Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

AGENDA

Meeting Title	Primary Care Commissioning Committee – Part 1	**Date**	3 February 2023
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 23-02.01	Apologies for absence	Dr Niti Pall	I	Verbal	9.30
PCCC 23-02.02	Declarations of Interest	Dr Niti Pall	S	Verbal	
PCCC 23-02.03	Minutes of the Meeting held on 2nd December 2022	Dr Niti Pall	A	Enc. No. 1	
PCCC 23-02.04	Actions Raised from Previous Meetings and Matters Arising	Dr Niti Pall	A & S	Enc. No. 1A	
	Items Requiring Decision				
PCCC 23-02.05	Proposal to change PCCC agenda structure	Nick White	A	Enc. No. 2	9.45
PCCC 23-02.06	Albrighton Medical Practice – request to change practice boundary	Berni Williams	A	Enc. No. 3	9.55
	Standing Agenda Items				
PCCC 23-02.07	Finance Report	Angharad Jones	A	Enc. No. 4	10.05
PCCC 23-02.08	Workforce Report	Phil Morgan	A	Enc. No. 5	10.15
PCCC 23-02.09	Performance and GP Access Improvement Plan Report	Emma Pyrah	A	Enc. No. 6	10.25
PCCC 23-02.10	Risk Register	Emma Pyrah	A	Enc. No. 7 Enc. No. 7A	10.35
	For information items				
PCCC 23-02.11	Primary Care Team Work Programme Progress Report	Emma Pyrah	I	Enc. No. 8	10.45
PCCC 23-02.12	ICB Briefing on the Delegation of Pharmacy, Optometry and Dentistry	Emma Pyrah	I	Enc. No. 9	10.55
PCCC 23-02.13	Shrewsbury Health and Wellbeing Hub Development: • Project Progress Update • Communications Handling Plan	Gareth Robinson Jackie Robinson	I	Enc. No. 10 Enc. No. 10A	11.05
PCCC 23-02.14	2022-23 Practice E-Declaration Summary	Berni Williams	I	Enc. No. 11	11.15
PCCC 23-02.15	Any Other Business	Niti Pall	I	Verbal	11.20
PCCC 23-02.16	Date of Next Meeting: Friday 31 March 2023 Time: 9.30 a.m.				
	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.				

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

Friday 2 December 2022 at 9.30 a.m.
Via Microsoft Teams

Present:	
Mrs Niti Pall	**Lay Member – Primary Care (Chair)**
Mr Nick White	**Chief Medical Officer (Deputy Chair)**
Mr Roger Dunshea	**Lay Member**
Mrs Laura Clare	**Deputy Director of Finance (On Behalf of Claire Skidmore)**
Mrs Tracey Jones	**Deputy Director – Partnerships (On Behalf of Claire Parker)**

Attendees:	
Mrs Julie Garside	**Director of Planning & Performance**
Dr Julian Povey	**Primary Care Partner Member**
Dr Ian Chan	**Primary Care Partner Member**
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**
Mrs Vanessa Barrett	**Chair, Healthwatch Shropshire**
Mrs Chris Billingham	**Corporate PA; Minute Taker**

Apologies:	
Ms Alison Bussey	**Chief Nursing Officer**
Mrs Claire Skidmore	**Chief Finance Officer**
Ms Nicola Dymond	**Executive Director of Strategy & Integration**
Mr Gareth Robinson	**Executive Director of Delivery & Transformation**
Dr Deborah Shepherd	**Deputy Chief Medical Officer**
Ms Claire Parker	**Director of Partnerships & Place**
Ms Emma Pyrah	**Associate Director of Primary Care**
Mrs Angharad Jones	**Finance Business Partner**

Minute No. PCCC 22-12.30

1.1 Apologies received were as noted above.

Minute No. PCCC 22-12.31 – Members' Declarations of Interests

2.1 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)

2.2 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 for that item of discussion.

Minute No. PCCC-22.12.32 – Minutes of Meeting held on 7 October 2022

3.1 The minutes of the meeting held on 7 October 2022 were accepted and approved as a true and accurate record of the meeting.

Minute No. PCCC-22.12.33 – Actions Raised from Previous Meetings and Matters Arising

4.1 The Action Tracker was reviewed and updated as appropriate.

Minute No. PCCC-22.12.34 – GP Access Report to ICB

5.1 Mrs Jones advised the Committee that her report had been submitted to the ICB Board meeting which took place on Wednesday 30 November 2022.

5.2 The report was prepared by Ms Emma Pyrah, Associate Director of Primary Care, and reported on the issues around GP access. Points to note were:-

- Face-to-face appointments had increased. The November data showed that seven out of ten patients were seen face-to-face.

- Issues exist around workforce and estate which are limiting factors for some Practices in terms of improving access.

5.3 Discussion at the ICB Board reflected the fact that Primary Care can be accessed via other routes which we must ensure patients are aware of. Consideration must also be given as to how performance is monitored in relation to answering calls, and how to help Practices whose data identifies issues with length of call wait and call abandonment. Ms Pyrah and Ms Parker have discussed how this piece of work can be taken forward over the coming months.

5.4 Mrs Jones invited questions.

5.5 Dr Chan made the following points: -

- It would be useful for NHS STW to benchmark ourselves against other systems in the Region.

- Trainee GPs were included in the figures and should be shown separately in future as they were inflating the number of GPs in the system.

- Data relating to Telford Practices should be compared with data relating to Shropshire Practices in terms of telephone access. It may be useful to benchmark that data at a point in the future to stress the difference in demographics between Shropshire and Telford and the health inequalities which play a part in patients' perception of the service.

5.6 Mrs Jones agreed with Dr Chan's point in relation to benchmarking NHS STW against other systems in the Region, advising that within the GMS contract there were no standards or targets, and it would be necessary to identify a way by which the data could be compared.

5.7 Mr Dunshea suggested that it would be helpful if the report contained tables and graphs to highlight trends, demand, etc.

He also suggested that future reports should identify the issues and possible solutions to mitigate them.

ACTION: Mrs Jones to feed Mr Dunshea's comments regarding the style and format of the GP Access report back to Ms Pyrah.

5.8 Dr Garside currently had a member of staff who had been recruited on a fixed term basis into the BI Team from the Commissioning Support Unit to focus solely on Primary Care data. She suggested that this colleague could work with the Primary Care team to improve benchmarking and data reporting.

She had discussed with Dr Lyttle how the BI team can support Primary Care in measuring demand and capacity. Work is currently under way to identify how we can better support demand and capacity for Primary Care appointments. This work will help to inform potential solutions. Dr Garside will report back to a future Committee once this work has been completed and analysed.

5.9 Mr Dunshea offered his support and input to this work if required.

He believed that as NHS STW is an integrated care system, it would be important to gain input from Shropcom, SaTH, and colleagues in Social Services to gain a more generic picture as to how these concerns can be addressed.

5.10 Primary Care Commissioning Committee was asked to note the contents of the report and the recommendations made to ICB Board as follows: -

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 regarding the future of General Practice premises.

The Committee discussed the recommendations within the report.

Recommendation (a): Mrs Jones provided assurance that both she and Claire Parker, Director of Partnerships & Place, were very much involved in the Integrated Care Partnership strategy, therefore the elements of Primary Care will have been included.

Recommendation (b): The Committee discussed whether the recommendations of the Fuller report should be included in development of the Primary Care Strategy.

Mr White advised that the Fuller report was the first of two pieces of work which outlined high level aspirations. More detailed actions were still to follow in the next report. He was supportive of everything that came out of the report but was cautious of treating aspirations as actions to be implemented.

Committee members agreed that the ICB should await the Government response regarding the Fuller report and recommendations.

Recommendation (c): Review of telephone access had already been discussed. Mr Dunshea referred to the fact that there is no requirement upon Practices to provide the ICB with data relating to telephone access. After discussion, the meeting concluded that the subject of access in general needs to be considered, and not merely telephone access.

Recommendation (d): A discussion took place at Board regarding public estate. Mrs Jones will follow this up and identify which Board member was actioned to follow this up.

ACTION: Mrs Jones to follow up with the relevant Board member the discussions and actions at the November Board meeting regarding Public Estate.

RESOLVE: ***The Committee noted the contents of the report and supported the recommendations made to ICB as outlined above.***

Minute No. PCCC-22.12.35 – Community Pharmacy Consultation Service – Implementation Update

6.1 The purpose of Mrs Williams' report was to provide the Committee with information on progress with implementation of the GP Community Pharmacy Consultation Service (GP CPCS).

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

6.3 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.

6.4 The aim of this service is to alleviate pressure on GP appointments. It is believed that 6-10% of Practice appointment capacity could be effectively directed into community pharmacy.

6.5 As of 28 November 2022, 433 referrals had been completed.

6.6 Mr Dunshea referred to the numbers within the report and believed them to be small. He queried what kind of increase could be expected throughout the County and whether there were targets to be met.

6.7 Mrs Williams confirmed that referrals into community pharmacies must be a suitable minor illness. There is an investment and impact target of 0.65 per 1,000. However, there are also workforce issues in pharmacy and care must be taken not to overwhelm local pharmacies.

6.8 Mr Brettell wished to ensure Committee members were aware that in a rural community such as Shropshire there are areas of the County where access to pharmacy is difficult.

RESOLVE: ***The Committee noted the contents of the report which was submitted to the Committee for information.***

Minute No. PCCC-22.12.36 Ethnically Diverse Staff Survey

7.1 Mrs Gittins presented the Ethnically Diverse Staff Survey report on behalf of Mr Morgan who was unable to attend the meeting.

7.2 The report was compiled following the launch of the Ethnically Diverse Staff Network earlier in the year. That group had developed the survey and want to understand the experience of all staff working in Primary Care around issues of ethnic diversity.

7.3 The survey includes questions around role, training, work choices, complaints, and racism at work.

7.4 The overall aim of the survey is to understand the issues, challenges and barriers faced by Practices and individuals. The aim is to have information to better inform staff retention and recruitment campaigns.

7.5 The survey has been tried and tested elsewhere. The group now seeks approval of the Committee to go live.

7.6 Mrs Gittins invited questions.

7.7 Mrs Jones asked whether, during the survey, there was an opportunity to look at other protected characteristics to make it a wider survey, for example LGBT communities. Certain members of staff may feel excluded by a survey that has a particular focus on one characteristic.

Mrs Gittins advised that the survey was based on a model from elsewhere.

7.8 Ms Robinson asked whether the survey requested demographic characteristics to be completed.

7.9 Mrs Gittins confirmed that questions were asked such as ethnic group, religion and age, but no others around any other characteristics.

7.10 A short discussion took place around contents of future surveys.

Mrs Pall summarised the views of the Committee, stating that the Committee approved the survey to go live but going forward any future surveys should include all other protected characteristics.

Mr Dunshea suggested that the Committee should see the survey questionnaire to establish what had been covered and see the results in due course.

ACTION: The results of the Ethnically Diverse Staff Survey to be brought back to the Committee to highlight and inform workforce implications.

RESOLVE: ***The Committee noted the contents of the report which had been submitted to Committee for information and confirmed that the survey should now go live.***

However, the Committee highlighted that any future surveys should include all other protected characteristics.

Minute No. PCCC-22.12.37 Shrewsbury Health & Wellbeing Hub

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.

Mr Dunshea chaired the discussion of this Agenda item.

8.2 Jackie Robinson, Associate Director – Comms & Engagement, presented her paper which provided the Committee with an update on the Comms & Engagement Plan in relation to SHWBH.

8.3 For the purposes of assurance, Ms Robinson provided a brief update on the key points of the plan outlined in her paper.

- With regard to the timeline, the project is currently at Stage 4 which is applying essential criteria.
- Potential locations were submitted to a meeting with the GPs which included the six Practices who are fully relocating and the two Practices that are going to do an extended provision to allow the GPs to share what their preference would be.
- All locations will still go through a full assessment, the outcome of which will not be known until the middle of January 2023.
- The outcome of the preferred option will then be shared with the Stakeholder Reference Group and this Committee.

8.4 Ms Robinson invited questions.

8.5 Dr Povey referred to the timeline being pushed back and expressed concerns around the impact of the lack of space within some Practices in the Primary Care network if the timeline continues to slip. There must be a balance between being realistic in the timeline and having a timeline we are confident we can adhere to.

8.6 Ms Robinson advised that the Planning Department within the Local Authority had carried out an overview of the first tranche of potential locations. However, for the next 14 locations to be considered in January, a full process would be required which will take longer.

She expressed the importance of following due process. Failure to do so could leave the ICB open to legal challenge which will stop the process and cost a considerable amount of money in litigation. We must work with our partners in the Local Authority Planning Department and ensure that all appropriate steps are taken.

8.7 Mr Dunshea requested a more structured plan of the various steps within the process.

8.8 Mrs Jones had discussed this paper with Ms Pyrah and her understanding was that the discussion around potential locations that is taking place in mid-January will allow preparation of a timeline in terms of all the subsequent next steps.

8.9 Mr Dunshea suggested that the Committee should be regularly updated via email on a key step basis and kept informed as to progress. Risks should be highlighted.

He referred to the communications strategy, stating the importance of good communication. He requested that the Committee should be kept informed and given the opportunity to be involved in that part of the work.

Mr Dunshea handed Chairmanship of the meeting back to Mrs Pall.

Minute No. PCCC-22.12.38 PCN Maturity Survey Results and Output from the King's Fund OD Work

9.1 Mrs Jones' report was submitted to the Committee for information.

9.2 The report described two pieces of work that has taken place around PCN development.

9.3 On the whole, most PCNs are progressing.

9.4 The report also refers to the work of the King's Fund which was a piece of survey work carried out by that organisation with six of our eight PCNs and followed up by a PCN Development Day where the themes were discussed. The report provides a rich narrative around discussions that are taking place regarding PCN development. As we consider the wider ICS strategy, PCNs need to be developing and maturing to start having conversations with Shropcom and consider working differently.

9.5 The one topic that PCNs rated themselves lowest at was population health management.

9.6 Mrs Jones invited questions.

9.7 Mrs Pall referred to population health management and asked how involved Public Health colleagues were in that risk stratification. She requested information as to what risk tools were being utilised and asked whether Public Health colleagues in the PCNs have an idea of evidence-based interventions that can be put in place.

9.8 Mrs Jones advised that both Directors of Public Health are very much engaged with our PCNs in terms of development around our population's health. Helen Onions (Telford) and Bernie Lee (Shropshire) are leading cross-system groups. One group is looking at CVD early detection, and the other is looking at early diagnosis around cancer.

9.9 Population health management is a relatively new concept, which is probably why PCNs had scored it as an area where they need most support.

9.10 Mrs Jones then referred to risk stratification, advising that we do have a risk stratification tool in Aristotle. She referred to the other areas that the PCN survey reviewed and believed that those other areas need to be developed in order to provide a support infrastructure for population health management.

9.11 Dr Chan believed that in terms of the longer-term development of PCNs, the maturity index needed to be more comprehensive and longer term. Not all Practices within PCNs are ready for some of the objectives.

9.12 Mr Dunshea referred to the aims and objectives of the PCNs and asked whether it was possible to begin to consider what they are aiming to achieve in the next financial year.

Mrs Jones stated that she and Ms Pyrah would be happy to discuss PCNs and their deliverables with him. The objectives of the PCNs are currently all being delivered via the national DES. However, in terms of aspirations, the ICB would want PCNs to be moving more towards the place-based space, integrating more with the Community Trust, and delivering services differently to the neighbourhood.

9.13 Dr Povey believed that many Practices viewed the PCN merely as a method of delivering the PCN DES specification. He and Dr Chan were working on a piece of work with the LMC around establishing a GP Voice which they are trying to bring together under the auspices of the LMC.

ACTION: Mrs Jones, Ms Pyrah, Mr Dunshea and Mrs Pall to meet to discuss PCN background, DES, and requirements around reporting and look at the functions of PCNs with Public Health colleagues to see where the connections are with the ICB.

Minute No. PCCC-22.12.39 Risk Register

10.1 Mrs Jones referred to the updated Risk Register and drew the attention of the Committee to Risk No. 8 relating to Highley Medical Practice. Risk 8 was closed as the situation relating to the Practice had changed and there is now a new risk.

10.2 Mrs Jones will check the coding of Risk 10 with Ms Pyrah.

10.3 Three new risks had been added to the register - workforce, and two risks relating to Shrewsbury Health and Wellbeing Hub.

10.4 Committee members were assured by the Risk Register which underpinned both the information regarding Primary Care in the system and the information submitted to Board.

Minute No. PCCC-22.12.40 Finance Update

11.1 Mrs Clare reviewed the Finance report and drew the attention of the Committee to the following key points:-

11.2 At Month 7 there was an underspend in delegated budgets of £2.9m year to date with a reported full year forecast underspend of £3.3m. This is mainly in relation to the release of prior year benefits.

11.3 The underlying in year position is a year-to-date underspend of £1.3m. This is currently being reviewed with the Primary Care team as part of 2023-24 financial planning to establish whether that funding is already committed.

11.4 The 2023-24 planning round is already under way across the whole system, of which Primary Care is a key element. Committee will be provided with regular updates in the Finance report as to how the financial plan is developing.

11.5 It is expected that national guidance on the plan – normally issued on Christmas Eve - will not be issued until the end of December. As soon as more information is received, an update will be provided by the Finance team.

11.6 Mrs Clare referred to the POD (Pharmacy, Optometry and Dentistry) delegation which is due to come across to the ICB in April. Those financial budgets are being incorporated into planning and updates will be provided to the Committee going forward.

11.7 The Finance report included a risk framework produced by NHS England. 2023-24 will be the first year that the ICB has taken delegation of these budgets. Conversations across systems and across the Region indicate that it would be beneficial to have a risk framework between ICBs in the initial period at least to help possible variations in budgets to be managed across the Region.

11.8 Mrs Clare requested the Committee's support to progress that framework with NHS England. Mrs Skidmore, Chief Finance Officer, is part of the group across the Region who will be considering the way forward with this work.

11.9 The meeting requested information regarding capital for Estates.

Mrs Clare confirmed that the capital for Primary Care Estates sits with NHS England. It was referred to in paragraph 19 of the report as GP Estates Capital. It is an allocation, although the ICB must bid for it.

11.10 There were no further questions from Committee members regarding the Finance report.

11.11 The Committee was 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.

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

The Committee supported the principles of the Draft POD Delegation Financial Risk Framework and supported its development going forward.

Minute No. PCCC-22.12.41 Primary Care Team Update

12.1 The Primary Care report was taken as read.

12.2 Mr Brettell referred to the mass rollout by NHS England of patients being able to access their records which was due to be implemented on 30 November 2022. He advised that the BMA have negotiated an agreement with NHS England to place this on hold.

12.3 Mrs Clare asked about the work that had been done on estates around the Primary Care Estates Strategy and asked how that had been linked in with the wider estates work across the system to avoid individual groups working in isolation.

12.4 Mr Brettell replied that both he and Mr Francis regularly attend several strategic forums including the System Estates Group and One Public Estate Group. There should not be an occasion where there is a lack of linking up or an opportunity missed.

ACTION: Mr Brettell to provide an update on Estates, including visuals, in the Primary Care Update report to the next Committee.

12.5 Mr Dunshea suggested that the Primary Care Update paper should have higher prominence on the Agenda.

He then referred to adverse performance where certain targets are not being met, e.g. the national Diabetes Prevention Programme, and suggested that it would help the Committee to know the way forward in terms of how that is addressed, whether the target is unrealistic, or if steps need to be taken to improve mechanisms.

Referring to the discussion on population health, he suggested acquiring a read-across to what other sectors are doing and suggested obtaining a view across some of these programmes going into Social Services or within Shropcom.

12.6 Dr Garside advised that the Quality & Performance Committee have asked for an update and a "deep dive" into severe mental illness health checks and the LD health checks due in February. That information should be submitted to February PCCC before submission to Quality & Performance Committee at the end of the month.

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

Minute No. PCCC-22.12.42 Any Other Business

13.1 **PCCC**
Dr Pall advised the meeting that she would be discussing PCCC and how it is run in the future with Mr White, Mr Dunshea, and Sir Neil McKay, Chair of the ICB.

Dr Povey requested that he and Dr Chan should be included in the above discussions.

13.2 **RCN Strike Action**
Dr Pall referred to risks posed to the ICB by the strike action.

Dr Povey confirmed that there would be no direct impact on Practices because of the strike action. SaTH is not part of the strike action, but the Community Trust is, therefore there may be an impact on patient services in the community.

Ms Whateley confirmed that the main Unions – RCN and Unison – had not reached the threshold for agreeing strike action. None of the Unions were proposing strike action to extend to Shropshire.

Minute No. PCCC-22.12.43 Date of Next Meeting

The next Primary Care Commissioning Committee will take place on Friday 3 February 2023.

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.)

Shropshire Telford and Wrekin ICB Primary Care Committee Action Tracker
Part 1 Meeting – 3 February 2023

Agenda Item	Action Required	By Whom	By When	Date Completed
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	**December Update:** Mrs Williams has prepared a brief for Ms Parker which she had not yet shared with her. Update to be provided to February Committee.
PCCC-22.10.23 Supporting PCNs Through Winter	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 A&E and moving services into primary community.	Mr Robinson Mr White	December 2022 meeting February 2023 meeting	**December update:** Ongoing piece of work – there are frequently multiple conversations taking place. A formal presentation from the Local Care Programme would be useful. Mr White will pick up this action and arrange for a formal paper to be submitted to February Committee.
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 Mr White	December 2022 meeting February 2023 meeting	**December update:** As a small team we do not currently have the available capacity to do this work. Mr White will pick this up with senior colleagues within the Primary Care team.
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	Mrs Skidmore / Ms Jones Mrs Pall / Ms Jones	December 2022 meeting December 2022 meeting	**February update:** Mrs Pall and Ms Jones have discussed and Ms Jones will

	Committee and the format and content of financial updates going forward.			endeavour to incorporate possible changes in April report.
PCCC-22.12.34 **GP Access Report to ICB**	Mrs Jones to feed back Mr Dunshea's comments regarding the style and format of the GP Access report to Ms Pyrah. Mrs Jones to follow up with the relevant Board member the discussions and actions at the November Board meeting regarding Public Estate.	Mrs T Jones Mrs T Jones	February 2023 meeting February 2023 meeting	**February Update:** The Team will endeavour in future reports to include more focus on numbers, graphs, trends as opposed to narrative
PCCC-22.12.36 **Ethnically Diverse Staff Survey**	The results of the Ethnically Diverse Staff Survey to be brought back to PCCC to highlight and inform workforce implications.	Mrs J Gittins	Future meeting – t.b.c.	**February Update:** Survey has been launched
PCCC-22.12.38 **PCN Maturity Survey Results and Output from the King's Fund OD Work**	Mrs T Jones, Ms Pyrah, Mr Dunshea and Dr Pall to meet to discuss PCN background, DES, and requirements around reporting and look at the functions of PCNs with Public Health colleagues to see where the connections are with the ICB.	T Jones / E Pyrah / R Dunshea / N Pall	February 2023 meeting	**February Update:** Meeting to be arranged
PCCC-22.12.41 **Primary Care Team Update**	Mr Brettell to provide an update on Estates, including visuals, in the Primary Care Update report to the next Committee.	Mr Brettell	February 2023 meeting	**February Update**: PC Estates Strategy in process of being updated. All 8x PCNs engaged on clinical work. Estates work follows in Feb/March. Current timeline for first draft is April 2023. Final version May 2023.

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Shropshire, Telford and Wrekin

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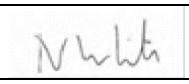
PRIMARY CARE COMMISSIONING COMMITTEE

Agenda item no.	PCCC 23-02.05
Meeting date:	3rd February 2023
Paper title	Primary Care Commissioning Committee – Structure of Future Agendas
Paper presented by:	Nick White, Chief Medical Officer
Paper approved by:	Nick White, Chief Medical Officer
Paper prepared by:	Nick White, Chief Medical Officer
Signature:	
Committee/Advisory Group paper previously presented:	First presentation

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

Previous considerations:	

1. Executive summary

In accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended), NHS England/Improvement has delegated the exercise of the functions specified in Schedule 2 to NHS Shropshire, Telford and Wrekin (NHS STW).

NHS STW has established the NHS Shropshire, Telford and Wrekin Primary Care Commissioning Committee (PCCC) to function as a corporate decision-making body for the management of the delegated functions and the exercise of the delegated powers.

The Committee has been established in accordance with statutory provisions to enable the members to make collective decisions on the review, planning and procurement of primary care medical services in Shropshire, Telford and Wrekin under delegated authority from NHS England/Improvement. This will extend to Pharmacy, Optometry and Dentistry when these functions are delegated on 1st April 2023.

The role of the Committee is to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act which includes the following:
• Decisions in relation to the commissioning and management of Primary Medical Services;
• Planning Primary Medical Services in the Area, including carrying out needs assessments;
• Undertaking reviews of Primary Medical Services in respect of the Area;
• Management of the Delegated Funds in the Area;

• Co-ordinating a common approach to the commissioning and delivery of Primary Medical Services with other health and social care bodies in respect of the Area where appropriate; and
• Such other ancillary activities that are necessary in order to exercise the Delegated Functions.

