BNSSG ICB Primary Care Committee Meeting

Minutes of the Meeting Held on 23rd July 2024

Approved Minutes

Present		
Alison Moon (*Chair*)	Chair of Committee, Non-Executive Member – Primary Care	AM
Georgie Bigg	Healthwatch Bristol, North Somerset and South Gloucestershire	GB
Katrina Boutin	GP Collaborative Board Representative	KB
Jenny Bowker	Deputy Director of Performance Delivery, Primary Care and Children's Services, BNSSG ICB	JB
Richard Brown	Chief Officer, Avon Local Pharmaceutical Committee	RB
Jamie Denton	Head of Finance, Primary, Community & Non-Acute Services, BNSSG ICB	JD
Ellen Donovan	Independent Non-Executive Member, BNSSG ICB	ED
Jeff Farrar	Chair of the BNSSG ICB & Independent Non-Executive Member	JF
David Jarrett	Chief Delivery Officer, BNSSG ICB	DJ
Matthew Jerreat	Clinical Chair of the Southwest Local Dental Network	MJ
Matt Lenny	Director of Public Health, North Somerset Council	ML
Joanne Medhurst	Chief Medical Officer, BNSSG ICB	JM
Susie McMullen	Head of Contracts: Children's, Community and Primary Care, BNSSG ICB	SMc
Ruth Povey	Service Improvement Project Manager BNSSG ICB - for item 6	RP
Sarah Purdy	Partner Non-Executive Member, North Bristol NHS Trust	SP
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	RS
George Schofield	Avon Local Dental Committee Secretary	GS
Apologies		
Katie Handford	Models of Care Development Lead, BNSSG ICB	KH
Nikki Holmes	Head of Primary Care, Southwest, NHS England, and Improvement	NH
John Hopcroft	Avon Local Optical Committee	JH
Geeta Iyer	Deputy Chief Medical Officer, BNSSG ICB	GI
David Moss	Locality Director – North Somerset, BNSSG ICB	DM
Shaba Nabi	Chair, Avon Local Medical Committee	SN
Sarah Truelove	Chief Financial Officer and Deputy Chief Executive, BNSSG ICB	ST
In Attendance		
Holly Hardy	Training Hub Clinical Lead, BNSSG ICB – for Item 11	HH
Bev Haworth	Deputy Head of Primary Care Development, BNSSG ICB	BH
Linda Ruse	Training Hub Programme Manager, BNSSG ICB – for Item 11	LR
Sandie Cross	EA to Dave Jarrett, BNSSG ICB	SLC

	Item	Action
1	**Welcome and Apologies** Alison Moon (AM) welcomed everyone to the Committee. Apologies are noted as above. AM observed there was no NHSE commissioning hub representative present.	
2	**Declarations of Interest** There were no new declarations of interest, and no existing declarations of interest relating to agenda items at the meeting today.	
3	**Minutes of the previous meeting held on 21st May 2024** The minutes from the meeting on 21st May 2024 were agreed to be an accurate record of the meeting. These minutes have been approved.	
4	**Review of Action Log** The Committee reviewed the action log: (*Please refer to the action log for full details*)	
5	**Primary Care Risk Register & Strategic Risks** Dave Jarrett (DJ) pulled out the key highlights in terms of the risk register and strategic risks:- **Risk PCC 48** around commissioning hub support - DJ and Shane Devlin had met with Jonathan Hickman (CEO Somerset ICB) and Steve Sylvester (NHS England – Southwest) and agreed to escalate our concern around capacity and support from the commissioning hub. It has been agreed that a regional oversight board will be established to oversee resourcing and prioritisation of the hub. There will be a refresh of the MoU of the arrangement with the commissioning hub which will provide more clarity around what we can expect from the commissioning hub with assurance and oversight. This should mitigate associated risks. GP Collective Action ➢ **Risk PCC 62** – Collective Action - Jenny Bowker (JB) outlined the emerging high-risk situation due to GP collective action, set to begin on August 1st, if the ballot supported it. The action includes nine proposed actions and measures, such as limiting daily patient contacts (25 per day), stopping engagement with E-Referrals, and ceasing data-sharing agreements, which could significantly impact the healthcare system. 1. Planning and Mitigation Efforts: The ICB has initiated a system-wide planning group and a cross-functional team to identify risks and develop mitigation strategies. There is also a focus on financial planning, despite uncertainty around cost reimbursements. 2. System-Wide Response: Joe Medhurst (JM) emphasised the need for a coordinated response across different healthcare providers to manage patient care effectively, especially during the GP collective action. Lessons from recent system outages are being used to inform these strategies. 3. Long-Term Implications: There is an acknowledgment that some changes might need to be permanent, beyond the immediate crisis, to improve system efficiency and support for general practice. 4. National Guidance and Local Response: Beverly Haworth (BH) reported that a national letter and toolkit are guiding the ICB's actions, including a self-assessment template to identify common risks. Ongoing collaborative efforts and communication strategies are being developed to manage the situation effectively.	

