Bristol, North Somerset and South Gloucestershire
Integrated Care Board

BNSSG ICB Primary Care Committee Meeting

Minutes of the meeting held on 22nd November 2022 at 9.00am, held virtually via Microsoft Teams

Minutes

Present		
Alison Moon	Chair of Committee, Non-Executive Member – Primary Care	AM
Georgie Bigg	Healthwatch Bristol, North Somerset and South Gloucestershire	GB
Katrina Boutin	GP Collaborative Board Representative	KB
Richard Brown	Chief Officer, Avon Local Pharmaceutical Committee	RB
Jamie Denton	Head of Finance, Primary, Community & Non-Acute Services, BNSSG ICB	JD
Nikki Holmes	Head of Primary Care, South West, NHS England and Improvement	NH
John Hopcroft	Avon Local Optical Committee	JH
Geeta Iyer	Primary Care Provider Development Clinical Lead, BNSSG ICB	GI
David Jarrett	Director of Primary and Integrated Care, BNSSG ICB	DJ
Philip Kirby	Chief Executive, Avon Local Medical Committee	PK
Sarah Purdy	Partner Non-Executive Member, North Bristol NHS Trust	SP
Michael Richardson	Deputy Director of Nursing and Quality	MR
George Schofield	Avon Local Dental Committee Secretary	GS
Apologies		
Jenny Bowker	Head of Primary Care Development, BNSSG ICB	JB
Debbie Campbell	Deputy Director (Medicines Optimisation), BNSSG ICB	DC
Amanda Cheesley	Partner Non-Executive Member, Sirona care & health	AC
Matt Lenny	Director of Public Health, North Somerset Council	ML
Jon Lund	Deputy Chief Financial Officer, BNSSG ICB	JL
Joanne Medhurst	Chief Medical Officer, BNSSG ICB	JM
David Moss	Delivery Director – Woodspring Locality Partnership, BNSSG ICB	DM
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	RS
Sarah Truelove	Chief Financial Officer and Deputy Chief Executive, BNSSG ICB	ST
In attendance		
Sarah Carr	Corporate Secretary, BNSSG ICB	SC
Louisa Darlison	Senior Contract Manager Primary Care, BNSSG ICB	LD
Katie Handford	Models of Care Development Lead, BNSSG ICB	KH

Bev Haworth	Senior Programme Lead PCN & Workforce Development, BNSSG ICB	BH
Sukeina Kassam	Interim Head of Primary Care Contracts, BNSSG ICB	SK
Susie McMullen	Senior Programme Lead Access, Quality and Resilience (ARQ)	SMc
Sandra Muffett	Head of Patient Safety and Quality	SM
Nwando Umeh	Programme Manager – Supplementary Services (Interim)	NU

	Item	Action
1	**Welcome and Apologies** Alison Moon (AM) welcomed everyone to the meeting and the above apologies were noted. It was noted that due to the ICB transition Lisa Manson would no longer attend the Primary Care Committee. Dave Jarrett (DJ) confirmed that the primary care responsibilities previously held by Lisa in her role as Director of Commissioning had been transferred to his portfolio. AM thanked Lisa for all her hard work for the Committee.	
2	**Declarations of Interest** Sukeina Kassam (SK) confirmed that Katrina Boutin (KB) had an interest in item 14 as the paper discussed the procurement of services. KB would be asked to leave the meeting for this item.	
3	**Minutes of the previous meeting held on 25th October 2022** The minutes were agreed as a correct record.	
4	**Review of Action Log** The Committee reviewed the action log: **Action 218**. SK confirmed the paper would come to the February Committee meeting. The action remained open. **Action 19**. DJ noted Joanne Medhurst would provide an update at the next meeting. **Action 25:** AM asked Jamie Denton (JD) to provide more information regarding the flexibility of primary care funding use. JD confirmed that budgets were allocated and set at the start of the year and therefore any slippage could be considered for other programme areas within primary care. The action remained closed. All other due actions were closed	
5	**Review of Risk Register** SK explained that the risks regarding delegated services would be added to the register following a focused discussion with NHS England and Improvement (NHSEI). SK noted that this meeting would include discussions regarding risk appetite and what risks would be held by NHSEI. It was agreed that the outcomes of the meeting would be emailed to Committee members as the next meeting would be in February. AM highlighted the challenges relating to dental services and asked for further information to be provided as part of the delegation item. **The Primary Care Committee:**	**SK**