Following the introduction of the ICB in July 2022, a new PCCC was formed and has met 3 times since its inception. In December, a meeting of key committee members, including the committee chair, was held to review how the committee is functioning, whether it was fulfilling its core delegated functions and any improvements that could be made.

The outcome of that meeting is a proposal to restructure where primary care related reports and updates appropriately feed into the system. This is particularly important given the very significant integration and transformation developments set out in the Fuller report which, while the Fuller report puts General Practice integration at the heart of neighbourhood and place based working, cannot be achieved by General Practice alone and requires greater links with wider ICB strategy and place and neighbourhood based development work. The inclusion of this work in PCCC risks overloading the agenda and a loss of focus on the core functions the committee is required to deliver on under the delegation arrangements.

Proposal 1
It is therefore proposed that PCCC agenda is restricted to core delegated function items with a standing open section agenda covering finance, performance, workforce, quality (ie risk register), decisions to be made and any other business. Closed section items will be restricted to any items that are financial/commercial in confidence or risk related items that are not yet in the public domain ie CQC activity prior to publication of inspection report.

Proposal 2
It is recommended that another committee or group is established with a focus on primary care strategy/transformation development. This would be more informal in nature than PCCC, providing a discussion and recommendation forming/decision making forum with a different membership including PCCC Chair, ICB CMO and clinical leads, GP Board members, PCN Directors for example.
There are 3 options as to where this committee would report:-
1. ICB Strategy Committee
2. SHIPP/TWIPP
3. Or be a meeting in Common of SHIPP/TWIPP/GP Board reporting to the Integrated Delivery Committee

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	x
Enhanced engagement and accountability	
Creating system sustainability	
Workforce	x

2. Recommendation(s)

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

1. Approve the proposal that PCCC focuses on core delegated primary care function items.
2. Approve the proposal to establish a separate forum with a primary care strategy/transformation development focus
3. If 2 is approved above, decide which reporting route the newly formed group should report into.

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

None

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	
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	

PRIMARY CARE COMMISSIONING COMMITTEE – February 2023

Agenda item no.	PCCC 23-02.06
Meeting date:	3rd February 2023
Paper title	Albrighton Medical Practice: Application to reduce practice boundary.
Paper presented by:	Bernadette Williams. Primary Care Lead - contracting
Paper approved by:	
Paper prepared by:	Bernadette Williams. Primary Care Lead – Contracting. Tom Brettell. Partnership Manager
Signature:	*B Williams*
Committee/Advisory Group paper previously presented:	Primary Care Operational Group (PCOG)

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

Previous considerations:	

1. Executive summary and points for discussion

Albrighton Medical Practice has applied to reduce their current practice boundary. A practice boundary forms part of the contract for primary medical care services and any changes are considered contract variations. This paper provides Primary Care Commissioning Committee with the opportunity to consider this variation and subsequently accept or decline the variation.

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	
Workforce	

2. Recommendation(s)

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

Approve the application to reduce the practice boundary.

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

A: Application to change practice area.
B: Map of proposed boundary (provided by the practice)
C: Two maps to show the area of development and the Shropshire/Staffordshire border.
D: Practice information

5. What are the implications for:

Shropshire, Telford and Wrekin's Residents and Communities	
Quality and Safety	Supports the practice to maintain a quality service for its patients.
Equality, Diversity, and Inclusion	None
Finances and Use of Resources	None
Regulation and Legal Requirements	None
Conflicts of Interest	None
Data Protection	None
Transformation and Innovation	None
Environmental and Climate Change	None
Future Decisions and Policy Making	None

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

Albrighton Medical Practice has submitted an application to reduce the practice boundary in line with the application process set out in the NHS England Primary Medical Care Policy and Guidance Manual [1](PGM) v4 May 2022 section 8.14 boundary changes. The required template is completed and included as appendix A to this paper.

Any changes to the practice area must be considered as variation to the contract and the definitions of these areas amended under a variation notice. The contractor must notify the commissioner in writing of its intent to vary its area setting out the reasons for the change and full details of proposed practice area with any additional supporting evidence that may assist the commissioner in reaching a decision.

The contractor and the commissioner must engage in open dialogue concerning the circumstances that have led to the request to change the boundary and discuss the possible implications of the action. For example, the impact this may have on neighbouring practices already covering the area.

Commissioners are required to consider the application with regards to other practice boundaries, patient access to other local services and in general other health service coverage within the location. The commissioners may also seek to involve the public to gather their views.

Albrighton has requested to reduce the current boundary due to a new significant housing development taking place on the very far south-east corner of Albrighton's boundary adjacent to the large village of Perton. The site falls entirely within the jurisdiction of South Staffordshire District Council and South-East Staffordshire and Seisdon Peninsula Integrated Care Board (ICB). There are two medical practices in Perton (Lakeside & Tamar) which are both within ¼ mile of the site who provide services for the majority of the residents of Perton.

This development will deliver 220 dwellings, equating to approx. 550 people in total. Due to this site proximity to Perton the expectation is that these residents will look to Perton for all of their services i.e. shops, schools, leisure and healthcare.

Planning consent has been gained and building is now underway. Analysis of the planning documentation highlights that the development is an addition to Perton and fails to mention any healthcare requirements or provision. Consequently, there is no suggestion of any financial investment in healthcare infrastructure to support the new development.

2. Engagement

The Practice and primary care team members have met and discussed the reasons for the request; the following points were raised during the discussion:

[1] https://www.england.nhs.uk/publication/primary-medical-care-policy-and-guidance-manual-pgm/

- The houses have no natural relationship with Albrighton as a service centre making the two GP practices in Perton the natural choice for these new residents to access primary care services.
- Albrighton medical practice would like to maintain their current outstanding level of service which is safe, effective, value for money quality patient services that meet the needs of the local population.
- There is currently a housing development being constructed in Albrighton (circa 250 dwellings) as well as the housing development in the Perton area.
- Increasing the practice list size by potentially circa. 550 if all residents choose to register with Albrighton would impact service delivery.
- The practice has discussed the boundary change with their patient participation group who are fully supportive of the application.
- The practice understands that any patients currently registered with Albrighton will remain registered and are not to be removed at any time in the future (if the application is approved).

Advice has been sought from NHS England General Medical Advice and Support Team (GMAST); which was that both ICBs needed to collaborate to work through the implications.

Primary care team members have also met with counterparts in South-East Staffordshire and Seisdon Peninsula (SESSP), to discuss primary care provision. Discussions focussed on the issues identified in this paper and requested SESSP colleagues to ask one of two of the practices if they would extend their practice area to enable patients to register easily. Two practices have been asked however they have both refused. SESSP confirmed this development was not included in their estates strategy therefore an S106 application for funding has not been made.

We have tried to progress and collaborate with SESSP colleagues, for example, one of the suggestions was that we should establish a rota for the patient allocation, we have requested a further meeting to scope this however there hasn't been a response.

3. Conclusions

- The application is in line with the process as detailed in the PGM.
- The practice wants to continue to provide safe, effective, value for money quality patient services that meet the needs of the local population.
- There is potential for future strains on clinical and administrative capacity if the patient list increases rapidly.
- The new development is clearly within the Staffordshire ICB area.
- There are 2 SESSP practices within a quarter of a mile of the new development.

4. Recommendations

Primary Care Commissioning Committee are asked to

- Approve the application to reduce the practice boundary.

Appendix A:

Annex 13A

Template Application to Change the Practice Area

21st July 2022

Dear Commissioners,

Application to Change the Practice Area

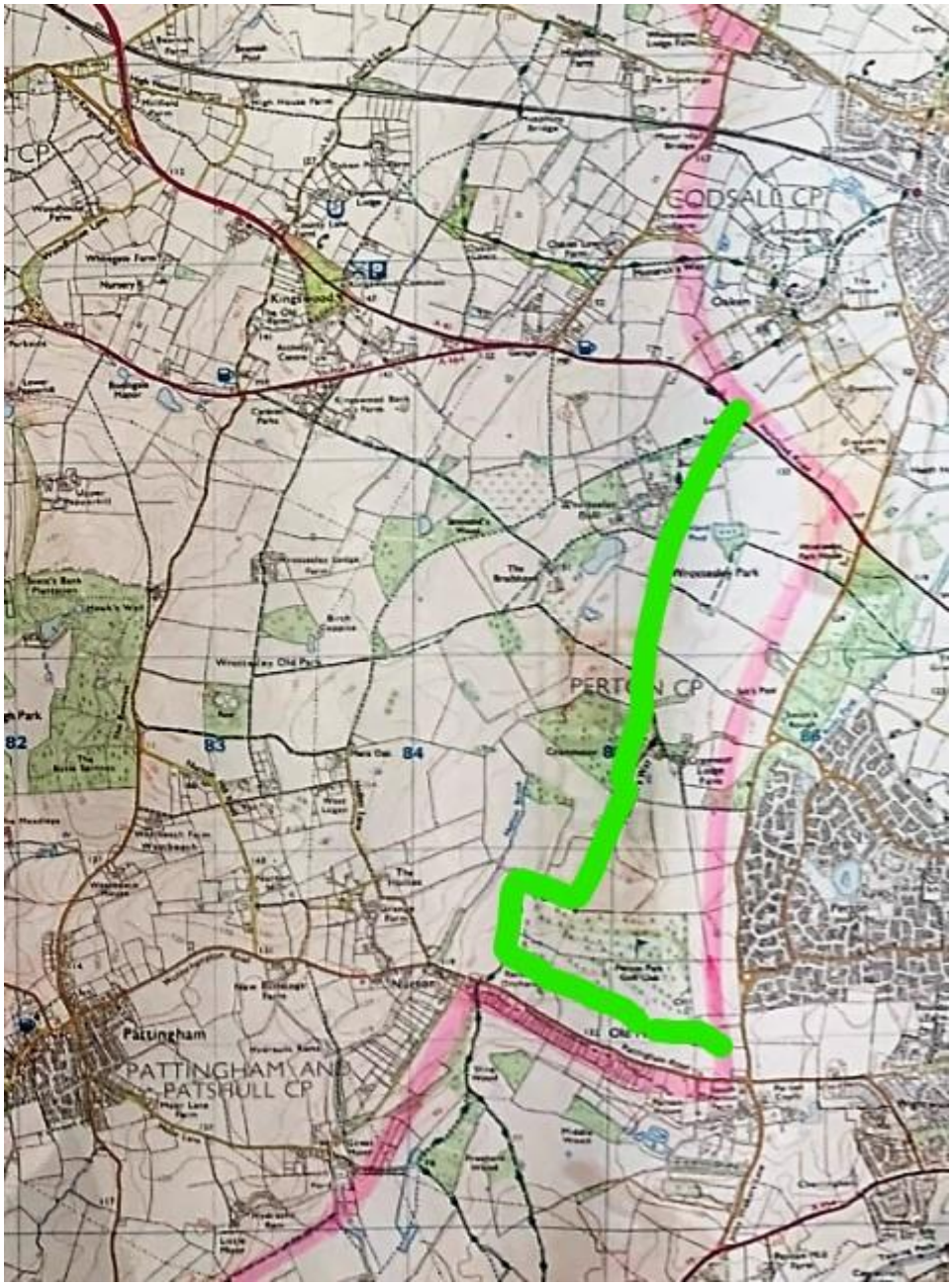
Please provide the information below to the Commissioner no less than 28 days before the requested contract variation.

1. Affix practice stamp:	Albrighton Medical Practice Shaw lane Albrighton WV7 3DT
2. Provide full details of the proposed practice area:	Proposal to adjust the boundary in the southeast corner of the practice area to follow the line of the Staffordshire Way between Pattingham Road and Holyhead Road
3. Explain the reasons for the change of practice area:	The area proposed to be removed is currently arable farmland/golf course. A new housing development of initially 220 dwellings is being constructed of Wrottesley Park Road, adjacent to Perton. This development would be within our current practice area.
4. Provide any additional supporting evidence that may be relevant (e.g. current capacity, challenges or under utilised capacity, patient distributions, future service development plans (including knowledge of local developments such as housing):	1.There is currently housing development being constructed (up to 250 dwellings) within Albrighton that will significantly increase the practice list size. 2. The current practice building is at capacity, we have gained planning permission for expansion of the current building but there is likely to be a prolonged wait before any building occurs. 3. The natural flow of the residents within the new development in South Staffordshire would be to Perton which has two existing GP practices and to Codsall and Wolverhampton. We are a Shropshire practice. 4. I have had discussion with the chairperson of our patient Group who supports our application. It will be discussed with the group as a whole at our forthcoming Patient Group meeting

Note: fully signed pdf doc received.

Appendix B: Proposed boundary for Albrighton Medical Practice.

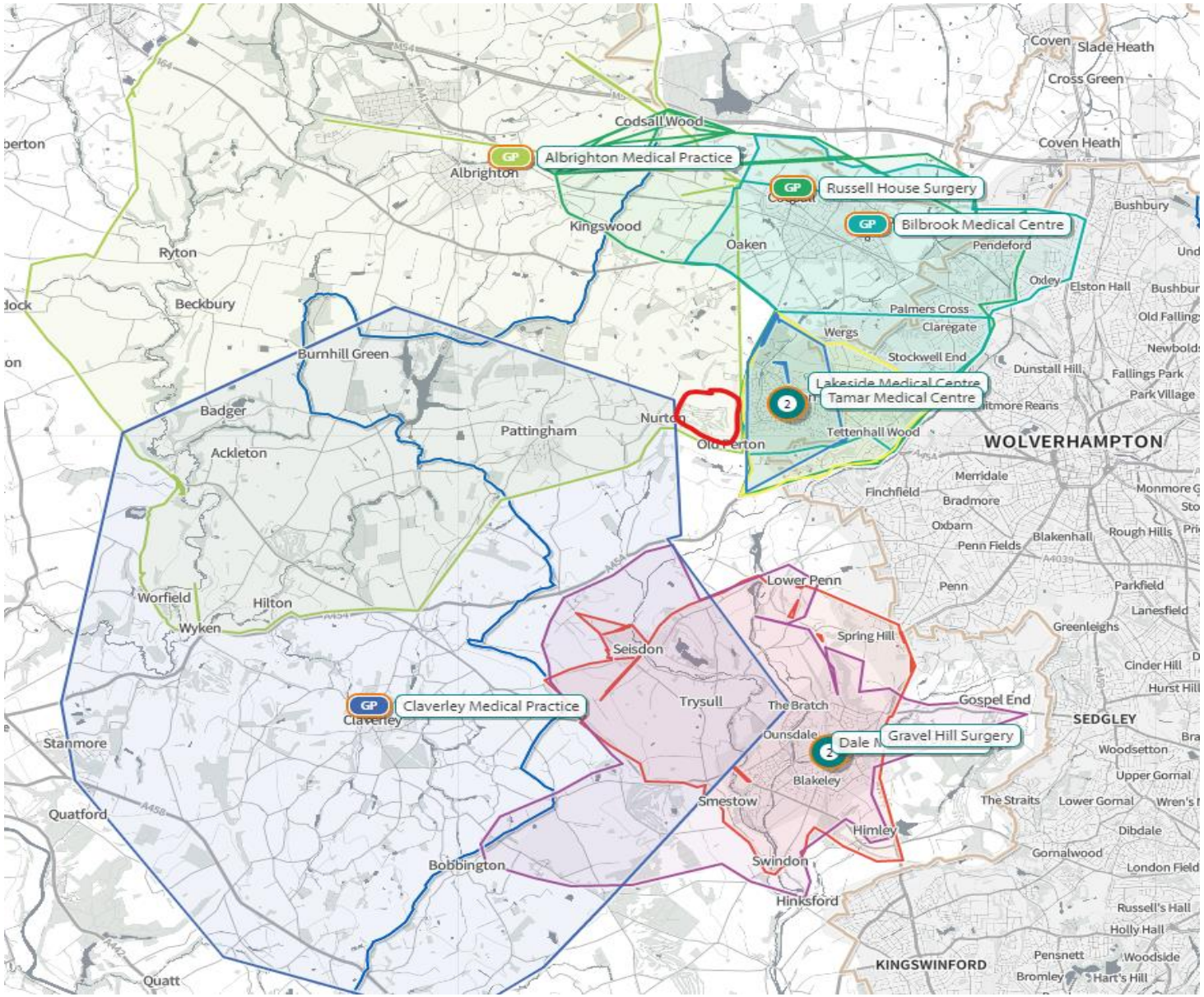
The Pink line indicates the existing boundary. The Green line indicates the proposed boundary line.



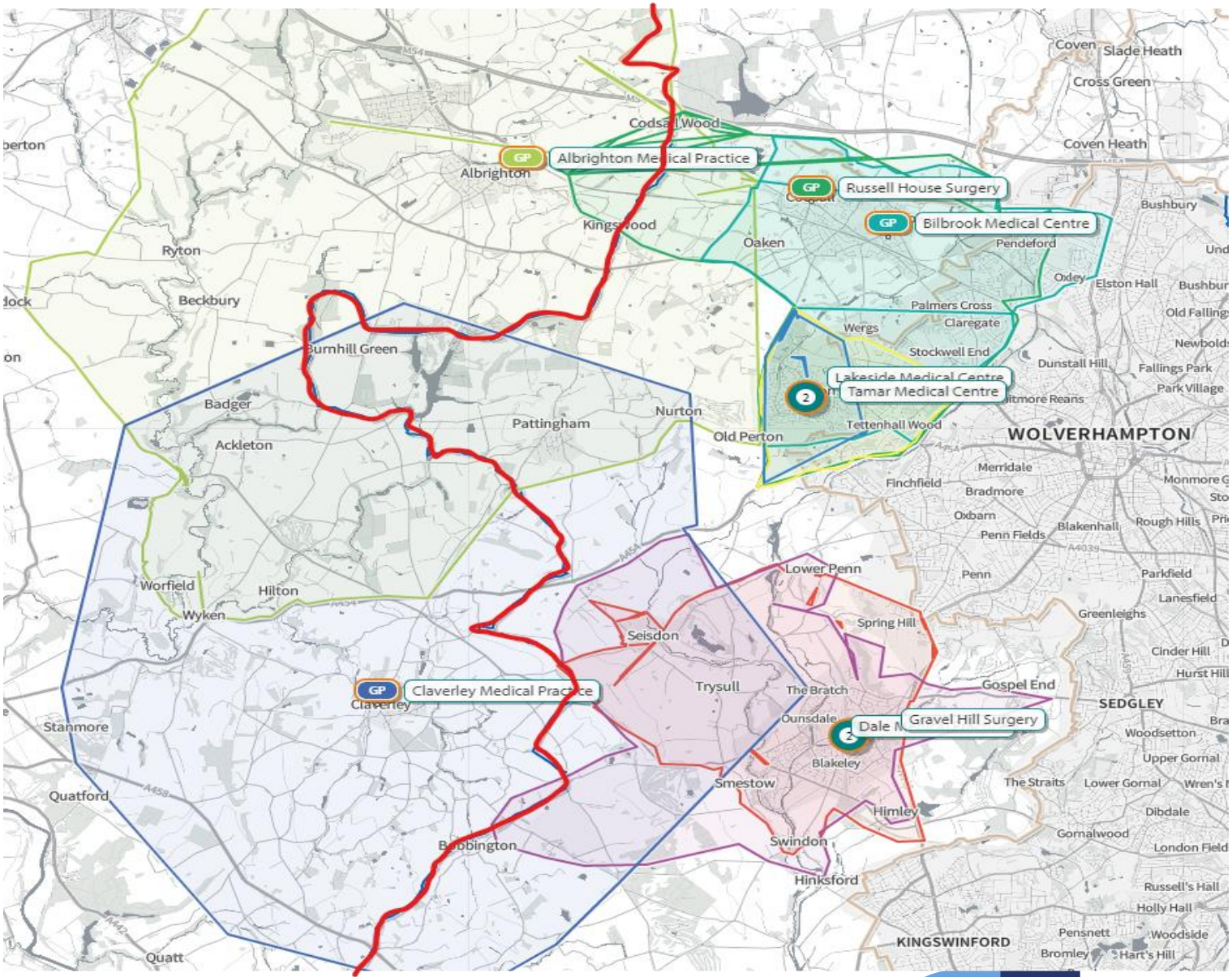
Appendix C: 2 maps

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin



Map 1: shows surrounding practices with housing development area in the centre.



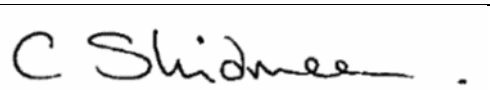
Map 2: shows Shropshire border and how far into Staffs the area is.

Appendix D: Practice Information

- Albrighton Medical Practice is a well-established GP practice providing primary medical care under a general medical services (GMS) contract.
- List size @ Q1 2022-23 is 8,185 (8,269 as of 13/09/22)
- CQC rated as Outstanding
- Purpose built premises
- 30 parking spaces + staff parking
- The practice has 6 partners 2 GP registrars and 2 salaried GPs.
- Other clinical roles include 4 Nurses and 3 Healthcare Assistants (HCA)
- The practice is open 08.00 to 18.00 Monday to Friday and provides Enhanced Access via the Primary Care Network Directed Enhanced Service.

- Premises currently fully utilised and in need of additional capacity for existing population. Practice currently in process of putting together a business case to get approval for an extension to accommodate additional patients expected as a result of housing development in the Albrighton area – expected February PCCC – awaiting quotes for work proposed – DV report done for uplift in rent/rates – architect drawings already done – practice to consult patients mainly on arrangements for whilst construction work ongoing

Primary Care Commissioning Committee Part 1 – 3rd February 2023

Agenda item no.	**PCCC 23-02.07**
Meeting date:	**3rd February 2023**
Paper title	**2022/23 Month 9 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:	
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 9, December 2022:

Co-Commissioning budgets (those delegated to the ICB from NHSE) are currently underspent by £3,098k with a reported full year forecast underspend of £3,409k. 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 £936k with a forecast underspend of £1,197k.

For information, other Primary Care budgets (those that form part of the ICB's core budget) have a year-to-date underspend of £1,137k and a full year overspend forecast of £532k. The main driver of the year-to-date underspend is the release of prior year benefit in relation to Prescribing and Enhanced Services which is non recurrent in nature. The main driver of the forecast overspend is increased Prescribing expenditure associated with national Price Concessions.

The finance team are working to review the underlying position as part of the 23/24 planning round as whilst there are some financial benefits 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 guidance has been received and detailed plans are currently being worked through by the Finance team alongside the Primary Care team and NHSE for the first draft submission on the 23rd February. ICB Board sign off is then required before the final submission due in March. A detailed plan will be presented at the April committee meeting.

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 April Committee.

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. M9 Reported Position Delegated

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

2022/23 Month 9 Financial Position

Introduction

1. The financial performance reported in this paper is for Month 9 – December 2022.

Delegated Budget

Table 1: M9 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 ARRS Additional Allocation £'000	Forecast Variance £'000
General Practice - GMS	39,745	38,796	949	52,993	51,905	0	1,088
QOF	5,933	5,918	15	7,911	7,906	0	5
Enhanced Services	9,237	10,129	(892)	13,154	16,628	3,372	(102)
Premises Cost Reimbursements	5,365	4,524	841	7,153	7,007	0	146
Dispensing & Prescribing	2,204	2,175	30	2,939	2,865	0	74
Other GP Services	935	(1,221)	2,156	1,246	(952)	0	2,198
Total Primary Care Delegated	**63,419**	**60,321**	**3,098**	**85,396**	**85,359**	**3,372**	**3,409**

2. The above table shows the year to date and forecast position for delegated budgets (this includes non-recurrent adjustments in relation to prior year benefits). The below table shows the underlying position (which excludes the non-recurrent adjustments).

Table 2: M9 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 ARRS Additional Allocation £'000	Forecast Variance £'000
General Practice - GMS	39,745	38,796	949	52,993	51,905	0	1,088
QOF	5,933	5,918	15	7,911	7,906	0	5
Enhanced Services	9,237	10,129	(892)	13,154	16,628	3,372	(102)
Premises Cost Reimbursements	5,365	4,788	577	7,153	7,322	0	(169)
Dispensing & Prescribing	2,204	2,175	30	2,939	2,865	0	74
Other GP Services	935	676	258	1,246	945	0	301
Total Primary Care Delegated	**63,419**	**62,482**	**936**	**85,396**	**87,571**	**3,372**	**1,197**

3. 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%.

4. 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.

5. Enhanced Services – The Additional Roles Reimbursement Scheme (ARRS) represents 41% of the annual budget on Enhanced Services. The forecast on ARRS is based on 100% utilisation of the baseline allocation as well as additional drawdown from the central fund. The year to date variance is due to budget phasing for ARRS due to the additional drawdown having not yet been received from NHSE. The latest complete monthly reimbursement claim (August 2022) shows that 125 WTE staff are employed within the scheme. Latest PCN recruitment plans forecast 226.35 WTE staff to be in post by the 31st March 2023 and PCNs have confirmed that they have expenditure plans for the full £8.809m to be spent in this financial year.

