Bristol, North Somerset and South Gloucestershire
Integrated Care Board

BNSSG ICB Primary Care Committee Meeting

Minutes of the meeting held on 30th January at 9.00am, held virtually via Microsoft Teams

Minutes

Present		
Alison Moon	Chair of Committee, Non-Executive Member – Primary Care	AM
Ellen Donovan	Independent Non-Executive Member, BNSSG ICB	ED
David Jarrett	Chief Delivery Officer, BNSSG ICB	DJ
Joanne Medhurst	Chief Medical Officer, BNSSG ICB	JM
Sarah Purdy	Partner Non-Executive Member, North Bristol NHS Trust	SP
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	RS
Apologies		
Sarah Truelove	Chief Finance Officer and Deputy Chief Executive, BNSSG ICB	ST
John Hopcroft	Vice Chair, Avon Local Optometry Committee	JH
Amanda Cheesley	Partner Non-Executive Member, Sirona Care & Health	AC
Amah Shah	Chair, Avon Local Optical Committee	AS
In Attendance		
Georgie Bigg	Healthwatch Bristol, North Somerset and South Gloucestershire	GB
Jenny Bowker	Deputy Director of Primary Care, BNSSG ICB	JB
Richard Brown	Chief Officer, Avon Local Pharmaceutical Committee	RB
Debbie Campbell	Chief Pharmacist, BNSSG ICB	DC
Loran Davison	Team Administrator, BNSSG ICB	LD
Jamie Denton	Head of Finance, Primary Care, Community & Children, BNSSG ICB	JD
Connor Evans	Executive PA, BNSSG ICB (Note taker)	CE
Jeff Farrar	Chair of the BNSSG ICB & Independent Non-Executive Member	JF
Katie Handford	Models of Care Development Lead, BNSSG ICB	KH
Bev Haworth	Deputy Head of Primary Care, BNSSG ICB	BH
Nikki Holmes	Head of Primary Care, Southwest, NHS England, and Improvement	NH
Geeta Iyer	Deputy Chief Medical Officer, Primary and Community Care, BNSSG ICB	GI
Matt Lenny	Director of Public Health, North Somerset Council	ML
Susie McMullen	Head of Primary Care Contracts, BNSSG ICB	SMc
Alison Mundell	Community Pharmacy Clinical Lead, BNSSG ICB	AMu

Shaping better health

Claire Ripley	Interim Dental Programme Consultant (non-clinical)	CR
George Schofield	Avon Local Dental Committee Secretary	GS

	Item	Action
1	**Welcome and Apologies** Alison Moon (AM) welcomed everyone to the Primary Care Committee (PCC). Apologies were noted as above.	
2	**Declarations of Interest** There were no new declarations of interest and no declarations pertinent to the agenda.	
3	**Minutes of the previous meeting held on 21st November 2023** The minutes were agreed as a correct record.	
4	**Review of Action Log** The Committee reviewed the action log: **Action 53** – David Jarrett (DJ) noted that the action around the delegation of POD services would remain open until June. **Action 80** – DJ noted the continued development to refine the risk register indicators. The risk register would be managed following the routine risk management approach. Item closed. **Action 89** – Jamie Denton (JD) updated the action regarding the review of opportunities across Pharmacy, Optometry and Dental (POD) services for the relative service underspends. Investments would be scoped and centred around retention and activity recovery for Local Dental Council, Continued Professional Development, rate of UDA, stabilisation for children in care and capital opportunities. There was a national call during January which could require the ICB to create a bad debt provision as a result of dental debt arising from contract hand backs. Item closed. **Action 90** – DJ noted that the deep dive into dental contracts and finance would come to the Primary Care Committee in an appropriate timeframe. Item remained open. **Action 91** – 6 monthly update including heat map of practices and variation to include health inequalities due in March 2024. Item remained open. **Action 92 –** Key messages from the last Primary Care Committee were shared with the ICB Board in December 2023. Item closed. All other due actions were closed.	
5	**Primary Care Risk Register** AM noted that the Primary Care Risk Register had developed and improved for each subsequent Primary Care Committee meeting. DJ explained that there was a commitment to ensure that the risk register was front and centre of the agenda for each Primary Care Committee. DJ noted that all the general practice primary care risks had been updated in month and included mitigating actions. Risks going forward to the Corporate Risk Register remained the same, noting themes around capacity and workload.	

	Item	Action
	DJ highlighted a key area to note around the joint working with commissioning hub colleagues to ensure that POD risks were noted on the risk register, ensuring that the scoring and risk ratings were in line with the ICB methodology. DJ noted the key themes detailed in the risk register: - UDA rate - Risk of corporate closure, notably BUPA. - Access for children - Access issues related to community dental services DJ suggested to link in the risks related to dental to the dental strategy item. Debbie Campbell (DC) requested clarity around scoring of pharmacy related risks as some of the scores appeared to be lower than expected. Jenny Bowker (JB) noted that only risks scoring above 12 were brought to the Primary Care Committee. Jenny Bowker (JB) to meet with DC to review the scoring of pharmacy related risks. George Schofield (GS) raised a new risk regarding the directive to phase out all Amalgam in the European Union by January 2025. This would cause disruption to the supply chain for the UK and have a large impact to dental services. AM was thankful to GS for registering the risk with the committee and noted that the risk implications and mitigations would be monitored through the Primary Care Operational Group. Ellen Donovan (ED) praised the risk register and noted how helpful the active updates were. ED referred to risk 30 on the register and queried if the post mitigation score could come down considering the savings to medicine. DC noted there was a remaining financial risk in relation to a forecast £1.7m overspend. AM noted the importance of active review of mitigations and scorings. Sarah Purdy (SP) raised concerns around the capture of risks relating to primary care workforce and capacity sustainability. DJ explained that delivery of the primary care strategy and the access & recovery work would manage the totality of that risk but noted it was not captured as a line on the register, but as an amalgamation of multiple risks. Jeff Farar (JF) added that primary care was an issue for the ICB Board and noted that the Primary Care Committee focus would be understanding key specific significant issues. Joanne Medhurst (JM) noted that it could be beneficial to have an overarching emerging issues log. Georgie Bigg (GB) highlighted the importance of capturing how people experienced services and the management of communication with the public, noting the necessary changes needed regarding public behaviour towards the NHS.	**JB/DC**

	Item	Action
	AM was supportive of making patient experience central to the Primary Care Committee. AM referred to the national issue around funding for dentistry and the need to identify the risks which could be controlled and where there was flexibility. AM was assured that David Jarrett, Shane Devlin and Jeff Farrar were linked in both regionally and nationally to provide a voice for the challenges out of the remit of the Primary Care Committee. AM supported JM point with regards to capturing issues which could become emerging risks and working out how they could be resolved before escalation. JF suggested that the GP Collaborate Board (GPCB) and OneCare received messages from the Primary Care Committee so that they could feedback to the ICB Board. **The Primary Care Committee received and discussed the Risk Register**	
6	**Primary Care Operational Group (PCOG) Report A** DJ noted that there were 2 months of reporting to bring to the attention of the Committee. In terms of the January PCOG, DJ summarised 5 key areas: • Supported guidance to PCNs around the use of clinical pharmacists Additional Roles Reimbursement Scheme (ARRS) roles and how to engage third parties in providing those posts where internal recruitment plans were challenged. Guidance supported by the ICB with representation from the LPC. • Considered a new provider selection regime approach within primary care for the re-procurement of the special allocation scheme which was provided by a practice located in South Birstol. • Recommended to proceed with a direct award with a current provider under the provider selection regime. Continuing to work through ICB SFIs and contracting process. In order to enable the direct award, approval and assurance would be required on the ICB boards behalf. • Reviewed further merger application through the Mendip Vale practice regarding the merger of Monkspark and Coniston with Southmead and Henbury (practices located in North West Bristol and South Gloucestershire) to create a Bristol hub for Mendip Vale. PCOG were not assured by the application process and sought further information from Mendip Vale in advance of approving the merger. • Continued investment in supporting international dental graduates. AM queried the size of Mendip Vale following the previous mergers, DJ noted it had a practice list size of close to 100k. AM questioned how there would be assurance that the things that work well in smaller practices were being retained, such as patient experience whilst benefiting from the resilience of having a larger team.	

	Item	Action
	Susan McMullen (SM) noted that as part of the application process, Mendip Vale would have to demonstrate patient impact and benefit assessments. Additional questions were asked regarding concerns about access following feedback from the recent patient GP survey. SM informed the Primary Care Committee of communications with Mendip Vale about ensuring patient choice for things such as registration, access or behaviour. SM noted that there had already been a partnership merger between the mentioned practices as they were able to undertake partnership merger without seeking permission. SM noted that applications would come to the ICB for approval when there was a request to merge contracts which were usually driven by seeking a shared patient list on EMIS. JM highlighted a strategic point with regards to reviewing the pros and cons of large practices compared to small practices by looking at sustainability and resilience of general practices, digging deeper and exploring what model would deliver the best service. DC requested that any potential review of general practice models also captured locally supported services in the system such as flu outbreak management. ED queried if practices could partake in merger if there were ongoing CQC concerns. SM noted that they would still be able to engage in partnership merger but would need ICB approval for contract related mergers. GB considered the social issues related to practice mergers such as the location of practices and potential travel issues around public transport or the cost of taxis, which could impact the overall quality of care a patient received. SM noted that there was a separate application process for the closure of a site which would review patient impact. AM noted that the role of the Primary Care Committee was to be assured and confident that the systems and processes in place were capturing the important aspects of general practice. In terms of the December Dental PCOG, Jenny Bowker (JB) summarised 3 key areas: • Considered adopting flexible dental commissioning guidance locally, recognising work with a small number of practices who had reached out for support around UDA rates. Proposed to develop principles to provide dental practices with support, focused on those performing well, and those with the lowest UDA rate. Considered adopting principles around uplifting UDA rate without removing activity for dental practices which were operating in a Core 20 + 5 area. Principles supported with the proviso that further modelling would be reviewed to determine if a wider approach could be used across providers.	

	Item	Action
	JB confirmed a regional group was looking at this work and was a priority for all 7 systems across the South West. • Received a proposal to develop a specification for delivering dental support to care home settings. Decision approved to support the workup of a specification noting the requirement to look at how it would work in the geography of BNSSG. • Request to support funding into regional oral health leads work. This was active a couple of years ago and the ask was to continue investment. PCOG decided not to support the request on the basis that more work was needed locally to maximise joint working with local authority partners. AM was supportive of the final point with regards to not making a decision if it was not the best choice for the population. Matt Lenny (ML) acknowledged the thoughtful approach as to what would work best locally. Regarding the update around care home settings, ML offered support from a local authority and social care perspective. GS raised concerns around ambition and equity. JB noted that modelling work would be undertaken to understand activity consequences and to develop an equitable approach. **The Primary Care Committee received and noted the update on the decisions made by PCOG**	
7	**Primary Medical Services Report** DJ noted that updates on the merger and procurement had already been highlighted in the PCOG Report. SM provided an update on Graham Road Surgery and the East Trees Health Centre incident. SM noted that Graham Road Surgery and Horizon Health Centre remained in special measures with the CQC. A reinspection was anticipated before the end of March 2024. There was a visit with regards to the warning notice from the CQC and the published reports show that the CQC were satisfied with the actions which had been taken in relation to the warning notice. BNSSG ICB undertook a visit on the 11th January and were in the process of finalising the report. A number of areas recorded significant improvement and a clear change in culture and drive to tackle issues at root cause. SM updated on the East Trees Health Centre and Eastville pharmacy incident which took place before Christmas. The incident resulted in significant damages to the health centre and pharmacy. SM noted that a number of activities had taken place since the incident including staff being provided counselling support. SM explained that there were closures initially as the site was deemed not safe for patients. SM noted a number of strands of learning which would be taken	

	Item	Action
	forward including work to support practices around raising the alarm, lockdown protocol and revisiting work on business continuity plan templates. Learning had been shared with pharmacy colleagues in the hub and were taken forward by OneCare for general practice. SM noted an upward trend in incidents involving violence and aggression. AM noted the shocking incident at East Trees Health Centre and was supportive of the shared learning. DJ requested that violence and aggression across health care services was revisited as a future agenda item at Primary Care Committee to discuss what further support could be provided to practices. GB updated that Healthwatch met with Graham Road Surgery and reported a receptive response around changes to the Patient Participation group (PPG). Healthwatch were invited to visit the practice to be given assurance that the recommendations had been completed. ED highlighted the multiple areas of learning and queried if there was an effective mechanism to share good practice and how improvement could be measured over time. SM explained that Jacci Yuill from the Access, Resilience and Quality (ARQ) team had completed a series of activities in preparing practices for CQC readiness prior to inspection, which involved best practice learning. SM noted a series of webinars, the production of a toolkit, previous work with the Local Medical Committee (LMC) and work around supporting the roles of lead nurses in ensuring that practices were CQC ready. SM acknowledged the key role that Jacci had in supporting practices in BNSSG which were upcoming for inspection and was integral in helping practices improve their rating. AM was keen for the committee to continue to receive wider learning consistently as part of the assurance papers. **The Primary Care Committee received the report and noted the key decisions and information from PCOG**	**DJ**
8	**Primary Care Finance report** Jamie Denton (JD) noted 2 finance papers in the report for November 2023. JD reported an overspend of £2.7m year to date which included retrospective and anticipated allocations. JD reported a forecast of £4m overspend which was an improvement of £1.5m since the last update to the Primary Care Committee and was directly attributable to medicine management. With regards to the additional roles reported, the allocation issue was £22.9m which was a significant increase over last years allocation. There was a planned spend of £21.7m which was £1.2m under the total allocation but represented an	