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	• **Reviewed the Corporate Risk Register ensuring that appropriate and effective mitigations were in place for risks reported and specifically those areas relating to the Committee's remit** • **Reviewed risks recommended for closure to ensure it was assured that the risk score had been sufficiently reduced** • **Considered whether the Corporate Risk Register (CRR) was an accurate reflection of the risks brought to the Committee's attention**	
6	**Primary Care Operational Group (PCOG) Report** DJ provided an update on the decisions made at the November PCOG meeting which included approval of a £223k investment to continue the primary care collaborative bank pilot. DJ noted that the work was managed by One Care and had been rolled out to 4 Primary Care Networks (PCNs). The continuation of the pilot had been approved to enable continued evaluation of the benefits of the programme. The non-recurrent funds were agreed for the year and if the programme continued then a full business case would be developed. DJ highlighted that the approach to procurement of the Special Allocation Scheme (SAS) contract had been approved and this would be discussed later in the meeting. AM asked that future PCOG reports included detail of processes to make decisions as well as the outcomes for assurance. DJ agreed to include this in future reporting. SK noted that the teams had discussed how to provide the assurance within the report without providing too much detail which was included in the PCC papers where appropriate. It was agreed that the report would evolve as both PCOG and PCC embedded. AM highlighted that the report also offered an opportunity for PCOG to outline any risks or complex issues which required PCC intervention. Susie McMullen (SMc) noted that the report was an opportunity to provide clarity for PCC on how PCOG works which would support assurance. Sarah Purdy (SP) noted that the report from PCOG would provide partner organisations the information needed to support primary care particularly if risks and concerns were outlined. **The Primary Care Committee received the report**	**DJ**
7	**Primary Care Strategy** Geeta Iyer (GI) presented the update noting that the Primary Care Strategy had been reviewed following the Fuller Report and had been folded into the 2022-23 operational plan and focused on primary care access, wider system working, addressing health inequalities and primary care recovery. GI outlined the 4 key areas; models of care, infrastructure, quality and resilience, and developing the workforce. GI confirmed that the strategy was developed for 2019-2024 and had been developed with system engagement including the patient voice and the Local Optical, Dental and Pharmaceutical Committees. GI noted that	

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	although the Operational Plan did not include a section for primary care, the work of PCNs and practices to support urgent care through enhanced access and the focus of the new PCN contracts regarding anticipatory care had been included. GI highlighted the strategy priorities against the timetable of delivery noting that the work already delivered included supporting PCNs to work collaboratively and the regular reviews of maturity. Primary Care continued to work closely with system population health and prevention groups to maximise opportunity to ensure that every contact counted. GI also highlighted the remote consultation work implemented during the pandemic. Bev Haworth (BH) noted that it was expected that the future focus of the strategy would be on delivery against the Fuller Report recommendations and alignment with the ICS Strategy and emerging GP Collaborative Board (GPCB) Strategy as well as plans for Pharmaceutical, Optical and Dental services. BH provided an example of the work undertaken as part of the Primary Care Strategy noting that access was a challenge for primary care. BH highlighted that the slides included the results from the GP Patient survey as well as other insights gathered from the Citizen's Panel, Healthwatch and access survey. BH noted as part of this a proactive Communications approach across the system has been developed to support patients to access services. The Strategy reflected the changes in activity due to the pandemic which included access to appointments and noted that the primary care development team alongside the medicines optimisation team had supported the community pharmacist consultation service which supported practices by moving activity. BH noted that the Strategy supported shifting activity from hospitals and noted the engagement work with the system to understand the interdependencies between primary care and the wider system. There was still work to do to demonstrate the support that primary care could provide and also work to understand the impact on primary care. BH highlighted that the team had started to review patient journeys through the system to identify the impact on GP Practices particularly in terms of patients who have waited a long time for treatment. GI noted that the pandemic had accelerated the delivery of the Primary Care Strategy and this had highlighted areas of health inequalities and the ICB was working with practices, PCNs and system colleagues to reduce these. GI noted that the GP patient survey had included a question around whether patients felt supported in managing their long-term conditions and/or disabilities and it was identified that more work was needed to support patients in this area particularly in terms of access to services and self care options. GI highlighted that many of the ideas developed to reduce health inequalities as part of the	

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	vaccination programme continued especially when working with community leaders and groups. GI noted that uptake had been greater when the communities had managed the communication and these relationships would be developed further. GI highlighted the continued focus on physical health checks for patients with learning disabilities or severe mental illness noting that the checks had been supported by the PCN Care Coordinator roles. These roles have had a significant positive impact on the coordination of care for patients. The additional roles were also supporting PCNs to advance along the maturity matrices as they supported increased working with local pharmacy and communities to tailor services to the local populations. GI noted that health equality champions within PCNs were driving this work and the population health management team were working closely with PCNs to support understanding of the population data. GI noted that work continued to collect and maintain patient registers relating to ethnicity and caring responsibilities. These registers supported communications around work programmes such as vaccinations to ensure those at risk received the care they needed. GI highlighted the work within practices relating to COPD and respiratory which supported patients waiting for secondary care treatment. BH highlighted that workforce was a significant challenge within primary care medical services and work continued to support recruitment and retention of staff. The ICB recognised that there was an increase in demand and complexity of patients and therefore was identifying ways to support this. BH highlighted that, through the ICS People Committee, the system was coming together to discuss the workforce challenge as a system. BH noted that work continued to improve primary care medical services workforce data collection to support demand and capacity. BH noted that the additional roles were supporting the system and it was important that the roles were embedded within practices. The ICB recognised that there would be some concerns from patients in seeing a professional other than a GP in a practice and communications to patients were the focus to explain any changes. BH noted the shift to digital support for patients which included improving GP websites and telephony systems to support access. GI outlined the key risks which were workforce, workload and estate and highlighted the significant work within primary care medical services currently and particularly into the winter. GI highlighted that the Strategy outlined General Practice as the leadership in the system in relation to discharge to assess schemes, home first and the shift of patient support into the community. GI noted that consideration needed to be given on what interventions would best support patients.	

