NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

# BNSSG ICB Primary Care Committee Meeting

**Minutes of the meeting held on 26th September 2023 at 9.00am, held virtually via Microsoft Teams**

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## Minutes

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| **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, Old School Surgery & Medical Director of GPCB | KB |
| Jenny Bowker | Deputy Director of Primary Care, BNSSG ICB | JB |
| Richard Brown | Chief Officer, Avon Local Pharmaceutical Committee | RB |
| Amanda Cheesley | Partner Non-Executive Member, Sirona Care & Health | AC |
| Jamie Denton | Head of Finance, Primary Care, Community & Children, BNSSG ICB | JD |
| Ellen Donovan | Independent Non-Executive Member, BNSSG ICB | ED |
| Geeta Iyer | Deputy Chief Medical Officer, (Primary & Community Care), BNSSG ICB | GI |
| David Jarrett | Director of Primary and Integrated Care, BNSSG ICB | DJ |
| Susie McMullen | Head of Primary Care Contracts, BNSSG ICB | SMc |
| Joanne Medhurst | Chief Medical Officer, BNSSG ICB | JM |
| 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 |
| George Schofield | Avon Local Dental Committee Secretary | GS |
| **Apologies** | | |
| Debbie Campbell | Chief Pharmacist, BNSSG ICB | DC |
| Jeff Farrar | Chair of the BNSSG ICB & Independent Non-Executive Member | JF |
| Nikki Holmes | Head of Primary Care, Southwest, NHS England, and Improvement | NH |
| John Hopcroft | Vice Chair, Avon Local Optometry Committee | JH |
| Matthew Jerreat | Clinical Chair, Southwest Local Dental Network | MJ |
| Rosi Shepherd | Chief Nursing Officer, BNSSG ICB | RS |
| Sarah Truelove | Chief Financial Officer and Deputy Chief Executive, BNSSG ICB | ST |
| **In Attendance** | | |
| Josh Cooper | One Care | JC |
| Sandie Cross | Executive Assistant to Dave Jarrett, BNSSG ICB (*note taker*) | SLC |
| Loran Davison | Team Administrator, BNSSG ICB | LD |
| Aishah Farooq | Associate Independent Non-Executive Member, BNSSG ICB | AF |
| Bev Haworth | Deputy Head of Primary Care, BNSSG ICB | BH |
| Jim Hodgson | Programme Manager – Urgent Care, One Care | JHo |
| Laila Pennington | Head of Primary Care Commissioning & Transformation, NHSE | LP |
| Clare Ripley | Programme Manager, BNSSG ICB | CR |
| Mona Thacker | Avon LOC | MT |

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| 1 | **Welcome and Apologies**<br>Alison Moon (AM) welcomed everyone to the Primary Care Committee (PCC). Apologies are noted as above. AM introduced Ellen Donovan (ED) as a new member to the Committee. ED is one of the independent non-executive members at the ICB, and also chairs the Outcomes, Performance and Quality Committee (OPQC). AM mentioned in return, she would be attending future OPQCs. It was suggested this to be an effective way to make connections between both assurance Committees. | |
| 2 | **Declarations of Interest**<br>There were no new declarations and no existing declared interests that conflicted with agenda items at the Committee today. | |
| 3 | **Minutes of the previous meeting held on 25th July 2023**<br>The previous minutes were reviewed and agreed as an accurate record, with no inaccuracies to amend. These can be signed off as a true reflection of the meeting. | |
| 4 | **Review of Action Log**<br>The Committee reviewed the action log:<br><br>**Action 53:** Delegation of POD Services - As Nikki Holmes (NH) was not at PCC today, it was suggested to keep this action open, and for NH to provide an update at the next PCC in November. Action open.<br><br>**Action 57**: Good news stories - The Committee agreed this as this was on the agenda for the meeting today. Action can be closed.<br><br>**Action 64:** PCOG Report (Fair Shares Allocation) - AM agreed for this action to be closed for PCC, however, would like this action to be monitored through PCOG - Action closed.<br><br>**Action 66**: Closure of Child Friendly Practices in BNSSG - As NH was not at PCC today, it was suggested to bring this back for NH to update at the next PCC in November. JB mentioned some of the work around child friendly practices, will be picked up through part of the dental plan moving forward. It was felt there was a route to take some of this forward. - Action open.<br><br>**Action 69**: POD Risks to be included on ICB/ICS Risk Register - DJ explained the delays with this action, which is related to the capacity within the commissioning hub and having to cross reference all the risks across the system. DJ advised the requirement to ensure we are able to report the POD risks, as any other risks in the system with scoring, methodology and wording, which is challenging. DJ advised this will be completed by November, with fully worded risks and clear mitigations. This will be ready for presenting at the PCC in November. Action open.<br><br>**Action 70**: PC CPQR Report - MR updated there was an enhanced surveillance paper being presented at the PCC today, and this is incorporated within the paper which has quite a detailed update. Agreed this Action can be closed. | **NH**<br><br>**NH** |
| 5 | **Patient Experience**<br>AM invited Georgie Bigg (GB), to provide an update on patient experience feedback. GB shared slides with the Committee. GB explained Healthwatch had made some changes, and are now using "Power BI," which is a system that allows the upload of data and information on a monthly basis, rather than waiting for the information quarterly. There are currently 60 people accessing this system, which allows an | |

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| | opportunity of bringing good news stories and patient feedback to the attention of Healthwatch. There is now a walk-in unit opened in the Galleries Shopping Centre (Bristol), to make this system even more accessible to more people, allowing more footfalls, to potentially a more vulnerable cohort of people across BNSSG. GB provided 2 examples of patient feedback received, including some challenges of trying to access GP services and urgently needed medication. Another example was positive feedback had been received concerning a local GP practice (*The Old School Surgery*), who had supported a service user with trans issues. The practice was extremely sensitive and understanding in their approach. (*Both examples shared in the slide pack for further information*).<br><br>GB explained that Health Watch are working on a GP Access Project with system partners. This Project had been informed by the Fuller Stocktake Report and started in April 2023. Funding for this Project comes through Local Authority. The Healthwatch team are highlighting 11 different case studies, which mirrors the aims of the GP Access Recovery Programme. Healthwatch also intend to monitor how the GP Access Recovery work, embeds those different ways in which Healthwatch can reach out and make changes that people need in the future, to better improve their wellbeing. GB provided some examples including the Community innovation lead at the Swift PCN, & the Care Navigator at Greenway GP surgery.<br><br>AM thanked GB for providing this information, and reiterated the importance of using the rich data that Healthwatch brings within the workings of the ICB.<br><br><u>Questions / Reflections Raised</u>:<br>➢ DJ expressed gratitude to Healthwatch colleagues and was in support in providing a walk-in bureau in the Galleries Shopping Centre, to allow access for feedback and support. DJ asked on the specific case of the service user unable to access GP services, what the outcome was, and did Healthwatch contact that specific GP practice, as the ICB have not received direct contact regarding this specific case? GB explained that Healthwatch do not have the resources each time to discuss individual cases with each GP practice, however it was recognised and noted that the ICB would require details of such cases, to be able to help support both the person and the GP Practice.<br><br>**Action** - For DJ/SMc to ensure they are receiving and proactively acting on information about feedback associated with some GP practices, and the lack of accessing services and urgent medication, following the Health Watch report.<br><br>➢ Katrina Boutin (KB) mentioned she would feedback to the team at The Old School Surgery, regarding the positive experience the service user experienced, as this was a really positive outcome.<br>➢ ED mentioned she would be interested to learn the process of understanding some of the challenges, and how the ICB and the system, would be responding to those.<br>➢ Bev Haworth (BH) mentioned there were already several meetings in place which have representation from Healthwatch colleagues. There is the “Insights Team Meeting,” the “Communication Team Monthly Meeting” & the “Fortnightly Access Recovery Group.” It was suggested to start to bring themes through these meetings in order to cross check against the data we have at practice level. **The Committee agreed to this proposal.**<br>➢ Richard Brown (RB) suggested to change some of the narrative around it being called a “GP Access Project,” and felt it would be better named as a Primary Care Project, as he received feedback from patients who are unable to access their pharmacist etc. **Healthwatch agreed to this proposal**. | **DJ/SMc**<br><br>**KB** |

