IPSWICH AND EAST SUFFOLK CCG
PRIMARY CARE COMMISSIONING COMMITTEE

(This meeting will be held with the Primary Care Commissioning Committee of West Suffolk CCG in line with ‘in common’ meeting arrangements)

Tuesday, 22 October 2019 at 2.30pm
The Mix, 127 Ipswich Street, Stowmarket, Suffolk, IP14 1BB

AGENDA

1430  1. Apologies for Absence

1432  2. Declarations of Interest

1437  3. Minutes of Previous Meeting
To approve minutes of Ipswich and East Suffolk CCG Primary Care Commissioning Committee meeting held on 23 July 2019

To review outstanding issues from the previous meeting of the Ipswich and East Suffolk CCG Primary Care Commissioning Committee.

1445  5. General Update
To receive a verbal report from the Chief Operating Officer, Ipswich and East Suffolk CCG

1450  6. Primary Care Networks – An Update
To receive and note a report from the Deputy Chief Operating Officer

1500  7. Primary Care Delegated Commissioning – Finance Report
To receive and note a report from the Director of Finance, Ipswich and East Suffolk CCG

1510  8. Workforce Update
To receive and note a report from the Director of Corporate Services and System Infrastructure

1520  9. Primary Care Performance – unwarranted variation
To receive and note a report from the Primary Care Commissioning Manager
10. Integrated Care System – 5 Year Strategic Plan update
To receive and note a report from the Primary Care Commissioning Manager

11. Primary Care Estates Strategy Framework
To receive and approve a report from the Director of Corporate Services and System Infrastructure

12. Date and Time of next meeting
2.00pm – 4.00pm, Tuesday, 26 November 2019, Two Rivers, 30 Woodbridge Road East, Ipswich, Suffolk.

13. Questions from the public – 10 minutes
This is a meeting in public and not a public meeting. Members of the public are invited to attend as observers. Questions on the commissioning of primary care are welcome. It is helpful if these are received at least three working days in advance* so that as full an answer as possible may be given at the meeting. Questions may still be asked without prior submission and if it is not possible to provide an answer at the meeting then a written response will be supplied within seven days and also circulated to members of the committee.

In relation to the business to be covered, it is possible for members of the public to ask a question or raise an issue on a specific matter, subject to time available. Questions will be taken at the chair’s discretion at a suitable point in the discussion but after the paper has been presented.

Questions prior to the meeting can be submitted to:

Jo Mael, Corporate Governance Officer – jo.mael@suffolk.nhs.uk
Ipswich and East Suffolk CCG
Endeavour House
8 Russell Road
Ipswich
Suffolk
IP1 1BX

Exclusion of the Press and Public

The Primary Care Commissioning Committee is recommended to exclude representatives of the press, and other members of the public, from the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest; Section 1(2), Public Bodies (Admission to Meetings) Act 1960.
<table>
<thead>
<tr>
<th>Title</th>
<th>First Name</th>
<th>Last Name</th>
<th>Type of Interest</th>
<th>Financial Interest</th>
<th>Type of Interest</th>
<th>Non Financial Interest</th>
<th>Date of Interest</th>
<th>Date of Receipt</th>
<th>From</th>
<th>To</th>
<th>Date of Action</th>
<th>Action Taken to Resolve</th>
<th>Action Taken to Publish</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior Partner of PMS practice</td>
<td>Peter</td>
<td>Hague</td>
<td>Ongoing</td>
<td>Ongoing</td>
<td>Ongoing</td>
<td>To declare when appropriate</td>
<td>10/05/2019</td>
<td>01/04/2018</td>
<td>Direct</td>
<td>Yes</td>
<td>01/04/2018</td>
<td>Yes</td>
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<tr>
<td>Wife is Biomedical Scientist at NEESP</td>
<td>Peter</td>
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<td>Ongoing</td>
<td>Ongoing</td>
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<td>03/04/2018</td>
<td>10/05/2019</td>
<td>Direct</td>
<td>Yes</td>
<td>10/05/2019</td>
<td>Yes</td>
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<tr>
<td>Practice participates in research ethics approved GSK clinical trial.</td>
<td>Peter</td>
<td>Hague</td>
<td>Ongoing</td>
<td>Ongoing</td>
<td>Ongoing</td>
<td>To declare when appropriate</td>
<td>03/04/2018</td>
<td>05/10/2018</td>
<td>Direct</td>
<td>Yes</td>
<td>05/10/2018</td>
<td>Yes</td>
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<tr>
<td>Male partner of PMS practice</td>
<td>Peter</td>
<td>Hague</td>
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<td>16/04/2019</td>
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<td>Yes</td>
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<tr>
<td>Senior Partner GP Peninsula Practice which is in receipt of JVC and CCG funding for compassionate communities project</td>
<td>Watson</td>
<td>Imaad</td>
<td>Ongoing</td>
<td>Ongoing</td>
<td>Ongoing</td>
<td>To be declared when appropriate</td>
<td>11/12/2018</td>
<td>01/09/2018</td>
<td>Direct</td>
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<td>Daughter is an Adult Social Care Inspector for the Care Quality Commission</td>
<td>Watson</td>
<td>Imaad</td>
<td>Ongoing</td>
<td>Ongoing</td>
<td>Ongoing</td>
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<tr>
<td>Indirect</td>
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<tr>
<td>Practice is a member of Suffolk GP Federation</td>
<td>Watson</td>
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<td>Wife volunteers for St Elizabeths Hospice and MNDA</td>
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<td>01/06/2008</td>
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<td>Seconded one session a week to Cambridge University to carry out student teaching and evaluation</td>
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<td>Imaad</td>
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<td>Ongoing</td>
<td>To declare when appropriate</td>
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<td>05/10/2018</td>
<td>Direct</td>
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<td>05/10/2018</td>
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<td>Yes</td>
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<tr>
<td>Partners have working collaboration with Orbital Media Ltd to develop digital patient information AI self care tool Virt Turi</td>
<td>Watson</td>
<td>Imaad</td>
<td>Ongoing</td>
<td>Ongoing</td>
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<td>Watson</td>
<td>Imaad</td>
<td>Ongoing</td>
<td>Ongoing</td>
<td>Ongoing</td>
<td>To declare when appropriate</td>
<td>11/12/2018</td>
<td>03/04/2018</td>
<td>Direct</td>
<td>Yes</td>
<td>03/04/2018</td>
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<td>Watson</td>
<td>Imaad</td>
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Meeting of the Ipswich and East Suffolk CCG Primary Care Commissioning Committee held on Tuesday 23 July 2019, in public, at Riverside Centre, Stratford St Andrew, Saxmundham, Suffolk

PRESENT:
Irene Macdonald Lay Member: Patient and Public Involvement, IESCCG
Maddie Baker-Woods Chief Operating Officer
Steve Chicken Lay Member
Dr Lorna Kerr Secondary Care Doctor
Jane Payling Chief Finance Officer, IESCCG
Simon Jones Local Medical Committee
Stuart Quinton Suffolk Primary Care Contracts Manager, NHS England
Luke Bacon Healthwatch
Mike Ogden Healthwatch

IN ATTENDANCE:
Ameeta Bhagwat Head of Financial Planning and Management Accounts
David Brown Deputy Chief Operating Officer
Jo Mael Corporate Governance Officer
Claire Pemberton Head of Primary Care
Caroline Procter Primary Care Commissioning Manager
Daniel Turner Estates Development Manager

19/42 APOLOGIES FOR ABSENCE

Apologies for absence were noted from:

Ed Garratt Chief Officer
Cllr James Reeder Health and Wellbeing Board
Dr Mark Shenton CCG Chair
Jane Webster Acting Chief Contracts Officer

19/43 DECLARATIONS OF INTEREST

No interests, other than those already published, were received.

19/44 MINUTES OF PREVIOUS MEETING

The minutes of a meeting of the Ipswich and East Suffolk CCG Primary Care Commissioning Committee held on 21 May 2019 were approved as a correct record.

19/45 MATTERS ARISING AND REVIEW OF OUTSTANDING ACTIONS
There were no matters arising and the action log was reviewed and updated with comment as follows;

18/73 – Primary Care Transformation Resources – the Committee noted that it would be receiving regular updates on primary care network development going forward.
19/35 - Primary Medical Care Policy and Guidance Manual – consultation to take place with North East Essex CCG.
19/41 – Public Questions – Communications – the Committee noted that a patient conference was scheduled to take place the following week. Whilst it was noted that regular newsletters were already circulated to patient participation groups it was suggested that consideration should be given to development of a communications action plan.

19/46 GENERAL UPDATE

The Chief Operating Officer reported;

- That the development of Primary Care Networks (PCNs) was progressing positively. The CCG had met with the Clinical Directors of the PCNs and individual visits to the practices were planned.
- Prescribing – the receipt of two months data indicated a current £50k overspend. Antibiotic prescribing continued to improve.
- Annual Assessment – as reported in the Governing Body meeting earlier, the CCG had achieved an ‘outstanding’ rating from NHS England following its annual assessment. Workforce had been identified as a key challenge going forward.

19/47 PRIMARY CARE CONTRACTS AND PERFORMANCE REPORT

The Committee was in receipt of a report which provided an update on contractual and performance related matters in respect of GP Practices, together with actions taken.

The report provided information and outlined ongoing actions in respect of the following areas;

- Primary Care Networks
- Public Health
- Prescribing and medicines management
- Learning Disabilities (LD) health checks
- Severe mental illness physical health checks
- Dementia
- Quality Outcomes Framework reporting
- GP Patient Survey

Key points highlighted during discussion included;

- PCNs had been officially formed on 1 July 2019. All 40 Ipswich and East Suffolk Practices were part of a Primary Care Network. There were 11 PCNs within the CCG area.

The first year of the new GP Contract was focussed largely on recruitment of new staff, ensuring extended hours provision, starting to organise some internal fundamental processes such as; how the funding would flow, what the funds would be used for and how the role of the Clinical Director would
develop. The CCG was supporting the process with a series of opportunities for practices to meet at Training and Educations events and Practice Manager Forums.

- Learning Disability (LD) health checks – five practices had completed less than 50% of LD health checks. LD nurses were visiting practices to review registers.

- GP patient survey results had been encouraging with an overall high satisfaction level. The improvement of Constable Country Practice in respect of access was noted.

- Public Health – at a recent flu summit, providers had given assurance that delays to the distribution of vaccine would not be experienced in 2019/20. The CCG had been invited to attend a Suffolk Sexual Health conference led by Public Health. The conference had discussed changes and challenges in Suffolk and a range of transformation opportunities. It was anticipated that, when appropriate, a progress report would be provided to the CCG’s Community Engagement Partnership.

The Committee noted the content of the report.

19/48 CARE QUALITY COMMISSION (CQC)

The Committee was in receipt of a report which informed on the outcomes of Care Quality Commission (CQC) inspections of Ipswich and East Suffolk GP practices and the actions proposed to address issues, share good practice and facilitate improvement.

The CQC had changed the way it carried out inspections and was introducing an annual regulatory review. That meant each year the inspectors would formally review all of the information that they held on each practice and consider whether it indicated the quality of care might have changed since the last inspection or, in time, annual regulatory review. The new approach would help the CQC to prioritise its inspections where there had been most change, either deterioration or improvement. The CQC would contact the CCG prior to making contact with practices in order to gather soft intelligence.

Practices contacted for Annual Regulatory Reviews (ARR) in June and July 2019 were as follows, with the outcomes detailed in Section 3 of the report.

Dr Badcock & Partners (Felixstowe Road)
Debenham Group Practice
Framfield House
Holbrook Surgery
Little St John Street
Mendlesham Medical Group
Norwich Road Surgery
The Peninsular Practice
The Chesterfield Drive Surgery
Two Rivers

Martlesham Surgery had received a revisit on 10 July 2019 due to a change in lead partner, although the outcome of that visit was, as yet, unknown.

The Committee noted the report and that information in respect of the new inspection regime was shared across practices.
INTEGRATED CARE SYSTEM (ICS) PRIMARY MEDICAL CARE STRATEGY

The Committee was in receipt of a report which provided an opportunity to review the draft STP primary medical service strategy; to provide assurance as to how primary care would meet the objectives of the NHS Long Term Plan and continue to deliver the commitments of the General Practice Forward View (GPFV) whilst remaining consistent with local Alliance and primary medical care strategies.

General practice played a pivotal role in delivering localised, high quality, safe and effective services to its population. There had been an increased focus on the role of primary care, how it was structured and how services were delivered.

NHS England had recently written to the STP/ICSs requesting that joint primary care strategies be refreshed or developed in the context of the NHS Long Term Plan and the new GP Contract which supported the formation of Primary Care Networks.

A draft strategy had since been produced using existing primary care strategies that were locally co-produced between 2015-2017 by GPs, practice managers, patients and partner organisations. Those documents remained relevant and were aligned with the current priorities.

In 2017, the STP had collectively submitted a GPFV submission which had been rated ‘green’ by NHS England.

The draft document, as appended to the report, focused on existing, agreed local plans and fulfilled the requirements requested by NHS England for submission within the required timeframe. It was recognised that action plans needed to go further to respond both to new national requirements, local need, and to articulate:

- Further local demand management measures including alignment of Alliance prevention and self-care strategies;
- local support for Primary Care Networks, specifically including their Clinical Directors;
- workload management measures beyond national measures;
- further workforce plans (specifically but not limited to recruitment and retention issues);
- estates and digital integration;
- a local funding strategy for primary care.

The CCGs had received concise feedback from both Suffolk and Essex Local Medical Committees (LMCs) that the further definition was essential to secure primary care’s future role within the system and to support the strategy. The draft strategy document was intended to be part of an iterative process, with a strong commitment to work with the LMC, local GPs and partner organisations to ensure further development of the next stage of plans but also agreement that local implementation plans were co-produced for each CCG with primary care stakeholders and partners.

It was intended that further versions of the strategy and subsequent implementation plans would be brought to the Committee for approval and to enable progress to be reviewed. The draft strategy had been reviewed by the STP Partnership Board and submitted to NHS England for review and comment.

Points highlighted during discussion included;
• Workforce was recognised as the main challenge going forward as many GPs and practice nurses were choosing to retire early from the age of 50/55. The importance of ensuring that work undertaken by skilled staff remained key for the patient was highlighted.
• There was a need to concentrate on the development of local implementation plans in order to facilitate easy onward communication of the Strategy.
• There was an intention to work more closely with patient participation groups going forward and to include local people in the planning, development and monitoring of services.

The Committee noted the report and draft Strategy.

19/50 PRIMARY CARE DELEGATED COMMISSIONING – FINANCE REPORT

The Committee was provided with an overview of the Primary Care Delegated Commissioning Budget at month three.

In month three the CCG had received a non-recurrent allocation of £313k in respect of dispensing doctors. At the end of month three, the GP Delegated Budget spend was £283k over spent. Key variances were set out in Section 2 of the report.

Having been informed that future funding of the clinical indemnity scheme for GPs was, as yet, undetermined, the Chief Finance Officer agreed to investigate.

The Committee noted the financial performance at month three.

19/51 INTEGRATED CARE SYSTEM UPDATE

The Chief Operating Officer reported that there was ongoing work to look at alignment between CCGs, Primary Care Networks and the Alliances.

19/52 HEALTHWATCH GP REPORT

The Committee was in receipt of the most recent summary of patient feedback shared with Healthwatch Suffolk about GP practices in Suffolk. The report was produced following engagement with practices by Healthwatch’s Community Development Team, and covered the period from March 2018 to March 2019.

Key points highlighted from the report included;

• 2619 comments had been received across the County in relation to 77 GP practices. 1472 of those comments had been applicable to Ipswich and East Suffolk CCG.
• Overall there had been positive feedback with key themes being access, staff interaction, waiting times, triage and communications. 1546 references across the County had been in relation to ease of access to services.

The Committee noted the content of the report and welcomed its circulation to practices and patient participation groups.

19/53 ANNUAL PLAN OF WORK

The Committee reviewed its annual plan of work and noted that it would be updated in line with today’s discussions.

19/54 DATE AND TIME OF NEXT MEETING
A meeting ‘in common’ with West Suffolk CCG has been scheduled to take place on Tuesday, 22 October 2019 from 2.00pm-4.00pm at The Mix, 127 Ipswich Street, Stowmarket, Suffolk, IP14 1BB

19/55 QUESTIONS FROM MEMBERS OF THE PUBLIC

Alan Rose, Patient Participation Group (PPG) member, Felixstowe, advised that Felixstowe PPGs felt some degree of disconnect from Healthwatch and Healthwatch representatives in attendance agreed to attempt to address the situation going forward. Circulation of the Healthwatch GP report to PPGs was welcomed.

Pauline Quinn, PPG member, Aldeburgh, supported circulation of the Healthwatch GP report to PPGs and went on to ask the following questions/queries:

a) Whether it was normal for those attending a first dementia assessment with a GP to attend alone?

b) Whether the CCG was aware of recent redundancies/cuts proposed within Public Health?

c) Work with patients in respect of development of the primary care strategy would be welcomed.

d) In light of workforce challenges, had there been consideration of ways to retain staff and explore whether staff were paid appropriately?

