AGENDA

Meeting Title	Primary Care Commissioning Committee – Part 1	**Date**	2nd June 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 23-06.28	Apologies for Absence	Dr Niti Pall	I	Verbal	9.30
PCCC 23-06.29	Declarations of Interest	Dr Niti Pall	S	Verbal	
PCCC 23-06.30	Minutes of the Meeting held on 3rd February 2023	Dr Niti Pall	A	Enc. No. 1	
PCCC 23-06.31	Actions Raised from Previous Meetings and Matters Arising	Dr Niti Pall	A & S	Enc. No. 1A	
	Items Requiring Decision/Ratification				
PCCC 23-06.32	Ratification of Approvals given by Committee since the last formal meeting	Emma Pyrah	R	Enc. No. 2	9.45
PCCC 23-06.33	Digital Update: • Digital Programme and Budget 2023/24 • System Digital Strategy development update	John Gladman/ Antony Armstrong Masood Ahmed	R	Enc. No. 3 Enc. No. 3A	9.50
PCCC 23-06.34	Hodnet Medical Practice – Request for Boundary Change	Berni Williams	A	Enc. No. 4	10.05
PCCC 23-06.35	Locally Commissioned Service (LCS) for Near Patient Testing for 'C reactive protein (CRP) – commissioning options paper	Janet Gittins Claire Stallard	A	Enc. No. 5 / Enc. No. 5A	10.20
	Standing Agenda Items				
PCCC 23-06.36	Finance Report • M12 22/23 Financial Position • 2023/24 Planning	Jill Price	A	Enc. No. 6 Enc. No. 6A	10.35
PCCC 23-06.37	Workforce Report • General Practice Nurse Strategy Operating Plan • GP Delivery Plan • GP Strategy • GPN Strategy	Sara Edwards	A	Enc. No. 7 Enc. No. 7A Enc. No. 7B Enc. No. 7C Enc. No. 7D	10.45
PCCC 23-06.38	GP Access: - • GP Access Improvement Plan – summary of national requirements and key next steps • GP Access Performance Report – March 23	Emma Pyrah Berni Williams	A A	Enc. No. 8 Enc. No. 8A	10.55
PCCC 23-06.39	Pharmacy, Optometry and Dentistry Report	Emma Pyrah	A	Enc. No. 9	11.10
PCCC 23-06.40	Risk Register (General Practice)	Emma Pyrah	A	Enc. No. 10	11.15

	For Information Items				
	Primary Care Team Work Programme Progress Report	Emma Pyrah	I	Enc. No. 11	
	Shrewsbury Health and Wellbeing Hub Progress update	Gareth Robinson	I	Enc. No. 12	
	Any Other Business	Niti Pall	I	Verbal	
	Date of Next Meeting: 4 August 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 3 February 2023 at 9.30 a.m.
Via Microsoft Teams

Present:	
Mrs Niti Pall	**Non-Executive Director (Chair)**
Mr Nick White	**Chief Medical Officer (Deputy Chair)**
Mr Gareth Robinson	**Executive Director of Delivery & Transformation**
Mrs Claire Skidmore	**Chief Finance Officer**
Mr Roger Dunshea	**Non-Executive Director**

Attendees:	
Ms Emma Pyrah	**Associate Director of Primary Care**
Dr Julian Povey	**Primary Care Partner Member**
Dr Ian Chan	**Primary Care Partner Member**
Mrs Angharad Jones	**Finance Business Partner**
Mr Tom Brettell	**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**
Ms Nicola Dymond	**Executive Director of Strategy & Integration**
Mrs Julie Garside	**Director of Planning & Performance**
Ms Claire Parker	**Director of Partnerships & Place**

Minute No. PCCC 23-02.01- Apologies for Absence

1.1 Apologies received were as noted above.

Minute No. PCCC 23-02.02 – 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)

Minute No. PCCC-23.02.03 – Minutes of Meeting held on 2 December 2022

3.1 The minutes of the meeting held on 2 December 2022 were approved as a true and accurate record of the meeting, provided the undernoted amendment is made: -

3.2 The job titles of Mrs Pall and Mr Dunshea to be amended. "Lay Member" to be replaced with "Non-Executive Director".

Minute No. PCCC-23.02.04 – Actions Raised from Previous Meetings and Matters Arising

4.1 The Action Tracker was reviewed and updated as appropriate. Mrs Pall questioned whether some actions had been omitted from the previous version and requested this be checked.

ACTION: Mrs Pyrah to review the current action tracker with the previous version to ensure all outstanding actions are included.

Minute No. PCCC-23.02.05 – Proposal to Change PCCC Agenda Structure

5.1 Mr White's report provided options as to how we move forward from being a Primary Care Commissioning Committee (PCCC) statutory function as a CCG to now, and particularly how statutory functions can be separated from reporting functions but also provide an opportunity for robust, forward thinking discussions about how Primary Care is developed going forward and also take into account that, from the start of the next financial year, it will include elements of pharmacy, optometry and dentistry.

5.2 The function of the Part 1 meeting will be core delegated functions.

The function of the Part 2 meeting will be for commercially sensitive items or risks which are not currently in the public domain e.g. CQC inspection outcomes not yet in the public domain

A separate meeting will be established for strategic discussions. This meeting will have a slightly different membership to PCCC in order to provide broader input. There are three options as to where this Committee could report :-

- A Primary Care Development Group which will feed into the System Strategy Committee.
- A Primary Care Development Group which will feed into the two Place Boards, TWiPP and SHiPP.
- Some form of meeting in common between the two Place Boards and the GP Board.

5.3 Mr White invited discussion, but advised that wider discussion would be required, particularly amongst the Executive Directors and Non-Executive Directors of the ICB.

5.4 Dr Povey and Dr Chan both agreed with the recommendations regarding the structure of the Part 1 and Part 2 meetings and the establishing of a separate strategic group.

5.5 With regard to creation of a Primary Care Development Group, Dr Povey believed that the decision as to where that Committee should report depended on the aim of that Committee.

He believed that members of the Primary Care Development Group should also be members of SHiPP, TWiPP and the GP Board. The Committee should report into the ICB Strategy Committee for ICB decisions, but SHiPP and TWiPP must be aware of discussions.

5.6 Mr Dunshea expressed a preference for Option 3 and suggested that the Primary Care Development Group should report to PCCC initially, although at a point in the future it may report elsewhere. Any proposed changes must have the support of the ICB Chair, Sir Neil McKay, and Cathy Riley, Managing Director, MPFT.

5.7 Dr Chan stated that the development of the GP Board must also be understood and suggested that Dr Pall should join a GP Board meeting.

Dr Pall confirmed that she would be pleased to attend such a meeting.

5.8 Mrs Skidmore acknowledged the merit in divorcing the statutory role from the strategy and development work. On that basis she disagreed with Mr Dunshea's comment that the new group should report into this Committee. It must be close to, or linked into, the Place proposition.

5.9 Mr Robinson believed that our strategy going forward must be driven not at Place level but at Primary Care Network level. He viewed this as being part of a Place discussion, but there is a question mark over whether the Place Boards report into the right place.

