Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

AGENDA

Meeting Title	Primary Care Commissioning Committee – Part 1	Date	2 December 2022
Chair	Dr Niti Pall	Time	9.30 a.m.
Minute Taker	Mrs Chris Billingham	Venue/ Location	Virtually via Microsoft Teams

A=Approval R=Ratification S=Assurance D=Discussion I=Information

Reference	Agenda Item	Presenter	Purpose	Paper	Time
PCCC 22-12.30	Apologies for absence	Dr Niti Pall	I	Verbal	9.30
PCCC 22-12.31	Declarations of Interest	Dr Niti Pall	S	Verbal	
PCCC 22-12.32	Minutes of the Meeting held on 7 October 2022	Dr Niti Pall	A	Enc. No. 1	
PCCC 22-12.33	Actions Raised from Previous Meetings and Matters Arising	Dr Niti Pall	A & S	Enc. No. 1A	
	Delegated Functions				
PCCC 22-12.34	GP Access Report to ICB 30th November	Tracey Jones	D	Enc. No. 2	9.45
PCCC 22-12.35	Community Pharmacy Consultation Service – Implementation update	Berni Williams	I	Enc. No. 3	9.55
PCCC 22-12.36	Ethnically Diverse Staff Survey	Phil Morgan	A	Enc. No. 4	10.05
PCCC 22-12.37	Shrewsbury Health and Wellbeing Hub – • Communication and Engagement Strategy • Timeline	 Jackie Robinson Gareth Robinson	 I I	 Enc. No. 5 Enc. No. 5A	10.15
	PCN Development				
PCCC 22-12.38	PCN Maturity Survey results and output from the Kings Fund OD work	Tracey Jones	I	Enc. No. 6	10.30
	Quality				
PCCC 22-12.39	Risk Register	Tracey Jones		Enc. No. 7	10.45
	Primary Care Team updates				
PCCC 22-12.40	Finance Update	Angharad Jones	S / I	Enc. No. 8 / 8A	10.55
PCCC 22-12.41	Primary Care Team Update Report	Tracey Jones	I	Enc. No. 9	11.10
PCCC 22-12.42	Any Other Business	Niti Pall	I	Verbal	11.20
PCCC 22-12.43	Date of Next Meeting: Friday 3 February 2023				
	To resolve that representatives of the press and other members of the public be excluded from the remainder of the meeting, having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest. Section 1(2) Public Bodies (Admission to Meetings) Act 1960.				

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NHS Shropshire, Telford and Wrekin
Primary Care Commissioning Committee Part 1 Meeting

Friday 7 October 2022 at 8.30 a.m.
Via Microsoft Teams

Present:

Mrs Niti Pall	**Lay Member – Primary Care (Chair)**
Mr Nick White	**Chief Medical Officer (Deputy Chair)**
Mrs Claire Skidmore	**Chief Finance Officer**
Mr Gareth Robinson	**Executive Director of Delivery & Transformation**
Mr Roger Dunshea	**Lay Member**

Attendees:

Dr Deborah Shepherd	**Deputy Chief Medical Officer**
Ms Claire Parker	**Director of Partnerships & Place**
Ms Emma Pyrah	**Associate Director of Primary Care**
Dr Julian Povey	**Primary Care Partner Member**
Dr Ian Chan	**Primary Care Partner Member**
Ms Angharad Jones	**Finance Business Partner**
Mr Tom Brettell	**Partnership Manager**
Mrs Janet Gittins	**Partnership Manager**
Ms Jane Sullivan	**Senior Quality Lead**
Mrs Bernadette Williams	**Primary Care Lead for Contracting & Delegated Commissioning**
Mr Phil Morgan	**Primary Care Lead for Workforce**
Mrs Vanessa Barrett	**Chair, Healthwatch Shropshire**
Mrs Chris Billingham	**Corporate PA; Minute Taker**

Apologies:

Ms Alison Bussey	**Chief Nursing Officer**
Ms Nicola Dymond	**Director of Strategy & Integration**
Mrs Julie Garside	**Director of Planning & Performance**

1.1 Mrs Pall welcomed Primary Care Commissioning Committee members to the meeting and thanked Mr White for chairing the July meeting on her behalf.

Minute No. PCCC-22.10.14 – Apologies

2.1 Apologies received were as noted above.

Minute No. PCCC-22.10.15 – Members' Declarations of Interests

3.1 Members had previously declared their interests, which were listed on the ICB's Register of Interests and was available to view on the website at:

[Register of Interests - NHS Shropshire, Telford and Wrekin (shropshiretelfordandwrekin.nhs.uk)]

3.2 Members were asked to confirm any new interests that needed declaring or any existing conflicts of interest that they had relating specifically to the agenda items.

3.3 Mrs Pall declared that as an independent health systems consultant she has been working with the national Cavell Centre programme. When that item is discussed, she will step down as Chair and ask Mr Dunshea to Chair the meeting on her behalf for that item of discussion.

Minute No. PCCC-22.10.16 – Minutes of Meeting held on 6 July 2022

4.1 The Committee received and approved the minutes of the meeting held on 6 July 2022 as a true and accurate record of the meeting.

Minute No. PCCC-22.10.17 – Actions Raised from Previous Meetings and Matters Arising

5.1 The Action Tracker was reviewed and updated as appropriate.

Minute No. PCCC-22.10.18 – Terms of Reference

6.1 Mr White confirmed that the last time the Committee met the draft Terms of Reference had been reviewed.

6.2 When the ICB came into being on 1 July 2022 the ICB Board approved all Terms of Reference but requested that they should be reviewed by each separate Committee going forward. It is likely that as the ICB develops the Terms of Reference will be reviewed regularly.

6.3 The Committee reviewed the TOR and suggested the following amendments: -

Item 10.3: "The Committee will make allowance for consultation with members of the public and other ICBs".

Mrs Barrett believed this to be rather ambiguous and questioned whether the allowance referred to was a time allowance or a financial allowance or both. Mr White agreed and suggested that the paragraph could be amended to read "The Committee will make allowance to ensure we engage and have appropriate resource to enable us to engage".

Dr Shepherd referred to the previous meeting where discussion took place as to whether she could be included as an Attendee to the meeting rather than merely deputising for Mr White when required. The Committee agreed with Dr Shepherd's request.

Item 5.2 Membership:
The paragraph stated that voting members should include “a second Non-Executive Director for Remuneration”. Mr White confirmed that this should read “a second Non-Executive Director”.

Item 3 Role of the Committee
Mr Dunshea referred to integration with Primary Care and other sectors within the ICS and believed that this role should be reflected in the Terms of Reference. Community Health services has an overlap with Primary Care and he questioned whether reference to Community service partners should also be included.

Dr Povey referred to Community Care and the Committee’s delegated power from NHS England around commissioning Primary Care that will broaden to include pharmacy, optometry and dentistry next year and questioned whether those services were part of the delegated responsibility of the ICB or part of the day-to-day running of the ICB that should sit elsewhere.

Discussion followed regarding the governance structure, integration, and whether reference should be made to development issues in the Terms of Reference for this Committee. The Committee agreed that the following wording should be inserted into the TOR: -

“There will be a developmental space around which the Primary Care Commissioning Committee will receive papers”.

Minute No. PCCC-22.10.19 Extension to Practice Boundaries

7.1 Mrs Williams reviewed her paper relating to the extension of Practice boundaries and provided the following background.

7.2 During 2021/22 the Primary Care team undertook an exercise to ensure that all geographical areas of Shropshire Telford and Wrekin were covered by a GP Practice boundary.

7.3 A number of Practices were approached, and the following agreed to extend their boundary: -
- Alveley
- Cambrian
- The Meadows

7.4 Following approval of the boundary change, the relevant documentation was sent to the Practices for completion.

7.5 Cambrian Medical Practice advised that after discussions with partners they no longer wished to proceed.

7.6 Consideration then had to be given as to how the ICB could assign patients if they needed to register in areas that were not covered.

7.7 As the Primary Care Team have been unable to secure any agreement from other Practices to extend their boundaries, the only viable solution is to assign patients on a case-by-case basis. There are no contractual obligations to boundary changes on Practices so these cannot be imposed. However, if negotiations to register a patient fail, the ICB can assign the patient to a Practice.

7.8 The number of enquiries from patients has diminished so the need to allocate/negotiate with Practices is less. Despite the identified areas not having full Practice coverage, patients do have access to primary medical care.

7.9 The Chair invited comment.

7.10 Dr Povey referred to the statement in Mrs Williams' paper that patients would be allocated as an out of area patient to a Practice. His understanding was that the ICB has no Practices that have opted to visit and see out of area patients at home. His concern was the issue in relation to the ICB allocating out of area patients to Practices where a visiting service has not been commissioned for those patients between 9.00 a.m. and 5.00 p.m. He also referred to the potential risk of allowing that to happen without a provider to provide those visits.

7.11 Mr Dunshea questioned what had happened previously when Practices had not matched the population need. He also asked how communication takes place with patients who are not on the list and how they would get primary care access going forward. Mrs Williams provided assurance that all patients are registered and do have access to primary care.

7.12 Dr Povey confirmed that all patients resident in Shropshire are covered by the ICS and the ICB. Many of these areas will be covered by Practices outside our boundaries, i.e. non-Shropshire Practices. For example, Claverley is a Shropshire Practice geographically but is in a different ICB/ICS area.

ACTION: Ms Parker to pick up the issues around out of area patients with the Primary Care team and provide an update to the December Committee.

RESOLVE: ***The Committee noted the contents of the report and supported the approach to assignment of patients when required.***

Minute No. PCCC-22.10.20 Shrewsbury Health & Wellbeing Hub – Progress Update

8.1 Mrs Pall stepped down as Chair for this item due to a potential conflict of interests and declared that in the event of the Committee being required to vote on any action, she would not vote.

8.2 Mrs Pall handed over Chairmanship of the meeting to Mr Dunshea.

8.3 Ms Pyrah's paper provided the background to, and status of, the Shrewsbury Health & Wellbeing Hub project which represents a significant investment from national funds of between £40m and £60m if the business case is approved.

8.4 The Outline Business Case is currently on hold while the site options appraisal is re-run in response to significant concerns raised by both members of the public and Councillors when the ICB announced the Otley Road site.

8.5 The dialogue and messaging need to be improved although it had already been made very clear publicly of the consequences for the six Practices of not proceeding with the project.

8.6 A public meeting took place on Tuesday 4 October 2022 attended by the Project Team, STW GP representatives and Shropshire Council.

8.7 On Thursday 6 October a second Stakeholder Reference Group meeting took place which included the Patient Participation Group, patients, Councillors, Healthwatch and other stakeholders. The meeting discussed all appraised options and ICB representatives reiterated to those present that the Hub was the only viable option. No other form of funding was available on the scale required to support those Practices to be sustainable going forward.

8.8 Delays to the timeline mean that an indicative date for the formal consultation start is April 2023.

8.9 There is currently significant risk attached to this programme which the Committee need to be aware of. The Council's position on the project has changed in the sense that they have confirmed they will not pay for any required public transport links to the chosen site. The Committee needed to be aware of the tone of public support. The Primary Care team were re-opening the site options appraisal and casting the geographical net for potential sites slightly wider to bring in more locations which will help with management of our population. It was confirmed that there is only one viable solution to providing these 6 practices with sustainable fit for purpose premises and that is the Shrewsbury Hub.

8.10 Mr Dunshea believed that the project is hugely important, and communication is critical.

8.11 Ms Parker referred to input by the clinicians to the Council meeting and the difficulties they encountered because of the restrictions imposed at the time by the national Cavell Programme.

8.12 If the project does not go ahead, the Practices involved all have significant estates issues that will threaten their viability and sustainability in the medium term.

8.13 Mr Robinson had attended the Council meeting on 4 October 2022 and wished to specifically thank Dr Jutsum, Dr Ingram and Dr Hart who had all given very personal views on the importance of this project.

8.14 Mr Dunshea endorsed the points made by Mr Robinson and thanked the GPs who stood up and spoke at the Council meeting on 4 October 2022.

8.15 Dr Chan made the point that this initiative was a centrally driven pilot with a specific objective to co-locate services to drive a new way of working. He acknowledged the limitations on communication but believed that the narrative for the Cavell Centre should be pushed centrally with the public rather than by GPs. He also believed that projects such as this need to be communicated well in advance of meetings with the Council and the public.

8.16 Mr Dunshea agreed with Dr Chan, stating that normally this kind of project would have a communication strategy prepared well in advance. A key message was evolving, particularly about protecting the GPs who are involved, and taking the initiative with communication. He queried the communication strategy going forward and suggested that a more proactive approach should be adopted.

8.17 Mr Robinson agreed with Mr Dunshea's suggestion that this Committee should have detailed assurance on the communication strategy going forward. However, he disagreed with Dr Chan's comment and believed that GP support for the project was a vital component of its success.

ACTION: Edna Boampong to provide Committee members with detailed assurance of a communication strategy and timeline for future communication regarding the Cavell Centre project as a matter of urgency.

RESOLVE: ***Primary Care Commissioning Committee Members NOTED the content of the report.***

8.18 Mr Dunshea returned Chairmanship of the Committee to Mrs Pall.

Minute No. PCCC-22.10.21 Implementation Plans – Enhanced Access from 1 October 2022

9.1 The purpose of Mrs Williams' report was to provide the Committee with information on the Primary Care Network (PCN) Enhanced Access service and to advise on the process used for the approval of the PCN enhanced access plans.

9.2 The service commenced on 1 October 2022. All PCN plans were approved. However, several PCNs had flexibilities around digital, and these were being worked through with NHSE colleagues at Region. Otherwise, the service is up and running.

9.3 These are two services that have been combined - capacity is not increased.

9.4 The Committee discussed one of the challenges faced by all PCNs which is the requirement to provide both routine and same day appointments and the requirement that several same day appointments are ring fenced. At weekends, urgent same day appointments are provided by Shropdoc who are commissioned to provide that service.

9.5 Mrs Pall referred to digital and asked how it will integrate with virtual wards.

9.6 Mrs Williams advised of feedback received from one PCN that they were experiencing difficulties with demographic import of patient information when a patient is consulting at a Practice where they are not registered. The clinical supplier can offer a solution although varying costs are being quoted.

9.7 Mrs Pall believed this to be an important issue and asked for it to be brought back to a future meeting. She requested information regarding a solution to the digital issues as it would become an integration issue going forward.

9.8 Mr Robinson confirmed that information would be brought back to the Committee regarding digital and virtual ward. A huge amount of work was being undertaken under the local care programme.

9.9 Dr Povey stated that virtual ward is an important piece of work, but he was not entirely sure how it aligned with the PCN DES. Mrs Pall confirmed that she would discuss this with Dr Povey offline.

9.10 Mr Dunshea referred to paragraph 2.8 of the report regarding Charlton Medical Practice which was still not part of a PCN and asked whether this was a concern. Mrs Williams replied that those patients do have access to Primary Care and it is not a concern.

ACTION: Mrs Williams to investigate solutions to the issues around digital including costs and information.

ACTION: Mrs Pall to discuss with Dr Povey how virtual ward aligns with the PCN DES.

RESOLVE: ***Primary Care Commissioning Committee Members NOTED the contents of the report.***

Minute No. PCCC-22.10.22 PCN Development Workshop – 31 October 2022

10.1 Mr Morgan provided a verbal update regarding the background to the forthcoming PCN Development Workshop.

10.2 In 2021-22 funding was received from NHS England badged as PCN Development funding. A decision was made by the PCNs that most of that funding should be distributed to the 8 PCNs for their own development work. However, an amount was retained to carry out an element of joint work and that funding was used to commission the King's Fund to work with each individual PCN to look at issues and processes.

10.3 That work was undertaken by six of the eight PCNs over the summer. One of the other two PCNs had already done something similar and the eighth one chose not to be involved.

10.4 Following further discussion, it was agreed to hold a Development Day. Consultants from the King's Fund will lead on that together with senior leaders from the ICB, bringing forward all the themes and issues from their work with the individual PCNs to consider solutions and next steps.

10.5 The PCNs have also requested that time is spent during the workshop examining the relationship between PCNs, the wider ICS and the part PCNs will play in the wider system.

10.6 The Agenda for the day was currently being finalised and will be issued prior to 31 October 2022. Unless agreed otherwise at the event, this will be the end of the current contract with the King's Fund.

ACTION: Mr Morgan to provide the next Committee with an update as to benefits and key learning points of the PCN Development Day to assist with evaluation of the benefits, and information as to how this will be communicated through the PCNs.

RESOLVE: ***Primary Care Commissioning Committee Members NOTED the contents of Mr Morgan's update which was provided for information only.***

Minute No. PCCC-22.10.23 Supporting PCNs Through Winter

11.1 The purpose of Ms Pyrah's report was to provide the Committee with information on national and local requirements on Primary Care for winter planning and any associated funding streams. There are both national and local sources of funding available to support winter. The details are set out in this report.

11.2 Plans are in development and the Committee will be provided with updates on progress at future meetings.

11.3 Ms Pyrah had shared the outcome of the evaluation panel with senior clinical Primary Care leaders and the accompanying caveat that it must be targeted towards specific Practices for maximum impact. Significant concern had been raised as to how that would be done and the impact it would have in terms of creating tension between Practices who do receive it and Practices who do not. Practices who do not need it now may need it during the winter pressures.

11.4 As a result, Ms Pyrah had written to the planning team to explain the rationale and to request removal of the caveat, thereby allowing the funding to be distributed as it was previously on a fair shares basis across all Practices as winter impacts equally on all Practices.

11.5 The Chair invited comments and questions.

11.6 Dr Povey supported Ms Pyrah's proposed solution of distributing the funding on a fair shares basis.

11.7 Mr Robinson undertook to work with Ms Pyrah and the planning team to make sure that this issue is resolved.

ACTION: Ms Pyrah and Mrs Tilley to work through winter planning to take account of best use of the funding. Mr Robinson to pick this up with Ms Pyrah and Mrs Tilley.

11.8 Discussion took place as to how impact from this investment would be measured. Mr Robinson advised that as part of the bidding process the funding request had to be accompanied by a set of KPIs against which it would be measured. The 28,000 additional appointments that this is likely to deliver will be tracked through winter. The leading KPI is the number of appointments. The intention is to relieve the pressure within Primary Care and to attempt to reduce the pressure on ED and all parts of the urgent and emergency care pathway.

11.9 Mrs Pall asked to receive more information relating to outcome-based impact at future Committees. Mr Robinson advised that those impacts are monitored through the Integrated Delivery Committee

ACTION: Mr Robinson to share the paper relating to winter planning submitted to Integrated Delivery Committee with Primary Care Commissioning Committee members.

11.10 The meeting discussed funding and the estimated figure required to ease pressure on A&E and ED. Mr Robinson did not believe that the answer to winter sits within funding. The constraint is not resource in financial terms; the constraint is workforce. He believed that the route in terms of moving services into the right place is the local care programme and suggested that it would be helpful for representatives of that programme to attend a future Committee to promote a better level of understanding of the programme.

ACTION: Local Care Programme representatives to attend a future Committee to provide an update as to what the programme offers in terms of alleviating the pressures on ED and A&E and moving services into primary community.

11.11 Ms Pyrah referred to the national support offer which comprised two funding streams. One stream supports this winter and is a monthly payment to PCNs to help them increase the number of clinical services and workforce to support them during the winter. The other stream is a separate funding stream which is the system development fund which links to PCN development work.

11.12 The Primary Care team were pulling together a survey to be issued to PCNs to gather their views on where they need help and support.

RESOLVE: ***Primary Care Commissioning Committee Members NOTED the content of the report which was submitted to the Committee as a discussion item.***

Minute No. PCCC-22.10.24 GP Survey Results

12.1 Ms Pyrah presented her paper relating to the results of the GP Survey. The report summarised the overall results of the survey for Shropshire, Telford & Wrekin Integrated Care System (ICS), compared against:-

- 2021 results
- 2022 national results
- 2022 ICB results for the system.
- Results at both PCN and GP Practice level against the 2022 GPPS.

- Overall, GP Practices across Shropshire, Telford and Wrekin scored equal to or above national averages. However, local results compared to the 2021 survey showed a reduction on patient satisfaction against all criteria. The largest reduction in results relates to the front door of General Practice and patients' ease of accessing the service. This compares to only a small reduction in satisfaction with the quality of patient experience during a consultation.

- Although overall average scores across the system were in line with or exceeded the national average, individual Practice scores ranged widely in some areas.

- The Primary Care and Quality teams will work with the GP Practices that scored below the national average on multiple domains of the GPPS or where scores are particularly low in one or more domain. Practice level data will also be incorporated into the planning of future Practice visits carried out by the Primary Care team and will be an area of focus where required.

- Access to online services remains a key area for improvement. The Primary Care Team is working with NHSEI on an improvement programme in conjunction with relevant teams within the ICB.

12.2 Mrs Pall asked Mr White whether he would like to see any other aspects of Primary Care included in the report.

12.3 Mr White replied that the survey was a national one and the ICB did not ask the questions. The key is what we do with the information.

12.4 Mrs Pall queried whether the report should be submitted to Quality Committee or whether PCCC needed to discuss future actions.

12.5 Mr White replied that any actions coming from the report would need to go through PCCC because the ultimate decision will be how the ICB spends the money.

12.6 Mrs Pall requested that information from the GP Survey should be triangulated against patient outcomes, patient safety and clinical effectiveness and triangulated with patient experience, the results to be submitted to a future PCCC.

ACTION: GP Survey data to be triangulated against patient outcomes, patient safety and clinical effectiveness and submitted to a future PCCC.

12.7 Mr Dunshea presumed that the GP survey was discussed within each GP Practice. Dr Chan confirmed that GP Practices are paying active attention to feedback from the survey because the survey forms a large part of CQC monitoring, especially in terms of access. However, questions had been raised about its validity in terms of the number of surveys being sent out which do not relate to the size of the Practice. Several hundred surveys had been sent to Practices with thousands of patients.

Primary Care Commissioning Committee was asked to:

- Note the 2022 GPPS results, and in particular the very high scores achieved by many Practices against the challenges of the preceding 12 months.
- Agree to receive an update from the Primary Care team at a later date on progress with those Practices that scored lowest in this year's GPPS.
- Agree to receive updates from the Primary Care team on work to support performance across specific domains e.g. online consultation, telephone access.

***RESOLVE:* Primary Care Commissioning Committee Members NOTED the content of the report and the requests as outlined above.**

Minute No. PCCC-22.10.25 Risk Register

13.1 The Risk Register had been reviewed and updated by Ms Pyrah.

13.2 A Covid funding related item had been removed as there is no more Covid funding available from the national team. This had been added to the list of closed risks.

13.3 An update was added regarding the risk relating to Highley Medical Practice which will be outlined in more detail in the Part 2 Confidential section of the meeting.

13.4 Mrs Pall asked if a Risk Register was held at Quality Committee or Audit Committee and asked how risks from other Committees were escalated into this Committee.

13.5 Mrs Skidmore advised that this Committee is responsible for overseeing the Risk Register for the area that it covers therefore PCCC was the appropriate place for the Risk Register to be reviewed. If the Committee believes that there is an escalation point, then escalation would be to the Board Assurance Framework. If there is a risk that would be detrimental to our system priorities it would be escalated to Board for discussion.

Audit Committee has a slightly different remit which is to make sure that the process is robust and there is read across between different Committees.

13.6 Ms Parker questioned whether the ICB had a risk management and escalation policy to ensure that an escalated Directorate risk would reach the Board Assurance Framework from all levels of the organisation. She suggested that this could be monitored by Audit Committee. It was usual practice that closure of risks from statutory Committees was approved by Audit Committee, an action she would like to see embedded in the ICB.

13.7 Mr Dunshea advised that work was being carried out by Nicola Dymond and Alison Smith on the Governance Framework and the Board Assurance Framework. The Risk Register will change and will become more focused on our strategic objectives to ensure and assure our delivery processes. In terms of this Committee, it would very much relate to the risks around digital, integration, virtual wards, etc. and become much more transformational than at present.

13.8 Dr Povey asked whether the Moderate rating was an accurate reflection of the potential risks around workforce including the underspend on ARRS funding and the lack of GPs. He also asked whether the Cavell development should appear on the Risk Register, as failure of the Cavell process would result in potentially problematic impacts on Shrewsbury in terms of GP provision.

13.9 Mr Morgan referred to the potential underspend on ARRS and agreed that it was a risk, but such a risk had always existed, predominantly because of the lack of staff available to be recruited rather than unwillingness to use the funding.

Mr Morgan then referred to the ongoing drop in the number of GP partners and the work being done to encourage newly qualified GPs to become partners. There are broadly the same number of GPs across our Practices but more of them are working fewer hours.

13.10 Mr White advised that the ICB Risk Register at Board level reflected the risks posed by workforce in general across the entire system.

13.11 Ms Parker replied that risks relating to operational delivery sat with Committees and groups at a lower level within the organisation and changes to those risks should be escalated and be reflected in the detail of the Board Assurance Framework. She suggested that the workforce element of the GP Strategy should be reflected in the BAF.

ACTION: Risks around ARRS and GP numbers to be reflected in the Risk Register – higher risk for GP numbers; lower risk for ARRS.

***RESOLVE:* Primary Care Commissioning Committee Members NOTED the content of the Risk Register and the suggested amendments.**

Minute No. PCCC-22.10.26 Finance Update

14.1 Ms Jones' paper was submitted to the Committee for information and summarised the Month 5 financial position for Primary Care. Key points of her paper were: -

- Co-Commissioning budgets (those delegated to the ICB from NHSE) were currently underspent by £381k with a reported full year forecast underspend of £1,051k. This mainly relates to some prior year benefits where expenditure had been slightly less than 21/22 year end estimates, an in-year underspend on ARRS (Additional Roles Reimbursement Scheme) and expected income in relation to the rates rebates efficiency scheme.

- Other Primary Care budgets had a year-to-date underspend of £2,768k and a full year underspend forecast of £914K. The main driver of this underspend is prior year benefit in relation to Prescribing and Enhanced Services which is non-recurrent in nature.

- Both the delegated and non-delegated Primary Care areas are currently anticipated to deliver expenditure less than plan this year. The Finance team are working to review the underlying position in this area, as whilst there is a benefit in 22/23, there is a risk that there will be an underlying pressure in the recurrent budget which would be carried into future years and will need to be addressed.

14.2 Ms Jones invited questions.

14.3 Dr Shepherd commented on the significant underspend on the Primary Care budget which the ICB must ensure is kept within Primary Care and used to improve and support Primary Care services.

14.4 Mrs Skidmore responded to Dr Shepherd that a large element of the figure in the report was the result of prudence in accounting assumptions.

14.5 Mr Dunshea asked whether it was possible for performance data to be included in the report in terms of numbers of attendances, visits, etc.

14.6 Dr Chan believed that the current underspend in the ARRS scheme should be recognised as a risk around the deliverability of the PCN DES which poses a risk to the outcomes of patients.

ACTION: Mrs Skidmore and Ms Jones to discuss with the Performance team inclusion of performance data in the Finance report.

ACTION: Mrs Pall and Ms Jones to discuss Primary Care financial reporting outside of this Committee and the format and content of financial updates going forward.

Minute No. PCCC-22.10.27 Primary Care Team Update Report

15.1 Ms Pyrah's report had been submitted to Committee for information only.

ACTION: Comments on the Primary Care team update report to be fed back via email to Ms Pyrah.

Minute No. PCCC-22.10.28 Any Other Business

16.1 There was no other business.

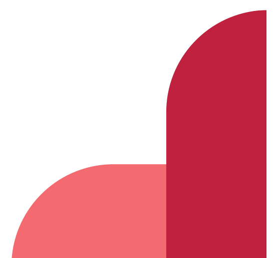
Minute No. PCCC-22.10.29 Date and Time of Next Meeting

17.1 The next meeting of the Committee will take place on Friday 2 December 2022 at 9.30 a.m. via Microsoft Teams.

17.2 The Part 1 meeting closed at 10.35 a.m.

NHS Shropshire, Telford and Wrekin Primary Care Commissioning Committee RESOLVED that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (section 1(2) Public Bodies (Admission to Meetings) Act 1960.)

SIGNED ……………………………………………… DATE …………………………………..



