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NHS Gloucestershire

Primary Care & Direct Commissioning Committee PT1

Thursday 4th August 2022
2:00pm to 4:20pm, Sanger House/MS Teams

Chair: Colin Greaves

N.	TIMING	ITEM	LEAD	RECOMMENDATION
		PART A		
1.	**2:00pm – 2:10pm**	**Introduction & Welcome**	**Chair**	**Note**
2.		**Apologies for absence**	**Chair**	**Note**
3.		**Declarations of interest**	**Chair**	**Note**
4.		**Minutes of the last meeting**	**Chair**	**Approval**
5.		**Matters arising**	**Chair**	**Discussion**
6.	**2:10pm - 2:20pm**	**Terms of Reference** - **PC&DC** - **PCOG**	**Chair**	**Note** **Approval**
7.	**2:20pm – 2:25pm**	**Partners in Health Contract Novation**	**Jo White**	**Note**
8.	**2:25pm – 2:35pm**	**Enhanced Access Update and Next Steps**	**Jo White**	**Support**
9.	**2:35pm - 2:45pm**	**Primary Care & PCN Performance Report**	**Jo White**	**Discussion**
10.	**2:45pm – 2:50pm**	**Primary Care Delegated Commissioning – Pharmacy, Optometry, Dentistry Highlight Report**	**Jo White**	**Note**
11.	**2:50pm – 3:00pm**	**Quality Report**	**Marion Andrews-Evans**	**Note**

12.	**3:00pm – 3:10pm**	**Financial Report**	**Cath Leech**	**Note**
PART B				
13.	**3:10pm – 3:25pm**	**Primary Care Strategy Overview**	**Helen Goodey**	**Support**
14.	**3:25pm - 3:35pm**	**Next Steps for Integrating Primary Care: Fuller Stock Take Report**	**Jo White**	**Support**
15.	**3:35pm – 3:45pm**	**ILP Highlight Report**	**Helen Goodey**	**Note**
16.	**3:45pm – 3:50pm**	**Any Other Business (AOB)**	**Chair**	**Note**
17.	**3:50pm - 4:00pm**	**Questions From the Public**	**Chair**	**Discussion**
Dates in Diaries				
PC&DC Committee PT1 (Public): 6th October 2022 2:00pm – 4:00pm **PC&DC Committee PT2 (Confidential): 6th October 2022 4:00pm – 5:00pm**				

NHS Gloucestershire Clinical Commissioning Group

4

Primary Care Commissioning Committee

(Meeting held in public)

Minutes of the meeting held at 2:00 pm on 30th June 2022

Virtually via Microsoft Teams

Present:		
Alan Elkin (Chair)	AE	Lay Member, Patient and Public Experience
Colin Greaves	CG	Lay Member, Governance
Julie Clatworthy	JC	Registered Nurse and Lay Member, Quality
Cath Leech *(until 2:57 pm)*	CL	Chief Financial Officer
Matthew Lowe *(deputising for CL from 2:57)*	ML	Head of Management Accounts
Jo Davies	JD	Lay Member, Patient Engagement
Mark Walkingshaw	MW	Director of Commissioning and Deputy Accountable Officer
Marion Andrews-Evans	MAE	Executive Nurse and Quality Lead
In Attendance:		
Lauren Peachey	LP	Governance Manager (minutes)
Helen Goodey	HG	Director of Primary Care & Locality Development
Jo White	JW	Deputy Director of Primary Care & Locality Development
Dr Laura Halden *(until 2:25 pm)*	LH	Chair Gloucestershire Primary Care Training Hub
Carole Allaway-Martin	CAM	Councillor, Gloucestershire County Council
Vareta Bryan	VB	Lay Member, Developmental Role
Becky Parish	BP	Associate Director, Engagement and Experience
Andrew Hughes	AH	Associate Director, Commissioning
Declan McLaughlin	DM	Senior Primary Care Project Manager
Nigel Burton	NB	Healthwatch Representative
Lauren Peachey	LP	Governance Manager (minutes)

1	**Apologies**
1.1	Apologies received from Mary Hutton and Denise Johnson-Carr
1.2	It was confirmed that the meeting was quorate.
1.3	The chair welcomed the members of the public who had joined the meeting.
2	**Declarations of Interest**
2.1	There were no declarations of interest raised for the items on the agenda.
3	**Minutes of the Previous Meeting**
3.1	The minutes of the previous meeting were agreed as an accurate record, subject to minor changes within the members and attendees list being made.
4	**Matters Arising**
4.1	**24.02.2022, Item 8.3, Action: CL will obtain some more detail on contract payment variances.** **Item to remain open**
5	**GP Recruitment and retention in Gloucestershire**
5.1	LH explained that Gloucestershire remained ahead of the national figures for GP recruitment and retention. However, according to the workforce survey carried out in October 2021, there was a decline in GPs before the pandemic, which further declined during the pandemic due to multiple factors including but not limited to increased workload, changing patient demographics, negative media portrayal, complaints, poor work-life balance, and changing of roles from a partnership role to a salaried or locum role.
5.2	LH stated that figures detailing numbers of GPs in the county were received quarterly, with the latest published in June 2022. These numbers showed a small upward trend compared to the previous figures in December 2021.
5.3	LH explained innovative training and support fellowships had been developed, such as for health inequalities and support for creative opportunities for GPs to develop special interests. These fellowships had encouraged the recruitment of new GPs into the Inner City and Forest of Dean.

5.4	LH reminded all that there was an active Spark scheme to support newly qualified GPs; since 2020 there have been 70 GPs across four cohorts supported by the Spark scheme.
5.5	LH stated that this county is one of the highest achievers in the area for the number of trainees that convert into qualified GPs. The Training Hub is a net importer of bringing these trainees into Gloucestershire.
5.6	LH explained that there was a scheme in place to support GPs returning to practice. If a GP had been away from practice for more than two years, then there was a health education scheme to support their return. This included one-to-one sessions with a support lead and a retainer scheme for those having difficulty readjusting. The retainer scheme provided more flexibility, and additional educational support.
5.7	LH raised that GP morale was currently low. Within Inner City Gloucester, the weighted list size does not adequately reflect the workload. LH said QOF attainment, immunisations and vaccinations uptake did not adequately reflect the workload. This made it more difficult to recruit in those areas.
5.8	HG added that work was ongoing with practices within Inner City Gloucester to help improve the situation, such as offering flexible jobs. Developing new ways of working for GPs in practice, particularly within larger practices, should be a priority focus for the ICB.
5.9	JD added that for GPs, there may be a feeling of isolation, particularly in rural parts of the county. There was an opportunity to emphasise how well supported they would be in the ICB. LH agreed and highlighted that Gloucestershire was a supportive place to work. LH was a GP trainer and had frequent opportunities to discuss support for GPs.
5.10	JC highlighted that there needed to be clear commitment on providing support for Practice Nurses. LH responded that there was an equivalent Spark scheme for newly qualified nurses within Primary Care. However, it was acknowledged that the scheme was only for newly qualified nurses, and it had been recognised that there needed to be support for nurses coming into Primary Care from Secondary Care. Work was ongoing with the BSW ICS and Gloucestershire, where a Preceptorship nurse scheme was being piloted to support these nurses.
5.11	CG explained that Inner City Gloucester experienced many challenges and were perhaps not recompensed to the level they should be. CG explained that this was an issue which should be raised at a national level as it was expected that all inner-city areas

	would experience these additional challenges. HG responded that the formula governing resourcing allocation needed to be reviewed at a national level to support the required changes. HG said that locally mental health practitioners and additional training was prioritised in inner-city practices. CG highlighted that pressure needed to be raised at a national level.
5.12	VB explained that there was a connection between limited resources in inner city areas and health inequalities. LH responded that there were health inequalities fellowships which have been running successfully for a few years within Gloucester City.
5.13	**RESOLUTION: The committee noted the contents of the GP Recruitment and retention in Gloucestershire update**
6	**Primary Care Infrastructure Plan 2016/ 2026 Handover Report**
6.1	AH presented the Primary Care Infrastructure Plan 2016/ 2026 Handover Report for the newly established Primary Care and Direct Commissioning Committee. AH reminded members that an extensive annual review of Primary Care Infrastructure had been presented at the previous meeting.
6.2	AH explained that the Primary Care Infrastructure Plan 2016/ 2026 Handover Report provided an overview of the responsibility of the Integrated Care Board (ICB) for Primary Care infrastructure.
6.3	AH highlighted that the report included some key achievements of the Primary Care Commissioning Committee, particularly in approving and delivering many schemes, including the recently opened Wilson Centre on Prestbury Road in Cheltenham. AH said there were around seven business cases which had been completed and were due to be taken to the Primary Care and Direct Commissioning Committee over the coming months.
6.4	AH summarised some of the unique challenges faced in the construction industry at the current time including rising costs of materials and inflation. AH said these challenges were creating significant barriers for progressing projects.
6.5	AE said the report summarised the current situation very clearly. AE highlighted that the development of Primary Care infrastructure had been hugely successful over recent years. Unfortunately, the financial situation going forward may create significant challenges going forwards.
6.6	CG highlighted that the Primary Care Infrastructure was one of the major successes of the CCG. CG added that PCCC had scrutinised and approved many projects over recent years. CG

	asked that a subsequent was submitted to the Primary Care and Delegated Commissioning (PC&DC) committee for formal approval. **ACTION: AH to produce Primary Care Infrastructure Report for PC&DC.**
6.7	CG explained that business cases needed to be refreshed and brought back to the PC&DC if they had been approved but not yet progressed to the development stage after an extended time period. CG explained that business cases needed to be updated due to the dynamic challenges faced in the industry.
6.8	AH said the PCIP would be refreshed this year 2022-23. AH agreed timely progression of business cases was important given the changing climate/challenges. AH said that some business cases had not progressed due to extenuating circumstances.
6.9	HG said there had been many underdeveloped Primary Care premises that were not fit for purpose prior to the establishment of the CCG, and these premises had since been developed. HG said a new model of care was being driven to improve Primary Care resilience. General Practice will need to continue to adapt, and improved premises will support this.
6.10	**RESOLUTION: The Committee approved the Primary Care Infrastructure Plan 2016/ 2026 Handover Report**
7	**Primary Care Delegated Financial Report**
7.1	CL explained that the Primary Care Delegated Financial Report covered the period up to May 2022. CL explained that the financial reporting for the current financial year, 2022-23, would be split between the accounts for the Clinical Commissioning Group (CCG) and the accounts for the Integrated Care Board (ICB). CL said that, in terms of the phasing for some of the budgets, variances would be produced and this would be noticeable within the Primary Care Delegated Financial Report. CL explained that, at the end of May 2022, there was an underspend reported to some of the budget phasing and some uncertainty around some of the allocations.
7.2	CL explained that as the ICB progresses over the coming months, there will be a better understanding of the allocations and those variances will no longer occur.
7.3	**RESOLUTION: The Committee noted the contents of the Primary Care Delegated Financial Report**
8	**Primary Care Quality Report**

8.1	In terms of safeguarding, MAE explained that there had been a project underway to integrate the three Safeguarding teams across the ICS. MAE explained that two of the Safeguarding Teams had been successfully integrated. MAE highlighted that the Health Integrated Safeguarding Group had been established. MAE explained that an integrated Safeguarding Team would provide a single point of access for Primary Care and the local Authority.
8.2	MAE highlighted that a new assistant director for safeguarding was due to commence in post on the 1st of August 2022.
8.3	MAE explained that additional pressure had been placed on Primary Care due to the number of asylum seekers and refugees arriving in the county. Some health information is arriving in the county prior to refugees arriving which supports the planning of health services. MAE said there were three asylum hotels in the county and all hotel residents needed to be registered with a local GP. MAE explained that turnover at the asylum hotels was high.
8.4	MAE explained that the CCG appointed two nurses to focus on healthcare for asylum seekers and refugees; this would relieve some pressure from Primary Care and provide focused support to refugees and asylum seekers. MAE commended the support provided by Primary Care in the county to the asylum seekers and refugees.
8.5	MAE said many Ukrainian guests were arriving to stay with local families; families were expected to support their Ukrainian guests to register with a local GP.
8.6	MAE said GP Safeguarding Forums continued to run and were working well. The named GP for Safeguarding in Primary Care was also offering Supervision Sessions.
8.7	In terms of foster care and adoptions, Hadwen Medical Centre were due to commence a pilot project to undertake adult medicals for those looking to foster or adopt a child. MAE explained that this work had previously been completed by Gloucestershire Hospitals Foundation Trust (GHFT).
8.8	In terms of Serious Incidences, MAE explained that a new method and process for reporting Serious Incidents called Learning from Patient Safety Events had been developed and would accompany a relaunch of the approach to reporting serious incidents and patient safety in Primary Care.
8.9	In terms of the Patient Advice and Liaison Service (PALS), BP explained that there had been a noticeable number of inquiries from people who have started treatment for transgender services privately and contacting their GP to arrange NHS services, such

	as blood tests, and are experiencing barriers. BP explained that processes around these shared care arrangements between NHS care and Private care were not clear; discussions were underway with GP colleagues and commissioning colleagues to look towards resolving the situation.
8.10	BP explained that there had been contacts made to the PALS team with regard to obtaining specific types of HRT medication; there were some shortages with regards to particular brands.
8.11	BP said that the Fit for the Future engagement with local communities had been extended until the end of July 2022.
8.12	BP said the national GP Patient Survey results were due to be published on the 14th of July.
8.13	BP explained that the Friends and Family Test had been suspended throughout the pandemic. However, it was due to recommence in Primary Care and from July 2022 Friends and Family Test data will be available from local GP practices.
8.14	In terms of Medicines Management MAE explained that there had been a steady increase in the cost of medicines; a savings plan was underway. MAE added that a PCN Medicines Optimisation Group had been established.
8.15	MAE explained that, in terms of Infection, Prevention and Control, the rate of Clostridium Difficile was higher than it had been during the Covid pandemic however they remained lower than pre-Covid levels. MAE explained that rates of Covid in the county had been increasing. MAE said the increase in Covid had an impact on Primary Care staffing.
8.16	MAE highlighted the Care Home Infection Control Team (CHIP) continued to work with local care homes to support infection control and help them manage outbreaks.
8.17	MAE highlighted that the comprehensive seasonal Influenza plan was being finalised. MAE explained that, unfortunately, the number of staff having their Influenza vaccines had decreased. MAE said the ambition was to offer the Influenza and Covid vaccinations at the same time.
8.18	In terms of the Covid vaccinations, MAE said the spring Booster campaign had gone well and there had been a good uptake. MAE said the rate of children aged 5 – 11 was very low at less than 20%, however, this was the highest in the country. MAE said there was a national drive to focus on all vaccinations.

8.19	MAE said there was very little Monkeypox in the county, and the cases were being well-managed. The recommended vaccine for Monkeypox was the Smallpox vaccine.
8.20	MAE explained that the ICS Quality Surveillance Group continued to meet. The key focus of this meeting at the moment was around Maternity Services and the response to the Ockenden Report.
8.21	AE raised concern about the shortfall in services for children in care. MAE responded the CCG had invested heavily in the children in care team recently. MAE added that children with particularly challenging needs were being placed in county from other counties.
8.22	**RESOLUTION: The Committee noted the contents of the Primary Care Quality Report**
9	**Enhanced Access Update**
9.1	JW provided an update on Enhanced Access planning in Gloucestershire. JW explained that the Enhanced Access service was planned to go live from October 2022 as part of the Primary Care Network DES. JW said all Gloucestershire practices had signed up to the Enhanced Access Service. JW explained that the Improved Access offer, and the Extended Hours service were being combined to offer a single Enhanced Access service.
9.2	JW explained that the amalgamation of the Extended Hours service and the Improved Access offer was designed to improve patient understanding of the offer, remove the confusion between the two different services and remove variability across the country. JW said the NHS England specification asked that PCN's use Population Health Management and capacity and demand tools to engage with their registered population to ensure that the range of services that they propose to offer considered patient needs and preferences.
9.3	JW explained that the service that was being nationally commissioned will run from 6:30 to 8:00 pm on Monday to Fridays from October 2022. On Saturdays, the service will run from 9:00 am to 5:00 pm. PCNS can choose to offer services on Bank holidays and Sundays if they wish to.
9.4	JW explained that, as part of the specification, NHS England were asking PCNs to offer 60 minutes of time per thousand population; for example, a 30,000 PCN must deliver 30 hours per week under the new Enhanced Access specification. PCNs need to ensure the appointments are available for any general practice services.

	Appointments must be bookable and digital infrastructure must be in place to support booking and cancellation of appointments.
9.5	JW said the appointment data needed to be available to GPAD, the general practice appointment data set. Currently, the data set did not include additional appointments provided through improved access.
9.6	JW explained the PCNs were due to submit their plan by the 31st July 2022 and sign-off for these plans was due by the 31st August. However, JW said that some PCNs would like a decision to be made much sooner so they can develop rotas two months in advance to start in October.
9.7	JW had proposed to take the plans to the PCN development group for discussion and comment and bring a summary report to PC&DC in August.
9.8	JW explained that there were challenges to implementing the changes to the services, including offering services such as phlebotomy. JW explained that pathology resources had been mapped out to cover Monday to Friday for community services and that she was investigating the possibility of a Saturday service with the Pathology Department.
9.9	JW said there was a risk nationally that practices may pull out of the PCN DES. JW explained that it was unlikely local practices would pull out of the PCN DES and that they were all working on their plans. JW explained that ensuring the digital capabilities was in place was challenging however some practices were moving towards the system of choice of the PCN.
9.10	**RESOLUTION: The Committee noted the contents of the Enhanced Access update.**
10	**Blakeney Practice**
10.1	JW explained that Blakeney practice was a small practice with a list size of just over 3000 patients. Blakeney Practice had two partners who had expressed a desire to relinquish their contracts and had since commenced working with GDoc.
10.2	JW explained that a novation of contract had taken place and was effective from the 1st June 2022 and a Contract Award Notice (CAN) had been issued. JW said the Forest of Dean PCN was supportive of the proposal with GDoc.
10.3	**RESOLUTION: The Committee noted the contents of the Blakeney Practice update.**

12	**<u>Any Other Business</u>**
12.1	It was acknowledged that this was the last committee of the CCG prior to transition to the ICB. CG expressed thanks to the excellent leadership and chairing of AE. AE expressed gratitude to the committee members, attendees, and Primary Care Team for the excellent work over the years.
	The meeting closed at 3:20 pm
	The next meeting (PC & DC) will take place on the 4th of August 2022 at 2 pm

6.1

NHS GLOUCESTERSHIRE INTEGRATED CARE BOARD

PRIMARY CARE & DIRECT COMMISSIONING COMMITTEE

TERMS OF REFERENCE

Version	Author	Approved by	Review	Type of changes
V01	Helen Edwards			Creation of ToR
V02	Christina Gradowski			Content
V03	Jo White			Content
V04	Dan Corfield			Consistency changes in line with other committee ToRs. Formatting.
V0.5	Dan Corfield			Final reconciliation of membership
V0.6	Dan Corfield			Incorporating feedback from Committee Chair Designate
V1.0	Dan Corfield	Board of ICB 01/07/2022	Annually	Final version for ICB start date

Contents

1. Introduction

1.1. The Primary Care & Direct Commissioning Committee, PC&DC (the Committee) is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution and in accordance with Delegations made under section 65Z5 of the 2006 NHS Act[1] as amended by the Health Bill 2021.

