NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Meeting of BNSSG ICB Board

Date: Thursday 7th March 2024
Time: 9.30am-11.30am
Location: MS Teams

Agenda Number :	6.3
Title:	Recommendation for Allocating Funding to General Practice: Supplementary Services Review

Confidential Papers

Commercially Sensitive	No
Legally Sensitive	No
Contains Patient Identifiable data	No
Financially Sensitive	No
Time Sensitive – not for public release at this time	No
Other (Please state)	No

Purpose: Decision

Key Points for Decision:

The Board is asked to note the conclusion of the supplementary services review. The Board is asked to:

- endorse the proposal for allocating funding to Practices by employing a weighted Population option derived from the Cambridge Multimorbidity Score Index
- consider the impact on practice resilience
- approve the revised service specification.

Recommendations:	To approve the following: • the revised specification for introduction from 2024/2025 • allocate funding to Practices across BNSSG by employing a weighted Population option derived from the Cambridge Multimorbidity Score Index • Offer a 3-year phased transition period of funding to support practice resilience during this period. • Offer a 3 + 2 year contract to practices to enable planning over the short-medium term
Previously Considered By and feedback:	The recommendation underwent scrutiny at the Supplementary Service Steering and Reference Groups, GPCB as well as PCOG and PCC and the Population Health Management Steering Group. It was additionally reviewed at the ICB Executive Team meeting. Feedback and associated risks are detailed in the risk section of the document.

	Overall, the diverse groups expressed that while this option best addressed population needs fairly, some reservations were noted. Nevertheless, there was a broad consensus among the groups for the recommendation to be presented to the Board for final decision. The Primary Care Committee suggested further areas to provide full assurance to the Board in making the decision and these have been incorporated into the paper. These were to incorporate more of the historical context in relation to the PMS review and wider primary care investment, set out the rationale for recommending the Cambridge Multi-Morbidity Score as the preferred funding formula earlier in the paper, clarify where the decision was made not to consider levelling up as an approach, ensure the Equality Impact Assessment presented to the Board reflects any potential adverse impacts as a result of redistribution as well as to reflect the risks to other providers should general practice not continue to provide these services.
Management of Declared Interest:	All practice representatives involved in the review have a Conflict of Interest. These have been declared. Practice representatives from Bristol, South Gloucestershire and North Somerset have been engaged in the review to ensure balance and the LMC has been engaged throughout. The Steering Group has also involved HealthWatch and Local Authority representatives to ensure independent challenge. Decision-making by the ICB Board ensures separation from those impacted.
Risk and Assurance:	Changes to funding could affect the resilience of practices and might prompt them to discontinue services, leading to unintended consequences for patients and the system. This comes at a time when there is significant uncertainty for practices with the future of the GP contract and PCN DES arrangements. There is a risk of tension in BNSSG Practice areas due to shifts in funding streams, which could strain relationships between the ICB and practices, and among practices themselves. To mitigate the impact a 3-year phasing of the new financial allocation is proposed. The risk assessment is set out in full within the body of the paper and a practice impact assessment is set out in the Closed paper to the Board.
Financial / Resource Implications:	See finance section – The total budget is currently within its limits, with an additional £164,000 of uplift in 23/24 being added to the overall fund. This brings the overall pot to £9.328 million. Allocation of funding is broken down into existing payments to practices and payments proposed under the new funding model.

Legal, Policy and Regulatory Requirements:	Contractual notice has been served on the existing arrangements in anticipation of a new offer being introduced from April 2024.
How does this reduce Health Inequalities:	The weighted Population option, derived from the Cambridge Multimorbidity Score Index, utilises individual patient data to generate a multimorbidity weighting factor and demonstrates a strong correlation with deprivation.
How does this impact on Equality & diversity	As a component of the thorough review process, an Equality Impact Screening Assessment has been undertaken to ensure that the review thoroughly examines any potential equality impact and is detailed in the report.
Patient and Public Involvement:	The Steering Group includes HealthWatch membership, who provide valuable insights and perspectives from a patient-centred viewpoint for the Supplementary Services review. These have been taken into consideration in revising the service specification.
Communications and Engagement:	Regular updates are provided to stakeholders through various channels such as the Reference Group, Forums, Practice Manager Drop-in sessions, and the GPCB, ensuring that they are well-informed. Communication is also disseminated through the GP Bulletin and a dedicated Team Net page. Further communications and engagement to be developed post ICB Board decision.
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Sponsoring Director:	David Jarrett, Director of Integrated and Primary Care

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Recommendation for Allocating Funding to General Practice: Supplementary Services Review

1. Executive Summary

BNSSG ICS is committed to:

- improving outcomes in population health and healthcare;
- tackling inequalities in outcomes, experience and access;
- enhancing productivity and value for money and
- supporting broader social and economic development for our community's one million residents.

The creation of an updated Supplementary Services Offer for BNSSG practices is aligned to the ICS aims in ensuring a consistent offer across BNSSG.

The former CCGs in BNSSG allocated £9,166,642 for Supplementary Services and the South Gloucestershire Basket as part of a 5-year PMS reinvestment agreement ending in March 2021. Bristol practices currently receive a greater £ per head for Supplementary Services compared to South Gloucestershire and North Somerset practices. Supplementary Services recognises a range of services provided by general practice not considered as part of their core contract. As this is an important part of the care our population receives, we need to review our provision of services commissioned via these agreements to address the inequality of funding and services. The project parameters from the outset of the review as approved by the CCG were that the funding was ring-fenced to general practice and that the financial envelope was fixed. This therefore necessitates a redistribution of funding. This has been part of regular communications with general practice over the past 2 years.

The aim of the review is to develop consistent, high quality, evidence based enhanced primary care which meets population needs, addresses inequity of access, improves health outcomes, and offers value for BNSSG. Underpinning this aim are the ICB principles that seeks to evaluate the outcomes of Supplementary Services and the South Gloucestershire Basket within BNSSG, enhance patient access and experience, tackle health disparities, involve stakeholders to enhance primary care in alignment with priorities, assess the impact on practice resilience, establish transparent funding agreements, gather insights from other regions, and review criteria including population needs, value, necessity, and scale.

In May 2022, a Project Steering Group was established to lead the review of Supplementary Services and formulate a revised plan for approval by the ICB Board. The Steering Group is supported by a reference group with representation from general practice stakeholders, including GPs and practice managers. Primary Care Committee has received reports throughout the two years to enable it to provide assurance of the process.

The collaborative review process with GPs, GPCB, and the LMC over the last two years investigated multiple options to devise a funding model that ensures equitable allocation for Practices and

improved accessibility to services for patients. The four key funding options considered were:

- Weighted population (Carr-Hill formula)
- Health Inequalities Index
- Weighted population based on practice Cambridge Multimorbidity Score Index
- Allocation by activity derived from a Delphi approach

The Cambridge Multimorbidity Score (CMS), was developed in 2020, based on data from UK general practice records. Patients are given a 'severity score' for each of several non-communicable illnesses e.g., diabetes, hypertension, anxiety. It predicts patient mortality, unscheduled attendance at emergency departments and primary care consultations. For the purposes of the redesign of the Supplementary Services LES, the CMS was used in a novel way to create observed and expected multimorbidity scores for individual practices. This data was then used to produce practice weightings. The weighting represents the proportion of multimorbidity in a practice population – relative to that which exists across of all BNSSG – accounting for the population distribution of individual practices. The key advantages of the CMS are that it has a strong correlation with deprivation and given the relationship between patient complexity and some of the activities in the basket it is a better triangulation of the expected work than using the purely Health Inequalities or Weighted population Carr-Hill formula.

After assessing the pros and cons of each option, the preferred option recommended to the Board by the Steering and Reference Group and supported by the January GPCB meeting is to utilise the Cambridge Multimorbidity Score (CMS) Index. Whilst there are some limitations with each of the funding options considered, this option was felt to best balance the aims of both the ICS and the review process in moving to a fairer funding allocation which recognises deprivation and complexity and seeking to mitigate the impact on practice resilience. Both the Health Inequalities formula and allocation by activity introduced greater "swings" in practice level resource allocation.

The supplementary services review also led to updates in the service specification, including integrating the basket of services and South Gloucestershire basket to avoid duplication. Specific services like Postnatal checks, Nebulising, and Pulse oximetry were removed as they're now considered core or standard practice. Common activities like processing referrals for Interventions Not Normally Funded (INNF) and those covered by other contracts or regulations were omitted. The revised specification clearly outlines the rationale, expected delivery methods, outputs, outcomes, and anticipated ICB support for each service.

Potential impacts of funding modifications include but are not limited to reduced practice resilience and possible discontinuation of services, leading to unintended consequences on the system as a whole. There is also a risk of tension within BNSSG practices due to shifts in funding streams and between practices and the ICB. It should also be noted that this comes at a time when after a period of considerable investment in Primary Care Networks there is future uncertainty over the long-term of the GP contract and about the funding to support core delivery in general practice. Individual practice statements have now been issued. At the February meeting GPCB members raised significant concerns about not adopting a levelling up approach and the wider resilience of general practice. This approach is also supported by the LMC. We have conducted financial impact analyses at practice and locality levels and are engaging with practices most at risk on alternative means of

support. The impact on each practice is detailed in the closed Board paper. To ease the pace of change a 3-year transition period has been proposed.

The recommendation to Board is that the CMS funding allocation methodology is used and that the revised specification is approved. Future consideration of measures to support practice resilience and enhance primary care should also be made to realise our ambitions and the recommendations of the Kings Fund review of making care closer to home a reality.

2. Background

The Bristol, North Somerset, and South Gloucestershire (BNSSG) CCG allocated £2.4 million towards Local Enhanced Services. Additionally, an extra £9,166,642 was earmarked for the Supplementary Services specification and the South Gloucestershire Basket, as part of a 5-year PMS reinvestment agreement that concluded on March 31st, 2021. Recognising the significant value of these schemes and the need for a comprehensive review, the Primary Care Commissioning Committee (PCCC) agreed in September 2020 to extend the timeline for the review. Consequently, practices received payments at the same rates in 2021/2022 as in 2020/2021 under these agreements.

The national PMS review was instigated in 2014. A national framework was published requiring area teams to work with CCGs to review local PMS agreements by 2016. A review of PMS expenditure was triggered as the premium nationally had reached £325 million and therefore exceeded GMS expenditure by this value. Analysis of the data nationally indicated no obvious relationship between PMS expenditure and deprivation and this is cited in the NHS gateway letter of 3rd February 2014. Area teams were therefore requested to review these premiums in order to egualise funding across GMS and PMS practices. In BNSSG this was significant as 63 of 80 practices are on PMS contracts currently in BNSSG. Key parameters were set out for the PMS review. The funding should be ringfenced to general practice and in addition should:

- Reflect joint AT/CCG strategic plans for primary care;
- Secure services or outcomes that go beyond what is expected of core general practice or improve primary care premises:
- Help reduce health inequalities;
- Give equality of opportunity to all GP practices:
- Support fairer distribution of funding at a locality level

In November 2015, the former Clinical Commissioning Groups (CCG) made the decision to utilise the PMS Premium funding for the purpose of investing in a Supplementary Services specification. The specification was developed in collaboration with the LMC (Local Medical Committee) and NHS England, and its implementation was planned over a five-year timeframe, with a review scheduled after two years.

- The allocated funding for Bristol amounts to £5,561,476.00.

- The allocated funding for South Gloucestershire amounts to £2,422,234.80 and an additional 0.16p per head was allocated to the South Gloucestershire basket pot based on a separate agreement.
- In January 2016 North Somerset Governing Body agreed to use their PMS funding to develop a Supplementary Services specification with a view to fund the continuation of non-core services. At the time it was noted that this was less than the value of the premium in both Bristol and South Gloucestershire but was noted as reflective of historic PCT investment.
- The allocated funding for North Somerset amounts to £1,140,162.00

Table of allocated funding per area

PCN	Current Funding	£ per Weighted Head
	£	%
Bristol	5,475,878	£ 10.72
North Somerset	1,140,162	£ 4.91
South Gloucestershire	2,550,606	£ 10.03
Totals	9,166,646	£ 9.19

In line with other NHS contracts, the supplementary services funding was uplifted 2.9% with an efficiency saving of 1.1% applied, totalling a 1.8% uplift on the funding available in 2023/24. This now brings the total value of the pot to £9.328 million.

In April 2022 the CCG Executive team and CCG Primary Care Committee agreed to initiate a full review of the Supplementary Services. As part of this it was confirmed that this would be within the existing financial envelope. Options of Do Nothing and terminating the agreement, continuing the roll-over of existing arrangements and conducting a full review were considered. The Primary Care Committee approved a full review of the services given the current inequity in allocation across BNSSG.

The latest PMS review aims to redistribute the payments more equally across all practices within BNSSG. One option to do this could be to level up all practice funding in line with the higher rates that Bristol practices currently receive, therefore ensuring that no practice will lose funding as part of this review. The impact of this would see an increase in funding requirements by the ICB of circa £1.7m. Financial limitations placed on the PMS review to not increase ICB financial burdens, as well as a value for money exercise undertaken which deemed that the overall pot of funding available was sufficient to cover the level of overall activity completed, resulted in this levelling up option not being considered appropriate. The Supplementary Services payment represents 4.75% of total practice funding excluding prescribing payments.The system financial challenge for 2024/2025 is a £93.1 million saving across our system partners.