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| | ➢ Michael Richardson (MR); having personally worked with Healthwatch, wanted to thank GB for the work that Healthwatch has been involved in within the system, and what an amazing advocate for our patients and population.<br>➢ Susie McMullen (SMc) advised with regard to the example of the patient unable to access the GP practice, she would like a rapid communication method in place, as the ICB are able to assist with allocating patients to a practice, if there are significant difficulties. There is also a special allocation scheme; recognising it would be good to work together around the themes which have been mentioned, together with any complex patients to ensure they are able to get a registration. | **DJ/SMc** |
| 6 | **Risk Register**<br>DJ explained the risk register is on the agenda for the Committee today to bring attention and focus, following a session at ICB Board in September. It is noted the ICB are taking stock of its risk management processes, in terms of corporate and system risks. Corporate risks are risks that the ICB has the ability to manage on its own, whereas system risks are those risks that can only be managed across system partners. To note, risks are only considered at ICB Board when they score 15 and above. DJ summarised the first 2 risks on the risk register, and wanted to draw out some of the themes from the other risks:-<br><br>***PCC48 - Corporate Risk - Scoring 15***<br>DJ mentioned the ICB have recently taken on delegated responsibility for pharmacy, optometry, and dentistry services, and going through that delegation and transition process, it has been made clear that for the ICB to be able to do what we want to do with those services by way of support, there are concerns around the capacity available in the commissioning hub. DJ explained a Memorandum of Understanding (MoU) has been developed, looking at our ways of working with the commissioning hub. Laila Pennington (LP) from NHSE has joined the Committee today, and DJ would be meeting regularly to look at capacity issues, which NHSE are managing but it is meaning that our ability to support transformation in the service is limited. To mitigate this, the ICB will be appointing some transformation support to support specifically dentistry, noting the risk being identified around access to dentistry. DJ is liaising with Steve Sylvester, who is the Director of Specialised & Dentistry at NHSE who is also helping support this process.<br><br>***CMO39 - Scoring 20***<br>This risk describes that there will be an overspend on the allocated budget for primary care prescribing for 23-24. There has been an increase in savings target that leaves a gap of approx. £1.14m to savings projects. Although additional budget has been allocated for Cat M/ Inflation and growth there continues to be uncertainty around the volatility of NCSO & Category M price fluctuation, the degree of inflation that may occur on drug prices and the degree of growth in prescribing in certain areas such as diabetes which may be higher than budget allocated. Jamie Denton (JD) had noted this risk last month and will be picked up again later in his finance report to the Committee.<br><br>AM noted this risk is noted to have the oversight from the PCOG/OPQ, which does not feel correct, and asked if this risk log could be amended to reflect the correct oversight committee is shown. Also, it currently reflects no further action is required on this risk to lower the score from 20, but it was agreed this was also incorrect.<br><br>**Action** - to apply the correct oversight committee to risk CM039 on the risk register. To amend the column to the risk register, as this should not be empty.<br><br><u>Questions Raised</u>:- | |

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| | ➢ AC wanted to mention the risk PCC48 came onto the risk register in November 2022, with a target date for resolution in March 2023, so wanted to check if this was a typographical error.<br>➢ AC noted the risk with NHSE has been known for some considerable time (over 12 months), but from an assurance point of view, it felt difficult to be confident how at what point we can actually hold this; understanding the challenges of capacity and being able to recruit. - DJ responded and mentioned in terms of how long we hold the risk, we did not feel we could hold it any longer in terms of dentistry, therefore mitigating that by putting in further capacity ourselves.<br>➢ DJ mentioned in terms of next steps, one of the actions that has been noted from the audit report, is assurance of the Delegation Transition Plan (DTP), which breaks the overarching support of the commissioning hub in a more granular level of detail. DJ suggested to bring the DTP to the Primary Care Committee and ask for senior management representation to join to discuss this further. DJ would take this as an action.<br>➢ DJ mentioned in terms of escalation, both AM and DJ attended a session with the local regional director for commissioning (Rachel Pearce) and could certainly take further escalation through that route. **AM, on behalf of the Committee agreed to this proposal.**<br><br>**Action** - DJ to invite Steve Sylvester & Liz Cosford from NHSE, to a future PCC to discuss the DTP.<br><br>**Action** - for DJ to escalate risks around POD service through the Local Regional Director for Commissioning.<br><br>DJ explained the other risks scoring over 12, included resilience support to practices and have the ARQ program is mitigating that issue. DJ mentioned there is a robust check and challenge to check the accuracy of the scoring of the risks and looking at the mitigations regularly. Jenny Bowker (JB) reviews the risk register on a monthly basis, and all teams review their risks on a monthly basis, this also goes through PCOG.<br><br>**The Committee received the Risk Register** | **JD**<br><br>**DJ**<br><br>**DJ** |
| 7 | **PCOG Report**<br>As PCOG did not meet in August, there were 2 months of reporting to bring to the attention of the Committee.<br>DJ outlined the decisions made at PCOG, and it was suggested for ED to view the ToR for the PCOG, to view representation and attendance; noting it has similar stakeholder attendance to PCC, and PCOG has delegated responsibility for the commissioning of primary care services and a forum where we transact those delegated commissioning functions.<br><br>**Action** - for the ToR for PCOG to be sent to ED.<br><br>**August Decision Log Report**<br>At the August PCOG meeting, 2 decisions were made, and 1 deferral was received.<br><br>➢ Procurement of Language Services for primary care across BNSSG, where the contracts expired end of September. An options appraisal was given to PCOG within the current contract for a further year. Reviewed the options and to conclude, PCOG are in support and have made recommendations for PP to contact providers, to award for another one year, to allow for framework cool off, for a slightly longer period for primary care, between three and five years, | **JB** |

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| | to end at such point where we would have time to consider a fully engaged system procurement.<br>➢ Monks Park / Coniston Merger. The ask of PCOG would be to support the application to merge the two contracts. This has had already received the support from the LMC. - In Conclusion, PCOG are in support for this merger application.<br>➢ Lloyd George Digitisation Options Appraisal. The members were asked to consider all options available, in 10 practices piloting the digitalisation of their patient records, which was historically started in 2021 by NHSE, practices are still waiting for this to happen - In Conclusion PCOG have discussed and agreed for the next step in this, prior to a formal decision, in terms of regional commitments, PCOG are asking that there is direct contact with each of these practices, setting out what the actual offer is, and what they would be getting from this. Then seeking onward and continued commitment, which would inform our decision. For AC to bring back for further discussion at PCOG for 12th September 2023.<br><br>**September Decision Log Report**<br>At the September PCOG meeting, 5 decisions were made.<br><br>➢ PCOG - ToR were asked to be approved. - these were approved<br>➢ System General Practice Access Recovery Plan - PCOG have discussed and are in support for this approach.<br>➢ Lloyd George Digitisation Options Appraisal - In Conclusion PCOG have discussed and based on the pros - removal and scanning of LG records to free up GP Practice space for other purposes with no on-going storage costs for the 10 practices listed in the paper above, NHS England funded apart from the £7k shortfall, PCOG have decided to continue with Option 1 to remain in the LG digitisation pilot for the 10 practices noting that the two practices (one no reply, one not interested to continue) may need to be replaced, timeframe allowing, by two other practices that previously expressed interest invited to take part in the pilot.<br>➢ Finance Update - JD presented £750K savings in our Primary Care Budget this year we did not make. As there was not enough time at the meeting, this will be discussed in the October PCOG meeting. In Conclusion PCOG have discussed and agreed that decision of support for the savings plan is to be considered in the October PCOG with an expectation that a costed alternative proposal be made if not agreed.<br>➢ Pharmacy, Ophthalmic & Dental Update - Alison Mundell presented on the success of the minor ailments program in Community pharmacy, and it had been recognised the success of that initiative at this committee previously. In Conclusion PCOG have discussed and are in support of the pilot. The ICB has funding to support the establishment, service delivery and evaluation of the pathfinder pilot. A working group will be established to take this forward. Key areas to support will be digital record keeping and integration and clinical governance. Funding is currently confirmed until end March 2024, but it is hoped this will continue into 2024/2025. Service delivery is expected to start by end November.<br><br>Questions / Reflections Raised<br>➢ AM asked if the contract team already knew the contracts were expiring in Sept 2023, but it only went to the PCOG meeting in August, was there a forward planner that could have been used to record this much earlier? SMc responded and said she had now been appointed the contract lead for the Primary Care | |