1.2. NHS England has delegated authority to the ICB for the commissioning of primary care. Part 1 of Schedule 2A (Primary Medical Services)[2] sets provision regarding the carrying out of those Delegated Functions relating to Primary Medical Services, being in summary:

- decisions in relation to the commissioning and management of Primary Medical Services;
- planning Primary Medical Services in the Area, including carrying out needs assessments;
- undertaking reviews of Primary Medical Services in respect of the Area;
- management of the Delegated Funds in the Area;
- co-ordinating a common approach to the commissioning and delivery of Primary Medical Services with other health and social care bodies in respect of the Area where appropriate; and
- such other ancillary activities that are necessary in order to exercise the Delegated Functions.

1.3. The committee acknowledges that, in addition to the statutory duties set out in Part 1 Schedule 2A (Primary Medical Services) that it already complies with, it must comply with the following as regards primary care:

a) *duty to consult with Local Medical Committees[3] and other stakeholders in accordance with the duty of public involvement and consultation under section 14Z2 of the NHS Act;*

1.4. These Terms of Reference (ToR), which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

1.5. Committee members including those who are not members of the ICB Board, are bound by the Standing Orders and other policies of the ICB.

[1] *See Part 1, Health Bill 2021 s.60 Joint working and delegation arrangements*

[2] *The National Health Service (Personal Medical Services Agreements) Regulations 2015*

[3] *Consultation to include Local Pharmacy Committee, Local Optical Committee and Local Dental Committee when delegated authority extends to Pharmacy, Optometry and Dental services.*

2. Purpose

2.1. The purpose of the Committee is to manage the delivery of those elements of the primary care healthcare services delegated by NHS England to the ICB. The aim will be to deliver to the people of Gloucestershire, on behalf of the ICB, services that are of high quality, clinically effective and safe, within available resources. This will be delivered through a culture of openness supported by sound governance arrangements.

2.2. The Committee is currently responsible for the commissioning of primary care. NHS England may at some point delegate authority to the ICB for the commissioning of primary dental services, primary pharmacy and ophthalmic services. The Primary Care and Direct Commissioning Committee will at the point of delegation of these services to the ICB, review its terms of reference and include these services within its committee remit.

3. Delegated Authority

3.1. The purpose of the Committee is to manage the delivery of those elements of the primary care healthcare services delegated by NHS England to the ICB. The aim will be to deliver to the people of Gloucestershire, on behalf of the ICB, services that are of high quality, clinically effective and safe, within available resources. This will be delivered through a culture of openness supported by sound governance arrangements.

3.2. The PC&DC Committee is a formal committee of the ICB. The Board has delegated authority to the Committee as set out in the Scheme of Reservation and Delegation and may be amended from time to time.

3.3. The PC&DC Committee is authorised by the Integrated Care Board to:

3.3.1. Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) as outlined in these terms of reference;

3.3.2. Commission any reports it deems necessary to help fulfil its obligations;

3.3.3. Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice.

3.4. The PC&DC Committee holds only those powers as delegated in these Terms of Reference as determined by the ICB Board.

4. Membership

4.1. The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

4.2. The Board will appoint the six committee members:

- Committee Chair: shall be an Independent Non-Executive Director of the ICB who is not the Chair of the Audit Committee;
- Committee Vice-Chair: Independent Non-Executive Director of the ICB with a remit for Quality;
- Chief Executive Officer or Deputy CEO of the ICB;
- ICB Chief Medical Officer;
- ICB Chief Nursing Officer;
- ICB Chief Financial Officer;

4.3. Members will possess between them knowledge, skills and experience in primary care development and contracting, patient safety and quality and technical or specialist issues pertinent to the ICB's business (such as dentistry, optometry and pharmacy). When determining the membership of the Committee, active consideration will be made to diversity and equality.

4.4. Membership will be reviewed, and other individuals may be invited to become members of the Committee as and when appropriate to meet the needs of the agenda.

4.5. Attendees and other Participants

4.5.1. Only members of the Committee have the right to attend Committee meetings, however all meetings of the Committee will also be attended by the following individuals who are not members of the Committee:

- Director of Primary Care & Place;
- Deputy Director of Primary Care and Place (Primary Care Development);
- Citizen Member;
- Head of Primary Care Contracting;
- Councillor, Gloucestershire County Council.

4.5.2. Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter, including representatives from the primary care estates, workforce developments and the Training Hub.

4.5.3. The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

4.5.4. If the membership of the Committee includes the Deputy CEO rather than the CEO, then the Chief Executive should be invited to attend the meeting at least annually.

4.6. Attendance

4.6.1. Where an attendee of the Committee (who is not a member of the Committee) is unable to attend a meeting, a suitable alternative may be agreed with the Chair.

5. Quoracy

5.1. For a meeting to be quorate a minimum of four members must be present at the meeting including:

- One Independent Non-Executive Director of the ICB;
- Chief Financial Officer or their nominated deputy.

5.2. If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

5.3. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

6. Voting and decision-making

6.1. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

6.2. Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter. Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.

6.3. If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

7. Frequency and Notice of Meetings

7.1. The Committee shall meet up to six times a year. The Chair of the Committee may convene additional meetings as required.

7.2. Meetings of the Committee shall:

7.2.1. Be held in public; and

7.2.2. The Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

7.3. In accordance with the Standing Orders, the Committee may meet virtually when necessary, and members attending using electronic means such as telephone or videoconferencing shall be counted towards the quorum.

8. Committee Secretariat

8.1. The Committee shall be supported with a secretariat function provided by the Corporate Governance Team. The Governance Team shall ensure that:

8.1.1. The agenda and papers are prepared and distributed in accordance with the Standing Orders at least five (5) working days before the meeting, having been agreed by the Chair with the support of the relevant Executive Lead – Director of Primary Care & Place;

8.1.2. Attendance by members of the committee is monitored and reported annually as part of the Annual Governance Statement (contained within the Annual Report);

8.1.3. Records of members' appointments and renewal dates are maintained, and the Board is prompted to renew membership and identify new members where necessary;

8.1.4. Good quality minutes are taken and agreed with the Chair and that a record of matters arising, action points and issues to be carried forward are kept;

8.1.5. The Chair is supported to prepare and deliver reports to the Board;

8.1.6. The Committee is updated on pertinent issues/ areas of interest/ policy developments;

8.1.7. Action points are taken forward between meetings and progress against those actions is monitored.

8.2. All members or attendees at the Committee are required to declare any potential or actual conflict of interest before items are discussed. There will be a standing agenda item at the beginning of each meeting for this purpose. Even if an interest has been recorded in the register of interests, it must still be declared in meetings where matters relating to that interest are records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary.

9. Remit and Responsibilities of the Committee

9.1. In accordance with its statutory powers under section 65Z5 of the NHS Act, NHS England has delegated the exercise of the Delegated Functions to the ICB to empower it to commission Primary Care Services for the people of Gloucestershire.

9.2. Each Integrated Care Board Committee will have a remit which encompasses two primary areas of responsibility.

9.2.1. The Committee will exercise the delegated authority of the Board to execute assurance against a sub-set of its statutory duties and functions. It will retain oversight of progress against the Integrated Care Board's strategic priorities through the developing partnership and integrated working of its members. This balanced approach will ensure that the governance focus of the Committee spans both current performance and risk as well as strategic development and system effectiveness. Committees will have a core membership spanning both areas of its responsibility, which can be enhanced as required by the addition of co-opted attendees or participants who are invited to contribute to the debate and deliberation of the Committee. The decision on the use of co-opted attendees or participants rests with the Chair of the Committee.

9.3. The role of the Primary Care Commissioning Committee shall be to carry out delegated functions that are related to the commissioning of primary medical services from NHS England to the ICB as set out in Schedule 2A (Primary Medical Services). This includes delegated responsibility for the following:

9.3.1. The award of GMS, PMS and APMS contracts. This includes: the design of PMS and APMS contracts; and monitoring of contracts;

9.3.2. Locally defined and designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services");

9.3.3. Making decision regarding local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);

9.3.4. Reviewing, analysing, and providing constructive challenge regarding primary care performance, including requesting both remedial and preventative programmes of work and individual action plans.

9.3.5. Procurement of new practice provision;

9.3.6. Discretionary payment (e.g., returner/retainer schemes);

9.3.7. Approving practice mergers;

9.3.8. Primary Care Estates Strategy;

9.3.9. Premises improvement grants and capital developments;

9.3.10. Contractual action such as issuing breach/remedial notices and removing a contract; and

9.3.11. Reporting details of 22a – i to the ICB.

9.4. The Committee shall also have oversight of the landscape, development plans and performance/usage of digital information system (notably clinical/patient information systems) and other technology, uptake of and compliance with local and national digital transformation and integration programmes, and the adoption of innovative medical technology.

9.5. Primary Care Networks (PCNs)

9.5.1. PCNs shall be accountable to the PC&DC Committee.

9.5.2. The Committee shall review the ICB plans for the management of the Network Contract Directed Enhances Services, including plans for re-commissioning these services annually where appropriate.

9.5.3. The Committee shall receive assurances that the planning of Primary Care Networks in Gloucestershire complies with published specifications and guidance including:

- Maintain or establish identified Network Areas to support the local population in the Area;
- Review any waived PCN list size requirements wherever possible and appropriate to best support the local population in the Area;
- Ensure that each PCN has at all times an accountable Clinical Director;
- Align each PCN with an ICB that would best support delivery of services to the local population in the Area;
- Collaborate and work with other ICBs as appropriate to agree which ICB will be the lead ICB for the PCN.

9.5.4. The Committee shall receive assurances that the planning of Primary Care Networks in Gloucestershire complies with published specifications and guidance including maintaining or establishing identified Network Areas to support the local population in the area.

9.5.5. The Committee shall receive highlight reports regarding the activities of Primary Care Networks, including PCN transformation and improvement plan progress, shared risks and issues, and interaction with individual member practices and Integrated Locality Partnerships (ILPs).

9.6. Financial Accountability

9.6.1. The Committee's authority for procuring services is covered in the ICB Scheme of Reservation and Delegation and Standing Financial Instructions.

9.7. The Committee shall refresh the Primary Care Strategy for Gloucestershire and report on and make recommendations to the ICB on the following:

- Primary Medical Care Strategy for Gloucestershire;
- Planning primary medical care services in Gloucestershire (including needs assessment);
- Performance management of primary care services and contracts.

9.8. The Committee may delegate some tasks to such individuals, sub-committees or individual members as it shall see fit, provided that any such delegations are consistent with the parties' relevant governance arrangements, are recorded in a scheme of delegation, are governed by terms of reference as appropriate and reflect appropriate arrangements for the management of conflicts of interest. The Committee may not delegate the procurement of services to any individual or sub-committee.

9.9. The Committee shall be structured to address two core parts: statutory functions, and the transformational agenda which will link with the Clinical Programmes Approach and interface with, but not oversee, ILPs.

9.10. The Committee shall receive information regarding the allocation of operational and transformation funding provided to individual practices and PCNs, both capital and revenue, and similarly shall receive information on the use of those funds relative to the achievement of agreed objectives. The Committee shall hold practices and PCNs to account for value for money and other pertinent metrics regarding any such funding. Such monitoring and accountability notably includes, but may not be limited to, all items listed under sections 9.3 and 9.4 of these Terms of Reference.

10. Relationship with the ICB and other groups / committees / boards

10.1. The Committee has delegated authority for the commissioning of some primary care services as outlined in section 7.2, a-l.

10.2. The Committee shall make recommendations to the ICB for the primary care services and functions listed at section 7, 1-2.

10.3. The ICB Primary Care Operational Group (PCOG) shall undertake the operational management, implementation and oversight of the nationally defined primary medical care contracts and the primary medical care workstreams. In addition, the PCOG will also monitor complaints and quality.

10.4. The Primary Care Operational Group will act as a sub-committee and shall report to the Committee and submit the minutes of their meetings to the Committee for review.

10.5. The Primary Care Operational Group shall provide a timely summary highlight report of primary care planning, performance (operational and financial), quality and transformation activities for review by the PC&DC Committee.

11. Policy and Best Practice

11.1. The Committee has delegated authority for the commissioning of some primary care services as outlined in section 7.2, a-l.

11.2. When considering matters, the Committee should take into account the following:

- All statutory requirements applicable to the ICB;
- NHS England requirements and standards;
- Best professional practice and standards, e.g. CIPD;
- Emerging risks and issues;
- Relevant Business Information and Data analyses.

11.3. In exercising the Delegated Functions, the Committee must have due regard to the Guidance set out at Schedule 9 and such other guidance as may be issued by NHS England from time to time, including on the Primary Care Guidance web page.

11.4. The Committee will have full authority to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, within its terms of reference and within a limit determined by the Chief Financial Officer. The Committee shall have regard to current good practice, policies and guidance from NHSE&I, the ICS and other relevant bodies.

12. Monitoring and Reporting

12.1. The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

12.2. The minutes of each meeting of the Committee shall be formally recorded and retained by the Integrated Care Board. The minutes shall be submitted to the Board of the ICS.

12.3. The Chair will provide assurance reports to the Board after each meeting and shall draw to the attention of the Board any issues that require disclosure to the Board or require action.

12.4. The Committee will provide an annual report to the Board to describe how it has fulfilled its terms of reference, details on progress and a summary of key achievements in delivering its responsibilities.

12.5. The Committee will undertake an annual committee effectiveness review using the existing template model.

13. Conduct of the Committee

13.1. Members will be expected to conduct business in line with the ICB values and objectives

13.2. Members of, and those attending the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy

13.3. Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make.

13.4. Conflicts of interests: In discharging duties transparently, conflicts of interest must be considered, recorded and managed. Members should have regard to both the ICB's policies and national guidance on managing conflicts of interest. All potential conflicts of interest must be declared and recorded at the start of each meeting. A register of interests must be maintained by the Governance Team and submitted to the PC&DC Committee at each meeting and to the Board annually. If the Chair considers a conflict of interest exists then the relevant person must not take part in that item, and the Chair may require the affected member to withdraw at the relevant point.

14. Review of ToR

14.1. These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

NHS Gloucestershire Integrated Care Board

Primary Care Operational Group

Draft Terms of Reference

V1.0 July 2022

July 2022

Introduction

1. NHS England has delegated authority to the Integrated Care Board (ICB) for the commissioning of primary care.

2. In responding to this delegation, the ICB has established the Primary Care and Direct Commissioning Committee, PC&DC, as a Committee of the Board in accordance with its Constitution and in according with the Delegations made under section 65Z5 of the 2006 NHS Act[1] as amended by the Health bill 2021. The PC&DC ("Committee") is a corporate decision-making body for the management of the delegated functions and the exercise of the delegated powers.

3. The Primary Care Operational Group ("Group") has been established to implement and monitor the progress of the operational functions that delegated commissioning responsibilities provide, while making recommendations to the Committee where decisions are required. The delegated powers from the ICB Board to the Committee have been established within the terms of reference for the Committee, and set out within the ICB's Scheme of Reservation and Delegation.

Role of the Group

4. The Group has been established by the ICB in order to provide the operational delegated management, implementation and oversight of the nationally defined primary medical care contracts and the primary medical care workstreams specified below. The guiding principle of the functions undertaken at this Group is that only nationally defined contracts and actions can be implemented without referral and recommendations to the Committee.

    - To make decisions against policy and/or make recommendations for decision making to the Committee concerning primary care contractual and commissioning issues;

    - GMS, PMS and APMS contract reviews and monitoring

    - Implementation and monitoring of locally and nationally defined and designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services");

    - Implementation and monitoring of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF), (if appropriate);

    - Agree the structure, terms of reference, deliverables, and the subsequent co-ordination, of the following primary care workstreams and have oversight and delivery of the primary care related groups:

        - Primary Care Clinical Quality (direct report)
        - Primary Care Estates workstream (direct report)

[1] See Part 1, Health Bill 2021 s.60 Joint working and delegation arrangements

- Primary Care Workforce & Education Planning workstream (direct report)
- Enhanced Services (Minutes of Enhanced Services Review Group meetings)
- Primary Care Network Development Group (minutes)

- To receive a status report from the Primary Care digital workstream
- Implementation of NHS Gloucestershire CCG's Primary Care Strategy;
- Primary Care budgets – to hold financial oversight and awareness of financial implications and risks when making recommendations to the Committee;
- Patient Experience Feedback and monitoring of complaints
- Oversight of quality issues arising from primary care to ensure delivery of high quality primary care

The Group shall provide a timely summary highlight report of primary care performance (operational and financial), quality and contracting for review by the PC&DC Committee.

Membership

5. The Group will consist of the following members:

- Chief Medical Officer (Chair)
- Director of Primary Care and Place (Vice-Chair)
- LMC representative
- Deputy Director of Primary Care and Place
- Deputy Director of Primary Care and Place (ILPs and Workforce Development)
- Associate Director of Finance
- Associate Director, Commissioning
- Deputy Clinical Quality Director or Deputy Director of Nursing and Quality
- Associate Director of Communications
- Associate Director Engagement and Experience
- Head of Primary Care Contracting
- Primary Care Development & Engagement Manager

6. The Group may also invite any person to attend meetings to provide advice and/or expertise as required. Any such person shall not be a member of the Group and shall withdraw upon request.

7. Any individual invited to attend the Group may contribute to the proceedings and provide advice and/or guidance to the Group as requested.

8. All members or attendees at the Group are required to declare any potential or actual conflict of interest before items are discussed. There will be a standing agenda item at the beginning of each meeting for this purpose. Even if an interest has been recorded in the register of interests, it must still be declared in meetings.

Meetings of the Group

9. The Group will be administered by the Primary Care Team of the ICB, who will be responsible for giving notice of meetings. This will be accompanied by an agenda and supporting papers and sent to each member representative no later than 5 days before the date of the meeting. The Chair of the Group may deem it necessary, in light of urgent circumstances, to call an extraordinary meeting at short notice on a specific subject.

Quoracy

10. The Group shall be quorate when at least one of the Chair or Vice-Chair, or their nominated deputies, is in attendance, along with a minimum of four other members of the Group, which should include at least two representatives from Directorates other than the Primary Care and Place Directorate.

Frequency of meetings

11. The Group will meet bi-monthly, although the Chair may determine that a more frequent meeting interval is required on occasion.

12. Members of the Group shall respect confidentiality requirements as set out in the CCG's Constitution.

13. It is envisaged that these Terms of Reference, including membership will be reviewed annually, reflecting experience of the Group in fulfilling its functions. If changes are recommended it will be the responsibility of the PC&DC to sign-off an amended version.

Accountability of the Group

14. The Group will report to the PC&DC and present its minutes to the Committee following each meeting.

15. This will be accompanied bi-monthly by a performance report across the functions and workstreams overseen by the Group, including finance position, along with identified key risks and issues.

16. If recommendations are being made for decisions by the Committee, this will be set out within an accompanying pack of information.