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	5. There is a role of community pharmacists in this, and the need to ensure people are clear on the NHS app, linking in for repeat prescriptions. 6. BH advised the difference from the acute's perspective is they use ESR system, so they can rota plan, which has more flexibility, and this also gives visibility of live workforce data - we do not have this level of information for general practice. The discussion concluded with reflections on the potential long-term benefits of the current crisis in driving systemic improvements and better integration between primary and secondary care. JB updated that the LMC is very clear if the collective action ceases, there are still some areas they will be keen to have discussions about, particularly around voluntary services. The LMC have already encouraged practices to give notice on some specific areas in relation to those. This is a local risk to understand we need to be working towards. Ellen Donovan (ED) thanked JB, JM & BH for their updates and confirmed there is a lot of assurance contained within this with significant planning in place. Sarah Purdy (SP) wanted to reinforce the final catalyst, which is for us to look at how we offer care across the system, and to support primary care. SP is keen to be part of those discussions with colleagues in acute also. **Conclusion** AM thanked everyone for their input into the agenda item. It was noted that the Collective Action item may need to go to an Extra-ordinary ICB Board meeting on 5th August 2024 but will be going to the ICB Board on 5th September for a further update. **The Primary Care Committee received and discussed the Primary Care Risk Register & Strategic Risks, and discussed the GP Collective Action, noting the advice this item will go to the ICB Board.**	
6	**Primary Care Assurance Framework** JB presented an update on the Primary Care Assurance Framework, which is an annual self-assessment covering General Medical Services, as well as Pharmacy, Optometry, and Dental Services. The Framework is designed to ensure compliance with mandated guidance and to assess service provision, planning, contracting, and contractor compliance and performance. This framework focuses on how the ICB is managing its responsibilities rather than assessing the quality of services provided. JB highlighted the self-assessment outcomes, noting that while many areas were rated positively (green), there were significant concerns in the dental sector, where four domains were rated red. These issues include lack of oversight on waiting lists, insufficient contract monitoring, delays in mid-year review action plans, and inadequate workforce data collection. These red ratings indicate that the ICB could not provide full assurance in these areas due to gaps in data, resources, and oversight processes. AM welcomed and thanked Ruth Povey, for the work she had undertaken within the Primary Care Assurance Framework. The Committee discussed these concerns, emphasising the need for better contract monitoring to address these issues. The lack of capacity in the commissioning hub was noted as a significant barrier and there was a call for additional support to ensure improvements in these areas. The discussion also highlighted the importance of recruiting a clinical lead for dental services to provide better oversight and support. DJ	

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	acknowledged this would be discussed by the Team, and capacity has been a factor in taking this forward. The Committee supported the submission of the self-assessment and stressed the need for ongoing monitoring and resource allocation to address the identified gaps, particularly in the dental services area. There was also an agreement to further discuss these issues at a regional level to seek broader solutions across the Southwest. The Committee understood the constraints faced by the ICB in funding dental services, the need for proactive oversight, and the importance of adapting to potential future changes in the national contract. JB provided further assurance and advised conversations will continue at the Southwest PCOG meeting, to understand any differences between the ICB self-assessments and any commonalities, which will continue following submission of the return. The Primary Care Committee are asked to endorse the presentation of the Primary Care Assurance Framework to the ICB Board in the Autumn, following submission to NHSEI. **The Primary Care Committee received the briefing on the Primary Care Assurance Framework and the approach to completing this. The Primary Care Committee endorsed the self-assessment for return to NHSE.**	
7	**Primary Care Operational Group (PCOG) Report - A** DJ provided an update on the decisions made at the June and July 2024 PCOG meetings. **Key Highlights included:-** June PCOG Meeting The PCOG have discussed refreshing their Terms of Reference (ToR) and ways of working which would be complemented by a review of PCC ToR. The Committee discussed the need for a review of Committee effectiveness and alignment with other ICB Committees, with plans to revisit this in the Autumn. July PCOG Meeting – Strategic Development Funding - BH and the team have been in liaison with the General Practice Collaboration Board (GPCB0, to reach agreement for where the specific funding is allocated, to support the transformation in primary care. Service development funding is being allocated to support: • Fellows & Mentors Scheme • Practice Nursing Funding • Primary care network OD • Further support for the access, resilience & quality programme • Digital workstreams • Recruitment and retention initiatives July Extraordinary Dental PCOG Meeting 1. Units of Dental Activity (UDA) Rebasing: The ICB decided on a £30 uplift per UDA, with varied implementation options depending on a practice's current NHS contract performance. Practices delivering less than 50% of their contract will undergo an in-depth review to assess their viability with proposals for rebasing contracts to deliverable levels. Practices performing at high levels will be invited	