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	GI outlined next steps noting that the Strategy needed to be developed into a system strategy which further considered the GP Collaborative Board (GPCB) and the Fuller Report recommendations. It was important that the Strategy outlined what primary care did, what it can do and what the future direction was. A planning day was arranged which would provide the wider system an opportunity to discuss and develop the future strategy. GI highlighted that the focus was on making sure patients have the right access for their needs and noted that patient communication was important and could be strengthened by the wider system reiterating the same messaging. KB highlighted the schemes in place to support patients such as the physical health checks for patients with severe mental illness and noted the significant benefit for these patients in undertaking these checks. However, KB noted that the schemes were often highly labour intensive and investment needed to be considered to support practices to continue these schemes and start new schemes to support other cohorts of patients. KB also noted the importance that GP Practices were involved with the planning and development of the Strategy. BH confirmed that the ICB had met with the GPCB and discussions continued on how best to work with General Practice on the Strategy. Michael Richardson (MR) noted that the National Patient Safety Strategy and Patient Safety Incident Response Framework published this year would result in the ICB developing a system quality and patient safety strategy in 2023 and noted the importance that the Strategy was entwined with it. AM highlighted the importance of continuity of care particularly in terms of a named GP and noted that although work continued to support access for patients, access continued to be a challenge. AM asked whether all the PCNs and localities were maturing at the same rate and offering the same level of access and asked for a visual representation of this in order for the Committee to identify where there were challenges and opportunities. AM also noted that it would be helpful for workforce to be translated into a heat map so particular areas which need support could be identified. AM highlighted that as the key challenge was workforce, PCC needed more information regarding the mitigations of workforce risks. BH noted that the PCC had been presented with papers specifically related to workforce and noted that the team were developing papers in line with what the PCC needed to see and suggested that future papers could be developed alongside the GPCB. AM highlighted that the importance was that PCC could identify the areas of excellence and areas of challenge in order to support the teams. SMc agreed with the idea of a visual representation of the data but noted that for the resilience team this had become unusable due to the huge amounts of data. **The Primary Care Committee received the Primary Care Strategy Update**	

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8	**Update on Supplementary Services Review** GI explained that as a system, £2.4m was invested in Locally Enhanced Services which were services provided by GP Practices outside of the national contracts which enhanced the care for the local population. An additional £9.1m has been set aside to fund the Supplementary Services specification and the South Gloucestershire Basket. A steering group had been set up to undertake the review and the project mandate was to address the differential payments across the practices and review the activity to ensure that the services remained appropriate for the local population. The review was not a money saving exercise. GI explained that engagement with practices had started to understand the impact of any changes in funding and to mitigate for these whilst addressing the differential payments and delivering high quality care to patients to improve health outcomes and address inequalities of care. Nwando Umeh (NU) explained that a detailed communications plan for stakeholders had been developed and the steering group members had attended a number of meetings such as GP Forum meetings and hosted drop in sessions for practice managers in order to provide updates and share next steps. NU noted that concerns had been raised regarding the data shared and practices had fed back that data quality may have reduced during the pandemic. To address this the ICB agreed for practices to undertake a two month concentrated period of data collection starting from 21st November. Practices have fed back that there continued to be issues with coding and the ICB was working with One Care on a solution. Practices have been informed that the collection period has paused and will commence later. A survey has been shared with practices to gather some intelligence on what services are being provided through Supplementary Services and the South Gloucestershire Basket. The Steering Group has been working with Public Health to identify the top 10 needs of the public to map these against the services to review what services would add the most value for the population. The practices also raised concerns regarding capacity whilst collecting the data and NU explained that the ICB was asking practices to undertake a review of current arrangements to support any changes. Practices have noted that should services cease this may lead to loss of income. It was explained that there would be a two year transition period if the review recommended moving to new services or stopping existing services and the ICB was considering the effects of this on practice resilience. It was highlighted that the purpose of the review was to address the inequity across practices and reach a fairer approach to funding allocation. NU highlighted that a number of options were being considered to achieve this which included considering a number of factors such as population, patient list characteristics and deprivation to review	