6. Premises Cost Reimbursements – Further analysis of premises costs has been carried out 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 and the position is now reported as an underspend. £315k of this underspend is in relation to the non-recurrent rates rebates efficiency scheme. The forecast underspend reduces over quarter 4 due to the provision for any outstanding arrears being profiled towards the end of the year.

7. Dispensing and Prescribing – In Month 9 charges were 67% higher than the previous month, an unexpected increase which has also been experienced by other ICBs in the Midlands. At this stage we believe this to be a one off occurrence and remaining months of the year are forecast at the average spend for Month 1-8.

8. 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 forecast variance on Premises Cost Reimbursements.

9. The difference between the reported position and the underlying position is £2.2m. This is predominantly driven by taking out the benefit of accruals set in 2021/22 that are no longer required now that actual costs have been accounted for.

10. Although there is an underlying in year forecast of £1.2m underspend, there are known future commitments in relation to premises, in particular new developments, that will reduce this underspend significantly.

Non Delegated Budget

Table 3: M9 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	64,332	64,706	(374)	84,943	86,860	(1,917)
Central Drugs	1,827	1,962	(135)	2,436	2,622	(186)
Oxygen	688	740	(52)	917	1,017	(100)
Prescribing Incentive Schemes	283	149	133	377	241	137
Out of Hours	2,934	2,954	(20)	4,391	4,415	(24)
Enhanced Services	4,156	2,274	1,882	5,651	3,627	2,023
Primary Care Pay	2,214	1,748	467	3,040	2,521	518
Primary Care Other	198	124	74	301	260	40
Primary Care IT	1,668	1,708	(40)	2,253	2,301	(47)
GP Forward View	1,896	1,931	(35)	2,693	2,854	(161)
Primary Care Planning Adjustment	(764)	0	(764)	(815)	0	(815)
Total Primary Care Non Delegated	**79,433**	**78,296**	**1,137**	**106,187**	**106,719**	**(532)**

11. The year to date position is an underspend of £1.1m, The main driver for the reported underspend is the release of prior year benefits in relation to Prescribing and Enhanced Services.

12. The Prescribing forecast has increased by a further £1m between Months 8 & 9. The forecast is based on the National EPACT system forecast which is updated on a monthly basis. In addition to this a further £0.5m has been included into the forecast in relation to Category M drugs following the January price announcement. The main driver of the overspend is the cost pressure from NCSO (No Cheaper Stock Obtainable) price concession and Category M Drugs tariff, totalling £1.9m higher year to date compared with 21/22 expenditure. Price concessions are granted when community pharmacists cannot source a drug at or below the reimbursement price as set out in the Drug Tariff, The Department of Health and Social Care can then introduce a concessionary price.

13. The table below shows the spend, number of items prescribed by month and cost per item compared with Apr-Oct 2021.

Month	Items	Net Ingredient Cost	Net ingredient cost per item	Year on Year Growth (Cost)	Year on Year Growth (Items)	Year on Year Growth (cost per item)
April	765,346	£ 7,049,470	£ 9.21	-6.1%	-1.8%	-4.4%
May	826,142	£ 7,734,696	£ 9.36	8.0%	11.5%	-3.1%
June	794,184	£ 7,421,601	£ 9.34	-3.2%	0.5%	-3.7%
July	816,151	£ 7,827,244	£ 9.59	3.7%	2.0%	1.7%
August	820,512	£ 7,892,059	£ 9.62	10.2%	7.7%	2.3%
September	811,103	£ 7,892,071	£ 9.73	2.8%	0.4%	2.3%
October	862,564	£ 8,552,006	£ 9.91	13.4%	6.7%	6.3%
Year to Date				**4.0%**	**3.8%**	**0.2%**

14. The forecast overspend on non delegated budgets is £532k. 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 & 3, 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 4: M9 Efficiency Schemes

Efficiency Scheme	M9 YTD Plan £'000	M9 YTD Actual £'000	M9 Variance £'000	Full Year Plan £'000	Full Year Forecast £'000	Forecast Variance £'000
DOAC	640	186	(454)	884	336	(548)
Optum	247	377	130	247	393	146
Prescribing Decision Support	377	442	65	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	137	150	13	150	175	25
NR Safer Medicines (LCS)	0	108	108	0	108	108
NR Prescribing Decision Support	0	136	136	0	136	136
Total	**1,401**	**1,471**	**70**	**1,781**	**1,781**	**(0)**

15. The ICB has a number of efficiency schemes to be delivered from prescribing budgets which are detailed in table 4 above. These contribute to the 1.6% system efficiency 'ask' that all system partners have agreed.

16. At Month 9 an over achievement of £70k is reported, with a forecast position of breakeven. The underachievement on the DOAC (Direct-acting oral anticoagulants) scheme 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. This underperformance is being netted off by non recurrent savings identified elsewhere in the prescribing budgets and overperformance reported on all other schemes.

Capital

17. 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**

18. Recent national guidance has been published regarding support to GPs/ PCNs through winter and beyond, which includes potential additional capital funding. The ICB submitted a bid for additional hardware replacement, the bid has been partially successful, with £204k being allocated of the original £587k bid.

Risks

19. 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.

20. 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 Price Concessions. The additional costs are unpredictable and are unable to be controlled or mitigated locally.

Planning 23/34

21. The 23/24 National guidance was released at the end of December. Submission of the 1st draft of the ICB plan is due on the 23rd February. ICB Board sign off is then required before the final submission due in March.

22. For Primary Care, the guidance focuses on improving patient access to GP services by ensuring that appointments can be secured within two weeks, and urgent issues can be seen on the same or next day based on clinical need. Systems are asked to develop plans to improve digital access to GP practices.

23. The NHS will be expected to deliver 50 million more primary care appointments by the end of March 2024 (on 2019/20 levels) which will be supported by the recruitment of 26,000 roles through the additional roles reimbursement scheme (ARRS). Greater use of the community pharmacist consultation service (CPCS) is also intended to redirect lower acuity care away from general practice and NHS 111. NHSE will also publish a recovery plan for general practice access in the new year.

24. ICBs' primary care allocations in 2023/24 will increase by 5.6% on average given the rise in GP contract entitlements and the increase in ARRS entitlements. Below is an extract detailing the draft recurrent 2023/24 delegated allocation for the ICB, indicating a recurrent growth in allocation of 6.18% for STW.

System Name	2022/23 Adjusted recurrent baseline (£k)	2022/23 Distance from target (%)		2023/24 Base growth (%)	2023/24 Convergence (%)	2023/24 Recurrent allocation (£k)	2023/24 Recurrent allocation £/head	2023/24 Post-convergence distance from target (%)	2023/24 Recurrent allocation growth (%)
NHS Shropshire, Telford and Wrekin ICB	86,175	0.02%		6.21%	-0.0%	91,504	175	-0.00%	6.18%

25. From 1st April 2023, in addition to General Practice delegated budgets, the ICB will gain delegated responsibility for POD (Pharmacy, Optometry and Dentistry) from NHSE. A focus within the planning guidance specifically in relation to POD is to recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels.

26. The utilisation of POD allocations is subject to an additional rule in 23/24, that dental budgets are ring-fenced. The rationale of this is to ensure that the NHSE safeguards resources earmarked for dental services. The 23/24 ringfenced element for STW ICB is £33.969m

27. Below is an extract detailing the draft recurrent 2023/24 POD allocation for the ICB, indicating a recurrent growth in allocation of 3.1% for STW.

	2022/23	2023/24	2023/24	2023/24	2023/24	2023/24
	Recurrent baseline	Base growth	Base growth	Convergence	Recurrent allocation	Total allocation growth
	£k	£k	%	%	£k	%
NHS Shropshire, Telford and Wrekin ICB	48,290	1,478	3.1%	0.0%	49,789	3.1%

28. A POD planning workshop was held by NHSE in January with ICB representatives from both planning and finance teams in attendance.

29. The detail behind these headline figures are being worked through with the Primary Care team and will be presented at the April committee meeting.

Conclusion

30. Delegated budgets 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. Non-delegated

budgets are now forecasting to overspend by £0.5m, due to the increased expenditure on Prescribing due to Price concessions.

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. 2023/24 planning guidance has been received and detailed plans are currently being worked through by the Finance team alongside the Primary Care team and NHSE for the first draft submission on the 23rd February. ICB Board sign off is then required before the final submission due in March. A detailed plan will be presented at the April committee meeting.

Appendix 1

Month 9 Reported Position

The table below 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).

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	39,472	38,796	676	52,721	51,905	816
General Practice - PMS	0	0	0	0	0	0
QOF	5,868	5,918	(51)	7,845	7,894	(49)
Enhanced Services	8,262	10,129	(1,867)	15,550	16,640	(1,090)
Premises Cost Reimbursements	5,863	4,524	1,339	7,651	7,001	650
Dispensing & Prescribing	2,221	2,175	46	2,955	2,865	90
Other GP Services	1,116	(1,221)	2,338	1,428	(946)	2,374
Co Commissioning Planning Adjustment	618	0	618	618	0	618
Total Primary Care Delegated	**63,419**	**60,321**	**3,098**	**88,768**	**85,359**	**3,409**

Integrated Care System
Shropshire, Telford and Wrekin

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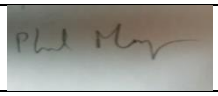
Shropshire, Telford and Wrekin

Primary Care Commissioning Committee 3 February 2023

Agenda item no.	**PCCC 23-02.08**
Meeting date:	**3 February 2023**
Paper title	**Workforce and Training Hub Update**
Paper presented by:	**Phil Morgan and Sara Edwards**
Paper approved by:	**Emma Pyrah**
Paper prepared by:	**Phil Morgan, Sara Edwards & Laura Kinsey**
Signature:	
Committee/Advisory Group paper previously presented:	

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

Previous considerations:	

1. Executive summary and points for discussion

This report provides committee with a high-level description on progress made against each of the following core functions of STW Primary Care Workforce and Training Hub. These functions form the basis of the Workforce and Training Hub Strategy which is currently in draft form.

1. **Learner Placement Capacity –** develop and expand high quality clinical placements for all learners. To support workforce supply and the creation of multi-disciplinary teams, student/trainee placement in primary care is crucial. Exposure to general practice at this stage can result in learners choosing a career in primary care.

   Key points
   - HEE are supporting Quality Assurance for all learner placements and have provided funding to recruit a Quality Assurance Training Programme Director for STW primary care.
   - Capacity currently remains low across STW general practice for all learner types.

2. **Workforce Planning –** supporting PCNs, aligning with system initiatives and population health intelligence.

Key points

- Full utilisation of 22/23 Additional Roles Reimbursement Scheme (ARRS) funding by PCNs
- Due to the increased effort made by PCNs on recruitment there are now over 230 ARRS funded staff working across the 8 PCNs.

3. **Recruitment of Primary Care Workforce –** covering all roles.

Key points

- Stable numbers of GPs, but more working fewer hours, leading to a drop of 41 WTE
- A significant drop in the number of partners
- A slight drop in the number of GPNs
- A significant increase in the number of Advanced Practitioners
- A bid increase in Direct Patient Care – this includes HCAs, Clinical Pharmacists, Paramedics etc (not ARRS)

4. **Enable New Roles in Primary Care** – enable, support and embed new roles into primary care

Key points

- Clinical Facilitators are recruited/being recruited with resources allocated for contract extensions (Clinical Pharmacist, Physician Associate, First Contact Practitioner MSK, Advanced Practitioner, Nurse, Paramedic and HCA)
- Enabling package includes supporting access to supervision, funding, preceptorship programmes, peer support, training and development opportunities.

5. **Workforce Retention** - Supporting the retention of the primary care workforce across all key transitions including promoting primary care as an employment destination. Supporting training, education and development programmes.

Key points

- NHSE/I funded GP retention initiatives continue to be developed – mentoring, Fellowships and support roles for specific GP groups
- Return to regular PLT and GP update sessions
- A comprehensive 2023 Training, Education and Development offer is available across all staff groups.

Further detail on the current position, challenges and next steps on all of the above is outlined in the table below.

1. Learner Placement Capacity **Current Position/Challenges**	**Next Steps**
Supports supply and recruitment. Training Hubs (THs) are required to facilitate all learner placements in primary care (non-medical). Current activity focuses on student nurses, Physician Associates and Paramedics. Numbers are currently low across STW with clinical capacity an issue to support students. An additional challenge is facilitator resource to support increasing placement capacity.	Long term strategy is to support all professions into primary care placements. This is underpinned by compliance with regulatory standards and **HEE's Quality Framework**. HEE have provided THs with funding to recruit a Quality Assurance Training Programme Director to help move this agenda forward and develop our approach. This role is currently out to advertisement. The team are working closely with Universities in relation to the above. Further funding has been allocated for a Placement Facilitator for student nurses. This role is to be advertised shortly.
2. Workforce Planning **Current Position/Challenges**	**Next Steps**
PCNs/ARRS All of STW 8 PCNs have submitted plans setting out their recruitment intentions for their ARRS staff from Jan 23 to March 24. This data has been used to assess the extent to which the ICB will be utilising our overall ARRS budget. The latest data suggests that, unlike previous years where the ICB/CCG underspent quite considerably, the 8 PCNs will be close to fully using the ICB allocation. This is being closely monitored to ensure that there is no overspend. **GMS Practice Workforce** Unlike the PCNs, who are contractually obliged to submit workforce plan, there is no contractual requirement on the 51 practices to provide the ICB with recruitment intentions. However, engagement	The ICB will be working with the PCNs to further refine their ARRS staff recruitment plans for 2023/24. This will include continuing to enable them to access relevant Population Health data so that they are able to assess which of the current 17 ARRS roles would be of most use to them. In order to improve the ICB's ability to report to NHSE on projected practice workforce numbers further engagement will take place with practices to develop an approach that is designed to provide more accurate workforce planning data.

takes place on an ad hoc basis with individual practices to assist with their own recruitment plans where requested. **NHS Workforce Regional Planning** Each year the ICS is required to submit data on anticipated workforce numbers. In order to complete this request for the 8 PCNs the ARRS data referred to above is used. For the practices the forward planning figures are based on what the ICB knows about current trends around recruitment for different cohorts of staff.	
3. Recruitment of Primary Care Workforce **Current Position/Challenges**	**Next Steps**
GP Trainees The ICB works with the local GPVTS to encourage and enable as many of the GP trainees as possible to secure employment once they are fully qualified. This includes running "speed-dating" sessions which link up those trainees interested in working in our practices, with those practices that are interested in recruiting newly-qualified GPs. **Recruitment Support** Practices are able to advertise their vacancies on the Workforce and Training Hub website, in addition, individual clinicians are able to advertise their availability and interest in work. Clinical Facilitators also support PCNs to recruit into ARRS and nursing roles linking in to HEIs to access soon- to- be-qualified or newly- qualified clinicians. A suite of preceptorship programmes also support recruitment making coming to work in STW more attractive for newly-qualified clinicians. **Lantum GP Locum Platform** The ICB is continuing to work with Lantum who have been commissioned to provide a digital locum booking platform. There are nearly 70 fully approved GPs on the Platform and a small, but	The ICB will continue to work with the VTS TPDs to provide information to soon-to-qualify VTS doctors to encourage and enable them to work in STW practices following their qualification. The ICB will encourage practices to become sponsoring employers to enable them to recruit IMGs following their CCT. Further engagement will take place with practices to increase take-up of the Lantum platform. One of the key challenges with practice data is to ensure its accuracy – to this end practices will be asked to review their process for updating

growing, number of nurses, ANPs and other clinicians. Use of the Platform by practices has been low but is gradually growing.

Data

The latest data for staff across the 51 practices is shown below:

Cohort	Sept 2015		Nov 2022	
	Headcount	FTE	Headcount	FTE
GPs (fully qualified)	321	285	321	244
GP Partners	241	229	190	163
Practice Nurses	183	117	170	113
ANPs	34	25	63	50
Direct Patient Care	155	97	214	147

their workforce records on the NHS National Workforce Reporting System.

4. Enable New Roles in Primary Care **Current Position/Challenges**	**Next steps**
STWTH is working with Practices/PCNs to identify the training needs of Additional Roles Reimbursement Scheme (ARRS) staff, ensuring they are aware of training and development opportunities available to staff groups.	Clinical Facilitators to further develop and maintain existing support packages which include supporting access to supervision, funding, preceptorship programmes, peer support, training and development opportunities.
The TH is supporting the delivery of the local Personalised Care Programme in partnership with Shropshire Council. In addition, training programmes specific to developing Personalised Care Roles have been commissioned and delivered. Since the start of the	Next steps to include further identifying funding to extend facilitator contracts and provide support to other staff groups such as Personalised Care Roles.

Programme in 2021, 297 colleagues across the STW Primary Care system have benefitted from Personalised Care Training delivered as part of the Programme. Multi-disciplinary Clinical Supervision Model of Practice training is being offered to PCNs to support new roles and existing professions post-qualification and beyond preceptorship year.	Next steps for Clinical Supervision model will be to pilot across a PCN.
5. Workforce Retention **Current Position/Challenges**	**Next steps**
Local GP Retention In order to effectively utilise the NHSE allocation "Local GP Retention" a GP Strategy has been developed and signed off by Committee. The key pieces of work designed to implement this strategy, and funded by the allocation, are as follows: • Commissioning an external provider (PCC) to carry out two pieces of linked work: an extensive piece of work to gather data and intelligence on the experiences, challenges and concerns of our GPs, and a survey of practices as employers of GPs • Recruiting a number of GP lead roles to champion different specific sub-cohorts of GPs including women GPs, older GPs, Locum GPs and Ethnically Diverse GPs • The ICB continues to run the GP Fellowship scheme which is funded by NHSE. This is a two-year scheme for newly-qualified GPs to access training and development. There are currently just over 20 GPs on this scheme. • STW GPs are able to access free, confidential mentoring, provided by a trained, local team of mentors. Funding for this is provided by NHSE.	The ICB will use the findings of the PCC work to better focus future funding with a view to retaining more of the GP workforce. The findings will also be used to assist practices in improving their approach to recruitment, induction and retention of their GPs.

PLT GP and Advanced Practitioner sessions have been face- to-face in 22/23 covering Palliative Care (attended by 104 GPs and APs) and Women's Health (attended by 191 GPs and APs). Other staff groups have been offered support and diabetes training has been commissioned (attended by 102 clinical staff) Hot Topics update sessions have also been delivered (attended by 195 GPs). Some challenge for the team to manage the face- to- face sessions due to capacity.	PLT dates are being confirmed with Shropdoc for 23/24. Topics are being discussed with GP Educator leads.
Clinical and Non-clinical Workforce Retention – Upskilling and development 100% of the Primary Care Workforce (both clinical and non-clinical staff groups) have been offered training provided by STWTH. In addition, 100% of eligible staff (nurses and allied health professionals) have been offered training using HEE CPD monies. STWTH were allocated £84,667 HEE CPD Investment monies for 22/23. Training commissioned using this monies is forecasted to provide upskilling opportunities for 327 GPNs and 60 AHPs working in general practices across STW Some challenges around staff being able to access or attend training due to capacity issues around their release. STWTH has a comprehensive Training and Education plan to support workforce retention. Data from a recent Training Need Assessment is being used to inform future commissioning and ensure the TH's training and education offer remains relevant for service delivery, meets the needs of the primary care workforce, ensures quality and supports the health inequalities agenda.	Training is currently being commissioned for the year ahead.

One of the key challenges with practice data is ensuring it captures the training and development needs of the entire primary care workforce. Low response rate from practices also results in training needs not being identified and raised and therefore not included in funding plans. Continued work with system partners to ensure there is a joined-up approach towards the development of the Primary Care workforce with our out of hospital partners. Peer support groups and forums managed by the Clinical Facilitators provide an additional element in assisting retention.	

2. Recommendation(s)

The Primary Care Commissioning Committee is asked to:

- Note the content of the report for assurance purposes.

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

None

5. 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	Multi-disciplinary teams are in place with the right skill mix to serve population health needs.
Quality and Safety	Training, education and development of clinical workforce to ensure quality patient care.
Equality, Diversity, and Inclusion	No implications
Finances and Use of Resources	Full use of NHSE/I & HEE funding
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:**	

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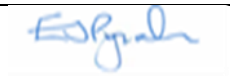
Primary Care Commissioning Committee

Agenda item no.	**PCCC 23-02.09**
Meeting date:	**3rd February 2023**
Paper title	Performance and GP Access Improvement Report
Paper presented by:	Emma Pyrah, Associate Director of Primary Care Berni Williams, Contracts Lead Ruth Float, BI Team
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	x	D=Discussion		I=Information	

1. Executive summary and points for discussion

The purpose of this report is to provide the Committee with the latest General Practice performance data and trends and an update on actions to develop a GP Access Improvement Plan.

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

Improving safety and quality	x
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	
Economic regeneration	
Climate change	
Leadership and Governance	
Enhanced engagement and accountability	
Creating system sustainability	
Workforce	

3. Recommendation(s)

The Primary Care Commissioning Committee is asked to:

- Note the contents of this report.

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

Appendix 1 –plan on a page for GP Access

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	
Quality and Safety	
Equality, Diversity, and Inclusion	
Finances and Use of Resources	
Regulation and Legal Requirements	
Conflicts of Interest	
Data Protection	
Transformation and Innovation	
Environmental and Climate Change	
Future Decisions and Policy Making	
Citizen and Stakeholder Engagement	

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

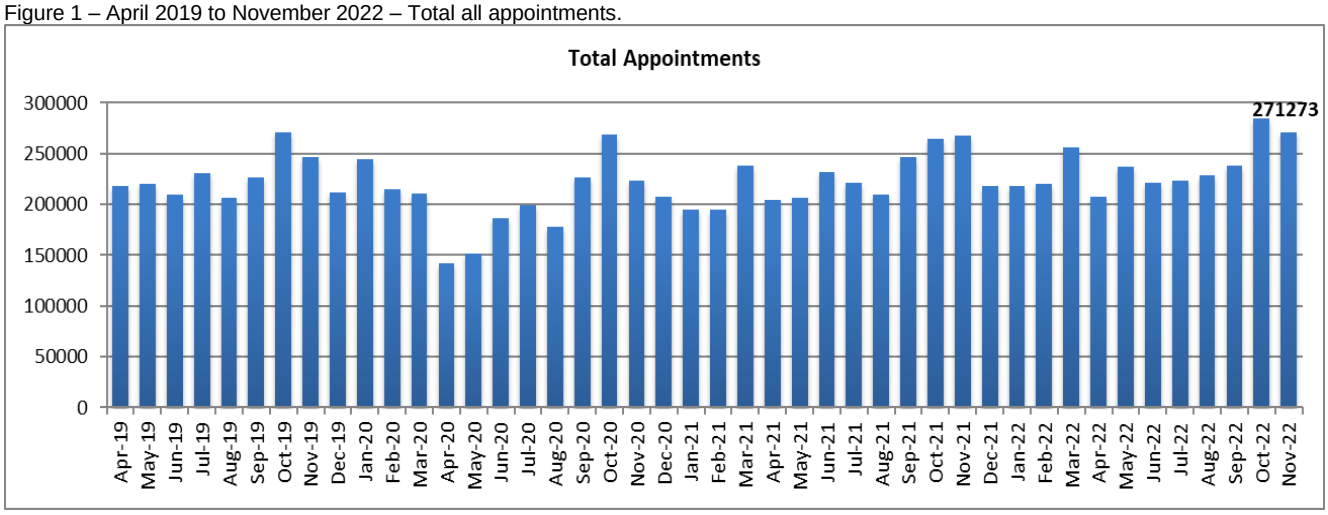
General Practice Performance and GP Access Improvement Plan Report – February 2023

The most recent data for GP appointments is for November 2022[1] when there were 271,273 appointments recorded (figure1).

When comparing to the same period in 2019, April to November 2022 data shows:

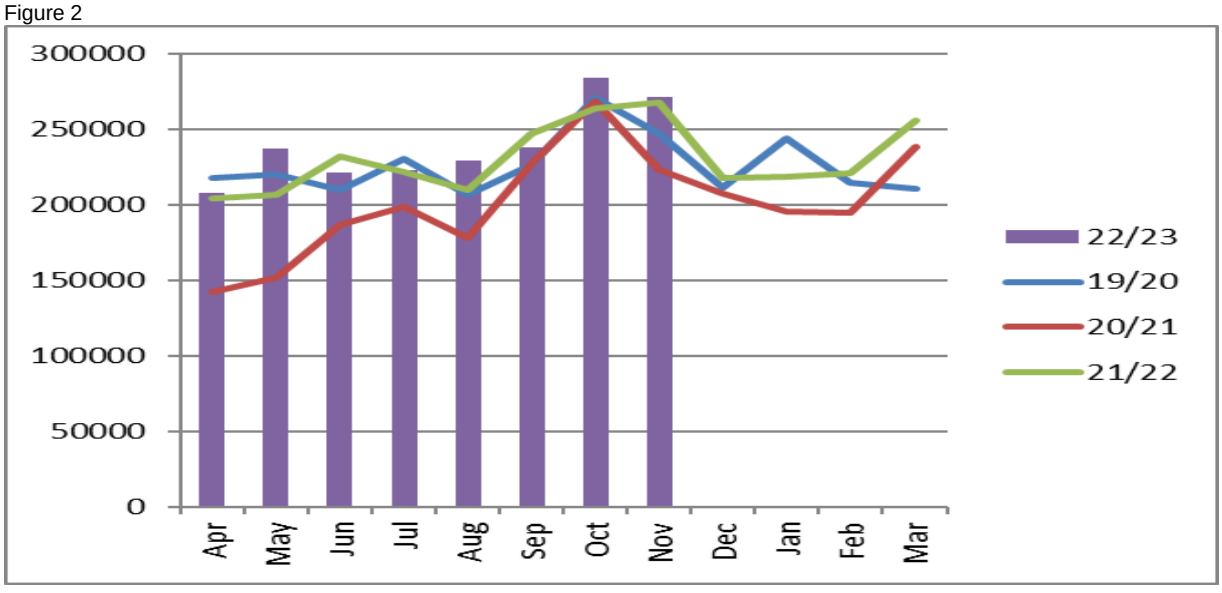
- 83,227 additional appointments (4.5% increase).
- 7 out of 10 patients seen face-to-face

Figure 1 – April 2019 to November 2022 – Total all appointments.