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	to increase their contracts at enhanced rates. This latter element of increasing contracts will be a temporary measure as the ICB anticipates potential national changes to the dental contract with the incoming government. 2. Challenges and Concerns: George Schofield (GS) , argued that the £30 UDA is insufficient to attract dental professionals and maintain sustainable NHS dental services, suggesting a £35 minimum would be more effective. However, the ICB lacks the funds to raise the UDA further and see full contract delivery at these rates. 3. Proactive Monitoring: The ICB aims to shift towards more proactive and supportive monitoring of dental practices to improve contract delivery and service provision. AM confirmed that the PCC noted the decisions made at PCOG. **The Primary Care Committee received and discussed the PCOG report.**	
8	**PCC Committee Effectiveness Review** This was discussed in item 7 and it was agreed would come back to the Committee at a later date, as part of a broader approach to review Committee effectiveness.	
9	**Contracts & Performance of Primary Medical Services Report** Susie McMullen (SMc) provided a brief update to the Committee this month and advised the main focus of the work, which was being discussed in the closed session of Primary Care Committee today, namely the Graham Road, Horizon Health & Charlotte Keel procurement. Several key points included. 1. **Clinical Waste Contracts**: These contracts were previously managed by NHS England (NHSE), including a procurement for the contracts, which ended 31st March 2024. In December 2023, the ICB were advised NHSE would no longer be running the procurements process. The ICB have extended the contracts until March 2025. The ICB is considering a joint procurement process with the CSU, together with other regional colleagues, working in partnership. 2. **Reduced capacity in the Primary Care Contracts Team**: The contracts team has reduced capacity and roles within the team due to the recent ICB restructure. This reduction has led to a more reactive approach in their work. The team is also dealing with a vacancy that has remained unfilled since January 2024 which has added to the workload. **Committee Acknowledgement**: AM acknowledged the capacity issues and suggested that the Committee could support the development of any priorities by the team. SMc emphasised that the team remains focused on essential tasks, including the ongoing procurement. **Delayed Discussion on Pharmacy, Optometry, and Dental Services**: The Committee noted the absence of a representative from the Southwest Commissioning Hub to discuss these services, indicating ongoing challenges in getting specific and actionable reports for the ICB. To note, DJ has already escalated this concern to the hub this morning. **The Primary Care Committee received and noted the key decisions and information from the Contracts & Performance Primary Medical Services Report.**	

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10	**Primary Care Finance Report** Jamie Denton (JD) provided a finance update for Month 2 highlighting ongoing financial challenges, the measures being taken to manage risks, and maintaining financial stability in the face of limited resources. The following key points were raised: 1. **Limited Reporting**: The financial report for the second month is limited due to a lack of substantial transactions, making it challenging to report meaningful variances. Currently, there are no significant deviations from the budget plan. 2. **No Contingency Budget**: There is no contingency budget for general practice, meaning any cost pressures will require mitigation to maintain a balanced financial position. 3. **APMS Contracts**: These contracts, which typically come with higher costs than core contracts, could add financial pressure. 4. **Section 96 Applications**: There is a risk of receiving Section 96 applications, which may lead to discretionary payments. If this occurs, further financial adjustments will be needed to balance the budget. 5. **POD Services**: The expected contractual underperformance this year could lead to a £13 million clawback. Efforts are being made to improve dental service activity and reduce this potential financial impact. 6. **Debt Management**: The ICB inherited a debt position from NHS England. While it is not currently expected to result in significant bad debt, this will continue to be monitored. 7. **Local Enhanced Services (LES) Contracts:** Concerns were raised about the insufficient uplift (0.6%) applied to LES contracts, which does not cover the increasing costs of service provision, potentially leading to practices opting out of these services. This issue may be revisited if sign-up rates drop. 8. **Risk Management:** The absence of a contingency budget is a concern, but the ICB has retained reserves to offset potential financial pressures in general practice, avoiding the imposition of savings targets in this area. Katrina Boutin (KB) mentioned the core contract for general practice, which has not been inflated sufficiently to recognise cost of living increases. This, in conjunction with the LES inflation rise has been raised by practices as an issue, therefore some practices have not signed up to the LES Contract. JD advised the ICB have applied the national approach to the uplift to the LES, which applies both an inflationary uplift and an efficiency target across all contracts. SMc advised that sign up to LES is being monitored and risks to this will be reported to the Committee through future contract reports. **The Primary Care Committee:** • **Noted the summary financial plan for all primary care services.** • **Noted the key risks and mitigations to delivering the financial plan and support these reports.**	
11	**Training Hub Update** Linda Ruse (LR) and Holly Hardy (HH) from the BNSSG Training Hub, presented the Training Hub's strategic focus, operational challenges, and financial management. Slides were shared and LR referenced these with the Committee members. Key Points Included:	