	Item	Action
	additional £7m spend on additional roles this financial year. JD noted that in total 600 WTE roles had been recruited through the additional roles scheme. JD noted an improvement in the reported financial position of medicine management. There remained a £2.7m overspend year to date attributable to price increases. JD explained that there was a 2-month delay on the actual invoices reported which would represent a larger forecast compared to other areas with more up to date reporting. AM positively acknowledged the news about additional roles. AM noted the potential effects on value for money and productivity and queried if a story could be told to demonstrate the impact of the additional roles scheme. DJ noted that more detailed information would be drawn out in future reports to provide an evidence impact assessment. JD reported on the POD position. DJ noted an improvement on the reported position of a £5.3m underspend year to date with a reported forecast underspend of £8.1m. JD noted 2 key contributors: • The national balance of optometry allocation expected this year has been confirmed for the next financial year. JD reported the underspend of 900k this financial year was reported in the collective and did not anticipate that underspend in future financial years. • JD noted a publication from November 2023. When the budgets were set, underperformance against contracts was placed into a reserve. The national confirmation was that the ringfencing would remain on the funding but there would not be a claw back by the national team to take funding away from ICBs. This was to support the overall financial position for ICBs nationally, recognising the emerging pressures from strike action and the cost of pharmacy products. JD noted that the impact of that change was a £4.6m increase on the underspend against dentistry. At the same time the pay allocation was aligned to activity and would have an equal underspend against the overall budget total, leading to an increase of £600k compared to the previous £4m reported to the Primary Care Committee. Rosi Shepherd (RS) noted planned conversations with DC regarding the under activity and prescription fees to determine if the issue was with people not being able to access medicine or if it was strictly a processing issue around charging. GS noted that funding had already been paid to dental practices so the claw back would cause major financial problems for practices. GS queried if the underspend included patent charges. JD noted that both the reduction in patient charge revenue and reduction in contract activity were included in the report. DJ agreed to meet with GS and JD regarding concerns raised regarding the financial implications to dental practices.	DJ DJ DC

	Item	Action
	DC asked to meet with JD to discuss how the pharmacy first budget would filter down and be allocated to local systems. ED noted the importance of having local flexibility to manage the reported underspend. DJ noted an action on the risk log to schedule a deep dive discussion on dentistry for the March meeting. **The Primary Care Committee:** • **Noted the summary financial plan** • **Noted the key risks and mitigations to delivering the financial plan** • **Noted that at month 8 (November), combined Primary Care budgets were reporting an overspend of £2.742 year to date, and a forecast overspend of £4.084m (including retrospective & reimbursable funding)**	**DJ**
9	**Delegation of POD Services** JB explained that following the delegation of POD services, it was agreed that there would be a period of transition to recognise the ongoing work that would need to be undertaken to be delegation ready with NHS England. JB highlighted that the report contained detail around actions, areas which were outstanding and an assessment against these points. JB noted that there were 2 amber rated areas within the report with supporting actions to address them. JB updated on the decision making process. A decision making framework had been agreed to support the decision making at both a regional level at South West PCOG and to describe the decision making processes ICBs would need to take going forward. Work had also taken place to review the development of regional priorities and to provide clarity of priorities for the commissioning hub. JB noted an internal review of FOI and SAR processes. JB explained the key areas worked on which included live risk logs, a complaints process and platforms for information sharing. JB noted the recommendation to close the transition period. The ways of working had developed significantly over the past few months and there would be continuous assessment of the joint working with the commissioning hub. AM thanked JB and the team for all the work undertaken to complete the transition period. AM asked for further details on the risks and mitigations related to the commissioning hub. JB noted that capacity in the commissioning hub remained constrained. Recruitment would mean the commissioning hub would be fully staffed from February onwards. JB highlighted the importance of being aligned on priorities as a region to maximise the capacity available. JB noted the top 3 priorities as UDA levelling, Flexible commissioning guidance and Reviewing stabilisation and urgent care pathways.	

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	JB updated on the monthly report for future proposals noting that there was a mock-up of what a future dental report could look like including a simpler explanation of primary care UDA reporting and the inclusion of benchmarking. Further information on the timeline would be available once a check was completed with other ICBs in the region. AM noted that the committee would also want to see a simplified optometry and pharmacy report alongside dental. **The Primary Care Committee received and noted the update on the delegation of POD Services**	
10	**Monthly Primary Care Activity Report** Nikki Holmes (NH) presented the monthly primary care activity report. Dental NH highlighted an updated position around stabilisation pilots and urgent care pilots and noted that they remained at a relatively high level. More information on primary care would be included in future reports. NH explained that the current position on the dental care group was not yet available but an update would be shared with the committee once ready. Pharmacy NH noted additional information around changes to community pharmacy, including the changes to the three Boots sites and the contract closures which were due. NH explained that the report noted the support being provided to practices and patients during the transition to a new provider. NH noted the regulation change which allowed 100-hour pharmacies to reduce their hours which the majority of pharmacies had taken up. The impact of each change had been reviewed and consideration was being given to any additional work required as part of the rota review. Optometry NH noted good progress on receiving responses from providers regarding quality in relation to optometry. ED referred to page 8 of the report and highlighted a significant spike to waiting list numbers. NH would check with the team and provide an update. GS noted a nation-wide issue regarding wait times for general aesthetic. AM suggested a ‘so what’ narrative to explain the detail behind activity reporting. JM added that the use of data would make it easier to understand benchmarking and requested that rates were included in the report to allow benchmarking against peers.	**NH**

	Item	Action
	AM queried if there was a specific update on the impact of the Boots closures in BNSSG. Richard Brown (RB) noted planning work was being undertaken in the Weston-Super -Mare area to provide the best support for residents by looking at resilience within the Weston area during the transition period. RB explained that the consolidation of the Boots estate in the Hartcliffe area of Bristol had not received the same level of interest. RB confirmed this had also been the case for the recent closure of the Boots estate in the Staple Hill area of Bristol. ML thanked colleagues for proactively working to identify and mitigate potential issues. ML noted that on 14th February, the Health and Wellbeing Board would be considering a response to an application received for a replacement to the pharmacy on the Bournville estate. ML noted that pharmaceutical needs and risk assessments were being worked through and explained that public communications had been shared with residents through various contact points. GB noted that in Portishead, patients had resorted to receiving prescriptions via the post and queried if there were any concerns about patients missing out on the value of attending local pharmacies. RB acknowledge the value of attending a local pharmacy but noted that the online prevision worked better for some patients. AM referred to page 40 of the report and highlighted that some of the data was out of date. AM requested that more up to date data was considered for future committee reports. **The Primary Care Committee received and noted the update on Primary Care Activity.**	
11	**Dental Strategy Update** DJ thanked all those involved in the dental strategy update. DJ noted that improving access to dental services was a key priority for the ICS, overseen by both the ICB and ICP. DJ explained that the paper had been brought to the Primary Care Committee to test the priority areas, identify any gaps and to outline the key messages to be emphasised in preparation of being presented to the ICB Board on Thursday 1st February. Claire Ripley (CR) joined the meeting to talk through the strategy document and shared the strategy on a page. CR explained that the strategy had been devised over the course of two workshops and a staff survey. CR noted that the final outcome determined three keys aims: • Reducing health inequalities by increasing access to NHS dental provision • Developing the workforce, retaining staff and attracting more applicants • Reducing the burden of dental disease through oral health promotion and integration with other services	

	Item	Action
	CR stated that further public and patient involvement would need to be undertaken, however within the next 12 months there was a commitment to prioritise a significant review of current NHS provision with the aim to sustain and increase population based access. CR noted that the review would include a capacity and demand audit, understanding capacity around workforce, understanding the services and activity being delivered and identifying what work would need to be done to sustain or increase provision. CR referred to the point raised by ED who highlighted concerns around waiting list numbers. CR noted consideration of local opportunities to reduce waiting list numbers as a priority over the next 12 months. CR gave an example of increasing the use of tier 2 services to provide sedation rather than waiting for general anaesthetic in secondary care. CR noted the key points detailed as part of the two-year focus on access to NHS dental provision: • Reduction of the administrative burden regarding the current referral pathways which was highlighted as a significant frustration throughout the staff survey • Increase public awareness of dental services. CR referenced conversations with the communications team to produce a roadmap of how people access different services whilst also stressing the importance of good oral health and increasing public understanding of NHS dentistry and other areas of primary care CR noted the key points detailed as part of the development of workforce, retaining staff and attracting more applicants. CR recognised that some of the targets could span between twelve months to three years due to the detail of work required whilst working regionally and any potential national developments: • Increasing the dental workforce by improving staff moral. CR noted that the staff survey indicated low morale amongst staff. This would be improved by looking at opportunities to increase population based access across different areas of interest to make NHS dentistry an interesting and varied role. • Consider a coordinated and locally focused dental recruitment plan. Look at the current workforce, understand the current skills available and identify opportunities to upskill staff. CR noted that a business case was being developed to fund and support people with continuing professional development. • Maintain the NHS dental provision by retaining the existing workforce, exploring how to prevent trainees moving to other areas following training and providing post foundation training support.	

	Item	Action
	CR noted the key points detailed as part of the reduction to the burden of dental disease through oral health promotion and integration with other services in coordination with local authority colleagues: • Consider opportunities to think about new roles • Embed oral health promotion throughout the population • Identify targeted interventions to improve oral health of the population CR explained that further work on public and patient involvement would be required prior to 1st April 2024. There would also be an evidence-based review related to ideas trialled in other areas and how they could be incorporated into the strategy, such as the consideration of fluoride and toothbrushing schemes. CR noted flexible commissioning opportunities were being looked at, in particular UDA rates had been reviewed and a set of principles had been agreed. CR noted urgent consideration continued to make a decision on contracts which were in a position to overperform up to permitted threshold of 110%. CR referenced the governance which would need to be put in place to support and deliver this work as well understanding the capacity required to support the data perspective in terms of audits, contracts and understanding activity finance. JB noted that commissioning hub had a big role to play in terms of ensuring the contractual commissioning cycle for dental. JB explained that strategy, transformation and identifying gaps and priorities for the population would be driven by the ICB. JM noted that to improve health inequalities there would need to be an understanding of variation across the population and a requirement to focus resource on areas with the highest level of need. GS raised concerns and the need for staff within dental services to feel valued to retain workforce. AM queried if the points highlighted in the strategy on a page alleviated any of the issues raised by GS with regards to workforce. GS explained that with the limited resource it would be tricky to ensure that everyone felt valued. There would need to be focus on areas with higher levels of health inequalities as providing a universal service for the population would not be achievable. GS noted that the UDA rate would not be viable due to cost pressures within dental services. ML noted that although the strategy on page referenced the reduction of health inequalities, by increasing access there could be an adverse impact which would instead widen inequalities by creating more access for those in a position to use it. ML queried if a change in wording could provide more clarity. ML positively acknowledged the oral health promotion but raised concerns about local capacity. ML noted that prevention and early intervention through early year providers, schools, and children and family hubs could have a significant impact.	