Year on year comparison shows more appointments recorded in 2022/23 (figure 2)

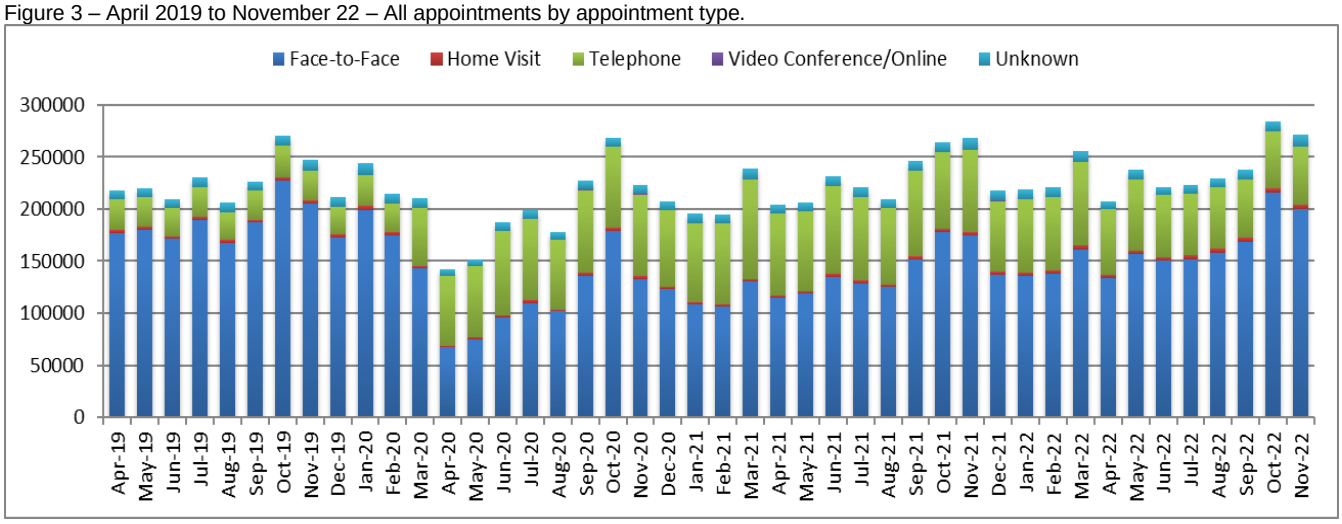
Figure 2



[1] Appointments in General Practice report - NHS Digital

There has been 110% increase in remote access (227,041 remote appts in 2019, 477,732 remote appts in 2022) (figure 3).

Figure 3 – April 2019 to November 22 – All appointments by appointment type.



The number of appointments by GP and other healthcare professionals is greater now than it was for the same period, pre-pandemic however when expressed as a percentage they are similar.(figure 5).

Figure 4 – appointment by professional

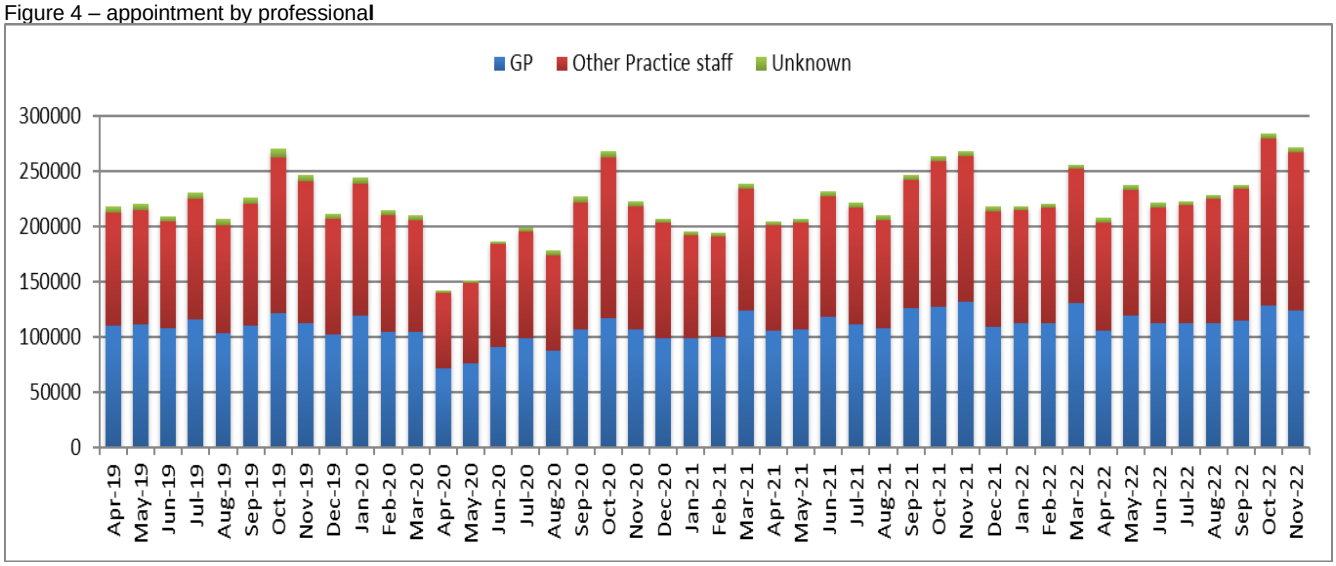
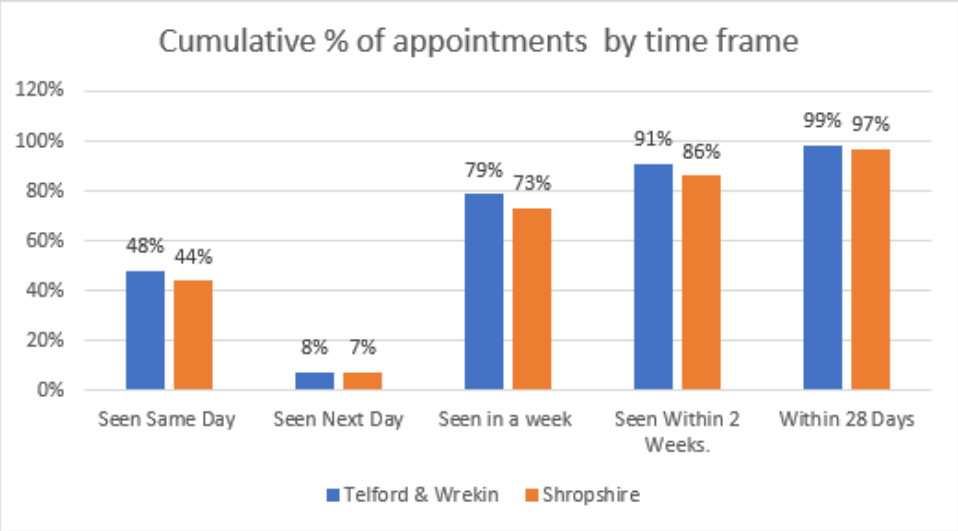


Figure 5 – appointment by professional numbers and percentage.

	GP	Other Practice staff	Unknown	Grand Total
Nov-19	112717 45.62%	128578 52.04%	5764 2.33%	247059 100%
Nov-22	123963 45.70%	142754 52.62%	4556 1.68%	271273 100%

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.



System	Per 10000 weighted patients	Recovery to 2019 levels	% Face to Face	% Appts with a GP that are Face to Face	% GP Appointments	% Same Day	% within 14 Days
Birmingham and Solihull ICB	9968.6	115%	69%	59%	53%	48%	88%
Black Country ICB	9865.7	116%	73%	64%	48%	42%	85%
Coventry and Warwickshire ICB	10740.6	118%	65%	55%	54%	48%	88%
Derby and Derbyshire ICB	11469.6	113%	72%	66%	46%	39%	76%
Herefordshire and Worcestershire ICB	13468.3	117%	67%	53%	48%	43%	82%
Leicester, Leicestershire and Rutland ICB	12795.2	116%	74%	67%	44%	42%	82%
Lincolnshire ICB	12010.7	121%	71%	62%	34%	43%	81%
Northamptonshire ICB	11102.7	113%	67%	59%	43%	45%	84%
Nottingham and Nottinghamshire ICB	10497.9	109%	69%	62%	46%	40%	79%
Shropshire, Telford and Wrekin ICB	10474.7	110%	74%	66%	46%	43%	84%
Staffordshire and Stoke-on-Trent ICB	10065.3	116%	74%	67%	45%	43%	85%
Midlands	10987.6	115%	70%	62%	47%	43%	83%
England	10714.7	116%	69%	60%	47%	42%	83%

The heatmap above shows how ICBs compare across a number of different metrics using the November GPAD data and the England and Midlands average for each metric. The heatmap reflects a snapshot in time and provides an overview of the current data being captured via appointment books. The metrics are not aligned to national targets.

GP Access National developments

In late December 2022, NHSE published the operational planning guidance for 23/24. A summary of the key elements directly relevant to General Practice are:-

1. Recover core services:

- Make it easier to access primary care particularly GP Practice
- Self referral for community services where GP intervention is not clinically necessary
- Increase use of community pharmacies
- Increase permanent workforce
- Narrow health inequalities
- Maintain quality and safety of services

2. Deliver key LTP ambitions and transformation

- Improve population health management
- Prevention and effective management of LTCs
- Sustainable workforce
- Right digital foundations – level up digital infrastructure and driver greater connectivity
- Continuous improvement

Specific NHS primary care objectives for 23/24 are described as:-

- Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need
- Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024
- Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024
- Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels

The December guidance states that additional guidance will be issued specifically in relation to a GP Access Recovery Plan. This is expected in March 2023 as it is interdependent on the outcome of current national GP Contract for 23/24 negotiations. Regional NHSE have indicated that they will provide ICBs with a high level summary of the key workstream areas covered by the Recovery Plan to aid local planning in advance of publication of the definitive guidance.

Local GP Access Improvement Plan Development – Progress since the last meeting

1. Work has begun to develop a GP Access Improvement Plan and in response to a request from the System Planning lead in week commencing 16th January, a Plan on a Page for GP Access has been developed (Appendix 1).

2. The T&W Demand Management and Winter Resilience Locally Commissioned Services (LCS) specifications are being combined and repurposed to focus on and incentivise GP Access Improvement across all patient access routes. The recent LCS review has identified that these LCS were introduced just before the pandemic and so not long after

introduction all non essential service requirements were stood down. Practices are therefore unable to provide evidence of value for money and this provides an opportunity to retain investment in T&W but refocus to incentivise improvements in GP Access.

A first draft is in production, when complete this will be shared at an early stage with the LMC/GP Board for review and feedback prior to bringing to PCCC in April 2023 for approval. The value of these 2 LCS is c£1m across 13 practices. They are paid based on an amount per weighted head of population. There is no equivalent LCS for Shropshire and no source of recurrent funding to introduce for Shropshire practices. A recent suggestion to the LMC that this T&W funding is repurposed across all STW practices was not supported due to the risk of destabilising the T&W practices.

3. At its meeting in November 2022, the ICB asked that telephone access improvement be a priority area of focus. We are currently working with a local volunteer practice to undertake a pilot in partnership with Business Intelligence colleagues to scope what telephone data can be obtained from the telephone systems, the most constructive approach to analysis and a consistent interpretation methodology to inform the way forward with roll out to other practices.

4. The Primary Care IT lead has undertaken an assessment of the current telephony systems used by practices, their functionality and further opportunities and associated costs to enhance that functionality. A summary of the findings is below.

<u>ST&W GP Practice Voice over Internet Protocol (VoIP) Cloud Telephony Assessment</u>

In 2017, the then CCG took the opportunity through the Estates, Technology, Transformation Fund (ETTF) to join a regional procurement with 5 CCGs to procure and implement a cloud-based telephony system for General Practice. Funding secured allowed the CCG to fund any upfront costs for hardware as well as fund the license/support costs for 3-years. The contract was awarded to Redcentric. The contract duration was an initial minimum 3-years plus the option of a 2-year extension (at the same cost to the practice as agreed regionally).

All but a handful of STW 51 GP practices took up the offer of moving to the Redcentric cloud-based telephony system. All practices are now outside of the initial minimum 3-year term with Redcentric, so practices are now contracting directly with their preferred provider, a breakdown of which is below:-
- Redcentric – 26 practices
- Fluid – 20 practices
- Check-comm – 4 practices
- TIC – 1 practice

All practices are using cloud-based telephony systems and all provide the standard functionality of free inclusive calls to most mobile carriers, call recording, call reporting, as well as optional advanced telephony features such as ‘keep my place in the queue’, see below.

Although these cloud-based telephony systems are much more advanced than previous years offering resilience and many more features, there are still patient concerns on time spent calling into a practice, concerns of long call wait before calls being answered, constant engaged tone when calling the practice during peak hours... etc.

The ICB have been exploring some of the advanced telephony features that are available that will improve the patients experience, as well as assist the practice call handling staff in making their roles more efficient.

ARC (Keep my place in the queue)
Allows patients calling into a practice to exit the call queue at any time. When their queue position reaches number 1 in the queue, the patient will be automatically called back.

Below is an example of Redcentric costs for this additional functionality:-

£150 Setup
£10 Per Call handling phone per month
1 x £15 License per practice

Using the Redcentric costs to forecast indicative cost if scaled up to include all 51 Practices:-

ARC Setup	Arc Monthly Charge	Annual Charge
£ 7,500	£ 7,050	**£ 84,600**

GP Call Connect
Functionality - The telephone number the patient is calling from is automatically matched against their contact details held within the practices clinical system, this then automatically opens the patient record when the caller is next in queue for the practice call handler to verify patient details and increasing efficiency.

GP Call Connect
£250 Setup per practice
£4.50 - Basic License
£12.50 - Advanced License per call handler
Server Charge Approx £80 per month per practice
Clinical System Integration - £40 per practice

Again using the Redcentric costs to forecast indicative costs for all practices below:-

GP Call Connect Setup	GP Call Connect Monthly Charge	Annual Charge
£ 12,500.00	£ 20,553.00	£ 246,636.00

The Primary Care Team currently has no source of recurrent funding to support introduction of these telephony enhancements.
It has been very difficult to obtain telephony charges from the non-Redcentric practices for the optional advanced telephony features. This may be due to the contract being between the 3-telephony providers and these practices. There may also be some nervousness by the 3-telephony providers and these practices in releasing this information and what implications it may have on them, because up until 2017 these 3-telephony providers held the contracts with the majority of STW practices, that were then ceased for nearly all practices and replaced by the awarded regional procurement provider, Redcentric.

In early December 2022, NHSE/I wrote out to practices looking to obtain existing baseline information on the practices current contract term and buy-out costs for their telephony systems.

Alongside this there is a new Mobile, Voice and Data framework soon to be released that aims to 'simplify the procurement process and provide best pricing and core services' so will likely create a competitive market on both cost and functionality.

On-line Consultation (OC) procurement
STW is currently recording one of the lowest usage rates for on-line consultations. Up until November 2022 there was a requirement in the PCN DES associated with increasing on-line referrals. This was stood down as part of the Government's response to supporting primary care through the winter and beyond. It is anticipated that it will be reinstated in the 23/24 DES.

The ICB are currently re-procuring the OC systems used by STW practices. The existing OC systems were procured prior to the 2 CCG organisations merging into one, so currently there is a legacy of 2 separate OC systems for Shropshire practices and Telford & Wrekin practices.

At the time of the original OC procurement there were only 3 OC providers on the original framework. There are now many more OC providers offering additional functionality including integration with Practices clinical systems.

In replacing our existing practice OC systems, it will give practices greater flexibility in how they manage their Online Consultations. Patients will also be able to complete free-text boxes providing full details for the clinician in addition to the existing drop-down boxes/checkbox. This combined with the already commissioned AccuRX Plus system allows 2-way messaging between the clinician and the patient, including images to be securely shared to assist with the diagnosis.

This can relieve a considerable amount of patient telephone contacts if OC is promoted within the practice, is placed prominently on practices website homepage and practice staff actively encourage patient use of their OC service. OC may not be suitable for all patients, and the greater usage may be younger and working patient groups, but these groups are then relieving the practice telephony system for other groups of patients who don't have access to a mobile phone or PC or who prefer a telephone call with their practice.
A small number of practices are making use of the "comfort message" whilst the patient waits in their telephone queue and announces that sicknote/return to work are only handled through their OC e-form. A patient will then hang-up their telephone call and complete the OC e-form that is automatically work flowed into the practice and dealt with. For future sicknote/return to work requests, the patient then knows to use their practice OC e-form process and does not need to make a telephone call to their practice.

Integrated Care System
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Appendix 1

PROGRAMME: Exit Criteria 4		PROJECT NAME: Operational Planning Framework		Level of PMO Support:			
Executive Sponsor	Gareth Robinson, Executive Director Transformation and Delivery	**Senior Responsible Officer**	Claire Parker, Director of Partnerships and Place	**Corporate Dept.**	Transformation and Delivery	**Specialities / Sub Dept.**	Primary Care
Operational Lead	Emma Pyrah,Associate Director of Primary Care	**Clinical lead**	tbc	**Finance Lead**	Angharad Jones, Finance Business Partner	**PMO Lead**	tbc

Project Scope
• *The project aim is to develop and implement a GP Access Improvement Plan covering the range of patient access routes from telephone, through on-line to face to face*

Resource Requirements
• Senior project management capacity within the PC Team • BI support for data analysis • Practice capacity to engage with the project • Potential pump priming funding to incentivise practices

Project Impact
The main impact of the project relates to improved patient experience and timeliness of getting through to their practice on the telephone and timely access to an appointment which meets their clinical needs. An associated impact of patients accessing their GP practice more easily is a reduced demand on other parts of the urgent and emergency care system such as ambulance and A&E

Interdependencies
• *Publication of the national guidance on GP Access* • *Practice permission to access practice telephone data for performance analysis* • *If access targets are not in the GP contract, PCN DES or Locally Commissioned Services (LCS) then it requires practices to voluntarily agree to implement changes* • *Ongoing improvements in workforce recruitment and retention to increase capacity* • *Reduction in elective backlog to reduce demand on primary care*

High Level Key Milestones	Date
Undertake telephone data analysis pilot with one practice	February 2023
Based on the outcome of the above work with outlier practices to develop a telephone access improvement plan	April 2023
Repurpose the T&W Demand Management and Winter Resilience LCS to focus on GP Access Improvement– approval of revised specification by PCCC	April 2023
Develop a plan for improvement in online consultation availability and uptake	June 2023
Develop a plan for improvement in sign up and referrals through the Community Pharmacy Consultation Service	June 2023
Implement the Year 2 elements of the GP/GPN Workforce Strategy to increase capacity	March 2024
PCNs recruit to their full 23/24 ARRS allocation	March 2024
Support practices to develop and implement ways of educating their patients on alternative access routes than telephone	Sept 2023
NB the above may change following publication of the national GP Access Improvement Plan guidance (expected March 2023)	

Key Measurable Outcomes	Baseline Metric	Improvement/Target Metric	Data Source	Frequency
Increase in online consultations		5/1000 practice population		
Increase in referrals to Community Pharmacy Consultation Service		0.6/1000 practice population		
All patients who need a routine appointment have one within 2 weeks		tbc		
All patients requiring urgent appointment receive one same day/next day		tbc		

Key Project Risks	Score
Practices will not engage or agree to required change as not in the GP contract	20
Elective backlog recovery is not fast enough to materially impact on the associated knock on primary care demand in 2023/24	15
Recruitment and retention of staff when primary care is under increasing demand and public criticism	15
No additional funding to incentivise change	20
Capacity within the Primary Care Team (which is small) to support this project	9
Transfer of Pharmacy, Optometry and Dentistry in April 2023, although hosted support service remain, dilutes the focus of the Primary Care Team from purely GP	9

Version Control
1.0

NHS

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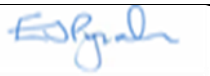
Primary Care Commissioning Committee

Agenda item no.	PCCC 23-02.10
Meeting date:	**3rd February 2023**
Paper title	Risk Register Part 1
Paper presented by:	Emma Pyrah, Associate Director of Primary Care
Paper approved by:	Emma Pyrah, Associate Director of Primary Care
Paper prepared by:	Emma Pyrah, Associate Director of Primary Care and Project Director for the Shrewsbury Hub
Signature:	
Committee/Advisory Group paper previously presented:	

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

1. Executive summary and points for discussion

The purpose of this covering sheet is to provide Committee members with a summary of the key changes to the risk register for ease of reference since the last submission.

Amendments to existing risks
STW 03 – Closed – this relates to Covid 19 response – which is now business as usual
STW 05 – Closed – this relates to risk of financial overspend – this risk is minimal now
STW 08 – Closed – replaced with STW 09
STW 12 – Update to action section

New risks
STW 15 – Charlton Practice 'orphan' as not a member of a PCN – patients not able to access the full range of PCN DES services

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	
Workforce	

3. Recommendation(s)

The Primary Care Commissioning Committee is asked to:

- Note the changes to the Part 1 Risk Register

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	
Quality and Safety	
Equality, Diversity, and Inclusion	
Finances and Use of Resources	
Regulation and Legal Requirements	
Conflicts of Interest	
Data Protection	
Transformation and Innovation	
Environmental and Climate Change	
Future Decisions and Policy Making	
Citizen and Stakeholder Engagement	

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

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 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	**GP Access -** 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	**PCN ARRS recruitment -** 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	**Covid Backlog -** 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)	Telephone Access Improvement Plan GP Access Improvement Plan	3 x 4 = 12 HIGH	Exec: C Parker Lead: E Pyrah	E Pyrah 17.1.23 update to action section	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 colleages 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
STW-15		E Pyrah 19.1.23	**Charlton Medical Practice** - an 'orphan' practice as not a member of a PCN - risk is there patients do not have access to the PCN DES services if another PCN/practice will not agree to provide		Dialogue with surrounding PCNs taken plan without success Contract in place with Hollinswood to provide all but Enhanced Access		Extended Access not covered by another practice No PCN has agreed to take the practice in as a member THe other practice indicating they do not wish to continue with the sub contract arrangement indefinitely	5x4 = 20 HIGH	Continue dialogue with surrounding PCNs to take the practice Seek alternative solution for Enhanced Access (but no additional source of funding) Last resort - ICB can allocate the practice to a PCN	5x4 = 20 HIGH	Claire Parker Lead: E Pyrah		Open
STW-16		B Williams 9.1.23	**GP Occupational Health Service** - SHT given notice to end contract from 1st April 2023 - risk insufficient time to procure a replacement and new contract may cost more		Regional contract framework for providers already in place			4x4=16 High	Confirm budget availability Commence procurement process Approval from PCCC required to direct award	3 x 4 = 12 HIGH	Claire Parker Lead. B Williams		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
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-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	Cllose
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	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.

Primary Care Commissioning Committee

Agenda item no.	PCCC 23-02.11
Meeting date:	Friday 3rd February 2023
Paper title	Primary Care Team Work Programme Progres Report
Paper presented by:	Emma Pyrah, Associate Director of Primary Care
Paper approved by:	Emma Pyrah, Associate Director of Primary Care
Paper prepared by:	Janet Gittins, Tom Brettell, Bernadette Williams, Darren Francis, & 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=Information	I
Previous considerations:	N/A – this is a monthly update report from the Primary Care team										

1. Executive summary and points for discussion

The purpose of this report is to provide Committee with a summary overview of the activities and developments across the portfolio of primary care workstreams. More detailed reports are provided as separate agenda items where this is required.