The Chief Operating Officer responded to the above questions/queries as follows;

a) The Chief Operating Officer agreed to raise the issue of lone attendance at first dementia assessments with the Dementia Forum and report back.

b) Conversations in respect of Public Health were ongoing through the Alliance. Public Health, the CCG and Suffolk County Council had recently carried out a joint recruitment process to appoint a new Director of Public Health.

c) The implementation plan associated to the primary care strategy would include patient and public involvement.

d) Pay awarded to staff was determined within practices. Practices were encouraged to participate in CCG training and education days and a workforce plan was being progressed.
### Meeting of 25 September 2018

<table>
<thead>
<tr>
<th>18/59</th>
<th>Primary Care Contracts and Performance Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action: Having queried whether the CCG collected data on the number of vacancies that existed across practices it was explained such information was gained via the NHS workforce portal that was updated by practices. There was concern at the quality and regularity of information put into the portal and it was requested that more detail be provided to the next meeting.</td>
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<tr>
<td>By Whom: Julie White</td>
<td></td>
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<tr>
<td>Timescale/Update: 21/05/19 - The Committee requested that it be presented with an indication of the number of vacancies that existed across practices to a future ‘in common’ meeting.</td>
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### Meeting of 22 January 2019

<table>
<thead>
<tr>
<th>19/06</th>
<th>Annual Review of Terms of Reference</th>
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</thead>
<tbody>
<tr>
<td>Action: The Chair advised that due to differing versions of the terms of reference being in circulation, further work would be carried out prior to their presentation to the March 2019 meeting.</td>
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<tr>
<td>By Whom: Maddie Baker-Woods</td>
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<tr>
<td>Timescale/Update: 23/07/19 – Further work was required in light of closer working with North East Essex CCG. A joint meeting with primary care staff at North East Essex CCG was planned to take place on 13 August 2019. Lay Members were also currently discussing the feasibility of committees ‘in common’ across three CCGs.</td>
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### Meeting of 21 May 2019

<table>
<thead>
<tr>
<th>19/35</th>
<th>Primary Medical Care Policy and Guidance Manual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action: The Committee noted the content of the report and requested that consideration be given to providing a briefing on the Primary Medical Care Policy and Guidance Manual to Committee members in respect of the type of decisions most likely to be presented.</td>
<td></td>
</tr>
<tr>
<td>By Whom: Stuart Quinton</td>
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<tr>
<td>Timescale/Update: 23/7/19 – Further discussion to take place in respect of closer working with North East Essex CCG.</td>
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<table>
<thead>
<tr>
<th>19/41</th>
<th>Public Questions</th>
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<tbody>
<tr>
<td>Action: A Patient Participation Group Chair highlighted that recent NHS changes in respect of the development of East Suffolk and North Essex NHS Foundation Trust, Primary Care Networks, Integrated Neighbourhood Teams, and the introduction of Care Navigators and Physician Associates, was very confusing for patients. The Committee was asked to consider the development of communications to explain the recent changes and initiatives. The Committee requested that the CCG’s Chief Officer and Communications Teams consider the development of such communications.</td>
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<tr>
<td>By Whom: Chief Officer Team</td>
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<tr>
<td>Timescale/Update: 23/7/19 – Ongoing. Healthwatch was assisting with the development of communications. The Committee noted that a patient conference was scheduled to take place the following week. Whilst it was noted that regular newsletters were already circulated to patient participation groups it was suggested that consideration should be given to development of a communications action plan.</td>
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### Meeting of 23 July 2019

<table>
<thead>
<tr>
<th>19/47</th>
<th>Primary Care Contracts and Performance Report</th>
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<tr>
<td>Action: Public Health – the CCG had been invited to attend a Suffolk Sexual Health conference led by Public Health. The conference had discussed changes and challenges in Suffolk and a range of transformation opportunities. It was anticipated that, when appropriate, a progress report would be provided to</td>
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<tr>
<td>By Whom: Maddie Baker-Woods</td>
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<td>MINUTE</td>
<td>DETAILS</td>
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<tr>
<td>19/50</td>
<td>Primary Care Delegated Commissioning – Finance Report</td>
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</table>
| 19/55  | Questions from Members of the Public | a) Alan Rose, Patient Participation Group (PPG) member, Felixstowe, advised that Felixstowe PPGs felt some degree of disconnect from Healthwatch and Healthwatch representatives in attendance agreed to attempt to address the situation going forward. Circulation of the Healthwatch GP report to PPGs was welcomed.  

b) The Chief Operating Officer agreed to raise the issue of lone attendance at first dementia assessments with the Dementia Forum and report back. | Luke Bacon/ Mike Ogden | Maddie Baker-Woods |
<table>
<thead>
<tr>
<th>Title</th>
<th>Primary Care Networks (PCNs) – An update</th>
</tr>
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<tbody>
<tr>
<td>Lead Officer</td>
<td>David Brown, Deputy Chief Operating Officer</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Lois Wreathall, Head of Primary Care, West Suffolk CCG</td>
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<tr>
<td>Purpose</td>
<td>To provide an update on the development and maturity of the Suffolk PCNs</td>
</tr>
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**Applicable CCG Clinical Priorities:**

1. To promote self care
2. To ensure high quality local services where possible
3. To improve the health of those most in need
4. To improve health & educational attainment for children & young people
5. To improve access to mental health services
6. To improve outcomes for patients with diabetes to above national averages
7. To improve care for frail elderly individuals
8. To allow patients to die with dignity & compassion & to choose their place of death
9. To ensure that the CCG operates within agreed budgets

**Action required by Primary Care Commissioning Committee:**

To note the report.
1. **Purpose**

1.1 To update the Committee on the progress of the Suffolk Primary Care Networks (PCNs)

2 **Progress to date**

2.1 In May 2019 the Primary Care Commissioning Committees approved the proposed configuration of PCNs in Suffolk. All PCNs went live on 1 July 2019.

2.2 Each PCN is considering its position and response to the offer of two reimbursed roles, that of a social prescriber (100%) and a clinical pharmacist (70% contributed by the CCG). There is a comprehensive NHSE template made available to support their claims (Appendix 1).

2.3 The PCNs all have a maturity matrix diagnostic tool (Appendix 2), to assess where they think they are in order to progress towards maturity in their systems and localities. A development support prospectus has also been circulated (Appendix 3) for them to consider where their PCN funding would be best directed.

2.4 There is funding available to support PCNs across several ledger lines whose governance is set according to where the funding sits. Appendix 4 has the funding available for Suffolk. It should be noted that GP retention, reception and clerical training funding is being managed through Training Hub Advisory Group. Discussions are taking place to identify the key priorities and proposals will be presented at the December meeting. The online consultation monies have been spent via the IT team with every non Suffolk Primary Care (SPC) practice in Suffolk being offered E – consult. SPC is using iPLATO and this has been fully rolled out.

2.5 The PCNs are planning to fulfil their extended hour obligations individually and so have not begun to share patient care and data across their PCN.

2.6 On 1 October the One Clinical Community Programme began in West Suffolk, which 4/6 Clinical Directors are attending. We also have participants from West Suffolk Foundation Trust, Community Services and Social Care which will be split into localities. This programme has been designed to give clinicians and senior managers protected time to work together on key priorities in their locality. Not only is this an opportunity to learn new and develop existing leadership skills, but it is a real opportunity to bridge some of the historic lack of join up in services and improve integration of those services across health and social care for the population within localities.

2.7 Many of the Ipswich and East Suffolk Clinical Directors have participated in the two One Clinical Community programmes last year or the GP Development Programmes which ran in previous years. Three further Clinical Directors are also participating in this year’s programme. Each programme has County Council, acute and mental health colleagues participating alongside them.

2.8 There are plans to implement a Population Health Management system across the ICS footprint with 3 PCNs initially. Further rollout will be scheduled for other PCNs that wish to be part of this programme.

2.8 The CCG is working with the Local Pharmaceutical Committee to ensure local pharmacies are able to deliver on their PCN element of their new contract.

3. **Next Steps**

3.1 Primary Care Networks will continue to develop incrementally over the next five years. There are a number of areas of work to consider in the next twelve months:
- Receive and manage the funding for enhanced access (GP+ service)
- Deliver 7 network specifications (introduced over the next few years) that include:
  - Medicines reviews and optimisation
  - Advanced health in care homes
  - Anticipatory care for high need patients
  - Personalised care (Personal Health Budgets)
  - Supporting early cancer diagnosis
  - CVD prevention and diagnosis
  - Tackling neighbourhood inequalities

4. **Recommendation**

4.1 The Committee is invited to note the PCN update.
## Contents

<table>
<thead>
<tr>
<th>Page number</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Introduction</td>
</tr>
<tr>
<td>5</td>
<td>Ambitions and Expectations</td>
</tr>
<tr>
<td>6</td>
<td>Benefits</td>
</tr>
<tr>
<td>7</td>
<td>Sustainable and transformational change</td>
</tr>
<tr>
<td>8</td>
<td>Available resources</td>
</tr>
<tr>
<td>9</td>
<td>Two areas of development support</td>
</tr>
<tr>
<td>10</td>
<td>Proposed process for PCN development support</td>
</tr>
<tr>
<td>11</td>
<td>PCN development support domains</td>
</tr>
<tr>
<td>12</td>
<td>Supporting the development of PCN Clinical Directors</td>
</tr>
<tr>
<td>13</td>
<td>Proposed process for Clinical Director support</td>
</tr>
<tr>
<td>14</td>
<td>Roles and responsibilities in PCN development</td>
</tr>
<tr>
<td>15</td>
<td>Key milestones for mobilising PCN development support in 2019-20</td>
</tr>
</tbody>
</table>
# Contents

<table>
<thead>
<tr>
<th>Page number</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>16</td>
<td>Appendices</td>
</tr>
<tr>
<td>17</td>
<td>The development support domains</td>
</tr>
<tr>
<td>18</td>
<td>PCN set up support</td>
</tr>
<tr>
<td>19-21</td>
<td>Organisational development and change</td>
</tr>
<tr>
<td>22</td>
<td>Leadership development support</td>
</tr>
<tr>
<td>23</td>
<td>Supporting collaborative working</td>
</tr>
<tr>
<td>24</td>
<td>Population health management support</td>
</tr>
<tr>
<td>25</td>
<td>Social prescribing and asset based community development</td>
</tr>
<tr>
<td>26-27</td>
<td>PCN maturity matrix</td>
</tr>
<tr>
<td>28</td>
<td>Where to find further information</td>
</tr>
<tr>
<td>29</td>
<td>For more information on the GP Contract and Network DES</td>
</tr>
<tr>
<td>30</td>
<td>Who’s my PCN contact?</td>
</tr>
</tbody>
</table>
Introduction

Purpose

Implementing the NHS Long Term Plan requires the development of effective Primary Care Networks (PCNs). To help all PCNs mature and thrive, every STP and ICS needs to put in place high quality support.

In practice, responsibility for ensuring effective support falls to primary care leads in STPs/ICSs, working hand-in-glove with PCN Clinical Directors, and critically their wider community partners: community providers, the voluntary sector, and local government. This document is written for them.

Nationally, we have provided new dedicated PCN support funding, £43.5 million was released to ICSs and STPs in June to support PCNs develop in 2019/20. We also committed to ongoing support in subsequent years. This extra money is a floor not a ceiling. Many CCGs have already been providing extensive local support over and above their share of the national funding, and we encourage all systems to consider doing the same.

The national funding should be used for two purposes: (a) PCN development and (b) a specific Clinical Director development programme in each STP/ICS. The funds are intended to help PCNs make early progress against their objectives – for example supporting much closer practical collaboration between PCNs and their community partners, including preparatory activity for the forthcoming national service specifications.

How should this document be used?

The first part is guidance that sets out parameters that all STPs and ICSs should work within, and a process which we expect many STPs and ICSs will want to use to develop support programmes. The second part sets out key components that should be used as the basis of any support offer. Systems will want to build upon the key components, adding specific details and requirements to meet local need. Different PCNs and different parts of the country are at different stages of development, and as a result, development support needs will vary.

How has it been developed?

The document has been developed in consultation with a wide range of people, including front line staff, CCG, STP and ICS primary care teams, development experts, NHS and local government representative and professional bodies, and voluntary organisations. The content has been shared and tested to ensure that it reflects the views of interested groups, and crucially has been developed alongside those that will be using the development support to ensure that it meets their needs.
Ambitions and expectations

What are our ambitions for PCNs over the next 5 years?

Your development support offer should match the scale of our collective ambitions for PCNs. PCNs were established on the 1 July 2019. Looking ahead and towards 2023/24, we aspire to PCNs having done five things:

- First, **stabilised general practice**, including the GP partnership model
- Second, **helped solve the capacity gap** and improved skill-mix by growing the wider workforce by over 20,000 wholly additional staff as well as serving to help increase GP and nurse numbers
- Third, become a **proven platform for further local NHS investment**
- Fourth, **dissolved the divide between primary and community care**, with PCNs looking out to community partners not just in to fellow practices
- And fifth, systematically delivered new services to implement the Long Term Plan, including the seven new service specifications, and **achieved clear, positive and quantified impacts** for people, patients and the wider NHS.

What is expected of PCNs by March 2020?

With the support outlined in this prospectus, by March 2020 we would like to help all PCNs to:

- **Understand their own journey**: know where they are aiming to get to over the next five years, use a diagnostic process to establish development need, using a maturity matrix or similar tool, and put a development plan in place
- Be functioning increasingly well as a **single team**
- Be part of a ‘**network of PCNs**’ that helps shape the STP/ICS plan to implement the Long Term Plan
- Formed clear and agreed **multi-disciplinary teams** with community provider partners
- Building on existing relationships, form **links with local people and communities** to understand how to work most effectively for their benefit
- **Have made 100% use of their funding entitlement for additional roles** in line with national guidance
- Have started work on at least one **service improvement project** of some kind, linked to Long Term Plan goals
- Have started thinking about their **future estate needs**, jointly with community partners
- Be ready to deliver **new national service specifications** from April 2020
Benefits

We have heard from people working in and with PCNs that good development support should help PCNs to:

- **Make a real difference for staff**, including:
  - more sustainable and satisfying roles for staff, and development of multi-professional teams;
  - reduced pressure on GPs by drawing on the skills of the wider team where these are the best fit, and enabling a more balanced workload;
- **Build from what people know about communities and their wider population**, and understand and **build on existing neighbourhood working and community assets**;
- **Reflect the priorities of local people**, including for example better urgent care access and digital services;
- Provide more proactive, coordinated care and **improved outcomes** for patients and the wider population, better health and reductions in health inequalities;
- Focus on **prevention and anticipatory care** and maximise the difference we can make by encouraging different professional teams, independent contractors and organisations to work together;
- Promote and **support people to care for themselves** wherever appropriate;
- **Provide care as close to home as possible**, with networks and services based on natural geographies and population need rather than organisational boundaries;
- **Put in place joined up NHS care** (for both physical and mental health) across primary care and other providers of NHS community care, and remove the historic separation of these parts of the NHS;
- **Improve the link between primary care networks and secondary care/place-based care** with more clinically-appropriate secondary care in primary care settings;
- **Put in place joined up care with social care and the voluntary and community sector**, working with partners to plan and deliver personalised care and support;
- **Help systems to plan and discharge resources more effectively**, with primary care providers involved in decisions about how resources are used.

Behaviours and leadership styles are critical. Your development support will need to focus on building open, honest and collaborative relationships, and helping Clinical Directors achieve results through energetic and inclusive leadership.
**Sustainable and transformational change**

**How will we deliver sustainable and transformational change?**

Experience from Sustainability and Transformation Partnerships (STPs) and Integrated Care systems (ICSs) around the country has taught us that PCN development support is most effective when it has three characteristics which are closely aligned to elements of the NHS Change Model (described in more detail in the appendix).

| **Owned and driven by teams** | • Ensuring collective ownership of the change that needs to take place  
| | • Developing a culture which is based on collaboration, integration and involves early partnership working across professions and organisations |
| **Focused on improving care for local people** | • Working on specific projects, aligned with local strategies, to change the way care is provided – as a means both to improve care and develop collaborative working  
| | • Focused on population health needs |
| **Backed by a clear sense of purpose** | • Understanding where the PCN is trying to get to and why  
| | • Understanding how this fits with wider system and partner organisations’ goals, and the range of assets and partners available to help get there |
Available resources

Additional funding has been allocated to ICS/STPs for in-year delivery of PCN development support. The funding is over and above that set out in the GP contract agreement. It is for Clinical Director and PCN development support only and must be used for this purpose and no other. The funding has been made available from national transformation funds – we would encourage each local system to supplement this with additional funding wherever possible. It is a floor not a ceiling.

Funding should be used for development support for PCNs and broader professional teams, including staff from wider organisations and independent contractors who provide care in a community setting. It must not be used to pay for or supplement anything which is already covered in the GP contract or the day to day running of PCNs, or to pay for activities already funded by CCGs/systems.