	Item	Action
	JB supported the good work taking place in North Somerset and noted the ambition to connect oral health promotion within the system to identify any gaps. ED queried the governance arrangements and asked whether the Primary Care Committee had a role to play in supporting delivery. DJ explained that he had executive oversight of the performance and delivery of dentistry working closely with RS and JM. DJ explained that the governance route was PCOG to Primary Care Committee to ICB Board. Dental services would sit within the overarching primary care governance. JF thanked DJ, JB and CR for the work on the strategy. JF supported the need be explicit about prioritisation and to be clear about what was being asked of the ICB Board and the choices which needed to be made. JF noted that in terms of public engagement, there would need to be consideration on how feedback would be captured from the vulnerable parts of the population. GS informed members of a pilot which took place in Cornwall in which a dental practice would only take on children up to 18, exempt patients and patients over 85. The 4000 patients who did fit the criteria were informed and although some feedback was negative, others were supportive and understood the decision. The additional capacity was used to see urgent patients who did not have a dentist. AM raised a few final points with regards to next steps: • Does the evidence and data support the identified priorities? • Was the proposed solution ambitious enough? • What enabling strategies would be needed from the rest of the system to make this work? • To be clear on what issues could derail the strategy objectives. • The ability to look up and out at other systems. • To be clear that this is an all-age strategy. • The development of smart objectives to monitor and measure progress. AM was impressed with the first draft of the strategy and thanked DJ, JB and CR. JB noted that the discussion at Primary Care Committee would be reflected at the ICB Board. **The Primary Care Committee:** • **Reviewed the information included in the draft strategy** • **Agreed the next steps including areas of escalation to the Board**	
12	**Pharmacy First update** Alison Mundell (AMu) joined the meeting to provide an update on Pharmacy First. AMu explained that on 9th May 2023 NHS England and the Department of Health and Social Care (DHSC) published a delivery plan for recovering access to primary care. The community pharmacy elements of the plan were to improve	

	Item	Action
	access to patients by GPs and community pharmacists collaboratively working together. AMu highlighted three things that the Pharmacy First service included: • GP referral into community pharmacist consultation service and seven new pathways. • Increasing provision of NHS pharmacy contraception service and blood pressure checks • An improved digital infrastructure between general practice and community pharmacy AMu noted that on 1st December 2023, there had been an expansion of the contraception service and the relaunch of the blood pressure service. The expansion of contraception services enabled community pharmacists who were signed up and trained to initiate contraception to enable greater use of pharmacy skill mix. Patients would also be able to find local pharmacies by using a postcode search tool. AMu explained that with the relaunch of the blood pressure service there would be blood pressure checks to help identify the 5.5m people with undiagnosed blood pressure at risk of heart attack and stroke through greater use of pharmacy team skill mix and heling GPs meet QoF targets. AMu explained that Pharmacy First was a new advanced service that would include 7 new clinical pathways and would replace the community pharmacist consultation service (CPCS). The full service would consist of three elements: • Pharmacy First (clinical pathways) • Pharmacy First (urgent repeat medicine supply • Pharmacy First (NHS referral for minor illness) With regards to infections to be managed via national clinical pathways, AMu highlighted that UTI, impetigo and sore throat were already being delivered through Local Enhanced Services which should support a smooth transition. AMu noted that BNSSG delivered approximately 2000 Patient Group Directions (PDGs) per month. AMu stated that BNSSG had undertaken an ear pilot for Otitis Externa and delivered approximately 300 a month across 30 pilot sites. AMu explained that the plan was to expand Otitis Externa locally and keep Hydrocortisone and Chloramphenicol PGDs. AMu assured that there would be a strict gateway process so there would not be an automatic supply of medication. It was explained that development of the clinical pathways would be delivered by multi professional experts, adhering to NICE guidelines and with Antimicrobial Resistance (AMR) Programme Board oversight. AMu noted that within BNSSG support would be provided through local training events. Work would be undertaken with practices to ensure that frontline staff understood how to refer to community pharmacy. AMu explained that 96% of community pharmacies had signed up within BNSSG. NHS England would closely monitor the Pharmacy First Service post-launch.	

	Item	Action
	AMu shared next steps: • Community pharmacy Primary Care Network (PCN) event on 31st January • Work with community pharmacy PCN leads to work with practices • LES PGDs papers presented to PCOG with view to expand Otitis Externa PGD • Training events organised by Community Pharmacy Avon • Additional Otoscopy training for contractors to attend • Training with Urgent and Emergency Care (UEC) • Roll out Community Pharmacy Services to North Bristol Trust and BrisDoc DC noted that the update had come to the Primary Care Committee to provide assurance that all plans had been put in place to support a smooth transition. DC asked members what data would be useful in future reports. AM stated that the Primary Care Committee would need to monitor impact and quality of interventions in terms of outcomes and improvements by tracking progress and identifying risks which could hinder delivery. AM responded to DC request for comments on future reporting and highlighted 5 key areas: progress, risk and mitigation, monitoring, assurance and next steps. AM noted that data benchmarking comparisons would be useful for the Primary Care Committee to see. DC noted that it would be important monitor impact on general practice in the wider system. **The Primary Care Committee received and noted the update on Pharmacy First**	
13	**Access Recovery Plan Update** DJ welcomed Katie Handford (KH) to ask questions of the committee in advance of providing a more detailed update in March. KH shared positive feedback from NHS England on the previously submitted plan which was being used as an exemplar. Identified actions would be implemented into the March 2024 report which also include the Healthwatch report. AM referred to the access recovery KPIs within the report and noted that some were not shifting and remained below target. AM requested an update on how progress would be made against these KPIs to provide confidence for the committee. AM noted general practice capacity and escalation and asked for clarity on the impact of general practice alert states being completed. ED agreed with AM and suggested focusing on a few of the KPIs at the next committee meeting. Bev Haworth (BH) explained that the March update would be a detailed board report, noting previous comments from the committee to articulate the data to provide better understanding.	

	Item	Action
	The Primary Care Committee received and noted the update on the Recovery Plan	
14	**Training Hub Update** **Item deferred to March**	
15	**Supplementary Services** Geeta Iyer (GI) joined the committee to update on supplementary services. GI acknowledged the work done by Jason Sarfi-Annin, clinical lead for value and population health. GI explained that committee members had been sighted on the background to the review which had been undertaken over the past 2 years. The slide deck included detail on historic payments made to practices and the activity in the basket. GI reiterated the principles around the review which were to develop fair consistent payments across practices, a consistent offer for patients, improve outcomes and deliver value for money. GI explained that there would be a fundamental impact to practices and highlighted the importance of understanding the impacts and mitigating them. GI highlighted that the work had considered the redistribution of a fixed fund and outlined the constraints. From a governance perspective, work had been done through both the Reference Group and the Supplementary Services Steering Group to develop options around funding allocations. These options had also been discussed with the General Practice Collaborative Board (GPCB) and LMC colleagues. GI outlined the four options which were considered, noting that one would be put forward to the committee as a recommendation with the view of going to the ICB Board in March 2024. Option 1 - Carr-Hill Formula Established model of resource allocation. Does not consider individual practices or atypical populations. This approach did not reflect the specified activity within the LES. Option 2 - Health Inequalities Index Nationally set formula. Considered factors related to wider determinates of health by designing geography and then applying to an individual practice population. Not ideal and did not reflect the specified activity within the LES. Option 3 – Weighted population based on practice Cambridge Multimorbidity score index Developed for use in general practice. Patients would be given a score based on non-communicable disease conditions e.g. diabetes, hypertension and mental health. This method also looked at 1 & 5-year mortality, general practice appointments and unscheduled emergency department attendances. GI noted that Jason Sarfi-Annin had used the score index for the BNSSG population	

	Item	Action
	demographic to apply a score to each practice based on its population. The data produced represented the multi-morbidity within that practice population whilst also standardising the BNSSG population to draw comparisons. Option 4 – Delphi method Panel of experts convened to look at activity and give relative weight to that activity, looking at how much resource would be needed to deliver. Subjective approach due to the use of a panel and also heavily reliant on data received which was not consistent amongst all practices. GI noted that the slide deck provided a high-level comparison of existing payments and what the payments would be for each funding option. GI highlighted the importance of being clear about what was trying to be achieved by the review and noted that delivering an excellent service for patients and implementing a fair funding agreement would need to be balanced against practice resilience. GI explained variations in the funding options. Some looked at whole populations regardless of activity whilst others were more triangulated with activity level data. GI noted that feedback from the Reference and Steering Groups caused some swings in relation to the different options. The Cambridge Multimorbidity option was deemed as the most equitable approach as it looked at the needs of the practice population and the level of activity that would be driven to the practice. GI explained that it ticked the boxes with regards to delivering value for money, provided a fair reflection of practice activity whilst adhering to the previously established principals behind this work. A recommendation was made to the Primary Care Committee from the Supplementary Services Steering Group to use the Cambridge Multimorbidity score index method. GI noted that individual practice level impacts would need to be completed and triangulated against existing resilience work which could impact the final recommendation to the ICB Board. GI highlighted the identified risks outlined in the report, as this was a redistribution of a fixed funding envelope, there could be an impact to resilience leading to changes in service delivery. GI noted that this work was of high interest to practices and the population. Throughout the review communication had been maintained with practices and key stakeholders. GI noted that a communication plan would be developed. GI explained that there would be a transition period of two years to provide practices with reassurance. GI noted that a phasing-in period was being modelled so practices could anticipate changes to income. It was explained that throughout the process drop-in sessions had been made available to practice managers and these would continue.	

	Item	Action
	An extra-ordinary Primary Care Committee would be convened prior to the March ICB Board to provide the Committee with the detail of the practice level impact statements. AM emphasised the point previously raised to be brave and explicit about what was being prioritised and asked of the ICB Board. AM noted that although option 3 was being recommended there was a big caveat around local resilience work which could impact the recommendation. ED highlighted the importance of having the analysis and further detail available when taking the recommendation to the ICB Board to ensure that Board members had clarity around what was being asked. SP referred to the report and queried the proposed uplift to practices in Woodspring. GI noted that the starting point for practices in North Somerset was lower and it was anticipated that there would be an uplift regardless of the option chosen. JM supported the recommendation and noted that general practices were used to changes in financial formula allocation but stressed the importance of keeping resilience and safety in check. GI explained that there were avenues to support practices such as Section 96 funding. JB flagged that a lot of engagement work had been undertaken but disruption was expected and it was understood that some practices would be unhappy. DC supported the recommendation and asked what could be done differently to improve any future decisions using data. GI noted that the practices who were not providing data could start following the recommended changes. AM noted that it would be important to be clear about the transition period when taking the recommendation to the ICB Board. DJ referenced the suggestion of an extra-ordinary Primary Care Committee at the end of February to formally make the recommendation to the ICB Board. AM suggested a conversation offline to agree on an extra-ordinary committee meeting. **The Primary Care Committee:** • **Noted the progress of the review** • **Acknowledged the recommended funding allocation option put forward by the Steering Group** • **Noted and supported the next steps including a further briefing before a final proposal is presented to the ICB Board in March 2024**	**DJ/AM**

	Item	Action
16	**Key Messages for the ICB Board** • Improvement of risk-based approach used by the Primary Care Committee • Importance of decision making of PCOG • POD closure plan • Dental Strategy • Supplementary Services	
	For Information	
17	**Primary Care Operational Group (PCOG) Minutes** **The Primary Care Committee noted the minutes.**	
18	**Forward Plan** **The Primary Care Committee noted the forward plan**	
	Date of Next Meeting Tuesday 26th March 2024, at 9.00am, via Microsoft Teams.	

NHS
Bristol, North Somerset
and South Gloucestershire
Integrated Care Board

BNSSG ICB Extra Ordinary Primary Care Committee Meeting

Minutes of the meeting held on 27th February 2024 at 9.00am, held virtually via Microsoft Teams

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Minutes

Present		
Alison Moon	Chair of Committee, Non-Executive Member – Primary Care	AM
Amanda Cheesley	Partner Non-Executive Member, Sirona Care & Health	AC
David Jarrett	Chief Delivery Officer, BNSSG ICB	DJ
Joanne Medhurst	Chief Medical Officer, BNSSG ICB	JM
Sarah Purdy	Partner Non-Executive Member, North Bristol NHS Trust	SP
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	RS
Apologies		
Debbie Campbell	Chief Pharmacist, BNSSG ICB	DC
Ellen Donovan	Independent Non-Executive Member, BNSSG ICB	ED
Jeff Farrar	Chair of the BNSSG ICB & Independent Non-Executive Member	JF
Sarah Truelove	Chief Finance Officer and Deputy Chief Executive, BNSSG ICB	ST
In Attendance		
Georgie Bigg	Healthwatch Bristol, North Somerset and South Gloucestershire	GB
Katrina Boutin	GP, Old School Surgery & Medical Director of GPCB	KB
Jenny Bowker	Deputy Director of Primary Care, BNSSG ICB	JB
Richard Brown	Chief Officer, Avon Local Pharmaceutical Committee	RB
Loran Davison	Team Administrator, BNSSG ICB	LD
Jamie Denton	Head of Finance, Primary Care, Community & Children, BNSSG ICB	JD
Vittorio Graziani	Senior Contracts Manager, BNSSG ICB	VG
Bev Haworth	Deputy Head of Primary Care, BNSSG ICB	BH
John Hopcroft	Vice Chair, Avon Local Optometry Committee	JH
Geeta Iyer	Deputy Chief Medical Officer, Primary and Community Care, BNSSG ICB	GI
Matthew Jerreat	Local Dental Network Chair, NHS England	MJ
Matt Lenny	Director of Public Health, North Somerset Council	ML
Susie McMullen	Head of Primary Care Contracts, BNSSG ICB	SMc
Shaba Nabi	Chair, Avon Local Medical Committee	SN
Lucy Powell	Corporate Support Officer, BNSSG ICB (Note taker)	LP

Shaping better health

George Schofield	Avon Local Dental Committee Secretary	GS
Nwando Umeh	Programme Manager (Interim), BNSSG ICB	NU

	Item	Action
1	**Welcome and Apologies** Alison Moon (AM) welcomed everyone to the Primary Care Committee (PCC). Apologies were noted as above. AM welcomed Shaba Nabi (SN) to her first meeting of PCC as Chair of the Avon Local Medical Committee (LMC). AM explained that the extraordinary meeting had been convened for further discussion on the outcome of the supplementary service review prior to presentation to the March ICB Board meeting for approval. AM asked the Committee to consider the papers against the 4 aims of the ICB: to improve outcomes in population health and healthcare, tackle inequalities in outcomes, experience and access, enhance productivity and value for money, and support broader social and economic development.	
2	**Declarations of Interest** AM noted that every member registered with a BNSSG GP Practice had an interest in the outcome of the review. It was not expected that this would be declared and was not considered a conflict. Katrina Boutin (KB) was noted as having a conflict of interest as KB held a financial interest in the items to be discussed as a GP Partner for Old School Surgery. AM confirmed that KB had received the papers and would be invited to discuss the items. SN was noted as having a conflict of interest as SN held a personal professional interest in the items as a GP for Charlotte Keel Medical Practice. AM confirmed that SN had received the papers and would be invited to discuss the items. It was noted that neither KB nor SN were voting members of the Committee and therefore were not responsible for recommending the preferred option to the ICB Board. AM confirmed that every member of the Committee had received the papers with the papers for Part B being confidential and commercially sensitive. There were no new declarations of interest.	
3	**Supplementary Services** KB held a financial interest in this item. It was agreed that KB would have access to the papers and contribute to the discussion. It was noted that KB was not a voting member of the Committee. SN held a personal professional interest in this item. It was agreed that SN would have access to the papers and contribute to the discussion. It was noted that SN was not a voting member of the Committee.	

