NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

BNSSG ICB Primary Care Committee Meeting

Minutes of the meeting held on 25th July 2023 at 9.00am, held virtually via Microsoft Teams

Minutes

Present		
Alison Moon	Chair of Committee, Non-Executive Member – Primary Care	AM
Amanda Cheesley	Partner Non-Executive Member, Sirona care & health	AC
Geeta Iyer	Deputy Chief Medical Officer, (Primary and Community Care), BNSSG ICB (Deputising for Joanne Medhurst)	GI
David Jarrett	Director of Primary and Integrated Care, BNSSG ICB	DJ
Sarah Purdy	Partner Non-Executive Member, North Bristol NHS Trust	SP
Michael Richardson	Deputy Director of Nursing and Quality, BNSSG ICB (Deputising for Rosi Shepherd)	MR
Sarah Truelove	Chief Financial Officer and Deputy Chief Executive, BNSSG ICB	ST
Apologies		
Jenny Bowker	Deputy Director of Primary Care, BNSSG ICB	JB
Katrina Boutin	GP Collaborative Board Representative	KB
Matt Lenny	Director of Public Health, North Somerset Council	ML
Susie McMullen	Head of Primary Care Contracts, BNSSG ICB	SMc
Joanne Medhurst	Chief Medical Officer, BNSSG ICB	JM
David Moss	Head of Locality Weston and Worle, BNSSG ICB	DM
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	RS
In attendance		
Georgie Bigg	Healthwatch Bristol, North Somerset and South Gloucestershire	GB
Richard Brown	Chief Officer, Avon Local Pharmaceutical Committee	RB
Debbie Campbell	Chief Pharmacist, BNSSG ICB	DC
Loran Davison	Team Administrator, BNSSG ICB	LD
Jamie Denton	Head of Finance, Primary Care, Community and Children, BNSSG ICB	JD
Katie Handford	Models of Care Development Lead, BNSSG ICB	KH
Jim Hodgson	Programme Manager – Urgent Care, One Care	JHo
John Hopcroft	Vice Chair, Avon Local Optometry Committee	JH
Nikki Holmes	Head of Primary Care, South West, NHS England and Improvement	NH
Matthew Jerreat	Clinical Chair, South West Local Dental Network	MJ

Mark O'Connor	Chief Medical Officer, One Care and GP Collaborative Board Representative	MO
Ruth Povey	Service Improvement Project Manager, Primary Care, BNSSG ICB	RP
Lucy Powell	Corporate Support Officer, BNSSG ICB (minute taker)	LP
Lee Salkeld	Director, Avon Local Medical Committee	LS
George Schofield	Avon Local Dental Committee Secretary	GS
Kat Showler	Senior Contract Manager Primary Care, BNSSG ICB	KS

	Item	Action
1	**Welcome and Apologies** Alison Moon (AM) welcomed everyone to the meeting and the above apologies were noted.	
2	**Declarations of Interest** There were no new declarations and no existing declared interests that conflicted with agenda items.	
3	**Minutes of the previous meeting held on 27th June 2023** The minutes were agreed as a correct record.	
4	**Review of Action Log** The Committee reviewed the action log: **Action 52:** There was no longer access to a child friendly practice in BNSSG. This was a national pilot which was ending. The local focus was now on the stabilisation programme which would support both children and adults. It was agreed to close the action but open a new action for assurance around the support for children from the stabilisation programme. George Schofield (GS) confirmed that dentists had been positive about the child friendly practices although some had not realised the initiative existed. GS suggested that information was often buried in newsletters and dedicated emails to promote initiatives was a more effective way to communicate. **Action 53:** Nikki Holmes (NH) confirmed that this action remained open and agreed to follow up and provide an update at the next meeting. AM noted the importance that actions were closed promptly. **Action 57:** Michael Richardson (MR) agreed to follow up on this action and provide an update. **Action 61:** The ICB continued to wait for the national guidance regarding reducing violence against staff. It was confirmed that this was a standing item at the Primary Care Leads meeting. Amanda Cheesley (AC) noted that violence against staff was not primary care specific and it remained a concern across the system including urgent care centres. AC highlighted that the recent industrial action was also about recognising that staff needed improved working conditions. It was noted that any mitigating actions needed to be system wide and not undertaken in isolation. The Committee agreed to open a new action which recognised local actions and mitigations whilst waiting for the national guidance. Georgie Bigg (GB) noted that sometimes patients in distress did not recognise the impact they were having on staff and patients and offered the	**NH** **DJ**