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Shropshire, Telford and Wrekin

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Shropshire Telford and Wrekin ICB Primary Care Committee Action Tracker
Part 1 Meeting – 2 December 2022

Agenda Item	Action Required	By Whom	By When	Date Completed
PCCC 22-07.08 Primary Care Appointments: Report to Governing Body June 2022	Ms Parker to lead a discussion offline as to how to improve communication, understand, and monitor for signs of improvement, the challenges and issues around GP access and discuss with Primary Care colleagues.	Ms Parker	October 2022 meeting	**October Update:** A paper has been requested for ICB Board in November and will be submitted to December PCCC. Dr Shepherd advised that work is already taking place on this and she will take comments made by Committee members back to the appropriate colleagues who are carrying out the work. **December Update: Agenda item**
PCCC-22.10.19 Extension to Practice Boundaries	Ms Parker to pick up the issues around out of area patients with the Primary Care team and provide an update to the December Committee.	Ms Parker	December 2022 meeting	
PCCC-22.10.20 Shrewsbury Health & Wellbeing Hub – Progress Update	Edna Boampong to provide Committee members with detailed assurance of a communication strategy and timeline for future communication regarding the Cavell Centre project as a matter of urgency.	Edna Boampong	As soon as possible	**December Update: Agenda item**
PCCC-22.10.21 Implementation Plans – Enhanced Access from 1 October 2022	Mrs Williams to investigate solutions to the issues around digital including costs and information as to how this enhanced service will help towards the virtual ward, and update a future Committee. Mrs Pall to discuss with Dr Povey how virtual ward aligns with the PCN DES.	Mrs Williams Mrs Pall / Dr Povey	December 2022 meeting December 2022 meeting	

Agenda Item	Action Required	By Whom	By When	Date Completed
PCCC-22.10.22 **PCN Development Workshop – 31 October 2022**	Mr Morgan to provide the next Committee with an update as to benefits and key learning points of the PCN Development Day to assist with evaluation of the benefits and information as to how this will be communicated through the PCNs.	Mr Morgan	December 2022 meeting	**December update: Agenda item**
PCCC-22.10.23 **Supporting PCNs Through Winter**	Ms Pyrah and Mrs Tilley to work through winter planning to take account of best use of the funding. Mr Robinson, Ms Pyrah and Mrs Tilley to pick this up. Mr Robinson to share the paper relating to winter planning submitted to Integrated Delivery Committee with PCCC members. Local Care Programme representatives to attend a future Committee to provide an update as to what the programme offers in terms of alleviating the pressures on ED and A7E and moving services into primary community.	Mr Robinson / Ms Pyrah / Mrs Tilley Mr Robinson Mr Robinson	December 2022 meeting December 2022 meeting December 2022 meeting	**December update:** Agreed that winter monies will be allocated on a fair shares basis, monitoring will be number of appointments, fill rate and DNA rate.
PCCC-22.10.24 **GP Survey Results**	GP Survey data to be triangulated against patient outcomes, patient safety and clinical effectiveness and submitted to a future PCCC.	Ms Pyrah	December 2022 meeting	**December update:** As a small team we do not currently have the available capacity to do this work.
PCCC-22.10.25 **Risk Register**	Risks around ARRS and GP numbers to be reflected in the Risk Register. Higher risk for GP numbers, lower risk for ARRS.	Ms Pyrah	December 2022 meeting	**December update:** Risk register updated to incorporate
PCCC-22.10.26 **Finance Update**	Mrs Skidmore and Ms Jones to discuss with the Performance team inclusion of performance data in the Finance report. Mrs Pall and Ms Jones to discuss Primary Care financial reporting outside of this Committee and the format and content of financial updates going forward.	Mrs Skidmore / Ms Jones Mrs Pall / Ms Jones	December 2022 meeting December 2022 meeting	

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Primary Care Commissioning Committee

Agenda item no.	**PCCC 22-12.34**
Meeting date:	2nd December 2022
Paper title	GP Access Report
Paper presented by:	Tracey Jones, Deputy Director of Partnerships and Place
Paper approved by:	Gareth Robinson, Director of Delivery and Transformation
Paper prepared by:	Emma Pyrah, Associate Director of Primary Care
Signature:	
Committee/Advisory Group paper previously presented:	NHS ICB 30th November 2022
Action Required (please select):	
A=Approval [ ] R=Ratification [ ] S=Assurance [ ] D=Discussion [x] I=Information [ ]	
Previous considerations:	

1. Executive summary and points for discussion

The purpose of this report is to provide the PCCC with the latest position on GP access performance and the challenges faced, the mitigations to address them together with information on the longer-term plans to deliver sustainable general practice.

This report has also been submitted to the ICB but at the time of circulation to PCCC members, the outcome is unknown.

Key points:-

a) General Practice are delivering more appointments now than before the pandemic
b) This additional capacity is outstripped by the significant increase in demand (estimated 30%) on General Practice resulting from the elective backlog and changing work patterns in other parts of the system.
c) It is acknowledged that for some patients they continue to experience significantly long waits to get through to the practice on the telephone, much of which is a result of the increase in demand which practice telephone systems and call handling workforce are not able to cope with.
d) The number of face to face appointments are increasing – with 7 out of 10 patients being seen face to face.
e) The limiting factors for increasing GP access are increasing demand, workforce and estate.
f) General Practice is optimising the way in which it uses its available capacity by undertaking clinical telephone triage and offering a range of modes of consultation including telephone and online and through a range of different health and non-

health professionals. Patients are therefore streamed to the most appropriate worker in the practice to meet their needs, this often does not require a GP.

g) There have been increases in some parts of the General Practice workforce compared to 2019, however, compared to 2015 there are 12% fewer GPs and 27% fewer GP partners. The attractiveness of General Practice as a job/career choice has significantly reduced due to the stress of increasing demands and increasing incidence of abusive and aggressive behaviour towards General Practice front line workers from patients and public.

h) A number of initiatives are in place to support increased General Practice recruitment and retention. This includes GP and GP Nurse (Workforce) Strategies and dedicated and targeted training and development resources and ensuring the full utilisation of the STW Primary Care Network (PCN) Additional Roles funding.

i) Although the ICB has a small number of new build and developments to existing premises projects in planning, being built or delivered in the next few years, availability of adequate, fit for purpose premises remains a significant limiting factor in recruitment and retention. This is compounded by there being no current identified source of national capital funding at the scale required to meet the need. The system therefore needs to think creatively about how it can utilise a 'One Public Estate' approach to support General Practice and needs also to maximise access to potential sources of external capital funding through such routes as Section 106 applications associated with new housing developments. Funded nationally, a PCN Estates Strategy is in development.

j) The ICB has 8 PCNs which vary in size considerably and are at different stages of maturity. The Kings Fund has been commissioned to work with each PCN to develop an organisation development plan. Key themes from this work were fed back to a joint ICB senior exec/PCN Clinical leads workshop at the end of October. A key limiting factor to developing at pace is time out from clinical work for PCN leadership to do the development work/contribute to the wider system plans.

k) National proposals for sustainable General Practice are set out in the Fuller Report published in May 2022. The key elements of this are around integration of primary and community services and redesign of same day urgent care. PCNs are at the heart of these developments and the ICB/PCNs have begun dialogue with wider system partners particularly in relation to integration. It is important to ensure that this work aligns to and complements other system change programmes, in particular the Local Care Transformation Programme. PCNs cannot achieve the Fuller recommendations alone.

l) A refresh of the Primary Care Strategy 2019-24 is planned for early next year. This needs to align with the ICB Strategy.

Which of the ICB Pledges does this report align with?

Improving safety and quality	x
Integrating services at place and neighbourhood level	x
Tackling the problems of ill health, health inequalities and access to health care	x
Delivering improvements in Mental Health and Learning Disability/Autism provision	
Economic regeneration	
Climate change	
Leadership and Governance	
Enhanced engagement and accountability	
Creating system sustainability	x
Workforce	x

2. Recommendation(s)

NHS Shropshire, Telford and Wrekin Primary Care Commissioning Committee is asked to:

Note the contents of the report and the recommendations made to ICB below when the report was considered on 30th November 2022:

a) Request PCCC to drive and review the refreshed Primary Care Strategy as a development from the overall ICS strategy and as a core component of the system five year plan
b) Request PCCC to receive and review the report from the Deputy Medical Director on the implications, opportunities and actions resulting from the Fuller report and ensure they are included in the development of the Primary Care Strategy. Specific consideration will be attached to how the PCNs are maximised in delivering the integration agenda
c) Request that PCCC urgently review telephone access, agree an improvement plan with Practices and update the Board on the progress being made
d) Request that the One Public Estate approach be looked at in regards to the future of General Practice premises.

3. Does the report provide assurance or mitigate any of the strategic threats or significant risks in the Board Assurance Framework? If yes, please detail

No.

4. Appendices

Appendix 1 – NHS STW General Practice Workforce profile by staff group 2019 to-date
Appendix 2 – PCN Additional Roles recruitment plans 2022/23
Appendix 3 – GP Retention Fund – Schedule of Initiatives

5. What are the implications for:

Shropshire, Telford and Wrekin's Residents and Communities	Improved access to General Practice services
Quality and Safety	
Equality, Diversity, and Inclusion	PCNs are targeting prevention and health inequalities
Finances and Use of Resources	
Regulation and Legal Requirements	
Conflicts of Interest	
Data Protection	
Transformation and Innovation	PCNs are at the heart of the Fuller Report recommendation for integration of primary and community services which links with the STW Local Care Transformation Programme
Environmental and Climate Change	
Future Decisions and Policy Making	

Action Request of Paper:	

Action approved at Board:			
If unable to approve, action required:			
Signature:		**Date:**	

Meeting:	
Meeting date:	
Agenda item no.	
Paper title	

Report to Primary Care Commissioning Committee

GP Access Report

2nd December 2022

1. Key facts about General Practice In Shropshire, Telford & Wrekin

1.1 There are 51 GP practices in STW with 376 GPs (headcount), 296 (whole time equivalent (wte) (as @ Sept 2022, including GP Trainees)

1.2 Shropshire has 38 GP practices covering a total registered population of 320,372. These practices vary in size from the smallest at 2,346 to the largest at 20,714 patients. Shropshire has 265 GPs (headcount), 203 (wte).

1.3 Telford & Wrekin has 13 GP practices covering a total registered population of 198,495. These practices vary much more in size than Shropshire with the smallest at 5,142 patients and the largest at 50,156 patients. T&W have 111 GPs (headcount), 93 (wte).

2. GP Access – Latest appointment activity data

2.1 The latest activity data is to the end of August 2022. The data in the table below is analysed for T&W and Shropshire individually. Compared to the same period in 2019, April to August 2022:

	.	Face to Face	Non Face to Face	Restored to pre pandemic capacity
T&W	+15,625 (+4%)	7 out of 10	46% increase	10/13
Shropshire	+41,311 (+5%)	7 out of 10	56% increase	31/38

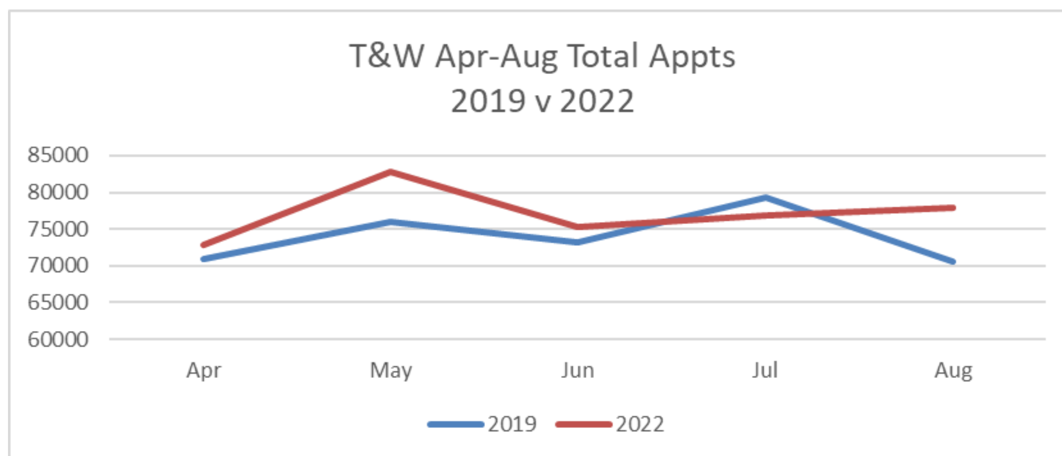
2.2 The ICB should note that by the time of the Board meeting, NHS Digital (NHSD) will have published practice level data (24 November) as laid out in the Secretary of State for Health and Social Care's "Our Plan for Patients".

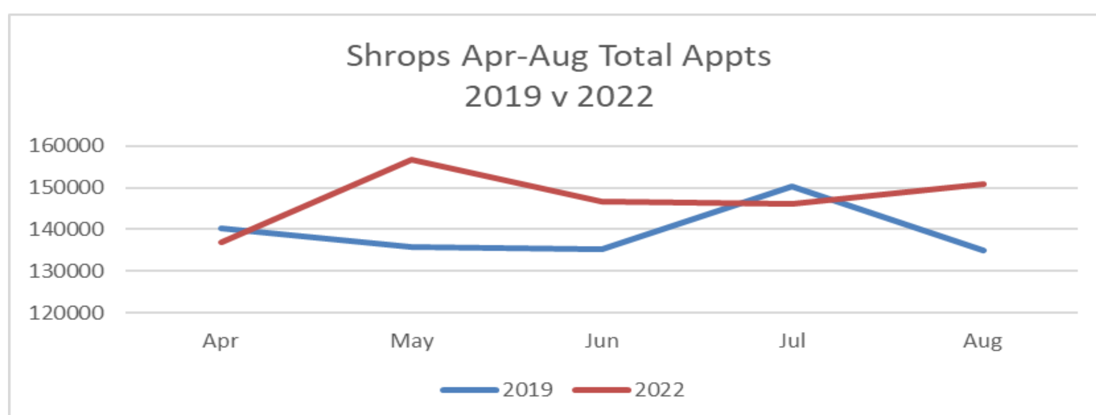
"Patients will have more information available to choose the right practice for them. From November 2022, we will publish easy-to-use data showing exactly how many appointments each practice in England is delivering and how long people wait between booking an appointment and receiving one."

2.3 It contains data for every practice in the country covering a breakdown of, for example, time between booking and appointment date, total appointments, how the patient was seen (eg telephone or in person) and who patients were seen by (eg GP or nurse). This means that for the first time ICBs and other NHS organisations as well as the public are able to view data about appointments undertaken at a local practice or compare several practices in a community, ICB area or region. The ICB has received advance restricted access to t his data so that practices who are showing low numbers have the opportunity to review to ensure that their appointment recording is accurate prior to publication.

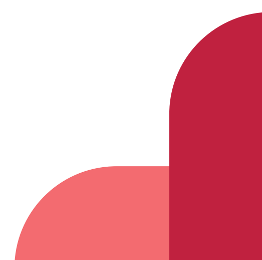
2.4 Whilst transparency about the number of appointments provided at practice level is important in supporting patient choice, the ICB are asked to note this data has limitations and does not represent the complete picture of GP workload or capacity. There is no national standard that GP practices are asked to work to when recording patient appointment information so practices may record information differently, for example activities such as reviewing test results, referrals and so on are not included, also an appointment at a care home may be recorded once, but a number of patients are seen during the visit, it does not include appointments provided via PCN staff. This means that any ranking of practices based on appointment numbers will not be a fair or appropriate reflection of either work carried out in general practice or patients' experience of access at specific practices. In summary, GPAD only measures data about appointments and is not a measure or indication of practice quality or patient care.

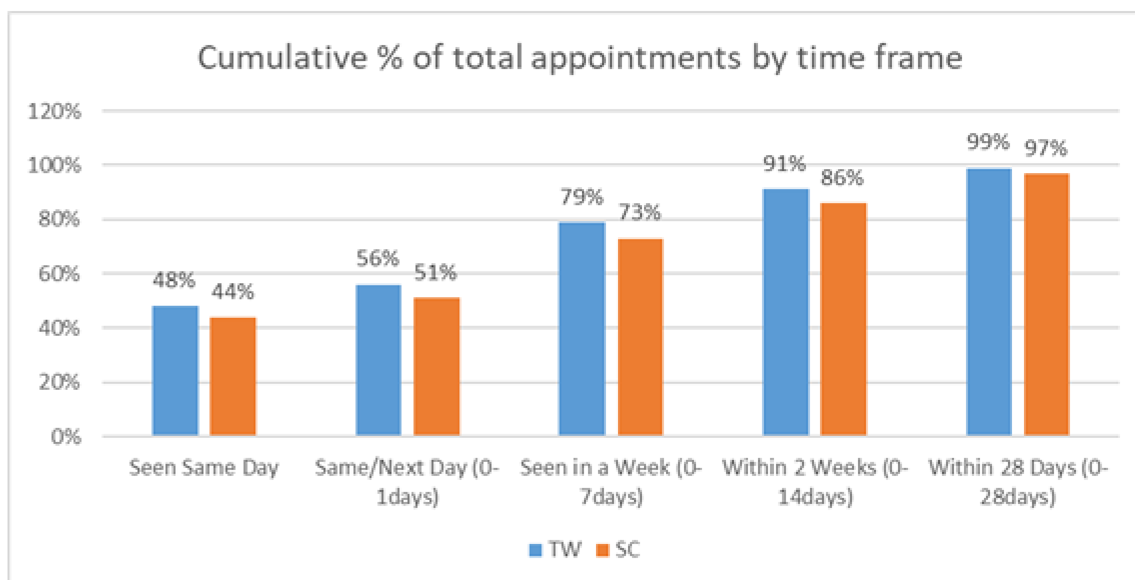
2.5 The graphs below show the appointment trends split by T&W and Shropshire practices from April to August this year inclusive compared with the same period in 2019.





2.6 The graph below shows the waiting times for appointments. This indicates that 91% of patients in T&W and 86% of patients in Shropshire are seen within 2 weeks.





3. Telephone response times

3.1 The ICB Primary Care Team is aware that some patients are experiencing delays in getting through to their practice on the telephone. The ICB does not have access to data on telephone answering waits and abandonment rates. This data is the property of and held by individual practices. The significant increase in General Practice demand in general but more particularly the increase in use of telephone triage/ appointments has put many practices telephone systems and reception capacity under significant strain.

3.2 Given the current challenges in this area then the ICB will be looking to work more closely with Practices in terms of the data that is available. Clearly, we have a collective responsibility to understand the challenges and to develop an improvement plan on this issue. Cloud based telephony is one part of this solution but there is a need to recognise that the access challenges are also linked to the numbers of people that are available at any one time to take the calls.

4. Online consultations

4.1 This mode enables patients to access an online triage service that allows them to easily seek support and self- help advice. It is accessed via the practice website. Patients can use the service to request a sick/fit note for example and to access resources that can help them manage and understand their own health.

4.2 This mode of consultation is underutilised as compared to the rest of the region. STW usage is 1.8 per 1,000 patients, currently the lowest in the West Midlands region compared to the highest area in the region which is 18.3 per 1,000 patients. NHS England regional digital team are working with STW Primary Care Team to support increase in uptake. A target of 5 online consultations per 1000 head of population was a funded incentive target in the PCN DES this year, however, this has now been deferred nationally until 2023/24 for the reasons described in section 5 below therefore given other competing priorities and pressures in General Practice this winter it is unlikely that the improvement plan will be implemented until after winter.

5. Community Pharmacy Consultation Service

5.1 The GP Community Pharmacy Consultation Service (GP CPCS) offers patients same day minor illness consultations with a community pharmacist. The service was developed to allow practice teams to refer low acuity patients for convenient, same day consultations with clinical advice.

Benefits to practices	Benefits to patients
• Improve access for patients with higher acuity illnesses or for those with complex health needs to GPs by diverting appropriate consultations to trained community pharmacists in a way that is convenient, safe and effective.	• Improved access to treatment and advice that can be provided by Community Pharmacy, where a GP appointment is not necessary. • Identify ways that individual patients can self-manage their health more effectively with the support of Community Pharmacists, and to recommend solutions that could encourage self-care for minor illness symptoms in the future.

Implementation stage	Number of practices
3 = Ready	32
2 = Engaged	15
1 = Pre- engagement	4
TOTAL	**51**

5.2 STW practices are encouraged and supported to implement GP CPCS in collaboration with colleagues from the Local Pharmaceutical Committee (LPC) and the nationally funded Primary Care Commissioning (PCC). Practices are offered resources and hands on support and training to assist them with using the software and speaking with patients. The support from PCC end in November 22, we continue to work closely with the LPC implementation lead however their nationally funded contract will cease in January 2023.

5.3 Next steps are to continue to support practices to implement the service to offer to patients and to increase the number of referrals.

5.4 Some of the reported barriers are:-

- Patients do not want to buy over the counter (OTC) medicines
- The workload in community pharmacies is also increasing
- Workforce issues in community pharmacies and general practice
- Becoming more difficult to spend the time needed to go through the process

5.4 Data on the type of conditions being referred into this service is captured. This is provided in the table below, however, there are a large number of instances where the type of condition has been stated as ‘other reason’. The Primary Care Team will try to understand why this is used and phase it out so that the data is more meaningful.

Condition	Activity	Condition	Activity
Sore throat	99	Earache Ear discharge	61 46
Skin rash	142	Eye, sticky or watery Eyelid problems Eye, red/irritable	50 15 33
Other	378	Cough	96
Diarrhoea	38	Cold/Flu	28
Bites/Stings	44	Urinary Tract Infection Pain passing urine	38 65
Vaginal itch or sore	32	Constipation	13
Acne, spots, pimples	17	Allergic reaction	14

5.5 There is an indicator in the Primary Care Network (PCN) Directed Enhanced Service (DES) Investment and Impact Fund (IIF) that incentivises PCNs to refer into GP CPCS. It is 0.65 CPCS referrals per 1,000 registered patients per week e.g. list size of 10,000 = 6.5 referrals per week. The PCN dashboard isn't showing a current position on achievement, this has been requested from NHSE.

6. Additional General Practice capacity this winter

6.1 General Practice has received 2 sources of funding for additional capacity this winter:-

6.1.1 Local system winter monies: £216,000. This has been distributed on a fair shares basis to all 51 practices to deliver additional same day appointments between October 2022 and March 2023 but with the primary focus from November to January, the anticipated peak in demand. Practices will be measured on the number of appointments offered, their fill and DNA rates. It is not possible to demonstrate a direct causal link between additional capacity in General Practice and a reduction in A&E footfall. The impact is assumed to be that in the absence of these additional General Practice appointments patients would have accessed other urgent and emergency care services including A&E.

6.1.2 National monies for PCNs: NHSE have made changes to the PCN DES contract requirements from October 2022 to release funding to be repurposed as a PCN Support Payment. This payment is to be used to purchase additional workforce and increase clinical capacity to support additional appointments and access for patients. NHSE have also introduced 2 additional roles which can be recruited to utilising the Additional Roles Reimbursement Scheme (ARRS), one of which is a GP Assistant. The Primary Care Workforce lead has shared details of the post criteria with PCNs and offered support to any who wish to recruit to these posts.

6.2 The above is significantly less funding than General Practice received to support through last winter.

7. Key challenges and constraints to improving GP access

7.1 These are threefold:-

Increasing demand

Workforce

Estates

7.2 The following sections of this report address each one of the above in turn, describing the challenges and constraints and the actions being taken to address them.

7.3 Increasing Demand

7.3.1 The elective backlog created by the necessary standing down of services during the pandemic continues to significantly impact on General Practice through increased demands as patients turn to their GP to support them whilst their tests/diagnosis and treatment are delayed. It is estimated that this has increased demand in General Practice by 30%. Examples of how the backlog is impacting are:-

a) Patients look to their GP to support them with their symptoms eg pain relief
b) Patients telephone the practice for an update on waiting times for their elective intervention or about concern having received an appointment letter due to the length of time until their appointment
c) Patients telephone the practice for diagnostic results that are delayed in reporting
d) Patient conditions deteriorate requiring more frequent or intensive General Practice support
e) The public are more anxious about their health in general because of the pandemic
f) Patients suffering from ongoing covid symptoms (Long Covid)
g) Patients suffering the mental health impact of the pandemic

7.3.2 In addition, increased demands on General Practice are created when other parts of the system change their working patterns, eg increasing requests to do referrals, actions for other people such as prescribe, refer on, talk to linked services. Some of this demand is generated because hospital and community staff are not aware they can do these things direct for themselves.

7.4 Workforce Profile in Primary Care

7.4.1 In September 2022, there were 1237 whole time equivalent (WTE) staff working in primary care across STW. The split by Shropshire and T&W is set out in the table below. The workforce data is monitored by 4 staff groups: GPs, Nurses, Direct Patient Care (DPC), Administration.

	Telford & Wrekin		**Shropshire**		**STW**	
	Headcount	**WTE**	**Headcount**	**WTE**	**Headcount**	**WTE**
GPs (including trainees)	111	93	265	203	376	296
Nurses	76	57	158	102	234	159
DPC	44	36	175	113	219	149
Admin	311	233	561	400	872	633
Totals	**542**	**419**	**1159**	**818**	**1701**	**1237**

7.4.2 Trends in the workforce profile are monitored over time. STW has data split by T&W and Shropshire by staff group from 2019. The table below shows a comparison of

the position by staff group in 2019 and September 2022, together with an indication of the highest recorded monthly number in that period.

Telford & Wrekin (wte)				
	March 2019	**September 2022**	**Variance**	**Highest recorded number in the period 2019-2022**
GPs (including trainees)	93	93	0	101 (Sept 21)
Nurses	52	57	+5	61 (June 21)
DPC	27	36	+9	40 (Sept 21)
Admin	191	233	+42	233 (May 22)

Shropshire (wte)				
	March 2019	**September 2022**	**Variance**	**Highest recorded number in the period 2019-2022**
GPs (including trainees)	189	203	+14	209 (Jan 22)
Nurses	89	102	+13	102 (Sep 22)
DPC	84	113	+29	115 (Aug 22)
Admin	352	400	+48	404 (Aug 22)

7.4.3 The full trajectory of the workforce profile is provided at Appendix 1. The key message from above is that for T&W the workforce gains made in 2021 have not been maintained but the picture in Shropshire is better. However, whilst the increases in workforce noted above compared to pre-pandemic are showing encouraging signs, compared to 2015 there are 12% fewer GPs and 27% fewer GP Partners.

7.4.4 There are significant challenges to recruitment and retention of General Practice staff because:-

a) They have worked tirelessly to keep General Practice open during the pandemic and the increasing demands mean that an increasing number of staff are approaching burn out. This has been compounded by media stories indicating that General Practice is or has done less than other providers during the pandemic
b) The demands on General Practice are unprecedented and continue to increase.
c) Incidence of patient abusive or aggressive behaviour towards staff on the telephone or in person has increased significantly
d) The above makes General Practice as a job/career choice unattractive
e) Challenges of recruiting in rural practices (cost of living etc)

7.5 Initiatives to increase the General Practice workforce

7.5.1 **PCN Additional Roles Reimbursement Scheme (ARRS)** – Introduced in 2019, the objective of the Network Contract DES was for primary medical services contractors to establish and develop PCNs whereby local practices group together to deliver services in their local area (it was envisaged that each PCN would have a patient size of 30-50,000).

PCNs have received national investment to increase the General Practice workforce. They can recruit to a range of specified roles. The 8 PCNs in STW have been given an annual allocation of £8,481,699 in 2022/23 for ARRS roles. Plans are in place to recruit to 200 ARRS roles by the end of March 2023 (based on August submission). A breakdown of the planned number of posts by type by PCN is provided at Appendix 2. Numbers reported in post in October 2022 were 180. The planned 200 roles, however, only utilise 80% of the PCNs' allocation.

The challenges faced by PCNs in utilising their full allocation and the actions taken to mitigate them are:-

Challenge/constraints	Mitigation
Lack of Human Resource capacity/ expertise within the PCN to support effective recruitment	Outsource the work
Lack of suitable available candidates	Ensure maximum flexibility in the application of the criteria for the posts
Employment arrangements – PCNs cannot employ staff as they are not an 'employing organisation'	Some PCNs have or are considering creating limited companies to enable direct employment Partnering arrangements with other practices or other providers to employ/host the posts
Some of the criteria for the posts is restrictive in terms of the number each PCN can recruit to as well as other elements	Ensure maximum flexibility in the application of the criteria for the posts. NHSE announced in October 2022 some additional flexibilities to some of the posts and the introduction of 2 new posts a) GP Assistant and b) Digital and Transformation Manager
Lack of suitable available estate to accommodate these additional roles. ICB annual business as usual capital allocation is not sufficient to accommodate the needs of 51 practices and the PCN ARRS roles. Currently there is no alternative source of national capital. Any extension/increase in primary care estates has a revenue consequence for the ICB for which it does not have an identified source of funding	Needs to be tied in with the wider One Public Estate work Nationally funded programme to support each PCN to develop a workforce and estates strategy. It is hoped that NHSE will use this information to prioritise capital funding for General Practice estates in the next spending review. Maximise uptake of potential external sources of funding for estates
STW is a small system with limited cross border movement of workforce. If PCNs are successful in recruiting, the risk is it depletes another local providers workforce	Need to be tied into a One System Workforce Strategy Introduction of hybrid approach to roles for example – clinical pharmacists
ARRS funding is for the salary costs, there is no additional funding for other costs such as IT	Bid to NHSE for additional digital monies potentially available through the national winter programme Factor into IT budget setting for 2023/24
A lack of knowledge in some organisations/PCNs about how new	The Training Hub has recruited a number of Clinical Facilitators to provide peer support and

roles can be utilised as part of multi-disciplinary teams to support service delivery. A lack of understanding about the level of clinical support and supervision the new roles need whilst transitioning into primary care.	develop a full support package for PCNs and clinicians. They also help in raising awareness of the scope of practice for the roles in the context of supporting service delivery.

7.5.2 GP (Workforce) Strategy

Earlier this year the Primary Care Commissioning Committee approved a new GP Strategy. In line with the STW ICS People Plan, and workforce strategies in other systems, the strategy is based around attracting, recruiting and retaining GPs. It incorporates actions covering the following interventions: -

Key Interventions	8 Key Intervention Stages
• Marketing the role of the GP • Supporting the recruitment and deployment of GPs • Engaging and networking • Ensuring that professional development is available • Ensuring that personal support is available • Developing career opportunities/new ways of working	• School/sixth-form students choosing medicine courses at universities • Medical Students • Foundation Year Doctors • GP Trainees • Newly-Qualified GPs • First5 GPs • Mid-Career GPs • Late-Career GPs

The supporting action plan contains over 50 actions, and 50% of those actions are already underway. The Primary Care Team is small and therefore does not have the capacity to take forward all the actions at one time. Together with a group of GPs and Practice Managers the action plan has been prioritised to ensure maximum impact as early as possible. Prioritised actions that need funding to be implemented have been included in the Local GP Retention funding plan which is now being implemented (the schedule of projects being funded is provided at Appendix 3).