Agenda Item 7

Primary Care & Direct Commissioning Committee

4 August 2022

Report Title	Partners in Health Contract Novation						
Purpose (X)	**For Information**						
Route to this meeting	There have been detailed discussions with the PCCC. The PCCC concluded the innovation of the Partners in Health Contract to G Doc Ltd was the best option for the practice population of Partners in Health and the resilience of practices in Inner City Gloucester. The PCCC agreed to the novation of the Partners in Health contract to G Doc Ltd at a meeting on 2.12.21.						
	ICB Internal	**Date**	**System Partner**	**Date**			
Executive Summary	The purpose of this report is to provide a brief background to the novation and confirm that the novation of the Partners in Health contract to G Doc Ltd has been completed.						
Key Issues to note	The contract changes will ensure stability and resilience both for the practice and Inner City Gloucester. The contract novation to G Doc Ltd has been completed and a CAN will be issued.						
Key Risks: **Original Risk (CxL)** **Residual Risk (CxL)**	Risks and mitigations have been discussed in detail with the PCCC prior to the decision to novate the Partners in Health contract. A general risk relating to practice resilience is included in the risk register (5x5) 15 (3x2) 6						
Management of Conflicts of Interest	GDoc Ltd is a membership organisation of all practices in Gloucestershire, which includes Partners in Health practice.						
Resource Impact (X)	**Financial**		**Information Management & Technology**				
	Human Resource		**Buildings**				
Financial Impact	No change to GMS contract funding						
Regulatory and Legal Issues (including NHS Constitution)	Issues have been discussed with the PCCC						

Impact on Health Inequalities	The ICB seeks to ensure the continuation of safe primary medical services for the Partners in Health patient population.		
Impact on Equality and Diversity	N/A		
Impact on Sustainable Development	N/A		
Patient and Public Involvement	The contract novation will provide full GMS service provision.		
Recommendation	The Committee/Board (delete as appropriate) is requested to: • Note this update		
Author	Jeanette Giles	**Role Title**	Head of Primary Care Contracting
Sponsoring Director (if not author)	Director of Primary Care and Place		

Glossary of Terms	Explanation or clarification of abbreviations used in the paper
ICS	Integrated Care System
ICB	Integrated Care Board
GHC	Gloucestershire Health & Care Foundation Trust
GHFT	Gloucestershire Hospitals NHS Foundation Trust
GCC	Gloucestershire County Council
VCSE	Voluntary, Community and Social Enterprise
PCCC	Primary Care Commissioning Committee

Agenda Item 7

Primary Care & Direct Commissioning Committee

4 August 2022

1. Introduction

The partnership at Partners in Health has significantly changed over recent years mainly as a result of retirements. There were five partners in March 2017 reducing to two partners, i.e. Dr Somasundram and Dr Pietroni in June 2020. Both partners were finding the pressures of general practice very challenging.

Due to recruitment difficulties they had been unable to attract any new partners to the contract. The two remaining partners had voiced their concerns regarding the future of the practice due to the pressure of workload, in this challenging area of Gloucester City. However, both partners indicated they would be happy to remain as a salaried GP and were committed to their patient population.

The partners entered into discussion with their chosen partner, G Doc Ltd, to provide the same services to their patients and take on the GMS contract. The G Doc Board was unanimous in their support for Partners in Health and worked together on a proposal for a contract novation to G Doc Ltd.

2. Practice Profile of Partners in Health

2.1 Practice name and addresses:

Practice name and addresses:

Partners in Health

Main site: Pavilion Family Doctors, 153a Stroud Road, Gloucester, Glos

GL1 5JJ

Branch surgery: St James Family Doctors, St James, Quedgeley, Gloucester, GL2 4NF

Dispensing Practice: No

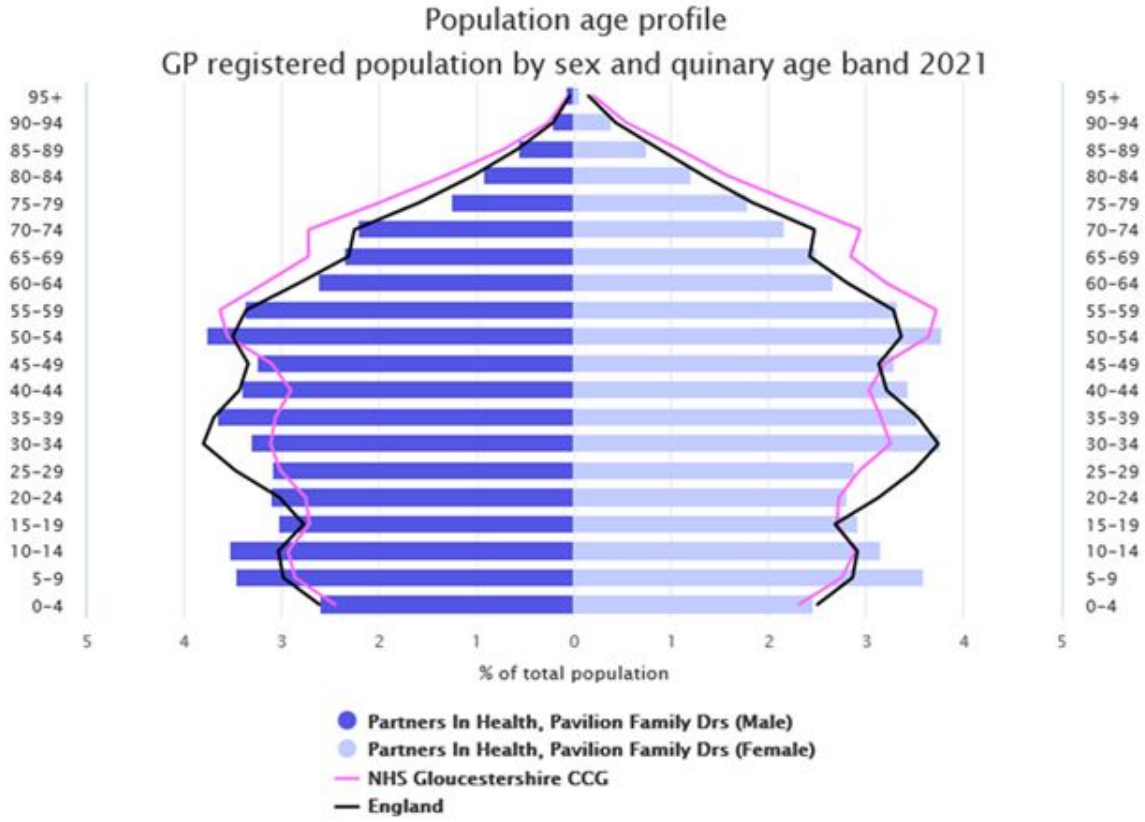
Contract type: GMS

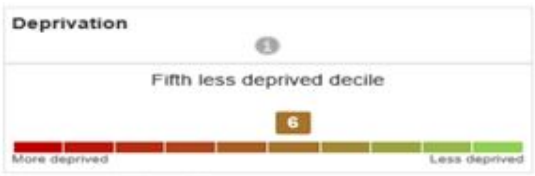
2.2 CQC rating: Good.

The practice was last inspected in January 2016 and rated good. The CQC reviewed the information and data available to them on 7.7.22 and found no evidence that they needed to reassess the rating at that time.

2.3 List size and demographics

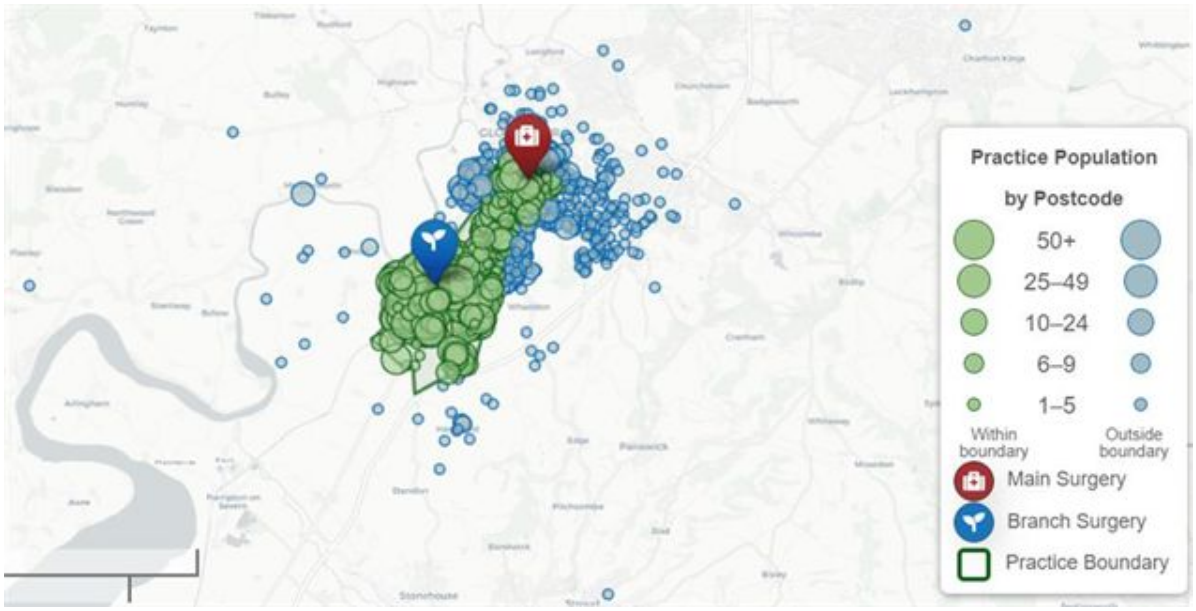
The list size on 1.4.22 was 12,569 patients.





2.4 Premises

The maps below show the location of both sites and the spread of the patient population within the practice boundary. St James Family Doctors is annotated as the branch surgery.



3. G Doc Ltd

G Doc Ltd is a respected provider of primary care services in Gloucestershire including a contract for services at Gloucester Health Access Centre/Matson Lane Surgery and services at Lydney Practice.

It is a membership organisation and the organisation is well led by its Chief Executive, Dr Jo Bayley, with an experienced Board and management team. All 70 GP practices are shareholders and G Doc Ltd has worked with a lot of GPs across the county to ensure general practice is sustainable. They provide a countywide Parachute Nurse Service, as well as an Improved Access service at weekends and bank holidays.

G Doc Ltd also holds the contract for the Gloucester Health Access Centre. The management team responsible for Gloucester Health Access Centre puts patients at the heart of what they do and delivers patient centred care in areas of Gloucester City that can be very challenging.

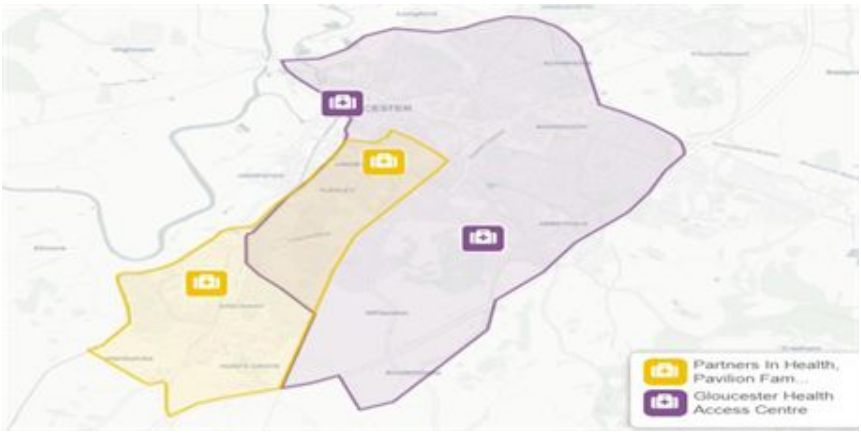
GHAC also provides an 8 – 8 urgent primary care centre service from its Eastgate House premises.

GHAC practice is rated good for all indicators by CQC.

G Doc Ltd also holds GMS contracts for Lydney, Newnham and Blakeney practices.

4. Benefits of Partners in Health and G Doc Ltd proposal

The map below shows the location of GHAC and Partners in Health locations and highlights the extent their boundaries overlap.



The proposal to find a solution with GDoc Ltd was a personal choice by the Partnership of Partners in Health, allowing the partners to continue to work as salaried GPs as part of the team providing GP medical services to the registered patients. Both Drs Pietroni and Somasundram are committed to

their patient population and the practice teams work well with their neighbouring practices and Inner City PCN.

G Doc Ltd is a local GP organisation. Since taking on the Lydney GMS contract which was novated to them in January 2021, they have introduced a hub and spoke model to improve practice resilience. Each practice has its own practice manager and clinical lead GP, so they remain able to operate autonomously, while sharing some back office functions. This ensures business continuity in the event of a major problem at one practice (IT/Covid/flood etc), ensuring that there should be only minor effects on the other practices. The expansion of the hub and spoke model of organisation would therefore provide greater resilience for the provision of primary medical services for the patients of Partners in Health.

The G Doc Ltd strategy is to retain as much of the existing organisational infrastructure as possible to ensure continuity of care and so as to not unnecessarily disrupt existing practice teams, while bringing in the benefits of being part of a larger organisation.

Partners in Health is in the same PCN as GHAC, i.e. Inner City PCN.

5. Contract Novation

There have been detailed discussions with the PCCC since October 2021. The PCCC concluded the novation of the Partners In Health contract to G Doc Ltd was the best option for the population of Partners in Health and the resilience of practices in Inner City Gloucester.

The PCCC also noted that G Doc Ltd is known to the CCG and having taken on the Lydney Surgery GMS contract in January 2021 a novation was tried and tested as a solution.

To maintain the provision of primary medical services and enable the practice to develop and remain resilient well into the future the CCG agreed the novation of the Partners in Health contract to G Doc Ltd at a meeting on 2nd December 2021.

The effective date of the novation of the Partners in Health contract to G Doc Ltd is 1.8.22. A Contract Award Notice (CAN) will be issued.

The CCG are reassured that G Doc Ltd will deliver a high level of care and service for the practice population of Partners in Health.

6. Recommendation(s)

The PC&DC is asked to note this update report.

Agenda Item 8

Primary Care & Direct Commissioning Committee

4 August 2022

Report Title	**Enhanced Access Update**						
Purpose (X)	**For Information**		**For Discussion**		**For Decision**		
	x						
Route to this meeting	Weekly Primary Care Team review meetings of Enhanced Access Plans, PCOG						
	ICB Internal	**Date**	**System Partner**	**Date**			
	Primary Care Team	Weekly throughout June/July					
Executive Summary	To provide PCDC members with an update on the PCN DES Enhanced Access service which goes live nationally on 1 October 2022. Enhanced Access aims to remove variability across the country and improve patient understanding of the service. This paper gives assurance around the process and asks PCDC to delegate authority for sign off of the final plans by the end of August 2022.						
Key Issues to note	Key issues include: • Practices potentially pulling out of the PCN DES due to additional workload and workforce pressures • Saturday service for Phlebotomy • Saturday afternoons currently delivered by GDoc Ltd						
Key Risks: **Original Risk (CxL)** **Residual Risk (CxL)**	No risks at this early stage in the 2022/23 year but regular (monthly) reviews of practice and PCN data is taking place regularly to monitor any risks.						
Management of Conflicts of Interest	Enhanced Access has been raised at many Clinical Director and Business Manager meetings; conflicts of interest are always noted within these meetings. Other conflicts of interest include GDOC Ltd who currently lead on the Saturday afternoons, Sundays and Bank Holidays for Gloucestershire as part of the Countywide offer for Improved Access.						
Resource Impact (X)	**Financial**		**Information Management & Technology**				
	Human Resource		**Buildings**				

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Financial Impact	Enhanced Access funding will come centrally from NHSE/I. Two funding streams to combine and a nationally consistent offer of £7.44 per head: • Extended Hours Network Contract DES £1.44 per head • CCG Improved Access offered locally as £5.75 per weighted patient (£6 per head)		
Regulatory and Legal Issues (including NHS Constitution)	None		
Impact on Health Inequalities	Enhanced Access aims to remove variability across the country and improve patient understanding of the service. PCN services and appointments will not reduce, it is just being repurposed.		
Impact on Equality and Diversity	As noted above, Enhanced Access aims to remove variability across the country and improve patient understanding of the service.		
Impact on Sustainable Development	N/A		
Patient and Public Involvement	PCNs should utilise population health management and capacity or demand tools to engage with their registered population to ensure the range of services offered take into account patient needs and preferences. PCNs plans should be based on available data at practice or PCN level and evidenced by patient engagement.		
Recommendation	The Committee/Board (delete as appropriate) is requested to: • The committee is asked to note the status of the Enhanced Access plans and the governance route. • The Primary Care team request that PC&DC chair confirms where delegated authority can be given to sign off the final plans in August (by 31/08).		
Author	Jo White	**Role Title**	Deputy Director, Primary Care & Place
Sponsoring Director (if not author)	Helen Goodey		

Glossary of Terms	Explanation or clarification of abbreviations used in the paper
BMA	British Medical Association
CCG	Clinical Commissioning Group
DES	Direct Enhanced Service
GCC	Gloucestershire County Council
GDOC	Gloucestershire's GP Cooperative
GHAC	Gloucester Health Access Centre
GHC	Gloucestershire Health & Care Foundation Trust
GHFT	Gloucestershire Hospitals NHS Foundation Trust
ICB	Integrated Care Board
ICS	Integrated Care System

LMC	Local Medical Committee
NHSE	NHS England
PC & DC	Primary Care & Direct Commissioning
PCN	Primary Care Network
VCSE	Voluntary, Community and Social Enterprise

Agenda Item 8

Primary Care & Direct Commissioning Committee

4 August 2022

1. Introduction

From 1 October 2022, as part of the PCN DES, a PCN must provide Enhanced Access between the hours of 6.30pm and 8pm Mondays to Fridays and between 9am and 5pm on Saturdays. PCNs must provide a minimum of 60 minutes of appointments per 1,000 PCN adjusted patients per week. PCNs must submit their draft Enhanced Access Plans to the CCG by 31 July for final sign off by the ICB by 31 August.

2. Purpose and Executive Summary

2.1. The purpose of this paper is to provide an update on the Enhanced Access planning in Gloucestershire. It summarises what we know, NHSE/I expectations, process & planning, challenges, digital aspects, and next steps. The paper gives assurance around the process and asks PCDC to delegate authority for sign off the final plans by the end of August 2022.

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3. Enhanced Access Planning

3.1 To prepare for delivery of Enhanced Access from 1 October 2022, PCNs must work with their commissioner to produce and agree an Enhanced Access Plan. This Plan will need to set out how the PCN will deliver Enhanced Access from October.

PCNs must submit their draft Enhanced Access Plan to their commissioner by 31 July, with a final iteration agreed by 31 August. As at the date of writing this report we have received 9 out of 15 draft plans to date (21/07). Of those received 3 have been agreed in principle by the Primary Care Team to allow further planning using Appendix 2 as a guideline for approval. The other 6 plans require further information from the PCNs. The remaining PCNs are all working on their plans for submission end July. Commissioners will need to ensure the PCN Enhanced Access Plans form part of a cohesive ICS approach.

The governance process for the PCN Enhanced Access Plans is as follows:

- review by the Primary Care Team
- a summary report presented to PCDC
- detailed plans discussed at PCN Development Group
- However due to the timing of the PC&DC meeting in August (on the 4th) and given PCN plans will have only just been submitted in draft (31/07), the Primary Care team is asking PCDC to agree delegated authority from the ICB Operational Executive team to sign off the final plans in August (by 31/08).

The accompanying slides provide an outline of an example PCN Enhanced Access Plan.

3.2 Regional principles agreed for consistent approach across ICBs

We continue to work with NHS England to develop these plans and with regional Primary Care leaders across the other 6 Integrated Care Systems. As part of this we have begun to develop a set of principles (see table); particularly the discussion around putting in place Improvement Plans where PCNs are unable to meet the criteria immediately including for digital requirements.