The funding is intended to be recurrent for five years dependent on need and effective use, with funding confirmed on an annual basis. Over time how funding is deployed may alter. Systems should use the funding to deliver support according to the following parameters:

1. A universal offer, with all PCNs and every CD receiving support matched to their needs.
2. Support designed alongside and agreed with PCNs and CDs, promoting collaboration and shared understanding between wider PCN members including community services providers, other NHS organisations, local government, social care, the voluntary sector, and local people and communities, at the neighbourhood and place level of the system, and with LMCs engaged in the process.
3. Alignment with commitments set out in the NHS Long Term Plan and the Network Contract Direct Enhanced Service (DES), and supporting delivery of system strategies.
4. Alignment with the approach laid out in this prospectus, including (a) based on a self-assessment of development in each PCN (b) making use of the development domains for PCN development support (c) ensuring all key components are covered in the CD development offer.
5. Adequate resourcing and sponsorship in place at ICS and place level, with a director-level lead in every STP/ICS, known to PCN CDs.
6. System plans for PCN development being agreed with NHS England and NHS Improvement regional teams, with level of regional involvement varying dependent on STP/ICS maturity.

Funding should be used for:

✓ Freeing up clinical time
✓ Local transformation resource
✓ Support from ‘NHS family’ bodies e.g. the Leadership Academy, CSUs, federations, at scale primary care providers, NHS Trusts, and from local authorities and the voluntary, community and social enterprise sector
✓ Commissioning support from providers and partners via the HSSF or through other procurement mechanisms

Funding should not be used for:

× Anything that is already covered in the contract
× Anything that is already funded by the CCG or another system partner
× Non-transformation costs
× Work that isn’t related to PCNs

Systems should also ensure that a culture of identifying best practice, developing case studies, evaluating effectiveness, sharing learning and networking is created.
Two areas of development support

Each system will need to put in place development support in two linked areas. Proposed approaches for these two areas are covered in turn on the following slides. The PCN development funding allocated to systems in June includes funding for both PCN and CD development, with around 10% of the funds intended for CD-specific development.
Proposed process for PCN development support

This diagram sets out the suggested process to put in place PCN development support.

As of 1 July 2019, PCNs have established membership, appointed clinical directors and completed Network Contract DES registration requirements. Wider PCN members and partner organisations identified.

ICSs/STPs, places and CCGs facilitate conversations with PCN teams to help them build relationships, a sense of identity and purpose, and identify areas of initial focus. PCNs and systems use a self-assessment tool to support this process, identifying where they are on a journey of development. Each PCN identifies a specific service improvement priority to focus on as a means for closer collaboration. Wider PCN members, including for example community services providers, mental health, voluntary sector, local authorities, local communities and others, included in conversations.

ICSs/STPs, places, CCGs, PCN CDs and other systems partners agree specific development support needs for 2019/20. The PCN Development Support Prospectus is used to identify potential areas for development with consideration of 2020/21 service specifications, the wider system strategy and support already in place.

Who are we?

Where are we now and what do we want to achieve?

What help do we need?

Who can help us?

Is the support helping us achieve our goals?

We’re on our way

Support is delivered, enabling PCNs to move along development journey.

Systems and CCGs support PCNs to review progress against PCN priorities and self-assessment. Areas for additional support identified. Learning and best practice shared.

Systems deploy PCN development support funding to implement agreed development support programme, supporting PCNs and partners to come together individually and as a collective. Systems ensure existing support offers are used, including through regional networks, before additional support is put in place, making use of internal NHS support as well as external expertise.

Tools are available to support this process, including the PCN maturity matrix and associated self-assessment tool, and descriptions of the six PCN development domains. Please see the appendix of this document for further info. It should be noted that development funding can be deployed to support steps 2 and 3 of the above process as well as later steps.
In 2019/20 we expect PCNs will prioritise specific service improvements that will build a common sense of purpose, focussed around the needs of local people and communities. Working in partnership on the agreed priorities will enable trusted relationships and ways of working to develop.

This Prospectus sets out a co-produced, consensus view of the six development support domains that PCNs will want to access as they do this. Descriptions of each of the six domains are included in the appendix. The development domains are the agreed essential elements that systems will want to use as the basis of any support offer. Systems may want to build upon these and make them more specific according to local needs. The domains do not have to be used in their entirety or sequentially, but we expect appropriate core components will be reflected in corresponding development support offers. For example, PCNs may want to access organisational development support initially to help create plan how their development journey, but initial support may not cover all the core components in that domain.

PCN development support should be considered alongside specific support for PCN CD development, which is outlined on the following slides.
Supporting the development of PCN Clinical Directors

Supporting the development of PCN Clinical Directors so that they can create thriving PCNs is a significant priority. Given the importance of these new roles this prospectus sets out the key components of a leadership and development support programme for this professional group. Considerable funding (£3,000-4,000 per CD) has been allocated to systems for this purpose so that they can ensure there is a comprehensive offer available for all. The following slide sets out ‘how to get started’ on a programme that focusses on development of the individual, leadership of PCNs, and leadership within an ICS.

Role and responsibility:

PCN Clinical Directors will provide leadership for networks’ strategic plans, through working with member practices and the wider PCN to improve the quality and effectiveness of network services. Together, CDs will play a critical role in shaping and supporting their ICS, helping to ensure full engagement of primary care in developing and implementing local system plans to implement the NHS Long Term Plan. The role of each CD will vary according to the particular characteristics of their PCN, but key responsibilities are likely to include: providing strategic and clinical leadership for the network and supporting implementation of agreed services changes; fostering collaboration and developing relationships across the PCN; working closely with other network Clinical Directors, clinical leaders of other health and social care providers, local commissioners and Local Medical Committees (LMCs); and representing the PCN within the wider ICS. A fuller description is available in the Network Contract DES documentation.

CDs will need to be skilled in fostering goodwill and co-operation to achieve the PCN’s objectives. The CD role will be a practising clinician from within the PCN member practices and may be undertaken by professionals including: general practitioners, pharmacists, nurses and allied health professionals.

It is crucial that we support CDs, all of whom are new to their roles, to lead PCNs in this way.

“The key challenge facing all NHS organisations is to nurture cultures that ensure the delivery of continuously improving high quality, safe and compassionate healthcare. Leadership is the most influential factor in shaping organisational culture and so ensuring the necessary leadership behaviours, strategies and qualities are developed is fundamental.” West et al, 2015
As of 1 July 2019, PCN Clinical Directors have been appointed. Supporting CDs in this new role is critical. Therefore each system will need to provide a comprehensive leadership development programme to its CDs, focusing on personal development, establishing & leading a PCN, and leadership within an ICS.

By going through the development cycle, CDs should receive support to develop the following skills, alongside others:
- Change management – leading complex change processes to deliver quantified impacts
- Use of data and information to aid clinical decision making
- Managing finances and budgets
- Establishing and developing a team
- Influencing and engaging staff and stakeholders to get the best out of self, team, place, neighbourhood and system
- Learning how to recognise, engage and utilise the voice of local citizens
- Building the workforce – operational management and organisational development
- Understanding newer primary care roles and how they can best be deployed

They should also develop an understanding of:
- The CD role, and what it means in practice
- Presenting the vision: how do I tell the story to different stakeholder groups?
- The system they are part of, its strategy, and how to engage with it
- Trust as a foundation of strong relationships: establishing and nurturing trust
- Establishing relationships: understanding key relationships; seeking to understand the worlds of partners;
- Getting to know local communities: understanding their needs, issues, what makes them tick, and how to identify community assets

CDs should also develop an understanding of their own leadership style, values, beliefs, and behaviours, and how they can apply these to the CD role, as specified under 2 above.

ICSs/STPs, places and CCGs contact PCN CDs and provide them contacts for a named PCN/CD development lead

1. Who can help me?**
2. What is my role and how do I want to develop?
3. What help do we need?
4. What help is available?
5. I'm being supported
6. Is the support helping me?

With support from systems PCN CDs review progress against priorities. Areas for additional support identified, revised development plan produced and learning and best practice shared.

Support is delivered, enabling CDs to develop their leadership skills and support one another as a group.

Systems deploy CD development support funding to implement agreed CD leadership programme based on the above, making use of support available from within the system, wider NHS and public sector, and external expertise where necessary

**A list of contacts in each system is included in the appendices. Buddying arrangements are also being considered, please e-mail: england.PCN@nhs.net for further information.

It should be noted that development funding can be deployed to support steps 2 and 3 of the above process as well as later steps.
### Roles and responsibilities in PCN development

<table>
<thead>
<tr>
<th>PCN Clinical Director</th>
<th>Responsible for leading their network, Clinical Directors will:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Provide overall leadership to their network</td>
</tr>
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<td></td>
<td>• Be responsible for providing strategic and clinical leadership to the PCN, developing and implementing strategic plans, leading and supporting quality and improvement and performance across many practices</td>
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</tbody>
</table>

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<thead>
<tr>
<th>STP/ICSs (through their constituent CCGs)</th>
<th>Responsible for PCN development, systems (and where appropriate, places) will:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Have a lead (named director level) for PCN development, and proactively make PCN CDs aware of appropriate contact points</td>
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<tr>
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<td>• Partner with PCNs to support them to identify level of development and support needs, forming an aggregate view across the system</td>
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<td>• Identify and deploy funding and associated support to meet PCNs' collective development needs, making use of system, wider NHS and external expertise and holding suppliers to account for delivery</td>
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<td></td>
<td>• Understand PCN progress and impact of support, and gather and share learning for subsequent years</td>
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<td>• Deliver the primary care requirements set out in the LTP</td>
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<table>
<thead>
<tr>
<th>Regions</th>
<th>Accountable for system delivery, regions will:</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>• Work with their ICS/STPs to ensure PCNs are supported to progress and that all support offers put in place meet the guidance set out in this prospectus</td>
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<td>• Support system primary care leads to develop effective system PCN development plans, sharing learning and approaches between systems</td>
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<td></td>
<td>• Understand system plans for PCN development, and agree specifications for how funding is deployed</td>
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<td></td>
<td>• Understand how development support is progressing</td>
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<td>• Be able to review a summary of the outputs of development support, and impact on PCN progress</td>
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<thead>
<tr>
<th>National</th>
<th>Accountable for enabling overall delivery, the national team will:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Support co-creation of an iterative PCN Development Prospectus</td>
</tr>
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<td>• Develop tools including PCN maturity matrix</td>
</tr>
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<td>• Mobilise PCN development set-up support</td>
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<td>• Support clinical directors, system primary care leads and regions to convene and form communities at the national level</td>
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<td></td>
<td>• Engage with stakeholders to ensure the right support offers are in place</td>
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<td></td>
<td>• Capture learning and share best practice</td>
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<td></td>
<td>• Ensure progress and delivery impacts can be measured</td>
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Key milestones for mobilising PCN development support in 2019-20

This diagram sets out the suggested timeline for putting in place PCN development support. To make best use of available resources, it is important that systems move quickly to identify how it should be deployed. It is recognised, however, that systems have different starting points, and that the process of self-assessment is in itself important in bringing teams together. This timeline is considered as a guide to support systems rather than a requirement.

- **Jun**: Funding Released to ICS/STP
- **Jul**: ICS/STPs support PCNs in self-assessment, identifying areas of initial focus, and determining support needs
- **Aug/Sep**: Funding parameters agreed. PCN development prospectus finalised
- **Sep**: ICSs and STPs collate support needs and put together system plan for PCN development
- **Oct**: Development support mobilised
- **Oct-Mar**: Systems and CCGs support PCNs to review progress against PCN priorities. Areas for additional support identified. Learning and best practice shared.
Appendices

1. Development support domains
2. PCN maturity matrix
The development support domains

The diagram below summarises what PCNs want from support partners based on the engagement carried out. This has provided helpful context in developing the initial domains defined for 2019/20. The domains and their content will be updated in 2020 to reflect national service specifications and other deliverables within the PCN contract.

To note: reflecting their importance to PCN development, a number of the support domains and the PCN maturity matrix cover areas that may, from April 2020, be part of PCN service specifications. Systems and PCNs should therefore consider draft and final service specifications, once these are published, to further inform and adapt support requirements. The support domains outlined here should not be taken as an indication of what is likely to be in service specifications, beyond the detail already laid out in the contract documentation.
PCN ‘set up’ support

Impact and expected outcomes
There is significant variation in primary care network maturity. Some PCNs are progressing at pace and some remain at the very early or ‘setting up’ stages of development. This means that for some areas, the foundations of PCN development need to be put into place before they can begin to progress through the levels identified in the PCN maturity matrix.

PCN set up support would be expected to:
• Help those in the very early stages of development to progress.
• Recognise variation and timescales for PCN set up and development.
• Address an immediate need for development support.

What good looks like
Key components of good PCN development support would be expected to include:

• **Policy and context**
  • Understanding the current system and why it needs to change.
  • What will be different – what are the clear intended impacts?

• **Expected ways of working**
  • Building relationships and working with the wider community.
  • Identifying support through networks and shared expertise.
  • Building on success and learning from what works.

• **Facilitating transformational change**
  • Building capacity, capability and resilience.
  • Building a culture of trusted and valued relationships across systems which includes the wider community
  • Creating a shared purpose, aligned belief, systems and values with a common challenge, vision and goals.
  • Creating operational rigour
  • Quality improvement
  • Achieving quantified impacts
  • Accountability.

• **Where do we start?**
  • Assessment of current state and areas for development.
  • Testing and measuring incremental change. Learning from experience and being prepared that your first idea may not be the best or right solution.
  • Making a start – identifying a project linked to Long Term Plan goals and the ambitions and expectations for PCNs

Accessing PCN set up support
Elements of this domain are being provided by the NHS England Sustainable Improvement team, further information can be found at england.pcn@nhs.net
Organisational development and change

“Organisation development applies behavioural science to organisational and system issues to align their strategy with their capability. It enhances the effectiveness of systems by providing interventions that build people’s collective capacity and capability to achieve shared goals.  (Do OD & LLA OD network agreed definition 2018)

How will we deliver sustainable and transformational change?

Nationally, the NHS Long Term Plan was based on clear evidence and changes that people told us needed to happen. It provides an incredibly powerful starting point for local action, and informed the creation of new GP contract, PCNs and the new national service specifications. It would be deeply inefficient – as well as contrary to a National Health Service – if every system invented their own answers to common problems. Wherever it makes sense, PCNs will be adopting or adapting standard methods for example on medication management or care homes support

At the same time, experience tells us that change in health and care settings is most effective when teams drive and own the changes that need to take place. This ensures that the changes fits with their context, their patients and their communities. Transformational and Sustainable change is often supported by the change model illustrated at Figure 1.

The NHS Change Model is built around creating a ‘shared purpose’, aligned belief, systems and values with a common challenge, vision or goal. It has eight components that should be considered when planning and implementing change. Much more than a prescribed methodology; its intention is to support the generation of ideas, provoke thoughts and provide a tool which can be used in different situations. In this case by those who are leading or contributing to the development of PCNs.

By using a tool which encourages people to question “why change needs to happen” it guides and drives decision making and action planning and ultimately encapsulates peoples’ cognitive, emotional and spiritual commitment to a common cause.

This ‘bottom-up’ approach is critical to the organic development and sustainability of PCNs, alongside the ‘top-down’ national work to establish common metrics, standard operating models in PCN services specifications, the PCN dashboard, and contracts. Your development programme will need to synthesise both perspectives.
Organisational development and change

Impact and expected outcomes

Organisational development and change management support are closely aligned. In the context of PCN development support, organisational development should focus on PCN development and consequent maturity through the PCN maturity matrix; and as evidenced in the forthcoming PCN dashboard and change management on supporting individual changes. Cumulative individual changes contribute to overall organisational change.

Organisational development support would be expected to:

• Provide a framework that ensures all aspects of PCN development can be considered and aligned: set up, strategy, culture, ways of working, skills, and staffing all brought together by having a common purpose and shared values.
• Bring PCN staff together around a shared vision or purpose, supporting effective collaboration, building capacity and capability that enables new ways of working, and delivery of specific service improvements for local people.
• Recognise the importance of collaboration across a ‘patient-focused’ or ‘person-focused’ whole system of care rather than care within single organisations.
• Address the need for collaboration across NHS organisations, local government departments, private and third sector organisations and local communities to find new and different ways of working together to build a health and care system.

Change is fundamental to the success of PCNs. It is about altering the way in which care and support is currently provided and making it distinctly different. In the context of PCN development this will mean having to push the boundaries of what is currently thought to be possible, challenging the status quo and leading the way to encouraging and motivating individuals into new ways of working.

Change as PCNs develop and mature through the PCN maturity matrix is likely to be on several levels. Change will be particularly recognisable as individuals begin to work more collaboratively with each other and across organisational boundaries, as traditional models of leadership break down and as PCNs establish cultures which are developed through sustainable partnerships built on collaboration, trust and mutual respect.

Change management support would be expected to:

• Address and support the cultural shift required to develop and build open, honest and collaborative relationships, recognising the value that everyone within the PCN brings regardless of profession, so reducing the existing power differentials and creating safe environments for people to speak and generate fresh ideas.
• Encourage ownership and responsibility so that individuals within PCNs know what they need to do and where to get support from to change patterns of working and bring about fresh ways of thinking, new cultures and fresh and innovative ideas.
• Recognise the importance of collaboration across a ‘patient-focused’ or ‘person-focused’ whole system of care rather than care within single organisations.
• Provide and develop technical expertise to implement specific service changes in the most effective and efficient way.
• Build momentum and enthusiasm through achieving early results – quick wins that become part of the PCN story.
• Achieve results - demonstrate how the PCN can implement service changes to improve care and outcomes, as clearly shown through the forthcoming PCN dashboard.
Organisational development and change

What good looks like

Key components of good organisational development support would be expected to include highly practical and specific help on:

• **Building flourishing teams**
  - Multi-disciplinary team (MDT) development focused on joint work across practices and with community partners.
  - Team development
  - What will be different?

