NHS
Lincolnshire
Integrated Care Board

NHS Lincolnshire Integrated Care Board - Public Primary Care Commissioning Committee

Date: Wednesday 19th October 2022
Time: 11.15 am – 12.30 pm
Location: MS Teams

AGENDA

ITEM NUMBER		ACTION	ENC/ VERBAL	LEAD
STANDING ITEMS				
1.	Welcome, Introduction and Apologies for Absence: Jacqui Bunce, Wendy Martin, Professor Van-Tam,	-	Verbal	Dr Gerry McSorley
2.	Declarations of Pecuniary and Non-Pecuniary Interests and Conflict of Interests	-	Verbal	Dr Gerry McSorley
3.	To approve the minutes of the NHS Lincolnshire CCG Public Primary Care Commissioning Committee Meeting Dated 15th June 2022	Approve	Enc	Dr Gerry McSorley
4.	To consider matters arising not on the agenda.	-	Verbal	Dr Gerry McSorley
GENERAL ISSUES/PROGRESS UPDATE				
5.	To receive a Progress Update including:- • Sidings Procurement Contract Award • Spalding Update including Expression of Interest Process	Receive	Enc	Nick Blake Shona Brewster/ Kev Gibson
6.	To receive an update in relation to Enhanced Access	Receive	Enc	Sarah Starbuck

STRATEGIC ISSUES				
7.	To receive the Primary Care Work Programme	Receive	Enc	Nick Blake
8.	To receive an update in relation to Winter Planning	Receive	Enc	Shona Brewster
9.	To receive an update in relation to the Pharmacy, Optometry and Dental Transitions	Receive	Verbal	Sandra Williamson
SERVICE DELIVERY AND PERFORMANCE				
10.	To receive an update in relation to Performance	Receive	Enc	Nick Blake
11.	To receive an update in relation to Service delivery and performance – ABCD Priorities	Receive	Verbal	Sarah-Jane Mills
FINANCE				
12.	To receive an update by exception in relation to Finance	Receive	Verbal	Emma Rhodes
QUALITY				
13.	To receive an update by exception in relation to Quality, Patient Experience and Effectiveness	Receive	Enc	Martin Fahy
14.	To receive an update in relation to Lakeside Medical Practice	Receive	Enc	Martin Fahy
15.	To receive an update in relation to the Hawthorn Medical Practice CQC Inspection	Receive	Enc	Martin Fahy
GOVERNANCE AND ASSURANCE				
16.	To receive the Risk Register including an update in relation to Asylum Seekers	Receive	Enc	Nick Blake
MINUTES FROM COMMITTEES AND ESCALATION REPORTS				
17.	None noted			
INFORMATION				
18.	Any New Risks	Note	Verbal	Dr Gerry McSorley
19.	Items of Escalation to the ICB Board	Note	Verbal	Dr Gerry McSorley

INFORMATION				
20.	The next meeting of the Public Primary Care Commissioning Committee will take place on Wednesday 21st December 2022 at 11.15 am	Note	Verbal	Dr Gerry McSorley

Please send apologies to: Sarah Bates, ICB Deputy Board Secretary via email at: s.bates@nhs.net

The quorum of the Committee is a minimum of four voting members. This must include the Chair or Vice Chair.

Membership

Name	Position
Dr Gerry McSorley	Non-Executive Member (Chair)
Professor Sir Johnathan Van Tam	Non-Executive Member
Julie Pomeroy	Non-Executive Member
Martin Fahy/Nominated Deputy	Director of Nursing and Quality
Sarah-Jane Mills	Director of Primary Care, Community and Social Value
Sandra Williamson	Director of Health Inequalities and Regional Collaboration
Emma Rhodes	Assistant Director of Finance
Anna Nicholls/Bal Dhami /Gary Lucking	NHSE/I
Councillor Sue Woolley	Health and Wellbeing Board Representative
Dean Odell	HealthWatch
Dr Reid Baker/Kate Pilton	LMC
Wendy Martin	Associate Director of Nursing
Dr John Parkin	Clinical Leader

***Definition of a Conflict of Interest**

Conflicts of interest can arise in many situations, environments and forms of commissioning, with an increased risk in primary care commissioning, out of hours commissioning and involvement with integrated care organisations, as clinical ccommissioners may here find themselves in a position of being at once commissioner and provider of primary medical services. Conflicts of interest can arise throughout the whole commissioning cycle from needs assessment, to procurement exercises, to contract monitoring.

Interests can be captured in four different categories:

Financial interests:

This is where an individual may get direct financial benefits from the consequences of a commissioning decision. This could include being:

- A director, including a non-executive director, or senior employee in a private company or public limited company, partnership or other organisation which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations;
- A shareholder (of more than [5%] of the issued shares), partner or owner of a private or not for profit company, business or consultancy which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations.
- A consultant for a provider;
- In secondary employment (see paragraph 52-53)
- In receipt of a grant from a provider;
- In receipt of research funding, including grants that may be received by the individual or any organisation in which they have an interest or role; and
- Having a pension that is funded by a provider (where the value of this might be affected by the success or failure of the provider).

Non-financial professional interests:

This is where an individual may obtain a non-financial professional benefit from the consequences of a commissioning decision, such as increasing their professional reputation or status or promoting their professional career. This may include
situations where the individual is:

- An advocate for a particular group of patients;
- A GP with special interests e.g., in dermatology, acupuncture etc.
- A member of a particular specialist professional body (although routine GP membership of the RCGP, British Medical Association (BMA) or a medical defence organisation would not usually by itself amount to an interest which needed to be declared);
- An advisor for the Care Quality Commission (CQC) or the National Institute for Health and Care Excellence (NICE);
- A medical researcher.
- GPs and practice managers sitting on the governing body or committees of the ICB should declare details of their roles and responsibilities held within member practices of the ICB.

Non-financial personal interests:
This is where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit. This could include, for example, where the individual is:

- A voluntary sector champion for a provider;
- A volunteer for a provider;
- A member of a voluntary sector board or has any other position of authority in or connection with a voluntary sector organisation;
- A member of a political party;
- Suffering from a particular condition requiring individually funded treatment;
- A financial advisor.

Indirect interests:
This is where an individual has a close association with an individual who has a financial interest, a non-financial professional interest or a non-financial personal interest in a commissioning decision (as those categories are described above). This should include:

- Spouse/partner
- Close relative e.g., parent, [grandparent], child, [grandchild] or sibling;
- Close friend;
- Business partner.
- Whether an interest held by another person gives rise to a conflict of interests will depend upon the nature of the relationship between that person and the individual, and the role of the individual within the ICB.

NHS
Lincolnshire
Clinical Commissioning Group

Minutes of the Primary Care Commissioning Committee held in Public on Wednesday 15th June 2022 at 11.30 am via MS Teams

Present:	Dr Gerry McSorley	Chair – Non-Executive Director (Chair)
	Mr Graham Felston	Non-Executive Director
	Ms Sue Liburd	Non-Executive Director
	Dr John Parkin	Clinical Leader - Lincolnshire West Locality
In Attendance:	Ms Sarah Bates	Deputy Board Secretary
	Dr Reid Baker	Medical Director, LMC
	Mr Nick Blake	Acting Director of Primary Care
	Mr Kevin Gibson	Senior Communications and Engagement Manager
	Ms Sarah-Jane Mills	Chief Operating Officer – Lincolnshire West Locality
	Mrs Emma Rhodes	Assistant Director of Finance
	Mrs Sarah Starbuck	Head of Transformation – Lincolnshire East Locality
	Mr Terry Vine	Deputy Director of Nursing and Quality
22/144	Dr David Boldy	Secondary Care Doctor
Apologies:	Mr Martin Fahy	Director of Nursing and Quality
	Mrs Wendy Martin	Associate Director of Nursing and Quality – West Locality
	Mr Pete Moore	Non-Executive Director
	Mrs Clair Raybould	Director of Operations
	Mr Andy Rix	Chief Operating Officer – Lincolnshire South Locality

Dr McSorley welcomed members to the meeting and provided a brief outline of the agenda items for discussion. Dr McSorley advised that the Committee is a meeting that is held in public and that members of the public have the facility to ask or raise queries through the chat function and that these will be responded to after the meeting. Dr McSorley requested that if members of the Committee were asked to speak or presenting reports that they introduce themselves beforehand.

22/145 DECLARATIONS OF INTEREST PECUNIARY OR NON-PECUNIARY

Dr McSorley reminded members of the importance in the management of Conflicts of Interest and asked members to consider each item carefully as the meeting progressed in order to identify any risk or conflicts that may arise during the course of the meeting. Members were also asked to consider if an interest required declaring before, during or after the meeting that relevant steps are taken to ensure that plans are in place to mitigate the risk.

22/146 MINUTES OF THE PUBLIC PCCC MEETING HELD ON 20th APRIL 2022

The minutes of the previous Public Primary Care Commissioning Committee meeting held on 20th April 2022 were received and approved. The Primary Care Commissioning Committee agreed to:-

- Approve the minutes.

22/147 MATTERS ARISING

22/105 – Dashboard – LD and SMI Health Checks – it was noted that this item had been included on the agenda and a report presented at the meeting***. Action closed.***
22/105 – Childhood Immunisations – update to be provided at a future meeting.
22/107 – Risk Register – Livi Pilot – update to be provided at a future meeting***.***

QUALITY (SAFETY, EFFECTIVENESS, PATIENT EXPERIENCE AND EFFECTIVENESS)

22/148 QUALITY, PATIENT EXPERIENCE AND EFFECTIVENESS UPDATE

Mr Vine advised that there continues to be a significant demand for GP and other healthcare services. In addition, general practice is still experiencing some staff absences due to Covid-19 which is having an impact on the delivery of services. It was highlighted that patient feedback has indicated that there are still some access issues and where there are trends the CCG is supporting Practices.

Mr Vine stated that three Practices have been rated as "Requires Improvement" by the CQC: Branston, Marisco and Spalding and that the CCG is supporting these Practices.

An update was provided in relation to the 20-week support programme that Practices can access voluntarily when Practices are experiencing significant pressures. Furthermore, it was noted that the LMC GP Improvement Team has been developed and will provide targeted support to those Practices that are most challenged. The Primary Care Commissioning Committee agreed to:-

- Note the update.

22/149 LAKESIDE PRACTICE

Mr Vine stated that the Practice had been re-inspected by the CQC in March 2022 and that the report has recently been published. It was noted that the Practice has been rated as "Requires Improvement" and "Inadequate" in the safety domain and will remain in "Special Measures" for a period of six months. It was noted that the Practice is required to submit an Action Plan to the CQC to address the issues highlighted that predominantly relate to the processes to support structured medications, long term condition reviews, dispensary management, issues with risk assessment processes and the review and learning from incidents.

An update was provided that the CCG is meeting the Practice on 25th June 2022 to review the CQC Action Plan and understand the actions and that a further update will be provided at the next meeting. In addition, a meeting has taken place with Gareth Davies MP, John Turner and Sarah-Jane Mills on 10th June 2022. The Primary Care Commissioning Committee agreed to:-

- Note the update.
- Receive an update at the next meeting.

DEVELOPING PRIMARY CARE

22/150 HEALTH CHECKS FOR PATIENTS WITH A LEARNING DISABILITY AND SEVERE MENTAL ILLNESS UPDATE

Mr Blake provided members with an update in relation to the Learning Disability Annual Health Checks and that these were provided to 3,513 people in 2021/22 – 79% of the total number of people on GP Practice Learning Disability registers. It was highlighted that this is above the national target (75%) but below the local stretch target and lower than the previous year by around 5% (237 checks) and that the reasons for the reduction was due to the management and treatment of patients with urgent care needs, delivery of the Covid-19 Spring Booster programme and the workforce capacity constraints within primary care.

In relation to Severe Mental Illness Physical Health Checks, it was noted that 44% of the total number of people on GP Practice Severe Mental Illness registers had received a health check which is lower than the national target of 60%. It was noted that Lincolnshire's performance is in line with that of both national and regional data. Work is taking place on delivering a coordinated community model with Lincolnshire Partnership NHS Foundation Trust to provide increased access. The Public Primary Care Commissioning Committee agreed to:-

- Note the update.

22/151 COMMUNITY PHARMACY AND RESPECTING NHS STAFF CAMPAIGN

Mr Gibson shared a presentation on the two public awareness campaigns that the CCG delivered across Lincolnshire during April and May 2022. It was noted that the CCG received a budget to undertake the campaigns and appointed media buying ad agency Forward & Thinking to support with the campaign delivery. Mr Gibson advised that the campaigns aimed to support GP Practices over busy periods by encouraging patients to use community pharmacies for a range of minor ailments and reminding patients to always be respectful towards NHS staff. Mr Gibson stated that there were four aims of the campaign including:-

- Awareness raising.
- Humanising – highly skilled workforce is being overlooked.
- Support to GP Practices.
- Myth busting.

An update on the methods of campaign delivery was shared with the members including the statistics to support this area. Mr Gibson advised that what went well with the campaign which included:-

- Good engagement with primary care networks prior to the campaign launching.
- High number of interactions with the Lincolnshire population across all platforms.
- On the whole, more positive comments from the public on Facebook posts than negative.
- Good experience delivering the campaign alongside Forward & Thinking

In terms of those areas that could have been done better it was highlighted that:-

- Better engagement with primary care networks and the Lincolnshire population on the rationale for which the campaigns were built on.
- Deliver the campaigns over a longer time period.

It was noted that there had been a significant amount of positive feedback received and that the next steps include:-

- Evaluation of the campaigns.
- Engage with colleagues in GP practices and community pharmacies to see if they saw any impact / behaviour change whilst the campaigns were being delivered.
- Consider topics for future public awareness campaigns, for example: Access to primary care, Prevention and self-care and Health inequalities.

Dr McSorley queried the Facebook and if there are any early insights from community pharmacy and staff in Practice who were making observations on the Facebook pages. Mr Gibson responded and advised that the comments are in the process of currently being collated. It was noted that on the whole the comments were constructive however it was acknowledged that further work needs to take place in terms of educating the general public to increase their understanding and how to access services in the right place.

Ms Mills added that the campaign was produced in English and advised that work is underway with one of the Practices to target the uptake of cervical screening and one of the issues that has arisen is that the information that is produced is not accessible for people whose first language is not English.

Dr Baker thanked the team for the work and any communications that inform the public in terms of healthcare in the county is very much welcomed. The Public Primary Care Commissioning Committee agreed to:-

- Note the update.

22/152 LIST CLOSURE EXTENSION FOR MERTON LODGE PRACTICE

Mrs Starbuck presented the report regarding an application from the Practice to extend the current list closure by a further three months which would allow breathing space for the Practice to pursue options to ensure the continuity of the GMS contract and continuity for patients. It was noted that the Committee had approved the temporary six-month closure in January 2022 which concludes on 27th July 2022. It was highlighted that a three-month extension to the list closure would allow the CCG and Dr Tant to support discussions with interested partners to make the Practice more resilient. Members supported the recommendation. The Private Primary Care Commissioning Committee agreed to:-

- Note the update.
- Approve the recommendation to extend the list closure application for an additional three months to allow further time for the practice to pursue options to ensure the continuity of the GMS contract and service continuity for patients.

22/153 PCN DEVELOPMENT AND DES DELIVERY

Mr Blake provided members with an update in relation to the Primary Care Network (PCN) development and delivery of the PCN Network Contract Directed Enhanced Service (DES). It was noted that PCNs are formed via sign up to the Network Contract Directed Enhanced Service (DES) Contract Specification, which was first introduced on 1 July 2019 and sets out core requirements and entitlements for a PCN and that there are 15 PCNs in Lincolnshire covering the entire County.

Mr Blake added that PCN's are a group of GP Practices to understand the needs of the local population and delivery needs ensuring that the resources are focused in the right place.

It was reported that the most recent formal review of PCN development was carried out in October 2021 using the national PCN Maturity Matrix tool. PCNs self-assessed their maturity against a range of criteria with maturity levels. As part of this exercise PCNs were asked what the main challenges and barriers were and what support would be helpful. The main barriers included:-

- PCN capacity including clinical leadership.
- Recruitment issues.
- Wider primary care workforce shortages.
- Unforeseen disruptions including the covid pandemic.

The support identified included:

- Clear guidance on PCN DES requirements and how these will be monitored.
- Administration support.
- Support with recruitment.

Mr Blake advised that the exercise will be re-visited later in the year and also include the PCN Alliance in preparation with the move to the ICB. The Public Primary Care Commissioning Committee agreed to:-

- Note the update.

22/154 LMC UPDATE

Dr Baker advised the Committee that general practice continues to experience significant challenges in meeting the needs of their patients and that the pattern of seeing a reduction in the number of requests for appointments in the summer is not being seen. It was noted that patients are presenting with new and significant medical conditions. Furthermore, there is an ongoing impact of Covid-19 in terms of capacity.

In terms of the communications and engagement the GP Community Pharmacy services continue to be utilised across the County in particular for conditions such as hay fever which is releasing capacity from general practice.

An update was provided on the GPAS system which highlights the level of demand and the implications with a reduced workforce and that this level of pressure cannot be sustained long term. The Public Primary Care Commissioning Committee agreed to:-

- Note the update.

22/155 HEALTHWATCH UPDATE

Mr Odell advised that general feedback relates to access to both GP and dental appointments. Furthermore, there has been concern expressed that some Practices are switching off the digital services at Practices.

Discussions took place that Practices have switched off their digital services when patient safety issues have been highlighted which is constrained by capacity. Dr Baker advised that patients can still access Practices via the telephone or visiting the Practice to request an appointment. Further discussions took place regarding the patients experience and keeping patients informed and that further communication education exercises on the appropriate use of the system will take place. It was noted that Lincolnshire County Council are currently conducting a survey on oral health and that all aspects are being reviewed across the County. The Public Primary Care Commissioning Committee agreed to:-

- Note the update.

22/156 REVIEW OF DATA UPDATE

Ms Mills presented the data dashboard and advised that an update was provided on the GP appointment numbers for the latest 8-week period and are 7% higher than the "like" pre-COVID 8-week period from 3 years ago in 2019. The latest period has a similar number of appointments completed by a GP, a higher proportion dealt with within 7 days, but a lower proportion recorded as face-to-face. However, issues remain in relation to the availability of GP appointments and challenges with access and clinicians responding to the level of demand. The Primary Care Commissioning Committee agreed to:-

- Note the update.

GOVERNANCE

22/157 INVESTMENT/DISINVESTMENT/RISK AND MITIGATIONS UPDATE

It was noted that there were no issues to escalate. The Primary Care Commissioning Committee agreed to:-

- Note the update.

22/158 PUBLIC PRIMARY CARE COMMISSIONING COMMITTEE RISK REGISTER

Ms Mills advised that the Risk Register has been reviewed and updated by the risk owners and that there are two risks with a score of 12 and over. These relate to Additional Roles and that the risk has been maintained and Access to Primary Care again the risk has been maintained. The Primary Care Commissioning Committee agreed to:-

- Note the update.

22/159 BOARD COMMITTEE HANDOVER TEMPLATE

Mr Blake advised that the Board Committee Handover Template will be populated and shared with members prior to presenting at the last CCG Board meeting at the end of June 2022.

Dr McSorley stated that this is the last CCG Public Primary Care Commissioning Committee and that CCG's will cease to exist as statutory bodies by the end of June 2022 and that ICB's will assume the CCG's functions with effect from July 2022.

Dr McSorley wished to thank all members for their support in particular during the challenging times with the Covid-19 pandemic and looked forward to working with colleagues within the ICB.

The Primary Care Commissioning Committee agreed to:-

- Note the update.

22/160 ESCALATION OF ISSUES/RISKS TO THE BOARD

Dr McSorley referred to the areas of escalation to the Board including:-

- Lakeside Medical Practice.
- Community Pharmacy and Respecting NHS Staff Campaign.

22/161 ANY OTHER BUSINESS

None noted.

22/162 DATE AND TIME OF NEXT MEETING

Wednesday 17th August 2022 at 11.10 am via MS Teams.

Not Delivered/Off Track
In Progress
On Track to Deliver
Delivered

Public Primary Care Commissioning Committee

Action Log as of 15th June 2022

Minute Number	Meeting	Item	Action Required	Responsible Officer	Date to be Completed By	Progress as at Month/Year	Status
22/107	20.04.22	Risk Register	• Update on the Livi pilot to be shared at a future meeting.	Ms Mills	TBC		

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PUBLIC PRIMARY CARE COMMISSIONING COMMITTEE

Date: 19th October 2022 – 9.30 am
Location: MS Teams

Agenda Number:	5
Title of Report:	Primary Care Commissioning Update – Sidings Procurement
Authors:	Nick Blake, Acting Programme Director – Integrated Primary Care and Communities Sue Oakman, Operational Delivery Manager
Appendices:	

1.	**Key Points for Discussion:**

This report covers:

- The Sidings procurement contract award and service mobilisation

2.	**Recommendations**

The Committee is recommended to note the contents of this report.

3.	**Executive Summary**

The Sidings Medical Practice procurement contract award and service mobilisation

Following the termination of the Sidings Medical Practice General Medical Services contract in 2019 a temporary caretaking contract with Lincolnshire Community Health Services was put in place to ensure continuity of care for patients. Procurement of a new provider was approved by NHS Lincolnshire CCG with aim of awarding a contract from 1 July 2022.

The procurement process to identify a new provider was completed in March 2022 with Omnes Healthcare identified as the preferred provider. Completion of the due diligence and mobilisation planning phases led to roll-out being delayed until September 2022. Omnes Healthcare completed mobilising the service and commenced delivery on 1 September 2022. All patients have been written to advising of the new provider and a press release was issued on 30 August 2022.

The ICB Primary Care team are currently meeting with Omnes on a fortnightly basis to monitor full-service mobilisation and to agree planning for additional services to be implemented. A revised mobilisation plan is expected to have been agreed by 29 October 2022 expanding the practices offer to patients e.g. digital first approaches, proactive

service delivery including outreach and linking with community assets and developing the practice's Patient Participation Group approach.

Omnes Healthcare continue to flag ongoing issues with the TUPE data from LCHS and legacy issues which are now resulting in additional cost pressures to Omnes, which will flow onto the ICB as part of the commercial deal. Estimated annual cost increase equates to c.£100k plus additional locum costs (to be confirmed).

The Omnes Board have met and concluded they should honour these staff Terms & Conditions, with all additional costs showing in their open book accounting. This approach will comply fully with TUPE legislation and support practice capacity going into winter.

Discussions were held with the ICB procurement SRO, relevant Head of Transformation and Primary Care Finance lead - the Omnes approach is supported by the ICB. Any additional costs will be monitored through the open book accounting processes set up as part of the contract negotiation.

ICB-Omnes monitoring meetings will continue until ongoing quarterly contract monitoring commence in April 2023.

4.	**Management of Conflicts of Interest**

None identified.

5.	**Risk and Assurance**

Risks and project delivery assurance are managed within the projects and overseen by the ICB Primary Care structures and governance arrangements.

5.	**Financial/Resource Implications**

All financial implications relating to the Sidings procurement have been reviewed and approved by PCCC.

Ongoing ICB resource implications associated with service mobilisation, assurance and ongoing contract management will be managed within existing Primary Care team and Commissioning Support Unit capacity.

6.	**Legal, Policy and Regulatory Requirements**

None identified.

7.	**Health Inequalities implications**

N/A.

8.	**Equality and Diversity implications**

N/A.

9.	**Patient and Public Involvement (including Communications and Engagement)**

Patient communication in in relation to the Sidings procurement will be ongoing and

managed through ICB-Omnes mobilisation meetings.

11.	Report previously presented at

N/A.

12.	Sponsoring Director/Partner Member/Non-Executive Director

Sarah-Jane Mills
Director of Primary Care, Community & Social Value
West Locality
NHS Lincolnshire ICB

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PUBLIC PRIMARY CARE COMMISSIONING COMMITTEE

Date: 19th October 2022
Location: MS Teams

Agenda Number:	5b
Title of Report:	Spalding GP Surgery Stakeholder Engagement Report
Author:	Claire Hornsby, Primary Care Engagement Manager. Presented by Kevin Gibson, Senior Communications & Engagement Manager – Primary Care Team
Appendices:	Appendix 1: Spalding GP Surgery Stakeholder Engagement Report

1. Key Points for Discussion:

The purpose of this report is to outline the results of the 56 day stakeholder engagement exercise that took place between 13th July and 7th September 2022. This includes the survey results and the feedback received at the patient engagement drop in events. The report identifies any emerging issues for consideration by the NHS Lincolnshire Integrated Care Board's (ICB) Public Primary Care Commissioning Committee.

2. Recommendations

The committee is asked to note the patient and stakeholder feedback received and discuss the options available to support the concerns raised.

3. Executive Summary

Spalding GP Practice operates from the Johnson Community Hospital in Spalding and is one of three practices within the Spalding Primary Care Network (PCN). It is the smallest of the three in terms of registered patient list with 3,361 patients (July 2022). The small size of the practice means there is little resilience in the delivery model. This increases the risk of service delivery failure and impacts on patient safety.

All three practices in the area have seen an increase in the rate of patient registrations over the last six months due to housing developments and subsequent population increases.

Following the Lincolnshire Community Health Service NHS Trust (LCHS) withdrawal from contract extension discussions, several options were explored to ensure continuity of patient care. These options were presented to the Primary Care Commissioning Committee on the 15th of June and the recommendation to conduct a managed list dispersal via an open expression of interest process was formally agreed. Following this, the ICB commenced with an engagement process on Wednesday the 13th of July, which ran for 56 days and closed on the 7th September. The aim of this process was to seek the views of registered patients and other key stakeholders on what is important to them for the provision of medical services. Feedback will be considered and where appropriate will be included within the expressions of interest process.

The engagement process started with the normal dissemination of information through various routes – letter to households of registered patients, press release, social media, ICB website and direct communication with key stakeholders such as local MPs, Councillors and LMC.

A patient survey was also included and has been circulated via the Spalding GP practice, via PALS and was available to download from the ICB website. 218 people responded to the survey, this equates to a response rate of 6.7% (218/3,232).

A number of drop-in sessions were arranged at various times of the day and at different locations. Due to issues in the timeliness of the initial letter being sent to all patients, which meant it was received after the first two events had taken place, an additional two sessions were added to the programme. The delay to the letter was due to unforeseen circumstances with the agency, who had been instructed to carry out the mail shot on behalf of the ICB.

There is depth of public feeling on this managed list dispersal linked to the historic situation and subsequent closure of the Pennygate Surgery in 2018. There was consistent themes of feedback from both the patient engagement events and the survey. The following are key points and themes:

- Concerns relating to Access, including parking
- Concerns for the continuity of care (appointments, medications, vaccinations, prescriptions)
- Concerns over location of the new service and concerns for travel
- High level of concerns with the access and quality of the two large Spalding surgeries – Beechfield and Munro.
- Continued growth of the town from housing developments
- The commitment of South CCG to put a facility on the West side of the Town that has not materialized
- Enquires relating to the EOI process and Patient Choice.
- Positive feedback about the current service
- Care (Personalised, quality and continuity).

The full results can be seen in Appendix 1.

4.	**Management of Conflicts of Interest**

None declared.

5.	**Risk and Assurance**

A number of risks have been identified related to the managed list dispersal.

Expressions of Interest Process - If there are no submissions the ICB and PCCC will have to decide on the dissemination of the list. This could impact on the resilience and capacity of those practices identified.

As a result of the public consultation and engagement – registered individuals may choose not to wait on the EoI process concluding and proactively register at another practice within their boundary. This could also impact on the resilience and capacity of those practices.

5.	Financial/Resource Implications

ICB resources including Primary Care Team and Communication and Engagement Team capacity will be needed to support the managed list dispersal. The Engagement events required, venue hire costs and staffing costs.

6.	Legal, Policy and Regulatory Requirements

All legal, policy and regulatory requirement will be adhered to throughout this process. The main reference document with regards to the list dispersal is the Primary Care Policy and Guidance Manual NHS England » Primary Medical Care Policy and Guidance Manual (PGM)

7.	Health Inequalities implications

An Equality Impact Assessment was presented at the August meeting to ensure that all patient groups were included in the stakeholder engagement process, for example translation services were commissioned to translate the patient letter in the top 5 language as 37% of patients did not have English as a first language.

8.	Equality and Diversity implications

The ICB will adhere to the Equality Act 2010 and will ensure the list dispersal process consider the access to service are accessible to all.

9.	Patient and Public Involvement (including Communications and Engagement)

The Spalding GP Surgery Stakeholder Engagement Report is provided in Appendix 1
.

10.	Report previously presented at

A report was presented to the CCG PCCC on the 15th of June 2022 recommending the managed list dispersal as the preferred option for managing the APMS contract end date with LCHS.

A report was presented to the ICB PCCC on the 20th of July 2022 updating on the project plan including the communications and engagement plan. This included the application submitted by LCHS to close the list at Spalding GP Surgery which was approved.

A report was presented to the ICB PCCC on the 17th of August 2022

11.	Sponsoring Director/Partner Member/Non-Executive Director

Sarah-Jane Mills, Director of Primary Care, Communities and Social Value
Telephone Number: 07870 898428
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Lincolnshire
Integrated Care Board

Spalding GP Surgery
Closure and Patient List Dispersal

Stakeholder Engagement Report

September 2022

Spalding GP Surgery Stakeholder Engagement Report

Purpose of this report
The purpose of this report is to outline the results of the 56-day stakeholder engagement exercise that took place between 13th July and 7th September 2022. This includes the survey results and the feedback received at the patient engagement drop in events. The report identities any emerging issues for consideration by the NHS Lincolnshire Integrated Care Board's (ICB) Primary Care Commissioning Committee.

Background
Spalding GP Practice operates from the Johnson Community Hospital in Spalding and is one of three practices within the Spalding Primary Care Network (PCN). It is the smallest of the three in terms of registered patient list with 3,361 patients (July 2022). The small size of the practice means there is little resilience in the delivery model. This increases the risk of service delivery failure and impacts on patient safety.

All three practices in the area have seen an increase in the rate of patient registrations over the last six months due to housing developments and subsequent population increases.

Following the Lincolnshire Community Health Service NHS Trust (LCHS) withdrawal from contract extension discussions, several options were explored to ensure continuity of patient care. These options were presented to the Primary Care Commissioning Committee on the 15th of June and the recommendation to conduct a managed list dispersal via an open expression of interest process was formally agreed.

Following this, the ICB commenced with an engagement process on Wednesday the 13th of July, which ran until the 7th of September. The aim of this process was to seek the views of registered patients and other key stakeholders on what is important to them for the provision of their medical services. Feedback will be considered and where appropriate will be included within the expressions of interest process.

Engagement Process
The engagement process started with the normal dissemination of information through various routes – letter to households of registered patients, press release, social media, ICB website and direct communication with key stakeholders such as local MPs, Councillors and the Local Medical Committee.

A patient survey was also included and has been circulated via the Spalding GP practice, via the Patient Advice and Liaison Service (PALS) and was available to download from the ICB website and was communicated directly to patients via letters to households and text messages. In addition to this, five engagement events took place in Spalding to give patients, carers the public, and stakeholders an opportunity to ask any questions or raise concerns. The team had originally planned three engagement events, however, two additional drop-in events were scheduled following delays to the initial letter being received.

Summary of Activity
The 56 day engagement ran between 13th July and 7th September 2022, which included:

Communication to patients
All registered patients received direct communications via two letters, that were sent to the households of registered patients. In addition, every adult patient who had consented to receive communications via text message received this as well as supplementary messages. The letter and text communication invited registered patients to complete the engagement survey, and to attend engagement events, to raise any queries they may have. The telephone number of the Patient

Advice and Liaison Service was also provided so that patients were able to request the survey in other languages and feedback concerns.

Interpretation services were commissioned to translate the patient letter in the top 5 language as 37% of patients did not have English as a first language.

A number of drop-in engagement events were arranged at various times of the day and at different locations. Due to issues in the timeliness of the initial letter being sent to all patients, which meant it was received after the first two events had taken place, an additional two sessions were added to the programme. The delay to the letter was due to unforeseen circumstances with the agency, who had been instructed to carry out the mail shot on behalf of the ICB. The events are discussed in more detail below.

Paper survey
Paper surveys were made available in the practice and from the Patient Advice and Liaison Service (PALS), as well as printed versions of the frequently asked questions

NHS Lincolnshire ICB website
Information, including the patient letter, frequently asked questions, online survey link, and information about the events, was included on NHS Lincolnshire ICB's website and can be viewed here: Spalding GP Surgery Consultation - Lincolnshire ICB

A press release to local media/ Briefing note was disseminated which included the following key Stakeholders:

- Local Press
- MPs, district and parish councillors
- Patient Advice & Liaison Service
- Local Medical Committee
- Healthwatch Lincolnshire
- NHS provider comms
- LinCa
- Spalding Neighbourhood Team Lead
- Lincs Pharmacy Committee
- VCS/LVCS
- Every-One
- Spalding Primary Care Network
- 7 practices within the boundary area.
- All Lincolnshire practices

Press release to local media/ Briefing note

Spalding GP Surgery

Press Release

Patients at a GP surgery in Spalding are being informed they will be automatically registered at an alternative GP surgery as early as October this year as part of plans to transform services in the area.

Spalding GP Surgery based at the Johnson Community Hospital in the town provide primary care medical services to over 3000 patients.

Since 2018, services at Spalding GP Surgery have been provided by Lincolnshire Community Health Services NHS Trust (LCHS). The contract that is currently in place with LCHS ends on the 30 September 2022.

LCHS have decided not to extend their contract, however, they have agreed to continue providing services at Spalding GP Surgery until an alternative service is in place.

NHS Lincolnshire Integrated Care Board (ICB), previously known as NHS Lincolnshire Clinical Commissioning Group), have now outlined plans to undertake a managed list dispersal through an Expression of Interest process.

This means that when the Expression of Interest process has been completed, patients registered at Spalding GP Surgery will be automatically registered at an alternative GP surgery.

In a letter sent to patients, Sarah-Jane Mills, Director of Primary Care, Communities and Social Value at the ICB reassured patients that during this process, they should continue to access services at Spalding GP Surgery as normal and encourages patients to share their views about what is important to them when accessing local primary care medical services.

To have their say, patients can complete an online survey (or collect a paper copy from the surgery).

Patients are also being invited to attend one of three drop-in events where they can talk to a member of the NHS team about the process.

The events are as follows:

- Event 1 – 6-8pm, 20 July 2022, Patio Room, Springfields Events & Conference Centre, Camel Gate, Spalding PE12 6ET
- Event 2 – 10am-12pm, 22 July 2022, Room ADM124/125, Johnson Community Hospital, Spalding Road, Pinchbeck, Spalding PE11 3DT
- Event 3 – 2.30pm-4.30pm, 18 August 2022, Patio Room, Springfields Events & Conference Centre, Camel Gate, Spalding PE12 6ET

If patients would like more information in general about the process or to request information in alternative formats, please contact the Patient Advice and Liaison Service (PALS) by telephone on 0300 123 9553 or by email at LHNT.LincsPALS@nhs.net. The service is open 9am – 5pm Monday to Friday (except Bank Holidays).

The consultation runs from Wednesday 13th July 2022 until midnight on Wednesday 7th September 2022.