7.5.3 Training and Development

A procurement exercise was undertaken with STW ICB emerging as the preferred bidder to host an ICS Training Hub. Training Hubs are a Health Education England (HEE) initiative to support primary care workforce transformation. The contract ensures that the system receives both infrastructure and development funding for the next 3 -5 years to deliver against key workforce priority areas. In relation to GP Access, the Primary Care Workforce and Training Hub team, which sits within the ICB Primary Care team, currently support the following initiatives to create workforce capacity:-

- **ARRS roles** - supporting embedding these new roles into primary care. Through the recruitment of ARRS Facilitators, various support programmes for these new roles transitioning into primary care have been put in place. These include peer support networks, training and clinical supervision needs assessments and plans to address these as well as access to preceptorship programmes, all of which support recruitment and retention of these roles. Furthermore, support is provided to PCNs to recruit to these roles.

- **Workforce training and development –** the training hub offers a comprehensive training and education programme to all clinicians to support upskilling, new ways of

working and supply. The programme is wide ranging and provides opportunities for clinicians to upskill and advance their practice by providing access to funding and training. This in turn creates capacity within teams and supports retention. The programme also includes support for the required blend of remote and face-to-face consultations through the provision of triage and video group consultation training.

- **Recruitment and supply –**The recruitment of newly-qualified clinicians is supported by the Fellowships and Preceptorship programmes. The hub also supports and coordinates access to Apprenticeship programmes to support supply and enable PCNs to develop existing staff and grow their own to create capacity and appropriate skill mix to deliver services. In addition, the Hub links into local Higher Education Institutes to coordinate student placement within primary care to support supply and recruitment as exposure to general practice is crucial in influencing a career choice in primary care.

- **The Nursing workforce -** The Training Hub supports the general practice nursing workforce through the delivery of the objectives of the STW GPN Strategy. The workstreams to support this include the co-ordination of STW allocations for the Fundamentals of GPN programme to support nurses new to general practice, student nurse placement, GPN to Advanced Nurse Practitioner pathway, HCA development programme, Nurse Associate Apprenticeship programme, careers events, GPN and HCA education forums and clinical supervision planning

7.6 Estates

7.6.1 The ICB has an annual business as usual capital allocation for General Practice of £300,000 which has to cover 73 practice sites (including branch surgeries). This is only sufficient to support minor expansions/improvements to practice premises. Historic larger sources of capital funding for General Practice ceased in 2019 when the Estates Transformation and Technology Fund (ETTF) stopped. Other than the national Cavell programme (of which Shropshire is one of the 6 pilots) there is no other source of NHS capital funding for large GP estates developments. ICB should also note that expansion of General Practice premises can have revenue consequences for the ICB for which there is only a very limited source of funding.

7.6.2 Examples of current and in planning new builds for STW are:-

- **Shawbirch** – opened in July 2022 – current patient list size around 13k – planned housing bringing around 5k additional patients – building sized for 22,000
- **Shifnal** – about to start – completion by Dec 2023/Jan 2024 – current list size c12k – building sized for 20k patients
- **Whitchurch** – Pauls Moss development – current list size is around 15k – building sized for 20k+ - started February 2022 – completion by Sept 2024
- **National Cavell Programme** – colocation 6x South Shrewsbury GP practices with additional space to accommodate PCN staff, Community Trust services and left shift activity (incl diagnostics) – current list size of 6 practices c45k, new building would be sized for 60k+ patients (and additional services). This development is in the planning stage and funding is subject to NHSE approval of a Full Business Case.

7.6.3 Current estates improvement schemes funded by our annual capital allocation which will impact positively on improving access are:

a) **Stirchley** – creating additional 2x clinical rooms – this is mainly aimed at creating space in advance of the development planned for The Hem (around 350 houses = 900 patients)
b) **Broseley** – creating additional 3x clinical rooms (this will absorb most of the patients coming into the area from the Ironbridge Power Station development – around 1,100 houses = 2,750 patients)
c) **Wellington Road** – creating an additional 3x clinical rooms – addresses the need for more space resulting from housing development around Newport area – around a 1,000 houses planned for development over next 5-10 years (extra 2,500 patients)

7.6.4 The Primary Care Team Estates lead is also looking to maximise potential external sources of funding through such routes as Section 106 Planning Obligations which are a means to get property developers to agree to make a capital contribution towards healthcare to offset the impact (and cost) caused by the increased population resulting from the development they are undertaking. The aim is to create an additional pipeline of capital funding to enable new builds/extensions. Six applications have been made to-date but only 1 confirmed @ £915k – outstanding remainder totals around £1.7m.

7.6.5 The Board are asked to support, via partners, the opportunities that exist with the One Public Estate approach to support the premises challenges faced by local Practices. There is very little capital available, as detailed, yet the need for integration with partners has never been greater.

8 Longer term General Practice developments

8.1 PCN Development

8.1.1 There are 8 PCNs in NHS STW. They vary in size (as can be seen from the table below). It is a requirement that every PCN has a Clinical Director.

PCN	Population size	No. of practices	Clinical Director
Shrewsbury	127,734	16	Charlotte Hart
SW Shropshire	36,389	6	Finola Lynch
SE Shropshire	58,989	9	Jess Harvey
North	90,391	7	Tim Lyttle
Teldoc	61,621	2	Ian Chan, Rashpal Bachu
SE Telford	37,895	3	Nitin Gureja, Melanie Thompson
Wrekin	47,147	4	Derek Ebenezer, Nav Singh, Rohit Mishra
Central and Newport	57,904	4	Stefan Waldendorf

8.1.2 The Network Contract DES is updated annually and forms part of a long-term, larger package of general practice contract reform. It is intended that there will be a Network Contract DES each financial year until at least 31 March 2024 with the requirements of the Network Contract DES evolving over time.

8.1.3 The PCN DES includes a number of service requirements which PCNs must deliver as well as a number of incentive targets (IIF) for which PCNs receive payment if achieved. The primary focus for the PCN DES for 22/23 is:-

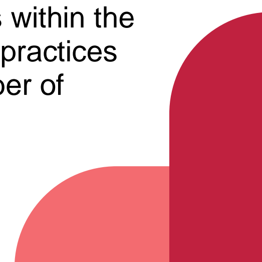
- **Enhanced Access** – 6.30-8pm Monday to Friday, 9-5 Saturday, same day and bookable in advance including digital modes of accessing appointments
- **Health in Care Homes** – lead GP, MDT approach, weekly ward rounds Enhanced, personalised plan
- **Early Cancer Diagnosis** – cervical, bowel, prostate, skin
- **Learning Disability/Severe Mental Illness Annual Health Checks** – identify and on the register, receiving annual health check
- **Cardiovascular Disease** – improve diagnosis of hypertension (more blood pressure checks), improve identification of atrial fibrillation (pulse checks), early identification of heart failure
- **Structured medication reviews** for those who would most benefit
- **Anticipatory care** – contribute to the design and development of the system model (in line with the soon to be published national model)
- **Targeting Health Inequalities**/Social Prescribing

8.1.4 Although established in 2019, PCNs are at different stages of development and maturity which was hindered by the pandemic and the PCNs necessary focus on supporting the covid vaccination programme.

8.1.5 This year the PCNs used some of their national development monies allocation to commission the Kings Fund to work with each individually to develop an Organisation Development Plan. This piece of work culminated in a workshop at the end of October attended by the PCN leaders and senior members of the ICB to hear the key themes of the Kings Fund exercise and agree next steps. This included both how the PCNs can support each other and also how the ICB and ICS can support. One of the key challenges, particularly for the smaller PCNs, in their further development, delivering impact and influencing the wider system programmes of change is clinical leadership and management capacity/time/headspace. As a first step to address this, in November the PCNs agreed to top slice some of their national PCN Development Fund and divide it equally (rather than on a fair shares basis) amongst the 8 PCNs so that each has equal access to funds to facilitate backfill for an additional day per month of Clinical Director time.

8.1.6 The ICB is also considering ways to address this as we move into the next focus for PCNs on integration with other services as set out in the Fuller Report. This also forms part of a dialogue currently underway to ensure that the wider GP voice is loud and strong in the system following the transition from a CCG (GP membership organisation) to an ICB (where General Practice are one amongst all the other providers within the system). There is work underway, led by Dr Deborah Shepherd, to ensure that there is an effective system for the GP Voice to be heard going forward.

8.1.7 It should also be noted that PCNs are at different stages of where their focus should be, some are focussed purely on their national service contractual requirements, others are looking wider than the DES to developments within the place based ICS work. Similarly there are differences in the way that practices view the PCNs status within the ICS. Feedback indicates that a number of



practices see the PCNs as only there to fulfil the delivery of the DES and question PCN involvement, or place, when talking about wider service changes.

8.1.8 PCN Development is a standing agenda item at the Primary Care Commissioning Committee.

8.2 Professor Claire Fuller's National Stocktake Report 'Next Steps for Primary Care Integration' May 2022

8.2.1 In November 2021 Amanda Pritchard asked Professor Claire Fuller, CEO designate Surrey Heartlands ICS and GP, to undertake a stocktake on integrated primary care, looking at what is working well, why it's working well and how the implementation of integrated primary care (incorporating the current 4 pillars of general practice, community pharmacy, dentistry and optometry) across systems could be accelerated. The review report was published at the end of last month.

8.2.2 The Fuller report set out the current context of General Practices as follows:-

a) Every day, more than a million people benefit from the advice and support of primary care professionals – acting as a first point of contact for most people accessing the NHS and also providing an ongoing relationship to those who need it. This enduring connection to people is what makes primary care so valued by the communities it serves.

b) Despite this, there are real signs of genuine and growing discontent with primary care – both from the public who use it and the professionals who work within it.

c) Inadequate access to urgent care is having a direct impact on GPs' ability to provide continuity of care to those patients who need it most. In large part because of this, patient satisfaction with access to general practice is at an all-time low, despite record numbers of appointments: the 8am Monday scramble for appointments has now become synonymous with patient frustration.

d) At the same time, primary care teams are stretched beyond capacity, with staff morale at a record low.

e) Left as it is primary care as we know it will become unsustainable in a relatively short period of time.

8.2.3 The report goes on to describe a new vision which includes helping people to stay well for longer, redesign of same day urgent care and integrating primary care bringing together previously siloed teams and professionals to do things differently to improve patient care for whole populations.

8.2.4 It suggests this is usually most powerful in neighbourhoods of 30-50,000, where teams from across primary care networks (PCNs), wider primary care providers, secondary care teams, social care teams, and domiciliary and care staff can work together to share resources and information and form multidisciplinary teams (MDTs) dedicated to improving the health and wellbeing of a local community and tackling health inequalities.

8.2.5 All 42 ICS Chief Executives signed a letter of support for submission with the review report and a commitment to implement the necessary changes, however, nationally and locally the report has received a mixed reception from the GP body.

8.2.6 The national response is awaited, however, STW have begun to consider how best to take the recommendations forward and in what priority order. It is important to note that the Fuller report does not just involve General Practice, it is a call to the system to redesign how services are delivered and integrated. Therefore it is important that our next steps link in with rather than duplicate work already underway or planned in the wider system. A key alignment will be with the Local Care Transformation Programme and the PCNs have begun a dialogue with Shropshire Community Health NHS Trust about how they can jointly take forward integration initiatives.

8.2.7 Dr Deborah Shepherd, Deputy Medical Director and lead for Primary Care and PCN development has taken a report to SHIPP and TWIPP to introduce the Fuller recommendations and commence a dialogue about how the system can support PCNs as they cannot achieve the Fuller requirements alone. The actions required to deliver the Fuller requirements will be incorporated in our primary care and related strategies and action plans.

8.3 Overarching Primary Care Strategy

8.3.1 There is an existing Primary Care Strategy covering the period 2019-2024. The plan was to refresh this in 2020 but this was paused due to the pandemic. The Primary Care Strategy will be refreshed in the next 6 months focused on the delivery of the ICB and ICS strategy and outcomes. Ideally a more ambitious view through the PCNs needs to be designed. Key challenges to delivery of the strategy is how general practice is funded and resourced. This needs to have the integration strategy central to its recommendations and core focus.

8.3.2 The potential opportunities that may be available with the other primary care services (Pharmacy, Optometry, Dentistry) being delegated to ICB's from April 2023 will need to be fully explored (notwithstanding the contractual restrictions).

8.4 Primary Care Estates Strategy

8.4.1 In 2022/23 NHSE have funded and commissioned external resources to support a programme of work with PCNs to develop workforce and estates strategies. This work with individual PCNs is due to complete by January 2023. These individual plans will be consolidated to form the ICB Primary Care Estates Strategy and will be fed up to the national team along with all other systems to inform the national estates and funding programme for the future.

APPENDIX 1 – General Practice Workforce Profile

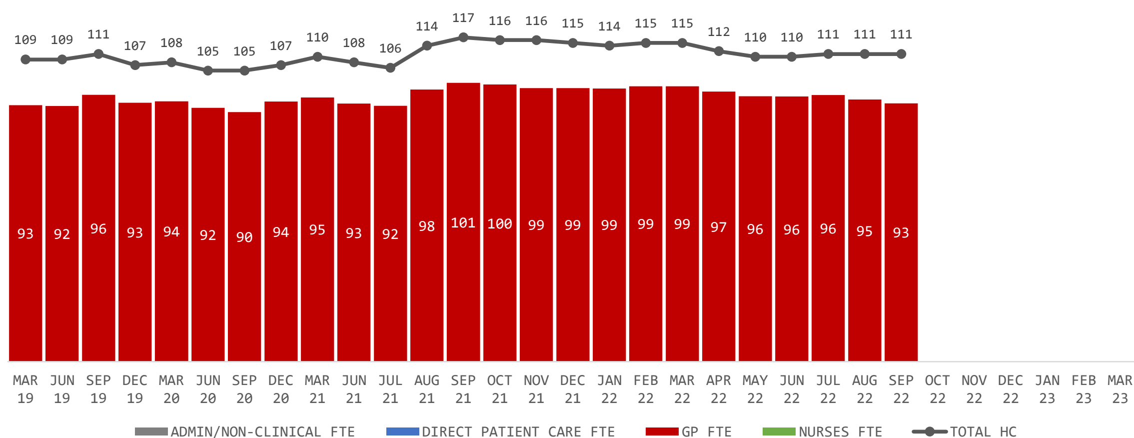
Workforce Data September 2022 – Overview

	Telford & Wrekin		Shropshire		ICS	
	HC	WTE	HC	WTE	HC	WTE
GPs	111	93	265	203	376	296
Nurses	76	57	158	102	234	159
DPC	44	36	175	113	219	149
Admin	311	233	561	400	872	633
Totals	542	419	1159	818	1701	1237

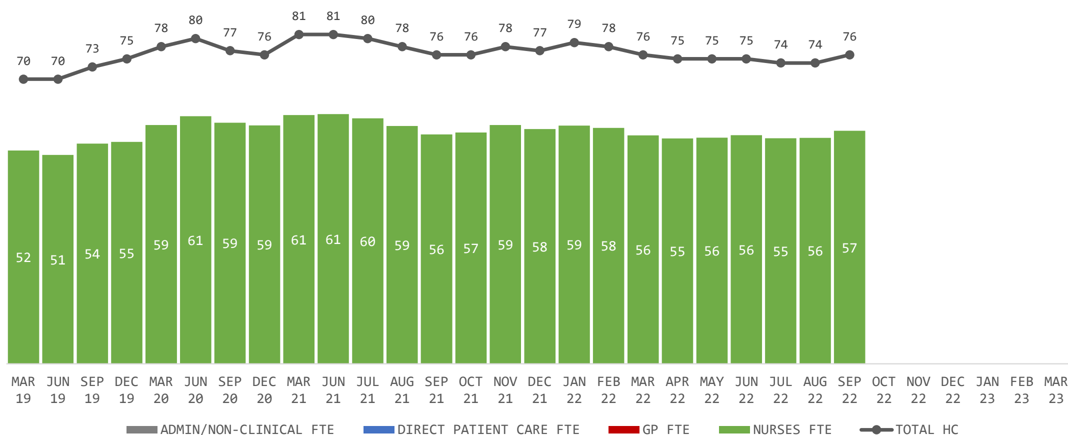
Workforce Data September 30th, 2022 – the 13 Telford Practices

NB: Headcount (line) and WTE (bars)

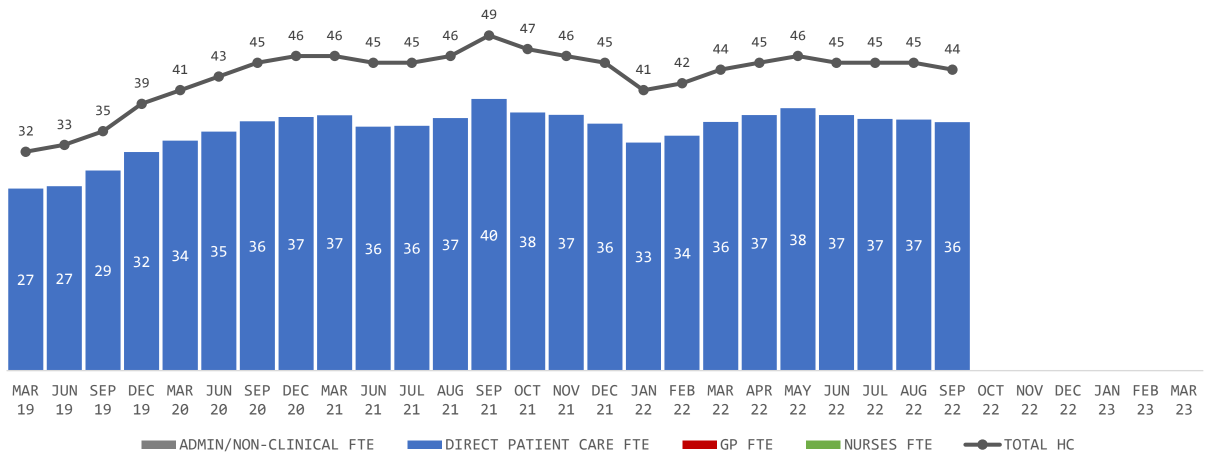
GPs (including Trainees)



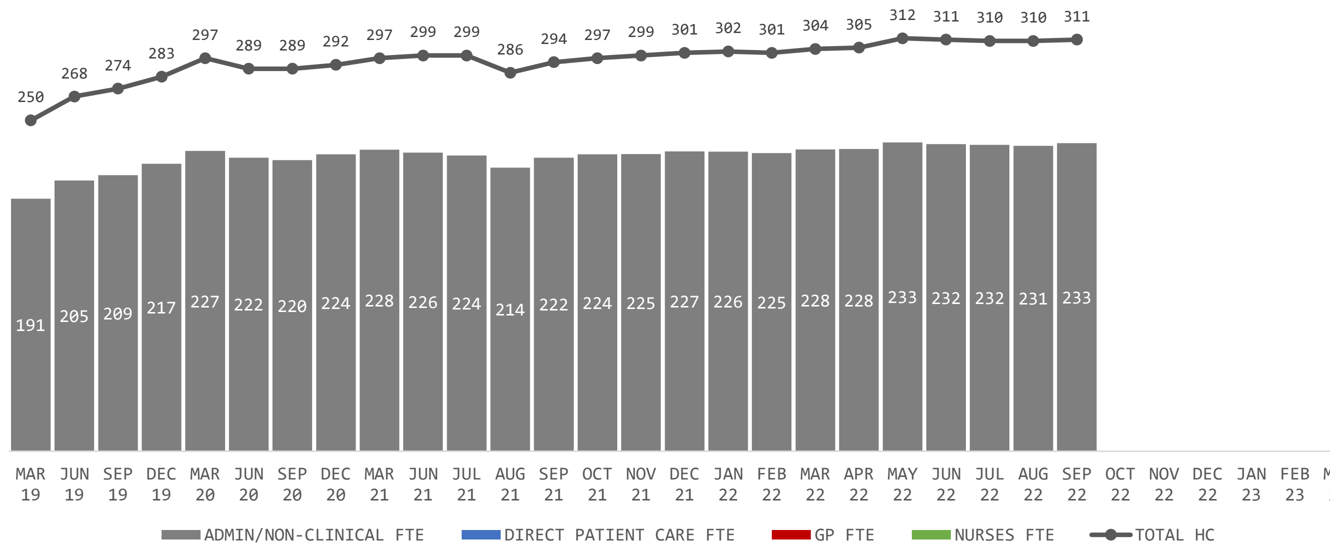
Nurses

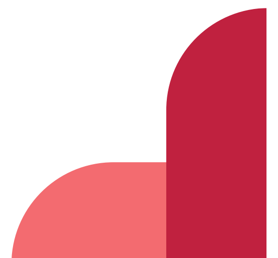


Direct Patient Care



Admin

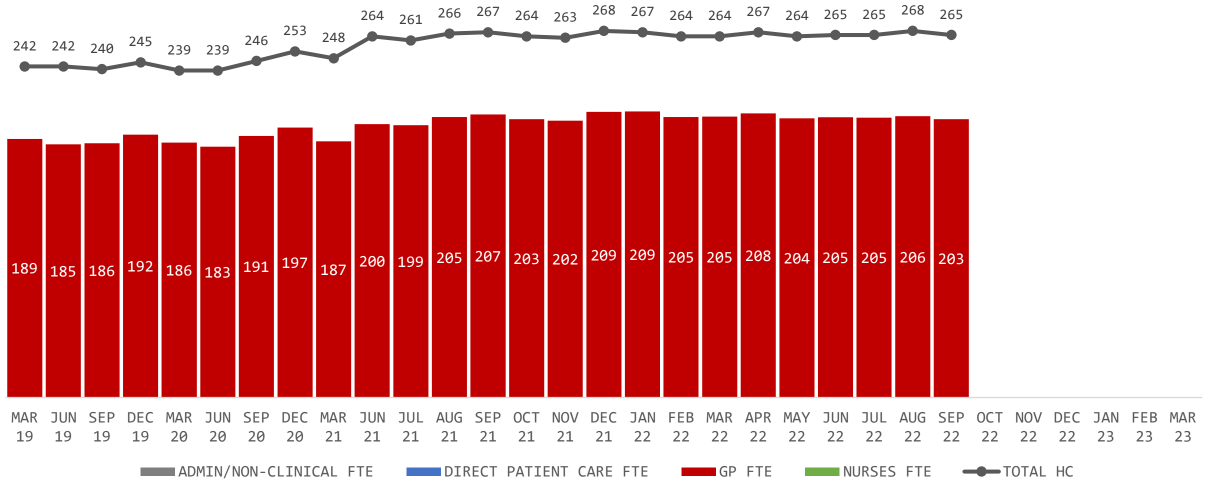




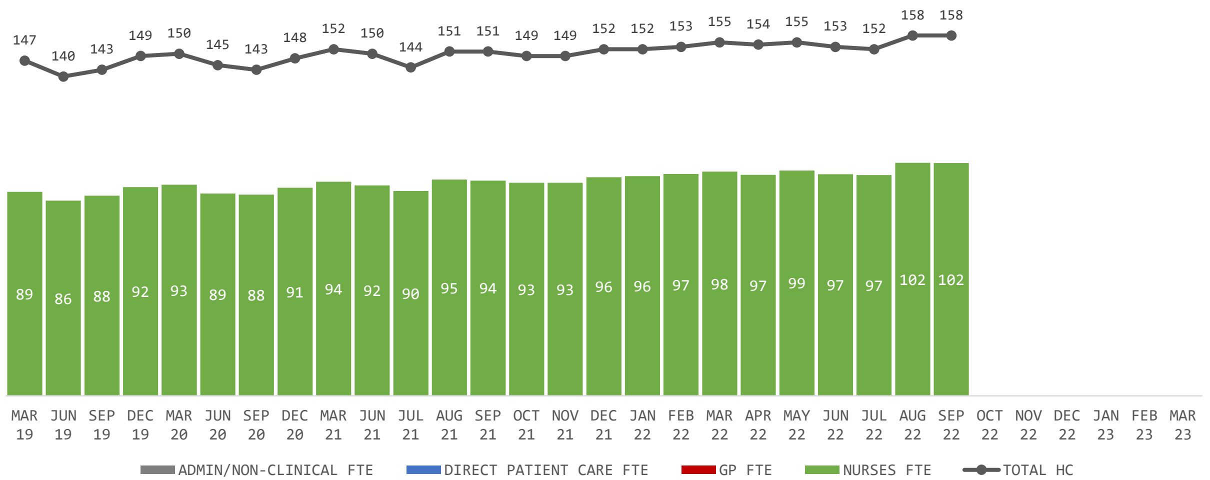
Workforce Data September 30th, 2022 – the 38 Shropshire Practices

NB: Headcount (line) and WTE (bars)

GPs (including Trainees)



Nurses



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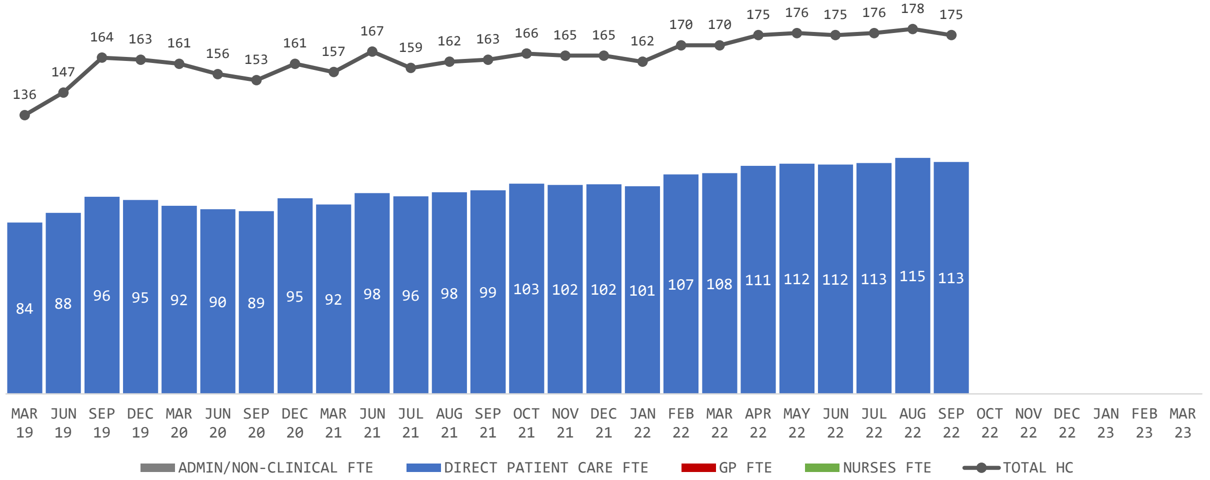

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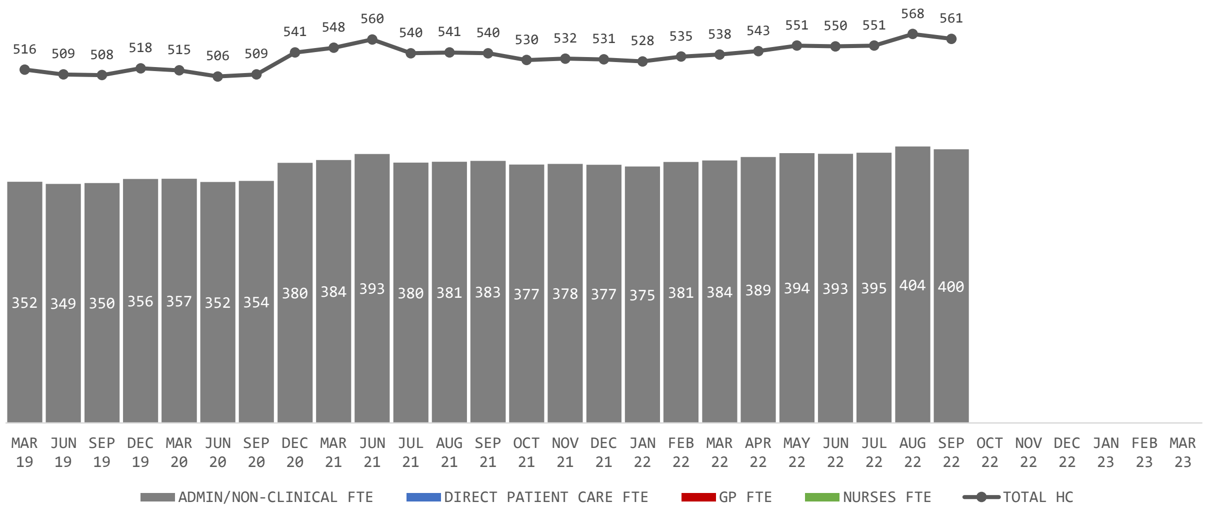

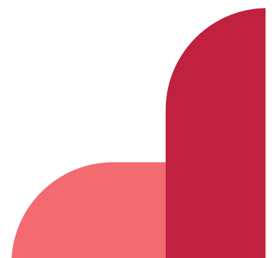

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APPENDIX 2 – PCN Additional Roles Reimbursement Scheme (ARRS) recruitment plan 2022/23 (based on August 22 submission)

