We are led to believe, based on the criteria applied by NHS England for investment in estates, that there would not be. Furthermore, any NHS England funding, were it to be secured, would only be up to a maximum of 66%, requiring a further 33% investment (minimum) from elsewhere.

The Partnership has recently made significant investments and improvements at Holt and Melton Surgery. Whilst some of the costs of these improvements were covered by funding from NHS England and our Landlord (at Holt Surgery) there was a significant investment from the Partners. This amounted to approximately £83,000 at Melton Surgery and £55,000 at Holt Surgery.

Alongside any investment in expansion or improvement to enable them to continue, there are associated and ongoing costs. For Holt Surgery, since the extension and expansion, the running costs have now increased to reflect the increased space that needs heating, lighting, and maintaining. If Blakeney were to receive initial capital investment, there would be associated ongoing (or increased) running costs.

d) **Running Costs** – the cost of running three sites is expensive. Utilities have increased at a much higher percentage than any reimbursements we receive from NHS England. Surgeries running multiple sites do not receive any additional funding (other than rent) to reflect the additional costs of three sites, despite these costs being proportionately greater. Our rental income for BS is currently £9000 per annum. Our running costs in 22/23 (attached solely to the premises) came to £10,100. This included utilities and building maintenance etc but excluded staff. Then, on top of *expected* costs associated with running premises, there are *unexpected* costs – such as the roof at Melton Surgery needing replacing in December 2023 at a significant cost to the partnership of £25,000. Running and maintaining buildings is expensive.

e) **Staff Facilities** – there is no space for a staff room or kitchen, as recommended in the report. This makes for less comfortable working conditions for staff at a time when it is important to do what we can to support them.

f) **Infection, Prevention and Control** – the current standards fall below those that are now routinely expected. As part of any refurbishment, we would need to: replace the carpets, fabrics, furnishings, sinks, and create a clean and dirty utility. One of the report's recommendations is to have a clean and dirty sluice. ON the site's current footprint, this could only be created by further reducing the space in the clinical rooms or the already minimal storage.

We were last inspected by the CQC in 2016 and again in 2018. It is not clear from the 2016 report whether the inspectors visited either of our branch sites. In 2018 the inspectors

visited Melton Surgery (not BS). We do not believe BS would now pass as compliant for infection, prevention, and control standards, on re-inspection.

g) **Layout of Clinical Rooms** – whilst one of the clinical rooms hits the required minimum 15m², the patient couch is located within an alcove (previously used for a cupboard). This causes issues with access to the patient during examinations. The other room has equally prohibitive but different, design issues with its layout. Both rooms need gutting and redesigning to improve the clinical and patient experience. Even the report highlights the need to redesign the layout.

h) **Accessibility** – neither of the two toilets are compliant with accessibility standards. This is the same for the reception desk. One suggestion is to make the current patient toilet larger to enable disabled access, which would reduce the space in the waiting room. There is not currently a suitable disabled parking space as the car park's surface would need relaying due to issues caused by the gravel.

i) **Availability of a chaperone** – we are noticing many more requests for chaperones (from patients and staff). Under the current footprint, you would only ever have a maximum of three people in the building, which could mean the receptionist needing to lock the front door to be able to be a chaperone for one of the two clinicians who cannot leave their clinics. This is not workable.

j) **Lone working** – as evidenced during the recent incident during the engagement period, staff have valid concerns about lone working. There is no operational need (and it is operationally inefficient and difficult, causing further fragmentation of the centralised reception team located at Holt Surgery) to have two members of administrative staff in BS meaning the receptionist would, at times, be working on their own. We have a duty to ensure our staff are safe (lone working is not an issue at Melton or Holt Surgeries as there are always more staff) and we must ensure the working environment is attractive to encourage staff retention.

k) **Asset of Community Value** – in April 2023 BPC applied to register BS as an Asset of Community Value.[22], [23] HMP objected[24] and North Norfolk District Council ("**NNDC**") ultimately rejected the application in May 2023.[25] Blakeney has a range of other community buildings, many of which are in better condition than BS and underutilised. The response from NNDC indicated other existing options within Blakeney as premises where community initiatives could be located or co-located.

l) **Conclusion:** any investment in BS needs to be proportionate to the benefits that it will bring. With regards to the future viability of the site (see below) the investment and future ongoing associated costs seem at odds with the reasonable needs of the population and future viability of the site.

[22] Appendix A16 – BPC Ltr to NNDC Applying to register BS as an ACV
[23] Appendix A16a – BPC Application FORM to NNDC to register BS as an ACV
[24] Appendix A17 – Ltr from HMP to NNDC Objecting to Registering BS as an ACV
[25] Appendix A18 – Ltr from NNDC to BPC rejecting application to register BS as a ACV

6) Operational Futureproofing

a) **PCN Model of General Practice** – PCNs were first introduced by the Government in 2019 to help enhance and share the provision of general practice services within a local area. HMP is in a PCN with Sheringham and Fakenham Medical Practices.[26] PCNs are focused on hub-based, multidisciplinary team working. Blakeney's geographical location (on the periphery of our PCN boundary), small size (and all issues identified in the Premises and Workforce sections) makes it unsuitable for use as a PCN Hub.

b) **Future PCN Based Funding** – we are already seeing a focus on PCN based working and many funding streams are not attached to this type of joined up working. We can only offer these services at Holt Surgery, or we risk losing that funding. This means we must make sure we are operationally able to bid for/deliver these services (from PCN suitable premises) with a workforce based at those PCN suitable sites. Creating further inflexibility in our workforce to work from branch sites.

c) **The Future of General Practice and the Wider NHS** – the direction of travel for Primary Care (driven by the current Conservative government) has been to hub-based working with multidisciplinary teams, within the PCN.[27] With the uncertainty of future governments and policy (for example, Labour most recently suggesting they wish to focus on hub-based urgent primary care services), we need to focus our business development on sites that can operate in these ways.

d) **Future Population Growth** – x660 houses have recently been built or are soon to be built in or around Holt.[28] We also know that there are approx. 100 new dwellings planned at Melton Constable. There is also a newly opened x66 bed care home and a new x66 bed nursing home opening early next year, both in Holt. The ICB Estates Team have assumed a population growth of 1,243 patients over the next 15 years based on *approved* planning permissions. Taking into account the *pending* (yet established) plans as well, this figure is more likely to be in the region of 1650 - 2000 patients.

e) **Adequate Space at Holt and Melton Surgery?** - Blakeney at 76m2 is one of the smallest premises within the Norfolk & Waveney ICB. There are only 5 (out of the total 155) other sites within this area which are smaller than the Blakeney. With reference to the ICB Estate Team's Capacity and Growth Chart we can look at the historical, existing, and future estates capacity at HMP. [29]

In Jan 2020, the m² of HMP was as follows:

- Holt - 900m² (open 8 – 6.30, 5 days a week)
- Melton - 185m² (open 8.30 – 6, 5 days a week)
- Blakeney - 76m² (open 8 – 1, 5 days a week)
- Total = **1161m²** (3 sites, all open 5 days a week).

14000 registered patients

[26] North Norfolk PCN - Norfolk & Waveney Integrated Care System (ICS (improvinglivesnw.org.uk)
[27] The future of general practice (parliament.uk)
[28] North Norfolk Site Allocations (north-norfolk.gov.uk) & Proposed Submission Version (Regulation 19 Publication) Local Plan (north-norfolk.gov.uk)
[29] Appendix A19 – N&W ICB Estates Capacity and Growth Chart

23 clinical rooms (16 at Holt, 5 at Melton, 2 at Blakeney).

If HMP were now to close BS, taking into consideration the new extension at Holt Surgery and the recent improvements at Melton Surgery, HMP would look as follows:

- Holt - 1186m² (open 8 – 6.30, 5 days p/w PLUS extended PCN hrs)
- Melton - 185m² (now open longer hours: 8 – 6.30, 5 days a week).
- Total = **1371m²** (210m² more than in 2020)

14250 registered patients
27 clinical rooms (21 at Holt, 6 at Melton)

This shows a net increase of 4 additional clinical rooms. In addition, we also now have 6 new admin rooms and a large multifunctional meeting room.

The data also shows that our patient population has increased, and we know that it is due to increase further due to the approved and planned housing developments in Holt (660 dwellings + 120 care home beds), Melton (100 dwellings) and Blakeney (27 dwellings).

The ICB Estates Team have modelled this predicted growth[30] (both on HMP's predicted growth of 2,000 weighted patients, and on their more conservative growth of 1,234 weighted patients). The data shows that, based solely on Holt and Melton Surgery's footprints, that HMP could still offer more than the required m² per patient, as recommended by NHS England.

The recent improvements and expansion at Holt Surgery have also created a net increase of 4 clinical rooms.

Conclusion – a lot of thought, operational resources, finances and effort has gone into ensuring that HMP's sites are able to service our population now and into the future. We have a finite amount of resources and we must make sure they are used wisely for the widest benefit of our entire population.

7) <u>Partnership Finances/Future</u>

a. **Recruitment of GP Partners** – there is currently a national shortage of GPs. Newly qualified rarely look for the responsibility, commitment and financial constraints associated with Partnership. More GPs choose to work as salaried or portfolio GPs than ever before, so the remaining pool is further reduced. Holt recently failed to recruit for an additional salaried GP role, which has never happened before.

b. **Succession Planning** – we are very mindful that within the next 6 years, we have 5 of our current 7 GP partners wishing to retire. Without active measures to recruit for future GP Partners, the Partnership would be unsustainable on these numbers. This is of concern for two main reasons:

    a. Operationally – two GP Partners could not run a GP practice the size of HMP. We are a well led practice, with the numerous business and clinical roles and responsibilities divided between the partners; we have never operated at less than six GP partners.

[30] Appendix A20 – N&W Estates Future Capacity without BS

b. Financially – outgoing partners need to be bought out of their investment. Without the introduction of new investment from new partners buying into the Partnership, it would become insolvent.

c. Nationally – it is hard to find GPs to work in rural areas. The day after the public meeting in Blakeney, Farming Today featured a piece on the issues a rural practice in Wales were facing recruiting a GP, despite offering a golden hello. Then, at 12 noon later that day, You and Yours also ran a piece on this topic. There are less GPs wanting to work in general practice, and even less wanting to be Partners. This, coupled with our rurality, makes recruitment a challenge and retention a priority.

c. **Property Portfolio** – our current property portfolio is approximately £375,000. In 2019, BS was valued at £101,500 and Melton Surgery was valued at £260,000.[31] Partners must buy into their *equal* share of the property (irrespective of the number of sessions they work) *and* their working capital, currently set at approximately £40,000. Our newest 6 session partner was required to invest £85,000 to buy into the Partnership. And this is at a time when loan rates are at an all-time high and the pool of GPs wishing to become Partners is shallow. By reducing our property portfolio, we are taking proactive measure to make the buy-in to the Partnership more achievable, more attractive and less daunting and the buy-out of retiring partners is more affordable.

d. **Sensible Investment** – not only does the amount of investment matter to new Partners, but also the commerciality of that investment must stack up. Asking people to invest in bricks and mortar that might not retain their future value (see issues identified under Premises and Operational Futureproofing above) is not viable.

e. **Conclusion** – the proposal to close BS will help in a small way protect the future of the partnership and thus the future of the healthcare we can continue to provide for all our patients.

[31] Appendix A21 – Blakeney and Melton Valuation September 2019

Section B

Patient Consultation and Engagement Phase

In accordance with national guidance[32], HMP ran a public consultation and engagement exercise between August - September 2023 to gain the feedback of patients, partner organisations and wider stakeholders in the community on proposed options for BS and how HMP might continue to provide the reasonable healthcare needs of its population.

Pre-engagement Activity

Before the formal engagement phase commenced, there had been some written communications between HMP and key stakeholders in the community regarding the changes in service levels at BS and what the future of BS might look like. Then in December 2022 a meeting was held between HMP, BPC and Duncan Baker.

In addition to communications that HMP were directly involved in, in early 2023 the "Save Blakeney Surgery" campaign had gained political support via Duncan Baker which was promoted through local media and social media channels.

The future of BS was the topic of two surveys conducted in February and May 2023, one led by Duncan Baker and the other by BPC in conjunction with Healthwatch. The future of BS was also the main topic of BPC's AGM in March 2023.

For 7.5 weeks, from 15 February to 31 March 2023, HMP ran a data collection exercise from BS noting down the number of prescriptions that were collected daily and the number of in person queries raised with the receptionist. The average number of prescriptions collected each day were 37, with the number of queries averaging approximately 10 per day.[33]

Prior to the formal commencement of the application to close BS, there had been several articles about BS featured in the local publication, *The Glaven Valley* newsletter, and via other local articles/flyers. BPC's website regularly posted updates on the matter and circulated minutes of their meetings. These raised awareness of the topic across the local community prior to the commencement of HMP's application to close BS and throughout the engagement period.

The Engagement Plan

HMPs proposed plan and timeline for its patient engagement phase[34] was agreed in advance with Healthwatch and shared for final approval with the ICB and with Norfolk Health Overview and Scrutiny Committee in advance of commencement.

HMP's official patient engagement period ran for a period of approximately 9 weeks from 1st August to 30th September to allow sufficient time for the community to engage over the summer period. The public, patients, and wider stakeholders were invited to provide feedback through an online survey and in writing.

[32] Appendix B1 – ICB Advice Note 3 on Branch Closures
[33] Appendix B2 – Blakeney data capture – Activity from 09.02 – 31.03
[34] Appendix B3 – Plan for Patient engagement

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During this period, HMP used a range of methods and formats to raise awareness of the engagement opportunity with our patient population and the wider community (not just with those patients local to BS) and to seek feedback, ensuring that all patients and stakeholders had the opportunity to contribute meaningfully to this process.

This incorporated a mix of face-to-face, digital, and postal engagement opportunities. This multifaceted approach ensured the process was as accessible as possible for local people during the consultation period. A summary of the communication and engagement activities is outlined below.

HMP's Communication and Engagement Activity

An integrated and accessible programme of face to face, digital, and print communications and engagement activities were developed to raise awareness of the engagement opportunity and support local people and organisations to take part in the process.

Healthwatch Norfolk were regularly consulted both at the planning phase and throughout the engagement period. This provided useful guidance to HMP and reassurance to patients and stakeholders that HMP were conducting this phase objectively, with transparency and in a professional manner.

The opportunities to engage included:

- A **public meeting** was held in Blakeney Village Hall on 1 August 2023. It was independently chaired by Healthwatch Norfolk and hosted by two panels from BPC and HMP. It was widely publicised. The **presentation** (see Appendix A) provided at that meeting was then widely shared in printed and electronic form (and available for collection at the end of the meeting). This meeting was covered by BBC Look East.
- Paper copies of HMPs **consultation document** (see Appendix A) and **survey**[35] were available for collection at all three sites. Both documents were also available to collect in **Easy Read** format. **Braille, translated and large print** copies were available on request. Copies could be requested to be posted to patients via a **dedicated phone line**.
- **Comments boxes**[36] were available at feedback stations all three sites with **comment cards**[37] for patients to share their feedback easily and anonymously.
- Feedback and comments could be provided by email to a **dedicated email address** (nwicb.blakeneypatientengagement@nhs).
- A specific page was created on our **website**[38] detailing the reasons and background behind HMPs application and the various ways patients could engage. It also contained links to the consultation document, survey, and public presentation.
- HMP's **survey** was live from 14th August – 30th September. It was advertised widely via the website, **QR codes**[39] on **posters** at our sites, via **medication bag flyers**, through **letters**, **texts** and **emails** to patients and through third party posts or articles on community **Facebook** pages, **local websites, and publications**.[40]

[35] Appendix B4 – HMPs Blakeney Survey
[36] Appendix B5 – Photos of Comments Box Stations
[37] Appendix B6 – Comments card template
[38] Appendix B7 – Website landing page
[39] Appendix B8 – QR Code Poster
[40] Appendix B9, B10, B11 – FB posts Blakeney Parish Council, Steffan Aquarone, Martin Batey

- **Drop-in sessions** at Holt Surgery, Melton Surgery, Blakeney Village Hall, and Holt Library were organised and run by Healthwatch. They provided an opportunity to receive assistance to complete the survey or provide comments via an independent third party. They were run at various times of days/early evening (details are provided in the Summary of Patient Engagement Feedback section) and widely advertised via **posters**[41] and on the website.

Communication activities to raise awareness of the engagement opportunities included:

- Early updates and ongoing communications were sent to **Parish Councils, County Councillors, District Councillors, key local organisations (like Holt Caring Society), the ICB, the Local Medical Council, Healthwatch and the Health Overview and Scrutiny Committee** to ensure early notification of key dates and to ensure widespread awareness to encourage the sharing of engagement opportunities through their communication channels. A **communications toolkit** containing promotional materials was provided.
- **All registered patients** were **text**[42]**, emailed**[43] **or written**[44] to, to make sure they were aware of the consultation and the range of engagement opportunities.
- **Patients with Learning Difficulties** were **written to individually**[45] and provided with an Easy Read copy of the consultation document[46] and survey[47] along with a pre-paid return envelope.
- **Care home residents and housebound patients** were **written to individually**[48] and provided with a copy of the survey, consultation document and pre-paid return envelope. **Care home managers** were also **written** to[49], encouraging them to support their residents with the opportunity.
- Our **PCN** remained fully appraised of our application. **Neighbouring practices** were informed of the proposal and encouraged to engage if they had any concerns. All **Practices in North Norfolk** were updated at the monthly practice managers' meeting.
- Our **Patient Participation Group** was regularly updated to ensure awareness and understanding of the evolving situation. A member of our PPG attended the Public Meeting and all members have reviewed the patient communications we received during the engagement phase.
- Promotional **posters**[50] were put up at all three sites and on our reception display screens. These were sent electronically to interested parties for further distribution. The posters advertised the consultation topic and engagement phase generally, the public meeting, and the drop-in sessions run by Healthwatch.
- **The right-hand side of our prescriptions**[51] were updated twice with relevant information about the consultation, engagement and when the survey went live. **Flyers**[52] were placed in bags of medication collected in the lead up to the consultation and the survey.

[41] Appendix B12 – Poster - A3 - Healthwatch Drop In Sessions
[42] Appendix B13 – Text message to patients
[43] Appendix B14 – Email to patients (with no mobile)
[44] Appendix B15 – Letter to patients (with no email or mobile)
[45] Appendix B16 – Easy Read Letter
[46] Appendix B17 – Easy Read Consultation Document
[47] Appendix B18 – Easy Read Survey
[48] Appendix B19 – Letter to care home resident
[49] Appendix B20 – Letter to Care Home Managers
[50] Appendix B21 & B22 – Posters: Save the Date Public Meeting & General Blakeney Surgery
[51] Appendix B23 & B24 – RHS Script Update & RHS Script Update 2; Live Survey
[52] Appendix B25 – Flyers in Medication Bags

Press and 3rd party coverage included:

- **Third party media articles and campaigns** further raised awareness of this topic and the opportunities to engage. There were articles in the Eastern Daily Press, on BBC Radio Norfolk, in the North Norfolk News and the Public Meeting was covered on BBC Look East.
- The topic has received **political interest** and been promoted locally by Duncan Baker, Conservative MP via letters, survey and by his Facebook page. Steffan Aquarone (Liberal Democrat Parliamentary Candidate for North Norfolk), produced an insert for his summer circular that was widely distributed within our catchment area.
- The Save Blakeney Surgery Campaign has done a lot of work locally to raise awareness of the consultation and ran a **petition** (hosted both online and on paper) that received 100s of signatures.
- An **original song** was penned about the potential closure that was sung by local shantymen at several public events over the summer, the recording of which was widely shared via local websites and is available on you tube.
- **Healthwatch Norfolk** shared information about the engagement on its website and through its social media channels.