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	1. Strategic Focus and Challenges: - The 2024-2025 strategy aligns with the long-term workforce plan, addressing key challenges such as funding, estate issues, and retention. - The Training Hub's contract ending in March 2025, faces uncertainty regarding renewal. - Strategic goals include mental health parity, support for children and young people, and improving workplace culture. 2. Training Hub Operations: - The hub is hosted by the People Directorate, focusing on workforce supply, productivity, and retention. - Efforts are being made to enhance educator and supervisor capacity, maximize apprenticeships and placements, and support long-term workforce planning. 3. Financial Management: - The hub has a robust fiscal management model, ensuring efficient use of funds, particularly for the newly qualified GP programme. - Collaboration with finance teams has led to effective budget tracking and management. 4. Newly Qualified GP Programme: - Despite the abrupt halt of national funding, the hub has secured local funding for a scaled-down programme. - The programme offers CPD support, mentoring, and peer support groups, focusing on retaining newly qualified GPs. 5. Governance and Reporting: - The hub maintains up-to-date governance, fiscal, and reporting requirements. - Regular regional updates, management meetings, and strategic planning are in place. 6. Collaboration and Integration: - Emphasis on working collaboratively with various directorates and external partners. - Future plans may include expanding the training hub's scope to cover all primary care disciplines. - Training Hub (TH) governance requires us to provide 6 monthly Assurance reports to Regional NHSE, together with x 3 Oversight Boards per annum (which Jo Hicks chairs). TH outcomes, successes and learnings are shared via this governance, and wider as needed. To note, GPs from other areas coming to BNSSG, as a result of our Newly Qualified GP offer, was anecdotal, at the point of the Primary Care Committee (PCC) meeting. Should this be borne out, it will be shared via our governance as indicated. <u>Questions and Comments:</u> • Richard Brown (RB) highlighted the importance of including community pharmacy in the training hub's scope, advocating for a primary care-wide focus. • Matthew Jerreat (MJ) suggested integrating dental training and apprenticeships within the hub, emphasising the need for a dental lead in BNSSG. • ED suggested to consider this as an agenda item for the People Committee for read across. • Jo Hicks and Alison have agreed that the TH will conduct a high-level evaluation (via a Survey) in Q4 24/25 based on the 22-25 three year TH contract, and to inform the future +1 25-26 contract. • Committee also encouraged support to POD services in future iteration. Conclusion: The BNSSG Training Hub is well-managed demonstrating good governance and financially sound, with a strong focus on strategic goals and collaboration. However, there are challenges regarding contract renewal and future funding, which need addressing to ensure continued support for newly qualified GPs and potential expansion to other primary care areas.	

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	AM thanked the BNSSG ICB Training Hub colleagues for the update. and on behalf of committee members, thanked Sharon and Holly for all their work. **The Primary Care Committee received and noted the Training Hub Update.**	
12	**Key Messages for the ICB Board** AM highlighted four key messages during her summary: 1. **Collective Action:** Assurance received on the system wide structured approach to planning, through the EPRR process. . 2. **Primary Care Assurance Framework:** Assurance received on the process by which the self-assessment has been completed and endorsement to submission to NHSE. 3. **Dental Hub:** Continued and escalated risk to ICB Board 4. **Training Hub:** Evidence of good work underpinned by sound governance. Continued funding needing clarity, evaluation of service to date expansion to POD encouraged.	
	Part B minutes to be taken in closed ICB Board	
13	**Primary Care Operational Group (PCOG) Minutes 11th June 2024** **The Primary Care Committee received the PCOG minutes for information.**	
14	**Any Other Business** There was no AOB to note.	
	Date of Next Meeting Tuesday 22nd October 2024 –Via MS Teams	

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NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

BNSSG ICB Primary Care Committee Meeting

Minutes of the Meeting Held on 22nd October 2024 9:00 – 11:00

Minutes

Present		
Alison Moon (*Chair*)	Chair of Committee, Non-Executive Member – Primary Care	AM
Richard Brown	Chief Officer, Avon Local Pharmaceutical Committee	RB
Debbie Campbell	Chief Pharmacist and Director of Medicines Optimisation	DC
Terrance Chikurunhe	Senior Hub Manager, Southwest Collaborative Commissioning Hub	TC
Jamie Denton	Head of Finance, Primary, Community & Non-Acute Services, BNSSG ICB	JD
Ellen Donovan	Independent Non-Executive Member, BNSSG ICB	ED
Jeff Farrar	Chair of the BNSSG ICB	JF
Katie Handford	Models of Care Manager, BNSSG ICB	KH
Bev Haworth	Head of Primary Care, BNSSG ICB	BH
Nikki Holmes	Head of Primary Care, Southwest, NHS England, and Improvement	NH
John Hopcroft	Avon Local Optical Committee	JH
David Jarrett	Chief Delivery Officer, BNSSG ICB	DJ
Matthew Jerreat	Clinical Chair of the Southwest Local Dental Network	MJ
Shaba Nabi	Chair, Avon Local Medical Committee	SN
Michael Richardson	Director of Nursing and Deputy CNO, BNSSG ICB	MR
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	RS
George Schofield	Avon Local Dental Committee Secretary	GS
Apologies		
Katrina Boutin	GP Collaborative Board Representative	KB
Jenny Bowker	Deputy Director of Performance Delivery, Primary Care and Children's Services, BNSSG ICB	JB
Dr Barbara Brown	Chair of Sirona Board, Sirona Care & Health	BB
Geeta Iyer	Deputy Chief Medical Officer, BNSSG ICB	GI
Matt Lenny	Director of Public Health, North Somerset Council	ML
Susie McMullen	Head of Contracts: Children's, Community and Primary Care, BNSSG ICB	SMc
Joanne Medhurst	Chief Medical Officer, BNSSG ICB	JM
Sarah Purdy	Partner Non-Executive Member, North Bristol NHS Trust	SP
In Attendance		
Sandie Cross (*minutes*)	EA to Dave Jarrett, BNSSG ICB	SLC

Georgina Leonard	Team Administrator, Primary Care Team, BNSSG ICB – for observation	GL
Paul Roy	Associate Director for Research, BNSSG ICB - For Item 5	PR
Laura Winwood	Primary Care Team, BNSSG ICB – for observation	LW