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	the allocation. As part of these considerations a data sharing agreement was being developed. NU confirmed that the Steering Group would continue to meet with stakeholders to provide updates and it was expected that proposals would be developed in January or February 2023 and these would be shared with stakeholders. NU highlighted the risk related to changes in funding affecting practice resilience and noted that this could not be determined until the final proposals were developed. The ICB would work with any affected practice to support access to alternative models and funding that might be available. NU also noted that there was a risk that practices would be unable to engage with the data collection exercise due to lack of capacity. The ICB was supporting practices with the exercise and a dedicated route for enquiries had been set up. DJ explained that the item had been presented to the PCC for assurance and noted that the level of funding involved would need ICB Board approval. PCC would be asked to recommend the ICB Board approve the proposals and therefore PCC needed to be assured that the work to develop the proposals had been robust. It was confirmed that the recommendation paper would be presented to the February PCC meeting. **The Primary Care Committee received the update on the Supplementary Services Review**	
9	**Delegation of POD Services** Nikki Holmes (NH) provided an update on activity for the services to be delegated in April 2023 noting that dental service activity had been discussed in depth as part of the earlier seminar session. NH noted that as part of the Pharmacy reform programme there was no proposed change to pharmacy numbers or core hours but there was a minor change regarding supplementary hours. The impact of this would be reviewed. NH confirmed that the Christmas and Bank Holiday rotas had been shared with primary care and the public health operational group and any late notifications of changes would be communicated to the ICB. NH noted that incomplete referrals as part of the discharge medicine service would be raised with colleagues at the Local Pharmaceutical Committee (LPC). There continued to be good engagement between GPs and Pharmacies particularly in relation to the Community Pharmacy Consultation Service (CPCS). However, there was slightly lower uptake of flu vaccination in community pharmacy and the NHSEI team were working with pharmacists to understand stock levels and engagement. NH noted that the LPC had been engaging with GPs regarding the hypertension case finding service and this would continue.	

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	NH noted that there had been one new mandatory contract application received for optometry and this was being processed. The NHSEI team have been working with optometry providers to receive the Quality in Optometry (QiO) toolkits and only 3 toolkits had yet to been received. SK confirmed that the ICB team continued to attend the safe delegation checkpoint meetings with NHSEI and the initial checklist would be submitted on the 13th January 2023 with final Chief Executive approved submission on the 24th February 2023. A discussion panel would be convened on the 6th March 2023 between the ICB and NHSEI to review the checklist submission. The PCC would continue to be updated on progress and kept informed of the risks. It was confirmed that the submission would be presented to the PCC meeting on the 21st February 2023. SK noted that a primary care assurance framework was being developed to include the delegated services which would provide oversight and assurance of the activities that were required as set out in the standard delegation agreement. The framework would also be presented at the February meeting. AM asked PCC members to contact NH if they had any comments and feedback on presentation and content of the primary care activity report. **The Primary Care Committee received the delegation update and primary care activity paper**	
10	**Primary Care Contracts, Performance, Quality and Resilience Report** SK reported that the advert for the Charlotte Keel procurement had been issued. Michael Richardson (MR) explained that the quality report had been included within the paper and Sandra Muffett (SM) reported that there had been persistent issues related to discharge from hospital and this was the most commonly reported event during quarter 2. The quality team were currently undertaking a deep dive into the work required to improve discharge. AM asked whether it was likely that the patient list for Fallodon way would reopen before March. Louisa Darlison (LD) explained that it was unlikely but was meeting with the practice next week and would provide an update at the next meeting. AM highlighted that there would be another relaunch of Datix within primary care. It was noted that there had been a number of relaunches for Datix and AM asked that the next quality report outline what would be different this time to fully embed Datix within primary care processes. SM noted that Datix support would be included within the Patient Safety Strategy work and agreed to provide an update at the next meeting.	**SK/LD**

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	The Primary Care Committee noted the content of the report	**RS/MR**
11	**Primary Care Finance Report** JD reported that the year to date position was an underspend of £2.5million but noted that there were a number of planning differences. JD highlighted two key areas of variance. JD explained that that PMS/GMS contract values were based on population and population growth had been planned for 1.5% but actual was around 1% and therefore there was a £410k underspend against planning. JD also noted that primary care IT was also included within the primary care reporting and there was an underspend of £214k identified and plans were being developed to utilise the funds. JD explained that there was an overspend attributable to the Additional Roles Reimbursement Scheme (ARRS) which represented a positive position for the system as the ICB could utilise nationally held funding of £5.5million of which £6.3m was available. The year-end forecast position was £3.5m underspend after the ARRS reimbursement at the end of the financial year. **The Primary Care Committee:** • **Noted the summary financial plan** • **Noted the key risks and mitigations to delivering the financial plan** • **Noted that at Month 7 (October), combined Primary Care budgets reported a £2,495k underspend, and a forecast of £3.546m (including the Additional Roles Reimbursement)**	
12	**Key Messages for the ICB Board** The Committee agreed the key messages for the ICB Board which included: • The progress made on delegation • The update provided to the Committee around the Primary Care Strategy	
13	**Good News Stories** AM explained that positive news could be added as a standing agenda item to provide an opportunity for the Committee to reflect on areas where the system excels. AM asked the Committee to consider how this could be actioned.	**All**
	Part B minutes to be taken in closed ICB Board	
14	**Primary Care Contracts, Performance, Quality and Resilience Report** AM noted that the Contracts Team had identified that KB had a conflict of interest in relation to this item and asked KB to leave the meeting. KB explained that she was at the meeting representing the GPCB who were partners with the ICB and asked the Committee to consider whether there was a conflict of	