5.10 Dr Pall summarised discussions as follows:-

- The Committee agreed that the contractual aspect should be separated. However, the contractual aspect also included enhanced services.
- GP access may be considered differently in light of discussions in this Committee.

In her opinion, Mr Dunshea's view was the correct one for the time being although the Primary Care Development Group may report elsewhere going forward. For the moment, the membership of that group needs to be different to the membership of PCCC.

5.11 Dr Chan observed that there was no input at all from General Practice into the major piece of five year planning.

That was also a concern of Dr Pall's and was the reason why she wished to have the new Committee either report to the Strategy Committee or report into a forum that also has a commissioning voice.

5.12 As a result of these discussions, Dr Pall suggested that a Primary Care Development Group should be established that reports to PCCC for the time being with a view to moving it to where it suitably sits in the new structures. She had already discussed the proposed changes to the Committee structure with Sir Neil McKay who wished to hear the arguments for and against. She believed he would be supportive of this Committee's proposals, provided they are flexible to meet future requirements.

5.13 Mr White stated that if a Primary Care Development Group was established which was temporarily hosted by this Committee but with a view to moving it elsewhere as and when the Integrated Care System develops, a relatively short but broad Terms of Reference would be required to identify the correct membership and make recommendations to the ICB.

ACTION: Mr White and Ms Pyrah to implement the recommendations regarding establishment of a Primary Care Development Group, identifying membership of that Committee, and preparing Terms of Reference.

Minute No. PCCC-23.02.06 – Albrighton Medical Practice – Application to Reduce Practice Boundary

6.1 Ms Val Eastup, Practice Manager, Albrighton Medical Practice, was in attendance for this item.

6.2 An application had been received from Albrighton Medical Practice to reduce the Practice boundary which currently falls within Staffordshire. The request was made because of a housing development of approximately 500 houses in Staffordshire. The housing development is in South Staffordshire therefore the Practice feel that the health care of residents should be covered by a South Staffordshire Practice rather than a Shropshire Practice. This would not impact Shropshire patients but would impact Staffordshire patients.

6.3 Mrs Williams had engaged with ICB colleagues in Staffordshire to try to establish a joint plan or to reach agreement that the Practices in Staffordshire should increase their boundaries, but they have not been willing to discuss the situation or co-operate. The difficult decision has therefore been taken to support our own Practice.

6.4 Dr Povey did not agree with this proposal as the ICB ultimately provides health care for people who register with our Practices. The Council commissions social care for people within the County boundaries. That has always been the difference between social care and health care. The ICB provides health care for people who register in the Practice areas rather than the Council boundaries. He could not support a reduction of Practice area where there is no other Practice covering that area and did not believe that this situation could be progressed without reaching an arrangement with the neighbouring ICB as to who will provide the cover.

6.5 Mr Dunshea believed that responsibility lies with Staffordshire ICB and their Primary Care commissioning element to discuss this case with us.

6.6 Discussion took place regarding the scale of the development, the location of which could mean that the area becomes a development "belt". The flow of people for health care services will be to Perton. It makes very little practical sense for those people who are living there to seek health services in Albrighton.

6.7 Colleagues in Staffordshire appear to have been unsighted on plans for the housing development and neither of the Perton Practices appear to have been approached at any time regarding the proposed development. It was suggested that an Executive level conversation should take place with colleagues in Staffordshire.

6.8 Dr Chan agreed with the views of Dr Povey. However, local Practices must be protected otherwise there may be long term implications in terms of staffing.

It is not feasible to shrink Practice boundaries every time a new housing development is built. Consideration must be given to co-planning in the future.

6.9 Mrs Williams intimated that she had received emails from two Practices about reducing their boundary and believed that there may be more such requests in future.

6.10 Dr Pall summarised:-

- Executive level discussion must take place with our counterparts to make sure that patients are not compromised.
- Consultation must take place with our Community teams where District Nurses and Health Visitors would also be required to provide care.

ACTION: Mr Robinson to speak to his counterpart in South Staffordshire to find a mutually acceptable solution to the issues around Albrighton Practice Boundary.

ACTION: Mrs Williams to ensure that Shropcom and the Council are aware of the potential implications for District Nurses and Health Visitors.

<u>Minute No. PCCC-23.02.07 – 2022/23 Month 9 Primary Care Financial Position</u>

7.1 Ms Jones' report was taken as read and she invited questions.

7.2 Mr Dunshea requested a separate meeting with Ms Jones regarding audit trails around the contents of the report.

ACTION: Mr Dunshea and Ms Jones to liaise regarding audit trails around the contents of the monthly Finance reports.

7.3 Mr Dunshea referred to a request made at a previous meeting for performance activity data to be supplied in parallel with the report and asked how soon that might be available.

7.4 Ms Jones advised that the information requested will be included in the report submitted to the March Committee. It was not possible to action the request for today's meeting.

ACTION: Ms Jones to liaise with Dr Garside and the BI team to establish who the nominated lead will be to provide the requested data information going forward.

7.5 Mr White said that the performance data aspect was discussed at the ICB Board meeting as a result of a request from the Council Leaders and Council CEO's as to how it can be presented at ICB Board level in a way which is easily understood. He requested that the information relating to GP access should be highlighted and the page number made clear to allow him to refer Committee members to a specific page within the accompanying appendix.

ACTION: Mr Robinson to pick up with Dr Garside and the BI team the Council's request for changes to the way in which GP access information is presented in ICB Board papers.

7.6 Dr Pall requested information regarding issues in year-to-date performance and the projections.

7.7 Ms Jones advised that there was an underlying underspend but no issues in terms of this year. The underspend is non-recurrent.

7.8 Planning had started for 2023/24 and it appears that there is slippage within the allocation. However, that is based upon assumptions until the contract data becomes available. At the present time it does not look as if there are any risks for next year.

7.9 Dr Pall believed that if the underspend is non-recurrent then it should be used for Primary Care this year.

Mrs Skidmore clarified that the underspend figure is part of the forecast out-turn for the totality of the organisation therefore it is assumed that the forecast underspend remains until the end of the year. Spend cannot be implemented now as it will deteriorate the finance position.

7.10 Dr Povey referred to the non-delegated budget and the enhanced services and asked how much is incorporated into the plans for the next year to increase the amount of money in enhanced services.

7.11 Mrs Skidmore confirmed the planning process, advising that budgets are re-set to look at QOF achievement, enhanced services, etc. Any redesign of services would be reflected in the budget setting process.

7.12 Ms Pyrah advised the Committee of work that the Primary Care team had undertaken over the last 12 months around reviewing locally commissioned services. However, because the unit price is not believed to be value for money for the Practices, not all Practices will sign up to every LCS.

Mrs Pall left the meeting for a short time and asked Mr Dunshea to act as Chair in her absence.

Minute No. PCCC-23.02.08 – Workforce Report

8.1 Ms Pyrah spoke to this paper in the absence of Ms Edwards and Mr Morgan. The report was taken as read and she invited questions.

8.2 Mr Dunshea referred to learning and development for Primary Care and asked whether the ICB had a strategy in place or whether it was the responsibility of each Practice.