3rd Party Engagement Activities

Duncan Baker conducted a survey back in early April 2023 via his website. The report[53] compiled by his office detailed that 434 surveys were completed following a mail drop of over 1700 letters to households in the villages of Blakeney, Langham, Kelling, Morston, Salthouse, Stiffkey, Wiveton, Cley and Weybourne. This amounted to 3% of our patient population.

BPC conducted a survey[54] (with the assistance of Healthwatch) that ran from 5th May to 16th June 2023. The report[55], compiled by Healthwatch, showed that 270 surveys were completed either online or in hard copy. This amounted to 1.8% of our patient population.

Local groups have continued to raise awareness of the topic and provided **pro forma letters**[56] and wording in both local publications (to be torn out or copied) and online (to be printed or copied). We have received multiple copies of these letters, re written, or topped and tailed with senders' names.

Save Blakeney Surgery campaigners ran **a petition** that garnered approx. 1500 signatures (approx. 370 of which were obtained online, and 1130 in person).[57] A full copy of the petition and signatures is available for inspection on demand.

The focus of these third-party engagement activities was very much around BS remaining open and a wish for a return of more services to BS. The themes from these third-party engagement exercises have been included alongside those obtained during HMP's formal engagement period, to ensure a full picture is given to the reader.

[53] Appendix B26 – Duncan Baker Blakeney Surgery Survey Report 2023
[54] Appendix B27 – BPC Survey Results
[55] Appendix B28 – Healthwatch Report on BPC Survey
[56] Appendix B29 & B30 – First Proforma Letter & Second Proforma Letter
[57] Appendix B31 – Save Blakeney Surgery Petition Letter & Summary of Results

Holt Medical Practice – Application to Close a Branch Surgery: Blakeney Surgery

Overview of the Options Discussed and Raised within the Engagement Period

The options outlined in HMPs consultation document were:

- **Close Blakeney Surgery** (and relocate current reception and medication collection services)
- **Maintain and Invest** – keep Blakeney Surgery open (maintain current service levels and invest in the premises (on the building's existing footprint))
- **Improve and Invest** – keep Blakeney Surgery open (increase range of services *and* invest in the premises on the building's existing footprint)
- **Rebuild and Invest** – keep Blakeney Surgery open (make a significant investment in premises by way of a larger, improved footprint allowing for an increased range of services)

These options were discussed at the Public Meeting and contained within the supporting presentation.

HMP's consultation document outlined the evolution of services provided at BS and the possible options (together with their pros and cons) for the future. People were invited to share their thoughts on the whole range of possibilities for the future use of BS: ranging from investment and through to closure.

The consultation document provided the reader with information designed to allow a better understanding of why HMP was proposing closure "option 1" (above) and the various ways HMP may be able to mitigate any resulting impact, should BS close.

We explored the pros and cons of the various options at the public meeting intended to enable the public a better platform of understanding from which to share their views during the following engagement period.

By the time the *formal* engagement period began, there had already been two local surveys (one from Duncan Baker and the other from BPO), together with many letters, emails and conversations direct with HMP indicating many wished for Blakeney Surgery to remain open, along with their reasoning and concerns.

At the point HMPs survey was designed, we had the benefit of two previous surveys and multiple media and local campaigns supporting the wish for BS to remain open, and concerns about its proposed closure. Through discussion with Healthwatch, HMPs survey was designed to ask questions to gain information and data that would help compliment that which had already been collated.

It asked questions on transport and access, medication collections and more general questions asking the respondent to identify the factors important to them when accessing general practice services. HMPs survey provided free text areas and two questions allowing respondents to provide their feedback on the possible impact of and concerns about the proposed closure of BS.

Holt Medical Practice – Application to Close a Branch Surgery: Blakeney Surgery

Responses and Communications Received by HMP/Healthwatch

HMP started a period of public engagement from 1st August to 30th September 2023. During this approx. 9-week period of engagement many patients took the opportunity to share their views and comments with the practice in a variety of ways. No requests for hard copy documents to be posted to patients or for the consultation document or survey to be provided in alternative formats, braille or to be translated were received.

- **A total of 675 HMP surveys were completed** (either online or in hard copy, some of which were in Easy Read format). 656 of these were completed by registered patients which amounts to **4.6% of our patient population**. A full breakdown of the responses to the survey (compiled by Healthwatch) and all hard copies received are available for inspection. Here is a more detailed breakdown of the surveys completed:

  - 584 surveys were completed online.
  - 20 Easy Read surveys were received in hard copy and then manually entered online.
  - 71 surveys were received in hard copy and then manually entered online.

- **Written feedback** was also sought and gained via letters, the dedicated email address, online forms and comment cards. Copies of all correspondence received have been kept and are available for inspection. In summary we received:

  - 60 letters/emails/online forms before the engagement phase commenced.
  - 140 letters/emails/online forms during the engagement phase
  - 155 comments cards[58] were completed across the three sites during the engagement phase;
    - Holt x44
    - Melton x38
    - Blakeney x53

- The **Public Meeting** held at the start of the engagement period allowed many people an opportunity to hear the information first hand and listen to questions and themes raised therein. It was the first opportunity that HMP had had to share its reasoning for making its application. Approximately 200 people attended. Presentations were given by 3 BPC members and HMP. Questions were taken from attendees in the second half of the meeting.

- Healthwatch ran **5 drop-in sessions** at Melton Surgery, Holt Surgery, Holt Library and Blakeney Village Hall. The content of the interactions at the drop-in sessions were captured by Healthwatch and a report of the discussions provided to HMP[59]. The number of interactions were as follows:

  - 5 people attended and 2 surveys were completed at the session between 10.30 and 12.30 on Wednesday 16th August @ Holt Surgery

  - 5 people attended and 0 surveys were completed between 10.30 and 12.30 on Thursday 31st August @ Melton Surgery

[58] Appendix B32 – Comment Card Responses and Locations
[59] Appendix B33 – HW Report on Drop-in Sessions

Holt Medical Practice – Application to Close a Branch Surgery: Blakeney Surgery

- 8 people were spoken to at the session and 0 surveys were completed between 10.30 and 12.30 on Tuesday 29th August @ Holt Library

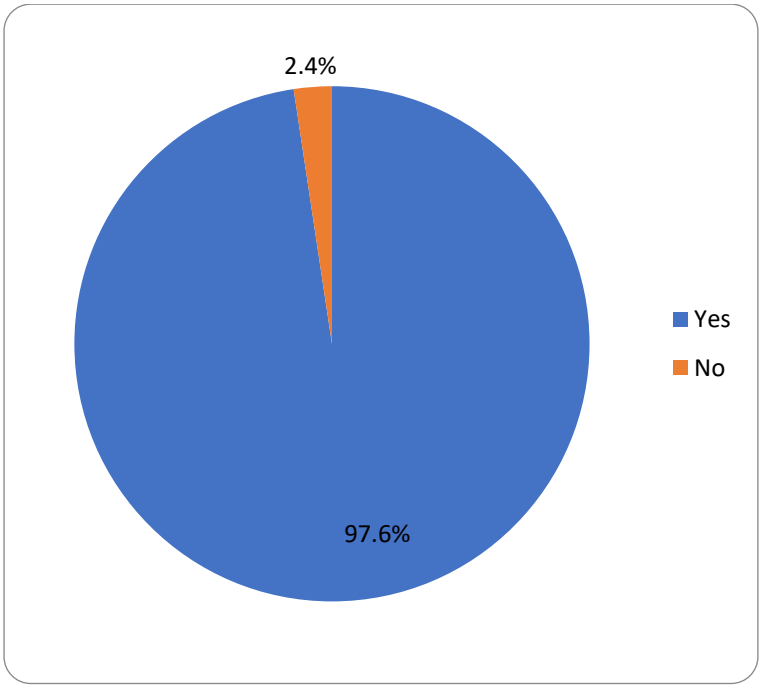
- 34 people were spoken to, 4 surveys were completed, and 6 comments cards were completed between 10 and 12noon on Thursday 7th September @ Blakeney Village Hall

- 1 person attended and 0 surveys were completed between 6 and 7.30 pm on Tuesday 12th August @ Holt Surgery

Responses to HMPs Survey Questions

A total of 675 HMP surveys were completed (either online or in hard copy, some of which were in Easy Read format). 656 of these were completed by registered patients which amounts to **4.6% of our patient population**. A full breakdown of the responses to the survey was compiled by Healthwatch.[60] Here is a summary of those responses:

1. Are you a registered patient at Holt Medical Practice?



The data show that 97.6% of respondents who completed the HMP survey were registered patients of HMP.

[60] Appendix B34 – HMP Survey Results RAW (from Healthwatch)

Holt Medical Practice – Application to Close a Branch Surgery: Blakeney Surgery

2. What are the first 5 digits of your postcode?

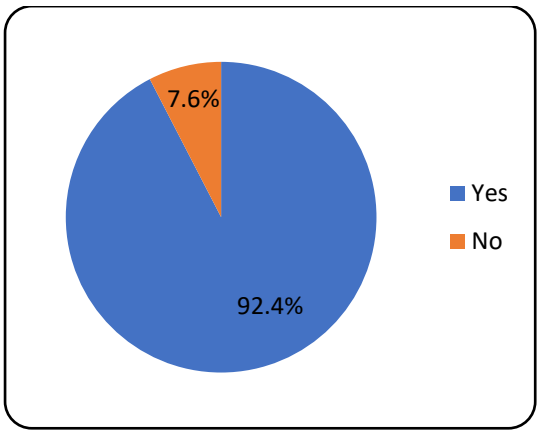
The data shows that over half of responses came from the NR25 7 postcode area. BS is within this area. Almost a quarter of responses came from the NR25 6 area, which includes Holt Surgery. 12% of responses came from the NR24 2 area, which includes Melton Constable Surgery. Maps showing these areas have been generated for the reader's ease of reference.[61]

Answer Choices			Response Percent	Response Total
1	NR11 6		1.04%	7
2	NR11 7		1.19%	8
3	NR11 8		0.30%	2
4	NR20 5		1.94%	13
5	NR21 0		2.53%	17
6	NR23 1		0.89%	6
7	NR24 2		12.67%	85
8	NR24 8		1.19%	8
9	NR25 6		22.06%	148
10	NR25 7		55.14%	370
11	NR26 8		0.15%	1
12	NR27 9		0.00%	0
13	Other (please specify):		0.89%	6
			answered	671
			skipped	1

[61] Appendix B35 – Maps of 3 Main Postcode Areas of Survey Respondents

Holt Medical Practice – Application to Close a Branch Surgery: Blakeney Surgery

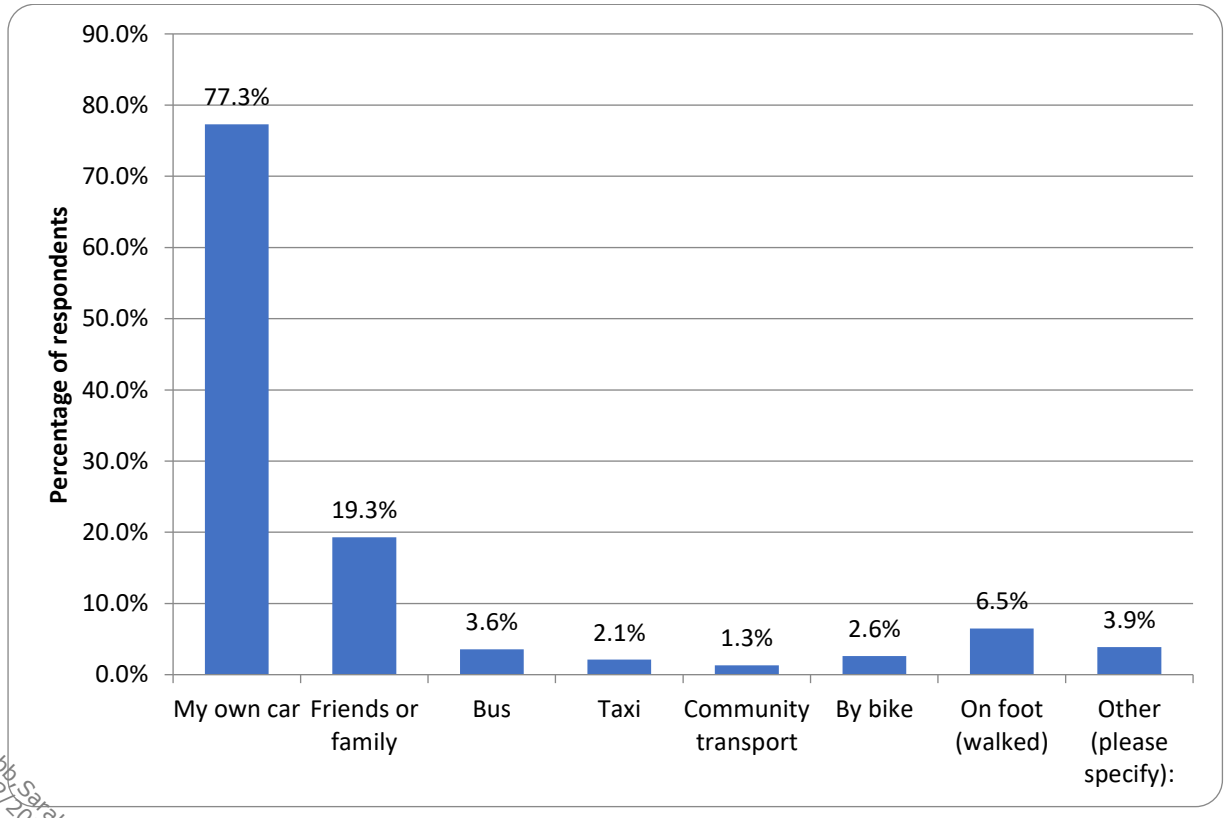
3. In the last 3 years have you gone to either Holt or Melton Surgery for an appointment?



The data shows that of the respondents that submitted a survey, 92% of them had travelled to Holt or Melton Surgeries for an appointment in the last 3 years.

If yes to Question 3, how did you travel to Holt or Melton Surgery for an appointment?

The data further shows that of the 92.4% who had travelled to Holt or Melton for an appointment in the last 3 years, 77% had travelled to that appointment using their own car, with nearly 20% having been taken by friends or family. Over 8% of survey respondents declined to answer this question.



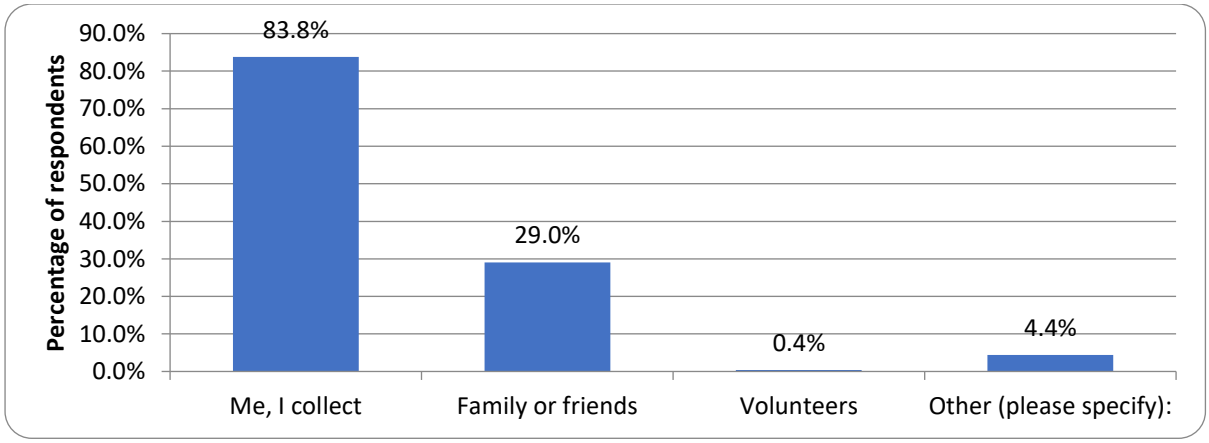
Holt Medical Practice – Application to Close a Branch Surgery: Blakeney Surgery

4. Do you have regular medication delivered to and collected from Blakeney Surgery?

Answer Choice		Response Percent	Response Total
1	Yes	41.2%	277
2	No	58.8%	395
	answered		**672**
	skipped		**0**

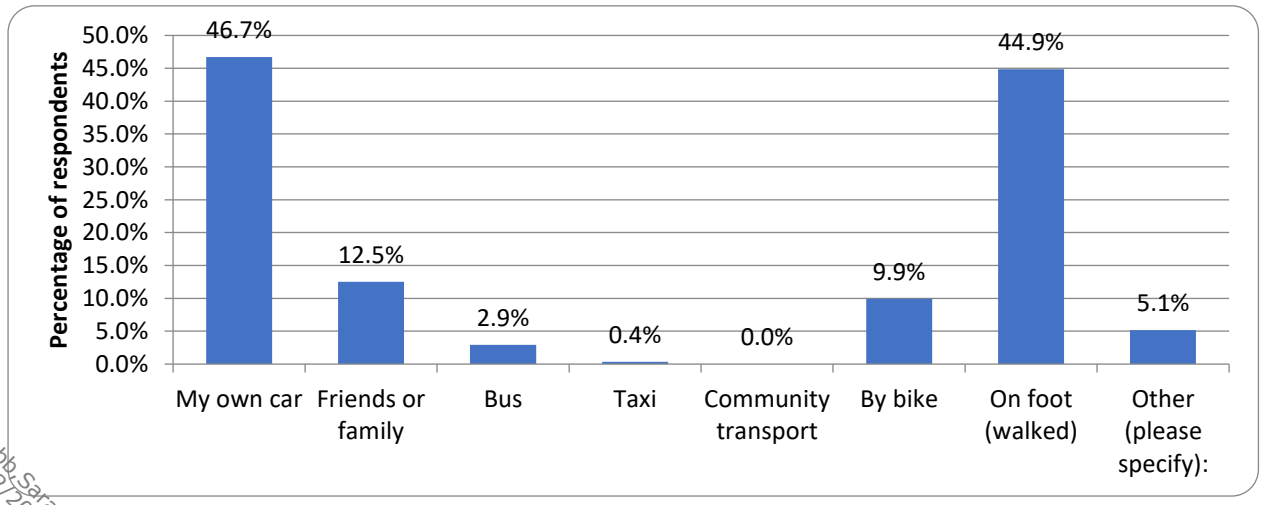
The data showed that approximately 2/5ths collected regular medication from Blakeney Surgery, with the other 3/5ths confirming that they did not.

If yes to Question 4, who collects your medication from Blakeney Surgery?



The data showed that most patients collected their own medication. Carers were also cited in responses to "other" as collecting medication on behalf of respondents.

If yes to Question 4, how do you/they travel to collect your medication from Blakeney Surgery?



The data showed that 127 respondents collected their own medication using their own car, and another 122 walked to collect theirs. Carers' vehicles were cited under several responses to "other".