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	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:**	

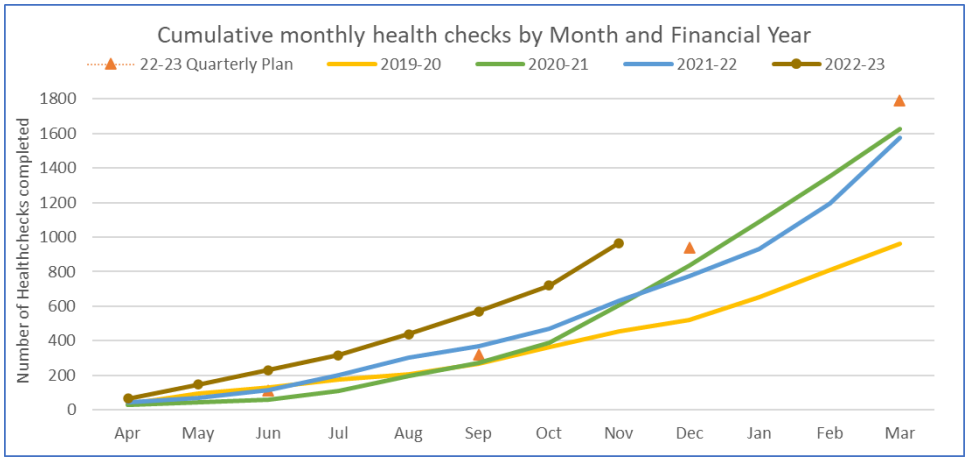
		If unable to approve, action required:	
Signature:		**Date:**	

Partnership Managers Update – Janet Gittins & Tom Brettell

Learning Disability Annual Health Checks (LDAHCs)
At the end of November 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 November STW practices have completed 965 LDAHCs compared to 630 in 2021-22 and is currently above trajectory at 38.2% against the 80% annual target.

MPFT continue to support General Practice with this work through checking registers, contacting patients, and providing home visits and follow ups as required.

LD register list sizes also continue to grow with 2527 patients at November 2022 compared to 2298 in April 2021.



Macmillan Community Care Project (MCC)
The Macmillan Team are currently working with 19 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: 12 new practices are now engaged with the project.
- A bid has been successful to gain additional funds from Macmillan to align the team end date to 31 May 2023.
- At end of November 615 CCRs have been completed since January 2022.
- Patient feedback continues to be collated - initial findings are positive.
- The evaluation of the pilot project commenced at end of November with a final report due at the end of March 2023.

- A communications plan is being developed to raise the profile and promote the pilot project.
- Work is developing with the training hub to offer cancer related training opportunities to primary care staff from early 2023.
- Conversations with PCNs about their cancer support needs when the pilot ends are ongoing. Conversations are also taking place with Macmillan to bid for funding to fill these needs and continue to support primary care cancer work across STW.

National Diabetes Prevention Programme
The Healthier You NHS Diabetes Prevention Programme, is a nine-month, evidence-based lifestyle change programme to help prevent developing type 2 diabetes.

A joint service from NHS England and Diabetes UK, the programme is provided by Living Well, Taking Control (LWTC) in STW and available both as a group face-to-face or a digital service.

Practices are paid £10 per referral on to the programme, and patients must meet the following eligibility criteria:

- Ages 18 years or over
- Not pregnant
- HbA1c between 42-47 mmol/mol (6.0-6.4%) or Fasting Plasma Glucose between 5.5-6.9 mmol/l within the last 12 months
- If patient has a history of Gestational Diabetes (GDM) then patient is eligible with HbA1c < 42 mmol/mol or FPG < 5.5mmol/l
- If aged over 80, the referrer must confirm that they consider that the benefits of this programme are likely to outweigh the potential risk

STW currently has the highest uptake rate to MS1 (Milestone 1 is attending their first session) in the region, at 47.04%.

Contact with Practices regarding this service has paused during winter, with a streamlined toolkit for General Practice being developed between the ICB and LWTC, to be circulated later this month.

From 2023/24 a different patient cohort will be focused on each quarter, including ethnic minorities, areas of higher deprivation and our rural population.

Digital Weight Management Programme - Enhanced Service (DWMP ES)
No update available this month as November and December data is not available from NHSE.

Severe Mental Illness (SMI) Health Checks
General Practice has a target of providing an SMI Health Check to over 60% of those with a SMI by end March 2022. At end of November STW is showing that 41% of those on SMI registers have received a health check in the last 12 months.

Locally Commissioned Services (LCS) Review
The LCS review set out to achieve several outcomes:

a. undertake a comprehensive review of services commissioned from practices in Shropshire & Telford and where necessary to design a new suite of fit for purpose LCS for implementation from 2022/23

b. ensure that the LCS fit, add value, and maximise opportunities to work alongside other services and do not duplicate services commissioned through a separate route
c. ensure the LCS offer is consistent and equitable across STW other than where there is evidence for variation to meet local population need
d. ensure practices are reimbursed appropriately and fairly for all LCS delivery.
e. fully cost any new LCS and repurpose identified savings within primary care

These outcomes have proven a significant challenge to achieve in full for several reasons:

- LCS are voluntary and not within the GMS contract
- We do not have 100% sign up for all LCS leaving gaps in service provision
- Some LCS can be described as essential services- as such Patients whose General Practice are not delivering the LCS receive no service (eg spirometry, ear irrigation, low risk diabetic foot screening).
- Therefore where these gaps exist a back-up service needs to be commissioned to achieve a universal offer for which there is no source of recurrent funding.
- To take money out of General Practice to commission an alternative provider/or alternative model for services risks destabilising primary care.
- The majority of LCS have been in place for several years and the LMC have indicated that the LCS funding is now viewed as core baseline funding, and it will not support any change options that:
  - decommission one LCS to provide additional funding for other LCSs
  - take funding out of a T&W or Shropshire only LCS and divide it on fair shares basis across both Shropshire and T&W to provide equity across STW
  - take funding out of primary care altogether to commission a different model from an alternative provider (e.g., to commission SCHT or PCNs to deliver LCS on a network basis through several hubs).

A paper describing this position was presented to Commissioning Working Group in December to seek advice and guidance on the way forward and the principles on which such redesign projects should be progressed (ie in the current status removing clinical risk cannot be achieved without increasing the financial deficit). The committee held a further focussed workshop with clinical input on Wednesday 4th January and agreed:

- there needs to be system level/exec buy in to provider collaborative/integrated working and repurposing of resources for any sustainable solution to be found.
- To channel any solutions to gaps in service provision to be plugged by primary care through the new GP Board established by the LMC
- The current review work to be paused and the existing LCS to be rolled forward into 23/24 with work to ensure that the specs are fit for purpose.

CVD/ Hypertension Delivery

STW have been successful in securing funding via the Innovation for Healthcare Inequalities Programme (InHIP) to undertake community-based CVD prevention utilising trained volunteers working in target populations that suffer health inequalities, including those living in our most deprived neighbourhoods and our most rurally isolated communities. The final delivery model is currently being developed with significant input from Primary Care.

Veteran Friendly Practices
28 practices are now accredited as Veteran Friendly with ongoing work with the aim to get all practices accredited as soon as possible. The target of 31st March has proven to be too ambitious with the various pressures on Primary Care. Work is ongoing to ensure that Veterans' needs are embedded in all appropriate programmes of work.

Remote Monitoring Project
The new provider continues to develop strong relationships with the larger Care Home providers. The next stage is to work closely with the practices that look after patients within these homes to support them to integrate the remote monitoring tool as appropriate.

Access to (Future) Patient Records
The national requirement for practices to make all future health records accessible by patients from 1st November was relaxed following BMA intervention. All our practices have engaged with the programme and are continuing to progress the implementation of system changes despite the national directive being paused.

Estates Update – Darren Francis

Whitchurch – ETTF New Build

- On site works underway– 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 now started
- Expected completion due Jan/Feb 2024

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 were due for completion by end December 2022 – although some practices are running late (but still due for completion by end Feb latest)
- Claims being processed for payment as schemes are completed (and documentation submitted by practices)
- Awaiting confirmation on amount of funding for FY2023/24 (suspect this will be around £307k)
- Once confirmed a call for bids will be sent to all practices for them to submit their proposals/business cases to secure funding
- 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
    - 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 clinical strategy and workforce planning work Dec 2022 to Feb 2023; Wave 2 completing this work Jan 2023 to Feb 2023. Once both Waves completed, the estates work will then commence from Feb 2023 to end March 2023
- Once PCN work completed output will be combined into a single Primary Care Estates and Workforce strategy – 1st draft expected April 2023
- Final version expected around May 2023

Contracting Update – Bernadette Williams

STW Contract changes

Contract variations have been requested for the following:

Practice name	Details
Churchmere	Resignation of partner (TL)

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

Asylum seekers

Asylum seekers are entitled to NHS care as UK residents. To accommodate the arrivals from Manston accommodation centre, a service specification has been created to support practices with the additional clinical and administrative pressures placed on primary care. The specification was adapted from the Ukrainian service specification that was previously signed off by PCCC in July 2022. Funding for the health check has been claimed from NHS England.

GP Occupational Health

In December, NHS England advised that Shropshire Community Health Trust has given notice on the contract to provide GP occupational health, the service will cease at the end of March 2023. The Primary Care Team were not aware before this point that this contract was in jeopardy as the service was commissioned by NHSE. We are awaiting confirmation of the budget available and will seek to procure a replacement through an established regional framework of providers. This has been added to the risk register as we may not have time to find a replacement provider and the service may cost more.

GP IT Update – Antony Armstrong

The Digital Lead/Partnership Managers within the ICB 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 52/55 sites live on the new Zeus Domain. The final 3 sites within this phase have dependencies relating to their dispensing software not being compatible with a domain and the ICB are working with CSU IT to look at ways around this.

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

Decommissioning of onsite EMIS Spoke servers.
One a practice has migrated to the new Zeus domain the server providing this functionality onsite will also provide the EMIS spoke server services and supported by the MLCSU IT team. During this work, the existing old EMIS spoke server is being decommissioned in favour of the new server. 42 sites have been completed to date with much of the work being carried out weekends due to the downtime requirements.

Notes Digitisation
Project is underway with 2 of the 8 practices now having their notes taken offsite to have their prep work carried out and scanned into a digital format before handing over to EMIS for the upload. A further practice has received their prerequisites and are in the process of boxing these notes prior to handover to the provider.

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
Deployment has been carried out by the provider in all but 3 practices that are part of this project. Re-engagement is being carried out with these practices as the Project lead is not getting acknowledgement from the practices to secure deployment dates and clarification on the practice contacts has been provided.

N365 (Office 365) Apps for Enterprise
Fully deployed of Microsoft Apps for Enterprise to all practices on the Zeus domain. There are over 2000 N365 licenses applied to Primary Care staff within STW and the ICB are

carrying out periodic reporting on activity for these accounts as they incur an annual subscription cost.

Enhanced Access
EMIS Clinical Services had been deployed for 6 of the 8 PCN's. ICB used a recommended consultation working within the region to setup the prescribing codes as well as the data sharing agreements for the practices within their PCN's. Service was live as of 1st October. Further work is on-going with James Harley who is working on behalf of many systems to address the ongoing issues with Pathology as results can currently only be sent back to the PCN hub level rather than practice. At present there is no resolution to this.

IT Equipment replacement Project
All 22 sites within Phase 1 of this project have had their replacement hardware deployed. Within Phase 2 a further 15 sites have now had their hardware deployed with 4 additional sites having scheduled dates.

The ICB have also issued 4 laptops with 'Always on VPN' software installed. This allows the device to connect to the NHS network automatically and has clinical applications installed locally on the device.

The ICB have a significant cost pressure with the additional ARRS roles and the IT requirements (hardware/software licensing) that run alongside this that we have not budgeted for in 23/24. However, we have now had confirmation that we have been successful in securing £207k of the £586k national winter capital monies we bid for which will address this in 22/23 but we need to factor ARRS requirements into the budget setting next year.

Towergate House
HSCN circuit was ordered several months ago, and we are awaiting confirmation that local deployment has been completed by the providers. Internal network and comms cabinet installs can then be carried out.

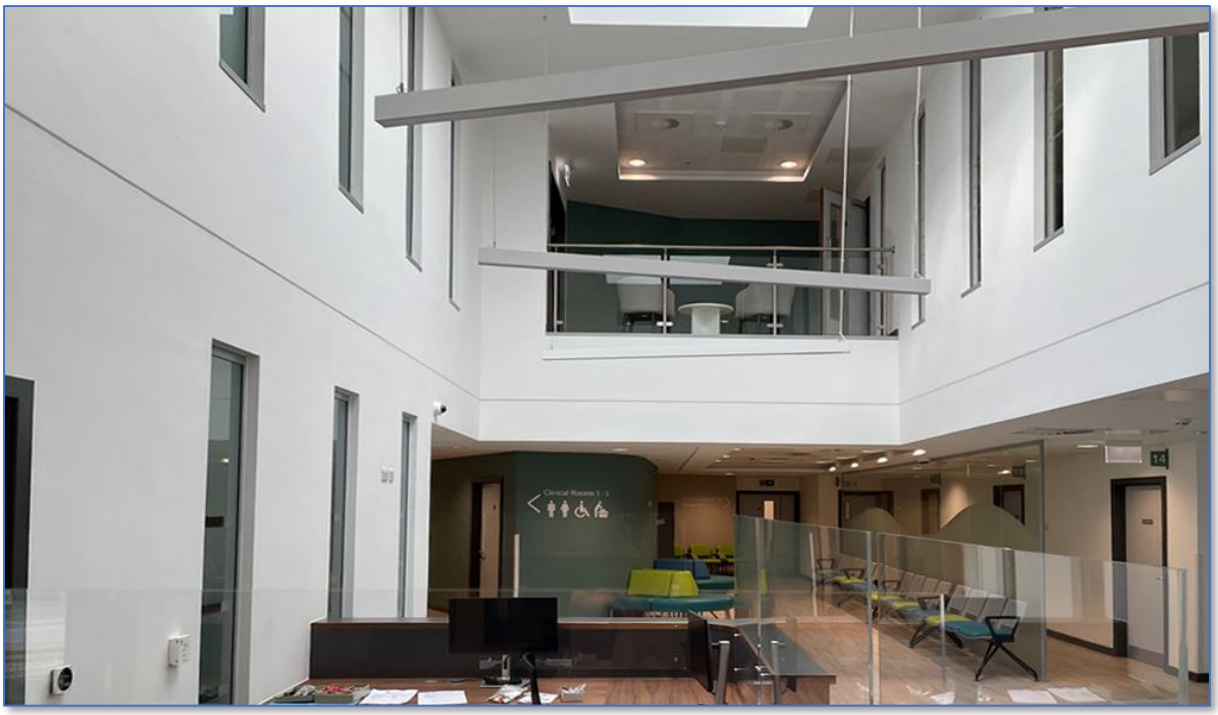
All PC's have been imaged ready for deployment; floor plan received from the site.

Appendix to Primary Care Update Paper – Feb 2023 PCCC - Sample Images of Estates Projects

Recent New Build Projects

Riverside Nov 2020

Shawbirch July 2022




Clinical Rooms 1 - 5

Shifnal – Due Feb 2024

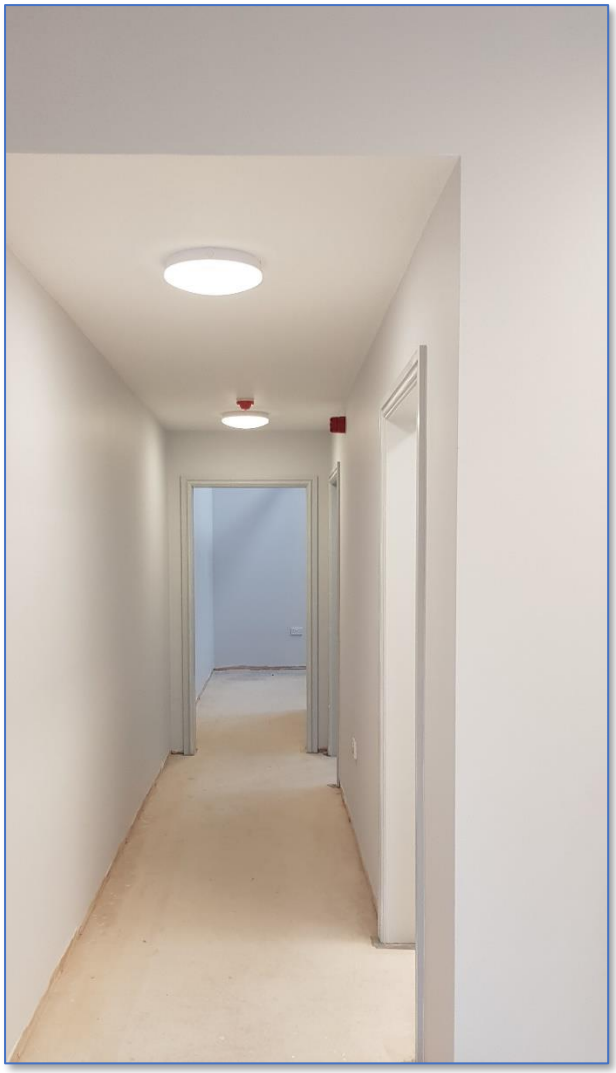
Whitchurch Pauls Moss – Due Sept 2024

Premises Improvement Projects

Stirchley MP – Jan 2023

Bridgnorth – Dec 2022

Linden Hall – May 2022



Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

PRIMARY CARE COMMISSIONING COMMITTEE

Agenda item no.	PCCC 23-02.12
Meeting date:	3rd February 2023
Paper title	Delegation of Pharmacy, Optometry and Dentistry to ICBs – Progress Update
Paper presented by:	Emma Pyrah, Associate Director of Primary Care
Paper approved by:	Not applicable, briefing paper produced by NHSE
Paper prepared by:	As above
Signature:	
Committee/Advisory Group paper previously presented:	ICB January 2023

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

1. Executive summary

The purpose of this report is to provide the Committee with the up-to-date position on plans to transfer the delegation of commissioning functions for Pharmacy, Optometry and Dentistry to ICBs from 1st April 2023.

The following is a briefing document supplied by NHSE and will also be presented to ICB at the end of January 2023.

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	x
Enhanced engagement and accountability	
Creating system sustainability	
Workforce	x

2. Recommendation(s)

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

1. Note the contents of this report.

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

None

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	
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.	

ICB Briefing from NHSE

The Delegation of NHSE Functions to ICBs

Overview

1.1 By delegating some of NHS England commissioning functions to ICBs the aim is to break down barriers and join up fragmentated pathways to deliver better health and care so that our patients can receive high quality services that are planned and resourced where people need it. The services that will be delegated to ICBs are

- Primary Pharmacy, Optometry & Primary and Secondary Dental Services on 1st April 2023
- Complaints functions associated with Primary Pharmacy, Optometry & Primary and Secondary Dental Services
- Specified Specialised Services (Acute & Pharmacy) April 2024

1.2 Delegation of these services is a national policy. In all cases the responsibility and liability for the planning, performance, finance, quality, and improvement will move from NHS England to ICBs upon delegation. The ICB will be responsible for any claims (negligence, fraud, recklessness, or breach of the Delegation). However, in all cases NHS England remains accountable to the Secretary of State for the services, which means that NHSE will have oversight, set standards and service specifications for the services.

1.3 ICS and NHSE have working together to Co-produce our approach to delegation in order to achieve the safest and most effective approach, given the challenges facing the NHS at this time and as we head into what will inevitably a challenging winter period for individual systems and the Midlands region as a whole, we do need to be clearly focussed on our operational accountabilities alongside this important work to ensure we deliver for our populations.

2 Planning Footprints and Hosting

2.1 The planning footprints of the East Midlands, West Midlands and Midlands are the continued basis for multi-ICB planning and decision making where it makes strategic sense in order to meet the quadruple aim objectives.

2.2 As a basis for joint planning for delegated and devolved functions, ICB Chief Executives and NHSE Executives have worked on the principle of pragmatic strategic planning ensuring that skills are retained and that specialised resources are shared between ICBs and between ICBs and NHSE, where appropriate.

2.3 Whilst all decisions will be through formal joint committees ensuring equal and equitable decision making for each individual ICB with no one ICB having primacy over another, the hosting of the workforce requires one ICB to provide this function on behalf of the other ICBs (and, for specialised services, NHSE).

2.4 The Host ICB will provide, oversight, leadership, and support for the workforce. The workforce will work for and on behalf of, each ICB within the planning footprint (East/West or Midlands). This will be supported by a formal hosting agreement between the ICBs and, for specialised services, between the ICBs and NHSE.

2.5 The Host will not make commissioning decisions on behalf of other ICBs or NHSE; all decisions will be made through the Joint Committees and their sub-groups

2.6 Recognising that authority do not rest with one individual or individual ICB a model of Distributed Leadership will be adopted to implement shared vision and values and continue the ICB and regional commitment to collaboration and building a strong learning culture.

2.7 The **Primary Care Pharmacy, Optometry and Dentistry workforce will be hosted** on an East and a West footprint. The host ICBs have been approved by the ICB CEOs and now subject to ICB board approval are as follows:

East Midlands - Nottingham & Nottinghamshire ICB
West Midlands – Birmingham & Solihull ICB

2.8 The Distributed leadership model of strategic leadership for Primary Care POD will be through Herefordshire & Worcestershire ICB for the West, Nottingham & Nottinghamshire ICB for the East.

2.9 The complaints workforce that align to Primary Care will also transfer to the Hosts outlined above. However, there is recognition that there are still some national policy agreements and operating model challenges to be resolved, informed by national policy discussions.

2.10 Services will be delegated from 1st April 2024; however, it is planned that, subject to consultation, workforce transfers for POD, primary medical service support and complaints staffs will transfer on 1st July 2023. This will be on a multi-disciplinary basis, also including commissioning finance and clinical reviewers but with specialised healthcare public health team members aligned or embedded to teams, not transferred.

2.11 The **Specialised Services** joint ICBV and NHS England workforce will be hosted by one Midlands ICB on behalf of all 11 ICBs and NHSE. Subject to ICB board approval **will be Birmingham & Solihull ICB.** This will be supported by a formal hosting agreement between the ICBs and NHSE.

2.12 Further discussions are ongoing regarding the Distributed Leadership model for specialised services, which will be resolved in advance of formation of formal joint working arrangements and delegation.

2.13 The **governance arrangements** for the delegated and devolved functions will be through joint committee arrangements. The current East Midlands and West Midlands collaborative Commissioning Boards will transition into formal joint committees, with quarterly Committee in Common where both East and West Midlands Boards will come together as 11 ICB for decisions that require a whole Midlands planning footprint. The governance framework is illustrated below

2.14 For Primary Care Pharmacy, Optometry and Dentistry a Joint Commissioning Group led by ICB directors will be formed in shadow by March 2023, to be fully operational in April 2023. (Refer Appendix One re Proposed Governance Structure).

2.15 The model of distributed leadership will continue through the POD Joint Commissioning Group. To ensure clinical and financial expertise into the group 1 POD ICS finance lead and 1 POD ICS Quality lead will be core members of the group

3. Further Delegated functions

3.1 Subject to confirmation of the national policy position, it is expected that **Immunisation and Vaccination Services** will be delegated to ICBs from April 2024. NHSE are currently integrating the Covid programme with the Vaccination team and separating Vaccination/Immunisation and Screening functions. We will work with ICBs through 2023/24 to develop the operating model ready for delegation.

3.2 Given the strategic, infrastructure, and digital development work needed to underpin safe, effective and equitable **Screening Services**, and the complex end-to-end nature of those services, delegation of screening services is unlikely to be possible or desirable within the same timeframe.