Advertising the engagement Survey and events

The engagement survey and events were advertised on the ICB websites and social media pages, the social media activity and statistics are shown below:

Twitter

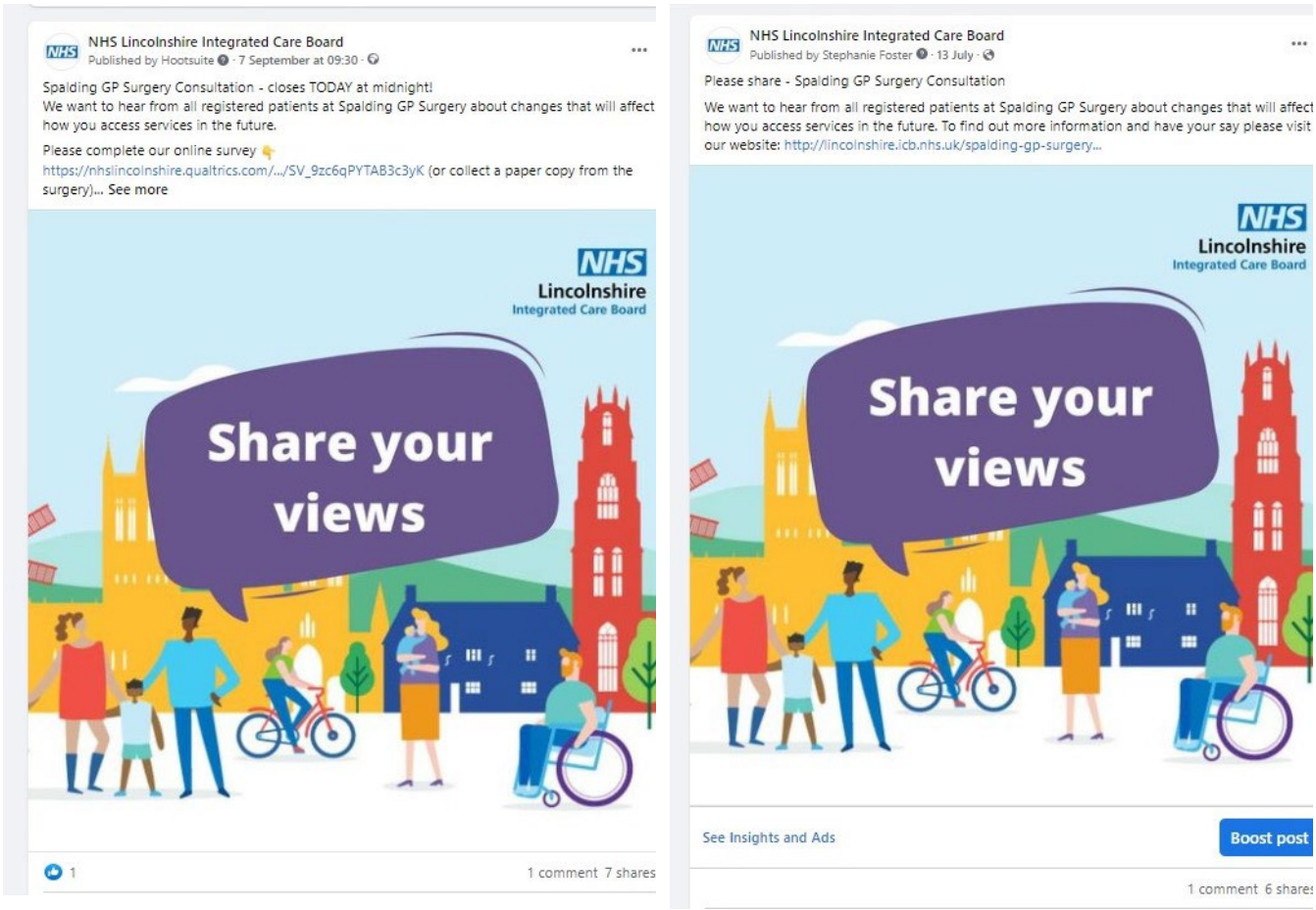
11 tweets

- 3,351 impressions (the number of times any content from or about your page entered a person's screen)
- 61 engagements (Retweets *shares of our tweets by other users*; replies; likes and clicks)

Facebook

- 10 posts
- 7,625 reach (the number of people who saw any content from or about your page)
- Engagements: total – 40 (likes, shares, comments)
- 4 likes
- 7 comments
- 29 shares
- 20 photo/image views
- 283 total clicks

The Top posts are shown below:



Engagement Events

The format of 5 ICB led events were drop-in sessions, where staff from the ICB, and LCHS were available to answer questions from patients and stakeholders; these were in small group discussions or one to one conversations. This approach was taken to ensure that the views of all patients could be heard, and any of their concerns investigated.

The drop in events were arranged, at a range of times and locations to ensure that people had a range of options to take part. The engagement events were as follows:

• **Event 1** – 6-8pm, 20 July 2022, Patio Room, Springfields Events & Conference Centre, Camel Gate, Spalding PE12 6ET *attended by 14 members of the public, including two Spalding councillors- Cllr Angela Newton and Cllr Elizabeth Sneath*
• **Event 2** – 10am-12pm, 22 July 2022, Room ADM124/125, Johnson Community Hospital, Spalding Road, Pinchbeck, Spalding PE11 3DT • *Attended by 33 members of the public.*
• **Event 3** – 2.30pm-4.30pm, 18 August 2022, Patio Room, Springfields Events & Conference Centre, Camel Gate, Spalding PE12 6ET • *Attended by 37 members of the public, including the local MP, Sir John Hayes and Cllr Angela Newton*
• **Event 4 –** 6.00pm – 8.00pm, Tuesday, 23rd August 2022, Patio Room, Springfields Events & Conference Centre, Camel Gate, Spalding PE12 6ET • Attended by 10 members of the public
• **Event 5** – 6.00pm – 8.00pm, Wednesday, 31 August 2022, South Holland Centre, South Holland Centre (23 Market Place, Spalding, Lincolnshire, PE11 1SS) • *Attended by 12 members of the public*

In addition to the engagement events, two public meetings were arranged by the South Holland District Council staff, who asked senior ICB staff to attended to answer further questions. These meetings took place at the South Holland District Council Offices on Friday 26th August from 10am and Monday, 5th September from 6pm.The themes that arose out of these meetings was similar to the engagement events.

Findings from the engagement events are summarised below:

The engagement events were attended by over 100 members of the public, a small number of attenders came to more than one event, and some attended multiple times. Most people in attendance were patients who had been registered at the Spalding GP practice, and some patients attended who were registered at neighbouring practices or were family members or carers of Spalding GP practice registered patients.

ICB and LCHS staff who facilitated the table discussions identified a number of key themes of feedback from the events, which are presented under the headings below:

Concerns expressed over the closure

- Most patients had concerns over the decision to disperse the list of the practice and were frustrated that this had happened to them again after Pennygate was closed in 2018 by NHS South Lincolnshire Clinical Commissioning Group. One patient commented *"It is awful situation to put people in. Doesn't look very good! It isn't very good!"*
- Some patients commented that they are disappointed that they cannot remain at the practice, but now understand the need for a dispersal after attending the patient engagement events. Many patients thanked the ICB staff for the engagement events and taking the time to listen and explain the situation to them.
- Patients were concerned that they would be left with gaps in their care whilst they were assigned to a new practice and for the continuity of their care regarding medications. Staff confirmed that LCHS will provide the service until the process is concluded and that there won't be a gap in care for patients.
- Attendees queried why LCHS weren't continuing with the service and queried the type of contract they were on.
- Some patients asked why this service planning had not started three years ago, so that arrangements were in place when the LCHS contact ended.

Enquiries relating to the Expressions of Interest (EOI) Process

- People asked for more information about the expressions of interest process and were concerned what would happen if none of the Lincolnshire GP practices expressed an interest to deliver the service. The ICB staff clarified the timeline for the EOI and why the ICB is taking this approach, they also confirmed that patients would be allocated to an existing practice in the scenario that no one applied.
- Queries were raised regarding how any surgery that has submitted an EOI will get their premises ready in two months when the LCHS contract ends.
- Queries were raised to how the ICB will monitor the services of those patients moved from Spalding GP, including checking on application the capacity of the provider to cater for the number of patients.
- Queries were raised about who would make the decisions and staff explained that the decision will be made by ICB – meeting will be in public, and that details can be found on the ICB website.
- ICB staff were asked to share the indicative timetable for the EOI process, and this has been included in the Frequently Asked Questions section of the website.
- Reassurance was provided to patients, carers and stakeholders that the Spalding GP practice will stay open beyond 30/9/22 while the EOI process is ongoing and through the mobilisation period.

Enquiries relating to Patient Choice

- Some patients asked if that had any choice over which practice, they were assigned to. ICB staff discussed that people could register where they wanted given, they lived with the practice boundary area, this information is also included in the FAQs.
- Some patients asked if the boundaries would be expanded of other surrounding practices so that they had more choice of alternative practices.
- Some patients raised concerns that they didn't feel they had patient choice if it was only between two practices – Beechfield and Munro.
- Some patients asked what they could do if they were allocated to a practice they didn't want to be registered at.

Feedback regarding the current Spalding GP practice

- A lot of patients fed back that they get a really good service from the practice, and really liked the staff, so did not understand why it was closing, discussions took place with patients explaining the reasons why this had to happen.
- Some people were concerned that LCHS had not wanted to continue to deliver the service and were asking the reasons why.
- Very positive feedback was received about the new LCHS GPs at Spalding GP Practice, as well as good feedback about AccuRx. There was a general feeling the service has improved over the last 6 months.
- A lot of patients said that the current practice is convenient for them as it is very easy to park and the service is located in a hospital, alongside other services. People commented that it is reassuring having the Urgent Treatment Centre next door.
- There are also good cycle and walk paths and Buses stop at the Johnson Hospital.
- Some patients, on the other hand commented that "Parking at Johnson can be a nightmare."
- The staff at the practice received positive feedback, *"All staff are excellent and treat you like a person rather than a number." Feels like staff know their patients personally and they feel well provided. "Everything done in timely manner*." Excellent feedback was given for the GPs
- Some patients expressed concerns over the continuity of care at the practice due to the practice using locum GPs. Concern was expressed that access to a named GP is difficult.
- Some patients said that the Johnson GP practice is not very private as both receptionists are next to each other, and that space is also an issue.

- Amy Hall, Head of Operational Business Services, LCHS attended the events to support patients and look into any current service concerns.

Concerns over Access (phones, appointments availability)

- Concern was expressed over the number of patients already registered at the other surgeries in Spalding and people feel that they are already overwhelmed.
- People were worried that they may not be able to access services when they need them, or get through to these practices on the phone to make appointments. Many patients said that this would result in increased A&E attendance, need for home visits and an increased strain on the ambulance service.

Concerns over the continuity of care

- Patients expressed concerns over the continuity of their care by their practice changing again and the importance of not losing their treatment and appointment schedules. A lot of patients mentioned that this news was very frustrating after already being made to change practices in 2018, due to the closure of Pennygate.
- Patients were concerned if their prescriptions would continue when they were allocated to another practice.
- Patients asked if the doctors and staff would move to a new practice along with the patients. Staff discussed that the TUPE process would apply to staff directly employed by the practice (LCHS).

Concerns over the quality of care provided at alternative Spalding GP Practices

- At all of the events patients expressed a high level of concern regarding the access and quality of care provided at the two large Spalding surgeries – Beechfield and Munro.
- Some patients said that they would not want to be registered at either practice due to their personal experience or that of their friends/ family.
- Concerns were raised regarding the levels of staffing at the Beechfield and Munro.
- A key theme was also real concerns that the other two Spalding practices will not cope with another 3,000+patients. Some patients explained that Munro and Beechfield are not coping now with the demand as they never answer the telephone and access is poor.
- Some patients were scared about what would happen when the practice closed and explained how unsettling and anxious this was making them feel.
- Patients expressed concern that parking an issue at Munro and Beechfield, and that Spalding GP practice had been much easier for parking.
- There were some specific patient concerns about being registered with the two remaining practices and the ICB offered that those patients contact PALS. Also the team looked into concerns to address with the relevant practice.

Concern was expressed over the commitment of NHS South Lincolnshire CCG to look into a facility on the West side of the Town that has not materialized

- Many patients were deeply concerned, frustrated, and some very angry that a new practice on the west side of Spalding had not been arranged, and informed staff that this had previously been promised when Pennygate Closed. ICB staff explained that there was still the commitment to look into this, however the Covid pandemic where all ICB staff were re-deployed for up to two years caused delays. Patients felt that progress on this was still too slow.
- Concerns were raised that there are currently no Primary Care facilities in west of the town. Patients said that the town is divided by the railway – both surgeries and the ambulance station are on one side and there is nothing on the other side, this is where a lot of the development is happening. Patient explained that that railway line can be closed 20 minutes of every one hour making it difficult to cross and therefore access the service.

- One of the suggestions received by many patients was to re-utilise the previous Pennygate estate, some queries raised if the ICB could purchase the estate. Other patients had a preference for an independent 3rd practice based on the Johnson site or another new site altogether due to growing population which was mentioned across the town.

Concern expressed over the continued growth of the town from housing developments

- Many patients expressed concerns that the practice was closing considering the amount of housing developments in Spalding rapidly increasing the population, giving the need for more healthcare facilities and not less.
- Some patients asked why Spalding only have 3, soon to be 2 practices, when other areas with smaller populations have more. Suggestions were made to have a completely new practice due to the size of the growth in the town.
- Section 106 funding was discussed in all events and how the CCG (and ICB) are working/ have worked with South Holland District Council. It was explained how the developer must pay funds to the NHS and Local Authorities at certain milestones of their development. It was explained that the ICB is carrying out some work to review the estate needs, and will keep population need under review (including whether further primary care services are required).

Concerns related to Transport/ Travel

- There was concerns for patients that don't drive in accessing services from a different location.
- Concerns were made regarding the location of GP services and the time to travel from the west of the town, school traffic and train lines can mean long journey times – this should be considered as well as location. Opening up Pennygate or similar premises would be more accessible for Spalding West residents.
- A suggestion was made that a new surgery would be ideally located at Hereward Road.
- Distance to the practice and ease of access/travel times are important considerations along with parking.
- People were concerned that they may be expected to travel further and outside of the Spalding area.

Concerns for the elderly and vulnerable

- Concerns expressed about what would happen in the future as people age and access to GP services is already difficult.
- Some people were particularly concerned about care for the elderly, as this change causes more stress and anxiety to them.

Concerns expressed regarding the delay of the patient letter

- At the first and second events comments were made that the event wasn't known about and people had picked up information about them through social media which isn't accessed by everyone. Staff apologized for the delays and the frustration that this caused.

Other Feedback

- An attendee recommended that patient engagement letter should been more specific that all people over the age of ten in the household were encouraged to complete the patient engagement questionnaire. This feedback is welcomed, and will be taken on board for future work.
- Suggestion that the Patients Charter is more visible to patients so that they know their rights. The Patient's Charter has been replaced with the NHS constitution and this is on the ICB website.
- Concern was expressed that the Spalding GP practice did not have a Patient Participation Group, and the suggestion was made that these would be more effective if they were

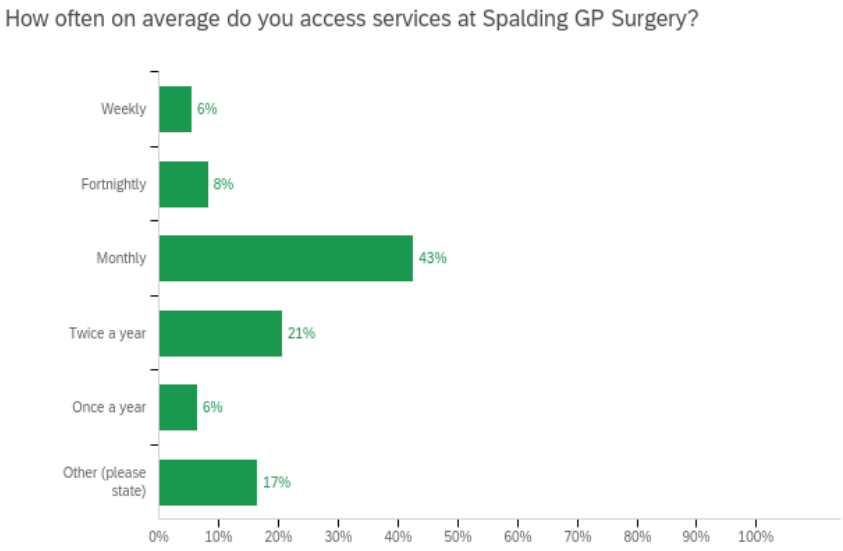
geographically based and included patient representatives for secondary care.

What do patients want from new GP practice?
Some of the patients fed back what they would like to see at a new practice and these were summarised as follows**:**

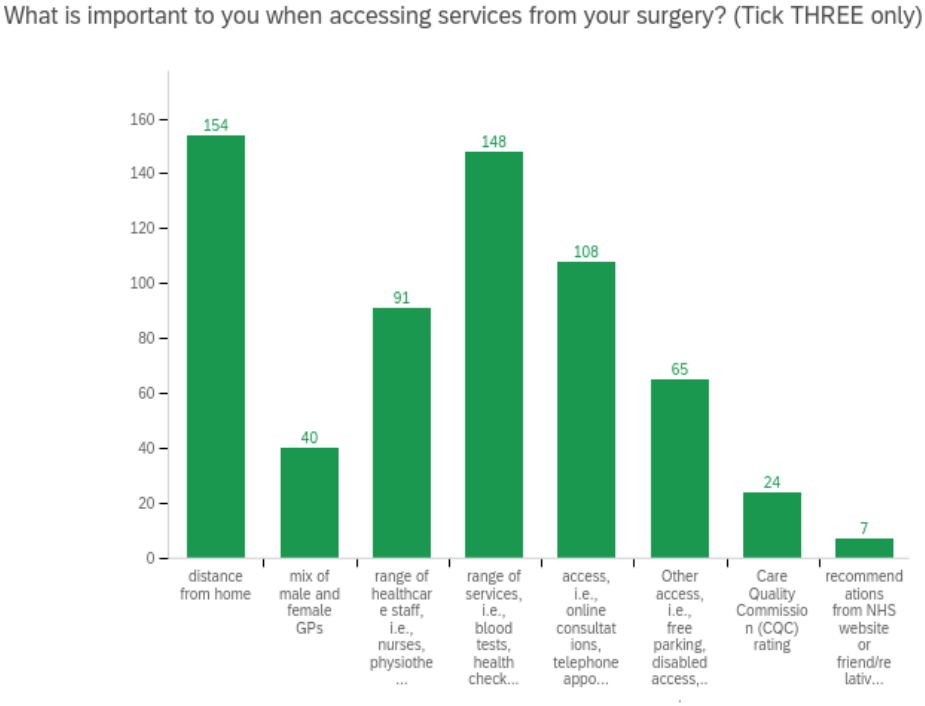
- I want to ***see*** a GP
- Location important – don't want to wait for a goods train
- Provision of pharmacy – delays in picking up script, as they can't issue without a pharmacist on site, even if script made up already
- Clear information provision
- Phones answered promptly – long waits to be answered noted
- Options for access other than using AskMyGP/Internet
- Longevity of service
- Consistency of doctors – seeing the same one (family doctor!)
- Stay where we are
- Consider the Pennygate site
- More doctors
- Excellent quality of care
- Good parking
- More appointments – evenings and weekends
- Communicate with patients in timely manner

Summary of survey Results
The below points present the results of the survey.

- 279 people had clicked on the Qualtrics survey link to look at the survey, and in total 218 people responded, this equates to a response rate of 6.7% (218/3,232). *Please note: not all questions in the survey were answered, some of the questions were skipped. The number of people who answered each question will be provided below*.
- 96% (185/192) of respondents was a patient or carer registered the Spalding GP practice, the remaining respondents were registered at the Beechfield or Munro practices.
- When asked how often on average they accessed services at the practice, the majority of people said they accessed this monthly, followed by twice a year as shown in the graph below:



- When asked to tick their top three options for what is important when accessing services (as shown in the chart below), the top 3 were distance from home, followed by the range of services, i.e blood tests, health checks, dispensing, etc, followed by access.i.e., online consultations, telephone appointments (a small number of patients commented that all of the options were important):



- When asking patients/ carers if they had any other comments concerns, or suggestions that the ICB should take into consideration, 131/218 responses were received, the themes of feedback were very similar to those captured at the engagement events and have been summaried into the table below. (*please note most respondents covered multiple topics in their comments resulting in the theme count being greater than the total comments received*).

Key themes	**Number of comments the theme was discussed in**
General Feedback about the closure and list dispersal	
Do not understand the rationale / why it is necessary to close the practice	19
Would prefer to stay registered at the Spalding GP practice/NHS need to keep it open	18
Concerned for the continuity of care (appointments, medications, vaccinations, prescriptions) if moved	12
Concern expressed re the commitment of South Lincolnshire CCG to look at a facility on the West side of the Town that has not materialized	11
Concerns over Access (phones, appointments availability)	9
Detrimental to health if this surgery closed/ will put patients at risk	9
Disappointed/ sad about this news	6
Feel frustrated to be asked to move surgery again	5
Patients should have been informed earlier	2
Would like a choice not to just be allocated	3

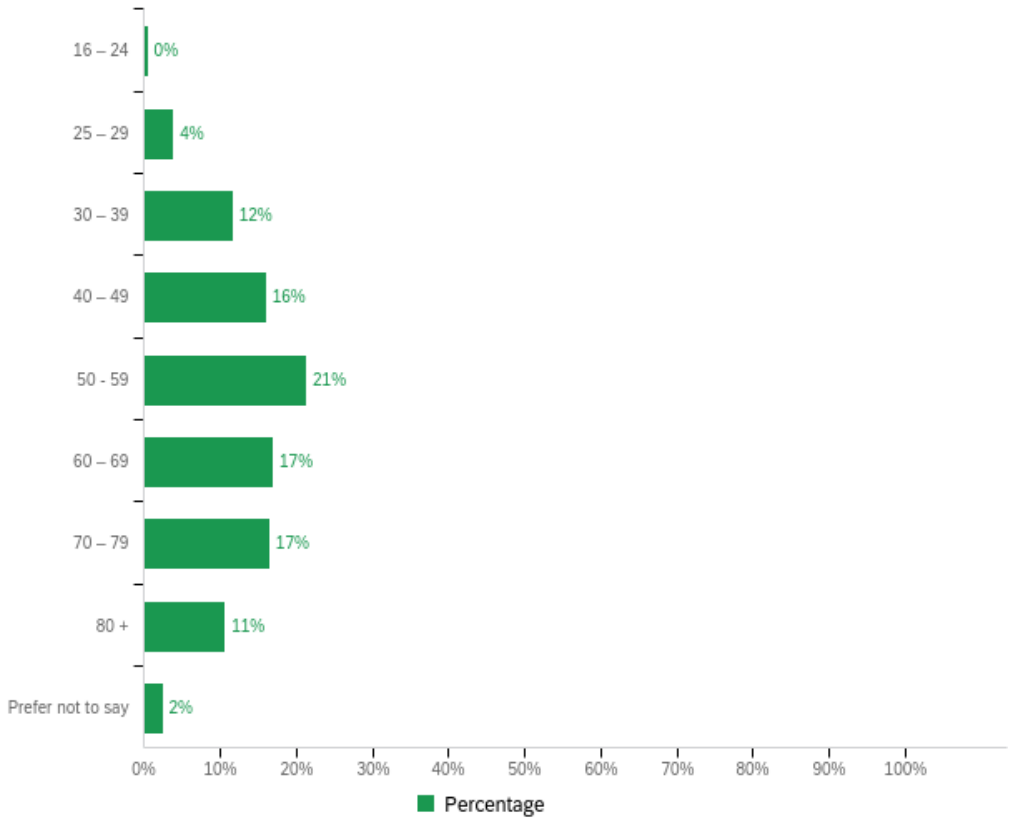
Key themes	Number of comments the theme was discussed in
Would like to register at practices outside of Spalding	2
Hopes that a new provider will provide a good service	2
Concerns expressed regarding the delay to the patient letter	7
Transport/Travel	
Concerns related to Transport/Travel (concerned will be too far away, or don't drive)	9
Important that can access the new practice via public transport	1
Feedback on the other Spalding GP practices	
Concerns that the remaining 2 Spalding practices will not cope with another 3,000+patients	20
Concerns over the quality of care provided at alternative Spalding GP Practices	5
Would not be happy to be registered at either of the other practices in Spalding	4
Already difficulties accessing the other Spalding Practices	2
Concerns over the quality of care provided at alternative Spalding GP Practices - Beechfield	2
Beechfield are already full	2
Previously registered at Beechfield and not happy with care	1
No Parking at Munro	2
Previously registered a Munro and not happy with care/ practice overwhelmed	9
Would like to be transferred to Munro	2
Feedback on Location of service	
Re-utilise the Pennygate estate	8
Surgery needs to be in the west area of Spalding as no surgery there, the other practices are on the east side	9
Access to medical service with the town centre would be helpful	1
Specifically mentioned would like the practice to remain at Spalding Hospital site (due to housing development/ inability to travel)	2
Feedback about the current service at Spalding GP Surgery (Positive -56, Negative -8)	
Spalding GP practice positive feedback- (staff, service)	43
Spalding GP surgery feedback - Good Parking and Disabled at Spalding GP Practice	8
Spalding practice is convenient as located alongside other services	4
Excellent Interpretation at Spalding GP practice, worried won't be like this elsewhere	1
Spalding GP - concerns over continuity of care due to use of Locum GPs & lack of trained staff for appointments	2
Spalding GP - access is difficult	2
Spalding GP - annual reviews have not been carried out	1
Spalding GP surgery feedback - Facilities were getting crowed	1
Spalding GP surgery feedback- had double booked an appointment	1
Spalding GP surgery - very limited services	1
Suggestions for new service/s:	
Important to have a range of services available	1
More planning required to consider future growth of Spalding	1
Need a third practice due to growing population	5
Need more face-to-face appointments	6
Need a new dental surgery	1
Need to see someone who specialises in mental health	1

Key themes	Number of comments the theme was discussed in
New practice must do home visits for the housebound	3
Parking facilities are essential	3
Would like better access	3
Increased availability of GP appointments	2
Early morning, evening Saturday appointments would be good	1
Would like self check-in screen	2
Would like staff trained in immunistations	1
Cater for people with Special Educational Needs	2
Would like return of well women clinic to ask advice on minor worries	1
Choice of male/female doctor/nurse practitioner	2
Population Growth	
Concern expressed over the continued growth of the town from housing developments	15
Queries over if section 106 monies available from developments	1
One response included a response letter from South Holland District Council re the number of dwellings and population growth, these have been circulated to the Primary Care Team	1
Other	
Confusing for the elderly to have to change practice	2
CQC ratings are also important	1
Will Spalding GPs remain in the area?	1
Worried other services will go from Spalding	1
Would be happy for the Johnson GP practice staff to move with the patients	1
Bad decision by LCHS	1
	308

Equalities Monitoring
A number of optional questions were asked so that the ICB can assess how well it engages with it's population. Some patients entered limited data in some sections, however, it was encouraging that we could see from those that did complete, that the survey was completed by a range of ages, people with a range of disabilities and from people from different ethnic groups. The charts, tables and summary below represent the demographics of people completed the survey, where they answered these questions:

Age: As shown in the graph below, a mixture of age ranges completed the survey, however the survey was not well completed by younger people with only 9 (4%) of responses from people ages under 29. This is common with this type of survey and consistent with the age demographic of attendees at the patient events, however it would have been good to better understand the views of younger people.

Age: What age group do you belong to?



Gender: The gender of respondents was male 29% (61/209) and female 67% (139/209), 4% (9/209) stated that they would 'prefer not to say'.

Gender Identity: No respondents stated their gender identity did not match their sex registered at birth, however 5% (7/150) stated that they would prefer not to say.

Sexual Orientation: Most respondents (86%,171/199) described themselves as heterosexual, two respondents identified themselves as gay, one identified themselves as lesbian, one respondent identified as bisexual, six said that they would prefer to self-identify and eighteen said they would prefer not to say.

Religion/ Belief: Most respondents identified themselves as Christian (52%,105/201), 2 people identified themselves as Jehovah's Witnesses and 35% (71/201) selected "no religion", 10% (20/201) said that they would "prefer not to say".

Ethnicity: Although the majority of respondents described themselves as White: Welsh / English / Scottish / Northern Irish / British (85%,176/207), the survey was also completed by people a variety of ethnic backgrounds including: Any other Asian background (1); Black or Black British: Caribbean (1); Black or Black British: African (1); Any other Black background (1); White: Irish (2); White: Eastern European (7) and Any other White background (4).

Carer Status: 28% (57/200) of respondents identified as a carer of someone with a long term physical or mental ill-health/disability or problems relating to old age.

Pregnancy: Two respondents stated they were pregnant or were providing maternity care for a newborn baby.

Employment Status: The table below shows the employment status for the 207 people that answered this question, the majority of respondents were retired (37%) or worked full time (36%).

Answer	%	Count
Employed full time	36%	75
Employed part time	5%	11
Self-employed	6%	12
Unemployed looking for work	1%	2
Unemployed not looking for work	4%	8
Retired	37%	77
Ill health retired	1%	2
Student	0%	0
Prefer not to say	5%	10
Home maker	1%	2
Other, please state	4%	8

Next Steps
Patients were keen to receive feedback after the patient engagement events, keeping them informed of progress and further information about where they would be registered. During the events people were assured that they would be written to again with further information.

The report identities the emerging issues for consideration by the NHS Lincolnshire Integrated Care Board's (ICB) Primary Care Commissioning Committee and to be considered in the Expressions of Interest Process.

NHS
Lincolnshire
Integrated Care Board

PUBLIC PRIMARY CARE COMMISSIONING COMMITTEE

Date: 19th October 2022
Location: MS Teams

Agenda Number:	6
Title of Report:	Enhanced Access 2022/23
Report Author:	Sarah Starbuck, Head of Transformation and Delivery
Appendices:	n/a

1.	Key Points for Discussion:

From 1 October 2022 the requirements of the Network Contract DES included a requirement for Primary Care Networks to provide Enhanced Access to deliver evening and weekend appointments. This paper provides an overview of the requirements of the DES and the arrangements are that are now in place in Lincolnshire.

2.	Recommendations

The Committee is asked to note the content of the report.

3.	Executive Summary

As set out in the Network Contract DES, from 1st October 2022 PCNs were required to provide enhanced access appointments between the hours of 6.30pm and 8.00pm Monday to Friday and between 9.00am and 5.00pm on Saturdays. PCNs are required to provide 60 minutes per 1000 PCN adjusted population.

From 1 April 2022 the PCNs were required to work collaboratively with the commissioner to produce an enhanced access plan which was to be submitted to the commissioner on or before 31 July 2022. Meeting were held with PCNs and the ICB to discuss and confirm arrangements with written plans then submitted by PCNs by the national deadline.

As part of the enhanced access plan the PCN was required to confirm how they had engaged with their patient population and considered patient preferences, considered the mix of services to be provided during the Network Standard Hours and how the PCN would ensure a reasonable number of face-to-face appointments were available.

The new arrangements supersede the extended hours provided by PCNs and the APMS Extended Access contracts. Evening and weekend access is now combined under the Network Contract DES requirements. Bank holiday and Sunday provision is no longer mandated.

The access plans build on the previous Extended Access contracts; however, all plans have been reviewed and assessed by an ICB panel, which also included Lincolnshire LMC. Additional locations have been agreed to ensure good patient access and access outside of the mandated Network Standard Hours have been approved by the ICB where it was seen to improve patient access. This included maintaining access before 8.00am at some practice locations where this has been previously provided under extended hours arrangement and has been well utilised by patients. Some access on Sundays has also been agreed for some PCNs.

A number of PCNs have agreed subcontracting arrangements with ICB approval, with a national template subcontracting being made available nationally to support such arrangements.

PCNs within Lincolnshire put forward plans with a variety of models, which included fixed hub locations, access models that rotated around the PCN practices and hub and spoke models. All plans were considered to ensure the balance of patient access and the DES requirements were met whilst balancing the various PCN needs, including geographical boundary, workforce and estates availability.

New hubs are in place for SOLAS PCN at Spilsby Surgery and an additional hub location is added to the Boston PCN footprint, at Swineshead. A further review of the First Coastal provision is in progress with First Coastal PCN, and LADMS as subcontractor, to review options for provision within Skegness. Remote access for Saturday afternoons has been agreed with Spalding PCN due to workforce constraints, this will be reviewed after a 3-month period.

A summary of the PCN arrangements is as below. There is mix of static hubs, hub and spoke models, rotating hubs with multiple locations used on a rotational basis and roving hubs, which is more complex rotational model whereby each rota will vary, for example weighted hours based on the list size of the practices.

PCN	Practice Code	GP Practice	Delivery Model (Practice, Hub, Rotating, Roving)
Apex	C83014	Boultham Park Medical Practice	**Rotating**
	C83025	Richmond Medical Centre	
	C83041	The Woodland Medical Practice	
	C83082	Birchwood Medical Practice	
Boston	C83004	Liquorpond Surgery	**Hub & Spoke** Hub @ The Sidings Spoke @ Swineshead
	C83010	Parkside Medical Centre	
	C83015	Swineshead Surgery	
	C83057	Kirton Medical Centre	
	C83059	Greyfriars Surgery	
	C83060	The Sidings Medical Practice	
East Lindsey	C83027	Horncastle Medical Group	**Roving** **Mon-Fri**: Rota including all practices, with minimum 2 practices covering 18:30-20:00
	C83043	Market Rasen Surgery	
	C83061	North Thoresby Surgery	

	C83083	The New Coningsby Surgery	**Sat**: 3 hubs at Market Rasen, Horncastle and North Thoresby
	C83613	Caistor Health Centre	
	C83635	Woodhall Spa New Surgery	
	C83643	Binbrook Surgery	
	C83650	The Wragby Surgery	
First Coastal	C83019	Beacon Medical Practice	**Hub** Hubs @ Marisco and Beacon (Ingoldmells Site)
	C83045	Hawthorn Medical Practice	
	C83064	Marisco Medical Practice	
Four Counties	C83007	Lakeside Healthcare Stamford	**Rotating** **Mon-Fri:** M-W-F Stamford, Tu&Th Hereward **Sat:** Hub @ Stamford, 1x Sat per month at Hereward
	C83035	Hereward Medical Centre	
Grantham and Rural	C82076	The Welby Practice	**Hub & Spoke** Hub @ Grantham Spokes at individual practices
	C83008	Swingbridge Surgery	
	C83024	The Glenside Country Practice	
	C83040	St. Peters Hill Surgery	
	C83048	St. Johns Medical Centre	
	C83053	Colsterworth Surgery	
	C83067	Dr Longfield and Partners	
	C83075	Vine Street Surgery	
	C83080	The Harrowby Lane Surgery	
	C83649	Market Cross Surgery	
Imp	C83009	Lindum Medical Practice	**Roving** **Mon-Thu**: Practices **Fri&Sat:** Roving hub
	C83031	Nettleham Medical Practice	
	C83037	Welton Family Health Centre	
	C83051	Abbey Medical Practice	
	C83052	The Ingham Surgery	
	C83072	Minster Medical Practice	
	C83073	Cliff House Medical Practice	
	C83074	Willingham-By-Stow Surgery	
	C83079	Glebe Park Surgery	

K2 Healthcare Sleaford	C83011	Millview Medical Centre	**Hub & Spoke** Hub @ Sleaford (SMG) Spokes @ individual practices
	C83013	Ruskington Surgery	
	C83020	Caythorpe & Ancaster Medical Practice	
	C83023	Sleaford Medical Group	
	C83030	Billinghay Medical Practice	
	Y01652	The New Springwells Practice	
Lincoln Healthcare Partnership	C83001	Heart of Lincoln Medical Group	**Practice Sites - Rotating**
	C83626	Brayford Medical Practice	
Meridian	C83042	Marsh Medical Practice	Hub (Louth Woldside) with practice spokes
	C83056	East Lindsey Medical Group	
	C83085	James Street Family Practice	
	C83634	Tasburgh Lodge Surgery	
SOLAS	C83005	Spilsby Surgery	Hub @ Spilsby Spokes @ Practices
	C83032	Merton Lodge Surgery (Alford)	
	C83049	Dr Sinha & Partners (Old Leake)	
	C83055	Stickney Surgery	
South Lincoln	C83002	Navenby Cliff Villages Surgery	**Practice Sites** Rotating
	C83029	Branston & Heighington Family Practice	
	C83046	The Heath Surgery	
	C83058	Washingborough Surgery	
	C83062	Church Walk Surgery	
	C83078	Brant Road & Springcliffe Surgery	
	C83611	The Bassingham Surgery	
South Lincolnshire Rural	C83026	The Deepings Practice	**Practice Sites - Rotating**
	C83028	Holbeach Medical Centre	
	C83036	Gosberton Medical Centre	
	C83039	Moulton Medical Centre	
	C83054	Bourne Galletly Practice Team	
	C83063	Long Sutton Medical Ctr.	