Principle	Approach
Plans developed locally to meet local needs	Recognition of PCNs as key building blocks in the integrated care systems
Engaging and working with local communities	Looking for EA plans which demonstrate evidence of engaging with the local population so expecting variation in the profile of services and method of delivery
Key stakeholder engagement	PCN plans which demonstrate joint working across constituent practices to meet the requirements of enhanced access of 60 minutes per 1000 patients per week
Workforce planning to develop skill mixed teams	Using multidisciplinary workforce and examples of innovative solutions to balance the ask for routine bookable as well as urgent on the day
Digital access and responding to patient need	Use of remote as well as face to face appointments to demonstrate that the PCN has control over how EA capacity is being used to meet population need as well as manage demand on practices.
System working	System partners providing support for PCN's with delivery of plans Looking for EA plans which support System resilience and demand for primary care services as part of the wider system responsibilities Recognition of the request for PCNs to deliver/support the Autumn/Winter Vaccination Programme
Measuring impact	Supporting PCN's to build data and intelligence about how services respond to population need - developing digital tools
Improving quality and outcomes of care	For those plans which don't meet all the contractual requirements in extenuating circumstances, an improvement plan in year 1 will be recommended (including review of patient feedback; demand and capacity; and development of system interoperability)

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4. Challenges

4.1 Saturday afternoon countywide service – GDoc

Following discussions with PCNs it is evident that an opt in Countywide GP Saturday afternoon service is needed in Gloucestershire. NHSE have, in principle, verbally accepted our approach to try and offer a countywide Saturday afternoon option, if the PCNs provide robust provision against the criteria for EA for the rest of the hours and it's part of a cohesive system approach. We are in discussions with GDoc Ltd around how this could be delivered, the costings and the number of minutes per PCN that could be attributed to the models and we have agreed that in principle the current proposal is for:

- Minimum of 2/3 GPs
- 1 Gloucester Location plus a possible location in Cheltenham, therefore either Face-to-Face or virtual where appropriate
- Minimum of 4 hours between 12:30-17:00

- The payment contribution by PCNs is expected to be circa ~£0.17pp which is substantially lower than the current model of £0.51pp as Sundays and Bank Holidays are not included

4.2 Saturday Phlebotomy service

As the Enhanced Access specification outlines that PCNs need to offer appointments on Saturdays 9am-5pm, PCNs want to understand what services as available as a system on a Saturday, in particular pathology as PCNs can then offer a fuller range of GMS services including blood tests and health checks.

We wrote to PCNs last month to understand the need for a possible Phlebotomy service on a Saturday morning. The majority of all PCNs have expressed an interest in a Saturday morning phlebotomy service. Therefore, the ICB have been in discussions with the Pathology department to understand what is required to deliver the service. The Pathology team are in the process of writing up a draft plan of what is likely to be achievable by when. The plan may be incremental, and we hope to confirm this as soon as possible with further information on the approach for PCNs from October 2022.

4.3 Practices withdrawing from PCN DES

Due to the requirements of Enhanced Access there are still some strong views being aired nationally by the BMA, LMCs and some practices advising practices to consider leaving the PCN DES. Discussions with practices and PCNs have taken place to understand the situation locally and while it is clearly very challenging given the current workforce challenges all 15 PCNs are working on, or have already submitted, their plan.

4.4 Digital capabilities

PCNs must ensure, when available, appropriate telephony and IT interoperability will be in place between the practices of the PCN, as well as any other parties involved, such as sub-contracted providers. For example, ability to view, book into, and cancel appointments, make referrals and request tests, to view and update patients' records. The functionality to achieve all of these requirements is still limited in some instances. The ICB digital team have been working with PCNs to support the implementation of appropriate digital solutions.

5. Recommendations

- The committee is asked to note the status of the Enhanced Access plans and the governance route.
- The Primary Care team request that PC&DC chair confirms where delegated authority can be given to sign off the final plans in August (by 31/08).

APPENDIX 1 – Network Contract Directed Enhanced Service

https://www.england.nhs.uk/wp-content/uploads/2022/03/B1357-Network-Contract-Directed-Enhanced-Service-contract-specification-2022-23-primary-care-network-requireme.pdf

APPENDIX 2 – NHSE Enhanced Access Template

PCN template_FINAL V2.xlsx

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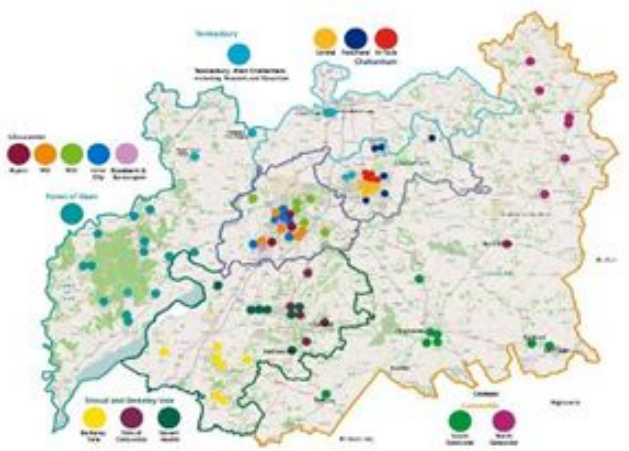
Enhanced Access Plans Update

Jo White
August 2022

@NHSGlos
www.nhsglos.nhs.uk

Part of the One Gloucestershire Integrated Care System (ICS)

Gloucestershire's Enhanced Access Offer



15 PCNs

Mon – Fri 18:30-20:00 & Saturday (AM)

F2F and remote clinics

Bookable, routine & urgent appointments

Multidisciplinary teams (including ARRs) offering clinics based on PHM data and patient need

Saturday (PM)

Countywide GP service

Sub-contracted to GDoc

Clinics can include: QOF, IIF, Enhanced Services, Vaccinations etc. to support general practice activity.

Saturday (AM) Phlebotomy in progress

QOF (Quality and Outcomes Framework)

I'VE HAD MY COVID VACCINATION

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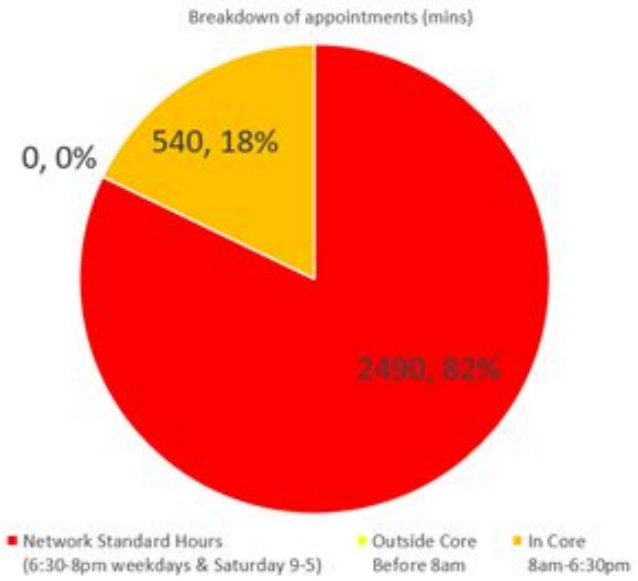
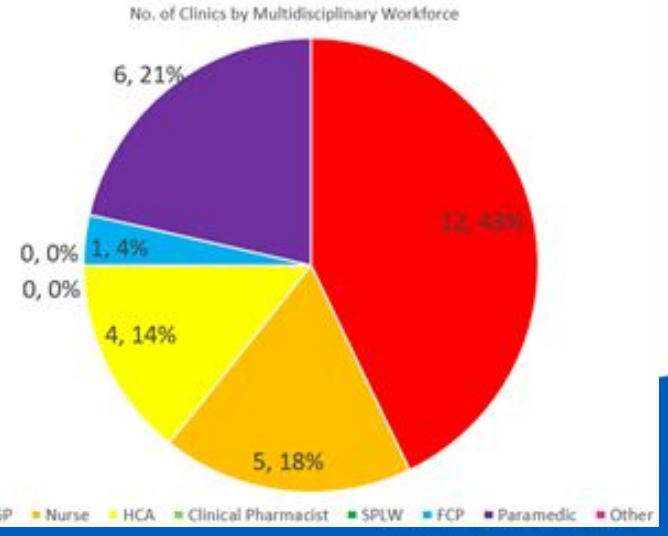
1

Example 1: PCN Plan

NHSE requirements	PCN Plan
Planning & governance	Single PCN; Agreed with practices; Signed off by PCN & CD
Contracting	Hybrid model; subcontracting Saturday PMs to Gdoc countywide offer
Workforce	GPs, nurses, HCAs, paramedics and FCPs
Digital	All TPP practices; utilising all existing online consultation software used in-hours across the Network Standard Hours
Patient engagement & health inequalities	Surveyed patients; engaged PPGs and ILP. Saturday mornings and weekday evenings were most popular, while Friday evenings and Saturday afternoon clinics often much less popular, either not filling or for those that were booked, regularly DNA'd.





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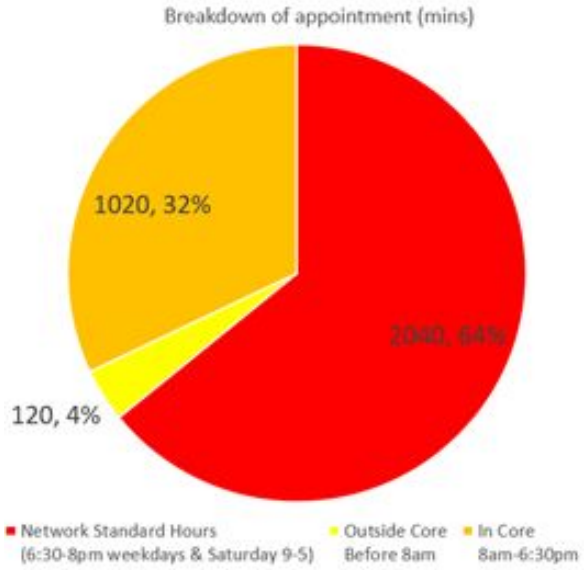
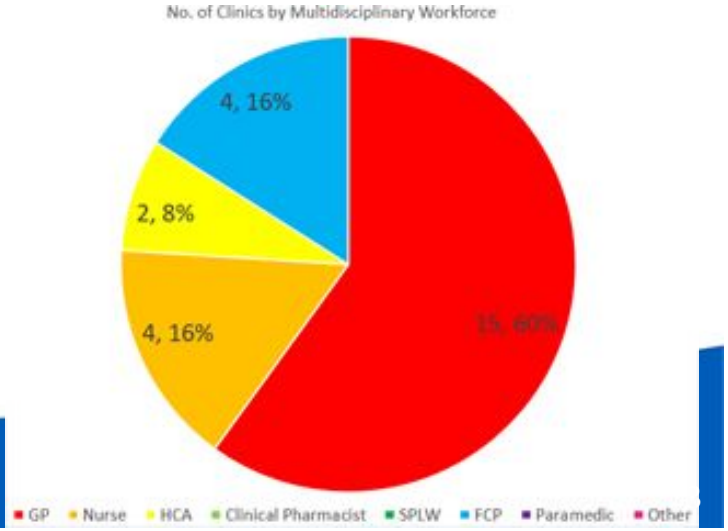
Example 2: PCN Plan

NHSE requirements	PCN Plan
Planning & governance	Single PCN; Agreed with practices; Signed off by PCN & CD
Contracting	Hybrid model; subcontracting Saturday PMs to Gdoc countywide offer
Workforce	GP, Practice Nurse, Healthcare Assistant, Phlebotomist PCN hope to also hold education events and group consultations with Social Prescribing Link Workers, perhaps including youth groups on a weekend
Digital	TPP Hub Model and using Accurx
Patient engagement & health inequalities	Surveys sent to patients who have had an appointment in the last 6 weeks. PPGs have shared their recommendations. Identified a need for more cervical screening and contraceptive appointments outside of working/school hours; prompting the delivery of the Women's Health Clinic on Saturdays. Identified a significant number of GP appointments were related to joint pain. This has informed the delivery of our popular MSK service, which in turn directly supports our ARRS staff as the GP supervises our two First Contact Practitioners.

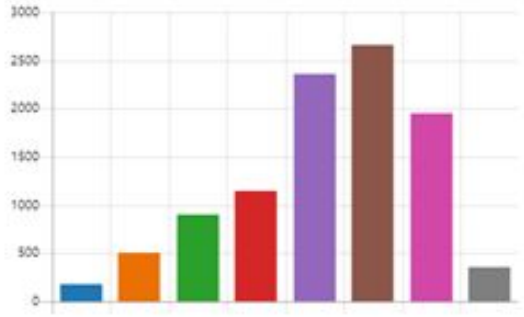




Example PCN – Patient Survey (10055 responses to date)

1. Please select your age bracket

16 - 20	173
21 - 30	509
31 - 40	905
41 - 50	1140
51 - 60	2354
61 - 70	2659
71 - 80	1954
81 -	361



2. Do you agree that offering additional appointments with your local clinical team during weekdays, 8.00-6.30pm, would be beneficial?

Agree	9311
Disagree	105
Neither Agree or Disagree	639

3. Would you be interested in being offered additional clinical appointments on a/some weekday evenings or early mornings (pre-8am)?

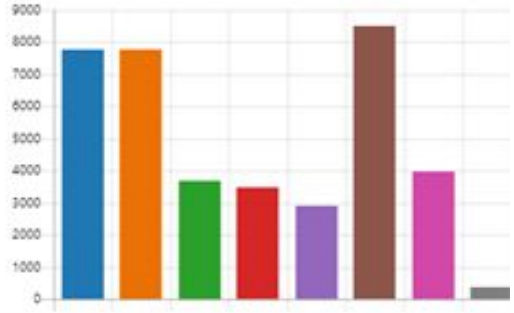
Early morning	2255
After 6.30pm	3864
Neither, I would prefer extra a...	3936

4. Would you be interested in being offered additional clinical appointments on a Saturday?

Saturday morning	7052
Saturday afternoon	1007
Neither, I would prefer additio...	1996

5. In the additional appointments we are going to make available, what services would you like to be available? Please click all that apply:

Routine appointments for ong...	7763
On the day urgent illness	7791
Long-term condition clinics	3699
Womens Health Clinics	3471
Mens Health Clinics	2894
Face to Face appointments	8517
Telephone appointments	3977
Other	352



6. If available and relevant to your health (e.g. if you have a long term condition), would you be interested in attending specialist clinics set up for a group of patients with a similar condition?

Yes- that sounds like it would ...	2807
Perhaps - I would need to und...	3353
No- I only want to speak to so...	3895

Joint Working Across the South West

- We continue to work with NHS England to develop these plans and with Primary Care leaders across the other 6 Integrated Care Systems.
- As part of this we have begun to develop a set of principles (see table)
- South West ICBs have also discussed putting in place *Improvement Plans* where PCNs are unable to meet the criteria immediately including for digital requirements

Principle	Approach
Plans developed locally to meet local needs	Recognition of PCNs as key building blocks in the integrated care systems
Engaging and working with local communities	Looking for EA plans which demonstrate evidence of engaging with the local population so expecting variation in the way in the profile of services and method of delivery
Key stakeholder engagement	PCN plans which demonstrate joint working across constituent practices to meet the requirements of enhanced access of 60 minutes per 1000 patients per week
Workforce planning to develop skill mixed teams	Using multidisciplinary workforce and examples of innovative solutions to balance the ask for routine bookable as well as urgent on the day
Digital access and responding to patient need	use of remote as well as face to face appointments to demonstrate that the PCN has control over how EA capacity is being used to meet population need as well as manage demand on practices.
System working	System partners providing support for PCN's with delivery of plans Looking for EA plans which support System resilience and demand for primary care services as part of the wider system responsibilities Recognition of the request for PCNs to deliver/support the Autumn/Winter Vaccination Programme
Measuring impact	Supporting PCN's to build data and intelligence about how services respond to population need -developing the DiiS and other digital tools
Improving quality and outcomes of care	For those plans which don't meet all the contractual requirements, we will be recommending an improvement plan in year 1 (including review of patient feedback; demand and capacity; and development of system interoperability)

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Enhanced Access Service – Governance process

31 July: PCNs submit their plans to ICSs for approval

31 days
22 'working' days

31 August: ICSs sign off plans

ICS Primary Care Team — Flexible

PCN Development Group — Weds 10 Aug

ICB Primary Care Operational Group — Tues 26 July

ICB Primary Care & Direct Commissioning Committee — Thurs 4 Aug

ICB Operational Executive — Tues 16/23 Aug

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Agenda Item 9

Primary Care & Direct Commissioning

4th August 2022

Report Title	**Primary Care & PCN performance data (Issue no. 2)**						
Purpose (X)	**For Information**		**For Discussion**		**For Decision**		
	x						
Route to this meeting	This report has been via PCOG.						
	ICB Internal	**Date**	**System Partner**	**Date**			
	PCOG	26/07/2022		dd/mm/yyyy			
Executive Summary	The report aims to give an overview of the performance within Primary Care & PCNs including • Investment & Impact Funding • Severe Mental Illness physical health checks • Learning Disability annual health checks • Quality Improvement Projects • Local Enhanced Service Sign Up • GP patient survey • General Practice Reporting Data • PCN Additional Roles Reimbursement (ARR) Scheme						
Key Issues to note	In month 4 we have not identified any key issues; however we are regularly reviewing and monitoring performance and offering support to practices and PCNs where appropriate.						
Key Risks: **Original Risk (CxL)** **Residual Risk (CxL)**	No risks at this early stage in the 2022/23 year but regular (monthly) reviews of practice and PCN data is taking place to monitor any risks.						
Management of Conflicts of Interest	If the below data is shared at meetings, it is ensured that the data is treated in confidence. The local PCN DES/IIF Dashboard is shared monthly with PCNs.						
Resource Impact (X)	**Financial**		**Information Management & Technology**				
	Human Resource		**Buildings**				
Financial Impact	None – data information sharing. IIF has financial incentives for PCNs.						
Regulatory and Legal Issues (including NHS Constitution)	Data is anonymised when shared and meets data security and information governance requirements.						

Impact on Health Inequalities	The primary care performance data can help identify areas that may require additional support.		
Impact on Equality and Diversity	N/A – paper is on primary care performance data		
Impact on Sustainable Development	N/A – paper is on primary care performance data		
Patient and Public Involvement	N/A – paper is on primary care performance data		
Recommendation	The Committee is requested to: • Note the information provided		
Author	Jo White	**Role Title**	Deputy Director, Primary Care & Place
Sponsoring Director (if not author)	Helen Goodey		

Glossary of Terms	Explanation or clarification of abbreviations used in the paper
AHC	Annual Health Check
ARRS	Additional Roles Reimbursement Scheme
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
CYP	Children & Young People
F2F	Face to Face
GCC	Gloucestershire County Council
GHC	Gloucestershire Health & Care Foundation Trust
GHFT	Gloucestershire Hospitals NHS Foundation Trust
HAP	Health Action Plan
ICB	Integrated Care Board
ICS	Integrated Care System
IIF	Investment and Impact Fund
LD	Learning Disability
PCN	Primary Care Network
PCOG	Primary Care Operational Group
PCSP	Personalised Care and Support Plan
QOF	Quality Outcomes Framework
SMI	Severe Mental Illness
SMR	Structured Medication Review
VCSE	Voluntary, Community and Social Enterprise

Agenda Item 9

Primary Care & Direct Commissioning Committee

4th August 2022

1. Introduction

1.1. Primary Care performance is being monitored and reviewed through many channels including the PCN DES/IIF Dashboard, Appointment Data, QOF, and ARR uptake. This report collates some of the performance data that is currently available and shared in Primary Care for review by PCDC. It particularly focusses on end of year performance and 2022/23 progress.