8.3 Ms Pyrah replied that there is no over-arching learning and development strategy in place. However, the Training Hub would create a work programme based on a needs assessment to meet the needs of the wider Practice population.

8.4 Mrs Sullivan advised that Mr Morgan had developed a GP Workforce Strategy in conjunction with local GPs.

In conjunction with local Practice Nurses, Mrs Sullivan had created a GPN Workforce Strategy.

Work is being carried out on an over-arching Workforce & Training Hub Strategy and consideration is being given as to how this can be fed into the over-arching People Strategy for STW ICB.

8.5 Mr Dunshea suggested that this should be a future Agenda item.

ACTION: As requested by Mr Dunshea, Workforce Strategies to be a future Agenda item.

Mrs Pall re-joined the meeting.

Minute No. PCCC-23.02.09 – Performance and GP Access Improvement Plan

9.1 Ms Pyrah highlighted key points of her report.

- Primary Care is over-performing in terms of the number of appointments now compared to before the pandemic. 7 out of 10 of those appointments are face-to-face.
- The proportion of GP face-to-face appointments now compared to before the pandemic is almost the same.
- There has been a massive step-change in remote access.
- Not all Practices have restored to pre-pandemic levels and the Primary Care team are working on an improvement plan with those Practices.

9.2 Mrs Barrett, Healthwatch Shropshire, referred to the fact that STW ICB is currently recording some of the lowest usage rates for online consultations.

Healthwatch Shropshire had received feedback from patients about their Pay As You Go mobiles and mobile batteries running out before they can get through to speak to a specific person or a department, adding to the number of patients who give up trying. She asked whether the Practice data being captured includes calls where patients hang up before being able to get through. This is an important issue for patients - particularly cancer patients - who are not getting the call-backs.

9.3 Ms Pyrah advised that the ICB does not currently have access to telephone data as that sits within the telephone system of the Practice therefore abandonment rates are not available to the Primary Care team. That information would need to be requested from each individual Practice.

9.4 Dr Pall was hearing from practitioners nationwide that patients are still experiencing issues with access to practitioners. If we cannot obtain the information from Practices then we need to ask patients via surveys, etc.

9.5 Mr Dunshea still questioned why GP Practices cannot report abandonment rates – which are a key quality factor - to the ICB.

He also found it surprising that emailing into Practices or online booking systems are still not available. A strategy is required to address modernising the ways in which patients can contact GPs.

9.6 Mr White referred to feedback from the November Board meeting. The data presented to that meeting was high quality and we must ensure that some of that is included in the Board papers as it will go some way to answering the questions.

9.7 Mr Robinson agreed with Dr Pall's point regarding a potential survey which would provide a balanced view and provide a basis for resolving the issues going forward.

9.8 Dr Chan referred to the report and the term 'performance improvement' and 'access improvement plan'.

His Practice had tried on-line bookable appointments, allowing patients to make contact by email, and on-line appointments, none of which proved to be a satisfactory solution.

GPs are now seeing patients who would historically have been referred to secondary care, but because of long out-patient waiting times they return to the GP for the same reason because they have a medical need, which has a considerable knock-on effect on GP capacity. These issues are larger, structural issues that have a national context, the impact of which is reflected in GP access.

9.9 Dr Pall agreed, stating that this is not merely about GP access but about matching access, capacity and unmet need. She believed that this issue should come back to a future Committee for structured consideration, possibly as an item for our Transformation Committee to establish how it can be resolved.

9.10 Dr Povey believed that the issue related to controlling demand as opposed to controlling capacity because of staff shortages within the system.

He then referred to the discussion around telephone data and stated that there is no contractual obligation to provide telephone data.

He highlighted an error on page 7 of the report which referred to Practices having free calls. The Practices do not offer free, inclusive calls. They offer local rate calls. Practices would be happy to share the data but most of them do not have the data to share as the telephone systems do not have that functionality.

9.11 Dr Povey referred to on-line access, stating that in the current GP contract there is a contractual obligation for all pre-bookable appointments to be offered on-line for booking and suggested that the Primary Care team may wish to investigate the percentage uptake of pre-bookable appointments.

9.12 Ms Pyrah referred to the national GP survey, the results of which confirmed that access was one of the key issues. The survey is currently being repeated, therefore if another survey was conducted, we would have to be very clear what questions – in addition to that survey– patients are being asked to answer.

9.13 Dr Pall requested that the GP Practice survey should be repeated in view of Mrs Barrett's feedback and brought back to a future Committee.

9.14 Discussion took place and the Committee agreed that we would need to understand what added value a local survey would have over the national survey which is currently live before a decision is made.

9.15 Mr Robinson believed that today's discussion had been extremely useful and would contribute to the Primary Care access programme of work being submitted to PCCC in April.

He believed that part of the solution to the issues was demand management. The system must be reviewed, and solutions found in order to reduce the demand.

9.16 Dr Pall wished to place population health management on the list of priorities because patients with increasing complexities are being seen in General Practice. This issue is not just a General Practice problem, but is also a Community Services problem, a social care problem, and must be addressed.

ACTION: Mr Robinson and Ms Pyrah to liaise with Ms Parker to make sure the Primary Care access programme reflects discussions at PCCC and have a way forward by April.

Mr Robinson left the meeting at 11.00 a.m. due to a diary clash with another meeting.

Minute No. PCCC-23.02.10 – Risk Register

10.1 Ms Pyrah's summary identified the key changes to the Register. It highlighted risks that had been closed together with reasons for doing so and identified a new risk that had been added.

10.2 The item was for information.

10.3 There were no questions from Committee members.

Minute No. PCCC-23.02.11 – Primary Care Team Work Programme Progress Report

11.1 Ms Pyrah intimated that the Primary Care Team's report provided an overview of the programme of work currently being worked upon.

11.2 The report was provided for information.

Minute No. PCCC-23.02.12 – Delegation of Pharmacy, Optometry and Dentistry

12.1 Ms Pyrah stated that whilst the functions would be delegated from 1st April 2023, a phased approach to transition is being adopted and therefore the key implications at ICB level will not come into play until July. t

12.2

12.3 Both pharmacy and dental contracts are very strictly negotiated at national level and it is still not clear what the ICB's level of influence over that will be in the future.

12.4 One area we know there may be an issue is funding. The Committee's view on the type of reporting they would like to see in relation to pharmacy, optometry and dentistry would be welcomed.

12.5 Dr Chan referred to anticipatory care which he understood was no longer nationally mandated and therefore had no associated funding.

Mr Dunshea advised that the ICB were including anticipatory care in development of the strategy. He also asked how we as a committee would engage with the professions in pharmacy, optometry etc. going forward.

12.6 Dr Pall replied that there is a considerable amount of evidence that anticipatory care works well. She referred to Mr Dunshea's question and expressed her concern as to reference made in the national plan that states how many more Primary Care appointments will go into pharmacy and queried the capacity of pharmacists to deal with them.

Mr Dunshea asked whether the ICB had a Chief Pharmacist who advised the Board about pharmacy matters. Mr White advised that national guidance stipulated that each system must have a Chief Pharmacist. Funding has been obtained for one year for a secondment of System Chief Pharmacist and we are now able to advertise that role.