	C83065	Littlebury Medical Centre	
	C83614	Sutterton Surgery	
	C83617	Abbeyview Surgery	
Spalding	C83003	Beechfield Medical Centre	**Practice Sites - Roving** 4-weekly rotating basis for Fri PM, Sat cover remote via Push Doctor
	C83022	Munro Medical Centre	
Trent Care	C83018	Cleveland Surgery	**Hub** @ Cleveland Surgery, Gainsborough
	C83033	Hibaldstow Medical Practice	
	C83038	The Glebe Practice	
	C83044	Caskgate Street Surgery	
	C83641	Trent Valley Surgery	

4.	Management of Conflicts of Interest

None noted.

5.	Risk and Assurance

The impact of the loss of the APMS contracts held for Extended Access and risk to access to the NHS Pension Scheme for providers as a result is noted on the risk register.

5.	Financial/Resource Implications

Funding arrangements as per the Network Contract DES.

6.	Legal, Policy and Regulatory Requirements

The National Health Service (General Medical Services Contracts) Regulations 2015 apply.

7.	Health Inequalities implications

The Health Inequalities Team were part of the Enhanced Access Panel and were involved in the assessment of all PCN plans.

8.	Equality and Diversity implications

Equality Impact Assessments (EqIA) are undertaken on all service change/development proposals.

9.	Patient and Public Involvement (including Communications and Engagement)

All PCNs undertook patient engagement with their practice populations to inform their access plan which was a requirement of the DES. This was supported by Claire Hornsby, Primary Care Engagement Manager for the ICB.

11.	Report previously presented at

Not applicable.

12.	Sponsoring Director/Partner Member/Non-Executive Director
Sarah-Jane Mills, Director of Primary Care, Community and Social Value sarah-jane.mills1@nhs.net	

NHS
Lincolnshire
Integrated Care Board

PUBLIC PRIMARY CARE COMMISSIONING COMMITTEE

Date: 19th October 2022
Location: MS Teams

Agenda Number:	7
Title of Report:	Primary Care Work Programme
Author:	Nick Blake: Acting Programme Director – Integrated Primary Care and Communities
Appendices:	

1.	Key Points for Discussion:

This report provides an overview of the current Primary Care, Communities and Social Value directorate and how it will be developed further.

2.	Recommendations

The Committee is recommended to note the contents of this report.

3.	Executive Summary

Introduction

The Integrated Care Board (ICB) Primary Care, Communities and Social Value directorate is building on the work programme developed within the former Clinical Commissioning Group and extending the scope of the work. This will be an iterative process and will require coordination with other ICB programmes of work as well as with system partners.

This report aims to set out the current programme position and provide information on intended future developments. As well as setting out the scope of the programme this paper will cover relevant aspects of programme management and governance.

Programme Scope
The programme currently focusses on two main areas associated with General Practice:

- commissioning and contracting General Practice (GP) and primary care services
- Primary Care Network (PCN) led transformation projects and delivery of care

The ICB Primary Care team are aligned to these two key work areas with nominated Heads of Transformation and senior managers leading on the two areas across the County and Locality Managers working at a GP practice and Primary Care Network level across both work areas.

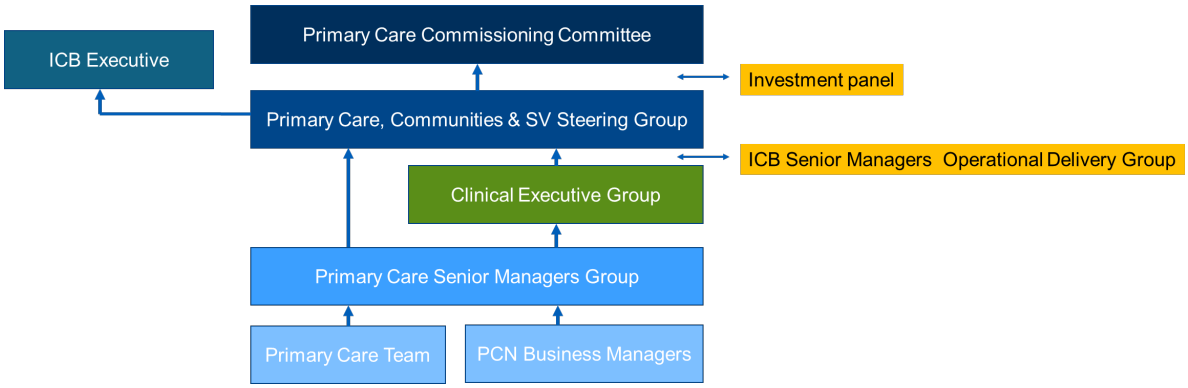
The two main areas of work are supported by enabler workstreams covering:

- Digital
- Communications and engagement
- People and workforce

Programme Governance

Governance of the Programme sits under the ICB Executive and the Primary Care Commissioning Committee: Sarah-Jane Mills, ICB Director for Primary Care, Communities and Social Value is the Senior Responsible Officer. The four ICB GP Clinical Leads provide clinical leadership to the Programme and a clinical link to GP practices within their respective localities.

The diagram below gives a summary of the Governance arrangements.



There are a number of specific work stream meetings that report to the Primary Care Communities and Social Value Steering Group and PCCC e.g. the Primary Care Transition Oversight Group.

The governance process where new investment is proposed is aligned with ICB and system requirement – proposals for new investment coming from the Programme will be presented for approval to the ICB Senior Managers Operational Delivery Group and, subject to approval and as required, the Lincolnshire Investment Panel prior to implementation.

Programme delivery and performance is reported through to the Primary Care, Communities and Social Value Steering Group on a monthly basis. This also includes escalation of risks in terms of programme delivery.

Operational management of the Programme is the responsibility of the Primary Care Senior Managers Group.

Programme workstreams

Workstream	Lead	Status	Summary
Access	Sarah Starbuck	G	• Enhanced Access contracting • Winter Access Project delivery
IPCC	Sarah Starbuck	G	• Transfer of pharmacy, optometrist and dentistry commissioning • GP practice commissioning projects
Estates	Sarah Starbuck	G	• Estates strategy development • GP estates development and commissioning
Enhanced Services	Shona Brewster	A	• Commissioning and contracting for GP enhanced services e.g. wound management services
LD & MH Transformation	Nick Blake	G	• Delivery of LD Health Checks • Delivery of SMI Health Checks
Neighbourhood Integration	Sarah Button	G	• PCN Strategic Partnership Pilots • Social prescribing and care navigation projects
Prevention	Nick Blake	G	• Supporting PCN DES delivery: - Long Term Conditions - Health Inequalities - Anticipatory Care
Primary Care Interface	Nick Blake	R	• Transitional bed review – medical requirements
People	Wendy Cundy	G	• Primary care recruitment, retention and development
Communication	Kev Gibson	G	• Rolling primary care communication and engagement
Digital	Steve Pitwell	G	• A broad programme including GP IT equipment, online resources, patient digital inclusion

The programme currently includes the workstreams in the table above, on the whole delivery of the workstreams are on track with the exception of the Primary Care Interface workstream and the work to review GP practice input to short-term residential and nursing care home placements. Accessing data to inform and progress the review has been delayed, the approach to this work has been considered and will now be taken forward through the Enhanced Health in Care Homes group.

Following the transfer to NHS Lincolnshire ICB and broadening of the directorate portfolio the Programme is under review and will be developed further to include:

- Frailty, palliative and end-of-life and long-term conditions
- A quality workstream (coordinated with the ICB Quality Team's work programme)
- Winter planning for 2022/23

Existing workstreams will also be reviewed and any additional priority projects included.

Discussions to coordinate and align the Programme with other ICB and system programmes is underway including Population Health Management, Health Inequalities and Personalisation.

The revised Primary Care, Communities and Social Value Programme will be presented to PCCC once finalised and approved by the Steering Group in November.

4.	Management of Conflicts of Interest

None identified.

5.	Risk and Assurance

Programme delivery risks are monitored and managed by the Primary Care team with escalation through to the Primary Care, Communities and Social Value Steering Group where required.

5.	Financial/Resource Implications

Finance and resource implications are addressed through the programme management process.

6.	Legal, Policy and Regulatory Requirements

N/A.

7.	Health Inequalities implications

Health inequalities impact assessments are undertaken and reviewed as part of project development and approval.

8.	Equality and Diversity implications

Equalities impact assessments are undertaken and reviewed as part of project development and approval.

9.	Patient and Public Involvement (including Communications and Engagement)

Patient and stakeholder engagement is managed as part of through project planning and delivery.

11.	Report previously presented at

N/A.

12.	Sponsoring Director/Partner Member/Non-Executive Director

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PUBLIC PRIMARY CARE COMMISSIONING COMMITTEE

Date: 19 October 2022
Location: MS Teams

Agenda Number:	8
Title of Report:	Winter Plan 2022/23 – Primary Care
Report Author:	Shona Brewster, Head of Transformation SW Locality and Primary Care Commissioning, Ops and Delivery
Appendices:	Appendix 1 – Winter Plan Spreadsheet

1. Key Points for Discussion:

The committee is asked to note the content of the initial draft winter plan for primary care.

2. Recommendations

The committee is asked to support this draft report recognising it will develop as the wider system plan is progressed and further discussions and progress on actions with primary care take place.

3. Executive Summary

National Publications
The precursor to winter planning this year was the publication in August of the letter – Next steps in increasing capacity and operational resilience in urgent and emergency care ahead of winter. This letter outlined a number of system objectives and key actions for operational resilience in the lead up to winter.

More recently on the 26th September - Supporting general practice, primary care networks and their teams through winter and beyond was published. This details that NHS England has taken steps to boost capacity ahead of winter which links back to the August letter. The actions listed in this document cover the following areas

- An ICB framework for supporting general practice – to rapidly assess the needs of practices / Primary Care Networks (PCNs), building on local knowledge, and identify the practical and supportive interventions to boost resilience and patient access. Priority to be given to where it is most needed
- Immediate changes to the Network Contract Directed Enhanced Service (DES) via contract variation.
- Reducing bureaucracy and primary/secondary care interface – the Department of Health and Social Care (DHSC) and NHS England have worked to jointly identify areas to reduce workload in primary care.

There is a number of annexes to this publication that detail key lines of enquiry to inform where investment and support is focused.

- Patient contacts
- Use of data for improvement
- Operational efficiency
- Clinical and administrative workspace
- Enhanced access (from the previous extended access)
- Patient communication

System Planning and Reporting

The Urgent and Emergency Care Team lead the co-ordination of the system wide winter plan. There is a requirement to report to NHS England on the Board Assurance Framework on a monthly basis (please refer to appendix 1)

Primary Care Plan

The initial plan for primary care is in draft format and can be found at appendix 1. This plan is still in development but aims to pull the requirements detailed within the national publications and the Board Assurance Framework (BAF). In addition, it captures elements from discussions with various groups within primary care. Those discussions have taken place with the Clinical Leads, Lincolnshire Local Medical Committee and Primary Care Network Clinical Directors. We are currently supporting PCNs to submit ideas / initiatives to support with access and resilience. There will not be a one size fits all solution for Lincolnshire Primary Care and PCNs to prepare for winter, so initiatives and ideas are encouraged that meet the diverse needs across the county. Geography, demography and health inequalities are parameters for consideration.

There is a lot of work to do and there is a level of complexity attached to the different strands from across the system that need to be linked in. There are identified barriers to the implementation of the winter plan linked to capacity, available workforce, primary care fragility and expected impact from influenza and covid infections which will have a double impact on increasing demand and whilst reducing capacity within Practices / PCNs. Workforce is both a key enabler and risk.

In summary Primary Care and PCNs will support the wider system in boosting capacity this winter and will support through the following

- Using available funding from System Delivery Fund (SDF), GP IT, Additional Roles Reimbursement Scheme (ARRS) and Impact Investment Fund (IIF) indicators to support initiatives within primary care
- Delivering the Network DES including in year changes and repurposing of available resource
- Proactive review of patients most at risk
- Stocktake of the Care Co-Ordinator role (clinical and non-clinical) and continued development and integration with NT position
- Assessment of cloud-based telephony in use within Primary Care and expand where there is identified gaps
- Use of data for service improvement particularly related to front door of acute services
- Consideration of operational efficiency via innovation and automation
- Use of available resource to support access to workforce
- Monitor and promote use of Community Pharmacist Consultation Service
- Work in collaboration with the Lincolnshire Local Medical Committee (LMC) Support programme
- Refresh of targeted communications, engagement and education relevant to access to primary care and other urgent care pathways as alternatives to acute.
- Ensure enhanced access (routine GP services evenings and weekends) is fully utilised including NHS 111 booking
- Review of same day access initiatives at a PCN footprint for mobilisation this winter

4.	Management of Conflicts of Interest

None identified at this point.

5.	Risk and Assurance

Risks identified are capacity, available workforce, primary care fragility, funding streams and funding availability.

The Board Assurance Framework will provide the assurance at system level and to the regulators

Please state if the risk is on the CCG Risk Register.

Yes		No	x

5.	Financial/Resource Implications

There are several funding streams aligned to winter planning for 2022/23.

- Investment Impact Fund (IIF) – this is from indicators that have been stood down
- Additional Roles Reimbursement Scheme (ARRS) linked to the Primary Care Network (PCN) Directed Enhanced Service (DES) from current unallocated resource. There are contractual restrictions on the use of this funding
- Primary Care System Development Funding (SDF) and GPIT funding guidance. This is funding provided to systems as part of the long-term plan. This is linked to the formation of Integrated Care Boards and the publication of the Fuller Stocktake Report. The main aim from this funding is to support workforce and estates. The detail of this funding at system level and how it will flow to primary care has not been provided yet

One of the issues with the funding streams for winter planning is the non-recurrent status. This makes it difficult to put sustainable plans in place. Plans that will not only support in the winter period but throughout the year, whilst helping with a more robust and attractive recruitment process to increase the workforce and capacity.

6.	Legal, Policy and Regulatory Requirements

As per the national publications detailed within this report and the Board Assurance Framework as required by NHS England.

7.	Health Inequalities implications

Health Inequalities will have to be considered in the evaluation and implementation of any potential primary care initiatives to ensure there is no negative impact.

8.	Equality and Diversity implications

These will be considered in the evaluation and implementation of any potential primary care initiatives to ensure there is no negative impact.

9.	Patient and Public Involvement (including Communications and Engagement)

Any requirement for patient and public involvement will be considered in the evaluation and implementation of any potential primary care initiatives. It is to be noted that any schemes or initiatives are often to support the surge in demand associated with winter. They are not normally a change to service delivery or pathways that are business as usual.

11.	Report previously presented at

Winter planning is an annual requirement for organisations this is the first report for 2022/23.

There also a requirement to report to NHS England as part of a Board Assurance Framework. Currently the reporting requirement is every 4 weeks. Please refer to appendix 1 for more information.

12.	Sponsoring Director/Partner Member/Non-Executive Director

Sarah-Jane Mills, Director of Primary Care, Communities and Social Value
Telephone Number: 07870 898428 Email: sarah-jane.mills1@nhs.net

Item 8b

	Winter Plan Actions	Detail	Actions	BAF Strategic Objectives	Primary Care Specific - Lincolnshire	Enhanced Health in Care Homes
1	New variants of COVID-19 and respiratory challenges	SPI-M scenarios for COVID-19, combined with scenarios for flu, suggest that even in optimistic scenarios, high numbers of beds may be needed for respiratory patients during winter. Resulting IPC requirements will make bed management complex, especially if bed occupancy remains high. We will do further work with you in the coming months on stress-testing planning for the operational response to realistic worst-case scenarios. We are working with local areas to:	• Deliver an integrated COVID-19 booster and flu vaccination programme to minimise hospital admissions from both viruses. • Implement UKHSA's IPC guidance in a proportionate way and develop strategies to minimise the impact of 'void' beds.		**Vaccination Programme Overview** - The Autumn covid vaccination programme went live on 5th September and is expected to run for 15 weeks, over the course of the programme all patients aged 50+ and those who are deemed clinically vulnerable will be offered a covid vaccination with cohorts being released in priority of those most at risk in line with JCVI guidance. As well as those patients who are eligible for an Autumn booster vaccine the evergreen offer for patients that have not had a full course of the vaccinations they are eligible for will remain. **Vaccination Delivery Pillars** - As with previous phases of the vaccination programme, Lincolnshire will administer vaccinations from all four pillars eligible to provide covid vaccinations, these are Mass Vaccination Centres, Hospital Hubs, PCN local vaccination sites and Community Pharmacy local vaccination sites. Hospital hubs will be inviting healthcare staff for their vaccinations and this will be done through a local booking system. Primary Care Networks will be using a combination of a local booking system and the national booking system to invite eligible patients forward for their vaccinations. The two mass vaccination centres in Lincolnshire (one located just outside of Boston and one just outside of Lincoln city centre) will be offering slots on the national booking system. In total there are 29 vaccination sites across the county. **Vaccination Co-administration** - Autumn covid boosters can be co-administered with the seasonal flu vaccine and this is encouraged where clinically appropriate. The start of the Autumn covid campaign should not be delayed whilst providers wait for flu deliveries and it is crucial that all sites signed up to deliver in this phase of the programme commence inviting patients in to clinics when covid vaccination deliveries are received. With most providers of the flu vaccine receiving their vaccine deliveries towards the end of September and beginning of October we expect to see a greater level of co-administration as we work down the cohorts with those patients who have already has their covid vaccine being invited back for another appointment, care homes will also be revisited if they have already had a covid vaccination.	Monitor uptake in care homes via the capacity tracker
	Respiratory Challenges	As above	As above		**Respiratory challenges** - 1) Respiratory clinics in primary care, consider at PCN level. Potential to use enhanced access as a specific plan for winter period with protected slots for acute exacerbations of respiratory conditions (not chronic disease management). 2) Need primary care investment to support the developed service specification for the community respiratory diagnostic service (RDS) which will encompass spirometry / Feno requirements. 2a) Use of CDC to support community capacity for RDS. These strands will support with admission avoidance, self-care, keeping people well at home, care closer to home.	
2	Demand and Capacity	A lack of capacity across the NHS has an impact on all areas of the system. It is essential that ambulance and NHS 111 services have the necessary capacity in place and that access to primary care, community health services and mental health services for urgent patients is sufficient to ensure patients do not need to present to emergency services. We are working with local areas to:	• Open additional beds across England, to match the additional capacity identified by ICSs to be able to deliver against expected winter demand. This should create the equivalent of 7,000 additional general and acute beds, through a mix of new physical beds, scaling up virtual wards, and improvements in discharge and flow. • Increase the number of NHS 111 call handlers to 4,800 and the number of NHS 999 call handlers to 2,500. • Increase provision of High Intensity User services. • Support good working relationships with the independent sector, building on the success so far, and facilitating patient choice.	See BAF tab	• We will maximise recruitment of new staff in primary care across the winter, including care co-ordinators and social prescribing link workers. • ICBs to actively support and engage with PCNs to work with each other and other providers to develop collaborative models to manage seasonal preparedness and specific winter pressures (such as oximetry monitoring for COVID-19 patients) alongside the digital development of primary care. • Ensure enhanced access is well embedded and monitored and that 111 DOS is kept updated. • Arrange targeted primary care capacity for specialist clinics not ad hoc additional general GP and nurse capacity e.g. acute respiratory exacerbation clinic • Appropriate use of SDEC • Lessons learned from 2021/22 WAF build into this year's planning	• Use of CAS for Care Homes and 2 hour UCR - ongoing coummunication reminders to care home sector to improve utilisation. Care Homes to use CAS (not 111). If they call CAS, LCHS make the decision as to the most appropriate response which could be the 2 hour UCR • Gap in CAS / UCR / MH urgent response - for people with Dementia and complex MH issues. Project group established to address gap
3	Discharge	While challenges are often seen at the 'front door', we know that their root cause is often in the ability to discharge patients from, and flow through, hospitals. There is a significant number of patients spending longer in hospital than they need to, often due to a lack of availability of social care. While the provision of social care falls outside of the NHS's remit, the health service must ensure patients not requiring onwards care are discharged as soon as they are ready and can access services they may need following a hospital stay. We are working with local areas to:	• Implement the 10 best practice interventions through the 100-day challenge. • Encourage a shift towards home models of rehab for patients with less severe injuries or conditions. • Maximise support available from the Seasonal Surge Support Programme, provided by VCS partners.		• EDD issues must be resolved to support efficient discharge and care planning in primary care. Consideration of the lost time to practice admin staff and clinical pharmacist in chasing missing information. Note the clinical risk • Use of FCP, social prescribers and in particular practice care co-ordinators linked to the wider framework of the Neighbourhood Teams to support discharge and the Home First Partnership	• Hospital discharge - deep dive into delayed discharged underway

4	Ambulance service performance	While ensuring there is enough capacity for ambulances to respond to the most urgent calls and take patients to hospital is essential, it is also important to focus on what can be done to reduce avoidable ambulance activity, through treating patients at the scene. We are working with local areas to:	• Implement a digital intelligent routing platform and live analysis of 999 calls. • Agree and implement good practice principles for the rapid release of queuing ambulances in response to unmet category two demand. • Work with the most challenged trusts on ambulance handover delays to develop solutions, including expanding post-ED capacity. • Increase the utilisation of rapid response vehicles, supported by non-paramedic staff, to respond to lower acuity calls. • Model optimal fleet requirements and implement in line with identified need. • Implement the ambulance auxiliary service which creates national surge capacity to enhance the response and support for ambulance trusts. • Deploy mental health professionals in 999 operation centres and clinical assessment services and deliver education and training to the workforce. • Increase the use of specialist vehicles to support mental health patients.	Business Intelligence tools roll out to General Practice: Expand availability of Business Intelligence tools (to understand demand and capacity). Provide support to build capability to use them for improvement	• Ensure the clinician to clinician telephone number directory is accurate. • Engagement work with practices / GPs on the importance of these clinical conversation where it could avoid admission and support patients to remain in place of residence. Is the GP the correct person could it be NT or CCO? • Encourage use of other pathways - minor injury pathways. Many GPs hold contracts for minor injury support to frailty pathway for low level injury - trips, falls etc requiring wound dressing, stitches etc where appropriate. Use of the Urgent Care Unit at SMG who can take ambulances. Rural practices routinely provide urgent care to patient population tap into this	
5	NHS 111 performance	The NHS 111 service can only work if it has sufficient clinical capacity to provide consultations if required and patients are able to be directed to the right service for their needs. We are working with local areas to:	• Improve call handling performance through the implementation of regional call management which will enable better integration between providers and ensure the entire NHS 111 capacity is used effectively. • Continue pilot of national Paediatric Clinical Assessment Service and build on what we are learning. • ICBs to update details of the 24/7 urgent mental health helplines for patients experiencing a mental health crisis, and ensure these services are promoted.			• Appropriate use of CCAS promoted
6	Preventing avoidable admissions	A full range of urgent care services should be available to ensure patients can access the right care in the right place. The Directory of Services should be used by staff to direct patients to the most appropriate place, while same-day emergency care, frailty and 'hot' outpatient services should also be available for patients requiring urgent specialist treatment but not necessarily via an ED. We are working with local areas to:	• Increase number and breadth of services profiled on the Directory of Services to ensure only patients with an emergency need are directed to A&E. • Develop and protect capacity for same-day emergency care services so that operational hours are profiled against demand and surgical availability. • Review non-emergency patient transport services so that patients not requiring an overnight hospital stay can be taken home when ready. • Improve the provision of the Acute Frailty service, including the delivery of thorough assessments from multidisciplinary teams. • Implement out of hospital home-based pathways, including virtual wards, to improve flow by reducing hospital attendances. Reduce unnecessary attendances for patients with mild illness through revised NHS @home pathways that incorporate broader acute respiratory infections.	Use of a unified directory of services across ICS to direct patients to the right services and communicate clearly on primary care pathways and processes	• East Lindsey Same Day Access Pilot - 2 hubs in Hornastle and Market Rasen, improved same day access as a priority linked to Fuller report. Hubs to stream appropriately. • Free up capacity for practices to manage LTC and chronic disease management • Primary care to have more defined links to urgent care (what funding is available) • Ensure the clinician to clinician telephone number directory is accurate. • Engagement work with practices / GPs on the importance of these clinical conversation where it could avoid admission and support patients to remain in place of residence. Is the GP the correct person could it be NT or CCO? • Encourage use of other pathways - minor injury pathways. Many GPs hold contracts for minor injury support to frailty pathway for low level injury - trips, falls etc requiring wound dressing, stitches etc where appropriate. Use of the Urgent Care Unit at SMG who can take ambulances. • Proactive care of the elderly and frail better links to the community services • Appropriate use of SDEC, requires good comms to practices • GPs ability to use CDC for routine testing. Direct access for urgents but via the back door to A&E. Monitor levels of referrals and any duplication	• Falls - The falls steering group priorities for 2022/23 are training, falls pathway, proactive groups for people at risk of a fall, strength and balance. Use of sensor based falls technology (falls prevention) • EMAHSN Managing Deterioration Commission - Roll out of Train the Trainer model to PCNS and Care Homes for managing deterioration. With an aim to reduce harm and ED attendances / hospital admissions (Sept 22 to March 23). Linked to Whzan telehealth • Care Closer to Home: Integrating Community Nursing with PCNs •New Care Homes Medication Policy - requires approval, due September • Delegated Healthcare Interventions - national framework in development • Respect and Care Plans - local audits and locally owned improvement plans underway. Clarity on coding provided

7	Workforce	NHS staff have worked incredibly hard throughout the pandemic and both current and future pressures on the health services mean teams will remain stretched. The health and wellbeing of the workforce is crucial and interventions targeting recruitment and retention will be important in managing additional demand this winter. We are working with local areas to:	• Implement your recruitment and retention plans including staff sharing and bank arrangements. • Utilise international support for UEC recovery, identifying shortages of key roles and skills and targeting recruitment as such. • Implement the Wellbeing Practitioners' Pack. • Develop roles for volunteers that reduce pressure on services and improve patient experience, such as community first responders and support in discharge.		• Continue to encourage staff to use Lantum and for those who are supported by Livy to use it and to flag any operational issues for review. • Restructure the way in which community nursing and neighbourhood teams work. • Standardised Commissioning Framework for CCOs, PCN or Federations employ move away from LCHS as employer • Invest in Practice base care co-ordinators • More paramedics working in primary care (ARRS) to support removing patients direct from the stack • Lessons learn from 2021/22 WAF build into this year's planning - how to tap into available workforc, how do we use the workforce to best effect • Maximise recruitment of new staff in primary care across the winter, including care co-ordinators (ARRS) and social prescribing link workers • ICBs to actively support and engage with PCNs to work with each other and other providers to develop collaborative models to manage seasonal preparedness and specific winter pressures (such as oximetry monitoring for Covid 19 patients) alongside the digital development of primary care Link to Wend C for more info / detail	
8	Data and performance management	Making the full use of data at a local, regional, and national level will help inform operational decision-making and improve the delivery of services. We are working with local areas to:	• Ensure timely and accurate submission to the Emergency Care Data Set. • Encourage use of the A&E Forecasting Tool.		• Data for flu by practice will start flowing from the Immform website around 13th October and will be for the first 5 weeks of the campaign and then updated weekly • The focus will be on monitoring 6 key targets further work to understand the primary care impact - 111 call abandonment; Mean 999 call answering times; Category 2 ambulance response times; Average hours lost to ambulance handover delays per day; Adult general and acute type 1 bed occupancy (adjusted for void beds) and Percentage of beds occupied by patients who no longer meet the criteria to reside.	• Need monthly date flow from EMAS, CAS and UCR which we can then triangulate to PCNs and Care Home data pack to provide improve intelligence • EMAS data packs - are already provided to PCNs to review warranted / unwarranted ED attendance / admission • Regular PCN data packs are in development
9	Communications	We are undertaking the following actions to enable strong communications:	• Implement your winter communications strategy to support the public to minimise pressures on urgent and emergency services. • Deliver the NHS 111 and GP Access strands of the Help Us Help You campaigns.	See BAF tab	Kev Gibson / Tony Crowden	
	Digital (added locally)	Linked to the Primary Care Digital Delivery Programme Road Map	Online Consultation Tools LIVI ARDENS Care Portal Enhanced Access Care Technology		• Establish a risk register around practices not engaging with OCTs and agree and implement an action plan and escalate to ICB if not unsolved. Remedial package of help under development. Practice performance link to be added soon. • Scoping opportunities to close down AccuRx video and SMSPlus with built-in solutions within TPP/EMIS (adequate system now in place). Explore practicalities and time frames with PCNs and Digital Delivery Group. • Practices can be set up with it when ready. Support ad hoc • Analysis underway through Method Analytics. Potential data quality Accreditation as part of SLA contract • Video / In person Group Clinics - as VGCs are a delivery method rather than a softeware, there is currently no integrated tool to upload information gathered during session into the system. Work is underway with the Training Hub anda a PM to come up with a template that will be then finalised into an Arden Template and tested. Timelines tbc. • IIF requirement for PCNs to have PCSP (Personal care and support plan) for certain patients. These should be uploaded onto the care portal. LCHS and EPACS now live on the portal. Use EPACS and Care Portal for holistic review • Support to enhanced access workstream • ICBs to actively support and engage with PCNs to work with each other and other providers to develop collaborative models to manage seasonal preparedness and specific winter pressures (such as oximetry monitoring for Covid 19 patients)	

Primary Care Winter Planning Summary Plan

Key principles

Winter planning provides the opportunity to increase capacity to manage the anticipated increase in demand.
It should be developed in line with core service provision and the primary care improvement plan rather than be a separate start / stop intervention.

The core elements include:

- Prior to the winter surge in demand ensure that every opportunity to reduce the probability of people becoming unwell has been taken
- Plan to increase capacity to support surge demand
- Understand key points of interface with other services and ensure processes are stream- lined
- Develop robust plans to deal with operational pressures i.e. business continuity plans
- Recognise patient access expectations and develop arrangements to address these particularly with regards telephone / digital systems

Key themes and actions

	Lead	Status	Progress Notes
1. Develop a shared plan re. role of community pharmacy and links with GP	TBC		
2. Complete stock-take of current care co-ordination capacity to ensure the arrangements are sustainable – including but not limited to funding	Locality Leads	In progress	
3. Enhance care co-ordination capacity at practice / PCN – both non-clinical and clinical	Sarah Button	In progress	
4. Proactively seek feedback from GP / PCNs re local opportunities to provide increased capacity including opportunity to complete reviews of patients who are at high risk of becoming acutely unwell – confirm funding available to support this	Shona Brewster / Sarah Button	In progress	
5. Proactively seek feedback from GP/PCN's re local opportunities to provide increased capacity to manage increased demand - confirm funding available to support this	Shona Brewster / Sarah Button	In progress	
6. Identify key points of interface and streamline processes – e.g. contact in acute hospitals to arrange direct admissions	Via UEC Team	In progress	
7. Simplify / develop mechanisms to access step-up facilities (virtual wards/community hospital beds), accessing urgent response (non EMAS) in the community,	Via UEC Team	In progress	
8. Identify opportunities to increase support for patients with low level mental health issues – ie 'granny at the front door' – can we extend the wellbeing hub ?	MH Team		
9. Explore opportunity to extend physio and clinical pharmacy capacity in partnership with other providers / agencies	TBC		
10. Are there digital solutions that we aren't using ?	Steve Pitwell		
11. Review 111 pathway	UEC Team / National		
12. Proactive management of long term conditions and frailty (risk stratification and better management within primary care - MDT and community models around specialties (respiratory, diabetes, CVS and frailty)	Lisa Foyster		
13. Review current projects and confirm whether any should be paused to release capacity to support winter pressures	HoTs and Seniors	In progress	
14. Review and refresh business continuity plans – specifically re respiratory conditions	Locality Leads	To be started	
15. Identify any practices that might benefit from accessing icloud telephony	Steve Pitwell	In progress	
16. Review and refresh Livi to optimise benefits	Sarah Starbuck	In progress	
17. Identify opportunities to extend remote consultations through local arrangements	Steve Pitwell	In progress	
18. Review links with UTC where relevant	Val Blankley	In progress	
19. Comms campaign to encourage patients to access the right service	Tony Crowden / Kev Gibson	In progress	

Key enablers

	Lead	Status	Progress Notes
Pharmrefer: funding to extend to the end of March		Approved	
Pharmrefer: can funding be agreed for 23/24?			
Medicines discharge service: seek update from ULHT			
Funding: to enable increase in capacity at practice/PCN			
Funding: to extend remote consultation capacity through local arrangements			

Funding: to support sustainability of care co-ordination arrangements			
Funding: to extend care co-ordination arrangements			

Integrating digital/online to support self-care e.g. improvements to functionality and clarity of practice websites, availability of self-care guidance, use of the NHS App and other patient facing services

Increasing use of blood pressure monitoring at home (BP@home) and LTC remote / self-monitoring by people, using digital tools and with appropriate support from Primary Care (especially from ARRS roles)

Use technology to support at-scale working across general practice to better align capacity with demand: e.g. using virtual hubs across a PCN footprint; implementation of enhanced access.
• support staff skills and capabilities;
• improve ways of working, reduce unwarranted variation and increase operational efficiency; and,
• drive integrated working.

Improve ways of working that support timely access for patients and carers to Primary Care – particularly by enabling:
- reduced unwarranted variation and spread good practice (e.g. through accessing and analysing relevant data taking a population health management approach)

Practices and PCNs will require a diverse range of support such as organisational development (OD), quality improvement (QI), analytics, digital, service design etc. ICSs will need to create the right conditions and culture for change, including creating time for practices to participate in improvement activities.

Some examples of specific interventions are provided below:
• Deployment and use of Business Intelligence tools to aid understanding of demand and capacity, and drive improvements in based on this understanding
• Supporting embedding of ARRS staff to create multi-disciplinary teams with clear operational ways of working and pathways. Providing clinical supervision and support and supporting flexible ways of working
• Opportunities for effective pathway redesign which may include:
o automating routine administrative tasks such as call/recall systems for monitoring high risk drugs, long term condition reviews, vaccination, and screening appointments
o automating some clinical tasks, within defined clinically safe parameters, such as Long-Term Condition monitoring, pathology results, post discharge medication reconciliation, coding of clinical correspondence etc

• Integrating digital/online to support self-care e.g. improvements to functionality and clarity of practice websites, availability of self-care guidance, use of the NHS App and other patient facing services
• Increasing use of blood pressure monitoring at home (BP@home) and LTC remote / self-monitoring by people, using digital tools and with appropriate support from Primary Care (especially from ARRS roles)
• Use technology to support at-scale working across general practice to better align capacity with demand: e.g. using virtual hubs across a PCN footprint; implementation of enhanced access.