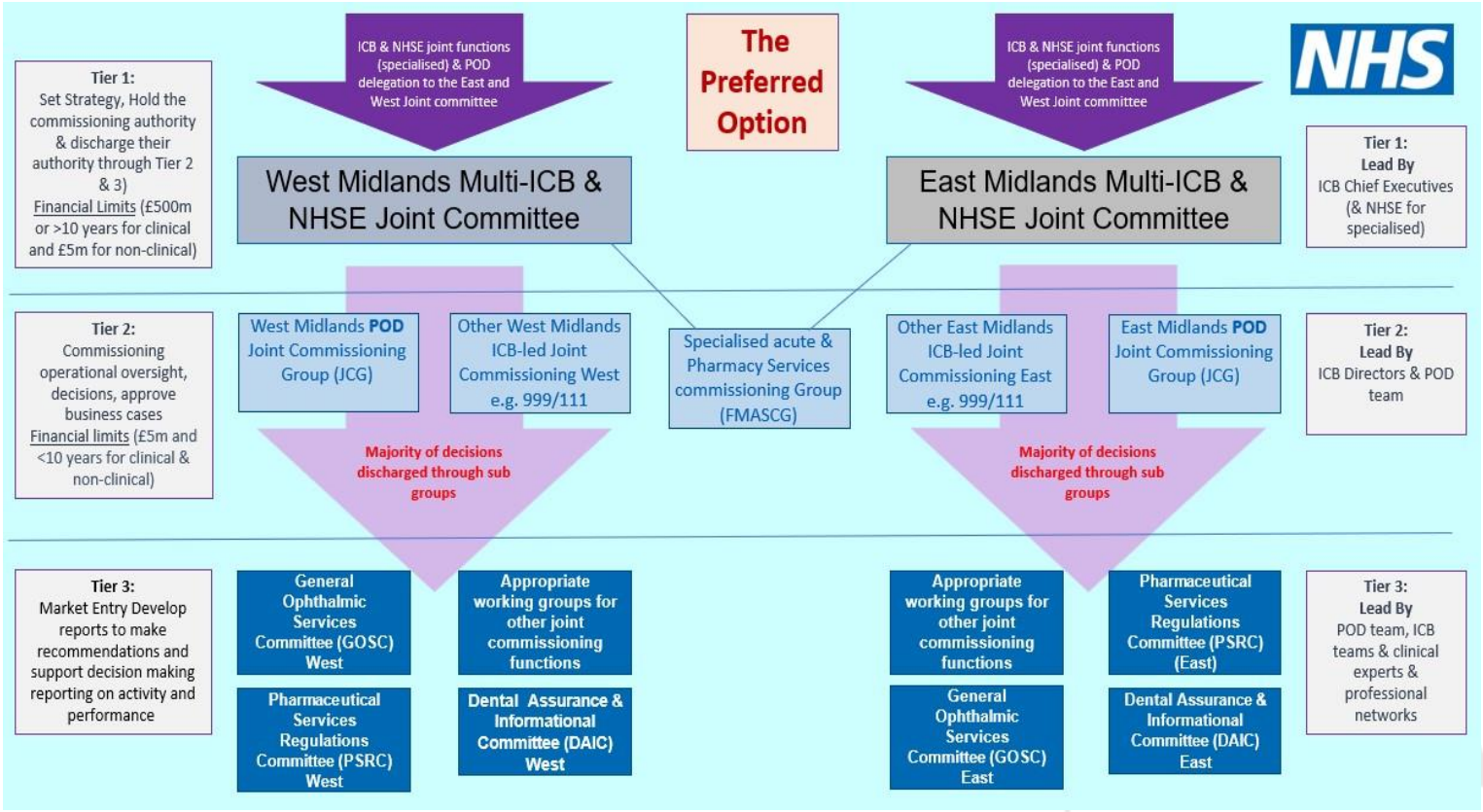
Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

JOINING UP HEALTH & CARE in the Midlands

Future Governance & DecisionMaking

NHS

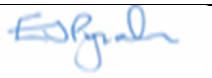


Appendix One Proposed Governance Structure

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Primary Care Commissioning Committee

Agenda item no.	PCCC 23-02.13
Meeting date:	**3rd February 2022**
Paper title	Shrewsbury Health and Wellbeing Hub (SHWBH) Development – progress update, key risks and timeline
Paper presented by:	Gareth Robinson, Executive Director Transformation and Delivery
Paper approved by:	Gareth Robinson, Director for Delivery and Transformation and Shrewsbury Hub SRO
Paper prepared by:	Emma Pyrah, Associate Director of Primary Care and Project Director for the Shrewsbury Hub
Signature:	
Committee/Advisory Group paper previously presented:	

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

1. Executive summary and points for discussion

Background
The Committee has asked for regular updates on progress with the Shrewsbury Health and Wellbeing Hub development.

Progress Update

Site options appraisal
The main focus of work continues to be the re-run of the site options appraisal. We have taken the long list of 47 sites down to 10 sites (which was informed by applying technical criteria and obtaining the views of the practices). The process of applying the second stage technical criteria is underway.

The Stage 2 criteria to be applied to determine a preferred site/prioritised list of sites is provided at Appendix 1. The assessment against each of the criteria and scoring will be undertaken by subject matter experts (externally commissioned where necessary).

Travel Impact Assessment
This will form part of the site options appraisal and the Integrated Impact Assessment. The Council are supporting the project team with this work and we are commissioning an external company they are working with on transport related work as subject matter experts who understand the local area and public transport arrangements.

Timeline
Until we have a preferred site it is not possible to provide a revised timeline to project closure. This is because if the preferred site is a new site it will require significantly more due diligence work than if it is the original preferred site at Oteley Road as this work has already been done. The timeline for completion of the site options appraisal is 24th March with the outcome going to Project Board in April and then OSC and Stakeholder Reference Group subsequently. It is disappointing for all concerned with the project, not least the practices, that the timeline has been so delayed but given the significant amount of public and councillor concern about the site it is important that we have rerun the exercise and that our approach to the travel impact assessment is robust and will stand up to scrutiny.

Stakeholder Reference Group - The last SRG was held on 14th December. The key purpose of this session was to share the process we are following for the site options appraisal and our plans for further comms and engagement work and the consultation. This was a really positive session and given the membership consists of a number of town councillors and PPG members this represents a real sea change. Comments we received included:

- *"Grateful for the information provided in the meeting and the way in which the sites are being considered"*
- *"Shows a real effort to step back, which is welcomed and that the hope is another meeting with the SRG will be held when further forward and the stage of 3C has been reached".*
- *"I hope lessons have been learned within the ICB or ICS regarding this proposal and the contrast with how open and engaged you are being now compared with at the start of this scheme"*
- *"We know that it's not just operating the GP service, but also a facility to offer other services".*

Overview and Scrutiny Committee – The Project Team will be attending Shropshire OSC on 30th January 2023 to update them on the process and progress with the site options appraisal and the comms and engagement plan.

Key risks

- No viable alternative site for the hub can be identified.
- No identified source of funding for the capital/revenue consequences of the diagnostics element.
- No Delays to the timeline add cost to the project which could result in a cost pressure to the ICB.
- Delays to the timeline mean that the 2 practice leases expire before the hub is operational. Landlords may not agree to short term extension. Marden are in negotiation with their landlords for an interim arrangement. Marysville are delaying starting negotiations with their landlord as their priority is to address some significant GP workforce issues.
- Delays to the timeline risks NHSE withdrawal of support for us to continue as a pilot.
- If the hub does not proceed, risks the future viability of some of the practices and them giving notice on their contracts.
- Revenue consequences of the hub have to be met by the ICB. No current figure available and no current source of funding.
- Economic/political climate may mean further spending cuts impacting the NHS and availability of national capital in the spending review in 2025.

The key risks are included in the PCCC Risk Register.

2. 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

3. Recommendation(s)

The Primary Care Commissioning Committee is asked to:

- Note the contents of the report and the key risks associated with this project.

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	Improves patient choice through wider service offer
Quality and Safety	Improves GP access through improved recruitment and retention
Equality, Diversity, and Inclusion	Will be determined as part of IIA
Finances and Use of Resources	NHSE capital funding available subject to approval of national Cavell business case and local project fbc. Revenue consequences will need to be picked up by ICB. Building will be owned by the ICB
Regulation and Legal Requirements	No implications
Conflicts of Interest	No implications
Data Protection	No implications
Transformation and Innovation	Provides opportunities for increase use of digital/technology solutions.
Environmental and Climate Change	Building is designed to be Carbon Neutral and environmentally sustainable (Passivhaus design)
Future Decisions and Policy Making	No implications
Citizen and Stakeholder Engagement	Comms and engagement plan in place

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

Appendix 1

Shrewsbury Health and Wellbeing Hub
Stage 2 Technical Assessment - Shortlist criteria

Scores will be from 1-5 according to the following definitions:-

1 – Does not meet the required criteria
2 – Partially meets the required criteria
3 – Meets required criteria
4 – Exceeds the required criteria
5 – Has additional benefits beyond those identified in 4

Stage 2(A) Technical Assessment

Criteria			
1. The site should be available to acquire i.e. public sector asset disposal, on the open market or sale by private treaty.	**Yes/No**	**If no, discard**	
	Weighting	**Score**	**Weighted score**
~~2.~~ Ability to achieve planning permission to deliver a Health Hub on the site	40		
3. The site should have 'clean title' ie. free from any insurmountable restrictive covenants and low amount of general covenants	30		
4. The site should have access to statutory utilities and adopted highways, existing or to be created	30		
		Total	

Stage 2(B) Technical Assessment

Criteria for Short List The weightings in this table are subject to approval by Project Board on 14th February 2023	**Weighting**	**Score**	**Weighted score**
5. The site location should be well located and in close proximity to serve the patients of the 6 participating practices	35		
6. The site should be easily accessible by sustainable travel methods eg. on foot, cycle and by public transport (on existing primary bus route, park and ride	25		

or to a proposed route in conjunction with Shropshire Council) and also by car			
7. The site should be located within or near to an area in Shrewsbury which has the highest levels of overall deprivation	20		
8. The site should allow for future adaptability, expansion and development for future partner services	5		
9. The site is flexible in terms of the building plan which will impact upon the footprint subject to planning constraints	5		
		Total	

Scoring will be carried out by the individual subject experts and will be 1 - 5

Shrewsbury Health and Wellbeing Hub: Site Location Announcement

Communications Handling Plan

Situation Analysis

Since the beginning of this programme, and especially after the initial site location was publicly announced, the proposal for a Shrewsbury Health and Wellbeing Hub has received strong levels of scrutiny and criticism.

A number of stakeholders have rightly challenged our processes as well as our communications and engagement activity; the most vocal of which have been elected members for the area. We therefore need to ensure that elected members, as well as the local authority, are integral to our approach and are fully utilised within this handling plan.

Mitigation

Since the establishment of the Stakeholder Reference Group (SRG) and closer relations with our practices, we have been successful in shifting the dial and ensuring that we are being transparent, open about our work and involving everyone within the local community in these plans. We now need to ensure that public perception follows.

Activity

Below are six key strands of activity that we will undertake to effectively disseminate information regarding the site location of the Shrewsbury Health and Wellbeing hub to the relevant audiences.

1. Telling the right people at the right time

To ensure effective management of our messaging, we need to stick to the following sequence of who to brief, when and how.

Activity	Timeframe
Completion of the site options appraisal and travel analysis.	Mid-March 2023 (approx.)
Liaison with Shropshire Council to determine announcement date and to allow time for Rachel Robinson to brief Council Leader.	Mid-March 2023 (approx.)

Verbal briefing with practices (GPs and PMs) and project partners on the outcome of the options appraisal, travel analysis and plans for public announcement.	Mid-March
Approval from the March Programme Board.	Emma to provide date
Update HOSC and request this is part of a closed meeting.	Monday 27 March *Closed meeting TBC*
Media/MP and councillor briefing with embargo until after the SRG meeting (TBC).	March TBC *Same week as SRG*
Stakeholder Reference Group (SRG) meeting.	March TBC
Official dissemination of information into the public domain, please see below for further details.	March (straight after SRG)

2. A united front

Our practices and partners need to stand together and sing from the same hymn sheet.

Activity	Audience	Timeframe
Press release – including quotes from Simon Whitehouse, Sir Neil McKay, Gareth Robinson as well as Rachel Robinson. *To be issued to local media, via ICB website, practice websites, and cascaded via social media.*	Media and general public	March (after SRG) *Approved by relevant parties prior to the media briefing*
Open letter/stakeholder update - signed by programme leads and issued to key stakeholders and partners. *Including information on the site options appraisal process, travel analysis, the process from 47 options to 10, next steps for the programme and consultation.*	Stakeholders including media as an open letter	Same as above *Approved by relevant parties prior to the media briefing*

3. Direct patient communication

It will be imperative for our practices to lead on communications to patients and to feel empowered to answer any questions that may come their way.

Activity	Audience	Timeframe

Open letter to practice patients – signed by Simon Whitehouse, Sir Neil McKay and Gareth Robinson. *To be issued via practice email/text system with details as outlined above.*	Patients	March TBC (after SRG)
FAQ document with easy read information – update the current FAQ with site location details and produce a separate FAQ specific to the announcement. *To be shared with patients as part of the open letter distribution as well as for practice staff regarding patient enquiries.*	Patients and GP colleagues	Same as above
Social media and website messaging – practices to utilise a communications toolkit for social feeds and websites (including information flyer). *Toolkit to be shared as part of the above activity.*	Patients and general public	Same as above (March)

4. Media management

We need our local media to help us make the case to the public and to set it out in a balanced way.

Activity	Audience	Timeframe
Media/MP and councillor briefing (as above in section 1) – invite key representatives from the local press for a full and frank briefing, making it clear the information is under embargo until TBC. *Gareth Robinson, Emma Pyrah, Rachel Robinson and Phil Brenner to potentially be involved and to answer any questions.*	Media and elected representatives	March TBC
Radio interview – the site announcement will inevitably attract interest from the broadcast media. *Suggested spokespeople to include Gareth Robinson, Rachel Robinson and Dr Charlotte Hart with briefing notes to be provided.*	General public	Post distribution of the announcement (March)
Day in the life feature – identify a GP who will work with the comms team to develop a	General public	Beforehand (perhaps offer to

blog/feature that can argue the case from a real time perspective. Highlight current pressures, where the gaps are, how the hub could help and why the location is suitable for the need.		the media as part of the briefing, alongside the embargoed release)

5. Social media

We have several active social media channels and propose the below actions to highlight the key messages of the site announcement.

Activity	Audience	Timeframe
Awareness campaign across all channels featuring graphics, stats, GP and patient stories, and GP opinion pieces.	General public	Ongoing – with an extra push during the announcement
Myth busters - we will issue a key fact each day, dispelling some of the misinformation about the hub in the public domain. This will be in the form of social media graphic outlining the myth and then the fact.	General public	March TBC
Video content – interviews with GPs. Short positive clips with punchy messages to get our points across. *Use video to increase our social activity – content of which can be revisited when launching the consultation.*	General public and patients	Same as above

6. Utilising system support

We need to share our messages widely via partners. This will include Shropshire Council, SCHT, SaTH, VCSE organisations, Healthwatch Shropshire etc. to help broaden our reach.

Activity	Audience	Timeframe
Ask partners to share/publish the press release/open letter within their own newsletters or bulletins - Shropshire Council colleagues being integral to this.	ICS colleagues	March TBC
Collaborate and staff newsletters – include update in the stakeholder bulletin, Practice Bulletin, and ICB colleague bulletins for update across the system.	ICB/ICS colleagues and the GP network	Same as above

PRIMARY CARE COMMISSIONING COMMITTEE

Agenda item no.	PCCC 23-02.14
Meeting date:	3rd February 2023
Paper title	Annual electronic practice self-declaration (eDec) submission, 2022.
Paper presented by:	Bernadette Williams, Primary Care Lead – Contracting
Paper approved by:	Emma Pyrah
Paper prepared by:	Bernadette Williams, Primary Care Lead – Contracting
Signature:	B Williams
Committee/Advisory Group paper previously presented:	Primary Care Operational Group (PCOG)

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

Previous considerations:	

1. Executive summary and points for discussion

The General Practice Electronic Declaration (eDec) is an annual contractual requirement in which practices provide answers to a series of questions with the purpose of providing assurances of contract compliance.

The declaration was opened on the 17th October 2022 and closed on the 25th November 2022. It is usually submitted by a senior member of the practice staff, usually the practice manager and/or a senior partner.

The 2022 eDec was prepopulated with responses from the previous year. A number of questions are voluntary, but all practices were encouraged to provide an answer.

There were a number of anomalies identified from submissions where practices provided 'no' answers however these have been queried and assurances have been obtained to confirm that these were errors.

The outcome of the review of the responses is that the Committee can be assured regarding contract compliance.

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	
Workforce	

2. Recommendation(s)

NHS Shropshire, Telford and Wrekin Primary Care Commissioning Committee is asked to: Receive and note the satisfactory level of assurance of contract compliance arising from the eDec submissions.

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

Appendix A: eDec guidance document.

5. What are the implications for:

Shropshire, Telford and Wrekin's Residents and Communities	None
Quality and Safety	None
Equality, Diversity, and Inclusion	None
Finances and Use of Resources	None
Regulation and Legal Requirements	Provides assurances on GP practice compliance with contractual requirements.
Conflicts of Interest	None
Data Protection	None
Transformation and Innovation	None
Environmental and Climate Change	None
Future Decisions and Policy Making	None

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. Introduction and purpose

1.1 This report summarises the content of the GP Practice self-declaration completed by each practice in 2022/23. It provides assurances to the committee on a range of markers that demonstrate practice compliance to a number of contractual requirements.

2. Context

2.1 In accordance with NHS England's Primary Medical Care Policy and Guidance Handbook (PGM), commissioners of Primary Medical Care are responsible for the quality and safety and performance of services delivered by providers, within their area of responsibility. Commissioners have a statutory duty to conduct a routine annual review of every primary care medical contract it holds. This is covered through the annual GP Practice e-declaration (eDEC) collection which NHSE has established. In Shropshire, Telford and Wrekin, this has been undertaken by the primary care team.

3. Background

3.1 The annual eDec mandatory data collection was first introduced to practices in April 2013. Information is collected in eight categories:

- Practice details
- Practice staff
- Practice premises and equipment
- Practice services
- Information about the practice and its procedures
- Governance
- Compliance with CQC
- GP IT

It captures information such as operating policies, opening times and assurance about practice procedures. This information will link with contractual requirements and may also contain responses to 'reasonable requests for information' e.g. from other government departments and bodies. The information declared can be shared within the ICB and CQC, reducing the burden of separate information returns across organisations e.g. as part of pre-inspection information requests.

4. Annual e-Declaration for 2022/23

4.1 All practices were required to submit their eDec electronically through the NHS Digital Strategic Data Collection Service (SDCS); this is usually during a six week period. The declaration was opened on the 17th October 2022 and closed on the 25th November 2022. It is usually submitted by a senior member of the practice staff, usually the practice manager and/or senior partner. There was a 100% completion rate by GP Practices in the Shropshire, Telford and Wrekin area.

4.2 The 2022/23 eDec was prepopulated with responses provided from the previous year's collection. It included mandatory and voluntary questions. For questions that were marked voluntary, practices were encouraged to complete responses to these questions but could leave the questions blank if they preferred. There were three new questions this year in section 8, General Practice IT.

4.3 Following the submissions by practices, commissioners are then expected to review the practice eDec returns. It is important to note that whilst exercising of the functions passes to the ICB, the liability for the exercise of any of its functions remains with NHSE/I.

5. Outcomes of the 2022/23 submission

5.1 Individual practice declarations for 2022/23 were reviewed by the primary care lead for contracting. The following anomalies were followed up:

- **Network Contract DES data sharing:** A practice answered 'No' to the question about having data sharing in place **The practice has since confirmed that this was incorrect, and they do.**
- One practice answered 'No' to the question that asked if the practice can process directly booked appointments from NHS 111. **This was checked with the practice who then confirmed that they can.**
- Two practices answered 'No' to the question that asked if all healthcare workers employed by the practice are familiar with the Prevent strategy and have all GPs participated in Prevent training in the past 3 years. **The practices have confirmed that staff have completed the training, any outstanding will completed by the end of the year.**
- **Mental Capacity Act:** A practice answered 'No' to this question; within the last 3 years, has the practice provided training on mental capacity / Mental Capacity (Amendment) Act for practice staff health care professionals and/or other staff (where relevant) and got a system for assessing staff competency? **The practice confirmed this was an error.**

6. Recommendations

The Primary Care Commissioning Committee is asked to:

- Receive and note this update and the satisfactory level of assurance the results of the eDec submissions provides on contract compliance

Appendix A

Annual Electronic Practice Self-Declaration (eDec) Submission Support Guidance

October 2022

Contents

Background

The annual electronic practice self-declaration (eDEC) was first introduced to practices in April 2013 and has replaced the variable arrangements (such as the submission of annual reports) which existed between former Primary Care Trusts and providers of Primary Medical Services. The eDEC is an annual mandatory data collection.
Information collected in the eDEC is covered in 8 categories, these include: 1. Practice Details, 2. Practice Staff, 3. Practice Premises and equipment, 4. Practice services, 5. Information about the practice and its procedures, 6. Governance, 7. Compliance with CQC. 8 GP I.T.

To meet the Care Quality Commission (CQC) registration requirements, all services regulated by CQC must comply with the law, but in particular, they must comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) (as amended). A number of the questions asked in this declaration therefore relate to CQC's registration requirements In addition however this version of the declaration has been amended to reflect our commitment in the General Practice Forward View to reducing workload in regulatory duplication. The CQC has reviewed the questions such that responses will form part of their pre-inspection documentation thereby reducing workload for practices.

Onward Uses of the Information

CQC inspection teams and NHS England regional local teams work closely together and share information on a regular basis. The information provided to NHS England in this declaration will be shared with CQC. Similarly, the outcome of CQC inspections will be shared with NHS England, this includes any action plans which practices may submit to CQC (where relevant).

In maintaining NHS England's commitments towards transparency and supporting patient choice, the following sections and items could be shared either with public facing NHS websites (e.g. NHS.UK) and/or other information modules visible to all users of the primary care indicators website (www.primarycareindicators.nhs.uk) for instance may be used within the GPIT digital maturity index and General Practice Indicators:

Could be published in the public domain in the near future e.g. NHS.UK website	• Question 1H. Practice telephone number (for patients). • Practice Services Section (i.e. Chapter 4): all content. • Premises and Equipment Questions on wheelchair accessibility questions 3E and 3F. • The electronic practice catchment area, the practice website address, branch practice opening times, practice email address for patients, and where relevant practice Facebook page. • Question 8J: the practice is enriching the Summary Care Record of patients who have given their consent. • Question 8O: The practice makes 25% of their appointments available for booking online (this

	relates to the complete range of appointments practices offer to patients).
Will be available to anyone in the NHS and approved stakeholders with access to www.primarycareindicators.nhs.uk	• Interoperable patient records questions: 6F. • GP IT section (i.e. Chapter 8): all content. • The electronic practice catchment area.
Email address of submitters may be made available to NHS Digital staff	The email address of GP practice users registered with the Strategic Data Collection Service (SDCS) for submitting eDEC may be contacted by NHS Digital with regards to data quality queries related to onward use of GP catchment areas arising to GP finder services

NHS England regional teams will receive information from the annual electronic practice self-declaration.

Integrated Care Boards that commission primary care services under formal delegation from NHS England will receive information from the annual electronic practice self-declaration that is necessary in support of their delegated functions.

Legal Disclaimer

NHS England, as with all NHS organisations is required to share intelligence with other statutory bodies, both in circumstances where they have a legal right to request it e.g. National Audit Office, CQC; or where it is necessary or expedient for them to receive it in order to protect the welfare of individuals or to discharge their functions.

Practices are therefore reminded of the significance to ensure that responses provided to questions are accurate and can withstand legal scrutiny, the declaration is treated and considered to be a formal submission once declared. All information in the eDEC is subject to the requirements of the Freedom of Information Act 2000. In response to a request for information, exemptions to disclosure will be considered on a case by case basis.

Strategic Data Collection Service (SDCS)

Getting Started

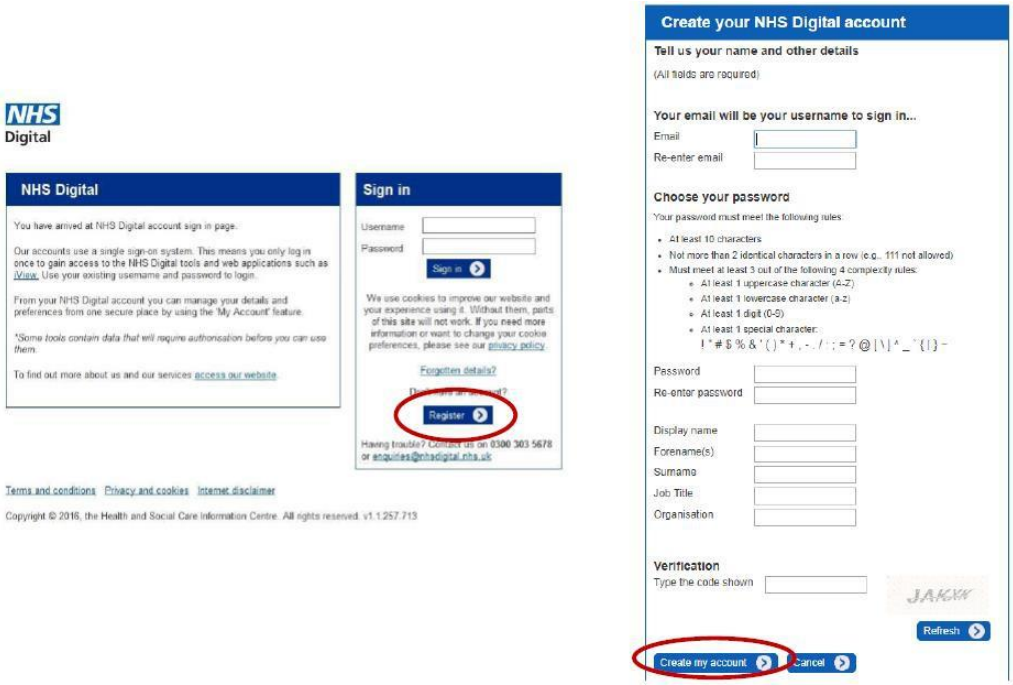
The Data Collections Service grants access to SDCS for the eDec. Users will receive an automatic email from SDCS confirming which collection you have been registered to submit for and on behalf of which organisation (you can submit for multiple organisations, just outline this in your request to the Data Collections Service). The email will also include a link to SDCS: https://datacollection.sdcs.digital.nhs.uk/

Registering your Single Sign on (SSO) Account

To access SDCS, you must have a valid SSO account. SDCS/SSO accounts can only be registered to personal, work email addresses (e.g. jane.example@nhs.net / paul.example@organisation.gov.uk). Generic, team, shared or personal private email addresses (e.g. example@hotmail.com) are not accepted.
To register your SSO account and create your password, click the link in your invitation email to navigate to the 'Sign In' screen. Click '**Sign In'**.