12.7 Mr Dunshea suggested that anticipatory care should be discussed in the forthcoming Board Development session on 22 February 2023.

12.8 Dr Povey referred to the POD team and the approach taken by NHS England to the delegation of POD as opposed to Primary Care commissioning for General Practice which had been delegated to individual CCGs and now ICBs. He queried whether the information was expected to come to this Committee or whether it would take the form of an ICB Board update from delegated committees.

ACTION: Ms Pyrah to liaise with Tracey Jones as to how reporting will be carried out regarding POD.

Minute No. PCCC-23.02.13 – Shrewsbury Health & Wellbeing Hub Development

13.1 Dr Pall was conflicted for this item and stepped down as Chair as she had contributed to the clinical KPIs at national level. She asked Mr Dunshea to chair the meeting during discussion of this item.

13.2 Mr Robinson was still absent from the Part 1 meeting therefore could not speak to his paper.

Mr White suggested that this item should either be transferred to the Part 2 meeting, or the discussion should be with-held in Mr Robinson's absence.

13.3 The Committee agreed this course of action.

Minute No. PCCC-23.02.14 – 2022-23 Practice e-Declaration Summary

14.1 Mrs Williams' paper was taken as read and she invited questions.

14.2 Dr Povey observed that the report did not provide information regarding the responses from the Practices, other than for the four areas of anomalies.

14.3 Mrs Williams advised that the declaration is already pre-populated from the previous year. She could provide more information if necessary.

14.4 The noted the contents of Mrs Williams' report.

Minute No. PCCC-23-02.15 Any Other Business

15.1 ***Healthwatch Shropshire***
Mrs Barrett intimated that she had placed a link in the Chat Box to HealthWatch Shropshire's recent report regarding calling for an emergency ambulance. It was not directly related to Primary Care but focused on people's experiences and the impact upon them of the very well publicised delays in responding to 999 calls. It was a difficult read but she was sure that colleagues would find it useful to assist with tackling the situation.

15.2 ***Restructured and Reformatted Agenda***
Mr White requested feedback by email regarding the restructured Agenda.

Minute No. PCCC-23-02.16 Date of Next Meeting
The next Primary Care Commissioning Committee will take place on Friday 31 March 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.)

The meeting closed at 11.10 a.m.

Shropshire Telford and Wrekin ICB Primary Care Committee Action Tracker
Part 1 Meeting – 2 June 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. **March 2023 update**: Mrs Williams is waiting for further information from GMAST colleagues in relation to the GMS regulations and if there is still a requirement for commissioners to offer an out of area service. **June 2023 update:** whilst commissioners may not be mandated to have an ES OOA scheme in place, they are responsible to ensure there are arrangements in place for those patients who register as out-of-area patient without home visits. Therefore, the obligation to arrange primary medical services sits with the commissioner.
PCCC-22.10.21 Implementation Plans – Enhanced Access from 1 October 2022	Mrs Williams to investigate solutions to the issues around digital including costs and information as to how this enhanced service will help towards the virtual ward and update a future Committee.	Mrs Williams	December 2022 meeting	**December Update:** Issues around digital are ongoing. Our digital solution does not fully support the requirements in the DES. An example is online booking should be made available, but the digital solution does not support that for enhanced access. NHSE are aware and are linking with the digital

				supplier which for NHS STW is EMIS. The capability is not available to enable a patient to book online through the new clinical services hub. The supplier is working on the issue. NHSE colleagues have regular meetings with the supplier and are pressing them for a solution. **March 2023 update:** NHS E continue to work with system suppliers on the capability issues. **June 2023 update:** As above, there are no further updates.
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. **March update:** given the agreement to only deal with delegated function matters in PCCC, this action to be transferred to the proposed Primary Care Development Group when established.
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. **March update:** As December **June update:** No change. Propose closing the item.

PCCC-22.10.26 **Finance Update**	Mrs Skidmore and Ms Jones to discuss with the Performance team inclusion of performance data in the Finance report. Mrs Pall and Ms Jones to discuss Primary Care financial reporting outside of this Committee and the format and content of financial updates going forward.	Mrs Skidmore / Ms Jones Mrs Pall / Ms Jones	December 2022 meeting December 2022 meeting	**December Update:** Mrs Pall and Ms Jones will discuss the format and content of the Finance report going forward. Not yet actioned due to Mrs Pall's absence abroad. **February Update:** Meeting held; changes will be introduced from the next meeting report.
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.	Mr P Morgan	Future meeting – June 2023	**March update:** Verbal update on progress as part of March Workforce and Training Hub report with analysis of survey, key themes and proposed actions planned for June PCCC meeting in the form of a full report. **June Update:** The survey was completed in late April 2023 with a summary of the findings presented to a workshop on May 9th. A working group is being established to draft an action plan to address the issues raised in the survey. A full report on the findings, along with the action plan, will be presented at a future PCCC meeting.
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		**March update:** Meeting with EP and RD on 24th March. IC and NP unable to attend due to diary availability. **June update:** EP and RD met on 24.3.23 – item to be closed.
PCCC-23.02.05 Proposal to Change PCCC Agenda Structure	Mr White and Ms Pyrah to implement the recommendations regarding establishment of a Primary Care Transformation Committee, identifying membership of that Committee and preparing Terms of Reference.	Mr White / Ms Pyrah	March 2023 meeting	**March update:** Currently under development particularly around wider, inclusive membership
PCCC-23.02.06 Albrighton Medical Practice – Application to Reduce Practice Boundary	Mr Robinson to speak to his counterpart in South Staffordshire to try and find a mutually acceptable solution Make Shropcom and Public Health aware of possible implications for cross border	Mr Robinson Mr Brettell	March 2023 Meeting March 2023 meeting	

	working for District Nurses and Health Visitors.			
PCCC-23.02.07 2022/23 Month 9 Primary Care Financial Position	Mr Dunshea and Ms Jones to liaise regarding audit trails around the contents of the monthly Finance reports. Ms Jones to liaise with Dr Garside and the BI team to establish who the nominated lead will be to provide the data information going forward. Mr Robinson to pick up the Council's request for information in ICB Board papers relating to GP access that is easier to understand with Dr Garside and the BI team.	Mr Dunshea / Ms Jones Ms Jones Mr Robinson	March 2023 Meeting March 2023 Meeting March 2023 meeting	**March update:** AJ, BW and CL met with RD and went through information/finance etc and BW followed this up with an email to RD with some website links that explain GP payments etc. JG suggested meeting with CL as there is no identified Primary Care Performance Lead within her team. AJ with CL to go through what is available in terms of the data they hold and is aiming to add some performance data within the finance report for March report.
PCCC-23.02.08 Workforce Report	As requested by Mr Dunshea, workforce strategies to be a future Agenda item.	Sara Edwards/Phil Morgan	March 2023 meeting	**March update:** Relevant Strategies included in Workforce and Training Hub report with progress update against key deliverables. **June Update:** The GP Strategy is due to be reviewed in the summer of 2023. The timing of the review has been informed by the recent establishment of a team of seven "GP Leads" who will be working with the PC Team Workforce Lead to review the GP Strategy.
PCCC-23.02.09 Performance and GP Access Improvement Plan	Determine what added value a local GP Practice Survey would provide in terms of patient experience of accessing their practice compared to the currently running national GP patient satisfaction survey Mr Robinson and Ms Pyrah to liaise with Ms Parker to make sure the Primary Care access programme reflects discussions at PCCC and have a way forward by April.	Ms Pyrah Mr Robinson / Ms Pyrah	March 2023 Meeting March 2023 meeting	**March update:** Insufficient capacity in the team to run a separate survey in addition to the already running national survey. **March update:** Completion of an ICB GP access improvement plan is now delayed following the publication on 7th March 2023 by NHSE of a letter setting out the key changes to the GP contract and PCN