	Item	Action
	David Jarrett (DJ) provided the background to the programme noting that this had been a long and complex piece of work. DJ explained that the supplementary services had been reviewed through the lens of the 4 ICB aims. The ICB undertook significant engagement across the primary care community throughout the review. The programme remained a challenging process for both the ICB and individual practices but the ultimate aim was to redistribute the available fixed fund envelope in a way which was equitable and targeted reductions in health inequalities. Geeta Iyer (GI) explained that at the January PCC meeting the four funding allocation options had been presented with the recommendation to proceed with option 3 derived from the Cambridge Multimorbidity Score Index. The PCC approved the recommendation in principle with the caveat that the individual practice impacts needed to reviewed and presented to the Committee before final recommendation could take place. GI confirmed that further work had taken place to review the impact on the individual practices and additional assurance had been included in the paper which was due to the presented to the ICB Board on the 7th March 2024 for approval. GI explained that the ICB Board would be presented with the same paper which outlined the background to the programme and explained that the draft specification had been reviewed by clinical members of the reference group and LMC and GP Collaborative Board (GPCB) colleagues. GI noted that further feedback on the draft specification was expected. It was confirmed that the draft specification and individual financial impact statements had been circulated to practices to support the practice decisions to sign up to the supplementary services. GI explained that information had been provided and feedback gathered through GP Forums over the past 18 months. GI noted that work on the programme continued to provide more information on the outcomes and delivery of the specification. The ICB continued to source best practice and link the specification with the BNSSG Remedy pathways. GI confirmed that the ICB also continued to develop the requirements for contract monitoring. GI confirmed that the GP Forum meeting feedback had included concerns related to the impact of the redistribution of funding on practice resilience. There had also been questions about the transition period, payment method and service delivery. This included questions about the consequences if a practice was unable to deliver the services and the lead in time to delivery. GI noted that queries had also been raised about capping activity. This was not preferred by the ICB as the aim was for services to be available to the whole BNSSG population. GI confirmed that the ICB was committed to monitoring activity and	

	Item	Action
	identifying any under provision but also increasing demand so that support could be targeted and provided to any practices which needed additional help. GI explained that the feedback had informed the risks and these had incorporated the impact and concerns around practice resilience. Individual impact statements had been developed for each practice and the ICB had contacted the practices who would be the most affected. GI noted the importance that the ICB supported mitigations to reduce disruption of services and noted that Primary Care Network (PCN) coverage for practices unable to deliver the services had been considered. GI also noted the importance of working with system partners such as Sirona and Community Pharmacy to support the schemes. GI explained that once implemented, the impact on healthcare partners would be monitored to ensure that there were no unintended consequences elsewhere in the system. GI confirmed that if the proposal was approved by the ICB Board then the ICB would confirm the offer with practices and have direct support meetings. The Expression of Interest process was expected to take place in March 2024 with the finalisation process in April 2024. The ICB would be working closely with Healthwatch to support communications and consultation with the public and practices. GI brought the Committees attention to the Quality Impact Assessment (QIA) which had been prepared and detailed the system partner impacts. The Equality Impact Assessment (EIA) was in development. AM asked whether the additional layer of detailed work had indicated that the recommended funding option was still preferred. GI confirmed that following the work, option 3 derived from the Cambridge Multimorbidity Score Index remained the recommended option. KB raised concerns with the principle behind the programme which redistributed the funding down rather than up with no additional investment. KB noted that the cap on the funding would impact most practices outside of North Somerset and some practices would lose significant funding. KB acknowledged that North Somerset practices had been underfunded in this area for long time. KB emphasised the resilience concerns for practices which were significant. KB highlighted that the programme method and consultation had been positive, and the aim to provide the least impact on practices was welcome, but the principle to redistribute the capped funding rather than invest in GP services would have a significant negative impact on practices who were struggling. KB noted that this fundamental principle of not increasing the funding for GP Practices was the challenge to the ICB Board. KB confirmed that the GPCB had significant	

	Item	Action
	concerns on the impact of the work on Practices across Bristol and South Gloucestershire. GI explained that the ICB had been clear that the supplementary services review related to a fixed pot of funding and the risks of redistribution included the financial impact on practices. GI also confirmed that the services included in the review had not been monitored since 2018 and not every practice was delivering the elements of the service specification. The outcome of the review would support monitoring of the services which in turn may identify that further investment was needed. KB asked that the ICB Board received information detailing who made the decision to cap the funding and what would have been the required investment to equalise the practices upwards. DJ agreed and suggested that to ensure the ICB Board received the full context it was important that the paper also included the total investment into primary care and PCNs as well as the money allocated due to growth. AM welcomed the challenge and confirmed that providing the background on the initial project decisions, as well as providing additional financial context would be helpful for the ICB Board. It was agreed that this additional detail would be added to the ICB Board paper. SN agreed with the points made by KB and noted the importance that the ICB Board paper framed the information in the sense of the past, present and future. SN explained that the envelope of funding had been part of a PMS review process in 2016 where GP funding had been rebadged as money for supplementary services. SN explained that GPs were receiving money for non-core services which had previously been practice money and therefore historically the money should have been provided without having to undertake additional work. SN acknowledged that the 2016 review had taken place to redistribute the money more fairly as practices were receiving different amounts per patient but the redistribution had resulted in anomalies. SN highlighted that future investment should not be capped and noted that where monitoring indicated increases in activity the price per patient needed to increase. SN also noted that option 3 did not appear to support the inner city practices which were situated within deprived areas and therefore would not support equitable improvement of health inequalities. Jamie Denton (JD) highlighted that the project had faced a challenging decision as the amount of funding was fixed but highlighted that the funding was subject to NHS annual inflation and would increase by this percentage per year. AM noted that the ICB Board paper needed to consider the support of the transition plans and the resilience of the practices as well as the consequences if a practice was unable to function. AM asked whether it was reasonable for PCNs	DJ DJ

	Item	Action
	to be able to support practices. GI noted that there had been practical working examples where PCNs had temporarily covered services where local machines were broken or teams were waiting for training. GI explained that the ICB would need to explore how permanent these arrangements could be through testing with other LESs. GI explained that some practices had expressed an interest in covering those patients for some schemes and so there were potential opportunities. KB noted that PCN support was complicated often by the limitations of EMIS and financial remuneration complexities. KB asked whether the inflation rate offered was the 1.9% as the cost of living increase would have a significant impact on GP Practices. JD confirmed that it was the 1.9% but noted that the increase for all other NHS organisations would be 1.2%. SN explained that the wage increase pressures were more relevant in primary care who had greater numbers of staff on the lower wage bands which would need to increase. AM highlighted the point made by SN that the recommended option did not support reduction of health inequalities in the inner city. Jenny Bowker (JB) confirmed that the recommended option was based on comorbidities and therefore was not a perfect fit for the younger populations of the inner city. JB explained that the option recognised the health inequalities prevalent in North Somerset, South Bristol and some areas of South Gloucestershire. JB noted that some of the inner city practices would lose funding more than some other practices and also there were other practices that lose more than inner city practices. The Steering Group had considered a purely health inequalities approach but this had resulted in much larger swings in funding and one of the principles of review was to ensure that practices were not destabilised. The comorbidity option had been the best median position in balancing the considerations. JB noted that no option was perfect. The changes were also linked to the differential funding allocations from which practices started across BNSSG. AM highlighted the importance that the considerations for all the options were communicated to the Board including the pros and cons of the recommended option. SN appreciated there was no perfect solution but asked the Committee to reflect on the concerns that the CMS method appeared to support a specific cohort of deprived population which was mostly white and there was a disproportionate negative impact on those deprived areas with a predominantly non-white populations. Jo Medhurst (JM) agreed with all the points made and noted that the ICB had recognised that there was inequitable funding and needed to make a decision rather than continue compounding the issue. JM highlighted that the EIA should have been presented with the papers to enable the Committee to make an	**DJ**

	Item	Action
	educated recommendation to the ICB Board. JM noted that the service specification needed to outline clear clinical measurable outcomes which would allow the specification to change when differential outcomes were identified. JM also noted that there were more programmes of work coming into primary care which needed a standard approach and process to include these programmes into the practice contracts. SN noted that the LMC would oppose using the supplementary services as a vehicle to introduce further non-core work. Sarah Purdy (SP) highlighted two issues; inadequate funding for general practice and efficient decision making to support practices. SP highlighted that the EIA would have been a helpful document to support recommendation to the ICB Board. Amanda Cheesley (AC) confirmed that there would be significant impact on Sirona should GP Practices be unable to deliver services particularly regarding home visits where patients could potentially be supported by another part of the system. AM suggested that the impact for patients having their care through another service needed to be considered for the risk section. AC agreed and explained that the risks relating to other partners needed additional detail and consideration. GI confirmed that the QIA had been expanded and included more information regarding where the activity may possibly shift. GI confirmed that the impact on other services would be monitored. Georgie Bigg (GB) noted that patient feedback was a good indicator of patient experience of services and confirmed that Healthwatch would be able to support this work. GB noted that collection of activity data was important but equally as important was the patient outcome data. AM recognised that there was no perfect model but there was a clear ambition to provide equity across the system. AM explained that the ICB Board paper needed to clearly outline the rationale for the approach and the EIA would be crucial in reviewing the impact on health inequalities. SN noted that language requirements was an important part of the EIA as this was not addressed in the formulas for the global sum price per patient. AM confirmed that the PCC had noted the report and provided feedback to incorporate into the paper for the ICB Board. AM noted that the PCC members would have preferred to have seen the EIA before endorsing the recommendation to the ICB Board. The feedback had been included in the minutes and outlined the additional information the ICB Board would need to make an informed decision. This included: • More background information including the initial project decisions • Greater financial context for past, present and future	

	Item	Action
	• More information about the transition plans and resilience of practices • The advantages and disadvantages of option 3 for reducing health inequalities AM noted the three year rather than two year transition period and emphasised that the context behind this position needed to be presented to the ICB Board. AC noted the importance that any disparities were monitored during this three year period and any concerns acted on quickly. **The Primary Care Committee provided feedback and asked that several amendments for clarity were made to the paper for ICB Board.** **The Primary Care Committee endorsed the approach for ICB Board approval but noted that these endorsements were made without sight of the Equality Impact Assessment:** • **The revised specification for introduction from 2024/25** • **To 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 practice to enable planning over the short-medium term**	
4	**Supplementary Services Practice Impact Assessment**	
5	**Any Other Business** There was none.	
	Date of Next Meeting Tuesday 26th March 2024, at 9.00am, via Microsoft Teams.	

Lucy Powell, Corporate Support Officer, Feb 2024

Bristol, North Somerset and South Gloucestershire
Integrated Care Board

BNSSG ICB Primary Care Committee Meeting

Minutes of the meeting held on 26th March 2024 at 9.00am, held virtually via Microsoft Teams

Minutes

Present		
Alison Moon	Chair of Committee, Non-Executive Member – Primary Care	AM
Amanda Cheesley	Partner Non-Executive Member, Sirona Care & Health	AC
David Jarrett	Chief Delivery Officer, BNSSG ICB	DJ
Sarah Purdy	Partner Non-Executive Member, North Bristol NHS Trust	SP
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	RS
Apologies		
Ellen Donovan	Independent Non-Executive Member, BNSSG ICB	ED
Debbie Campbell	Chief Pharmacist, BNSSG ICB	DC
Joanne Medhurst	Chief Medical Officer, BNSSG ICB	JM
Nikki Holmes	Head of Primary Care, Southwest, NHS England and Improvement	NH
Amah Shah	Chair, Avon Local Optical Committee	AS
Sarah Truelove	Chief Finance Officer and Deputy Chief Executive, BNSSG ICB	ST
In Attendance		
Georgie Bigg	Healthwatch Bristol, North Somerset and South Gloucestershire	GB
Katrina Boutin	GP, Old School Surgery & Medical Director of GPCB	KB
Jenny Bowker	Deputy Director of Primary Care, BNSSG ICB	JB
Richard Brown	Chief Officer, Avon Local Pharmaceutical Committee	RB
Loran Davison	Team Administrator, BNSSG ICB	LD
Jamie Denton	Head of Finance, Primary Care, Community & Children, BNSSG ICB	JD
Jeff Farrar	Chair of the BNSSG ICB & Independent Non-Executive Member	JF
Bev Haworth	Deputy Head of Primary Care, BNSSG ICB	BH
John Hopcroft	Vice Chair, Avon Local Optometry Committee	JH
Matt Lenny	Director of Public Health, North Somerset Council	ML
Susie McMullen	Head of Primary Care Contracts, BNSSG ICB	SMc
Shaba Nabi	Chair, Avon Local Medical Committee	SN
Lucy Powell	Corporate Support Officer, BNSSG ICB (Note taker)	LP
George Schofield	Avon Local Dental Committee Secretary	GS