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	interest given the role and asked how other Committees managed conflicts of interest. SC noted the importance that declarations of interest were considered on a case by case basis and explained that should a procurement be discussed at the ICB Board, any conflicts would have to be considered and members asked to leave if appropriate. SC agreed that this would be further discussed with the Primary Care teams to identify a way forward. SC explained that the ICB had a duty to act with probity and transparency when discussing the use of public funding. SK highlighted that the ICB needed to ensure that any procurements were undertaken in a fair and unbiased manner to ensure good use of public money but also to reduce the risk of legal challenges to decisions. KB raised that the PCC was different as there were no other Committees dedicated to other specific parts of the system. SC agreed and noted that the risk was around when the Committee was discussing details regarding procurements. KB noted that there were GPs who worked for the ICB and asked how interests were managed in these circumstances. SC confirmed that these were considered on a case by case basis. AM asked KB to send SC, AM and DJ any questions or specific comments regarding her views on how interests were managed at the ICB and these would be responded to and a position confirmed. KB left the meeting.	**SC**
15	**Primary Care Operational Group (PCOG) Minutes** **The Primary Care Committee received the minutes**	
16	**Any Other Business** It was noted that the next meeting would be on the 21st February as both the December and January meetings had been stood down. AM confirmed that an emergency meeting could be arranged if required.	
	Date of Next Meeting 21st February 2023, Location to be confirmed	

Lucy Powell, Corporate Support Officer, November 2022

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

BNSSG ICB Primary Care Committee Meeting

Minutes of the meeting held on 27th September 2022 at 9.00am, held in the Lower Ground Boardroom, 360 Bristol, Marlborough Street, Bristol, BS1 3NX

Minutes

Present		
Alison Moon	Chair of Committee, Non-Executive Member – Primary Care	AM
Georgie Bigg	Healthwatch Bristol, North Somerset and South Gloucestershire	GB
Richard Brown	Chief Officer, Avon Local Pharmaceutical Committee	RB
Debbie Campbell	Deputy Director (Medicines Optimisation), BNSSG ICB	DC
Amanda Cheesley	Partner Non Executive Member, Sirona care & health	AC
Nikki Holmes	Head of Primary Care, South West, NHS England and Improvement	NH
Carolyn Hudd	Lay Secretary, Avon Local Optical Committee	CH
Geeta Iyer	Primary Care Provider Development Clinical Lead, BNSSG ICB	GI
David Jarrett	Director of Primary and Integrated Care, BNSSG ICB	DJ
Philip Kirby	Chief Executive, Avon Local Medical Committee	PK
Matt Lenny	Director of Public Health, North Somerset Council	ML
Lisa Manson	Director of Performance and Delivery, BNSSG ICB	LM
David Moss	Delivery Director – Woodspring Locality Partnership, BNSSG ICB	DM
George Schofield	Avon Local Dental Committee Secretary	GS
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	RS
Apologies		
Katrina Boutin	GP Collaborative Board Representative	KB
Jamie Denton	Head of Finance – Primary, Community & Non Acute Services, BNSSG ICB	JD
Jon Lund	Deputy Chief Financial Officer, BNSSG ICB	JL
Joanne Medhurst	Chief Medical Officer, BNSSG ICB	JM
Sarah Truelove	Chief Financial Officer and Deputy Chief Executive, BNSSG ICB	ST
In attendance		

Jenny Bowker	Head of Primary Care Development, BNSSG ICB	JB
Louisa Darlison	Senior Contract Manager Primary Care, BNSSG ICB	LD
Katie Handford	Models of Care Development Lead	KH
Bev Haworth	Senior Programme Lead PCN & Workforce Development	BH
Sukeina Kassam	Interim Head of Primary Care Contracts	SK
Lucy Powell	Corporate Support Officer	LP

	Item	Action
1	**Welcome and Apologies** Alison Moon (AM) welcomed everyone to the meeting and the apologies above were noted. It was highlighted that there was no finance representative available to attend the meeting and it was agreed that any questions would be passed to Jamie Denton to respond to after the meeting. AM outlined the four core objectives of the Integrated Care System (ICS) and asked the Committee to consider the papers and their comments against these: • Improving outcomes in population health and healthcare • Tackling inequalities in outcomes, experience and access • Enhancing productivity and value for money • Helping the NHS support broader social and economic development	
2	**Declarations of Interest** There were none. AM reminded Committee members to send any new or amended declarations to the Corporate team.	
3	**Minutes of the previous meeting held on 26th July 2022** The minutes were agreed as a correct record.	
4	**Review of Action Log** The Committee reviewed the action log: **Action 287:** Sukeina Kassam (SK) confirmed that the paper reviewing the work undertaken to close Helios Medical Centre would be presented to both the Primary Care Operational Group (PCOG) and the Primary Care Committee (PCC) in October. **Action 218:** SK confirmed that the paper reviewing the Green Valleys resilience work would be presented to both PCOG and PCC in October. **Action 3:** Louisa Darlison (LD) confirmed that current clinical waste services would lift and shift as part of the NHS England procurement plans. LD confirmed that management of the procurement would take place through PCOG with exception reporting through PCC. The action was closed. **Action 4:** SK confirmed that further information regarding the clinical waste procurement had been included in the contracts report. LD confirmed that the outcomes of the review of legacy agreements would be presented to the Committee. The action was closed. All other due actions were closed	**SK/LD**
5	**Strategic Development Funding**	