The Primary Care SDF is available for nine workforce programmes:
a Additional Roles Reimbursement Scheme (ARRS);
b General practice fellowships for GPs and nurses new to practice;
c Supporting mentors' scheme;
d New to partnership payment scheme;
e International GP Recruitment Programme, International Induction Programme, and visas;
f Local GP Retention Fund;
g Flexible staffing pools;
h Practice Resilience; and,
i Training Hubs.

Submission Timetable

Submission Month	Submission Deadline	Date for sending to leads for updates	Date for sending to Urgent Care Lead
Sep-22	22/09/2022		20/09/2022
Oct-22	20/10/2022	14/10/2022	18/10/2022
Nov-22			
Dec-22			
Jan-22			
Feb-22			
Mar-22			

RP#	Strategic Objective	Action	Deadline	Implementation Status	Risks	Gaps	Controls In Place	Deadline
1.6	**Aligning Demand & Capacity**	**1.6 Primary Care**						
1.6.1	Aligning Demand & Capacity	ICB to actively engage and support General Practices and Community Pharmacies with seasonal preparedness and operational delivery.	Dec-22	Planned implementation (What are the actions, timeframe, risks?)	Primary care capacity alongside delivery of flu and covid booster programmes; system pressures impacting on primary care	Further development of engagement with community pharmacies and LPC - plan developed by end of October. POD transfer ongoing - full transfer in April 2023.	ICB primary care dedicated team actively engaging with Practices; oversight and governance in place through PCCC. Weekly GP resilience monitoring in partnership with LMC. Work on POD transfer through the ICB oversight group enable monitoring of pressures on community pharmacies.	Dec-22
1.6.2	Aligning Demand & Capacity	ICBs to complete system framework for supporting General Practice to rapidly prioritise practical interventions to improve patient experience of access and staff workload locally and engage in national process to secure potential funding for technology/estates solutions	Dec-22	Partially implemented (What is the status, actions, timeframe, risks?)	Recruitment to Lantum system ongoing - current capacity limited, recruitment and retention in general a challenge for GP practices. LMC commissioned to support practices in relation to access, quality and delivery.	Longer term workforce strategy refresh under development.	Dedicated primary care workforce resource, primary care digital programme supporting online and telephony access and well placed to respond to IT opportunities, primary care estates programme progressing with estates review. ICB Primary Care Team engaging with practices through the existing Access Workstream. Livi pilot is suspporting practices with virtual clinical capcaity and available as required. Piloting of winter hub underway with East Lindsey PCN.	Dec-22
1.6.3	Aligning Demand & Capacity	Consider and support PCNs working with each other and other providers to develop collaborative models to manage specific winter pressures (for example oximetry monitoring for COVID; winter hubs; community and VCS led support for vulnerable)	Dec-22	Partially implemented (What is the status, actions, timeframe, risks?)	System pressures including workforce and demand; cost-of-living issues impact on more vulnerable communities; primary care capacity and demand.	Further development of PCN collaboration required.	Planning underway, pilots of local strategic partnership arrangements in 3 localities to support colaborative working. Links through social prescribing to VCS - MH transformation programme supporting access to VCS MH support.	Dec-22
1.6.5	Aligning Demand & Capacity	ICBs to offer intensive hands-on quality improvement support to practices working in the most challenging circumstances (such as areas of high deprivation, areas with highest need or workforce challenges) via the national 'Accelerate' support programme available to 400 practices for 22/23 alongside addressing barriers outside the scope of the support	Oct-22	Fully implemented (What evidence supports this?)	Practice take up of offer limited; practice capacity to engage.		Quality support framework developed and support commissioned from LMC; promotion of Accelerate with LMC and directly with practices; Primary care team ongoing engagement with practices and monitoring of issues. LMC have supported with Accelerate - there is good take up in Lincolnshire.	Oct-22
1.6.6	Aligning Demand & Capacity	Technology and Telephony to digitally enable Primary Care - **Cloud Based Telephony in General Practice:** Expand number of practices on cloud-based telephony, supporting transition from analogue to cloud-based through expanded scope and pace of current pilots in advance of the national cloud based telephony framework going live in April 2023. **Business Intelligence tools roll out to General Practice:** Expand availability of Business Intelligence tools (to understand demand and capacity). Provide support to build capability to use them for improvement Use of a **unified directory of services** across ICS to direct patients to the right services and communicate clearly on primary care pathways and processes	Oct-22	Partially implemented (What is the status, actions, timeframe, risks?)	Practice capacity to engage with BI capability development, ICB capacity to support with BI capbility development.	Unified directory of services - to be developed, potential to link with practice development programme to support access.	Cloud based telephony offer available to practices through ETTF funding - no further funding in GPIT 5, stocktake of practices position required and potential support for those not using cloud based solutions; BI tools available through the PHM programme with PCN level support from Optum - linked data sets avalable in October; ICB dedicated Primary Care BI capacity available to support and linked to HI and PHM programmes.	Oct-22
1.6.7	Aligning Demand & Capacity	Promote use of the following community pharmacy services the expansion of CPCS to divert demand away from general practice into community pharmacies aligned to metrics outlined in the Primary Care Investment and Impact Fund the Discharge Medicines Service to community pharmacies to help prevent readmissions to hospital	Oct-22	Partially implemented (What is the status, actions, timeframe, risks?)	Practice and pharmacy capacity to use the CPCS system given demand and workforce issues. Acute pharmacy team capacity and demand.	CPCS is in place and promoted to practices, practice feedback is that the service can have limited impact particularly in more rural areas. Further promotion of Discharge Medicines Service to Community Pharmacies required.	Primary Care Team monitoring of CPCS uptake and targetted engagement with practices. Work to further promote and improve uptake is ongoing - support with ongoing mobilsation and infrastructure including PharmRefer.	Oct-22
7.2	**Workforce**	**7.2 Recruitment and retention**						
7.2.1	Workforce	Implement recruitment and retention plans which include: •Staff sharing arrangements and maximising collaboratives banks •Embed reservist model in each ICS to increase capacity and capability to respond to surge and major incidents •Develop and launch managing attendance challenge toolkit •Utilise international support for UEC recovery, identifying shortages of key roles and skills and targeting recruitment as such. •Ensure plans to maximise the use of the national protocol and reduce the pull-on registered healthcare professionals to deliver this autumn's COVID-19 and flu vaccination programme.	Dec-22	Partially implemented (What is the status, actions, timeframe, risks?)	Risks identified via the LICB People Board risk register and PC People Group as a subcommitee. - Insufficient workforce to meet the potential surge in demand.	Resource gaps in some parts of the ICB/PC to support PC People Plan - recruitment underway.	Retention Lead and 2 x People Promise Managers in post and Attraction Lead starting on 3 Oct 22. - MOU in place for staff sharing and meetings re collaborative Bank ongoing. Wider Workforce Lead is coordinating this work. - Reservist programme ongoing and first recruits join ULHT in Oct 22. - International Recruitment ongoing and ULHT completing in-house exercise relating to every vacancy. - System in discussion with regional colleagues regarding new models relating to National Protocol. PC People Group chaired by PCN Clinical Director established from Feb 22, alignment to national and local People Plans working within 5 Pillars and People Promise. PC People Plan framework being developed at engagement session and Time Out on 18/10. Draft PCPP to be in place by end of 2022. Local Workforce Transformation team investment within ICB and PCN resources identified in parallel to above. Strategic leads report into LICB People Board	Dec-22
9.2	**Communications**	**9.2 Campaigns**						
9.2.1	Communications	Deliver the 'Help Us, Help You' NHS 111 and GP Access campaigns; to increase the number of people using NHS 111 when they have an urgent, but non-life-threatening medical need and of people using online access routes to contact their practice. ICBs to deliver local campaigns including messaging on triage, prioritisation and MDTs/ARRS staff	Feb-23	Fully implemented (What evidence supports this?)	Operational challenges impacting the call to action eg. IF GP appts are unavailable THEN Choose Well messages directing there are redundant GP access campaign: engagement of public with the campaign - system pressures may impact on effectiveness.	Identified gaps are mitigated by the shared regional plan, pooling lead roles across operation prog comms support Further phases of comms programme planned e.g. MDTs/ARRS staff.	Operational dashboard re flow impact Communications reach measure (eg engagement per channel etc) Continuing to work with system colleagues to develop a winter comms plan that will cover the key campaigns, ensuring appropriate public messaging are promoted using a range of communication channels.	ongoing

Date	Document Type	Document Name	Document	Action required	Lead	Status
12th August 2022	Link	https://www.england.nhs.uk/next-steps-in-increasing-capacity-and-operational-resilience-in-urgent-and-emergency-care-ahead-of-winter/				
12th August 2022	Link	https://www.england.nhs.uk/publication/next-steps-for-urgent-and-emergency-care/				
26th September 2022	Letter	NHSE: Supporting general practice, primary care networks and their teams through winter and beyond	 B1998-Supporting-general-practice-primary-care-			
26th September 2022	Guidance	NHSE: Primary care system development funding (SDF) and GPIT funding guidance: Analysis of programmes and funding in 2022/23	 B1605-Primary-care-system-development-			
27th September 2022	Presentation	Strategic Group Presentation	 Strategic group update 27th Sept .pptx			

NHS
Lincolnshire
Integrated Care Board

PUBLIC PRIMARY CARE COMMISSIONING COMMITTEE

Date: 19th October 2022 – 9.30 am
Location: MS Teams

Agenda Number:	10
Title of Report:	Primary Care Performance Report
Author:	Nick Blake, Acting Programme Director for Integrated Primary Care and Communities
Appendices:	Appendix 1 – KPI definitions Long Term Conditions Appendix 2 – PCN Primary Care Dashboard

1. Key Points for Discussion:

This report sets out performance against key metrics and performance indicators and provides commentary on areas of positive performance alongside actions to mitigate performance issues.

2. Recommendations

The Committee is recommended to note the contents of this report.

3. Executive Summary

Introduction
Primary Care Programme Key Performance Indicators (KPIs) have been agreed by the Primary Care, Communities and Social Value Steering Group and are reported through to the ICB Executive.

Three main areas are covered currently:

- Quality as indicated by Care Quality Commission (CQC) ratings – Inadequate and Requires Improvement
- Access to General Practitioner (GP) and Enhanced Access appointments
- Management of Long Terms Conditions (LTC) and delivery of Health Checks

KPIs are under review and it is anticipated these will be developed further to align with the Lincolnshire System Plan and could include additional areas such as primary care workforce, prescribing, Primary Care Network services and digital access.

A recent review of the current KPIs by the Primary Care, Communities and Social Value Steering Group has highlighted that the current high-level measures give an indication of performance but potentially mask variation in performance at a PCN and practice level.

There are some issues with access KPIs in terms of understanding the measures within the context of increasing demand for GP services and the wider introduction of triage and online consultation systems.

Deep dives into priority KPIs are under discussion and could look at data at PCN and practice levels.

KPIs Overview

Indicator	Standard / Target	Period	YTD Target	YTD Performance	Trend against target/trajectory
Number of practices rated as Inadequate by CQC	0	Sep-22	0	1	-
Number of practices rated Requires Improvement by CQC	-	Sep-22	-	4	-
GP appointments - % seen by a GP	-	Jul-22	-	34%	⇩
GP appointments - % seen face-to-face	-	Jul-22	-	69%	⇧
GP appointments – booking to appointment: same day	-	Jul-22	-	48%	⇩
GP appointments – booking to appointment: 1-7 days	-	Jul-22	-	24%	⇩
Number of Enhanced Access appts excl. DNAs	5,589	Jul-22	-	5,625	⇧
% of Enhanced Access appts utilised	80%	Jul-22	-	74%	⇩
LD Health Check Delivery rate	85%	Aug-22	746 (16.7%)	748 (16.7%)	⇧
SMI Health Check Delivery rate	60%	Sep-22	2,555 (54%)	2,124 (45%)	⇩
CVD - hypertension	50%	Aug-22	-	19.1%	⇧
Diabetes – 8 care processes	58.90%	2021	-	31.3%	-
Asthma – NCD 105	72.10%	Aug-22	-	68.10%	⇧

Table 1 – Primary Care KPIs, September 2022

Quality

Of the 85 Lincolnshire GP practices registered with the CQC, at the time of writing:

- One practice is rated as Inadequate – Hawthorn Medical Practice (inspection report published 30.09.2022).
- Four practices are rated as Requires Improvement
  - Branston Surgery (inspection report published 09.11.2022)
  - The Spalding GP Centre (inspection report published 30.11.2022)
  - Marisco Medical Centre (inspection report published 19.01.2022)
  - Lakeside Health Care Stamford (inspection report published 01.06.2022)

The Integrated Care Board (ICB) Primary Care and Quality Teams continue to work with the above practices to support them in making further service improvements.

Access

The ratio of primary care patient appointments seen by a GP in July dropped slightly from June at 34% (-3%), with face-to-face appointments remaining roughly the same at 69%. The overall rate of face-to-face appointments is above the national average of 65% and regional average of 66%.

The rate of appointments booked on the same day remains fairly constant at 48% (49% in June), with appointments booked from 1-7 days following contact dropping slightly.

It is important to note there are a number of caveats with current access data and consistency of data across practices. Work is ongoing to better understand the available data and to improve access reporting to support the primary care access work programme.

The number of Enhanced Access appointments (appointments available outside of core GP hours) increased in July although there was a lower utilisation rate of the available appointments. Enhanced access activity is currently under-reported, the available data doesn't accurately reflect levels of activity. The Primary Care team are working with providers to improve reporting, this is included within the work to transfer contracts for Enhanced Access provision to Primary Care Networks (PCN) from October 2022.

Long Term Conditions and Health Checks
This set or measures includes two system priority health check targets:

- Annual health checks for people with a Learning Disability (LD)
- Annual health checks for people with a Severe Mental Illness (SMI)

Health check delivery is broadly on plan to deliver against the system targets: 85% or people registered with their GP practice as having a learning disability receiving a health check and 60% of people registered with SMI receiving a health check. Work is ongoing with practices and PCNs to support performance and quality including additional funding from NHS England to support practices engage and offer health checks to people with LD who didn't receive a check over 2021/22.

A review of patient experience of LD health checks is underway and will inform guidance to GP practices on improving access and quality of checks. In addition, the Lincolnshire LD Friendly Practice quality mark has been rolled out with applications received and the first award to a practice imminent.

Work to improve SMI health checks uptake is taking place with Lincolnshire Partnership Foundation Trust (LPFT) – LPFT are providing additional health check capacity and the ICB will be funding additional system capacity to develop and, subject to approval, implement a proposed community outreach model to improve uptake. Work with the Personalisation Programme to embed further the principles of personalisation within the SMI Health Check process.

The Long Term Condition measures included are informed by the Royal College for General Practice's guidance on primary care post-covid recovery and currently includes KPIs on the management of:

- Hypertension
- Diabetes
- Asthma

Please see Appendix 1 for Long Term Condition and health check measure definitions.

Performance measures for cancer care and management of Chronic Obstructive Pulmonary Disease (COPD) are under development. The key area to note in relation to Long Term Conditions is the need to improve performance on diabetes care: identifying actions that build on previous work and reduce variation across practices will be developed with clinical leaders for inclusion in the Primary Care programme.

Further development of Long term Condition KPIs is proposed including the potential inclusion of case finding metrics based on GP practice disease registers.

Developing Performance Monitoring
Further discussion with ICB Clinical Leads and the ICB Performance Team is planned for September and October to further develop and refine performance measures and reporting processes.

Table 2 below gives the current metrics under discussion and the latest performance data available.

Indicator	Standard / Target	Period	YTD Target	YTD Performance	Trend against target/trajectory
Polypharmacy and SMRs - percentage with severe frailty with SMR	-	Aug-22	-	16.9%	⇧
High dose opioids for non-cancer pain (Pre-gab/Gabapentin/100 patients)	63.6	Mar-22	-	108.5	-
MH prescribing - Benzo as hypnotics ADQ/100 STAR PU	14.8%	Mar-22	-	20.3%	-
Antibacterial items/100 Star PU	22.0%	Mar-22	-	25.8%	-
Workforce - GP fte/100,000	56	Aug-22	-	56	⇧
Workforce - Nurses fte/100,000	26	Aug-22	-	41	⇔
Workforce - ARRS funding utilisation	100%	Aug-22	-	86%	-
Weight management - obesity register	88,265	Jul-22	-	84,659	⇧
Weight Management - referrals	-	Jul-22	-	2,067	⇩
Social Prescribing Patient Referrals	1,914 (Q2 21/22)	Mar-22	-	8460	-
CPCS utilisation (same day access) - referrals	27,857	Aug-22	11,607	3,711	-
Livi utilisation (same day access)	100%	Jul-22	-	31%	-
Electronic patient record - patients enabled	13.2%	Apr-22	-	12.6%	-
National ERS - referral rate from baseline	1.4%	Aug-22	-	-17.9%	⇧
Online consultation (digital)	81	01/09/2022?	-	73	-
Ardens (digital) - % practices active	100%	Jul-22	-	97.6%	-
Dementia Diagnosis Rate	67%	Jul-22		61%	⇩

Table 2: primary care metrics under development

PCN Primary Care Dashboard (please see Appendix 2)
The ICB Performance Team have developed Primary Care dashboards available at Practice, PCN and Locality levels across the ICB – a PCN level dashboard is attached at Appendix 2 for information. These reports provides a more detailed view of a wide range of performance data including those measure routinely monitored by the CQC. Key areas include:

- GP workforce
- GP patient survey
- GP online services
- Prescribing
- Quality Outcomes Framework (QOF) disease prevalence
- Immunisation and vaccination data
- Cancer measures
- Acute activity

Key measures from the dashboards could be included in the Programme KPI Highlight report in future.

It is worth noting that RAG rating for indicators doesn't always indicate poor performance, in some cases it indicates that the practice is an outlier e.g. a practice with an older population. It is also worth noting that some data sources use relatively old data e.g. QOF metrics relate to 20220/21 – this is the most recent validated data available but should be viewed with caution.

Data at practice level informs discussion at the locality Primary Care Quality Assurance Groups and is being shared with practices through locality clinical meetings.

4.	Management of Conflicts of Interest
Not applicable.	

5.	Risk and Assurance
Development of performance measures will inform Primary Care programme prioritisation and deployment of resources.	

5.	Financial/Resource Implications
Not applicable.	

6.	Legal, Policy and Regulatory Requirements
Not applicable.	

7.	Health Inequalities implications
Some KPI measures also link to Health Inequalities priorities e.g. hypertension management. Work to align and coordinate with the Health Inequalities programme is underway.	

8.	Equality and Diversity implications
Not applicable.	

9.	Patient and Public Involvement (including Communications and Engagement)
Not applicable.	

11.	Report previously presented at
Not applicable.	

12.	Sponsoring Director/Partner Member/Non-Executive Director
Sarah-Jane Mills, Director of Primary Care, Communities and Social Value. Email: sarah-jane.mills1@nhs.net. Telephone: 01522 515381.	

Appendix 1 – KPI definitions - Long Term Conditions

Measure	Description	Data Position
CVD	% of patients for whom there is evidence of clinically appropriate follow-up to confirm or exclude a diagnosis of hypertension by 31 March 2023: Cardiovascular Disease Prevention : Percentage of patients aged 18 years or over, not on the QOF Hypertension Register as of 31 March 2022, and who have: (i) a last recorded blood pressure reading in the 2 years prior to 1 April 2022 >= 140/90mmHg for whom there is evidence of clinically appropriate follow-up to confirm or exclude a diagnosis of hypertension by 31 March 2023 OR (ii) a blood pressure reading >= 140/90mmHg on or after 1 April 2022, for whom there is evidence of clinically appropriate follow-up to confirm or exclude a diagnosis of hypertension within 6 months of elevated reading.	Data is Monthly position so should increase on a month basis with the aim to be near target by end of year.
Diabetes	% of Type 1 & Type 2 Diabetic patients who have received 8 Care Processesses	Data is Quarterly position so should increase on a monthly basis with the aim to be near target by end of year.
Asthma	The number of Patient on the Asthma Register who received three or more inhaled corticosteroid (ICS, inclusive of ICS/LABA) prescriptions over the previous 12 months.	Data is Monthly position but covered all patients based on last 12 months so is retrospective.
LD	% of LD patients 14+ who have receievd a Health Check since 01 Apr 22 (working toward end of year poistion)	Data is Monthly position so should increase on a month basis with the aim to be near target by end of year and is know to be heavily weighted to Q4 each year.
SMI	% of Patient who have receievd all 6 Physical Health Checks in the last 12 Months (rolling Value)	Data is Monthly position but covered all patients based on last 12 months rolling activity so should ideally be increasing toward the target but patients can drop off as well as being added if one test is out of the 12 m period

Appendix 2 – PCN level Primary Care Dashboard

PC Dashboard all PCNs Jun22.pdf

Primary Care Indicator Profile - updated June 2022

NHS Lincolnshire Integrated Care Board

PCNs within Lincolnshire ICB

Table 1: Contextual Indicators

Indicator (see menu at the end of the report for futher detail)	Target	Period	sided test	polarity	East					West						South West		South			
					Boston	East Lindsey	First Coastal	Meridian Medical	SOLAS	Apex	Imp	Lincon Health Partnership	South Lincoln	Trent Care	Grantham and Rural	KL Healthcare	Sleaford	Four Counties	South Lincolnshire Rural	Spalding PCN	LINCS
Staffing (non ARRS funded)																					
GP FTE per 100,000 (incl Salaried & Trainees; excl Locums)	Nat_Avg: 56.01	May_22	1	↑	47.90	49.34	45.55	59.03	80.43	63.22	58.46	30.41	42.48	39.32	51.05	63.36		48.67	69.68	38.59	53.16
Nurse FTE per 100,000 (incl ANP, PN)	Nat_Avg: 26.38	May_22	1	↑	37.89	54.99	33.84	49.67	38.50	39.85	38.74	21.54	40.98	43.40	41.56	51.56		34.92	42.32	38.49	40.89
DPC FTE per 100,000 (Disp, HCA, Phleb etc)	Nat_Avg: 24.68	May_22	1	↑	30.35	71.52	59.56	88.15	102.39	19.98	45.19	18.96	23.86	52.08	39.16	101.39		42.19	72.16	59.11	54.04
DPC FTE per 100,000 (HCA, Phleb etc …excl Disp)	Nat_Avg: 21.06	May_22	1	↑	29.23	42.56	44.39	39.18	34.34	19.98	28.25	18.96	21.42	24.77	27.63	51.42		23.24	30.49	32.70	31.32
Patient List																					
% aged 0 to 4 years	Nat_Avg: 4.9%	Jun_22	2		4.8%	3.9%	3.6%	3.7%	3.1%	5.1%	4.8%	3.6%	4.5%	4.7%	4.3%	3.9%		4.1%	4.3%	5.1%	4.3%
% aged 65+ years	Nat_Avg: 17.7%	Jun_22	2		18.4%	28.5%	31.7%	28.8%	29.1%	21.0%	20.6%	9.8%	23.2%	23.3%	22.2%	25.4%		23.2%	25.8%	18.7%	23.3%
% aged 85+ years	Nat_Avg: 2.3%	Jun_22	2		2.5%	3.4%	3.3%	3.6%	3.6%	3.0%	2.7%	1.1%	3.0%	2.8%	2.6%	3.2%		3.6%	3.3%	2.8%	2.9%
Last 12 month List Growth	Nat_Avg: 1.4%	Jun_22	2		1.8%	-0.2%	0.5%	1.8%	2.4%	1.1%	1.6%	2.3%	-0.2%	0.8%	0.7%	0.7%		-5.1%	2.2%	1.4%	0.9%
Dispensing Patients	Nat_Avg: 5.1%	Mar_22	1	↓	5.0%	47.7%	8.3%	37.1%	69.7%	0.0%	19.8%	0.0%	14.1%	21.6%	23.9%	47.1%		25.1%	39.4%	11.3%	24.5%
Socio-Economic																					
Deprivation score (IMD 2019)	Nat_Avg: 21.7	2019	2		22.2	19.5	44.8	21.8	27.5	19.8	21.8	23.2	11.5	24.7	15.7	15.9		10.0	18.1	14.4	19.9
Life expectancy - Female	Nat_Avg: 83.2	2015_19	1	↑	82.6	83.9	80.5	82.7	83.2	82.5	83.2	80.2	83.7	82.6	83.9	83.6		84.6	83.4	84.3	83.2
Life expectancy - Male	Nat_Avg: 79.7	2015_19	1	↑	78.0	80.4	75.4	79.7	79.4	79.4	78.6	76.0	80.7	79.4	80.6	81.1		81.1	80.1	79.6	79.5
IDACI (Inc Dep - Child)	Nat_Avg: 17.1%	2019	2		15.7%	15.1%	33.0%	15.7%	19.1%	14.9%	16.7%	20.5%	10.3%	20.3%	12.1%	13.6%		9.8%	14.2%	11.3%	15.4%
IDAOPI (Inc Dep - Older)	Nat_Avg: 14.2%	2019	2		16.5%	11.3%	21.3%	12.8%	13.5%	14.6%	15.0%	21.6%	10.4%	12.9%	10.3%	10.6%		8.9%	11.0%	11.2%	13.0%

Table 2: National GP Patient Survey - Patient Responses (fieldwork Jan-Mar 21)

CQC moniotred target within GP Practice Evidence Tables

Indicator (see menu at the end of the report for futher detail)	Target	Period	sided test	polarity	East					West						South West		South			
					Boston	East Lindsey	First Coastal	Meridian Medical	SOLAS	Apex	Imp	Lincon Health Partnership	South Lincoln	Trent Care	Grantham and Rural	KL Healthcare	Sleaford	Four Counties	South Lincolnshire Rural	Spalding PCN	LINCS
Response Rate	Nat_Avg: 35%	2021_Q4	1	↑	39%	50%	47.3%	51.6%	49.3%	40.1%	42.3%	26.3%	51.1%	47.6%	47.6%	50.5%		48.3%	53.2%	38%	46%
Local GP Services																					
Q1 Ease of getting through by phone	Nat_Avg: 68%	2021_Q4	1	↑	57.0%	66.8%	24.0%	72.1%	77.6%	57.1%	82.8%	58.1%	78.6%	71.5%	75.5%	81.1%		45.9%	64.4%	76.1%	65.9%
Q2 Helpfulness of receptionists	Nat_Avg: 89%	2021_Q4	1	↑	88.7%	86.7%	78.1%	92.2%	93.0%	90.9%	92.5%	83.6%	92.2%	91.1%	90.2%	92.8%		86.2%	90.0%	90.1%	89.2%
Q6 Satisifed with Appt times available	Nat_Avg: 67%	2021_Q4	1	↑	61.9%	69.0%	50.7%	66.5%	68.5%	72.2%	72.1%	65.0%	73.1%	64.3%	71.0%	72.9%		54.5%	66.9%	74.4%	67.2%
Q7 Have a preferred GP - Yes	Nat_Avg: 46%	2021_Q4	1	↑	39.3%	39.8%	28.1%	33.8%	45.1%	37.7%	40.3%	35.1%	40.4%	46.8%	44.2%	44.0%		44.3%	46.3%	41.3%	40.8%
Q4 Ease of using practice website - Very/Fairly easy	Nat_Avg: 75%	2021_Q4	1	↑	71.6%	74.1%	78.5%	76.3%	81.2%	79.9%	87.3%	68.5%	79.6%	76.2%	80.2%	89.5%		64.5%	76.5%	80.2%	78.4%
Patient use of GP online services																					
Q3i Booking appointments	Nat_Avg: 19%	2021_Q4	1	↑	14.5%	32.3%	12.2%	13.6%	15.4%	19.6%	34.2%	20.8%	14.8%	18.0%	29.9%	30.1%		9.7%	17.7%	5.7%	20.2%
Q3ii Repeat precriptions	Nat_Avg: 26%	2021_Q4	1	↑	22.2%	27.8%	26.8%	19.9%	27.1%	37.8%	31.9%	26.1%	29.3%	28.8%	32.1%	32.0%		22.8%	29.9%	17.4%	28.0%
Q3iii Medical records	Nat_Avg: 7.1%	2021_Q4	1	↑	2.6%	6.1%	6.8%	5.5%	5.2%	13.0%	6.9%	10.1%	5.9%	8.0%	6.3%	4.9%		5.6%	8.7%	4.9%	6.6%
Q3iv Had Online consultation	Nat_Avg: 17.8%	2021_Q4	1	↑	11.8%	22.8%	10.2%	9.8%	14.3%	17.6%	32.5%	24.4%	16.0%	15.2%	30.7%	28.3%		18.2%	14.6%	8.4%	19.0%
Q3v None of these	Nat_Avg: 56%	2021_Q4	1	↓	67.0%	47.7%	63.0%	65.0%	60.5%	49.8%	38.9%	53.0%	55.8%	57.4%	40.8%	42.5%		58.8%	57.2%	70.5%	54.2%
Making An Appointment																					
Q14 Offered a choice of Appt	Nat_Avg: 69%	2021_Q4	1	↑	62.8%	69.9%	54.2%	66.7%	69.7%	66.9%	79.9%	60.5%	71.1%	67.5%	77.3%	79.4%		65.3%	64.8%	72.6%	68.8%
Q15 Satisfied with Appt type	Nat_Avg: 82%	2021_Q4	1	↑	79.5%	85.9%	75.5%	84.3%	85.0%	86.9%	89.1%	79.8%	86.0%	84.3%	89.1%	91.2%		80.7%	84.5%	84.3%	84.7%
Q20 Appointment making experience	Nat_Avg: 70.6%	2021_Q4	1	↑	62.0%	71.2%	45.0%	75.0%	76.5%	71.5%	79.0%	66.6%	79.2%	67.7%	77.7%	79.5%		59.9%	73.5%	76.6%	70.9%
At your last GP/Nurse/OHCP appointment																					
Q25i Gave you enough time	Nat_Avg: 88.7%	2021_Q4	1	↑	87.5%	90.0%	80.7%	89.2%	89.3%	87.0%	90.4%	81.6%	94.0%	86.8%	90.5%	91.2%		85.5%	89.7%	89.6%	88.5%
Q25ii Listened to you	Nat_Avg: 89%	2021_Q4	1	↑	88%	90%	80%	91%	90%	89%	92%	88%	94%	88%	88%	90%		86%	90%	88%	89%
Q25iii Treated with care/concern	Nat_Avg: 88%	2021_Q4	1	↑	86%	89%	78%	90%	91%	87%	90%	85%	92%	85%	88%	90%		85%	90%	87%	88%
Q26 Recognised or understood any MH needs	Nat_Avg: 86%	2021_Q4	1	↑	87.9%	86.9%	78.5%	88.1%	91.7%	84.8%	85.6%	77.0%	90.6%	90.6%	88.4%	92.0%		82.3%	85.1%	86.9%	86.3%
Q27 Involved you in decisions	Nat_Avg: 93%	2021_Q4	1	↑	90%	93%	86%	95%	94%	93%	95%	87%	97%	93%	95%	95%		94%	94%	89%	93%
Q28 Confidence and trust in HCP	Nat_Avg: 96%	2021_Q4	1	↑	95%	96%	93%	95%	96%	95%	97%	93%	98%	94%	97%	97%		97%	97%	96%	96%
Q29 Were needs met	Nat_Avg: 94%	2021_Q4	1	↑	93%	95%	92%	95%	96%	93%	95%	91%	96%	93%	96%	95%		93%	93%	91%	94%
Overall Practice Experience																					
Q30 Overall Practice Experience	Nat_Avg: 83%	2021_Q4	1	↑	77.0%	82.5%	66.9%	83.0%	84.4%	82.5%	89.0%	74.7%	88.6%	81.1%	84.5%	88.3%		71.3%	84.7%	86.5%	82.0%
Patient Health - LTC																					
Q32 Have long-term physical or MH conditions. disabilitv or illness	Nat_Avg: 52%	2021_Q4	1	↓	54.8%	58.2%	71.7%	59.2%	63.3%	63.8%	54.1%	46.6%	57.9%	63.6%	56.1%	57.3%		53.6%	58.3%	49.2%	57.7%
Q36 Supported to manage LTC	Nat_Avg: 74%	2021_Q4	1	↑	72.3%	71.4%	53.4%	70.9%	76.5%	73.9%	77.8%	64.0%	76.6%	75.9%	74.5%	78.6%		66.9%	72.2%	80.2%	72.1%

Table 3: GP Online Services

Indicator (see menu at the end of the report for futher detail)	Target	Period	sided test	polarity	East					West						South West		South			
					Boston	East Lindsey	First Coastal	Meridian Medical	SOLAS	Apex	Imp	Lincon Health Partnership	South Lincoln	Trent Care	Grantham and Rural	KL Healthcare	Sleaford	Four Counties	South Lincolnshire Rural	Spalding PCN	LINCS
EPS - Electronic Prescriptions																					
Patient list size with nominations	Nat_Avg: 70%	Mar_22	1	↑	66.5%	46.0%	74.4%	55.2%	32.5%	82.5%	62.7%	68.5%	76.8%	60.5%	61.9%	46.3%		61.8%	53.5%	61.2%	60.8%
EPS Utilisation	Nat_Avg: 91%	Mar_22	1	↑	89.5%	52.6%	92.4%	59.8%	33.0%	99.5%	75.7%	99.8%	86.0%	73.8%	76.6%	47.3%		74.5%	48.1%	85.8%	70.5%
ERD Utilisation	Nat_Avg: 15%	Mar_22	1	↑	2.9%	3.1%	9.0%	11.3%	0.1%	13.4%	6.7%	11.6%	1.5%	18.2%	10.4%	2.6%		0.0%	1.1%	0.0%	6.4%
NHS App Registrations																					
NHS App uptake (aged 13+)	Nat_Avg: 48.1%	20_Jun_22	1	↑	32.4%	38.2%	30.7%	39.9%	30.6%	44.8%	44.4%	49.0%	47.4%	39.7%	46.9%	44.6%		50.1%	47.8%	39.4%	42.2%

Patient Online Management Indicators (POMI)																		
POMI - registered for at least one online service																		
At least one online service - Patients Enabled	Nat_Avg: 46.9%	Apr_22	1	↑	37.2%	43.9%	45.9%	45.5%	39.6%	54.0%	43.1%	85.5%	49.9%	46.9%	42.9%	52.7%	44.3%	58.2%	49.8%	48.1%
POMI - Online Booking/Cancelling Appointments																		
Appt Book - Patients Enabled	Nat_Avg: 40.5%	Apr_22	1	↑	31.6%	41.5%	41.5%	43.9%	34.1%	49.3%	29.7%	58.6%	37.8%	41.5%	32.7%	40.7%	39.1%	56.2%	49.6%	41.3%
Appt Utilisation (those enabled)	Nat_Avg: 2.2%	Apr_22	1	↑	2.4%	1.9%	0.2%	6.1%	0.9%	3.1%	2.8%	0.5%	4.2%	1.7%	4.1%	2.5%	12.9%	6.5%	0.5%	3.6%
POMI - Online Repeat Prescriptions																		
Presc - Patients Enabled	Nat_Avg: 46.5%	Apr_22	1	↑	37.1%	43.9%	45.8%	45.4%	27.6%	53.9%	43.1%	85.4%	49.9%	46.6%	42.8%	52.4%	44.3%	57.9%	49.5%	47.6%
Presc Utilisation (those enabled)	Nat_Avg: 21.1%	Apr_22	1	↑	26.4%	30.8%	36.9%	31.0%	42.6%	41.0%	38.9%	24.9%	40.0%	35.4%	39.4%	39.9%	33.2%	35.8%	29.8%	35.3%
POMI - Online Access to Detailed Medical Record																		
Detail Record - Patients Enabled	Nat_Avg: 13.2%	Apr_22	1	↑	3.8%	9.4%	12.4%	6.8%	11.2%	19.0%	10.0%	13.0%	12.8%	14.2%	11.0%	9.1%	9.2%	26.9%	12.4%	12.6%