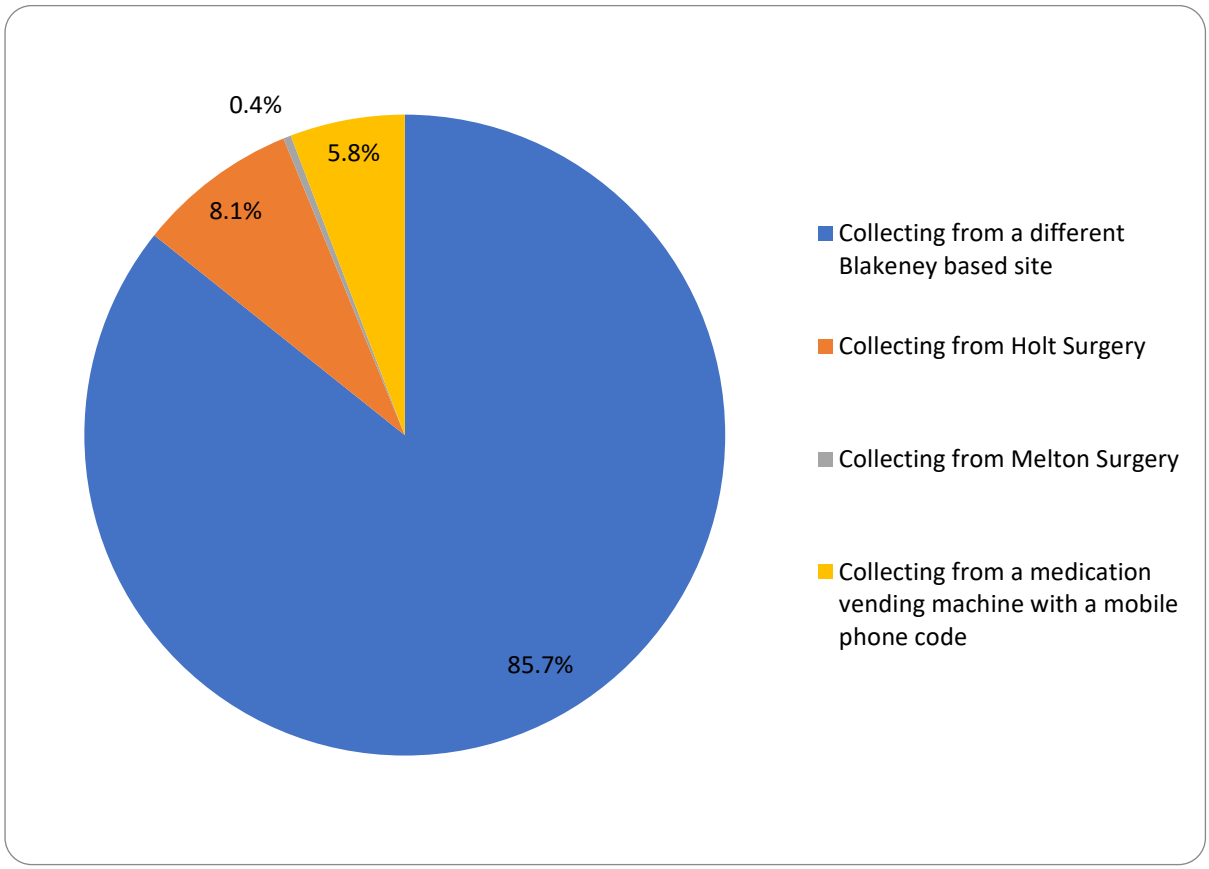
Holt Medical Practice – Application to Close a Branch Surgery: Blakeney Surgery

5. What impact would the closure of Blakeney Surgery have on you as a patient of Holt Medical Practice?

Answer Choice		Response Percent	Response Total
1		100.0%	635
		answered	**635**
		skipped	**37**

The detailed free text responses to this question are contained in the Healthwatch breakdown.

6. If Blakeney Surgery closes and patients can no longer collect their routine medication from the site, what other alternatives do you think would be most suitable?



In this situation, the data shows an overwhelming majority of respondents would wish to be able to continue to collect their medication from an alternative Blakeney site.

The report shows that 154 patients did not answer this question.

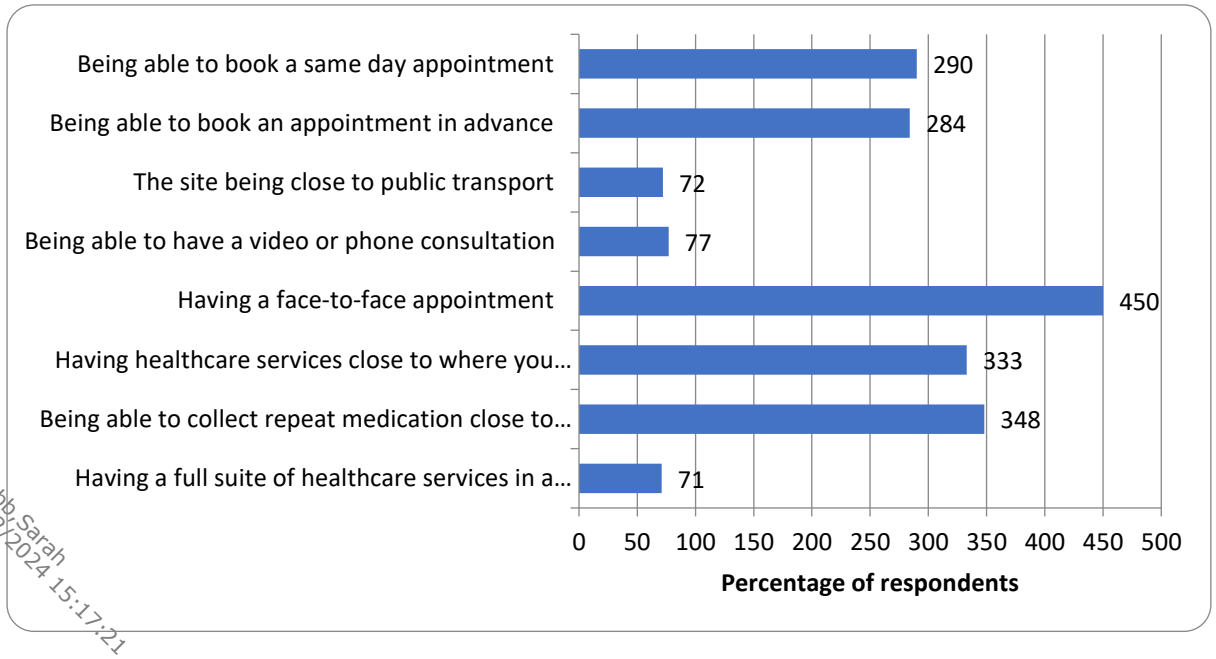
Holt Medical Practice – Application to Close a Branch Surgery: Blakeney Surgery

7. There are lots of important factors that influence your preferences for accessing general practice services. Please tick the top 3 most important factors to you from the list below.

Answer Choice		Response Percent	Response Total
1	Being able to book a same day appointment	44.1%	290
2	Being able to book an appointment in advance	43.2%	284
3	The site being close to public transport	10.9%	72
4	Being able to have a video or phone consultation	11.7%	77
5	Having a face-to-face appointment	68.4%	450
6	Having healthcare services close to where you live (within 2-3 miles)	50.6%	333
7	Being able to collect repeat medication close to where you live (within 2-3 miles)	52.9%	348
8	Having a full suite of healthcare services in a single centralised location (no matter the distance you must travel)	10.8%	71
		answered	**658**
		skipped	**14**

The data shows that the most important factor to those that responded was the ability to have a face-to-face appointment. The second most important factor was to be able to collect repeat medication close to where the respondents lived.

Only 10.9% of respondents thought that the site being close to public transport was in their top 3 important factors.



Holt Medical Practice – Application to Close a Branch Surgery: Blakeney Surgery

8. Please share any other comments about the proposed closure of Blakeney Surgery.

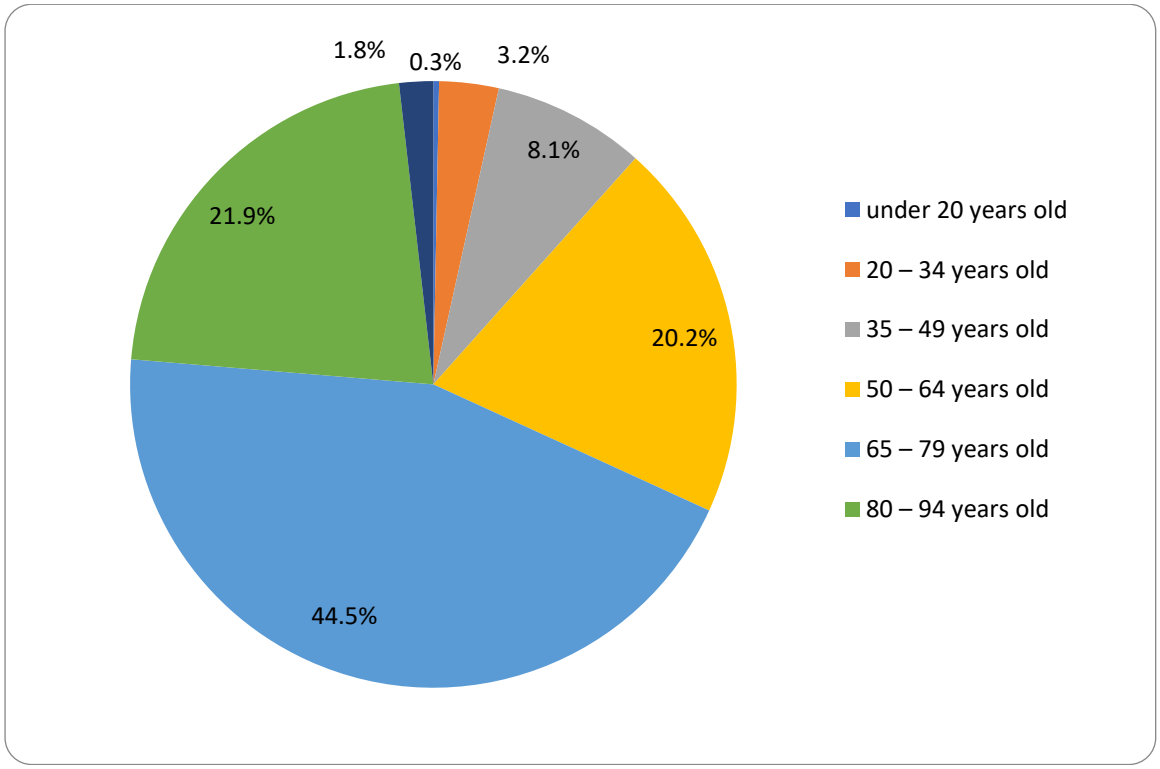
Answer Choice		Response Percent	Response Total
1		100.0%	418
		answered	**418**
		skipped	**254**

The detailed free text responses to this question are contained in the Healthwatch breakdown.

9. How old are you?

Of the 663 respondents that answered this question, nearly half were between 65-79 years old.

Only 77 responses were received from respondents under the age of 50. This is just 11% of those that responded.

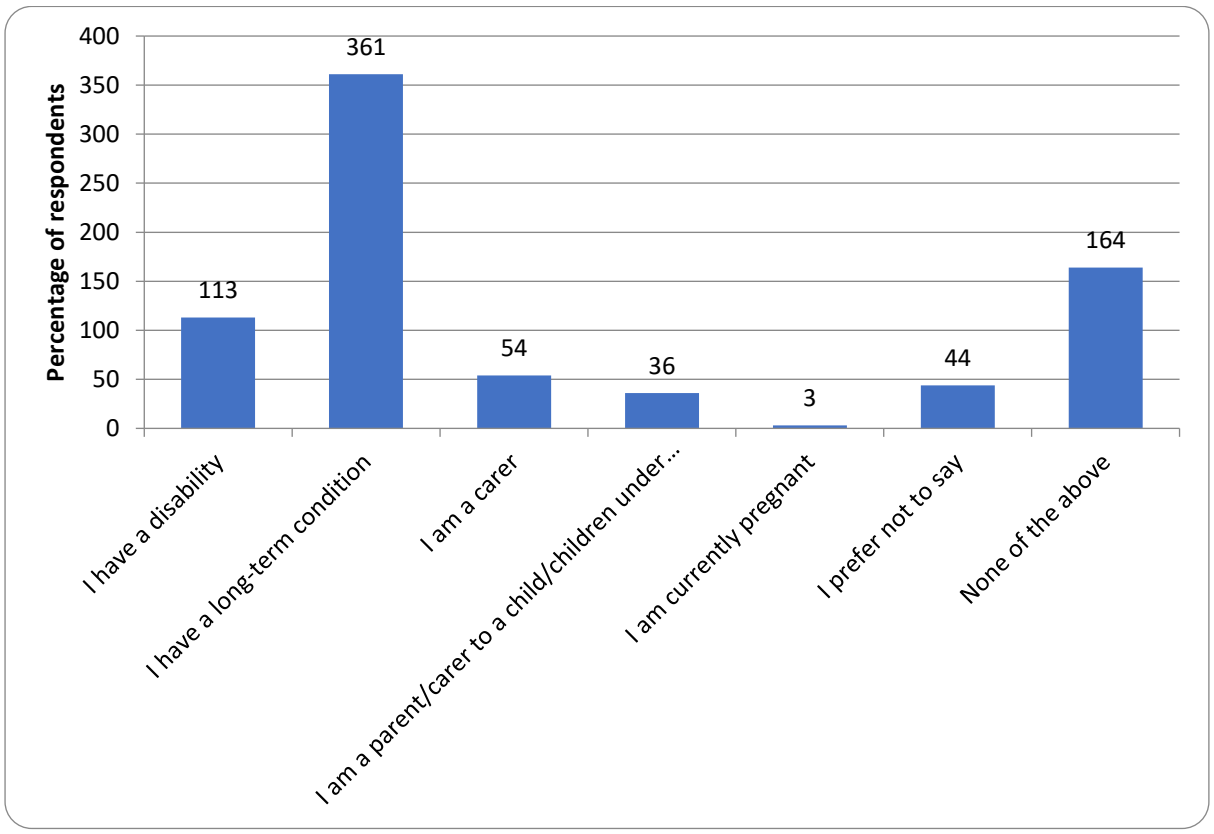


Holt Medical Practice – Application to Close a Branch Surgery: Blakeney Surgery

10. Please identify any of the following that apply to you.

	Answer Choice	Response Percent	Response Total
1	I have a disability	17.4%	113
2	I have a long-term condition	55.6%	361
3	I am a carer	8.3%	54
4	I am a parent/carer to a child / children under 16	5.5%	36
5	I am currently pregnant	0.5%	3
6	I prefer not to say	6.8%	44
7	None of the above	25.3%	164
		answered	**649**
		skipped	**23**

The data shows that 361 respondents ticked that they had a long-term condition; that is over 50% of those that responded. Over 1/4 of those that responded, confirmed that none of the options applied to them.



Holt Medical Practice – Application to Close a Branch Surgery: Blakeney Surgery

Key Themes from All Communications Received

HMP have carefully and diligently considered all feedback, reports and correspondence it has been sent, both before HMP's formal engagement period, and during. From that data and correspondence, we have highlighted the key trends and themes that arose. Healthwatch have reviewed this section and have confirmed that they are happy they represent a true and fair summary of the key themes from the engagement.[62]

1. **Keep Blakeney Surgery Open** – most respondents wished for BS to remain open. Most communications we received urged us to:

   "SAVE BLAKENEY"

   "DO NOT CLOSE"

   "Ensure Blakeney Surgery remains open and returns to providing a full range of medical services to the community…"

2. **Valued Community Asset** – BS is a much-valued service, and the community would like it to remain open. If it is unable to be used as a GP Surgery, patients have asked for it to remain as a building serving the community in an alternative way.

   "It is an essential local service that is needed."

   "I would like it to become a multi-service health hub, with nurse services, a fully functioning dispensary, appointments person to person on care, care homes, age uk, community connectors, etc. A strong focus on older persons' current and future needs. A "one step ahead" approach for locals. "

   "….extra funding to finance a loan could be obtained by making a room or rooms available for ancillary medical services such as foot clinics, ear clinics, eye examinations for which a rent would be charged."

   "I also encourage you to be progressive and revolutionary in your thinking to consider how Blakeney Surgery could evolve to become a medical hub in providing a GP and nurse appointed service that is fit for the current demands and needs of your patients but also in contributing to solve the wider challenges of the failing and deficient ambulance emergency response critical care provision."

3. **Return to wide ranging, pre-Covid Services** – many respondents wish to see a return of GP and nurse led appointments from BS and a return to services *"As it was before COVID."*

   Some respondents feel that BS should operate as a "*mini Holt"* and wish it to run a *full* suite of services, as occurs at HMP's main site.

   In BPC's published article in the November 2022 issue of the Glaven Valley News that provided a tear off section for respondents to sign one paragraph stated *"I would urge you*

[62] Appendix B36 – HW Report on Patient Engagement Phase

to ensure that Blakeney Surgery returns to providing a full range of medical services to the community as it used to."

4. **Local Medication Collection** – maintaining this service was important for many respondents. Many patients collect prescriptions not just for themselves but for family members or other members of the community and to have to travel further (to Holt or Melton Surgery) would be more inconvenient and costly.

   "It will be really difficult to collect prescriptions. I work all week and don't have the opportunity to make 50 minute round trip to Holt, Boots is closed on a Saturday so that's no help. It's a valuable local service."

   "The ordering and collection of prescriptions, however, remains a problem. I feel that this should be addressed as soon as possible, because it is one of the main causes of bad feeling."

   "The Glaven……has spare capacity and would be very suitable for the placing and collection of prescriptions….It is a great opportunity for Glaven Caring to expand its activities…"

   "I collect pills for 3 sometimes 4 people who is going to help with the cost of this if we have to go to Holt each time?"

5. **Transport** – respondents felt that closing BS would result in patients having to travel further and that this would be less convenient for them. Many patients noted the lack of public transport, their inability to drive or cost and availability of taxis to Holt Surgery as a concern should BS close. It was also regularly noted that Holt Surgery is not in Holt itself, but on the edge of High Kelling which is harder to get to than Holt.

   "Buses are hard to get to High Kelling."

   "Public transport is almost non existent to surrounding villages. Getting from Cley to Blakeney is relatively easy using the Coasthopper."

   "We are a massive community compared to some villages, and the effect of travel is a greatly underestimated downfall to care."

   "The current and future public connectivity should be considered, a decision to close Blakeney Surgery would result in the community suffering and falling into a situation of public health poverty, which is unacceptable."

   "For patients who do not drive, who do not have help from family or friends or whom would find paying for a taxi too costly, the alternative of using public transport is not a viable option….Using public transport would take a number of hours and especially in winter weather, would create serious problems for the increasingly large number of elderly and/or disabled patients."

   "Holt Medical Practice is not in Holt, but in High Kelling. It is disingenuous and the surgery should be called High Kelling Surgery. It is much harder to get to High Kelling than it is to get to Holt from Blakeney."

6. **Carbon footprint –** concerns were raised about the increased journey from Blakeney to Holt and the negative impact this would have on the environment due to the accompanying increased carbon footprint.

   "Climate change – how does it make any sense to have people drive over to Holt?"