From the 'Sign In' page, click the **'Register'** button and Complete the registration form by filling out each of the fields in the form. 'Email' must be the email address given to the Data Collection Service/

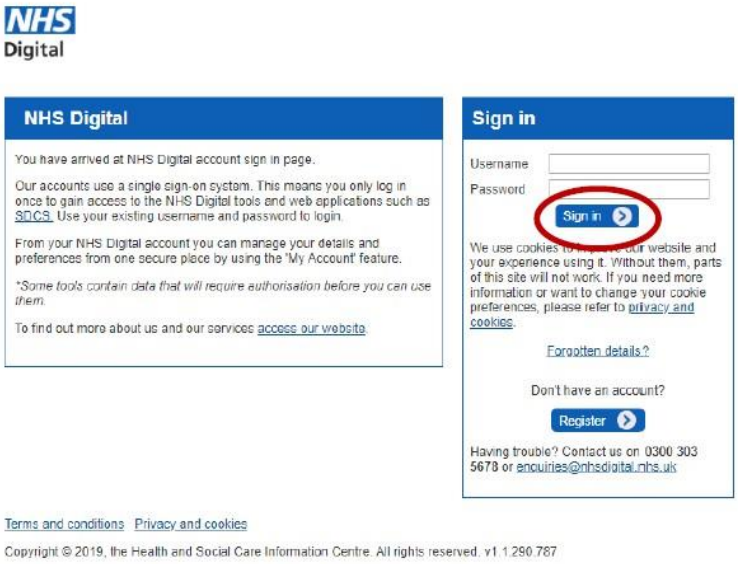
the email that received the invitation email. Once complete, click '**Create My Account**'.



Logging in to SDCS

Once you have registered your SSO, you can log into SDCS. Click the link in your invitation email to navigate to the 'Sign In' screen. Click 'Sign In'.

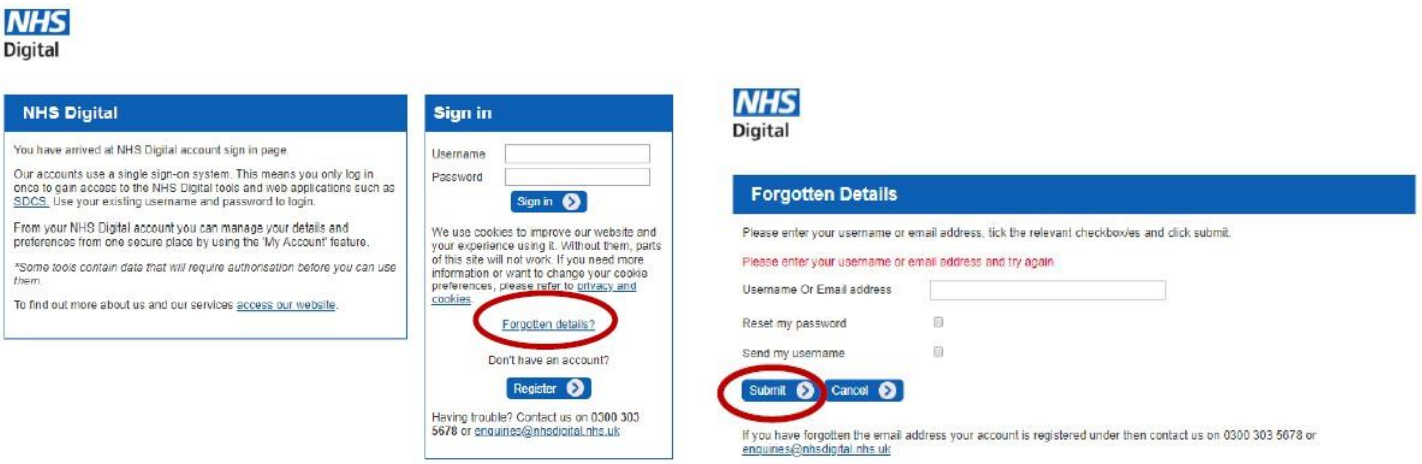
Enter your username and password and click the '**Sign In'** button.
Your username will be the email address given to the Data Collections Service and the email used to register your SSO. Your password will be the password that you created when registering your SSO.



You will then be taken to the SDCS home page.

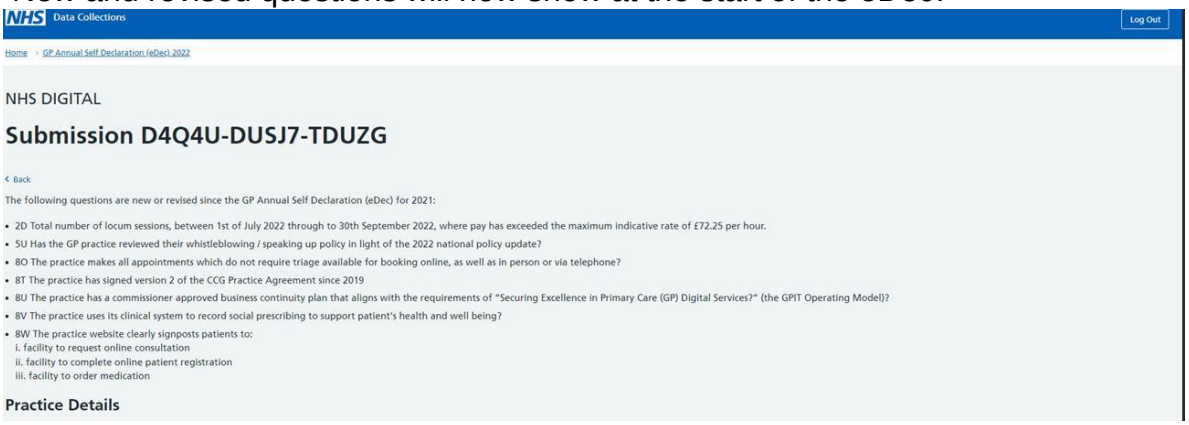
Resetting your password

You can reset your own password for your SSO account at any time. Please note that the Data Collections Service cannot action password resets. To reset your password, from the 'Sign In' page click '**Forgotten details?**' and complete and submit the subsequent form.



System Changes for 2022

New and revised questions will now show at the start of the eDec:



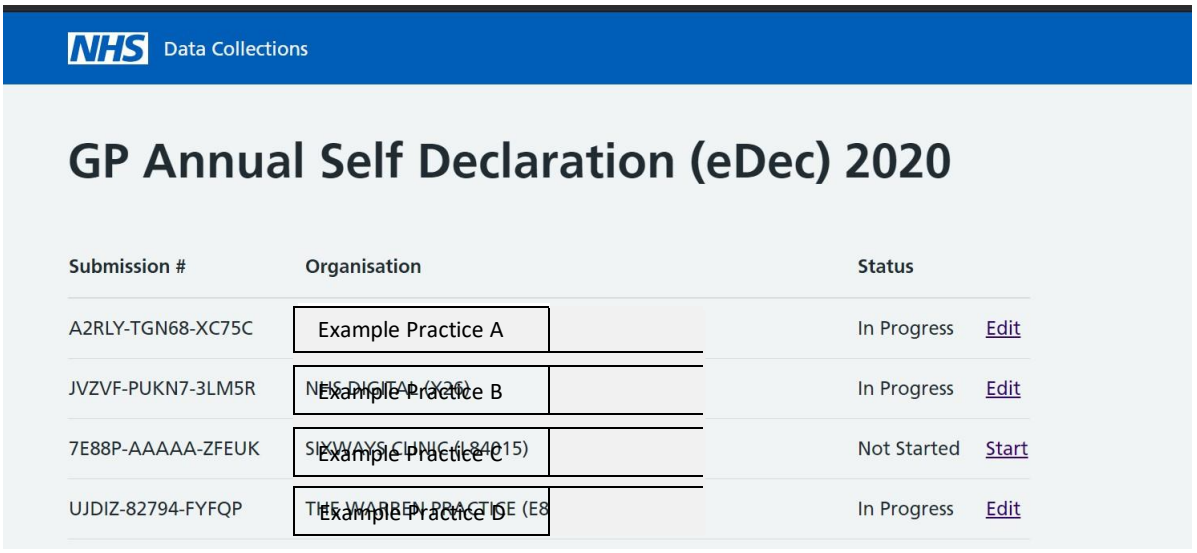
Revised and New questions will have the new highlighted heading:

Accessing the eDec

Submission Page

Once logged in to SDCS you will need to select **Submissions** > **New,** this will take you to the below page.

You will need to select **GeneralPracticeAnnualSelfDeclaration-eDec** from the dropdown then click **Create.** This will take you to the eDec submission page.



This screen will show all GP surgeries you are associated with and the current progress. It also contains a link to your previous declarations.
Once you click on the relevant GP surgery, you are presented with all the questions and their status.

Completion Guidance

General Information

The eDEC is a mandatory return and remains an organisational responsibility of the practice to complete within the requested time frame. The information is submitted by a senior member of practice staff usually the practice manager and/or senior partner as similar to requirements related to completing CQRS returns. Only the person in the practice who has the permission in their user account will be able to view/edit and submit the eDEC in NHS Digital's Strategic Data Collection Service https://datacollection.sdcs.digital.nhs.uk/

The eDEC for 2022/23 includes mandatory and voluntary questions. Questions which are voluntary have been marked voluntary, practices are encouraged to complete responses to these questions but can leave the questions blank if they prefer. Responses to voluntary questions will help enable the system to better support GP practices in the future. Responding no to questions which are voluntary does not mean the practice is not compliant with their contract.

Practices who require further support to gain access to the eDEC or have any specific questions about the content or experience any technical difficulties should contact NHS Digital enquiry service quoting eDEC.

In order to account for changes which have occurred in the contract, some changes to questions have been made from last year's declaration.

For practices who submitted an electronic declaration last year, the questions and responses provided have been presented back. Practices are asked to check these responses. If no changes have occurred practices can resubmit this back.

Practices are reminded of the need to ensure that responses provided apply to any new arrangements which have since occurred from when the declaration was submitted last year, for example when a practice has merged with another and is using the same practice organisation code. With respect to branch practices, registered under the same parent organisation code (main practice) it is assumed that all responses to all questions for the main practice equally apply to the branch practices. Should any responses to questions answered in this declaration be different for a branch practice, then practices are required to explain these differences further by making use of the free text entry available in the 'supporting Information' section found at the end of the declaration.

Practice Details

This is used to confirm the basic details of your practice e.g. the name, address and contract type. This information helps to ensure the records held by the regional team are correct.
To complete this section, you should confirm that the pre-filled boxes are correct in the 'Main Practice' section. If you have any concerns about this, you should discuss this with your regional team contract manager.

Practice Details		
1D	Practice Contract Type	(GMS/PMS/APMS/other)
1E	Organisation Type[1]	(Social Enterprise/NHS body/Non NHS body)
1F	Since your practice last completed this declaration, have you changed configuration[2] or structure? (e.g. the practice is declaring under the same organisation code as for last year's declaration and since this time, the practice has merged or divided from another practice).	Yes / No/ N/A[3]
1G	Contract start date/ end date[4] (where applicable)	DD/MM/YY
1H	Practice telephone number[5] (for patients)	
1I	Practice telephone number (other, if different)	
1J	Does the practice have any branches? If so, how many and what are their names?	

[1] This question relates to how the contractor elects to be regarded for the purposes of dispute resolution procedures, see definitions available in: http://www.england.nhs.uk/wp-content/uploads/2013/10/manag-disputes.pdf
[2] This means that there has been a change in the contractual entity of the practice.
[3] N/A applies if the practice is new and was not able to complete an electronic declaration last year.
[4] Mandatory question if responding 'Yes' to: 'new or recently changed configuration' and for APMS contracts, otherwise: optional.
[5] Response to this question could be shared with public facing NHS websites e.g. NHS.UK.

Practice Staff

For the purpose of this declaration the contractor is assumed to have sufficient staff, suitably qualified, skilled and experienced to provide a level of service sufficient to meet the reasonable needs of its patients. The practice should amend the declaration to 'NO' if it is not able to demonstrate this.

It is recognized that workforce pressures and including vacancies are increasing locum use in general practice, at a time when locum costs are rising. This section seeks to understand the extent practices are dependent on locums GP support, and how costs compare with the maximum indicative rate for locum cost.
This section relates to Regulations 18 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended).

Practice Staff Numbers and Suitability & Training and Support

Practice Staff (Numbers and Suitability)		
2A	The practice can evidence and make available the needs analysis and risk assessment it has used for deciding sufficient staff levels. Recognising the need to have the right knowledge, experience, qualifications and skills for the purpose of providing services in the practice and demonstrating capacity to respond to unexpected service changes.	Yes/No
2B	All health care professionals working in the practice are registered with the relevant professional body, and that this registration is checked on employment (along with satisfactory references) and where applicable annually thereafter, and that health care professionals that are required to revalidate do so and that for GPs, inclusion on the performer list is checked. *(GMS Regulations Part 7, PMS Regulations Part 8, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 18(2)(c))*.	Yes/No
2C	All relevant staff have been subject to the necessary Disclosure and Barring Service (DBS) checks. The DBS has replaced the Criminal Records Bureau https://www.gov.uk/government/organisations/disclosure-and-barring-service/about) See also the CQC myth buster on DBS checks. http://www.cqc.org.uk/content/nigels-surgery-2-who-should-have-disclosure-and-barring-service-dbs-check	Yes/No
2D (r)	*The following question relates to locum use and associated cost to the practice. This is an indicative figure only and does not represent what a practice must or should pay. Neither will it be used for performance management purposes.* Total number of locum sessions, between 1st of July 2022 through to 30th September 2022, where pay has exceeded the maximum indicative rate of £72.25 per hour.	
Practice Staff (Training and Support)		
2E	All health care professionals employed in the practice have annual appraisals and where applicable personal development plans and that this is aligned to revalidation for doctors and also for registered nurses and midwives (according to requirements issued by the Nursing and Midwifery Council) (GMS Regulations Part 7, Regulation 54, PMS Regulations Part 8, Regulation 47), CQC GP handbook	Yes/No
2F	Practice staff have written terms and conditions of employment conforming to or exceeding the statutory minimum *(relevant employment law and GMS Regulations Part 7, Regulation 49).*	Yes/No

2G	The Practice can demonstrate that it is compliant with Equal Opportunities legislation on employment and discrimination. *(Equality Act 2010)*	Yes/No
2L	*Are all healthcare workers employed by the practice familiar with the Government's Prevent strategy and have all GPs (partners and salaried) participated in PREVENT training in the past 3 years?* *Guidance note: participation could be either in person or on-line training. Ref. 10.143 page 88 Prevent Strategy:* *https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/97976/prevent-strategy-review.pdf*	Yes/No
2M	The practice has policy(ies) for safeguarding both children and adults which includes: Domestic Violence, Mental Capacity, FGM and the requirement for mandatory reporting, information sharing, freedom to speak up information. (This is a legal requirement to have policies and fits with CQC inspection regulations and Children Act 2004.) Supporting resources/ links: http://www.gpnotebook.co.uk/simplepage.cfm?ID=x20140305071001216972 Royal College toolkits: Child http://www.rcgp.org.uk/clinical-and-research/resources/toolkits/the-rcgp-nspcc-safeguarding-children-toolkit-for-general-practice.aspx Adult http://www.rcgp.org.uk/clinical-and-research/resources/toolkits/safeguarding-adults-at-risk-of-harm-toolkit.aspx)	Yes/No

Practice Premises and Equipment

This section covers the Practice premises and equipment with regards to service provision, compliance with Health and Safety regulations and infection control, as defined in the contract. Regulations 12(2)(d-f) and (h) and15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended) and the Health & Safety at Work Act 1974

Practice Premises and Equipment		
3A	The premises used for the provision of services under the contract are suitable for the delivery of those services and sufficient to meet the reasonable needs of the practice's patients. (GMS Regulations Schedule 3 Part 1, Paragraph 1, PMS Regulations Schedule 2 Part 1, Paragraph 2) and must meet Minimum Standards as defined in Schedule 1 of the Premises Costs Directions (2013)	Yes/No
3B	The premises used for the provision of services under the contract are subject to a plan that has been formally agreed with the NHS England (GMS Regulations Schedule 3, Part 1, Paragraph 1, PMS Regulations Schedule 2, Part 1, Paragraph 2) if rectification actions are required; or in order to comply with Minimum Standards as of the current Premises Costs Directions	Yes/No
3C	The practice is able to demonstrate that it complies with arrangements for infection control and decontamination in accordance with the Health & Social Care Act 2008	Yes/No

	code of practice on the prevention and control of infections. (GMS Regulations Schedule 3 Part 1 Paragraph 14, PMS Regulations Schedule 2 Part 1, Paragraph 9). In addition the practice will want to be aware of related guidance, such as the National Specifications of Cleanliness in the NHS. Appendix D: examples of interpretation for primary medical care, including carrying out annual audits as set out in the code. National specifications for cleanliness in the NHS: primary care medical and dental premises	
3D	The practice can demonstrate that it meets the requirements of the Health & Safety at Work Act 1974 and Fire Safety Regulations [this might include for example evidence of regular review or audit of any policies or procedures adopted by the practice. (Health & Safety at Work Act) The Regulatory Reform (Fire Safety) Order 2005. (http://www.legislation.gov.uk/uksi/2005/1541/contents/made)	Yes/No
3E	Does the practice have at least one consulting room which is accessible to wheelchair users?[6]	Yes/No
	If answering No to question 3E, what arrangements are in place to meet the reasonab needs of patients who are wheelchair users?[7]	Select all which apply: 1. Home visit 2. Other (free text)

Practice Services

This section primarily relates to the core hours of 0800 – 1830 every day except weekends and bank holidays. We assume that the practice is providing general medical services to meet the reasonable needs of its patients. When entering opening times outside this window, we assume that this relates to extended hours. This section covers the provision of services, including routine and emergency/out-of-hours medical care.

All responses to questions in this chapter will also be used to allow the general public to learn more about the practices which provide particular services. This may include the sharing of responses from questions 4A through to 4X with public facing NHS websites e.g. NHS UK.

Practice Services		
Opening Hours (reception and phone lines open)	Question 4A. Details of opening hours for reception	Question 4B. Details of opening hours for phone lines
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		
Closing Hours		
4C	Are there any regular periods during each week that the practice is closed to patients between the hours	Yes/No

[6] Response to this question could be shared with public facing NHS websites e.g. NHS UK.
[7] Ibid

	of 8.00 and 6.30pm Monday to Friday (except bank holidays)?	
4D	If yes, please provide details of days and times	
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
4E	Are there any other intermittent periods during each month that the practice is closed to patients between the hours of 8.00 and 6.30pm Monday to Friday (except bank holidays)?	Yes/No
4F	If responding yes to question 4E, please indicate frequency of intermittent closure period and provide details of days and times	

Day	Frequency of intermittent closure time: select from list: fortnightly / once every three weeks / once a month / once every other month / other (free text)	Time:
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		

Question 4Fb: Is the practice closed each week for half a day during core contract hours?	
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	

Extended Opening Hours – where the practice provides outside of core contract hours		
4G. Hours per week (not within 08:00-18:30 Mon-Fri)	4H. Funding mechanism (e.g. Network DES, Incentive Scheme, PMS growth, other)	4I. Contract/agreement end date

New Out of Area patients (GMS Regulations, part 5, Regulation 30, PMS Regulations, part 5, Regulation 25)	
4L. Does the practice offer primary medical services (excluding home visits) to new patients who are seeking to register with the practice and reside outside their usual practice boundary area? (Guidance Note: Provision of out of area registration by practices is optional).	Yes / No

In case of Emergency (during core contract hours)
The contract states that "the Contractor must provide the services described in Part 8 (namely essential services) at such times, within core hours, as are appropriate to meet the reasonable needs of its patients, and to have in place

arrangements for its patients to access such services throughout the core hours in case of emergency" (2014, NHS England, Standard GMS Contract)		
4M	During the preceding 12 months, the practice can confirm, that it can evidence (if requested), how it is meeting the reasonable needs of its patient population and the practice has arrangements in place for its patients to access such services throughout the core hours (08:00 – 18:30 Monday to Friday) in case of emergency?	1. The practice can confirm with evidence which has been obtained from patient sources in the preceding 12 months from: (select all that apply from list) • Patient Participation Group, • GP Patient Survey, • Local Survey, • Combination of PPG/GPPS/Local Survey, • Other: FREE TEXT entry: 2. **The practice is not able to confirm**[8]
4N	The practice can confirm it has arrangements in place for its patients to access essential services in case of emergency if the practice is not open during core contract hours.	Yes/No
4O	If practice services are not available to patients during core contract hours what arrangements are in place?	Select response from list: • Same OOH provider as that commissioned by ICB, • Sub contracted provider: (enter name and select from list provided), • Provided directly by the practice, • Other free text entry:, • None
Out of Hours		
4P	Is the practice responsible for the provision/commissioning of care in the Out of Hours period? (i.e. care which is provided by the practice or commissioned by the practice. This does not refer to Out of Hours Care commissioned by the ICB).	Yes/No (opted out)
4Q	If 'Yes' and the practice sub-contracts the provision of out of hours care, please provide the name of the accredited provider.	Enter name of OOH provider[9]
4R	If 'Yes' the practice can evidence that it has in place arrangements to monitor its contract with its OOH provider, including: frequency of meetings with the provider, and any action it has taken against its provider through non-compliance or complaints.	Yes/No
4S	If 'No (opted out)' the practice can evidence that it has in place arrangements to monitor and report on any patient or practice concerns about the quality of local OOH services. (GMS Regulations Part 5 Regulation 18, PMS Regulations Part 5 Regulation 22)	Yes/No

[8] Declaring "not able to confirm", means that you are not able to provide evidence from patient sources, this does not necessarily mean you are not meeting the reasonable needs of your patients.

[9] If your provider is not on the list provided then enter the name by selecting 'OTHER' and enter in free text.

4T	If 'No (opted out)' the practice can evidence that it also has in place arrangements to promptly review the clinical details of OOHs consultations made by its patients and for dealing with information requests from the OOH provider. (GMS Regulations Part 5 Regulation 18, PMS Regulations Part 5 Regulation 22)	Yes/No
Access to interpreting Services		
4U	Does the practice provide access to interpreting? Guidance note: Interpreting means: spoken word or British Sign Language.	Select all which apply Telephone Face to face interpreter (inclusive of British Sign Language) Video interpreting (inclusive of British Sign Language) Yes – other No
4V	If yes, who funds the interpreting service?	Select all that apply: i) Practice ii) ICB iii) NHS England iv) Other
Maintaining up to date information on the GP practice website		
4W	Does the practice review and update (where appropriate) the content of the practice website on at least two separate occasions, or more, per year?	Yes/No
4X	The practice is currently open to all patients for both virtual and face to face appointments as clinically appropriate? Yes/No	Yes/No

Information about the Practice and its procedures

This section covers the Practice procedures and includes how the practice communicates with patients, how it stores and records information regarding medication and compliance with regulations regarding children. This relates to Regulations 9, 10, 11, 12, 13 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended).