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	support of Healthwatch as an independent voice in developing communications to patients. **Action 64:** Jamie Denton (JD) confirmed he had met with Joanne Medhurst who had shared slides detailing the national allocation and distance from target methodologies and the calculations behind these. All GP Practices were paid on the current national tariff which was based on current population numbers so no convergence payment was required. For ICBs, there was convergence between the historical and current payment methods and concerns about the Carr-Hill method in terms of health inequalities. It was confirmed that the supplementary services review was expected to address some of the health inequalities and deprivation factors within the system. The outcome of the review was expected in time for the new approach to start in April 2024. JD confirmed that following the meeting, JM agreed to meet with the supplementary service lead for assurance and more information. Geeta Iyer (GI) clarified that although implementation of the supplementary services review outcome was expected in April 2024, it had been agreed that there would be a transition period to understand the impact of the funding model on practices. GI explained that the aim was to provide a further update on the review at the September Committee meeting. The action was closed. All other due actions were closed.	
5	**Good News Stories** The Committee welcomed Jim Hodgson (JHo) to the meeting. JHo shared the outcome of a winter project: Acute Respiratory Infection (ARI) hubs. This project had been a good example of GP Practices working at scale. JHo explained that ARI presentation in England peaked at over 5000 daily emergency department attendances during December/January. A third of the cases were minor and another third could have been managed elsewhere in the system. Funding had been received from NHS England to mobilise a project to support the system. The GP Collaborative Board (GPCB), Primary Care Network (PCN) Clinical Directors and GPs developed a model of care using a simple model hub from within existing GP estate. Workforce was a concern as GP staffing was already stretched, however a combination of agency, locums and paid overtime was used to ensure that the hubs were staffed. JHo confirmed that additional funding had been received from NHS England specifically for monitoring the scheme in specific areas. The ARI hub provided 18,000 appointments which represented people who had been treated closer to home which supported reduced A&E attendances and NHS 111 calls. JH explained that attendance at the ARI hub meant that other conditions were also treated. The appointments had been 95% face to face and continuity of care was an important part of the hub model. JH reported that the Did Not Attend rate was as expected and in line with usual rates. There were multiple ways to refer into the ARI hub with the majority through phone and e-	

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	consult. The monitoring showed that the outcome of these appointments was often reassurance and/or medication. The enhanced evaluation of the scheme had shown that patients were satisfied with the service and the less positive comments had concerned access to GP services generally. Staff satisfaction had been a mixed picture with staff expressing dissatisfaction with winter pressures. The monitoring had identified that in areas of greater deprivation, the majority of appointments had been for children whereas in less deprived areas the appointments were split 68% adults and 32% paediatrics. JHo noted that the staff supporting the ARI hubs were GPs and Advanced Nurse Practitioners (ANPs) and this would be replicated for 2023. JHo highlighted the importance that practices communicated the message that patients would see the most appropriate person at the point of contact and that multi-disciplinary teams (MDT) were an important part of GP practices. JHo noted that for 2023, the team were reviewing how the ARI hub could be utilised more, mobilised quickly and activity started faster. The 'at scale' project had demonstrated value for money. MR was impressed with the agility in setting up the hub and asked whether the project had a positive impact on non-respiratory presentation by releasing capacity. JHo noted that it had been assumed this was the case but explained that winter was a time of intense pressure on the system, so it was difficult to measure. JHo explained that with more time to plan the project for 2023, the team would consider how to monitor patient outcomes and onward pathways. Debbie Campbell (DC) asked whether the team had data regarding the numbers of referrals to community pharmacists and suggested that the Infection, Prevention and Control Board would have experts who could support diagnostic development and offer antimicrobial stewardship support. JHo explained that without baseline data it would be difficult to show the impact on community pharmacists, but it was likely to have been a positive impact. Antimicrobial stewardship was a concern due to pressures facing staff during the winter and this was an area which needed additional consideration. Point of care testing had been considered as part of the area hubs, however there were risks associated with this equipment in practices as only 6 were available which may create unbalanced increased demand. JH thanked DC for the offer of contact details. AC highlighted the importance of the MDT communications as patients needed to be encouraged to see other clinicians where more appropriate. AC asked whether there had been any triangulation of data from urgent care centres or A&E to review patient numbers. JHo noted that the enhanced evaluation was very project specific due to the rapid set up time. For 2023, the team would work	