	Item	Action
	David Jarrett (DJ) introduced the item noting that the proposals for the System Development Funding (SDF) related to transformation programmes including digital transformation and workforce. DJ highlighted that the proposals would be tested with the GP Collaborative Board (GPCB) and any feedback incorporated into the proposals therefore the team were seeking final approval delegated through PCOG. Bev Haworth (BH) provided the background to the SDF noting that the associated guidance had not yet been published but explained that the ICB was committed to start the process of funding allocation. BH explained that the SDF was received from NHS England and covered a wide range of areas to support primary care and transformation. BH noted that the SDF for 2022/23 has been indicated through draft guidance but not yet confirmed. The proposal recommended the allocation split between Digital First and Primary Care Network (PCN) Organisational Development for 2021/22 was applied alongside the proportional decrease in funding. BH highlighted that leadership and management funding introduced through 2021/22 would be utilised to top up the PCN Development Funding into 2022/23. BH noted that there was a significant drop in the funding available for Digital First and explained that the Digital First funding covered business to support GPs which was not supported through other funding. The proposal would be discussed with the GPCB and PCN Clinical Directors and feedback incorporated. BH noted that some suggestions had already been received from PCN Clinical Directors and these would be cross checked against the Digital First proposals to ensure there was no duplication. BH highlighted the importance that use of the funding represented value for money and was allocated in the right areas. Jenny Bowker (JB) confirmed that the Committee was asked to support the overall package. JB noted that although the guidance had not been published it was important that the Integrated Care Board (ICB) could demonstrate a commitment to support the plans. AM noted that the measure of success needed to be outcomes based rather than process based. BH agreed and explained that the measures would be developed with the PCNs to ensure they were based on measurable outcomes. BH asked that the Committee approve the recommendation that the final proposals were approved by PCOG but noted that any significant amendments would be presented to PCC. Lisa Manson (LM) asked the Committee to consider whether allocations were restricted to a particular primary care service area and highlighted that with delegation of other primary care services from April 2023, it was important to consider whether funding could be utilised across primary care. LM asked that	

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	these considerations were included in the Committee papers. David Moss (DM) asked whether these considerations included funding for other commissioned services such as community services. The Committee agreed that a set of principles would need to be developed. **The Primary Care Committee approved in principle the proposals in place to commit the SDF funding in support of General Practice and agreed delegated approval of the proposal for allocation of the 2022/23 Transformation Support SDF funding to the Primary Care Operational Group (PCOG)**	
6	**Recovery Funding for General Practice** JB noted that £791k had been received to support additional capacity to enable recovery of activity in general practice. The support would be through reducing clinical backlog, the Quality Outcomes Framework (QOF), improving coding and reviewing other processes which impact on activity. The Royal College of General Practitioners (RCGP) have published guidance to support recovery and a small working group has been set up to prioritise the areas of greatest need for recovery. JB confirmed that the ICB acknowledged the current issues and pressures facing general practice and was utilising data driven evidence to highlight these concerns. The outcome of this review would be shared with PCNs. JB confirmed that the funding was non recurrent and needed to be used this year. Data sharing agreements would be developed to ensure that capacity and demand was fully understood and responded to. JB noted that the ICB recognised the importance of supporting the COVID-19 vaccination programme and the impact of this on long-term condition management as well as other vaccination and screening programmes. JB noted that there had been mixed feedback on whether the funds to support recovery should be provided at PCN or practice level. JB noted the next steps included alignment of the proposed work with other pathways particularly around long-term condition management and review of the funding allocation. JB noted that funding was currently allocated by patient list size however it had been proposed that funding be weighted to consider health inequalities. JB noted that evidence showed that practices with higher levels of deprivation took longer to recover and explained that the change to the allocation would lead to a small variation to the current funding model but including this as a principle would demonstrate that this was a focus for the ICB. Distinct proposals were outlined for diabetes and respiratory pathways, with funding proposals described although more work would take place with the GPCB to develop these plans. JB noted that proposals outlined support with	