Notwithstanding this, general practice is a valuable system partner and as the first point of contact for most healthcare consultations, wider ICS consideration is required to support the Kings Fund

"Making Care Closer to Home a Reality" review recommendations that nationally and at system level there is a need to strengthen commissioning of primary and community services to enhance proactive care for our population and recognise the importance of dealing with complexity and holding risk in the community. The national allocation for total Primary Care Network spend for BNSSG grew to £41 million in 2023/2024 and £3 million of service development funding was available to provide a combination of direct and at scale support to PCNs and practices for digital, resilience, PCN OD and workforce retention schemes. PCN funding is not set to grow further in 2024/2025 although further flexibility in the use of the funds has been introduced. Practices are concerned about the impact of cost inflation and this not being covered by the proposed core contractual uplifts.

Locally the ICB invested £600k into winter funding support for general practice and the ICB has ringfenced a recurrent allocation of £2million from 2024/2025 to support the development of an integrated community model of care. In addition, the ICS will need to consider support to general practice in the future, in light of increasing workload and the outcome of national contract changes to ensure we maintain resilience in primary care.

3. Project Mandate

The primary objective of this review is to develop and implement a consistent, high-quality, evidence-based enhanced primary care services that effectively meet the diverse population needs of the Bristol, North Somerset, and South Gloucestershire (BNSSG) region. Through this endeavour, we aim to address inequities in access to healthcare, improve health outcomes, and deliver value-driven healthcare services.

Project Principles and deliverables

- Clear identification of the outcomes and impacts of the Supplementary Services and South Gloucestershire Basket specification across the BNSSG system.
- Understand patient experience and access to services to inform improvement.
- Population Health Management approach - focus on achieving outcomes tailored for our population.
- Address health inequalities and deprivation in our population
- Full engagement and consultation of stakeholders across our system to identify opportunities to develop enhanced care in primary care which aligns with system priorities.
- Understand and seek to mitigate any impact on practice resilience.
- To review funding arrangements and implement transparent funding agreement.
- Transition arrangements and new specification to be achievable within the current financial envelope.
- To capture learning and best practice from other areas

Key criteria for the review to include:

- BNSSG population needs.
- Value for money.
- Need for an enhanced service.
- Scale of the services delivered.

Stakeholder Engagement

A communication plan was developed to engage stakeholders from across the healthcare system, including General Practice, patient representatives, healthcare providers, policymakers, community providers and the wider ICB system to ensure alignment of goals, priorities, and resources.

Timeline

The project review will be concluded by April 2024 with regular checkpoints and milestones to monitor progress and make necessary adjustments.

Budget

The ICB is not looking to make, and would not be realising any, savings from this review. The funding is fixed and ringfenced for general practice.

Governance

Establish a governance structure with clear roles and responsibilities to oversee the implementation and coordination of the review, ensuring accountability and transparency.

4. Governance Structure

In May 2022, a Project Steering group was established to lead and organise the review of Supplementary Services and to formulate a revised offering from 2023 for approval by the ICB Board. The Steering group, operational from June 2022, is a short-term body tasked with supervising the review of Supplementary Services throughout BNSSG in anticipation of April 2023 however due to project delays, this was extended to April 2024.

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Membership and terms of reference for the Steering Group were confirmed in June 2022, with meetings scheduled every two weeks.

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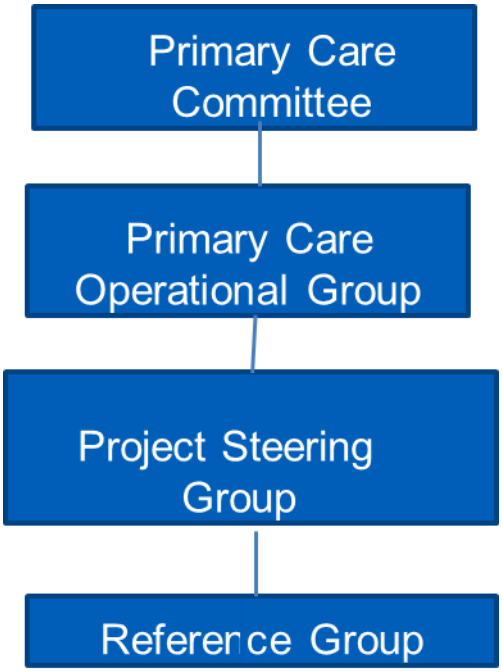
The Steering Group is complemented by a reference group, which includes broader representation from general practice, encompassing both clinical and non-clinical personnel, as well as wider primary and community care representatives as necessary.



Steering Group Membership

Name	Role
Dr Geeta Iyer (Chair)	Deputy Chief Medical Officer, Primary and Community Care
Jenny Bowker (SRO)	Deputy Director of Primary Care
Nwando Umeh (Project Lead)	Programme Manager, Supplementary Services – (Interim)
Jane Harding (Project Support)	Team Administrator (Primary Care Contracts)
Dr Jason Sarfo-Annin	Clinical Lead for Value and Population Health
Matt Barz	Financial Projects and Planning Accountant
Rebecca Kemp	General Manager, Avon LMC
Dr Shaba Nabi	Chair: Avon Local Medical Committee
Jacci Yuill	Lead Quality Manager Primary Care
Qichao Yang	BI Manager (Primary Care) & Principal BI Analyst – Contracts
Georgie Bigg	Chair of Healthwatch
Sam Hayward	Consultant in Public Health, North Somerset Council
Dr Kevin Haggerty/Robyn Clark	Locality/GPCB Rep

Reference Group Membership

Name	Role
Dr Geeta Iyer (Chair)	Deputy Chief Medical Officer, Primary and Community Care
Jenny Bowker (SRO)	Deputy Director of Primary Care
Nwando Umeh (Project Lead)	Programme Manager, Supplementary Services – (Interim)
Jane Harding (Project Support)	Team Administrator (Primary Care Contracts)
Dr Jason Sarfo-Annin	Clinical Lead for Value and Population Health
Matt Barz	Financial Projects and Planning Accountant
Dr Shaba Nabi	Chair: Avon Local Medical Committee
Dr Kevin Haggerty	Locality Rep
Robyn Clark	Locality Rep
Sarah Monteith	Locality Rep
Cara Fynn (until late 2023)	Locality Rep
Vivian Munday	Locality Rep
Dr Dougall Darvill	GP, Hartwood Healthcare
Keith Minty	One Care Rep

5. Project Milestones

- At the start of the review process, an in-depth analysis of activity data was conducted, spanning a four-year period to gain insights into service levels.
- In tandem, a Supplementary Services Return was developed and disseminated to practices, facilitating immediate access to actionable intelligence on service provision.
- 56 responses were received out of a total of 77 practices, reflecting a robust engagement rate.
- Following the responses received, a thorough examination of services not fully delivered in practices was conducted to identify systemic gaps, some of which included training needs, a pause as a result of Covid-19 and lack of equipment. Inconsistent coding practices was also highlighted as part of this exercise.
- Consequently, support was provided to practices including providing guidance through the LMC referral pathways to address identified training needs.
- It was also decided during the Steering and Reference meetings that the reported activity did not accurately represent the true level of activity occurring in general practice. Therefore, it was deemed necessary to conduct a 2-month coding exercise to obtain a more accurate depiction.
- The ICB partnered with Ardens and One Care to create a comprehensive array of reportable codes for the coding exercise. This was then shared with practices in preparation for the imminent coding exercise, ensuring readiness and consistency throughout
- A focused data coding period was initiated from January to March 2023, during which practices were provided with guidance on which codes to use. Weekly extracts of their coded activity were regularly shared with practices to facilitate their understanding of their activity levels.
- As part of the desktop review exercise, we also mapped the contents of the service specification with the needs identified in the local needs assessment and showcased this alignment and gaps during the local forum meetings.

- Population needs assessment was undertaken by Population Health Management & Joint strategic needs assessment which described which conditions are likely to have the largest impact on the health service for the population given.
- Ten conditions were prioritised based on their impact across all six localities and categorised according to identified needs. This assessment also underscored whether services were now classified as core or additional and identified any interdependencies with other providers. For example, Removal of stiches, dressings and wound check were categorised under painful conditions and some aspects of it provided by the community provider, Sirona. This exercise showed good correlation between the needs assessment and services provided within the basket and demonstrated the continued value of commissioning these services and supporting care closer to home.
- Subsequently, a Data Sharing Agreement was developed to facilitate the utilisation of specific data for various modelling purposes, with full participation from all practices, achieving a 100% sign-up rate.
- Practice data was then employed amongst other considerations of health inequalities, deprivation etc to develop, evaluate and discuss multiple options for funding allocation. These options were considered in consultation with the LMC, GPCB and the Steering and Reference Groups
- A working group comprising of clinicians from the Reference Group and LMC was established, assigned with the responsibility of conducting a comprehensive review and assessment of the service specification.
- After the review of the specification, it was decided to integrate the South Gloucestershire basket into the supplementary services basket and remove certain services that were now considered as part of the GP core contract or covered by other LESs. For the remaining services, it was decided to outline the justification for each service, its delivery approach, considering the interdependencies with other service providers. We integrated best practices observed in comparable LESs nationwide into the updated specification, customising them to suit the specific requirements of BNSSG.
- To adhere to a fundamental project principle of ensuring that the service basket offers value for money, One Care facilitated discussions on the costs associated with activities within the basket. Collaborating with the LMC and practice managers from each locality, a unified proposal was developed using assumptions that all practices performed all the activities in the basket. This demonstrated that across BNSSG, the costs of the activities would be met by the financial envelope.
- Served notice on Supplementary Services and South Glos Basket contract at the end of December 2023
- Proposals were developed to illustrate different funding allocations for practices, incorporating numerical data and potential fluctuations in gains and losses.
- The Steering Group convened in January 2024, culminating in a unanimous agreement to forward a recommendation to the General Practice Collaborative Board (GPCB) in January, to the Primary Care Committee in February and to the ICB Board in March.
- These proposals were then presented at stakeholder meetings, and feedback was solicited.
- In response to the feedback received, a practice impact statement demonstrating the financial implications of changes over a three-year transition period was distributed to practices, inviting additional feedback.
- A Quality Impact Assessment (QIA) and Equality Impact Assessment (EIA) was also developed to assess the impact of the revised specification and reallocation of funding to general practice.

- Throughout the process, stakeholders have been kept informed of project updates and milestones through various channels, including Practice Manager Drop-in sessions, GPCB, GP forums, GP Bulletin, and a dedicated Team Net webpage.

6. Service Specification

As part of the supplementary services review, updates were made to the service specification. This included integrating the basket of services and the South Gloucestershire basket, as agreed upon by the Steering and Reference groups due to the duplication of the content within the Supplementary Services specification. Furthermore, there was a consensus to exclude specific services from the basket, namely Postnatal checks, Nebulising, and Pulse oximetry as they are now considered core or standard.

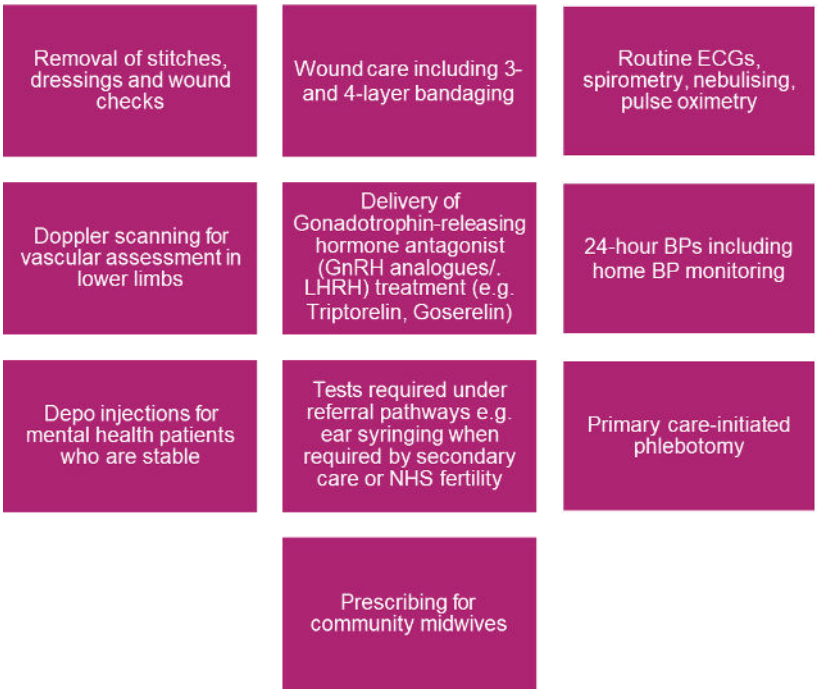
It was further decided that the service specification should omit activities in part B that are now commonplace, such as the processing of referrals for Interventions Not Normally Funded (INNF) initiated by General Practice. Additionally, practice activities covered elsewhere, either through locality partnerships, National Standard Contracts, or monitored by regulatory bodies like CQC, should be removed.

Regarding the remaining services, it was decided to clearly outline the cohort of patients, delivery methods, and criteria for service delivery. Consequently, the draft specification (see appendix) outlines the rationale, expected delivery methods, anticipated ICB support, and references such as NICE guidelines for each service.

As we do not have consistent equitable delivery of each service in the specification across practices in BNSSG, it has been decided that we will use activity as a proxy measure for outcomes.