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	with the insights and engagement team to ensure that patient level detail could be reviewed to provide more detailed data for another evaluation. Sarah Purdy (SP) agreed with the practice-focused approach and asked for more information regarding workforce and capacity. JHo explained that project relied on people working overtime and maximising agency and locum use which was not sustainable. The importance of communication with the public on the correct way to use the NHS was noted. DJ highlighted the scheme as a great example of how GPs through the GPCB adapted a scheme locally to deliver a service. This scheme provided a platform for learning from and building on this winter. The scheme also demonstrated how the system could provide services at scale. Mark O'Connor (MO) raised concerns about point of care testing in GP Practices and suggested that this was an area for primary/secondary care interface working. AM noted that it was important to target support particularly where health inequalities were identified and asked whether this had been considered as part of the project. JHo confirmed that the previous project had been based on PCNs and population number but consideration would be given to identified health inequalities for 2023.	
6	**PCOG Report** DJ outlined the decisions made at PCOG: **ARI Hubs** PCOG received an update and supported the plans for 2023. **Collaborative Bank** This was a project to support workforce for general practice which only had minimal PCN uptake. PCOG supported increasing uptake whilst the funding was in place to support a full evaluation. MO confirmed that the project had been presented to the GPCB and communications had been sent to all practices to encourage them to participate. The GPCB had agreed that One Care could provide zero hours contracts to support the bank. Losing staff was a concern as workforce was a significant challenge for general practice and workforce was noted as a key priority for One Care. **St Mary Street Surgery** This surgery had proposed buying the neighbouring building to expand their estate space. The District Valuer had assessed the options and concluded that no option was currently affordable for the practice. PCOG agreed that funding would need to be applied for through Minor Improvement Grant or capital funding. **South West (SW) PCOG Decision Making** PCOG was asked to support the governance arrangements under development with SW PCOG which had proposed that decisions could be agreed by ICB Directors up to £20,000 with deputies able to agree up to £10,000. PCOG agreed as long as the process was reviewed regularly. Further discussions would be held by the ICB Directors of	

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	Finance. DJ confirmed that the amounts were within the thresholds outlined in the ICB Standing Financial Instructions. **Tier 2 Dental Commissioning** PCOG supported the South West approach but asked that user evaluation was actively requested and noted that periodontal services should be prioritised for BNSSG. **Community Dental Services** PCOG had been asked to extend current contracts for community dental services beyond the end of March 2024 to allow time for further consideration of these services. A task and finish group would be convened, and a full procurement of services was proposed. DJ highlighted the importance that this service was commissioned in the right way to support local strategies. PCOG agreed the contract extension for a year to allow the necessary work to take place. AM noted the importance of evaluation and recognising that if a scheme or project was not delivering the intended outcomes, investment should cease. AM noted that it was important that any cases of this were acknowledged through the PCOG decision making. **The Primary Care Committee received the update on the decisions made by PCOG**	
7	**General Practice (GPCB) Strategy** MO provided the background to the development of the BNSSG General Practice Five Year Strategy. MO explained that this was a GP focussed strategy, however One Care had worked with pharmacy, optometry and dentistry (POD) representatives and established a wider Primary Care Board where primary care could share common concerns and learning. The recent changes to the NHS provided general practice the opportunity to work together and as the GPCB represented 100% of BNSSG general practices, the GPCB was able to make some decisions on behalf of the system. The Strategy had been developed to align general practice priorities with those of the Integrated Care System (ICS). The Strategy outlined the way One Care and the GPCB would support general practice and address the priorities whilst respecting the individual needs of the PCNs and localities. The Strategy had been developed through various meetings, workshops and surveys. Every practice had been given the opportunity to contribute and the Strategy had been ratified by the GPCB and One Care Board in May 2023. MO outlined the 4 priority areas within the Strategy: Workload, Workforce, Estates and Representation. MO noted the importance that the strategy recognised the 76 individual businesses which made up the practices within BNSSG and explained that there would be cultural shift in practices giving up some autonomy to work more collaboratively. MO noted that the Strategy needed support from the ICS to support general practice having more active role	