   "my carbon footprint would increase by driving to Holt"

7. **Vulnerable Patients (social and physical)** – widespread concerns were raised that the elderly, immobile, disabled and our most socially and physically vulnerable patients would find it very difficult to get to Holt should BS close and therefore be disadvantaged in terms of their care.

   "Please reconsider the closure as it will impact this community in so many ways and the elderly and disabled and poor disproportionately."

   "I suffer with anxiety and the easiness and familiarity of being able to go [to BS] *really helps."*

   "it would make it very difficult for me to collect meds or to get to appointments independently."

   "As I get older I might find it increasingly difficult."

   "I am registered blind, there is no direct bus that would get to Holt Surgery."

8. **Crowd funding –** in response to HMP sharing the level of capital investment that was required to improve the current footprint and/or rebuilt BS on a larger footprint, several respondents suggested we look to secure grant funding and/or that the community would consider contributing by way of crowd funding.

   "I presume that the trust that runs the practice is looking for extra funds and may be planning to sell Blakeney Surgery and its land….the villagers might be prepared to contribute to a maintenance fund."

   "HMP claim they cannot afford the cost of enlarging or re-building the surgery to bring it up to date. We understand that half this cost is provided by the National Health Service and it is highly likely that much of the remainder could be covered by grant aid from charities devoted to community assistance, the County or District Councils or bodies such as the offshore wind farms who provide financial help to local communities."

9. **Is Melton Next?** Several respondents were concerned that the closure of one branch surgery would inevitably lead to our closure of another.

   "I'm worried that it wont end with Blakeney, they'll want to close down our Melton surgery next."

   "I suppose Melton Constable will be next to close…"

10. **Further engagement** – several respondents have criticised the extent of the engagement period and that HMP should have done more.

> *"HMP should have done their presentation on more than one occasion as the public meeting in Blakeney was oversubscribed."*

> *"If there was a more meaningful consultation and engagement exercise of the current service provision at Blakeney Surgery then Holt Medical Practice would adopt a more holistic view of the wider challenges that our rural community and geographical isolation to professional health care currently experiences, which I would suggest is in a distressed position."*

11. **Better understanding of direction of travel** – many respondents have fed back that the engagement process has helped them gain a better understanding of why HMP is applying to close BS and the wider operational and financial implications in play. Some have complimented the content of the literature and the meeting.

> *"I am, of course, well aware that all Medical Practices like Holt are under huge financial pressure and staff shortages."*

> *"I thought the slides were really clear and well delivered. If I could have stayed I would have spoken in support of the difficulties in the NHS…I completely emphasise with the challenges you are facing as a practice and on a personal level, would accept the reasons to close, however difficult that may be for some patients."*

> *"I now have a better understanding of your financial and staffing constraints and do sympathise with that."*

> *"….my friends and I came away* [from the meeting] *saying how interesting the evening was and that we learnt a lot."*

> *"I was unable to attend the recent meeting but have read the arguments in favour of the closure of Blakeney Surgery. I am most impressed by the leaflet. It is clear, very well argued and well illustrated. Having read it, I can see no argument for the retention of Blakeney Surgery. I believe that everyone, patients and medical staff alike, will benefit from the concentration of scarce resources in two, rather than three, centres."*

> *"I recognise that no one affected is actively going to support removal of a greatly valued local facility but in the real world one should consider the wider picture rather than have selfish aspirations. I have no wish to see Blakeney Surgery closed but I recognise that the practice works hard to give the best possible service to all its patients and then need to play their part in achieving an outcome acceptable to both practice provider and beneficiaries."*

> *"Funds should not be spent on practice buildings which are empty most of the week, better to spend funds on providing transport to those unable to travel, or provide medication delivery services or collection points."*

"Having listened to the (very good) presentation at Blakeney village hall, I can now understand your decision to close the surgery. I can appreciate it will be very hard for the patients who have used it for years, but the other villages have always had to travel somewhere, I'm sure Blakeney residents will soon get used to it – they have had four years to practice!"

"I appreciate all the efforts which have been made to obtain opinions from all patients throughout the Holt Medical Practice."

"Having read your proposal I am struck by the fact that only 545 patients from Morston and Blakeney attended Blakeney Surgery [appointments during 2018 and 2019] *…….I support closing Blakeney Surgery and providing resources/places for medication pickup at Blakeney and subsidising community transport to help patients who are disabled, attend Holt Surgery. Invest in staff not buildings."*

12. **No concerns about the quality of healthcare from HMP**. Throughout the process, we have received almost exclusively positive comments and compliments about the care provided to HMP's patients.

    One patient was kind enough to make this point, openly, at the Public Meeting and another wrote to say *"I will continue to campaign for the Blakeney Surgery to continue, but….we do not doubt your continuing clinical care for us….".*

    A 90yr old patient wrote to us after the public meeting to say *"thank you for giving us, the patients, the opportunity to discuss the closure. It is at one with the courtesy, respect and care with which we are always treated."*

    Another said "Clinical expertise in the Holt Medical Practice is exemplary and we are very fortunate to have excellent doctors available."

Concerns about Data and the Data Controller

Data Quality
Some concerns have been noted about the quality and reliability of some of the data collected during this engagement (both before and during HMPs official period). There were also concerns about the tone and conduct of the engagement exercise. Healthwatch have provided some further comments on this in their report on the engagement.

Scrutiny of HMP
HMPs management has been criticised. One respondent stating that *"it is clear from the presentation, the increasing population of the current catchment area has simply outgrown the management capabilities of the practice…."*

HMP has come under scrutiny with some survey respondents believing that *"HMP are being economical with the truth"* and *"questioning the methods used by HMP in regard to the survey and data collection."* Some patients are *"really unhappy about the lack of candour and consultation."*

Some people felt that *"the survey and consultation have been poorly thought out and executed"* and some have concerns that *"the Survey by the Practice is designed to give them the answer that they*

want." One patient had concerns that *"the easy read statement about closing Blakeney Surgery is extremely biased."*

More generally, there have been suggestions that *"HMP are not following NHS Guidelines in relation to the attempted closure of Blakeney Surgery."* We have been criticised for not knowing the formal procedure to close a branch surgery.

In a letter from BPC to HMP they say *"Holt Medical Practice lacked the credibility to undertake the consultation process in an independent and impartial way…"*

We have been criticised for not using the Media, and our failure to attend the Parish Meeting on 16th March, where the main topic was BS.

Conversely, we have had several pieces of correspondence (see above) from patients thanking us for the information we provided and the approach we have taken to the engagement phase.

To provide further reassurance to the reader:

- Process - At the start of this process we were provided with a document from the Primary Care Estates Team at the ICB entitled Advice Note 3: Procedure for requests to close branch surgeries. We have taken advice and guidance at each stage from the ICB and Healthwatch to ensure we have followed it properly and carefully.
- Engagement Phase – we had a longer than required period of engagement to ensure everyone had an opportunity to engage should they wish. However, all communications received (both before, during and after this official period) have been considered and made available for review.
- Variety – we offered many ways, at different times, via different mediums to ensure that patients could meaningfully engage in a way that best suited them.
- Inclusivity – we tailored our promotional material to ensure we reached all patients, through numerous ways, and ensured the possibility of engagement for those who would find it the most difficult was made as easy as possible.
- Accessibility – documents were available in hard copy, by post, in easy read (compiled by a third-party, specialist company) and in different languages, text sizes and braille.
- Survey Questions – these were compiled with the assistance and approval of Healthwatch.
- Data Collection – the surveys were collected and summarised by Healthwatch. All other correspondence and material received before, during and after the official engagement period have been retained and made available for inspection by Healthwatch and the ICB.
- Media - the application has been widely covered by local newspapers, local publications, radio, television, social media, and flyers/letters. We were advised by the ICB not to attend the Parish meeting on 16th March as this would not have been in line with the timelines and guidance contained in Advice Note 3.
- Oversight – Healthwatch have provided a supplementary report on the engagement process in support of the methods and approach taken by HMP during the engagement exercise.

Holt Medical Practice – Application to Close a Branch Surgery: Blakeney Surgery

Section C

Conclusions & Mitigation

It has been long and difficult journey to get to this point. The discussions and proposed closure of BS has caused uncertainty with some of our population and been difficult for our Partners and staff with the unusually public cross-over of business and healthcare.

We have been impressed by the local communities' efforts, commitment, and spirit for this cause. We really do empathise completely at a rural community's concerns surrounding the proposed closure of BS. Our GPs liked working from BS and miss the historic, simple and traditional model of General Practice that allowed small, branch site working.

However, we cannot ignore change and the impact this is having on the way primary care is provided. Not just within the landscape of healthcare and politics but within technology and workforce. We have a responsibility to look at the bigger picture, across the whole practice area and have a duty to all our patients to do the best that we can, with the resources that we have.

This has been a very tricky period for HMP, for both Partners and staff. We try not to consciously disappoint patients, however, our application to close Blakeney Surgery has had that effect on some and caused unease amongst many. It has been an unsettling dynamic between healthcare provider and patient.

The Partners are not trying to disadvantage a section of our patients, they are trying to make hard decisions now that protect the future healthcare we can provide. Discussing business and finance alongside people's health is always tough for everyone involved. But sometimes you have to make hard decisions, designed to have the least impact, for the greatest good. Our priority remains as it always has; ensuring that we continue to meet the reasonable health needs of our current and future population. We must do this objectively and commercially and we cannot base these decisions on unsustainable or undeliverable wishes of a minority.

BS feels unsuitable as a site for modern general practice. It is operationally deficient. Any form of continued service from the site requires investment and ongoing costs with questionable justification and uncertainty of the future. A return to services at BS would see a reduction in services at Holt and Melton Surgery.

HMP are proud of the level of services that we offer to our patients, and the working environment we try to offer to our staff. We dedicate a large amount of time to running HMP responsibly and safely. Sometimes this means making proactive and difficult decisions for its future – and the future care of its patients.

This autonomy is invaluable to a private business such as a GP Surgery. HMP (like all other GP Surgeries that we know of) have always determined the levels of service offered from our sites and the corresponding opening times of the same. These have naturally evolved over time along with our healthcare provision. This approach has never previously been questioned by NHS England or the ICB. A private business must be able to shape itself, its staff, its finances, its buildings how it sees fit and to enable it to best meet the reasonable needs of its population.

As far as HMP is aware, it continues to meet these needs to the reasonable satisfaction of the commissioners, NHS England and the CQC.

Holt Medical Practice – Application to Close a Branch Surgery: Blakeney Surgery

Summary of HMPs Reasons in Support of Closure

The local community would like to see BS remain open and ideally, a return to face to face clinical appointments from the site.

We have detailed how any option associated with keeping BS open requires financial investment, the appetite for which is limited and the commercial viability of which is questionable.

The minimum investment required to maintain the status quo at BS (same footprint and same services) would be approximately £80,000. The investment required to rebuild on a larger footprint, would be hundreds of thousands of pounds. Even if the capital investment is found from willing third parties, there will be ongoing costs associated with running, maintaining, and staffing this 3rd site that will fall to HMP that we feel we cannot justify.

There are so many other reasons why we feel the best option for HMP and its whole population is to close BS. These have already been highlighted within section A of this document, but the following summarises the main points:

- **Holt Surgery** – patients local to BS have always travelled to Holt Surgery as many appointments and services have only ever been available at this main site.
- **Flexibility** - with many services only provided from Holt Surgery, there is less flexibility within our staffing pool to provide senior, autonomous clinicians to work at our branch sites.
- **Appointments** – there has only ever been a very limited range of appointments available at BS and in the 5 years before the pandemic (2015 – 2019), only 5% of HMPs total appointments were offered from BS.
- **Appointments** – postcode data for all appointments, at all 3 sites, during 2018 and 2019 show people travelled from all over the catchment to attend those appointments, they were not just utilised by patients local to those branch surgeries.
- **Training & Supervision** – with higher turnover of staff and increased numbers of new and evolving healthcare professionals, we need space and peer support for senior clinicians to be able to train and supervise these staff. This can only be done at Holt, creating further inflexibility of workforce at branch sites. These new healthcare professionals are often part of the Duty Team based solely at Holt so unavailable for branch site working.
- **Non-Clinical Staff** – for operational efficiency, these should be based more centrally, in suitably equipped premises, with no lone working and less travel between sites. The closure of BS would increase staff satisfaction and improve chances of retention.
- **Rurality and Transport** – access to public transport and difficulties with travelling to and from our sites are a reality shared by many patients across our entire catchment area. It is not just an issue for those patients living close to BS.
- **Local Population** – only 14% of our population reside in the villages surrounding BS with only 627 residing in Blakeney itself. Patients furthest away from Holt or Melton Surgeries (to the Northwest or West of BS) are within Wells' catchment area and so do have choice of GP Surgery.
- **Population Density** – the areas where the greatest density of our patients resides (and will reside in the future) are condensed around Holt and Melton Surgeries. With finite resources, it is logical to focus these resources in these locations.
- **Cost** – the ongoing costs and time associated with running 3 sites is large and not proportionally funded.
- **Operational hurdles** – these are increased by running 3 sites and we are less resilient and more inefficient.

- **BS Premises -** BS is very small and not fit for purpose. It needs investment to bring its structure (internally and externally) up to required standards but without a rebuild remains too small to operate in line with modern general practice and for multi-disciplinary team working.
- **Funding & Investment** – there is no appetite from the Partners or the NHS to invest in BS. If third party funding could be raised, there will still be future and ongoing maintenance and running costs that will fall to HMP.
- **Not an ACV** – BPC recently tried to list BS as an ACV. This was rejected by NNDC who cited other existing community buildings in better standing and that would be suitable for co-location of community services if there was a need.
- **PCN Working** – even if improvements were made to bring the premises up to acceptable standards, BS is not located geographically sympathetically within our PCN to enable it to be easily used for PCN work.
- **Succession Planning** - the required financial buy-in to HMP for new partners would be reduced so become more attractive to new partners in a market where few GPs now wish to become partners. If we cannot attract new partners, the partnership will fail.
- **The Future** – the Government and NHS England have clearly indicated its move towards Hub-based and multidisciplinary team working. We do not want to be in a position where our business and investments are focused on redundant assets.
- **Other Branch Closures** – others have recently been permitted to close their branch sites with lower thresholds and less scrutiny.

One key point that is often misunderstood by those local to BS, and by our larger population, is that if we returned to face-to-face appointments at BS, there would be a corresponding reduction in the availability of appointments at Holt and Melton Surgeries. Inevitably, Melton Surgery would need to reduce its hours and operate on a part-time basis to allow us to divert staff and resources to BS.

But it is not just the staff - HMP would still have 100% of the costs associated with running three sites, with two of those sites open, perhaps, only 50% of the time: full-time costs and part-time utilisation.

Furthermore, NHS England would need to continue to fund the full-time rent for both sites, that were occupied only on a part-time basis. This feels increasingly hard to justify, and even harder if the site had an increased footprint, with increased rent, yet is still operated on a part-time basis.

<u>Bespoke Blakeney</u>

It is worth noting that there are many things that make this consultation about the potential closure of this branch site different to others.

In many other situations where a practice is seeking to close a branch site, they will be asking to cease the provision of clinical services if their application to close is permitted. In HMPs situation, these face-to-face services ceased at the start of COVID and for the last 4 years have remained dormant. Therefore, the last 4 years have allowed all parties to reflect on any issues or considerations that have arisen during this significant “trial” period relating to a lack of clinical appointments out of BS.

To this end we would like the ICB and PCCC to note the following points, bespoke to this application:

- HMP has 3 sites, which is unusual. There are only 11 practices in Norfolk & Waveney with 3 or more sites. The costs and operational issues associated with running 3 sites (as opposed to 2 or even just the one) are many – as noted in Section A.
- There are only 5 other sites in the whole of Norfolk & Waveney that are smaller than BS and only 3 of them are operational. Of those 3, none of them are open full-time hours.
- Prior to March 2020, patients have always needed to travel to Holt Surgery for many appointments or services only offered from Holt Surgery.
- There have been no appointments at BS since March 2020; almost 4 years ago. During this period patients have been travelling to Holt and Melton Surgery for their routine and acute appointments. Therefore, if BS were now to close, the only services that would "stop" are the medicines ordering and collections and the drop in reception.
- Since the cessation of clinical services from BS, HMP have extended Holt Surgery by 286m² (nearly 4 times the footprint of BS) and added a further 6 clinical rooms to Holt and Melton Surgeries.

More generally, it has felt that HMP and this application has come under an unusual amount of attention and scrutiny for the closure of a very small, rural branch surgery that hasn't hosted any clinical appointments since March 2020, and prior to that a very limited number and range. This is despite the national direction (from the NHS and Government) promoting (and funding) the modern model of general practice and hub based multidisciplinary team working is impossible to deliver from BS in its current form. Any investment in expanding the BS footprint fraught with issues.

It feels that the thresholds being applied to HMP are higher than have been for others and the approach to our application is being managed differently.

The management time and cost that it has taken to achieve these thresholds, respond to the vast amount of correspondence and extract the levels of data and reporting that has been asked, has been significant.

<u>Reasonable Healthcare Needs of our Population.</u>

Over the last 4 years (where there have been no face-to-face appointments offered from BS) HMP feels that it has continued to meet the reasonable healthcare needs of its population.

For example, over the last 4 years HMP has:

- Increased its capacity for appointments across its other 2 sites by approximately 12% since 2019.

- Where possible enabled patient choice to switch the mode of that appointment from face to face to telephone if it suited the patient better.

- Had no known Significant Events or concerns raised by any individual patients that they were unable to access the healthcare they needed.

- Increased our capacity for home visits should the demand have arisen. This was achieved through continuing to run a dedicated, daily, early visiting GP whose sole role between 8am and 1pm is to make home visits to those patients who are clinically or socially housebound.

And then enhancing this offering through the recruitment of Paramedics and Physician Associates who are also able to visit. Interestingly, our data would appear to show the demand for home visits has decreased slightly over the last few years.

- Embraced online development of clinical forms and queries (allowing another mode of communication and consultation for patients if they would prefer) and promoted the benefits of the NHS App and online ordering of medication.

- HMP receives many compliments from its patients about the quality of care they have received. Sometimes this is from temporary patients who have become poorly during their stay who are so complimentary of HMP when comparing us to their local surgery.

- Our metrics, collated centrally by the ICB, show we are a high performing practice when positioned within our PCN, North Norfolk and the wider Norfolk & Waveney:

    - Since July 2022 (the earliest data available on the PowerBI website, containing data collated by the ICB) HMP has maintained an average of at least 85% of all its appointments being face to face. This is significantly higher than some surgeries and noticeably higher than the other 2 surgeries within our PCN. The availability of face-to-face appointments was identified as the most important factor to our patients who responded to Question 7 on HMPs survey.

    - Between 43% and 48% of ALL our appointments are with a GP. This is a significantly higher percentage than the other surgeries within our PCN and the highest average rate (often by a significant amount) than all other surgeries in North Norfolk. This high number of GPs comes at a cost to HMP but ensures excellent service.

    - As at the end of November 2023, HMP was seeing 96% of patients within 2 weeks of booking their unplanned appointment (as per the PCN Directly Enhanced Service specification). A significantly higher rate than other Surgeries within our PCN and North Norfolk averages.

We would suggest the data supports the fact that HMP is providing an excellent service to its patients and more than meeting their healthcare needs, despite only offering appointments across two of its sites.

<u>New Mitigation if BS Closes</u>

The predominant concern should HMPs application for the closure of BS be approved is, in our opinion, the maintenance of the medicines ordering and collection service from a local site.