Summary of Formal, Submitted Plans @ August 2022

NB all figures are FTE

PCN	Year	Care Coordinators	Clinical Pharmacists	Dieticians	First Contact Physios	Health & Wellbeing Coaches	Adult Mental Health Practitioners	CYP Mental Health Practitioners	Nursing Associates	Occupational Therapists	Paramedics	Pharmacy Technicians	Physician Associates	Podiatrists	Social Prescribing Link Workers	Trainee Nursing Associates	Totals
North Shropshire	22/23	1.6	7	1	2.75	1	0.5			2.75	3	2	4		3.83		29.43
Shrewsbury	22/23	9	8	1.6	4.2	4	2	1			5.32	5	4	0	6.4		50.52
South West Shropshire	22/23	2	3.5	1	2	2	2			1	1	2	1		3.5		21
South East Shropshire	22/23	4	5	1	3	3	1	1			1	1	2	1	4		27
Teldoc	22/23		5		2						1	1	3		3		15
Wrekin	22/23		4		1		1		2						2		10
Newport & Central Telford	22/23	2	4	1	3	2	1			1	3		4		5		26
South East Telford	22/23	5.5	1		1.8	1	2		2			1		1	5		20.3
Total	22/23	24.1	37.5	5.6	19.75	13	9.5	2	4	4.75	14.32	12	18	2	32.73	0	199.25

APPENDIX 3 – Schedule of Initiatives to Support Delivery of the GP Strategy funded through the GP Retention Fund

Project/Initiative	Comments
Supervision Training	A course for local GPs who are not trainers, but who are increasingly involved in supervision of trainees in their practices. groups of GPs who would benefit are: ➢ Fellowship GPs who have no supervisory experience and may want to "test the water" to see if they would like to go on to become GP trainers ➢ Any other GPs working in training practices, where they themselves are not trainers, but who regularly carry out trainee supervision ➢ Shropdoc GPs who supervise trainees on out of hours shifts ➢ Any GPs from non-training practices who may be involved in supervision of ARRS staff (e.g. physicians associates, pharmacists etc.)
Clinical Supervision Pilot	The pilot would be carried out across the South East Shropshire PCN in those practices wishing to take part. The expectation will be for GPs to be paired together and meet for two separate one-hour sessions each month with the role of supervisor and supervisee reversing for the second session. This hour will be protected time within the clinical working day and the meeting can be face to face or online depending on the preference of those paired.
ED Network Chair	One session a month for a GP to lead the development of the Ethnically Diverse Primary Care Staff Network
First 5s Network	Funding for two joint leads plus commissioning of training and development events. The joint leads to be funded at 1 session a month each.
Research	Commissioning a research project looking into a range of topics/issues. Specific areas where research/surveys should take place include understanding the career choices of GP Trainees, getting more data on Locums and discovering the key issues that would assist in the retention of mid to late career GPs. The possible cost amount is an estimate - we will need to confirm this and either expand or retract the extent of the research depending on the costs.
ED Champion	We currently fund an ethnically diverse GP Champion at one session a month – this has proved successful in providing support to IMG doctors. Increase the funding to 2 sessions a month, with increased focus on smart outcomes and deliverables.
Sponsoring Practice Worker	Given the large rise in the number of International Medical Graduates (IMG) doctors on our Vocational Training Scheme (VTS) and the slow growth of practices choosing to become sponsoring practices this role will publicise the scheme and provide hands-on support and guidance to individual practices and/or PCNs who are considering applying to become a sponsoring practice. The challenge will be to find someone with the necessary skills and knowledge – funding for two sessions a month

Project/Initiative	Comments
Reimbursement for Practice Sponsorship Fees	As an incentive to encourage practices to apply to be a sponsoring practice offering reimbursement of their fees - normally around £500 per practice.
Differential Attainment Support	Anecdotally we know that there are a number of IMG doctors on our VTS who face additional challenges in successfully completing the exams and assessments. HEE West Midlands are addressing this issue and this proposed project will seek to learn from the HEE work and commission relevant, additional training and support for specific IMG doctors.
Marketing Role	Funding for a GP and/or a PM (possible joint role) to design, develop and implement a series of marketing activities aimed at the following groups: 6th Form Students considering studying medicine at University, Medical Students and Foundation Year doctors. The role would also involve visits, talks and presentations. Two sessions a month.
Recruitment Support	Commissioning an external recruitment professional to develop a suite of recruitment tools for use by practices. The role would involve some initial work to understand the specific needs of practices and then to produce the required information/tools.
Career Breaks role	Funding for a GP and/or a PM (possible joint role) to develop information resources and tools to provide information to GPs (mainly mid to late career) who are interested in taking career breaks. Two sessions a month.
Women's GP Network lead	Funding for a GP to set up and run a Network dedicated to addressing the specific issues encountered by female GPs including (but not exclusively) childcare, return to work, menopause and part-time working). Two sessions a month.
Older GPs Network lead	Funding for a GP to set up and run a Network dedicated to addressing the specific issues encountered by older GPs including (but not exclusively) retirement planning, pensions, and part-time working. Two sessions a month.
Locum support	Provision of funding to the Shropshire Sessional GP Network to provide specific, dedicated training/development events/opportunities for the Network members.
Locum Lead	We currently fund a "Newly-Qualified GP Locum Champion" at one session a month – this has proved successful in providing support to doctors coming off the VTS and considering working as a Locum. The proposal is that this role is widened to include all Locums and to increase the funding to 2 sessions a month, with increased focus on smart outcomes and deliverables.

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PRIMARY CARE COMMISSONING COMMITTEE

Agenda item no.	**PCCC 22-12.35**
Meeting date:	2nd December 2022
Paper title	GP Community Pharmacy Consultation Service (GP CPCS)
Paper presented by:	Bernadette Williams
Paper approved by:	Claire Parker, Director of Partnerships and Place
Paper prepared by:	Bernadette Williams
Signature:	B Williams
Committee/Advisory Group paper previously presented:	N/A

Action Required (please select):									
A=Approval		R=Ratification		S=Assurance		D=Discussion		I=Information	

Previous considerations:	

1. Executive summary and points for discussion

The purpose of this report is to provide the committee with information on progress with implementation of the GP Community Pharmacy Consultation Service (GP CPCS).

Since January 2022, there has been steady progress with implementation of the service and an increase in the number of referrals into community pharmacies.

The aim of this service is to alleviate pressure on GP appointments, because every referral made is a practice appointment freed up. It is believed that 6-10% of practice appointment capacity could be effectively directed into community pharmacy.

Which of the ICB Pledges does this report align with?

Pledge	
Improving safety and quality	
Integrating services at place and neighbourhood level	x
Tackling the problems of ill health, health inequalities and access to health care	x
Delivering improvements in Mental Health and Learning Disability/Autism provision	
Economic regeneration	
Climate change	
Leadership and Governance	
Enhanced engagement and accountability	
Creating system sustainability	
Workforce	

2. Recommendation(s)

NHS Shropshire, Telford and Wrekin PRIMARY CARE COMMISSIONING COMMITTEE is asked to:

Note the contents of this report.

Consider what / if further support needed post January 2023

3. Does the report provide assurance or mitigate any of the strategic threats or significant risks in the Board Assurance Framework? If yes, please detail

N/A

4. Appendices

Graph - Total pharmacy consultations by month.

Graph – Consultation outcome.

Graph – Types of Minor illness.

Table – Regional Integrated Care System (ICS) position for October 2022.

Case study – Stirchley Medical Practice.

5. What are the implications for:

Shropshire, Telford and Wrekin's Residents and Communities	Managed referral route to access Community Pharmacy services for minor illness.
Quality and Safety	Patients with a minor illness are referred safely to community pharmacy.
Equality, Diversity, and Inclusion	Patients entitled to free NHS prescriptions unlikely to purchase over the counter medicines.
Finances and Use of Resources	Service is funded via NHS E
Regulation and Legal Requirements	No implications
Conflicts of Interest	No implications
Data Protection	No implications
Transformation and Innovation	
Environmental and Climate Change	No implications
Future Decisions and Policy Making	No implications
Citizen and Stakeholder Engagement	Practices/PCNs promotion of the service.

Action Request of Paper:			
Action approved at Board:			
If unable to approve, action required:			
Signature:		Date:	

Meeting:	
Meeting date:	
Agenda item no.	
Paper title	

1. Background

The GP Community Pharmacy Consultation Service (GP CPCS) offers patients same day minor illness consultations with a community pharmacist. The service was developed to allow practice teams to refer low acuity patients for convenient, same day consultations with clinical advice.

Benefits to practices

- Improve access for patients with higher acuity illnesses or for those with complex health needs to GPs by diverting appropriate consultations to trained community pharmacists in a way that is convenient, safe and effective.

Benefits to patients

- Improve access to treatment and advice that can be provided by Community Pharmacy, where a GP appointment is not necessary.
- Identify ways that individual patients can self-manage their health more effectively with the support of Community Pharmacists, and to recommend solutions that could encourage self-care for minor illness symptoms in the future.

When a patient with minor illness symptoms contacts their GP practice requesting an appointment the care navigator or receptionist will ask them a series of questions using a standard appropriate symptom checklist. If their symptoms are appropriate the GP practice can refer them for a same day consultation with a community pharmacist. With the patient's consent the practice team will send an electronic referral to the pharmacy the patient has chosen, to support safe follow up and audit.

Following the referral, the pharmacist will contact the patient the same day by telephone and will either carry out the consultation by phone or arrange for the patient to attend the pharmacy, if appropriate.

Pharmacists are trained to recognise 'red flag' symptoms suggestive of more serious illness and after initial triage if symptoms do suggest something more serious, the pharmacist will help the patient to arrange an urgent GP appointment using the practice's dedicated professional number or escalate to an urgent care setting such as the emergency department, if needed. The pharmacist will make a record of the outcome of the consultation and send it to the patients GP by secure digital message. All practices have access to a secure electronic referral process (electronic interoperable messages between IT systems) ensuring integration between IT systems

2. Report

There are 51 GP practices in NHS Shropshire, Telford and Wrekin (STW) of which 32 are at stage 3 and have been referring patients.

Implementation stage	Number of practices
3 = Ready	32
2 = Engaged	15
1 = Pre- engagement	4
TOTAL	**51**

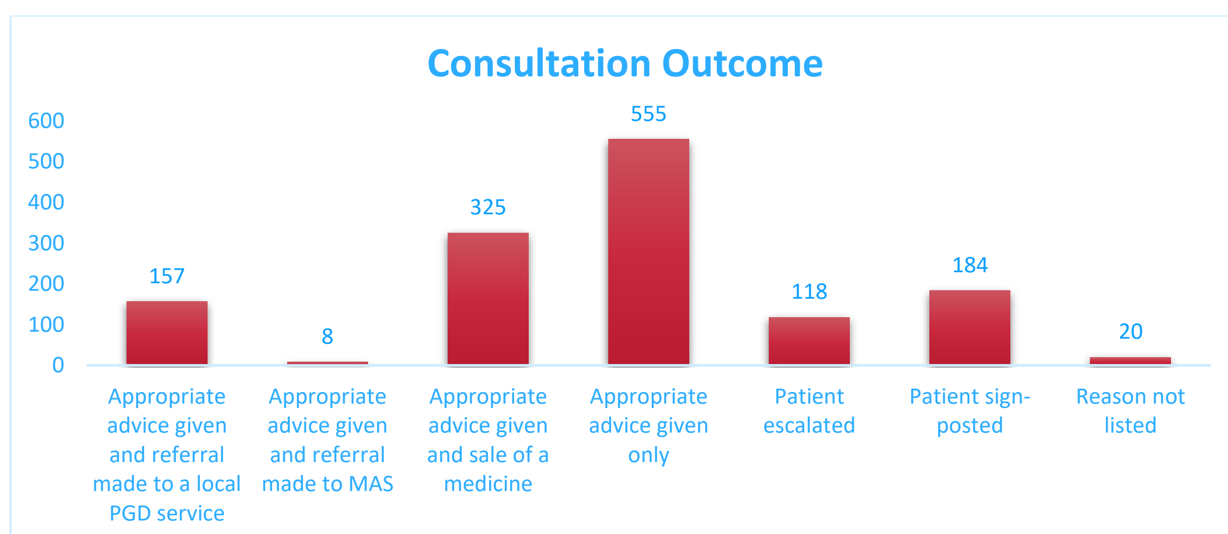
STW practices are encouraged and supported to implement GP CPCS in collaboration with colleagues from Local Pharmaceutical Committee (LPC) and the nationally funded Primary Care Commissioning (PCC). Practices are offered resources and hands on support and training to assist them with using the software and speaking with patients. The support from PCC ended in November 22, we continue to work closely with the LPC implementation lead however their contract will cease in January 2023.

Next steps are to continue to support practices to implement the service to offer to patients and to increase the number referrals with the practices that have implemented.

Some of the reported barriers are,

- Patients do not want to buy over the counter (OTC) medicines.
- The workload in community pharmacies is also increasing.
- Workforce issues in community pharmacies and general practice.
- Becoming more difficult to spend the time needed to go through the process.

More than 300 referrals were completed in June and October (referrals were lower during the summer months). The majority (555) of the consultation outcome was for appropriate advice given and there have been 118 patients (5%) escalated either back to the GP or to A&E.



There are a number of instances where the type of condition has been stated as 'other reason', we will try to understand why this is used and phase it out so that the data is more meaningful. Some of the types of conditions are detailed in the table below.

Condition	Activity	Condition	Activity
Sore throat	99	Earache Ear discharge	61 46
Skin rash	142	Eye, sticky or watery Eyelid problems Eye, red/irritable	50 15 33
Other	378	Cough	96
Diarrhoea	38	Cold/Flu	28

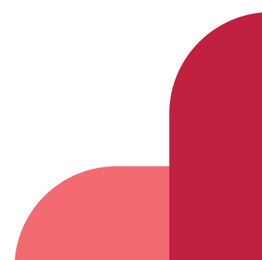
Bites/Stings	44	Urinary Tract Infection Pain passing urine	38 65
Vaginal itch or sore	32	Constipation	13
Acne, spots, pimples	17	Allergic reaction	14

STW ICB attend a monthly GP CPCS oversight group meetings to share information on the regional position and share learning – see appendices.

There is an indicator in the Primary Care Network (PCN) Directed Enhanced Service (DES) Investment and Impact Fund (IIF) ACC-09 that incentivises PCNs to refer into GP CPCS. It is, 0.65 CPCS referrals per 1,000 registered patients per week e.g. list size of 10,000 = 6.5 referrals per week. The PCN can achieve 27 points for this indicator and the value of a point is £200 (adjusted for list size and prevalence). The PCN dashboard isn't showing a current position on achievement, this has been requested from NHS England colleagues.

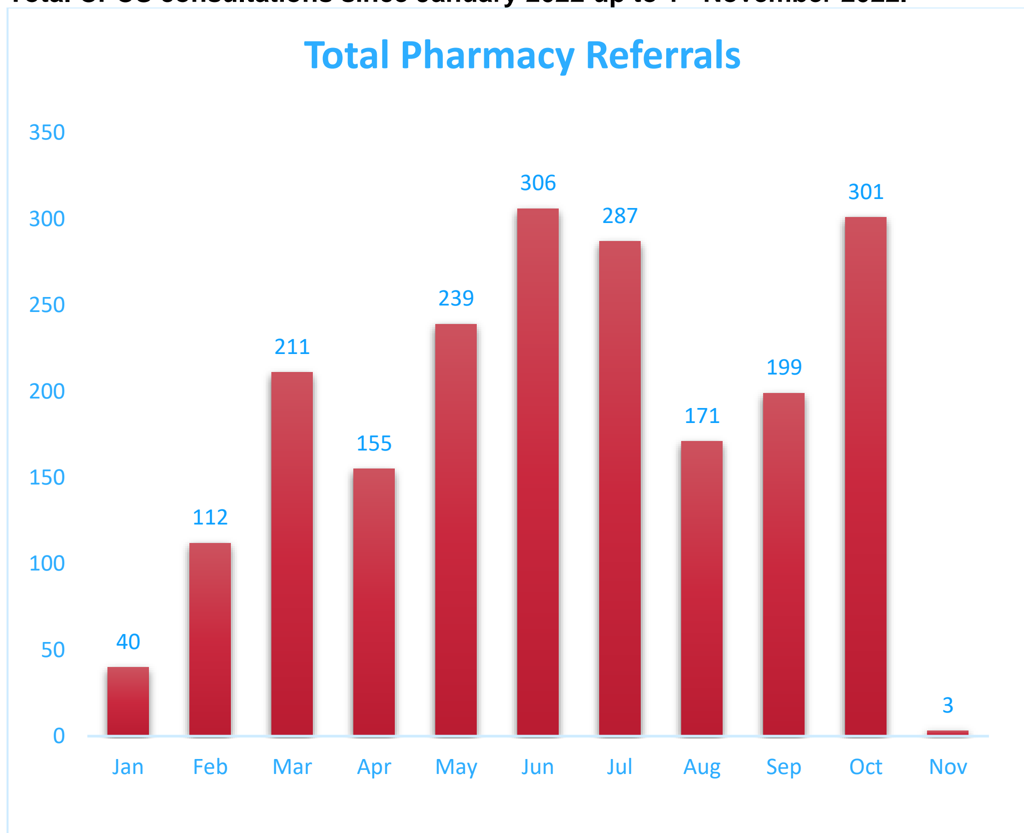
3. Summary

- Implementation and the number of referrals has been progressing well since January 2022.
- Continue to support practices to implement the service.
- Attendance at the monthly GP CPCS oversight group set up by NHS England.
- Monitor IIF achievement data when available.

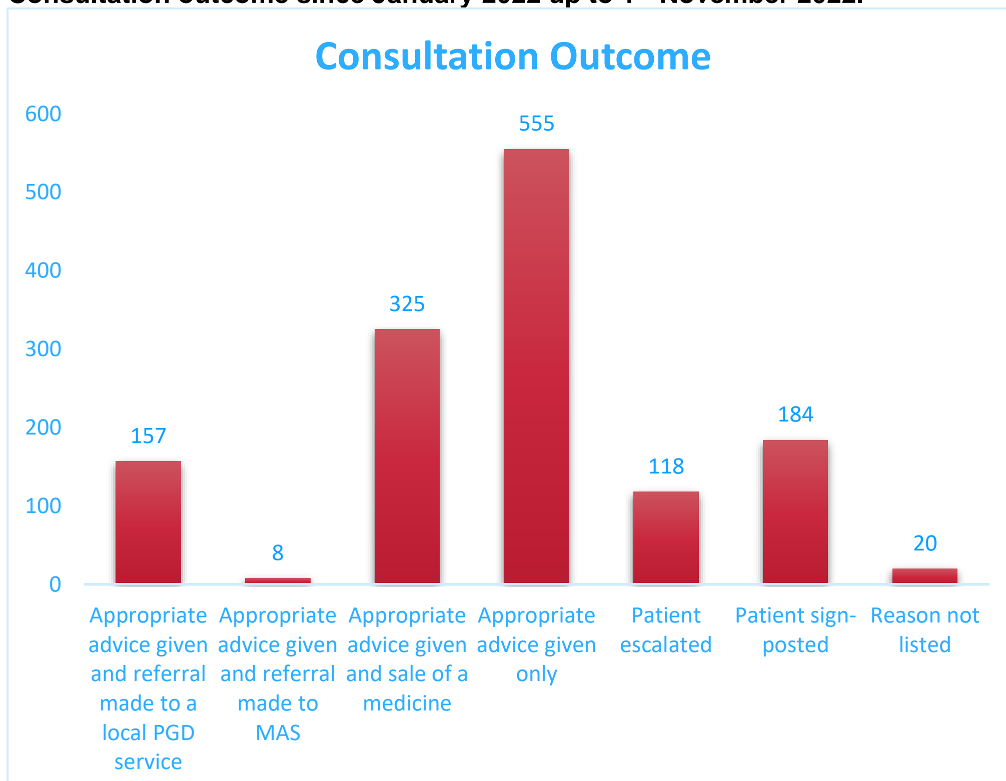


Appendices

Total CPCS consultations since January 2022 up to 1st November 2022.



Consultation outcome since January 2022 up to 1st November 2022.

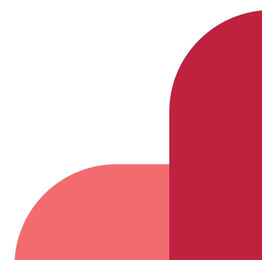


Type of minor illness since January 2022 up to 1st November 2022.

Minor Illness

Reason	Number
Wrist, hand or finger pain or swelling	3
Wound problems	4
Vomiting	12
Vaginal itch or soreness	32
Vaginal discharge	13
UTI	38
Toe pain or swelling	3
Sore throat and hoarse voice	99
Sleep difficulties	3
Skin, rash	142
Sinusitis	5
Shoulder pain	2
Scabies	3
Rectal pain, swelling, lump or itch	7
Pain and/or frequency passing urine	65
Other reason	378
Nasal congestion	12
Mouth ulcers	4
Medication enquiry	3
Lower back pain	9
Knee or lower leg pain swelling	4
Itch	24
Hearing problems or blocked ear	3
Headache	13
Head lice	1
Hay fever	1
Eyelid problems	15
Eye, sticky or watery	50
Eye, red or irritable	33
Eye, painful	5
Earache	61
Ear discharge or ear wax	46
Diarrhoea	38
Cough	96
Constipation	13
Cold or flu	28
Blisters	9
Bites or stings, insect or spider	44
Athlete's foot	2
Arm, pain or swelling	4
Ankle or foot pain or swelling	4
Allergic reaction	14
Acne, spots and pimples	17

0 50 100 150 200 250 300 350 400



Integrated Care System
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General Practice Referral to Community Pharmacist Consultation Service (GP-CPCS)
October 2022 Data

	ITK REFERRALS	NHS.NET REFERRALS	TOTAL REFERRALS OCT 22	DIFFERENCE TO SEPT 22	ICS % OF MIDLANDS REFERRALS	NUMBER OF PRACTICES REFERRED IN OCT 22	DIFFERENCE TO SEPT 22	ICS % OF PRACTICES REFERRING
BLACK COUNTRY	709	73	782	41	11%	86	3	17%
BSOL	402	361	763	138	11%	38	-1	7%
C&W	721	2	723	92	10%	54	9	11%
H&W	592	15	607	105	9%	45	4	9%
STW	301	1	302	97	4%	19	4	4%
SSOT	2023	2	2025	493	28%	103	2	20%
JUCD	331	237	568	258	8%	54	10	11%
LINCS	112	164	276	69	4%	25	1	5%
LLR	0	505	505	-23	7%	45	-8	9%
NORTHANTS	208	117	325	7	5%	28	-2	6%
NOTTS	165	87	252	125	4%	11	-1	2%
Total Midlands October referrals	5,564	1,564	7,128	1,402	Total Midlands Practices referring to CPCS October 22	508	21	

Integrated Care System
Shropshire, Telford and Wrekin

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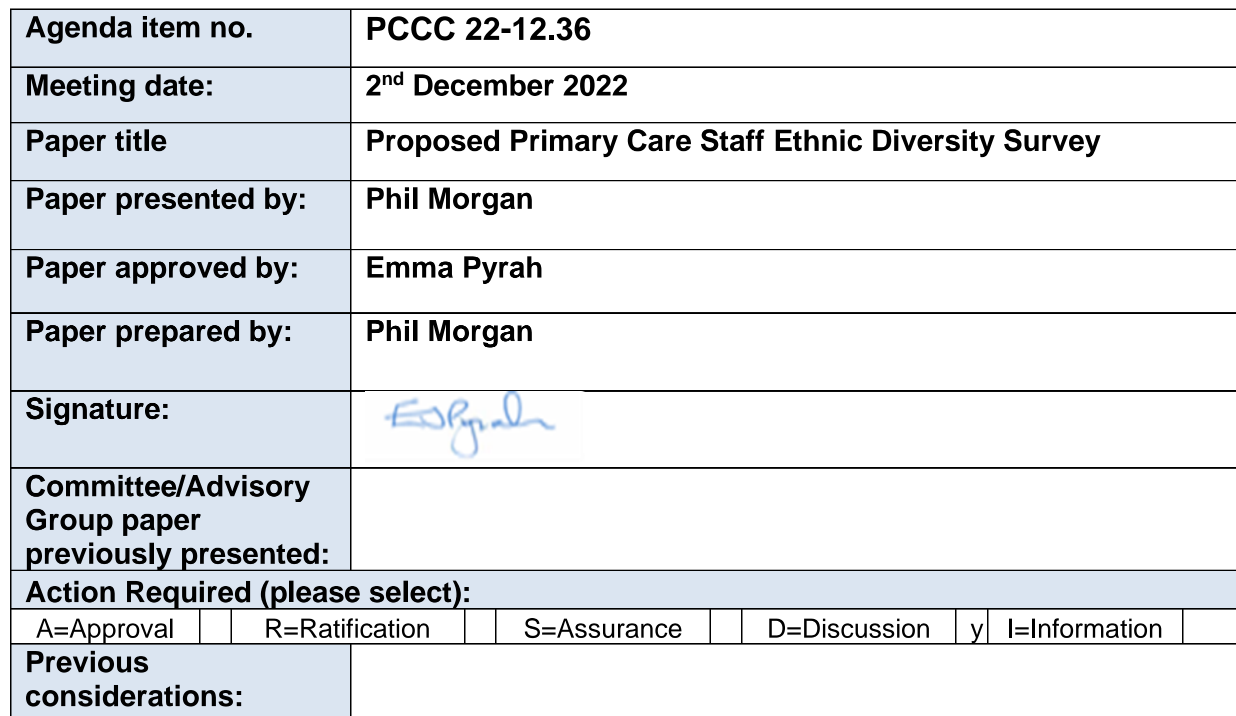
Primary Care Commissioning Committee



Agenda item no.	PCCC 22-12.36
Meeting date:	2nd December 2022
Paper title	Proposed Primary Care Staff Ethnic Diversity Survey
Paper presented by:	Phil Morgan
Paper approved by:	Emma Pyrah
Paper prepared by:	Phil Morgan
Signature:	
Committee/Advisory Group paper previously presented:	

Action Required (please select):									
A=Approval		R=Ratification		S=Assurance		D=Discussion	y	I=Information	

Previous considerations:	

1. Executive summary and points for discussion

Background

- Led by the STW ICS Clinical Lead for Equality, Diversity and Inclusion (Dr Priya George) the Primary Care Team has been involved in the setting up of the STW Primary Care Ethnically Diverse Staff Network.
- The Network was launched in May 2022 where Dr Mary Ilesanmi was elected as Chair of the Network.
- One of the main items at the event was a presentation by Dr Zoe Norris, a member of the Humberside LMC, who talked about a survey which was carried out across all general practices in Humberside looking at issues affecting ethnic minority staff, including racial discrimination.
- Following a discussion among the STW Network members it was suggested and agreed that STW should carry out a similar survey to better understand the issues, challenges and barriers faced by ethnically diverse staff in STW practices.
- The intention is to seek the views not only of ethnically diverse primary care staff, but all staff who have experiences of, and views on, any aspect of racial discrimination in the workplace.
- The current ethnic make-up of the 51 STW practices is as follows:

Headcount showing ethnicity from the four key staff groupings across STW ICS - May 2022 Data							
	Asian/Asian British	Black/African/ Caribbean/Black British	Mixed/Multiple Ethnic Groups	White	Other ethnic group	Not recorded	Totals
GPs	47	22	2	246	13	50	380
Nurses	1	1	2	203	0	26	233
Direct Patient Care	8	0	0	193	1	22	224
Admin	12	0	4	768	2	91	877
Totals	68	23	8	1410	16	189	1714

Percentage of overall staff from BAME background from the four key staff groupings across STW ICS - May 2022 Data							
	Asian/Asian British	Black/African/Caribbean/Black British	Mixed/Multiple Ethnic Groups	White	Other ethnic group	Not recorded	Totals
GPs	12.4	5.8	0.5	64.7	3.4	13.2	100.0
Nurses	0.4	0.4	0.9	87.1	0.0	11.2	100.0
Direct Patient Care	3.6	0.0	0.0	86.2	0.4	9.8	100.0
Admin	1.4	0.0	0.5	87.6	0.2	10.4	100.0
Totals	4.0	1.3	0.5	82.3	0.9	11.0	100.0

- As can be seen from the above data, the only staff group that is not mainly “white” is GPs where just over 35% are recorded as being non-white.
- The other staff groups – Nurses, Direct Patient Care and Admin are all predominantly white – e.g. there are only four nurses out of 233 who are recorded as coming from one of the minority ethnic groups

Proposal

- The Primary Care Ethnically Diverse Staff Network wishes to carry out a survey of all STW general practice staff using a slightly modified version of the survey used in Humberside (permission to use it has been granted by Humberside LMC). The final draft of the online “Survey Monkey” can be accessed here
- The survey has been reviewed and approved by Dr George, Dr Ilesanmi and Dr Muhammad Zeb (the STW Ethnically Diverse GP Champion)
- The intention is to follow up the survey with a series of targeted interventions designed to address whatever key issues are identified in the findings. Without pre-judging the findings, the overall aim of these interventions will be to:
  - Increase retention of existing staff from ethnically diverse groups
  - Increase the number of staff being recruited to all roles within primary care from ethnically diverse backgrounds
- It is proposed that the Primary Care Team, and the Primary Care Ethnically Diverse Staff Network work with the ICB comms team to design a comms campaign to ensure maximum response to the survey.