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	in discussions which would allow primary care to affect change within the community more effectively. MO explained that alongside the 4 priorities, the strategy outlined the 10 goals which would support achievement of the priorities as well as the priorities of the ICS. There was a detailed strategy behind each of the 4 priorities and operational plans had been developed. Each operational plan would be able to be integrated with the other system strategies to support a more unified system. AM supported the collaborative approach to developing the strategy and welcomed the alignment with national and local priorities. AM asked whether models of care, and value for money and effectiveness were included as consideration within the ten goals. MO explained that the strategy outlined the partnership model of general practice and the ability to offer continuity of care rather than reviewing models of care. The goals outlined pragmatic and practical ways to deliver services and challenged unwarranted variation in practices and encouragement of accepting access, resilience and quality support. The strategy provided an approach for all GP Practices and was not focused on specific practices. AM noted that the strategy outlined the 'what' rather than the 'how' and asked how the specifics would be monitored. MO explained that this would be outlined in the appendices to the Strategy. DJ welcomed the approach and said that the system was fortunate to have the consolidated work of One Care and the GPCB and highlighted the ARI Hubs as an excellent piece of work managed through general practice. DJ noted that he had discussed the strategy with the Interim Chief Executive of One Care and noted the importance of robust and strong general practice within the system. The strategy needed to support practices to be resilient which would enable all the other goals and priorities including those aligned with the ICS. ST agreed and felt the Strategy demonstrated the benefit of having the GPCB and One Care in the system. ST recognised the 4 priorities within the work of the ICB and noted that it was important to understand that particularly around estates the ICB would have to make some difficult choices, and these would be aligned to reducing health inequalities. ST welcomed the approach and supported further communication to the system to demonstrate the links between primary care and system. **The Primary Care Committee received the General Practice Five Year Strategy for information**	
8	**General Practice Recovery Plan Update** Katie Handford (KH) provided an update on the progress of the General Practice Recovery Plan. **Capacity and Access Plans** The ICB, with GPCB and Local Medical Committee (LMC) support, had developed a template alongside engagement and data	

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	packs to support completion of the improvement plans. The PCNs have now submitted their plans. The ICB would review the plans and provide the PCNs with feedback. Once the KPIs were received from NHS England, the plans would be cross-referenced against these and a system level plan would be developed. KH explained that for some of the areas it would be challenging to monitor improvement. **General Practice Activity Data** KH noted that improving the appointment book was part of the capacity and access plans. This was a challenge as there were known data quality issues. A deep dive was being undertaken with some practices to understand the data flows to identify the data quality issues. There was an added complication as AskmyGP data did not flow into the normal routes. **Modern General Practice Access** KH confirmed that this was around self-empowering patients to use the NHS App to access their records. Only 25 practices had currently opted in. The ICB had used feedback from these practices and videos to encourage practices to opt in. All practices were using cloud-based telephony contracts although work as needed to improve the contracts and a review of the consultation tools would be undertaken. Care navigation tools were being tested. **Support to Practices** The ICB continued to support practices through the Access, Resilience and Quality (ARQ) programme and the programme continued to be communicated to practices. **General Practice Capacity and Escalation** KH explained that this was part of the urgent care network work who were exploring the urgent care aspects of the plan as well as capacity demand, BMA guidance criteria for general practice and the impact on NHS 111 when general practice had no capacity. OPEL action cards were being developed to align with the system so there could be a recognised way to communicate when general practice was over capacity. A task and finish group had been set up to work through the actions before winter. **Pharmacy First** This was seven medical conditions which would be treated through national Patient Group Directions (PGDs). Four of these were already being delivered locally. BNSSG had the highest number of referrals per month in the South West which was positive and the next steps involved expanding the work although this was on hold awaiting funding agreement from NHS England. **Primary and Secondary Care Interface** GI outlined that the interface between primary and secondary care was a key risk and it was important that colleagues had the opportunity to meet and discuss some of the challenges and agree key priorities. Working with the LMC, the GPCB and the Acute Contracting Team it	