				contract for 23/24 which includes a major refocus to and repurposing of incentive funding to support improving patient access and experience. More time is required to digest the contents of the letter and develop plans in response with PCNs. The dialogue with PCNs started at PCN Development meeting on 9.3.23. National GP Recovery Plan requirements to be published by the end of March 23. **June update:** GP Access Recovery Improvement Plans primary aim is to improve GP access and patient experience, PCNs to submit by 30th June – proposed close this item
PCCC-23.02.12 Delegation of Pharmacy, Optometry and Dentistry	Ms Pyrah to liaise with Tracey Jones as to how reporting will be carried out regarding POD.	Ms Pyrah	March 2023 meeting	**March update:** It is still not clear how the soon to be introduced regional governance structure with 3 tiers including a Joint Board will work in practice and therefore what the consequent role and function and reporting requirements to PCCC will need to be. It is assumed that the answer will emerge over the coming months as the governance structure is enacted. **June update:** 3 tiers of regional governance now in the early days of operation. Links with the hosted team being established. Need to review the role of the committee in POD to ensure that the delegation is not just a tick box exercise and local needs are known and prioritised as well as opportunities for integration harnessed

CLOSED ITEMS

Agenda Item	Action Required	By Whom	By When	Date Completed
PCCC 22-07.08 Primary Care Appointments: Report to Governing Body June 2022	Ms Parker to lead a discussion offline as to how to improve communication, understand, and monitor for signs of improvement, the challenges and issues around GP access and discuss with Primary Care colleagues.	Ms Parker	October 2022 meeting	**December**
PCCC-22.10.20 Shrewsbury Health & Wellbeing Hub – Progress Update	Edna Boampong to provide Committee members with detailed assurance of a communication strategy and timeline for future communication regarding the Cavell Centre project as a matter of urgency.	Edna Boampong	As soon as possible	**December**
PCCC-22.10.22 PCN Development Workshop – 31 October 2022	Mr Morgan to provide the next Committee with an update as to benefits and key learning points of the PCN Development Day to assist with evaluation of the benefits and information as to how this will be communicated through the PCNs.	Mr Morgan	December 2022 meeting	**December**

PCCC-22.10.25 **Risk Register**	Risks around ARRS and GP numbers to be reflected in the Risk Register. Higher risk for GP numbers, lower risk for ARRS.	Ms Pyrah	December 2022 meeting	**December**
PCCC-22.10.26 **Finance Update**	Mrs Skidmore and Ms Jones to discuss with the Performance team inclusion of performance data in the Finance report. Mrs Pall and Ms Jones to discuss Primary Care financial reporting outside of this Committee and the format and content of financial updates going forward.	Mrs Skidmore / Ms Jones Mrs Pall / Ms Jones	December 2022 meeting December 2022 meeting	**February**
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**
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**

Primary Care Commissioning Committee

<table>
<tr><td colspan="3">Agenda item no.</td><td colspan="7">PCCC 23-06.32</td></tr>
<tr><td colspan="3">Meeting date:</td><td colspan="7">2nd June 2023</td></tr>
<tr><td colspan="3">Paper title</td><td colspan="7">Ratification of Decisions Taken by the Voting Members of the Committee since the last meeting</td></tr>
<tr><td colspan="3">Paper presented by:</td><td colspan="7">Emma Pyrah</td></tr>
<tr><td colspan="3">Paper approved by:</td><td colspan="7">Gareth Robinson</td></tr>
<tr><td colspan="3">Paper prepared by:</td><td colspan="7">Emma Pyrah</td></tr>
<tr><td colspan="3">Signature:</td><td colspan="7">EPyrah</td></tr>
<tr><td colspan="3">Committee/Advisory Group paper previously presented:</td><td colspan="7">N/A</td></tr>
<tr><td colspan="10">Action Required (please select):</td></tr>
<tr><td>A=Approval</td><td></td><td>R=Ratification</td><td></td><td>S=Assurance</td><td></td><td>D=Discussion</td><td></td><td>I=Information</td><td>x</td></tr>
<tr><td colspan="3">Previous considerations:</td><td colspan="7">N/A – this is a monthly update report from the Primary Care team</td></tr>
</table>

1. Executive summary and points for discussion

There have been a number of occasions where urgent decisions have been required of PCCC which have had to be taken outside of a formal committee meeting. This is because the urgency of the decision could not wait until the scheduled meeting and the meeting scheduled in March being cancelled.

The purpose of this report is to ensure for the purposes of the minutes that these decisions are formally ratified and recorded.

1. 3-month caretaking contract award for Dr Allen, Highley Medical Practice
2. Contract award of Highley Medical Practice to Bridgnorth Medical Practice following a formal procurement exercise.
3. In principle approval to top slice £150,000 of the Primary Care BAU capital budget as the ICB's contribution to the necessary funding to reconfigure part of the Severn Centre, Highley to accommodate Highley Medical Practice (subject to a viable business case being produced).
4. Revenue rental funding to support Shrewsbury PCN to increase their estate to accommodate ARRS staff – Ground Floor, Morgan Place, Shrewsbury Business

Park, top floor of the Tannery Building, Town Centre. Approval for Tannery Building comes with the caveat that this is only progressed once all options for space in the Severnfields building have been exhausted.

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:

Ratify the approvals above for the purposes of the committee minutes.

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

5. Appendices

N/A

6. 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	
Citizen and Stakeholder Engagement	

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

Primary Care Commissioning Committee – 2 June 2023

Agenda item no.	PCCC 23-06.33
Meeting date:	2 June 2023
Paper title	Primary Care Digital Plan 23/24 Report
Paper presented by:	John Gladman, Digital Strategic Advisor
Paper approved by:	Nick White, Chief Medical Officer and ICB Digital Exec Lead
Paper prepared by:	Antony Armstrong Primary Care IT & Digital Manager John Gladman IT & Digital Strategic IT Advisor
Signature:	
Committee/Advisory Group paper previously presented:	First presentation

Action Required (please select):

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

Previous considerations:	None

1. Executive summary and points for discussion

The purpose of the report is to provide Committee with details of the Primary Care Digital Plan for 23/24 including the funding available and the associated expenditure plan. It also includes a high-level summary of current digital related risks and opportunities.