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| | Team, and assurance given that she would be looking at this in her work plan, this will be picked up sooner moving forward.<br>➢ JM asked about the Lloyd George Digitalisation programme, was there a clear baseline of valuation metrics? DJ responded this was a regional programme, so unable to comment on a national level.<br>➢ KB recognised the scale of challenges with GP estates being at capacity; noting in her practice alone, they have over 30,000 records to be uploaded digitally, so therefore mentioned this is a big but crucial project, with the scanning of each patient notes will be vast.<br>➢ AM asked if this work should be linked to an estate's strategy around Primary Care? JB responded and confirmed that it does link in, and there was an opportunity for digital and estates to come together, with the support of Tim James and Andy carpenter, who are already connected and linked into this crucial piece of work, to obtain a resolution.<br>**The Committee received and noted the update on the decisions made by PCOG.** | |
| 8 | **System Access Improvement Plan**<br>AM noted this was an important paper which will be presented to the ICB Board in November. AM thanked Bev Haworth (BH) for a well written, detailed briefing paper to share at PCC today.<br><br>BH provided an update on the delivery against the Access Recovery Plan to the Committee, and to give first sight of how the System Access Improvement Plan (SAIP) is developing, which will go to the ICB Board in November; recognising there is no Primary Care Committee meeting in October. BH advised the Access Recovery working group continues to meet fortnightly, with updates and approval of this approach being taken through PCOG and the ICB Executive Team. BH drew out some of the key points to date, in terms of activity.<br><br>➢ We are above plan for the number of appointments being delivered.<br>➢ We are above the national average for appointments within the 14 day target, recognising more work required to reach our targets of the national average for the same day and for face to face, however, our baseline was 17 practices being below the national average, and we are now at 12 and we do align with the SW at the moment, our CPCS referrals have already reached their targets 5000 a month.<br>➢ With regard to workforce, we are currently best in the Southwest in terms of our additional roles' recruitment. BH mentioned there is a total of 584 roles and in post and that is 67 above plan for Q1.<br>➢ In terms of online access for our patients, we have improved from the last position to 58 of all 76 practices now implementing online access to records for patients and all of the remaining practices have been contacted for support ahead of the 31st of October deadline.<br>➢ With regard to care navigation, 71 out of our 76 practices have accessed care navigation training, covering 100% of our PCN's. We are on target to reach 100% and doing a piece of work looking at understanding embedding raining within our practices.<br>➢ The primary and secondary care interface group has met twice. Priority areas have been agreed: culture, planned care including FIT notes, prescriptions, discharge summaries and advice and guidance supported by our GPCB planned care group and urgent care network looking at winter planning.<br>➢ The governance arrangements have been agreed at the last meeting and with the link to the HCPE and work is underway to understand our current position | |

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| | and how we measure our improvement and progress as it's proving not as easy as you would think. The aim is to start building on current work in place and to continue the good engagement so far from secondary care colleagues. In terms of our self-referral pathways, it was noted that to date, there had been no feedback received from NHS England since our first submission of baseline position. However, they have come out again to ask for information because there was quite a tight turnover for the first baseline position and other areas did not really put as much detail in as we did. W used it an opportunity to share what we have in place, but also to highlight where there would be challenges or where self-referral may not be appropriate.<br><br>BH concluded, by way of the next steps, in terms of what will be improved, there will be clarity on the links with the ICS strategy and the joint forward plan which we are currently doing a review and update on. There will be more detailed data and metrics and practice level anonymized data coming through, and we have done a great piece of work on the triangulation of our patient feedback to date. This all feeds into updating the health inequalities section because a significant amount of work has been completed in that area.<br><br><u>Questions/ Reflections Raised</u><br>➢ ED highlighted there is a digital theme coming across, especially with online digital patient records, and mentioned there may be a risk that all practices may not sign up to patient access, and mentioned the percentage of practices on advanced telephony solution is quite low. - BH responded the online access to records has been mandated for practices, and some concerns have been raised around workload that it entails, and some safeguarding issues, that need to be worked through.<br>➢ ED also wanted to further discuss the core actions to note, as a result of the Insight report, where 8 practices with a lowest overall GP patient satisfaction survey, which is being cross referenced with a number of other reports, and wanted to further understand how we are targeting those areas. BH responded and advised all practices are linked through a series of metrics, to give us an early warning on the resilience and sustainability, so ICB are cross checking this around patient feedback, for those practices that were already on the list of the support being provided; namely ARQ Team, with a combined ICB & One Care GPCB support team, who support individual practices with a 1:1 intense support, rather than the access toolkit that is available to all as a self-service.<br>➢ JM mentioned she had attended 2 meetings of the Interface Group, and felt it was a very collaborative, positive and productive space, which was a good function block to start with. JM recognised there is a gap between primary care and secondary care conditions, and the Group had opportunities to discuss what was working well in a constructive and useful way. Remedy infrastructure and IT infrastructure have been brought into the conversations. The Interface Group has agreed to tackle culture to allow it to shift and use the Group as a think tank. It was agreed this was a positive space with providers, who have agreed to lead on certain work streams.<br>➢ GB had attended the meetings, and from a Healthwatch perspective, was very pleased to be involved with the group, as a voice for those people with experiences, to be heard, and reiterated that collaboratively working together across system partners is key.<br>➢ GI reiterated that it was positive that providers are coming forward, to lead on some of the work that needs to be completed, (requests from NHSE)<br><br>AM thanked BH for a helpful discussion and summary and agreed to email BH with suggestions for the next iteration of the paper. | |

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| | **The Committee received the System Access Improvement Plan** | |
| 9 | **Delegation of POD Services**<br>AM noted the importance of having representatives of the local Pharmacy, Ophthalmology and Dentistry Committees present at the Primary Care Committee today.<br><br>DJ advised there was no update to report, as we are now delegated, but wanted to discuss that we would start to bring the risk register to PCC, in terms of assurance of the delegation process. DJ also noted that access to dental services is a key priority for the integrated care system, and the ICB have been clear since taken on delegation, that we wanted to develop our own strategy and priorities for improving access.<br><br>DJ introduced Claire Ripley (CR), who the ICB have asked to support developing our own dental strategy. CR had recently supported the ICB in bringing together key stakeholders working in the dental and oral health sector, to a dental workshop, to start to frame thoughts around priorities. DJ wanted to bring this through to the Committee for oversight.<br><br>CR shared slides with the Committee and mentioned at the Dental Workshop, there was focus on four key areas:-<br><br>➢ Improving access and addressing variation<br>➢ Workforce development<br>➢ Population level<br>➢ Oral health interventions, including integration and collaboration.<br><br>CR continued with discussions on the dental workshop, which was an opportunity to have conversations on utilising the funding that was available in different ways, focus on refining the referral pathways and, increasing the awareness as to the roles that are operating currently within dentistry. CR explained there were also opportunities to review the reasons why patients are not attending appointments. There was a detailed discussion on workforce and the opportunities to look at career progression pathways and retention opportunities, particularly for nurses and hygienists, and discussions included the opportunities for utilising students to work with schools and care homes. It was recognised there was some crossovers with diabetes, and the opportunities to improve the health of the population, with diabetic retinal screening services.<br><br>In terms of next steps, it is for the development of the three-year strategy. There would be a stakeholder survey, with drop-in sessions. There is another workshop planned in November, for which the draft of the initial plan and the strategy would be presented. CR reported she would be continuing to work with colleagues; particularly engaging with local authority and public health colleagues, around the oral health interventions and improving the health of the population.<br><br><u>Questions / Reflections</u>:<br>➢ JB mentioned the need to review the flexible commissioning arrangements that are in place, and twin track that as we are developing the plan, and how we want to reshape beyond March 2024, to bring in and build in oral health promotion. | |