	Item	Action
1	**Welcome and Apologies** Alison Moon (AM) welcomed everyone to the Primary Care Committee (PCC). Apologies were noted as above.	
2	**Declarations of Interest** There were no new declarations of interest. Shaba Nabi (SN) noted that as an employee of Charlotte Keel Medical Practice she had a professional interest in the decisions made regarding the contract in PCOG (Item 6). It was agreed that the due to the level of information shared, the interest did not give rise to a conflict.	
3	**Minutes of the previous meetings held on 30th January 2024 and 27th February 2024** Both sets of minutes were agreed as a correct record.	
4	**Review of Action Log** The Committee reviewed the action log: **Action 53** – Jenny Bowker (JB) explained that the monthly primary care report now included benchmarking and comparisons to other areas in the South West. The ambition was for the report to include national comparisons and the report would continue to evolve. It was agreed to close the action. **Action 90** – David Jarrett (DJ) asked that the intention to hold a deep dive into dental contracts was included on the PCC forward planner. This was agreed and the action was closed. **Action 91** – The 6 monthly update for the Joint Forward Plan would include the heat map of practices and variations. It was agreed to capture the item on the PCC forward planner and close the action. **Action 93 –** JB and Debbie Campbell had met and refreshed the risks. The action was closed. **Action 94 –** DJ confirmed that violence and aggression to primary care staff needed to be added to the forward planner as an agenda item. This was agreed and the action was closed. DJ noted that the issues was wider than primary care and suggested a discussion at the ICB Board as well. **Action 95 –** DJ confirmed that additional financial detail regarding the Additional Roles Reimbursement Scheme (ARRS) would be built into the finance report. Wider information regarding ARRS would be built into the appropriate reports. The action was closed. **Action 96 –** As part of business as usual, JB and George Schofield (GS) met regularly. The action was closed. **Action 97 –** Jamie Denton (JD) confirmed that the Pharmacy First allocations would be discussed as part of budget setting. The action was closed. All other due actions were closed.	
5	**Primary Care Risk Register** DJ presented the risk register and noted one risk over 20. This risk related to the capacity of the commissioning hub. The latest update had confirmed that some capacity had returned to the hub, leadership roles were changing, recruitment	

	Item	Action
	continued and the structure of the hub was being considered. The ICB was not receiving the service expected from the hub particularly in addressing individual practice concerns. DJ confirmed that the score remained the same despite the recruitment plans. The concerns had been escalated to Shane Devlin. DJ highlighted a risk related to the Access, Resilience and Quality (ARQ) programme and its capacity to support GP practices. DJ explained that with the change in GP contracts and the impact of the supplementary services review, the ARQ programme was a valuable asset and there were challenges with funding the programme this year. Funding for the programme was through the System Development Funding (SDF) and the ICB was currently working through the prioritisation for this funding. JB noted that the prioritisation process was live and Bev Haworth (BH) would be updating the GP Collaborative Board (GPCB) on the process and options would be considered with stakeholders. It was expected that a decision would be made in April 2024. Ellen Donovan (ED) had asked whether the reduction of the score to 12 was appropriate given the uncertainty of funding for the ARQ programme. It was noted that this was correct given the current position and ongoing work. AM asked what the impact was of the reduced commissioning hub capacity. DJ provided an example of a dental practice who had raised concerns with the hub which had not been acted upon. The ICB was now having to manage the resilience issue and the risk of contract withdrawal. AM noted that the Committee had discussed ARQ support for all primary care services previously and DJ confirmed that the ICB would want to provide resilience support wider than just primary care medical services but the resource was not available. DJ noted that if the hub was unable to provide the support needed then the system would have to consider how to deliver this. GS noted that there were long standing concerns about the responsiveness of the hub which led to dental staff feeling undervalued and ceasing NHS services. AM noted that there was currently a lack of assurance from the hub regarding capacity. JB explained that there were wider concerns which included the mid-year contract review process taking place at the end of the year and contract variations being delayed. The ICB continued to escalate these concerns. DJ explained that the hub was hosted by Somerset ICB who had called together all the system Chief Executives to discuss assurance across the Integrated Care System (ICS) and Shane Devlin would continue to raise this with system Chief Executives. DJ noted that the Primary Care Committee Chairs and Executive Directors used to meet regularly with NHS England to discuss concerns but these meetings had ceased. AM offered to provide support as required. Jeff Farrar (JF) would raise the concerns with the Regional Director.	

	Item	Action
	The Primary Care Committee received and discussed the Risk Register	
6	**Primary Care Operational Group (PCOG) Report A** SN noted that an employee of Charlotte Keel Medical Practice she had a professional interest in the item. It was agreed that the due to the level of information shared, the interest did not give rise to a conflict. The decisions from the March PCOG meeting were included in the paper. DJ confirmed that all items had been discussed in depth but highlighted the key decisions: • PCOG had received the additional information requested and supported the merger application for Monks Park, Sea Mills and Southmead and Henbury practices. PCOG had originally declined the application and asked for further assurance which had been provided. • PCOG approved the clinical waste contract extensions to enable consideration of a national procurement approach. • Following PCOG approval, the ICB was undertaking a market engagement exercise for Graham Road Surgery, Horizon Health Centre and Charlotte Keel Medical Practice (CKMP) contracts. PCOG had considered the conflicts of interests of members and managed these to ensure a decision was made. Katrina Boutin (KB) highlighted that following the previous procurement for CKMP, the ICB had committed to undertaking a lessons learnt review. DJ confirmed that a specific paper relating to lessons learnt from the procurement had been developed as well as a wider procurement lessons learnt paper which included learning from all recent procurements. This paper had been presented to the ICB Board and DJ agreed to circulate the report to the Committee. DJ confirmed that the lessons learnt from the previous CKMP procurement had been embedded into the new procurement programme. KB noted that the risk of conflict of interest often meant that there was no GP involvement in the decisions and little consultation. DJ noted the importance that the procurement succeeded and therefore the ICB needed to manage conflicts very carefully to ensure the risk of challenge was low. DJ explained that the Local Medical Committee (LMC) General Manager had been present at PCOG for the decision and engagement regarding specification development had been planned into the programme. SN highlighted the importance that the lessons learnt were shared with those affected and explained that Geeta Iyer, GP, was a member of PCOG so there was some GP representation. SN explained that there could be LMC representation throughout the process, but it needed to be the right people to avoid potential conflicts of interest. AM asked what percentage of practices were now owned by Mendip Vale. DJ confirmed it was around 10% of practices.	**DJ**

	Item	Action
	The Primary Care Committee received and noted the update on the decisions made by PCOG	
7	**Primary Medical Services Report** Susie McMullen (SMc) highlighted the received 2024/25 GP contract arrangements letter. The ICB continued to wait for the financial guidance. The British Medical Association (BMA) GP Committee England (GPCE) had rejected the changes to the contract and a referendum would be held to ascertain the opinion of the contract changes from GPs. NHS England had designed the contract with simpler arrangements to allow for greater flexibility and the ICB was committed to being as flexible as possible within the national parameters. SMc outlined the 8 indicators within the letter regarding digital and telephony and explained that GP practices were concerned about what the metrics might be used for, how the national extraction process would work and how this would be managed for practices unable to provide the information. The letter described a more open and flexible approach to ARRS roles but did not include what restrictions would be lifted. The capacity and access payments would continue into 2024/25 with 70% of the funding paid in 12 equal instalments and the letter outlined a simpler description of what practices needed to provide to obtain the remaining 30%. SMc noted that some practices had issues regarding call back services and BH was reviewing whether there was additional support which could be provided for these practices. The letter did not describe how the 8 Directed Enhanced Services (DES) specifications would be reduced into 1 specification and the ICB was waiting for this information. AM asked what risks and mitigations the ICB should consider if GPs do not accept the contract. SN confirmed that the profession would not accept the contract and it was expected that the BMA GPCE would share the results of the referendum which would highlight the strength of opinion. SN expected the next steps would be a ballot and a potential dispute against NHS England which may affect ICBs in terms of managing services. SN expected practices to work only within the contract and therefore a significant amount of interface work may not be completed. GP Practices would be prioritising patient contacts and working safely. Amanda Cheesley (AC) explained that the impact of potential GP industrial action on services within the community and across the system would be significant and highlighted that the ICB and system needed to anticipate this risk and start to prepare effectively. AM asked whether the ICB had undertaken the preparatory work to understand the risks and potential mitigations. JB explained that any action would be unprecedented for GPs but there were parallels with other industrial action and SMc noted the importance of working with ICB colleagues within the acute sector to review learning. JB highlighted that the ICB would be looking at scenario and contingency plans and asking providers to	

	Item	Action
	prepare plans and mitigations. The ICB would look to 111 services and the system Clinical Assessment Service (CAS) for support. The system would need to understand interface and workforce concerns. DJ noted that the emergency planning team had led the coordination for the acute industrial action, and they would outline key actions and learning to inform the thinking. Richard Brown (RB) highlighted the potential impact on pharmacies in terms of business continuity and the requirement for emergency supplies. RB noted that any arrangements to mitigate industrial action in primary care would be more complex than actions needed for secondary care. AC agreed and explained that this could lead to more violence and aggression within communities. AC expected that pharmacies, Urgent Care Centres and Minor Injury Units would be overwhelmed. AC noted the importance of a public awareness campaign strategy supported by local media and communities. KB believed that the system had exacerbated the problems facing primary care by approving the outcome of the supplementary services review and reducing income for two thirds of practices. KB explained that the contract decisions as well as the impact of the minimum wage increase meant that an already challenging situation for GP Practices had been made worse and would negatively impact on resilience of practices. John Hopcroft (JH) noted that there was no pathway for practice optometrists to support the system by seeing patients with urgent or minor eye conditions and explained that currently patients would be attending primary or secondary care. JH explained that the pathway had been outlined in 5 year plans but not yet implemented. Sarah Purdy (SP) asked what action had been taken to highlight the impact on the system to NHS England. JF suggested that the concerns were escalated to the Board and continued to be raised with himself and Shane Devlin for regional escalation. KB noted that NHS England had presented a webinar for GPs and received thousands of comments on the potential impact. SN welcomed the escalation and highlighted that ICS's needed to escalate the impact together as systems and provide objective feedback to NHS England. DJ agreed to share the views of the Committee with Shane Devlin who could share the feedback with other ICB Chief Executives. SMc presented the primary care GP dashboard to the Committee noting that the dashboard was being continuously improved. SMc confirmed that the presented dashboard was an anonymised PDF but the actual dashboard was a fully interactive document. SMc outlined the pages of the document and the information the dashboard contained about GP Practices which included a resilience and quality rating and rank, property type, demographic, deprivation	

	Item	Action
	levels and age considerations. The dashboard also included detail regarding workforce data, list size, CQC inspections data, and prescribing data. SMc noted that the data captured were good indicators of a practices resilience and would signal any concerns. The quality section included data on immunisations and quality targets and the dashboard also included a section on patient experience which included complaint data, and family and friend test outcomes. Every Quality Outcomes Framework (QOF) indicator was available to review and the dashboard also included data on cancer, two week waits and access. Matt Lenny (ML) noted the valuable information included in the dashboard and asked whether the public health teams would be able to review the data relevant and appropriate to their work. SMc explained that the data was not published or publicly available but agreed to review whether there was a way to share appropriate data with system partners. AC asked whether the data in the dashboard had been triangulated with other system data as there were elements of the work which took place in areas outside of primary care. JB explained that there may be teams who have oversight on the whole system data for specific areas such as flu immunisation but the dashboard was to review activity within GP primary care only. AM asked how the ICB prioritised which practices needed support and which could manage without. SMc explained that a sub-group of PCOG owned the dashboard and reviewed every other month for changes. The group would review and discuss any updated QOF and workforce data as well as review changes in practice RAG ratings. Practices consistently red and amber would be referred to the ARQ programme. SMc explained that some indicators frequently moved through the RAG ratings and for these ratings the group would review trends in the data. Where the dashboard identified practices who may be experiencing challenge, the group would review against other local intelligence and triangulate the data. SMc reported that practices were able to self-refer to the ARQ programme and the ICB provided other proactive support to GP Practices in other ways unrelated to the dashboard. AM asked whether practices had access to the dashboard data. SMc noted that the dashboard was shared with practices who needed support and PCNs had asked for see their dashboards to share with practices. SMc confirmed that proactive sharing of the dashboard would be difficult as the ICB team did not have the capacity to action this. KB highlighted that it would be helpful for practices to see their data as it may indicate where the practice is an outlier which may support them to improve without ICB intervention. AM asked DJ to consider what would need to be in place to share the data with practices and explained that although this was something the ICB aspired to do it may be difficult currently due to capacity.	**SMc** **DJ**

	Item	Action
	Georgie Bigg (GB) noted that it would be useful for Heathwatch data to be incorporated into the dashboard. BH explained that work was ongoing to link the systems so Healthwatch data could be included within the dashboard. JF noted the importance of sharing data and asked DJ to provide him with more information regarding the practices not sharing data so that the issue could be escalated. Rosi Shepherd (RS) presented the quality report and highlighted that Graham Road and Horizon Health Centre had been stood down from enhanced surveillance and managed through the business as usual quality oversight process. RS noted that Emersons Green and Leap Valley practices had improved to green within the dashboard which highlighted the good work of the practices and the quality team. The draft patient safety strategy continued to be developed and this was a significant piece of work for the combined teams which would result in changes to reporting for practices and the ICB was working with the GPCB to develop this. ML thanked colleagues for their work supporting Graham Road and Horizon Health Centre and welcomed the re-review by CQC. AM highlighted the medication patient safety events slide and noted the increase in reporting near misses but the lack of narrative explaining these. AM asked whether the increase was the positive result of an improving safety culture. RS explained that the organisation was improving reporting which would then shift into the learning phase and the appropriate information would be shared to support this. RS confirmed that work continued between the quality and medicines optimisation teams to improve the report. **The Primary Care Committee received the report and noted the key decisions and information from PCOG**	**DJ** **RS**
8	**Primary Care Finance report** JD reported that the financial position for primary care medical services was £2.8m overspent, this included the retrospective and anticipated allocations. The forecast position was £1.9m overspend at the end of the year. The key contributor to the overspend was primary care prescribing products. JD reported on the positive transformation funding and explained that the system had anticipated receiving £3.8m of funded support for primary care transformation and had received just over £5m to support transformation schemes.	