Existing Service Specification

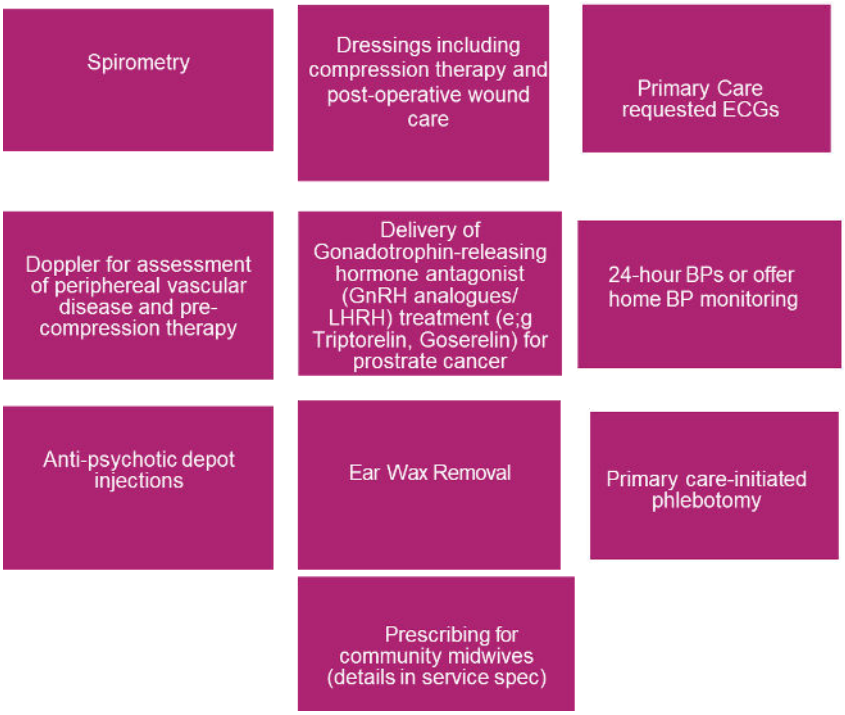
Service Specification - Part A



Service Specification - Part B

South Glos Basket at 0.16p per patient

Revised specification offer



7. Financial resource implications

Background

The allocation of resources in health care is fraught with difficulty. Population health needs vary across regions and within cities and towns – therefore allocation needs to vary to match these needs. Systematic formulas are commonly used by Governments to weave equity aims as part of the resource allocation process. Commonly used approaches include:

- Capitation
- Raw list size

- Adjusted list size – weighted for deprivation or another factor e.g. age
- Deprivation or "health inequality" weightings
- Fee for service – based on previous or predicted activity.
- Bundled payments.

For the purposes of this LES, bundled payments and fee for service were not considered as the funding allocation is capped.

Consequently, four funding allocation methodologies were developed and discussed with the Supplementary Services Steering and Reference group. These were shared using pseudonymised data to ensure that recommendations were made based on addressing the project mandate principles and assessing best fit in achieving these.

Option 1 - Weighted population (Carr-Hill formula)

This approach considers the registered number of patients in a practice and adjusts the list size based on:

1) An assessment of the drivers of workload at GP practice level based on:

   – patient age and sex, including patients from nursing and residential homes
   – additional needs of patients
   – an adjustment for list turnover

2) An adjustment for GP practices experiencing different 'unavoidable costs' for meeting the same workload using:

   – a 'Staff Market Forces Factor'
   – an assessment of the rurality of the practice

Pros

- Well established model of resource allocation

Cons

- The formula is unable to cater for the needs of atypical populations such as unavoidably small rural practices and university practices.
- The needs of some population groups, particularly very deprived populations, are inadequately reflected in the formula.
- This approach doesn't reflect the specified activity within the LES

Option 2 - Health Inequalities Index

This approach essentially considers the factors used to define deprivation. Health inequalities (HI) weighted population is from NHS England's latest publication of supporting spreadsheets for allocations 2023/24 to 2024/25.

It creates ICB normalised weighted populations for the health inequalities adjustment for the 2022/23 allocations. Uses indirectly standardised avoidable mortality rates (bespoke definition, <75 current OECD definition and some causes of death all ages based on 2016 ONS definition) 2015-2019 by MSOA.

Pros:

- Considers factors commonly referred to as the wider determinants of health

Cons:

- Uses a measure used to define a geography and applies it to individual patients.
- The link between deprivation and individual patient need isn't precise
- This approach doesn't reflect the specified activity within the LES

Option 3 - Weighted Population based on practice Cambridge Multimorbidity Score Index

The Cambridge Multimorbidity Score (CMS), was developed in 2020, based on data from UK general practice records. Patients are given a 'severity score' for each of several non-communicable illnesses e.g., diabetes, hypertension, anxiety. It predicts patient mortality, unscheduled attendance at emergency departments and primary care consultations.

For the purposes of the redesign of the Supplementary Services LES, the CMS was used in a novel way to create observed and expected multimorbidity scores for individual practices.

This data was then used to produce practice weightings. The weighting represents the proportion of multimorbidity in a practice population – relative to that which exists across of all BNSSG – accounting for the population distribution of individual practices.

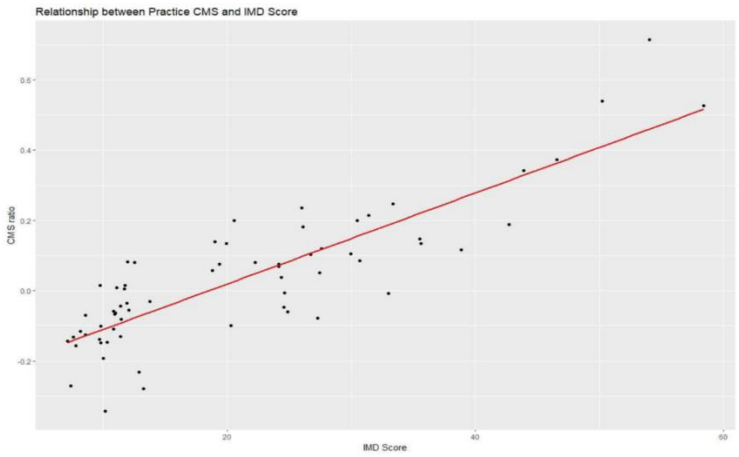
Pros

- Uses patient condition data, which is very well reported in general practice data, compared to activity data
- Patient data is used to create a practice-level multimorbidity weighting factor
- Appears to correlate strongly with deprivation
- Given the relationship between patient complexity and some of the activities in the basket it is a better triangulation of the expected work than using the purely Health Inequalities or Weighted population Carr-Hill formula.

Cons

- The practice weightings were created using data from practice population aged 20 and over and applied to the entire list size. The CMS doesn't consider multimorbidity in children
- Formal validation of the CMS using SNOMED CT codes hasn't yet been performed.
- Requires the disclosure, from all practices, of individual patient data
- This approach doesn't directly reflect the activity required within the LES

CMS and IMD (unadjusted)



$R^2 = 0.7255$, p value = 2.2e-1

Option 4 - Allocation by activity also known as Delphi Approach

The activity specified in the basket required attributed values. Relative weights attributed to activities following the outcome of a Delphi process involving practice mangers and GP partners. Practice activity data was used to allocate funding on a per activity basis – capped at £9.3 million

Pros

- Funding is specific to the activity within the basket, and therefore practices that perform more activity receive more funding
- Relative weights have been chosen by GPs and practice managers.

Cons

- Requires the use of coded practice activity data, which is not as well recorded as condition data
- Use historical data to inform future needs
- As the allocation sum is a fixed amount, the differences in per unit cost reflect relative differences not absolute differences i.e. the per unit costs of an activity may not reflect their true cost

Average per Head Income per Locality

Locality	Average of £ per head	Average of CMS £ per head	Average of HI £ per head	Average of Weighted Pop £ per head	Average of Delphi £ per head
North & West	£10.45	£8.04	£8.16	£8.20	£7.97
Inner City & East	£10.70	£9.35	£12.76	£8.71	£7.88
South Bristol	£10.79	£10.24	£11.61	£9.67	£8.77
South Gloucestershire	£9.17	£8.29	£6.64	£8.63	£10.33
Woodspring	£4.97	£7.98	£6.06	£8.83	£10.21
Weston Worle & Villages	£5.55	£10.38	£10.16	£10.41	£9.53
Grand Total	**£8.99**	**£8.99**	**£8.99**	**£8.99**	**£8.99**

Risks implications of funding methodologies

The various allocation methods measure different things. Using the Carr-Hill formula, for example, considers the whole (weighted) practice population irrespective of whether they receive any activity in the supplementary services basket. Allocation by activity, focuses purely on the patients in receipt of the services. Consequently, there is a likelihood of swings of projected income depending on the approach used i.e. a practice that has a relatively young and healthy population would likely be subject to a significant negative swing from using Carr-Hill to using allocation by activity.

Practice populations vary across BNSSG. We have young practice populations in Bristol and older populations in South Gloucestershire and North Somerset. Given the nature of the LES, allocation by activity is highly likely to favour practices with older patients. The choice of approach will be due to priorities. The LES has two objectives of potentially competing interests of:

- Implementing a fair funding agreement across BNSSG practices
- Mitigating practice resilience impacts

Each allocation option presents both advantages and drawbacks, with certain options more tailored to achieve specific objectives than others.

Key findings discussed at Steering and Reference Group

The utilisation of the weighted population method illustrates a more stable pattern in payment distribution, minimising fluctuations. However, it's important to acknowledge that the Carr Hill formula tends to disproportionately disadvantage socioeconomically deprived populations, thereby exacerbating pre-existing inequalities in resource allocation.

Comparatively, the use of the CMS presents itself as a more equitable approach, as it ensures a more proportional distribution of financial resources aligned with the adult practice population. This financial model balances both fiscal prudence and ethical considerations.

The Delphi method exhibits significant variability in its outcomes, primarily due to the influence of practice demography. This approach relies heavily on potentially incomplete activity data, thereby prompting inquiries into the strength and dependability of the methodology utilised.

Recommendation – Option 3 using Weighted Population based on practice Cambridge Multimorbidity Score Index

The Steering and Reference Group considered the financial options and are in favour of recommending the CMS method. The Group felt that this option was the fairest and most reflective of the population need.

This recommendation was later presented to the GPCB on 24th Jan 2024 for voting on approval and implementation. The final vote count was as follows:

- The majority voted yes in support of CMS proposal with concerns 69%.
- 18% voted yes with no concerns.
- 4% no.
- 8% abstained.

A practice impact assessment has since been undertaken by ICB officers to RAG rate all practices for their current quality and resilience dashboard ratings. Indicative practice impact assessments have also been shared with practices to support them to plan for the next financial year and to enable them to identify their risks and plan for any redundancies should these be required.

A separate board paper to be considered in a closed session sets out the approach to the practice impact assessment undertaken to support the conclusion of the Supplementary Services Review and identifies next steps for approval.

8. Feedback from GPCB and GP Forums

At the Jan 2024 GPCB meeting, concerns arose regarding the fixed envelope and its potential impact on practice resilience. There were apprehensions about practices discontinuing services due to a reduction in funding. Transition period management was also a focal point of the discussion, with participants considering strategies to facilitate a smooth transition. Additionally, the possibility of applying the CMS funding allocation method to other funding streams was deliberated, exploring potential benefits and challenges. The conversation further addressed data sharing and recalculations, particularly focusing on the participation of practices that had not previously shared data and the potential implications for future allocations. Finally, a polling vote concluded the discussion, revealing that 69% expressed support for the CMS proposal with concerns, 18% were in favour without concerns, 4% voted against, and 8% abstained.

During GP Forums held in February 2024, similar concerns were raised regarding the potential ramifications on practice resilience and the expected adjustments practices would need to make to align with the proposed changes. Furthermore, apprehensions were voiced about the systemic risks posed if practices were unable to fulfil service obligations or opted to terminate their contracts. There was also expressed unease about the lack of access to the revised service specifications and financial impact statements prior to presenting the recommended funding option to the Board. Practices emphasised the importance of comprehending the implications for their future operations, any staff redundancy implications and having sufficient time for feedback, as this would enable the

Board to thoroughly assess associated risks. Additionally, discussions centred around the transition and phasing option, with some expressing reservations regarding the proposed timeline. Practices also asked what would happen if they are not currently delivering all services (e.g. spirometry due to lack of a trained nurse) and the specification allows for a 12-month lead in time to support this. Practices also asked about capping activity levels. The ambition of the Supplementary Services specification is to ensure a consistent offer to the population so this is not proposed, however, we can monitor whether some practices are experiencing higher than expected activity volumes. In addition, the specification has clearer criteria in place to support service delivery.

In light of the feedback received, practices received their financial impact statements on 19 February 2024, and were encouraged to provide feedback. Additionally, they were provided with a draft service specification to familiarise themselves with the service requirements and prepare for implementation. Practices were also assured of the availability of support through section 96 and informed that the transition period would be a phased approach over three years. Furthermore, practices were informed of the option to subcontract services or collaborate through PCNs. It was also proposed that during the initial quarter of implementation, sign-up and service delivery would be monitored by the LES Steering Group, with any identified need for additional support addressed accordingly and that risks to service delivery would be reported to the Primary Care Committee.

We have since had feedback from practices directly which are impacted with funding reductions. The most common question has been to understand how the CMS score has been calculated in more detail. Practices negatively impacted have raised concern about their resilience and ability to continue to provide wider services. 3 practices have raised a formal objection with 2 requesting an appeal of either their allocation or a delay to the introduction of changes.