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| | ➢ A suggestion to work on a small set of priorities which are achievable yet challenging, rather than having a long list of things is going to be crucial and the data needs to drive.<br><br>AM thanked CR for the update and requested for an updated report on progress to be submitted to the Primary Care Committee in November.<br><br>**The Committee received and noted the update on Delegation of POD Services, and the Dental Strategy Development** | |
| 10 | **Monthly Primary Care Activity Report**<br>JB drew out the key points from the Primary Care Activity Report.<br>➢ UDA for 21/22 and 22/23: The monthly percentage of usual annual contracted UDAs submitted and scaled up to 12 months for the South-West was 69%. The value for BNSSG was 69%.<br>➢ To note that the JHoots pharmacy, which is a 40-hour pharmacy closed in July.<br>➢ There were some changes in pharmacy regulations, with a change in opening hours, which allow 100-hour pharmacies to apply to reduce their hours to 72 hours. In BNSSG, a total 12 contractors have applied and had approved a reduction to their hours that still does support Saturday and Sunday coverage.<br>➢ The Community pharmacy assurance framework cycle started for 23/24, with the survey opened to pharmacies, equally for the quality in Optometry 22/25 that process is underway as well. JB reported there was a self-assessment framework for optometrists.<br>➢ JB noted in terms of pharmacy and a further discussion at PCOG, the independent prescribing pilot; noting we have funding for three pilot sites, and Ali Mundell and Richard are working this through. It is recognised this was an exciting development for Community pharmacy, and would be the way forward, because pharmacists will become prescribers as they become trained going forward.<br><br><u>Questions / Comments Raised:</u><br>➢ George Schofield (GS) raised a question regarding the UDA target of 69%, and asked was this a month-on-month target, where people run it at 69% where they should be 30% behind on their UDA targets? If this were correct, then concerns raised that many practices may go bankrupt, if they were behind 30% on new data; recognising that in April 2024, if 30% of the clawback is of the contract value.<br>JB advised she would double check this fact, but agreed further conversations were needed.<br><br>**Action** - For JB, DJ, GS to meet to discuss clawback and out-turn position on dental. These items would also be raised at the next PCOG meeting on 11th October 2023<br><br>**The Committee received the Primary Care Activity Report** | **DJ/JB/GS** |
| 11 | **Winter Planning GPCB UCN /GPAS & Collaborative Bank Update**<br>KB provided an overview of the ARI Hub, which was a successful project for 2022. Funding was awarded for this year, and it has gone back out to practices with the opportunity for them to start in a slightly more flexible period this time, to encompass winter pressures. This will be starting in November 2023. KB updated One Care have | |

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| | contacted Bristol University for guidance around the flexible approach to offer all face-to-face appointments for upper respiratory and respiratory illness, for children and adults. One Care is going to monitor outcomes and build on the success of last year. KB advised One Care are also looking at working with the NHS at Home services, ensuring that pathways related to this are clear.<br><br>Jim Hodgson (JHo) presented to the Committee, by way of an update on Winter Planning and GPCB UCN . JHo agreed to share the slides with the Committee after the meeting for further reference.<br><br>JHo explained the work he is involved in which focuses on issues relating to urgent care on the day, winter preparedness, and to support general practice over months ahead. JHo explained the Operational Procedures Escalation Levels (OPEL) escalation, which was introduced to acute trusts in 2016. This is a system to understand and support pressures to help the system to be prepared over rapid change, such as Winter Pressures. JHo has also been involved with general practice alert state (GPAS), which showed the data that is being collected, and an admission of avoidance proposal, which is part of the productive clinical offering, to support admission of avoidance over the focus on discharge.<br><br>JHo further updated engagement work with GP Forum, working through the GPCB, both of which supports OPEL and GPAS within general practice, to understand what the current pressures are, and to support remedial action and general practice.<br><br>JHo discussed the acute respiratory infections project where demand had been higher, with a peak at the end of December 2022. It is reported there were 18,000 additional appointments, which resulted in using additional agency staff and locums to support that additional demand. JHo explained this data enabled the design of a much more robust project, allowing for better data for adults and paediatrics. JHo had worked closely with the Bristol Children's Hospital to monitor the situation over the last Winter. This project in aiming to commence at the end of October 2023 through to the end of February 2024.<br>JHo noted this equated to an average of £8000 per practice for those additional slots, which will continue to be monitored. JHo mentioned he is currently looking at the interface between general practice and the virtual ward, so from a patient's perspective, there was nothing different, as everything else remains the same in terms of the triaging the interface with community pharmacy.<br><br>JHo discussed a proposal he had been working on which was looking at the great work in the South Somerset and PCN level frailty teams, which as a system, make this shift from focusing on discharge to admission avoidance. This project has yet to obtain funding, but noted there was a cohort of 4000 patients across BNSSG, who are over 75, not in a care home, and who have a Cambridge multi-morbidity score of four or five. JHo concluded this project would be part of a proactive care package that would be delivered for general practice, which is ambitious, bringing 20 care coordinators into this space. It was hoped that funding be in place over this Winter.<br><br><u>Collaborative Bank</u><br>Josh Cooper (JC) provided an update on the collaborative bank project, which is a project that has been running for 18 months aiming to set up a collaborative Bank of resource to increase the agility and the resilience of the general practice workforce by enabling staff to move between organisations for one off, or short term work. | |

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| | One Care work with a company called Rialto to help facilitate the Collaborative Bank and have developed the technology to post shifts out to the network of available staff, who can then pick up the shifts.<br><br>JC reported there had been a lot of success in setting up clinics for vaccinations and Covid clinics. One Care has received feedback from practices to understand how they could be involved. One Care has now committed to recruit an additional 10 staff; which in turn has led to significantly more interest; noting there are 9 practices who are using this. In addition to this JC reported, there are 36 staff that they put forward under the role types; with One Care looking to recruit those additional staff.<br><br>Questions / Comments Received:<br>➢ SMc mentioned, with regard to action card development for practices; particularly in Opel levels four or five; it needs to be further worked up; noting this was becoming increasingly important. There is evidence that some practices are grappling to manage this independently, when they are reaching this level of escalation, trying to implement actions themselves, rather than working through a structured process where actions have already been agreed as appropriate. SMc advised she would be keen to get involved, by way of a support mechanism already in place for practices to follow.<br>➢ Mona Thacker (MT) asked whether optometrists could also be included in the Collaborative Bank list, as they also can ease the pressure from primary care in terms of dealing with it in practice. - JC agreed and would be happy to have a further conversation offline in this regard.<br><br>AM thanked JHo and JC on a helpful update.<br><br>**The Committee received and noted the update on Winter Planning GPCB UCN, GPAS & Collaborative Bank.** | |
| 12 | **Supplementary Services**<br>Geeta Iyer (GI) advised that Supplementary Services (SS) was coming back through the Committee by way of an update, as opposed to a highlight report. There is a slide deck to support this item, which had previously been shared with the Committee members.<br><br>GI provided the background, and mentioned this is a local service with our general practices. It started in 2016 under a 5-year contract, as a result of the PMS review and was a way of reinvesting the money into general practice, to deliver a basket of services that are considered to be non-core activity. GI explained we are now undertaking the review, and asked Committee to note the progress and revisions to the timelines.<br>To note, that we want to address the differential payments around the current funding arrangements, understand equity and the access of the services for our population needs. GI explained that as part of the review process, a template had been developed to record activity levels. There had been a focussed data collection period earlier in the year of two months, for which data is continuing to be collected around that data activity levels and analysed.<br><br>GI explained this information has been given back to practices, so they can look at their own data and we are linking back with our practices around certain variations in some of the activity, which we are not sure whether it is due to coding, or whether it is reflecting actual demand from that population. Based on the activity that has come through with the data collection period, there had also been work on some initial costings of that activity, which has shown that there could be some room in the budget | |