We know that from the data we collected during February and March 2023 and the questions posed in HMP's survey that people really value the ability to collect their regular medication from a local site. We know that patients are concerned about the viability, cost and environmental impact on needing to regularly travel to Holt or Melton Surgery to collect their medication and secondary factors such as capacity and queuing at the same.

HMP were aware that this would be a concern of many and so, at the start of the application process, contacted three local community sites to enquire if they would be interested in supporting continued medication collection from a different local site, should BS close. Initially all three sites

seemed receptive to the possibility, however as the consultation evolved these sites indicated a preference to wait until the outcome of the application process was known before confirming whether or not they would be able to help mitigate any future impact. It appeared they did not wish to be seen to be connected to any kind of discussions around a potential solution, which made any responsible planning discussions challenging.

That said, HMP have continued to give this area a great deal of thought and have summarised below the possible mitigations that we could look at were BS to close and the current medication collection and ordering service and drop in reception be removed.

- **Working with local sites** (such as The Glaven, Blakeney Garage or the Harbour Rooms) to explore whether it would be possible to host medication collections from these alternative sites. This would involve considering things such as space, parking, staffing, training, rent, secure storage etc. This model has been tried and tested in many other rural areas with great success.[63] We could provide a member of staff to assist with the staffing and running of the service from these sites at the outset, and ongoing training of any third parties able to man the service on into the future.

- If no other suitable local location can be found, we could consider temporarily **running the service from a container** located at the far end of the site on part-time hours.

- We have some **capacity within our free home delivery medication service** that would be able to assist those most vulnerable patients who were negatively impacted by the cessation of this service from BS.

- We would consider the purchase of an **electronic dispensing machine** that would be located in the wall of the dispensary at Holt Surgery. This would allow collections outside of core opening hours and help reduce queues. It would also assist those patients that have been negatively impacted on the closure of Boots, Holt on Saturdays.

- We would consider **extending the sheltered canopy** outside the Holt Pharmacy. This would mean that even in inclement weather, anyone waiting outside the building would be sheltered from the weather.

- We could better promote the use of our **buzzer system at Holt** that allows vulnerable patients or patients with mobility issues to bypass the queue and collect a buzzer allowing them to return to their car and wait for their medication to be ready. This would then be taken out to them in the car park.

- We have recently begun **texting patients when their medication is ready** to collect. This has been extremely well received and reduced unnecessary queuing.

- We would run a campaign on the **benefits of ordering prescriptions via the NHS App,** which since COVID, many patients now have. We would assist in supporting and training patients on this new technology – which is very straight forward to use, once installed.

[63] Prescriptions at the Village Shop - The Wilbrahams, Great Wilbraham, Little Wilbraham and Six Mile Bottom

Holt Medical Practice – Application to Close a Branch Surgery: Blakeney Surgery

We want to work with the local community to find a way to help with any impact the potential closure of BS may have. Once a formal decision on this application has been made, we are hopeful this will be possible.

In final summary – we remain extremely aware of the disappointment some will feel with our continued wish to close BS. However, we believe that we have a responsibility to proactively manage the finite resources of our business in the way we believe will carry the widest benefit and protect the ongoing quality of the healthcare we provide to our current and future patients.

The Partners,
Holt Medical Practice,
16th January 2024

Norfolk and Waveney
Integrated Care Board

Agenda item: 08

Subject:	**Joint Forward Plan - Primary Care**
Presented by:	**Oliver Loveless, Head of Primary Care Strategic Planning**
Prepared by:	**Oliver Loveless, Head of Primary Care Strategic Planning**
Submitted to:	**Primary Care Commissioning Committee**
Date:	**13 February 2024**

Purpose of paper:

The purpose of this paper is to provide an update on progress against the published Joint Forward Plan Primary Care ambition and objectives.

Executive Summary:

The Joint Forward Plan (JFP) was published in July 2023 following broad engagement with patients and system partners. The primary care ambition outlines the aim of integrating primary care services to deliver improved access to a wider range of services from a multi-disciplinary team, delivering more proactive care, preventing illness and improving outcomes, for local communities closer to home.

Two key objectives were developed for 2023-2025:

a) Developing our vision for providing a wider range of services closer to home, improving patient outcomes and experience.
b) Stabilise dental services through increasing dental capacity short term and setting a strategic direction for the next five years.

Key progress updates are outlined within the main body of the report.

Report:

The Joint Forward Plan (JFP) was published in July 2023 following broad engagement with patients and system partners. The primary care ambition outlines the aim of integrating primary care services to deliver improved access to a

wider range of services from a multi-disciplinary team, delivering more proactive care, preventing illness and improving outcomes, for local communities closer to home.

Two key objectives were developed for 2023-2025:

a) Developing our vision for providing a wider range of services closer to home, improving patient outcomes and experience
b) Stabilise dental services through increasing dental capacity short term and setting a strategic direction for the next five years.

Progress against the milestones developed to support the delivery of the objectives is outlined below for the period **October 2023 to March 2024**.

a) Developing our vision for providing a wider range of services closer to home, improving patient outcomes and experience

Key milestones for the period October 2023 to March 2024 were outlined as:

- Overarching Primary care strategy vision and principles developed
    - It is likely there will be a delay to the development of our strategic plan for General Practice. Following a status update to the ICB Transformation Board on 18th January alongside all ambitions it was highlighted there would likely be a delay to our original timescales. Firstly, the ICB organisational change programme may impact on the implementation of strategic plans that are to be delivered at Place. Lastly due to resilience issues in a number of practices and ongoing vacancies in the team, capacity has been affected which is impacting on delivery of the ambitions.

- Engagement with our local population and system partners.
    - Planning has commenced along with draft timelines, however it will not be completed in this financial year. This has been escalated through the ICB Transformation Board.

- General Practice Strategic Plan developed.
    - This has been delayed as outlined above and has been escalated through the ICB Transformation Board.

Previous milestones completed between April 2023 to September 2023 were:

- Develop an outline for key milestones for strategy development including which stakeholders we will engage with and by when.
    - See above for overall delay to the Primary Care Strategic Plan.
- Review population health data to identify key priorities within each Place.
    - Population health data packs have been produced for each Place with locality teams reviewing the opportunities and priority areas of focus at a very local level.
- Develop local definition of an Integrated Neighbourhood Team
    - As a system, we are looking to move away from the term “integrated neighbourhood team” and take on the term of “integrated

neighbourhood working" as this better fits the current development work being undertaken by the locality teams. The Community Services Review is focused on developing our approach to integrated neighbourhood working, in conjunction with our PCNs.

b) Stabilise dental services through increasing dental capacity short term and setting a strategic direction for the next five years.

Key milestones for the period October 2023 to March 2024 were outlined as:

- Develop and publish the Dental strategic plan by Spring 2024.
    - The development of the Dental Long-term Plan remains on track following the approval of the Dental Short-term Plan at PCCC and EMT in September 2023. Public engagement has started on our long-term plan and will run for four weeks from the 24th of January 2024. The Dental Strategy will be brought to Committee in April 2024 to allow for feedback. This will then be included in the development of the wider Primary Care Strategy outlined in Objective 2a.
    - Urgent Treatment Service pilot commenced October 2023.
    - A range of workforce schemes launched.
    - A short-term pilot for supporting children.

Previous milestones completed:

Dental Review data information published in Spring/Summer 2023
    - The Oral Health Needs Assessment (OHNA) was published pre-covid however Dental Data have been reviewed and updated, identifying opportunities for improving service provision in both the short and long term.
- Develop plan for short term interventions based on Dental Review update to the OHNA, targeting the areas requiring the greatest interventions.
    - The Dental Short-Term Plan was approved by PCCC and the executive management team in September 2023 with the Long-Term Dental Plan and strategic plan being developed by Spring 2024.

Recommendation to the Primary Care Commissioning Committee:

Members are asked to note the update and progress to date including the notification of delays to the relevant milestones.

Key Risks	
Clinical and Quality:	The JFP outlines the ambitions to improve clinical outcomes and quality of patient care through local partnerships and collaborative working and to ensure safe patient care
Finance and Performance:	Delivery of the objectives outlined within the Joint Forward Plan is subject to existing budget allocations.

Impact Assessment (environmental and equalities):	The JFP aims to support commissioning for health inequalities and to consider any environmental factors in the solution.
Reputation:	Failure to plan adequate care for patients in primary care or ensure general practice resilience will impact on the ICB's reputation and patient care.
Legal:	None identified
Information Governance:	None identified
Resource Required:	This is a system wide piece of work requiring resource from all system priority teams and enabling functions, without this there is a real risk of further delays.
Reference document(s):	Norfolk and Waveney 5-Year Joint Forward Plan - Norfolk & Waveney Integrated Care System (ICS (improvinglivesnw.org.uk)
NHS Constitution:	None identified
Conflicts of Interest:	None identified
Reference to relevant risk on the Board Assurance Framework	The resilience of general practice The resilience of NHS dental services

Governance

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

Norfolk and Waveney
Integrated Care Board

Agenda item: 09

Subject:	**Advice Note for Branch Surgeries seeking to change their service provision or opening hours**
Presented by:	**Fiona Theadom, Head of Primary Care Commissioning**
Prepared by:	**Fiona Theadom, Head of Primary Care Commissioning** **Catherine McWalter, Senior Primary Care Estates Manager**
Submitted to:	**Primary Care Commissioning Committee**
Date:	**13 February 2024**

Purpose of paper:

To seek approval for the attached Advice Note which aims to provide guidance for practices who want to apply to change the service provision offered at a branch surgery either on a short/medium term temporary basis or on a permanent basis.

Executive Summary:

This proposed Advice Note sets out how branch surgeries can apply to make temporary or permanent changes to service provision or opening hours of a branch surgery and gives some examples of the specific reasons that may apply.

The separate Advice Note No 3 for branch surgery closures should be followed where an application for branch closure applies in line with NHS England's General Practice Policy and Guidance Manual.

Norfolk and Waveney ICB area covers a large geographical area, which is mainly rural with three key urban areas in King's Lynn (West Norfolk), Norwich and in the east of the ICB area around Great Yarmouth and Lowestoft.

There are 105 general practice contracts working across our system, in 157 sites of which 54 are branch surgeries.

The GMS Regulations state that practices must provide essential and additional services to meet the reasonable need of their patients. This must be done in a way that is safe for patients, GPs, clinical staff and admin staff. Remote consulting and triage are accepted as a safe and effective way of delivering care.

While some of our branch surgeries are purpose-built, there are many branch surgeries in Norfolk and Waveney which have been in use for a significant number of years when building standards for the provision of healthcare services were less rigorous than they are now. Some are small in relation to the main site and may not be regarded as suitable for the delivery of modern general practice, staffed by a GP-led multi-disciplinary team. Some operate with reduced hours different to the main site as a result of historical decisions and in response to daily business continuity requirements.

The NHS England Primary Care Medical Services Policy and Guidance Manual states that:

> *"**Branch Surgeries***
>
> *It is important to note that unless there are specific reasons for variation, branch surgeries should be held to the same standard of service level as a 'main surgery', unless there is **specific reason** for a lesser service provision. An example of this may be in rural areas, where the principle is ensuring local access and this would be for local commissioning determination*. "

The way in which general medical services are delivered and the staff who work there has changed significantly, particularly since 2019 when Primary Care Networks were established alongside a multi-disciplinary skill mix teams to provide care through the Additional Roles.

This proposed Advice Note recognises that the general practice in the modern world is GP-led rather than GP-provided with GPs supervising and working alongside a team of many other clinicians including nurse practitioners, physician associates, first contact physiotherapists, paramedics, nurses, care coordinators, mental health practitioners, clinical apprenticeships and health and wellbeing coaches. Reception staff and care coordinators play a key role in signposting patients to the right person for their care at that time. GPs now form 15% of the general practice workforce (this excludes GP training grades).

Report

Norfolk and Waveney ICB area covers a large geographical area, which is mainly rural with three key urban areas in King's Lynn (West Norfolk), Norwich and in the east of the ICB area around Great Yarmouth and Lowestoft.

The ICB's strategic approach for primary care is towards creating the right environment for at scale working and an integrated neighbourhood model of care. The expectation is that this will be delivered through the ongoing development of Primary Care Networks and continuing expansion of PCN Additional Roles and a mixed disciplinary team approach to delivery of healthcare.

This proposed Advice Note sets out specific reasons why a branch surgery in Norfolk and Waveney may not provide the same level of service provision as the main site and proposes a process for agreeing changes in the future. It recognises that general practice in the modern world is GP-led rather than GP-provided, with GPs supervising and working alongside a multi-disciplinary team.

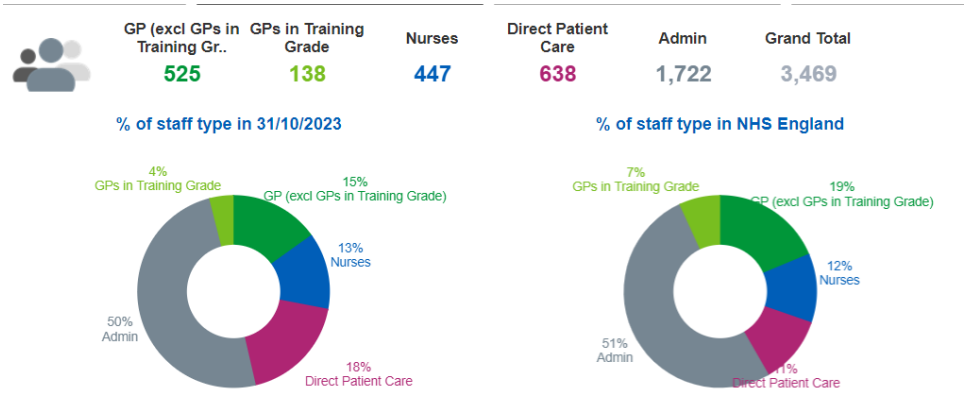
Background

There are 105 general practice contracts working across our system, in 157 sites of which 54 are branch surgeries.

The number of GPs working in N&W, particularly GP partners, (and across England) is decreasing and fewer are also working full time (8-9 sessions per week). Recent statistics show that Norfolk and Waveney's workforce position has shown an increase for:

- 0.5% growth in Nursing workforce roles across N&W during the period from October 2022 to October 2023. 447 WTE are in place across the system.
- 1.1% increase in GP workforce roles (excluding training GPs) during the same period. 525 WTE are in place across the system.
- 7.1% growth in GP Trainees across N&W during the same period. 138 FTE are in place across the system.
- 8.3% growth in Direct Patient Care workforce roles across N&W during the same period (638 WTE).
- 0.0% growth in non-clinical roles (1722 WTE)
- 58% increase on Additional Roles across N&W during this period (213 WTE)

Workforce numbers as of October 2023 are shown below:



The GMS (Schedule 3, paragraph 1 of the regulations and corresponding schedules in PMS and APMS regulations) state that providers are required to ensure that premises are suitable for the delivery of services and sufficient to meet the needs of its population.

ICB Strategic approach to primary care

Our vision is to ensure all our primary care services are delivered in a way that is sustainable, prioritising transformation of services locally, to provide care that meets the needs of our population.

Through working in partnerships with other health and care providers, we will design integrated pathways of care, that focus not only on a patient's health needs, but also their socio-economic needs, to provide more holistic and joined up care across all partners, focusing on patients only having to tell their story once.

We aspire to make it easier for people to access our services, addressing variation in access to services across the system, to enable people to lead happy and healthier lives. The NHS England Primary Care Access Delivery Plan 2023 sets out the preferred model for modern general practice and the ICB's local plan for delivery was agreed in November 2023.

Our vision will be supported by a population health management approach to proactively use our data in a joined-up way to put in place targeted support to deliver improvements in health and wellbeing.

This proactive approach will be focused on prevention, reducing inequalities, delivering equitable access, excellent experience and optimal outcomes, improving the quality of care for all people and communities living in Norfolk and Waveney. It will also be driven by our knowledge of local communities, and by partners working together to identify new solutions that can really help to improve health.

Our decision making will be informed by the needs of local communities, interventions designed to support them, and the circumstances of the practice, working with our partners from across the ICS to plan new services or models of care in an integrated way.

Role of Branch Surgeries in general practice

The GMS Regulations state that practices must provide essential and additional services to meet the reasonable need of their patients. This must be done in a way that is safe for patients, GPs, clinical teams and admin staff. Remote consulting and triage are accepted as a safe and effective way of delivering care.

The way in which general practice is provided has changed significantly in the past five years. Patients no longer need to see a GP for their care if another clinician is better placed with the relevant expertise to see and treat the individual patient. There are also greater digital opportunities for service delivery, where clinically appropriate, that are widely accepted for accessing general practice today.

This proposed Advice Note sets out how branch surgeries can apply to make changes to service provision or opening hours of a branch surgery and gives some examples of the specific reasons that may apply. In preparing this Advice Note, the ICB has considered the independent contractor role of general practices who are best placed to determine how to deliver high quality, safe care to their registered

population and with the expertise to understand how practices should operate at local level. It therefore provides guidance about whether practices may need to make reasonable adjustments to fit local population needs, while also having the ability to respond to business continuity issues.

Any changes to the hours of operation and the services provided from a branch surgery must be agreed in advance with the ICB. The process for Urgent Temporary service changes to a branch surgery will be followed once the contractor has exhausted all options under their business continuity arrangements. The contractor must notify the ICB's Primary Care Commissioning Team that business continuity plans have been invoked. Urgent applications in exceptional circumstances will be dealt with quickly according to the need.

Risks

This Advice Note sets out specific reasons why branch surgeries in Norfolk and Waveney may not provide the same level of service provision and operate to the same standard as the main site. Without this Advice Note, there is no formal set process for practices to apply to the commissioner if there is a short or long term issue affecting service delivery which may result in unplanned disruption to services and patient care for all patients registered with the practice.

The ICB intends to baseline the arrangements for branch surgery provision to confirm the current situation and to establish a commencement date if the Advice Note is approved by the Committee.

The key risk is sustainability and resilience of general practice overall. If branch surgery provision has to be maintained at the same standard as the main site regardless of the situation, there is a high risk that there will be an increasing level of requests to close branch surgeries. To mitigate this risk, Norfolk and Waveney ICB has identified examples where branch surgery provision may vary from the main site which are described in Annex A of the Advice Note:

- Rurality
- Health inequalities
- Site and configuration of practice premises and activity delivered
- Suitability of branch surgery premises for the delivery of essential services in primary medical care (it should be noted, there is no specific definition of what constitutes "essential services"), and
- Viability of services and resources

There is a longer term risk that without the ability to change the way in which service delivery is provided, this may impact the overall viability of the whole practice and its workforce and therefore its ability to provide care to the whole registered population. It should be noted that the ICB has a separate responsibility to engage with patients and members of the public and key stakeholders about any changes to service delivery and the ICB will therefore need to consider how it will meet its duty in this respect when an application is received and ensure that it is reasonable and proportionate to the scale of the proposed change and timeframe if temporary. Feedback will be used to inform the ICB's decision where appropriate.

Next steps

If the Advice Note is agreed by the ICB's Primary Care Commissioning Committee, it will be published to all general practice contractors in Norfolk and Waveney to take immediate effect.

To support general practice, it has been suggested that the ICB includes examples that apply in each scenario and to set out some Frequently Asked Questions and these will be developed in collaboration with the LMC.