At the February GPCB meeting concerns were raised about the ability of practices to continue to provide wider services outside core contract that are not currently recognised through Local Enhanced Services and on the impact of relationships between practices and between practices and the ICB going forward. In addition, calls were made for the position with regards to levelling up to be reconsidered or for services to be removed from the basket. The LMC is surveying all practices to understand the impacts for practices. Details of the GP contract arrangements are now being released and it is understood that the BMA is balloting members in response to the proposals.

9. Next Steps

The following next steps are proposed:

- Subject to approval, formally confirm the new arrangements with practices in March.
- Make a proactive offer of support with meetings to be held with the practices most significantly impacted and assessed as at highest risk as set out in the Closed paper to the Board. These meetings have already started in anticipation of changes.

- Issue Expressions of Interest (EOIs) to practices to sign up to the new Supplementary Services LES in March and promote offers of support to practices where resilience is impacted. This includes support through:
    - the Access, Quality and Resilience programme provided by One Care which offers resources as well as intensive support to practices including workforce planning and financial analysis
    - financial assistance through Section 96 funding subject to practices meeting the criteria for discretionary funding in line with the Policy Guidance Manual
    - contractual advice and guidance available to practices from the Local Medical Committee as well as pastoral support and advanced practice and nursing support
- Practice EOIs to be returned by mid-April.
- Where practices do not sign up, encourage PCN sign up to ensure population coverage April-May. Risks to coverage to be reported to the Primary Care Committee
- Continued monitoring of practice resilience via the Primary Care dashboard and referrals to the Access, Quality and Resilience programme.
- Formal closure of the Supplementary Services Review by end Quarter 1 2024/2025 and monitoring of the LES to be incorporated into existing LES monitoring arrangements

10. Legal implications

Notification was issued regarding the termination of the Supplementary Services and South Gloucestershire Basket contract at the end of December 2023, with a new contract scheduled to be issued from April 2024.

11. Risk implications

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The review aims to develop a fairer funding allocation within a fixed pot. With this comes a number of risks. Changes to funding could affect the resilience of practices and might prompt them to discontinue services, leading to unintended consequences for patients and the system. This comes at a time when there is significant uncertainty for practices with the future of the GP contract and PCN DES arrangements and there are significant financial challenges in the system across all our providers. There is a risk of tension in BNSSG Practice areas due to shifts in funding streams, which could strain relationships between the ICB and practices, and among practices themselves.

To mitigate the impact a 3-year phasing of the new financial allocation is proposed. The risk assessment is set out below and a practice impact assessment is set out in the Closed paper to the Board.

WORKSTREAM	DESCRIPTION	LIKELIHOOD	CONSEQUENCE	RAG RATING	MITIGATION ACTIONS
Supplementary Services – Funding	Modifications to funding could impact the overall resilience of practices	4	3	12	Conduct financial impact analyses at the practice, PCN, and locality levels. Provide support through the Access, Quality and Resilience Programme and Section 96 as needed
Supplementary Services – Service specification	Introducing a new proposal may lead to the discontinuation of services by practices, potentially causing unintended consequences within the system	4	3	12	Establish agreed-upon transitional period of a minimum of 2 years to support the smooth pace of change. Implement a phasing option over 3 years for funding in the transition period to alleviate pressure. Sustain ongoing communication with practices at every stage to prevent unexpected outcomes. Where practices do not take up the LES seek PCN coverage for the population
Supplementary Services – Relationships	There is a risk of tension emerging in BNSSG Practices areas due to potential shifts in funding streams, which may contribute to strained relationships between the ICB and practices, as well as among practices themselves.	3	3	9	Maintain close collaboration with stakeholders to keep practices informed about progress. Providing regular updates, feedback mechanisms, and opportunities for dialogue.
Supplementary Services – Funding	There is a risk that practices may hand back their contracts as a result of changes in funding	4	3	12	Encouraging practices to collaborate with other healthcare providers, and create economies of scale. Collaborative models such as federations, alliances, or joint ventures can help practices mitigate

					financial risks and enhance their overall resilience.
Supplementary Services – Timeline	Failure to obtain ICB Board approval for the recommended option can introduce uncertainty and disruption to the project timeline and resources potentially resulting in delays in project implementation and achievement of milestones	3	3	9	Continuously engage with stakeholders, address concerns, and seeking alternative solutions to keep the project on track.
Supplementary Services – service delivery	There is a risk that practices will only deliver part of the services in the specification or seek to cap activity impacting on access to patients	3	3	9	The service specification allows for 12 month transition for practices to be able to fully deliver all aspect of the specification in recognition of need to plan training and equipment needs and in response to staff turnover. Practice activity will be monitored via the LES Steering Group. In instances of continuous non-delivery contractual measures including seeking remedial action plans and ultimately financial withholding may be applied.
Supplementary Services – service delivery	There is a risk that if some practices do not take up the offer, this will result in other healthcare providers experiencing increased referrals/capacity issues/resilience issues.	3	4	12	Where practices do not take up the LES seek PCN coverage for the population Practice activity will be monitored via the LES Steering Group. We will monitor impacts on other healthcare partners through the LES Steering Group

Risk Assessment (likelihood v Impact)					
	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost Certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5
	Inherent Risk Rating				

12. How does this reduce health inequalities?

The option being considered takes into consideration factors that will ensure a consistent and equitable offer addressing inequities of service for our population. Equitable provision of healthcare services means that all individuals, regardless of their socioeconomic status, geographic location, race, ethnicity, gender, or other factors, have equal access to essential healthcare services. The weighted Population option, derived from the Cambridge Multimorbidity Score Index, utilises individual patient data to generate a multimorbidity weighting factor and demonstrates a strong correlation with deprivation.

13. How does this impact on Equality and Diversity?

The recommended equitable funding methodology ensures that supplementary basket of services is accessible to everyone, regardless of their background, socioeconomic status, ethnicity, gender identity, sexual orientation, age, or disability. An Equality Impact Screening Assessment has been undertaken to ensure that the review thoroughly examines any potential equality impact and is detailed in the report attached in the appendices.

14. Consultation and Communication including Public Involvement

Healthwatch, a patient representative group has been involved in the Steering group to inform the Supplementary Services review from a patient perspective. Regular updates are provided to stakeholders through various channels such as the Reference Group, Forums, Practice Manager Drop-in sessions, and the GPCB, ensuring that they are well-informed. Communication is also disseminated through the GP Bulletin and a dedicated Team Net page. Patients should not experience a significant change in the provision of services, but communications approaches and further communications and engagement will be developed for practices and Healthwatch to use to inform patients about any changes post ICB Board decision.

15. Glossary of terms and abbreviations

LMC	Local Medical Committee
LES	Local Enhanced Services
CMS	Cambridge Morbidity Score
IMD	Index of Multiple Deprivation
GPCB	General Practice Collaborative Board
S.96	Section 96 of the NHS Act (2006) (as amended) makes provisions for commissioners to provide assistance and support to primary medical services contractors, including financial support
PMS	Personal Medical Services contracts – provide similar core medical services to GMS contracts and were introduced nationally to recognise extra health services
GMS	General Medical Services contracts – provide core medical services as part of a nationally agreed contract

16. Appendices:

Item 1 - Pseudonymised practice income changes

Item 2 - Draft Service Specification

Item 3 - Quality Impact Assessment

Item 4 - Equality Impact Assessment (to follow)

HI method - How many practices changed in different payment range?

	Range1	Range2	Inner City & East	North & West	South Bristol	South Gloucestershire	Weston Worle & Villages	Woodspring	Grand Total
Change more than -40%	<-40%		0	1	0	0	0	0	1
Change between -25% and -40%	<-25%	>-40%	0	5	0	14	0	0	19
Change between 0% and -25%	>-25%	<0%	2	6	7	9	0	0	24
Change between 0%-25%	>0%	<25%	5	2	2	0	1	3	13
Change between 25%-40%	>25%	<40%	1	0	3	0	0	3	7
Change more than 40%	>40%		3	0	2	0	7	0	12
Total			11	14	14	23	8	6	76

CMS method - How many practices changed in different payment range?

	Range1	Range2	Inner City & East	North & West	South Bristol	South Gloucestershire	Weston Worle & Villages	Woodspring	Grand Total
Change more than -40%	<-40%		0	0	0	0	0	0	0
Change between -25% and -40%	<-25%	>-40%	0	6	2	0	0	0	8
Change between 0% and -25%	>-25%	<0%	10	7	6	17	0	0	40
Change between 0%-25%	>0%	<25%	1	1	4	6	0	0	12
Change between 25%-40%	>25%	<40%	0	0	2	0	0	0	2
Change more than 40%	>40%		0	0	0	0	8	6	14
Total			11	14	14	23	8	6	76

Weighted population method - How many practices changed in different payment range?

	Range1	Range2	Inner City & East	North & West	South Bristol	South Gloucestershire	Weston Worle & Villages	Woodspring	Grand Total
Change more than -40%	<-40%		0	1	0	0	0	0	1
Change between -25% and -40%	<-25%	>-40%	0	2	0	2	0	0	4
Change between 0% and -25%	>-25%	<0%	11	11	11	11	0	0	44
Change between 0%-25%	>0%	<25%	0	0	3	10	0	0	13
Change between 25%-40%	>25%	<40%	0	0	0	0	0	0	0
Change more than 40%	>40%		0	0	0	0	8	6	14
Total			11	14	14	23	8	6	76

Delphi method - How many practices changed in different payment range?

	Range1	Range2	Inner City & East	North & West	South Bristol	South Gloucestershire	Weston Worle & Villages	Woodspring	Grand Total
Change more than -40%	<-40%		3	3	4	2	0	0	12
Change between -25% and -40%	<-25%	>-40%	2	1	2	3	1	0	9
Change between 0% and -25%	>-25%	<0%	3	8	4	5	0	0	20
Change between 0%-25%	>0%	<25%	3	2	3	4	0	0	12
Change between 25%-40%	>25%	<40%	0	0	1	0	1	1	3
Change more than 40%	>40%		0	0	0	9	6	5	20
Total			11	14	14	23	8	6	76

Service Specification - Review of Basket of Services

Services

Spirometry

Rationale

Spirometry is the recommended objective test performed to identify abnormalities in lung volumes and air flow in children (5-16) and adults. It is used in conjunction with physical assessment, history taking, blood tests and x-rays,
The aim of the spirometry service is to exclude or confirm a diagnosis of COPD or Asthma enabling timely diagnosis and treatment closer to home.

Delivery

Practices to provide spirometry testing to confirm diagnosis of COPD or Asthma* by completing a reversibility test and signpost patients to appropriate support services when diagnosed.
It is recognised that Asthma can also be diagnosed by other alternative tests to spirometry
The service should be delivered by appropriately trained clinicians and have appropriate quality assurance processes in place.*
Practices should use a device that provides the full range of measurement.

Referral to secondary care

Appropriate reasons for referral into secondary care services would be:
A patient has already been tested at the GP practice but has poor technique which they feel a more experienced practitioner would be able to coach the patient through to be able to achieve a set of results.
Please see Remedy for further details: https://remedy.bnssg.icb.nhs.uk/adults/respiratory/spirometry-and-lung-function-tests/

Transition Arrangement
Practices not currently delivering a primary care based spirometry service to confirm diagnosis of COPD or Asthma will have a 12 months lead in time during this transition period to ensure they have a device that provides the full range of measurement and that practice based clinicians are trained to an appropriate level with quality assurance processes in place
Practices may liaise with the LMC for support on training
This intervention can also be delivered through practices working together
Practices will be required to provide the following:
1. Evidence of skills and relevant accreditation to deliver a spirometry service
2. Evidence of skills or subcontracting arrangements to deliver a spirometry diagnostic service
ICB Assurance: Evidence of skills and relevant accreditation to deliver a spirometry service (if no sub-contracting arrangements in place) and Primary Care activity reports

*Action - What kind of accreditation do we need? Check with CT regarding competency document being developed and embed if relevant

Output/Outcomes

Expected Outcomes and Benefits
Spirometry testing plays a crucial role in diagnosing, managing, and monitoring respiratory conditions, ultimately improving patient outcomes and quality of life

References

Spirometry is the recommended objective test performed to identify abnormalities in lung volumes and air flow. It is used in conjunction with physical assessment, history taking, blood tests and x-rays, to exclude or confirm particular types of lung disease, enabling timely diagnosis and treatment. To be valid spirometry that is used for diagnosis must be quality-assured and should only be performed by people who have been trained and assessed to ARTP2 or equivalent standards by recognised training bodies in the performance and interpretation of spirometry. Without this overall quality assurance, the accuracy of the diagnosis cannot be relied on. (A Guide to Performing Quality Assured Diagnostic Spirometry. Source: British Lung Foundation; British Thoracic Society, 2013)
https://patient.info/doctor/spirometry-pro

Service Specification - Review of Basket of Services

Services

Phlebotomy initiated by primary care

Rationale

The aim of the service is to:
Provide an accessible primary care-initiated phlebotomy service for patients over 12 years of age within a general practice setting
Deliver a service local to patients
To o er patients a choice of appointment times and locations as close to their home as possible
To deliver the shortest pathway possible, compatible with best outcomes for patients
Improve the monitoring and management of Long-Term Conditions and to investigate patients appropriately.

Delivery

Practices to provide a comprehensive non urgent primary care-initiated phlebotomy service for registered patients. Refer to https://remedy.bnssg.icb.nhs.uk/children-young-people/phlebotomy/paediatric-phlebotomy/ for paediatric phlebotomy services.
Time frames and location for delivery should be clinically appropriate in accordance with the specific clinical requirements of the patient. To support the delivery of a quality assured service, practices are encouraged to comply with evidence based best practice guidelines for the taking, storage and transportation of blood samples to ensure valid, reproducible, and accurate results.
This intervention can also be delivered through practices working together.