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| | to think about how we allocate resources a little bit differently, based on some of those factors. This is called the Delphi process.<br><br>GI advised the SS document has also been shared with the LMC and the General Practice Collaborative Board (GPCB), to talk about the progress that has been made, and discussion to ensure the data is robust and the calculations are tested a bit wider and also making sure that we do still adhere to the principles. GI went through the detailed next steps, and mentioned there was further work to complete on activity and costings, to further develop the funding options on this basis, and then refresh the specification as well. The timeline is shared in the slide deck.<br><br>AM thanked GI for the work that has gone into this item and mentioned this had been to the Primary Care Committee on several occasion. AM described some of the issues, in terms of feedback from GPCB feedback from LMC; recognising there were strong issues and concerns that this is on track to deliver for April 2024, albeit in a transition phase.<br><br><u>Questions / Comments Raised:</u><br>➢ KB raised a concern around the inaccuracy of the calculations in the slides. KB suggested to GI to look at the supplier of supplementary services payment v costed activity. KB also expressed her surprise that the slides have been presented to the Committee with very inaccurate costings; noting there is a shortfall of £55M, and GPs are strongly disagreeing with this calculation and massively under representation.<br><br>A further discussion took place around the concern of staff costings and overhead time in terms of buildings.<br><br>GI responded and took on board the comments raised by KB and also understood the concerns raised at GPCB and mentioned this was why we have committed to doing a lot more work around the costings, and to be really clear about being absolutely transparent in in this review. GI mentioned she wanted to share where we are and have that direct challenge back. GI mentioned there is something around sharing this across, as well with those when we test it wider with different practice managers and we are getting some of those differences coming through.<br><br>AM mentioned there was a request from GPCB not to use or share the slides wider, in what they consider contain inappropriate costings. AM felt there was quite a gap between where SS are now, compared to where we need it to be in April 2024, because the decision around costing has to happen. It was recognised there was still more work to do. It will come back to PCC in November 2023, prior to being presented at the ICB Board in January 2024. AM mentioned there was confidence received by GI, to have this on track for delivery in April 2024. AM thanked GI and reiterated there would be further conversations required offline with GPCB, LMC and other colleagues and stakeholders.<br><br>**The Committee noted the contents and update of the report and the work ongoing to support supplementary services and will await next steps.** | |
| 13 | **Primary Care Contracts, Performance, Quality and Resilience Report**<br><br>The Green Valleys Health CQC rating was noted and welcomed by Committee. | |

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| | AM thanked MR and SMc for the detailed report and took this opportunity to compliment Green Valleys Health which showed good improvement. DJ had personally written to the practice to give his thanks and congratulations to them.<br><br>**Action** - DJ to send an addendum to Dr Jon Evans, as senior partner, to note the Committees' gratitude for their effort.<br><br>**The Committee noted the contents of the Primary Care Contracts, Performance, Quality and Resilience Report, including the key decisions and information from PCOG.** | **DJ** |
| 14 | **Primary Care Finance Report**<br>AM noted she would like the Primary Care Finance Report to appear earlier on the agenda for future Committee meetings, to allow the correct amount of time that was required for discussion. The Committee agreed.<br><br>Jamie Denton (JD) highlighted the key points from the report; notably:-<br><br>➢ Since the ICB last reported the financial position to the PCC, it has significantly deteriorated. The key driver for that is the cost of prescribing products, particularly the medicine management area is overspent year to date by £1.3 million and then as a collective, the total general practice area is overspent by £5.2 million for the financial year and again the key driver being prescribing products.<br>➢ JD explained the first table essentially groups the products by BNF track chapter which is British national formulary and across that, we compare Q1 from last financial year to Q1 this financial year, recognising the cost of products has increased.<br>➢ JD highlighted a point to note from the data, in general terms, the overall numbers of products being prescribed has reduced, however it is the price increase which has caused the cost pressure.<br>➢ In terms of the PCC responsibility for managing this risk, JD noted it was about maximizing the opportunity to mitigate this risk, with the challenge being so high, we would not expect to own this risk within isolation; recognising the wider portfolio of the ICB, is reporting a balanced financial position and that does not include this overspend. JD reported that over time, the ICB are hoping to have some further improvement on the overall financial position for month 6, with plans in place to offset this pressure, and to close some of the gap.<br><br><u>Questions / Comments Raised:</u><br>➢ Richard Brown (RB) mentioned the drug tariff is likely to continue to increase in terms of the pricing model. RB also highlighted the reimbursement from NHSE to one of his pharmacist colleagues was £20,000 less in July, than what he actually had to pay to buy those medicines from the wholesalers; noting as prices increases, there is the potential our pharmacies will not sustain these price increases and some may fold as it is not viable.<br>➢ JD mentioned, in terms of planning, the ICB have year on year, backed the increase in the cost pressures; noting there is an appropriate savings target against that, to try and challenge ourselves to achieve as much as we can against this.<br><br>JD noted the POD finances, the main headline is the ICB are reporting an underspend year to date of just under £1.8 million and then currently forecasting breakeven; recognising that the dental funding is ring fenced at a system level. | |

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| | **The Primary Care Committee noted both finance reports and have deferred the Medium-Term Finance Plan to the November meeting, due to time restraints.** | |
| 15 | **Key Messages for the ICB Board**<br>The Committee agreed the key messages for the ICB Board to be:<br>➢ Access Recovery Plan.<br>➢ The Dental Strategy Development.<br>➢ The Winter Planning Update from GPCB.<br>➢ Updating the "*closed session*" on Graham Road / Horizon Health output.<br>➢ Acknowledge and celebrate Green Valleys practice in the public domain. | |
| | **For Information** | |
| 16 | **Primary Care Operational Group (PCOG) Minutes**<br>**The Primary Care Committee noted the minutes.** | |
| 17 | **Any Other Business**<br>There was no other business to note. | |
| | **Date of Next Meeting**<br>Tuesday 21st November 2023, at 9.00am, via Microsoft Teams. | |

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

# BNSSG ICB Primary Care Committee Meeting

**Minutes of the meeting held on 21st November at 9.00am, held virtually via Microsoft Teams**

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## DRAFT Minutes *(Agreed by Chair and Executive only)*

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| **Present** | | |
| Alison Moon | Chair of Committee, Non-Executive Member – Primary Care | AM |
| Amanda Cheesley | Partner Non-Executive Member, Sirona Care & Health | AC |
| Ellen Donovan | Independent Non-Executive Member, BNSSG ICB | ED |
| Joanne Medhurst | Chief Medical Officer, BNSSG ICB | JM |
| Rosi Shepherd | Chief Nursing Officer, BNSSG ICB | RS |
| Sarah Truelove | Chief Finance Officer and Deputy Chief Executive, BNSSG ICB | ST |
| **Apologies** | | |
| Debbie Campbell | Chief Pharmacist, BNSSG ICB | DC |
| John Hopcroft | Vice Chair, Avon Local Optometry Committee | JH |
| David Jarrett | Chief Delivery Officer, BNSSG ICB | DJ |
| Sarah Purdy | Partner Non-Executive Member, North Bristol NHS Trust | SP |
| **In Attendance** | | |
| Georgie Bigg | Healthwatch Bristol, North Somerset and South Gloucestershire | GB |
| Katrina Boutin | GP, Old School Surgery & Medical Director of GPCB | KB |
| Jenny Bowker | Deputy Director of Primary Care, BNSSG ICB | JB |
| Richard Brown | Chief Officer, Avon Local Pharmaceutical Committee | RB |
| Loran Davison | Team Administrator, BNSSG ICB | LD |
| Jamie Denton | Head of Finance, Primary Care, Community & Children, BNSSG ICB | JD |
| Jeff Farrar | Chair of the BNSSG ICB & Independent Non-Executive Member | JF |
| Debbie Freeman | Senior Contract Manager – Primary Care, BNSSG ICB | DF |
| Katie Handford | Models of Care Development Lead, BNSSG ICB | KH |
| Bev Haworth | Deputy Head of Primary Care, BNSSG ICB | BH |
| Nikki Holmes | Head of Primary Care, Southwest, NHS England, and Improvement | NH |
| Susie McMullen | Head of Primary Care Contracts, BNSSG ICB | SMc |
| Sandra Muffett | Head of Patient Safety and Quality, BNSSG ICB | SMu |
| Alison Mundell | Community Pharmacy Clinical Lead, BNSSG ICB | AMu |
| Lisa Pottenger | Deputy Chief Pharmacist, BNSSG ICB | LPot |
| Lucy Powell | Corporate Support Officer, BNSSG ICB (Note taker) | LP |

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| Lee Salkeld | Director, Avon Local Medical Committee | LS |
| George Schofield | Avon Local Dental Committee Secretary | GS |