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	
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	x

2. Recommendation(s)

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

The Committee are recommended to note the Digital Plan and Expenditure for 23/24 set out in 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

1. Our ICB strategy “Delivering Digital Evolution – Our digital & IT strategy 2020 – 2025”.

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	Maintaining modern, supported and cyber secure IT & digital information systems is essential for minimising digital Data Protection risks
Transformation and Innovation	Investment in modern, supported and cyber secure IT & digital information systems is a key enabler for Primary Care path 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:			

Meeting:	
Meeting date:	
Agenda item no.	
Paper title	

Report to Primary Care Commissioning Committee – 2 June 2023

Primary Care Digital Plan and Expenditure 2023/24

1. Our Primary Care IT & Digital Estate

1.1 The ICB is required to commission IT and digital equipment, software and services for its GP Practices in accordance with NHSE prescribed national standards. The ICB mainly commissions these services from the Midlands and Lancashire Commissioning Support Unit (MLCSU) and Redcentric.

1.2 The Primary Care IT & Digital Estate has grown rapidly over the past few years resulting from the increased use of IT and digital enabled working during the COVID pandemic and the increased number of PCN and ARRS roles.

1.3 The latest Primary Care IT & Digital Estate volumes are as follows:

Item	Quantity
Users	2240
PC's	1826
Laptops	322
Printers	1351
Monitors	2500
Servers	52
Network Sites	71

2. Budget 23/24 and sources of funding which make up that total budget.

2.1 The 23/24 Primary Care IT and digital budget comprises £2.652m of revenue budget and £568k of capital budget.

2.2 The revenue budget of £2.652m is funded by £2.2m of ICB core revenue budget and £452k of NHSE Digital First Primary Care funding (NHSE has now incorporated DFPC funding into the System Development Fund SDF).

2.3 The capital budget of £568k is funding by the ICB core capital budget.

2.4 In addition, the ICB receives a ring-fenced allocation of £887k (22/23 figure) from the GP IT Futures Fund to procure some (but not all) Primary Care software licences on behalf of practices.

2.5 Finally, there may be adhoc opportunities during each year to bid for additional revenue and capital funding from NHSE which is ring-fenced for specific purposes and projects, however, this “windfall” funding is one-off and not guaranteed. In 2022/23 the ICB successfully bid for NHSE winter support package monies of £200k for replacement IT hardware/equipment for example.

3. Proposed plan for spend/key priorities in 23/24

3.1 Our current spend/key priorities are set using: -

- “Delivering Digital Evolution – Our digital & IT strategy 2020 – 2025” (Appendix 1)

- NHS England's "Securing Excellence in Primary Care (GP) Digital Services - The Primary Care (GP) Digital Services Operating Model 2021-2023" https://www.england.nhs.uk/wp-content/uploads/2022/07/the-primary-care-gp-digital-services-operating-model-21-23.pdf

3.2 Our strategy "Delivering Digital Evolution – Our digital & IT strategy 2020 – 2025" Digital First in Primary Care has 4-key priorities: -

3.2.1 Digital as Standard: reducing reliance on paper.

There are three key areas we are focussing on including (italics means successfully delivered or projects in-flight): -

a. Digitisation of patients notes; we have a programme (in line with national recommendations) to digitise the Lloyd George Envelope (introduced in 1911 when the eponymous politician introduced the National Health Insurance scheme) – *phase 1 is now underway involving 8 practices.* Awaiting notification of further phases by NHSE.

b. Making our practices paper "free"; this also facilitates a move to 'best place working' instead of being allocated to a specific building, floor, room and desk – *rollout of new Virtual Desktop Infrastructure (VDI) service to allow practice staff to securely work anywhere including from home, rollout of new Speechwrite 360 digital dictation software, rollout of new Docman Share to practices and PCN's, increased rollout of On-Line Consultation (OC) and Video Consultation (VC) systems, increased rollout of SMS text messages to patients for appointments etc, practice website reviews.*

c. Embedding MS Teams and other tools to enable better communication, sharing and collaboration using digital technology rather than passing pieces of paper around – *rollout out of Microsoft 365 Applications for Enterprise.* Planned rollout of NHS Microsoft 365 One Drive for practice home drives and MS Teams/SharePoint for practice shared drives.

3.2.2 Assuring cyber and data integrity

a. Compliance with NHS Data Digital Security and Protection Toolkit.

b. Secure practice Zeus Network: rollout of a fully managed and supported Microsoft Domain to replace individual EMIS practice Workgroup Servers.

c. Planned migration of practice staff home drive data to secure NHS Microsoft 365 One Drive.

d. Planned migration of practice shared drive data to secure NHS Microsoft Teams/SharePoint.

e. Planned migration from Microsoft Windows 10 to Microsoft Windows 11.

3.2.3 Resilience through refresh

a. *Moving towards planned upgrade of old and out-of-support practice desktop IT equipment every 4-years.*

b. *Upgrade of practices data communications*

c. *Design technical IT & digital resilience into new practice buildings*

d. *Planned upgrade of practice data communications cabinets and network switches*

e. *Planned upgrade of all IT infrastructure to ensure fully supported and not end-of-life.*

3.2.4 Best place and collaborative working

a. *Rollout of secure Virtual Desktop Infrastructure (VDI) to support remote working during the COVID pandemic.*

b. *Increase the number of laptops rolled out to practices to enable remote working.*

c. *Rollout of secure Virtual Private Network (VPN) onto practice laptops to enable secure remote working.*

d. *Planned rollout of GovWifi in practices*

4. Revenue Budget Spend

4.1 The main items for Revenue budget spend are as follows: -

Activity / Project / Improvement	Revenue £k	DFPC £k
Primary Care Base Revenue IT Costs (Includes MLCSU IT & Digital SLA £953k, Redcentric £329k, Practice Software £323k, Microsoft Licences £205k, Practice SMS Text Messages £180k, Virtual Desktop Infrastructure VDI £159k, Online Consultation OC £160k, Video Consultation VC £76k, AccuRX Plus £87k)	£2,498	
Redcentric Network Cost Savings	-£23	
VDI Cost Saving	-£49	
Transfer OC costs from Revenue budget to DFPC	-£160	£160
Transfer VC costs from Revenue budget to DFPC	-£76	£76
Transfer AccuRX Plus 2-Way Messaging from Revenue budget to DFPC	-£87	£87
Temporary Project Staffing		£129
Temporary Programme Staffing	£87	
Re-procurement of Practices Health & Social Care Network (HSCN) links	£10	
Total Costs	**£2,200**	**£452**

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5. Revenue Budget Exclusions

5.1 Please note the ICB does not have responsibility for funding and providing practice telephony services which are devolved to individual practices, however, approximately half of practices choose to continue to use the Redcentric telephony service procured on their behalf by the ICB 3-years ago.

6. Other Revenue Budget Pressures

6.1 The ICB does continue to fund practices SMS text messages to patients reminding them of appointments etc and the cost of this has grown significantly over recent years to over £150k p.a. of which the ICB is only funded for 2 SMS texts per patient equivalent to [£8,638].