Transition Arrangements:
Practices not currently delivering a primary care based phlebotomy initiated service will have a 12-month lead in time during this transition period to help assure themselves that the in house service is fully up and running in accordance with service requirements.
Practices will be required to provide evidence of subcontracting arrangements if service not in place

ICB Assurance: Review of Primary Care activity -
Clarify with ICE (pathology system) - is it possible to review the activity from here instead of primary care

Output/Outcomes

Expected Outcomes and Bene ts
By commissioning a primary care-based phlebotomy service, it is anticipated that the following outcomes will be achieved:
•Improved patient experience of phlebotomy services
•Delivery of a local service that is closer to the patient's home.
•Timely access to blood testing and reporting within the primary care environment.
•Supporting the delivery of diagnostic tests closer to the patient's home
•Supporting the delivery of holistic care

References

WHO guidelines on drawing blood: best practices in phlebotomy. World Health Organisation 2010; These guidelines were produced to improve the quality of blood specimens and the safety of phlebotomy for health workers and patients, by promoting best practice in phlebotomy.
https://patient.info/doctor/spirometry-pro
https://www.accurx.com/floreys

Service Specification - Review of Basket of Services

Services

Dressings including compression therapy and post-operative wound care

Rationale

The Non-Complex Wound Management service aims to provide primary care wound management at practice premises for non-complex wounds and dressings. This supports ICB strategic commissioning intentions for high-quality, patient-centered care close to home. The service focuses on preventing, assessing, and treating wounds to optimise healing, reduce the burden on patients and care providers, and minimize complications. By delivering compression therapy wraps closer to home, the service aims to enhance timely access to care, promote shared care, and empower patients to have autonomy over their treatment while ensuring awareness of the processes involve

Delivery

Practices will provide a quality assured service that includes:
•Managing post-operative wounds and wound infections that would be expected to heal within 6 weeks.
•Simple venous leg ulcer management that would be expected to heal within 6 weeks.
•Providing assurance on the processes and protocols that are in place to ensure patients are receiving timely access to wound care management.
•Skin damage including pressure injury management.

After 6 weeks, patients should be referred to the community team for ongoing complex management.
The specialist nurses support healthcare staff and patients with any type of wound that has been present for more than six weeks and is failing to heal, deteriorating or is a complex wound. All dressing recommendations/initiations must be in accordance with NICE guidelines and local guidance. Please see Remedy https://remedy.bnssg.icb.nhs.uk/adults/dermatology/tissue-viabilitywound-care-service/ and https://remedy.bnssg.icb.nhs.uk/adults/dermatology/leg-ulcer/ for definition of complex wounds

Clarify with Sirona on contents of contract? JB/GI
Check with LMC re training opportunities

Transition Arrangements:

Practices not currently delivering a Non-Complex Wound Management service will have a 12-month lead in time during this transition period to help assure themselves that the in house service is fully up and running in accordance with service requirements.
Practices will be required to provide evidence of subcontracting arrangements if service not in place
This intervention can be provided by Practices working together e.g. use of leg clubs
ICB Assurance: Review of Primary Care Activity.

Output/Outcomes

Expected Outcomes and Benefits

The benefit of the service is to improve the quality of life for people requiring management of their wounds through the delivery of clinically effective care and advice which reduces the risk of recurrent infection and promotes independence.

The service will help to deliver this objective by:

- Delivering a timely, e ective and personalised wound management and healing service in a safe environment.
- Improving local symptoms such as reducing pain and improving healing rates through the use of appropriate treatment in accordance with best practice, published guidance and clinical evidence and reducing unnecessary or inappropriate use of dressings and wound care products in a primary care setting.
- Detecting, and where appropriate treating, any infection to prevent deterioration of the wound or systemic involvement.
- Providing appropriate patient education so that patients may make informed choices and fully participate in their care and improve concordance.
- Promoting the use of individualised care management plans for all patients with communication at the point of discharge to patients, carers and healthcare professionals that promotes long term leg care and reduces the risk of recurrence.
- Preventing unnecessary referrals and admissions to community or specialist services, urgent care centres, hospital or nursing homes. Where onward referrals are necessary, completing these in a clinically appropriate timeframe.

References

Wound care is expensive and can cause immeasurable stress and inconvenience to patients and their significant others. It is therefore in the best interest of the patient, their significant others and the NHS as a whole that wounds are expertly assessed,
managed and healed in the quickest timeframe possible (Holistic wound assessment in primary care. Cornforth A. Br J Community Nurs. 2013).

Accurate wound assessment and an understanding of the complexities of wound management is essential in ensuring that cost-effective and evidence-based interventions are used. The results of the wound assessment will determine the treatment prescribed, and practitioners need to ensure they have the essential skills required to plan, implement and evaluate care on an individual basis. (Wound assessment in primary care. Nursing in Practice. Atkin, L ,2013).

The cost of wound care is significant. The most important components are the costs of wound-related hospitalisation and the opportunity cost of nurse time. Putting in place care pathways to avoid hospitalisation and avoiding the development of hospital-acquired pressure ulcers and other wound complications are important ways to reduce costs (Vowden, et al. (2009) The resource costs of wound care in Bradford and Airedale primary care trust in the UK. Journal of Wound Care).
https://remedy.bnssg.icb.nhs.uk/adults/dermatology/tissue-viabilitywound-care-service/

Service Specification - Review of Basket of Services

Services

Primary Care requested ECGs

Rationale

Providing a 12-lead stable patient ECG interpretation service in primary care aims to prevent unnecessary hospital referrals for routine 12-lead ECGs and minimize interpretation delays. The service supports patient diagnosis, ongoing assessment, monitoring, and management of those with a pre-existing condition in primary care. Practices are not expected to interpret ECGs for patients presenting with acute chest pain indicative of an Acute Coronary Syndrome but dial 999 and refer to the A&E department any patient presenting with such acute chest pain in a general practice setting. Practices are not commissioned to provide and ECG recording or interpretation service for any other Provider

Delivery

Practices will provide a non-urgent 12 lead ECG recording and interpretation service for primary care-initiated requests to all registered patients over the age of 16 years.

This intervention can also be delivered through practices working together.

The ECG Recording Service is for stable patients only and should not delay any proposed admission to hospital.

The service should be delivered, and ECGs interpreted in a clinically appropriate time frame according to the specific needs of the patient. Interpretation of ECG can be done within general practice competency or referred to specialist if needed for interpretation. ECGs should be performed in line with best practice and clinical indication.

Practices should be able to demonstrate that they have a process in place for agreed follow up (where required) and to inform the patient of findings

This intervention can also be delivered through practices working together.

Transition Arrangements

Practices not currently delivering a primary care based stable patient 12 lead ECG recording and interpretation service will have a 12-month lead in time during this transition period to help assure themselves that the in house service is fully up and running in accordance with service requirements.

Practices will be required to provide:
•Evidence of subcontracting arrangements to deliver 12 lead ECG recording and/or Interpretation if unable to provide the service in practice
•Evidence of practice protocol (including timescales) for delivering a ECG recording and interpretation service and patient follow up (where required) to advise findings

Output/Outcomes

Commissioning a primary care service for 12-lead ECG recording and interpretation aims to achieve several local outcomes, including improved access to 12-lead ECG diagnostics, increased routine interpretation in primary care, reduced referrals to secondary care, enhanced patient experience, equitable service delivery, optimal patient settings for diagnosis and treatment, early identification of conditions, provider accreditation assurance, minimised waiting times for diagnosis and treatment (supporting improved health outcomes such as for Atrial Fibrillation), and a streamlined approach to cardiac disease diagnosis or exclusion

References

There is increasing desire among service commissioners to treat arrhythmia in primary care. Accurate interpretation of the electrocardiogram (ECG) is fundamental to this. (Begg G, et al Electrocardiogram interpretation and arrhythmia management: a primary and secondary care survey. The British Journal of General Practice. 2016). Electrocardiography in addition to history taking and physical examination, may be an important tool in primary care. It can reduce considerably the number of unnecessary referrals. (Electrocardiography in primary care; is it useful? F.H Rutten, et al, International Journal of Cardiology, July 2000).

Service Specification - Review of Basket of Services

Services

24-hour BPs or offer home BP monitoring

Rationale

The aim of the Blood Pressure Diagnosing Service is to provide a primary care based blood pressure measurement service through either ambulatory 24-hour blood pressure mesurement or if more practical and would avoid long waits to offer home blood pressure measurement where ABPM is unsuitable for a patient to identify and diagnose hypertension.

Delivery

To provide a primary care initiated Blood Pressure Monitoring Service (either though Home Monitoring or 24 hour ABPM Monitoring) for all appropriate patients in general practice in a timely and convenient manner to support the diagnosis, management and control of blood pressure. This intervention can also be delivered through sub-contracting arrangements.

Practices are also expected to work with Community pharmacies who can now provide blood pressure monitoring services to support identification of hypertensive patients and reviews of existing patients as part of the nationally commissioned hypertension case-finding (HCF) service. Referrals can be made by asking patients to attend a pharmacy offering the service, explaining that they have been sent by their GP practice for a blood pressure test.

The gold standard diagnostics for hypertension is ABPM as per NICE guidance 2023. However, should ABPM not be available in the practice or community pharmacy in a reasonable timescale then the use of HBPM should be considered in order to reduce the risk of delay in starting treatment.

Transition Arrangement

Practices not currently delivering a 24-hour BPs or offer home BP monitoring will have a 12-month lead in time during this transition period to help assure themselves that the in-house service is fully up and running in accordance with service requirements.
This intervention can also be delivered through practices working together

ICB Assurance: Primary Care Activity and an assurance from Practices that they have the right calibrated equipmet and appropraitely trained clinicians to provide the service

Output/Outcomes

Hypertension is associated with a higher risk of cardiovascular events. Setting blood pressure to recommended levels aims to promote primary and secondary prevention of cardiovascular disease, and to lower the risk of cardiovascular events.

References

People with suspected hypertension should be offered ambulatory blood pressure monitoring (ABPM) to confirm a diagnosis of hypertension. ABPM is the most accurate method for confirming a diagnosis of hypertension, and its use should reduce unnecessary treatment in people who do not have true hypertension. ABPM has also been shown to be superior to other methods of multiple blood pressure measurement for predicting blood pressure-related clinical events (NICE Quality Statement). The option of Home Blood Pressure Monitoring as an alternative to ABPM 24 hour should also be offered.

Service Specification - Review of Basket of Services

Services

Doppler for assessment of peripheral vascular disease and pre-compression therapy

Rationale

Doppler assessments prior to compression therapy or for the diagnosis of peripheral vascular disease in general practice supports early diagnosis, personalised care, accessibility, and efficient resource utilisation, ultimately contributing to better patient outcomes and overall healthcare effectiveness.

Delivery

All patients presenting with a lower leg wound that has failed to heal within a clinical reasonable time (Remedy specifies 2 weeks) require a lower limb and Doppler assessment to identify the aetiology of the wound and detect any underlying arterial disease. Compression should not be applied until a full assessment and ABPI has taken place and should be delivered by appropriately trained clinicians

https://remedy.bnssg.icb.nhs.uk/adults/dermatology/leg-ulcer/

Conduct a thorough patient history and physical examination, identifying those at risk for vascular issues.
Use Doppler devices to evaluate blood flow, aiding in the diagnosis and severity determination of peripheral vascular disease.
Discuss findings with patients, explaining the importance of managing vascular conditions and potential interventions.
Determine the type and level of compression based on Doppler findings, educate patients, and provide guidance on proper application.
Schedule regular appointments to monitor treatment effectiveness and adjust plans as needed.
Consider specialist referrals when necessary and collaborate with other healthcare professionals for comprehensive care
This intervention can also be delivered through practices working together.

Action - Link in with treatment room nurses and practice nurses to gain opinions on when they would perform a Doppler - LMC

Transition Arrangement

Practices not currently delivering a Doppler for assessment of peripheral vascular disease and pre-

Output/Outcomes

This integrated approach in primary care ensures timely and personalized management of peripheral vascular diseases, promoting patient-centered and effective healthcare delivery
Appropraite referrals/management of ulcers

References

https://remedy.bnssg.icb.nhs.uk/adults/dermatology/leg-ulcer/
https://cks.nice.org.uk/topics/leg-ulcer-venous/management/venous-leg-ulcers/

Service Specification - Review of Basket of Services

Services

Delivery of Gonadotrophin-releasing hormone antagonist (GnRH analogues/ LHRH) treatment (e;g Triptorelin, Goserelin) for prostrate cancer

Rationale

Deliver GnRH analogues to give patients convenient access to treatment for prostate cancer.

Delivery

Foster collaboration between primary care and secondary care for comprehensive care.
Develop personalised treatment plans based on individual factors and disease stage.
Have a Practice system to follow up any missed appointments.
Guide patients on managing side-effects
.

Transition Arrangement

Practices not currently delivering a Gonadotrophin-releasing hormone antagonist (GnRH analogues/ LHRH) treatment (e;g Triptorelin, Goserelin) for prostrate cancer will have a 12-month lead in time during this transition period to help assure themselves that the in house service is fully up and running in accordance with service requirements.
Ensure healthcare providers are trained in proper injection techniques and adhere to established guidelines.
Ensure proficient injection technique, including proper site selection and aseptic procedures.
Equip the setting for emergencies and train providers in recognising and responding to adverse reactions

ICB Assurance: Review of Primary Care activity

Output/Outcomes

Expected Outcomes and Benefits
GnRH analogues play a crucial role in the long-term management of prostate cancer, helping to maintain disease control and prevent recurrence after primary treatments closer to home

Offering GnRH analogue treatment provides patients with a well-established, effective, and generally well-tolerated therapeutic option, contributing to patient-centered care in prostate cancer management.