• **Developing good, healthy and positive environments to work in**
  - Building environments and creating cultures which are driven by continuous development and support.

• **Setting up to succeed**
  - Development of system-wide learning culture.
  - Enabling and encouraging sharing of good practice.
  - Encouraging progression through organisational and personal growth.
  - Enabling a culture of continuous improvement.

• **Working collaboratively**
  - Developing trusted relationships with STPs, ICSs and the wider community.
  - Developing trusted relationships with local people and their communities.

Key components of good change management support would be expected to include:

• **Overview of the change process in the context of**
  - System wide change.
  - Organisational change.
  - Building capacity and capability to make change happen as a practitioner, as a carer and as a patient/citizen.

• **Building a sense of purpose and motivation to change**
  - Shared purpose.
  - Improving practice including expected quantified benefits
  - Achieving quick wins to build confidence and momentum

• **Building knowledge and skill in leading change**
  - Creating behaviours to embed new ways of working.
  - Recognising barriers.
  - Learning through improvement techniques such as lean methodology and quality improvement techniques.
  - Supporting individuals and connecting others to build support for change.
  - Identifying the enablers.
  - Provide and develop technical expertise to enable implementation of service changes in the most effective and efficient way
  - Focusing on getting operational processes right
  - Measuring and achieving intended impacts.
Leadership development support

**Impact and expected outcomes**
To ensure there is a comprehensive and connected approach to development support, the leadership domain takes into account the work already underway to provide leadership development to ICSs and STPs and to PCN Clinical Directors.

Leadership development support is relevant at all levels in the overall structure of a PCN and regardless of their maturity. The right leadership will support ongoing maturity and will guide and encourage individuals, teams and the entire PCN towards the accomplishment of their shared purpose.

Leadership development support would be expected to:
- Distinguish between the different leadership styles and the impact each has when supporting collaboration, a cycle of continuous improvement and an understanding of the skills required to work across organisational cultures and boundaries to make change happen.
- Emphasise the fact that all PCN members are leaders and the value this brings when seeking to bring about transformational change and the way care and support is accessed and provided.
- Stress the difference between clinical and non-clinical leadership and highlight the opportunities and positive difference this brings when working across organisational boundaries and an integrated health and care system.

**What good looks like**
Key components of good leadership development support would be expected to include:
- **Leadership in a changing and complex environment**
  - Managing change.
  - Cross system leadership.
  - Managing conflict in the context of a changing environment.
- **Leadership styles**
  - Behavioural
  - Situational
- **Developing clinical and non-clinical leadership skills**
- **Leading a compassionate community**
  - Shared purpose.
  - Improving practice.
  - Key to success and learning from others.
- **Leadership through the use of quality improvement tools and techniques**
  - Lean methodology and process re-design
  - Plan, Do, Study, Act
  - Capacity and demand analysis and impact modelling
  - Reducing avoidable consultations tool
Supporting collaborative working

Impact and expected outcomes

PCNs will only succeed if they look out to partners – not just other providers, but patients, their carers and the wider community. PCNs are about creating a joint model of more personalised care, delivered by multi-disciplinary teams. This requires collaboration, sharing resources and better care coordination. It makes the most of the opportunity that different professions and expertise (clinical and non-clinical) can offer.

Support to encourage better collaboration would be expected to:
• Support teams to understand scale the of the opportunity to improve through further collaboration
• Highlight the importance of case finding and case management through multidisciplinary working – an integral part of anticipatory care.
• Highlight the impact and opportunity of an integrated workforce.
• Emphasise the value of personalised care and prevention, including shared decision making and supported self-management (based on people’s levels of knowledge, skills and confidence) and health promotion. This domain directly supports preparation for the forthcoming Personalised Care national service specification.

What good looks like
Key components of good support to encourage better collaboration would be expected to include:

• **Relationship between collaborative working**
  • Population health management, including case finding and risk stratification
  • Personalised care and support planning.

• **Understanding the value of existing, new and emerging clinical and non clinical roles that make up a strong MDT**
  • Opportunity and impact.
  • Involvement of local people and communities as partners including patients, carers, families and residents.

• **Competencies and skills of a strong MDT**
  • Professional and operational responsibility, as well as the responsibilities of patients.
  • Governance and accountability.
  • Effectively balancing the voices of clinical and non-clinical members of the MDT.

• **Six components of the Comprehensive Model for Personalised Care, as set out in Universal Personalised Care**
  • Shared decision making.
  • Personalised care and support planning.
  • Social prescribing and community-based support
  • Supported self-management, especially for people living with long term conditions - specifically through Patient Activation Measurement (PAM) and tailored support delivered through health coaching, supported self-management education, or peer support
  • Choice of provider, including for those choosing an elective care pathway.
  • Personal health budgets and integrated personal budgets

• **Opportunities to learn together**
  • Self directed learning and facilitated learning.
  • Group training hubs.
  • Ad hoc access to peer support/buddying.
Population health management support

Impact and expected outcomes
Population health management (PHM) is a data-driven approach to improving the care provided to a PCN population. By using data systematically, PHM can support networks to understand and anticipate the needs of their population, so that services act as early as possible to keep people well. Primary care clinicians who work in this way describe a change so that their job isn’t about reactively providing appointments to patients on a registered list, but proactively caring for the people and communities they serve. This domain directly supports preparation for the Anticipatory Care national service specification.

Population health management support would be expected to:
• Support a better understanding of the opportunity to use data in decision-making and proactive care and support.
• Identify opportunities to link primary care data with other datasets across health, care and wider health determinants working closely with Public Health colleagues.
• Bring data intelligence together with insight from frontline staff and the local community, supporting PCNs to understand their local population’s health needs – including health inequalities and unwarranted variation – and target support where it is most needed.
• Support PCNs to work with partners across health, care and the voluntary sector to develop interventions tailored to individual need.
• Promote the opportunity for prevention, including through tackling the root causes of ill health in the network’s population.
• Support a cultural shift in the way PCNs provide services – moving from a focus on managing sickness to keeping people well.
• Provide data and evidence which allows commissioners to make decisions based on evidenced need rather than assumption and supports an opportunity to identify and address health inequalities on a much broader basis.

What good looks like
This domain would work well alongside the domain which focuses on personalisation, collaborative working and MDTs. Key components of good population health management support would include:
• **Background to PHM**
  - The PHM cycle and core PHM capabilities; relevance to PCNs and relationship with personalisation, collaborative working, MDTs.
  - Introduction to segmentation, stratification and identifying interventions likely to have the most impact (“impactability”).
• **Data and information governance (IG)**
  - Identifying available datasets and working with the wider STP/ICS to link data for the purposes of PHM, including support to put in place robust IG arrangements to ensure that data flows between organisations are both effective and lawful.
• **Creating intelligence**
  - Understanding PCN populations through analysis of quantitative and qualitative data, including unwarranted variation.
  - Application of risk stratification and advanced analytical techniques to target support most effectively.
  - Bringing clinicians and analysts together to ask questions of the data and use these insights to improve care and outcomes.
• **Delivering benefit for and with people and communities**
  - Rapid learning cycles to design, test and implement new integrated models of care.
  - Working across health, social care, the voluntary and community sector, and local authority to map and join up resources.
  - Working as a PCN to design and implement interventions to improve the health outcomes of a targeted cohort.
  - Improvement tools and techniques to rapidly evaluate success and refine interventions.
Social prescribing and asset based community development

**Impact and expected outcomes**
Social prescribing empowers people to take control of their health and wellbeing through referral to non-medical ‘link workers’ who give time, focus on ‘what matters to me’ and take a holistic approach, connecting people to community groups and statutory services for practical and emotional support. Link workers support existing groups to be accessible and sustainable and help people to start new community groups, working collaboratively with all local partners.

Social prescribing can help to strengthen community resilience and personal resilience, and reduces health inequalities by addressing the wider determinants of health, such as debt, poor housing and physical inactivity, by increasing people’s active involvement with their local communities. It particularly works for people with long term conditions (including support for mental health), for people who are lonely or isolated, or have complex social needs which impact on wellbeing.

Social prescribing link workers will have a key role in supporting delivery of the Comprehensive Model of Personalised Care and will work under supervision of the GMS Contract holder as part of the PCN team. This domain forms part of the preparation for the forthcoming Personalised Care national service specification.

Social prescribing and asset based community-based development would be expected to:

- Enhance an understanding of social prescribing and it’s impact on individuals and the community overall
- Emphasise the importance and impact of patient and practitioner partnerships.
- Develop a community wide understanding of the value and fundamentals of building strengths-based community partnerships and the role PCN social prescribing link workers play in enabling this.

**What good looks like**
Key components of good social prescribing and community-based support would be expected to include:

- **Understanding the role of PCN social prescribing link workers**
  - Both individually and their role as part of an effective MDT;
  - Connecting people with community-based support;
  - Measuring quality and impact on health and wellbeing (through use of the social prescribing common outcomes framework).

- **Understanding asset based community development**
  - Mapping, connecting and building partnerships of trust with community assets;
  - Relationships and engagement with the VCSE and its significance to PCN development to build a shared vision;
  - Building local community capacity and creating social value;
  - Volunteers and volunteering as an integral element of PCNs;
  - Optimise access to and use of all capacity within the local system including local communities.
  - Governance.
What is the 2019/20 PCN maturity matrix?
• The PCN Maturity Matrix outlines core components that underpin the successful development of networks.
• It sets out a progression model that evolves from the initial steps and actions that enable networks to begin to establish through to growing the scope and scale of the role of networks in delivering greater integrated care and population health for neighbourhoods.
• The matrix that accompanies this Prospectus is an evolution of an earlier matrix that will be familiar to many ICSs and STPs. The updated version reflects feedback received from systems on the previous versions.
• A number of systems have developed their own maturity matrices and/or built upon earlier drafts of this matrix to meet local needs.

Purpose of the maturity matrix
The matrix can be developed and tailored to meet local circumstances and is designed to support system and network leaders, working in collaboration with their commissioners and other local leaders within neighbourhoods, to work together to:
• Identify where PCNs are now in their journey of development – and how PCNs can build on existing improvements such as those that may have been enabled by the GP Forward View and other local integration initiatives.
• Develop plans for further development – that help networks to continue to expand integrated care and approaches to population health.
• Identify support needs – using the PCN Development Support Prospectus as a guide for framing support plans and coming together to form links with their new team.

A development journey for PCNs
• PCNs are at varied stages of development. Many PCNs will already be collaborating with partners across sectors on transformation schemes and initiatives. It is important the momentum of these existing ways of working is retained and built on where that is already adding value for patients, staff and the wider population.
• The matrix is designed to complement Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan, setting out the wider development journey in how networks can grow their capabilities to support local priorities and deliver LTP commitments.
• The matrix will help STPs and ICSs to work with providers within networks to enable those journeys.
• As for the 2019/20 support domains, the PCN maturity matrix covers areas that may, from April 2020, be part of PCN service specifications. Systems and PCNs should therefore consider draft and final service specifications, once these are published, to further inform and adapt support requirements. The support domains outlined here should not be taken as an indication of what is likely to be in service specifications, beyond the detail already laid out in the contract documentation. The domains and matrix will continue to evolve beyond 2019/20.
PCN maturity matrix

A basis for discussions
• The matrix should be used pragmatically and flexibly, with networks and their partners viewing PCN development as a multi-year journey, and one that can build on progress that has already been made in improving and transformation care and services for patients and populations.
• Experience from ICSs shows that the matrix can be used most effectively where general practices within a network come together with their CCGs and other local providers (for example this could include community services, local authorities and other primary care providers) for a shared discussion on current progress, future plans for integrated care and system support for PCN development. The output of these discussions can often be a shared development plan for how the network could evolve.
• The PCN Development Support Prospectus and the funding available to systems for PCN development can be utilised to support these local development discussions.

Using the matrix and diagnostic tool
• Learning from ICSs and STPs is that local development discussions framed round the matrix have been beneficial for providers within networks and for commissioners. Use of the matrix is recommended for networks and their systems to help identify on-going and future support needs, and to target deployment of transformational funding. What is important is that PCNs are active participants in development discussions, and these generate useful outputs when considering and planning for the support required using this Prospectus.

• The Primary Care Network Maturity Matrix, including full suggested instructions for use, is available as a Powerpoint presentation by e-mailing: england.pcn@nhs.net and will be available to download from the FutureNHS platform in Mid August.

• A simple excel diagnostic tool has been developed to put the matrix into action and help systems and PCNs to discuss local PCN maturity, target support and inform any local development plans. The excel tool is available by e-mailing: england.pcn@nhs.net and will be available to download from the FutureNHS platform in Mid August.

Further references
In supporting PCNs to identify their development journey using the matrix, systems may also find it helpful to consider how they may already have undertaken any reviews using the ICS maturity matrix and the PHM matrix. It is for local determination how the outputs from these various reviews (where held and relevant) can help inform together the overall picture of the transformations required for primary care within systems.
• The PHM maturity matrix can be downloaded here: https://future.nhs.uk/connect.ti/populationhealth/view?objectid=50226789
Where to find further information

• Contact your PCN system lead (on slide 30)

• Contact your regional primary care team or the national PCN team at england.PCN@nhs.net

• You can join our FutureNHS site which includes a highly active discussion forum and a range of PCN resources – you can request access to the site by emailing england.PCN@nhs.net

• A WhatsApp discussion group has been established for PCN leaders. To gain access to the group, please email england.pcn@nhs.net

• Webinars and events are helping to share best practice and advice. Full details at www.england.nhs.uk/pcn

• Frequently asked questions (FAQs) and other materials are available to help explain what a primary care network is. You can also watch a short animation giving further details about primary care networks at www.england.nhs.uk/pcn

• Listen to our latest #primarycarenetworks podcast online at www.england.nhs.uk/gp/gpfv/redesign/primary-care-networks/primary-care-network-podcasts

• Join our monthly Twitter chat with Dr Nikki Kanani, Acting Director of Primary Care, using #primarycarenetworks to join in the conversation.

• Regional contacts to help you engage with councils, social care, public health and pre-existing health and social care integration work:
  • https://www.local.gov.uk/our-support/lga-principal-advisers
  • https://www.adass.org.uk/
  • https://navca.org.uk/
  • https://www.adph.org.uk/adph-networks/
  • https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/regional-contacts/
For more information on the GP Contract and Network DES


The following contracting documents can all be located on the NHS England and NHS Improvement [GP Contracts page](https://www.england.nhs.uk/gp-contracts/) or if you have any specific queries you can email the team directly at: england.gpcontracts@nhs.net

- Network Contract Directed Enhanced Service (DES) Registration Form
- The Network Contract DES and VAT Information Note
- Mandatory Network Agreement
- Network Agreement Schedules
# Who’s my PCN contact?

## East of England Region

<table>
<thead>
<tr>
<th>System</th>
<th>Name</th>
<th>E-mail</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cambridgeshire and Peterborough</td>
<td>Dawn Jones</td>
<td><a href="mailto:capccg.primarycare@nhs.net">capccg.primarycare@nhs.net</a></td>
</tr>
<tr>
<td>Norfolk and Waveney</td>
<td>General Practice Support Hub</td>
<td><a href="mailto:gywccg.nwgpfvretention@nhs.net">gywccg.nwgpfvretention@nhs.net</a></td>
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<tr>
<td>Suffolk and North East Essex</td>
<td>Caroline Proctor</td>
<td><a href="mailto:caroline.j.procter@ipswichandeastsuffolkCCG.nhs.uk">caroline.j.procter@ipswichandeastsuffolkCCG.nhs.uk</a></td>
</tr>
<tr>
<td>Bedfordshire, Luton and Milton Keynes</td>
<td>Hannah Baker</td>
<td><a href="mailto:bedsccg.pccc@nhs.net">bedsccg.pccc@nhs.net</a></td>
</tr>
<tr>
<td>Hertfordshire and West Essex</td>
<td>Denise Boardman</td>
<td><a href="mailto:denise.boardman2@nhs.net">denise.boardman2@nhs.net</a></td>
</tr>
<tr>
<td>Mid and South Essex</td>
<td>Alison Alexander</td>
<td><a href="mailto:england.midsouthsessexstp@nhs.net">england.midsouthsessexstp@nhs.net</a></td>
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</tbody>
</table>
This matrix has been created to help primary care networks and other local organisations involved in the development of PCNs to self-assess the current maturity of a network and to help understand the development trajectory of the network. The matrix is provided here in the format of a simple spreadsheet tool, that is intended to be used flexibly and in a way that most effectively supports local PCN development.

It is recommended the matrix will have most value when completed as part of a facilitative discussion, involving the providers who will be delivering services within the network now and in the future, and with their commissioners. It is for local agreement whether the matrix is completed by a single network or a number of networks undertake a review collaborating together across a place or CCG footprint. What is more important is that the outputs from the discussion can meaningfully inform the on-going development of the network(s) involved, and the development needs for each network is understood.

### Components of the matrix

The matrix is divided into five development themes (by row):

1. Leadership, planning and partnerships
2. Use of data and population health management
3. Integrating care
4. Managing resources
5. Working with people and communities

For each development theme there are then up to four development steps - Foundation, Step 1, Step 2 and Step 3 (by column).