Recommendation to the Committee:

Members of the Committee are asked to approve the Advice Note for general practice.

Key Risks	
Clinical and Quality:	There are no identified clinical or quality risks associated with this Advice Note however each request for change will need to highlight any clinical or quality concerns to inform decision making.
Finance and Performance:	There are no identified finance or performance risks associated with this Advice Note however each request for change will need to highlight any finance or performance concerns to inform decision making.
Impact Assessment (environmental and equalities):	The are no risks identified with this Advice Note however each request for change will need to highlight any impact for environmental or inequalities to inform decision making. An Equality Impact Assessment is part of the process.
Reputation:	Consideration of the overall resilience and stability of general practice is critical to ensuring delivery of safe patient care and staff safety. This Advice Note sets out a process for change requests to be considered therefore reducing the likelihood of unplanned changes and the subsequent impact on the overall registered population of a practice and the ICB's reputation.
Legal:	NHS England Primary Medical Care Policy and Guidance Manual, GMS Regulations (and PMS/APMS)
Information Governance:	None identified
Resource Required:	Primary Care Commissioning and Estates teams
Reference document(s):	NHS England Primary Medical Care Policy and Guidance Manual, GMS Regulations (and PMS/APMS)
NHS Constitution:	None identified
Conflicts of Interest:	None identified

Reference to relevant risk on the Board Assurance Framework	PC14 – Resilience of General Practice

Governance

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

Norfolk and Waveney
Integrated Care Board

NORFOLK AND WAVENEY ADVICE NOTE FOR REQUESTS TO CHANGE SERVICE PROVISION AND HOURS OF OPERATION AT A BRANCH SURGERY

Norfolk & Waveney Primary Care Commissioning **Advice Note 4: Procedure for requests to change service provision and hours of operation**	This advice note aims to provide guidance for practices who want to apply to change the service provision offered at a branch surgery. The Primary Care Commissioning Team are happy to discuss queries directly and can be contacted via the generic email address. Commencement date:

Introduction

This Advice Notice sets out Norfolk and Waveney's expected standards for operating general practice branch surgeries in the ICB area during general practice core hours and the process for requesting changes to existing provision. This Advice Note aims to provide guidance for practices who want to apply to change the service provision offered at a branch surgery.

The separate Advice Note No 3 for branch surgery closures should be followed where this applies in line with NHS England's General Practice Policy and Guidance Manual.

Background

Norfolk and Waveney ICB area covers a large geographical area, which is mainly rural with three key urban areas in King's Lynn (West Norfolk), Norwich and in the east of the ICB area around Great Yarmouth and Lowestoft. There are 105 general practice contracts working across our system, in 157 sites of which 54 are branch surgeries.

The GMS (PMS and APMS regulations) state that providers are required to ensure that premises are suitable for the delivery of services and sufficient to meet the needs of its population[i] .

Role of Branch Surgeries in general practice

The GMS Regulations state that primary medical care contractors must meet the reasonable needs of their patients[ii]. This must be done in a way that is safe for patients, GPs, clinical staff and admin staff. Remote consulting and triage are accepted as a safe and effective way of delivering care.

GP practices must take steps to ensure that a patient who contacts the practice either by attending one of the practice premises, by telephone, through the online

consultation system or through any other online systems, is provided with an appropriate response. This may be either to invite the patient for an appointment (either at the premises, via the telephone or video consultation) or to signpost patients to an appropriate service for their concern. The response must be based on the clinical needs of the patient and not jeopardise their health and where appropriate, take into account the patient's preferences.

This Advice Note recognises that the general practice in the modern world is GP-led rather than GP-provided with GPs supervising and working alongside a team of many other clinicians including nurse practitioners, physician associates, first contact physiotherapists, paramedics, nurses, care coordinators, mental health practitioners and health and wellbeing coaches. Reception staff and care coordinators play a key role in signposting patients to the right person for their care at that time.

Any permanent or temporary changes to the service provision from branch surgeries must be agreed in advance with the ICB, including any change to opening hours or service provision. This Advice Note does not replace the requirement to have robust business continuity plans in place.

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

All applications must be considered in accordance with NHS Regulations and NHS England policy. The NHS England Primary Care Medical Services Policy and Guidance Manual (PGM) states that

> *"**Branch Surgeries***
>
> *It is important to note that unless there are specific reasons for variation, branch surgeries should be held to the same standard of service level as a 'main surgery', unless there is **specific reason** for a lesser service provision. An example of this may be in rural areas, where the principle is ensuring local access and this would be for local commissioning determination*. "

The PGM does not provide guidance to commissioners or general practice as to the specific reasons for offering a lesser service provision and therefore this Advice Note is intended to set out the specific reasons for Norfolk and Waveney practices and the process to be followed should a practice wish to change the service provision at a branch surgery. The ICB recognise that in some cases there may be unforeseen circumstances which fall outside of the expected reasons covered below and, in these cases further discussion will be had with the practice in question.

The ICB will work with the contractor throughout the process offering support and guidance where appropriate and necessary. In considering any change requests, the ICB will have a view from the perspective of the practice's whole registered patient population.

Process for seeking approval for changes to service provision in a branch surgery

Prior to starting this process practices should have early and open discussions with the ICB Primary Care Commissioning Team, and the LMC, around the pressures on the practice and what steps might be required to allow the practice to continue to provide safe care to their whole patient population. This should include exploring all the available options in terms of adapting opening hours and the division of staffing between the practice sites. Both parties should work towards a solution which is practical, achievable, financially viable and agreeable to all and then the process below is to formalise this agreement.

Any resulting changes to service provision or hours of provision will generally fall into one of three categories.

- **Urgent temporary** changes – Requests for urgent temporary changes may be made only after exhausting business continuity arrangements. These may be changes which need to happen immediately or within the next 48hrs and will only last for a short, defined period of time. i.e changes as a result of staff sickness (critical clinical capacity is unsafe), adverse weather, loss of utilities or IT connection, and last up to a week.

- **Temporary** changes – changes which do not need to commence immediately but may need to start within 1-4 weeks and are expected to last less than 12 months.

- **Permanent** changes – changes which do not need to commence within the next 4-6 weeks but are expected to be permanent.

Stage 1 – Preliminary discussions

Where the practice invokes their business continuity plans, the practice will inform the ICB that plans have been mobilised. The ICB will contact the practice to follow up and agree necessary next steps, for example, agreeing urgent temporary changes.

For **Urgent temporary** changes that may last up to a week: the contractor will inform the Primary Care Commissioning team of the situation and agree the adaptations required with the ICB. Where needed practices will inform the DoS (Directory of Services) team (nwicb.111dos@nhs.net) of the changes required following discussion with the Primary Care Commissioning team. These requests only need complete stage 1.

For all other proposed changes, the contractor should have a preliminary discussion with the ICB's Primary Care Commissioning Team about its intentions. The ICB will make a record of the discussion. Practices are also encouraged to seek guidance from the Local Medical Committee (LMC), and either the contractor or the Commissioner may invite them to be a party to discussions at any time.

Temporary changes can be agreed by the Primary Care Commissioning Team and their decision notified to the General Practice Delivery Group (GPDG) in the event a timely decision is required. The process is completed at Stage 4. The contractor will inform the local DoS team of changes following approval by the ICB.

Permanent changes will be approved via the GPDG and will require completion of all stages detailed below.

Stage 2 – Involvement of patients and key stakeholders (where applicable)

The contractor is actively encouraged to involve patients and other key stakeholders as part of their evidence base around the reasons for the proposed change and to evidence their ability to continue to fulfil their contractual obligations in providing safe patient care and which meets the reasonable needs of its patient population.

The ICB Communications and Engagement Team will provide support and advice to the contractor as appropriate and if requested. The engagement process should be proportionate to the level of change being proposed and whether the change in provision is likely to be permanent or short/medium term. In some cases, only limited patient engagement will be required.

The preferred approach to patient engagement will be discussed and agreed between the contractor and the ICB; in some circumstances it may be appropriate and necessary for the ICB to carry out a patient and key stakeholder engagement exercise as the commissioner and to use the feedback received to help inform the ICB's decision.

The contractor remains responsible for informing the registered patients and key stakeholders of the proposed changes. It is the ICB's responsibility to ensure that involvement activities have met legal requirements in line with the policy and guidance set out below.

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

The following describes who the contractor may consider engaging with to discuss the proposed changes in service provision:

a. Patients of both the main and branch surgery site(s)
b. Patient Participation Group
c. Local Medical Committee (LMC)
d. Local Community Groups e.g. Parish Councils

e. Any identified groups within the community that may be particularly affected by the proposals
f. Other NHS providers who use the branch site or who may be affected by services transferring out of the site

The following describes who the ICB may wish to engage with and inform of proposed changes, depending on the extent of the proposed change to service provision:

g. Healthwatch
h. Local Pharmaceutical Committee (LPC)
i. Health Overview and Scrutiny Committee (if appropriate)
j. Local MPs and local Councillors (if appropriate)
k. Internal ICB Teams e.g. Digital, Place, Finance and Estates

The practice should be able to demonstrate that they have engaged with those who may be affected by the proposed changes. The methods of communication and approach taken should be proportionate to the change in delivery of medical services to patients and may include:

a. Texts/email/social media
b. engagement with their Patient Participation Group
c. Practice led drop in sessions or engagement meetings which vary in times to ensure access for all groups
d. Website – including ICB website if appropriate
e. Posters at all surgery sites and other venues accessible to patients
f. 'Seldom heard' patients – including information in alternative formats or identifying groups and ensuring efforts are made to engage in ways which are appropriate for that group.

Results of the engagement exercise should be provided to the ICB.

The ICB is committed to fulfil its obligations under the Equality Act 2010, and to ensure services commissioned by the ICB are non-discriminatory on the grounds of any protected characteristics.

The practice will be required to take health inequalities into consideration such as transport, rurality, site accessibility, whether any reasonable adjustments need to be made, vulnerable patients, health inclusion, etc and is encouraged to carry out an Equality Impact Assessment, which includes consideration of health inequalities. The ICB will be able to offer guidance on the completion of the Equality Impact Assessment. It may be helpful to consider drafting the Equality Impact Assessment at the outset and then adding to/revising it throughout the engagement.

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

The contractor will meet their own reasonable costs associated with the stakeholder engagement and application, as determined by the contractor.

Stage 3 – Request

After the preliminary discussions, the contractor must make a request in writing to the ICB. The letter/application should set out:

- the rationale for the change in service provision;
- a short options appraisal demonstrating the options that the contractor has considered and who has been involved in discussions to date. The contractor may wish to consider the examples described in Annex A that may apply to their situation.
- patient feedback already received, for example, the Patient Participation Group.

The template application form can be requested from the ICB norfolkandwaveney.delegatedcommissioning@nhs.net As much detail as possible should be included to assist in the decision making.

A template to support an options appraisal is attached as Annex B.

Stage 4 – Assessment of the application by the Primary Care Commissioning Team

The Primary Care Commissioning Team will assess the request, which must be received in writing, for any temporary or permanent changes.

Temporary changes may be agreed by the Primary Care Commissioning Team and confirmed to the contractor in writing for audit purposes. The practice will inform the local DoS team of changes required to the DoS. The Primary Care Commissioning Team will inform GPDG of the decision made and the review timescale. No contract variation will be made for temporary changes.

The ICB will agree a date with the contractor for review and if necessary, a permanent change request may be needed, or service provision is restored.

The process for temporary changes can be concluded at stage 4. In certain circumstances, the Primary Care Commissioning Team may decide to seek approval from GPDG for a temporary change and the contractor will be informed if this is the case and timeframe for a decision.

For permanent changes, and where required temporary changes, the Primary Care Commissioning Team will prepare a report for GPDG for a decision to be made. The report will be shared with the LMC prior to submission to GPDG.

Stage 5 –General Practice Delivery Group

The application will be presented to the next available meeting of GPDG and will include a recommendation from the Primary Care Commissioning Team.

The Primary Care Commissioning Team, supported by the Estates Team if

appropriate, will draft the papers to GPDG providing sufficient information for a decision to be made. The commissioner should document how it has taken the various factors into account. GPDG may request additional information to help with decision making.

If GPDG approves the changes to branch service provision, then the ICB Primary Care Commissioning Team will agree a date for the changes to take effect with the contractor.

If GPDG refuses the application the contractor will be notified and given feedback within 7 working days. In these circumstances discussions will take place to understand what further support the practice may require to enable them to continue to provide their existing services from the site, or what alternative adaptations to services may be accepted by the GPDG. An amended application may need to be submitted.

The contractor has the right to appeal and should refer to the NHS Dispute Resolution Process.

In certain situations, the DG may decide to escalate to the Primary Care Commissioning Committee for consideration and final decision. This will be agreed by all Voting Members of the ODG and the reasons documented in the DG minutes.

Stage 7 – Patient and Stakeholder Notification

The contractor will be responsible for advertising the changes in service provision and informing any relevant stakeholders. This can be done in several ways, which should be proportionate to the extent of the change, the size of practice, and the number of patients potentially affected. It could be via the practice website, social media, NHS.uk, DoS, prescription notices, posters, practice leaflet and other means. The contractor will be responsible for all costs incurred.

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

Stage 8 – Varying the GMS/PMS/APMS Contract

The ICB Primary Care Commissioning Team will issue a variation to the GMS/PMS/APMS contract to highlight the permanent changes agreed for the provision of services at the branch surgery, effective from the agreed date, for signature by both parties. A copy will be retained on ICB files for the contractor.

Annex A

Service Provision – examples of specific reasons for branch surgery provision to differ from the main site

The following reasons are not exhaustive however they are examples of what will be considered when determining whether a branch surgery can provide a different level of service provision to the main site.

Delivery of safe patient care and staff safety will be critical factors when deciding whether to agree any changes to service delivery at a branch site.

- **Rurality**

The ICB area is significantly rural and practice boundaries may cover large geographic areas and are often unique, that is, there is little or no overlap with other practice areas. Branch surgeries may have been established historically to reduce travel distances for patients or have arisen due to practice mergers; they may however no longer fit with the current general practice approach to health care and the multi-disciplinary skill mix that general practice relies on to ensure patients see the right person for the right care appropriate to their individual health and care needs.

The size of the population served by the branch site will be taken into consideration. In these circumstances, it may be appropriate for the branch surgery to provide a service for the local population that may differ to that provided at the main site, for example, offering fewer hours, having a different level of service provision or a different staffing model. Patients may therefore be expected to access certain services at one of the practice's other sites.

- **Health inequalities**

Every practice has a responsibility to consider the clinical needs of its patient population when determining how general practice services should be provided. In determining if the branch surgery service provision meets the local need, the practice will have regard to whether health inequalities are being addressed and that no patient groups are being unfairly disadvantaged in accessing general practice services. Areas of deprivation, including rural deprivation, must be a key factor.

Under the Equality Act 2010, practices must make reasonable adjustments for any patient who may need additional support in accessing services, including those with mobility difficulties, physical or sensory disabilities. Safety of staff is important and lone working arrangements are not encouraged. It may have to consider whether there is sufficient space to safely allow a chaperone, a carer or interpreters or others agreed with the patient in the surgery room at same time.

In proposing changes to branch surgery services, the practice must also have regard to travel distances of their registered population to the another of its sites and if

alternative transport options available or if it is acceptable to put alternative arrangements in place.

- **Size and configuration of practice premises and activity provided**

The size and configuration of practice premises and the ability to deliver a full modern general practice access model is an important factor and is very likely to influence the practice's ability to provide the full range of primary care medical services from a practical and safe quality of care perspective.

With a shift towards multi-disciplinary team working, practices should assess their ability to accommodate the Additional Roles and other clinicians working at the branch site while still providing safe supervision. The significant expansion of multi-disciplinary teams and their need for supervision and additional estates capacity is a barrier and a challenge for many practices, with branch surgeries facing even greater challenges. Basing a GP at a branch site could therefore cause a disproportionate use of GP clinical resource compared to the main site and a practice's ability to ensure adequate GP cover and supervision is available during core hours to their wider patient population. The practice will consider the reasonable needs of its entire registered population when considering how to balance services across its sites.

Some clinics and other services are best provided in premises that can accommodate groups of patients, e.g. managing and supporting long-term conditions, health and wellbeing services. Other services may require a specific size of room or infection control standard which may not be achievable in all branch sites, e.g. cervical smears, minor surgery services.

The ICB would be prepared to consider a branch site to be advanced practitioner-led with a GP available at another site for clinical oversight, advice and guidance.

- **Suitability of branch surgery premises for the delivery of all essential primary medical services**

The National Health Service (General Medical Services – Premises Costs) Directions 2013 include Minimum Standards for Practice Premises.
Practices are responsible for ensuring their premises are fit for purpose.

The ICB receives an annual capital allocation covering both general practice premises and IT which is limited and does not allow for all proposed premises schemes to be supported. The NHS – under the current Directions – can only fund up to 66% of an eligible scheme. NHS grants for premises cannot be used for repairs, redecoration or maintenance (along with a number of other restrictions). Due to the limited funding available to support premises improvements, proposals brought forward will be prioritised against agreed criteria and should form part of a PCN Estates Strategy.

The ICB will take into consideration any survey carried out on the building and its compliance with infection and prevention control standards.

As a result, there may be circumstances where a branch surgery is no longer suitable for the delivery of certain aspects of primary medical services and there is no funding available to resolve this.

- **Viability of services and resources**

In making a final decision, the ICB will consider the overall viability of services and resources in terms of financial viability and value for money alongside staff resources and ability for the branch surgery or surgeries to operate at the same level of provision as the main site.

The ICB will take into consideration the rising costs of running premises and the necessity to duplicate staffing to avoid lone working.

The GP practice may be asked to consider what additional support can be made available to the meet the needs of their registered patient population if full-service provision cannot be provided at the branch surgery.

Template to be completed – practices should complete this in as much detail as possible to inform the decision-making process, setting out the proposed changes, the reasons and what options have been explored to date. Further options may be added if appropriate.