References

https://prostatecanceruk.org/prostate-information-and-support/treatments/hormone-therapy#:~:text=GnRH%20antagonists%20(gonadotrophin%2Dreleasing%20hormone,has%20spread%20to%20the%20bones.

https://cks.nice.org.uk/topics/prostate-cancer/management/management/

Service Specification - Review of Basket of Services

Services

Anti-psychotic depot injections

Rationale

Administering antipsychotic depot injections to stable mental health patients in primary care facilitates community-based care, allowing patients to receive treatment in familiar and accessible settings. This can contribute to increased engagement and continuity of care. The aim is improve treatment adherence, preventing relapses, reducing hospitalisations, and ultimately enhancing the overall well-being of individuals with psychotic disorders

Delivery

Ensure healthcare providers are trained in proper injection techniques and adhere to established guidelines.
Ensure proficient injection technique, including proper site selection and aseptic procedures.
Equip the setting for emergencies and train providers in recognising and responding to adverse reactions.
Collaborate with mental health specialists for consultation and referral.
Educate patients about the injection process, potential side effects, and the importance of follow-up.
Maintain accurate records of injections, including doses and patient responses.
Report adverse events to regulatory authorities as part of pharmacovigilance efforts
Establish a clear pathway for practices to go back to AWP, ensuring that practices know how to escalate concerns.

Transition Arrangement

Practices not currently delivering Anti-psychotic depot injections will have a 12-month lead in time during this transition period to help assure themselves that the in house service is fully up and running in accordance with service requirements.
Practices will be required to provide evidence of subcontracting arrangements if service not in place

ICB Assurance: Review of Primary Care activity

Output/Outcomes

Expected Outcomes and Benefits

Ensure these patients are on the Severe Mental Illness practice registers and are invited for an annual physical health check

Increased patient adherence to antipsychotic treatment due to the consistent and convenient nature of depot injections.

Enhanced control and stability of psychotic symptoms, reducing the risk of relapses and hospitalizations.

Improved overall quality of mental health care by providing a comprehensive and patient-centered approach.

Higher patient satisfaction resulting from reduced treatment burden and improved symptom management.

References

Service Specification - Review of Basket of Services

Services

Prescribing for community midwives

Rationale

GPs prescribing for community midwives is driven by the need for seamless, collaborative, and efficient care in managing maternal health. It supports timely access to medications, fosters collaboration between healthcare professionals, and contributes to the overall well-being of pregnant women receiving care in community settings.

Delivery

GPs in primary care may engage in limited prescribing for community midwives, typically focusing on medications directly related to maternal and newborn care. The scope of prescribing for community midwives can vary but it is expected that midwifery teams will be developed to prescribe independently. Prescriptions should exclude medications that can be obtained over the counter. Some examples of prescribing activities for community midwives in primary care include:

Prescribing essential prenatal vitamins and supplements, such as folic acid or iron, to support maternal and fetal health during pregnancy.

Prescribing antibiotics for the treatment of minor infections, such as urinary tract infections or vagnal infections, which can occur during pregnancy.

Prescribing pain relief medications, such as paracetamol, for mild to moderate pain relief during pregnancy or postpartum.

Prescribing antiemetic medications to alleviate nausea and vomiting commonly experienced by pregnant women.

Prescribing topical preparations, such as creams or ointments, for minor skin conditions or irritations during pregnancy.

Prescribing medications for specific pregnancy-related conditions, such as gestational diabetes or gestational hypertension, in collaboration with obstetricians or other specialists

Prescribing medications for postpartum care, including pain relief medications or treatments for perineal discomfort.

Prescribing medications to address common breastfeeding issues, such as nipple pain or mastitis. This dees not include medications for labour at home or anticoagulation for pregnant women at risk.

Transition Arrangement

Practices not currently prescribing for community midwives will have a 12-month lead in time during this transition period to help assure themselves that the in house service is fully up and running in accordance with service requirements.

Output/Outcomes

Expected Outcomes and Benefits
Swift access to essential medications for immediate maternal and newborn care.

Supports a holistic approach to maternal care beyond birthing.
Continuity:

Promotes continuity of care with midwives managing routine cases seamlessly.
Enhances patient-centered care by offering comprehensive services.
Reduced Referrals:

Lessens dependence on immediate referrals for minor health issues.

Provides convenience for patients, receiving medications during routine visits.

References

Service Specification - Review of Basket of Services

Services

Ear Wax Removal

Rationale

Ear wax removal to improve hearing loss or other symptoms, subject to clinician assessment or to aid diagnosis with a service provided close to home.

Delivery

NICE recommends that ear irrigation (flushing the wax out using water) using an electronic irrigator, microsuction (using a vacuum to suck the wax out under a microscope), or another method of earwax removal (such as manual removal using a probe) may also be considered if the expertise is available, there are no contraindications to the methods, and the correct equipment for the procedure is used. This should be performed by trained staff.

Criteria for ear wax removal in primary care include:

-

Presence of hearing aids, with ear wax removal required to prevent interference with the proper functioning of the devices.
Pateints with significant learning disabilities and people with impaired communication and dementia
Need for accurate diagnostic assessments, such as audiometry or tympanometry, where ear wax removal is necessary for accurate results.

Transition Arrangement

Practices not currently offering ear wax removal will have a 12-month lead in time during this transition period to help assure themselves that the in house service is fully up and running in accordance with service requirements.
Practices will be required to provide evidence of subcontracting arrangements if service not in place.
Check with LMC re training opportunities

ICB Assurance: Review of Primary Care activity

Output/Outcomes

Expected Outcomes and Benefits
Removal of impacted earwax can lead to immediate improvement in hearing, addressing symptoms of hearing loss or muffled sounds.
Relief from Discomfort and resolution of Tinnitus:
Removal of earwax may alleviate or reduce symptoms of tinnitus (ringing or buzzing in the ears).
Earwax removal helps prevent complications such as ear infections, which may occur when wax buildup creates a favorable environment for bacterial growth.
Facilitation of Diagnostic Assessments
Improved Effectiveness of Hearing Aids
Prevention of Self-Removal Complications
Clearer Diagnostic Visuals
Earwax removal in primary care reduces the need for unnecessary referrals to specialists, streamlining patient care and minimizing healthcare system burdens.

References

https://remedy.bnssg.icb.nhs.uk/adults/ent/ear-wax-and-microsuction/
https://cks.nice.org.uk/topics/earwax/management/management/
Front page (thebsa.org.uk)
https://earcarecentre.com/uploadedFiles/Pages/Health_Professionals/Protocols/Ear%20irrigation%20guidelines%202022.pdf
https://cks.nice.org.uk/topics/earwax/management/management/#:~:text=NICE%20recommends%20that%20ear%20irrigation,is%20available%2C%20there%20are%20no

Supplementary Services LES - Quality Impact Screening & Full Assessment

The Programme lead will identify and engage with a Quality Lead who is responsible for approving the QIA document for all BNSSG Programmes. In doing so the Quality Lead is ratifying that the paperwork has been completed correctly and full consideration has been given to potential impacts on quality as well as how ongoing monitoring will be managed within the scheme/project/Programme.

Quality is defined in terms of three domains:

- Patient safety (doing no harm to patients)
- Patient experience (care should be characterised by compassion, dignity, and respect).
- Effectiveness of care (to be measured using survival rates, complication rates, measures of clinical improvement, and patient-reported outcome measures)

The quality and safety domains should be used to outline the details of the potential impacts of the plans on quality.

Part 1: Screening Tool

Is there an impact on patient safety?	Yes, equitably distributing health services and funding among general practices should have a positive significant impact on patient safety. When services are fairly distributed, patients benefit from timely access to care. This approach helps reduce health disparities by ensuring that all individuals, regardless of their location or socioeconomic status, have access to essential healthcare. Additionally, equitable distribution of funding ensures that general practice have the necessary resources and staff to provide safe and effective care to all patients. Furthermore, it fosters continuity of care by allowing patients to establish relationships with healthcare providers and receive consistent, coordinated care over time, thereby reducing risks and improving overall health outcomes.
Is there an impact on delivery of national standards?	Providing patient-centred care is widely recognised as a fundamental principle of general practice. An expanding body of research suggests that this method not only improves patient satisfaction but also encourages individuals to actively manage their health. The primary goal of the Supplementary Services Basket Offer is to ensure that services provided result in measurable advantages and favourable results for patients across the entirety of BNSSG. Additionally, these services are designed to align with the priorities of the ICB and fulfil the NHS Outcomes Framework Domains & Indicators.
Is there an impact on the provider's duty to protect people?	Overall, while the redistribution of funds may introduce new challenges or constraints, GP Practices must continue to prioritise patient safety and well-being, ensuring that their duty to protect people remains central to their practice. They may need to adapt their practices and decision-making processes to effectively navigate changes in funding allocation while upholding their ethical and legal obligations to patients
Is there an impact on clinical workforce capability and skills?	Equitably distributing health services and funding among general practices positively influences the capability and skills of the clinical workforce in several ways. Firstly, it exposes healthcare professionals to diverse patient populations and practice settings, fostering skill development and cultural competence. Secondly, it

	encourages the development of specialised services in underserved areas, leading to the expansion of clinical expertise. Thirdly, efforts to address workforce shortages in these regions may involve training programs and incentives, further enhancing the workforce's capabilities. Additionally, interdisciplinary collaboration is promoted, enabling healthcare professionals to learn from one another and deliver higher quality care.
Does the plan create an impact on the prevention of violence and aggression; or contribute to service users feeling less safe?	The service specification outlines the reasoning behind service delivery methods and expected outcomes, which helps mitigate uncertainties and alleviate pressure on other parts of the system, such as hospitals and emergency departments, which often experience overcrowding and high stress levels. Hospitals can be overwhelming environments, especially for vulnerable individuals with cognitive impairment and concurrent illnesses, increasing the risk of behavioural challenges or aggression. To mitigate this risk to both patients and staff, it's beneficial to provide continued care in settings closer to the individual's home.
Is there an impact on partner organisations and any aspect of shared risk?	• **Sirona -**. Due to clarity in the new specification around certain activity eg wound care and when to refer to Sirona as per current local guidelines, we will be linking with Sirona colleagues to understand any increased referrals to Sirona services and impact on resilience • **Community Pharmacists -** the specification has up to date detail on the community pharmacy contract regarding hypertension case finding and monitoring. There will be closer collaboration between general practices and community pharmacies. • **Integrated Governance Framework (IGF)** - IGF has been developed and endorses a shared approach to decision making, collective learning and improvement across system partners. It is recognised and intended that the MDT approach pools expertise to enable better assessment of clinical risk, shared decision making and risk holding to support the patient's best interests: *03. Integrated Governance Framework - Healthier Together - FutureNHS Collaboration Platform* (ACE addendum developed)
Provide a rationale for assessing the impact on Patient Safety	Ensuring that patient safety remains a priority after redistributing funds confirms that the quality of care provided is not compromised. By assessing the impact, GP Practices can verify that safety measures are maintained or improved despite changes in resource allocation. Redistributing funds may lead to shifts in staffing, infrastructure, or services, which could introduce new risks to patient safety. Assessing the impact helps identify and mitigate these risks promptly, preventing adverse events or patient harm. Patients and stakeholders have a right to know how changes in funding allocation affect their safety. Assessing the impact demonstrates transparency in decision-making and holds Practices accountable for maintaining patient safety standards. Regular evaluation of the impact on patient safety allows Practices to learn from successes and failures. This feedback loop facilitates continuous improvement efforts, ensuring that patient safety measures are refined over time to better meet evolving needs. Legal and Ethical Obligations: Practices have legal and ethical responsibilities to prioritise patient safety. Assessing the impact on

	safety after redistributing funds helps fulfil these obligations by ensuring that patient welfare remains central to decision-making processes.

2. Does your plan affect clinical outcomes?

Does your plan comply with the best evidence guidance including NICE? **Find guidance | NICE**	Yes
Does your plan impact on the delivery of services in line with national clinical and quality standards? **Quality standards | Standards and Indicators | NICE**	Yes
Does your plan lead to a change in care pathways?	No. The patient will continue to be managed in existing available pathways based on the needs identified by the service specification. The specification supports the better co-ordination of a patients care into existing pathways including Sirona, UHBW and other community services.
Is there an impact on the delivery of clinical outcomes?	Yes, there can be both positive and negative impacts on the delivery of clinical outcomes after the redistribution of funding for healthcare services. When funding is redistributed, it can lead to changes in resource allocation, service availability, and the way care is delivered. These changes can affect various aspects of healthcare delivery, including access to services, quality of care, patient outcomes, and overall population health. On the one hand, redistribution of funds can ensure that resources are directed towards areas with the greatest need, thereby optimising resource allocation and potentially improving the efficiency of healthcare delivery. On the other hand, redistribution of funding may exacerbate existing health inequities, as certain populations may bear a disproportionate burden of cuts to services or may not receive adequate funding for their specific healthcare needs.
Provide a rationale for assessing the impact on Clinical Outcomes	Assessing the impact on clinical outcomes after redistributing funds for healthcare services is essential for optimising resource allocation, ensuring equity and accessibility, driving quality improvement initiatives, promoting accountability and transparency, and facilitating evidence-based decision-making in healthcare policy and practice. There needs to be routine quality assurance and improvement – activity. Including standard monitoring and reporting, due diligence, and contract management, which would be further developed.