Table 4: Prescribing Indicators

CQC moniotred target within GP Practice Evidence Tables

					East					West					South West			South			
Indicator (see menu at the end of the report for futher detail)	Target	Period	sided test	polarity	Boston	East Lindsey	First Coastal	Meridian Medical	SOLAS	Apex	Imp	Lincoln Health Partnership	South Lincoln	Trent Care	Grantham and Rural	K2 Healthcare	Stamford	Four Counties	South Lincolnshire Rural	Spalding PCN	LINCS
Overall																					
All Prescribing NIC/ASTRO-PU	Nat_Avg: £10.51	Jan_Mar22	2		£10.63	£12.01	£14.81	£13.55	£11.36	£11.86	£10.86	£9.67	£11.64	£12.40	£10.98	£11.91	£11.11	£11.91	£10.46	£11.74
Percentage Generic Items	Nat_Avg: 84.8%	Jan_Mar22	1	↑	84.8%	86.4%	86.0%	85.3%	84.9%	84.6%	85.3%	85.3%	85.4%	86.6%	86.0%	86.4%	87.9%	88.5%	89.2%	86.6%
Infections																					
Antibacterial items/100 STAR PU	Nat_Avg: 22.00	Jan_Mar22	1	↓	22.49	24.27	31.97	26.19	24.04	25.67	26.48	21.21	26.56	25.99	23.49	27.49	22.19	30.39	23.55	25.84
Co-Amoxic, Cephs and Quins % Items	Nat_Avg: 8.6%	Jan_Mar22	1	↓	11.1%	13.9%	10.4%	15.4%	12.5%	10.5%	11.9%	8.7%	13.4%	12.1%	9.9%	11.9%	11.6%	11.6%	9.0%	11.6%
3 Day ABx uncomplicated UTI ADQ/Items	Nat_Avg: 5.30	Jan_Mar22	1	↓	5.31	5.48	6.12	5.86	5.34	5.18	5.73	5.19	6.20	5.43	4.76	5.55	5.61	4.87	5.17	5.41
Minocycline ADQ/1000 Patients	Nat_Avg: 2.67	Jan_Mar22	1	↓	11.09	8.74	12.51	9.19	12.15	-	8.49	-	20.60	13.65	-	5.37	7.04	6.70	3.23	8.98
Diabetes																					
Long-acting insulin analogues %	Nat_Avg: 80.9%	Jan_Mar22	1	↓	92.7%	84.0%	79.5%	89.1%	84.9%	90.3%	87.0%	90.0%	91.8%	89.5%	89.7%	88.1%	84.7%	92.2%	94.0%	88.5%
Mental Health																					
Drugs acting on benzodiazepine recep ADQ/100 STAR PU	Nat_Avg: 144.30	Jan_Mar22	1	↓	198.53	174.32	224.55	269.03	244.18	203.42	227.98	318.22	211.17	270.02	125.81	139.77	197.64	207.26	90.42	199.25
Benzo as Hypnotics ADQ/100 STAR PU	Nat_Avg: 14.80	Jan_Mar22	1	↓	20.79	18.15	22.66	26.91	24.73	19.57	23.03	26.58	21.94	27.65	13.19	14.08	19.61	23.20	8.46	20.34
Dosulepin: % of selected AD items	Nat_Avg: 0.6%	Jan_Mar22	1	↓	0.7%	0.8%	1.2%	1.4%	1.3%	0.6%	0.8%	0.4%	0.7%	0.3%	0.7%	1.0%	1.1%	1.3%	0.9%	0.9%
Antidepressants: First line as % of all A/D items	Nat_Avg: 66.9%	Jan_Mar22	1	↑	69.7%	67.6%	67.5%	65.6%	68.7%	67.8%	67.0%	63.5%	68.4%	66.7%	74.0%	74.5%	73.1%	72.0%	72.6%	69.5%
Antidepressants: ADQ/100 STAR PU	Nat_Avg: 332.50	Jan_Mar22	1	↓	316.91	372.28	474.74	412.39	344.10	424.77	409.08	478.15	379.71	470.74	331.81	378.07	346.74	371.98	324.26	383.05
Drugs for Dementia ADQ/100 STAR PU	Nat_Avg: 54.10	Jan_Mar22	2		42.83	52.47	47.52	53.45	50.40	79.34	66.97	68.80	67.33	72.81	42.92	41.32	56.37	40.27	46.03	52.62
Circulatory																					
Statins ADQ/100 STAR PU	Nat_Avg: 530.60	Jan_Mar22	1	↑	534.92	471.32	586.37	530.02	521.79	537.03	503.82	511.15	469.57	549.81	496.13	535.04	416.72	516.34	557.54	515.73
Drugs affecting renin angiotensin syst ADQ/100 STAR PU	Nat_Avg: 354.90	Jan_Mar22	2		347.41	324.91	370.63	361.35	355.23	365.98	352.84	363.67	337.82	370.43	398.31	380.41	344.96	354.80	361.59	359.44
Respiratory																					
Bronchodilators ADQ/100 STAR PU	Nat_Avg: 146.90	Jan_Mar22	1	↓	145.97	128.44	264.07	156.91	148.60	149.90	146.54	156.23	128.71	154.51	117.50	114.43	130.30	131.94	109.95	145.50
Inhaled Corticosteroids NIC/10 ADQ	Nat_Avg: £2.55	Jan_Mar22	1	↓	£3.09	£2.85	£3.17	£2.87	£3.28	£3.35	£3.18	£3.26	£3.43	£3.31	£3.19	£2.97	£2.77	£2.70	£3.47	£3.09
Inhaled Corticosteroids ADQ/100 STAR PU	Nat_Avg: 63.60	Jan_Mar22	2		58.12	65.78	91.83	81.29	68.20	63.67	65.00	58.07	73.71	68.64	63.70	64.75	65.68	64.79	51.44	67.17
Gastrointestinal																					
Proton pump inhibitors ADQ/100 STAR PU	Nat_Avg: 539.00	Jan_Mar22	2		602.39	624.25	756.93	658.37	638.23	610.96	570.90	519.53	618.64	675.25	539.62	595.94	510.23	641.09	602.67	614.61
Musculoskeletal/Pain																					
Pregabalin+Gabapentin per 1,000 patients	Nat_Avg: 63.63	Jan_Mar22	1	↓	90.21	116.58	210.66	130.71	128.78	102.19	106.30	86.80	87.18	129.42	77.00	98.03	76.95	115.25	95.25	108.54
Analgesics ADQ/100 STAR PU	Nat_Avg: 64.10	Jan_Mar22	2		86.39	86.99	152.46	88.38	101.46	77.90	77.33	76.50	85.22	94.43	79.86	79.09	62.34	81.70	47.12	86.13
Bisphosphonates ADQ/100 STAR PU	Nat_Avg: 152.40	Jan_Mar22	1	↑	150.71	147.87	152.30	192.05	170.05	177.84	186.63	136.11	192.14	178.48	157.15	188.33	152.57	185.07	228.94	173.02
Oral NSAIDs ADQ/100 STAR PU	Nat_Avg: 97.40	Jan_Mar22	2		103.27	96.93	138.84	104.76	102.53	97.35	118.91	101.06	117.90	124.12	128.21	125.93	116.99	111.20	115.05	114.90
NSAIDs Ibuprofen & Naproxen % Items	Nat_Avg: 79.9%	Jan_Mar22	1	↑	82.9%	83.9%	77.8%	80.2%	84.6%	79.7%	80.5%	85.4%	80.2%	74.7%	86.9%	79.6%	78.4%	77.0%	73.4%	80.2%
NSAIDs NIC/10 ADQ	Nat_Avg: £1.44	Jan_Mar22	1	↓	£1.41	£1.20	£1.39	£1.41	£1.12	£1.24	£1.20	£1.27	£1.23	£1.42	£1.20	£1.35	£1.42	£1.80	£1.16	£1.35

Table 5: QOF Recorded Disease Prevalence - 2020/21

CQC moniotred target within GP Practice Evidence Tables

					East					West					South West			South			
Indicator (see menu at the end of the report for futher detail)	Target	Period	sided test	polarity	Boston	East Lindsey	First Coastal	Meridian Medical	SOLAS	Apex	Imp	Lincoln Health Partnership	South Lincoln	Trent Care	Grantham and Rural	K2 Healthcare	Stamford	Four Counties	South Lincolnshire Rural	Spalding PCN	LINCS
Total QOF points (Total)	Nat_Avg: 96.2%	2020_21	1	↑	94%	98%	93%	98%	96%	98%	98%	93%	97%	98%	98%	99%	100%	99%	92%	97%
Cardiovascular/Circulatory																					
Atrial Fibrillation	Nat_Avg: 2.0%	2020_21	2		2.1%	3.2%	3.9%	3.4%	3.4%	2.3%	2.4%	1.2%	2.6%	2.5%	2.6%	3.0%	2.8%	3.0%	2.4%	2.7%
Coronary Heart Disease	Nat_Avg: 3.0%	2020_21	2		3.4%	4.7%	6.5%	4.8%	4.7%	3.9%	3.5%	1.8%	3.8%	4.4%	3.9%	4.2%	3.6%	4.4%	3.3%	4.1%
Heart Failure	Nat_Avg: 0.9%	2020_21	2		1.1%	1.3%	2.1%	2.1%	1.9%	1.1%	1.2%	0.5%	0.9%	1.1%	1.7%	1.4%	1.5%	1.6%	1.9%	1.4%
Hypertension	Nat_Avg: 13.9%	2020_21	2		14.9%	17.4%	22.9%	19.3%	19.1%	15.0%	15.3%	8.5%	15.1%	16.7%	17.7%	18.8%	15.9%	19.0%	16.9%	17.0%
Peripheral Arterial Disease	Nat_Avg: 0.6%	2020_21	2		0.6%	0.7%	1.4%	0.7%	0.8%	0.6%	0.6%	0.3%	0.5%	0.8%	0.7%	0.7%	0.6%	0.7%	0.6%	0.7%
Stroke and TIA	Nat_Avg: 1.8%	2020_21	2		2.1%	2.8%	3.6%	2.7%	2.9%	2.1%	2.0%	1.0%	2.1%	2.4%	2.0%	2.4%	2.3%	2.6%	2.0%	2.3%
Respiratory																					
Asthma (6+)	Nat_Avg: 6.4%	2020_21	2		5.4%	8.1%	8.4%	8.6%	7.6%	6.9%	7.4%	5.0%	7.1%	7.7%	6.6%	7.0%	7.5%	7.9%	5.6%	7.1%
COPD	Nat_Avg: 1.9%	2020_21	2		2.0%	2.3%	4.7%	2.7%	2.9%	2.2%	2.0%	1.3%	2.0%	2.7%	2.0%	2.3%	1.7%	2.3%	2.0%	2.3%
Lifestyle																					
Non-diabetic hyperglycaemia (18+)	Nat_Avg: 5.3%	2020_21	2		4.3%	5.2%	5.1%	6.3%	5.2%	3.1%	6.1%	2.5%	3.9%	6.3%	5.8%	4.2%	7.3%	7.9%	5.1%	5.4%
Obesity (18+)	Nat_Avg: 6.9%	2020_21	2		7.8%	8.2%	10.3%	5.9%	6.5%	10.2%	8.2%	5.3%	5.9%	10.2%	9.7%	9.7%	3.5%	8.9%	7.8%	8.1%
High Dependency and Long Term Conditions																					
Cancer	Nat_Avg: 3.2%	2020_21	2		2.6%	4.5%	5.1%	4.8%	4.6%	3.7%	3.8%	1.8%	3.9%	4.1%	4.0%	4.5%	4.3%	4.7%	3.6%	4.0%
Chronic Kidney Disease (18+)	Nat_Avg: 4.0%	2020_21	2		5.0%	7.8%	10.3%	8.1%	7.6%	6.7%	6.1%	3.1%	5.6%	8.6%	6.3%	7.9%	6.4%	6.5%	8.6%	6.9%
Diabetes (17+)	Nat_Avg: 7.1%	2020_21	2		7.1%	8.7%	12.2%	8.0%	9.3%	7.4%	7.0%	4.3%	7.2%	8.4%	7.5%	8.1%	6.6%	9.0%	7.0%	7.9%
Palliative Care	Nat_Avg: 0.5%	2020_21	2		0.5%	0.9%	1.0%	1.5%	0.9%	0.7%	0.5%	0.5%	0.9%	0.5%	0.5%	0.7%	0.6%	0.4%	0.4%	0.7%

Neurological and Mental Health																		
Dementia	Nat_Avg: 0.7%	2020_21	2		0.8%	1.0%	1.2%	1.1%	1.0%	1.0%	0.8%	0.4%	1.1%	1.1%	0.8%	0.9%	1.0%	0.9%	0.9%	0.9%
Depression (18+)	Nat_Avg: 12.3%	2020_21	2		11.1%	11.3%	13.7%	14.0%	12.2%	17.7%	14.1%	12.0%	11.9%	15.5%	14.9%	10.2%	12.8%	15.8%	10.5%	13.3%
Epilepsy (18+)	Nat_Avg: 0.8%	2020_21	2		0.8%	1.0%	1.2%	1.1%	1.0%	0.9%	0.9%	0.6%	0.8%	1.1%	0.8%	1.0%	0.8%	0.8%	0.8%	0.9%
Learning Disability	Nat_Avg: 0.5%	2020_21	2		0.5%	0.6%	1.0%	0.9%	0.9%	0.8%	0.6%	0.4%	0.5%	0.7%	0.5%	0.6%	0.4%	0.5%	0.7%	0.6%
Mental Health	Nat_Avg: 0.9%	2020_21	2		0.7%	0.8%	1.0%	1.0%	0.7%	0.9%	1.1%	1.0%	0.7%	1.1%	0.7%	0.8%	0.7%	0.6%	0.7%	0.8%
Muskoskeletal																		
Osteoporosis (50+)	Nat_Avg: 0.8%	2020_21	2		0.6%	0.7%	0.9%	1.0%	0.8%	0.7%	0.8%	0.4%	0.7%	0.5%	1.2%	0.6%	1.2%	1.0%	1.5%	0.8%
Rheumatoid Arthritis (16+)	Nat_Avg: 0.8%	2020_21	2		0.7%	1.0%	1.1%	1.2%	0.8%	0.8%	0.8%	0.4%	0.9%	1.0%	0.8%	1.0%	0.7%	1.0%	0.9%	0.9%

Table 6: Primary Care Indicators

CQC moniotred target within GP Practice Evidence Tables

					East					West					South West		South			
Indicator (see menu at the end of the report for futher detail)	Target	Period	sided test	polarity	Boston	East Lindsey	First Coastal	Meridian Medical	SOLAS	Apex	Imp	Lincoln Health Partnership	South Lincoln	Trent Care	Grantham and Rural KL	Healthcare Sleaford	Four Counties	South Lincolnshire Rural	Spalding PCN	LINCS
Childhood vaccination programme																				
Yr1: DTaP/IPV/HIB	95% (Nat_Std)	May_22	1	↑	88%	93%	95%	92%	94%	92%	90%	86%	99%	87%	97%	94%	98%	83%	88%	91%
Yr2: Hib/MenC booster	95% (Nat_Std)	May_22	1	↑	85%	90%	96%	89%	100%	95%	94%	85%	98%	82%	94%	95%	92%	91%	89%	92%
Yr2: MMR	95% (Nat_Std)	May_22	1	↑	85%	90%	94%	92%	100%	94%	94%	87%	98%	86%	94%	95%	94%	91%	88%	92%
Yr2: PCV Booster	95% (Nat_Std)	May_22	1	↑	86%	90%	94%	94%	100%	94%	89%	83%	95%	84%	94%	92%	92%	90%	84%	90%
Yr5: DTaP/IPV booster	95% (Nat_Std)	May_22	1	↑	65%	81%	69%	84%	82%	87%	83%	74%	76%	72%	76%	78%	85%	81%	67%	77%
Yr5: MMR 2nd Dose	95% (Nat_Std)	May_22	1	↑	72%	87%	87%	91%	97%	93%	92%	81%	91%	79%	91%	91%	87%	81%	72%	85%
Flu Vaccination Programme 20/21 - 75% end of season target																				
Patients Aged 65+	82.1% (Nat_Avg)	Sep_Jan_22	1	↑	82%	83%	74%	84%	82%	88%	85%	80%	89%	85%	86%	87%	88%	86%	86%	84%
Patients 6 mths to <65 at Clinical Risk	52.5% (Nat_Avg)	Sep_Jan_22	1	↑	54%	60%	49%	59%	59%	58%	58%	46%	67%	56%	59%	66%	61%	63%	59%	58%
All Pregnant Women (as at 1 Sep)	37.6% (Nat_Avg)	Sep_Jan_22	1	↑	42.2%	50.1%	38.0%	44.8%	57.5%	49.7%	48.7%	46.6%	54.4%	47.0%	41.6%	50.5%	42.5%	43.6%	39.9%	45.8%
Carers aged 16 to 64 registered	50.7% (Nat_Avg)	Sep_Jan_22	1	↑	50.2%	56.2%	52.1%	55.3%	50.9%	54.8%	54.3%	39.3%	60.6%	54.1%	59.3%	66.7%	56.4%	58.2%	40.2%	54.2%
Other																				
Dementia Prevalence (est.)	67% (Nat_Std)	May_22	1	↑	68%	56%	59%	60%	53%	73%	57%	69%	73%	76%	56%	52%	67%	54%	68%	61%
Mental Health Care																				
SMI Healthchecks - 6 Tests (target 60%)	42.8% (Nat_Avg)	Q4_2122	1	↑	38.4%	54.6%	39.0%	53.1%	36.8%	55.2%	40.2%	37.3%	54.5%	46.6%	45.0%	64.8%	34.9%	65.8%	24.2%	45.6%
LD Annual Healthchecks (prov)	5.9% (CCG_Plan)	YTD_May22	1	↑	8%	5%	0%	3%	5%	6%	8%	11%	14%	3%	6%	9%	6%	3%	5%	6%

Table 7: Cancer Prevention (National Screening Programmes)

Note eligibility criteria differs from QOF

CQC moniotred target within GP Practice Evidence Tables

					East					West					South West		South			
Indicator (see menu at the end of the report for futher detail)	Target	Period	sided test	polarity	Boston	East Lindsey	First Coastal	Meridian Medical	SOLAS	Apex	Imp	Lincoln Health Partnership	South Lincoln	Trent Care	Grantham and Rural KL	Healthcare Sleaford	Four Counties	South Lincolnshire Rural	Spalding PCN	LINCS
Breast Cancer Screening (National Standard: 80%)																				
Breast Screening (age 50-70)	61.6% (Nat_Avg)	R3Y Oct21	1	↑	57%	67%	55%	62%	67%	74%	71%	60%	69%	70%	57%	44%	70%	71%	74%	64%
Breast Screening (age 47-73)	53.1% (Nat_Avg)	R3Y Oct21	1	↑	50%	59%	49%	52%	61%	66%	61%	52%	59%	62%	48%	38%	59%	62%	66%	56%
Cervical Cancer Screening (National Standard: 80%)																				
Cervical Screening (25-49)	67.2% (Nat_Avg)	R3Y Feb22	1	↑	59%	75%	69%	77%	68%	77%	73%	59%	79%	74%	75%	76%	75%	79%	70%	72%
Cervical Screening (50-64)	74.4% (Nat_Avg)	R5Y Feb22	1	↑	68%	76%	73%	77%	75%	79%	78%	72%	78%	77%	79%	80%	79%	81%	79%	77%
Bowel Cancer Screening (National Standard: 60%)																				
Bowel Cancer Screening (60-74)	69.8% (Nat_Avg)	R2Y Oct21	1	↑	68%	74%	67%	73%	72%	74%	73%	69%	75%	72%	75%	76%	76%	75%	73%	73%
Bowel Cancer Screening (Age 56 - started Apr-21)	44.9% (Nat_Avg)	uptoOct21	1	↑	33%	43%	36%	50%	35%	50%	46%	35%	50%	47%	33%	34%	#DIV/0!	43%	30%	41%

Table 8: Cancer Incidence & Outcomes (CCT dashboard indicators) - UPDATED

CQC moniotred target within GP Practice Evidence Tables

					East					West					South West		South			
Indicator (see menu at the end of the report for futher detail)	Target	Period	sided test	polarity	Boston	East Lindsey	First Coastal	Meridian Medical	SOLAS	Apex	Imp	Lincoln Health Partnership	South Lincoln	Trent Care	Grantham and Rural KL	Healthcare Sleaford	Four Counties	South Lincolnshire Rural	Spalding PCN	LINCS
QOF Registers																				
Cancer Register	Nat_Avg: 3.2%	2020_21	2		2.6%	4.5%	5.1%	4.8%	4.6%	3.7%	3.8%	1.8%	3.9%	4.1%	4.0%	4.5%	4.3%	4.7%	3.6%	4.0%
Cancer PCA (Exceptions)	Nat_Avg: 1.3%	2020_21	1	↓	2.8%	0.9%	20.8%	2.6%	0.8%	0.0%	2.2%	0.0%	0.5%	4.3%	3.6%	4.3%	0.6%	1.2%	2.6%	1.5%
Cancer Waiting Times																				
2WW referrals ALL cancers per 1,000	Nat_Avg: 33.9	2020_21	2		30.9	42.4	50.6	53.6	43.8	44.3	33.0	24.5	42.9	38.9	37.3	43.6	33.4	45.8	23.8	39.2
2WW referrals with cancer Conversion rate	Nat_Avg: 7.0%	2020_21	2		8.4%	8.7%	8.9%	6.8%	10.4%	8.2%	8.3%	5.7%	6.8%	9.1%	7.3%	7.6%	8.2%	7.4%	9.4%	8.0%
New cases treated (% 2WW referrals)	Nat_Avg: 54.8%	2020_21	1	↑	58.5%	52.8%	54.0%	56.7%	57.6%	65.4%	54.7%	54.5%	55.2%	54.9%	52.5%	58.4%	59.5%	59.2%	52.0%	56.4%
2WW BREAST referrals per 1,000	Nat_Avg: 6.9	2020_21	2		4.9	7.4	6.5	8.3	5.3	6.8	5.2	3.8	6.4	6.3	6.6	6.8	7.8	8.1	4.9	6.4
2WW LOWER GI referrals per 1,000	Nat_Avg: 6.1	2020_21	2		6.8	8.9	11.2	11.9	9.3	9.0	6.4	4.6	9.4	7.9	6.7	9.9	6.3	9.2	5.2	8.1
2WW LUNG referrals per 1,000	Nat_Avg: 0.7	2020_21	2		0.6	0.9	1.0	2.4	1.1	1.1	0.9	0.5	1.0	0.9	0.7	0.7	1.1	0.9	0.4	0.9
2WW SKIN referrals per 1,000	Nat_Avg: 6.9	2020_21	2		6.6	8.5	9.8	9.4	6.9	8.0	6.5	3.8	7.9	7.3	7.1	7.5	7.8	10.1	4.8	7.6
Other Presentations																				
Emerg Cancer Admissions per 1,000	Nat_Avg: 4.6	2020_21	2		4.2	5.6	8.0	7.2	5.7	5.6	5.3	2.6	5.2	5.5	4.4	5.7	4.4	4.7	2.8	5.1
Emerg Presentations per 1,000	Nat_Avg: 0.9	2020_21	2		0.9	1.2	1.8	1.6	1.4	0.9	0.8	0.5	1.0	1.2	1.1	0.8	0.9	1.0	0.7	1.0
Managed Referral Presentations per 1,000	Nat_Avg: 3.0	2020_21	2		2.7	4.4	5.5	4.4	5.3	3.9	3.5	2.4	3.7	3.8	3.8	4.0	4.3	4.1	3.1	3.9

Table 9: Acute Activity Indicators

Indicator (see menu at the end of the report for futher detail)	Target	Period	sided test	polarity	East					West						South West		South			
					Boston	East Lindsey	First Coastal	Meridian Medical	SOLAS	Apex	Imp	Lincoln Health Partnership	South Lincoln	Trent Care	Grantham and Rural	K4 Healthcare Sleaford	Four Counties	South Lincolnshire Rural	Spalding PCN	LINCS
Outpatient Attendances per 1,000 Directly Age Standardised Rates - GP Referral Source																				
First Attendances	181.9 (Linc_Avg)	Apr_Mar22	1	↓	158.4	186.0	198.7	220.2	174.7	178.3	170.0	157.5	184.7	178.6	186.0	203.7	177.6	196.4	151.8	182.5
First Attendances with discharge outcome	61.1 (Linc_Avg)	Apr_Mar22	1	↓	49.0	54.9	57.8	68.5	54.9	62.9	59.2	64.0	62.7	62.1	72.2	74.1	62.0	62.5	50.9	62.2
Follow-Up Attendances	289.8 (Linc_Avg)	Apr_Mar22	1	↓	273.2	331.0	314.8	347.6	303.5	283.6	270.0	208.5	292.7	306.8	270.8	323.1	264.3	319.2	237.3	292.3
Elective Inpatients per 1,000 Directly Age Standardised Rates																				
Elective & Daycase	116.9 (Linc_Avg)	Apr_Mar22	1	↓	123.6	135.0	126.4	139.5	125.1	125.0	117.3	84.8	121.7	128.8	108.9	113.0	97.7	115.3	97.5	118.2
Daycases	102.8 (Linc_Avg)	Apr_Mar22	1	↓	109.7	120.0	110.4	122.9	110.9	109.8	103.0	73.8	106.5	113.1	94.1	98.4	88.1	101.9	84.5	103.9
Ordinary Electives	14.1 (Linc_Avg)	Apr_Mar22	1	↓	13.8	15.0	16.0	16.6	14.2	15.1	14.3	11.0	15.2	15.7	14.8	14.7	9.6	13.4	13.1	14.4
A&E attendances per 1,000 Directly Age Standardised Rates																				
All A&E T1 & T3 (inc UCS)	399.2 (Linc_Avg)	Apr_Mar22	1	↓	414.0	377.1	634.0	514.1	428.2	355.9	365.8	399.3	312.5	432.2	377.4	313.1	298.9	380.0	461.9	391.0
T1 - Major A&E	210.4 (Linc_Avg)	Apr_Mar22	1	↓	224.8	210.4	217.5	214.1	194.5	188.6	192.7	211.3	160.2	225.1	263.5	207.7	183.1	212.7	181.7	210.1
T3 - MIU & UCS	187.8 (Linc_Avg)	Apr_Mar22	1	↓	188.8	166.0	415.8	298.8	232.9	166.5	172.3	187.1	151.5	206.5	109.7	104.0	115.0	166.7	280.0	179.6
T1 - Major A&E - disch no f/u	97.3 (Linc_Avg)	Apr_Mar22	1	↓	106.4	108.3	95.1	112.1	91.6	85.0	87.9	94.7	71.7	115.9	98.0	85.1	100.6	107.1	89.7	96.6
T1 - Major A&E - admitted	62.7 (Linc_Avg)	Apr_Mar22	1	↓	76.5	58.7	84.4	61.9	68.4	58.6	58.3	67.2	50.2	60.1	55.9	57.5	51.9	68.0	60.6	61.6
Emergency Spells per 1,000 Directly Age Standardised Rates																				
All Emergency Admissions	86.8 (Linc_Avg)	Apr_Mar22	1	↓	98.1	86.3	108.9	97.0	91.3	85.5	81.2	91.9	71.8	90.7	79.0	79.9	74.5	91.5	82.7	86.1
Same day discharges	28.8 (Linc_Avg)	Apr_Mar22	1	↓	34.9	31.2	36.4	35.9	33.0	27.3	25.1	32.7	23.0	32.4	23.7	24.7	21.4	32.7	28.2	29.0
Same Day & Overnight Stay	41.8 (Linc_Avg)	Apr_Mar22	1	↓	49.5	44.2	52.5	51.4	47.0	38.9	36.1	46.1	33.8	44.2	36.4	37.5	32.8	46.9	40.4	41.9
Discharged after 14 days	8.7 (Linc_Avg)	Apr_Mar22	1	↓	9.2	8.0	10.9	8.2	7.8	8.9	8.7	8.2	7.0	7.8	8.4	8.1	9.1	10.0	7.8	8.5

Indicator Definitions and data sources

1 sided RAG rating:

Where X% is the stated RAG threshold above table

Polarity: lower rate is better
higher rate is better

2 sided RAG rating:

Note: for 2 sided testing RED shading highlights score or rate is higher than Target; not necessarily "bad".

Table 1: Contextual Indicators

Staffing (non ARRS funded)	https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services
GP FTE per 100,000 (incl Locums & Registrars)	GP Full Time Equivalent per 100,000 registered patients (incl partners, salaried, retainers, and training grade, but excl ad-hoc locums)
Nurse FTE per 100,000 (incl ANP, PN)	Nurse Full Time Equivalent per 100,000 registered patients (incl practice nurse, adv nurse practitioner, extended role PN)
DPC FTE per 100,000 (Disp, HCA, Phleb etc)	Direct Patient Care FTE per 100,000 (Disp, Pharmacist, HCA, Phleb, Physio, Therap[ist, Podiatrist etc)
DPC FTE per 100,000 (HCA, Phleb etc …excl Disp)	Direct Patient Care FTE per 100,000 (Pharmacist, HCA, Phleb, Physio, Therap[ist, Podiatrist etc … but excluding Dispensers)
Patient List	
% aged 0 to 4 years	Proportion of the practice population (in percent) aged under 5 years
% aged 65+ years	Proportion of the population (in percent) aged 65 years or over
% aged 85+ years	Proportion of the practice population (in percent) aged 85 years or over
Last 12 month List Growth	% growth in practioce registered list size over the past 12 months
Dispensing Patients	% patients who are eligible for drug dispensing at the GP practice
Socio-Economic	http://fingertips.phe.org.uk/profile/general-practice/data
Deprivation score (IMD 2019)	The English Indices of Deprivation 2019 use 39 separate indicators, organised across seven distinct domains of deprivation which can be combined, using appropriate weights, to calculate the Index of Multiple Deprivation 2019 (IMD 2019).
IDACI (Income Depr. - Children)	Proportion of children aged 0–15 years living in income deprived households as a proportion of all children aged 0–15 years.
IDAOPI (Income Depr. - Older People)	Adults aged 60 years or over living in pension credit (guarantee) households as a proportion of all those aged 60 years or over.
Life expectancy - Female Life expectancy - Male	Life expectancy at birth. Population weighting applying MSOA Life expectancy to GP registered patients.

Table 2: National GP Patient Survey - Patient Responses (fieldwork Jan-Mar 21)

https://gp-patient.co.uk/

Response Rate	Response rate
Local GP Services	

Ease of getting through by phone	Q1: Ease of getting through to someone at GP surgery on the phone - Very or Fairly Easy
Helpfulness of receptionists	Q2: Helpfulness of receptionists at GP surgery - Very or Fairly Helpful
Satisifed with Appt times available	Q6: Satisfaction with general practice appointment times available - Very & Fairly
Have a preferred GP	Q7: Have a preferred GP - Yes
Ease of using practice website	Q4: Ease of using your GP practice's website to look for information or access services - Very or fairly easy
Patient use of GP online services	
Booking appointments	Q3: Use of GP online services in past 12 months - Booking appointments online
Repeat precriptions	Q3: Use of GP online services in past 12 months - Ordering repeat prescriptions online
Medical records	Q3: Use of GP online services in past 12 months - Accessing medical records online
Online Consulation	Q3: Use of GP online services in past 12 months - Had an online consultation or appointment (e.g. completed online form or had a video call)
None	Q3: Use of GP online services in past 12 months - None of these
Making An Appointment	
Offered a choice of Appt	Q14: Whether offered a choice of appointment- Combined 'yes, a choice of place' and 'choice of time or day' and 'choice of HCPl'
Satisfied with Appt type	Q15: Satisfaction with type of appointment offered - Combined 'yes, and I accepted an appointment' and 'no, but I still took an appointment'
Appointment making experience	Q20: Overall appointment making experience - Combined 'Very Good and Fairly Good'
At your last GP/Nurse/OHCP appointment	
Gave you enough time	Q25: Rating of HCP giving you enough time - very good or good
Listened to you	Q25: Rating of HCP listening to you - very good or good
Treated with care/concern	Q25: Rating of HCP treating you with care and concern - very good or good
Recognised or understood any MH needs	Q26: Rating of HCP recognising/understanding any MH needs you may have - 'yes, definitely' and 'Yes, to some extent
Involved you in decisions	Q27: Rating of HCP involving you in decisions about your care - very good or good
Confidence and trust in HCP	Q28: Confidence and trust in HCP - Yes definitely or Yes to some extent
Were needs met	Q29: In relation to reasons for last visti were your need met - Yes definitely or Yes to some extent
Overall Practice Experience	
Overall Practice Experience	Q30: Overall experience of your GP Practice - very or fairly good
Patient Health	
LTC - Physical, MH, disbaility, illness	Q32: Have a long-term physical or mental health conditions, disabilities or illnesses
Supported to manage LTC	Q36: Last 6 months, enough support from local services/orgs to help manage long-term conditions - yes definitely or to some extent

Table 3: GP Online Services

	EPS allows prescribers to send prescriptions electronically to a dispenser (such as a pharmacy) of the patient's choice
EPSR2 - Electronic Prescriptions	https://digital.nhs.uk/Electronic-Prescription-Service/statistics-and-progress
Patient Nominations	Patients with a least 1 nomination type set (Pharmacy, DAC or Dispensing Doctor - Source - NHS Spine)
EPS Utilisation	Electronic Prescriptions (EPS) Items as a % of Total Presctption Items
ERD Utilisation	Estimated Percent of EPSr2 items that were Repeat Dispensing
NHS App Registrations	
NHS App uptake (aged 13+)	% registered patients (aged 13+) who have a fully validated registeration for the App (P9) i.e. full photo ID and video validation
Patient Online Management Indicators (POMI)	
POMI - registered for at least one online serv	https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/pomi
Patient - Online Booking/Cancelling Appts	https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/pomi
Patients Enabled	Proportion of patients enabled to electronically book or cancel an appointment
Utilisation	Occasions that the functionality is used as a proportion of those enabled
Patient - Online Repeat Prescriptions	https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/pomi
Patients Enabled	Proportion of patients enabled to electronically order repeat prescriptions
Utilisation	Occasions that the functionality is used as a proportion of those enabled
Patient - Online Detailed Medical Record	https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/pomi
Patients Enabled	Proportion of patients enabled to View Detailed Coded Records Online

Table 4: Prescribing Indicators

https://apps.nhsbsa.nhs.uk/infosystems/welcome

Overall	
All Prescribing NIC/ASTRO-PU	Total Net Ingredient Cost for all precribing per Astro-PU (standardised)
Percentage Generic Items	
Infections	
Antibacterial items/100 STAR PU	Prescription items for antibacterial drugs (BNF 5.1) per Oral antibacterials (BNF 5.1 sub-set) ITEM based 100 STAR-PU.
Co-Amoxic, Cephs and Quins % Items	Prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total prescription items for selected antibacterial drugs (sub-set of BNF 5.1)
3 Day ABx uncomplicated UTI ADQ/Items	Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection
Minocycline ADQ/1000 Patients	Average daily quantities (ADQs) for minocycline per 1000 patients.
Diabetes	
Long-acting insulin analogues %	Prescription items for long-acting human analogue insulins as a percentage of the total prescription items for all long- acting and intermediate acting insulins excluding biphasic insulins.
Mental Health	
Drugs acting on benzodiazepine recep ADQ/100 STAR PU	From BNF 4.1 sub-set: Loprazolam Mesilate, Lormetazepam, Nitrazepam, Temazepam, Zaleplon, Zolpidem Tartrate, Zopiclone, Chlordiazepoxide, Chlordiazepoxide Hydrochloride, Diazepam, Lorazepam & Oxazepam
Benzo as Hypnotics ADQ/100 STAR PU	Average daily quantities (ADQs) for benzodiazepines (indicated for use as hypnotics) and “Z” drugs per Hypnotics (BNF 4.1.1 sub-set) ADQ based STAR-PU.
Antidepressants: ADQ/100 STAR PU	Antidepressants (BNF 4.3)
Antidepressants: First line as % of all A/D items	2015 definition: Items for SRRIs (sub-set of BNF 4.3.3) prescribed by approved name as a percentage of total items for ‘selected’ antidepressants (sub-set of BNF 4.3)
Dosulepin: % of selected AD items	Items for dosulepin as a percentage of items for as a percentage of total items for ‘selected’ antidepressants (sub-set of BNF 4.3)
Drugs for Dementia ADQ/100 STAR PU	BNF section 4.11
Circulatory	
Statins ADQ/100 STAR PU	From BNF 2.12 sub-set: Rosuvastatin Calcium, Simvastatin & Ezetimibe, Atorvastatin, Cerivastatin, Fluvastatin Sodium, Lovastatin, Pravastatin Sodium & Simvastatin
Drugs affecting renin angiotensin syst ADQ/100	BNF sub section 2.5.5: Angiotensin-Converting Enzyme Inhibitors, Angiotensin-II Receptor Antagonists
Respiratory	
Bronchodilators ADQ/100 STAR PU	BNF section 3.1
Inhaled Corticosteroids NIC/100 ADQ	Inhaled Corticosteroids (BNF 3.2)
Inhaled Corticosteroids ADQ/100 STAR PU	BNF section 3.2
Gastrointestinal	
Proton pump inhibitors ADQ/100 STAR PU	BNF 1.3.5 sub-set excluding 1.3.5.0A0 Helicobacter Pylori Eradication Therapy
Musculoskeletal/Pain	
Pregabalin+Gabapentin per 1,000	Total Pregabalin and Gabapentin Items per 1,000 registered patient list size
Analgesics ADQ/100 STAR PU	BNF sub sections 4.7.1 and 4.7.2
Oral NSAIDs ADQ/100 STAR PU	Average daily quantities (ADQs) for all NSAIDs (BNF 10.1.1) per Oral NSAID (BNF 10.1.1 sub-set) COST based STAR-PU.
NSAIDs NIC/ADQ	Non-steroidal anti-inflammatory drugs (BNF 10.1.1)

Table 5: QOF Recorded Disease Prevalence - 2020/21

Cardiovascular/Circulatory	
Atrial Fibrillation	% of practice patients on the QOF Atrial Fibrillation register (all ages)
CHD Secondary Prevention	% of practice patients on the QOF Coronary Heart Disease register (all ages)
Cardiovascular Disease Primary Prevent	% of practice patients on the QOF Cardiovascular Disease Primary prevention register (aged 30-74)

Heart Failure	% of practice patients on the QOF Heart Failure register (all ages)
Hypertension	% of practice patients on the QOF Hypertension register (all ages)
Peripheral Arterial Disease	% of practice patients on the QOF PAD register (all ages)
Stroke/TIA	% of practice patients on the QOF STIA (all ages)
Respiratory	
Asthma	% of practice patients on the QOF Asthma (aged 6+)
COPD	% of practice patients on the QOF COPD register (all ages)
Lifestyle	
Non-diabetic hyperglycaemia (18+)	% of practice patients on the QOF NDH (aged 18 and over)
Obesity (18+)	% of practice patients on the QOF Obesity register (aged 18 and over)
High Dependancy and Long Term Conditions	
Cancer	% of practice patients on the QOF Cancer register (all ages)
Chronic Kidney Disease (18+)	% of practice patients on the QOF Chronic Kidney Disease register (aged 18 and over)
Diabetes Mellitus (17+)	% of practice patients on the QOF Diabetes Mellitus register (aged 17 and over)
Palliative Care	% of practice patients on the QOF Palliative Care register (all ages)
Neurological and Mental Health	
Dementia	% of practice patients on the QOF Dementia register (all ages)
Depression (18+)	% of practice patients on the QOF Depression register (aged 18 and over)
Epilepsy (18+)	% of practice patients on the QOF Epilepsy register (aged 18 and over)
Learning Disabilities	% of practice patients on the QOF Learning Disabilities register (all age)
Mental Health	% of practice patients on the QOF Mental Health register (all ages)
Muskoskeletal	
Osteoporosis (50+)	% of practice patients on the QOF Osteoporosis register (aged 50 and over)
Rheumatoid Arthritis (16+)	% of practice patients on the QOF Rheumatoid Arthritis register (aged 16 and over)

QOF Exception reporting for all indicaors combined within each Clinical Domain . Patients are excepted from the indicator denominator because they meet at least one of the exception criteria outlined in the GMS Statement of Financial Entitlements.