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	was hoped that a group would be convened by the end of August. The Group would be chaired by Jo Medhurst and the focus would be on agreeing key priorities which would be developed into an ICB Board report. GI noted that there was already work ongoing in this area and it was hoped that the group would join this up. **Self-Referral Pathways** GI reported that this concerned expanding self-referral pathways to seven required pathways. A self-assessment had been returned which outlined the current position of the pathways. The self-assessment had identified that self-referral options existed, but these were inconsistent across BNSSG. Work was ongoing to understand where self-referral could have the most impact. GI highlighted the importance that the ICB and General Practice consider whether self-referral would have a negative impact on waiting lists and backlogs, and the workforce challenge. **Communications and Engagement** KH highlighted the importance of communication and engagement with the public to support understanding of the new models of access. The primary care team was working with the insights and engagement team to understand the user experience of access. KH confirmed that next steps included approval of proposals for funding support to practices to implement some of these changes and approval of the capacity and access plans. The System Plan would be developed and presented to PCC in September with onward approval to the ICB Board in October. AC asked whether staff in Sirona was sighted on the self-referral plans. GI confirmed that they were. AM noted that several plans were rated amber and asked whether these would be green when next presented at PCC. KH noted that there were many elements underneath these plans and many of these were green and therefore there would be more green rated items for the ICB Board report. KH outlined that there was a key risk around patient access to records and noted that pharmacy first was amber as the funding was yet to be agreed. KH noted that additional detail such as timelines for completion, baseline position and improvement plan detail would be included in the report for the ICB Board. AM noted that sign up for patient records access had been slow. KH expected that there would be a sudden increase in sign up. AM also asked whether there would be an update on the primary and secondary care interface in September. GI was hopeful there would be a meeting in August but it was dependent on annual leave. ST asked whether the AskmyGP data issue needed to be escalated to NHS England to resolve. KH confirmed that current work had identified that some of	

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	the AskmyGP data was showing in the General Practice Appointment Data (GPAD) and therefore the team was investigating whether this could be replicated for other practices. **The Committee received the update on the General Practice Recovery Plan**	
9	**SW Dental Reform Programme Update and next steps** Matthew Jerreat (MJ) was welcomed to the meeting to discuss the South West Dental Reform Programme which prioritised three areas: Access, Workforce and Oral Health. Three working groups had been set up to reflect these priorities and these were being reviewed. A bi-monthly Programme Board, which included representatives from the ICBs, had been set up to review progress and make decisions. As part of the review of the working groups, the Access group would restart in September 2023 and task and finish groups had been set up to focus on specific access issues. The Oral Health group would pause during August and September 2023 to review possible duplication in other meetings. The group was looking to reform in October 2023 and become a space for Local Authority and ICB information sharing. The Workforce group would pause during August and September to allow staff time to support the Dental Educational Reform Plan and the NHS Long Term Workforce Plan. The Dental Reform Programme was prioritising; Stabilisation, Tier 2, Digital Referrals, and the Dental Hub. MJ explained that both Tier 2 and Digital referrals had been discussed at the South West Primary Care Operational Group (SW PCOG) and although decisions hadn't been made, these conversations continued. MJ reported that stabilisation continued to be the key method of increasing access to dental services, noting that without stabilisation more patients would need urgent care services. The aim of stabilisation was supporting patients after urgent care to get them to a stable position. Eight providers in BNSSG provided stabilisation sessions to 100 patients a week. MJ explained that Tier 2 services were a clinical priority. There were two oral surgery contracts within BNSSG which would end in March 2024. The suggestion from NHS England, was for the commissioning of Tier 2 services for oral surgery, endodontics and periodontics using a standard specification across the South West. More work was needed to understand the value this would bring. It was expected that these services would increase access and reduce referrals to secondary care. MJ highlighted that a proposal had been presented to the SW PCOG proposing NHS England procure a digital solution for dental referrals. The South West was the only region without a digital referral service. It was noted that Dorset did have a system and analysis was being undertaken to review if this was the right	