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	equipment and training, and further discussions would take place regarding long term condition management to support further joint working. AM supported the health inequalities weighting as did Amanda Cheesley (AC) and Matt Lenny (ML). DJ confirmed that the proposed approach was in line with the ICB principle to tackle health inequalities. Philip Kirby (PK) supported this and noted that practices would be used to this type of allocation weighting. AM highlighted that the funding was non recurrent and asked whether there was the capacity for staff to focus on these plans. JB explained that the proposal was for PCNs to design the plans so that they were achievable. JB noted that there was a risk that there would be capacity and workforce issues during winter. JB noted that the previous Memorandums of Understanding (MoUs) had been amended to build in some safeguards around effective use of monies. JB noted that practices were keen to begin planning and start the work. Geeta Iyer (GI) noted that similar work had been undertaken and mobilised quickly as part of the Winter Access Fund work last year. Richard Brown (RB) noted that the Pharmacy Consultation Service supported GP capacity and had been shown to take activity from GP Practices to free up appointments. RB noted the importance that the specific plans around respiratory and diabetes were supported by pharmacies to ensure that GPs could focus on the priority areas which only GPs could support. GI noted that this level of joint working was supported at PCN footprint and noted that pharmacy links were present as part of the PCN Boards and JB explained that processes were in place to support joint working. DJ asked whether the ICB could be more proactive to support joint working and uptake of the Community Pharmacist Consultation Services (CPCS) . BH explained that practices receive monthly reports on CPCS activity. CPCS was discussed at PCN Practice Manager Forums and feedback was shared on a monthly basis with RB. GI highlighted that Alison Mundell in her new role would further support this work. DJ suggested that this joint working was reflected in the practice plans. AM noted that any variation needed to be considered across all the Committees and suggested that heat maps were an effective way to show this. BH agreed and noted that this work was undertaken as part of the monthly reporting and agreed to add this to future PCC papers. JB highlighted the importance that any PCN or GP practice variation was considered against the resilience levels of the local pharmacies. Debbie Campbell (DC) noted the importance of long-term condition management as a focus and explained that BNSSG practices were at different levels of maturity/appetite in identifying and managing long term conditions and asked how this would feed into the work to ensure less inequity for our patients. DC noted that a system discussion would be required to review the current	**DJ/BH**

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	baselines and expected outcomes. AC highlighted the public health element to the work particularly around enabling people to self-manage their conditions or the programmes of work in place to prevent long term conditions developing. AC highlighted that the workstream needed a collaborative approach to support treatment, prevention and reduction of long-term conditions. DC confirmed that the ICB was working with the Public Health Management Group and Programme groups to discuss money being invested in prevention programmes. DM highlighted that these programmes also linked with the Ageing Well programme and noted that the Localities could assist in searching for patients which could be supported through these programmes. DM noted that voluntary services were also very important when considering long term condition management. GI agreed and noted that the collaborative working approach was important and that working across PCNs would allow more practices to develop their skills in managing long term conditions by learning from each other. ML highlighted the importance that the effectiveness of the programmes were evaluated as it was important to understand what would make a difference to patient's lives. ML noted that patient behaviours needed to be understood so that barriers and opportunities could be identified. DJ highlighted that GPCB and PCN Clinical Director feedback needed to be incorporated into the plans, and asked that due to the timing of the meetings approval of the recovery funding plans be delegated to PCOG. AM agreed but asked that consideration be given in the future to timelines to ensure that PCC was the approving Committee. **The Primary Care Committee:** • **Supported the proposal for recovery funding to support practices and PCNs to address clinical backlogs** • **Discussed the preferred funding methodology and agreed weighted list size** • **Supported the proposals for the specific diabetes and respiratory workstreams subject to further engagement on the Long Term Condition approach with GPCB and considerations noted by PCOG** • **Supported the development of an integrated recovery and Long Term Conditions offer** • **Agreed that any additional amendments would be delegated to PCOG for approval**	
7	**Support for delegation of Pharmaceutical, Ophthalmic and Dental Services** LM presented the Pre Delegation Assessment Framework (PDAF) to the Committee noting that this process had been completed previously prior to the possibility of delegation of services from April 2022. The PDAF for the delegation of services from April 2023 was due to be submitted. A number of risks were highlighted which included the ability of the Commissioning Hub to	

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	support 7 ICBs and the ability for BNSSG ICB to support the delegation given no additional costs within the management structure. It was noted that discussions continued regarding the dental services allocation and the ICB supported an allocation based on patient need. AM asked for further information regarding the dental allocation. LM confirmed that as part of the delegation of services, the current funding allocation for dental services would transfer to the ICB and the ICB was considering how the allocation reflected local population needs given the current pressures within dental services. George Schofield (GS) explained that from the LDC perspective the current funding for dental services was not enough and services were destabilising. GS noted that there was no capacity in the local system to register NHS patients and explained that dentistry services were run as small businesses. LM explained that the comments from GS outlined why delegation was important as the ICB had the insights to ensure that the population received the fair share of the allocation. GS noted that the entire dental system was pressured across all areas of the local population. LM noted that Sukeina Kassam (SK) and JB had been working on the PDAF for 6 months to understand the opportunities and the risks of delegation. LM noted that there were a number of elements which needed review which included allocations. LM highlighted that when primary care medical services was delegated there had been additional investment including management costs to support the contracts which may not be available this time. Georgie Bigg (GB) highlighted the importance that children could receive dental services and highlighted a report completed by Healthwatch regarding national and local dentistry services which included recommendations to support services. LM agreed that dentistry services were important for people and noted that the ICB needed to consider how to support dentist surgeries to continue to be viable businesses. GS noted that there was a national shortage of dentists and highlighted that the private sector was more appealing for current dentistry students. GB noted the impact on inequalities as people who can afford to do so have used private dentistry services. AM noted that there were significant challenges in terms of resilience for dentistry services and highlighted the need for local flexibility and the development of a set of actions to support dentistry AM asked for more information regarding the Commissioning Hub. LM noted that the Commissioning Hub held a high level of expertise with small numbers of people and noted that an evaluation would take place by the 7 South West Integrated Care Systems (ICSs) to develop proposals on the future working of the Commissioning Hub. This would take place in November 2022. The final recommendation would be presented to PCC for approval. LM noted that all 7	