OPTIONS APPRAISAL	**Option 1**	**Option 2**	**Option 3**
	Do nothing		
Rurality			
Health Inequalities			
Size and configuration of practice premises and activity provided			
Suitability of branch surgery premises for the delivery of all essential primary medical services			
Viability of services and resources			

Overall rating			

[i] Schedule 3 paragraph 1 of regulations https://www.legislation.gov.uk/uksi/2015/1862/schedule/3/paragraph/1
[ii] Part 5, Regulation 20 (2)(b) https://www.legislation.gov.uk/uksi/2015/1862/regulation/20

Norfolk and Waveney
Integrated Care Board

Agenda item: 10

Subject:	**General Practice Operational Delivery Report**
Presented by:	**Sadie Parker, Director of Primary Care**
Prepared by:	**Sadie Parker, Director of Primary Care** **Shepherd Ncube, Associate Director of Primary Care**
Submitted to:	**Primary Care Commissioning Committee**
Date:	**13 February 2023**

Purpose of paper:

To provide the Board with a report of the General Practice Operational Delivery Group meetings held on 20 December 2023 and 23 January 2024

Group:	General Practice Operational Delivery Group
Chair:	Mark Burgis, Executive Director of Patients and Communities
Meetings since the previous update:	20 December 2023 and 23 January 2024
Overall objectives of the GPODG:	The purpose of the Delivery Group is to provide a framework for effective decision making in relation to certain contractual matters for general practice under delegated authority from the ICB's Primary Care Commissioning Committee.
Main purpose of meeting:	To contribute to the overall delivery of the ICB's objectives to create opportunities for the benefit of local residents, to support Health and Wellbeing, to bring care closer to home and to improve and transform services by providing oversight and assurance to the Primary Care Committee on the exercise of the ICB's delegated primary care commissioning functions and any resources received for investment in primary care.
BAF and any significant risks relevant / aligned to this Group:	December committee agreed BAF (Board Assurance Framework) risks would continue to be monitored by committee with an overview of all risks, while the

	remaining risks would be monitored in detail at the operational delivery groups. There are two BAF risks – • The resilience of general practice • The resilience of NHS dental services
Key items for assurance/noting:	<u>20 December 2023</u> • Workforce recruitment and retention – the group received updates on the progress of the work and the positive uptake achieved to date. 84% of practices are now training practices, incentives have been successful in signing up 10 new GP partners and 25 GPs completing the training scheme. A monthly task and finish group has been established to support retention of PCN roles. • Estates – the group was updated on the progress of the wave 4b schemes, with Rackheath delayed due to drainage issues. The ICB has received 14 PCN estates strategies and is supporting the remaining 3. These will be used in drafting the system primary care estates strategy. The estates team understand that around 70% of practices are interested in some form of estates development. It should be noted that capital remains relatively low at £1.9m per annum for both GPIT and estates schemes. • Digital – all practices will have full cloud-based telephony by the end of 2024, a key part of the system access improvement plan. The shared care record has now completed its first two phases with the majority of SystmOne practices live. The cost to the system of text messaging continues to rise and the team is considering how to support practices to use other methods and this is being progressed at national level too. • Learning Disability Health Checks – the latest performance was reviewed, additional clinical resources have been agreed to accelerate delivery against a national target of 75%. Mitigations were being put in place to provide additional capacity to support patients of practices who were unable to provide the capacity in house. Reports for the rest of the financial year would take a locality by locality focus. <u>23 January 2024</u>

	• CQC reports for Magdalen Medical Practice in Norwich and The Lawns Medical Practice in Diss were reviewed. Both practices had received a Good rating. • An update was received on the Capacity and Access Improvement Plans. PCNs were making good progress and the quarterly meetings had been constructive. • The prescribing report was reviewed, and good overall progress was noted. The team was working with individual practices which were not making the progress hoped for in areas such as reducing opioid prescribing. Antimicrobial stewardship was acknowledged as vital for all to engage with and the potential risk associated with Pharmacy First was noted. • E-declaration action plan – only 2 practices had failed to submit their e-declaration which was a contractual requirement. One was due to the transition of the contract to a new provider and the other was due to staff sickness. Both contracts would continue to be monitored through the meeting framework in place. • PCN directed enhanced service – the early draft proposals for monitoring were shared with the group for discussion. There was general support and it was noted the paper would be finalised once the ICB's organisational change process had been concluded. • Learning disability health checks – a national issue leading to incorrect additions to practice registers since November was noted. This was expected to be corrected by the end of January. 91% of checks included a health action plan, which was an improvement over last year. There was a focus on Norwich practices in the report, with five showing strong uptake and support being provided to others.
Items for escalation to Committee:	• The resilience of general practice and community pharmacy remain of concern, with more practices seeking support for resilience related issues. • Vacancy controls due to organisational change, along with unplanned absences in the team are having an impact on capacity and limiting the team to managing the immediate and higher risk areas.
Items requiring approval:	20 December 2023

	• Locally commissioned services – the group agreed to re-commission 3 LCS due to expire at the end of March 2024, noting there were ongoing discussions with the LMC. <u>23 January 2024</u> • A new advice note to provide a clear process for applying changes in service provision in branch surgeries was reviewed and the group agreed to recommend approval to committee. • The group considered revised terms of reference to reflect the experience of full delegation over the past 9 months. These were agreed and would be recommended to Board in March.
Confirmation that the meeting was quorate:	Yes. Attendance at the meeting is set out below: <u>20th December 2023</u> **Voting members** Mark Burgis, Executive Director of Patients and Communities Sadie Parker, Director of Primary Care, Shepherd Ncube, Associate Director of Primary Care Commissioning Daniel Abrahams, Primary Care Finance Lead (representing James Grainger) Marie McDermott, Senior Nurse for Primary Care (representing Karen Watts) **In attendance** Fiona Theadom, Head of Primary Care Commissioning Carl Gosling, Senior Primary Care Commissioning Manager (General Practice) Lisa Drewry, LMC Joni Graham, LMC Cath McWalter, Senior Primary Care Estates Manager Oliver Loveless, Head of Primary Care Strategic Planning Jayde Robinson, Head of Primary Care Workforce Transformation Mel Benfell, LMC <u>23rd January 2024</u> **Voting members** Sadie Parker, Director of Primary Care Shepherd Ncube, Associate Director of Primary Care Commissioning

	Lisa Read, Acting Head of Quality and Nursing (representing Karen Watts) Stuart White, Finance Manager, Delegated Primary Care James Grainger, Head of Finance, Primary Care & Corporate/Reporting **In attendance** Fiona Theadom, Head of Primary Care Commissioning Carl Gosling, Senior Primary Care Commissioning Manager (General Practice) Lisa Drewry, LMC Joni Graham, LMC Oliver Loveless, Head of Primary Care Strategic Planning Michael Dennis, Associate Director of Pharmacy and Medicines Optimisation (Chief Pharmacist) Debbie Ebenezer, Delegated Commissioning Manager – Primary Care Ian Wilson, LMC Andrew Hayward, Trustee of Healthwatch Norfolk

Key Risks	
Clinical and Quality:	The group monitors progress in developing our dashboard and our overall monitoring framework
Finance and Performance:	Finance and BI are part of the group, performance will be monitored in detail with a dashboard in development.
Impact Assessment (environmental and equalities):	There is a focus on the delivery of LD and SMI health checks.
Reputation:	Healthwatch Norfolk and Suffolk and the Local Medical Committee is part of the group.
Legal:	Terms of reference, primary medical services contracts, premises directions and policy guidance manual
Information Governance:	No risks identified.
Resource Required:	Primary care commissioning team
Reference document(s):	Primary medical services regulations, statement of financial entitlements, premises directions and policy guidance manual, delegation agreement with NHS England
NHS Constitution:	No risks identified.
Conflicts of Interest:	Arrangements are in place to manage conflicts of interest

Norfolk and Waveney
Integrated Care Board

Agenda item: 10

Subject:	**Dental Services Operational Delivery Group report**
Presented by:	**William Lee, Senior Primary Care Commissioning Manager – Dental**
Prepared by:	**William Lee, Senior Primary Care Commissioning Manager – Dental**
Submitted to:	**Primary Care Commissioning Committee**
Date:	**13 February 2024**

Purpose of paper:

To provide the Committee with a report of the meetings of the Dental Services Operational Delivery Group ("DSODG") held on 14th December 2023.

Group:	**Dental Services Operational Delivery Group**
Chair	Sadie Parker, Director of Primary Care, Norfolk and Waveney ICB
Meetings since previous update	14th December 2023 The meeting scheduled for 11th January 2024 was cancelled
Overall objectives of DSODG	The purpose of the meeting is to provide a framework for effective decision making in relation to certain contractual matters for dental services under delegated authority from the ICB's Primary Care Commissioning Committee ("PCCC")
Main purpose of the meeting	To contribute to the overall delivery of the ICB's objectives to create opportunities for the benefit of local residents, to support Health and Wellbeing, to improve access and transform services by providing oversight and assurance to PCCC on the exercise of the ICB's delegated primary care commissioning functions and any resources available for investment in primary, community and secondary dental care
BAF and significant risks relevant / aligned to this Group	At this stage, the risk register is monitored by PCCC however work is being undertaken to agree how operational and strategic risks can be monitored across DSODG and PCCC respectively. The BAF risk has been updated to include workforce matters.

Key items for assurance / noting	• The Group received a verbal report from the Quality Team. It outlined the work being conducted to reduce health inequalities and improve access with our local providers. This work will form part of the overall long term dental strategy, with the collaboration with the Vulnerable Adult Service being highlighted as a key initiative to help this patient group get out of pain and stabilise people's oral health. It was noted the team have started to review homeless patient groups, including a patient reflection to aid reviews of quality improvement outcomes in the future. • The Group discussed a report for approval pertaining to a contractor who had requested a merging of two contracts into one. It included a reduction in NHS Activity due to significant workforce challenges, and an increase in UDA value to the ICB average. Considering the approval at December's PCCC regarding the UDA rate review, and the underperformance of the current contract, it was approved from an administrative and financial point of view, alongside ensuring the continuity of NHS provision from this provider through stabilising their debt and regaining financial viability moving forward. • The Group discussed a report for approval relating to a contractor requesting a temporary reduction in UDAs and an increase in UOAs due to the providers current workforce skill mix. The paper was discussed and shown to have limited financial risk to the ICB, with benefits being highlighted as continuity of care and reduction in Orthodontic waiting times. The LDC and LDN views were sought prior to the meeting and their input set out in the paper outlining their support, the paper was approved. • The Group reviewed a paper for approval, relating to a 12-month extension of the Electronic Referral Management Service. The paper outlined a preferred option of a 12-month extension, which incorporated an independent and comprehensive review of the current service provider, to aid future procurement of the referral management service. It was noted this approach was supported by clinical colleagues and was approved.

Items for escalation to Committee	No areas of escalation were raised.
Items requiring DSODG approval	• Approved a contract change for a Practice, including merging of contract, reduction of activity and increased UDA value. • Approved temporary contract change for a contractor including one-off non-recurrent increase of Units of Orthodontic Activity (UOA) with a corresponding temporary reduction of Units of Dental Activity (UDA) for two practices until end of April 2024 • Approval of 12-month extension to FDS contract to provide the Electronic Referral Management Service.
Confirmation that the meeting was quorate	The meeting was quorate

Recommendation to the Committee:

To note the report for assurance purposes

Key Risks	
Clinical and Quality:	The Group will be monitoring quality improvement and development of a performance dashboard and overall assurance framework
Finance and Performance:	Finance is part of the membership, performance and spend against the dental budget will be monitored in detail and reported to the Committee
Impact Assessment (environmental and equalities):	Each proposal will be accompanied by an inequalities impact assessment to inform the Group's decision making
Reputation:	Healthwatch Norfolk and Healthwatch Suffolk, Local Professional Network and the Local Dental Committee are all represented on the Group
Legal:	Terms of reference, general dental services contracts, regulations and Dental Policy Handbook
Information Governance:	None identified
Resource Required:	Primary Care Commissioning Team
Reference document(s):	General dental services contracts, regulations and Dental Policy Handbook
NHS Constitution:	None identified
Conflicts of Interest:	Arrangements are in place to manage conflicts of interest
Reference to relevant risk on the Board Assurance Framework	The resilience of NHS dental services

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Norfolk and Waveney Integrated Care System

2023/24 Primary Care Commissioning Committee

Finance Report Norfolk & Waveney ICB

December 2023

Primary Care Commissioning Committee 13th February 2024

Contents

1.0 Executive Summary

- As the financial reporting for Primary Care and Prescribing is produced in arrears this report will relate to Month 9 (December 2023) of the ICB accounts.

- As at Month 9 (M9), the Year to Date (YTD) spend is £ 408.8m as against a plan of £403.9m leading to an overspend of £4.9m for Primary Care and Prescribing in combination.

- The forecast spend is £528.2m as against a plan of £543m leading to a forecast underspend of £14.8m. The Primary care spend is mainly a combination of Prescribing, Delegated Commissioning, Pharmacy Optometry and Dental (POD) which the ICB has taken over from April-23.

- The Efficiencies this year have been identified at 5% for all areas and whilst in Prescribing, most efficiencies are identified, it is not the case in other areas and hence the majority of adverse variance is due to Unidentified Efficiencies.

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

2.0 Total Financial Summary

23/24 Primary Care & Prescribing:	12months Budget ICB	Year to Date(December)			Forecast (ICB)		Forecast as at November		Comments on material Forecast Variances and M08 and M09 FOT movements
	Budget £m	Budget £m	Actual £ m	Variance (Fav)Adv £m	Actual £ m	Variance (Fav)Adv £m	Actual £ m	Movement in FOT (Fav)Adv £m	
GP & Other Prescribing									
GP Prescribing	190.5	143.5	146.0	2.5	194.2	3.7	193.9	0.3	The FOT adverse variance of £3.7m is due to year on year increase in SGLT 2 £2m ,Continuous Glucose Monitoring £0.7m, £0.6m in Direct Oral Anticoagulants (DOAC) between April to October 22/23 and 23/24 mitigated by Prior Year benefits £1.3m, Reduced Edoxaban rebate £1.2m and balance is lower flu recharges and rebates from drug companies. The FOT movement between M8 and M9 is marginal at £0.3m due to lower Apixaban prices expected from Q4
Other Prescribing costs	18.2	13.5	14.1	0.6	19.0	0.9	19.1	(0.0)	The FOT adverse variance of £0.9m is due to budget reduced in Central Drugs and Oxygen due to unidentified efficiencies £0.5m and increased electricity cost pressures in Oxygen mitigated by lower Dressings costs
Total GP & Other Prescribing	**208.7**	**157.0**	**160.1**	**3.1**	**213.3**	**4.6**	**213.0**	**0.3**	
Primary Care									
Delegated Primary Care	213.1	159.7	159.9	0.3	207.7	(5.4)	207.5	0.2	The FOT favourable variance of £5.4m is offset against £4.3m adverse variance in LES as budget is reported In Delegated and spend is reported separately in LES due to NHSE directives. The balance favourable is due to prior year benefits. The movement in FOT between M8 and M9 is due to increased dispensing fees.
Local Enhanced Services(LES)	9.5	6.2	9.7	3.5	13.8	4.3	15.6	(1.9)	£1.9m prior year benefits were released in M9 and hence the favourable M8 to M9 movement
Other Primary Care	14.2	8.6	7.6	(1.0)	12.7	(1.5)	12.6	0.1	£1.1m favourable FOT variance is made of £0.7m underspend in surge capacity funding and balance in non-recurrent prior year benefits. Slight movement in FOT between M8 and M9
Total Primary Care	**236.8**	**174.4**	**177.2**	**2.8**	**234.1**	**(2.7)**	**235.7**	**(1.6)**	
DOP									
Dental	65.5	48.7	46.5	(2.2)	47.2	(18.3)	47.2	(0.0)	£18.3m favourable FOT variance is in historic underperformance funding workforce incentives.
DOP Delegated pay	0.8	0.5	0.4	(0.0)	0.8	(0.0)	2.5	(1.7)	The change is FOT between M8 and M9 is due to budget reduction resulting in FOT reduction as budget moved to Dental and released as part of lower activity
Optom	10.2	7.6	8.4	0.8	11.2	1.1	10.6	0.6	Increased home visits, NHS funded sight test and NHS funded glasses is the reason for both FOT adverse variance and movement between M8 and M9
Pharmacy	20.9	15.7	16.1	0.4	21.6	0.6	21.6	0.0	The FOT adverse variance is due to higher professional fees £0.5m and advanced services £0.7 mitigated by Quality Payment scheme £0.6m
Total DOP	**97.5**	**72.5**	**71.5**	**(1.0)**	**80.8**	**(16.6)**	**81.9**	**(1.1)**	
Total Prescribing and Primary Care	**543.0**	**404.0**	**408.8**	**4.9**	**528.2**	**(14.7)**	**530.6**	**(2.4)**	
Variance as a % of Budget				*1.2%*		*-2.7%*		*-0.5%*	

3.0 GP And Other Prescribing

23/24 Primary Care: Prescribing	12months Budget ICB	Year to Date(December)			Forecast (ICB)		Forecast as at November		Comments on material Forecast Variances and M08 and M09 FOT movements
	Budget £m	Budget £m	Actual £m	Variance (Fav)Adv £m	Actual £m	Variance (Fav)Adv £m	Actual £m	Movement in FOT (Fav)Adv £m	
GP Prescribing Costs	199.7	150.2	152.9	2.7	202.7	3.1	201.7	1.0	The FOT adverse variance of £3.1m is due to year on year increase in SGLT 2 £2m ,Continuous Glucose Monitoring £0.7m, £0.6m in Direct Oral Anticoagulants (DOAC) between April to October 22/23 and 23/24 mitigated by Prior Year benefits £1.3m, Reduced Edoxaban rebate £1.2m . The £1m adverse movement between M8 and M9 is due to increased flu costs which are recharged by ICB to NHSE. This is shown below under recharges and rebates section.
Recharges to Local Authorities & NHS England	(5.6)	(4.2)	(4.6)	(0.4)	(5.2)	0.4	(5.0)	(0.2)	Overall lower flu rebates as against full year plan for the FOT variance but a increased flu rebate in October than estimate and hence £0.2m favourable movement between M8 and M9
Rebates from pharmaceutical companies	(3.5)	(2.4)	(2.3)	0.1	(3.3)	0.2	(2.8)	(0.5)	Marginal £0.2m lower rebates as against full year plan for FOT variance and increased Edoxaban rebate expected for full year and hence £0.5m favourable position between M8 and M9
Central Drugs	5.1	3.8	4.1	0.3	5.4	0.3	5.4	0.0	Unidentified efficiency is the reason for adverse FOT variance
Dressings & wound care	5.3	4.0	3.6	(0.4)	4.9	(0.4)	4.9	(0.0)	Small reduction in dressings hence favourable FOT variance
Others (Medicine Management, Oxygen, incentives etc.)	7.8	5.7	6.4	0.7	8.7	0.9	8.8	(0.0)	£0.9m adverse FOT variance is due to unidentified efficiencies in Oxygen and Medicine Management budget, increase in electricity costs for both Oxygen and Medicine Management,
Total Prescribing	**208.7**	**157.0**	**160.1**	**3.1**	**213.3**	**4.6**	**213.0**	**0.3**	
Variance as a % of Budget				*2.0%*		*2.2%*		*0.1%*	

Variance Signage: (Favourable)/Adverse

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

4.0 Delegated Co Commissioning

23/24 Primary Care: Delegated	12months Budget ICB	Year to Date(December)			Forecast (ICB)		Forecast as at November		Comments on material Forecast Variances and M08 and M09 FOT movements
	Budget £m	Budget £m	Actual £m	Variance (Fav)Adv £m	Actual £m	Variance (Fav)Adv £m	Actual £m	Movement in FOT (Fav)Adv £m	
Contractual	133.71	100.09	99.54	(0.6)	133.06	(0.6)	133.1	(0.0)	Favourable FOT variance is due to benefit in contract and contract KPI's, where contract paid out in full and clawed back where necessary.
QOF	16.17	12.13	12.13	0.0	16.17	0.0	16.2	(0.0)	On Plan
Premises cost reimbursements	15.56	11.67	11.91	0.2	15.69	0.1	15.8	(0.1)	FOT variance is due to rent reviews and arrears payments
Other - GP Services	14.89	11.17	12.05	0.9	15.79	0.9	15.3	0.5	FOT variance is due to emergency locum spend at South practice. Movement due to national price tariff for Q3 & Q4 not as expected
Enhanced services	11.19	8.39	8.48	0.1	11.30	0.1	11.3	0.0	Adverse variance from increased activity in Minor surgery
CCG Spend	0.57	0.42	0.40	(0.0)	0.55	(0.0)	0.5	0.0	On Plan
PCN ARRS Staff	17.40	13.05	17.55	4.5	17.40	0.0	17.4	0.0	On Plan
PMS to GMS	4.18	3.14	0.00	(3.1)	0.00	(4.2)	0.0	0.0	FOT Variance offset in LCS cost centre
Prior Year	(0.53)	(0.40)	(2.12)	(1.7)	(2.26)	(1.7)	(2.1)	(0.2)	Negative budget from allocation shortfall for current year spend, mitigiated by PY ARRS release, IIF and rates
Total Delegated	**213.1**	**159.7**	**159.9**	**0.3**	**207.7**	**(5.4)**	**207.5**	**0.2**	
Variance as a % of Budget				*0.2%*		*-2.6%*		*0.1%*	

Variance Signage: (Favourable)/Adverse

- The above table details the category of expenditure within Delegated Co Commissioning
- The Forecast variance is underspent as the PMS GMS budgets are in Delegated and the spend is recorded in Local Enhanced Services.