Table 6: Primary Care Indicators

Under 5 vaccination programme	
Yr1: DTaP/IPV/HIB	Children aged 1 who have completed immunisation for diphtheria, tetanus, polio, pertussis, Haemophilus influenzae type b (Hib) - (i.e. all 3 doses of DTaP/IPV/Hib)
Yr2: Hib/MenC booster	Children aged 2 who have completed immunisation for Haemophilus influenzae type b (Hib) and meningitis C (MenC) (i.e. received Hib/MenC booster)
Yr2: MMR	Children aged 2 who have completed immunisation for measles, mumps and rubella (i.e. one dose of MMR)
Yr2: PCV Booster	Children aged 2 who have completed immunisation for pneumococcal infection (ie received pneumococcal booster) (PCV booster)
Yr5: DTaP/IPV booster	Children aged 5 who have completed immunisation for diphtheria, tetanus, polio, pertussis (DTaP/IPV) (ie all 4 doses)
Yr5: MMR 2nd Dose	Children aged 5 who have completed immunisation for measles, mumps and rubella (MMR) (i.e. 2 doses)
Flu Vaccination Programme	https://www.gov.uk/government/statistics/seasonal-flu-vaccine-uptake-in-gp-patients-winter-2019-to-2020
Flu Vacc - Patients Aged 65+	For current Winter Season - All patients aged 65+
Flu Vacc - Patients 6 mths to <65 at Risk	Under 65 clinical at-risk group data includes pregnant women with other risk factors but excludes otherwise 'healthy' pregnant women and carers.
Flu Vacc - All Pregnant Women	Total all pregnant women (pregnant as of 1st September)
Flu Vacc - Carers aged 16 to 64	16 years to under 65 years not at-risk who fulfil the 'carer' definition
Other	
Dementia Prevekance (est.)	Estimated Dementia Prevelance - denemtia registers patients aged 65+ as a proportion of expected register numbers (all ages)
Mental Health Care	
SMI patients - Annual Tests	% of people on SMI registers who have received a full set of comprehensive physical health checks in the last 12 months (6 tests)

LD Annual Healthchecks	% of people on GP Learning Disability Registers who have received an Annual Health Check during the year.

Table 7: Cancer Prevention (National Screening Programmes)

https://nww.openexeter.nhs.uk/nhsia/index.jsp

Breast Cancer Screening	
Breast Cancer (50-70)	% of eligible women aged 50-70 screened within the last 36 months
Breast Cancer (47-73)	% of eligible women aged 47-73 screened within the last 36 months (extended age range)
Cervical Cancer Screening	
Cervical Cancer (25-49)	% of eligible female patients aged 25-49 screened with the last and 3.5 years.
Cervical Cancer (50-64)	% of eligible female patients aged 50-64 screened with the last 5.5 years.
Bowel Cancer Screening	
Bowel Cancer (60-69)	% of eligible people aged 60-69 screened with the last 30 mth period.
Bowel Cancer (60-74)	% of eligible people aged 60-74 screened with the last 30 mth period (extended age range)

Table 8: Cancer Incidence & Outcomes (CCT dashboard indicators) - UPDATED

http://fingertips.phe.org.uk/profile/general-practice/data

QOF Registers	
Cancer QOF Register	% of practice patients on the QOF Cancer register (all ages)
Cancer PCA (Exceptions)	The proportion of patients on the disease register who are not receiving the intervention due to a Personalised Care Adjustment (PCA). Exceptions/PCAs relate to patients who would ordinarily be included in the indicator denominator. However they are excepted from the indicator denominator because they meet at least one of the exception/PCA criteria.
Cancer Waiting Times	
2WW referrals ALL cancers per 1,000	2WW referral rate for all suspected cancers per 100,000 patients (crude rate)
2WW referrals with cancer Conversion rate	% of 2WW referrals that are subsequently diagnosed and treated for cancer:
New cases treated (% 2WW referrals)	% of new cancer cases treated who were referred through the Two Week Wait route.
2WW BREAST referrals per 1,000	2WW referral rate for suspected breast cancer per 100,000 patients (crude rate)
2WW LOWER GI referrals per 1,000	2WW referral rate for suspected lower GI cancer per 100,000 patients (crude rate)
2WW LUNG referrals per 1,000	2WW referral rate for suspected lung cancer per 100,000 patients (crude rate)
2WW SKIN referrals per 1,000	2WW referral rate for suspected skin cancer per 100,000 patients (crude rate)
Other Presentations	
Emerg Cancer Admissions per 1,000	Emergency admissions with invasive, in-situ, uncertain or unknown behaviour, or benign brain cancer diagnosis per 100,000 patients (crude rate)
Emerg Presentations per 1,000	Emergency presentations per 100,000 patients (crude rate) - patients diagnosed via a emergency route
Managed Referral Presentations per 1,000	Non-Emergency presentations per 100,000 patients (crude rate) - patients diagnosed via a non-emergency route

Table 9: Acute Activity Indicators

https://gemima.gemcsu.nhs.uk/

Outpatient Attendances per 1,000 Directly Age Standardised Rates - GP Referral Source	
First Attendances	First consultant and non consultant attendances; all Specific Acute Specialities (excl Mat & MH)
First Attendances with discharge outcome	First consultant and non consultant attendances discharged at first attendance; all Specific Acute Specialities (excl Mat & MH)
Follow-Up Attendances	Follow-Up consultant and non consultant attendances; all Specific Acute Specialities (excl Mat & MH)
Elective Inpatients per 1,000 Directly Age Standardised Rates	
Elective & Daycase	Planned Elective and Daycase admissions; all Specific Acute Specialities (excl Mat & MH)
Daycases	Planned Daycase admissions; all Specific Acute Specialities (excl Mat & MH)
Ordinary Electives	Planned Elective admissions; all Specific Acute Specialities (excl Mat & MH)
A&E attendances per 1,000 Directly Age Standardised Rates	
All A&E T1 & T3 (inc UCS)	A&E attendances - all A&E departments (T1, T2, T3 - inc UCS)

T1 - Major A&E	A&E attendances - Type 1 departments (Major A&E)
T3 - MIU & UCS	A&E attendances - Type 3 (Minor Injuries & Urgent Care Streaming)
T1 - Major A&E - admitted	A&E Type 1 attendances where patient was admitted
T1 - Major A&E - disch no f/u	A&E Type 1 attendances where patient was discharged with no follow-up required
Emergency Spells per 1,000 Directly Age Standardised Rates	
All Emergency Admissions	Total unplanned Emergency admissions; all Specific Acute Specialities (excl Mat & MH)
Same day discharges	Total unplanned Emergency admissions discharged same day; all Specific Acute Specialities (excl Mat & MH)
Same Day & Overnight Stay	Total unplanned Emergency admissions discharged same or next day; all Specific Acute Specialities (excl Mat & MH)
Discharged after 14 days	Total unplanned Emergency admissions discharged after 2 weeks; all Specific Acute Specialities (excl Mat & MH)

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PUBLIC PRIMARY CARE COMMISSIONING COMMITTEE

Date: 19 October 2022
Location: MS Teams

Agenda Number:	13
Title of Report:	Quality Update Report
Author:	Wendy Martin, Associate Director of Nursing & Quality
Appendices:	None

1. Key Points for Discussion:

The purpose of this report is to highlight any general quality concerns for General Practice with information on any mitigating actions.

The ICB Locality & Quality Teams continue to work to support Practices and to receive assurance on required improvements being taken to address areas of concern and ensure measures to improve safety, quality of care and patient experience are implemented.

2. Recommendations

To ensure the PCCC are aware of any significant Quality concerns for General Practice, where Quality covers the domains of patient experience, patient safety and clinical effectiveness. The Committee to receive assurance on the mitigations in place to address the highlighted concerns.

3. Executive Summary

Quality surveillance of each General Practice is undertaken by the ICB Nursing & Quality and Locality Teams. Wide ranging Quality information pertaining to each Practice is considered in detail through the Locality Primary Care Quality & Operational Assurance Groups that usually meet monthly. This enables a Quality Risk Register to be constructed for each of the ICB General Practices, which highlights the issues, but also the actions being taken by the ICB, in conjunction with the relevant Practice and associated Primary Care Network, to mitigate any concerns.

Higher risk Practices are also considered at the county wide Primary Care Quality and Performance Oversight Meeting, which meets monthly, to further assure the mitigation of any significant concerns. The ICB GP Clinical Leads also regularly meet together and with the wider GP cohort through Clinical Forums, which also enables risks/concerns to be highlighted and addressed.

There are known and ongoing significant quality issues with a few of our General Practices which rate higher on the ICB Quality GP Risk Register and these are considered fully through the Private PCCC. The ICB locality and quality teams work to support any General Practices with required improvements. To note below specifically:

The CQC inspection report for Lakeside Stamford, published 1st June 2022, rates the Practice as Requires Improvement overall, with Inadequate in the Safety domain. This is an improvement on the previous inspection when Lakeside was rated Inadequate, discussed previously at this committee. ICB and LMC continue to meet with the Practice to provide support and seek assurance on progress being made.

Hawthorne Practice in Skegness had a CQC inspection in August 2022 and has been rated as inadequate overall and placed in special measures, with a further CQC inspection planned within 6 months. The inspection report is now available on the CQC website via Hawthorn Medical Practice - Care Quality Commission (cqc.org.uk). Concerns identified include access issues, dispensary oversight, infection prevention and control, staff training and supervision and also the adequacy of governance systems and processes. The ICB is now meeting with the Practice regularly and in conjunction with the LMC to ensure the Practice has a robust plan to address the improvements required, providing support with those improvement actions where necessary.

There are three other Practices to note that have overall 'Requires Improvement' ratings from CQC inspections. These are Marisco, Branston and the Spalding Practice as previously reported to this Committee. Marisco had a recent re-inspection with likely positive outcome, however the published inspection report is awaited.

CQC report for Merton Lodge Surgery was published 13th September 2022 and the Practice is rated good overall and across all 5 domains.

4.	**Management of Conflicts of Interest**

ICB PCCC members, particularly General Practitioners may have a direct or indirect conflict of interest for some of the Practices which will need to be declared if attending the Public PCCC. Chair will determine the management of the conflict dependent on the nature of the interest

5.	**Risk and Assurance**

All General Practices are risk rated via our Quality Assurance Process previously described. High Risk Practices are reported to PCCC and included on the ICB Risk Register

5.	**Financial/Resource Implications**

Where required additional funding has been provided by the ICB to facilitate additional support to vulnerable practices as appropriate, where not covered via existing funding routes.

6.	**Legal, Policy and Regulatory Requirements**

Maintaining good quality Primary Care including General Practice provision across Lincolnshire

7.	Health Inequalities implications
Nil relevant to note	
8.	**Equality and Diversity implications**
Nil relevant to note	
9.	**Patient and Public Involvement (including Communications and Engagement)**
Patient & Public engagement processes, including Listening Clinics as appropriate, are utilised to secure patient experience information for each Practice that informs the Quality Risk Rating and Quality Improvement actions.	
11.	**Report previously presented at**
Nil applicable	
12.	**Sponsoring Director/Partner Member/Non-Executive Director**
Martin Fahy, Director of Nursing m.fahy@nhs.net	

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PUBLIC PRIMARY CARE COMMISSIONING COMMITTEE

Date: 19th October 2022
Location: MS Teams

Agenda Number:	14
Title of Report:	Lakeside Medical Practice Update
Report Author:	Wendy Martin, Associate Director of Nursing & Quality Nick Blake, Programme Director – Integrated Primary Care and Communities
Appendices:	Nil included

1.	**Key Points for Discussion:**

To update the Committee on Lakeside Stamford's progress in addressing the matters identified through the CQC inspection report (published August 2021) and subsequent inspections: Latest CQC full inspection March 2022, CQC inspection visit report published 1st June 2022 (overall Requires Improvement).

2.	**Recommendations**

The Committee is recommended to review and consider the contents of this report to ascertain satisfaction with mitigating actions to improve care provision from Lakeside Healthcare General Practice (Stamford).

3.	**Executive Summary**

General Background for Lakeside Healthcare, Stamford.

Lakeside Healthcare General Practice at Stamford operates from two sites: Sheepmarket Surgery, Ryhall Road, Stamford and the branch surgery: St Mary's Medical Centre, Wharf Road, Stamford. Patients can access services from either surgery. The service has an onsite dispensary situated at both sites.

The practice is situated within NHS Lincolnshire Integrated Care System and delivers General Medical Services (GMS) to a patient population of just under 31,000 patients. The Lakeside Healthcare Group has practices across Northamptonshire, Lincolnshire and Cambridgeshire. The organisation's central support function is situated in Corby, Northamptonshire. The practice is part of Four Counties Primary Care Network (PCN) and the Practice is a Training Practice.

Public Health England report deprivation within the practice population group as nine on a scale of 1 to 10. Level one represents the highest levels of deprivation and level 10 the lowest. The average life expectancy of the practice population is higher than the national average for both males and females (81.4 years for males, compared to the national average of 79 years and 85.5 years for females compared to the national average of 83 years). The National General Practice Profile states that most registered patients are white with approximately 1.2% Asian and 1.5% other non-white ethnic groups. The age distribution of the practice population closely mirrors the local averages. There are slightly more female patients registered at the Practice compared to males.

Due to the enhanced infection prevention and control measures put in place with the pandemic and in line with the national guidance, most General Practitioner (GP) appointments are initially telephone consultations. If the GP or Advanced Nurse Practitioner (ANP) needs to see a patient face-to-face then the patient is offered a choice of either the main GP location or the branch surgery. Other consultation methods such as video calls and advice via email are offered.

June 2021 CQC Inspection outcome.

The final Care Quality Commission (CQC) Inspection Report from the June 2021 inspection was published on the CQC website on the 2 August 2021. The Practice received an overall Inadequate rating, was rated inadequate in 5 out of 6 domains. The Practice was also rated Inadequate for all population groups.

Re-inspection (Sept 2021).

The CQC re-inspected the Practice in early September 2021, the CQC confirmed that the required actions in relation to long-term condition reviews and structured medication reviews have been addressed. However, the CQC served a continued warning notice in September 21 in relation to section 17, good governance. Specifically, this referenced short comings in clinical and management oversight of staffing, quality assurance and management of the dispensary.

Since the outcome of the initial inspection visit in June 2021, Senior CCG staff met regularly with the Practice throughout 2021 to support with the improvement actions required and receive assurance on progress with the improvement actions. Support visits were provided by the CCG Patient Safety, Safeguarding, Health Protection and Medicines Management Teams. The Lincolnshire Medical Committee (LMC) also provided support.

January 2022

Healthwatch Lincolnshire, on behalf of the CQC, ran a patient survey around Lakeside Healthcare in Stamford which closed at the end of January, receiving over 1450 responses. There was a high rate of negative responses relating to access and responsiveness.

February 2022 Update

Further follow up meeting between CCG Deputy Director of Nursing and the Practice Manager in February 2022. Practice aware of follow up CQC inspection visit planned for 2 March 2022. Positive assurances provided on progress with outstanding actions, including recruitment position, locum coverage, new appointments and improved ways of working.

March 2022

CQC completed a full inspection visit to the Practice in early March 2022.

1st June 2022

CQC publication of the March 2022 Inspection Report. Report available via the CQC website.
Lakeside Healthcare at Stamford - Care Quality Commission (cqc.org.uk)

Overall, the Practice is rated as **Requires Improvement**.

The ratings for each key question are: Safe – Inadequate; Effective – Requires Improvement; Caring - Requires Improvement; Responsive - Requires Improvement; Well-led – Requires Improvement.

The CQC noted the following:

- The Practice had carried out a significant amount of work to improve the service since the last inspection.
- The Practice still did not have all the effective systems in place for the appropriate and safe use of medicines, including medicines optimisation.
- We were not provided with assurance that sufficient systems and oversight were in place to ensure the dispensaries were adequately and safely managed.
- The process in place for medication reviews and the monitoring of long-term conditions was still not effective.
- Appropriate standards of cleanliness and hygiene were not always met.
- There were still gaps in systems to assess, monitor and manage risks to patient safety.
- The Practice organised and delivered services to meet patients' needs, although work continued to improve patient experience.
- Leaders demonstrated that they had the capacity and skills, but further work was required to embed systems and processes in order for them to deliver high quality sustainable care.
- Most governance arrangements were now in place, but further work was required to embed these systems and to ensure they were managed effectively.
- Whilst improvements were seen at this inspection, there was still processes that needed embedding and strengthening so the Practice will remain in special measures for a further six months.

June 2022

Clinical Commissioning Group/Integrated Care Board (ICB) senior representatives had a further meeting with the Practice Team at the end of June 22 to ascertain the areas of additional support required by the Practice to ensure the improvements required. LMC are also supporting the Practice. The Practice were very receptive to further support and were disappointed with the outcome of the CQC inspection as they considered they had worked hard to address the improvements required. The Practice perceived their local community to be disenfranchised in part due to historical incidents which had affected that relationship. The Practice reported staff turnover as high, with continued recruitment challenges.

July/August 2022

The ICB offered to support the Practice with development of their PPG, ICB staff have joined PPG members at a drop-in session to speak with patients and get feedback on their experience of the Practice.

The ICB Clinical Lead has offered ongoing support to the GP Partners and clinical staff to enable them to debrief any concerns and to offer any practical advice and guidance.

Support visits from relevant ICB staff to provide direct support in the areas of improvement still required are continuing. An ICB Quality Review and Improvement Action Plan has been agreed with the Practice through a joint working group to define ways of working to ensure the improvements required over the next few months The Practice also continue to submit progress on actions required to the CQC monthly.

Staffing numbers remain a challenge, particularly GP cover since recent GP retirements.

Further work underway to look at access concerns and Doctrin (online consultation platform).

The LMC continue to support the Practice and facilitate a more in - depth review of particular areas to support improvement.

September 2022

The ICB team met with Stamford Lakeside on 2 September, progress against CQC actions was noted alongside the withdrawal of the notice of proposal by the CQC, effectively moving the Practice out of special measures. Further support from the ICB in relation to the PPG, the Practice's dispensary and the ICB independent quality review were discussed.

An ICB pharmacist carried out a site visit on 22 September and reported that the dispensary is operating safely with no concerns raised.

Sarah-Jane Mills, ICB Director for Primary Care, Communities and Social Value, met with the incoming Chief Executive of Lakeside Health Care, Jessica Bawden, on 23 September to discuss the issues the practice faces, reiterate the ICB's support and agree future meetings.

4.	**Management of Conflicts of Interest**

ICB PCCC members , particularly General Practitioners may have a direct or indirect conflict of interest which will need to be declared if attending the Private PCCC. Chair will determine the management of the conflict dependent on the nature of the interest

5.	Risk and Assurance
Included on ICB Risk Register	

6.	Financial/Resource Implications
Any additional capacity required to support improvements will be considered by the ICB. To date support required has been from existing CCG teams e.g. Quality, Safeguarding, Health Protection, Medicines Optimisation Team etc. North West Anglia Foundation Trust provided additional blood test collections to support the practice's remedial work on patient reviews in 2021. LMC are also supporting.	

6.	Legal, Policy and Regulatory Requirements
The ICB has a statutory duty to engage with patients and the public. This includes ensuring the ICB acts fairly in making plans, proposals and decisions in relation to the health services it commissions and where there may be an impact on services. The ICB also a duty to secure the continuous improvement of services. This paper supports the patient rights in the NHS Constitution.	

7.	Health Inequalities implications
Nil relevant to note.	

8.	Equality and Diversity implications
Nil relevant to note	

9.	Patient and Public Involvement (including Communications and Engagement)
There has been communication via the practice's website and local media to ensure patients and public are kept updated regarding improvement actions. The PPG has been leading on communication campaigns through local media channels e.g. providing information on the flu vaccination campaign. Further Listening Clinics have been facilitated by the ICB within the community.	

11.	Report previously presented at
Not applicable	

12.	Sponsoring Director/Partner Member/Non-Executive Director
Martin Fahy, Director of Nursing m.fahy@nhs.net	

NHS
Lincolnshire
Integrated Care Board

COMMITTEE COVER SHEET

Public Meeting of Primary Care Commissioning Committee

Date: 19 October 2022
Location: via Teams

Agenda Number:	15
Title of Report:	Hawthorn Medical Practice Skegness CQC Report
Purpose:	To brief members on the published CQC report for Hawthorn Medical Practice, To brief members on the actions taken so far by the ICB and the practice in partnership
Appendices:	Appendix 1 – CQC report Appendix 2 – Evidence Table

1.	**Key Points for Discussion:**

- The Care Quality Commission (CQC) carried out a full inspection at Hawthorn Medical Practice in Skegness and the branch in Burgh Le Marsh on 23 August 2022.
- The report was published on 30 September 2022.
- The practice was rated “Inadequate” overall with “Inadequate” in the Safety, Responsiveness and Well Led domains and “Requires Improvement” in Effectiveness and Caring. This places the practice in “special measures”.
- The CQC have served enforcement actions for the provider for being in breach of the following regulations:
    - Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
    - Regulation 17, (1), Good governance, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
    - Regulation 18 (1), Staffing, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

2.	**Recommendations**

The committee are asked to note for information the outcome of the Hawthorn CQC visit, the actions that have been/are being taken to comply with the CQC enforcement actions and the support the ICB are providing to develop an improvement plan.

3.	**Executive Summary**

Hawthorn medical practice is based in Skegness with a branch surgery in Burgh Le Marsh

and has a list size of 17, 777.

The CQC visited the practice on 23 August 2022. The practice was rated "Inadequate" overall with "Inadequate" in the Safety, Responsiveness and Well Led domains and "Requires Improvement" in Effectiveness and Caring. The last review took place in March 2022 when the practice retained its previous rating of "Good". The CQC have therefore placed the practice in "special measures".

The report is attached as Appendix 1 and the table as Appendix 2. Both documents were published on the 30 September 2022 and thus are in the public domain. The practice team did not challenge the report for factual accuracy.

Summary of the findings were as follows:

- The practice did not always provide care in a way that kept patients safe and protected them from avoidable harm.
- There was no effective oversight of dispensary services that provided assurance as to its safety.
- Patients did not always receive effective care and treatment that met their needs.
- The practice had not taken reasonable steps to protect patients and others from the risks posed by healthcare associated infections.
- Staff dealt with patients with kindness and respect and involved them in decisions about their care.
- Patients could not access care and treatment in a timely way.
- The provider did not have effective oversight of the systems and processes designed to deliver safe and effective care.
- Governance systems were ineffective.
- Staff did not always have the training, supervision or appraisal required.

The ICB Team including Head of Transformation, GP Clinical Lead and Deputy Director of Nursing met with the Partners and the Senior Leadership Team on the 22 September 2022. Assurance was gained that the team had taken the report seriously and before the team arrived, the whole practice team were being briefed by the Partners. There were some frank and honest discussions, and it was outlined to the team the support that could be provided. This included as follows:

- ICB Chief Pharmacist and LIMPS Team's support with the dispensary issues identified.
- Clinical Lead offered a visit to his practice to look at how appointments were managed and triaged.
- Support from a nearby costal practice that had been through a similar CQC experience recently.
- Urgent support visit from the ICB Health Protection Team to advise on infection, prevention and control.
- Support from the Local Medical Committee Practice Support Team.
- Support from the ICB Primary Care Team.
- Support from the ICB Quality and Nursing Team.
- ICB to support with data analysis for telephone access.
- Access to the Accelerate Programme

The practice has taken some immediate actions around the clinical oversight of the dispensary, recruitment for pharmacy manager and dispensary manager, put plans in place to increase access to appointments, and infection prevention and control improvements.

It is planned that the ICB will hold a remote meeting with the practice team to discuss progress fortnightly and then the Lead Quality Officer and Operational and Delivery Manager linked to the practice will be on site on the alternative weeks.

The CQC are expecting to see a copy of the action plan by the end of October. They are also seeking assurance that the practice has taken immediate and urgent action with the items outlined in their enforcement letter and must provide evidence that they are compliant with Regulations 12, 17 and 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 by 1 December 2022. The practice will be reinspected by the CQC 6 months following the publication of the report which means the end of March 2023.

The ICB Health Protection visit took place on 5 October 2022 and the practice have identified some key actions that they need to take whilst awaiting the full report.

A progress meeting with the practice took place on 6 October 2022 and an update was given by the practice team on the progress made so far and enable them to identify other support they may need from the ICB and other partners.

4.	**Management of Conflicts of Interest**

No anticipated conflict of interest.

5.	**Risk and Assurance**

Provision of Primary Medical Services in an area with significant deprivation and a large lists size that absorbed a managed dispersal of a previous practice in Wainfleet.

6.	**Financial/Resource Implications**

The support that is required from the practice for improvement will require significant staffing resource from the ICB. It is not yet known if additional funding is yet required in order to complete this work.

7.	**Legal, Policy and Regulatory Requirements**

- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- Primary Medical Care Policy and Guidance Manual (PGM) (May 2022)
- The NHS Constitution for England
- The NHS Long Term Plan 2021

8.	**Health Inequalities implications**

Hawthorn's practice population is strikingly different from the Lincolnshire and England averages. It has the higher numbers of patients aged 65 and over, a higher deprivation score, higher numbers of patients with a long-term condition and the lower numbers aged 18 and under.

Life expectancy for males (75.7) and for females (81.3) is below the England average of 79.5 for males and below the England average of 83.1 for females.

There is a large transient population due to the area being a significant holiday destination which can increase temporary registrations of short term and long-term visitors and workers who are attracted by the seasonal work. Various estimates are given of between 100 and 500% increase in population during the summer.

9.	Equality and Diversity implications

Hawthorn's practice population has marginally more people from a black and minority ethnic background than the Lincolnshire average and with a higher level of patients with long term conditions than the Lincolnshire average it can be assumed higher levels of disability. Impact on other protected characteristics is not expected to be significant at this stage.

10.	Patient and Public Involvement (including Communications and Engagement)

ICB Communications support has been offered to the practice if required and a reactive statement has been prepared. At the time of this report there has been no significant news coverage.

The practice does not currently have an active Patient Participation Group (PPG).

11.	Report previously presented at

This report has not been previously presented but the issues contained within have been discussed extensively at the East Locality Primary Care Quality Assurance and Operational Group and at the Primary Care Quality and Performance Oversight Group in September 2022.

12.	Sponsoring Director/Partner Member/Non-Executive Director

Martin Fahy, Director of Nursing and Quality - m.fahy@nhs.net
Sarah-Jane Mills, Director of Primary Care and Community and Social Value - sarah-jane.mills1@nhs.net

Hawthorn Medical Practice

Inspection report

Hawthorn Road
Skegness
PE25 3TD
Tel: 01754896350

Date of inspection visit: 23 August 2022
Date of publication: 30/09/2022

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires Improvement
Are services caring?	Requires Improvement
Are services responsive to people's needs?	Inadequate
Are services well-led?	Inadequate

Overall summary

We carried out an announced inspection at Hawthorn Medical Practice on 18 and 23 August 2022. Overall, the practice is rated as Inadequate.

Safe - Inadequate

Effective – Requires Improvement

Caring - Requires Improvement

Responsive - Inadequate

Well-led - Inadequate

Following our previous inspection on 8 September 2016 the practice was rated Good overall and Good in all key questions and population groups.

The full reports for previous inspections can be found by selecting the 'all reports' link for Hawthorn Medical Practice on our website at www.cqc.org.uk

Why we carried out this inspection

We carried out this inspection to follow up concerns in response to risk in line with our inspection priorities.

How we carried out the inspection.

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

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

This included:

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

Our findings

We based our judgement of the quality of care at this service on a combination of:

- What we found when we inspected
- Information from our ongoing monitoring of data about services

Overall summary

- Information from the provider, patients, the public and other organisations.

We have rated this practice as Inadequate overall.

We found that:

- The practice did not always provide care in a way that kept patients safe and protected them from avoidable harm.
- There was no effective oversight of dispensary services that provided assurance as to its safety.
- Patients did not always receive effective care and treatment that met their needs.
- The practice had not taken reasonable steps to protect patients and others from the risks posed by healthcare associated infections.
- Staff dealt with patients with kindness and respect and involved them in decisions about their care.
- Patients could not access care and treatment in a timely way.
- The provider did not have effective oversight of the systems and processes designed to deliver safe and effective care.
- Governance systems were ineffective.
- Staff did not always have the training, supervision or appraisal required.

The provider must:

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed to meet the fundamental standards of care and treatment

I am placing this service in special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to remove this location or cancel the provider's registration.

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

Details of our findings and the evidence supporting our ratings are set out in the evidence tables.

Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA

Chief Inspector of Hospitals and Interim Chief Inspector of Primary Medical Services

Our inspection team

Our inspection team was led by a CQC lead inspector and an additional CQC inspector who spoke with staff using video conferencing facilities and undertook a site visit. The team included a GP specialist advisor who spoke with staff using video conferencing facilities and completed clinical searches and records reviews without visiting the location.

Background to Hawthorn Medical Practice

Hawthorn Medical Practice is located at:

Hawthorn Road

Skegness

Lincolnshire

PE25 3TD

The practice has a branch surgery at:

Hawthorn Surgery

Wainfleet Road

Burgh Le Marsh

Skegness

Lincolnshire

PE24 5ED

The Skegness site is open from 8am to 6.30pm Monday to Friday and the Burgh Le Marsh branch from 8.30am to 5pm Monday to Wednesday (closed for lunch 12.15 to 1.45pm) and Thursday from 8.30am to noon. Extended hours appointments are offered on two evenings a week.

The provider is a partnership of eight GPs and is registered with CQC to deliver the Regulated Activities;

• diagnostic and screening procedures

• maternity and midwifery services

• family planning

• treatment of disease, disorder or injury

• surgical procedures.

These are delivered from both sites.

There is a dispensary at the Burgh Le Marsh branch site. The practice can dispense to 3,114 eligible patients.

The practice is situated within the Lincolnshire Integrated Care System and delivers General Medical Services (GMS) to a patient population of about 17,777. This is part of a contract held with NHS England. The practice list is weighted to 22,958 which reflects the healthcare needs of its patient population. The reason for weighting for patient demographics is that certain types of patients place a higher demand on practices than others. The adjustment for deprivation acknowledges that deprived populations have higher health needs than less deprived populations with a similar demographic profile.

The practice is part of a wider network of GP practices known as a First Coastal Primary Care Network.

Hawthorn's practice population is strikingly different from the Lincolnshire and England averages. It has the higher numbers of patients aged 65 and over, a higher deprivation score, higher numbers of patients with a long-term condition and the lower numbers aged 18 and under.

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

The percentage of the practice's patients aged 65 and over is 27.3% (2021), higher than the

Lincolnshire average of 23.1% and England average of 17.4%.

Life expectancy for males (75.7) and for females (81.3) is below the England average of 79.5 for males and below the England average of 83.1 for females.

The percentage of the practice's patients aged 18 and under is 16.9%, lower than the ICB

average of 18.8% and the England average of 20.4%.

2.1% of Hawthorn's population are from minority groups, slightly higher than the Lincolnshire

average of 2%.