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| 1 | **Welcome and Apologies**<br>Alison Moon (AM) welcomed everyone to the Primary Care Committee (PCC). Apologies were noted as above.<br><br>AM highlighted Dave Jarrett's new role as Chief Delivery Officer which combined performance and delivery, and primary and integrated care. AM noted that although the role had changed, David's input and responsibilities in terms of PCC remained. | |
| 2 | **Declarations of Interest**<br>There were no new declarations of interest and no declarations pertinent to the agenda. | |
| 3 | **Minutes of the previous meeting held on 26th September 2023**<br>The minutes were agreed as a correct record. | |
| 4 | **Review of Action Log**<br>The Committee reviewed the action log:<br>**Action 53 –** Nikki Holmes (NH) confirmed the action had been shared with the dental team and changes had been made to the report. Further discussions would be had at the appropriate working group. Jenny Bowker (JB) confirmed that the Primary Care Operational Group (PCOG) had provided feedback on the amendments the ICB would like to see in the report. The new report template would be tested and amended as needed. It was agreed that the template would be reviewed at the next meeting and this should include the regional comparisons requested.<br>**Action 66 –** JB explained that the child friendly practice pilot had stopped and was being evaluated nationally. The learning from this would be incorporated into local services. NH and JB agreed to further discuss dental services for children and provide an update at the next meeting. AM noted the importance that actions were closed promptly or updates provided, noting this had been open for some months and it was important not to lose sight of the desired outcome with regards to children. Joanne Medhurst (JM) noted the importance that colleagues were prompted to complete their actions and suggested that a paper around dental services for children be presented to the next meeting. Amanda Cheesley (AC) asked that this specifically included consideration of children with learning disabilities. George Schofield (GS) noted that many dental practices had not known that the pilot existed and so there needed to consideration on how initiatives were communicated. AM asked that the paper include reflection on the learning from the national evaluation and how dental practices could be supported to be child friendly.<br>**Action 69 –** JB confirmed the risks related to Pharmacy, Optometry and Dentistry (POD) had been added to the risk register, this included a significant | **NH/JB**<br><br>**NH/JB** |

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| | number of dental risks. The risk register would continue to evolve and progress. The action was closed.<br>**Action 74 –** AM asked for confirmation that the Delegation Transition Closure Plan had been added to the forward planner. This was confirmed and the action was closed.<br>**Action 75 –** AM noted that the action had been closed without an update. JB confirmed Dave Jarrett had spoken to Steve Sylvester about recruitment and vacancies. The action was confirmed closed.<br>All other due actions were closed. | |
| 5 | **Primary Care Risk Register**<br>JB explained that work to include the South West regional dental risks on the ICB risk register had taken place. All the common headings had been copied across and although not all the fields had mapped, the important information was included. The pharmacy risks would be included in the next iteration of the register. There had also been a detailed review of general practice risks and these would also be included for the next meeting. JB noted that work had also taken place to ensure risks were time specific and clear on the actions and explained that some of the broader risks would be closed and more specific risks would be opened. JB highlighted that this was an evolving progress.<br><br>JB highlighted that the capacity of the Hub remained a significant risk. Recruitment for the Hub was underway but until staff were recruited and trained the risk would remain high.<br><br>Ellen Donovan (ED) noted the Hub capacity risk and asked what the short and medium term implications of this lack of capacity were. JB confirmed that the Hub had been asked to focus on specific priorities which included contract processes. The 7 ICBs needed to be clear on what these priorities were and a group had been established to consider these regularly. ED asked whether the lack of capacity created a risk for patients. JB noted that the risk related to the ability of the Hub to deliver what was required. Sarah Truelove (ST) explained that there was also a risk around the potential impact on ICB teams who may have to undertake the work. ST noted that this was significant as the ICB was going through organisational change to reduce running costs and the current resource to support the Hub may not be available in the future. ST noted that the lack of capacity in the Hub was creating additional pressures within the ICB teams.<br><br>GS noted that dentistry practices were private businesses and at risk of bankruptcy with the current contract models. GS highlighted this as a significant risk for the ICB and patients and noted the importance that dental practices were supported before crisis. AM noted that this had been the approach applied to | |

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| | primary medical services, where metrics and trigger points were considered to support general practice.<br><br>AM explained that the role of the Committee was to gain assurance and understanding of the mitigations and how they will lessen any impact. AM noted that the wording of the risk needed to be considered to ensure that the risk rather than the issue was described.<br><br>Jamie Denton (JD) noted the significant clawback from practices anticipated for 2023/24 and suggested that this risk be added to the risk register with the mitigation of contact review to rebase contracts at an appropriate level. NH confirmed that this work was part of the mid-year review and would be considered at the meeting to discuss prioritisation of work for the Hub.<br><br>JM noted the importance that risks were considered against quality outcomes, clinical outcomes and finance and where risks affected particular areas the lead directors were informed so that risks could be described adequately. JM agreed to convene a meeting of relevant people to review the risks and describe them and assign owners. AM noted that DJ was the lead executive for the PCC and would work with fellow executives and report back the Committee.<br><br>Georgie Bigg (GB) noted the importance of having good quality services in place and also the importance of public understanding. GB explained that the public did not understand why there were difficulties in accessing dental services or why pharmacies were closing and there was work for the ICB to issue targeted communications to aid public understanding. GS noted that the quality of dental services had not been measured and explained that the dental contracting was difficult for dentists to understand. GS also cautioned against rebasing contracts as the dental practice will have bought the equipment needed for all appointments including do not attends and this was the funding which would be removed through the clawback. GS suggested there needed to be a more flexible approach. NH confirmed that quality assurance processes were in place for dental services. JF agreed to raise the challenge around dental quality assurance with Shane Devlin.<br><br>AM noted the importance that the risk register was dynamic, and up to date to support the work of the ICB rather than a document used purely for assurance. AM welcomed the action to triangulate the risks at executive level.<br><br>ED noted the retirement of the Corporate Secretary and asked whether this had affected the coordination of risk registers between the ICB Board and Committees. ST explained that each directorate maintained a risk register which fed into the Corporate Risk Register on a monthly basis. ST agreed to discuss | **DJ**<br><br>**DJ**<br><br>**JF** |

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| | this further with Rob Hayday, Chief of Staff, particularly around Committee registers. Rosi Shepherd (RS) confirmed that the risks arising from the Outcomes, Performance and Quality Committee were included on the Chief Nurse Office and Chief Medical Office risk registers. RS agreed to share this with ED at their next 1:1 meeting.<br><br>**The Primary Care Committee received and discussed the Risk Register** | **ST**<br><br>**RS** |
| 6 | **Primary Care Operational Group (PCOG)**<br>JB noted that there were 2 months of reporting to bring to the attention of the Committee.<br>**October Decision Log Report**<br>At the October PCOG meeting, 3 decisions were made.<br>• Finance Report – The recurrent savings plan for 250k was approved. The savings were identified from planning differences in the Locally Enhanced Service (LES) budgets which meant there was no material impact on general practice budgets.<br>• Emergency Services – PCOG approved discontinuation of the Community Pharmacist Emergency Services LES as there was now a national option providing the service. PCOG requested that the funding was reinvested into other community pharmacy services.<br>• Health Inequality Winter Pilots - PCOG supported the health inequality winter pilot proposal for dental services for the homeless population which would be included in wider work around the contract variation for homeless health services.<br><br>**November Decision Log Report**<br>At the November PCOG meeting, 3 decisions were made.<br>• Inclisiran – Following a national reduction in funding for Inclisiran administration in general practice from £10 to £5, which had been challenged nationally, PCOG approved the introduction of a LES which provided practices with an additional £5 for each administration. This LES is to be place for 12 months whilst national negotiations take place.<br>• Merger approval – PCOG approved a contract merger between Crest and Merrywood practice.<br>• Dental Stabilisation Pilots - PCOG supported the extension into 2024/25 of the Dental Stabilisation Pilot whilst evaluation of the scheme is underway. The evaluation would inform the development of a long term offer and review access to this and spread of the offer across BNSSG.<br><br>AM asked whether the evaluation of the dental stabilisation pilots evaluated all the right elements. JB confirmed that activity and cost effectiveness would be reviewed but the ICB needed to check that patient experience was also part of the evaluation or whether this needed to be embedded as part of future plans. | |