5.0 System Development Fund / GPFV

23/24 Primary Care: SDF / GPFV	12months Budget ICB	Year to Date(December)			Forecast (ICB)		Forecast as at November		Comments on material Forecast Variances and M08 and M09 FOT movements
	Budget £m	Budget £m	Actual £m	Variance (Fav)Adv £m	Actual £m	Variance (Fav)Adv £m	Actual £m	Movement in FOT (Fav)Adv £m	
Training Hub	0.26	0.19	0.19	(0.00)	0.26	0.02	0.3	0.0	On Plan
Training Hub Default	0.32	0.19	0.18	(0.02)	0.32	(0.28)	0.3	0.0	On Plan
Online Consultation System	0.18	0.18	0.18	(0.00)	0.18	0.00	0.0	0.2	On Plan, Increase in FOT between M8 and M9 is due to allocation in M9
GP Fellowships	0.19	0.19	0.19	0.00	0.19	0.25	0.19	0.0	On Plan
Nurse Fellowships	0.00	0.00	(0.00)	(0.00)	0.00	(0.31)	0.0	0.0	On Plan
Supporting Mentors	0.09	0.09	0.09	(0.00)	0.09	0.04	0.09	0.0	On Plan
GP Retention	0.33	0.25	0.25	(0.00)	0.33	(0.11)	0.3	0.0	On Plan
Flexible Staff Pools	0.12	0.09	0.09	0.00	0.12	0.07	0.1	0.0	On Plan
Infrastructure & Resiliance	0.13	0.10	0.10	0.00	0.13	0.23	0.1	0.0	On Plan
ARI Hubs	0.00	0.00	(0.00)	(0.00)	0.00	0.09	0.0	0.0	On Plan
GP Accelerate	0.00	0.00	0.00	0.00	0.00	(0.01)	0.0	0.0	On Plan
Total SDF	**1.6**	**1.3**	**1.3**	**(0.0)**	**1.6**	**(0.0)**	**1.4**	**0.2**	£0.1m adverse variance is due to Unidentified Efficiencies
Variance as a % of Budget				*-1.3%*		*-0.7%*		*12.6%*	
Variance Signage: (Favourable)/Adverse									

- The above table details the schemes within the System Development Fund (SDF).
- NHSE have awarded the allocation under Transformation Fund and work is carried out by the Primary Care Commissioning Team to allocate funding to different projects.
- The ICB received separate allocation for GP Fellowship, GP Supporting Mentors.

6.0 Dental

23/24 Primary Care: Dental	12months Budget ICB	Year to Date(December)			Forecast (ICB)		Forecast as at November		Comments on material Forecast Variances and M08 and M09 FOT movements
	Budget	Budget	Actual	Variance (Fav)Adv	Actual	Variance (Fav)Adv	Actual	Movement in FOT (Fav)Adv	
	£m	£m	£m	£m	£m	£m	£m	£m	
Primary Dental									
Patient Revenue	(20.0)	(15.0)	(10.0)	5.0	(13.3)	6.7	(13.4)	0.1	FOT Variance is due to ongoing gap between targeted patient revenue and actuals received, as this was set on 19/20 levels and access is still limited.Slight deterioration between M8 and M9.
Baseline Payments (Inc Perf Adj)	59.7	44.8	41.7	(3.1)	39.7	(20.1)	39.7	(0.1)	FOT Favourable variance of £20.1m is due to £17m forecasted clawback for current year underperformance and £3m recurrent contractual underspend (handbacks)
Pay & Pensions	1.8	1.3	1.2	(0.1)	1.6	(0.1)	1.6	(0.0)	FOT variance broadly on Plan
Minor Oral Surgery	0.4	0.3	0.3	0.0	0.4	0.0	0.4	0.0	On Plan
Other Primary Dental	0.8	0.6	0.5	(0.1)	1.2	0.4	1.2	0.0	FOT contains £0.6m workforce incentives, offset by pension and property underspends (£0.2m).
General Reserve	5.1	3.9	0.0	(3.9)	(0.0)	(5.1)	(0.0)	(0.0)	Reserve budget funds underperformance in patient charge revenue and contributes to overall underspend.
Total Primary Dental	**47.8**	**35.9**	**33.7**	**(2.2)**	**29.6**	**(18.3)**	**29.6**	**(0.0)**	
Secondary Dental									
Baseline payments	13.8	10.3	10.4	0.1	13.9	0.1	13.9	0.0	FOT variance broadly on Plan
Low Volume Activity & NCA	0.1	0.1	0.1	0.0	0.1	0.0	0.1	0.0	On Plan
Other	0.4	(0.1)	(0.1)	(0.1)	0.4	(0.1)	0.4	(0.0)	Pay budget recategorised to pay cost centre
Total Secondary Dental	**14.3**	**10.4**	**10.4**	**0.0**	**14.3**	**0.0**	**14.3**	**(0.0)**	
Community Dental									
Baseline Payment	2.6	2.0	1.9	(0.1)	2.6	(0.1)	2.6	(0.0)	FOT variance broadly on Plan
Specific Items	0.7	0.6	0.5	(0.0)	0.7	(0.0)	0.7	(0.0)	On Plan
Other	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	On Plan
Total Community Dental	**3.4**	**2.5**	**2.4**	**(0.1)**	**3.3**	**(0.1)**	**3.3**	**(0.0)**	
DOP Delegated Pay									
Pay	0.5	0.4	0.3	(0.0)	0.5	(0.0)	0.5	0.0	On Plan
Other	0.4	0.1	0.1	0.0	0.4	(0.0)	0.4	0.0	On Plan
Total Delegated Property Costs	**0.8**	**0.5**	**0.4**	**(0.0)**	**0.8**	**(0.0)**	**0.8**	**0.0**	
Total Dental	**66.4**	**49.2**	**47.0**	**(2.3)**	**48.0**	**(18.4)**	**48.0**	**(0.0)**	
Variance as a % of Budget				*-4.6%*		*-27.7%*		*0.0%*	

Variance Signage: (Favourable)/Adverse

6.0 Dental Reserve's

	Actual FOT 000's	Budget 000's	Variance 000's	Comment
Contractual				
Revenue	(13,322)	(19,996)	6,675	Revenue based on 19/20 outturn so hugely overvalued
Missing Revenue			-	Some additional revenue may be forthcoming
Contract	55,628	59,718	(4,090)	Contract hand backs. Does not include underperformance of current year contracts
Reserve		5,139	(5,139)	NHSE Reserve budgeted for 23/24
Performance Adjustment 23/24	(17,890)	-	(17,890)	Underperformance in contracted activity not yet known. Based on forecast model
Performance Adjustment 22/23	(10,400)	-	(10,400)	Per NHS England, this will be retained by them NHS England
Claw back ICB to NHSE	10,400	-	10,400	Clawback as per NHSE
Sub-Total Contractual	24,417	44,860	(20,443)	
Investments				
Emergency Pathway	1,000	-	1,000	
Children's Pathway	400	-	400	
UDA Rate Reviews	400		400	
Other UDA & Activity Changes	91		91	
Workforce Incentives	600		600	
Sub-Total Investments	2,491	-	2,491	
Other	2,656	2,800	(144)	
Sub-Total Other	2,656	2,800	(144)	
Net variance			(18,097)	
Bottom Line Requirements				
Closing the Gap Requirement	509		509	Closing the Gap requirement after unmet need allocation
Problem / (Additional Reserve)			**(17,588)**	

NHSE Ledger		
		(17,588)
22/23 N&W Claw back Provision	6,100	
22/23 N&W Claw back actual	(16,500)	
Benefit	(10,400)	

This Reconciliation is essentially an "off-ledger" schedule of the general reserve within dental, and the additional **potential** for claw back within year. As there is a certain amount of risk in the value of the potential claw back, none has yet been recognised in the financial position.

In addition, there is an amount of budget held outside of the dental cost centre (due to ring fenced reasons). This reconciliation considers all these items for **illustrative purposes only**.

This does however show the affordability of the current investments agreed through PCCC and those in the pipeline for dental.

7.0 Optom

23/24 Primary Care: Optom	12months Budget ICB	Year to Date(December)			Forecast (ICB)		Forecast as at November		Comments on material Forecast Variances and M08 and M09 FOT movements
	Budget £m	Budget £m	Actual £ m	Variance (Fav)Adv £m	Actual £ m	Variance (Fav)Adv £m	Actual £ m	Movement in FOT (Fav)Adv £m	
Optician Sight Tests	6.2	4.6	5.0	0.3	6.6	0.5	6.3	0.4	Increased home visits, NHS funded sight test and NHS funded glasses is the reason for both FOT adverse variance and movement between M8 and M9
Vouchers for SuppSpec	3.3	2.5	2.6	0.1	3.5	0.2	3.4	0.1	Same as above
Domestic Visits	0.3	0.2	0.5	0.2	0.7	0.3	0.5	0.1	Same as above
Other	0.4	0.3	0.3	0.1	0.4	0.1	0.4	0.0	Same as above
Total Optom	**10.2**	**7.6**	**8.4**	**0.8**	**11.2**	**1.1**	**10.6**	**0.6**	
Variance as a % of Budget				*10.7%*		*10.7%*		*5.6%*	
Variance Signage: (Favourable)/Adverse									

8.0 Pharmacy

23/24 Primary Care: Pharmacy	12months Budget ICB	Year to Date(December)			Forecast (ICB)		Forecast as at November		Comments on material Forecast Variances and M08 and M09 FOT movements
	Budget £m	Budget £m	Actual £m	Variance (Fav)Adv £m	Actual £m	Variance (Fav)Adv £m	Actual £m	Movement in FOT (Fav)Adv £m	
Prescription Charges	(11.9)	(8.9)	(9.1)	(0.1)	(12.1)	(0.2)	(12.2)	0.1	
Professional Charges	26.6	19.9	20.3	0.3	27.1	0.5	27.1	(0.0)	Increased activity
Essential Services	2.4	1.8	1.8	(0.0)	2.4	(0.1)	2.4	(0.0)	
Advanced Services	2.1	1.6	2.2	0.6	2.9	0.8	2.9	(0.0)	Increased activity 7 services available for Pharmacies to offer
Quality Payment Scheme	1.4	1.0	0.6	(0.4)	0.8	(0.6)	0.8	(0.0)	Reduced Activity
Other	0.3	0.2	0.3	0.1	0.5	0.2	0.5	(0.0)	
Total Pharmacy	**20.9**	**15.7**	**16.1**	**0.4**	**21.6**	**0.6**	**21.6**	**0.0**	
Variance as a % of Budget				*2.9%*		*3.1%*		*0.0%*	

Variance Signage: (Favourable)/Adverse

9.0 Efficiencies (Planned)

23/24 Primary Care: Efficiencies	Scheme Reference	Planned / CTG	Area	12months Budget ICB	Year to Date(December)			Forecast (ICB)		Comments on material Forecast Variances
				Budget	Budget	Actual	Variance (Fav)/Adv	Actual	Variance (Fav)/Adv	
				£m	£m	£m	£m	£m	£m	
Continuation of 22/23										
Low Risk, cost effective switching programme	22/23 FYE	Planned	Prescribing	300.0	300.0	182.0	118.0	182.0	118.0	Underperformance in 22/23 continuation of plan is mitigated by 23/24 overperformance below so net effect is on plan
Opioid costs (supported by PQS/rebates) - 10%	22/23 FYE	Planned	Prescribing	600.0	600.0	208.0	392.0	208.0	392.0	
Greener/lower cost inhalers (supported by PQS/rebates) - 5%	22/23 FYE	Planned	Prescribing	450.0	450.0	565.0	(115.0)	565.0	(115.0)	
Oral Nutritional Supplements (supported by PQS/FK rebate) - 5%	22/23 FYE	Planned	Prescribing	150.0	150.0	46.0	104.0	46.0	104.0	
Over the counter	22/23 FYE	Planned	Prescribing	150.0	150.0	47.0	103.0	47.0	103.0	
Specials (supported by PQS) - 5%	22/23 FYE	Planned	Prescribing	90.0	90.0	84.0	6.0	84.0	6.0	
Subtotal Continuation of 22/23 Schemes				**1,740.0**	**1,740.0**	**1,132.0**	**608.0**	**1,132.0**	**608.0**	Underperformance in Low risk cost effective switches 22/23 continuation of plan is mitigated by 23/24 overperformance below so net effect is on plan
Switches & Medicines Review										
Transformation and expansion of Prescription Ordering Direct (POD)	MED034	Planned	Prescribing	1,506.0	330.0	161.0	169.0	321.0	1,185.0	Restructure resulting in reduced savings
Blood glucose testing strips (PQS and switch)	MED040	Planned	Prescribing	450.0	150.0	293.0	(143.0)	579.0	(129.0)	
Lancets (PQS and switch)	MED041	Planned	Prescribing	15.0	7.0	13.0	(6.0)	22.0	(7.0)	
Novarapid vs Trurapi	MED042	Planned	Prescribing	200.0	80.0	42.0	38.0	104.0	96.0	
Sitagliptin windfall and switch	MED043	Planned	Prescribing	250.0	100.0	55.0	45.0	173.0	77.0	
Home Oxygen targeted reviews	MED044	Planned	Prescribing	75.0	28.0	28.0	0.0	76.0	(1.0)	
OptimiseRx	MED045	Planned	Prescribing	1,800.0	900.0	951.0	(51.0)	1,929.0	(129.0)	
Low Risk Cost Effective Switches (facilitates all other switches)	MED046	Planned	Prescribing	100.0	40.0	336.0	(296.0)	396.0	(296.0)	
Opioid Costs (supported by PQS/rebates)	MED047	Planned	Prescribing	500.0	200.0	45.0	155.0	297.0	203.0	
DOAC edoxaban rebate and overall costs	MED048	Planned	Prescribing	1,000.0	500.0	441.0	59.0	831.0	169.0	
Lower cost greener inhalers (Luforbec switch)	MED049	Planned	Prescribing	750.0	300.0	0.0	300.0	412.0	338.0	
Oral Nutritional supplements (supported by PQS and FK rebates)	MED050	Planned	Prescribing	90.0	30.0	45.0	(15.0)	125.0	(35.0)	
Self Care	MED051	Planned	Prescribing	50.0	20.0	0.0	20.0	10.0	40.0	
Outlier Practices	MED052	Planned	Prescribing	150.0	60.0	60.0	0.0	150.0	0.0	
Specials and high cost items	MED053	Planned	Prescribing	75.0	37.0	37.0	0.0	75.0	0.0	
Dressings	MED054	Planned	Prescribing	300.0	0.0	0.0	0.0	300.0	0.0	
Repeat prescribing audit	MED056	Planned	Prescribing	75.0	28.0	28.0	0.0	75.0	0.0	
Stoma managed service pilot	MED057	Planned	Prescribing	100.0	40.0	0.0	40.0	30.0	70.0	
Subtotal Switches & Review				**7,486.0**	**2,850.0**	**2,535.0**	**315.0**	**5,905.0**	**1,581.0**	Restructure resulting in reduced savings
Unidentified Efficiencies as in July now identified in August				**1,885.0**	**170.0**	**191.0**	**(21.0)**	**3,219.0**	**(1,334.0)**	windfall savings sitagliptin and apixaban
Total Efficiency				**11,111.0**	**4,760.0**	**3,858.0**	**902.0**	**10,256.0**	**855.0**	
Variance as a % of Budget							*18.9%*		*7.7%*	
Variance Signage: (Favourable)/Adverse										

10.0 LCS Activity Tracker

Locally Commissioned Service	H1 Activity Budget (£)	H1 Claimed (£)	Utilisation %	Comment
Care Homes	172,927	143,730	83%	
Diabetes	192,562	214,685	111%	Over performance on the Key Care Processes and Treatment Targets elements of Diabeties
Eating Disorders	181,692	122,389	67%	
Inclusion Health	301,035	178,133	59%	
Mental Health SMI Health Checks	214,208	125,322	59%	
Phlebotomy	2,513,794	2,534,211	101%	
Proactive Healthcare	2,090,117	2,083,003	100%	
PSA	137,912	139,042	101%	
Shared Care	638,817	668,406	105%	
Spirometry	179,569	199,646	111%	Qtr 1 claimed in Qtr 2
Treatment Room	759,735	946,587	125%	Injections, Minor injuries and Post Op Wound Care based on activity hence overperformance
Warfarin	438,360	380,885	87%	
	7,820,728	**7,736,039**	**99%**	Qtr 1 and Qtr 2 windows in the CQRS Local portal now closed

- The above shows the take up of claims for Locally Commissioned Services for Q1 and Q2 23/24 combined.
- The above is a mixture of block and activity-based schemes up until first 6 months of 23/24 only.

Appendix Financial Risk(s)

Risk	Mitigation
2023/24 outturn position deteriorates from the current forecast	There is robust management and oversight arrangements, detailed review of the underlying position, via monthly review of actual expenditure compared to plan and specific mitigations agreed with budget managers.
Full Year Impact of 22/23 NICE Guidelines in 23/24	NICE guidance which was published in March-22 led to 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 full year impact of the same would be seen for the first time in 23/24, whilst this is included in Forecast numbers but there could be volatility.
Non delivery or under delivery of £14.2m Transformation Savings assumed in the financial position for Prescribing and Primary Care.	Practice Level Prescribing budgets, based on a scientific process to include deprivation, care home beds and list size has been calculated. Actual spend is being compared on a monthly basis to understand the outlying practices and take corrective steps. There is an oversight group also setup to monitor and take corrective action. Similar processes in the Dental and Primary Care areas.
Chance of clawback of dental underspends from NHSE	Regular monitoring and engagemnet with regional teams

Appendix Financial Risk(s)

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 which are inherently volatile.	Robust management and oversight, through collaborative working between finance and medicines management to understand trends, variances and cost
Financially unstable practices	There are practices which are receiving resilience support from the ICB. The mitigation of this potential risk is to ensure continued surveillance. We are also in receipt of allocation from NHSE/I which can be paid to practices "at risk".
Additional costs due to existing estates costs, e.g. rent rate reviews, and new estates costs as a result of practice premises and expansion (e.g. additional revenue costs due to expansion of premises)	The ICB cannot mitigate existing establishment rates changes, but can look to be assured by close liaison with the District Valuer. Continued oversight so that estates growth is matched by annual increases in delegated budgets
Delegated financial position and the inability to control the spend within the ICB due to nationally mandated expenditure.	Negotiation with NHS England and Improvement and involvement in national allocation working groups. Look to cease or defer non mandated expenditure where possible.