The practice's deprivation score in 2019 is 42.2, much higher than the Lincolnshire average

(19.9) and England average (21.7).

In 2021, 70.4% of the practice's population had a long-term health condition; much higher than

the Lincolnshire average of 56.3% and the England average of 51.1%.

There are stark differences between Hawthorn Medical Practice and the rest of the Integrated Care Board (ICB) in terms of disease prevalence.

Data provided by the ICB showed that in the year ending March 2021, Hawthorn Medical Practice had high attendances of A&E in total, with their Total and Type 3 attendances the highest in the East Lincolnshire locality, while their Type 1 attendances were the third highest in the locality.

Disease prevalence was higher than both the local and national averages in all but two of the Quality Outcomes Framework conditions.

The team of eight GP partners (6.9 WTE) provide cover at both surgeries. The practice has an advanced nurse practitioner (0.9 WTE), a nurse practitioner (1.0 WTE), four practice nurses (2.7 WTE) and one healthcare assistant (0.85 WTE) They are supported by a team of dispensers, reception, housekeeping and administration staff.

Due to the enhanced infection prevention and control measures put in place since the pandemic and in line with the national guidance, many GP appointments had been telephone consultations.

Extended access is provided where late evening and weekend appointments are available.

Out of hours services are provided by Lincolnshire Community Health Services NHS Trust

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose The registered persons had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. **In particular we found** Recruitment checks were not carried out in accordance with the regulations. The systems for assessing the risk of, and preventing, detecting and controlling the spread of, infections were ineffective and appropriate standards of hygiene were not met. Systems and processes were not in place in the dispensary to ensure the safe storage of medicine or competency of dispensers There was no oversight of the prescribing practice of non-medical prescribers. Home visits to the housebound to conduct long-term condition reviews had not re-started post pandemic. There had been no assessment of the risks to the health and safety of these service users. There was no system in place to appropriately monitor and review patients health who received medicines in accordance with the National Institute for Health and Care Excellence (NICE) national guidance. The medicines to be used in the case of a medical emergency did not include all recommended medicine and there were no risk assessments in place to cover the omissions.

This section is primarily information for the provider

Enforcement actions

This was in breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury Family planning services	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found that you are not ensuring that systems and processes are established and operated effectively to ensure compliance with the requirement in regulations 4 to 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. **In particular we found** There were no systems in place to regularly assess and monitor the quality of the services provided. This resulted in issues that threatened the delivery of safe and effective care which had not been identified or adequately managed There was no effective system to ensure that staff received regular appraisal. There was no Patient Participation Group, other patient representative body in place or system to seek feedback to enable you to regularly engage with service users to assess and monitor the quality of the services provided for the purposes of continually evaluating and improving such services. Clinical governance arrangements were not effective. The governance of dispensing services was not effective, oversight of dispensing practice or assurance as to the competency of dispensers was not demonstrated. **This was in breach of 17, (1), Good governance, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Diagnostic and screening procedures

Family planning services

Maternity and midwifery services

Surgical procedures

Transport services, triage and medical advice provided remotely

Regulation 18 HSCA (RA) Regulations 2014 Staffing

We found that you are not ensuring that systems and processes are established and operated effectively to ensure compliance with the requirement in regulations 4 to 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In particular we found

Appropriate support, training, professional development, supervision and appraisal was provided to staff to enable them to carry out the duties they were employed to perform.

You are required to become compliant with Regulation 18, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 above by 01 October 2022.

This was in breach of Regulation 18 (1), Staffing, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care Quality Commission

Inspection Evidence Table

Hawthorn Medical Practice (1-592683393)

Inspection date: 18 and 23 August 2022

Date of data download: 17 August 2022

Overall rating: Inadequate

At our last inspection of this service on 8 September 2016 it was rated as Good overall and Good in all key questions.

Safe Rating: Inadequate

At our last inspection of this service on 8 September 2016 it was rated as Good for providing Safe services.

At this inspection we have rated it as Inadequate because:

- Not all staff were trained in safeguarding to appropriate levels.
- Recruitment procedures were not effective.
- There was no assurance that Health and Safety, and infection prevention and infection control measures were effective.
- There were gaps in systems to assess, monitor and manage risks to patient safety.
- The practice did not have systems for the appropriate and safe use of medicines, including medicines optimization.
- There was no assurance regarding the safety of dispensing services.

Safety systems and processes

The practice did not always have clear systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
Partners and staff were trained to appropriate levels for their role.	Partial
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes

Safeguarding	Y/N/Partial
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes
Explanation of any answers and additional evidence: Information supplied to us by the practice indicated that some members of staff had not completed safeguarding training. For example, five of the eight GP partners were not recorded as having completed Children's Safeguarding Level 3.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	No (1)
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Yes
Explanation of any answers and additional evidence: (1) Some staff were employed as locums; however, the provider did not always undertake the appropriate recruitment checks or keep any records.	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment:	Partial March 2021
There was a fire procedure.	Partial
Date of fire risk assessment: Actions from fire risk assessment were identified and completed.	March 2021
(1) A Health and Safety Risk and Fire Risk assessment had been carried out by the practice's landlords of the main Skegness site in March 2021, but the practice was unable to provide us with a copy or details of any actions arising from it. An assessment had taken place at the main site on the day prior to our inspection but no details were available. The practice informed us that as far as they were aware no Health and Safety Risk Assessments had ever been completed for the branch site.	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	No (1)

Infection prevention and control audits were carried out. Date of last infection prevention and control audit:	Partial (2) August 2022
The practice had acted on any issues identified in infection prevention and control audits.	No (3)
The arrangements for managing waste and clinical specimens kept people safe.	Yes

Explanation of any answers and additional evidence:

(1) We saw that one GP was recorded as not having completed infection and prevention control training. However, they approached us after the inspection and said that they had but it had not been recorded on the practice systems.

(2) There had been an audit completed in 2020 for the main site which had identified actions that needed to be taken.

(3) There was no evidence that the actions identified had been completed.

A further audit had been completed in August 2022 of the Skegness site which had again identified areas for improvement, however no action plan had been raised. Staff who had undertaken the audit told us they were unaware they needed to develop an action plan.

The practice was unable to provide any evidence that the branch site at Burgh Le Marsh had ever had an infection prevention and control audit.

The patient reception area at the Skegness site had a significant build up of dust, cobwebs and dead flies on high level surfaces. The provider told us that high level cleaning was in the hands of the building landlords and that they had changed cleaning contractors. They could not tell us when they were last cleaned.

We found some areas of the Skegness site showed visible signs of dirt and inadequate cleaning. For example, in clinical rooms we saw desks and computers were dusty, waste bins visibly dirty and cleaning records not consistently completed, one had not been completed since 9 August.

Some doors had a sticky residue from removed labels that were not cleanable.

In one room there was a sharps bin that was not dated as to when it was taken into use.

In the male staff toilet, we saw that the wall immediately adjacent to the urinal was heavily stained with inadequate cleaning.

Fabric covered chairs were in use throughout the Skegness building including in two clinical rooms we looked in. Additionally, the arm of a treatment chair in one room had been repaired with sticky tape. In another room the treatment chair had a damaged covering, negating effective cleaning. We noted that Vinyl covered chairs for every clinical room had been requested at the nurses' meetings in June and July 2022, but the request had not been taken up.

Amongst the equipment used to deal with a medical emergency there was an aurascope which was visibly contaminated with what appeared to be ear wax. The checklist for the emergency equipment listed it as a required item and indicated that it was present and ready for use. It was shown as having last been portable appliance tested in 2018.

Infection prevention and control (IPC) was a standing agenda item at clinical governance meetings but the IPC lead, a nurse, did not attend the meetings. We looked at the minutes of five meetings and in only one was there any reference to infection prevention and control, and that concerned some out-of-date stock.

Risks to patients

There were gaps in systems to assess, monitor and manage risks to patient safety.

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Partial (1)
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Partial (2)
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes
There were enough staff to provide appointments and prevent staff from working excessive hours	Partial (3)

Explanation of any answers and additional evidence:

(1) Staff we spoke with confirmed that when fully staffed, there were just enough to cover the workload, including planned leave, albeit that the shortage of reception staff meant that there were delays in telephone answering. However, if there was any staff absence through sickness then the workload became overwhelming.

Recruitment of staff, reception staff had proved extremely difficult. The reception manager told us that they needed a minimum of five additional full time staff, preferably more.

(2) Reception and administration staff had completed sepsis training but were not up to date with basic life support training with some having last completed the training in 2014 or had never completed it according to the practice training records.

(3) We put it to the provider that the level of staffing across the practice, excluding GPs, was lower when compared to comparator practices within their primary care network. The practice employed 2.7 whole time equivalent nurses. This gave a nurse to patient ratio of 1:6559. The other two practices in their primary care network, with similar patient demographics, had nurse to patient ratios of 1:2289 and 1:1986. The Integrated Care Board (ICB) average ratio was 1:2469.
The direct patient care ratio was 1:3275 compared to the ICB average of 1:1934

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment.

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation. [1]	Yes

There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes

Appropriate and safe use of medicines

The practice did not have systems for the appropriate and safe use of medicines, including medicines optimisation

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHS Business Service Authority - NHSBSA)	1.30	1.01	0.79	Variation (negative)
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/04/2021 to 31/03/2022) (NHSBSA)	9.6%	11.6%	8.8%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2021 to 31/03/2022) (NHSBSA)	7.46	5.42	5.29	Significant Variation (negative)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	349.2‰	218.7‰	128.2‰	Variation (negative)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHSBSA)	1.03	0.84	0.60	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	9.5‰	8.5‰	6.8‰	No statistical variation

Note: ‰ means *per 1,000* and it is **not** a percentage.

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	No (1)
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines. [1]	No (2)
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. [2]	No
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Yes
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	No (3)
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	No (4)
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Yes

Explanation of any answers and additional evidence, including from clinical searches.

(1) The practice told us there was no audit to demonstrate the prescribing competence of non-medical prescribers, and there was no review of their prescribing practice supported by clinical supervision or peer review.

Medicines management	Y/N/Partial
(2) The provider was not able to demonstrate that it remained safe to prescribe medicines to patients where specific, frequent, monitoring was required. Patients were having blood tests arranged via the hospital, but the provider was not routinely recording that these indicated it was safe to continue prescribing the medicines. There were 34 patients with hypothyroidism who have not had thyroid function test monitoring for 18 months or more. We looked at the records of five patients and saw one had last had a thyroid stimulating hormone (TSH) test in June 2019, but prescriptions for thyroxin had been issued as recently as August 2022. None had a medication review coded within the last 12 months and there was no evidence that monitoring had been checked prior to issuing the last prescription for any of the five patients records we looked at. There were 60 patients who were prescribed methotrexate. Of those, two had not had the required monitoring. However, we saw that the practice had been proactive in ceasing prescribing for these patients who had not responded to requests for monitoring. There were 26 patients prescribed Azathioprine. Of these, two had not received the appropriate monitoring. One had last had a blood test in December 2021 and the other in January 2022. The guidance is that monitoring should be carried out at least every 12 weeks. There were eight patients in receipt of lithium of which four had not received the required monitoring. Five patients prescribed Amiodarone had not received the required monitoring which was for a liver function test and thyroid function test (TFT) every six months. One patient had no record of a TFT ever being done, for one patient it was last done in 2015, one in 2018 and two in 2021. (3) Although the data showed that the practice had a significantly higher rate of prescribing Nitrofurantoin , Pivmecillinam and Trimethoprim they did not provide us with any evidence to show that had taken steps to ensure the appropriate prescribing of these antimicrobials. (4) The medicines to be used in the case of a medical emergency did not include midazolam and Diclofenac. There were no risk assessments in place to cover the omission of these two medicines.	

Dispensary services (where the practice provided a dispensary service)	Y/N/Partial
There was a GP responsible for providing effective leadership for the dispensary.	Partial (1)
The practice had clear Standard Operating Procedures which covered all aspects of the dispensing process, were regularly reviewed, and a system to monitor staff compliance.	Partial (2)
Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.	No (3)
Where the Electronic Prescription Service is not used for dispensary prescriptions, prescriptions were signed before medicines were dispensed and handed out to patents. There was a risk assessment or surgery policy for exceptions such as acute prescriptions.	Yes

Medicines management	Y/N/Partial
Medicines stock was appropriately managed and disposed of, and staff kept appropriate records.	No (4)
Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective.	Yes
If the dispensary provided medicines in Monitored Dosage Systems, there were systems to ensure staff were aware of medicines that were not suitable for inclusion in such packs, and appropriate information was supplied to patients about their medicines.	n/a
If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability.	n/a
Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence.	Partial
Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc.	Yes
There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians.	Yes

Explanation of any answers and other comments on dispensary services:

(1) There was a lead GP for the dispensary, which was located at the Burgh Le Marsh branch site. The dispensary manager was also the reception manager. They had no previous experience of dispensing and had not been offered any training to upskill in this area. They did not work at the same site as the dispensary. When asked, they were unable to tell us how many dispensing patients there were or how many items were dispensed monthly.

(2) Whilst Standard Operating Procedures were in place, they were due for review.

(3) The practice did not take part in the Dispensing Services Quality Scheme and for that reason had not undertaken annual competency checks of the dispensers. The practice was unable to provide any explanation or assurances they had as to the competency of the dispensers.

(4) At the time of our visit the room temperature in the dispensary where the medicines were stored, and prescriptions prepared was 27 degrees. There was no policy or protocol in place to direct staff regarding regulating the temperature to ensure the efficacy of some medicines stored above the maximum recommended storage temperature of 25 degrees. There was a portable air conditioning unit in the adjoining room from which medicines were dispensed but no guidance of when it should be taken into use and no records kept of the ambient temperature. It was not operating during our inspection.

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes

Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	Six
Number of events that required action:	Six

Explanation of any answers and additional evidence:

The significant events recording and investigation was not particularly well recorded and it was not clear any learning had been disseminated. However, when we looked at the minutes of the clinical governance meetings, we saw that they had been discussed. As nurses, advanced nurse practitioners and nurse practitioners were not present at these meetings it was unclear as to how they would receive the learning, other than, as one member of staff told us, that if they wanted to see the minutes they could ask for them.

Example(s) of significant events recorded and actions by the practice.

Event	Specific action taken
A patient with temporary weakness in one hand, suffered a transient ischemic attack (TIA) following surgery. They were known to have atrial fibrillation, but the facts had not been communicated to secondary care.	All GPs & ANP's should consider a TIA when a patient presents with or mentions weakness. They should make the appropriate referrals.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.[1]	Partial
Staff understood how to deal with alerts.	Yes

Explanation of any answers and additional evidence:

We saw examples of actions taken on recent alerts, for example, regarding women of childbearing age prescribed teratogenic medication. However, we saw that an audit required in response to one alert regarding teratogenic medicine had been repeatedly put off for 14 months. It was documented that alerts were discussed at clinical governance meetings.

Effective Rating: Requires Improvement

QOF requirements were modified by NHS England and Improvement for 2020/21 to recognise the need to reprioritise aspects of care which were not directly related to COVID-19. This meant that QOF payments were calculated differently. For inspections carried out from 1 October 2021, our reports will not include QOF indicators. In determining judgements in relation to effective care, we have considered other evidence as set out below.

At our last inspection of this service on 8 September 2016 it was rated as Good for providing effective services.

At this inspection we have rated the service as Requires Improvement for providing effective services. This was because:

- The management of people with long term conditions was not always effective.
- The practice was not always unable to demonstrate staff had the skills, knowledge and experience to carry out their roles

Effective needs assessment, care and treatment

Patients' needs were not always assessed, and care and treatment was not always delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	No (1)
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	No (2)
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	No (1)
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Yes
Explanation of any answers and additional evidence: (1) Patients with long term conditions did not have immediate and ongoing needs assessed by regular review or treatment updated due to backlogs in completion. Home visits for patients with long term conditions had not recommenced since the pandemic. (2) Not all patients with symptoms which could indicate a serious illness were followed up appropriately. For example, not all patients with an acute worsening of their asthma receive a timely follow up	

Effective care for the practice population

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- There was a dedicated telephone line for nursing and residential homes, community staff and East Midlands Ambulance Service to contact the practice.
- Advice and guidance were provided following requests for emergency contraception
- Referral to smoking cessation service and other locally commissioned community health and wellbeing services.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder
- Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long term conditions

Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care. However, we saw that there was back-log of reviews. For example, between April 2022 and the day of our visit out of 3716 patients suffering from hypotension 260 had been reviewed and out of the 1524 patients suffering with diabetes 833 had received Hb1c to monitor the average blood sugar level to prevent deterioration in health.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.

- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.
- Patients requiring high dose steroid treatment for severe asthma episodes were not always followed up in line with national guidance to ensure they received appropriate care. We reviewed the records of five patients with asthma who had two or more courses of rescue steroids in the last 12 months. One patient had not been followed up to check the response to treatment within a week of an acute exacerbation of asthma.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	118	131	90.1%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	146	156	93.6%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	146	156	93.6%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	146	156	93.6%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	131	146	89.7%	Below 90% minimum

Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 31/03/2022) (UK Health and Security Agency)	69.6%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	18.9%	67.0%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	63.3%	70.0%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)	51.6%	56.8%	55.4%	No statistical variation

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Any additional evidence or comments
Eligible patients were invited to take part in cancer screening programmes centrally and were outside of the control of the practice, although staff told us that they actively encouraged patients to take part.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Yes
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Yes
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes

The practice had a suite of clinical audits that were run and re-run periodically. These included searches for patients prescribed sodium valproate, lithium and Sulfasalazine and patients with mechanical heart

valves. The practice had also completed two-cycle audits on patients prescribed the anticoagulant Apixaban and patients diagnosed with osteopenia.

Effective staffing

The practice was not always unable to demonstrate staff had the skills, knowledge and experience to carry out their roles.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Partial (1)
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	No (2)
There was an induction programme for new staff.	Yes
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	No (3)
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes

Explanation of any answers and additional evidence:

(1) A newly appointed manager had not been offered any training or up-skilling to enable them to effectively carry out their duties.

(2) Staff we spoke with told us they did not have any protected time for learning and had to do it (including the provider's essential training) in their own time without remuneration despite being told they would be paid for the time spent.

(3) Although we were provided with a timetable showing when staff appraisals were due to take place, the practice could not supply us with details of when the last appraisals had been carried out.

Coordinating care and treatment

Staff worked together and with other organisations to deliver effective care and treatment.

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Yes

Consent to care and treatment

The practice always obtained consent to care and treatment in line with legislation and guidance.

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Yes
Explanation of any answers and additional evidence: Our clinical review of notes where a DNACPR decision had been recorded had identified where possible the patient's views had been sought and respected. We saw that information had been shared with relevant agencies.	

Caring Rating: Requires Improvement

At our last inspection of this service on 8 September 2016 it was rated as Good for providing Caring services.

At this inspection we have rated the service as Requires Improvement for providing effective services. This was because:

- The provider could not demonstrate that they had taken any action to understand the deterioration in satisfaction levels or any actions to improve

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from patients was mixed about the way staff treated people.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Yes
Staff displayed understanding and a non-judgemental attitude towards patients.	Yes
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Yes

Patient feedback	
Source	**Feedback**
CQC Share your experience	Although much of the feedback we received was negative in terms of access, both telephone and for face-to-face appointments, we received a high volume of comments that were complimentary about the caring attitude of clinicians and the standard of treatment and care.

National GP Patient Survey results

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2022 to 30/04/2022)	68.1% (78.4%)	83.4%	84.7%	Variation (negative)
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very	68.5% (76.4%)	83.1%	83.5%	Variation (negative)

Indicator	Practice	CCG average	England average	England comparison
good at treating them with care and concern (01/01/2022 to 30/04/2022)				
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2022 to 30/04/2022)	85.8% (92.9%)	92.8%	93.1%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022)	58.9% (75%)	72.3%	72.4%	No statistical variation

Any additional evidence or comments
All of the values in this part of the GP Patient survey had decreased since the last survey. The previous results are shown in brackets in each indicator. The practice could not demonstrate that they had taken any action to understand the deterioration in satisfaction levels or any actions to improve.

Question	Y/N
The practice carries out its own patient survey/patient feedback exercises.	Yes (1)

Any additional evidence
(1) The practice carried out a continuing programme of gathering the views and feedback from patients using the digital triage and remote consultation system. Results were positive with high levels of satisfaction.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Yes
Staff helped patients and their carers find further information and access community and advocacy services.	Yes

National GP Patient Survey results

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2022 to 30/04/2022)	86.1%	89.5%	89.9%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Yes
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Yes
Information leaflets were available in other languages and in easy read format.	Yes
Information about support groups was available on the practice website.	Yes

Carers	Narrative
Percentage and number of carers identified.	671 which was 3.8% of the practice list.
How the practice supported carers (including young carers).	The patient registration pack asked whether new patients are carers or have carers. The practice offered flexible appointments for patients who need carers and for carers working around the people they look after. The practice used and actively promoted a form to enable the person with care needs to give consent to sharing information with their carer. When patients have dementia or suspected dementia, GPs advised that it is important to get a diagnosis as this can also help support the carer. The patients and their carers should be signposted to Dementia Support Services. In addition to the needs of the patient, carers were also asked about any stress they might be under and whether they have had any time off. This enabled GP to assist in arranging respite care to give carers, especially if they are partners, a break.
How the practice supported recently bereaved patients.	One nurse told us that a letter of condolence was sent to the deceased's next of kin, but they did not know what other staff did.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Yes
There were arrangements to ensure confidentiality at the reception desk.	Yes

Responsive Rating: Inadequate

At our last inspection of this service on 8 September 2016 it was rated as Good for providing Responsive services.

At this inspection we have rated the service as Inadequate for providing Responsive services. This was because:

- People were not always able to access care and treatment in a timely way
- The practice had not responded to deteriorating levels of patient satisfaction
- It was unclear how learning from complaints they had been used to improve the quality of care.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Yes
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Yes
The facilities and premises were appropriate for the services being delivered.	No
The practice made reasonable adjustments when patients found it hard to access services.	Yes
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes

Explanation of any answers and additional evidence:

The premises were purpose-built as a GP surgery in 2003 to cater for a patient list of 9,000. The list was now virtually double that size. When we last inspected the practice in 2016 there were 13,889 patients. Lack of space for consultation rooms as well as administration functions were a barrier to improving services, for example providing minor surgery, but also to recruitment as there was nowhere to accommodate staff. Evidence showed that negotiations for the practice to extend into adjoining unused space in the same building and formerly used by community nursing, had been protracted and gone on for about three years. Staff expressed their frustrations about the delays and the negative effect it was having on staff and their desire to enhance patient services.

Practice Opening Times	
Day	**Time**
Opening times: Skegness	
Monday	8am to 6.30pm
Tuesday	8am to 6.30pm

Wednesday	8am to 6.30pm
Thursday	8am to 6.30pm
Friday	8am to 6.30pm
Opening times: Burgh Le Marsh branch surgery	
Monday	8.30am to 5pm
Tuesday	8.30am to 5pm
Wednesday	8.30am to 5pm
Thursday	8.30am to noon
Friday	8.30am to 5pm
Extended hours appointments are available on two evenings a week.	
Extended access appointments are also provided by another provider at a surgery in a nearby village Monday to Friday 6.30pm to 8am and at weekends and Bank Holidays. These can be either face-to-face or telephone consultations.	
On-line GP consultations were available to patients by smart phone from 7am to 9.45pm.	

Further information about how the practice is responding to the needs of their population
• Patients had a named GP who supported them in whatever setting they lived. • The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues. • The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues. • All parents or guardians calling with concerns about a child were offered a same day appointment when necessary. • Before and after school appointments available with a GP or through Extended Hours, Extended Access and on-line appointments. • People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers. • The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

Access to the service

People were not always able to access care and treatment in a timely way.

The COVID-19 pandemic has affected access to GP practices and presented many challenges. In order to keep both patients and staff safe early in the pandemic practices were asked by NHS England and Improvement to assess patients remotely (for example by telephone or video consultation) when contacting the practice and to only see patients in the practice when deemed to be clinically appropriate to do so. Following the changes in national guidance during the summer of 2021 there has been a more

flexible approach to patients interacting with their practice. During the pandemic there was a significant increase in telephone and online consultations compared to patients being predominantly seen in a face to face setting.

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice	No
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Yes (1)
Patients were able to make appointments in a way which met their needs	No
There were systems in place to support patients who face communication barriers to access treatment	Yes
Patients with most urgent needs had their care and treatment prioritised	Yes
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Yes

Explanation of any answers and additional evidence:

Prior to the inspection we asked the practice to invite patients to provide feedback to CQC through our on-line tools. We received feedback from 299 people. Of those, 130 were positive comments. Of the remaining 169 negative comments, the themes that were evident were difficulty in getting through to the practice by telephone, lack of face-to-face appointments, rude reception staff, failure of GPs to call patients back when told that would happen and an inability to get long-term condition reviews.

We asked the practice to provide us with details of the number and type of appointments that had been completed by GPs, Advanced Nurse Practitioner (ANPs) NP and Nurse Practitioners (NPs) in three weeks, namely 13-17 June, 11-15 July and 15 -19 August 2022.

- For 13-17 June there had been a total of 884 appointments of which 295 (33.34%) had been face-to-face consultations.
- For 11-15 July there had been a total of 760 appointments of which 285 (37.5%) had been face-to-face consultations.
- For 15-19 August there had been a total of 739 appointments of which 312 (42.2%) had been face-to-face consultations.

The widely accepted number (as per, for example, The British Journal of General Practice) is between 70 and 72 appointments per 1,000 patients per week. These figures would indicate that for a list size of 17,777 one could expect to see around 1,239 appointments per week. In addition, the patient demographics and higher than average disease prevalence (the list is weighted to 22,958 as a reflection of enhanced need) would indicate the need for more appointment availability.

There was a back-log of long-term conditions reviews. Home visits to the housebound to conduct long-term condition reviews had not re-started post pandemic.

National GP Patient Survey results

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2022 to 30/04/2022)	21.0% (22.3%)	N/A	52.7%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	35.6% (45.8%)	59.2%	56.2%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2022 to 30/04/2022)	38.5% (53.8%)	56.6%	55.2%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	68.0% (77.4%)	76.4%	71.9%	No statistical variation

Any additional evidence or comments
Data from the GP Patient survey showed that positive patient feedback had decreased since the last survey. The previous survey figures are shown in brackets in each indicator. The provider informed that as a result of the known issues regarding telephone access the telephony system had been upgraded. The practice could not provide us with any evidence or audit of telephone performance such as average call waiting times, longest call waiting times or call abandonment rates that might indicate any improvement or worsening of performance.

Source	Feedback
For example, NHS Choices	There were three reviews posted on the NHS website since August 2021. Two were negative and concerned access and one positive which was complimentary about the care and treatment the respondent had received.

Listening and learning from concerns and complaints

Complaints were listened and responded to, but it was unclear how they had been used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	18 (1)
Number of complaints we examined.	18
Number of complaints we examined that were satisfactorily handled in a timely way.	18
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	Unknown

	Y/N/Partial
Information about how to complain was readily available.	Yes
There was evidence that complaints were used to drive continuous improvement.	Partial (2)

Explanation of any answers and additional evidence:

(1) We were provided with details of complaints that had been received between May 2021 and March 2022. Complaints for each month were recorded on separate documents.

(2) There had been no analysis to help identify common themes and although learning had been identified from some complaints there was no evidence of how or when it had been cascaded to staff. We could not identify if any of the complaints had been referred to the Ombudsman

Example(s) of learning from complaints.

Complaint	Specific action taken
	We were unable to ascertain how learning from complaints had been embedded.

Well-led Rating: Inadequate

At our last inspection of this service on 8 September 2016 it was rated as Good for providing well-led services.

At this inspection we rated the service as Inadequate for providing well-led services. This was because:

- Leaders could not demonstrate that they had the capacity and skills to deliver high quality sustainable care.
- There was no credible strategy to provide high quality sustainable care.
- The overall governance arrangements were ineffective.
- There practice did not have clear and effective processes for managing risks, issues and performance.
- The practice did not always act on appropriate and accurate information.
- In the absence of a patient participation group or other patient forum the practice did not always involve the public, staff and external partners to sustain high quality and sustainable care.

Leadership capacity and capability

Leaders could not demonstrate that they had the capacity and skills to deliver high quality sustainable care.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes (1)
They had identified the actions necessary to address these challenges.	Yes (2)
Staff reported that leaders were visible and approachable.	Yes (3)
There was a leadership development programme, including a succession plan.	No

Explanation of any answers and additional evidence:

1. It was clear from staff that we spoke with, and feedback forms we received, that leaders prioritised patient care and wanted to improve accessibility to and improve services. The physical constraints of the building made this challenging, as it had been purpose built to cater for 9,000 patients. The practice now had 17,777 patients. Negotiations to occupy more rooms within the building but not currently used by the practice had proved very protracted and frustrating. There was a desire to provide additional services, for example minor surgery, but these were on hold due to the accommodation constraints. The partners were clear that the additional space would be a major factor in them improving services, but it was unclear how this would help, bearing in mind the low staffing levels.
2. Staff at all levels also told us that they were very short-staffed, especially on reception which resulted in excessive demands being made of them and the expectation of them providing the necessary cover. One person occupied the reception desk at the Skegness site, and we observed that the self check-in machine was out of order, placing additional unnecessary demands on the receptionist. For example, during our visit we noted that patients were queuing outside of the building and into the car park in order to check in for their appointment. The practice employed 33 staff in total. Of those 10.85 WTE were reception and dispensary staff, but these were spread

across both sites. It is acknowledged that recruitment at all levels was difficult on the Lincolnshire coast and not confined to this practice. Staffing levels were low when compared to similar practices.

3. Staff feedback indicted that generally GPs were visible, especially as the duty GP was located behind the reception area.

Vision and strategy

The practice had a clear vision, but it was not supported by a credible strategy to provide high quality sustainable care.

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	No (1)
Staff knew and understood the vision, values and strategy and their role in achieving them.	Partial (1)
Progress against delivery of the strategy was monitored.	No

Explanation of any answers and additional evidence:

(1) We were not provided with the practice's vision in a written format. There was no mention of it on the practice website. It was clear however that the partners were keen to expand the range of services they offered, for example minor surgery but had been prevented for doing so by the constraints imposed by the limited accommodation.

(2) Of the 20 staff feedback forms we received, five respondents said that the practice had a vision, three stated they were unsure, and the remainder stated there was no vision. None of the 20 said they had been involved in developing the strategic planning (mission statement, vision or values) of the practice.

Culture

The practice culture did not effectively support high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes (1)
Staff reported that they felt able to raise concerns without fear of retribution.	Yes (2)
There was a strong emphasis on the safety and well-being of staff.	Partial (1)
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes

Staff had undertaken equality and diversity training.	Yes

Explanation of any answers and additional evidence:

(1) All staff we spoke with and written feedback we received expressed concerns regarding the low numbers of staff, in particular reception staff. We were told that this group of staff were working at the limit of what was possible. Although we accept that recruitment was a major issue in this part of Lincolnshire, we were not provided with any assurances by the practice that they had taken steps to seek an alternative solution. Low numbers of reception staff resulted in long delays in telephone answering and staff told us that this in turn had a knock-on effect in heightening tension and the potential for conflict with patients when they eventually got through to the practice. Although the practice had installed a revised telephone system there appeared to be a reliance on a call-back option to mitigate the situation. The practice could not provide any evidence that this was the case.

(2) Staff feedback indicated that they would be confident in reporting any concerns and the majority thought they would be listened to.

Examples of feedback from staff or other evidence about working at the practice

Source	Feedback
CQC staff feedback forms	Prior to the inspection we invited all 33 members of staff to provide written feedback, anonymously if they so wished. We received 20 responses. Generally, respondents were positive about working relationships and team working. Common themes that ran through the responses was short staffing, increased pressure of work and lack of physical space within the practice to enable them to improve the patient experience. Some respondents had stated that they did not think that the GP partners supported the managerial staff sufficiently.

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	No (1)
Staff were clear about their roles and responsibilities.	No (2)
There were appropriate governance arrangements with third parties.	Yes

Explanation of any answers and additional evidence:

(1) We were provided with a list that showed which of the eight GP partners, and some staff, were responsible for each area of service delivery. This included prescribing and dispensary, safeguarding, infection prevention and control, long-term conditions etc.

We noted that the lead for infection and prevention and control was a nurse and that no GP had oversight. The nurse lead did not attend clinical governance meetings, despite the IPC being an

agenda item. We looked at the minutes of five meetings and in only one was there a record of an infection prevention and control related matter, which was in respect of some out-of-date stock in a consulting room.

There was no named lead for performance or quality improvement.

The records of the clinical meetings indicated that perhaps not enough time was set aside for them and many matters were not resolved or even discussed and were postponed to subsequent meetings. For example, we saw in the minutes of the meeting held in October 2021 an item had been brought forward from March 2021 which concerned an audit of patients prescribed carbimazole being changed from 10mg to 5mg. This action was still outstanding as recorded in the minutes of the meetings held on 23 February 2022 and 25 May 2022.

Nursing staff, nurse practitioners and advanced nurse practitioners did not attend clinical governance meetings.

(2) Whilst staff that we spoke with knew what was expected of them, in one case they had been tasked with managing the dispensary when they had no experience and had not been offered any training in that area, regardless of whether the demands of their other duties would have facilitated that.

We found instances of 'silo' working, with nurses for example, adopting a methodology without knowing what other nurses were doing in the same circumstances.

Managing risks, issues and performance

There practice did not have clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	No (1)
There were processes to manage performance.	Partial (2)
There was a quality improvement programme in place.	No
There were effective arrangements for identifying, managing and mitigating risks.	No
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	No (3)

Explanation of any answers and additional evidence:

(1) The practice IT system, not the clinical IT system, was described as not secure. We were made aware of an occasion recently where a GP inadvertently deleted a nurse clinic and another instance of a member of staff deleting compliance records. The practice did not have resilience built into their governance systems. For example, some members of senior staff held information that was inaccessible to other members of staff. This posed a risk to the practice.

(2) We were made aware of a performance issue in relation to a member of staff. No formal investigation was carried out and not actions identified to help prevent re-occurrence.
(3) There was no evidence that the practice had an effective quality improvement programme.

The practice did not always have systems in place to continue to deliver services, respond to risk and meet patients' needs during the pandemic

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Yes
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Yes
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Yes
The practice actively monitored the quality of access and made improvements in response to findings.	No (1)
There were recovery plans in place to manage backlogs of activity and delays to treatment.	No (2)
Changes had been made to infection control arrangements to protect staff and patients using the service.	Yes
Staff were supported to work remotely where applicable.	Yes
Explanation of any answers and additional evidence: (1) The issues with telephone access and lack of audit or analysis made active monitoring unquantifiable. (2) There were back-logs in long-term condition reviews that had not been addressed. For example, for patients diagnosed with hypertension, 260 of 3,716 reviews had been completed. The practice had not recommenced the reviews of patients with long-term conditions who were housebound or living in care homes.	

Appropriate and accurate information

The practice did not always act on appropriate and accurate information.

	Y/N/Partial
Staff used data to monitor and improve performance.	No
Performance information was used to hold staff and management to account.	No
Staff whose responsibilities included making statutory notifications understood what this entailed.	Yes
Explanation of any answers and additional evidence: The partners were aware of the patient dissatisfaction regarding access to services as demonstrated in the GP patient survey. They had installed a new telephone system but had not used the data available from the system to monitor and improve performance. We were informed that nobody knew how to	

collect the data. They had not been in contact with the equipment providers to receive the necessary instruction and training.

Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes
The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Yes
Patients were informed and consent obtained if interactions were recorded.	Yes
The practice ensured patients were informed how their records were stored and managed.	Yes
Patients were made aware of the information sharing protocol before online services were delivered.	Yes
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Yes
Online consultations took place in appropriate environments to ensure confidentiality.	Yes
The practice advised patients on how to protect their online information.	Yes

Engagement with patients, the public, staff and external partners

The practice did not always involve the public, staff and external partners to sustain high quality and sustainable care.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Partial (1)
The practice had an active Patient Participation Group.	No (2)
Staff views were reflected in the planning and delivery of services.	No (3)
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Explanation of any answers and additional evidence: (1) Although the practice had gathered patients' feedback though the Friends and Family survey, there was no evidence to show that any views expressed had been considered. There were some changes evident resulting in the investigation of patient complaints. The practice had reacted to mounting pressures regarding the telephone system and had updated it in March 2022, including a call-back facility. The practice had not carried out any survey or feedback exercise to gauge any impact of the change.	

(2) The practice informed us that there had been no Patient Participation Group for some years, stating there was no interest from patients.
(3) Feedback from staff was mixed. Some said they thought their views were considered, others that they were not. We were provided with an example of a staff suggestion resulting in a change in the telephone answering message.

Feedback from Patient Participation Group.

Feedback
There was no patient participation group

Continuous improvement and innovation

There was little evidence of systems and processes for learning, continuous improvement and innovation.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	No
Learning was shared effectively and used to make improvements.	No

Explanation of any answers and additional evidence:
Staff told us and the practice confirmed that there was no protected learning time and staff were expected to complete their training, including the providers essential training outside of working hours. The dispensary manager who was newly appointed and without any experience had not been offered training in dispensing or dispensing management.

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique, we can be 95% confident that the practices performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

N.B. Not all indicators in the evidence table are part of the GP insight set and those that aren't will not have a variation band.

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	≤-3
Variation (positive)	>-3 and ≤-2
Tending towards variation (positive)	>-2 and ≤-1.5
No statistical variation	<1.5 and >-1.5
Tending towards variation (negative)	≥1.5 and <2
Variation (negative)	≥2 and <3
Significant variation (negative)	≥3

Note: for the following indicators the variation bands are different:

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have “Met 90% minimum” have not met the WHO target of 95%.

- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules-based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.

- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices.

Guidance and Frequently Asked Questions on GP Insight can be found on the following link: https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices

Note: The CQC GP Evidence Table uses the most recent validated and publicly available data. In some cases at the time of inspection this data may be relatively old. If during the inspection the practice has provided any more recent data, this can be considered by the inspector. However, it should be noted that any data provided by the practice will be unvalidated and is not directly comparable to the published data. This has been taken into account during the inspection process.

Glossary of terms used in the data.

- **COPD**: Chronic Obstructive Pulmonary Disease.
- **UKHSA**: UK Health and Security Agency.
- **QOF**: Quality and Outcomes Framework.
- **STAR-PU**: Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.
- ‰ = per thousand.

NHS
Lincolnshire
Integrated Care Board

PUBLIC PRIMARY CARE COMMISSIONING COMMITTEE

Date: 19th October 2022
Location: MS Teams

Agenda Number:	16
Title of Report:	Public Primary Care Commissioning Committee Risk Register
Report Author:	Nick Blake, Acting Programme Director for Integrated Primary Care and Communities
Appendices:	Appendix 1 – Primary Care Risk Register

1. Key Points for Discussion:

The Primary Care Risk Register provides the current assessment of risks that may impact on the delivery of Primary Care services across Lincolnshire.

2. Recommendations

The Primary Care Commissioning Committee is asked to:

- Consider the Risk Register and plans to mitigate identified risks.
- Note that the management of a number of key risks will only be achieved through the development of a comprehensive Primary Care strategy.
- The foundation of the Primary Care strategy requires the rapid development of Primary Care Networks.

3. Executive Summary

The Risk Register has been reviewed and updated by the risk owners. The following is a summary of the reviews by risk with a 'Current Risk Rating' score of 12 and over.

06 - Additional Roles
This risk has been maintained.
There is a risk that PCN won't be able to recruit to the additional roles identified in the long-term plan leading to reduced capacity / ability to develop MDT working within primary care and a loss of income for Lincolnshire from the national funding for additional role reimbursement.
Changes to the Extended Access have exacerbated this issue.

We are currently undertaking the following key actions:

1. Plans for 2022/23 have been submitted as part of system planning,
2. Working with the Peoples Board to develop the arrangements to support development of implementation of PC Workforce plans.
3. GP Community Pharmacy referral is currently in place across Lincolnshire.
4. Same Day access is being procured through Livi.
5. Develop future recruitment planning aligned with People Team & Board.
6. A proposal for a central Recruitment Hub to support PCNs went to PCN Business Managers on 21 April, work on this is ongoing and will be progressed through the Primary Care People's Group and the PCN Business Managers meeting.
7. Monthly budget plan reporting implemented with PCN managers and collated position produced and reported back to PCPG, PCN Managers and PCNA.
8. Plans being reviewed with individual PCNs with a focus on those PCNs who underspend is highest.
9. Review of ARRS spending on a 3-stage process, at PCN level, locality level and system level. Focus on PCN spending their allocations ahead of July submissions. Discussions being held with PCNs re opportunity to collaborate with other PCNs.
10. Refreshed workforce plans have been submitted by PCNs in line with contract requirements, these will be reviewed by the ICB by October for final submission and confirmation of expected year-end position.
11. PCPG looking to identify 'on the shelf' ideas for underspend that may become available at a system level post October.
12. LTH engaged and supporting the process re workforce planning and recruitment/training requirements.

17 - APMS Contracts

This is a new risk.

The loss of APMS Contracts will impact NHSL Federations ability to be an employing authority and offer employees access to the NHS Pension Scheme.

We are currently undertaking the following key actions:

1. Receiving legal advice from Beachcroft.
2. Meeting held with affected federations on 13 July to review advice and mitigations.
3. Plans to be developed with each federation to put in place interim solutions and seek advice/application to BSA.
4. Plans submitted by PCNs to ICB for Enhanced Access, all reviewed and progressing.
5. Mobilisation period up to 1 October 2022 to be utilised to make necessary amendments to arrangements to maintain access to NHS Pensions Scheme for affected staff. Further legal advice sought by the ICB to support each organisation. National subcontract released.
6. Ongoing work with NHSE regarding PCN governance arrangements and legal structure, supported by legal advice at system level.
7. Confed is to meet with ICB Primary Care Directors in August.
8. Regular meetings being held with NHSEI.
9. Bi-weekly meetings being held with GP Federations.

18 - Paediatric Referrals
This is a new risk.
Paediatric Referrals can take up to 2 years. This impacts on patient outcomes but is outside of primary care control.

We are currently undertaking the following key actions:

1. Current position with Paediatric Referrals is being kept under review with clinical leads and through locality forums.

20 - Data Sharing
This is a new risk.
Variation in GP practice sign up to data sharing arrangements to support data flow.

We are currently undertaking the following key actions:

1. Raised as an issue at the Primary Care, Communities and Social Value Steering Group - 12 July 2022.

21 – Energy Costs
This is a new risk.
Increasing energy costs are affecting GP practice finances and resilience.

We are currently undertaking the following actions:

1. The Government has announced a six-month energy cap scheme which will apply to GP practices, it is currently unclear whether GP practices will be categorised as a vulnerable business and receive support beyond the initial six months.
2. Monitoring of impact at a practice level by the ICB Primary Care Team and ongoing liaison with the Local Medical Committee.

22 – Secondary care referrals
This is a new risk.
Referral to hospital services for diagnosis and care can be lengthy across several pathways and impact on patient outcomes. This is outside of primary care control but can affect GP practices in terms of ongoing patient care and management.

We are currently undertaking the following actions:

1. Current position with referrals is being kept under review with clinical leads and through locality forums.

23 – Primary Care Capacity in relation to resettlement and refugees
This is a new risk.
Primary care may not have sufficient capacity to respond to all of the health needs of people placed in Lincolnshire under the resettlement programmes and refugees.

We are currently undertaking the following actions:
The issue is being kept under review with practices close to resettlement locations and is being raised through appropriate system forums.

4.	**Management of Conflicts of Interest**

None.

5.	Risk and Assurance

This section should identify known or potential risks and how these are being mitigated, including conflicts of interest.

Please state if the risk is on the ICB Risk Register.

Yes	X	No	

6.	Financial/Resource Implications

Risk mitigation is likely to require significant investment.

7.	Legal, Policy and Regulatory Requirements

The ICB is required to ensure the effective provision of Primary Care.

8.	Health Inequalities implications

Impacts on primary care capacity due to, long waits for paediatric services, acute care and variability in data sharing arrangements may exacerbate existing health inequalities. These risks will be reviewed and monitored with the Health Inequalities programme.

Improving GP sign up to data sharing will support monitoring and addressing health inequalities and the development of effective Population Health Management approaches.

9.	Equality and Diversity implications

Longer referral times for children and young people is an equality issue and likely to adversely impact on patient outcomes and experience.

Primary care workforce capacity may affect people with more complex health care needs or those who require additional support to access primary care services.

10.	Patient and Public Involvement (including Communications and Engagement)

The development and review of the risk register reflects the feedback from key stakeholders.

Arrangements to ensure that feedback from HealthWatch are incorporated into the review of the Risk Register have been established.

11.	Report previously presented at

Risk issues have been previously reviewed at the Primary Care Senior Managers' Group and the Primary Care, Communities and Social Value Steering Group.

12.	Sponsoring Director/Partner Member/Non-Executive Director

Sarah-Jane Mills
Director of Primary Care, Community & Social Value
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Item 16b

		Likelihood				
		Rare	Unlikely	Possible	Likely	Almost Certain
		1	2	3	4	5
Consequence	Negligible 1	1	2	3	4	5
	Minor 2	2	4	6	8	10
	Moderate 3	3	6	9	12	15
	Major 4	4	8	12	16	20
	Catastrophic 5	5	10	15	20	25

1-3	Low risk
4-6	Moderate risk
8-12	High risk
15-25	Extreme risk

PCCC Risk Register - 2022/23 - an Integrated Primary Care Risk Log to capture risks and issues that aren't practice or PCN specific but that affect primary care, including wider system issues

CRR - Overall Score of >12

			Inherent Risk Rating				Current Risk Rating								
ID	Date Opened	Description	Likelihood	Impact	Rating	Controls in place	Likelihood	Impact	Rating	Mitigation	Action points/Updates (SMART ACTIONS)	Last review date	Lead Officer	Risk Owner	Timeline
6		There is a risk that PCN won't be able to recruit to the additional roles identified in the long term plan leading to reduced capacity / ability to develop MDT working within primary care and a loss of income for Lincolnshire from the national funding for additional role reimbursement Changes to the Extended Access have exacerbated this issue.	4	4	16	1. There is a weekly ARRS Group attended by Heads of Transformation, Locality Workforce Lead & Primary Care Programme Lead. The group monitors plans and delivery against ARRS. Additional support is being secured through Optum to support the delivery of the SMRs, where there are current recruitment gaps for clinical pharmacists 2. PCNs report ARRS staffing as part of NWRS (quarterly submission). 3. Primary Care People Group meets bi-monthly and has membership from PCNA, PCN Managers, Primary Care Workforce Lead, Primary Care Programme Lead, LTH, LMC AHP Lead. 4. Primary Care Workforce Lead is in place (from 4 Jan 22).	4	4	16	1. Regular meeting with PCN Alliance, PCN Managers and PCN A Chair & deputy Chair to discuss issues. 2. PCN managers working closely with HoTs & CCG Locality Leads. 3. The Lincolnshire System is procuring a ICS-wide workforce tool (KPMG). This will scope primary care workforce but there is no tool in place. The Primary Care People Group (PCPG) is undertaking a review of needs, strategy meeting planned for 20 Sept-22. 4. A report goes to the PCPG on ARRS workforce and spend.	1. Plans for 2022/23 have been submitted as part of system planning. 2. Working with the Peoples Board to develop the arrangements to support development of implementation of PC Workforce plans. 3. GP Community Pharmacy referral is currently in place across Lincolnshire. 4. Same Day access is being procured through Livi, starting 18 April. 5. Develop future recruitment planning aligned with People Team & Board. 6. A proposal for a central Recruitment Hub to support PCNs went to go to PCN Business Managers 21/04/22, with the aim to procure in Q1 for implementation in Q2. 7. Monthly budget plan reporting implemented with PCN Managers and collated position produced and reported back to PCPG, PCN Managers and PCNA. 8. Plans being reviewed with individual PCNs with a focus on those PCNs where underspend is the highest. 9. Review of ARRS spending on a 3 stage process, at PCN level, locality level and system level. Focus on PCN spending their allocations ahead of July submissions. Discussions being held with PCNs re opportunity to collaborate with other PCNs. 10. PCPG looking to identify 'on the shelf' ideas for underspend that may become available at a system level post October. 11. LTH engaged and supporting the process re workforce planning and recruitment/training requirements.	08/08/2022	Sarah-Jane Mills	Martin Kay	Ongoing throughout 2022/23
17		**APMS Contracts** - the loss of APMS Contracts will impact NHSL Federations ability to be an employing authority and offer employees access to the NHS Pension Scheme.	3	4	12	1. Currently seeking legal advice, reviewing BSA guidance and seeking advice from NHSE.	3	4	12	1. Potential use of flexibilities through BSA including federations applying for direction status up to 31 March 2023. Flexibilities under use of NHS Standard Contract are unlikely to apply.	1. Legal advice requested from Beachcroft, due 12 July 2022. 2. Meeting to be held with affected federations on 13 July to review advice and mitigations. NHSE to attend. 3. Plans to be developed with each federation to put in place interim solutions and seek advice/application to BSA. 4. Plans to be submitted by PCNs to ICB for Enhanced Access by 22 July, panel to review submissions held on 29 July 2022. 5. Mobilisation period up to 1 October 2022 to be utilised to make necessary amendments to arrangements to maintain access to NHS Pensions Scheme for affected staff. Further legal advice sought by the ICB to support each organisation. National subcontract imminent which may support issues raised. 6. Ongoing work with NHSE regarding PCN governance arrangements and legal structure, supported by legal advice at system level. 7. Confed is to meet with ICB Primary Care Directors in August. 8. Regular meetings being held with NHSE/I. 9. Bi weekly meetings being held with GP Federations.	08/08/2022	Sarah Starbuck	Sarah Starbuck	Q2 22/23
18		**Paediatric Referrals** - Paediatric Referrals can take up to 2 years. This impacts on patient outcomes but is outside of primary care control.	4	3	12	1. Raised with DDON Wendy Martin and Clinical Leads as an issue. Further discussions with CYP commissioners planned.	4	3	12	1. Current system pathway issue, further exploration and identification of approach to address the issue required.	1. Current position with paediatric referrals is being kept under review with clinical leads and through locality forums.	09/08/2022	Sarah-Jane Mills	Sarah-Jane Mills	TBC
20		**Data Sharing** - variation in GP practice sign up to data sharing arrangements to support data flow.	4	3	12	1. Engagement across practices, digital team and AGEM DPO team. Work across the LMC and ICB performance team is planned to support improved data quality and sharing.	4	3	12	1. Currently reviewing issues and agreeing engagement plan with practices where needed. In discussion with LMC.	1. Raised as an issue at the Primary Care, Communities and Social Value Steering Group - 12 July 2022.	12/07/2022	Sarah-Jane Mills	Nick Blake	TBC
21		**Energy costs** - high energy costs are affecting GP practice resilience and financial viability.	4	3	12	Government 6 month energy cap announced - currently unsure whether this will continue beyond 6 months. The ICB has procedures in place to support GP practices.	4	2	12	Ongoing monitoring of impact on GP practices and on national support available.		12/09/2022	Sarah-Jane Mills	Nick Blake	TBC
22		**Secondary care referrals** - increased waiting times for diagnosis and care in acute settings is affecting patient outcomes but outside of priamry care control.	4	3	12	1. Raised with ICB cancer and planned care teams as an issue. Further discussions with clinical leads and ongoing monitoring through clinical fora.	4	3	12	1. Current acute trust capacity and bed flow issues alongside demand, further exploration of issues and monitoring required.	1. Current postion with acute referral waits to be kept under review with clinical leads and locality forums. Any consequent impact on primary care to be monitored and mitigated where possible.	12/09/2022	Sarah-Jane Mills	Nick Blake	TBC
23		Primary care capacity to respond to the health needs of people under the resettlement programmes or asylum seekers. Additional national funding is not indicated currently.	4	3	12	Raised through system resettlement forums, escalated to ICB Executive.	4	3	12	Monitoring impact on affected practices - ICB Team supporting where appropriate.	.	11/10/2022	Sarah-Jane Mills	Sarah Starbuck	TBC

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2		There is a risk of possible patient harm if there is a failure in quality, safety and patient experience in primary care services commissioned by the CCG	3	3	9	1. Quality risk assessment per practice using information gathered by locality leads and the quality team. 2. Primary Care Quality Assurance Group in localities reviews both data and soft intelligence relating to individual practices arising from a number of sources. 3. Increased CCG guidance and support is provided to practices via the risk stratification process and in response to identification of any CCG input required. 4. WAF funding has been used to establish a Quality Improvement Service (QJS) managed through the LMC.	3	3	9	1. Ongoing monitoring of practices through locality PCQAGs, the county wide PC quality oversight group & PCCC. 2. The CCG is still in receipt of information from CQC for high levels of concern or where a complaint/ whistle-blower has approached the regulators. 3. CQC regular attendee at PC county wide PC Quality Group. Healthwatch & LMC also attend this group. 4. Locality staff ensure on going assessment of available information and triangulate with any known historic information. Increasingly working with PCN Directors to develop ongoing quality assurance & improvement processes for PCN constituent practices. 5. The QJS will work with the Quality & Performance Oversight Group to identify practices that would appear as having issues. 6. Data sets are being established to look at a number of aspects of general practices to identify at risk patient groups. 7. The QJS has been asked to initially work with the 16 practices identified as those needing enhanced support within the WAF review.	1. Practice visits recommenced from Autumn 21, capacity of the Quality team remains constrained as vacancies recruited to within the team. 2. Continue work with PCN Directors to develop quality governance processes with constituent practices. 3. Support the LMC in establishing the QJS from April 2022. 4. Agree remit for the initial reviews and future reporting arrangements by end April 2022	1. Majority of Practices good risk ratings with CQC (x 4 Require Improvement). 2. The practice previously rated as Inadequate by the CQC has been re-rated as Requires Improvement following re-inspection - the CCG is offering support to the practice in making further improvements.	08/08/2022	Wendy Martin / Martin Fahy	Wendy Martin	
3		There is a risk that the business model for delivery of primary care services becomes unsustainable for individual practices.	4	3	12	1. Practices have Business Continuity Plans. 2. All PCNs to agree Business Continuity Plans, which cover a group of practices. 3. Practices undergo annual regulatory reviews by the Care Quality Commission.	3	3	9	1. There are regular meetings between ICB Locality Leads and their respective practices. This enables the monitoring of softer issues which provide information about the robustness of a practice. 2. The OPEL framework (GPAS) is being piloted by the LMC in 12 practices. This now covers 34 practices. Reports are received weekly. Whilst good to have additional information, it is not possible though from the granularity of the data to identify practices with specific issues, and therefore be proactive in providing support. 3. Primary Care providers will also form part of the Urgent Care Dashboard.	1. LMC implemented a GPAS pilot, further roll out will occur later in the year 2. Complete Action Cards to support the OPEL. 3. NHS Digital has put in place new workforce and appointment data collection processes/services. Data quality will be monitored to assess impact. 4. Agreement has been made with the LMC that they will lead a piece of work to improve data quality within practices. Plans are to be agreed in Q1 5. Continue to monitor the situation, in particular for small practices due to the current increase in cost of living e.g. energy costs, pay etc.	1. A review of Business Continuity plans is currently taking place with the expectation that moving forward these will all be at a PCN level. We are also reviewing as part of the restoration and recovery phase the new ways of working that have been implemented in response to COVID that we would like to maintain moving forward. 2. LMC, PCNs and CCG are working together to develop the Primary Care OPEL. 3. Discussions are due to be held following the publication of the report 'At you service' by the Policy Exchange.	08/08/2022	Sarah-Jane Mills	Martin Kay/HOTS	
4		There is a risk that Primary Care networks won't develop at the pace required to support delivery of the long term plan.	3	3	9	1. PCN Alliance meet on a weekly/monthly basis to oversee delivery of PCN DES priorities. 2. Development plans for the PCNs are currently being developed which will support the delivery of the LTP and the strategic direction of travel. 3. PCN Alliance is a member of the Provider Alliance. 4. PCN Managers and CCG leads meet monthly. 5. PCN managers work closely with both their Clinical Directors and Practice Managers. 6. Tricordant has been procured to support the PCN review. Plans are due in Q1. Plans received and currently sit with the PCNA 7 Beachcroft has been working with the pCNA to support the development to achieving a legal status. Outcome is expected in Sep/Oct	2	3	6	1. PCNs look at service delivery model on a PCN footprint. 2. A joint OD Plan to be developed across PCNs and practices. 3. A new ambitions framework has replaced the maturity matrix to create better conditions for PCNs to identify the asks and needs to realise improved maturity.	1. Develop as part of the Primary Care Strategic approach. 2. COVID and vaccinations needs have slowed this development down but is now back in traction. 3. Lincolnshire has agreed to be a National pilot for a new proposal currently being worked up by the Time for Care team to develop Primary Care Transformation teams within ICS'.	1. Work is ongoing between Primary Care Programme, PCNs and PCCC in developing the primary care strategy. This will provide the vision for PCNs to aim for, based on delivery of the Long-Term Plan. Subsequently it will be possible to identify development needs at specific PCN level. The initial 4 sessions have been completed. 2. We have appointed Tricordant (an external consultancy) to inform the further development of the PCNA and PCNs as part of the wider system development of the provider collaborative. 3. Programme manager appointed to support PCN A / PCN development. 4. Tricordant are holding further workshops during April to complete their final report on governance and workforce to form their report.	08/08/2022	Sarah-Jane Mills	Martin Kay	Tricordant report is expected towards the later half of Q1.
7		There is a risk that there will be insufficient capital and revenue funding to facilitate the development of Primary Care Estates and Community Hubs required to support delivery of the long term plan.	3	3	9	Lincolnshire is developing a system bid to become part of the Health Infrastructure Programme (HIP). This will set out the System case for its estates capital requirements. This will include all sectors including primary care and demonstrate the interdependencies for service delivery, capacity, quality, place, population health and impact of technology and hence the estate required. In addition Sleaford has been identified as a pilot for the Cavell Programme which is the follow on from the ETTF programme and focuses on Primary/Community Hubs. Louth, Gainsborough and Lincoln South have also been included on the programme although not a pilot. The Cavell Programme is expected to be included in the spending review due in November 2021. There is national funding to complete the development of the business case. BAU capital will still be available for small primary care developments. The work supports the development of PCN estates strategies and the ICS Estates Strategy which is likely to be required by March 2022.	2	2	4	1. Monthly Primary Care Estates meeting with relevant locality, finance and estates leads in attendance to review and support general practice premises issues and development. 2. Development of PCN Estates Strategies, informed by clinical strategies, to be developed.	1. A Full report was presented to the PC3 Development Session in March 22. 2. Community Health Partnerships and Exi have mobilised the PCN Strategy Support Programme in July 2022. 3. All PCNs will be supported to develop clinical and estates strategies during 22/23, split into two tranches. 3. The PCN Strategy Support programme will support robust assessment of estates prioritisation. 4. Neighbourhood Team requirements are being considered as part of the programme.	1. Submission provided to support the National Data Gathering Programme in relation to primary care estate in January 2021. 2. Ongoing CCG support at practice level where outline business cases for practice developments are being progressed where estates capacity risks impacting on patient care. Initial discussions taking place with PCNs regarding future estate needs based on local evidence from HIP work, and the data gathering programme. Work taking place with Grantham PCN on how they want to meet primary care needs from two large scale housing developments. Primary Care Data Gathering Programme has been completed. Routine meetings established with Community Health Partnerships to take forward the PCN Strategy Support Programme to support PCNs with their estate planning and development of estates strategies. 3. May 22 - Exi now commissioned to support the PCN Strategy Support Programme and mobilisation planning in progress.	08/08/2022	Jacqui Bunce	Sarah Starbuck	To complete the HIP bid by 31st March 2021. To complete the Sleaford OBC/FBC by 31st May 2022. PCN Strategy Support Programme. To be completed in 2 tranches during 22/23.

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10		There is a risk that functions previously supported by NHSE are not covered due to Primary Care team being diverted to support COVID 19 and not having the capacity to establish new arrangements / processes. This may result in Primary Care contract management issues not being completed in a timely manner, failure to secure section 106 funds to support future capital development - leaving practices exposed to financial risk.	3	3	9	1. A full list of key issues has been compiled by the Primary Care Team.	2	3	6	1. Primary care team address individual issues as they arise. 2. Discussion with ICB and AGEM contracting teams to confirm support to Primary Care, capacity is available. 3. S106 funding is managed through the Estates Group with dedicated support capacity.	1. Development of arrangements to ensure the key areas of responsibility are addressed. 2. Review of processes to ensure that the CCG can support key activities and where necessary negotiation of arrangements to minimise disruption.	1. Allocation of lead responsibilities within Primary Care Team has been completed. Work to develop team resilience and business continuity approaches is continuously under review. 2. This work needs further review to take account of the plans to transfer commissioning of Dental, Optoms and Community Pharmacy to CCGs as part of the Integrated Commissioning programme. This is part of the ongoing regional discussions and planning work managed through the IPCC programme.	09/08/2022	Sarah-Jane Mills	Sarah-Jane Mills	30/06/2022
14	10/11/21	As a result of the accelerated changes with regards to accessing primary care, including the introduction of triage and utilisation of remote consultation, there is increased criticism both by individual members of public and cross local and national media that is resulting in some GPs receiving abuse, and a general feeling across the profession of being singled out and not valued for the contribution that they make, or, the fact that they are managing increased demand. As a result there in an increased risk that GP staff become demoralised and fail to engage in improvement and transformation programmes, and a further risk that GP staff will leave.	3	4	12	1. Continued proactive dialogue through the LMC Clinical Leads and PCN Alliance to ensure that local plans are dealt with sensitively, sensibly and pragmatically.	3	3	9	1. Maintain open dialogue with General Practice. 2. Develop comprehensive comms and engagement programme that provides greater understanding and visibility of developments across primary care. 3. There has been a system wide campaign regarding being kind and supportive to staff across the NHS. 4. Work with General Practice, the LMC, PCNA and Clinical Leads to develop a comprehensive plan to ensure effective investment of the Winter Access Fund (WAF).	1. Comms & Engagement plan developed and launched. 2. Winter Access Fund (WAF) implementation plan progressed in partnership with primary care and system colleagues.	1. Comms and engagement plan delivery ongoing. 2. WAF has been implemented with practices - potential opportunities to extend to support access and mitigation of system demand pressures are currently under review. 3. Patient access is kept under review and part of the Primary Care programme KPI data set, workforce issues are monitored through the Primary Care People's Group and PCNA. 4. The 2021/22 Patient Survey is now available and being reviewed to identify any specific issues.	09/08/2022	Sarah-Jane Mills	Nick Blake	30/06/2022
16	12/11/21	1. NWAFT have notified the CCG that there has been a delay in 10K + patient discharge letters being issued to some GP surgeries in Lincolnshire. NWAFT are unable to send the letters in batches and practices will be emailed as they are usually for discharge summaries, so letters will not be easily identified as historic discharges from those which are from more recent/current admissions. 2. The additional volume and impact on capacity for practices when reviewing these letters, to safety net any review that NWAFT has undertaken and action any feedback, needs to be factored in. 3. LMC have raised query as to practice reimbursement for these reviews.	4	3	12	1. NWAFT Clinicians are reviewing the discharge information and highlighting those patients that may have suffered harm. 2. CCG Comms have sent out information to each of the effected practices with information as to their approach. 3. Locality Leads to link in with practices to ascertain additional time commitment on practices, required to review.	3	3	9	1. NWAFT will contact those patients whom they identify may have suffered harm as a result of this issue. 2. So that practices can easily identify the letters as they are sent through to generic mailboxes, NWAFT will send a list of patient names in advance to practices, so that they can be checked and reconciled within each practice. 3. NWAFT are arranging a series of webinars to inform practices of this issue and outline their own mitigating actions. 4. Clinical leads, who have been involved in the reviews can be contacted for further discussion on any patient referral where there may be practice concerns.	1. NWAFT to hold webinars for GP practices affected. 2. NWAFT to confirm approach to managing backlog and letter send out. 3. NWAFT to confirm timeline to address issue.	1. Webinars were held by NWAFT on 23rd and 25th November. 2. The risk associated with mail out of letters to GPs has been addressed - 3. NWAFT will be managing the reviews over time and won't be mailing out letters to practices in bulk. 4. Clinical risk is being held and managed by NWAFT. 5. The CCG is assured that NWAFT are progressing the work and reviewing the factors leading to the issue, however, lack of pace remains a concern. The CCG Contracts and Nursing and Quality Teams haven't had confirmation from NWAFT on the timeline for all patients to be contacted and will be seeking this in January 2022. 6. NWAFT have confirmed that around 2,000 patients' reviews are outstanding and are being progressed and are expected to be completed in May 2022. NWAFT report no patient has been identified so far. LCCG Quality Team are coordinating with Cambs and Peterborough CCG on this matter - a further update on progress and completion of the work is being requested from NWAFT.	08/06/2022	Nick Blake	Sarah-Jane Mills	Update from NWAFT on timeline for completion required by end of Jan 2022.

Closed Risks

ID	Date Opened	Description	Inherent Risk Rating: Likelihood	Inherent Risk Rating: Impact	Inherent Risk Rating: Rating	Controls in place	Current Risk Rating: Likelihood	Current Risk Rating: Impact	Current Risk Rating: Rating	Risk score change narrative (Mitigation)	Action points	Updates	Last review date	Lead Officer	Risk Owner	Timeline	
5		1. There is a risk that practice will withdraw from using total triage solutions as these were introduced rapidly to facilitate access to primary care as a response to the COVID-19 pandemic. The rapid role out did not provide adequate time for the change management associated to this new way of working. 2. Increase in activity puts further pressure on practices to manage what is seen as an open door access to them (24/7) Risk Now Closed as has moved into new Phase .	3	3	9	1. Primary Care Digital Group receive a monthly report on usage. 2. Close relationship/interface is in place with Primary Care Digital Lead to scan for early issues. 3. Close working relationship with NHSE/I & Digital for external signals and potential support in managing issues. 4. Project manager is in place to support practices with online consultation. 5. The use of online consultation has been incorporated in to the PCN DES of delivery of 5 online consultations per week per 1,000 population. 6. Total triage is now part of the GMS contract.	3	2	6	1. To continue to work with practices where opportunity allows to implement digital capability. 2. Review when the new GP contract is published. 3. build data knowledge on total triage usage to inform the overall demand on practices.	1. Work closely with the Regional Digital Transformation Director and NHSX Director of Digital Care to develop understanding and opportunities for improvement. 2. The timeline for the new GP contract is not clarified, but will be picked up as part of that work. 3. COVID and vaccinations needs have slowed this development down and but will continue to look to make progress.	A scoping piece of work to look at access to General Practice is underway which will review the impact of implementing both total triage and online consultation within General Practice. A key element of this will be to understand if this has released time to care or whether this has added additional workload to general practice. As part of the Digital Programme, a full evaluation of online consultation tools is underway with a view to recommending what approach Lincolnshire should take to future services, systems and provision. The Primary Care Programme Digital lead is working with PCNs, all their member practices and NHSD/X to maintaining and increase Total Triage coverage.	27/07/2022	Sarah-Jane Mills	Martin Kay	Review Q1	
8		There is a risk that Primary Care will be unable to provide appropriate support to enable residents with a learning difficulty to access their annual health checks.	3	4	12	1. Data regarding uptake during 2019/20 reviewed to identify areas of poor uptake. 2. CCG group established to support development of arrangements to facilitate health checks. 3. Locality teams supported by Neighbourhood Leads looking to identify individuals who may require personalised support. 4. Work across system partners to support the programme	2	4	8	1. PCN support to practices including review and sharing good practice. 2. Implementation of real-time data capture to monitor delivery. 3. Covid expansion funding supporting primary care capacity 4. Additional clinical capacity is available to support practices where required	A detailed programme plan is in development, in summary: 1. Implement real-time data monitoring approach 2. Comms and engagement with primary care, people with LD, other services 3. Identify delivery plans with target areas to improve uptake and delivery	Practice level plans have been reviewed and are being monitored. Real time data extract using Eclipse and System 1 available alongside practice sitreps to support monitoring and performance projection. LCC, LPFT and Neighbourhood Teams are engaged and supporting programme delivery. Weekly updates to CCG Exec on delivery of programme. Covid impact on demand and capacity in primary care and roll out of PCN covid vaccination programme may impact on delivery into Q4. Care home pilot project is underway - rapid roll-out is anticpated and will support access for people in living in a residential care setting. Additional clinical capacity is being provided across the County, further nursing and GP capacity is available in February.	02/02/2021	Andy Rix	Nick Blake	1. Programme plan finalised and comms begin 17 Nov 2020 2. Initial PCN level delivery plans in place 13 Nov 3. Data monitoring approach in place 27 Nov 2020	1. More detailed review of practice level capacity and capability to undertake required level of Health Checks.
9		There is a risk that practices will be unable to provide extended flu campaign	3	3	9	1. CCG flu plan. 2. Primary Care Flu team established working as part of CCG Flu Planning Team. 3. Locality Leads linking with practices to support development of local plans.	2	2	4	1. Regular review of plans. 2. Supporting partnership working.	Waiting on national direction	Progress has been made in offering the extended cohort flu vaccinations – national 'call' letters were sent to all eligible individuals. The extended cohort current figures show that for each locality the overall uptake for vaccination in the 50-64 range is as follows: Locality/ All 50-64/ 50-64 @ risk East/ 44.1% / 63.2% West / 51.0% / 70.1% South West / 51.5% / 72.5% South / 51.9% / 72.8% Lincs CCG / 49.1% / 68.8% The extended flu campaign starting for the 50-64 year group is dependent on the availability of vaccine once all other eligible cohorts have been completed. The go ahead to complete the vaccination for this extended group will be given nationally and is not for local determination. Once CCGs are informed this group is to be vaccinated the risk will need to be re-assessed depending on the current situation with the Covid vaccine and pandemic in Lincolnshire. Risk score has been re-assessed from 12 down to 9 until we get an national update.	02/02/2021	Pam Palmer	Shona Brewster	Jan - March 2021	None
15	07/09/21	Shortage of Blood Supplies of tubes. There has been a current suspension of current blood tests up until 17th September, clear guidance has been published by NHSE to detail the urgent tests that continue. We are working closely with Primary Care to support to ensure we can both manage any immediate risks whilst also trying to minimise any backlogs within primary care.	3	3	9	1. Comms have supported with both the Primary Care key messages and also public facing comms to share on website and social media to ensure the general public are aware of the current situation. 2. If the situation continues beyond the 17th September, the risk will need to be updated to reflect the situation as we move forward.	2	2	4	1. LDHC and other general health checks can continue as planned, there will however be a need to recall patients for their blood tests.	Practices have reported that currently there are no issues with supply and that they are receiving the volumes of supply as requested.	10/11/21 - Risk to be closed	10/11/2021	Alaina Foy	Alaina Foy		

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Scoring matrix:

1
2
3
4
5

IT'S THE CURRENT RISK THAT DETERMINES WHETHER THE RISK GOES ONTO THE >12 SHEET OR THE <12 SHEET. ONLY THOSE RISKS WITH A SCORE OF >12 GOES TO PCCC