	Item	Action
	The Pharmacy, Optometry and Dentistry (POD) position was forecast a year to date underspend of £7.6m with end of year expected to be £9.1m underspent. JD highlighted that previously he had reported to PCOG that the regional dental debt was expected to be around £5.6m, with £1m attributable to BNSSG. It was not expected that this debt would be considered bad debt against the ICB as delegation took place in April 2023 and some of the matters arising were prior to that period. The team were reviewing clawback for the current year to understand whether there was a requirement to create bad debt provision at the end of the financial year. This risk had been included on the risk register. A briefing paper would be developed for PCOG to review the risk. GS explained that clawback accumulated year after year and alongside the contract concerns, there was a risk that NHS dental practices would close which would result in patients looking for support in other areas of the system. GS explained that the dentists would receive the clawback letters in June, which was when issues may arise. DJ noted that the ICB was unable to change the national contract but would continue to escalate the concerns raised to NHS England. The ICB was focused on ensuring that the support was in place, across the commissioning hub and the ICB, to work in a more resilient and sustainable way with dental practices. GS provided an example of how timely intervention and support could help NHS practices remain open. AM asked about the position of the national contract. DJ confirmed that the contract was not likely to change. JD appreciated that the clawback was a sensitive issue and explained that the ICB may receive information which indicated dental practices who were trading insolvently. JD explained that the ICB had a professional duty to manage those contracts to safeguard public funding and noted that any debt related to insolvency would become a cost pressure to the ICB. GS noted that the ICB also had a duty of care to patients and to ensure that services were provided. JD agreed and highlighted the challenge within the contracting arrangements noting that the clawback was payment for revenue not earned through activity. AM noted that the Committee was unable to change the national contract but needed to focus on the support that could be provided through the ICB and the hub. AM highlighted that the Local Optometry Committee (LOC) had offered previously to review the low risk patients waiting on secondary care ophthalmology lists and asked whether there was any resource available to consider this offer. JD reported that the ICB did not know what the financial position would look like next year as there would be a national rebalancing of allocations across the UK. JD noted that if there was underspend available next year then supporting secondary care waiting lists may be the best way to increase care for patients. **The Primary Care Committee:**	

	Item	Action
	• **Noted the summary financial plan** • **Noted the key risks and mitigations to delivering the financial plan** • **Noted that at month 10 (January), combined Primary Care budgets were reporting an overspend of £2.775 year to date, and a forecast overspend of £1.863 (including retrospective & reimbursable funding)**	
9	**Pharmacy, Optometry and Dental Services Report** JB noted that for dental services there was only a quality report as the benchmarking had not been finalised but regional benchmarking had been included for pharmacy and optometry services. JB highlighted that the quality update included 20 dental service complaints for quarter 3 and there had been no serious incidents reported for pharmacy services. JB noted that there were no 100 hour pharmacies as these had moved to 72 hours. Pharmacy First sign up was around 91% of pharmacies and referrals were expected to exceed 6000 per month. RB confirmed that referrals had reached 7500 early 2024. BNSSG had received 98.6% of Quality in Optometry submissions and the outstanding submissions would be followed up by the commissioning hub. JB provided an update on the Boots pharmacy closures noting that a pharmacy in Portishead had been closed on a Friday and Saturday as it had received a significant number of nominations following the local Boots Pharmacy closure. The Local Pharmaceutical Committee (LPC), commissioning hub and ICB had provided support to rebalance outstanding nominations to the three remaining pharmacies in Portishead. A group has met to consider what work was needed to support a pharmacy strategy which included opportunity to further manage common conditions in pharmacy settings, and resilience of pharmacies and how this could be supported by local authorities. ML thanked the teams for their work to support the Portishead pharmacy and noted that there was learning to consider from the closures particularly the pressures on local pharmacies resulting from closures and how this could be managed through closer working with the local authorities. AM highlighted that there had been a serious incident related to a dental service subcontracted by UHBW and asked whether the ICB had the right assurance processes in place for subcontracted services and also noted that the 20 dental complaints had been for one named dental provider and asked whether the report needed to provide more detail regarding the particular issues regarding the complaints. JB agreed to request further detail regarding the complaints and agreed to consider how the ICB would receive assurance regarding subcontracted services. **The Primary Care Committee received and noted the update on Primary Care Activity**	**JB**
10	**Item deferred – Recovery Access Plan**	

	Item	Action
	DJ confirmed that the Recovery Access Plan item had been deferred as the information required had not been received. BH would continue to develop the report and this would be presented to the ICB Board in May 2024. DJ noted that the plan would need PCC approval prior to the ICB Board and proposed that once all the information had been collated, the report would be circulated to the Committee for comment and feedback, with formal sign off through AM and DJ before the ICB Board. The Committee agreed this approach.	
11	**Operational Planning Guidance 2024/25** BH confirmed that the planning guidance had not been received and the ICB continued to develop the planning based on the assumptions that the key messages for primary care would be improving access including dental access and recovering dental activity. System objectives have been set to allow the planning process to continue. The access to primary care plans had focused on the local objective of continuity of care which had been reflected within the new GP contracts. A series of system planning days had been arranged and the ICB was championing a provider led approach. The planning approach had been developed to provide assurance on the submission requirements and provide opportunity to flag any issues in terms of non-submission, as well as risks and issues associated with the plan and implications from the guidance. Someone from the ICB Primary Care team had attended each of the sessions so that primary care was represented in all system areas. BH highlighted that 2024/25 would be challenging year financially and the ICB was working with One Care, the GPCB and the LMC specifically regarding the reduced SDF funding and the prioritisation of that for workforce. BH noted that although there had been a 3% rise in workforce, GP numbers were falling and workforce remained a challenge. Challenges included retention of staff, supervision for ARRS roles, space requirements and the cost of living wage increase. BH noted that there had been a national proposal to remove the fellows and mentors' scheme funding which BNSSG had used successfully to retain staff so the system was not forecasting further growth in workforce for 2024/25 and although recruitment and retention schemes would continue, these would be scaled back. BH noted that previous assumptions had been accurate so it was expected that this would be the case for this planning round. BH noted the additional challenge regarding the new GP Contract and the team was planning for possible industrial action within primary care. BH noted that the system plans submitted had not included industrial action for any sector. BH reported that community pharmacy activity continued to grow particularly with the start of the pharmacy first programme and activity growth had been included in the plan. BH reported that there had been significant work regarding dental services and the trajectories would continue to be monitored in line with contract	

	Item	Action
	expansion plans, however we are not forecasting returns to pre-pandemic activity levels in 24/25. BH confirmed there were currently no operating plan KPIsfor optometry. The Joint Forward Plan included all areas across primary care and included metrics, deliverables and some narrative. The plan would be published internally initially but there were plans for a microsite on the website to be developed to provide an accessible version of the plan for the public. BH noted that in terms of risks, the majority had been discussed throughout the meeting but there were decisions to be made around prioritisation of funding and this work had started. AM noted that prioritisation was crucial for 2024/25 and asked for more information about the prioritisation process for the system and whether this would focus on health inequalities. BH explained that Jo Medhurst was leading on a piece of work to determine where health inequalities sat within the ICB structure and how this would align with ICS objectives and priorities. Funding had been received to support reduction of healthcare inequalities and high level discussions continued to understand what was needed operationally to support the work. ML noted that a strategic health inequalities oversight group would be convened which would plan this work across the system and align these plans with other local plans as well as within the locality partnerships. ML noted that primary care services were crucial within the health inequalities agenda and suggested that once the work was further developed, an item on health inequalities would be useful for the Committee to consider. ML also noted that the outcome of the locality partnership review would support discussions at the micro population level. BH agreed and highlighted the work being undertaken by practices and PCNs based on local needs and reduction of health inequalities which continued. BH confirmed that work would not stop for the review but clarity was needed as a system. AM asked when the planning guidance was expected and BH confirmed that weekly updates were being provided and it was expected that the plan would be submitted without the guidance and then the final version due to be submitted in May 2024 would be checked against the guidance to ensure nothing was missing. **The Primary Care Committee received the update on the Operational Planning Guidance**	
12	**Key Messages for the ICB Board** • Dental health capacity • GP contract risks • Work of the primary care dashboard and the benefit of data sharing	

	Item	Action
	For Information	
13	**Primary Care Operational Group (PCOG) Minutes** **The Primary Care Committee noted the minutes.**	
14	**Any Other Business** JB confirmed that following the Shaping Our Future Programme both JB and SM would have new roles within the ICB. SM would be Head of Contracts for Primary Care, Community Care and Children and JB would be Deputy Director for Primary Care and Children's Services.	
	Date of Next Meeting Tuesday 28th May 2024, at 9.00am, via Microsoft Teams.	

Lucy Powell, Corporate Support Officer, March 2024

Healthier Together
Improving health and care in Bristol, North Somerset and South Gloucestershire

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

BNSSG ICB Primary Care Committee

Minutes of the meeting held on 21st May 2024 at 13.30 via Microsoft Teams

DRAFT Minutes

Present		
Alison Moon	Chair of Committee, Non-Executive Member – Primary Care	AM
Ellen Donovan	Independent Non-Executive Member, BNSSG ICB	ED
David Jarrett	Chief Delivery Officer, BNSSG ICB	DJ
Apologies		
Katrina Boutin	GP, Old School Surgery & Medical Director of GPCB	KB
Jenny Bowker	Deputy Director of Performance Delivery, Primary Care and Children's Services, BNSSG ICB	JB
Amanda Cheesley	Partner Non-Executive Member, Sirona Care & Health	AC
Joanne Medhurst	Chief Medical Officer, BNSSG ICB	JM
Nikki Holmes	Head of Primary Care, Southwest, NHS England and Improvement	NH
Sarah Purdy	Partner Non-Executive Member, North Bristol NHS Trust	SP
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	RS
Sarah Truelove	Chief Finance Officer and Deputy Chief Executive, BNSSG ICB	ST
In attendance		
Georgie Bigg	Healthwatch Bristol, North Somerset and South Gloucestershire	GB
Richard Brown	Chief Officer, Avon Local Pharmaceutical Committee	RB
Debbie Campbell	Chief Pharmacist, BNSSG ICB	DC
Loran Davison	Team Administrator, BNSSG ICB	LD
Jamie Denton	Head of Finance, Primary Care, Community & Children, BNSSG ICB	JD
Jeff Farrar	Chair of the BNSSG ICB & Independent Non-Executive Member	JF
Katie Handford	Models of Care Development Lead, BNSSG ICB	KH
Bev Haworth	Deputy Head of Primary Care Development, BNSSG ICB	BH
Matthew Jerreat	Clinical Chair of the South West Local Dental Network	MJ
Matt Lenny	Director of Public Health, North Somerset Council	ML
Susie McMullen	Head of Contracts for Primary Care, Community Care and Children, BNSSG ICB	SMc

Shaba Nabi	Chair, Avon Local Medical Committee	SN
Lucy Powell	Corporate Support Officer, BNSSG ICB (Note taker)	LP
Michael Richardson	Deputy Chief Nurse, BNSSG ICB	MR
George Schofield	Avon Local Dental Committee Secretary	GS