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| | **The Primary Care Committee received and noted the update on the decisions made by PCOG** | |
| 7 | **Primary Medical Services Report**<br>Susie McMullen (SMc) introduced the joint report from across the ICB primary care teams. SMc highlighted the Crest and Merrywood practice merger, noting that these were two practices who shared a building who had asked to merge to form the new Downtown Road Surgery. The application had been strong with good patient and staff engagement. SMc noted that both practices were stable and had requested the merger to future proof services. There would be no change to patient access and no loss of coverage. There was a small financial cost to the application related to the merging of EMIS records, the ICB had funding available for this.<br><br>SMc welcomed the merger and explained that the ICB would support practices who wanted to merge to support future services. The ICB, One Care and the Local Medical Committee (LMC) have taken a proactive approach to mergers and developed tools and support for GP Practices who may want to merge. The ICB has contacted a small number of single and two handed partners asking if merging was something they wanted to consider.<br><br>Graham Road and Horizon Health Centre GP Practices had been inspected by CQC on the 20th September 2023 to review progress on the warnings issued in May 2023. The ICB was awaiting the formal outcomes of the inspection. CQC have confirmed that both practices would be re-inspected for ratings within 6 months of the 1st September 2023.<br><br>PCOG had welcomed the patient care and safety report particularly the “you said, we did” section. This report and the medicines optimisation report which had also been considered by PCOG, were included in the appendices.<br><br>Sandra Muffett (SMu) explained that two other GP practice ratings had been published with one receiving ‘good’ and the other receiving ‘requires improvement’. The ICB was working with the practice requiring improvement to review the concerns raised and improve the rating.<br><br>SMu assured the Committee that the learning from incidents was being reviewed through the learning forum which was attended by most of the partner organisations and facilitated system learning. RS highlighted the ‘good’ rating for Green Valleys and commended the work of the practice and CCG/ICB teams to get to this position. RS also welcomed the improvement seen at Graham Road and noted the importance that this was sustained. | |

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| | ED highlighted the CQC inspection ratings for GP Practices and the strong performance of practices. RS explained that this was one area of performance, and the ratings were triangulated with quality and other primary care dashboards. RS noted that when the data indicated that there were challenges the Access, Resilience and Quality (ARQ) programme team would work with the practice to support improvements.<br><br>Lee Salkeld (LS) noted the strong general practice within BNSSG which was staffed better than other areas in the country. LS praised the work of the ARQ programme and the medicines optimisation team. Both teams provided significant support to practices. LS welcomed the early support from the ARQ programme and the long term support which helped practices improve. Katrina Boutin (KB) noted that morale was currently low in general practice due to issues within navigation teams, verbal abuse from patients and high levels of staff leaving, particularly frontline staff. KB asked the ICB to consider how to communicate praise to practices. ST noted the recent planning work with the GP Collaborative Board (GPCB) where the ICB had communicated the positives and the strong delivery in primary care. ST confirmed that the ICB would reflect on how to communicate these messages to primary care as a whole.<br><br>GB noted that GP Practices were encouraging patients to provide feedback and acting on this which was reflective of the different approach being taken which was welcome. GB noted the medicines optimisation report and asked what was meant by harm, the impact on this for patients and how this was managed in terms of patient experience. SM confirmed that the references to harm were minor incidents as an event which resulted in significant harm would be explicitly explained. GB asked whether there was an education element to medication to support patients to look after themselves. AM asked how the Committee could be assured that these incidents have been managed and patients have been contacted. RS agreed to review this and noted that many of the primary care incidents reported on Datix were around issues happening in secondary care and so there was a piece of work needed to review this.<br><br>ST highlighted the low number of medication and patient safety events and asked how the ICB was encouraging practices to report near misses. RS explained that the ICB provided a good advice and guidance service to GP Practices which may reduce the numbers but agreed to review and provide an update at the next meeting.<br><br>Alison Mundell (AMu) explained that the medicines optimisation team reviewed the themes from Datix and worked with the communications team to send messaging to patients and GPs. AMu confirmed that individual patients would be contacted where appropriate. AMu noted that where there were high numbers of | **RS/ SMu**<br><br>**RS/ SMu** |

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| | similar incidents, working groups had been set up to review themes in more detail. It was important that the ICB was committed to an open culture which supported people to report.<br><br>AM noted that the last CQC inspections were a long time ago for some practices and welcomed the proactive work of the ICB in the absence of third party assurance. SMc noted the work of the ICB to support practices to be CQC ready particularly those not inspected since 2016/17. LS noted that the style of inspection was very different now and driven by data and clinical systems. LS noted the importance of the ongoing monitoring and continued communication between the LMC, GPCB, ARQ programme and practices. SMc noted that the ICB reviewed multiple data streams including soft intel about practices which had indicated a high turnover in reception staff as described by KB.<br><br>ED asked whether the CQC inspection ratings were reflective of the system. SMc confirmed that high risk issues would be reflected in the rating given by the CQC, but this was only one small area of data reviewed by the ICB. The ICB considered staff turnover, patient experience, and various datasets.<br><br>AM highlighted the ARQ programme and asked what could the ICB do for practices who declined the offer of help. AM also asked about the normal pattern of incident reporting for primary care, with more incidents being reported from other providers than primary care itself. Did the ICB want primary care to report on itself more. RS confirmed that where a practice was reluctant to engage with support, the ICB would encourage them and ask other partners to do the same. RS noted that this would depend on the situation and where there was a patient safety risk, escalation processes would take place. RS confirmed that primary care raised incidents internally and reviewed these through their own robust governance routes and noted that it was difficult for the ICB to identify themes across primary care.<br><br>Richard Brown (RB) explained that community pharmacy also managed incidents through robust internal governance processes. RB noted that the number of medication errors outlined in the report was wrong, there would be more and the majority of these would be rectified with no resulting harm. RB highlighted that that the Committee needed to review the incident reporting whilst understanding that the report did not reflect the full picture.<br><br>SMu highlighted the Patient Safety Strategy and how this would work in primary care. SMu confirmed that the ICB would be reviewing the culture of incident reporting following the implementation of a new reporting system. The ICB would be engaging with primary care colleagues to ask what primary care needs from the reporting so that it can be of use to both primary care and the system. RS | **RS**/ |

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| | suggested that a report on the Patient Safety Strategy be presented to the next Committee meeting particularly the impact on primary care. This would support understanding of the ask as well as the process to manage this. RS noted that the COVID harm reviews had indicated that the time spent on reporting was disproportionate to the time spent on improvement activities and so the balance needed to be considered. It was important that reporting did not place an unreasonable burden on primary care colleagues.<br><br>**The Primary Care Committee noted the key decisions and information from PCOG** | **SMu** |
| 8 | **Primary Care Finance report**<br>JD reported an overspend of £253k for primary care medical (delegated), this was attributable to slower population growth than plan resulting in a benefit of £228k and a section 96 application which represented an overspend of £420k.<br><br>JD reported an underspend of 193k for Core Primary Care Services, this was attributable to an underspend of £125k in LES activity and an £88k underspend for the system Clinical Assessment Service (CAS) due to workforce shortages.<br><br>JD reported an overspend of £1.7m for medicines management which was attributable to the cost of prescribing products. This had been reviewed and there was no single driver of these cost increases.<br><br>ST explained that JD was reporting the position at month 6, and this position was likely to change following additional funding to reflect the impact of the industrial action but also the national prescribing inflation issue. ST noted that the inflation issue was recurrent and so remained a risk for the system. It was noted that the ICB medicines optimisation team benchmarked well at maintaining costs at a reasonable level but the inflation issue was being negotiated nationally.<br><br>ED asked about the implication for patients of the underspend within the CAS. LS explained that a proportion of NHS 111 calls would be put through to the CAS, which provided a higher level of clinical oversight and therefore it was less likely that the patient would be advised to attend A&E. ED asked whether the implications of the underspend would have an impact on delivery of the operational plan and AM noted the reduced activity of the phlebotomy LES and asked whether there was an impact on other services if less blood tests were being undertaken in general practice. JD explained that the activity for phlebotomy had been assumed from the anticipated achievable capacity from general practice and this may need review. LS noted that the lower activity may be a coding issue. AC highlighted a significant increase in referrals from primary care to community care for routine blood testing and so there might be an impact on Sirona related to the lower phlebotomy activity. AC noted that the CAS had | |