	Item	Action
1	**Welcome and Apologies** Alison Moon (AM) welcomed everyone to the Primary Care Committee. Apologies are noted as above.	
2	**Declarations of Interest** There were no new declarations of interest, and no existing declarations of interest relating to agenda items at the meeting today.	
3	**Minutes of the Previous Meeting held on 23rd July 2024** The minutes from the meeting on 23rd July 2024 were agreed to be an accurate record of the meeting. These minutes have been approved and will be forwarded to the ICB Board 7th November 2024 for information.	
4	**Review of Action Log** The Primary Care Committee reviewed the action log: (*Please refer to the action log for full details*) It was agreed to close actions **102 & 103** – "Primary Medical Services Report" from the action log, and to add them to the PCC Forward Planner, to discuss at a future meeting.	
5	**Research Annual Report** AM introduced Paul Roy (PR); Associate Director for Research in BNSSG, to update on the Research Annual Report – this is to share information as a "*good news story*." PR shared the Annual Research Report with the Committee members. Key items to highlight included:- ➢ The research team are working through early ideas stage, through applying for external research grant funding. ➢ The ICB is performing at a very high level. Compared to our peers, we are ranked second out of all NHS organisations in England, in terms of research activity. ➢ Research Capability Funding are funds given to NHS organisations for research activity, which means that they can invest in capacity building and infrastructure to support research development. ➢ The research team have worked with our academic partners, including the University of West of England, to focus on working with our underserved and under heard communities. ➢ There are two main schemes – one of which is called Research Engagement Network. This has the most investment from NHS England. There is a focus on ethnically minoritised communities. ➢ PR reported the other large investment is around the GP Deep End Network. The research team are currently working with 17 practices in the 15% most deprived parts of BNSSG. ➢ PR highlighted the general practice performance in research as excellent when compared nationally. Co-location with two universities, who are doing high quality research, is beneficial in addition to highly engaged GPs and practice staff.	

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	PR explained there is no dedicated funding or support infrastructure to support general practices in research, which is something the research team are trying to advocate for. Questions/ Reflections Raised: ➢ Matthew Jerreat (MJ) thanked PR for highlighting the strong links with general practice and research in Primary Care, to include POD services. It was suggested for PR & MJ to meet, to further discuss research options and what support could be provided. ➢ DJ asked how we engage that GP pool with GPCB colleagues. It was suggested to make that connection, if not already in place. ➢ Dr Jeff Farrar (JF) asked how are we ensuring that the hard work that PR and the research team are doing, is informing policy, and how are we ensuring that it is affecting policy change? ➢ **PR** responded this was a challenge nationally. There is a lot of money spent on research, but how much of that makes a difference? PR explained the impact, where we see evidence impacting on patients and through policy, tweaks to pathways. The ICB have formed a partnership with the University of Bristol and University of West of England, where they are investing in the ICB. Impact accelerator units are existing in universities, where they push their evidence into their local systems. PR updated the team are trying to pull in the best evidence. There is funding in the system for a dedicated role coming through, to embed that evidence in a way that makes it easy for practitioners to use. PR agreed we need to be better at capturing where we are making those impacts, and we do want to drive this nationally. Summary AM thanked PR and the research team, for leading the way nationally around Primary Care Research, particularly the Research Engagement Network and the GP Deep End Network. **The Primary Care Committee noted the Research Annual Report, and are in full support, to try and accelerate how that impact can be captured, not just locally but nationally.**	
6	**Primary Care Risk Register** Dave Jarrett (DJ) pulled out the key highlights in terms of the risk register and strategic risks:- ➢ ***Risk PCC48 – support from the commissioning hub,*** it is noted that PCC have debated at length over the last few months. DJ confirmed we now have good engagement with the commissioning hub, noting they are attending the PCC meeting today. DJ suggested to reduce the current risk score, given that we have this in place; recognising that comes with a clarity of the commitment from the hub to each of the ICBs. DJ advised that he had attended the Commissioning Hub Oversight Board meeting on Friday 18th October 2024 with Shane Devlin (CEO BNSSG ICB), and this is the first of those meetings, chaired by Jonathan Higman of Somerset ICB. Questions Raised: ➢ ED mentioned the description around **Risk PCC48** does not feel it fully explains the impact. ED referenced there are three new posts within the commissioning hub so extra resource is in place – what is the result of that improvement? **DJ responded** and agreed the wording of that risk could be amended, recognising ICB had only just taken on delegated commissioning responsibility for NHS Dentistry, together with looking at ways of working internally and with the commissioning hub. DJ confirmed the posts have now been recruited to, to	