	Item	Action
01	**Welcome and Introductions** Alison Moon (AM) welcomed everyone to the meeting and thanked everyone for attending despite the change in the scheduled date. Apologies were noted as above. Michael Richardson (MR) would be joining as deputy for Rosi Shepherd (RS) and Debbie Cambell (DC) was joining as deputy for Joanne Medhurst (JM). It was noted that the meeting was not quorate but as an assurance Committee no decision making was required.	
02	**Declarations of Interest** There were no new declarations of interest and no declarations pertinent to the agenda. DC noted that although her declarations were not included on the register, she had no interests to declare pertinent to the agenda. It was agreed to include DC on the declarations of interests register for the Primary Care Committee (PCC).	**LP**
03	**Minutes of the previous meeting held on the 30th March 2024** The minutes were agreed as a correct record.	
04	**Review of the Action Log** The Committee reviewed the action log: **Action 102 and 103** – David Jarrett (DJ) explained that the ICB supported sharing the dashboard with GP and system partners and this was something that would be considered when capacity allowed. DJ expected that sharing the dashboard with partners would be in place by the end of 2024. AM asked how the ICB would support those practices not currently sharing data. DJ confirmed that this had been discussed by the ICB executive team and would be addressed directly with the practices. It was agreed to close the actions. **Action 105** – RS would provide an update at the next meeting. Bev Haworth (BH) explained that the 6 monthly reporting for the Access Recovery Plan included the primary and secondary care interface and NHS England had indicated that discharge summaries would be included in the future mandated reporting. All other due actions were closed	
05	**Primary Care Risk Register** DJ presented the Primary Care Risk Register and outlined the significant risks: **Risk PCC48: Dental Commissioning Hub Capacity –** This risk had been escalated to NHS England and discussed with the Chief Executive of Somerset	

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	Item	Action
	ICB as the host ICB for these services. Consideration had been given to developing the support of the Hub across the system. Mitigating actions were being progressed. **Risk PCC49: ICB Capacity –** DJ confirmed that following the conclusion of the Shaping Our Future programme the ICB had moved into the next phase. ICB teams were considering what work could be stopped, streamlined and paused to enable delivery of the ICB functions with reduced capacity. Work would continue to focus the team efforts. **Risk PCC57: Primary Care Contract Team Recruitment –** Susie McMullen (SMc) confirmed that the Senior Contract Manager role had been successfully recruited to and all roles within the team were now fully recruited. DJ noted that the possible primary care industrial action would be added to the risk register. This was a significant risk to the system and would be reflected on the risk register alongside the mitigations. DJ explained that the implications of the Commissiong Hub capacity on delivery of services was unclear. Escalation was currently being managed at Chief Executive level but further escalation would be through AM as Chair of the PCC. DJ noted that the work of the Commissioning Hub was currently limited to contract management only and there was no resource in the Hub to support the dental strategy work. The ICB had invested in ICB transformation resource to support the work although this was non-recurrent and the ICB was committed to support primary care. The Hub would focus on delivering and supporting practices through the contract management processes and actions which could happen once at a national level such as UDA levelling and workforce modelling at a regional level. Ellen Donovan (ED) asked whether the ICB was funding all the transformation resource required. DJ explained that the ICB would not find all the resource required but would work within the resource of the Commissioning Hub for the contract management and supplement ICB capacity to implement the dental strategy. AM asked whether the dental strategy action implementation needed to happen at pace and whether the Commissioning Hub needed to strengthen contract management processes to support the ICB. DJ confirmed that as part of Shaping Our Future process, capacity had been retained within the primary care team to support delivery of the dental strategy. If additional resource was needed then the ICB would need to consider how to provide this. George Schofield (GS) asked how many staff worked for the dental team in the Commissioning Hub and DJ confirmed that the ICB was not aware of workforce	

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	Item	Action
	numbers in the Hub. GS noted that it was often difficult to get a response from the Commissioning Hub. It was confirmed that the capacity of the Commissioning Hub was a concern and mitigations were in place. **The Primary Care Committee received and discussed the Primary Care Risk Register**	
06	**Primary Care Assurance Framework** BH outlined the approach to provide assurance to NHS England on the delegated functions. BH explained that the national framework included Primary Medical services and Pharmaceutical, Ophthalmic and Dental (POD) services. BH brought the Committee's attention to the self-declaration form which outlined four key assurance domains: • Compliance with mandated guidance issued by NHS England • Service provision and planning • Contracting • Contractor/provider compliance and performance Finance and contract leads would complete the relevant sections of the self-assessment alongside the Commissioning Hub. The self-assessment would be reviewed by the Primary Care Operational Group (PCOG) in June 2024 and approved by the PCC in July 2024. AM highlighted that the Commissioning Hub would be completing some sections for POD services and asked whether there was risk of this not being actioned due to the capacity concerns. BH confirmed that it was expected that the Hub would complete the template and ICB colleagues would supplement the data if needed. ED noted the significant amount of assurance the ICB was required to provide on an ongoing annual basis and asked whether the ICB teams had the resource to manage these processes alongside the work to implement the dental strategy. DJ confirmed that ICB team capacity had been recognised on the risk register and explained that the teams needed to deliver the statutory functions which included assurance and contracting processes. The whole ICB was considering what work could be stopped, slowed and prioritised to achieve the core aims of the ICB. DJ noted the importance that capacity was retained for transformation but acknowledged that this was a challenge. ED noted the importance of implementing the actions in the dental strategy to reduce healthcare inequalities and asked how the ICB was assured that critical pieces of work to support the local population continued. DJ explained that the plans outlined in the Joint Forward Plan and Operational Plan would be prioritised and the ICB Board would be provided with assurance plans for the management of capacity against the	

	Item	Action
	delivery of the plans. The operational planning process identified the key areas at risk of achievement and the progress and risks would be presented to the ICB Board and Sub-Committees. AM noted that the self-assessment was quite high level and some of the assessed areas relied on good quality data. AM asked what additional support was needed to deliver the plans. BH explained that the team had developed timelines working backwards from approval in July which allowed for good oversight and the opportunity to ask more questions around the risks. BH noted that there was no PCC meeting in June and therefore should there be an area which needed additional support then offline PCC support may be required. AM noted the concerns raised around the dental clawback and the need to support dental services in a flexible way. BH recognised the importance of supporting dental services and explained that the ICB had started to move into the new ways of working and review of capacity and resource was part of this. GS highlighted the risk around ICB capacity and explained that crisis management required more resource than supporting dental practices to never reach that point. GS noted that the clawback discouraged dentists from working for the NHS which could reduce access to NHS dental services. BH agreed and explained that the dental strategy outlined the steps needed to develop a proactive approach to reducing crisis and the ICB was working towards this. GS noted the lateness of the mid-year reports which was an important process to capture risk to practices before it was too late to manage. DJ agreed that the mid-year process had not been effective and the ICB would work with the Commissioning Hub to support practices more effectively for 2024/25. AM thanked DJ and BH for their work and the Committee supported the approach outlined. **The Primary Care Committee received the briefing on the assurance framework and the approach to completing this**	
07	**Primary Care Operational Group (PCOG) Report – A** DJ provided an update on the decisions made at the May 2024 PCOG meeting. PCOG supported the extension of the proposed clinical service model for the community pharmacy pilot funded by NHS England. However, PCOG requested that further discussion took place between the Local Medical Committee (LMC), Richard Brown (RB) and the ICB Medicines Optimisation Team.	

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	Item	Action
	PCOG supported some changes to the Local Enhanced Service (LES) specifications following the annual review process. PCOG supported the payments for Discharge to Assess pathway 3 beds but requested that additional work took place to review the payment methodology. RB noted the importance of the independent pathfinder project which supported community pharmacists to be qualified prescribers for a narrow range of low-risk clinical conditions. RB explained that the pilot was in place to ensure that the system processes were safe. Patients would not notice a difference during consultation. RB noted that he would contact the LMC and discuss the pilot further as requested by PCOG. DJ confirmed that the decision-making processes at PCOG were working well, members understood their roles and there was collective decision making. DJ highlighted that the numbers of decisions to be made was a challenge and the last meeting had overrun. DJ explained that to support PCOG to make decisions, any assurance items would be presented directly to PCC and PCOG would focus on decision making. **The Primary Care Committee received and discussed the PCOG report**	
08	**Primary Medical Services Report** SMc explained that the report contained additional information regarding the decisions made at PCOG but drew out the Special Allocation Scheme (SAS) contract decision. MR presented the quality report highlighting the patient safety and quality slides which outlined how the quality improvement demonstrated the "So what?" questions and identified themes in the reporting. MR reported that there had been a 28% increase in reporting of incidents since the last quarter however it was unclear whether this was related to increased pressures or better reporting processes. MR noted that there was a focus on determining whether primary care organisations were reporting themselves as the largest percentage of reports related to other organisations, particularly medication on discharge. Quality improvement work undertaken included reducing duplication of documents, unsafe discharge and responsibility for patients under Hospital at Home. The report also outlined the Datix medication safety events. MR explained that the system was replacing Datix with the new Learning From Patient Safety Events (LFPSE) process which would support system working.	

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	Item	Action
	AM highlighted LFPSE and noted that few practices had registered for the new system and asked what PCC would be expected to see to gain assurance that the new system had been embedded. MR explained that this was work in train as part of the Patient Safety Strategy. AM noted the importance that the information presented to Committees aligned between the Outcomes, Performance and Quality (OPQ) Committee and PCC. Shaba Nabi (SN) explained that there was no infrastructure in place to receive minors through the SAS programme. The concerns being raised indicated that this may be a necessary consideration in the future. SN asked for clarity on whether the increased reporting was due to a better reporting culture and explained that the LMC and GP Collaborative Board (GPCB) planned to capture the interface work via an F-12 protocol which would not provide the detail but would indicate volume. This resource would be helpful for data comparison. SMc explained that in terms of minors and the SAS contract, BNSSG ICB was linking with other ICBs to understand their arrangements. BNSSG ICB had also requested a call with the national lead who developed the SAS section in the Primary Care Policy and Guidance to gain their advice. SMc confirmed that BNSSG ICB had received one referral to the service for someone under the age of 18. Jeff Farrar (JF) noted the link with safeguarding services when considering this issue and asked that the ICB teams consider the scale of the issue that they were designing an approach for. AM asked that an update be provided to the next meeting to consider the scale of the issue and describe the current process and support which existed in the system. DC highlighted the Datix reporting and confirmed that the majority of the reporting related to other organisations and the system was lacking in self-reporting metrics. DC highlighted the importance of knowing about these incidents so that steps could be taken to mitigate the risk of similar incidents. DC noted that from a medication perspective, the risk of harm had increased and so it was important that this was monitored. DC confirmed that the usual themes had been identified plus some additional community pharmacy themes. The ICB had sent communications about these to the local pharmacies offering guidance and support. These themes were also shared with the Local Pharmaceutical Committee (LPC). ED asked whether the ongoing work would reduce the patient safety incidents and the harm position. ED noted the reduced capacity and resource in the ICB and highlighted that the assurance often came from the Acute Trusts. MR welcomed the quality improvement activity related to the themes of incidents	**SMc**

DRAFT

	Item	Action
	which aligned with the Patient Safety Instant Response Framework. MR explained that this system response work was a positive indication of increased patient safety work. MR noted that it was unclear whether the incidents would reduce and explained that the position would be monitored within the new Quality Management System Framework and acknowledged that there was more work to do to encourage primary care to report their own incidents. ED asked about escalation processes should the levels of incidents and harm not reduce. MR explained that there was a robust escalation/de-escalation process under the National Quality Board framework where providers would be monitored under enhanced surveillance, with reporting through the System Quality Group alongside other quality improvement groups. MR reported that the system had a mature framework for escalation. DC explained that the system did not necessarily want to see the numbers of incidents reduce but did want the level of harm to reduce. The system did not want to discourage reporting which supported a learning environment. DC noted that if levels of harm reduced then the mitigations put in place had worked. Working groups were in place to support existing and arising themes and there were areas such as anticoagulants and insulin which were under continuous improvement work.	
	Georgie Bigg (GB) highlighted that Healthwatch undertook focused engagement and encouraged the ICB to share areas of improvement so that Healthwatch could focus this engagement in areas which would make a difference to patients. GB noted that incidents was area not well reported by patients as there was a level of trust and reliance on professionals. AM noted the importance that the patient voice and experience of services was central to the quality improvement work and noted that this was not apparent within the report. MR reflected that the trust factor aligned with the duty of candour and agreed to consider how much of the incident information was conveyed to patients as part of the reporting.	
	AM asked that the Committee was provided with more information regarding the Patient Safety Strategy, particularly what would the Committee expect to see in terms of assurance such as what would improve and what were the risks of the new system. AM also asked for more information regarding the cultural approach the ICB was taking to support the Committee assurance process.	**RS/MR**
	AM noted that the report provided information regarding the LES specifications but asked that future reporting include data on the uptake of the schemes. SMc noted that there were no current issues with regards to uptake.	**SMc**
	The Primary Care Committee noted the key decisions and information from PCOG	

DRAFT

	Item	Action
09	**Primary Care Finance Report** Jamie Denton (JD) reported on the financial positions for primary care services at year end. General Practice ended 2023/24 with an overspend of just under £1.4m with the key contributor to the overspend two Section 96 applications. There had been some benefits to the position which had mitigated the final position. Primary Care Core ended with a reported underspend of £387k driven by the lower than expected activity for phlebotomy. Medicines Management reported an overspend of £1.4m which was attributable to the increased price of practice prescribing products. JD reported that the position had been mitigated by a drug which came off license during 2023/24. The position for POD services was reported as £9.5m underspent. JD noted that the PCC had been informed previously of possible issues related to dental debt recovery from 2022/23. JD confirmed that these debts had not been considered as bad but were at risk of recovery. The dental clawback for 2023/24 was around £2m and it was expected that the debt would be recovered however there was a risk that should a practice become insolvent then the debt would be irrecoverable. JD reported that regarding the variances within the POD position, pharmacy reported a £1m underspend. There was a large underspend on prescription dispensing charges as a result of reduced activity. Work was ongoing to understand why BNSSG was an outlier in this area as activity had recovered in other areas of the South West. Optometry reported a £800k underspend. The ICB had expected a rebalancing of allocation in 2023/24, but this has been deferred to 2024/25. Dentistry was significantly underbudget at £7.3m underspent. The reserve at the start of the year was £3.9m and this surplus increased to £4.6m following the Review Body on Doctors' and Dentists' Remuneration (DDRB) allocation. This reserve plus the lower than expected activity drove the underspend. Matthew Jerreat (MJ) explained that a regional working group had been convened to review the rebasing of the current UDA contracts and consider an appropriate uplift value for these. MJ confirmed that the group was also reviewing the wider debt piece. This work was a high priority for the ICB Chief Executives and the workplan and resource to drive the work had been agreed. MJ acknowledged that this work was only one part of the dental recovery plan but was the most significant in supporting ICBs to support dental providers. MJ noted that the money which came out of the work would be reinvested to support access. MJ confirmed that dentists were members of the working group and the group had reviewed what a sensible uplift would be as well as how capital	