6.2 The below table shows the SMS volumes over the last 12 months.

ICS/ICB	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Total
NHS STW ICB	691,031	329,099	397,977	559,930	511,399	361,679	756,435	545,971	508,717	551,177	451,045	381,997	6,046,457

6.3 The ICB are seeking ways of managing these increasing SMS text message charges including: -

- Working with our MLCSU procurement team to reduce the unit cost of sending SMS text messages, however, we already appear to be paying the lowest available tariff.

- Short term - working with Primary Care system suppliers (such as AccuRX) to reduce the length of automated and template messages resulting in fewer SMS text “fragments”, i.e., long messages may require multiple SMS texts to send the whole message and therefore incur multiple SMS text charges.

- Longer term - working with system suppliers and NHS England to use “smart messaging” via the NHS App whose messaging is free of charge. This means that patient messages would initially be sent by the NHS App. If the message wasn’t read by the patient using the NHS App within an agreed time period (it’s still to be discussed and agreed how long this time period would be), an SMS text message would automatically be sent to the patient as well.

6.4 It should be noted that some ICB’s in our region including Herefordshire & Worcestershire and Coventry & Warwickshire pass on these SMS text charges to their Practices.

7. Capital Budget Spend

7.1 The following capital priorities have been reviewed and agreed by the Digital Strategy Group (DSG) which is an internal ICB group chaired by Steve James, ICB CCIO.

Capital Activity / Project / Improvement	Cost £k
Rollout of remaining Practice IT hardware purchased from 2022/3 Winter Monies	£24

Continue refresh of old and out-of-warranty > 4 Years Practice IT hardware (rolling multi-year project)	£309
Rollout NHS Microsoft 365 Cloud (N365) SharePoint & OneDrive to Practices (multi-year project)	£125
Upgrade Practices PC's and laptops to Microsoft Windows 11 (multi-year project)	£50
Upgrade Practices Communications Cabinets (multi-year project)	£50
Support Practices website improvements	£10
Total Costs	**£568**

8. GP IT Futures Software Allocation

8.1 Table below shows what systems are purchased with the GP IT Futures allocation.

Supplier	Product	Spend	Total spend 22-23	Allocation 22-23
EMIS Health	EMIS Web GP	634,997.16	876,677.95	887,509.37
Cegedim Healthcare Solutions	Vision	22,516.20		
Advanced Health and Care Limited	Docman10X	141,401.42		
Advanced Health and Care Limited	Docman 7	4,712.66		
Prescribing Services	Advice & Guidance (Eclipse Live)	73,050.51		

9. Local Performance Framework (LPF) Days

9.1 As an integral part of its annual IT & Digital Service Level Agreement (SLA) with the MLCSU, the ICB procures LPF Days of IT & Digital Project Management services.

9.2 The planned allocation of LPF days for Primary Care IT & Digital projects is shown below: -

Activity / Project / Improvement	LPF Days
Continue to refresh old and out-of-warranty > 4 Years Practice IT hardware	15
Rollout NHS Microsoft 365 Cloud (N365) SharePoint & OneDrive to Practices (multi-year project)	80
Upgrade Practices PC's and laptops to Microsoft Windows 11 (multi-year project)	50
Upgrade Practices Communications Cabinets (multi-year project)	50
Pilot Robotic Process Automation (RPA) and Artificial Intelligence (AI) in Practices	50
Total Days	**245**

10. Primary Care IT & Digital Risks & Issues

10.1 The majority of the Primary Care IT and digital budgets are used for "compliance" related expenditure, i.e., to ensure that our Primary Care IT systems remain up-to-date, secure and supported. This means that very little is available to be invested in clinical digital transformation.

10.2 The current and historic annual expenditure on Primary Care IT and digital equipment and services falls below that recommended by the "fair shares" financial guidance. The actual level of underfunding is not known.

10.3 The ICB annual base Primary Care IT and digital revenue costs are £298k greater than our base Primary Care IT and digital budget of £2.2m. Therefore, we currently start each financial year in a budget deficit position and are required to subsidise this budget using the Digital First Primary Care (DFPC) Funding. This results in less remaining DFPC budget to invest in clinical digital transformation projects.

10.4 The Primary Care IT and digital capital budget of £568k is invested in essential Primary Care IT and digital infrastructure projects (i.e. Zeus domain, N365, Communications Cabinets, etc) and the remaining budget is invested in upgrading Primary Care IT equipment estate.

10.5 The amount of Primary Care capital budget currently required on a consistent annual basis to maintain a compliant Primary Care IT equipment estate (inc. PC's, laptops, tablets, printers, scanners, MFD's, monitors, servers, UPS's, network switches, firewalls, wi-fi AP's, comms cabinets etc) has been modelled to be circa £500-600k p.a. including deployment costs.

10.6 Historically, we have held onto our Primary Care IT equipment assets much longer than is currently considered prudent before refreshing, resulting in a backlog of Primary Care IT equipment that is old and out-of-warranty support. We are very reliant on being successful in bidding and winning one-off funding bids with NHSE to refresh our Primary Care IT equipment and reduce our current refresh backlog.

10.7 The ICB only has a single permanent full-time member of ICB staff responsible for managing all Primary Care IT & digital contracts, commissioning Primary Care IT & digital services, non-standard & adhoc requests and information queries. We therefore have very limited internal capacity within the ICB for leading IT & digital transformational change in Primary Care. In the current year, additional temporary IT & Digital staff have been engaged by the ICB funded by DFPC budget, to temporarily bolster our ICB Primary Care IT & Digital client team, to successfully deliver our ICB Primary Care IT & digital strategic programme roadmap of projects.

10.8 These issues are included in the ICB Corporate Risk Register.

11. System Strategy and Cross System Working Risks and Issues

11.1 Unlike some other more digitally mature ICS Systems, we do not currently have an overarching ICS System IT & digital strategy to support our future development as an ICS System.

11.2 The strategy should include (and not be limited to): -

- Future vision for the digital transformation of care pathways and care delivery
- Technology convergence
- Secure digital information sharing
- Digital collaboration and interoperability
- Cyber security
- Digital investment
- Digital shared services
- Digital cost savings

11.3 This represents a significant shortcoming and opportunity.

11.4 There is currently little or no IT & digital across system working between health ICS partners, particularly between primary and secondary care. This also represents a significant shortcoming and opportunity.

Delivering digital evolution

Our digital and IT strategy: 2020 - 2025

www.shropshiretelfordandwrekinccg.nhs.uk

Welcome

We are pleased to welcome you to this digital and IT strategy. The overriding challenge is to embrace the current revolution in digital health and provide the digital tools required by our healthcare system. This will allow health and care professionals, alongside their support staff, to deliver the best and most reliable outcomes for patients and service users.

This challenge is set against a backdrop of rapidly evolving circumstances leading to changes in delivery models and organisational structures, as well as the ever present, and rapid, development in available technologies.

This strategy is developed to be sub-set of the digital and technology strategy that is being created across the Integrated Care System (ICS) in Shropshire, Telford & Wrekin. We are a fully engaged partner in that development; the core intention being that all partners will develop sub-strategies that deliver their elements of the whole

All our strategic thinking is underpinned by guidance from NHS England & Improvement, along with the NHS Long Term Plan and vision for healthcare which are focused on the principle that each person is empowered to expect barrier free experiences in health and social care.