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	ICSs faced the same challenges in terms of management costs and the solution would be discussed across the South West. The PDAF would be presented to the ICB Board for approval and Rosi Shepherd (RS) outlined the importance that the ICB Board was sighted on the risks particularly the risks around dental services and the impact on population health. LM noted that the ICB was responsible for the population's health across all areas and by delegating these services there would be more local control to support these services. DJ noted that the detail needed to be discussed at PCC so that PCC could provide the required assurance to the ICB Board and recommend the PDAF for approval. DJ highlighted the monthly activity report included within the paper for pharmaceutical, ophthalmic and dental services and noted that these would continue to be shared. Nikki Holmes (NH) noted that dental services contracts were currently under procurement and highlighted the dental reform programme which would be presented in more detail next month. NH outlined the work being undertaken on unplanned pharmacy closures and highlighted the specific work being undertaken with Lloyds Pharmacy at a regional and local level. SK asked that any feedback on the report be provided to SK and JB so that the report could develop into something more meaningful for the ICB. JB noted that key areas of focus would be included in future reporting. **The Primary Care Committee recommended:** • **That the risk-based submission was made in support of delegation of the pharmaceutical, ophthalmic and dental (POD) services** • **That work with the South West NHS England team was undertaken to confirm and agree the allocations and that subject to satisfactory assurances that the ICB proceeds with delegation of POD services** • **Should these not be received the ICB will need to reconsider readiness to proceed**	**DJ/NH** **All**
8	**Primary Care Finance Report** The Committee received the finance report. DJ outlined that there was a current £2m underspend within the combined primary care budgets. The importance of utilising the funds was noted. DJ outlined that £0.5m of funding was currently uncommitted and therefore the ICB would continue to identify initiatives for the funds. AM asked the ICB to consider LM's earlier point about unrestricted funding and to consider all possible areas for funding. DC confirmed that the current prescribing forecasts would change which was driven by national concerns around stock availability and category M drug price increases. **The Primary Care Committee noted:**	

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	• **The summary financial plan** • **The key risks and mitigation to deliver the financial plan** • **That at Month 5 (August), combined Primary Care budgets reported a £2,152k underspend, and a forecast of £3,307k (including the Additional Roles Reimbursement)**	
9	**Primary Care Quality Report** RS outlined the themes included within the report and noted that the events reported on Datix by primary care medical services were usually concerns relating to other providers. RS noted that more work was needed to promote a culture of health and safety across the whole system. RS noted that the locality partnerships could lead on this work. The importance of the patient safety strategy was noted, and the implementation of the strategy would promote learning from themes across the system. RS highlighted the risk that there may not be the capacity across both the ICB and primary care to implement the strategy and this would be considered. AM asked whether there were any concerns to raise. RS highlighted that the key concerns were access to GP appointments, patient experience, patient discharge pathways and patient hand overs. GI noted that there was more work to undertake in primary care to understand how the GP Practices were disseminating information within newsletters and learning from the information. GI also highlighted that consideration was being given to how/whether Datix could be utilised across the whole system as more patient care is done in cross-organisational teams. RB noted that as part of the current delegated contract arrangements, pharmacy incidents were reported to NHS England to manage. RB noted the importance of shared learning across the system and welcomed receiving more information from the local area. RB explained that pharmacies across the South West shared information regularly. RS noted the ICB had started to review the patterns of prescribing across the South West as well as local data particularly around near misses and changing patterns of behaviour. RS asked for feedback on the format of the quality report. AM asked that reports contain less description and more information about the actions taking place. GB highlighted the importance of the quality team receiving patient experience information against the concerns raised. AM noted that this was important to ensure that the patient and service user voice was considered when developing actions to improve. **The Primary Care Committee noted the quality report**	
10	**Key Messages for the ICB Board** The Committee agreed the key messages for the ICB Board which included:	

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	• The discussions around delegation • The decisions regarding the Strategic Development Funding and Recovery Funding for GP Practices • The discussions to develop the Committee • The variations across the local area in terms of population health and the importance of developing plans for prevention • The importance of considering whether funding allocations were restricted to one particular area of primary care and if not, the importance of considering where the funding could be allocated to best improve health outcomes for the population	
11	**Item redacted**	
12	**Primary Care Operational Group (PCOG) Minutes** **The Primary Care Committee received the minutes**	
13	**Any Other Business** DJ noted that the PCOG Terms of Reference would be presented to the Committee next month. The Terms of Reference were being updated to reflect the decision making requirements needed for PCOG to support PCC to be the assurance committee for the ICB Board on matters relating to primary care.	**DJ**
	Date of Next Meeting 25th October 2022, Conference Room, 360 Bristol	

Lucy Powell, Corporate Support Officer, September 2022