Within each theme and step there are a number of maturity components (the cells). There are a number of blank cells in the matrix and this is intentional.

The development of PCNs is a partnership between the organisations within the network, supported by and working with other local health and care organisations. Therefore for each theme and development step, the matrix differentiates between maturity components that align with individual PCNs and those components that align with systems supporting PCNs. This is denoted in the spreadsheet as components 'For the PCN' and 'For Systems'. It is for local determination whether the matrix is only completed for the network components or for both network and system components, subject to the approach that will best inform discussions on the developments and transformation changes that are already in place, are underway or are required. For example, it may be agreed locally that each network undertakes its own review for the PCN maturity components, and then representatives from networks (e.g. PCN Clinical Directors) come together as a group with wider system and place organisations for a shared strategic review of current maturity of the system components.

To complete the tool

1. Agree locally who will complete the matrix and the nature of the discussion that will be held to build an overall view across the network, and whether this will include the system components. There is space on the matrix worksheet to record the name of the network and the date if this is useful locally.

2. For each maturity component, by theme and development step, assess whether the network (and system where applicable) already has the component in place and record with an X in columns D, F, H and J. The matrix worksheet it not protected and this provides the option for networks to additionally record in free text whether any components are 'in place', 'in plan' or 'in progress' - if that is the preferred local approach. In this case, an X would denote that a component is already in place.

3. Review the overall aggregate position across the themes for all development steps where components are in place and note in column K. It is normal if a network concludes that some development themes are overall (for example) at Foundation and others at Step 1. This should help identify areas for further focus and there is a final column L for capturing any free text comments that arise in reviewing the aggregate position.

4. Having completed the diagnostic, this should help inform discussions on where the network would like to prioritise its development, using the PCN Development Prospectus as a guide to framing this further and identifying specific support activities. This information could also be captured in summary in the free text boxes in column L where this is helpful.

It is recommended if the matrix worksheet is printed out this is done in A3.
# Leadership, planning and partnerships

**For the PCN**

- Clinical disorders are on the agenda of each PCN for at least 50% of PCNs. The PCN directorate is the lead for clinical disorders, which are staffed by at least four PCN leaders.
- The PCN directorate is responsible for clinical disorders.
- The PCN is responsible for clinical disorders.
- Clinical disorders are integrated into the local care plan.
- The PCN takes collective responsibility for clinical disorders.

**For Systems**

- Systems are providing clinical disorder support to PCNs, including the development of clinical disorder support teams and the implementation of clinical disorder strategies.
- The PCN and other providers have clinical disorder support teams.
- Systems support the PCNs to build local clinical disorder teams.
- Systems have developed and implemented effective clinical disorder strategies.

## Use of data and population health management

**For the PCN**

- Systems are supporting PCNs in accessing and using data for population health management.
- The PCN is using readily available data.
- Systems support the PCNs to build local teams to support population health management.
- Systems support the PCNs to build local teams to support population health management.
- Systems support the PCNs to build local teams to support population health management.

**For Systems**

- Systems are providing PCNs with data and tools to support population health management.
- Systems support PCNs to take collective responsibility for population health management.
- Systems support PCNs to take collective responsibility for population health management.
- Systems support PCNs to take collective responsibility for population health management.
- Systems support PCNs to take collective responsibility for population health management.

## Integrating care

**For the PCN**

- Systems are supporting PCNs in integrating care, including the development of integrated care models.
- The PCN is responsible for integrated care.
- Systems support the PCNs to build integrated care teams.
- Systems support the PCNs to build integrated care teams.
- Systems support the PCNs to build integrated care teams.

**For Systems**

- Systems are supporting PCNs in integrating care, including the development of integrated care models.
- Systems support the PCNs to build integrated care teams.
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## Managing resources

**For the PCN**

- The PCN is responsible for managing resources.
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**For Systems**

- Systems support the PCNs in managing resources.
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## Working with people and communities

**For the PCN**

- The PCN is responsible for working with people and communities.
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**For Systems**

- Systems are supporting PCNs in working with people and communities.
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### Primary Care Network Maturity Matrix

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<th>Element</th>
<th>PCN</th>
<th>Step 1</th>
<th>Step 2</th>
<th>Step 3</th>
<th>Step 4</th>
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<tr>
<td>Managing resources</td>
<td>PCN</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working with people and communities</td>
<td>PCN</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
Network Contract Directed Enhanced Service - payment claims form 2019/20

Introduction

1. This payment claim form has been produced by NHS England in partnership with the GPC, with advice and support from regional Primary Care Finance teams - and is intended for use by all PCNs and commissioners, and should be completed by:
   a. PCNs claiming workforce payments under the Network Contract Directed Enhanced Service (DES) in 2019/20; and
   b. commissioners (CCGs/STPs/ICSs) reviewing and approving those claims.

   It is to be used on a monthly basis to support workforce claims, including for any clinical pharmacists who have transitioned from the clinical pharmacist in general practice scheme (phases 1 and/or 2). It should also be resubmitted when there are any workforce changes.

Workforce reimbursement under the Network Contract DES for 2019/20

2. The calculations for Workforce Reimbursement Funding in 2019/20 are based on the Network drawing down its entitlements as set out satisfying the requirements in the DES Specification from 1 July 2019 for one FTE clinical pharmacist and one FTE social prescribing link worker for PCN populations of under 100,000 (or two FTE - Full Time Equivalent - of each for a population over 100,000; plus an additional one of each FTE for every 50,000 population thereafter i.e. from 150,000).

   The calculations are to be based on:
   - 70% of actual salary plus employer on-costs up to the maximum reimbursable amount for one Clinical Pharmacist, and
   - 100% of actual salary plus employer on-costs up to the maximum reimbursable amount for one Social Prescribing Link Worker.

   Claims are only applicable following the start of employment and to cover the period of employment (i.e. whilst the individual is in post), providing the baseline is as at 31 March 2019. For information on baseline and additionality rules, please see the Network Contract DES Additional Roles Reimbursement Guidance at: https://www.england.nhs.uk/publication/network-contract-directed-enhanced-service-additional-roles-reimbursement-scheme-guidance/

PCNs will be required to demonstrate that claims being made are for new additional staff roles beyond this baseline (including in future years, staff replacements as a result of staff turnover). Commissioners must be assured that claims meet the additionality principles above.

3. Where commissioners have agreed to allow PCNs to substitute between clinical pharmacists and social prescribing link workers, the relevant section of the claim form needs to be amended accordingly.

   NOTE: if you require amendments to the claim form to support substitution, please contact england.gpcontracts@nhs.net to have the claim form sheet unlocked.

Guidance notes on section 1 of the claim form

5. Row 20 on claim form: PCNs will, in due course, be allocated Organisational Data Service (ODS) codes. When available, this PCN code is to be used retrospectively on claim forms if not available on initial completion.

6. Row 25 on claim form: Please indicate from the “drop down” box the month that the Claim relates to.

Guidance notes on section 2 of claim form (PCNs to complete all sections in Green)

7. Row 30 on claim form: The PCN will decide who is authorised to sign the declaration related to the workforce claim. The individual authorised is declaring on behalf of the practice members of the PCN that the claim meets the additionality rules set out in the Network Contract DES. It may be the PCNs Clinical Director or another agreed individual.
Column A on claim form: unique identifier to be used to distinguish posts being claimed. This can be an employee number.

Column B on claim form: where the reimbursement claim includes more than one of the same workforce role (i.e. 2 clinical pharmacists etc.), please complete the relevant number of rows for each role recruited to. Equally, if only one role is included, please only complete that one role. Six rows for each role have been included, which should be sufficient for the vast majority of PCNs for 2019/20.

Each role being claimed must be within the tolerance of the maximum monthly amount per role i.e. not exceed the figures set.

NOTE: if you require amendments to the claim form to support substitution, please contact england.gpcontracts@nhs.net to have the claim form sheet unlocked.

Column C on the claim form: this is the FTE figure declared in the PCN baseline as at 31 March 2019 against each of the reimbursable roles. This information only needs to be entered once against the first relevant role (i.e. if you claim for two clinical pharmacists, then just include the baseline figure against one of the rows within the claim form).

Column D on claim form (evidence to support NEW workforce claims may include):

− Contract of employment - suitably anonymised to remove staff member's personal details
− Contract / agreement with provider for provision of services or staff - to include information on FTE that is being claimed for
− Network Agreement - if used as basis for sub-contracting for services / staff
− Agreement with locum (who is providing services for which funding is being claimed under the Additional Roles Reimbursement Sum). The locum would be someone engaged within one of the reimbursable roles and who meets the additionality rules. In the event a locum is engaged to cover long-term leave of a member of the PCN workforce (e.g. sickness absence or maternity leave), then the claim under the Additional Roles Reimbursement Scheme can continue to be made but only to cover the costs of one person (i.e. claims cannot be made for both the person on long-term leave and the person providing the cover).

Column E on claim form: please provide the employment start date for each post being claimed.

Column F on claim form: please provide the employment End date for each post being claimed.

Column G on claim form: this is the FTE for the individual for whom the claim is being made (workforce claims can only be claimed for additional staff beyond the PCN baseline, as outlined in the Additional Roles Reimbursement Scheme Guidance. Please state FTE as follows eg Hours worked 37.5=1.00 FTE, 30 hours worked =0.8 FTE etc

Column H on claim form: This is to confirm, from the guidance, the FTE maximum monthly amount for Individual claims per FTE role workforce claimed for additional staff beyond the PCN baseline, as outlined in the Additional Roles Reimbursement Scheme Guidance.

Column I on claim form: This must be the actual salary plus employer on-costs (NI and pension) incurred within the month - which is to be completed by the Primary Care Network.

Column J on claim form: This automatically calculates the amount being claimed based on a number of factors (including: Column I - Total monthly cost), (Column G - number of FTEs), (Column E & F - Start Date & End Date respectively).

Rows 62 and 63 - for optional completion by the commissioner

Row 62 on claim form: this is the running total for claims made to ensure it does not exceed the total maximum reimbursable amount noted in row 63.

Row 63 on claim form: For 2019/20 this figure will be the total maximum reimbursable amount for workforce as outlined in Table 1 of the Additional Roles Reimbursement Guidance. It is calculated by adding the 9-month equivalent maximum reimbursable amount for clinical pharmacist(s) and social prescribing link worker(s) relative to PCN size as per guidance note A above.

Additional guidance notes

VAT is not chargeable to the commissioner under the Network Contract DES.

Claims can only be made in respect of actual salary plus employer on-costs (pension and NI). No other expenses (e.g. management costs, travel etc) can be reclaimed under the Additional Roles Reimbursement Scheme.
Network Contract DES - payment claims form 2019/20

Instructions:
- For completion by the PCN
- For pre-population (completion before issue to PCN) by the CCG/STP/ICS as appropriate

Step 1:
- Please complete section 1 providing details of the PCN.

Step 2:
- Please insert your PCN’s registered list as at 1 January 2019 in the following cell:

**NOTE:** PCN registered list is the combined registered list figure taken from NHAIS (Exeter). CCGs to verify on Claim Form receipt (complete cell I10).

Step 3:
- Please complete section 2 (All Sections in green), including providing details related to any workforce claims. For workforce claims, please only claim the relevant FTE according to population size. See guidance notes for information on evidence to substantiate workforce claims.

### SECTION 1: Details of PCN

- **PCN Name:** [add details of PCN name]
- **PCN Code:** [add details of PCN ODS Code and is to be completed when this information is available - see guidance notes]
- **Name of nominated payee:** [add details of nominated payee]
- **Nominated payee code (if a GP practice paid via NHAIS):** [add details of GP practice code if a GP practice is the nominated payee]
- **Claim for month (Please select from Drop down list):** Aug-19

### SECTION 2: Workforce claim

With regards to the below workforce claims, the Core Network Practices of [add PCN name] confirms that the following claims meet the additionality rules outlined in the Network Contract DES and associated additionality guidance (see guidance notes on who is to sign the form).

- **Name of authorised signatory:** [add details of signatory]

<table>
<thead>
<tr>
<th>Unique identifier (see guidance notes)</th>
<th>Workforce Reimbursement (Only complete rows that are relevant to the claim - see guidance notes)</th>
<th>FTE (Full Time Equivalent)</th>
<th>FTE maximum monthly amount (Individual claims are not to exceed these figures which apply to FTE roles)</th>
<th>Total monthly salary costs, plus employer's costs (To be completed by PCN)</th>
<th>Amount being claimed (Pre calculated field)</th>
</tr>
</thead>
<tbody>
<tr>
<td>BC: Social prescribing link worker(s)</td>
<td>£2,842.75</td>
<td>£2,842.75</td>
<td>£2,842.75</td>
<td>£2,842.75</td>
<td>£2,842.75</td>
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<td>£2,842.75</td>
<td>£2,842.75</td>
</tr>
</tbody>
</table>

**Total workforce amount claimed to date:** [Please add in the running total here]

**Additional Roles Reimbursement sum allocation:** [Please add in PCNs total maximum additional roles reimbursement sum allocation]

**Remaining allocation available:** [Please add in PCNs remaining allocation available]
Appendix 4

<table>
<thead>
<tr>
<th></th>
<th>East</th>
<th>West</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP Retention</td>
<td>90000</td>
<td>56475</td>
</tr>
<tr>
<td>Practice Resilience</td>
<td>56800</td>
<td>35642</td>
</tr>
<tr>
<td>Reception &amp; Clerical Training</td>
<td>68000</td>
<td>42670</td>
</tr>
<tr>
<td>Online Consultation Systems</td>
<td>111200</td>
<td>69778</td>
</tr>
<tr>
<td>Primary Care Networks</td>
<td>309600</td>
<td>194274</td>
</tr>
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</table>
# PRIMARY CARE COMMISSIONING COMMITTEE

<table>
<thead>
<tr>
<th>Agenda Item No.</th>
<th>07</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reference No.</td>
<td>IESCCG PCCC 19-25</td>
</tr>
<tr>
<td>Date.</td>
<td>22 October 2019</td>
</tr>
</tbody>
</table>

## Title
Primary Care Delegated Commissioning- Finance Report

## Lead Officer
Jane Payling, Director of Finance

## Author(s)
Wendy Cooper, Finance Manager (Primary Care-Ipswich & East Suffolk and West Suffolk CCGs)

## Purpose
To provide the committee with an overview of the M6 Primary Care Delegated Commissioning Budget

## Applicable CCG Clinical Priorities:
1. To promote self care
2. To ensure high quality local services where possible
3. To improve the health of those most in need
4. To improve health & educational attainment for children & young people
5. To improve access to mental health services
6. To improve outcomes for patients with diabetes to above national averages
7. To improve care for frail elderly individuals
8. To allow patients to die with dignity & compassion & to choose their place of death
9. To ensure that the CCG operates within agreed budgets

## Action required by Primary Care Commissioning Committee:
To note the report.
1. **Purpose**

1.1 To provide the committee with an overview of the M6 Primary Care Delegated Commissioning Budget and other associated primary care budgets.