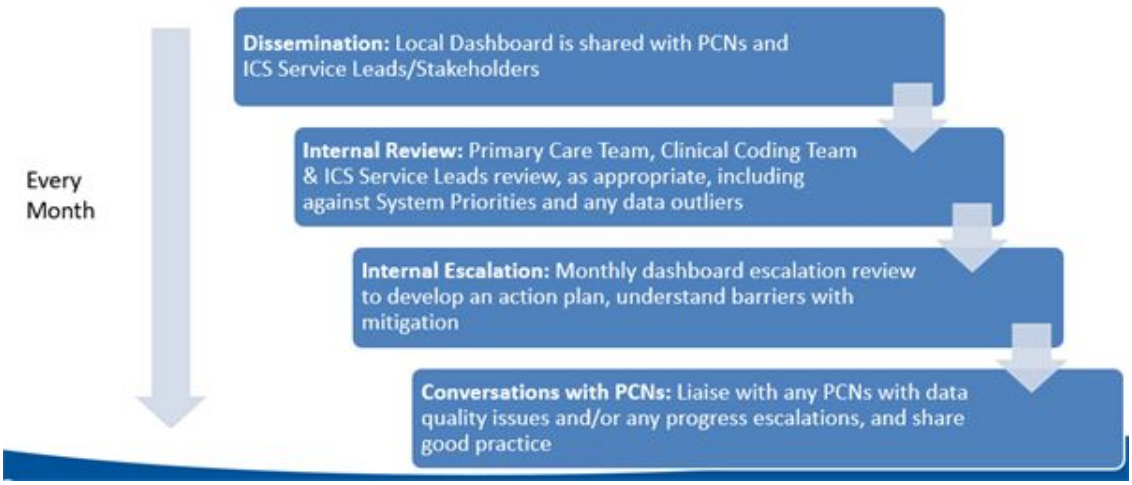
2. Purpose and Executive Summary

2.1. The report aims to give an overview of the performance within Primary Care & PCNs including:

- Investment & Impact Funding
- Severe Mental Illness physical health checks
- Learning Disability annual health checks
- Quality Improvement Projects
- Local Enhanced Service Sign Up
- General Practice Reporting Data
- PCN Additional Roles Reimbursement (ARR) Scheme

3. Investment & Impact Funding 2022/23

3.1 As noted in the June paper, for 2022/23 there will be a total of 1153 points across 36 IIF indicators. Below is the monthly process we plan to follow for 2022/23 for disseminating, reviewing, and considering (with PCNs) the indicators.



3.2 The PCN DES & IIF Dashboard for June was circulated to PCNs. The top-level reporting for PCDC to note are:

Vaccination & Immunisation	• The Flu indicators will commence from September in line with the Flu campaign
Tackling Health Inequalities	• % Patients with ethnicity recorded at ICB level is 93.3% which has achieved the Lower Threshold already
CVD Prevention	• ICB average has improved this month in all indicators • Data quality issues in some indicators, which the Team are liaising with PCNs
Personalised Care	• % Registered patients referred to a social prescribing service indicators continues to improve across the ICB; seeing an increase from 0.31% to 0.47% aiming for the Lower Threshold at 1.2%
Enhanced Health in Care Homes	• % Care home residents aged 18+ with a Personalised Care and Support Plan (PCSP) agreed/reviewed has increased by a further 10% in the last month to 30% at ICB level
Structured Medication Review	Improvements seen in all 4 SMR cohorts • % Patients at **risk of harm due to medication errors** received a SMR • % Patients living with **severe frailty** who received a SMR • % Patients using **potentially addictive medicines** who received a SMR • % **Permanent care home residents 18+** who received a SMR

9

4. Severe Mental Illness physical health checks

The national aim for SMI physical health checks for 2022/23 remains at 60%, and local plans are being put in place to help achieve this. The local PCN DES & IIF dashboard captures performance updates at practice and PCN level monthly. As at 30 June, the ICB average for SMI physical health checks was 12.5% for 22/23; this is an increase of 2.2% in the last month. A high performing PCN has completed 37% of their SMI physical health checks this year.

5. Learning Disability annual health checks

As a county, our end of year 21/22 performance for LD AHC for those aged 14 years and over is 79.2% which is above the national target of 75%. The local targets for 2022/23 are to aim for:

- 75% of people on the GP Learning disability register have received an annual health check during the year
- 100% of people having a LD Annual Health Check receive a Health Check Action Plan (HAP)
- Increase the number of people on the GP LD Register from 0.63% of the general population to 0.65%

- Increase the number of CYP onto the register to 1200; increasing the number of 14-17 year olds having LD AHC 75%

As at 30 June 2022, the ICB average for LD patients with an Annual Health Check (AHC) and a Health Action Plan (HAP) was 8.7%; an increase of 2.8% in the last month. Please note that historically most LD AHC take place in Q3 and Q4 in general practice.

The ICB are working collaboratively to target practices who have had the most patients that have either declined or not been offered an Annual Health Check at the end of March 2022. Practices will be asked to run searches to find these patients and help identify who to prioritise an invite. In addition, the ICB are also able to offer practices some support from an LD Liaison Nurse who can:

- support with completing Annual Health Checks with an HCA from the practice
- support contacting those that have not received an Annual Health Check
- support with considering reasonable adjustments

6. Local Enhanced Service Sign Up for 2022-23

Below is a summary for the sign up for the Local Enhanced Service specifications; still outstanding returns from 1 practice.

Primary Care Phlebotomy was a potential risk for sign up having removed it from the Primary Care Offer for 2022/23 and being a standalone Enhanced Service. However, all practices who have returned their responses have signed up to the Enhanced Service (70) which is encouraging.

CES	Yes	No	TBC
Anticoagulation	70	0	1
Care Homes (Top-Up)	65	5	1
Care Homes (non-CQC)	53	17	1
DVT	70	0	1
Diabetes	69	1	1
High Risk Drugs	69	1	1
PCO	70	0	1
Inter Practice Minor Surgery	28	42	1
Ear Irrigation	65	5	1
UKRS	48	22	1
Prophylaxis	61	9	1
Primary Care Phlebotomy	70	0	1
Secondary Care Phlebotomy	68	2	1
Respiratory Diagnostics	67	3	1

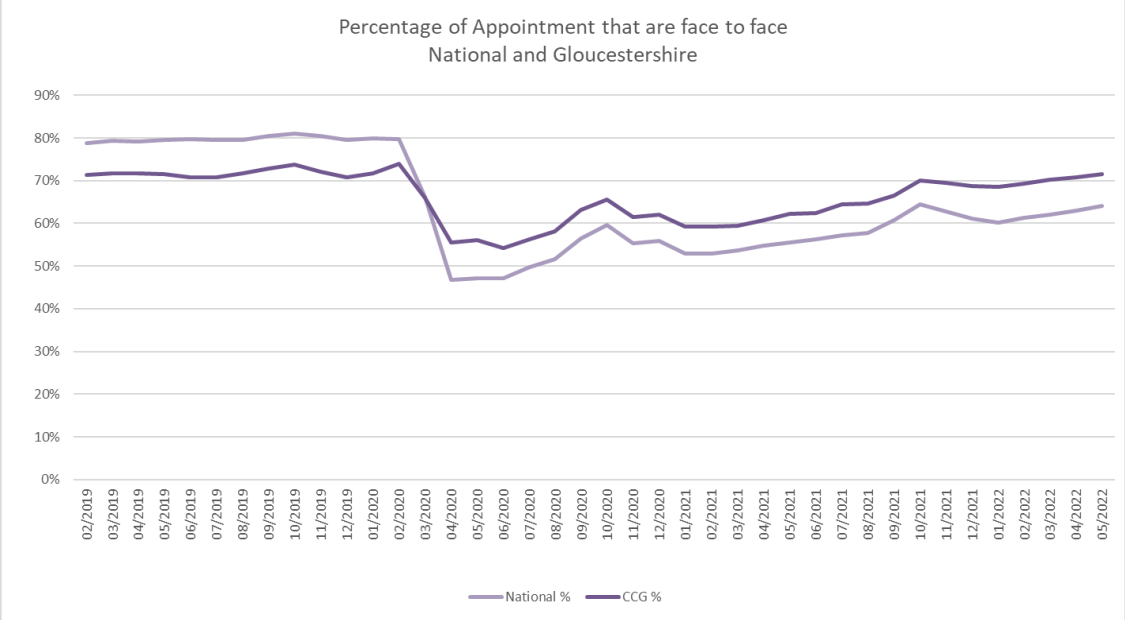
9

7. GP patient survey

The results of this year's national GP Patient Survey (GPPS) were published on 14 July. In the One Gloucestershire ICS area, 20,830 questionnaires were sent out and 8,239 were returned completed, representing a response rate of 40%.

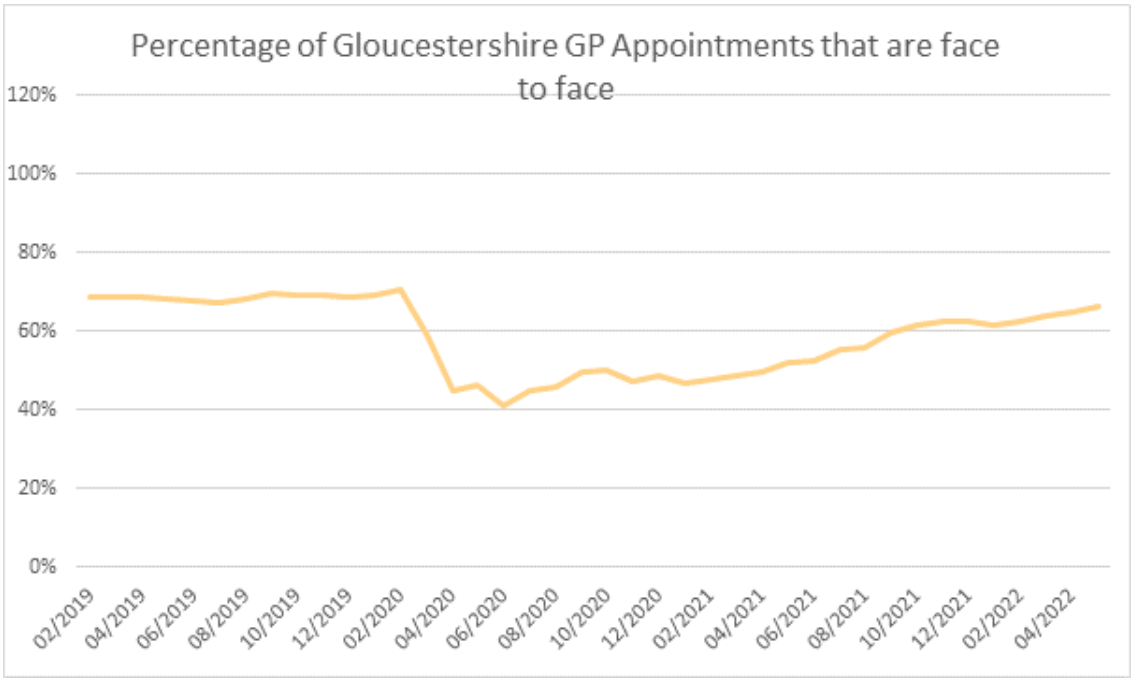
We are very pleased that the results for Gloucestershire show relatively high overall levels of patient satisfaction with GP practices at 81% - well above the national average of 72% and the highest in the South West. The Primary Care Team plan to review the data to work closely with the lowest performing practices and to understand any issues and offer support.

8. General Practice Reporting Data

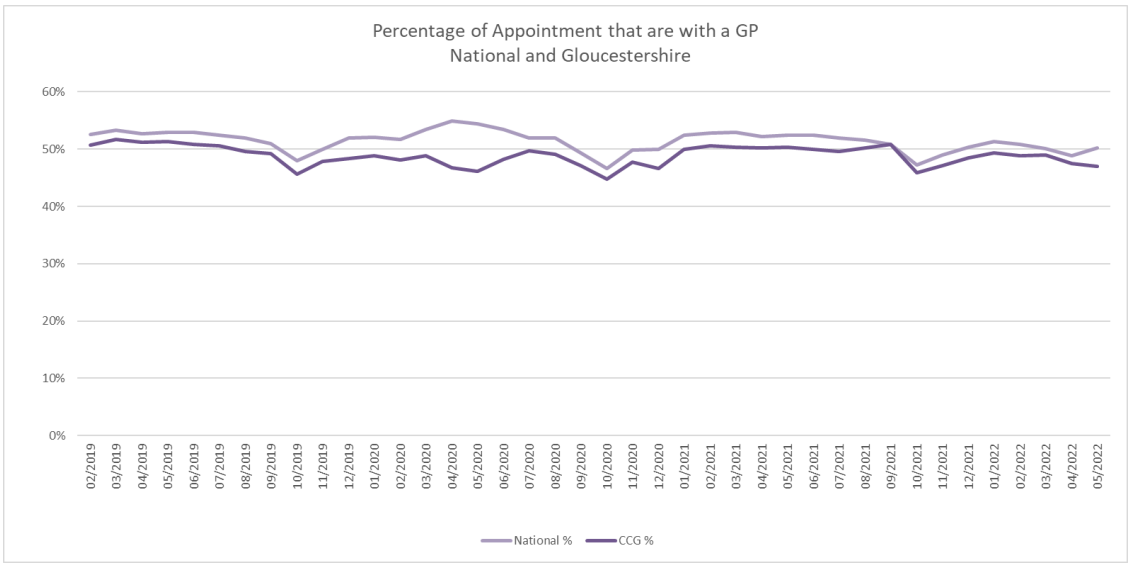


Gloucestershire continues to increase the percentage of face-to-face appointments, having increased from 69% in February 2022 to 72% in May 2022, which is 8% above the national figure of 64% in May 2022.

9



The percentage of face-to-face GP appointments continues to increase, in May 2022 it was at 66%, this is just 3% short of the pre covid figure of 69% at the end of 2020. There is no national data available for this measure.



The Gloucestershire percentage for GP appointments has slightly decreased over the last two months; this could be due to the level of sickness that we have had in the county and/or the level of GP vacancies and recruitment issues that we are aware of in our practices. Whilst the increase in the national percentage may be to do with the increased use of remote consultation services such as Livi.

9. PCN Additional Roles Reimbursement (ARR) Scheme

9.1 A summary table for the number of and type of ARR staff across the 15 PCNs is in Appendix 1.

10. Recommendations

10.1. The committee is asked to note the performance indicators above for information.

APPENDIX 1 – ARR Table

June ARR claims.xlsx

Pharmacy, Optometry, Dentistry (POD) Delegation - Highlight Report

Programme Name:	**POD Delegation**	**Key Points of Escalation**	
This highlight report updates the Board about the project's progress to date. It also provides an opportunity to raise concerns and issues with the Board, and alert them to any changes that may affect the project.		• Workforce requirements yet to be understood both pre and post delegation • Await NHSEI data and information packs	
Project Name:	POD Delegation	**ICS Programme Area:**	Primary Care Strategy
Project Lead:	Gayle Sykes	**Senior Manager Lead:**	Jo White
Programme Sponsor:	Helen Goodey	**Programme Director:**	Helen Goodey
Author of Report:	Gayle Sykes	**Clinical Sponsor:**	Dr Andy Seymour
Date of Report:	25 July 2022	**Reporting Period:**	July 2022

Project Overview:

Further to national mandate, from 01 April 2023 the ICB will be expected to take on delegated responsibility for pharmacy, optometry and dental services (POD) across the county. The Primary Care team is working with NHSEI South West, along with the other ICBs in the SW to ensure smooth transition of services to the ICB. Progress to date is as follows:

- Initial meeting with representatives from NHSEI South West has taken place, this was an introductory meeting with primary care and finance which set out communication and reporting to ICBs.
- A workshop with NHSEI took place on 25 July 2022 with representatives from primary care attending, this briefly set out pre-delegation timescales and requirement for completion of pre-delegation framework by the ICB for submission by 19 September 2022 (four domains to complete - Transformation & Quality, Governance & Leadership, Finance and Workforce, Capacity & Capability – as attached). A safe delegation checklist will also be provided by NHSEI for completion.
- Some information has been shared by NHSEI and the first communication briefing from them is expected early August 2022.
- A project team for Gloucestershire has been established and will meet for the first time on 09 August 2022. Membership includes representatives from primary care, quality, finance, procurement, complaints and will co-opt a representative from NHSEI as required. Initially, this group will meet fortnightly, develop and oversee the transition plan and report to PCOG and PC&DC on a regular basis.

Full understanding of risks will become clearer as more information is provided by NHSEI. Information already supplied and discussions within the ICB team have identified some level of risk and/or issues around:

- Transactional arrangements (including contracts, payments, complaints, risks)
- Quality (including quality schemes pharmacy, optometry and dentistry)
- Strategy and Policy (including service improvement)
- Financial processes (including approval of financial plans, contract awards, procurement, national returns)
- Workforce (general concerns post April 2023)

Programme Status: Amber

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Classification: Official

Publication reference:

Pre-Delegation Assessment Framework for 2023 Delegations: Pharmaceutical Services, General Ophthalmic Services, and Dental (Primary, Secondary and Community) Services

21 July 2022, Version 1

Pre-Delegation Assessment Proforma for Pharmaceutical Services, General Ophthalmic Services, and Dental (Primary, Secondary and Community) Services

The questions below are aligned to the domains and criteria set out within the pre-delegation assessment framework for Pharmaceutical Services, General Ophthalmic Services, and Dental (Primary, Secondary and Community) Services (see Annex 1) and should be completed and signed-off by each ICB, and the relevant NHS England Regional Director of Commissioning. The responses should be verified by the relevant Regional Director, and the completed proforma sent to england.directcommissioning@nhs.net by **Monday 3 October 2022**.

As part of this assessment process, regional teams will need to approve the accuracy of each response and to provide confirmation of whether they support the ICB's assessment of risk for each question. No additional attachments should be provided as part of the submission.

Completing the assessment

- Responses should be inputted into the template below.
- Examples of supporting activities can be found in the response column in grey italics. These should be deleted prior to submission.
- Responses should be concise and focus on key existing and planned activities that demonstrates capability to assume responsibility for these functions from April 2023.
- Alongside the PDAF, ICBs will also work through a Safe Delegation Checklist which sets out key actions to be completed to support a safe and smooth transition to new delivery arrangements.
- Further resources will be made available on NHS Futures to support completion of PDAF submission and preparations for delegation. If you require any further support, please contact england.directcommissioning@nhs.net.