3. Does your plan affect patient experience?

Does your plan have an impact on service user experience?	Streamlining services and reallocating funds can reduce wait times, improve appointment scheduling, and enhance overall service efficiency. This leads to a smoother and more timely experience for service users, as they can access care more easily and experience fewer delays. Reallocating funds to meet the needs of the population can result in better healthcare outcomes and a higher standard of care for service

	users. This may include investments in training for healthcare staff, upgrading medical equipment, or implementing evidence-based practices. As a result, service users may receive more effective treatments and experience better health outcomes. Reallocation of funds can support the development of integrated care systems and multidisciplinary teams, ensuring that service users receive comprehensive and coordinated care across different healthcare settings. This personalised approach can lead to a more positive experience for service users, as their healthcare needs are addressed in a holistic and responsive manner. By improving access, efficiency, quality, and personalization of care, the overall experience for service users is likely to be more positive. Increased satisfaction with healthcare services can result from shorter wait times, better communication with healthcare providers, improved outcomes, and a greater sense of involvement in decision-making regarding their care. This can lead to higher levels of patient satisfaction and engagement with healthcare services. However, it's important to note that streamlining services and reallocating funding may also introduce challenges, such as changes in service delivery models, potential disruptions during implementation, or resource constraints in certain areas. These challenges will need to be carefully managed to minimize any negative impacts on service user experience.
Does your plan have an impact on carer experience?	Streamlining healthcare services and reallocating funding can have a positive impact on the patient and carer experience by improving access, communication, quality of care, and caregiver support
Does your plan support the choice agenda?	Incorporating patient choice represents a fundamental aspect of Supplementary Services. Clinicians are tasked with centering their attention on the patient's preferences, requirements, desires, and values. The informed decision-making process and selection are influenced by patient choice, input from healthcare professionals, as well as perspectives from family members or next of kin.
Does your plan address concerns and issues identified through PALs, complaints, and national and local service user and carer surveys?	Yes, Healthwatch was involved in the project review and provided valuable insights and perspectives from a patient-centered standpoint for the Supplementary Services review. These have been taken into consideration in revising the service specification. There is a structure in place to address concerns and issues identified through PALs, complaints, and national and local service user and carer surveys.
Provide a rationale for assessing the impact on Patient Experience	The service specification and the funding allocation method used aims to provide improved patients experience, driving a person-centered model of care, taking into consideration the wants and needs of each patient and considering and discussing the risks associated with either receiving care closer to home or being treated in hospital. .

1. Risk Rating

Scoring: The scoring is based on a standard risk matrix scoring system. The score will therefore, reflect the potential risk to quality and is summarised below. The overall risk score should be the highest score from the individual quality domains.

Quality Domain	Risk Description	Probability	Impact	Total
Patient safety (doing no harm to patients)	There is a risk that modifications to funding streams could impact the overall resilience of practices which can in turn affect the quality-of-care patients receive. **Mitigation:** Conduct financial impact analysis at the practice, PCN, and Locality levels Establish agreed-upon transitional period of 3 years to support the smooth pace of change. Implement a phasing option for funding in the transition period to alleviate pressure. Sustain ongoing communication with practices at every stage to prevent unexpected outcomes.	3	3	9
Patient experience (care should be characterised by compassion, dignity, and respect).	Risk that Patient/ Family/ Carer not appropriately involved in decision making and care planning **Mitigation:** Maintain close working relationship with General Practices and the ICB Contract and Quality teams to ensure that patients are receiving quality care that is equitable, focused on reducing inequalities and addressing wider determinants.	3	3	9
Effectiveness of care (to be measured using survival rates, complication rates, measures of clinical improvement, and patient-reported outcome measures)	Potential risk that new service specification offer could affect patient safety and clinical outcomes whilst general practices adjusts to the reallocation of funding and service delivery. **Mitigation:** The service specification utilises existing patient pathways and support from clinicians to reduce risk. A system to monitor activity will be put in place to assess impact, reflect on cases, discuss learning, and make processes seamless.	3	3	9

5. Conclusion of Screening Tool *(Programme Lead to answer)*

Proceed to full QIA	Yes
Please explain your reasons	The reallocation of funding and the offer of a revised service specification could have a positive and negative impact on patients and the quality of care they receive. This may in turn affect their experience as well as their carers and families. Conducting a full QIA to ensure that no harm comes to patients and that they receive care that is characterised by compassion, dignity, and respect as well as improving health outcomes is vital in assessing potential risks and ensuring these risks are appropriately mitigated.

QIA Approver(s)

Date of Quality Assurance	QIA Approver	Comments from QIA lead
	Jacci Yuill jacci.yuill@nhs.net	

Part 2: Full Quality Impact Assessment

6. Please tell us how your plan impacts on the Quality Domains

Patient Safety	The aim of the Supplementary Services basket offer is to have a positive impact on patient safety as it will equitably distribute health services across the BNSSG GP Practices. Patients will benefit from more timely access to care which will be more consistent and coordinated reducing the risks and improving health outcomes, especially where there are health inequalities. There is a risk that modifications to the funding streams could impact the overall resilience of practices which could affect the quality of care patients receive and to mitigate this there will be financial analysis at practice, PCN and Locality levels. There will be a 3 year phasing in process and communication with practices to prevent any unexpected outcomes.
Clinical Outcome	There will be no change to the existing patient care pathways but there could be both positive and negative outcomes following the redistribution of funding impacting on resource allocation, service availability and the method of care delivery which might influence clinical outcomes. To mitigate this there will be a system established to monitor activity, reflect on cases, discuss learning and make quality improvements.
Patient Experience	The aim of streamlining of the service specification and the reallocation of funds is to improve patient care, clinical outcomes, and patient experience. Patients should experience a more effective and efficient service which will meet the needs of the population so that there is an improvement in health outcomes**.** The aim is to support the integrated care systems and multidisciplinary teams to deliver care, which is more accessible, efficient and personalized. There may be occasions when there are issues with the patient experience so there will need to be monitoring undertaken to manage any rising issues.

7. Are there any specialist advisors that will need to be consulted or involved in the development of your plan?

Please Comment: Examples: Safeguarding lead, PPI leads, Clinical Advisor. Evidence and Evaluation Specialists	Allocated Quality Lead: Jacci Yuill Clinical Leads: • Nwando Umeh (Programme Lead, Supplementary Services) • Dr Geeta Iyer (Deputy Chief Medical Officer, Primary and Community Care) • Dr Jason Sarfo- Annin (PHM and Public Health Lead) • Dr Sam Hayward (PHM and Public Health Lead)

8. What is the outcome of your Quality Impact Assessment?

The QIA identified actual or potential harm to patients, carers or public	There could be potential harm if not all GP Practices offer what is set out in the service specification due to the funding allocation which could lead to service disruption.
No major change (The QIA demonstrates that the plan is robust. The evidence shows no potential adverse impact on the quality of care or provision)	Yes
Changes have been made to the plan to remove any identified potential or actual harm	No

The plans are deemed 'business critical'. Clinical and / or legal advice has been sought and objectives justification for the plans are filed in the document folder	Not applicable

9. Full QIA Approval *[To be completed by QIA Lead only]*

Date of Quality Assurance	QIA Approver	Comments from QIA lead
15.2.2024	**Jacci Yuill**	

Equality & Health Inequality Impact Assessment

Other documents required to complete the Equality & Health Inequality Impact Assessment:

- **Equality & Health Inequality Impact Assessment Guidance**
- **Equality & Health Inequality Impact Assessment Resources**

Please ensure you read the guidance and resources in full before attempting to complete this template.

Title of proposal: Supplementary Basket of Services				Date: 21/02/2024
☐ Policy	☐ Strategy	x Service	☐ Function	☐ Other (please state)
EHIA type:	Screening EHIA ☐	Full EHIA ☐x	HEAT in progress/ completed ☐	Has an EHIA been previously undertaken? Yes Nox
Is the policy under:	Development ☐	Implementation ☐	Review x	
Which groups will this service/proposal impact (e.g. patients, service users, carers/family, staff, general public, partner organisations)? patients, service users, general practice staff, partner organisations				
Lead person(s) completing this assessment: Nwando Umeh				
Lead person job title(s) and service area: ICB Programme Lead, Supplementary Services				

Step 1: Outline

1.1 Briefly describe the proposal

Give a brief description of the context, purpose, aims and objectives of the proposal. Describe what services are currently being provided. Describe the intended outcomes and benefits and who these might impact. Include whether it is a new proposal or change to an existing one and the key decision that will be informed by the EHIA (e.g. whether or not to proceed with the proposal to publish an employee handbook)

The aim of the review of the Supplementary Services Basket is to develop consistent, high quality, evidence based enhanced primary care which meets population needs, addresses inequity of access, improves health outcomes, and offers value for BNSSG. Underpinning this aim are the ICB principles. The review was seeking to evaluate and improve patient access and experience and tackle health disparities for this bundle of services. There was a clear commitment to co-design and involve stakeholders to enhance primary care in alignment with national and local priorities, jointly assess the impact on practice resilience and establish transparent funding

agreements. Most of the services only apply to adults, however spirometry and primary care-initiated bloods can be undertaken for children over a certain age as detailed within the service specification.

Currently, funding is allocated according to different historical methodologies across BNSSG practices which has led to differential payments to deliver the same services. Contracts have not been monitored since this contract was put in place, and it was apparent on review that there has been inconsistent service provision for our population. The current service specification is brief which leaves practices and our patients with a lack of clarity regarding inclusion and exclusion criteria. This review seeks to address the equity of funding, the inconsistency of service provision, and clarify the specification. After the new funding allocation method is implemented, the ICB will monitor activity to ensure full population coverage for the services within the contract, and to assess and mitigate impacts on practice resilience (although this work has already started) and on other healthcare partners such as community pharmacy and Sirona.

The scope of the EIA is to consider:

- What is the impact of resource allocation on the equalities of our population?
- What is the impact of any changes in the specification on the equalities of our population?

Health inequalities (HI) are systematic, avoidable and unjust differences in health and wellbeing between different groups of people. Reducing health inequalities improves life expectancy and reduces disability across the social gradient. What health inequalities have or might emerge and what actions can you take to reduce or eliminate them? Include details of any evidence, research or data used to support your work, e.g. JSNA, ward data, meeting papers, NICE etc below. You can also consider completing the HEAT tool to support summarising key issues, this can help to systematically evaluate HI:

Add comments here

Whilst the aim of this review is to ensure better access to services for patients, there is a risk that changing funding for practices may result in some practices being unable to deliver the services for the funding provided. We know that there is currently an inequitable service and a contract specification without adequate detail, which is resulting in some patients being unable to access care. Their neighbour registered with another practice may have access to that service. The review is aiming to make the allocation of funding for the services within the specification more equitable within the boundaried financial envelope generated by the general practice PMS contract review. There is a risk that a sudden change to a practice's allocation will result in discontinuation of services.
In order to mitigate this risk we are proposing a 3 year transition period to the new funding allocation. An Expression of Interest process to practices, asking them to sign up to the new specification with detail of their allocation and transition period, will give us the detail of any gaps in population coverage. We will then seek full population coverage by asking PCNs to cover in the first instance, as well as asking practices to work with other healthcare providers to deliver services. We also need to monitor and evaluate the impact of the new funding allocation method and identify consequences and mitigations with a plan of action for practices.

The recommended methodology for financial allocation is to use a score allocated to each practice that uses the Cambridge Multimorbidity Score. This is a score given to individual patients based on data from general practice records. The score takes into account that patient's long-term conditions e.g. diabetes, anxiety, hypertension. The score also predicts patient mortality, GP appointments and A+E attendances. This then gives each practice a weighting based on their population's scores.
This will then rank practices across BNSSG and determine their allocation from the identified Supplementary Services monies. Individual practice impact statements show that using this method, there is a strong correlation between the score assigned to the practice and the practice population deprivation level, meaning that the need of that practice population is reflected in the CMS and therefore the financial allocation for that practice. This approach would go some way in addressing health inequalities in BNSSG but would not specifically target the health inequalities experienced in minority ethnic populations in Bristol Inner City, where all practices would see a drop in income. The nature of the bundle of services within the scheme will inevitably influence the funding allocation toward older populations and those who are identified with multiple long-term conditions and needs. This does not deny the wider variation in health outcomes experienced by certain groups within the population of BNSSG which may require a much more systemic and wider review.

We will explore other ways of supporting practices whose funding is reduced as part of this review and therefore experience resilience issues, but separate to that, we should explore whether there are other opportunities to support those practices whose populations face widening health inequalities and actively consider how to identify unmet need to enable accurate resource allocation. As the CMS recognises complexity and multi-morbidity this will positively impact older people and people with a with a long-term condition(s) and therefore come under the protected characteristic of disability

Considerations/ actions for addressing inequalities:

The ICB is dedicated to addressing health inequalities across BNSSG via the Supplementary Services Basket by:

- Working with services to identify what current health inequalities data is collected and ensure more complete data collection is carried out, to help identify who is accessing the services broken down by relevant protected characteristic and health inclusion groups.
- Ensuring inclusive communications approach, including targeted messaging for priority communities.
- Ensuring that services are accessible and tailored to meet the diverse needs of different age groups, including older adults and children and where appropriate signpost patients to other services.
- Addressing any disparities in access to services and outcomes experienced by individuals from different racial, ethnic backgrounds and gender.
- Ensuring GPs have access to translators.