2. Which of the ICB Pledges does this report align with?

Improving safety and quality	
Integrating services at place and neighbourhood level	
Tackling the problems of ill health, health inequalities and access to health care	
Delivering improvements in Mental Health and Learning Disability/Autism provision	
Economic regeneration	
Climate change	
Leadership and Governance	
Enhanced engagement and accountability	y
Creating system sustainability	
Workforce	y

3. Recommendation(s)

PCOG/PCCC is asked to:

- Approve the carrying out of the above survey

4. Does the report provide assurance or mitigate any of the strategic threats or significant risks in the Board Assurance Framework? If yes, please detail

No

5. Appendices

None

6. What are the implications for:

** For each section the ask will be to either refer to a section of the paper, identify that there are no implications or to submit a separate comment **

Shropshire, Telford and Wrekin's Residents and Communities	A better alignment between the percentage of ethnically diverse residents and ethnically diverse practice staff
Quality and Safety	No implications
Equality, Diversity, and Inclusion	Support for ethnically diverse GPs
Finances and Use of Resources	No implications
Regulation and Legal Requirements	No implications
Conflicts of Interest	No implications
Data Protection	No implications
Transformation and Innovation	No implications
Environmental and Climate Change	No implications
Future Decisions and Policy Making	No implications
Citizen and Stakeholder Engagement	No implications

Request of Paper:		**Action approved at Board:**	
		If unable to approve, action required:	
Signature:		**Date:**	

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Primary Care Commissioning Committee

Agenda item no.	**PCCC 22-12.37**								
Meeting date:	2 December 2022								
Paper title	Shrewsbury Health and Wellbeing Hub - Update on Communication and Engagement Plan								
Paper presented by:	Edna Boampong/Jackie Robinson								
Paper approved by:	Edna Boampong, Director of Communication and Engagement								
Paper prepared by:	Jackie Robinson, Associate Director, Communication and Engagement								
Signature:									
Committee/Advisory Group paper previously presented:									
Action Required (please select):									
A=Approval		R=Ratification		S=Assurance		D=Discussion	x	I=Information	x
Previous considerations:									

1. Executive summary and points for discussion

The Committee received a progress update on the Shrewsbury Health and Wellbeing Hub development at its last meeting. The Committee acknowledged the importance of a robust supporting communication and engagement plan and asked for this to be brought to the next meeting.

Communication and engagement progress since the last PCCC meeting:

- The communication and engagement team has undertaken gap analysis of those who were not engaged during the listening phase of engagement. The gap analysis has enabled our team to revisit the engagement and plan further engagement (in person meetings and online engagement) which will run from November 2022-February 2023. The team will be attending local community groups, dedicated networking events as well as targeted groups to discuss plans more informally and to provide updates when necessary.

- A series of meetings have also been held with each of the Patient Participation Groups (PPGs) for the practices involved within the programme which will continue as we progress towards consultation. The PPG sessions have been supported by GP colleague attendance to be clear about the demands on primary care and the need to change if services are to remain sustainable.

- A Stakeholder Reference Group (SRG) has been established which has patient representatives, GP practice PPG representatives, practice managers, local

councillors, Healthwatch and wider voluntary organisation partners. The SRG will be integral to the planning process.

- An Integrated Impact Assessment is being developed, an initial draft will be presented to the recently formed Equality and Involvement Committee (EIC) for review in January.

- The team are producing a series of short videos highlighting key messages about the proposal. The videos will include a range of stakeholders including messages from general practice staff, patients, voluntary and community services and social prescribers.

- A leaflet has been designed for display at GP practices to continue to remind patients of the proposed changes and when public consultation will commence.

Public Consultation – Commence June 2023

- In November-December the team will be scoping the operational plan for public consultation. A subgroup has been arranged and will be meeting on 23 November 2022 to agree timelines and next steps.

- During January-March 2023, a public facing consultation document will be created which will be circulated to PCCC for comments. The consultation document will clearly set out what is in scope for the consultation, what is not in scope, how to get involved, how views will be recorded, how decisions will be made and feedback on those decisions will be shared.

- From March-May 2023, the team will work with an extensive range of partner organisations to raise awareness of the consultation and ensure the consultation document is distributed widely. The team will ensure local engagement across Shrewsbury, particularly those areas where GP practices who are relocating from, and a concerted effect will be made to engage with those people considered as protected groups under the 2010 Equality Act. In addition, the team will work with provider partners and established groups to ensure the inclusion of vulnerable people and those who experience health inequalities.

- During February-April 2023, a range of communication collateral will be planned and produced and will comply with accessible information standards.

- The communication and engagement plan will adopt a matrix model of communication and engagement which is best practice to enhance reach, as a "one size fits all" approach is not appropriate, and therefore a range of communication mediums, platforms and existing mechanisms will be used.

- Clinical colleagues will be approached and offered media training (as required) prior to the consultation commencing.

- Briefings of relevant stakeholders will take place prior to the consultation commencing.

- As is good practice, the consultation will be carried out in accordance with the Gunning Principles which can reduce risk of legal challenge to the process.

  Gunning Principles

  1. When proposals are still at a formative stage
  2. Sufficient information about proposals to permit ‘intelligent consideration'
  3. Adequate time for consideration and response
  4. Responses must be conscientiously taken into account.

- An external independent partner will be commissioned to lead the consultation, and this will include the analysis of feedback and a consultation report being produced which will be public facing.

- Communication methods include online activity, social media, press release, website information shared by a range of partners. Engaging directly with patients, the team will work with primary care colleagues to contact their patient groups to inform them of the consultation, how to get involved and what support will be put in place to enable people who may have additional barriers for inclusion.

- The public consultation is planned to commence in the first week of June and will run for 8 weeks.

- We will hold a series of public events that are proportionate to the scale of the project. This will include focus groups, public meetings, drop-in sessions, panel sessions and a public deliberative event.

- When the consultation commences, an engagement matrix model will be employed to assist the team outreaching to diverse communities and ensure the involvement is demographically represented.

- A mid-term review (circa June 2023) of the consultation reach will take place which provides an opportunity to check and balance the range of people engaging and importantly, those we have not manged to engage. Where gaps are identified, the team will adapt the consultation plan accordingly.

Which of the ICB Pledges does this report align with?

Improving safety and quality	x
Integrating services at place and neighbourhood level	x
Tackling the problems of ill health, health inequalities and access to health care	x
Delivering improvements in Mental Health and Learning Disability/Autism provision	
Economic regeneration	
Climate change	
Leadership and Governance	
Enhanced engagement and accountability	x
Creating system sustainability	
Workforce	

2. Recommendation(s)

NHS Shropshire, Telford and Wrekin Primary Care Commissioning Committee is asked to:

Note the contents of the update on communications and engagement.

3. Does the report provide assurance or mitigate any of the strategic threats or significant risks in the Board Assurance Framework? If yes, please detail

4. **Appendices –** Communication and Engagement Plan

5. What are the implications for:

Shropshire, Telford and Wrekin's Residents and Communities	Additional services that enhance primary care provision. Travel for some people may be extended by GP relocation.
Quality and Safety	Increased services in an environment equipped to deliver health and care in a safe space with quality and delivery at the heart of all activity.
Equality, Diversity, and Inclusion	A comprehensive Integrated Impact Assessment will be used to identify the potential positive impacts. Where negative impacts are noted, mitigation plans will be put in place (where possible) to minimise the impact on communities, vulnerable people and those who are considered as protected characteristic groups.
Finances and Use of Resources	This is a capital funding allocation. The comms and engagement input are being funded from programme costs to the CSU and using the core team of the ICB to lead the process of public engagement and consultation.
Regulation and Legal Requirements	Health and Social Care Act Duty to Involve
Conflicts of Interest	N/A
Data Protection	The main legal obligations on NHS bodies to make arrangements to involve individuals, their carers, and representatives, are all set out in the

	National Health Services Act 2006, as amended by the Health and Care Act 2022: section 14Z45.
Transformation and Innovation	This is part of a system wide transformation across primary care and linked directly to Local Care Transformation Programme.
Environmental and Climate Change	N/A
Future Decisions and Policy Making	Decision will be taken by NHS England as part of Pre-Consultation Business Case being approved to proceed with a formal consultation.

Action Request of Paper:			
Action approved at Board:			
If unable to approve, action required:			
Signature:		**Date:**	

Meeting:	
Meeting date:	
Agenda item no.	
Paper title	

Integrated Care System Shropshire, Telford and Wrekin

NHS Shropshire, Telford and Wrekin

Shrewsbury Health and Wellbeing Hub Engagement Plan for Phase 3

Phase 3: Engagement focussed on underrepresented and disproportionately affected groups

Purpose of engagement

This phase 3 engagement has been designed to undertake both general and targeted engagement with key groups across all our stakeholders where so far there has been limited or no engagement.

This has been enabled through a gap analysis which has covered all engagement so far (listening exercise in September-October 2021 and case for change focus groups in summer 2022, as well as through the Strategic Reference Group (SRG)).

The team will be attending local community groups, dedicated networking events and targeted groups to discuss plans more informally and to provide updates when necessary.

Timeline

Engagement phase 3: engagement with under-represented groups (Dec 2022-March 2023)	***Start***	***End***
Gap analysis summary to identify under-represented audiences (using gap analysis developed by CSU)	**10-Nov**	**18-Nov**
Engagement with under-represented groups to arrange events (e.g., attending existing events or arranging small focus groups) and/or encourage distribution of questionnaire (warm up/generate interest)	**9-Dec**	**24-Feb**
Development of presentation and questions for use at targeted stakeholder events (inc. demographic profiling questionnaire and jam board)	**28-Nov**	**09-Dec**
Development of questionnaire for use with targeted stakeholders	**28-Nov**	**09-Dec**
Engagement phase live	**9-Dec**	**24-Feb**
Reporting and analysis of additional engagement with under-represented groups	**24-Feb**	**31-Mar**

Aims and objectives

The objectives of this engagement are:

- To build on engagement with under-represented groups and those who may be disproportionately affected by the development of the Shrewsbury Health and Wellbeing Hub.
- To demonstrate to the public that feedback shared so far through previous engagement activity has been listened to (through the development of the list of services that may be offered).
- To introduce and discuss plans for the hub increasing awareness and understanding of proposals.
- To understand more about satisfaction levels with local GP practices and what is perceived to be important from GP service delivery.
- To explore the key services local people feel would be most beneficial for inclusion in the hub and gain insight into the reasons for these preferences.
- To collect insight into what local people feel are the potential positive impacts of the hub and explore any worries or concerns, whilst offering an opportunity for participants to share how they feel any negative impacts could be responded to.

The outcomes from these objectives will be used to inform the development of the proposals and subsequent phase 4 consultation activity.

Target audience(s)

The communication and engagement team has undertaken gap analysis of those who were not as highly represented during the listening phase, focus groups engagement and through the SRG.

Work is also taking place to identify those audiences that may be disproportionately affected by plans to create a new health hub and we will use the list supplied from this work for targeting.

Gap analysis has enabled our team to revisit the engagement and plan further activity (in person Q&A sessions and online engagement) which will run from December 2022-February 2023. The team will be attending targeted local community groups to engage with hard to reach and vulnerable audiences and delivering an online survey to run alongside this.

Below are the key groups that have not been sufficiently engaged and will be approached for involvement in this activity:

- Local community organisations and groups
- Those identified as under-represented in engagement activity to date:

I. Ethnic minority groups
II. Male respondents
III. LGBTQ+
IV. Expectant and new parents
V. Youth audiences (Under 24)
VI. Elderly (Over 85)

VII. Carers

Channels for engagement

A number of face-to-face engagement events in the community will be delivered to specifically target the audiences specified. Stakeholder mapping will take place to build a list of suitable community groups to approach for inclusion in the engagement activity.

A user-friendly, concise survey will be delivered via Smart Survey.

The survey will be promoted via social media, in stakeholder newsletters and by email to broad stakeholder partners to support awareness.

Collateral and data collection methods

- Stakeholder email templates – copy to be produced which explains the background to the hub, the aim of this additional engagement activity and the benefits of participating in sharing feedback. A clear call to action will be provided explaining how stakeholders can get involved in supporting this phase of the engagement.

- Stakeholder telephone script – where a response is not received from stakeholders following the initial approach by email, a follow up telephone call may be required to boost participation and representation. A script will be produced to guide these conversations.

- Social media posts – copy for social media messaging and graphics to be produced so that the survey link and opportunity for involvement can be shared widely. There may also be opportunities for stakeholders to use these social media posts to share amongst their networks.

- Stakeholder lists – existing database of stakeholders will be reviewed and updated (if required). It will be used to assist in contacting under-represented and disproportionately affected groups within the community. The stakeholder database can be continually built upon and developed if new contacts are shared as we move through this phase.

- Event presentation - a slide pack will be prepared using previous collateral as a template to be adapted – content will include the background to the hub and why we are seeking involvement from those we are engaging with. Opportunities for questions will be included.

- Discussion guide for use at community events – a question guide will be developed for use at in person and virtual events. The aim will be to keep discussion questions as close as possible to the questions being delivered via the survey.

- Survey - a concise survey (around 10-12 questions, with demographic profiling questions) to be developed.

- Demographic profiling form/questionnaire for use at events – there will need to be printed copies of the demographic profiling form/questionnaire to take out to events if people prefer to share their feedback this way.

Feedback analysis and reporting

The report of findings will have the following structure:

- Executive summary
- Introduction
- Communications and engagement approach
- Profile of respondents
- Findings from the feedback from the survey and the events

Analysis of feedback from the survey

- The closed questions will be tabulated.
- The open questions will be read and coded and tabulated.
- All questions will be cross-tabulated by the demographic profiling questions to enable an intersectional analysis to be undertaken.

Analysis of feedback from the events

Notes from each of the events will be read and summarised and key themes identified by event.

Subsequent engagement phases

An additional document is being produced to cover the consultation phase.

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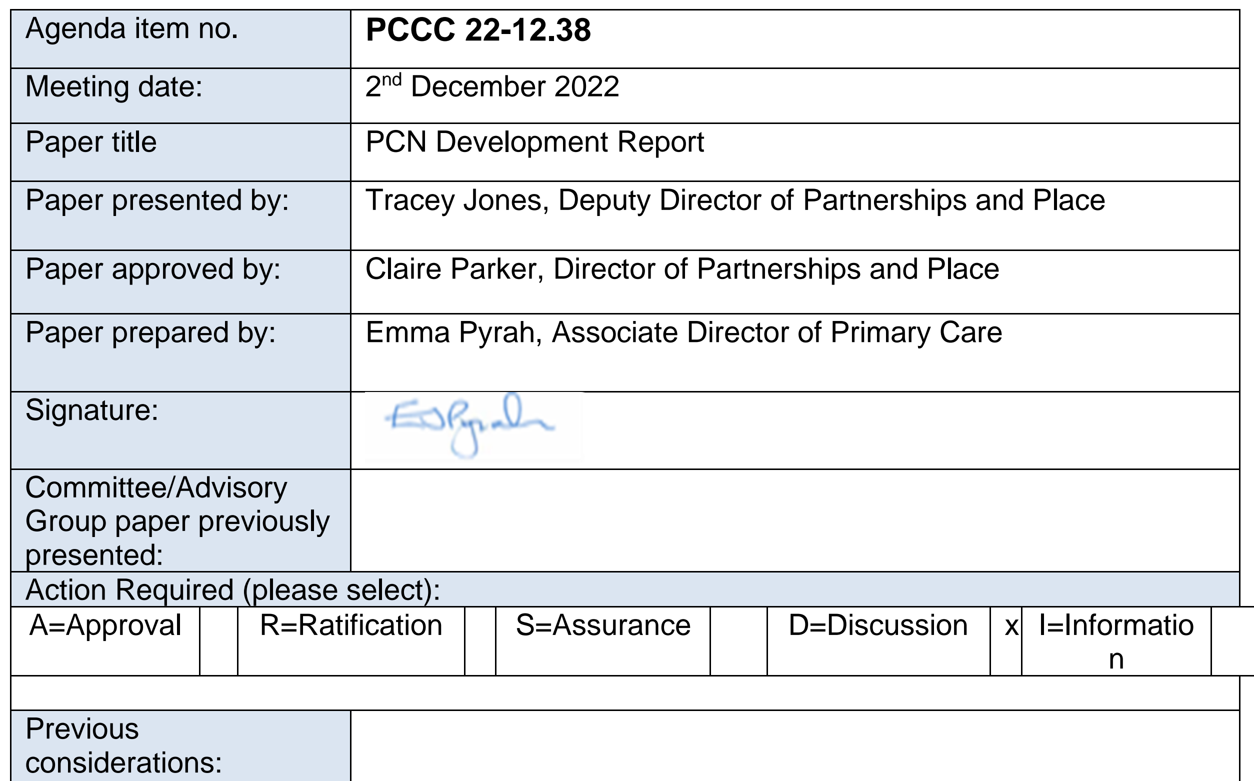


Agenda item no.	**PCCC 22-12.38**
Meeting date:	2nd December 2022
Paper title	PCN Development Report
Paper presented by:	Tracey Jones, Deputy Director of Partnerships and Place
Paper approved by:	Claire Parker, Director of Partnerships and Place
Paper prepared by:	Emma Pyrah, Associate Director of Primary Care
Signature:	
Committee/Advisory Group paper previously presented:	

Action Required (please select):

A=Approval		R=Ratification		S=Assurance		D=Discussion	x	I=Information	

Previous considerations:	

1. Executive summary and points for discussion

The purpose of this report is to provide the Committee with an update on the outcome and next steps in relation to plans for PCN Development.

Two pieces of work have been undertaken in the last 6 months to assess PCNs' organisational development needs and levels of maturity. These are described in the report together with their outcomes and any agreed next steps.

Which of the ICB Pledges does this report align with?

Pledge	
Improving safety and quality	x
Integrating services at place and neighbourhood level	x
Tackling the problems of ill health, health inequalities and access to health care	x
Delivering improvements in Mental Health and Learning Disability/Autism provision	
Economic regeneration	
Climate change	
Leadership and Governance	
Enhanced engagement and accountability	
Creating system sustainability	x
Workforce	x

2. Recommendation(s)

NHS Shropshire, Telford and Wrekin Primary Care Commissioning Committee is asked to:

The Committee are recommended to note the contents of this report and the actions being taken to support further PCN Development.

3. Does the report provide assurance or mitigate any of the strategic threats or significant risks in the Board Assurance Framework? If yes, please detail

No.

4. Appendices

Appendix 1 – PCN Maturity Survey results

5. What are the implications for:

Shropshire, Telford and Wrekin's Residents and Communities	
Quality and Safety	
Equality, Diversity, and Inclusion	
Finances and Use of Resources	
Regulation and Legal Requirements	
Conflicts of Interest	
Data Protection	
Transformation and Innovation	PCNs are increasingly becoming the national policy route to delivering integrated primary and community teams
Environmental and Climate Change	
Future Decisions and Policy Making	

Action Request of Paper:			
Action approved at Board:			
If unable to approve, action required:			
Signature:		Date:	

Meeting:	
Meeting date:	

Agenda item no.	
Paper title	

REPORT TO PRIMARY CARE COMMISSIONING COMMITTEE
2ND DECEMBER 2022

PCN DEVELOPMENT REPORT

Background

Introduced in 2019, the objective of the Network Contract DES was for primary medical services contractors to establish and develop Primary Care Networks (PCNs), whereby local practices group together to deliver services in their local area (it was envisaged that each PCN would have a patient size of 30-50,000).

The Network Contract DES is updated annually and forms part of a long-term, larger package of general practice contract reform originally set out in Investment and Evolution: A five-year framework for GP contract reform to implement the NHS Long Term Plan and subsequent updates. It is intended that there will be a Network Contract DES each financial year until at least 31 March 2024 with the requirements of the Network Contract DES evolving over time.

The Network Contract DES contract works hand in hand with the Primary Medical Services Contract. Where the DES Specification sets out a requirement or obligation of a PCN, each Core Network Practice of a PCN is responsible for ensuring the requirement or obligation is carried out on behalf of that PCN. A practice participating in the Network Contract DES must enter into a variation of its primary medical services contract to incorporate the provisions of this Network Contract DES Specification.

The PCN DES includes a number of service requirements which PCNs must deliver as well as a number of incentive targets (IIF) for which PCNs receive payment if achieved.

There are 8 PCNs in NHS STW. They vary in size (as can be seen from the table below). It is a requirement that every PCN has a Clinical Director.

PCN	Population size	No. of practices	Clinical Director
Shrewsbury	127,734	16	Charlotte Hart
SW Shropshire	36,389	6	Finola Lynch
SE Shropshire	58,989	9	Jess Harvey
North	90,391	7	Tim Lyttle
Teldoc	61,621	2	Ian Chan, Rashpal Bachu
SE Telford	37,895	3	Nitin Gureja, Melanie Thompson
Wrekin	47,147	4	Derek Ebenezer, Nav Singh, Rohit Mishra
Central and Newport	57,904	4	Stefan Waldendorf

PCN Financial Arrangements

PCNs received funding as follows: -

Network Participation Payment (NPP) (goes direct to practice not to PCN payee)	£1.761 per practice weighted pop
Clinical Director payment	£0.736 x PCN list size
Core PCN funding (PCN spend as they see fit)	£1.50 x PCN list size
Leadership and management	£0.699 x PCN list size
Care Home Premium	£120 per bed per year
Extended Hours (1.4.22 - 30.9.22)	£0.720 x PCN list size
Extended Access (1.10.22 - 31.3.23)	£3.764 x PCN list size
Additional Roles Reimbursement Scheme	£16.696 x PCN list size

There is also a national Primary Care Transformation Fund (PCTF) which is for PCN development, General Practice development and digital. The total allocation for this year is £674,000 and £213,000 is available to support PCN development, the remainder pre-committed to digital.

Because the PCN leadership and management payments are made based on list size, this means that the smaller PCNs are disadvantaged, having less funding and therefore capacity to undertake internal development work or to participate in the wider system transformation work. In November 2022, however, all PCNs (other than Teldoc) agreed to top slice a proportion of the PCTF (equivalent to one day per week of Clinical Director backfill) and distribute it equally to each PCN. There is currently no other source of Primary Care or ICB funding to support PCN development.

Two related but separate pieces of work have been undertaken in the last 6 months to assess and quantify each PCN's stage of maturity and their associated development needs. The outcome of this work is described below.

1. PCN Maturity Survey 2022

Midlands and East NHSE issued a PCN maturity survey to each ICS for completion and return in October 2022. The survey contained a variety of questions to assess PCN maturity, development needs and readiness to deliver the PCN DES. All 8 STW PCNs completed the survey. The detailed results of the survey are collated in Appendix 1. A summary of the key findings are below: -

- STW PCNs are at various stages of maturity and development.
- Slight improvements have been seen with leadership, and clinical director leadership with the majority of PCNs at step 2, and some at step 3, compared to last year where the majority were at foundation level and step 1.
- Areas where PCNs are less well developed (at foundation/step 1) are change management, population health management, collaborative working and managing resources.
- Overall maturity is showing that one PCN is at foundation/step 1, 5 PCNs are at step 1, and two PCNs are at step 2.

2. Kings Fund Organisation Development Work

The Kings Fund were commissioned in Spring 2022, to work with our PCNs to explore their development needs.

They worked with 6 PCNs with the following approach:

- Interviews with 3-4 leaders from each PCN – this was not trying to 'assess' or 'diagnose' but rather trying to bring more into view for consideration
- Creation of a framework to use in all feedbacks, after distilling key themes across the 6 PCNs
- Producing a summary presentation to guide feedback for each PCN
- Meetings with each PCN's leaders to share impressions and discuss priorities
- Sharing notes of these meetings with the PCN leaders for them to take forward

North PCN had previously and separately commissioned the Kings Fund to do a similar piece of work with them last year, so they did not participate. Wrekin PCN declined the offer to participate.

The key themes from the Kings Fund work are summarised below.

a) Strategy and Direction

- Uncertainty about policy direction – leads to a more reactive shorter-term focus and a reduced sense of power, when a longer-term focus would give more satisfaction and flexibility/stability.

- Needs differ widely - according to demography, deprivation, geography, rurality and PCN maturity/stability; this can make it hard to come to solutions that work for all PCNs and practices.

- Work with system partners and patients - varies and more is likely to be needed to make neighbourhood teams work

- Practical barriers – workforce availability, increasing patient demand, demand on time for supervision of ARRS, estate, lack of expertise in needs analysis/ data analysis

Ambitions (examples)
- Increase resilience through scale
- Incorporation (Limited companies)
- More work on inequalities
- More cross-PCN work

b) Systems and Structures

Variation in:
- Approaches to organising, reflecting variety of PCN compositions (eg super practice to 15 practices)
- Levels of engagement from practices in PCN work
- Extent of formalised governance arrangements – some 'just' working together, some incorporating (formally and in practice)
- Perception of effectiveness of time, effort, value
- Appetite to change practice ways of working, especially where it affects practice income
- Clarity about delegation of authority to PCN board members by practices, affecting decision making and engagement
- Models of employing ARRS roles, and some ambition for expanding

c) Shared Values

- Constant balancing of doing what's right for patients and doing what's needed to meet national requirements (not always the same!)
- Ongoing tension of practice autonomy vs collaboration
- Ongoing tension of different choices re income and patient service delivery
- Ability to talk about values, history, culture, preferred ways of working etc which can inhibit collaboration if not addressed

d) Quality of Relationships

- Appetite to offer mutual support, prioritise PCN projects, make the most of collective talents varies – links to whether the PCN is seen as functional or enjoyable (do you have to participate, or do you want to?)
- Working together is easier when stakes are lower/ there is much to be gained – need to develop skills to handle tension and conflict
- History of hierarchies (age, profession) important in some places
- Trust, fairness, transparency, are concerns in some places and hold back progress pending resolution

e) Practicalities

Opportunities to share learning/ innovate/get technical assistance about:

- Needs/data analysis
- Resolving VAT issues for hosting staff
- Recruitment and retention of ARRS
- Effective utilisation of space/estate
- Financial transparency
- Practice engagement
- Patient and citizen involvement
- Population health work
- Leadership and voice in the wider system

These should be enablers, but currently get in the way.

3. PCN Development Workshop 31st October 2022

This Kings Fund work was shared at a PCN Workshop with PCN Clinical Directors and senior ICB Executive/Director representatives. The workshop explored specific areas of challenge/constraints for PCNs, how they can support each other and how the ICB can support.

A summary of those discussions and agreed actions are below. One of the key actions is that the PCNs are going to set up a PCN Board, run by themselves (without ICB representation) as a forum for them to share learning, challenges and potential solutions and identify areas where they can work more collectively.

a) Aims/aspirations of PCN Clinical Directors

- To work more collectively/collaboratively, to multiply our efforts
- Understand where/how practices/PCNs/system interact and sit together. Clarify areas of overlap, especially between practices and PCNs

- Use areas of overlap to help each other and reduce duplication. Make system interaction relevant and useful
- Understand what integration means and how we can make it happen
- Developing and integrating the ARRS workforce

b) Simon Whitehouse key messages:

- General Practice is the cornerstone of the ICB, if General Practice doesn't work, the system doesn't work. It must be strong, sustainable, and as good as it can be – we are starting from a good place but need to maintain and develop. Question: How do we make General Practice as good as it can be?
- Important to spend every £ of the PCN ARRS monies and supportive of flexing the application of the role definition criteria as long as it is within the law.
- We are too rules focussed – inhibits problem-solving, switch to solution focus to make best use of available resource. Work creatively, art of possible, play to GP strengths.
- We need to do things differently,
- Make use of PCNs/DES to support development. ICB needs to support this, but need to know what PCNs/GPs want supported
- Where are the other partners in the conversation? Need to build clinical and professional leadership relationships and links. Can then develop action plan to build better integration between primary care and the rest of the system.

c) Key Discussion Points

- Consider what we can change locally, and what we can influence nationally, through ICS, LMC/BMA, NHS Confed.

- Flexibilities in applying the ARRS role criteria is important in securing full spend of our allocation ie use for locum staff.

- Just moving people around system gives no net improvement. Work differently, combining resources and people. Work together to make best use of resources within/between PCNs and other providers. Training Hub doing good work to draw people in especially with Further/Higher Education providers.

- Need a wider system approach to setting competitive rates/banding for roles v non-NHS employers but care not to destabilise individual providers within system – both primary and secondary/community care. Ensure primary care is part of this.

- PCNs need help to use data to inform decisions on where to focus. PCNs lack skills and capacity for data analysis. Reduce duplication – we are all looking at the same data – commission one team to do this and share with all, at different levels, from system, place, PCN, practice. Give PCNs the list, don't expect them to find it. Data sharing agreements need signing by all practices to enable this, not all have approved ICB BI to extract and interrogate data - help practices to understand this is for help and support, not for performance management.

- Current lack of accurate GP activity and other data means system asks the wrong questions and so gets the wrong answers.

- Need GPs in conversations, as coordinators of care, to help come up with solutions, but need headspace to do this.

- Left shift from primary care – develop the layers of the pyramid below GP. Currently inundated from both sides (above and below) – admin issues, care coordination, communication – not really practice's role.

- Failure demand is causing 25-30% current GP activity and clogging it up. No individual's fault, and individuals not sighted on what's happening in other parts of the system. Each needs to understand pressures on others and stop attributing blame.

- Work on primary/secondary care interface and consensus can help with this. Each has clinical responsibilities to each other, to work together to improve patient care and working life of clinicians. Management needs to facilitate these conversations and actions arising. Noted GP/Consultant exchange going well.