Name of ICB	[INSERT ICB NAME]
For completion of the Safe Delegation Checklist, please confirm that: ➢ A senior responsible officer and workstream leads have been identified ➢ A delivery plan, including key milestones has been agreed	 Yes / No [DELETE AS APPROPRIATE] Yes / No [DELETE AS APPROPRIATE]

Domain 1: Transformation and Quality				
Question	**Response**	**Current RAG[1] rating at [insert date]**	**Projected RAG[2] rating at March 2023**	**Regional commentary**
Will the ICB have a (shared) understanding of how the functions could be used to deliver additional benefit for people who use services, and could be integrated with current processes and pathways to do so?	Yes / No	R ☐ A ☐ G ☐ C ☐	R ☐ A ☐ G ☐ C ☐	
Are there current or expected mechanisms through which people who use services and the public could be actively engaged and involved in shaping the functions to be delegated?	Yes / No			
Please provide further details of the key actions that are planned /have	*ICB response*			

[1] R: Not on target, significant concerns; A: On target, minor concerns; G: On target, no concerns; C: Completed
[2] R: Readiness by Mar 2023 is not achievable; A: Delivery by Mar 2023 is at risk but mitigation plan in place; G: On target for readiness by Mar 2023; C: Completed

been undertaken in support of this domain *(400 words max).*	*Examples of supporting activities include: POD functions reflected in ICB forward plan; ICB strategies for engaging with people and communities include the delegated POD functions; Communications plans for POD delegations; Mapping of delegated functions and the benefits these will bring for the local population; POD functions reflected in overall ICB quality arrangements; Embedding POD within existing ICB quality and associated improvement priorities; Plan to ensure that quality in POD is measured consistently, using nationally and locally agreed metrics triangulated with professional insight and soft intelligence.*			
Please describe any known issues/risks associated with this domain. What mitigation plans does the ICB have to address these issues/risks?	*ICB response*			
What support is needed to ensure the ICB is ready to assume responsibility for these functions from April 2023?	*ICB response*			

Domain 2: Governance and Leadership				
Question	**Response**	**Current RAG[3] rating at [insert date]**	**Projected RAG[4] rating at March 2023**	**Regional commentary**
Will the ICB have sufficient general governance capability (mature structures, appropriate expertise) to oversee the functions at every appropriate tier of their commissioning and delivery?	Yes / No	R ☐ A ☐ G ☐ C ☐	R ☐ A ☐ G ☐ C ☐	
Will the ICB have sufficient clinical governance capability and leadership to oversee the functions?	Yes / No			
Will the ICB have mechanisms in place which allow for the identification and monitoring of emerging risks, impacts, and unanticipated dependencies in the immediate post-delegation period?	Yes / No			
Will the ICB have broad agreement amongst the parties[5] relevant to delivering the functions on the approach to monitoring and governance?	Yes / No			
Please provide further details of the key actions that are planned /have been undertaken in support of this domain *(400 words max).*	*ICB response* *Examples of supporting activities include: Identified board level leadership and expertise in relation to the POD functions; Integration of primary care into*			

[3] R: Not on target, significant concerns; A: On target, minor concerns; G: On target, no concerns; C: Completed
[4] R: Delivery by Mar 2023 is not achievable; A: Delivery by Mar 2023 is at risk but mitigation plan in place; G: On target for delivery by Mar 2023; C: Completed
[5] *For example, all parties (e.g. other ICBs) where joint arrangements for the delivery of the delegated functions are being developed.*

	system wide commissioning and development arrangements; Plans to ensure that quality and risk issues relating to POD are linked into existing ICB governance and accountability structures; description of clinical governance arrangements; proposed governance and accountability structure for POD and how this integrates into wider ICB governance and accountability structure and relationship with place based partnerships; robust governance arrangements for risk identification, management and escalation for the POD functions; plans to monitor performance and quality.			
Please describe any known issues/risks associated with this domain. What mitigation plans does the ICB have to address these issues/risks?	*ICB response*			
What support is needed to ensure the ICB is ready to assume responsibility for these functions from April 2023?	*ICB response*			

Domain 3: Finance				
Question	**Response**	**Current RAG[6] rating at [insert date]**	**Projected RAG[7] rating at March 2023**	**Regional commentary**
Does the ICB have an understanding of allocated ICB budgets and expenditure on other primary care services?	Yes / No	R ☐ A ☐ G ☐ C ☐	R ☐ A ☐ G ☐ C ☐	
Has the ICB undertaken a financial risk assessment and developed a plan to mitigate any financial risks identified?	Yes / No			
Please provide further details of the key actions that are planned /have been undertaken in support of this domain *(400 words max).*	*ICB response* *Examples of supporting actions include: Financial plans and risk assessments*			
Please describe any known issues/risks associated with this domain. What mitigation plans does the ICB have to address these issues/risks?	*ICB response*			
What support is needed to ensure the ICB is ready to assume responsibility for these functions from April 2023?	*ICB response*			

[6] R: Not on target, significant concerns; A: On target, minor concerns; G: On target, no concerns; C: Completed

[7] R: Delivery by Mar 2023 is not achievable; A: Delivery by Mar 2023 is at risk but mitigation plan in place; G: On target for delivery by Mar 2023; C: Completed

Domain 4: Workforce, Capability and Capacity				
Question	**Response**	**Current RAG[8] rating at [insert date]**	**Projected RAG[9] rating at March 2023**	**Regional commentary**
Will the ICB understand the capacity, capabilities and skills it needs to deploy to exercise the function upon assuming responsibility?	Yes / No	R ☐ A ☐ G ☐ C ☐	R ☐ A ☐ G ☐ C ☐	
Could the ICB confirm that the capacity, capabilities and skills needed to exercise the function upon assuming responsibility can be made available in due course?	Yes / No			
Please briefly provide further details of the key actions that are planned /have been undertaken in support of this domain (*400 words max).*	*ICB response* *Examples of supporting actions/information include: Agreed workforce model for POD; People Impact Assessment (or similar) which takes into account the impact of change on all affected staff (including POD, Complaints and supporting functions); Evidence of mapping of external support mechanisms (e.g. CSU, shared services etc); Staff transition plans; Staff OD plans including capabilities for the delegated functions.*			
Please describe any known issues/risks associated with this	*ICB response*			

[8] R: Not on target, significant concerns; A: On target, minor concerns; G: On target, no concerns; C: Completed

[9] R: Delivery by Mar 2023 is not achievable; A: Delivery by Mar 2023 is at risk but mitigation plan in place; G: On target for delivery by Mar 2023; C: Completed

domain. What mitigation plans does the ICB have to address these issues/risks?		
What support is needed to ensure the ICB is ready to assume responsibility for these functions from April 2023?	*ICB response*	

Signatories
This document should be signed by the ICB and the relevant NHS England Regional Director of Commissioning. It should also be verified and signed by the relevant NHS England Regional Director.
For completion by the ICB Chief Executive (and, where different, the duly authorised signatory of the delegation agreement as defined by the ICB Scheme of Reservation and Delegation): I confirm that the information provided is accurate and complete. This submission indicates our willingness to proceed with delegation and sign the Delegation Agreement. **Signed by** NHS [Insert name] Integrated Care Board [Name] [Name] [Title] [Title] Signature (insert scanned image of handwritten signature) Signature (insert scanned image of handwritten signature) Date: Click or tap to enter a date. Date: Click or tap to enter a date.
For completion by the NHS England Regional Director of Commissioning: I confirm that the information provided is accurate and complete. **Signed by** [Name] NHS England Regional Director of Commissioning Signature (insert scanned image of handwritten signature)

Date: Click or tap to enter a date.

For completion by the relevant NHS England Regional Director:

Based on the information provided, I am satisfied that the ICB will be ready to proceed to delegation in April 2023.

Please check box as appropriate.

Yes ☐
No ☐

Please provide any further comments below if 'No' has been selected and summarise the rationale behind this decision:

Signed by

[Name]

Regional Director

Signature (insert scanned image of handwritten signature)

Date: Click or tap to enter a date.

Annex 1: Pre-Delegation Assessment Framework: Pharmaceutical services, General Ophthalmic services and Dental services (primary, secondary and community)

Introduction and Context

In May 2022, NHS England set out its intention to delegate responsibility to all ICBs for all pharmaceutical services, general ophthalmic services and dental services (primary, secondary and community) (known collectively as 'POD services') in April 2023. Details of this have been set out here.

The pre-delegation assessment framework (PDAF) has been developed to support ICBs to prepare to take on POD services from April 2023. A separate PDAF for specialised services has been developed. This has been aligned to the POD PDAF but has been tailored specifically for specialised services commissioning.

The POD PDAF for the 2023 delegations is based on the Framework that was used to assess ICSs that wished to take on these functions in 2022. The Framework is structured around four domains with underpinning criteria that set out the minimum standards which should be met by ICBs prior to delegation in April 2023. The PDAF should be viewed alongside the Safe Delegation Checklist that has been developed to provide further details on the specific tasks and activities that will be required to support delegation against the four domains.

Each ICB will be required to complete the assessment proforma above with the support of their NHS England regional team. Regional teams will need to approve each ICB's submission and assessment of risk before the completed proforma is submitted nationally. These submissions will be reviewed by a National Moderation Panel in October 2022 which will provide a recommendation to the NHS England Board for formal approval on 1 December 2022.

Principles of Pre-Delegation Assessment Framework

Domain	Principle
Transformation and Quality	There is a clear understanding of how receiving each new responsibility will benefit population health outcomes, deliver improved care quality, reduce health inequalities, improve preventative capacity, and increase efficient use of resources.
	There is a shared understanding across all ICS partners on the benefits of delegation.
Governance and Leadership	Governance enables safe, high quality delivery.

	Clinical leadership combines the specialist expertise to lead and scrutinise individual functions, and the collaborative working necessary to identify, enable, and oversee clinical improvements.
Finance	There is an understanding of budgets and expenditure for other primary care services and an agreed plan for managing financial risks identified.
Workforce and Capability	There is an understanding of the workforce and capability and capacity requirements, with any major risks understood and processed for mitigation.

Domains and criteria

The principles detailed above have informed the development of underpinning criteria across the four domains. These criteria describe the plans, governance and activities that ICBs will need in place or to have undertaken prior to assuming responsibility for the functions in April 2023.

1. Transformation and Quality	
Domain description	**Criteria**
ICBs will have clear, feasible plans to improve population health outcomes which are compatible with the use of the delegated functions. These plans will be underpinned by realistic and sustainable financial assumptions, integrated with existing ICB plans and reflect patient priorities and engagement.	The ICB has plans which demonstrate how it could use the functions to improve population health, deliver improved care quality, reduce health inequalities, improve preventative capability, co-produce services with patients, and increase efficient use of resources.
	The ICB has demonstrated an understanding of how the functions could be integrated into wider pathways, including interfaces with provider collaboratives, for patient benefit. It will also demonstrate how this transformation aligns with national policy where appropriate.

2. Governance and Leadership	
Domain description	**Criteria**
ICBs will have a clear governance structure in place. This must involve the expertise necessary to scrutinise individual functions, and to oversee integrated planning and service development encompassing multiple functions. ICBs will determine whether the	The ICB will have clear governance and accountability structures covering every stage of the planning cycle.
	The ICB will have developed governance and accountability structures to make

decisions made on particular functions should be at system or place level, and develop governance accordingly. Clinical leadership should be robust and embedded throughout. Engagement mechanisms should enable people who use services to influence commissioning decisions.	decisions at the appropriate level for each function.
	The ICB will have sufficient expertise (clinical, operational, and financial and strategic) embedded in its governance and accountability structures to ensure that each function can be adequately overseen, including having robust impact assessment processes.
	The ICB will have robust governance processes that allow for the effective identification, evaluation, escalation, recording and monitoring of risk.
	The ICB will have cross-functional governance and accountability structures which can oversee integrated pathways, and which align with other stakeholders to support integration and co-commissioning.

3. Finance	
Domain description	**Criteria**
The ICB will have a plan to deliver financial objectives for the delegated POD functions	The ICB will have an understanding of allocated budgets and expenditure on other primary care services for 2022/23 and 2023/24.
	The ICB will have undertaken a financial risk assessment.
	The ICB will have developed a plan to mitigate financial risks identified.
	Additional criteria placeholder

4. Workforce, Capability and Capacity	
Domain description	**Criteria**
The ICB will assess the capability development and capacity needed to deliver the function, and to ensure a smooth transition for staff (in alignment with the applicable regional workforce model). The workforce model enables population health benefits. Evidence of consideration of the wider needs of staff – for example,	The ICB has assessed its current workforce capabilities through a People Impact Assessment (or similar) and future needs, demonstrating that it has, will possess, or will have access to sufficient resource, capability, and capacity to commission the delegated functions. This may incorporate assumptions on the number of staff already supporting the delegated functions required

OD and cultural integration – will be necessary.	now and in the future, and the mechanism for deploying them to align with the benefits identified.
	The ICB will map (where appropriate) where external support will be needed, and how this is expected to evolve over time. This may imply CSU support, shared services between ICSs, or interfacing with NHSEI regions to provide assurance in relation to their workforce capability to deliver delegated functions.
	The ICB will have developed an understanding of how transitioned staff will integrate into existing teams; the ICB's application for delegation will be based on utilising an employment model(s) from the HR Framework.
	The ICB will have aligned the development of new staffing capabilities and the integration of staff with broader OD and change management processes, connecting with any initiatives and stakeholders which will enable integration including where appropriate with wider stakeholders.
	The ICB will have demonstrated that its senior leadership has appropriate capability, capacity, and information. Robust clinical leadership should be demonstrably established.

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Primary Care Report

July 2022

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Quality – Assurance

GP CQC Inspections and Ratings

Practice	Last published Rating	Published date
Mythe Medical	OUTSTANDING	07/06/2017
Minchinhampton	OUTSTANDING	28/06/2018
Winchcombe	OUTSTANDING	10/11/2016
Walnut Tree	OUTSTANDING	27/12/2017
Drybrook	REQUIRES IMPROVMENT	18/07/2022

OOH CQC Inspections and Ratings

Provider	Last published Rating	Published date
PPG OOH	REQUIRES IMPROVEMENT	17/03/2022

GP CQC Inspections

The CQC last comprehensively inspected Primary Care between 2016 an 2018. At that time, four practices achieved 'outstanding' ratings, with all others being 'good'.

In the current round of inspections one practice, Drybrook Surgery, slipped to 'Requires Improvement'. The ICB will support the practice to improve.

Out of Hours

Classed as 'Primary Care' under the CQC inspection regime, the Gloucestershire GP Out of Hours service was recently inspected and was found to require improvements. The CQC told Practice Plus Group (PPG) that they must improve systems for continuous learning and improvement and 'achieve sufficient numbers of suitably qualified competent, skilled and experienced persons'.

PPG have shared their action plans and updates. Specific actions include:

- Revised audit process and tracker
- Workshops on weak areas / trends such as safety netting.
- Ensuring they have focused audits so that we are able to address trends.
- Develop medicines management prescribing audit data tracker.
- New revised QA pack with more granular detail
- Develop communications strategy.
- Developing a capacity and demand tracker – rota modelling
- Productivity report
- Recruitment and review of skill mix / roles

Progress is reviewed at each Contract Review Meeting.

Quality – Safety

Learn From Patient Safety Events (LFPSE)

A new national NHS Learn from Patient Safety Events service (previously called the patient safety incident management system – PSIMS – during development) is in the final stages of development as a central service for the recording and analysis of patient safety events that occur in healthcare.

LFPSE is replacing the current National Reporting and Learning System (NRLS) and Strategic Executive Information System (StEIS), to offer better support for staff from all health and care sectors.

This new online service has been designed for use by staff anywhere healthcare is delivered by organisations registered with an ODS code. As well as secondary care, this includes general practice, community dentistry and community optometry.

NHS Gloucestershire is planning to use Patient Safety Day as a springboard for LFPSE launch and will engage with GPs and Pharmacists working in primary care to help launch the new service.

This change is important as less than 1% of the 2.2 million national reports received by the NRLS each year are from primary care, despite this being where most patient interactions take place. At a national level, this provided only limited information about patient safety events occurring in primary care, limiting effectiveness to support improvement in these settings.

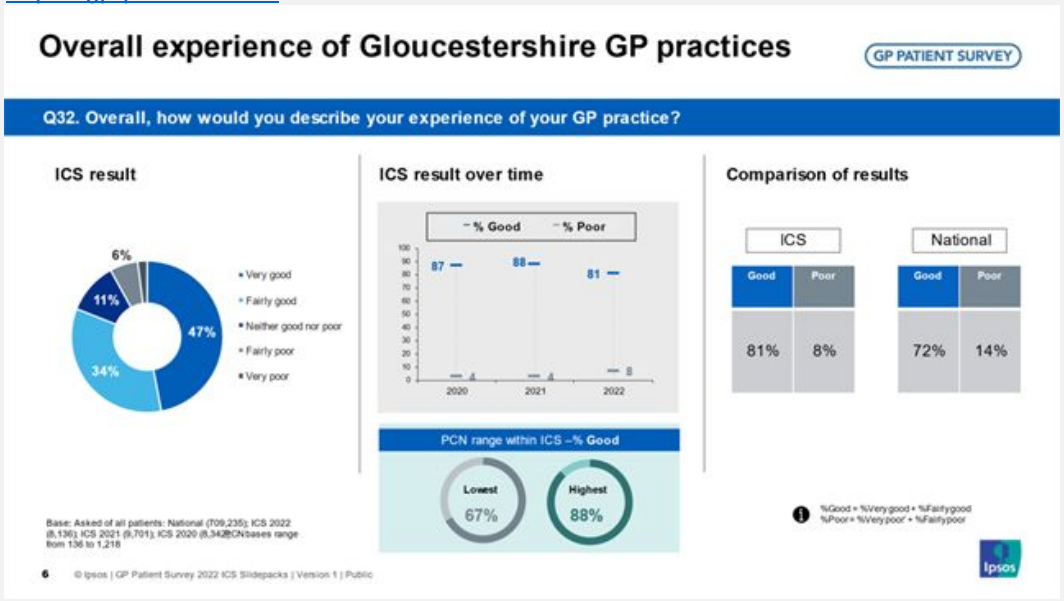
Through LFPSE, the data collected is structured in a way that directly supports understanding of the state of safety within all areas of healthcare delivery. The National Patient Safety Team analyse this data for maximum learning benefit, and to generate insights that can change the way we all work to improve the safety of care for all.

Equally as important to supporting national patient safety work, primary care providers can use their own data from LFPSE to support local response and governance around patient safety events. The LFPSE online service contains a number of new features specifically designed to support a positive patient safety culture in primary care and other non-trust providers.

Quality – Experience

National GP Patient Survey: published 14 July 2022

The GP Patient Survey (GPPS) is an annual England-wide survey about patients' experiences of their GP practice and is administered by Ipsos on behalf of NHS England. The slide below is a summary of overall ICS experience. In One Gloucestershire, 20,830 questionnaires were sent out, and 8,239 were returned completed. This represents a response rate of 40%. A full ICS slide pack and PCN, individual GP practice information is available at: https://gp-patient.co.uk/



Patient Advice and Liaison Service and Complaints

The ICB PALS Team manage and commissioning and primary care PALS enquiries.
During Q1 (2022/23) PALS supported 348 enquiries.
NHSE currently handles primary care Complaints – arrangements will change from 1 April 2022.

Friends and Family Test (FFT)

Friends and Family Test (FFT) is a feedback tool that supports the fundamental principle that people who use NHS funded services should have the opportunity to provide feedback on their experience.

The FFT asks a simple question: how likely, on a scale ranging from extremely unlikely to extremely likely, are you to recommend the service to friends and family if they needed similar care or treatment.

Data on all services is published on a monthly basis. During the 2020 reporting of FFT results was suspended. During the past 12 months phased reporting has resumed across all NHS funded services, with GP practices recommencing reporting from July 2022.

FFT is one of many experience measures used to inform service quality improvement, evaluation and development; for the purposes of providing a standard measure for the ICB it is useful as it highlights overall experience across all services using the same methodology.

Quality – Effectiveness

Each system partner has to reassure themselves that what they are doing is 'Effective'. However we know that there are opportunities to bring together our work across the ICB.