2. **Key Points**

2.1 At the end of M6, the GP Delegated Budget spend was £537k over spent – please see the table below for a summary of key variances:

<table>
<thead>
<tr>
<th>Application of Funds</th>
<th>YTD Budget £'000</th>
<th>YTD Actual £'000</th>
<th>Variance £'000</th>
<th>Full Year Budget £'000</th>
<th>Full Year Forecast £'000</th>
<th>Variance £'000</th>
<th>Variance Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Practice - GMS</td>
<td>4,843</td>
<td>4,851</td>
<td>(9)</td>
<td>9,686</td>
<td>9,741</td>
<td>(65)</td>
<td>Includes estimated 19/20 list growth.</td>
</tr>
<tr>
<td>General Practice - PMS</td>
<td>15,312</td>
<td>15,308</td>
<td>4</td>
<td>30,624</td>
<td>30,796</td>
<td>(172)</td>
<td>Includes estimated 19/20 list growth and movement of balance of locum costs</td>
</tr>
<tr>
<td>Other List-Based Services (APMS incl.)</td>
<td>2,460</td>
<td>2,267</td>
<td>193</td>
<td>4,919</td>
<td>4,595</td>
<td>324</td>
<td>Benefit from in year seniority reduction and addit dispensing Drs funding</td>
</tr>
<tr>
<td>Enhanced services</td>
<td>569</td>
<td>836</td>
<td>267</td>
<td>1,138</td>
<td>1,818</td>
<td>679</td>
<td>Variance relates mainly to insufficient budget for PCN Participation DES and</td>
</tr>
<tr>
<td>QOF</td>
<td>2,778</td>
<td>2,778</td>
<td>0</td>
<td>5,566</td>
<td>5,566</td>
<td>0</td>
<td>Increase in LD Health Checks claims in line with PC trajectory</td>
</tr>
<tr>
<td>Premises cost reimbursements</td>
<td>2,336</td>
<td>2,368</td>
<td>(22)</td>
<td>4,672</td>
<td>4,714</td>
<td>(42)</td>
<td>Variance relates to rent reviews</td>
</tr>
<tr>
<td>Other - premises costs</td>
<td>81</td>
<td>99</td>
<td>18</td>
<td>162</td>
<td>224</td>
<td>(63)</td>
<td>Variance due to increase in cost of clinical waste</td>
</tr>
<tr>
<td>Primary Care Network</td>
<td>97</td>
<td>268</td>
<td>(171)</td>
<td>194</td>
<td>804</td>
<td>(610)</td>
<td>Insufficient budget allocation to fund all PCN payments</td>
</tr>
<tr>
<td>Other - GP Services</td>
<td>42</td>
<td>289</td>
<td>(247)</td>
<td>84</td>
<td>150</td>
<td>234</td>
<td>Prior Year benefit</td>
</tr>
<tr>
<td><strong>Primary Care Delegated Commissioning</strong></td>
<td><strong>28,518</strong></td>
<td><strong>29,054</strong></td>
<td><strong>(537)</strong></td>
<td><strong>57,035</strong></td>
<td><strong>58,098</strong></td>
<td><strong>(1,063)</strong></td>
<td></td>
</tr>
</tbody>
</table>

Other Primary Care shows an under spend of £843k at the end of M6, as summarised in the table below:

<table>
<thead>
<tr>
<th>Application of Funds</th>
<th>YTD Budget £'000</th>
<th>YTD Actual £'000</th>
<th>Variance £'000</th>
<th>Full Year Budget £'000</th>
<th>Full Year Forecast £'000</th>
<th>Variance £'000</th>
<th>Variance Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Enhanced Services</td>
<td>1,410</td>
<td>1,298</td>
<td>112</td>
<td>2,822</td>
<td>2,695</td>
<td>127</td>
<td>Variance primarily relates to Prior Year benefit.</td>
</tr>
<tr>
<td>Primary Care Contingency</td>
<td>0 (615)</td>
<td>615</td>
<td>0 (615)</td>
<td>0 (615)</td>
<td>615</td>
<td>0</td>
<td>Prior Year underspends from other PC areas to offset PC Delegated budget over spend</td>
</tr>
<tr>
<td>GPFV</td>
<td>1,760</td>
<td>1,650</td>
<td>110</td>
<td>3,520</td>
<td>3,362</td>
<td>158</td>
<td>Variance relates to Prior Year benefit.</td>
</tr>
<tr>
<td>Practice Support</td>
<td>445</td>
<td>438</td>
<td>7</td>
<td>815</td>
<td>815</td>
<td>0</td>
<td>Assumes budgets for INT LES, Practice Resilience &amp; MDCH are fully spent</td>
</tr>
<tr>
<td><strong>Other Primary Care</strong></td>
<td><strong>3,615</strong></td>
<td><strong>2,772</strong></td>
<td><strong>843</strong></td>
<td><strong>7,157</strong></td>
<td><strong>6,257</strong></td>
<td><strong>900</strong></td>
<td></td>
</tr>
</tbody>
</table>

3. **Risks**

3.1 Other risks not reflected in the above full year forecasts are further increases in rent reimbursement, additional practice management support and an increasing number of claims for locum allowance for parental and sickness absence.

4. **Recommendation**

4.1 The Committee is asked to note the financial performance at month six.
## PRIMARY CARE COMMISSIONING COMMITTEE

<table>
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<tbody>
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<table>
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<tr>
<th>Title</th>
<th>Workforce Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead Chief Officer</td>
<td>Amanda Lyes, Director of Corporate Services and System Infrastructure</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Julie White, Primary Care Development Manager</td>
</tr>
<tr>
<td>Purpose</td>
<td>For Information</td>
</tr>
</tbody>
</table>

### Applicable CCG Clinical Priorities:

1. To promote self care
2. To ensure high quality local services where possible
3. To improve the health of those most in need
4. To improve health and educational attainment for children and young people
5. To improve access to mental health services
6. To improve outcomes for patients with diabetes to above national averages
7. To improve care for frail elderly individuals
8. To allow patients to die with dignity and compassion and to choose their place of death where appropriate
9. To ensure that the CCG operates within agreed budgets

### Action required by Primary Care Commissioning Committee:

To note the report.
1. **Purpose**

1.1 To provide an update on the work of the Primary Care Development Team in delivering the Suffolk and North East Essex workforce plan and the Suffolk and North East Essex Training Hub and the impact on local workforce.

2. **Background**

2.1 The NHS Long Term Plan, The GP Contract and the development of Primary Care Networks are all having an impact on General Practice Workforce. NHS England and Health Education England are channelling resources into the ICS and CCGs to develop the workforce to deliver these strategies.

2.2 General Practice has a major challenge created by having an aging workforce that could retire in the next five years (Appendix 1). However there are exciting new opportunities created by establishing multi-disciplinary teams in General Practice who are providing more appropriate, specialised patient care.

2.3 The development of collaborative working provided by Primary Care Networks is offering career development opportunities through training and upskilling programmes.

3. **Workforce Data**

3.1 The outcome of working collaboratively with Practice Managers to improve the quality of the workforce data that is inputted onto the NHSE Workforce Reporting tool is helping us to build a clearer picture of the workforce and its challenges.

3.2 There is further work to be undertaken to interpret the data and feedback to Practices to fully understand the importance of inputting the data accurately and to follow the NHSE guidance. The appointment of a Data Champion to work across the ICS is proving to be a valuable resource in achieving this goal. In the first quarter Suffolk and North East Essex could report a 100% achievement of practices are completing the return and have a registered user. The next step is to work on the quality of the data.

4. **Key Messages from the Data**

4.1 The data for quarter one confirms the view that Ipswich and East Suffolk has had an overall decrease in the number of GPs and Nurses. These are relatively small percentages and it is known that the summer GP data historically shows a decrease due to GP Trainees who have completed no longer showing in the data. There should be an increase in GPs in quarter 2 due to new GPs and GP Trainees being recorded.

4.2 Nursing is showing a small overall decrease but the more important data is the reduction of Practice Nurses and the increase of ANPs which is showing the greater use of Nurses to deliver clinics and patient services.

4.3 The increase of direct patient care practitioners confirms the new patient pathways which are being developed and implemented in Practices to deliver more appropriate patient care through direct access to the most appropriate clinician.

4.4 The age profile of the workforce is a cause for concern as it could destabilise patient services if members of staff decide to take immediate retirement. The positive is that staff feel they wish to continue working which indicates they feel valued and want to continue to deliver patient services. However work needs to be undertaken with PCNs to develop a local workforce plan which reflects the long term plans of individual members of staff to ensure continuity of patient services.
5. **Apprentices**

5.1 The data highlights a very low take up of apprenticeships by all GP Practices across clinical and non-clinical roles. The opportunities that the new Nursing Apprenticeship Standards offer Practices to upskill existing staff or recruit new staff are not being utilised and they provide unique opportunities to directly address the age of the workforce and widen participation.

5.2 Apprenticeships also provide opportunities to recruit apprentices into clinical and non-clinical roles from non-traditional backgrounds which would benefit General Practice and the wider health and social care system.

5.3 The Training Hub has therefore taken the opportunity of funding from HEE to develop a two year fixed term post for an Apprenticeship Co-ordinator to help practices recruit apprentices, upskill existing staff and work collaboratively with the Trusts to deliver Nursing Apprenticeships.

6. **GPs**

6.1 There are a number of initiatives to support GPs at all stages of their career:-

Clinical Lead – funding has been identified to create a 2 session a week, two year fixed term post for a GP to provide strategic lead on all of the work streams relating to GPs.

There are a number of GPs including Clinical Executive who have expressed an interest in leading/supporting some of these work streams:-

7. **GP Training Practices/GP Trainers/GP Trainees**

7.1 The number of GP Training Practices and GP Trainers is in decline and this needs to be addressed. There are new training curriculums for GP Trainees and GP Trainers. The intention is to host a half day workshop before the end of the year to discuss the changes and identify how to support GP Training Practices and support/recruit GP Trainers. A GP Skills Programme has been agreed for 2019/20. HEE is developing a regional GP Trainee programme to support those who require additional support to pass the exams and fund results. A programme of support for GP Training Practices is to be developed.

8. **Newly Qualified**

8.1 NHSE have provided funding to implement the New Qualified Programme for all GPs and Practice Nurses. The Training Hub has developed a draft proposal for a two year programme which is currently being discussed with GPs. A GP lead for First 5 Peer support network has been established and a programme will be circulated shortly.

Recently, a first Bring Baby Training Day has been held for GPs on maternity leave to address issues and concerns about returning to work. GP Support Hub is now providing individual support to GPs.

9. **Coaching**

9.1 Funding existing regional coaching and mentoring programmes for local GPs. This supports initiatives which have been developed by GP Appraisers.

10. **GP Support Hub**

10.1 Continuing to offer a bespoke support package for all GPs across Suffolk and North East Essex.
11. **Nursing**

11.1 The Training Hub has Nurse Educator Team who are supporting and developing General Practice Nurses across Suffolk.

12. **Nurse Forum**

12.1 Suffolk Nurse Educator established the Ipswich and East Nurse Forum over 18 months ago and has established a strong link with Practice Nurses delivering a programme of training and a regular newsletter. Recently held the first full day Nurse Conference which was opened by Karen Story NHSE Lead Nurse.

13. **Training Manual**

13.1 Developed a training manual which provides an up to date manual of all skills training required by Practice Nurses to deliver patient services in a GP Practice.

14. **Clinical Skills**

14.1 The 2019/20 clinical skills programme is being delivered across Suffolk to ensure Nurses have the appropriate skills to deliver clinics. Planning for the 2020/21 programme is already underway with HEE to identify the funding required to deliver next year’s courses.

15. **Newly Qualified Nurses**

15.1 The Nurse Educator Team have secured funding to be able to offer the Fundamentals Programme to all new to Practice Nurses across Suffolk and North East Essex. The team have developed an outline 2 year Nursing New to Practice programme as outlined in the Long Term Plan. The aim is to roll this programme out later this year.

16. **Wider Workforce**

16.1 The Training Hub are working with Practices and HEIs to increase the number of Physician Associates in Ipswich and East Suffolk. There is currently and offer from HEE to fund a one year preceptorship for Practices who wish to employ a PA.

16.2 Clinical Pharmacy is a role which is becoming increasingly important to General Practice but there are concerns about the ability to recruit staff without it impacting on other employers. The Training Hub are leading on delivering a workshop in early 2020 to bring together all sectors to discuss the issues and find a local solution.

16.3 The Training Hub is working with regional and national partners to ensure that all clinical roles can access clinical supervision, clinical skills training and mentoring.

17. **Practice Managers**

17.1 The Training Hub have secured training to support Practice Managers to develop skills and confidence in their roles. This has resulted in a series of two hour masterclasses delivered by the Practice Manager Association the programme has been agreed by the Practice Manager Forum.

18. **Clerical Workforce**

18.1 The Training Hub are working with the Practice Managers and the CCG to identify how they can support and develop the wider clerical team and ensure there are staff with the correct skills to be able to work in Practice as Medical Secretaries and Medical Assistants.
19. **Conclusion**

19.1 Workforce is the biggest challenge facing the whole health and social care sector of which General Practice is one employer. The sector needs to recruit new staff to ensure there are sufficient staff with the right skills to deliver patient services along the whole pathway and upskill existing staff to be able to take on new roles and deliver new services.

19.2 The Training Hub is working collaboratively with other employers through a career project Next Generation to attract young people to join the sector. The Training Hub is also working through the Ipswich and East Suffolk Training Hub Advisory Group to understand the specific local challenges in General Practice and identify solutions.

20. **Recommendation**

20.1 The Committee is asked to note the report.
**Ipswich & E Suffolk GPs**

FTE at June 2019

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Dec 17</th>
<th>Mar 18</th>
<th>Jun 18</th>
<th>Sep 18</th>
<th>Dec 18</th>
<th>Mar 19</th>
<th>Jun 19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Change from Dec 2017</td>
<td>154.9</td>
<td>150.1</td>
<td>150.3</td>
<td>158.4</td>
<td>151.8</td>
<td>159.5</td>
<td>177.5</td>
</tr>
<tr>
<td>Change from previous quarter</td>
<td>-4.9</td>
<td>-5.4</td>
<td>-2.1</td>
<td>-1.0</td>
<td>-1.3</td>
<td>-3.0</td>
<td>-4.0%</td>
</tr>
</tbody>
</table>

**Age Profile at June 2019 (Headcount)**

- GP Partners: 120.6 (224.7 from 2015)
- GP Locums: 6.5
- Salaried GPs: 83 (+11.5 from 2015)
- GP Registrars: 23.9

Source: National Workforce Reporting Tool June 2019

---

**Ipswich & E Suffolk Direct Patient Care**

at June 2019

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Dec 17</th>
<th>Mar 18</th>
<th>Jun 18</th>
<th>Sep 18</th>
<th>Dec 18</th>
<th>Mar 19</th>
<th>Jan 19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Change from Dec 2017</td>
<td>140.2</td>
<td>147.4</td>
<td>149.9</td>
<td>161.1</td>
<td>155.5</td>
<td>160.7</td>
<td>162.0</td>
</tr>
<tr>
<td>Change from previous quarter</td>
<td>7.3</td>
<td>2.6</td>
<td>0.8</td>
<td>6.4</td>
<td>5.2</td>
<td>1.3</td>
<td>15.66%</td>
</tr>
</tbody>
</table>

**Age Profile at June 2019 (Headcount)**

- HOA: 49.3
- Dispenser: 68.4
- Pharmacist: 11.2
- Paramedic: 10.2
- Apprentice: 2.2
- Other: 10.1

Source: National Workforce Reporting Tool June 2019

---

**Ipswich & E Suffolk Nursing**

at June 2019

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Dec 17</th>
<th>Mar 18</th>
<th>Jun 18</th>
<th>Sep 18</th>
<th>Dec 18</th>
<th>Mar 19</th>
<th>Jun 19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Change from Dec 2017</td>
<td>132.7</td>
<td>135.0</td>
<td>131.3</td>
<td>134.5</td>
<td>137.5</td>
<td>134.7</td>
<td>120.0</td>
</tr>
<tr>
<td>Change from previous quarter</td>
<td>0.2</td>
<td>-1.0</td>
<td>3.2</td>
<td>3.0</td>
<td>-3.8</td>
<td>-5.7</td>
<td>-2.75%</td>
</tr>
</tbody>
</table>

**Age Profile at June 2019 (Headcount)**

- Nurses over 55: 65
- ANP: 41.2
- Nurse Specialist: 5.1
- Student Nurse Specialist: 2.1

Source: National Workforce Reporting Tool June 2019

---

**Ipswich and East Suffolk Admin/Non-Clinical**

at June 2019

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Dec 17</th>
<th>Mar 18</th>
<th>Jun 18</th>
<th>Sep 18</th>
<th>Dec 18</th>
<th>Mar 19</th>
<th>Jan 19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Change from Dec 2017</td>
<td>468.5</td>
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<td>462.4</td>
<td>460.4</td>
<td>489.2</td>
<td>492.7</td>
<td>491.2</td>
</tr>
<tr>
<td>Change from previous quarter</td>
<td>7.5</td>
<td>7.0</td>
<td>4.6</td>
<td>4.5</td>
<td>-1.5</td>
<td>-13.4</td>
<td>2.00%</td>
</tr>
</tbody>
</table>

**Age Profile at June 2019 (Headcount)**

- Staff over 55: 220
- Staff over 65: 49
- Manager: 55.1
- Manager Partner: 45.8
- estates: 40.1
- Apprentice: 15.8
- Other: 113.7

Source: National Workforce Reporting Tool June 2019
## PRIMARY CARE COMMISSIONING COMMITTEE

<table>
<thead>
<tr>
<th>Agenda Item No.</th>
<th>09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reference No.</td>
<td>IESCCG PCCC 19-27</td>
</tr>
<tr>
<td>Date.</td>
<td>22 October 2019</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Title</th>
<th>Primary Care Performance – unwarranted variation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead Officer</td>
<td>Maddie Baker-Woods, Chief Operating Officer</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Caroline Procter, Scott Pomroy</td>
</tr>
<tr>
<td>Purpose</td>
<td>To provide the committee with detailed analysis of primary care performance for key measures and to understand the variation.</td>
</tr>
</tbody>
</table>

### Applicable CCG Clinical Priorities:

1. To promote self care
2. To ensure high quality local services where possible
3. To improve the health of those most in need
4. To improve health & educational attainment for children & young people
5. To improve access to mental health services
6. To improve outcomes for patients with diabetes to above national averages
7. To improve care for frail elderly individuals
8. To allow patients to die with dignity & compassion & to choose their place of death
9. To ensure that the CCG operates within agreed budgets

### Action required by Primary Care Commissioning Committee:

To review the identified variation and provide further comments and suggestions for action as appropriate.
1. **Purpose and context**

1.1 The CCGs primary care teams regularly analyse and report on performance data and metrics to the Primary Care Commissioning Committee.

1.2 The approach is generally a holistic one, aimed at understanding why a particular practice is performing better or worse in comparison to another, with an ultimate aim of supporting practices to achieve a certain standard; thus ensuring high quality across all practices in Suffolk.

1.3 The current general approach to variation is to engage with any practice below the average or national target and to offer targeted support and challenge as appropriate to the objective. Such variations’ are raised with practices individually via Link visits, more broadly in Chart of the Week or as part of a two-way dialogue with the practice.