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	system to roll out across the South West. A digital referral system was expected to improve information, improve waiting times, reduce referrals being sent to the wrong place and reduce clinical time on administration. MJ noted that there was a financial impact and the cost for BNSSG was estimated to be £112k. MJ highted that the Dental Hub was planned as two region wide hubs where dentists could access training, development and support. The hub would also provide access to patient care. The training would be to Tier 2 and Tier 3 level and the hubs would be situated within the north and south of the region. It was believed that the Dental Hub would support the South West to recruit and retain dental clinicians. Work continued to develop the idea with the ICBs. MJ highlighted other areas of work which included establishing a Managed Clinical Network, pathways of care in secure settings and an online platform which allowed dentists to record their actions towards sustainability as part of the Green Toolkit. MJ highlighted the November Dental Conference which was an opportunity to hear from ICBs. MJ noted that the local specialist care contracts were ending in March 2024 and so communication about a future procurement would need to be undertaken. MJ also noted the moving of the dental hospital and the opportunity to be proactive with Communications. It was noted that the dental hospital offered a primary care service for around 1000 children and although the hospital was committed to continue to treat these patients work was needed between NHS England and the ICB to support this. DJ confirmed that BNSSG ICB had supported the regional approach to Tier 2 services particularly periodontal through PCOG and asked whether this included oral surgery. MJ thanked DJ for the update and confirmed that endodontics and oral surgery were included and the plans around oral surgery would streamline the approach. DJ explained that he and GI met with the dental school last week and the issue regarding paediatrics had been raised. DJ noted that the ICB was actively engaged with the dental school as it offered a good opportunity for the system. DJ noted that digital referrals had not yet been presented to PCOG but welcomed the approach particularly as there was an ongoing dental underspend in the system and a digital referral service would provide an opportunity to review this. MJ explained that the NHS England team were currently reviewing digital options and believed this would be a real benefit to the system. GS noted the importance of contracted periodontal and endodontic services as the main contract did not fund these services but noted that consideration needed to be given to how to recruit to these roles. GS supported the digital referral system but noted that his preference would be for a single system across the region as many practices sat across system boundaries. GS highlighted the	

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	stabilisation programme and expressed concerns about affordability. MJ explained that recruitment for the Tier 2 services was a known risk although the Local Dental Committees (LDCs) had expressed an appetite for these services. The finance available was being reviewed and guidance for bandings had been issued. MJ acknowledged that the funding needed to be right to encourage recruitment. MJ agreed that a system wide digital referral service would be best. It was noted that it was important that the stabilisation programme model supported the reduction in health inequalities and provided increased access to care both of which would need financial investment. This model could then be used to support other groups of patients such as those with cancer or diabetes. GS agreed that access to NHS dentistry was an issue. MJ agreed and explained that to support NHS Dentistry for 100% of the population increased national funding was needed. DJ explained that the ICB wanted to work flexibly regarding dentistry and locally allocated dental budget would be ring-fenced for dentistry and the ICB would work within the constraints to optimise the allocation to increase access. GS noted that the national contract outlined the clawback of unused funding within the contracts and noted that this funding was not ring-fenced by the ICB. ST explained that the ICB allocation received for dentistry was ring-fenced for dentistry, but the contract clawbacks were a national issue. The ICB would continue to request that any funding allocated to dentistry stayed within dentistry and this had been escalated to the national team. ST asked that MJ provide a copy of the Green Toolkit to ensure that the ICB was linking in with the wider sustainability work. MR noted that a consistent concern from the local authorities was dentistry access for looked after children and care leavers and asked whether this was being considered as part of the reform programme. MJ confirmed this issue proved the importance of having local clinical leads who would identify local issues such as these and raise through the Managed Clinical Network for paediatrics and through Public Health. MJ explained that there was more work to do to identify whether there was any duplication across the system. MR thanked MJ for his response as it provided a framework the team could work to. AM thanked MJ for the presentation and noted the complexity of the challenges within the system. It was noted that several of the issues were national issues which were outside the remit of the PCC but, as an assurance Committee, PCC needed to be kept informed of reform programme progress and the need for assurance on those areas within the local responsibilities. **The Primary Care Committee received the update**	**MJ/ST**
10	**Delegation of POD Services – Update on delegation**	