For several years a CCG Clinical Effectiveness Group met to review 'effectiveness' across a limited number of areas. The last Clinical Effectiveness Group (CEG) was held on 27th June 2022 where there was a discussion regarding how the group can become more outward looking and harness the opportunities brought by the ICB. Over the next year this group will transition into a System Effectiveness Group and focus on:

- Understanding the standards we measure ourselves against
- Measure current provision against standards
- Describing variance
- Discussing and reporting why there are variants
- Working towards closing variance
- Challenging system partners to measure the benefit of our work to demonstrate the value

The new System Effectiveness Group will first focus on ensuring we achieve the 'must do' elements of effectiveness and will then build a programme of work that will link more effectively with the Clinical Programme Groups and Primary Care.

For this initial report, we would like to take the opportunity to share some highlights from the Nursing and AHP's initiatives, workstreams , planning and project work that is currently underway in Gloucestershire.

- 33% of our GPN workforce in Gloucestershire are age 55 and over therefore focused work on our Recruit, Remain and Return plan is well underway.
- Developmental programmes and support models for all new to practice nursing and the trainee nurse associate roadmap.
- We are developing a programme for strong Nursing leadership – with a system focus, plus our ambition and vision for the future.
- Preceptorship schemes for senior nurse leads and advanced clinical practitioner leads.
- Focused work to raise the profile of the Practice Nurse and AHP's working in Primary Care and additional funding to support supervision.
- Primary Care Training Hub - Nurse leads adopting a new and inclusive approach to learning and development.
- Collaboration forums with the University of Gloucestershire
- Population Health Management – Nurse Champions

Primary Care & Direct Commissioning Committee

Meeting Date	**4th August 2022**
Report Title	**Delegated Primary Care Financial Report**
Executive Summary	At the end of June 2022, the CCG's delegated primary care co-commissioning budgets were £752k underspent based on the M3 budgets.
Risk Issues: **Original Risk (CxL)** **Residual Risk (CxL)**	Risk of overspend against the delegated budget: Original Risk: 3 x 3 = 9 Residual Risk: 3 x 2 = 6
Management of Conflicts of Interest	None
Financial Impact	The current year to date position has been included within the CCG's overall financial position.
Legal Issues (including NHS Constitution)	None
Impact on Health Inequalities	None
Impact on Equality and Diversity	None
Impact on Sustainable Development	None
Patient and Public Involvement	None
Recommendation	The PC&DC is asked to • note the content of this report.
Author	Matthew Lowe
Designation	Head of Management Accounts
Sponsoring Director (if not author)	Cath Leech Chief Finance Officer

Primary Care & Direct Commissioning Committee - August 2022

Delegated Primary Care Commissioning financial report as at 30th June 2022

Introduction

This paper outlines the financial position on delegated primary care co-commissioning budgets as at the end of June 2022.

Please note that as at M3 the budgets are in accordance with the plan resubmission on 20th June.

Financial Position

The financial position as at 30th June 2022 on delegated primary care budgets is an underspend of £752k.

The underspend is explained by two key items –

1. £456k is a prior year benefit relating to GMS dispensing charges. This is partly due to the charges being lower than anticipated, and partly due to an improved calculation methodology. This underspend will be utilised throughout the remainder of the year.
2. £250k relates to minor improvement grants. This is due to the budgets being phased equally through the year whereas the costs are expected to be incurred later with the budget being fully spent.

There is an offsetting overspend in the Primary Care Network (PCN) DES driven by a prior year under-accrual of £103k. The balance is made up of other minor budget phasing differentials.

The M1-3 CCG underspend will be carried forward into M4-12 of the ICB.

The current forecast for the full financial year is breakeven.

Recommendation(s)

The PC&DC are asked to:
Note the contents of the paper

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Gloucestershire CCG
2022/23 Delegated Primary Care Co-Commissioning Budget

			Jun-22					
	Area	2022/23 Total Budget (for 3 Months Ending 30/06/22)	In Month Budget	In Month Actual	In Month Variance	YTD Budget	Actual YTD	YTD Variance
		£	£	£	£	£	£	£
SPEND	Contract Payments - GMS	15,263,494	5,087,831	5,064,218	23,613	15,263,494	15,192,653	70,841
	Contract Payments - PMS	636,662	212,221	222,377	(10,156)	636,662	642,130	(5,468)
	Contract Payments - APMS	594,251	198,084	192,004	6,079	594,251	576,931	17,320
	Enhanced Services	461,165	153,722	171,421	(17,699)	461,165	489,944	(28,779)
	Other GP Services	829,244	280,081	248,042	32,039	829,244	579,166	250,078
	Premises	2,390,064	796,688	816,133	(19,445)	2,390,064	2,354,769	35,295
	Dispensing/Prescribing	870,928	290,309	89,881	200,428	870,928	354,023	516,905
	QOF	2,445,765	815,255	805,598	9,657	2,445,765	2,416,775	28,990
	PCN	2,966,676	988,892	1,069,581	(80,689)	2,966,676	3,100,171	(133,495)
		26,458,250	**8,823,083**	**8,679,255**	**143,828**	**26,458,250**	**25,706,563**	**751,687**

Funding Allocation (YTD)

Global Sum per weighted patient moved from £93.46 to £96.78 in April 2021
The value of a QOF point increased from £201.06 to £207.56 in April 2022
(the size of QOF has stayed the same in 2022/23 at 635 points)
Other GP Services includes:

>Legal and Professional Fees
>Doctors Retainer Scheme
>Locum/adoption/maternity/paternity payments
>Other General Supplies and Services

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Gloucestershire CCG
Primary Care over the Years

Helen Goodey/Jo White

July 2022

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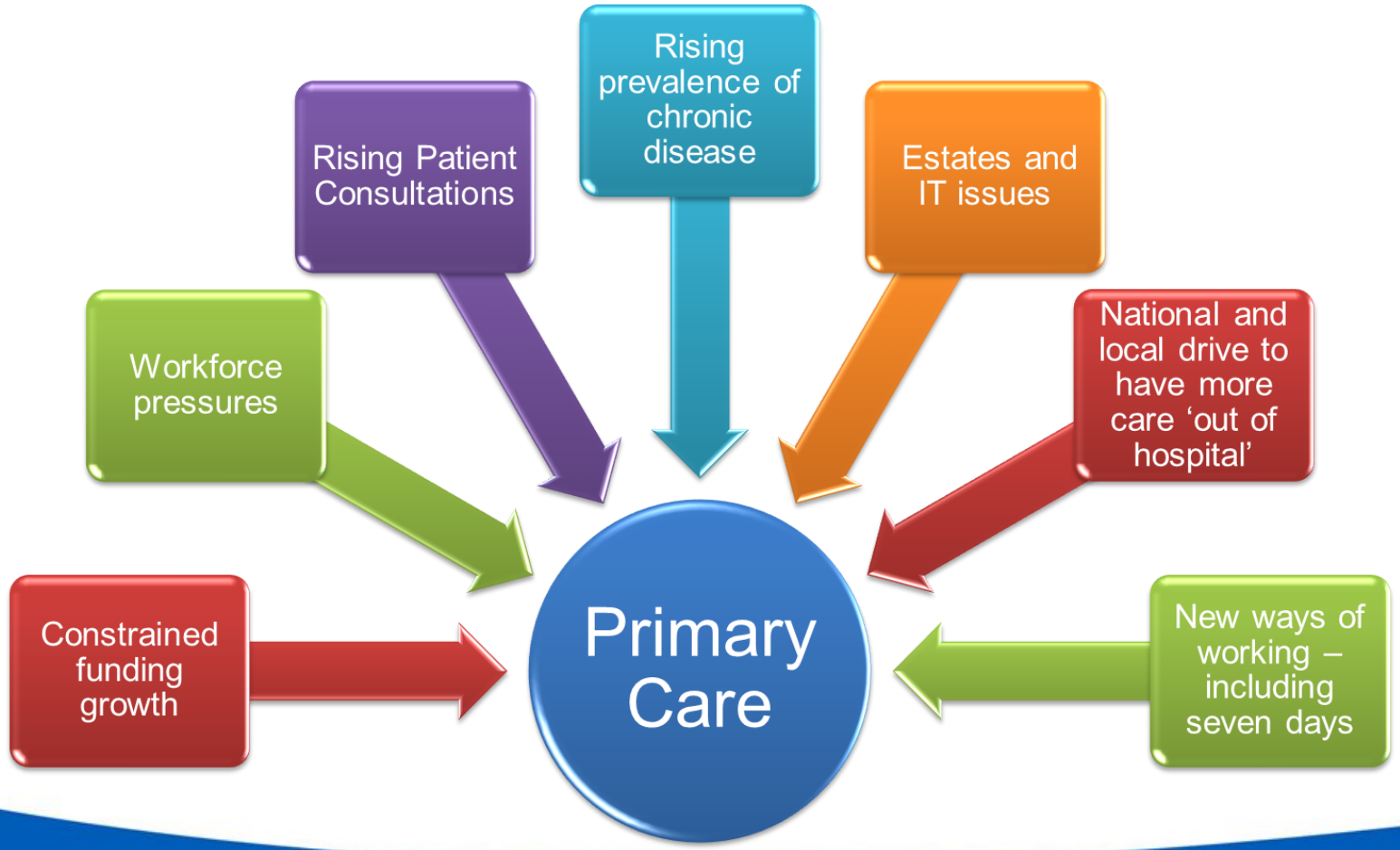
Part of the One Gloucestershire Integrated Care System (ICS)

National Primary Care Challenges



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NHS Gloucestershire Primary Care Strategy

First Published 2016

2019 Refresh

6 Primary Care Strategic Goals

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Access
Evenings and weekends; flexible to patient needs

From the early days of Choice+ appointments in 2014, we progressed to:

- PM Challenge Fund contract awarded to G Doc ltd from June 2015 which included 'Choice+' centres offering seven days a week access.

Social Prescribing Service:

- Pilots in FOD and S&BV.
- Service was a precursor to NHSE/I SPLW role as part of Additional Roles Reimbursement (ARR)

'She [Social prescriber] has helped to reduce the need to go to hospital sometimes because patients know where to turn to instead of the GP or A&E when it wasn't a medical concern'.
(A Practice Manager)

Improved Access (IA) cluster pilots from October 2017 to provide routine and urgent GPs appointment: evenings & Sat Mornings

The current IA services are provided from a range of providers:

- GDOC - countywide access – 2 x sites in Gloucester and Cheltenham
- GHAC: 8 – 8, seven days a week
- 15 PCN groupings delivering IA

PCN DES Enhanced Access to commence from October 2022, to combine IA and extended hours services.

GDOC
Gloucester Health Access Centre, Lydney, & Matson Lane Surgeries

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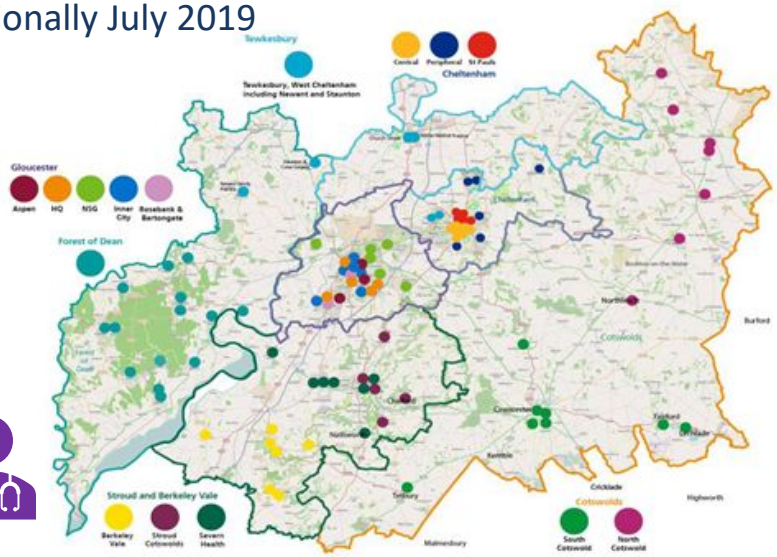
Primary Care at Scale
Working closer together to deliver a greater range of services for 30,000+ patients

Cluster Based Working /Developing our 30,000+ Model

- Cluster piloting commenced in S&BV in April 2016
- 16 Clusters live across Gloucestershire by 2017
- PCNs introduced nationally July 2019
- 14 PCNs → 15 PCNs



Bringing Primary Care Together & Developing Our Leaders:

GP Provider Lead Meetings, now CD Meetings
GP Leaders National Courses
Business Managers Meetings
BM Action Learning Sets
Practice Managers Meetings
Vanguard Visits

- **Transformation Funding** -(national non-recurrent £1.50, locally recurrent & topped up to £1.89) to support and build cluster based working via clinical roles: Paramedics, Clinical Pharmacists, Frailty Matrons – ahead of national ARR.

- **National Network DES** from July 2019 – ARR, Specifications, PCN meetings, IIF & local PCN dashboard, PCN newsletter
- **PCN QI Projects 2021-23**, local non-recurrent funding, bottom up design, improvements to meet PCNs local populations needs.

Countywide Primary Care Events to support national and local developments

By strategic design - practices reduced

86 → 70

9 practice mergers since delegated authority

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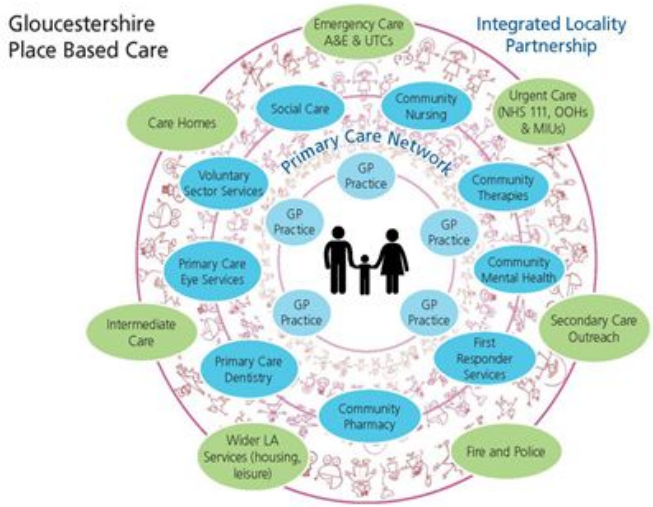
Integration
Across pathways especially urgent care, maximising partnerships in place-based care

Pathways, Partnerships and Place-Based Care:

- 6x ILPs: Collaborative partnership working
- Population Health Management approach to priority identification, design and delivery
- New care models for local populations
- New pathways developed – central repository
- Integration leveraged during Covid
- Plans to further build our locality partnerships

"Community-based wellbeing work is more effective and we feel we are all on the same side"



G-care

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Greater use of technology
Online patient records, appt booking, apps, self-care, Skype

Practice Clinical Systems convergence

emis health

tpp

Online consultations & remote access

eConsult

accuRx.
Powering Primary Care

Rollout of 800 Laptops to Practices (2020/21)

MS Teams and Office 365 rollout

Office 365

Shared Care Record

JUYI
Joining
Up Your
Information

GP Connect

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Estates
Improve the Primary Care estate to be fit for the future


Cinderford Medical Centre


Kingsway Health Centre, Gloucester


Cleevelands Medical Centre


The Wilson Centre, Cheltenham

The primary care strategy has a vision for a safe, sustainable, and high-quality primary care service, provided in modern premises that are fit for purpose. Within the strategy, there is a Primary Care Infrastructure Plan (PCIP), which covers GP Premises priorities for consideration up to 2026 that supports the following objectives: -

- ✓ Ensuring facilities are safe with focus on constraints caused by significant under sizing and the condition of the building.
- ✓ Ensuring facilities can support key service strategies
- ✓ Ensuring there is sufficient future capacity through understanding the impact of evidenced housing and population growth.

The plan sets out where investment is anticipated to be made in either new, or extended buildings, subject to business case approval

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Estates
Improve the Primary Care estate to be fit for the future

- Around the equivalent of £63m capital investment has been approved – 20 schemes.
- Nearly all completed and delivered.
- Four schemes will finish around the Autumn of this year and two schemes approved have yet to commence.
- There are a further 9 strategic priorities currently preparing detailed Business Cases estimated to be a further equivalent of £45m worth of capital investment that will be considered by the PCDC

Churchdown Surgery, Churchdown

Quayside House, Gloucester

The Devereux Centre, Tewkesbury


The Chipping Surgery, Wotton-under-Edge


Hadwen Health, Gloucester

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Developing the **workforce**
Attracting and retaining talent; an expanded workforce

Health Inequalities Fellowships

"Be a GP in Gloucestershire" promotional campaign

Spark

New to Practice GP and Nurse Fellowships

Annual Event for Locum GP's including training and updates

GLOUCESTERSHIRE PRIMARY CARE TRAINING HUB

Parachute Pharmacist and Nurse programmes to support challenged Practices

Role	Headcount	WTE
GP (all types)	558	418.9
Nurse	327	214.00
Direct Patient Care (minus ARR)	289	175.79
Admin	1,262	834.6
Additional Roles Reimbursement (ARR)	248	197.49
TOTAL (May 2022)	**2684**	**1840.78**

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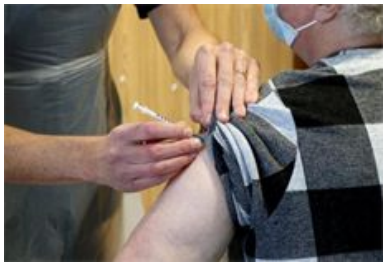
Developing the
workforce
Attracting and retaining talent; an expanded workforce

Conversations with each PCN to understand their key Objectives



Staff Pool assigned to PCN's to support Vaccine Programme

Support to develop specific ARR roles -
e.g. SPLW Ambassadors

Supporting PCNs with ARR workforce planning has helped to increase the number of roles in county

ARR Role	Headcount	WTE
Care coordinator	63	46.16
Clinical pharmacist	76	61.72
First contact physiotherapist	9	5.97
Health and wellbeing coach	1	1
Pharmacy technician	29	24.65
Physician associate	4	3.1
Social prescribing link worker	41	33.23
Trainee nursing associate	7	6.31
Nurse Associate	3	2.97
Paramedic	12	9.91
Dietician	1	1
Podiatrist	0	0
Occupational therapist	0	0
Mental Health Practitioner	2	1.47
Advanced Practitioner	0	0
Countywide (June 22)	**248**	**197.49**

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Primary Care Strategy - Patient Experience

Repeat prescriptions and efficient links with Community Pharmacy

Book online, via the NHS app or call/visit the practice

New methods of consultation

Care Coordinator actively signposts patients to the most appropriate healthcare professional (in practice or in the community)

Additional roles in General Practice include Clinical Pharmacists, Physiotherapists and Social Prescribers. Alternatively, community providers may be more appropriate i.e. Opticians, Community Pharmacy or Dentist

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Primary Care - Journey

National Journey

CCGs become Integrated Care Boards (ICBs)

2014 2015 2016 2017 2018 2019 2020 2021 2022 2023

Primary Care Offer commenced

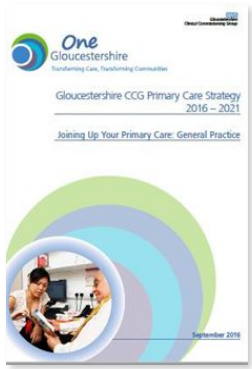
Extended Hours

7 Locality Exec Groups, LDPs & GP Liaison Leads

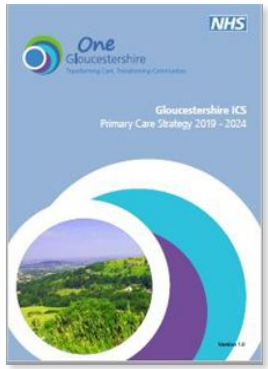
GP Provider Leads

S&BV & Gloucester Place Based Pilot Boards

CEPN (PCTH) commenced



14 Clusters



Improved Access

14 PCNs & Clinical Directors

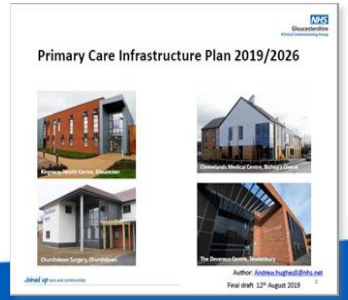
ILBs & ILPs (incl. Plans)

15 PCNs

10 PCN Local Vaccination Sites

PCN DES Enhanced Access

Delegated pharmacy, dental and optometry services



Local Journey

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Next steps for integrating primary care: Fuller stocktake report

Background

Amanda Pritchard, CEO NHSEI, asked Dr Claire Fuller, CEO designate Surrey Heartlands ICS and GP, on 10 Nov 2021, to provide specific and practical advice to all ICSs, as they assume new statutory form, on how they can accelerate implementation of the primary care, out of hospital care and prevention ambitions in the NHS Long Term Plan in their own geographies.