1.4 The approach to performance management is always incremental and proportionate.

1.5 The CCGs have recently undergone an exercise to try to gain a greater understanding as to what level variation in performance is recognised and accepted or is perhaps unwarranted.

2. **Approach**

2.1 The CCGs primary care teams have analysed a cross section of performance data with a view to understanding patterns, trends, variation and where possible, provide a quantifiable rational for identified variance.

2.2 To understand what is ‘unwarranted’ or variation that is deemed outside the normal range, a recognised formula of standard variation has been applied to each set of metrics to provide key focus. I.e. the best and worst performing practice in each category.

2.3 The primary care teams collectively analysed the results to provide a narrative, a logic and a reasoned explanation to help understand the findings. These results have been reviewed by the Ipswich and East Suffolk Primary Care workstream.

2.4 The standard variation formula has been applied to a broad range of information held by the CCGs in relation to Local Enhanced Service performance and national targets.

A selection of these targets and a brief analysis are available in Appendix A.

3. **Next Steps**

- To develop practice level trend data and relative context to be used at Link visits and for internal scrutiny and assurance
- To provide statistical process control data and importantly an ‘explanation over time’
- To consider the data measured by the CCG to include new indicators associated with the PCN DES. i.e. Stage one cancer diagnosis

4. **Recommendation**

4.1 The Committee is invited to review the information and note the variation and suggest actions as appropriate.
Appendix A.

**KEY:** Results with blue background are within standard deviation

**National Patient Survey – July 209.**

**Top:**
- Less deprived population
- More doctors per patient than other areas
- Good continuity of care
- Low patient turnover

**Bottom:**
- Recruitment issues
- Urban versus rural pattern recognised
- High demand areas
- Larger percentage of non-English speaking patients

---

**PATIENT SURVEY JULY 2015**

<table>
<thead>
<tr>
<th>Practice</th>
<th>Ease of getting through on telephone</th>
<th>Practice</th>
<th>Neighboorhood of reception</th>
<th>Practice</th>
<th>Experience of making an appointment?</th>
<th>Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressfield</td>
<td>100.0 Little St John's Street, Woodbridge</td>
<td>100.0 Pressfield</td>
<td>96.8 Pressfield</td>
<td>96.8 Pressfield</td>
<td>95.6 Largest Value</td>
<td>95.6 Largest Value</td>
</tr>
<tr>
<td>Alderhough</td>
<td>98.8 Woodbridge</td>
<td>98.8 Woodbridge</td>
<td>96.8 Woodbridge</td>
<td>96.8 Woodbridge</td>
<td>94.3 Small Value</td>
<td>94.3 Small Value</td>
</tr>
<tr>
<td>Bickerton</td>
<td>98.8 St John's Street, Woodbridge</td>
<td>98.8 St John's Street, Woodbridge</td>
<td>95.6 St John's Street, Woodbridge</td>
<td>95.6 St John's Street, Woodbridge</td>
<td>92.6 Average</td>
<td>92.6 Average</td>
</tr>
<tr>
<td>Mendlesham</td>
<td>97.8 The Broom</td>
<td>97.8 The Broom</td>
<td>96.8 The Broom</td>
<td>96.8 The Broom</td>
<td>92.6 Standard Deviation</td>
<td>92.6 Standard Deviation</td>
</tr>
<tr>
<td>Barnington Road, Ipswich</td>
<td>95.2 Ipswich Road, Ipswich</td>
<td>95.2 Ipswich Road, Ipswich</td>
<td>94.8 Ipswich Road, Ipswich</td>
<td>94.8 Ipswich Road, Ipswich</td>
<td>91.1 Standard Deviation</td>
<td>91.1 Standard Deviation</td>
</tr>
<tr>
<td>Barnstapole, Ipswich</td>
<td>95.2 Ipswich Road, Ipswich</td>
<td>95.2 Ipswich Road, Ipswich</td>
<td>94.8 Ipswich Road, Ipswich</td>
<td>94.8 Ipswich Road, Ipswich</td>
<td>91.1 Standard Deviation</td>
<td>91.1 Standard Deviation</td>
</tr>
<tr>
<td>Barnington Road, Ipswich</td>
<td>95.2 Ipswich Road, Ipswich</td>
<td>95.2 Ipswich Road, Ipswich</td>
<td>94.8 Ipswich Road, Ipswich</td>
<td>94.8 Ipswich Road, Ipswich</td>
<td>91.1 Standard Deviation</td>
<td>91.1 Standard Deviation</td>
</tr>
<tr>
<td>Minutes</td>
<td>65.9 Long Meadow Practice</td>
<td>65.9 Long Meadow Practice</td>
<td>65.9 Long Meadow Practice</td>
<td>65.9 Long Meadow Practice</td>
<td>61.9 1 SD Variation Lower</td>
<td>61.9 1 SD Variation Lower</td>
</tr>
<tr>
<td>Angell Hill Surgery</td>
<td>58.9 Clements and Christmas Mattingly Surger</td>
<td>58.9 Clements and Christmas Mattingly Surger</td>
<td>58.9 Clements and Christmas Mattingly Surger</td>
<td>58.9 Clements and Christmas Mattingly Surger</td>
<td>58.9 Clements and Christmas Mattingly Surger</td>
<td>58.9 Clements and Christmas Mattingly Surger</td>
</tr>
<tr>
<td>Heverhill Family Practice</td>
<td>54.7 Oakfield Surgery</td>
<td>54.7 Oakfield Surgery</td>
<td>54.7 Oakfield Surgery</td>
<td>54.7 Oakfield Surgery</td>
<td>54.7 Oakfield Surgery</td>
<td>54.7 Oakfield Surgery</td>
</tr>
<tr>
<td>Clements and Christmas Mattingly Surger</td>
<td>51.6 Hever Hill Family Practice</td>
<td>51.6 Hever Hill Family Practice</td>
<td>51.6 Hever Hill Family Practice</td>
<td>51.6 Hever Hill Family Practice</td>
<td>51.6 Hever Hill Family Practice</td>
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<tr>
<td>Heverhill Family Practice</td>
<td>51.6 Hever Hill Family Practice</td>
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<td>51.6 Hever Hill Family Practice</td>
<td>51.6 Hever Hill Family Practice</td>
<td>51.6 Hever Hill Family Practice</td>
<td>51.6 Hever Hill Family Practice</td>
</tr>
</tbody>
</table>

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**Notes:**
- Results with blue background are within standard deviation.
## Dementia Target

**Top:**
- Practices that have high number of residents in Care Homes

**Bottom:**
- Rural practices or those with no Care homes
- Professional perspective taken on diagnosis

<table>
<thead>
<tr>
<th>PRACTICE</th>
<th>Code 66.7% of Estimated prevalence - Aug 19 + comparison to previous month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hawthorn Drive, Ipswich</td>
<td>122.7</td>
</tr>
<tr>
<td>Haven Health, Felixstowe</td>
<td>88.8</td>
</tr>
<tr>
<td>Orchard Street (Solway), Ipswich</td>
<td>87.6</td>
</tr>
<tr>
<td>Holbrook</td>
<td>87.5</td>
</tr>
<tr>
<td>Constable Country Practice, East Bergholt</td>
<td>47.1</td>
</tr>
<tr>
<td>Felixstowe Road, Ipswich</td>
<td>43.9</td>
</tr>
<tr>
<td>Mendlesham</td>
<td>41.8</td>
</tr>
<tr>
<td>Alderton</td>
<td>41.3</td>
</tr>
</tbody>
</table>

**Ipswich and East Suffolk CCG**

- **Largest Value:** 122.7
- **Smallest Value:** 41.3
- **Average:** 67.5
- **Standard Deviation:** 16.3
- **NHS England:** 68.8

- **1 SD Variation Lower:** 51.29
- **1 SD Variation Higher:** 83.81
<table>
<thead>
<tr>
<th>Practice</th>
<th>Code 66.7% of Estimated prevalence - Aug 19 + comparison to previous month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Siam Surgery</td>
<td>95.1</td>
</tr>
<tr>
<td>Swan Surgery</td>
<td>92.9</td>
</tr>
<tr>
<td>Hardwicke House</td>
<td>85.9</td>
</tr>
<tr>
<td>Clements and Christmas Maltings Surgery</td>
<td>84.2</td>
</tr>
<tr>
<td>Lakenheath Surgery</td>
<td>41.8</td>
</tr>
<tr>
<td>Woolpit Health Centre</td>
<td>39.3</td>
</tr>
<tr>
<td>Botesdale Health Centre</td>
<td>36.3</td>
</tr>
<tr>
<td>Stanton</td>
<td>32.1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Largest Value</th>
<th>Smallest Value</th>
<th>Average</th>
<th>Standard Deviation</th>
<th>NHS England</th>
<th>1 SD Variation Lower</th>
<th>1 SD Variation Higher</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>95.1</td>
<td>32.1</td>
<td>61.1</td>
<td>17.5</td>
<td>68.8</td>
<td>43.59</td>
<td>78.57</td>
</tr>
</tbody>
</table>
## Learning Disabilities Target

### Top:
- Tends to be a nurse led service
- No rural/urban pattern
- Practice with no recruitment or less capacity issues

### Bottom:
- Practices with capacity issues
- Organisational or internal process model adopted
- Lack of LD nurse in West Suffolk
- No LD nurse contract

<table>
<thead>
<tr>
<th>Practice</th>
<th>% Health Checks Delivered 18/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alderton</td>
<td>100.0</td>
</tr>
<tr>
<td>Barrack Lane, Ipswich</td>
<td>95.9</td>
</tr>
<tr>
<td>Wickham Market</td>
<td>88.9</td>
</tr>
<tr>
<td>Felixstowe Road, Ipswich</td>
<td>86.3</td>
</tr>
<tr>
<td>Grove Surgery, Felixstowe</td>
<td>45.2</td>
</tr>
<tr>
<td>Mendlesham</td>
<td>37.5</td>
</tr>
<tr>
<td>The Birches</td>
<td>33.3</td>
</tr>
<tr>
<td>Little St John’s Street, Woodbridge</td>
<td>33.3</td>
</tr>
</tbody>
</table>

### Ipswich and East Suffolk CCG

**Largest Value**: 100.0
**Smallest Value**: 33.3
**Average**: 65.4
**Standard Deviation**: 15.2

### West Suffolk CCG

<table>
<thead>
<tr>
<th>Practice</th>
<th>% Health Checks Delivered 18/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Botesdale Health Centre</td>
<td>93.0</td>
</tr>
<tr>
<td>Mount Farm Surgery</td>
<td>86.8</td>
</tr>
<tr>
<td>Orchard House Surgery</td>
<td>77.3</td>
</tr>
<tr>
<td>Clare Guildhall Surgery</td>
<td>76.5</td>
</tr>
<tr>
<td>Oakfield Surgery</td>
<td>35.3</td>
</tr>
<tr>
<td>Wickhambrook Surgery</td>
<td>25.7</td>
</tr>
<tr>
<td>Brandon Medical Practice</td>
<td>23.5</td>
</tr>
<tr>
<td>Reynard Surgery</td>
<td>0.0</td>
</tr>
</tbody>
</table>

**Largest Value**: 93.0
**Smallest Value**: 0.0
**Average**: 54.1
**Standard Deviation**: 26.7

**NHS England**: no data

<table>
<thead>
<tr>
<th>1 SD Variation Lower</th>
<th>33.35</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 SD Variation Higher</td>
<td>74.82</td>
</tr>
</tbody>
</table>
Severe Mental Illness Target (SystmOne practices only)

<table>
<thead>
<tr>
<th>PRACTICE</th>
<th>% Health Checks Completed Q1 19/20 (rolling 12 months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Felixstowe Road Medical Practice</td>
<td>70.9</td>
</tr>
<tr>
<td>Deben Road Surgery</td>
<td>70.8</td>
</tr>
<tr>
<td>Stowhealth</td>
<td>59.5</td>
</tr>
<tr>
<td>Grove Medical Centre</td>
<td>59.1</td>
</tr>
<tr>
<td>Martlesham Heath Surgery</td>
<td>13.0</td>
</tr>
<tr>
<td>Bilstedon Health Centre</td>
<td>12.0</td>
</tr>
<tr>
<td>Church Farm Surgery</td>
<td>7.1</td>
</tr>
<tr>
<td>Mendlesham Medical Group</td>
<td>4.9</td>
</tr>
</tbody>
</table>

- Largest Value: 70.9
- Smallest Value: 4.9
- Average: 36.4
- Standard Deviation: 16.4
- NHS England: 40.4
- 1 SD Variation Lower: 20.01
- 1 SD Variation Higher: 52.82

Top:
- Recent CQC inspection (this is a key line of enquiry of the CQC)
- Capacity

Bottom:
- Improving position from a slow start
- Lack of system and processes in place
- Recruitment issues in the SMI team that have now been resolved
<table>
<thead>
<tr>
<th>PRACTICE</th>
<th>% Health Checks Completed Q1 19/20 (rolling 12 months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lakenheath Surgery</td>
<td>61.5</td>
</tr>
<tr>
<td>Mount Farm Surgery</td>
<td>56.0</td>
</tr>
<tr>
<td>The Rookery Medical Practice</td>
<td>43.0</td>
</tr>
<tr>
<td>Forest Surgery</td>
<td>41.1</td>
</tr>
<tr>
<td>Brandon Medical Practice</td>
<td>26.9</td>
</tr>
<tr>
<td>Reynard Surgery</td>
<td>25.5</td>
</tr>
<tr>
<td>Orchard House Surgery</td>
<td>16.4</td>
</tr>
<tr>
<td>Oakfield Surgery</td>
<td>10.3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Largest Value</th>
<th>Smallest Value</th>
<th>Average</th>
<th>Standard Deviation</th>
<th>NHS England</th>
<th>1 SD Variation Lower</th>
<th>1 SD Variation Higher</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>61.5</td>
<td>10.3</td>
<td>34.5</td>
<td>13.2</td>
<td>40.4</td>
<td>21.28</td>
<td>47.67</td>
</tr>
</tbody>
</table>
### Secondary Care data – Emergency Admissions

#### Lowest:
- Geography relative to the Acute hospital
- Rural practices

#### Highest:
- Elderly population
- Geography relative to the Acute Hospital
- Risk adverse GPs

<table>
<thead>
<tr>
<th>PRACTICE</th>
<th>EMERGENCY ADMISSIONS: YTD 19/20 July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fressingfield</td>
<td>19.16</td>
</tr>
<tr>
<td>Saxmundham</td>
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**Ipswich and East Suffolk CCG**

Largest Value: 41.31
Smallest Value (Good): 19.16
Average: 30.83
Standard Deviation: 5.30

**West Suffolk CCG**

Largest Value: 37.7
Smallest Value (Good): 21.4
Average: 30.8
Standard Deviation: 4.12

**Target**

| 1 SD Variation Lower | 26.6 |
| 1 SD Variation Higher| 34.9 |
## Secondary Care data – A&E Attendances

### Lowest:
- Geography relative to the Acute hospital
- Rural practices

### Highest:
- Higher levels of deprivation
- Geography relative to the Acute Hospital

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<th>PRACTICE</th>
<th>A&amp;E ATTENDANCES: YTD 19/20 July 2019</th>
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#### Ipswich and East Suffolk CCG

- **Largest Value**: 120.5
- **Smallest Value (Good)**: 49.5
- **Average**: 83.1
- **Standard Deviation**: 19.3

#### West Suffolk CCG

- **Largest Value**: 127.1
- **Smallest Value (Good)**: 66.5
- **Average**: 91.9
- **Standard Deviation**: 15.08

NHS England: no data

- **1 SD Variation Lower**: 76.8
- **1 SD Variation Higher**: 107.0
## Influenza vaccinations – 2018/19 data

**Top:**
- Rural with long established processes known to the community
- Close to a pharmacy or pharmacy attached to the practice

**Bottom:**
- High levels of non-English speaking patients
- High levels of deprivation
- All urban except 1 practice with capacity issues already identified and being supported by the CCG
- High level of movement of patients

### Table

<table>
<thead>
<tr>
<th>Practice</th>
<th>75% uptake reached patients over 65?</th>
<th>Practice</th>
<th>55% uptake reached all pregnant women?</th>
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### Key
- Results with blue background within standard deviation

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</tr>
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### West Suffolk CCG

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### PRIMARY CARE COMMISSIONING COMMITTEE

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<tr>
<th>Title</th>
<th>Integrated Care System (ICS) – 5 Year Strategic Plan update</th>
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<tr>
<td>Lead Officer</td>
<td>Maddie Baker-Woods, Chief Operating Officer</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Caroline Procter, Primary Care Commissioning Manager</td>
</tr>
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<td>Purpose</td>
<td>To provide the Committee with an update as to the ICS 5 year plan</td>
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**Applicable CCG Clinical Priorities:**

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<th></th>
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<td>1.</td>
<td>To promote self care</td>
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</tr>
<tr>
<td>2.</td>
<td>To ensure high quality local services where possible</td>
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<tr>
<td>3.</td>
<td>To improve the health of those most in need</td>
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<td>4.</td>
<td>To improve health &amp; educational attainment for children &amp; young people</td>
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<tr>
<td>5.</td>
<td>To improve access to mental health services</td>
<td></td>
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<td>6.</td>
<td>To improve outcomes for patients with diabetes to above national averages</td>
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<tr>
<td>7.</td>
<td>To improve care for frail elderly individuals</td>
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<td>8.</td>
<td>To allow patients to die with dignity &amp; compassion &amp; to choose their place of death</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>To ensure that the CCG operates within agreed budgets</td>
<td>X</td>
</tr>
</tbody>
</table>

**Action required by Primary Care Commissioning Committee:**

To review the ICS five Year Strategic Plan content for primary medical care.
1. **Purpose**

1.1 To provide the Committee with an opportunity to review the draft content of the ICS 5 year Strategic Plan; primary medical care sections.