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	improve access and delivery on our dental strategy, so this should provide a level of assurance now. ➢ ED mentioned **Risk PCC60 Dentistry** – there is a risk of 20 against a target risk score of 12, are we accepting this risk or are there further actions that we should be taking to reduce that risk? **DJ responded** this has been debated many times, but we are doing all we can within the realms of the national contracts, in terms of our approach to flexible commissioning, and working with practices on increasing UDA levels etc. ➢ ED mentioned Sirona, as she had attended several meetings recently on performance. ED reflected she was unsure whether this touches PCC, but suggested should there be anything on a risk register regarding Sirona, and some of the governance issues, together with the risk of what they may provide in terms of services linked to PCC. **DJ responded** and advised there is a risk on the ICB Board risk register, managed through an enhanced contract management process, which was agreed through the ICB Board. DJ suggested this is managed through the ICB Board, rather than the PCC. <u>Summary</u> AM provided a summary. **Risk PCC48,** describing the suggestion of down grading the risk, recognising the posts within the commissioning hub have been recruited, so this provides a level of assurance not seen previously. AM agreed the wording on some of the risks can be amended so it reads more accurately. **Risk PCC60, Dentistry** - It is a risk of 20.There are no other internal mitigating actions we can take to reduce that risk. Following a further conversation with GS & TC, it was suggested for them to meet outside of PCC, to discuss further, and the support of the Southwest Commissioning Hub. **Action – Agreed for TC & GS to meet outside of PCC, for a further discussion around dentistry and the support of the Southwest Collaborative Commissioning Hub.** **GP Collective Action Update (GPCA)** Bev Haworth (BH) shared slides with the Committee, and pulled the following updates:- ➢ The LMC have now received the results of their survey to practices asking about GPCA. An event was held on 19th September to discuss the results and then, subsequently, the LMC published guidance, which has been included in the slides. ➢ On suggested actions and suggested timelines, BH advised there is now a move to 25 appointments per clinician. ➢ There is to be no new Data Sharing agreements (DSA) without discussion with the LMC and One Care. ➢ From November there is a move to the use of a single referral form to all providers. ➢ Push back from work that was for community and secondary care. ➢ From January, BH had suggested a three month notice period on unfunded work. BH advised there are internal weekly meetings she attends, together with the governance required, through the Performance Oversight Meeting Group (POM), then escalation through the Performance Escalation Meeting (PEM) held on Fridays.	**TC/GS**

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	➢ BH advised there are fortnightly internal and system GPCA meetings. Governance is through the Performance Oversight Meeting Group (POM), then escalation through the Performance Escalation Meeting (PEM) held on Fridays. ➢ BH advised we still have fortnightly IMTS with the SW regional team and continue to provide highlight reporting. There is still an opportunity to feed into what it is like on the ground and continue to support practices in feeding that information up through to NHSE. ➢ BH advised two national returns have been completed in relation to questions from the national team and confirmed the team continue to work collaboratively with the LMC and One Care. ➢ Information has been sent out to practices on contractual responsibilities. ➢ BH updated on current live risks, in particular around cessation of monitoring of eating disorders. GPCB gave a clear steer, from a safety point of view, the supervision of children should not sit in general practice even with AWP support. A working group is in place and developing options. Shaba Nabi (SN) continued, from an LMC perspective. ➢ The LMC are continuing to meet with system partners. ➢ The LMC has already met and had a productive meeting with AWP, with another planned meeting to be held in the future. ➢ SN is due to meet with Rob Adams, and the referral management service. ➢ SN is setting up meetings with Sirona, who have an important role, particularly with the generic referral form. ➢ The LMS is trying to communicate with as many people as we can in advance, with regards to the single referral letter that they are advocating. ➢ SN mentioned on the subject of the eating disorders commissioning pathway, early insights into that survey shows there is a split. BH mentioned there is a communication and engagement plan to help support practices and system partners. It is noted we are unsure what action practices are taking, the ICB are finding out anecdotally. The ICB will be writing out to practices, working closely with the GPCB and the LMC, to understand action being taken and to add to an overview document. AM mentioned BH might not want to share the whole document with the PCC but considered what is important for an assurance committee. **Community Pharmacy Collective Action (CPCA)** BH noted community pharmacy are currently going through the same processes. BH has continued to work closely with Richard Brown (Local Pharmaceutical Committee) and our ICB medicines management team. Key updates include: ➢ National Pharmacy Association (NPA) is balloting members on collective action. ➢ Ballot opened on 19th September for 6 weeks. Results expected early November. ➢ Result of ballot will only be advisory for members because the NPA is not a trade union. ➢ Majority of BNSSG practices are NPA members. ➢ Potential actions include: - open only for minimum contracted hours (40) - withdraw free deliveries or free medicine dispensing packs - boycott data collection beyond what is required in their contract - consider serving notice on a range of locally contracted services, negotiated directly with local authorities. ➢ Actions aimed at enabling pharmacies to reduce cost base and secure ongoing financial sustainability. ➢ No actions will breach contract or pharmacy regulations.	