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| | been successful in reducing A&E attendance and so the staff shortages were likely to have an impact on the system.<br><br>JB agreed to raise phlebotomy activity with the LES steering group to include coding and the impact on the wider system. JB also agreed to feedback on the CAS with the urgent care teams, particularly on the impact and any mitigations in place. ED noted a wider question around oversight of these programmes. It was noted that this was for the executive team to discuss.<br><br>JD reported an underspend of £2.3m for POD services. The pharmacy position reported breakeven due to lower than budget prescribing fees and advanced services and higher than expected patient income and essential service charges. National negotiation continued and current guidance advised reporting a breakeven position until the negotiations had finalised.<br><br>Optometry was reporting a £396k underspend. Any sight test overspend was offset by a reserve budget for optometry. The national allocation was being reviewed with the potential rebalancing of the allocation. This was expected to be delayed to 2024/25.<br><br>Dentistry reported a £2.1m underspend which was attributable to contract hand backs and underperformance of activity. Dental funding continued to be ringfenced at a system level and the system would continue to pursue all investments within the dental system.<br><br>AM asked whether the system was exploring all opportunities for the underspend. JD confirmed that the system was exploring all options for investment into dentistry. AM noted that following a meeting with the Local Optical Committee, the ophthalmology waiting list had been highlighted as had the need to undertake low and high risk work in the right services. AM asked whether these types of opportunities had been considered. JD agreed to review and provide an update at the next meeting.<br><br>GS asked for clarity on the ringfenced funding for dentistry services. ST confirmed that the money ringfenced for dental services would be utilised for dental services and not to reduce the impact of industrial action. JF noted the importance that the centralised clawback funding was used to support dental services and ED asked what opportunities were available to the ICB to utilise the £2.1m underspend for dental. ST suggested that the Committee undertook a deep dive into the national dental contract and the flexibility for the ICB as the services were delegated within the framework of the national contract. JB agreed and explained that the focus was on how the ICB could commit and invest going forward. JB noted that the stabilisation pilot had been opened up to all dental | **JB**<br>**JB**<br><br>**JD**<br><br>**DJ** |

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| | practices and take up was low so there was more work for the ICB to do in terms of engagement and developing the right package and this was being explored. GS explained that there was an issue with the UDA rate which was lower than the national average and suggested raising this to support practices. JB noted that there were some considerations around activity as uplifting UDAs is a loss in patient activity. Thos needs balancing against future dental practice resilience.<br><br>**The Primary Care Committee:**<br>• **Noted the summary financial plan**<br>• **Noted the key risks and mitigations to delivering the financial plan**<br>• **Noted that at month 6 (September), combined Primary Care budgets were reporting an overspend of £1.755m year to date, and a forecast overspend of £5.938m (including retrospective and reimbursable funding)**<br>• **Noted the decision to implement the savings plan presented to PCOG in September**<br>• **Noted that at month 6 (September), combined POD service budgets were reporting an underspend of £2.345m year to date, and a forecast of £2.128m underspent** | |
| 9 | **Delegation of POD Services**<br>JB confirmed a transition close down report was in development and this would be presented to the Committee in January 2024.<br><br>JB highlighted the results of the survey answered by primary and secondary care dentists which had been developed to support the development of the Dental Strategy. JB explained that the survey had indicated that there were significant concerns regarding the resilience of dental practices and many dentists had indicated that they would not want to work for the NHS in 2 years. JB highlighted that the survey showed that dentists would value being networked with other providers within the system particularly within Primary Care Networks. The survey had also indicated the populations which were not currently accessing dentistry services, this included those with a dental phobia, looked after children and migrant populations. JB welcomed the information which would be used to develop the dental strategy.<br><br>JB highlighted that areas of prioritisation were; access to services, flexible commissioning and oral health promotion. It was noted that the ICB was unable to prioritise everything that needed to be done and initial work needed to take place to support flexible commissioning to support access and practice resilience.<br><br>AM highlighted the survey results as a good baseline for dental services. AM asked why there had been no response from Woodspring. JB explained that the | |

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| | ICB did not know enough to understand why there had been a good response from Bristol and low response from North Somerset and this would be reviewed.<br><br>GS was unsurprised by the results of the survey and noted that there were high levels of stress and depression in dentists. GS explained that the contracting mechanism was an issue.<br><br>JB confirmed a workshop had taken place to agree next steps and a dental steering group would be arranged to support access and oral health promotion and a regional group would be convened to develop a commonality of approach. JB explained that local authority leads would be involved in the conversations regarding oral health promotion.<br><br>ED noted the specific comment in the questionnaire responses around referral forms and asked how the ICB could support to make administrative tasks easier. JB confirmed all systems had agreed funding to support digital referrals for practices and a report and procurement proposal was being developed.<br><br>AM noted the importance that the ICB identified some areas of quick improvement and fed back to those who undertook the survey to show that progress was being made.<br><br>JB noted the overview in the paper of the flexible dental commissioning guidance and explained that this would be included within the overview of dental contracting at the next meeting. The St Pauls dental contract had been approved by the ICB Board, the contract award published and the 30 day formal challenge period would end on the 9th December 2024. Fortnightly mobilisation meetings have been arranged with the provider. The ICB has met with the local community Dental Action Group and communications for the public were being developed to support mobilisation and the opening of the dental practice.<br><br>NH noted that those optometrists who had not responded promptly to the Quality in Optometry (QiO) toolkit had been asked to respond quicker this cycle and the information received would inform the visiting approach for 2024/25.<br><br>**The Primary Care Committee received and noted the update on POD Services, the Dental Strategy Development** | |
| 10 | **Monthly Primary Care Activity Report**<br>This was discussed as part of item 9. | |
| 11 | **System Access Improvement Plan**<br>Bev Haworth (BH) explained that the comments and feedback from PCC had been incorporated into the System Access Improvement Plan which had been approved by the ICB Board. A further report would be presented to the ICB | |

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| | Board in March which would include the work to date. There was a significant amount of work to do and BH noted the importance that this was linked with practice resilience. A monthly highlight report would be presented to PCC.<br><br>**The Primary Care Committee received and noted the update on the System Access Improvement Plan** | |
| 12 | **Operational Plan Update and Joint Forward Plan Refresh**<br>BH explained that the operational guidance was expected in December 2023. The ICB had been proactive in terms of planning and events arranged. The first took place in October 2023 to review quarter 1 activity, workforce, health inequalities and the green plan. The second took place in November 2023 and reviewed quarters 1 and 2 as well as a focus on the refresh of the joint forward plan and assurance on the review approach. The event was structured as per the 4 Health and Care Improvement Groups (HCIGs) and was an opportunity to discuss successes and challenges with the system. BH highlighted that primary care colleagues were starting to drive the change with other system partners.<br><br>BH explained that the Joint Forward Plan would be updated annually with the focus on the deliverables and metrics and aligning the plan with the ICS Strategies 4 aims and 9 strategic commitments as well as the outcomes system framework. BH explained that the current deliverables remained relevant but there was work ongoing to refine these to the priority areas of workload, workforce and estates.<br><br>AM noted the variation between GP practices and asked whether the next iteration of the report could include these variances particularly around health inequalities. BH confirmed that the System Access Improvement Plan work had developed a heat map which outlined variance and also supported the discussions around anonymising practices. BH confirmed that this would be a part of the 6 month review taking place in December/January and would be included in the next report coming to the committee in March.<br><br>ST highlighted the positive planning work in primary care. Primary care was better represented in the system risk discussions which was an important development. POD had also been included and this was an important part of the transformation picture which was being developed. BH noted that the key risks had been highlighted as part of the planning days.<br><br>**The Primary Care Committee received and noted the Operational Plan update and Joint Forward Plan update** | **DJ/BH** |
| 13 | **Key Messages for the ICB Board**<br>AM noted that the ICB was starting to lead and influence system connections and decisions and welcomed the valuable contributions made by the Committee | |

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| | members. The Committee had discussed some significant challenges but also some successes. AM noted that many of the discussions could be a key message for the ICB Board and agreed to reflect on how to communicate this meeting as part of the ICB Board Primary Care Committee update. AM asked that any comments be sent to her via email. | **All** |
| | **For Information** | |
| 14 | **Primary Care Operational Group (PCOG) Minutes**<br>**The Primary Care Committee noted the minutes.** | |
| 15 | **Any Other Business**<br>The Committee were reminded that ED would be Chairing the January 2024 meeting. | |
| | **Date of Next Meeting**<br>Tuesday 23rd January 2023, at 9.00am, via Microsoft Teams. | |