DRAFT

	Item	Action
	investment could be considered. There was a recognition that the work needed to completed at pace to support dental practices. MJ reported that to support ICBs, the regional team was reviewing how BI information could be improved and templates had been created to support ICB conversations with dental practices. GS agreed that the work needed to happen at pace and asked for more information relating to the uplift value. MJ confirmed that any values discussed had not been agreed and reported that the working group had reviewed many elements including the percentage of private income when compared to the NHS model to develop a sensible figure. MJ noted that the most significant element was rebasing the contracts which would release money for the ICBs to support access improvement. MJ noted that there was work ongoing to increase activity which would in the longer term support additional investment in services. MJ added that there would be flexibility within the contract to support improvement of local healthcare inequalities. AM noted the lower activity within the phlebotomy service and reiterated her request that the next primary medical report included the uptake percentage for the LES schemes. AM asked whether the creation of the Additional Roles Reimbursement Scheme (ARRS) was prohibiting or restricting recruitment of GPs. SN explained that it was difficult to obtain robust data in some areas but it was believed that the level of competition for GP roles was significant and locums were struggling to find work. SN explained that GP Partnerships wanted to employ GPs but the funding mechanisms made this challenging. It was noted that this was a national issue and had been debated at national conferences. GPs had discussed the unintended consequences of the current contract and wanted core funding to be returned to 2009 levels so that GPs could recruit the roles needed to support the local population. **The Primary Care Committee:** • **Noted the summary financial plan** • **Noted the key risks and mitigations to delivering the financial plan** • **Noted that at Month 12 (March), combined POD Service budgets reported an underspend of £9.525m**	
10	**Budget Setting** JD reported that the primary care medical revenue resource limit for 2024/25 was £182.690m, with inclusion of the ARRS role funding this increased to £191.491m which represented a 5.9% increase from 2023/24. The ICB was around 0.87% away from its target allocation which represented a distance from target of	

DRAFT

	Item	Action
	£1.596m. JD confirmed that the budget assumed growth of population at 1.36%. The Delegated Primary Care budget included £1.5m of unidentified savings, £0.595m of which was mitigated through a net position reserve with the rest uncommitted. JD explained that the savings targets had been built into the budget for 2024/25. JD noted increases in both the Global Sum payment and the Quality Outcomes Framework (QOF) point value. Primary Care Networks (PCNs) represented £42.6m of the budget which included the central ARRS funding, this was £2.1m per PCN for BNSSG. JD explained that an element of the ARRS funding was held nationally for release on a draw down basis. Last year BNSSG drew down the entire fund and it was anticipated that this would occur again in 2024/25. The ARRS funding had been inflated by 2.4% for 2024/25 to account for pay rises. JD confirmed that the investment and impact funding had been reallocated within the funding streams and £800k had been reallocated to access and capacity funding. It was noted that there had been a simplification of the measures for this funding in 2024/25. JD reported that Non-Delegated Primary Care allocation for 2024/25 was £34.937m which included NHS 111 and the Out of Hours Service. Inflation of 1.7% had been applied with an efficiency requirement of 1.1%, so the net uplift to budgets was 0.6% for 2024/25 although 0.7% had been applied for growth funding. The allocation included £2.2m for the Primary Care Transformation (SDF) funding and £0.6m for funding the Acute Respiratory Infection (ARI) hubs. It was noted that One Care would attend PCOG and possibly PCC to outline what the ARI Hubs had achieved in 2023/24. JD explained that there was a budget reserve of £1m which was intended to support a reduced savings target with the budget. Three savings targets had been allocated to the Primary Care budgets: • £0.200m recurring savings due to a reduction in text message reminders with reminders to be sent through the NHS mobile App. VAT rules have confirmed that VAT was recoverable • £0.142m recurring savings to support the ICB digital strategy which would save time for general practice staff • £0.333m non- recurring savings, to support the ICB to achieve a balanced financial position Matt Lenny (ML) highlighted the NHS mobile app reminder service and asked whether there was a cohort of people less likely to use the app which may be	

DRAFT

	Item	Action
	disadvantaged by this plan. JD confirmed that the platform was smart enough to send text reminders to those people who had not opened the App. JD confirmed that there was no intention to stop the text message reminders. BH confirmed that the NHS App was part of the access and recovery plans and explained that there was an ongoing communications campaign to encourage sign up to the NHS App and turn on notifications. BH confirmed that uptake of app use was good, but it was important that people turned on notifications. Text messages would continue to be sent to those people who had not enabled notifications. ML asked that the communications were sent to the Local Authorities who would be able to include the information in newsletters. BH agreed and explained that One Care and the LMC were also sending out communications to support NHS App uptake. JD reported that the Medicines Management allocation for 2024/25 was £161.373k. This figure had been determined from the 2023/24 position plus anticipated cost pressures which represented growth of the budget of 9.2% including general inflation. A savings target of £5.25m had been built into the allocation. JD noted that cost pressures for the budget included the anticipated increase in growth. JD explained that the savings target had been achieved for 2023/24 and it was expected that this would be achieved again for 2024/25. JD explained that the budgets for POD services were specific payment values with the total allocation of £86.147m which represented a weighted increase of 2.4%. The ring fencing for dental remained for 2024/25 which meant that the ICB should not assume that the dental underspend could be utilised to support the ICB financial position and any unspent allocation would be returned to NHS England on a non-recurrent basis. Dental investment for 2024/25 was anticipated to be just under £4.2m. **The Primary Care Committee noted that the allocation was anticipated to be sufficient**	**BH**
11	**Pharmacy, Optometry and Dental Services Report** The Committee noted that Nikki Holmes (NH) was not in attendance and therefore the report was for information only. AM asked that NH arrange for a deputy to attend if she was unable to attend as NHSE were important partners with POD services.	
12	**System Access Improvement Plan** DJ explained that the paper was presented to PCC in advance of presentation to the ICB Board in July 2024. BH confirmed that six monthly reporting to the ICB Board on the progress of the access plan was a requirement from NHS England. BH noted that the report to PCC was marked as sensitive as it contained practice	

DRAFT

	Item	Action
	level information which would be removed from the ICB Board paper. BH noted that there had been increased communications regarding the plans from MPs and the ICB was attending the Health Overview and Scrutiny Committees to proactively keep people updated. BH outlined the progress on the 4 ambitions: **Empower Patients** BH noted the previous conversations about the NHS App and explained that the functionality of the App reduced workload for primary care staff and reduced costs. A group led by One Care would be increasing the pace of communications regarding the App. BH confirmed that all but two pharmacies had signed up for Pharmacy First and the Medicines Optimisation team continued to work with those practices. There had been 7000 referrals to Pharmacy First in January 2024 and the programme had been expanded to 7 minor ailments. The ICB continued to map the practices with the lowest consistent referrals. 56 practices had reinstated the Friends and Family Test and alongside this, practices and PCNs were developing other feedback mechanisms. **Implement new Modern General Practice Access approach** BH reported that all practices used cloud-based technology with 85% of practices moved to an advanced telephony system. These practices had provided positive feedback on the systems noting that it had changed patients' behaviours in terms of the 8am rush. Online consultation submissions increased from 35 to 92 per 1000 population. **Build Capacity** The ICB continued to work with practices to achieve the national target of a 4% increase in general practice appointments compared to 2022/23. For appointments within 14 days, BNSSG was consistently above the South West average and the number of practices below this average had reduced from 8 to 4. BH explained that the same day target was around people knowing where they would be directed rather than seen the same day and noted that BNSSG was just under the South-West average in this. Nine practices remained below average. BH reported that workforce grew by 3% in 2023/24 largely due to the additional roles. Workforce growth would be a challenge for 2024/25 as GP numbers were not increasing and it would be a challenging year financially. **Cut Bureaucracy** BH confirmed that all the local PCNs received their Capacity and Access Improvement funding and all practices received the Transition Cover and Transformation funding to support the work. Following a 6 month review of the capacity and access improvement plans, a monthly primary/secondary care interface group had been convened. This group had prioritised culture and	

DRAFT

	Item	Action
	building relationships so that the work in this area started in a collaborative way with the initial focus on planned and urgent care. BH explained that report also included the metrics with graphs which demonstrated the patterns of the key metrics over the past few years. The report also included maps indicating where the practices below the South-West or national averages were situated based on deprivation of area. These maps also included proximity to A&Es, hospitals, Urgent Care Centres and Minor Injury Units. BH noted that the appendix included the Quality and Resilience Dashboard which identified where support was needed, the Training Hub and the Access, Resilience and Quality (ARQ) team continued to provide significant support to practices. The Communications and Engagement plan was becoming more sophisticated in sharing the work of the ICB with practices and outlining the messaging and support available. BH explained that the next set of patient survey results would be triangulated with other data available including coordination with Healthwatch. BH highlighted that there were several challenges facing primary care access in 2024/25 including the new imposed contract, decreased funding streams and resource and the potential for industrial action. BH noted that the self-referral work was not as far forward as expected and although this was out of the remit for primary care, it would affect primary care and therefore reviews had taken place for the 7 initial pathways to determine where the system was in terms of self-referral. BH confirmed that not all areas within Community or Local Authority were appropriate for self-referral and so the ICB was working through this. BH thanked Katie Handford and James Cox for all their work supporting the outputs of the System Access Plan and monitoring and overseeing the work. ED thanked the team for the report and all the hard work to develop and support the plan. ED asked whether there were three or four key metrics for the system to focus on and would patients agree with these priorities. BH noted the importance that the ICB balanced the requirements of NHS England against what was meaningful for the practices and explained continued focus on specific metrics meant that challenges in other areas may be missed. BH explained that for the local practices continuity of care and supporting them with care navigation and triage was important in terms of managing access. BH noted that continuity of care was important for patients, who may wish to wait 15 days to see the same GP, and therefore outside of the NHS England targets. BH explained that practices were keen to understand the patient perspective of the new ways of	

DRAFT

	Item	Action
	working and it was expected that the patient survey results would be mixed which was why the ICB and practices wanted to consider other mechanisms for feedback which may be more rounded and therefore more meaningful. BH noted that where improved telephony has been implemented in practices, patient feedback had been positive as patients could get a call back rather than wait. ML thanked everyone involved in the work. ML highlighted that specific groups of the population may not be providing feedback and may be less engaged with the technological advances, and asked whether the ICB had identified these possible inequalities and were monitoring these. ML offered the support of the Local Authorities to support the work and noted that a behavioral science approach may be helpful to motivate people to take up the opportunities offered. BH explained that One Care led a Digital Inclusion Group which was reaching out to communities and some of the feedback had been that people did not want to use the technology available for religious reasons or simply because they preferred to see people in person. ICB communications has emphasised that all the normal routes of access remained but other ways were on offer. BH welcomed the idea of using behavioral science to make the process more sophisticated. AM welcomed the visuals within the report and suggested that for the ICB Board, the key metrics, enablers and challenges were set out clearly in the cover paper. AM noted the considerable risks and suggested that the team review the mitigations to ensure that they represented assurance for the ICB Board. AM noted the interface work and expected that the next iteration of the report would outline the outputs from the interface group, particularly those which made a difference to patients. AM also asked the team to consider the future and what the key pieces of work were. BH highlighted that an Executive Summary of the report would be developed specifically for the ICB Board and asked for feedback to be sent by email to BH by the 21st June 2024. AM asked that Committee members who were not at the meeting were given the opportunity to provide feedback. **The Primary Care Committee was asked to note the Year 1 progress in delivery of the BNSSG System Access Improvement Plan**	**ALL** **DJ**
13	**Key Messages for the ICB Board** AM outlined the key messages for the ICB Board: • Capacity of the Dental Commissioning Hub • Primary Care Assurance Framework • The Patient Safety Framework and the increase in incidents and increase in harm	

DRAFT

	Item	Action
	• System Access Improvement Plan	
	For Information	
14	**PCOG Minutes** The minutes were received for information.	
15	**Any Other Business** AM explained that this was the last PCC meeting that would be administrated by Loran Davison and Lucy Powell. AM thanked them both for their support. DJ's team would be supporting the next PCC meeting.	
	Date of Next Meeting Tuesday 23rd July 2024, held via Microsoft Teams	

Lucy Powell, Corporate Support Officer, May 2024

DRAFT