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	➢ Many large multiples have already taken many of these actions. Next Steps ➢ Collaborative working with LPC and Commissioning Hub ➢ Further work to understand current BNSSG position. ➢ Risk and mitigation work. ➢ Impact modelling ➢ Communications plan. ➢ Survey results (November) **The Primary Care Committee received and discussed the Primary Care Risk Register & Strategic Risks, and discussed the GP Collective Action, and the Community Pharmacy Collective Action, noting this item will go to the ICB Board.**	
7	**Primary Care Operational Group (PCOG) Report** DJ provided an update on the decisions made at the September 2024 PCOG meeting. **Key Highlights Included:-** ➢ Two items were presented at the September PCOG meeting ➢ 1. For the approval of the minor improvement grant allocation (MIGA). This process had previously been set out, in terms of a different approach to MIGA this year, to allocate a bulk allocation to a smaller number of practices to have a bigger impact. A significant element of the MIGA was for the Coniston Road Practice, which has been particularly challenged, both in terms of capacity and sustainability. Expansion there has been long overdue, so PCOG were pleased to be able to award that practice. ➢ 2. PCOG were in support of a commissioning hub proposal for procurement of further dental stabilisation. This is on top of the UDA rebasing work which was previously noted at the July PCC meeting. DJ explained this is another route, in terms of increasing access to dentistry. We now have the UDA rebasing, as well as this stabilisation approach up and running. DJ noted that at the PCOG meeting for October, there had been a lengthy discussion around a PCN move and reallocation of a practice between PCNs, which was the key area of discussion. It has been left for further work to be done, and work continues with the practices. **The Primary Care Committee received the PCOG report.**	
8	**Quality & Performance Report** **Patient Safety Report** The purpose of this paper is to update the Primary Care Committee on the status of BNSSG primary care patient safety, highlight key areas of information for noting, seek approval for key decisions and highlight key areas for escalation. Michael Richardson (MR) presented the papers and provided a brief overview. ➢ One key area to pull from the Patient Safety Report, - CQC have completed the reports for Horizon Health Centre (HHC), and Graham Road (GR), following their recent inspections. ➢ Now received two "*good*" ratings for Graham Road & Horizon Health Centre. MR felt assured and confident of those ratings. MR would like it noted, that special thanks to go to colleagues, especially within the Quality Improvement Group. It is commended the way that both practices had involved	

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	clinical colleagues, front line colleagues and adhered to the improvement plan. They had achieved that, which was required to a high standard. Questions Raised: ➢ ED asked how we identify potential emerging issues with general practices, recognising at present, we do not have any practices on enhanced surveillance? **MR responded** the importance of having triangulateration of information from different sources, and confirmed he works closely with the primary care contracting and commissioning teams – there is a dashboard of all GP practices, and different sources such as patient feedback is viewed. MR meets regularly with the CQC monthly, together with Healthwatch. In terms of enhanced surveillance, MR advised there is valuable feedback received from NHSE and the National Quality Board Enhanced Surveillance. The escalation process is very robust. **BH mentioned** the overview of the dashboard, Susie McMullen (SMc) had previously updated the PCC. BH advised the Primary Care Team work very closely with the practice support team, and the access Resilience and Quality Team, which is led by One Care, so practices can refer themselves. This is monitored through the subgroup of this Committee; The Quality and Resilience group and our performance SDU. AM reflected on the ARC Programme. This Programme supports practices who are open to support. It was suggested if this Programme could be opened to pharmacy, optometry, and dental practices also? this is a good example of joint working. RS mentioned regarding GR & HHC, there were some specific issues around stability of their clinical workforce and leadership, which has now improved. There is some learning to take from this, and how support can be given to more vulnerable practices inside a certain PCN area. AM asked for an update on a potential wider support programme plans at a future PCC. **Action – SLC to add to PCC forward planner, around potential support programme plans at a future PCC, around the progress of structure support for POD services.** **Action – MR to provide an update on potential support programme plans, at a future PCC, around the progress of structure support for POD services.** **Patient Safety Incidents Response Framework (PSIRF) Briefing Paper** The Primary Care Committee, is asked to consider the context of PSIRF adoption in general practice, as outlined in this paper and to review the options presented. The authors of this paper recommend Option 2, i.e. promoting PSIRF through the system and inviting expressions of interest for practices to become early adopters. MR advised that PSIRF is part of a large element of a new patient safety strategy, which came from NHS England last year, with a specific strategy for primary care. This has only just been published at the end of September. MR explained the Instant Response Framework is a much more flexible way of learning from incidents and described within the paper. With all colleagues and people involved, including patients and service users, a key part of this is being proportionate. MR	**SLC** **MR**

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	advised not all incidents require the same structure in terms of an investigation, and then an improvement plan, it is better if you can focus responses on themes. MR advised there is a national pilot approach to this at present, and as a result, we already have several practices, who are keen to be early adopters. The ICB is also working with BSW ICB, who also have eight or nine practices, who also want to be early adopters. It has been discussed and suggested, to have a community of practice, so that we can share, not just within practices across BNSSG, but also across the board with BSW, as well as the region and nationally. MR advised this paper had gone to PCOG meeting last month, was well supported with the proposed direction of travel. <u>Questions Raised:</u> ➢ ED advised she was in support of option 2, but questioned with regard to Expressions of Interest, these would normally be received by people we know would ensure it succeeds, but how do we encourage those that are not as skilled, to participate, so that we can measure their performance? **MR responded** –This question has not been addressed previously, but MR advised he had the same conversation with his colleagues in BSW, and there was a suggestion of a phase 2 or another round of invites for expression of interest, which feels a good approach. <u>Summary</u> AM noted the context is that nationally, patient safety themes in primary care are clear, 61% around missed or delayed diagnosis, which is a concern. AM queried as a system, where we are able to identify very clearly the themes that occur in our general practice setting, and if not, what learning could we take from the national data? From a patient point of view, Option 2 sounds the right option. AM confirmed to MR that support has been given for option two. A timeline is needed to describe what we want to achieve by when. **The Primary Care Committee are noting the Patient Safety Report and the Patient Safety Incidents Response Framework (PSIRF) Briefing Paper.**	
9	**Primary Care Finance Report** Jamie Denton (JD) provided a finance update for Month 5, highlighting ongoing financial challenges, the measures being taken to manage risks, and maintaining financial stability in the face of limited resources. The following key points were raised: ➢ <u>The system financial position</u> – we are seeing quite a challenged financial position. ➢ At the month five position, the net system financial position was an overspend of £12.4 million, but continuing to forecast a break-even position by the end of the financial year. ➢ The ICB is reporting a small overspend, and the system providers were forecasting the majority of that £12.4 million overspend. ➢ There was a £25 million unmitigated risk. This has improved, but it is still a challenged financial position.	