- Noted new consultant common induction being introduced. Question: are there opportunities to invite new GPs?

- Primary/community interface dialogue has begun between some of the PCN CDs and Angie Wallace, Shropcom Chief Operating Officer.

- Key message for the system is 'do it with us, not to us'.

- Practicalities of running a PCN are recurring challenge themes – how can the ICB help? Some PCNs are outsourcing this work eg HR (Martin Kaye solicitors, OHP) and recommended it to others.

- Leadership/management funding based on population size is not sufficient in general but particularly for the smaller PCNs. Practices would not support giving up PCN monies to support another PCN, however, are there non-financial ways the larger more developed PCNs can help the smaller ones? Funding is key to releasing the clinical leadership to develop the PCN and input to the wider system development discussions.

- Patient education is key to maximise the use of ARRS roles. Phil Morgan supporting Charlotte Hart with developing some video clips explaining the roles. Felt there was no positive ongoing campaign promotion in support of General Practice when they are doing great work.

- PCNs to introduce a monthly joint PCN CD/Manager Board, led and organised by the PCNs without ICB representation. Key areas of focus sharing learning and challenges and identifying opportunities to do things collectively.

- North PCN have introduced a Non-Executive Chairman role on their Board. This person's background is Kings Fund in leadership development and has been very helpful in development of their governance and bringing another dimension in supporting the PCNs development and addressing the usual tensions of establishing and developing the network.

- Help providers understand contractual requirements of GP, where these overlap with those of other services and where the boundaries are, identify, agree, and address issues together, with common understanding.

- Need protected time to do this, and increased management time also.

- Strategic plans e.g., for estates need to integrate and align with those of system.

Summary of Actions	Lead
ARRS flexibilities – Provide PCNs with written description of where flexibilities in applying the role criteria are	P Morgan
ARRS recording on the system – ensure all ARRS roles are recorded in the national system to maximise the baseline funding allocation from 2024	PCNs
Population Health Management – PCNs to confirm to the ICB what BI support they need to help interrogate their data at practice level? ICB to explore what BI support can be provided.	PCNs G Robinson
Data Sharing Agreements – ICB to provide PCNs with a list of the practices that have not signed up to the data sharing agreement. PCNs to support in achieving 100% sign up.	C Lovatt PCNs
Primary/Secondary Interface – explore opportunities to include newly qualified GPs	N White/ P Morgan
Layer below General Practice – explore opportunities to develop the layer below General Practice to support left shift from primary care	P Morgan
Supporting the smaller PCNs - PCNs to consider non-financial ways in which they can support each other	PCNs
Backfill funding for clinical leadership – PCNs/ICB to consider ways to increase/ringfence funding for this	PCNs/ ICB
System comms plan – find ways to increase the amount of positive promotion of General Practice and patient education on ARRS roles	E Boampong
Introduce a monthly PCN Board meeting – led and organised by the PCNs without ICB representation. First meeting to be held before Christmas	C Brown
Future workshop dates – Full day in January, half day follow up in March. Potential areas of focus suggested: invite comms, invite North NED Chair, invite Local Care Programme/SCHT	P Morgan/ PCNs
Circulate the workshop slides	P Morgan
PCN CD Whats App Group – make more use of it	PCNs

A further 2 workshops are being planned for January and March 2023.

Recommendation

The Committee are recommended to note the contents of this report and the actions being taken to support PCN Development.

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

NHSEI Primary Care Network Survey - October 2022
Shropshire Telford and Wrekin ICB - Summary of results

Midlands and East NHSE issued a PCN maturity survey to each ICS for completion and return in October 2022. The survey contained a variety of questions to assess PCN maturity, development needs and readiness to deliver the PCN DES. All 8 STW PCNs completed the survey, the summary results from which are set out below showing comparisons with last year's survey results where possible. Please note that new questions have been added where no comparison is able to be given.

Domains	South East Shrop PCN	Shrewsbury PCN	North PCN	South West Shrop PCN	Teldoc PCN	Newport & Central PCN	Wrekin PCN	South East Telford PCN
Leadership development	step 2 (1)	step 3	step 2 (1/2)	Foundation/step 1 (foundation)	step 2 (2)	step 1 (2)	step 1 (1)	step 1 (1)
Organisational development	step 1 (1)	step 2	step 2 (1)	Foundation/step 1 (foundation)	step 2 (2)	step 2 (2)	step 1 (1)	step 1 (1)
Change management	step 1 (foundation)	step 2	step 1 (foundation)	Foundation/step 1, (foundation)	step 2 (2)	step 1 (1)	step 1 (1)	step 1 (1)
Clinical director leadership	step 2 (2)	step 3	step 2 (1/2)	Foundation/step 1. (foundation)	step 3 (3)	step 1 (2)	step 1 (1)	step 1 (1)
Population health management	Foundation (foundation)	step 1	step 1 (foundation)	Foundation/step 1 (foundation)	step 1 (foundation)	Foundation (1)	Foundation (foundation)	step 1 (1)
Collaborative working – MDTs	step 1 (2)	step 2	step 1 (1/2)	Foundation/step 1 (foundation)	step 2 (foundation)	step 1 (1)	Foundation (foundation)	Foundation (1)
Managing resources	step 2 (foundation)	step 2	step 2 (foundation)	Foundation (foundation)	step 2 (1)	step 1 (1)	Foundation (foundation/1)	step 1 (1)
Asset based community development and social prescribing	step 1 (1)	step 2	step 1 (foundation)	Foundation/step 1 (foundation)	step 2 (1)	step 1 (2)	step 1 (foundation)	step 1 (1)

Overall maturity status of your PCN	step 1 (1)	step 2	step 1 (1)	Foundation/step 1 (foundation)	step 2 (1)	step 1 (1)	step 1 (1)	step 1 (1)

*Levels of PCN maturity are explained here

PCN Development Support Needs

The level of need for development support against the key maturity domains varies considerably from PCN to PCN. The below table shows where each PCN have placed themselves with 1=highest support needs (highlighted pink in the table below), and 7= lowest support needs. Across all PCNs the highest support needs are seen in the domains of population healthy management followed by managing resources and collaborative working.

Domains	South East Shrop PCN	Shrewsbury PCN	North PCN	South West Shrop PCN	Teldoc PCN	Newport & Central PCN	Wrekin PCN	South East Telford PCN
Leadership development	4	7	6	2	6	6	4	5
Organisational development	2	6	5	1	5	4	4	5
Change management	3	3	4	3	5	4	3	7
Clinical director leadership	4	7	5	3	6	5	4	4
Population health management	1	1	3	4	3	1	3	3
Collaborative working	5	5	3	4	3	3	3	3
Managing resources	5	2	5	2	5	3	3	3
Asset based community development and social prescribing	4	4	3	5	5	4	3	3

PCN DES Service Specification Delivery

All 8 PCN’s have implemented the DES service requirements for;

- Structured Medication Reviews and Medicine Optimisation
- Enhanced Health in Care Homes
- CVD Prevention and Diagnosis
- Tackling Neighbourhood Health Inequalities

- Social Prescribing Service and
- Early Cancer diagnosis

For the new DES Service specification requirements: Readiness

- 3 PCNs are 'not ready and will require further support' to deliver the Personalised Care DES specification
  - North, Newport and Central and South East Telford PCN
  - with South West Shropshire stating that this is currently not applicable, and
- 2 PCN's are 'not ready and will require further support' to contribute to the development of the ICB Anticipatory Care delivery plans,
  - North and South East Telford PCNs,
  - with South West Shropshire stating that this is currently not applicable.

The survey then asks PCNs specific questions about their development and infrastructure. A summary is given below, with this shown in a table by PCN in Appendix 1

Service Improvement/Development

Questions	Responses
Have you developed a specific service improvement area to enable closer collaboration with wider community providers?	South East Shropshire and South East Telford answered No. 6 PCNs answered yes with PCNs working with mental health, pharmacy, voluntary sector, community service providers, local authorities, and local communities. No PCNs were working with dentistry or optometry.
Have you made links with local Community pharmacies in relation to delivering SMRs?	All PCNs answered no
Have PCNs continued to form clear and agreed multi-disciplinary teams with community provider partners?	5 PCNs run MDTs with community providers and other partners. Care Home MDTs are well established and working well in some areas. Community providers employ some ARRs roles for some PCNs - SPLWs, MH practitioners and First Contact Physiotherapists. 3 PCNs have struggled to get engagement from community teams, (North, Wrekin, and SE Telford) these are due to geography and the capacity of community teams. In these areas the PCN staff manage the MDTs.

What are some of the barriers and what support is required?	Barriers include staffing, time, communication, and admin support. Community and Secondary providers need to challenge traditional approaches and accept primary care as an equal partner round table.
Do you have a PCN Development plan that captures your PCN support needs for 2021-22?	4 answered yes (compared to 3 in 2021). South East Shropshire, Teldoc, Wrekin and South East Telford PCN plans do not cover PCN support needs.
How is the local population health management tool being used by your PCN?	2 PCNs are using this tool minimally (South West Shrosphire and Newport and Central) compared to 1 last year, and the other 6 are currently not using this.

Workforce

Questions	Answers
Do you have the training and support to ensure the robust development of an effective PCN workforce strategy through to 2024?	6 PCNs answered yes. 2 answered no (South West Shropshire and South East Shropshire) citing the lack of people with the right skills people and recruitment as the reasons.
Do you have arrangements in place to ensure there is an assessment of clinical skill-mix to support the service provision?	6 yes, 2 no (South West Shropshire and South East Telford)
Do you have the training and support to ensure a robust development of an effective PCN workforce strategy through to 2024?	6 yes, 2 no (South West Shropshire and South East Telford)
What support is needed to ensure the robust development of an effective PCN workforce strategy through to 2024.	We need people with the right skills to help us develop. HR support. Successful recruitment

Leadership

What leadership challenges do PCNS face?	What support is required from NHSE/Midlands Leadership Academy?
• Capacity - not enough staff to take up the lead in the areas needed • Time in between board meetings to work through challenges and meet with PCN colleagues • Appropriate funding when specialist input is needed	• Flexible funding to release capacity to nurture leadership within PCNs • Funding for more PCN leads. Expand the PCN teams to practice/PCN requirements rather than prescriptive rules • To develop Practice Managers so they can engage with the PCN

• Staff members choosing to leave general practice (4/15 Practice Managers have left in et last 3 months) • Lack of GP Partners • Increasing patient expectation driving up demand and adding pressure • Providing clinical supervision for the ARRs roles • Ensuring that the PCN is prioritising the DES and not other work. Political meddling	

Estates

What are the key issues affecting optimal service provision?	Are PCNs working with NHS and non NHS partners in addition to primary care to utilise the whole PCN estate effectively?
• Investment into primary care premises • Severe shortage of clinical space limits availability to recruit to ARRs • Admin space also an issue • PCNs cannot expand into unused space due to rent requirements/lease expectations • Buildings not fit for purpose, room constrictions • Community providers unable or unwilling to share space	• 4 PCNs answered yes - SE Shropshire, Shrewsbury, North and Teldoc.

Digital Needs

Questions	Responses
Do you have access to digital staff resources, for example to assist with website, use of clinical systems by PCN-based staff, using digital tool for shared working including use of online consultations?	4 said yes, North, Teldoc, Newport & Central and SE Telford. 2 said some, SE Shropshire and SW Shropshire 2 said no, Shrewsbury and Wrekin Various resources are available to PCN's to enable access to digital resources via the ICB Primary Care Team who provide infrastructure and development support. Our Health Partnership also support practices signed up to them and some practices have IT support.
What proportion of PCNs share the same system for Online Consultations?	4 PCN's in T&W use EMIS online consult (50%) 4 PCN's in Shropshire use eConsult (50%)

What Advanced Telephony system does your PCN use?	3 PCNs share the same voice platform (38%) All PCNs have cloud based telephony but use different providers as they link into practice-based systems which are often all slightly different.

Access

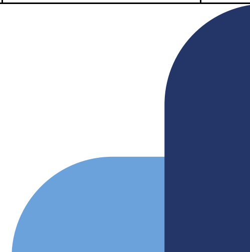
PCN Appointment systems
4 PCNs state that all ARRS staff appointments are captured in the practice appointment book
The roles listed as not being captured in the appointment book for some PCNs are Social Prescribing Link Workers, Care Coordinators and Paramedics. 1 PCN answered that roughly 20 ARRS appointments are not captured per week.

Appendix 1a

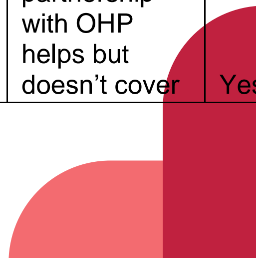
SERVICE IMPROVEMENT/DEVELOPMENT	South East Shrop PCN	Shrewsbury PCN	North PCN	South West Shrop PCN	Teldoc PCN	Newport & Central PCN	Wrekin PCN	South East Telford PCN
Have you developed a specific service improvement area to enable closer collaboration with wider community providers?	No	Yes	Yes – good relationship with MPFT, collaborative working.	Yes	Yes	Yes	Yes	No
Do you have a PCN Development plan that captures your PCN support needs for 2022-23?	No	Yes	Yes	Yes have a plan and Yes	No	Yes, have a plan and yes.	No	No
If Yes, how has your PCNs identified development needs?	The PCN has written a strategic plan that sets out our approach to achieving the DES and the IIF this year which covers workforce and resources required to achieve Through board and conversation/consultation. Kings Fund input. Through Kings Fund input and day with PMs to identify/ describe organisational needs							

Has your PCN, helped shape the STP/ICS plan to implement the Long Term Plan?	Unsure	Yes	We try – no evidence of impact. Influence routes not clear, only through LMC.	Yes, through attendance at meetings	No answer given	No	No	No
Has your PCN continued to form clear and agreed multi-disciplinary teams with community provider partners?	Yes	Yes	No	Yes, have tried	Yes	Yes	No	No
If yes, please briefly specify who and how	MPFT, Primary care Physio, Shropshire Council, ACP team MDT meetings organised, and updates provided to the PCN regularly. Shropshire Community Trust With MPFT and their transformation agenda. We have a well-functioning monthly MDT in partnership with LA, VCSO, Community Trust; Care Home MDT We have weekly care home MDT meetings with Shropcom, monthly with Mental Health Trust. FCPs employed through Shropcom. Social Prescribers employed through Mind. Mental Health Practitioner employed through MPFFT.							
If no, what are some of the barriers and what support do you require?	Communication and engagement with community services has been challenging. PCN staff manage MDTs Shropcom and SATH (hospital)– need to challenge traditional approach/attitudes to primary care and accept as equal partner round table It is not a requirement of the PCN DES. Time, admin support to facilitate MDT							
Please briefly describe how the local Population Health Management Tool is being used by your PCN?	Not sure this is being used - other than databases for health inequalities work. Training may be needed here.	It isn't, this is one of our areas of development need	Not currently using	To identify pockets of poverty/focus food bank work	Not currently using tool	Has been assessed to deliver plan, however the lead GP involved has left the surgery / PCN		
Workforce								

Do you have arrangements in place to ensure there is an assessment of clinical skill-mix to support the service provision?	Yes	Yes	Yes	No	Yes	Yes	Yes	No have plan/vision of future workforce development
Do you have the training and support to ensure a robust development of an effective PCN workforce strategy through to 2024?	Yes	Yes	Yes	No	Yes	Yes	Yes	No
If No, please outline what support is needed to ensure the robust development of an effective PCN workforce strategy through to 2024.	We need people with those skills to help us develop that. And lack of manager means our HR is thin on the ground Strategy will only work if recruitment successful							
Leadership								
What type of leadership challenges do PCNs currently face?	A lot of expectation to understand all areas when some things are quite specific and need additional input – which isn't correctly funded.	Practice Managers leaving their roles (x4 out of 15 in last 3 months) and lack of GP partners means there aren't many people to take a lead in areas that are needed	Time – capacity for additional time between board meetings to work through issues	The challenge is around capacity and also around addressing knowledge about PCNs. I think our PMs are a key force in the PCN.	Political meddling, increasing patient expectation, driving up demand	Loss of PCN Manager	Providing clinical supervision for all the various ARRS employees Ensuring that the PCN is prioritising the PCN DES, which is its primary role and not doing work that is not resourced or not appropriate to the PCN	

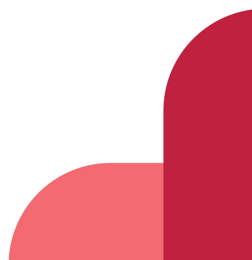


What type of PCN leadership development support is needed from NHSE/Midlands Leadership Academy?	Additional funding for more leads and to expand PCN teams to practice requirements rather than ARR requirements. Not currently needed Recruited a Chair which is really helpful to link to region/national To develop PMs understanding and engagement with PCN *none*							
Estates								
What are the key issues related to the estate within the PCN that prevents optimal service provision.	Practices need more space to accommodate ARR staff. The PCN cannot expand into unused spaces due to rent requirements/lease expectations and no funding.	Severe shortage of clinical rooms across the entire PCN limits our ability to recruit f2f ARRS roles	Space for staff, suitability of space, problems with converting space. Growth capacity.	Space in primary care. Two community hospitals but no linking between PCN and Shropcom despite several approaches from PCN	Some buildings not fit for purpose; Lack of adequate clinical space to support population growth	Room constrictions for growing ARRS workforce		Shortage of rooms
Are PCNs working with NHS and non NHS partners in addition to primary care to utilise the whole PCN estate effectively?	Yes	We are doing everything possible but have not identified any solutions yet	Yes	No	Yes	Yes/No	No	No
Digital								
Do you have access to digital staff resources, for example to assist with website, use of clinical systems by PCN-based staff, using digital tool for	Yes/No – Bit of Both	No	Yes	Some, our partnership with OHP helps but doesn't cover	Yes	Yes	No	Yes



shared working including use of Online Consultations?				all these requirements				
If Yes Please provide details.	We have a website and practices have knowledge on online consultations but its not PCN based its practice based. PCN staff use practice clinical systems so need to learn each practices way of working. All staff utilise tools. Will recruit to new digital transformation ARRS role We have dedicated IT support staff We have a website, Developing PCN EMIS system to enable Extended Access via GP Connect. Have video consultations for our remote physiotherapist – online consultations							
What Advanced Telephony system does your PCN use?	We don't. There isn't a way to put in a phone system when we don't have a base. All staff are put onto practice telephone systems, and they are all slightly different.		All on cloud-based systems		Redcentric		Redcentric- as per each member practice	
ACCESS								
Are all ARRS staff appointments captured in the practice appointment book?	No	Yes	Yes	Yes	No	Mostly, paramedics visits not yet since cross PCN appointment list	Yes	No

If not, which ARRS roles are not captured?	Care Coordinators				SPLW	Paramedics		Social prescribers
Where and how are they being captured?	No appointments being made – anyone who has appointments are all captured.		Emis/vision appointment book and mapped		Separate data reporting	Consultations are entered into clinical systems individually	On EMIS appointment books	
Provide an approximate figure of all ARRS appointments not captured per week.	0	0	0		No answer given	20	0	No answer given



Primary Care Risk Register (Public) - Shropshire, Telford and Wrekin CCG

1	2	3	4	5	6	7	8	9	10	11	12	13	14
Risk ID	**Objective**	**Opened / added by**	**Risk and description**	**Opportunity**	**Existing key controls**	**Existing sources of assurance**	**Gaps in controls or assurances**	**Risk score (consequences x likelihood)**	**Action plan / cost / action lead /(target date) /sufficient mitigation**	**Target risk score for end of financial year**	**Executive Lead and Risk Owner**	**Amendments: name and date**	**Status**
Active Risks													
STW-02		Shrop 19/01/19 T+W 18/05/19	**Workforce** There is a risk that the system fails to recruit and retain workforce clinical staff, reflecting the challenge nationally. This will impact on local GP workload and the delivery of transformational primary care in Shropshire.	1. Primary Care Transformation monies enables practices to create new creative roles 2. The Training Hub is providing a pivotal training service to primary care medical and other health professionals 3. ARRS funding is enabling additional roles to support PCN's	1. Primary care workforce funding projects are in place. 2. Delivery board and operational groups in place to support delivery in line with practice priorities. 3. Workforce and training hub are reported to system People Board to give system oversight and to ensure that primary care is looped into the workforce issues	1. PCN assurance meetings 2. PCN workforce plans aligned to priorities 3. Recruitment in line with ARRS financial envelope 4. Training hub board and group reporting to People Board fro system	1. PCN Workforce plans do not use full resource envelope.	3x3=9 Moderate	1. Promote PCNs to have staff responsible for workforce. 2. Integration of clinical staff/representation on the operational workforce groups 3. Attendance at regional workforce groups to share learning. 4. Report to people board and ensure understanding of primary care workforce issues 5. Implement GP Strategy	3x3=9 Moderate	Exec: C. Parker Owner: C Parker	26/11/2020 C. Ralph Reviewed 1 04 21 T Jones Amended C Parker June 2021 Updates by Phil Morgan 24.01.22 GP and GPN Strategies approved and being implemented	Open
STW-03		07/10/20 C. Ralph	**COVID-19** There is a risk that the COVID-19 pandemic will increase the demand on practices and may also increase the levels of sickness. This means that practices may not be able to maintain access to their services/or to deliver high quality clinical care. This includes ability to manage the backlog and manage staff shortages either through positive tests or self isolation	1. Pressures promote practices and the system to collaborate more effectively.	1. Changes in contractual requirements to relieve practices/support service delivery 2. Additional investment	1. information through newsletters and locality meetings, contact with partnership managers 2. refresh of weekly calls to be undertaken to get information to practice managers 3. Support for the national guidance on the return to work processes	1.Limited formal SITREP reporting 2. Demand and activity modelling needs to be done to show system pressure 3. electronic locum support service including all professions	4x4=16 High	1. Support practices to review business continuity plans 2. Support practices to link plans together/buddy practices 3. Commence work to develop SITREP 4. ICB to identify thresholds and triggers for system response 5. ensure access to IPC and public health support 6. ensure IMT under new national return to work guidelines are in place	3x3=9 Moderate	Exec: C. Parker Owner: C Parker	26/11/2020 C. Ralph Reviewed 1.04.21 T Jones Amended C Parker June 21	Open
STW 05 (Previously S-03)		PCCC 04/19	**Forecasted Expenditure** There is a risk that forecasted expenditure in relation to estates and other delegated functions will adversely affect the ICBs ability to deliver financial balance within the primary care directorate	1. To ensure the financial stability of practices by ensuring rent reviews and completed on time 2. to ensure that opportunities for pilots such as the 'Cavell' project is used to the benefit of the population in the ICB	1. Premises Cost Directions 2. Scheduled programmes of rent reviews 3. Clear approvals process for new business cases 4. Project boards with risk management and mitigation for each of the projects held at least monthly	1. Accurate record keeping 2. Regular contact/liaison with NHSE (GMAS team) 3. Project board oversight for each of the new builds	1. Changes in the primary care team at NHSE 2. Triple lock process for ICB 3. Links to One Public estate	3x4=12 High	1. Ensure the completion of a review of estates and the completion of estates strategy 2. Ensure business cases in development contain innovation to change models of care to deliver a return on investment. 3. Ensure pro-active record keeping/review of rent reviews. 4. To have clear records and monitoring systems that set out when abatements are ending predicting the impact on budgets.	3x4=12 High	Exec: C Parker Owner: E Pyrah	1 04 21 Risk reviewed T Jones Amended C Parker June 21	Open
STW 08		Tom Brettell 26/01/22	**Highley Practice CQC Rating** Risk to delivery of continuity of care to due adverse CQC rating for Highley Medical Practice. If CQC registration is revoked this will result in termination of GMS contract therefore options need to be worked through. Patient concern likely to lead to significant number of representations and the potential for patients to seek registration elsewhere.	1. an improved / safe service for patients (if actions addressed). 2. review of contingency planning. 3, PCN pilot opportunity	1 - ICB primary care, Quality and Meds man teams supporting the practice to address the actions required to support improvement. 2 - Formal action plan agreed with practice and CQC- meeting weekly to monitor and provide assistance	1 - Action plan 2 - Regular contact with practice 3 - Feeding back progress to CQC 4- CQC visit to review actions taken to address 2 warning notices has confirmed improvement 5 - Feedback on improvement work to key partners, patients and wider community	If the CQC registration is revoked the ICB will need to consider options such as; caretaking arrangements; procurement; list dispersal. Options appraisal complete and ready for deployment.	C = 4 L = 2 TOTAL: 8 Moderate risk	1) Develop a contingency plan to ensure arrangements are in place should redistribution of practice care be required. In place	C = 4 L = 1 TOTAL: 4 Low risk	Exec: C Parker Lead: E Pyrah	Close risk, practice have given notice to terminate their contract - new risk in this regard added E. Pyrah 17.11.22	Close
STW 09		E Pyrah 17.11.22	**Highley Medical Practice Termination of Contract** - risk unable to reprocure a suitable replacement service which would mean dispersing the list putting further pressure on existing surrounding practices and adversely impacting on patient experience and outcomes	Opportunity to design a new model of integrated service provision	Core project team established to oversee Range of conversations underway with key stakeholder partners and PCN ICB Policy being enacted Regular updates to PCCC Action plan in development			4 x 3 = 12 (MODERATE)		4 x 1 = 4 (LOW)	Exec: C Parker Lead: E Pyrah		Open

STW-10		E Pyrah 7.7.22	Patients experiencing delays in getting through to their practice on the telephone and getting a timely appointment risks increasing the demand on urgent and emergency care services and poorer patient outcomes, patient experience		Access rates are monitored by the Primary Care Team Practices with poor access rates are targetted/prioritised for quality visits GP Survey results	Practice improvement plans Practice visits	Practices are autonomous businesses with their individual service delivery models There are no KPIs in the national GP contract for response times to answering the telephone or timeframe for offering a GP appointment Telephone answering data is the property of the practice, ICB does not have access to this data to monitor performance	3 x 3=9 Moderate risk	Schedule of prioritised practice visits Redesign plan in response to national Fuller report	3 x 3=9	Exec: C Parker Lead: E Pyrah		Open
STW-11		E Pyrah 7.10.22	PCNs do not recruit to their full Additional Roles allocation. Risk we do not maximise the increase in the workforce this can deliver and March 2024 the ARRS funding will be baselined on the basis of actual spend rather than funding allocation available, so will be lost to the system if not fully spent		Regular monitoring of PCN plans and spend Maximum flexibilities on the application of the roles criteria PCNs reminded to ensure they record all ARRS roles in the national workforce database to ensure it fully reflects the local picture	PCN Development Meeting		3 x 2 LOW		2 x 2 = 4 LOW	Exec: C Parker Lead: E Pyrah		Open
STW-12		E Pyrah 17.11.22	Changes in working practice in other parts of the system and the impact of the elective backlog adding estimated 25-30% additional demand in primary care - risk demand outstrips supply adversely impacting on GP Access		Maximise recruitment/retention initiatives to ensure optimise workforce available Develop a better primary/secondary care interface so that they can better understand each others pinch points Communicate better what is core GMS work and what is not			4 x 4 = 16 (HIGH)		4 x 4 = 16 HIGH	Exec: C Parker Lead: E Pyrah		Open
STW-13		E Pyrah 17.11.22	Shrewsbury Hub - No alternative site is identified in the rerun of the site options appraisal - risks GP practice viability as no other viable solution to providing the 6 GP practices with sustainable fit for purpose premises		Long list of sites sourced from a variety of avenues to ensure every option is on the table for consideration Work with the Council to ensure all Council owned suitable sites are on the list			5 x 3 = 15 (HIGH)		5 x 2 = 10 (MODERATE)	Exec: C Parker Lead: E Pyrah		Open
STW-14		E Pyrah 17.11.22	Shrewsbury Hub - Delays to the project timeline risk may become unacceptable to NHSE risking withdrawal of their support for us to continue as a pilot site		Regular dialogue with Council colleagues Regular dialogue with NHSE Project Board monthly Pro-active problem solving to minimise level of delays Buy in additional capacity as required		Some of the delays are outwith the control of the project	5 x 3 = 15 (HIGH)		5 x 3 = 15 (HIGH)	Exec: C Parker Lead: E Pyrah		Open
Closed Risks													
S-02		PCCC 03/19	There is not an agreed process for the completion of practice visits. There is a risk therefore that there may be emerging issues affecting quality that the CCG is not aware of/cannot support improvement. This means that there is a potential for variation/poor quality of care or inefficient systems and processes.	1. Potential to share good practice across the system. 2. Potential to save process improvements and reduce hand-offs/inefficiencies in practices	1. Maintain and build relationships with GP practices to monitor quality standards. 2. Update quality dashboard regularly. 3. Primary Care to develop a dashboard and process for more effective monitoring of Primary Care Quality.	1. CQC reports and regular meetings with CQC. Regular liaison with NHSE/I. 2. Quality dashboard updated and presented to PCCC quarterly. 3. Regular reporting to Quality and Audit Committee on risks and achievements	1. Infrequent opportunities to review/work with practices 2. Inconsistent opportunities - levels of engagement with practices	3x3=9 Moderate	1. Maintain focus to identify triggers/early signs of issues 2. Triangulate data from multiple sources 3. Close liaison with other professionals/agencies 4. Review complaints/GPPS 5. Work to standardise practice visit approach across the emerging new CCG	3x3=9 Moderate	Exec: Z. Young Owner: S.Ellis/C. Ralph	26/11/20 Actions updated Request for this to be closed with new risk identified for Practice visits which incorporates work across STW CCG.	Closed
STW-01	T+W 4+5 Shrop	C/F Telford 24/06/19 C. Ralph	**Primary Care Networks (PCN)** These new organisations will have to establish how they will work together as a network and share resources. There is a risk of potential delay and/or conflict as the new roles and the new ways of working are established. This would mean that their is inconsistent development of PCNs across the CCG which may affect service provision and access to our patients.	1. There is a potential opportunity for PCNs to create additional competition in the market for services traditionally provided by acute/community services. 2.Opportunity to increase the resilience of practices by sharing resources and effort overtime	1. National guidance for PCN development and the associated network agreements signed by all practices 2. Clinical leadership identified by members of each PCN PCNs to follow guidance from NHSE in regards to their establishment. 3. Guidance on the delivery of DES' for 2020 released 4. 8 PCNs now exist within STW CCG - only one practice remains as an orphan practice but patients are allocated	Notes of PCN meetings/assurance meetings - PCN Development meetings re-established, PCN delivering vaccination programme through existing Enhanced services, PCN development feeding into refreshed single CCG governance. Regular formal and informal meetings in place to engage, collaborate and deliver shared working arrangements. PCN's engaged at place	None	3x3=9 Moderate	1. Take opportunities to seek out the views of practices on the PCN development processes (ongoing) 2. Establish regular meetings with CDs to enable monitoring of progress by August 2020 3. Support PCNs to complete/re-visit baseline assessments as part of the developmental programme by September 2020	1x3=3 Low	Exec: C. Parker Owner: S.Ellis/C. Ralph	Reviewed 1 4 21 Tjones Covid has impacted upon planned development work however risk remains low as new ways of working together arising form Covid opportunities Agreed CLOSE at PCCC June 2021	Closed