The stocktake considered:

- How ICSs can drive more integrated primary, community and social care services at a local level.
- Practical advice on how services should develop, with next steps towards that vision.
- What is needed for ICS to support and enable PCNs and practices to work with other parts of the health system

Additional purpose of the work:

Kick-start ICS development relating to primary care capabilities and ability to deliver service improvements, learning from all ICSs and wider stakeholders.

Scope

In scope

- ✓ A short, **action-focused report**, **sponsored by ICS leaders** and developed through **widespread engagement** across primary care
- ✓ Documenting **best practice**, including showcasing good models of integrated pathways and services that **already exist**
- ✓ Initiation of a **development process for ICSs** in relation to their primary care capabilities and ability to deliver service improvements
- ✓ Bringing together recommendations on areas of **national policy or guidance** that come up through engagement on the Stocktake but require further work, aligning with planned content on primary care in SoS' Reform White Paper in July.

- ✓ Alongside this scope, an external piece of work was commissioned to the **King's Fund on levers for change in primary care.**

Out of scope

- ❑ Changes to primary **legislation and regulations**
- ❑ Changes to national PC **contracts**
- ❑ Recommendations on the future of the **GP partnership model**
- ❑ Changes to **Carr Hill formula**

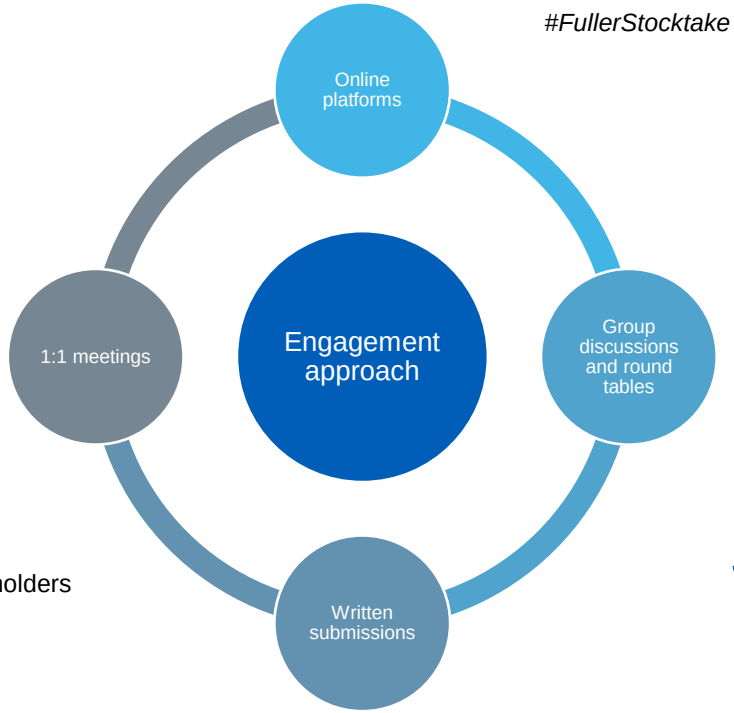
Engagement approach

- 12,000+ visits to our public crowd sourcing platform have informed a process in which we engaged nearly 1,000 people through a combination of formal working groups, roundtables, task & finish groups and many other sessions and events

12,000+
Views of: fullerstocktake.crowdicity.com

1.5m
#FullerStocktake twitter impressions

39
1-1 Meetings with ICS leaders



200+
Directly engaged across the nine workstreams

20+
Group discussion/roundtables not including workstream meetings

60+
1-1 with other key stakeholders

5 Task and finish groups: Episodic Care; Prevention; Mental Health; LD & Autism; and Local Authorities

What we heard

- **Primary care is one of the great strengths of the NHS.** Over a million people benefit every day from the advice and support of trusted professionals in general practice, community pharmacy, dentistry, optometry, audiology and other primary care services

- **For the NHS as a whole to succeed, primary care must thrive.** It has a crucial role in meeting the changing needs of a growing and ageing population, dealing with the disruption to routine care caused by the pandemic, and addressing persistent health inequalities. Integrated Care System (ICS) leaders strongly value primary care and are committed to working in partnership with primary care professionals to improve patient care.

- **However, primary care is today under serious pressure.** Growing demand, increasing complexity, and changing expectations have combined to put huge strain on GP services, leading to frustration for both patients and staff. While it is vital that we retain the core strengths of primary care, we also need to recognise that people's needs and expectations are changing – e.g. some people need more proactive, complex care, whilst others would prefer to prioritise rapid access to advice and support

- **We need a new approach.** Fixing capacity gaps in primary care will be part, but not all, of the solution. We also need to think differently about how primary care is delivered and organised, building on innovation already being led by primary care on the ground as well as learning from the pandemic.

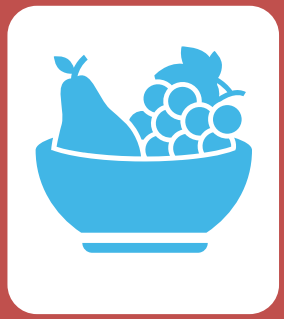
- The Fuller Stocktake sets out a **new vision for integrated primary care** based on developing streamlined access to urgent care for those that need it, more personalised care from a team of professionals for those with complex care needs, and a proactive approach to prevention at greater scale. This will be backed by support from both ICS leaders and national decision makers.

Outcome of work

What emerged was a consensus. What is not working is access and continuity, with frustrations shared by both patients and staff alike. What also emerged was a consensus on what we can do differently. **This consensus was shared by all ICS CEOs and led to a letter of commitment to the stocktake vision signed by all parties.**

- **Integrated neighbourhood 'teams of teams'** need to evolve from Primary Care Networks (PCNs), and be rooted in a sense of shared ownership for improving the health and wellbeing of the population. They should promote a culture of collaboration and pride, create the time and space within these teams to problem solve together, and build relationships and trust between primary care and other system partners and communities.
- **Streamlined access to urgent, same-day care** and advice from an expanded multi-disciplinary team, using data and digital technology to enable patients to quickly find the right support to meet their needs
- Ensuring those who would most benefit from **continuity of care in general practice** (such as those with long term conditions) can access more proactive, personalised support from a named clinician working as part of a team of professionals
- Taking a more active role in **creating healthy communities and reducing incidence of ill health** by working with communities, making more effective use of data and developing closer working relationships with local authorities and the voluntary sector.

The three functions of primary care



A step-change in our ambitions on Preventative Care

- **Supporting lifestyle change** via a combination of national and local programmes providing advice and support to improve diet, fitness and wellbeing, eg health coaches and capitalising on evidence-based health apps, and the NHS app. This should involve the extended primary care team, harnessing the growing role of community pharmacy and dentistry in prevention, VCS, and working at scale on prevention with LA Public Health colleagues.
- A scaled approach **to delivering population-level interventions**, including screening and health checks, and adult vaccinations, building on the community engagement that characterised the Covid-19 vaccination programme.

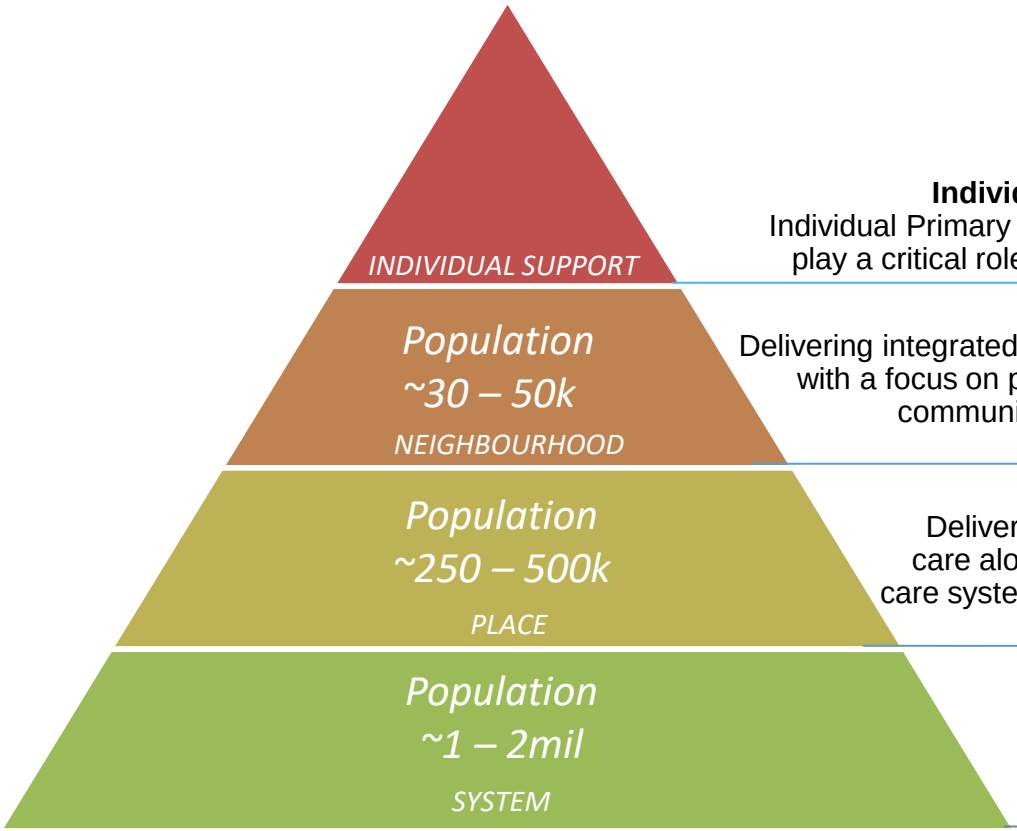
A scaled and streamlined model to deliver Urgent and Episodic Care

- Single, 24/7 point of **coordination for urgent and episodic care**, making best use of PCN and place-based MDTs, and building on CAS model. Incorporating NHS 111, community pharmacy, urgent community and mental health crisis response, GP out of hours, and potentially dentistry and other PC services.
- Flexibility to offer **virtual or face to face options in line with patient preference and need**. Delivered at a **scale** that makes sense for local systems, as part of a wider integrated urgent and emergency care system, enabled by risk stratification of patients and shared care records.

A person-centred, team-based approach to Chronic Disease Management and Complex Care

- **Secondary prevention**, driven by proactive management of chronic disease, to prevent deterioration in health and prolong healthy life expectancy, through regular review of disease registers. Enabling and supporting people to manage their own long-term conditions, in line with latest evidence, through the use of patient-held record systems, peer coaching, remote monitoring and group clinics.
- **Named clinician as care coordinator** working alongside patients and families to ensure timely access to holistic care and minimize time spent in hospital. Co-ordination of multi-disciplinary teams/ 'teams of teams', including from acute, community and social care providers, working across place to support case management of more complex patients (medical/social/psychological).

Our vision for integrated primary care



Individual access: for people and carers to professional support
Individual Primary Care Providers and sites such as GP Practices will continue to play a critical role in providing ongoing support for individuals and their families.

PCNs as part of Neighbourhood Care Teams
Delivering integrated primary care via multidisciplinary Neighbourhood Care Teams, with a focus on providing holistic care and working closely with local people and communities in order to improve health outcomes and address the wider determinants of health.

Partnership working at place
Delivering scaled approach to population-level primary prevention and care alongside key system partners, including outside of the health and care system, focusing on system-wide pressure points such as admission avoidance, patient discharge and flow.

Creating the conditions for success
Establishing an enabling leadership culture and ways of working, as well as the practical infrastructure and support to implement the vision, including through estates, workforce, data, digital and funding initiatives.

Next steps for integrating primary care: Fuller stocktake report

The Fuller review outlines a new vision for integrating primary care, improving the access, experience and outcomes for our communities.

Enable PCNs to evolve into integrated neighbourhood teams with shared ownership for improving health and wellbeing

- Support **preventive healthcare** with **generalist and specialists** from all sectors for a **holistic approach to health**
- Adopt **population-based approach** by wider health and care systems and **align secondary care to neighbourhood teams**
- Develop **models of personalised care**
- Proactively **identify and target** those who can benefit from interventions and **committing to CORE20PLUS5 populations**

Work with local people and communities to tackle ill health

- Genuine **co-production and personalisation of care** that are **tailored to local needs and preferences**
- Bring **local people into the workforce** to establish **integrated teams that are rooted in the community**

System-wide approach to a single integrated urgent care pathway

- Provide **same-day access to urgent care** from the most **appropriate local service**, whether remote or face-to-face
- Develop **new metrics and standards for access** including **new patient-reported experience measures**
- Deliver **better continuity of care** by having **better urgent care access**
- **Co-locate teams** around the **needs of the population** with **blended expertise** and **easy access to diagnostics**

Create a clear development plan to support primary care sustainability

- Focus on **unwarranted variation in access, experience and outcomes**
- Understand current **spending distribution compared with system allocation** and **health inequalities**
- Support **collaboration with other providers** including **community services**
- Work in **partnership with local authorities, communities** and **system partners** to pool data and resources

Primary care workforce should be an integral part of system and national level strategy

- Develop **system-level workforce data** to **inform long-term strategy**
- Support **innovative employment models** and creatively **maximise skills and experience of existing workforce**
- **Extend NHS Staff Survey** across primary care
- **National workforce strategy** to focus on primary care

System leadership to become driver of primary care improvements

- Develop and support **clinical directors to drive change**, allowing **protected time** to meet the leadership challenge
- Establish **primary care forums** to ensure **credibility** and **breadth of views**
- Encourage **multi-professional workforce and leadership**
- Establish **greater financial flexibility** for systems on primary care
- Maximise **system decision-making** on **future discretionary investment**

System-wide estates plan to support fit-for-purpose buildings

- Adopt **'one public estate' approach** by using **perspectives on access, population health and health inequalities**
- Maximise use of **community assets and space**

Improve data flow and embed digital transformation in holistic care

- Address **patient data sharing** challenges to **improve co-ordination of care**
- Develop **digital transformation** that **focuses on patient experience and outcomes**, made in **partnership with staff and patients** whilst **addressing barriers to digital tools**

Legislative, contractual, commissioning and funding frameworks

- DHSE and NHSE **enable and support new models of integrated primary care**, provide **practical support** and **build ICS estates expertise**
- Consider how to **improve equity in resource distribution** and **improve health outcomes**
- Ensure **primary care estates** is central in the next **Health Infrastructure Plan**

Action: Local approach – next steps

The Fuller Stocktake Report gives an excellent summary reflecting much of our work locally on implementing many of the recommendations i.e. Care navigation hubs, CAS, MH etc.

However we recognise that we need to bring together the multiple strands across the ICB that will help deliver the ambitions of joined up integrated care delivered at neighbourhood levels, maximising continuity of care through consistency of approach, using best practice evidence to develop the care pathways through our CPG.

We know that same day urgent care is driving demand across our system. We need to ensure that we have a system approach to this to avoid duplication and fragmentation and importantly, maximising the 111 and OOH to greatest effect.

To this end we will be seeking approach from PC&DC and ICB to develop a Transformation Group to support our next steps. We will update at next meeting with TOR etc

Key links

1. Link to the Fuller Stocktake page on the NHS website, including report and ICS CEOs commitment letter: https://www.england.nhs.uk/primary-care/next-steps-for-integrating-primary-care-fuller-stocktake-report/

2. Link to the King's Fund report on levers for change in primary care: https://www.kingsfund.org.uk/sites/default/files/2022-05/Levers-change-primary-care-literature-review.pdf

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ICS Transformation Programme Highlight Report

July 2022

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7.1 Integrated Locality Partnerships

Programme SRO	Mary Hutton	**Clinical & Care Lead**	Clinical Directors & ILP Chairs	**Programme RAG**	**GREEN**	**Date of Report**	24 June 2022
Programme Lead	Helen Goodey	**Report Author**	Bronwyn Barnes	**Previous RAG**	**GREEN**		

Programme Aim (from delivery plan)	**Decisions / Actions Required of Board**
The aim of the Place Based model is to improve the health, well-being and independence of people living in Gloucestershire through delivering a step change in more accessible, sustainable and higher quality out of hospital care. It is focused on supporting partnership working between PCNs and other key stakeholders. They key outcomes of the approach include improved health and wellbeing, reduced hospital admissions and length of stay, better experience and equality.	N/A

Programme Area/ Workstream (as per delivery plan)	**Key Achievements from last reporting period** (from delivery plan)	**Key Upcoming Milestones for the next reporting period** (from delivery plan)	**Key Areas of Variance - *that have occurred/ could occur*** (from delivery plan)
Place Based Model **Please note that individual locality breakdown of work is available on request from PMO.**	• Review of ToR completed across all ILPs alongside all members to ensure clarity of local vison and purpose. • Review of priorities across ILPs, including PCN QI projects which are underway. • Continued progress in ensuring Strengthening Local Communities funding to District Councils is linked to ILP objectives including addressing inequalities. • Delivery of NHS Charites Together funded projects across the six localities is now underway. • Development of a 'Plan on a Page' summary for each Locality/ ILP is progressing with ToR and priority reviews across the County. Locality Plan on a page will serve as an aide memoir for existing members of the partnerships. • Progress made in establishing several community engagement led projects e.g. health equality in Cheltenham, Health and Wellbeing in Tewkesbury and Life Years Lost in specific areas of Cotswolds.	• Continuing with the design and delivery of interventions for ILP priority population cohorts across the existing working groups. • Ensuring projects align with emerging national policy for example Ageing Well and ICS design Framework including system PHM maturity. • Work to progress the six NHS Charities Together locality projects. • Further support & alignment of priority at locality level. • Develop ways to showcase our work in preparation for July ILP and PCN showcase event. • Renewed focus on locality engagement and relationship building with partners.	

Key Risk, for escalation	**Current Scores**			**Risk Mitigation**	**Mitigated Scores**		
	Likelihood	**Impact**	**Total**		**Likelihood**	**Impact**	**Total**
There is a risk that political emphasis on elective recovery detracts from Place/partnership agenda (NEW)	3	4	**12**	Continued focus on impactful priorities for ILPs that contribute to continued Covid recovery efforts.			
There is risk of insufficient voice for the Place based agenda at ICB and ICP (NEW)	2	4	**8**	Development of Governance arrangements to mitigate this.			
There is a risk around Primary Care representation in ICB not yet being communicated to ILPs and PCNs (NEW)	2	4	**8**	Development of Governance arrangements.			