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	DJ noted the shift in decision making to the regional approach and noted that the transition plan had been shared for information. DJ highlighted a key action to translate the risks from the regional risk register to the local registers. Work continued aligning risk scoring and developing the right methodology, but DJ recognised the importance that the Committee had sight of the risks. AM asked when further information regarding POD priorities would be presented to the Committee. DJ confirmed that the dental priorities would be reviewed over the summer and an update would be provided in September. AM noted that she had spoken to a representative from the Local Optometry Committee who had been enthusiastic about the opportunities delegation provided. DJ noted that the same had been said at the Local Pharmaceutical Committee. **The Committee received the update on delegation**	**DJ**
11	**Monthly Primary Care Activity Report** **Dental** NH confirmed that delivery of UDAs for Bristol was in line with the South West average however UOAs was slightly higher. The dental contract procurement start date has been delayed to the 30th October 2023. **Pharmacy** NH reported that pharmacies have started to receive requests to 100 hour delivery following the introduction of new regulations which allowed the 100 hour contracts to reduce to a minimum of 72 hours if certain requirements were met. As these were received the team was reviewing the impact and this would be shared with primary care leads. This was also being reviewed for the South West through SW PCOG. An update to the unplanned closures policy has been agreed and this would be communicated to all providers. Lloyds Pharmacy have confirmed the Sainsbury's market exit processes have been completed. Reviews continued with neighbouring pharmacies to understand the impact and support required. The Lloyds changes of ownership were starting to be processed and these would be captured and monitored at the Pharmaceutical Services Regulations Committee. The team was working on the August Bank Holiday rotas for pharmacy. **Optometry** NH reported that an application has been received for a new optometry contract, it was noted that the location was not included in the paper and NH confirmed that additional information would be included in future papers.	

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	NH confirmed that working with the Local Optometry Committee and SW PCOG an approach had been agreed for the Quality in Optometry (QiO) cycle for 2022/25 which was a more structured approach with providers submitting their QiO questionnaires by the end of 2023. This would allow the team to collate the responses and understand exceptions and support needed. A visit programme was planned for 2024 and any learning would be shared with all providers. **The Primary Care Committee noted the contents of the report and the work ongoing to support delegated services**	
12	**Primary Care Contracts, Performance, Quality and Resilience Report** The Committee received the report and DJ confirmed that the Charlotte Keel Procurement lessons learned would be presented to the PCC in September. **The Primary Care Committee noted the contents of the report including the key decisions and information from PCOG**	
13	**Primary Care Finance Report** JD reported that the financial position year to date for the primary care medical and medicine management service was £187k underspent. The forecast was reporting a break even at year end. JD drew the Committee's attention to the risk of delivering the savings plan and noted that options were being considered with a plan back to the Committee in September. JD noted that the forecast would continue to be reported as per the report until month five at which point the forecast would be variation by programme area. Figures regarding POD services had been received. Previous reporting had been noted as on plan due to the transition. JD noted that there was a current primary care dental underspend of £340k. It was noted that the clawback was currently higher, and the patient care revenue was lower linked to activity. JD noted that this activity was always lower during the first quarter and would increase as the year progressed. The ICB had received one month of pharmacy data and this was reported as break even. Optometry was showing an underspend of £209k year to date. There was work ongoing to understand the data quality issues within the optometry data. JD confirmed that a report for POD finance would be developed for the Committee. **The Primary Care Committee:** • **Noted the summary financial plan** • **Noted the key risks and mitigations to delivering the financial plan** • **Noted that at Month 3 (June), combined Primary Care budgets were reporting an underspend of £0.187m year to date, and continuing to report a forecast breakeven position, per the financial plan**	

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14	**Key Messages for the ICB Board** The Committee agreed the key messages for the ICB Board: • The rapid set up and success of the ARI Hub • The Dental Reform programme • GPCB Five Year Strategy • GP Recovery Plan and the intention for the plan to be presented to the ICB Board in October 2023	
	For Information	
15	**Primary Care Operational Group (PCOG) Minutes** **The Primary Care Committee noted the minutes**	
16	**Any Other Business** There was none	
	Date of Next Meeting 26th September 2023, at 9.00am, to held via Microsoft Teams	

Lucy Powell, Corporate Support Officer, August 2023