Give details of any relevant patient experience data or engagement that supports your work and where there is significant impact and major change how have patients, carers or members of the public been involved in shaping the proposal. Note, where the proposed change results in significant variation public consultation is required, seek advice from your PPI team. If you have not undertaken any engagement, state how you will involve people with protected characteristics or vulnerable groups in the project or explain why there is not likely to be any involvement.

There are no significant changes to the services provided; the review seeks to clarify the specification and ensure better access for patients. The Steering Group has Health Watch on the membership and will be developing a targeted communication and engagement plan during the transition period to support practices and patients. As above, any unintended consequences on patient experience need to be monitored and identified and action taken. No specific patient engagement was undertaken, although feedback from Healthwatch and patient complaints to the ICB on specific services, such as the lack of access for ear syringing, has fed through into the specification development. Healthwatch will work with specific practices and practice populations as the new contract is implemented to manage patient expectations if the practice requires a transition period to reach full service delivery.

Has the project/service ensured that they have/will comply with the Accessible Information Standards (AIS)? Yes or No
Describe how the project/service will ensure staff are in compliance and have a consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents, where those needs relate to a disability, impairment or sensory loss.
For more information on AIS please refer to and NHS England » Accessible Information Standard and AIS at NBT - YouTube.

The services form part of an NHS Standard contract with general practices and are an extension to core activities therefore expected to be provided in ways which comply with Accessible Information Standards. A separate project is taking place to review practice websites in accordance with AIS led by One Care.

Step 2: Impact

2.1 Could the proposal have a positive or negative impact on any of the protected characteristic groups or other relevant groups?

Although some of your conclusions will be widely known and accepted (e.g. need for accessible information), your analysis should include evidence to support your statements to aid the decision-maker – references and links to documents can be listed in section 4.1. Evidence might include insights from your engagement, focus groups, stakeholder meeting notes, surveys, research paper, national directives, expert opinion etc. If there is insufficient evidence, state this and include an action to find out more in the action plan in Step 3. In addition to having due regard for the Equality Act 2010 Public Sector Equality Duty to eliminate unlawful discrimination, advance equality and foster good relationship between protected groups; you must also have due regard to the principles of the Armed Forces Act 2021 including regarding the unique obligations and sacrifices they make, removing disadvantage and making special provision to ensure services and employment opportunities are accessible.

Positive Impact:				
☐ Sex	☐ Race	☐x Disability	☐ Religion & Belief	☐ Sexual Orientation
☐x Age	☐ Pregnancy & Maternity	☐ Marriage & Civil Partnership	☐ Gender Reassignment	☐ Armed Forces x☐ Other health inequality (please state below)

Bristol, North Somerset, and South Gloucestershire form a dynamic and lively region characterised by a diverse mix of urban and rural populations. While Bristol is predominantly urban, North Somerset and South Gloucestershire have a more rural character. The area boasts a heterogeneous demographic, with older populations in North Somerset and South Gloucestershire, contrasting with a younger populace in Bristol. The population is steadily increasing, particularly among those aged 15 to 24 and individuals aged 60 and above. The most significant predicted population growth over the next 25 years is expected to occur among those aged 85 and older.

This region is ethnically diverse, with Bristol having the highest proportion of Black and Minority Ethnic (BAME) individuals (16%) in comparison to South Gloucestershire (5%) and North Somerset (2.7%). Among the younger demographic, a substantial number belong to a BAME group. Within our area, there are notable pockets of deprivation, with approximately one in ten residents residing in economically disadvantaged areas. Life expectancy varies significantly between residents in the most and least deprived areas, with an approximate six-year gap, and some locations even witnessing a 15-year disparity

Research shows that people from minority ethnic backgrounds, people with disabilities and people from more deprived backgrounds are more likely to access care late, have worse outcomes and higher mortality in certain conditions. Although it is widely recognised that deprivation is associated with higher use of urgent care services, there are examples of good practice around reducing health inequalities in General Practice, for example, through the use of Multidisciplinary care teams that include social workers, community health workers, and other professionals to address the complex needs of patients with socioeconomic challenges.

The aim of the Supplementary Services basket is to offer consistent, high quality, evidence based enhanced primary care which meets population needs, addresses inequity of access, improves health outcomes, and offers value for BNSSG. The Basket of services is able to support patients who have more ‘complex’ needs including multiple long-term conditions and provide timely access to care closer to home, support early diagnosis and promote shared care.As the review looks to improve access to the services for our population, there should be a positive impact. The CMS uses multi-morbidity to reflect patient

complexity and allocate resource proportionately. This will have a positive impact on older people and people with a disability. In addition the criteria for access to ear syringing has been clarified to include service provision for people with significant learning disabilities and people with impaired communication and dementia.

Continuous service monitoring and activity data will provide further intelligence on the cohort of patients supported by the service and will enable the project team to identify any further positive / negative impacts.

Negative Impact

☐ Sex	☐x Race	☐ Disability	☐ Religion & Belief	☐ Sexual Orientation
☐ Age	☐ Pregnancy & Maternity	☐ Marriage and Civil Partnership	☐ Gender Reassignment	☐ Armed Forces ☐ Other health inequality (please state below)

Provide a narrative about the negative impact for any of the protected characteristic groups plus health inequality groups (such as digital exclusion). Also include intersectional impact where possible here:

There are pros and cons of all funding allocations. However, as part of the review a robust process was followed to identify the most appropriate formula for this review. A number of practices in areas of high deprivation will gain from this funding redistribution. Changes in funding distribution are apparent within localities as well as across BNSSG to reflect the specific population needs of each practice. One of the findings from the redistribution is however, that practices in the Bristol Inner City (BIC) PCN all stand to see reductions in allocation. These practices serve some of our most ethnically diverse populations with many languages spoken which require translation support as part of healthcare consultations.

Practices in BIC have a CMS ratio against the BNSSG standardised ratio ranging from -0.0077 to 0.1883. This compares with CMS ratios in Weston, Worle and Villages ranging from 0.0046 to 0.7147. In South Bristol the range is from -0.0465 to 0.5397.

Differences in resource allocation also reflect the differential starting points in allocation across BNSSG. The average overall funding allocation across Inner City and East CMS funding is £9.35 per head of population which is higher than the BNSSG average of £8.99, albeit below the average of £10.38 for Weston and Worle and £10.24 for South Bristol. Please note that these calculations will be updated with current practice list sizes.

Regardless of the distribution of the resource, practices are asked to provide all of the services in the specification as part of signing up to the LES. The items in the Supplementary Services specification have individual SNOMED codes which practices will use to record activity; these codes will then be extracted by the ICB BI team and reported through to the LES Steering Group. This data will be looked at by practice and locality level to understand delivery, identify areas of concern such as emerging inequalities, and determine next steps.

(you can share further details and mitigations below in 2.2)

No Effect

Your policy might not have a positive or negative impact, or it might maintain a status quo – complete this section if 'not applicable'
Add comments here

2.2 Outline any negative impacts of the proposal on people based on their protected characteristic or other relevant characteristic. Consider how you might level the 'playing field' for all people

Protected Characteristic(s)	Details of negative impact (e.g. access to service, health outcome, experience, workforce exclusion)	Identify any mitigations that would help to reduce or eliminate the negative impact
Race	Bristol Inner City practices all stand to see a reduction in funding through the CMS allocation method. This may impact practice ability to provide these services, meaning that population access may be reduced.	Should there be any practices unable to provide services to their population, we would look for full population coverage by asking the PCN to provide these services or seek population coverage from practices outside the PCN. After the new funding allocation method is implemented, the ICB will monitor activity to ensure full population coverage for the services within the contract, and to assess and mitigate impacts on practice resilience (although this work has already started) and on other healthcare partners such as community pharmacy and Sirona.

2.3 Outline any benefits of the proposal for people based on their protected or other relevant characteristics?

Outline any potential benefits of the proposal and how they can be maximised. Identify how the proposal will support our Public Sector Equality Duty to:

To eliminating discrimination, harassment and victimisation.	Positive	☐
	Negative	☐
	No effect	☐x

Please describe: The Supplementary Services review seeks to implement a fairer funding allocation method, ensure full population coverage of services in the basket, and clarify the service specification. There have been no problems to date with respect to bullying, harassment and victimisation, and the proposals in the review are not anticipated to cause any impact. Add comments here

To advance equality of opportunity between people who share a protected characteristic and those who don't	Positive	☐x
	Negative	☐
	No effect	☐
Please describe: The CMS score will recognise age and disability as it measures complexity and multimorbidity. The specification makes specific acceptance criteria for ear syringing for people with significant learning disabilities and people with impaired communication and dementia		

To foster good relations between people who share a protected characteristic and those who don't (e.g. does the project raise any issues for community cohesion, or linked to current topics that are contentious in society; will it affect relationships between any groups)	Positive	☐
	Negative	☐
	No effect	☐x
Please describe: The Supplementary Services review seeks to implement a fairer funding allocation method, ensure full population coverage of services in the basket, and clarify the service specification. There have been no problems to date regarding relationships between groups, and the proposals in the review are not anticipated to cause any impact. Add comments here		

Step 3: Action Plan

3.1 What actions will you take to mitigate the negative impact outlined above?

Action	Timeframe	Success Measure	Lead
We have worked with Ardens to design a template practices will use to record the activity within the basket. Each activity has its own code, which the ICB	Quarterly monitoring	All practices sign up and demonstrate appropriate/increasing (if transitioning to service delivery) activity levels	LES Review Steering Group

BI team will extract from EMIS. Reporting on these codes and activity will be through the LES Steering Group. Any practices with high or low activity will then require focused work to understand reasons for this and determine next steps.			
Work with HealthWatch on communicating changes to patients as services are introduced over the next year.	Over the service transition period	No complaints and clear communication to patients from practices about introduction of services and changes in access criteria, if applicable	LES Review Steering Group

3.2 How and when will you review the action plan (include specific dates)?

Quarterly monitoring of the activity in the specification at LES review steering group

Step 4: Impact

4.1 What are the main conclusions of this Equality & Health Inequality Impact Assessment?

Share a brief summary of the positive impact the project will make and any negative impact and mitigations, e.g. what steps you have been taken to improve accessibility, and what recommendations you are making to the decision maker.

Explain how the EHIA has informed, influenced or changed the proposal and include a recommendation for the decision maker

The aim of the Supplementary Basket of Services review is to develop a revised offer that reflects a consistent, high quality, evidence based enhanced primary care service which meets population needs, addresses inequity of access, improves health outcomes and offers value for BNSSG ICS. The EHIA has highlighted that in line with the Steering Group plans, the evaluation of the new methodology, understanding the gaps and mitigations, and monitoring of services provided is important to understand. We will update the EHIA with any relevant findings and resulting action plan. Most of the services in the Supplementary Services apply to adults only with only a few being offered to children.

Select a recommended course of action:	
Outcome 1: Proceed – no potential for unlawful discrimination or adverse impact or breach of human rights articles has been identified. E.g. proposal is not likely to have any detrimental impact on any group	☐
Outcome 2: Proceed with adjustments to remove barriers identified for discrimination, advancement of equality of opportunity and fostering good relations or breach of human rights articles. E.g. arrangements put in place to produce a BSL video to promote changes to a service	☐
Outcome 3: Continue despite having identified some potential for adverse impact or missed opportunity to advance equality and human rights (justification to be clearly set out). E.g. pilot benefits one neighbourhood due to funding restrictions	☐x
Outcome 4: Stop and rethink as actual or potential unlawful discrimination or breach of human rights articles has been identified. E.g. dress code policy discriminates against people who practice particular religions; new service that proposes to detain patient but insufficient evidence of safeguarding or human rights considerations in place	☐

Step 5: Review

All Equality & Health Inequality Impact Assessments should be reviewed internally and obtain sign off to show an organisational commitment.

Reviewer's Feedback (this document should be reviewed by an equality officer or trained project lead/senior manager)
Add comments here Reviewed and discussed with wider colleagues and support recommendations as described above. David Jarrett , Chief Delivery Officer
Equality Officer Name: N/A
Equality and Inclusion Team Signature: N/A
Date: 05/03/24

Equality Delivery System 2022

Equality, Diversity & Inclusion is an evidence-based practice, Healthier Together partners are committed to demonstrating how we have taken steps to improve patient and service user access, experience and outcomes and how we have created an inclusive working environment for our staff, including supporting our workforce to have healthy and fulfilled lives. Please indicate which Domain your project will deliver against:

Domain 1 – Commissioned & Provided services

- 1A: People can readily access the service.
- 1B: Individual people's health needs are met
- 1C: When people use the service, they are free from harm.
- 1D:People report positive experiences of the service.

Domain 2 – Workforce health and wellbeing

- 2A: When at work, staff are provided with support to promote healthy lifestyles and manage their long term conditions
- 2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source.
- 2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source (response to Covid-19)
- 2D: Staff recommend the organisation as a place to work

Domain 3 – Inclusive Leadership

- 3A: Board members and senior leaders (Band 9 and VSM) routinely demonstrate their commitment to equality.
- 3B: Board/Committee papers (including minutes) identify equality related impacts and risks and how they will be mitigated and managed
- 3C: Board members, system and senior leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients

Domain 1 – Commissioned and Provided Services
1A: People can readily access the service – the review aims to provide a consistent offer across BNSSG
1B: Individual people's health needs are met – the funding allocation recognises individual patient complexity and multi-morbidity to support greater resource allocation to meet these needs