STW 06 Previously S-04		PCCC 12/20	Primary Care Services in Whitchurch are under increased pressures due to difficulty in recruiting staff and managing services across several unsuitable small sites. There is a risk that Churchmere Medical Group hand back their contract if the situation continues. The planned closure of Dodington Surgery at end March 2021 adds to this pressure.	To secure the future of Primary Care services in Whitchurch by building a purpose built health care facility - The Pauls Moss Development proposal..	1. GMS Contract in place. 2. Pauls Moss programme proposals in place, although currently awaiting judicial review decision. 3. CCG agreed a transformational funding package to support Churchmere Medical Group to merge with Dodington Surgery and to manage services across 3 sites.	1. Regular contact with Churchmere senior partners. 2. NHSE support with merger and ETTF monies for expansion space costs. 3. Flexible use of new ARRS roles to increase clinical capacity, 4. Judicial review against Pauls Moss development was not upheld there fore the build will now go ahead		2x1=2 Very low	1. Ensure regular contact with CMG to identify issues early. 2. Ensure close liaison with Pauls Moss Development partners to be alerted to judicial review decision and any further appeals. 3. Explore CCG options should a new contract holder be needed	2x1=2 Moderate	Exec: C. Parker Owner: C Parker	Reviewed 1 4 21 Tjones Amended C Parker June 21 Recommend for closure as further risks incorporated into financial risks	Closed
STW - 04		Jane Sullivan 04/21	**Quality Visits** Due to Covid 19 pandemic scheduled Practice Quality Visits have been paused since March 2020. Although remote monitoring has continued a Practice Quality Visit allows for further exploration of subjects and conversations between CCG and Practice to gain assurance and understanding. There is a risk that practices not receiving quality visits may be rated inadequate or RI by CQC without the support of the quality and primary care team as part of the practice visit programme due to Covid-19 outbreaks	1. Potential to share good practice across the system. 2. Potential to save process improvements and reduce hand-offs/inefficiencies in practices	1. Primary care and Quality Lead continue to meet quarterly with CQC to share intelligence. 2. Continue to monitor Practice performance using existing sources of assurance and speak to Practices individually if concerns identified.	1. CQC intelligence 2. Significant event reporting to CCG by Practices 3. Monitoring of Patient experience - PALs/Healthwatch/MP letters/ complaints shared with CCG by NHSE/GP Patient Survey/FFT/N2N 4. Quarterly Quality report submitted to Quality and Performance committee 5. EDEC	1. Missed opportunities during visits to explore specific areas with Practices in further depth. 2. Missed opportunities to share good practice and learning with CCG which discussions during a visit can generate.	3x2= 6 low	1. Proposal to establish a Task and Finish Group to re-establish Practice Quality Visits from Autumn 2021 with identified agenda and terms of reference to provide a unified approach across the CCG. 2. Data and intelligence will be reviewed prior to visit to ensure that they are individual to each Practice and target areas for assurance.	3 x 2 = 6 Low	Claire Parker Zena Young	Newly added 1 4 21 T Jones Amended C Parker June 21 Recommended for closure. A Task & Finish Group was arranged to agree visits to concerning areas. Visits have taken place with only January's planned visits postponed due to system level 4.	Closed
STW 07		PCCC 06/21 C Parker	**Covid Expansion Fund** Allocation of practice Covid expansion fund was incorrectly calculated in the national guidance and left a shortfall of 1.2m for the allocation received which was absorbed into the CCG baseline		1. Funding not utilised as part of the pulse oximetry service was put back into the baseline circa £200k		1. In ability to take any funding from primary care to ensure services are funded appropriately	3x3=9 Moderate		3x3=9 Moderate	Exec: C Parker & C Skidmore	New risk added June 2021	Closed

Audit Committee Meeting - Appendix B

RISK MANAGEMENT MATRIX

	Likelihood				
Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
1 Negligible	1 VERY LOW	2 VERY LOW	3 VERY LOW	4 LOW	5 LOW
2 Minor	2 VERY LOW	4 LOW	6 LOW	8 MODERATE	10 MODERATE
3 Moderate	3 VERY LOW	6 LOW	9 MODERATE	12 HIGH	15 HIGH
4 Major	4 LOW	8 MODERATE	12 HIGH	16 HIGH	20 EXTREME
5 Catastrophic	5 LOW	10 MODERATE	15 HIGH	20 EXTREME	25 EXTREME

	1 – 3	Very Low risk
	4 – 6	Low risk
	8 – 10	Moderate risk
	12 – 16	High risk
	20 – 25	Extreme risk

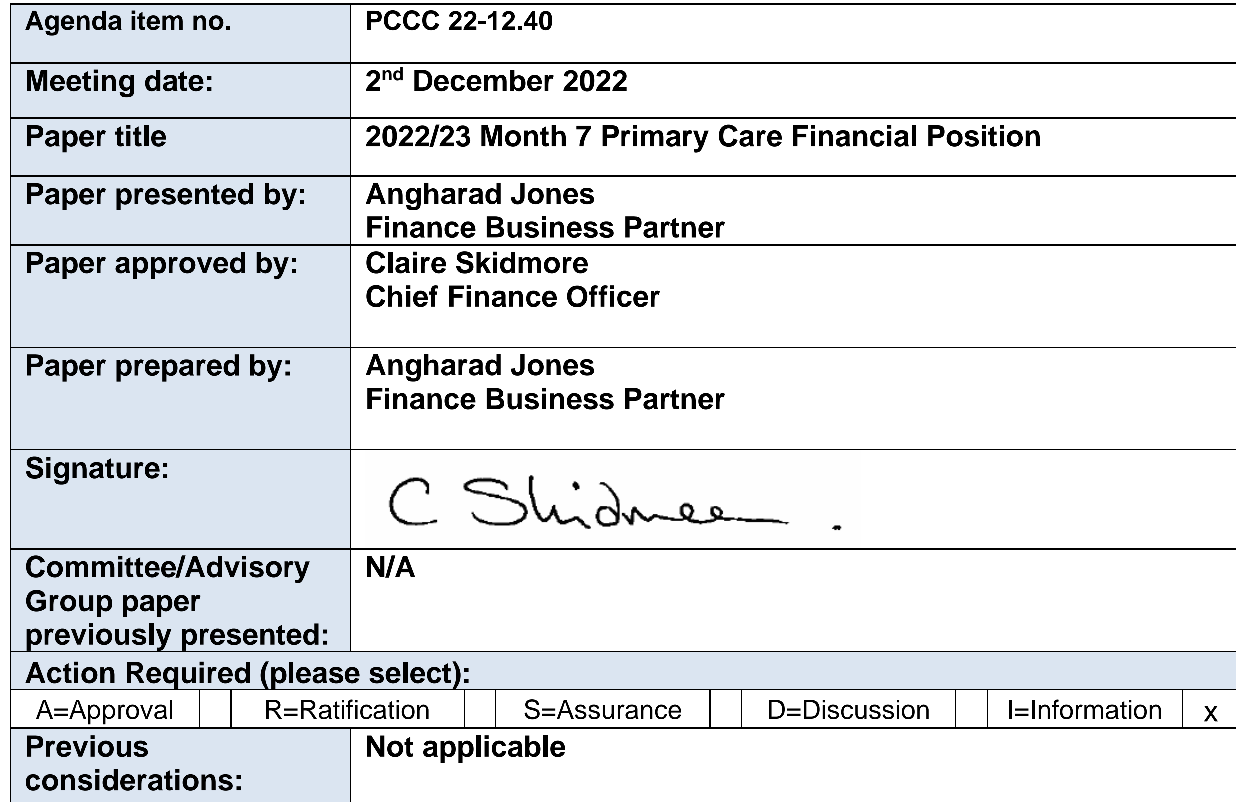
	Consequence score (severity levels) and examples of descriptions				
Domains	1. Negligible	2. Minor	3. Moderate	4.Major	5. Extreme
Impact on the safety of patients, staff or public (physical/psychological harm).	Minimal injury or illness, requiring no/minimal intervention or treatment. No time off work.	Minor injury or illness, requiring minor intervention. Requiring time off work for >3 days. Increase in length of hospital stay by 1-3 days.	Moderate injury requiring professional intervention. Requiring time off work. Increase in length of hospital stay by 4-15 days. RIDDOR/agency reportable incident. An event which impacts on a small number of patients.	Major injury leading to long-term incapacity/disability. Requiring time off work for >14 days. Increase in length of hospital stay by >15 days. Mismanagement of patient care with long-term effects.	Incident leading to death. Multiple permanent injuries or irreversible health effects. An event which impacts on a large number of patients.
Quality/complaints/audit	Peripheral element of treatment or service suboptimal. Informal complain/injury.	Overall treatment or service suboptimal. Formal complaint. Local resolution. Single failure to meet standards. Minor implications for patient safety unresolved. Reduced performance rating if unresolved.	Treatment or service has significantly reduced effectiveness. Formal complaint. Local resolution (with potential to go to independent review). Repeated failure to meet internal standards. Major patient safety implications if findings are not acted on.	Non compliance with national standards with significant risk to patient if unresolved. Multiple complaints/independent review. Low performance rating. Critical report.	totally unacceptable level or quality of treatment/ services. Gross failure of patient safety if findings not acted upon. Inquest/ombudsman inquiry. Gross failure to meet national standards.

Human resources/organisational/ development/staffing/ competence	Short term low staffing that temporary reduces services quality (1< day).	Low staffing level that reduces the services quality.	Late delivery of key objectives/service due to lack of staff. Unsafe staffing level or competence (>1 day). Low staff morale. Poor staff attendance for mandatory/key training.	Uncertain delivery of key objective/service due to lack of staff. Unsafe staffing level or competence (>5 days). Loss of key staff. Very low staff morale. No staff attending mandatory/key training.	Non-delivery of key objectives/service due to lack to staff. On-going unsafe staffing levels or competence. Loss of several key staff. No staff attending mandatory training /key training on an on-going basis.
Statutory duty/inspections	No or minimal impact or breach or guidance/statutory duty.	Breach of statutory legislation. Reduced performance rating if unresolved.	single breach in statutory duty. Challenging external recommendation/improvement notice.	Enforcement action. Multiple breaches in statutory duty. Improvement notices. Low performance rating. Critical report.	Multiple breaches in statutory duty. Prosecution. Complete systems change required. Zero performance rating. Severity critical report.
Adverse publicity	Rumours. Potential for public concern.	Local media coverage. Short term reduction in public confidence. Elements of public expectation not being met.	Local media coverage - long-term reduction in public confidence.	National media coverage with >3 days service well below reasonable public expectation.	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions raised in the House). Total loss of public confidence.
Business objectives/projects	Insignificant cost increase/schedule slippage	<5 per cent over project budget. Schedule slippage.	5-10 per cent over project budget. Schedule slippage.	Non-compliance with national 10-25 per cent over project budget. Schedule slippage. Key objectives not met.	Incident leading >25 per cent over project budget. Schedule slippage. Key objectives not met.
Finance including claims	Small loss. Risk of claim remote.	Loss of 0.1 - 0.25 per cent of budget. Claim less than £10,000.	Loss of 0.25-0.5 per cent of budget. Claim (s) between £10,000 and £100,000.	Uncertain delivery of key objective/loss of .5 - 1.0 per cent of budget. Claim(s) between £100,000 and £1 million. Purchasers failing to pay on time.	Non-delivery of key objectives/loss of >1 per cent of budget. Failure to meet specification/slip page. Loss of contract/payment by results. Claim(s) > £1 million.
Service/business interruption/environmental impact	Loss/interruption of >1 hour. Minimal or no impact on the environment.	Loss/interruption of >8 hours. Minor impact on environment.	Loss/interruption of >1 day. Moderate impact on environment.	Loss/interruption of >1 week. Major impact on environment.	Permanent loss of service or facility. Catastrophic impact on environment.

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Primary Care Commissioning Committee Part 1



Agenda item no.	**PCCC 22-12.40**
Meeting date:	**2nd December 2022**
Paper title	**2022/23 Month 7 Primary Care Financial Position**
Paper presented by:	**Angharad Jones** **Finance Business Partner**
Paper approved by:	**Claire Skidmore** **Chief Finance Officer**
Paper prepared by:	**Angharad Jones** **Finance Business Partner**
Signature:	C Skidmore
Committee/Advisory Group paper previously presented:	**N/A**
Action Required (please select):	
A=Approval | | R=Ratification | | S=Assurance | | D=Discussion | | I=Information | x	
Previous considerations:	**Not applicable**

1. Executive summary and points for discussion

Financial Position – Month 7, October 2022:

Co-Commissioning budgets (those delegated to the ICB from NHSE) are currently underspent by £2,915k with a reported full year forecast underspend of £3,310k. This is mainly in relation to the release of prior year benefits where expenditure has been slightly less than 21/22 year end estimates and expected income in relation to the rates rebates efficiency scheme.
The underlying in year position is a year-to-date underspend of £872k with a forecast underspend of £1,325k.

For information, other Primary Care budgets (those that form part of the ICB's core budget) have a year-to-date underspend of £1,641k and a full year underspend forecast of £432k. The main driver of this underspend is the release of prior year benefit in relation to Prescribing and Enhanced Services which is non recurrent in nature.

Both the delegated and non-delegated primary care areas are currently anticipated to deliver expenditure less than plan this year. This is predominantly driven by taking the benefit of accruals set in 2021/22 that are no longer required now that actual costs have been accounted for. The finance team are working to review the underlying position in this area as whilst there is a benefit in 22/23, there is a risk that there will be an underlying pressure in the recurrent budget which would be carried into future years and will need to be addressed.

The 23/24 planning round is now in progress; within the timeline we are looking to have a first draft of activity workforce and finance plans completed before the end of the calendar year, with a final version available by the end of February 2023.

From 1st April 2023 the ICB will have delegated responsibility for POD (Pharmacy, Optometry and Dentistry) from NHSE. The ICB have regular meetings with NHSE to discuss and plan for the transfer. ICBs from across West and East Midlands are in discussion with NHSE about options for financial risk sharing arrangements. A financial risk framework document has been drafted and is attached. A joint update paper from the Primary Care Team and Finance Team will be presented at the February Committee

2. Which of the ICB Pledges does this report align with?

Improving safety and quality	
Integrating services at place and neighbourhood level	
Tackling the problems of ill health, health inequalities and access to health care	
Delivering improvements in Mental Health and Learning Disability/Autism provision	
Economic regeneration	
Climate change	
Leadership and Governance	
Enhanced engagement and accountability	
Creating system sustainability	X
Workforce	

3. Recommendation(s)

The committee is asked to:

Note the financial position for the delegated budgets and that small risks are expected to be mitigated within the current budget
Note the non-delegated primary care position and the risk of volatility in the prescribing budget driven by factors outside of the ICB's control
Note that work is underway on the 23/24 plan and that further information will be brought to the February Committee
Note that delegated responsibility for Community Pharmacy, Optometry and Dental (POD) services will transfer to the ICB from April 23 and discussions are ongoing around options for risk sharing arrangements.
Support the principles of the Draft POD Delegation Financial Risk Framework.

4. Does the report provide assurance or mitigate any of the strategic threats or significant risks in the Board Assurance Framework? If yes, please detail

N/A

5. Appendices

1. Draft POD Delegation Financial Risk Framework

6. What are the implications for:

Shropshire, Telford and Wrekin's Residents and Communities	Availability of funding impacts on prioritisation of commissioned services.
Quality and Safety	Availability of funding impacts on prioritisation of commissioned services
Equality, Diversity, and Inclusion	No impact
Finances and Use of Resources	Risk highlighted to delivery of financial plan
Regulation and Legal Requirements	No impact
Conflicts of Interest	No impact
Data Protection	No Impact
Transformation and Innovation	No impact
Environmental and Climate Change	No impact
Future Decisions and Policy Making	22/23 recurrent exit position forms the basis of long term financial planning
Citizen and Stakeholder Engagement	No impact

Request of Paper:	**Note** the financial position for the delegated budgets and that small risks are expected to be mitigated within the current budget **Note** the non-delegated primary care position and the risk of volatility in the prescribing budget driven by factors outside of the ICB's control **Note** that work is underway on the 23/24 plan and that further information will be brought to the February Committee **Note** that delegated responsibility for POD services will transfer to the ICB from April 23 and discussions are ongoing around options for risk sharing arrangements. **Support** the principles of the Draft POD Delegation Financial Risk Framework.	**Action approved at Board:**	
		If unable to approve, action required:	
Signature:		**Date:**	

20212/23 Month 7 Financial Position

Introduction

1. The financial performance reported in this paper is for Month 7 – October 2022.

Delegated Budget

Table 1: M7 Reported Position Delegated

Primary Care Delegated	Budget Year To Date £'000	Actual Year To Date £'000	Variance Year To Date £'000	2022/23 Budget £'000	2022/23 Forecast £'000	Forecast Variance £'000
General Practice - GMS	30,640	30,143	497	52,721	51,905	816
General Practice - PMS	0	0	0	0	0	0
QOF	4,549	4,613	(64)	7,845	7,934	(89)
Enhanced Services	5,652	6,939	(1,288)	12,178	12,950	(772)
Premises Cost Reimbursements	4,670	3,925	745	7,651	7,450	201
Dispensing & Prescribing	1,731	1,524	206	2,955	2,699	256
Other GP Services	908	(1,291)	2,200	1,428	(852)	2,280
Co Commissioning Planning Adjustment	618	0	618	618	0	618
Total Primary Care Delegated	48,769	45,853	2,915	85,396	82,086	3,310

2. The table above shows the position reported in the CCG ledger (Q1 22/23 only) and the ICB ledger combined. In month 4, work was undertaken to realign the budget at category level after an extensive review of expenditure areas in light of the new GP contract. Unfortunately, we have been unable to backdate this budget realignment into the CCG ledger which is now closed. The table below sets out the impact on individual budget lines of the full adjustment (noting that expenditure distribution remains unaffected).

Table 2: M7 Realigned Budget Position Delegated

Primary Care Delegated	Budget Year To Date £'000	Actual Year To Date £'000	Variance Year To Date £'000	2022/23 Budget £'000	2022/23 Forecast £'000	Forecast Variance £'000
General Practice - GMS	30,913	30,143	770	52,993	51,905	1,088
QOF	4,615	4,613	2	7,911	7,934	(23)
Enhanced Services	6,628	6,939	(311)	13,154	12,950	204
Premises Cost Reimbursements	4,173	3,925	248	7,153	7,450	(297)
Dispensing & Prescribing	1,714	1,524	190	2,939	2,699	240
Other GP Services	727	(1,291)	2,017	1,246	(852)	2,098
Total Primary Care Delegated	48,769	45,853	2,915	85,396	82,086	3,310

3. The above table includes non-recurrent adjustments in relation to prior year benefits. The below table shows the underlying position which excludes the non-recurrent adjustments.

Table 3: M7 In Year Underlying Position Delegated

Primary Care Delegated	Budget Year To Date £'000	Actual Year To Date £'000	Variance Year To Date £'000	2022/23 Budget £'000	2022/23 Forecast £'000	Forecast Variance £'000
General Practice - GMS	30,913	30,143	770	52,993	51,905	1,088
QOF	4,615	4,613	2	7,911	7,934	(23)
Enhanced Services	6,628	6,939	(311)	13,154	12,950	204
Premises Cost Reimbursements	4,173	4,189	(16)	7,153	7,765	(612)
Dispensing & Prescribing	1,714	1,524	190	2,939	2,699	240
Other GP Services	727	488	238	1,246	818	428
Total Primary Care Delegated	**48,769**	**47,896**	**872**	**85,396**	**84,071**	**1,325**

4. General Practice GMS - The year to date and forecast variance is due to Qtr 2 & 3 list size growth being lower than originally planned. 2% growth was built into the plan for Q2 & 3. The actual growth seen was 0.22% and 0.45% respectively. The Global Sum payment is recalculated each quarter based on the latest list size data which is released on a quarterly basis. Quarter 4 growth has been forecast at 1%.

5. QOF – There are two payments associated with QoF. First, aspiration payments, based on 70% of prior year achievement. These payments are made on a monthly basis. The second payment is for achievement, which is paid in the following financial year once all QoF data has been submitted and total points calculated. The forecast for the achievement element is based on equivalent achievement levels as 21/22.

6. Enhanced Services – The Additional Roles Reimbursement Scheme (ARRS) represents 41% of the annual budget on Enhanced Services. The year-to-date variance is due to budget phasing for ARRS and is reflective of the in-month significant ARRS arrears claim that had not been factored into the year to date budget, however the cost is absorbed into the forecast position. The latest complete monthly reimbursement claim (August 2022) shows that 125 WTE staff are employed within the scheme. PCN recruitment plans, submitted at the end of August 2022 forecast 199 WTE staff to be in post by the 31st March 2023.

7. Premises Cost Reimbursements – Further analysis of premises costs has been carried out in jointly with the NHSE Estates team to identify any cost pressures in relation to rental review arrears and appeals outstanding. This review has reduced the forecast overspend which is currently offset by underspend on other budget rows. The overspend is phased into the latter part of the financial year due to the provision for any outstanding arrears being profiled towards the end of the year.

8. Dispensing and Prescribing – The forecast is based on average spend per month. This has resulted in an underspend both year to date and forecast.

9. Other GP Services – The year to date and forecast underspend is partially driven by Locum spend being less than originally anticipated and budgeted for. This underspend is partly offsetting the adverse variance on Premises Cost Reimbursements.

10. The difference between the reported position and the underlying position is an adverse movement of £2m. This is predominantly driven by taking the benefit of accruals set in 2021/22 that are no longer required now that actual costs have been accounted for.

11. Although there is an underlying in year forecast of £1.3m underspend, there are known future commitments in relation to premises, in particular new developments, that will reduce this underspend significantly.

Non Delegated Budget

Table 4: M7 Reported Position Non Delegated

Primary Care Non Delegated	Budget Year To Date £'000	Actual Year To Date £'000	Variance Year To Date £'000	2022/23 Budget £'000	2022/23 Forecast £'000	Forecast Variance £'000
Prescribing	49,420	49,155	265	84,772	85,367	(595)
Central Drugs	1,421	1,480	(59)	2,436	2,547	(111)
Oxygen	535	580	(45)	917	983	(65)
Prescribing Incentive Schemes	220	86	133	377	241	137
Out of Hours	1,981	1,980	1	4,391	4,415	(24)
Enhanced Services	3,067	1,182	1,884	5,651	3,626	2,025
Primary Care Pay	1,722	1,552	170	3,040	2,967	73
Primary Care Other	221	181	40	294	254	40
Primary Care IT	1,284	1,320	(36)	2,253	2,301	(48)
GP Forward View	1,523	1,473	51	1,765	1,950	(185)
Primary Care Planning Adjustment	(764)	0	(764)	(815)	0	(815)
Total Primary Care Non Delegated	**60,630**	**58,989**	**1,641**	**105,081**	**104,649**	**432**

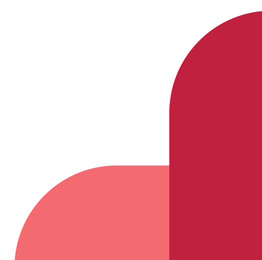
12. The year-to-date position is an underspend of £1.6m. The main driver for the reported underspend is the release of prior year benefits in relation to Prescribing and Enhanced Services.

13. The Prescribing forecast has increased by £1m between Months 6 & 7. The forecast is based on the National EPACT system forecast which is updated on a monthly basis. The main driver of the overspend is the cost pressure from NCSO (No Cheaper Stock Obtainable) price concession and Category M Drugs tariff, totalling £1m higher year to date compared with 21/22 expenditure.

14. The table below shows the number of items prescribed by month and cost per item compared with Apr-Aug 2021.

Month	Items	Net Ingredient Cost	Net ingredient cost per item	Year on Year Growth (Items)	Year on Year Growth (cost per item)
April	765,346	£ 7,049,470	£ 9.21	-1.8%	-4.4%
May	826,142	£ 7,734,696	£ 9.36	11.5%	-3.1%
June	794,184	£ 7,421,601	£ 9.34	0.5%	-3.7%
July	816,151	£ 7,827,244	£ 9.59	2.0%	1.7%
August	820,512	£ 7,892,059	£ 9.62	7.7%	2.3%

15. The forecast underspend on non-delegated budgets is £432k. The reduction in the forecast from the year-to-date underspend is due to the release of prior year benefits phased into Q1, the increase in prescribing costs seen in Q2, as well as the adverse variance of £815k on the planning adjustment line, offsetting against a favourable variance in Co Commissioning. (This is due to the plan having to match the allocation for co commissioning, planned underspends in co commissioning were budgeted for within the non-delegated area (there is an opposite and equal entry).



Efficiency

Table 5: M7 Efficiency Schemes

Efficiency Scheme	M7 YTD Plan £'000	M7 YTD Actual £'000	M7 Variance £'000	Full Year Plan £'000	Full Year Forecast £'000	Forecast Variance £'000
DOAC	480	64	(416)	884	200	(684)
Optum	229	336	107	247	393	146
Prescribing Decision Support	294	363	69	500	560	60
Procurement of Decision Support Tool	0	28	28	0	28	28
VAT Rebate on Decision Suport Tool	0	45	45	0	45	45
Switch Programme	119	141	22	150	175	25
NR Safer Medicines (LCS)	0	108	108	0	108	108
Unidentified	0	0	0	0	272	272
Total	**1,122**	**1,085**	**(37)**	**1,781**	**1,781**	**(0)**

16. The ICB has a number of efficiency schemes to be delivered from prescribing budgets which are detailed in table 5 above. These contribute to the 1.6% system efficiency 'ask' that all system partners have agreed.

17. At month 7 an under achievement of £37k is reported, with a forecast position of breakeven. The underachievement is due to the DOAC (Direct-acting oral anticoagulants) scheme and is due to a number of factors including a slow uptake of switching to Edoxaban in primary care (due to competing priorities) and secondary care continuing to use alternative DOACs. Local initiation guidance is being developed by the Medicines Management team to encourage clinicians to adopt Edoxaban as first line medication and general practices are being supported with implementation.

18. Forecasts are reviewed monthly and it is likely that other programmes of work will exceed plan which will help offset the £272k currently unidentified, due to the in year reduction in the DOAC forecast.

Capital

19. The ICB has a small capital allocation for GP Services, split between Primary Care IT and GP Improvement Grants. These assets sit on the NHSE Statement of Financial Position (balance sheet) and do not appear in the ICB accounts or asset register. Below is a summary of the 22/23 Plan and Forecast.

Capital Scheme	22/23 Plan £'000	22/23 Forecast £'000	22/23 Variance £'000
GP IT Hardware Replacement	286	286	0
N365 Deployment	282	282	0
GP Improvement Grants	305	303	2
Total	**873**	**871**	**2**

20. Recent national guidance has been published regarding support to GPs/ PCNs through winter and beyond, which includes potential additional capital funding. The ICB have submitted a bid which has been passed through to the second phase of approvals. We are currently awaiting the final decision.

Risks

21. Currently there are no significant risks emerging within the delegated budgets and there is confidence that small risks can be mitigated and managed within budget.

22. There is a risk within the non-delegated budgets. This is specifically in relation to Prescribing due to the volatility in forecasting based on recent data and the likelihood of increased Cat M costs in Q4 which will be unknown until the New Year. National Department of Health briefings have indicated that there will be a sizeable increase in the costs, however this is not quantifiable until the data is released.

Planning 23/34

23. The 23/24 planning round is now in progress with weekly meetings of the system planning group, where updates are given from all areas including activity workforce and finance to ensure consistency in approach, including
    - Agreeing Timelines for completion
    - Agreeing the baseline and ensuring triangulation,
    - Clear assumptions
    - Impact of interventions and the prioritisation framework

24. Within the timeline we are looking to have a first draft of activity workforce and finance plans completed before the end of the calendar year, which will be refined when the national guidance is available (usually published late December), with a final version available by the end of February to accommodate internal governance processes before national submission which is likely to be towards the end of March.