2. **Update**

2.1 On 28th September, the ICS Programme Director submitted to NHS England and NHS Improvement the DRAFT Five Year System Strategic Plan for Suffolk and North East Essex ICS.

2.2 This plan is still very much a draft and will not be finalised until November.

2.3 There are two main sections that relate to Primary care. A one-page summary of the recently drafted primary care strategy and an overview of Primary Care Networks (PCNs).

   See Appendix A and B for the extracts.

2.4 There are a number of opportunities for the plan to be reviewed, discussed and further developed between by the STP/ICS Chairs Group, STP/ICS Board, Suffolk and Essex Joint Health Overview Scrutiny Committee and the Health and Wellbeing Boards.

2.5 The plan will not be finalised or published until it has gone through the necessary assurance processes with NHS England and NHS Improvement and other forums within the ICS.

3. **Recommendation**

3.1 The Committee is invited to review the proposed draft content, attached, noting the next steps outlined.
Appendix A - One page overview of joint Primary Care strategy.

The joint primary care strategy brings together our vision and practical plans to build vibrant, sustainable primary care at the heart of high quality, integrated health and care services for the people we serve. Many of our plans are ICS wide; some are Alliance-focused; and others are neighborhood or community based. This is determined by patient need, appropriate partnership relationships and economic viability.

The patients of Suffolk and North East Essex are generally served by high quality practices with care delivered by experienced and qualified professionals. There is some variation in access and performance. Almost all practices, nationally and locally are facing significant and increasing pressure due to a number of factors:

- Increasing population
- Aging population
- Recruitment and retention issues
- The increase in the delivery of care outside of hospitals
- Funding

Running through our whole plan and its delivery there are seven golden threads which collectively will make a significant contribution towards our vision and aim to address those pressures described. The seven threads are:

- New models of care - Enabling primary care collaboration; Delivering joined up care in localities and within Primary Care Networks
- Workload - Reducing workload; Optimising Patient Care
- Workforce - Caring for every Professional, caring for patients
- Access - Enhancing patient access to GP-led services; Promoting and supporting patients in self care
- Infrastructure - Creating environments for future care needs, Enabling digital connectivity for patients and professionals
- Investment - Stimulating transformation; Delivering High Impact Changes
- Leadership, governance and programme management - Co-producing strategy and plans with clinical leadership, patients, public and partners; Enabling excellence in delivery with management support

The joint strategy also sets out how we will support the implementation of the NHS Long Term plan, namely; further integrate primary and community health services, reduce pressure on emergency services, support personalised healthcare and achieve digitally enabled healthcare. This requires system working at each level of the ICS. Using population health data management to locally design services that meet the needs at neighbourhood level.

Local delivery action plans will be co-developed at Alliance level to respond to both new and national requirements and local need, and to articulate:

- Further local demand management measures including alignment of Alliance prevention and self-care strategies;
- local support for Primary Care Networks, specifically including their Clinical Directors;
- workload management measures beyond national measures;
- further workforce plans (specifically but not limited to recruitment and retention issues);
- estates and digital integration, including uptake of patient online services and rollout of Digital First;
- Integration into Primary Care Networks for the wider community partners: community providers, the voluntary sector, and local government.
Primary Care Networks (PCNs) are crucial to the implementation of the Long Term Plan, both through more effective delivery of primary care in local neighbourhoods, and the integration of health and care services to better respond to the characteristics and needs of the local population. PCNs are key to addressing the wider ICS ambitions to improve population health and wellbeing, and to building lasting relationships between our partners.

We have 102 GP practices in our ICS footprint and as of 1st July, 24 PCNs. These cover the full geography and provide 100% coverage of the ICS area. All PCNs have been established with Clinical Directors identified.

It is increasingly recognised that PCNs play a significant role as an integral building block to support the national and local ambitions. With increased focus on PCNs, it is crucial to support and facilitate the clinical leadership and core teams to enable the capability and leadership to meet that expectation, deliver the national specifications and the local ambition. We are committed to the well-established clinical leadership programmes and intend to expand these further to other clinical and managerial staff. This approach to combined leadership supports the fundamental
blocks to integration and as a means for PCNs to interface with one another. Clinical Directors will be providing leadership, both strategically and clinically to the Alliances at ‘place’ level. The focus of Alliances and neighbourhoods, including PCNs, is to progress against the maturity matrix so that all streams of activity are following the same broad developmental stages. This is totally in line with national policy, moving primary care and community service towards integration and collaboration at neighbourhood level.

Public Health - We will continue to advance our partnerships with Public Health through Board membership of Alliances, a joint Director of Public Health appointment with the CCGs in Suffolk, joint posts and management of key programmes. Our focus will be delivery of JSNAs at Integrated Neighbourhood Team level, closely aligned to the PCNs.

This piece of enabling work, coupled with the Population health management and prevention workstreams will bring together health-related data to identify a specific population that health services may then prioritise; with plans to address inequalities between and within PCN areas.

Our local JSNAs have already identified Oral health as a critical issue, specifically in relation to children and emergency admissions. Across our ICS, we will be developing strategic and local plans, working with representative bodies and individual providers and Public Health to address these issues.

Work on quality improvement across a range of services to address local population needs has already begun and there are some well-established organisational collaborations of GP practices beginning to address many of the expectations of the NHS Long Term Plan; delivering ‘at scale’ services such as home visiting and ‘on the day’ services and extended access. Many groups of practices have already identified shared resource such as mental health link workers, physiotherapists and health care assistants and are working together to share additional functions such as administration and management. These networks and practice groupings will also provide the leadership to support the infrastructure at neighbourhood level and will be key to expanding MDT working, going further than the existing practice boundaries.

The Integrated Neighbourhood Teams and Care Closer to Home teams bring together physical, mental health and social care practitioners that work with General Practices within a locality to provide a single coordinated care response for people, underpinned by prevention, self-care, early intervention, reablement and rehabilitation, (including people living in nursing and care homes). We now have the opportunity to closer align these teams with the PCNs.

PCNs will deliver against the seven new service specifications that will be introduced over the next few years; Structured Medications Review, Enhanced Health in Care Homes, Anticipatory Care, Personalised Care, Supporting Early Cancer Diagnosis, CVD Prevention and Diagnosis and Tackling Neighbourhood Inequalities.

To ensure PCNs are in the best place to mature and thrive, and to enable them to deliver the expectations set out within the service specifications, the ICS will put in place high quality support and development, working hand-in-glove with PCN Clinical Directors, and critically the wider community partners, patients, Healthwatch, community providers, the voluntary sector and local government.

We will facilitate this via structured Training and Educations sessions, PPGs and other opportunities, recognising the need to break down organisational and professional barriers to deliver personalised care in the way that best meets the needs of local people. We will support PCNs in building partnerships with Healthwatch, drawing on success already achieved for individual practices in improving access and patient experience’.

Our plans between 2019/20 – 2023/24 to integrate healthcare in local neighbourhoods will include:
• Reviewing and approve local estates development to ensure sustainability.
• Enabling primary care to improve health in care homes with development of Care Home Enhanced Service.
• Developing local incentive and quality improvement schemes.
• Reviewing and expanding public and stakeholder engagement plans to help shape primary care services.
• Developing an approach to balance increased patient care within communities whilst also ensuring the development of a more resilient Primary Care system.
• Working across the ICS to ensure Pharmacists, Opticians, Dentists, GPs and other partners are involved within the PCNs.
• Supporting the integration of mental health services into PCNs.
• Complex patients - we will progress locality wide, emergency service and acute based approaches to management of complex patients to localities with PCNs and Integrated Neighbourhood Teams
• Pharmacies - We will progress our Healthy Living Pharmacies programme which supports development of pharmacies within our communities, including their relationships with PCNs.
• Support existing and new Social Prescribing schemes across our ICS footprint.
**PRIMARY CARE COMMISSIONING COMMITTEE**

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<tr>
<td>Lead Officer</td>
<td>Amanda Lyes, Director of Corporate Services and System Infrastructure</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Daniel Turner, Estates Development Manager</td>
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| Purpose | To provide the committee’s with an overview and seek approval of the proposed framework for the development of a Primary Care Estates Strategy. |

**Applicable CCG Clinical Priorities:**

1. To promote self care
2. To ensure high quality local services where possible X
3. To improve the health of those most in need
4. To improve health & educational attainment for children & young people
5. To improve access to mental health services
6. To improve outcomes for patients with diabetes to above national averages
7. To improve care for frail elderly individuals
8. To allow patients to die with dignity & compassion & to choose their place of death
9. To ensure that the CCG operates within agreed budgets X

**Action required by Primary Care Commissioning Committee:**

To consider the proposed framework for the development of a Primary Care Estates Strategy and to confirm if the Committee is happy to implement it across Ipswich and East Suffolk and West Suffolk CCG’s.
1. **Purpose**

1.1 To provide the Committee with an overview of the proposed framework which will be used to develop an ICS wide Primary Care Estates Strategy.

2. **Background**

2.1 The current CCG Strategic Estates Plan was developed in 2015 in conjunction with NHS Property Services. The existing estates plan provided an overview of the existing estate, opportunities for redevelopment/relocation and options around disposals up until approximately 2019. The Estates plan has now reached the end of its planned life and the social, environmental, political, economic and regulatory background has all moved on since this was developed. Therefore a new strategy is needed to ensure the health system is able to deliver the right level of care in the right places for our population.

3. **Proposal**

3.1 Whilst the 2015 Strategic Estates Plan focused on a broad range of estate at a high level including both local acute sites, NSFT, NHS PS, Community facilities there was very limited information on Primary Care estate. Since this plan was developed and adopted the health landscape has changed with the growth and development of the STP/ICS. The emergence of the alliances which aim to deliver the ambitions and goals of the ICS at the local level to meet the population health needs. Estates strategies have also been developed for both the acute providers which include the community estate and NSFT have also developed their latest strategy.

3.2 In order to ensure that primary care is planned and developed in a way which not only meets with the requirements and demands of the local population but also aligns with the wider acute, community, mental health and alliance strategies, it is proposed to develop a system wide Primary Care Estates Strategy.

3.3 Prior to the development of the strategy a framework has been developed for approval by both officers and the Primary Care Commissioning Committee. Whilst there will be ample opportunity to input and amend the strategy as it is developed it is important to make sure that the strategy starts moving in the right direction. The framework has been reviewed and approved by the CCG’s Primary Care Estates Operational Group. A full copy of the framework is provided in Appendix 1.

3.4 The framework breaks the strategy down into four key areas with a fifth section provided to enable us to review the delivery and success of the plan at various stages and amend where needed.

   The four key stages are summarised below:

   - Strategic context and local drivers (Background and drivers)
   - Overview of Current PC Estate (Where are we now)
   - Vision for primary care estates (Where do we want to be)
   - Opportunities and developments (How are we going to get there)

3.5 The full framework within Appendix 1 provides a break down under each of these headings on the key areas which will be explored to develop this section and the wider strategy. This list is not exhaustive and will be added to as other items come to light.
3.6 It is proposed in the development of the estates strategy that system wide stakeholders will be engaged including but not limited to, acute and community providers, mental health providers, GP’s and Primary Care Networks, Patient Participation Groups, Local Authorities, Health Watch etc. Through this approach and engagement the strategy will be developed holistically and enable key stakeholder to input and understand how the strategy is developed and what the future development plans will look like.

4. **Recommendation**

4.1 The Committee is invited to review and consider the approval of the framework to enable development of the strategy to commence.
Appendix 1 – Proposed Primary Cares Estates Strategy Framework

**Strategic context and local drivers (Background & Drivers)**

**Strategic Context**
- Five year forward view
- Long term plan
- One Public Estate
- GP Forward View
- General Practice Premises Policy Review
- ETTF
- Naylor Report
- Lord Carter Report
- Primary Care Networks

**Local Drivers**
- Out of hospital care within the community
- Implementation of ICS
- Alignment of estate with STP priorities
- Need to ensure local estate is well managed, fir for purpose and value for money
- Development of integrated hubs

**Overview of Current PC Estate (Where are we now)**
- Individual practices
- Community clinics & health centres
- Community hospitals
- Some shared accommodation with health and social care providers
- Office and support infrastructure

**Current premises provision**
- Type of building
  - Purpose built
  - Converted residential dwellings
  - Village halls
  - Community centres
  - Health centres
  - Porta cabins
  - Shopping centre
- Co-location
  - A small number of practices are co-located with either GP practices or wider health partners
  - These arrangements are in the minority rather than being the majority
- Converted residential buildings
  - Large number located in converted residential and historic buildings. Many of which are now reaching the limits of their capacity and scope for compliance with current statutory compliance
- Property ownership (mixture)
  - GP Owned
  - Leased (Public & Private)
  - NHS PS
  - Sessional space
  - 3PD
- Summary of six Facet data main headlines
• Summary of current revenue costs including voids
• Any key highlights, trends, points to note
  o Estate is typically in excess of 25 years old, majority is much older.
  o Limited investment and maintenance over the years
  o Costs associated with running and maintaining the estate are on an upward trend
  o Significant growth in patient list sizes predicted in key strategic areas

Key challenges
• Rent reviews typically upward trend
  o A number of leases agreed without NHS input
  o NHS PS leases very expensive and not best value for money
  o No additional funding from central to cover revenue increases
  o Improvements to estate result in additional revenue costs
• Lease renewals
  o Process and responsibility sits with practices, limited input from NHS
  o Long process
  o Landlords don’t typically understand NHS process and rules governing leases
  o NHS England change in direction moving away from FRI leases
  o Service charges being brought in on collocated premises
• Barriers to new partners
  o Estate ownership is causing problems with attracting GP Partners
• Review of Premises Costs Directions
  o Current PCD’s are complex and very rigid which restricts innovation
  o Confusion on what can and can’t be claimed by GP’s
  o Scope for service charges to be reimbursed
  o Maximum possible NHS contribution to scheme capital costs 66%
  o Timescales for delivery of revised PCD’s unclear, 2004 & 2013 versions will still be in force
• Improvements vs replacement
  o Typically more expensive both in terms of capital and revenue to replace than improve
  o Replacement results in increased floor area just to stay the same
  o Limited capital available to invest, complex and lengthy route to access
• Abatements
  o Complex impact on revenue
  o Can be costly to GP’s in terms of revenue received
  o Risk of unsustainable impact built up over a long period of time in small increment
• Workforce
  o Aging workforce
  o Limited workforce available nationally, difficulty attracting regionally
  o Changing workforce (roles, responsibilities)
  o Primary Care Networks
  o Changing attitudes of workforce (less desire to become partners?)
• Technology
  o Full impact of technology on required estate unknown
  o Time between scheme design and delivery lengthy, potential for change in estate needs over that period due to technology high

Vision for Primary Care Estates (Where do we want to be)
• Estates priorities
  o Accommodate growth in list size (sustainable size practices)
  o Support development and growth of PCN’s and rationalisation of their estate
- Support practices to address statutory compliance including CQC
- Identify, plan for and support practices with lease renewals/changes
- Understand and plan for rent reviews/increases
- Support & facilitate development of partnership working and integrated facilities with wider public sector partners
- Support key alliance objectives and drivers

- Future of primary care investment needs
  - Compliant fit for purpose facilities
  - Value for money maximised
  - Supporting primary care at scale
  - General Practice Premises Policy Review
  - Integration
  - Technology (digital)
  - Workforce
  - Key performance indicators (ERIC, PLACE type returns)
    - Strategy compliance and maintenance
    - Maximising value for money and minimising costs
    - Maximising space utilisation
    - Maximising shard space

**Opportunities & Developments (How are we going to get there)**

- **Estate transformation options**
  - WWD
  - Newmarket
  - Mildenhall
  - Took’s
  - Hawthorn Drive

- **Workforce**
  - Changing/expanding workforce (PCN’s)
  - Changes in attitude of workforce (less desire to be partners, more flexible working)

- **IT**
  - Developments in technology
  - E-consult
  - Online consultation

- **Finance interventions**
  - Changes to reimbursements (PCN level)
  - Consolidation of expenditure on fewer sites
  - Alternative financing opportunities around premises provision

- **Alliance**
  - Options for colocation/co-commissioning of estate
  - One Public Estate engagement and development
  - Integration with alliance partner estate and clinical strategies

- **Estate classification (long/medium/short term, disposal)**

**Investment prioritisation criteria**

- **Investment objectives**
  - Strategic
  - Financial
  - Quality
• Deliverability
• Efficiency

**Governance**
- Estates Governance structure

**Realisation and evaluation** *(Did we achieve our objectives, how do we check?)*
- Projects delivered and operational
- Investment objectives achievement analysis
- Ongoing benefits realisation assessment
- Post project evaluation
- Financial impact assessment

**Conclusions and recommendations**