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	➢ General practice position - year to date, there is a reported underspend of £1.5 million, which is an underspend in forecast to be £2.5 million by the end of the financial year. The driver of that is the medicines management position. ➢ We have seen lower than anticipated expenditure over the first three months of the financial year. ➢ ICB have only had actual invoices April to June within this reporting, and that generated the £1.5 million underspend. JD wanted to note there is a lot of volatility within prescribing bills; recognising from month to month, this can change by £1,000,000. ➢ JD advised he is monitoring the spend closely, and in the next month's report of trying to have a bit more detail on what is causing that underspend. ➢ The global sum payment was made in September, including the backdated payment of the April, the 1st with other Primary Care Networks (PCN) payments happening during the course of this current month. ➢ The provider position includes the two acutes and AWP, which are the three positions that report against the provider surplus or deficit. Their position is a £3,000,000 overspend year to date, however it was noted they are forecasting to be break even by the end of the financial year. ➢ Pharmacy, optometry, and dental position – reporting a small underspend year to date of £200,000, with a forecast to be £300,000 underspent by the end of the year. ➢ Within the secondary care dental, there is overspending of £500,000, year to date, with a forecast to be £1,000,000 overspent by the end of the financial year. JD advised the ICB are closely monitoring the dental debt, which is currently showing about £12.3 million, compared to 23/24. It is reported that within that debt, there are around about 13 contracts that are contributing. Those contracts have an insufficient revenue. It is envisaged that by the end of the year, the debt against those contracts would remain at just under £2.3 million. JD advised there is confidence however, that because the group of providers is related, large national companies, we are not anticipating that to materialise. The ICB will continue to be working with those providers. **The Primary Care Committee:** • **Noted the summary financial plan for all primary care services.** • **Noted the key risks and mitigations to delivering the financial plan and support these reports.**	
10	**POD Monthly Report from Commissioning Hub** Terrance Chikurunhe (TC) wanted to give assurance to the Committee, and confirmed he meets on a monthly basis to look at the repayments within the commissioning hub. TC reported there is a focus at the national level, in terms of repaying this debt. This is not a risk, as some providers have committed to three months payment, which is in line with the dental regulations and on exceptional cases they would ask for an extension for repayment. Within the current financial period, from a corporate perspective, we are assured that they will pay. TC & NH presented the POD monthly report, on behalf of the SW Collaborative Commissioning Hub. DJ thanked TC for providing the level of input and insight from the commissioning hub, which the Primary Care Committee had been seeking. DJ noted from an assurance perspective, around increasing activity, he had signed a number of contract variances over the past month, increasing activity in a number of practices across the region, in relation to the UDA, rebasing the expressions of interest, so it is starting to have an effect.	

	Item	Action
	AM thanked TC & NH for the report. It was agreed to move this item nearer to the top of the agenda for the next PCC meeting in December, to allow sufficient time for a full update. **The Primary Care Committee received and noted the POD Monthly Report from The Southwest Collaborative Commissioning Hub.**	
11	**General Practice Access Recovery Q1 Report** Due to the agenda running over, and BH having to leave the meeting, it was agreed to move this item to the next PCC, to provide an update on the Q1 report, and potentially Q2 report if this will also be available.	**SLC**
12	**Key Messages for the ICB Board** AM advised that she would consider the key messages for the ICB Board.	
13	**Primary Care Operational Group (PCOG) Minutes 9th July & 10th September 2024** **The Primary Care Committee received the PCOG minutes for information.**	
14	**Any Other Business** ➢ AM queried a tweet on social media, which had highlighted a North Bristol Practice who had arranged their flu vaccination clinic on a Saturday – it had reported 150 DNAs. AM mentioned as an assurance Committee, we need to understand the reasonings for these DNAs, and to understand where we are with vaccination rates. ➢ DJ mentioned to coincide with this, a practice in South Glos had reported they had 200 people+ queuing for their vaccinations. **Action – for DJ to provide an update regarding where we are with vaccinations, and to bring an update at the next PCC meeting in December 2024.** No other business to note and the meeting closed.	**DJ**
	Date of Next Meeting Tuesday 17th December 2024 –9:00 – 11:00 Via MS Teams	