Communicating with Patients

Communicating with Patients		
5A	The practice produces a leaflet that includes all of the requirements set out in its contract. (GMS Regulations Part 10, Regulation 78, PMS Regulations, Part 11, Regulation 71).	Yes/No
5B	The practice reviews and updates its leaflet at least once every 12 months. (GMS Regulations Part 10, Regulation 78,PMS Regulations Part 11 Regulation 71).	Yes/No
5C	The practice leaflet is made available for patients/prospective patients. (GMS Regulations Part 10, Regulation 78, PMS Regulations Part 11, Regulation 71)	Yes/No

5D	The practice has a complaints policy which complies with the NHS complaints procedure and it is advertised to patients. (GMS Regulations Part 11, Regulation 79, PMS Regulations Part 12, Regulation 72).	Yes/No
5E	The practice can demonstrate reasonable grounds where it has refused an application to register and keeps a written record of refusals and the reasons for them. (GMS Regulations Schedule 3, Part 2, Paragraph 21, PMS Regulations Schedule 2, Part 2, Paragraph 20).	Yes/No
5Z	The practice can demonstrate (e.g. practice policy, records of refusals) it has not refused any registration on the grounds any patient was unable to provide proof of identify or address or any evidence of immigration status. *(GMS Regulations Schedule 3, Part 2, Paragraph 21, PMS Regulations Schedule 2, Part 2, Paragraph 20).*	Yes/No
5F	When removing patients from its list the practice can demonstrate that it does so in accordance with contractual requirements and provides the required notice, including providing an explanation of the reasons in writing to the patient. (GMS Regulations Schedule 3, Part 2, Paragraph 21, PMS Regulations Schedule 2, Part 2, Paragraph 20)	Yes/No
5G	The practice can evidence that they have engaged with their PPG throughout the year and make available such feedback to the practice population including actions and reports, including where they have acted on suggestions for improvement. (GMS Regulations Part 5, Regulation 26, PMS Regulations Part 5, Regulation 20).	Yes/No
5H	The practice is able to show that the PPG is properly representative of its practice population or that it has made and continues to make efforts to ensure it is representative of its local population. (GMS Regulations Part 5, Regulation 26, PMS Regulations Part 5, Regulation 20)	Yes/No
5I	When undertaking call/recall activities as part of delivering vaccination programmes please specify when required how the practice's eligible population are contacted? (r)	Selection all options that apply: Letter to patient Text message to patient Phone call to patient During consultation/ appointment Other electronic technical solution (free text) Other non-electronic technical solution (free text)
5U (r)	Has the GP practice reviewed their whistleblowing/speaking up policy in light of the 2022 national policy upate? Ref: https://www.england.nhs.uk/ourwork/freedom-to-speak-up/developing-freedom-to-speak-up-arrangements-in-the-nhs/	Yes/No
5V	Has the practice identified someone external to the practice staff can raise concerns with in confidence (e.g. freedom to speak up guardian, local whistleblowing lead)?	Yes/No

5X	Practice confirms it is not advertising the provision of private GP services either by itself or through any other person (via the practice leaflet, practice website or any other written or electronic means)?	Yes/No

Medication		
5J	The practice has a written policy and procedures in line with the requirements of the Medicines Act (GMS Regulations Part 14 Regulation 87, PMS Regulations Part 14 Regulation 79) which will be made available if requested.	Yes/No
5K	Practice stores vaccines in accordance with the manufacturer's instructions (GMS Regulations Schedule 3, Paragraph 13, PMS Regulations Schedule 2 Paragraph 8).	Yes/No
5L	The practice has a procedure to ensure all batch numbers and expiry dates are recorded for all vaccines administered and that all immunisations, vaccinations and consent to immunisations are recorded in the patient record (GMS Regulations Schedule 1 Paragraph 4, PMS subject to local agreement).	Yes/No
5M	The Practice stores its Vaccines in fridges which have a max and min thermometer and can demonstrate, if asked, that readings are taken on all working days. (GMS Regulations Schedule 3, Part 1, Paragraph 13, PMS Regulations Schedule 2, Part 1, Paragraph 8).	Yes/No
5N	All staff involved in administering vaccines are trained in the recognition of anaphylaxis and able to administer appropriate first line treatment when it occurs (GMS Regulations Schedule 1, Paragraph 4, PMS subject to local agreement).	Yes/No
5O	With regard to dispensing doctors: the practice can demonstrate it has clear procedures, that are followed in practice, monitored and reviewed, for controlled drugs, unless they are taken by the person themselves in their own home, including: investigations about adverse events, incidents, errors and near misses; sharing concerns about mishandling.	Yes/ No/ N/A
5P	With regard to dispensing doctors: The practice has systems in place to ensure they comply with the requirements of the Controlled Drugs (Supervision of Management and Use) Regulations 2006, relevant health technical memoranda and professional guidance from the Royal Pharmaceutical Society of Great Britain and other relevant professional bodies and agencies.	Yes/ No/ N/A
5Q	With regard to dispensing doctors: The practice declares it complies with the terms of service of dispensing doctors outlined in schedule 6 of The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 and; The practice can demonstrate that for all patients which it dispenses to it is satisfied that they would have serious difficulty in obtaining any necessary drugs or appliances from an NHS pharmacist by reason of distance or inadequacy of means of communication (colloquially known as the "serious difficulty" test which can apply anywhere in the country); or A patient is resident in an area which is rural in character, known as a controlled locality, at a distance of more than one mile1 (1.6 km) from pharmacy premises (excluding any distance selling premises). The pharmacy premises do not have to be in a controlled locality.	Yes/ No/ N/A

Consent, Including Children		
5S	The practice records patients' consent for minor surgery including curettage and cautery and, in relation to warts, verrucae and other skin lesions, cryocautery (GMS Regulations Schedule 1 Paragraph 8, PMS subject to local agreement)	Yes/No
5W	The practice has a policy for patients to request chaperones, this policy includes children and young people as well as adult patients. **Addenbrooks Hospital NHS Trust has example of best practice**: https://www.cuh.nhs.uk/about-us/our-profile/policies-and-procedures **Further references of note, learning from:** **Myles Bradbury investigation report:** https://www.verita.net/wp-content/uploads/2016/04/Independent-investigation-into-governance-arrangements-in-the-paediatric-haematology-and-oncology-service-at-Cambridge-University-Hospitals-NHS-Foundation-Trust-following-the-Myles-Bradbury-case.pdf **Savile investigation recommendations:** https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/407209/KL_lessons_learned_report_FINAL.pdf	Yes/No

Information and Clinical Governance

This section covers information and clinical Governance, and includes questions about storage of data, transmission of data, allowing patients appropriate access to the data held about them and general practice information technology**.** This section in part relates to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended).

Information and Clinical Governance		
6A	The practice has a protocol to allow patients access to their records on request in accordance with current legislation (Data Protection Act 2018 and GMS Regulations Part 10, Regulation 71,PMS Regulations Part 11, Regulation 64)	Yes/No
6B	The practice has a nominated person who has responsibility for ensuring the effective operation of the system of clinical governance. (GMS Regulations Schedule Part 14, Regulation 87, PMS Regulations Part 14, Regulation 79).	Yes/No
6C	The practice is registered under the Data Protection Act 2018 (Data Protection Act 2018).	Yes/No
6D	The practice has a procedure for electronic transmission of patient data in line with national policy (Data Protection Act 2018 and GMS Regulations Part 10, Regulation 69,PMS Regulations Part 11, Regulation 62) including mechanisms to ensure that computerised medical records/data are transferred to a new practice when a patient leaves.	Yes/No
General Data Protection Regulation: GDPR general guidance include advise for general practice: https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/information-governance-alliance-iga/general-data-protection-regulation-gdpr-guidance Additional support references on DPO: https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr/accountability-and-governance/data-protection-officers/ http://pwc.blogs.com/data_protection/2017/02/data-protection-officer-do-you-need-to-appoint-one.html https://edps.europa.eu/data-protection/data-protection/reference-library/data-protection-officer-dpo_en		

Interoperable Patient Records		
6F	The practice has arrangements in place to ensure a validated NHS number is used in all NHS clinical correspondence, including referrals, generated by the practice, except in exceptional circumstances where the number cannot be ascertained.[10] (GMS Regulations Part 10, Regulation 70, PMS Regulations Part 11, Regulation 63).	Yes/No
Network Contract DES data sharing		
6N	For practices signed up to the Network Contract DES, if applicable does your PCN have in place suitable data sharing and data processing arrangements?	Yes/No/N/A

Clinical leads for Vulnerable Groups

In a context of patients living longer with greater and more complex comorbid conditions the health needs of practice populations are changing. These questions have been asked to support understanding, strategy development, develop systems and processes to manage vulnerable patients and are not related to contractual compliance.
CQC Regulation 17: Good governance, includes requirements to maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment (provided, this includes complying with the Data Protection Act)
This section contains 3 mandatory questions and 1 voluntary.

Clinical Leads for Vulnerable Groups		
6G	Does the practice have a lead for vulnerable adults? The broad definition of a vulnerable adult referred to in the 1997 consultation 'who decides' issued by the lord chancellor department is: 'A person who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation'	Yes/No[11]
6L	Does the practice have procedures and information sharing agreements to ensure information sharing with the multiagency teams for safeguarding vulnerable adults and children. (Children Act 2004) Supporting links: Royal College toolkits: Child http://www.rcgp.org.uk/clinical-and-research/resources/toolkits/the-rcgp-nspcc-safeguarding-children-toolkit-for-general-practice.aspx Adult http://www.rcgp.org.uk/clinical-and-research/resources/toolkits/safeguarding-adults-at-risk-of-harm-toolkit.aspx	Yes/No

[10] Ibid
[11] Declaring "no" does not mean the practice is not compliant with their contract.

6M	Does the practice have clear training agreements for safeguarding and records of training retained within the practice for audit requirements? Notable reference learning from Savile investigation recommendations: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/407209/KL_lessons_learned_report_FINAL.pdf Children Act 2004 requirements: http://www.gpnotebook.co.uk/simplepage.cfm?ID=x20140305071001216972 Supportive tool kits: Royal College of General Practice: Child http://www.rcgp.org.uk/clinical-and-research/resources/toolkits/the-rcgp-nspcc-safeguarding-children-toolkit-for-general-practice.aspx Adult http://www.rcgp.org.uk/clinical-and-research/resources/toolkits/safeguarding-adults-at-risk-of-harm-toolkit.aspx	Yes/No
6J	Mental Capacity Act Background: The House of lords select committee on the Mental Capacity Act 2005 (published 25/2/14) found that statutory services were often failing in their obligations in relation to the MCA. There is patch availability of training resource on the MCA, - but with increasing prevalence of dementia, NHS England wants to ensure that practices have access to appropriate training and support. Assessment of capacity is highlighted in BMA's guidance 'Safeguarding vulnerable adults – a tool kit for general practitioners. CQC inspectors will want GPs and other practice staff to demonstrate their competence in safeguarding adults at risk. Whilst not a contractual requirement, NHS England is keen to ensure all practices have access to the required level of support to ensure that practices are aware of good practice in relation to adult safeguarding and the issues regarding the MCA. The outcome will help to inform future training requirements. Question 6J: Within the last 3 years, has the practice provided for training on mental capacity / Mental Capacity (Amendment) Act for practice staff health care professionals and/or other staff (where relevant) and got a system for assessing staff competency?	Yes/No[12]
6P	The practice has a procedure in place to ensure that all DNAR decisions made in respect of patients with a learning disability are made in line with good clinical practice and are reviewed and updated regularly? (n)	Yes/No
6Q	The practice has a procedure in place to offer a maternal postnatal check at 6-8 weeks, as an additional appointment to that for the baby? (n)	Yes/No
6R	The practice has a procedure in place to record the ethnicity of all their registered patients (e.g. upon registration, regular reviews)? (n)	Yes/No

[12] Ibid

Registering with CQC

CQC Regulation 15, CQC (Registration) Regulations 2009 require that CQC is notified of specific changes in the running of the service so that CQC can be assured that the provider has taken appropriate action.

Registering with CQC		
7A	'Does your CQC registration accurately reflect the regulated activities you provide, and is each location where you provide them listed' Published guidance available here: Scope of registration What is a location: Guidance for providers and inspectors	Yes/No
7B	Have you notified CQC of any change relating to regulated persons and any of the events listed in the regulations[13], put in an application if required and are in in receipt of an up to date registration certificate?	Yes[14]/No[15]/N/A[16]

General Practice Digital Services The NHS provides general practices with digital services as required by the GP Contract and the ICB-Practice Agreement. This responsibility has been delegated to ICBs (or successor bodies). Details of how these digital services should be provided, the standards they should meet and how they are funded are published in the GP IT Operating Model.

This section will be consolidated with data collected from ICBs and other published data sets to constitute the Digital Primary Care Maturity Assurance Model which aims to:

- Support ICBs in the management or re-procurement of GP IT service provision.
- Provide assurance that ICBs are meeting the requirements of the GP IT Operating Model in the effective delivery of GP IT services
- Demonstrate progress and identify areas for investment in GP IT services and digital innovation
- Support CQC assessment by providing insight into the use of digital technology within the practice, to help meet patient need and improve delivery of clinical services
- Demonstrate local progress against GP contract digital requirements

The questions asked in this section are based on published guidance, NHS policies (in which case links to relevant documentation is given) or on good practice and known transformational enablers not all of which will be relevant to all general practices and localities. Declaring No in this section does not mean the practice is non-compliant with their contract.

Responses to questions in this section will be shared within other modules of the primary care indicators website GPIT section www.primarycareindicators.nhs.uk and will be visible to all other users.

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[13] Regulations here refers Regulation 15 of the CQC (Registration) Regulations 2009
[14] Declaring Yes means a change has occurred and the practice has informed CQC.
[15] Declaring No means a change has occurred but the practice has not yet notified CQC.
[16] Declaring N/A means no changes have occurred

General Practice IT		
8D	Where the practice is a member of a PCN it is able to use its principal clinical system and its IT infrastructure to support shared working between practices in the following ways	Yes / No: 1. Clinical system (records) 2. Appointment booking and management 3. Integrated telephony systems across practices 4. Reporting on activity & coded clinical data 5. Morbidity Registers across aggregated (federation) populations 6. None or N/A
8F	Local acute trust discharge letters/summaries received by the practice electronically in the following ways: (Reference: NHS Standard provider contract Everyone Counts: Planning for Patients 2014/15 to 2018/19)	Yes / No: 1. The majority of local acute discharge summaries/letters are received electronically for out patients 2. The majority of local acute discharge summaries/letters are received electronically for in patients 3. The majority of local A&E discharge summaries are received electronically None or N/A
8H	Where there is legitimate access and consent the practice and other local health & social care providers are able to share electronic patient data by view access to records in the following ways: (Ref: NIB framework)	Yes / No: 1. Other local health providers can access practice records 2. Local social care providers can access practice records 3. Practice can access records from other local health providers 4. Practice can access records from local social care providers 5. None or N/A
8M	The practice has completely digitised all of its paper records (Lloyd George), and with the exception of the empty Lloyd George Envelope, paper records are no longer kept on site or in storage.	Yes/No
8N	If NO, the practice uses off-site storage for its paper patient records?	Yes/No
8O (r)	The practice makes all appointments which do not require triage available for booking online, as well as in person or via telephone?	Yes/No
8P	The practice can process directly booked appointments from NHS 111? *Guidance note: No applies for circumstances where the capability has not been enabled or is not in use.*	Yes/No

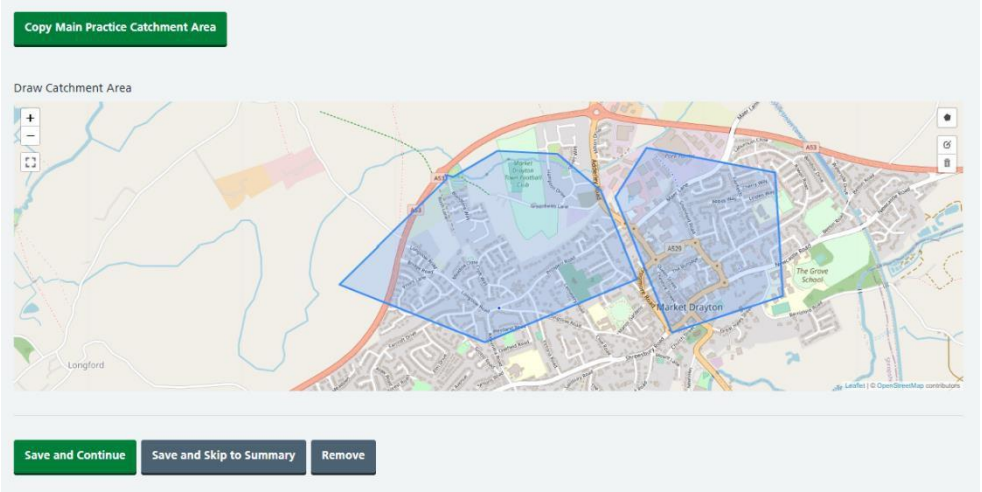
8R	The practice has facilities in place to enable remote working from home or settings outside the practice as part its business continuity plans and in response to Covid-19	Select all options that apply:
		NHS Provided laptops Personal computer (non-NHS) using virtual desktop (VDI) service
		Personal computer (non-NHS) with connection to the NHS network
		Personal Computer (non-NHS) using remote desktop protocol (a device in the surgery is kept switched on as a host)
		Other (not covered above)
		None of the above
8S	The practice has a telephony system that:	Tick all that apply
		Is based externally in the Cloud
		Integrates with the clinical system to make outgoing calls
		Can be accessed outside practice premises to make outgoing calls
		Has features which manage peak demands
		Currently it meets our practice needs
8T (r)	The practice has signed version 2 of the ICB Practice Agreement since 2019. (Securing Excellence in Primary Care (GP) Digital Services: The Primary Care (GP) Digital Services Operating Model 2019-21)	Yes/No
8U (n)	The practice has a commissioner approved business continuity plan that aligns with the requirements of "Securing Excellence in Primary Care (GP) Digital Services?" (the GPIT Operating Model)? (Reference: Securing Excellence in Primary Care (GP) Digital Services: The Primary Care (GP) Digital Services Operating Model 2021-23.)	Yes/No
8V (n)	The practice uses its clinical system to record social prescribing to support patient's health and wellbeing? (Guidance: - Long Term Plan and Investment and Evolution: A five year framework for GP contract reform to implement the NHS Long term Plan)	Yes/No

8W (n)	The practice website clearly signposts patients to: i) facility to request online consultation ii) facility to complete online patient registration iii) facility to order medication	Yes/No

Catchment Area

Inner catchment area (contract boundary)

This is a fictional area for demonstration purposes.



There are 3 tools in the top left corner of the map. Select the:

- plus sign to zoom in
- minus sign to zoom out
- focus square tool to view and edit in full screen mode, then to exit

There are 3 tools in the top right corner of the map. Select the:

- polygon tool (the first tool) to draw a new catchment area
- pencil tool to edit a current catchment area
- bin tool to delete a catchment area before drawing a new one

Select the tools in the top corners of the map to edit or draw the inner catchment area (contract boundary). Guidance steps are under the map.

To edit a current catchment area:

1. Select the pencil tool to edit the shape of the inner catchment area.
2. Click on 1 of your data entry points and continue to add more to complete the inner catchment area.

3. Use the zoom tools to get closer and draw more detail. To complete the shape, the last data entry point needs to finish on the first data entry point.
4. The inner catchment area is then presented on screen, with the content coloured in.
5. There should be no intersecting lines within your catchment area. If there are, draw a new catchment area or edit the current one.
6. When you have finished, tick to confirm your boundary accuracy, then either select "Save and continue" to continue your declaration, or select "Save and skip to summary".

To create a new catchment area

1. Select the polygon tool to draw the shape of the inner catchment area.
2. Move the map to the location of your practice and zoom out enough to see the practice area. If area is very large, draw a rough shape first and then zoom in to improve accuracy.
3. To start drawing your inner catchment area, click on the map to create the first point.
4. Use the zoom tools to get closer and draw more detail. To complete the shape, the last data entry point needs to finish on the first data entry point.
5. The inner catchment area is then presented on screen, with the content coloured in.
6. There should be no intersecting lines within your catchment area. If there are, draw a new catchment area or edit the current one.
7. When you have finished, tick to confirm your boundary accuracy, then either select "Save and continue" to continue your declaration, or select "Save and skip to summary".
8. Confirm boundary accuracy

☐ I confirm that this catchment area represents a reasonably accurate reflection of the GP practice's inner boundary held with the commissioner. I understand that I may be contacted by NHS Digital if there are issues with the accuracy of my catchment area when my data is used in the NHS website GP service finder.

Save and continue Save and skip to summary

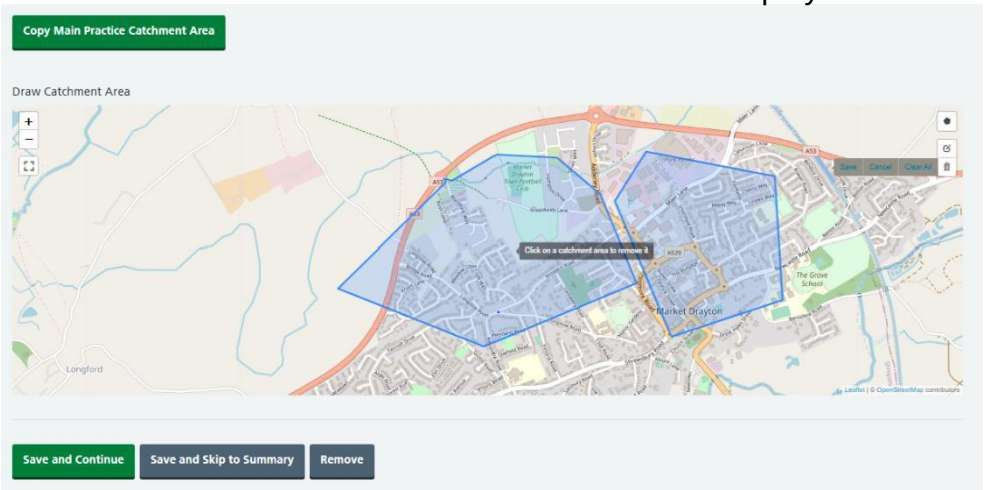
Catchment Area Changes for 2022

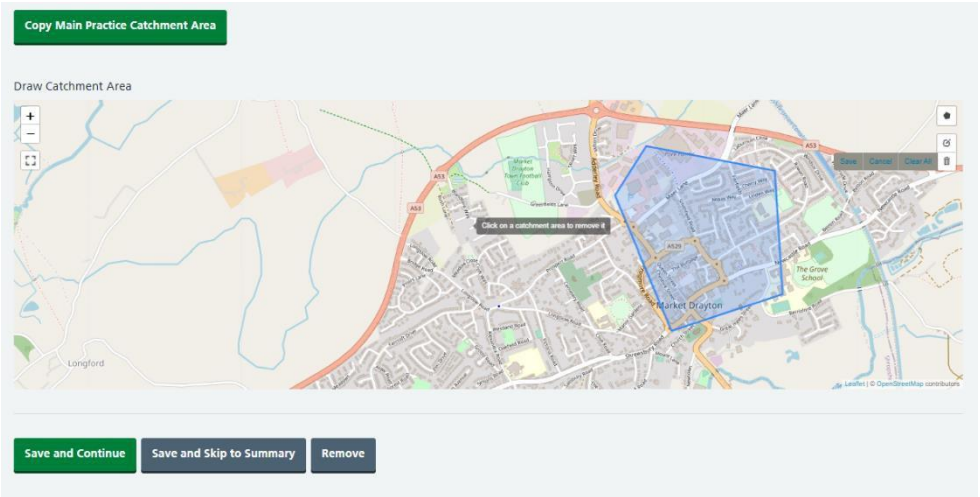
Changes to catchment area maps. In previous years you could draw catchment area maps for the main site and any branch sites on the same map. Now, you can split those out for the main and any branch sites.

Now, within a branch site section you can copy the shapes over from the main map and associate them with the selected branch sites. Use the map edit tools to select and remove the shapes you don't need – leaving only the maps for the branch site.

This is a fictional area for demonstration purposes.

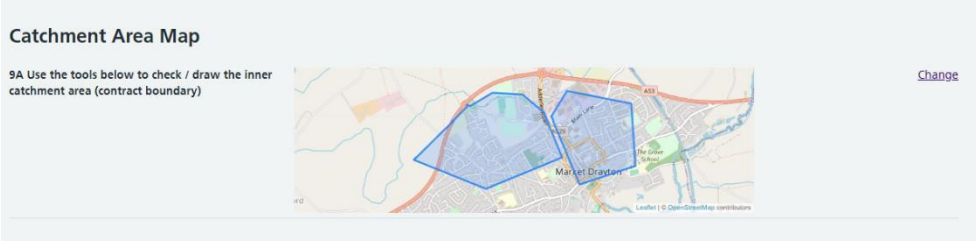
Use the ‘Delete a Catchment Area’ tool to select the shape you want to remove





When you save and continue and look at the submission summary page at the end of the form, remember to go and adjust the main map page to do the same to remove the branches.

Submission summary page:



Supporting Information

This information will be viewed by the commissioner when considering the Declaration submission.
You do not have to submit anything in the supporting information section - if you have answered all the mandatory questions, then no further information is required.
Practices are reminded that no personal information should be included in this section which would identify any patient, member of staff or third parties.
This section should not be used as a substitute for drawing a catchment area form from the previous section.
Practices experiencing any difficulty using the catchment area editor should contact the NHS Digital customer contact centre.
A separate free text section has been created for:

Supporting Information		
10a GP practice links to online presence is provided via the following routes [17]		
Link to practice website		
Link to practice Facebook page		
Link to alternative online presence page:		
Practice does not have an online presence:		
10C	Opening and closing times of branch practices (if different to main practice).[18]	
10D	Other Supporting information. This section allows you to submit information which may be relevant to your declaration. E.g. practice leaflet, copy of action plan, other information about branch practices.	Free Text
10E	To support an assessment of the time burden to practices on completing this data return. Please can you state how long has it taken the practice to complete the declaration?[19]	Enter time in minutes

The information is collected to support commissioners manage the contract, subsets of the data are shared with NHS.UK for use in the public domain, the entire content is shared with CQC, so practices do not have to share the same information twice prior to inspection, the content is also used for ministerial briefings and responding to FOIs.

- **NHS England**
- **CQC**
- **ICBs**
- **Local Regional Offices**

[17] Responses could be shared with public facing NHS websites e.g. NHS.UK.
[18] Ibid
[19] Response will be shared with NHS Digital Burden Advise Assessment Service.

Maps data is published online and shared with the NHS.UK team