25. A further detailed Primary Care update will be presented at the February Committee.

POD Delegation

26. From 1st April 2023 the ICB will have delegated responsibility for POD (Pharmacy, Optometry and Dentistry) from NHSE. The ICB have regular meetings with NHSE to discuss and plan for the transfer.

27. ICBS from across West and East Midlands are in discussion with NHSE about options for financial risk sharing arrangements. A financial risk framework document has been drafted and is attached for information. Pooling of budgets will not be possible across the region for primary care due to the way payments will be made through individual ICB ledgers and therefore risk sharing agreements will be important to manage in year variation.

28. The committee is asked to support the principles within the risk framework document.

29. The Primary Care and Finance Teams will present a joint update paper on delegation to the February Committee.

Conclusion

30. Both the delegated and non-delegated primary care areas are currently anticipated to deliver expenditure less than plan this year. This is predominantly driven by taking the benefit of accruals set in 2021/22 that are no longer required now that actual costs have been accounted for.

31. The finance team are working to review the underlying position as part of the 23/24 planning round as whilst there is a benefit in 22/23, there is a risk that there will be an underlying pressure in the recurrent budget which would be carried into future years and will need to be addressed.

32. The ICB is preparing for the delegation of Community Pharmacy, Optometry and Dental services from NHSE to commence 1st April 2023. The finance team are heavily involved in this work and more information will be made available to this committee in due course.

Proposed Financial Transitional Risk Framework – Pharmacy, Optometry, and Dentistry (PODs)

1. Changes to Delegation

This document has been written in response to the upcoming delegation of Pharmacy, Optometry, and Dentistry (PODs) commissioning to Integrated Care Boards (ICBs)(1). In November 2022 its expected that Midlands region ICBs the Midlands region will apply for delegation of these services to commence from April 2023.

(1) This document has been written prior to statutory changes relating to Clinical Commissioning Groups (CCGs) and Integrated Care systems (ICS). On the 1st July 2022 ICBs will become a statutory body.

2. What is a financial risk framework?

The financial risk framework is a set of rules and behaviours (as set out in section 5) which govern the way we manage the risk that may arise from variation in POD budgets between delegated ICBs of the Midlands Region. This will be to mitigate the potential risks to systems from allocation methodology change, as well as in year budget variation in year by ICB due to unknown factors. This will not include risk sharing as a result of individual commissioning decisions made by ICBs. The focus of this risk share being a pooling of resources enabling risks to be understood, as well as the impact of overspend risk.

It should be noted that the risk framework is intended to support the transition, and therefore will require review to determine its continuation or cessation.

The document aims to describe.

- How over, and underspends are managed within the regional hosted service,
- How the changes to services are managed between organisations and services,
- The risk mechanism that is in place,
- The process for changes to the risk mechanism.

3. Who/What does this document concern?

This document is intended for all ICBs within the Midlands Region that will be in receipt of delegated budgets at the 1st April 2023.

Initial entry into the risk share is for all ICBs in the region but to protect the risk share ICBs can only leave at the point of review (refer to section 8).

This agreement relates to the Pharmacy, Optometry and Dental budgets delegated at April 2023.

The document has been written with a ‘commissioner lens’. As a result this excludes the financial impact of under/overperformance within providers accounts as part of the risk share.

This risk share excludes previously delegated primary care budgets, on only those that transfer under the current delegation process.

This document may touch on expected financial reporting routes as part of the risk management, but reporting is subject to the development of a reporting framework. The two documents must be written and read in consideration of each other.

4. Why do we need a financial risk framework?

- ICBs are new organisations, and not all ICBs have experience managing these specific commissioning budgets. Until that knowledge is built up, this may mean additional caution in applying budgets in year, or additional exposure to risk. A risk share allows a mitigation to this while there is a common route to delivery.
- POD budgets are currently managed across the Midlands which provides a large budget in which to manage variability in activity across contracts and movements in patient charge revenue. After delegation budgets and areas covered will be smaller meaning risk management agreements will be needed to manage variability between ICBs.
- Allocations have been established using 2019/20 activity and spend levels. However, two years of alternative financial processes may impact on the accuracy of allocations at an ICS level. In addition, there are changes to the Dental contract expected in the second half of 2022/23 all of which creates additional uncertainty on ICB allocations
- As part of the move to delegated budgets, allocations may change as they are transferred to ICB level. There is an expectation of a move to a more capitated share of budgets after 2024. This raises the risk of variation to in year budgets which may not be fully known when budgets are first delegated, therefore future risk sharing needs to mitigate this risk.
- A number of 'wicked' problems as examples have been listed below to prompt the draft framework proposed in this slide/document.
  - How does the system minimise variation to plan?
  - An ICB may wish to make a change to service that is within the risk share, this could include additional investment, change in policy, or pathway. How will this be managed within the risk share?
  - An ICB may wish to withdraw a service from the risk share, how will this be managed?
  - An ICB may work unilaterally on service changes or savings which then impacts on the overall risk share. How is this managed?
  - Should risk sharing be the answer to an overspend?
  - If ICBs disagree on how a risk should be handled, how is this resolved?
  - If there are differential impacts against system allocations due to new allocation methodologies, how are these risks managed?

5. Behaviours and Standards

This document has been written with an expectation of openness, transparency, and trust in mind between ICBs. These risk principles should be considered in the application of the document. This also means that while we use this document there will be elements of clarity and refinement required. It's expected that in these cases partners use judgement for the spirit of document in its application; however, this should **not** be used to challenge each aspect of the framework.

Any ambiguity that cannot be resolved between partners, through use of the Finance and Contracting Sub-Group should then follow the escalation process (section 11); however, this should be avoided wherever possible.

6. In Year Financial Management

- Risk sharing should not be the primary source of net cost avoidance and should only be applied once the Finance and Contracting Sub-Group (FCAG) has assured itself that appropriate mitigations have been put in place.
- Virement should not be enacted between services or ICBs without express agreement by FCAG on POD budgets, to allow maximum knowledge gained in this first year by ICBs. Unlike specialised commissioning budgets, POD budgets should be risk shared on the total financial position for POD within ICBs.
- Should appropriate mitigation and virement proposals not bring the budget back to plan then risk sharing should be considered. Enacting the risk sharing should be a recommendation of the FCG to the East and West Boards.

7. Financial risk sharing

- The principles of any financial risk (and reward) sharing agreement are based on agreeing fair and equitable funding to control expenditure whilst optimising outcomes.
- Financial risk sharing agreements should be the final option after all efforts have been made to manage the risk in-year.
- It's expected these risk shares will work the risk share allows the movement of budget in year between systems within the hosting organisation in a balanced economy to resolve allocation methodology issues to system allocations mismatching to historical spend.
- The first route recognises individual ICB shortfalls in total POD budgets. Therefore allowing an adjustment to vire budgets between ICBs below the bottom line position to bring in line with plan. This excludes individual commissioning decisions made by ICBs, e.g., a variance to budget spend caused by investment. As a result variances to budget should be explained before virement or risk share is made to ensure it is due to unexpected causes.
- If the above is not possible due to an overall shortfall, the position will be shared based on proportionately based on plan budget values by ICB delegated budgets agreed at plan.

This is with the exception of decisions made by individual ICBs e.g., ICB investment/disinvestment above initial financial plan levels decisions are excluded from the risk share unless with the explicit agreement of all ICBs.

- System allocation mismatch assumes an overall balanced economy. As the reporting develops, reporting will also be produced at a system level (by Q2 of 2023), and a balancing adjustment between systems will be proposed by the hosted team to bring systems in line with budgets. Any overall shortfall from budget will be dealt with as highlighted in the previous paragraph. The balancing adjustment should be shown within the reporting to support transparency and understanding.
- Quarterly position statements of agreed risk sharing should be produced including a forecast at each quarter. These will form the basis of recommended adjustments, and at Q3 a forecast and recommendation will be made for the year end to support delivery of year end positions. This may be supplemented by a Month 11 update and recommendation.
- Reporting will be in place monthly to support budget monitoring. Application of risk arrangements will commence by Q2 of 2023 to allow sufficient actual activity to be available. Reporting will be at a level that allows the drilling down into PODs to understand the cause of variances. (This will be developed by a separate sub-group)
- Enacting the risk share will be a recommendation of the FCG to the East and West Boards.
- The risk share will be region wide, i.e., East and West Midlands. This should be part of a review after year 1 and a better understanding of budget variations.
- All services that are part of the delegation will be included in the risk share. Currently there are not specific risk shares for each speciality.

8. The future of risk sharing for Pharmacy, Optometry, and Dentistry (PODs)

- This risk share is intended to be in place to allow a greater degree of understanding by ICBs of the risks inherited from delegating budgets either from changes in allocation methodology, or in year changes in spend.
- Whilst the risk share continues to be in place it will be subject to annual review and amendment by consensus agreement
- The risk share is seen as transitional; however the risk share will continue by default in the absence of any agreed changes that would be recommended by the FCAG, and approved by the East/West Board.
- The review should consider the geographical coverage, as well as service coverage.
- Removal and addition of services from the risk share should be by agreement of all members of the risk share group, including resource flow. This means an ICB cannot unilaterally leave the risk share. This should form a review at the end of the first year. Changes should not remove the viability of a risk share.

9. Use of contingency/ unallocated funds

- Best practice looks to avoid holding back significant sums from the planning process, in terms of a central contingency. This is in part because of the requirement on the public sector to use the funds allocated for the purposes intended and in part to discourage organisations relying on such funds to 'bail them out' or ending with last minute year-end expenditure resulting in a sub-optimal use of resources. However, there are often unforeseen costs and a small level of contingency set aside to support may be required.

- To meet unforeseen costs a planned contingency of 1% should be aspired to from within the delegated budgets, and form a part of the mitigation process, however this should be reviewed each time plans are agreed to ensure affordability of contingency creation is possible, and if not possible, a recommended level put forward to the Finance and Contracting Sub-group.

10. Assurance

- Following delegation there will be joint commissioning boards for East Midlands and West Midlands with a specific finance sub-committee. Through delegation from the ICBs this sub-committee will have responsibility for oversight and delivery of the risk management framework. Regular financial performance reporting will facilitate monitoring and management of financial risk and application of the terms of the framework will be the responsibility of the finance sub-committee.

11. Appeals and escalation

- While there may be a financial risk sharing agreement, there will need to be a process for dispute resolution where consensus cannot be agreed.

- Primarily risk sharing disagreements will be managed by the chair of the FCAG, unless conflicted. In the case of conflict, an agreed independent party will provide arbitration.

- Escalation to the East and West Boards is required upon recommendation of the FCAG chair should a disagreement not be settled.

- Should this not be resolved, NHS E will be requested to provide arbitration, however this should be avoided where possible and alternative routes identified.

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Primary Care Commissioning Committee

Agenda item no.	**PCCC 22-12.41**
Meeting date:	Friday 2nd December 2022
Paper title	Primary Care Update Report
Paper presented by:	Emma Pyrah
Paper approved by:	Emma Pyrah
Paper prepared by:	Janet Gittins, Tom Brettell, Bernadette Williams, Darren Francis, Phil Morgan, Sara Edwards & Antony Armstrong
Signature:	EPyrah
Committee/Advisory Group paper previously presented:	N/A

Action Required (please select):									
A=Approval		R=Ratification		S=Assurance		D=Discussion		I=Informatio n	I

Previous considerations:	N/A – this is a monthly update report from the Primary Care team

1. Executive summary and points for discussion

The Primary Care Team continues to manage a complex and demanding workload.

The Team is managing this demand well and is on track/ target across all workstreams- there are currently no significant deliverability concerns.

This paper highlights work on Estates, IT, Workforce and Contracts however additional reports will continue to be provided to PCCC meetings to provide members with assurance of the plans and progress of the work of the Partnership Managers and wider Primary Care Team.

2. Which of the ICB Pledges does this report align with?

Pledge	
Improving safety and quality	
Integrating services at place and neighbourhood level	
Tackling the problems of ill health, health inequalities and access to health care	X
Delivering improvements in Mental Health and Learning Disability/Autism provision	X
Economic regeneration	
Climate change	
Leadership and Governance	X

Enhanced engagement and accountability	
Creating system sustainability	
Workforce	X

3. Recommendation(s)

The Primary Care Commissioning Committee is asked to:

Note the contents of the report and the work currently being undertaken by the Primary Care Team in relation to these areas.

4. Does the report provide assurance or mitigate any of the strategic threats or significant risks in the Board Assurance Framework? If yes, please detail

This paper is solely to provide the Committee with an update on the work happening in the Primary Care Team. It is for information only; any items which do require decisions to made will be presented to the Committee as a separate paper and this question answered alongside the respective paper.

5. Appendices

NA

6. What are the implications for:

This paper is solely to provide the Committee with an update on the work happening in the Primary Care Team. It is for information only; any items which do require decisions to made will be presented to the Committee as a separate paper and this question answered alongside the respective paper.

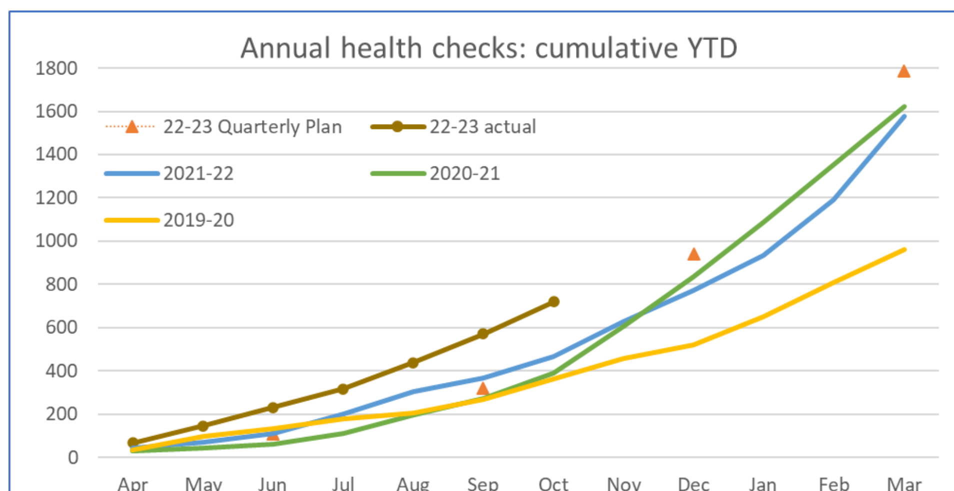
Shropshire, Telford and Wrekin's Residents and Communities	N/A
Quality and Safety	N/A
Equality, Diversity, and Inclusion	N/A
Finances and Use of Resources	N/A
Regulation and Legal Requirements	N/A
Conflicts of Interest	N/A
Data Protection	N/A
Transformation and Innovation	N/A
Environmental and Climate Change	N/A
Future Decisions and Policy Making	N/A
Citizen and Stakeholder Engagement	N/A

Request of Paper:		Action approved at Board:	
		If unable to approve, action required:	
Signature:		Date:	

Partnership Managers Update – Janet Gittins & Tom Brettell

Learning Disability Annual Health Checks (LDAHCs)
Recovery Plan: MPFT continue to offer support to general practice to complete LDAHCs and to try to reach those who are overdue. The team carry out patient observations, contact DNAs and do home visits targeting people who are overdue their health check. NHSE continue to monitor progress.

At the end of October 2022 STW practices are showing an increase in the number of LDAHCs completed in comparison to previous years as shown in the chart below. At the end of September STW has completed 719 LDAHCs compared to 468 in 2021-22 and is currently above trajectory at 29% against the 75% annual target. The majority of LDAHC activity continues to take place during quarters 3 and 4 each year.



Macmillan Community Care Project (MCC)
The Macmillan Team are currently working with 16 STW practices to deliver holistic Cancer Care Reviews alongside the clinical element completed by practices, to people living with cancer within 12 months of their diagnosis.

Current Status.

- Phase 1: 7 original practices continue to engage and are nearing the end of their patient lists in need of a CCR.
- Phase 2: 8 new practices are now engaging with the project. A further 8 practices are in conversation with the team although we are now limiting this to 5 or less due to team capacity.

- A communications plan is being developed to raise the profile and promote this pilot project.
- A bid has been successful to gain additional funds from Macmillan to align the team end date to 31 May 2023.
- Patient feedback continues to be collated - initial findings are very positive
- 393 CCR's have been completed since January 2022 (at end September 2022).
- Pilot evaluation is due to commence from November to end March 2023.

National Diabetes Prevention Programme
Across STW current referral figures are 779 YTD (April-September 2022) against an annual target of 2520.

A new communications plan is underway, with refreshed literature and information planned to launch to practices and services users to coincide with World Diabetes Day on 14th November 2022 and the end of the self-referral pathway on 15th November 2022.
Contact with Practice Managers is more personal and individual to the issues they may have or support they require, rather than generic communication to all. "Best practice case studies" were requested from high performing practices to congratulate them for their hard work and share across the system.
Further communications are planned for January 2023 with a focus around new year's resolutions and healthy lifestyles.

Digital Weight Management Programme - Enhanced Service (DWMP ES)
There are currently 46/51 practices (35 Shropshire and 11 Telford & Wrekin) signed up to the national DWMP ES for 2022/23. As at 6 October 2022, 919 referrals have been made against a target of 1332, reaching 69% of the STW annual target. Recent data shows that 18.4% of referrals are from the most deprived areas with a further 25.9% from the top 20% IMD.

Severe Mental Illness (SMI) Health Checks
SMI nurses are employed by MPFT to support general practice with completing SMI Health Checks by providing clinics to cover elements of Mental Health, Lifestyle and Medication helping to complete the 6 core checks. To agree with each practice the role needed, a draft agreement is being drafted giving practices options of the level of support offered to clarify responsibilities.
General Practice has a target of providing a SMI Health Check to over 60% of those with a SMI by end March 2022. At end of September STW is showing that 40.5% of those on SMI registers have received a health check in the last 12 months.
A new poster has been produced to raise awareness of the annual health checks. Practices are encouraged to upload a copy of this poster to digital ad boards in waiting rooms.

Locally Commissioned Services (LCS) Review
Good progress is being made on the review of LCS:

- Safe Prescribing of Medicines: review complete, all practices signed up and completed Q2 monitoring/payments.

- Demand Management / Minor Injuries: options for future service were taken to the LMC Committee by the LMC representatives working on the review. The LMC *felt unable to support any changes which might involve withdrawing previously available funds from practices who may have employed staff to provide a service, with the potential to leave practices at financial risk.* As such, the review group is reviewing options and will seek advice from Commissioning Working Group on the most appropriate way forward.

- Community & Care Coordinators: A successful workshop was held on 1st November with Shropshire Practice Managers and C&CCs to talk through review progress to date, identified findings, gain further input, ideas and insights and outline next steps. The feedback will be incorporated into a comprehensive report to inform the next stage of the review, modelling and service re-design for further engagement and sign off ready for commencement from 1st April 2023.

- CRP Testing: current service arrangements and suspected historical impact have been collated into a Service Assessment Document for review at the next LCS Working Group.

- Bariatric Surgery: current service arrangements and impact collated for review at the next LCS Working Group.

CVD/ Hypertension Delivery
Work continues through the STW CVD Prevention & Hypertension Group with recent focus on data and intel, the role of community pharmacy in detection and management, support to PCN's recognising that a one size fits all approach may not be appropriate, the role of Making Every Contact Count for detection and on establishing robust and clear clinical pathways.

Veteran Friendly Practices
27 practices are now accredited as Veteran Friendly with the aim to get all practices accredited by 31st March. Work is commencing to ensure that Veterans' needs are embedded in wider programmes such as Personalised Care.

Remote Monitoring Project
The new provider has made good progress in securing interest in the programme from the larger Care Home providers, the focus is now on engaging with the relevant practices to those homes.

Access to (Future) Patient Records
In a letter dated 21st July 2022 from NHS England, all Practices were advised that from 1st November 2022, patients will automatically have access to their prospective (future) health records, including free text and documents. A series of both local and national communications and resources have been shared to support Practices prepare for the switch on.

An update was shared by NHSE 1st November to advise that several GP Practices across the nation have requested a delay to the switch on (via EMIS and TRR). There has been a requirement for Practices to offer access to data since 2019/20 and there have been clear indications from NHSE since 2021 that the access to records function would be enabled nationally. Practices have therefore been offered an extended deadline of 30th November 2022 to prepare for the switch on.

STW ICB were asked by NHSE to confirm which GP Practices locally have requested this delay. To date, 13/17 GP Practices who responded to our enquiry have confirmed having delayed the switch on. Since this communication, GP Practices have raised concerns about the potential risk to patients, with some advising that they will not be adequately prepared in time for the 30th November deadline due to limited clinical capacity to review records.

There is therefore a risk that some patients may come to harm should they receive automatic access to their future healthcare records.

Ahead of the technical change, Practices have been shared guidance on how to exclude individual and groups of at-risk patients by adding the appropriate SNOMED code to their records. The Primary Care Team are currently in dialogue with Practices who have raised concerns about meeting the deadline to ensure this stage has been completed and that no harm will come to any patients considered potentially at-risk.

NHSE have asked that actions plans be submitted for those Practices who have coded more than 80% of their patients with a '104' code (preventing them from having automatic access to their record).

Estates Update – Darren Francis

Below is a brief update on the ongoing key estates projects and related activity. Where noted, papers are being taken to Primary Care Commissioning Committee and are attached or due to be submitted nearer the date for the next Primary Care Commissioning Committee:

Whitchurch – ETTF New Build

- On site works commenced – starting with demolition and site clear up
- Primary Care Centre on target for completion by September 2024

Shifnal – ETTF New Build

- Legals and bank borrowing arrangements now concluded
- Groundworks on site due to start imminently
- Expected completion due Nov/Dec 2023

Teldoc Estate Rationalisation Programme

- Teldoc has now expanded their Call Centre and Admin Hub into Towergate House in a move to increase capacity and improve access for patients (following negative feedback they had received over recent months)
- Paper for wider estates rationalisation now expected to come to PCCC in December 2022/February 2023 – practice has appointed a business case writer to complete this work and is in discussion with ICB execs and wider system colleagues around how a new build GP premises could be incorporated into a healthcare village development

Capital Funding for Estates Projects

- BaU Capital funding bids received from practices by end of April deadline and approvals given by PCCC and NHSE for work to commence
- All works are due for completion by end December 2022 – at least one practice is nearing completion (one of the bigger projects) and an interim payment is due to be processed via NHSE imminently to support practice with its cashflow
- All other practices currently on target to complete schemes before Christmas period
- Section 106 applications work progressing with Councils to generate pipeline of capital funding for practices in absence of any national schemes being available
- Shropshire Council has already agreed £915k for Ironbridge development
- Further applications for Bridgnorth (£450k) and Shrewsbury (£750k) are in process
- Future applications planned for Bridgnorth (Tasley Garden Village), Priorslee, The Hem, Allscott, Preston on Weald Moors, Lawley and Lightmoor

Estates Strategy Revision

- Community Health Partnerships (CHP), National Association for Primary Care (NAPC) and Primary Care Commissioning (PCC) all currently working with all 8x PCNs to formulate Workforce and Estates Plans – per national funded programme
- PCNs split into two Waves – Wave 1 completing work Oct > Dec 2022; Wave 2 completing work Nov/Dec 2022 > Feb 2023
- Once PCN work completed output will be combined into a single Primary Care strategy – 1st draft expected by end March 2023
- Final version expected around April 2023

Contracting Update – Bernadette Williams

STW Contract changes

Contract variations have been requested for the following:

Practice name	Details
Marysville	Resignation of partner (JV)
Mytton Oak	Resignation of two partners (SW & MP)
Station Drive	Resignation of partner (GC)

These are being processed by General Medical Advise Support Team (GMAST).

Application for practice boundary change

Practice name		Details
Hodnet Medical Practice		Application submitted to decrease the practice boundary.

Asylum seekers

A number of the asylum seekers currently at an Immigration Reception centre at Manston, Kent are needing to be relocation across England. The Lion Hotel in Shrewsbury has been identified as a location. This is a measure to fulfil a Home Office statutory duty to accommodate individuals who are assessed as destitute, whilst their asylum claim is progressing. This hotel is being commissioned as a Contingency Hotel, with exclusive use by these individuals. The operational factors surrounding this requires a multi-agency approach involving the Home Office, Serco (as a commissioned provider) and in partnership with local services across Police, Fire, Local Authority and ICB.

The primary care team are liaising with Shrewsbury PCN to: -

- secure GP registration; with 5 town centre practices.
- to support access to any other mainstream NHS services as needed.
- to ensure there is an initial health assessment offered.

Funding can be claimed from NHS England to support the health assessment however to undertake this activity at 'short notice' does create another 'strain' on an already over stretched workforce.

Workforce & Training Hub Update – Phil Morgan & Sara Edwards

GP/GPN Fellowships
No update this month.

Supporting Mentoring Scheme
No update this month.

Local GP Retention
No update this month.

Online Staff Booking Platform
No update this month.

Winter PLT
The dates for Winter PLT are 24th November 2022 for Shrewsbury and North Shropshire and Thursday 1st December 2022 for Telford and South Shropshire. Winter PLT sessions for Shropshire, Telford and Wrekin GPs and Advanced Practitioners will cover the topic of Women's Health at two face to face events. GPNs and other staff are being offered on-line live workshops on the topic of Diabetes - Best Practice in Diabetes Care and Eden Essentials Plus Training. For non-Clinical Staff, practices are being offered support to set up training in-house via providers and being signposted to the system LMS.

Supporting retention of multi-disciplinary teams
The following Clinical Facilitators are in place; Advanced Practice, Paramedic, Nurse, HCA, Physician Associate and FCP MSK. Work is underway to ensure sustainability of the initiatives which have been put in place through sourcing funding to extend contracts of the facilitators, which are all fixed-term and funded through non-recurrent funding. In addition, an advert is currently live to recruit a Clinical Pharmacist Facilitator to support this staff group. Further recruitment is planned for a Placement Facilitator for Student Nurses.

Education and Training
A Training Needs Assessment refresh is going out to Practices in November to help inform the Education and Development Training Offer for General Practice staff across STW for 2023. The Training Hub team is currently liaising with training providers and system partners to forward plan the schedule. Individual training requests continue to be managed utilising dedicated HEE & NHSE funding. Work continues on development of the training data dashboard which will allow improved reporting and analysis as well as intelligence on uptake/demand by staff group for training & education across STW. A Cancer Training Programme for Primary Care is being developed and the team continues to facilitate the STW Personalised Care Programme. Planned work will address training gaps in cancer and diagnostics, LDA and dementia awareness.

GP IT Update – Antony Armstrong

The Digital Lead/Partnership Managers within the CCG meet weekly with the MLCSU IT Project Team, to discuss on-going projects, progress reports and any risks and issues through the Digital Operational Group meeting.

Domains
A single domain across STW will secure the Primary Care estate and mitigate against the very real threat of cyber-attack faced by Primary Care and other health and care sector organisations.

Through a fully Midlands & Lancashire CSU (MLCSU) 'managed' GP domain infrastructure, the IT provider will replace all GP Practice and branch Practices existing standalone configurations. This would include installation of a central core infrastructure at Halesfield and replacement of existing local GP EMIS servers with new servers to provide domain, file/print services and EMIS spoke services. Also, a new perimeter edge firewall device will be installed at each site to provide an enhanced layer of security. Delays caused by the pandemic and teething issues at the early adopter sites have delayed the project from the originally agreed timescales.

Further engagement is currently being sought by NHS STW to assist the CSU with practices who are yet to engage, highlighting the importance of a fully managed domain, being cyber compliant and providing assurance on the IG DSP Toolkit return. These practices have been contacted by the locality managers and good progress is being made.

16 sites were completed in phases 1 and 2 of the project. Phase 3 is the final phase, and we now have 48/55 sites live on the new Zeus Domain. The final 7 sites within this phase have migration dates booked in or are under review to resolve comms cabinet/dispensing dependencies.

All 55/55 firewalls have been installed locally to date on this final phase.

Notes Digitisation
Project kick-off meeting held first week of September. Practice engagement sessions currently pencilled in for 21st September 2022 for the 8 pilot practices. Project plan has been shared with the ICB/practices. First two practice engagements have now commenced.

NHSEI have indicated that future funding streams for the Notes Digitisation Project will be through a 'scan on demand' service whereby all notes are held centrally. A meeting has been scheduled the end of April to discuss the existing pilots within the region as well as more details on the 'scan on demand' future project.

Digital Dictation
The provider has been engaging with practices and our MLCSU IT team on pre-requisites regarding the software installs and has recently commenced deployment of the cloud-based dictation solution. 33 sites live and go-live dates scheduled in for more practices in September/October.

N365 (Office 365) Apps for Enterprise
Fully deployed Microsoft Apps for Enterprise to all practices on the Zeus domain.

Enhanced Access
EMIS Clinical Services had been ordered for 6 of the 8 PCN's. ICB used a recommended consultation working within the region to setup the prescribing/pathology codes as well as the data sharing agreements for the practices within their PCN's. Service was live as of 1st October. Performance concerns had been escalated to both EMIS and NHSE. Other ICB's are also reporting similar issues with the GP Connect function not working first time.

The ICB await further feedback from NHSE who recognised there is an issue that is to be addressed their end.