We are fully committed to delivering supportive digital technologies to our own people, our partners, clinicians and to citizens that help to achieve exceptional care.

Claire Skidmore, Executive Director of Finance
Dr Stephen James, Chief Clinical Information Officer
August 2021

The context

What and why

NHS Shropshire, Telford and Wrekin Clinical Commissioning Group

Wider strategic objectives of the CCG

This digital strategy has been developed to ensure that we provide technology and digital tools to support, enhance and underpin these wider strategic priorities

To identify and improve ***health outcomes*** for our local population

To achieve ***financial balance*** by working more efficiently

To ensure the health services we commission are ***high quality***, safe, sustainable and value for money.

To reduce ***health inequalities*** by making sure our services take a preventative approach and take account of different needs, experiences and expectations of our communities

To improve ***joint working*** with our local partners, leading the way as we become an Integrated Care System (ICS)

Why create a digital strategy?

- The CCG has a clear aim to harness digital capability to enhance and improve experiences and outcomes for patients and service-users.
- Our strategy sets out how we will work with our partners, and alone, to define what types of digital capability our patients, staff and partners can expect to see developing and changing over time.
- It also recognises that we need to ‘level up’ and ensure that we start from a stable and level foundation; that we need to get the basics right in our technological and digital capability.

Our digital values

We will deliver digital technology and platforms that:

- Enhance and grow our services and those of our partners
- Embed learning from experience in developing new or novel and effective ways of working
- Deliver improved efficiency; delivering better, sooner and with improved outcomes
- Maintain the integrity of systems, data, processes and people

Quality
We will put patients at the heart of everything we do; delivering safe, excellent care and positive patient experiences

People
We will make how people work as seamless and flexible as possible; providing the right technology, in the right way, at the point of need

Sustainable
We will work with our partners to create and develop services that are high quality, scalable, wide-reaching and financially sustainable

Our digital principles

The benefits of outstanding digital services will be judged on the effectiveness of the clinical and corporate services that they underpin, alongside experiences of colleagues and patients. Our services will be typified by:

- **System optimisation** and the ways we can use systems and data to facilitate effective care pathways; contributing to high quality patient experiences
- **Facilitation of remote care opportunities** that are secure and safe; where enhanced care and outcomes can be delivered using the best available geographically dispersed skills and expertise
- **Making best use of operational data** by making real-time and historical data available in appropriate formats to the right people, and groups, at the right time
- **Empowering citizens** to take control of their own care and health by providing access to systems, tools and ways of engaging with clinicians that are new or novel or effective

Our partnership principles for the future

- System (ICS) as default
- Re-organisation of the system around key priorities i.e. directing resource at delivering key priorities and stopping doing those things that do not deliver these priorities
- Maintain pan-organisational governance and ensure it continues to support solution focused, rapid decision making
- Deployment of staff to support priorities – matching skills with tasks and working across traditional boundaries
- Embrace change – the system cannot stay the same and nothing is off the table
- Combine efforts of system restore, prioritised services and winter plan response

Aiding clinical agility

In all our actions we must assure that we maintain clinical stability whilst fostering a drive to delivery flexibility into our systems and agility in their use.

- **Deriving benefits and driving value** from existing investments in technology and tools
- **Strengthen our capability** by enabling colleagues to influence the solutions, tools and systems that are most appropriate for each pathway, care domain or type
- **Achieve both of these** whilst controlling a steady forward direction and ensuring that efficiency and efficacy are maintained or enhanced; and assuring value for money
- **Working with partners** and the wider health and social care system in Shropshire, Telford and Wrekin to assess the potential of opportunities and to derive economies of both scale and delivery

Enhancing the user experience

Excellent digital capability requires strong foundations – building blocks – upon which to build. Usability is a core factor for success. The basics must be continually enhanced and improved if we are to meet our own ambitions.

This will mean the modernization of our core infrastructure and the training and development of our people to enable optimisation to be continually achievable with limited constraints and barriers.

As a result of these necessary considerations, we must:

- **Assure that systems are intuitive** and easy to access, simple to use and reliable in operation
- **Assure that systems are accessible** by all types of users, with all manner of needs and backgrounds, so that no one is left behind
- **Provide flexible systems** that can be adapted and configured to various needs and clinical necessities
- **Provide responsive tools** that don't rely entirely on users to take all steps, which provide prompts and guidance as a user navigates through
- **Create a suite of seamless tools** so that data from one can flow reliably and securely between them – enabling a more efficient use of that data to support exceptional care and outcomes for patients

Finding the right delivery model

As the ICS model evolves and changes over the coming years, whether organically or as a result of direct legislative change, it will be necessary to consider how we deliver digital, ICT and technology services across all of our organisations and partners

- **Each organisation has, or contracts, its own services** as we do today; will this remain an efficient use of valuable and scarce resources?
- **Strengthen and make our services more resilient** by working across the system to commission services together?
- **Create fully shared arrangements** utilising all of our resources across the system jointly so that a unified and standardised approach to digital services delivery can be created?
- **Hybrid solutions** which incorporate some shared, some local and some contracted services?

These are considerations that we will actively explore with our partners and others over the coming years. There will be other ways of doing things that we can also consider, develop and embrace as technology changes and as the organisational landscape develops further

Our way forward

and the task ahead

Starting with a ‘new normal’

- Covid-19 has had a significant impact on how we operate, as a healthcare commissioner, as an organisation, as an employer and as a partner in the wider healthcare-system in the region.
- Whilst much of the planned transformation across the system was paused, by necessity, in the digital and technology space some things have had to develop at pace in order to ”keep the lights on” and to ensure that the response to the pandemic, continued consultation with and treatment of patients and the ability of our own people to continue working for the good of the people we serve; were manageable, supported and responsive. With the later advent of reliable vaccines, we have worked alongside system partners to deliver our elements of the the most rapid and large-scale population-wide treatment programme in history.
- From new devices to new digital tools, work was spun up quickly to offer agility to our teams and to make our systems as accessible as possible.
- We, and our system partners, realise and accept that some of that necessity to do things quickly has meant that some choices had to be made which, in the normal course of things, would have been differently made and with different outcomes. Where we need to look again at things, we will – given more space and time to consider and make appropriate decisions that fit into the wider-whole.
- We also know that much of what has been achieved – particularly in terms of keeping primary care accessible and in providing agile ways of working – will need to be revisited and, where possible, maintained with improvements and greater reliability of equipment, software, apps and tools.
- Much work has been done – and will continue to be done – across the whole healthcare system (with our ICS partners and others) to enable all to focus on the continued improvement in the health and care of our population.

Digital First

- NHS England is supporting primary care to move towards a digital first approach, where patients can easily access the advice, support and treatment they need using digital and online tools. These tools need to be integrated to provide a streamlined experience for patients, and quickly and easily direct them to the right digital or in-person service. From new devices to new digital tools, we worked quickly to offer agility to our teams and to make our systems as accessible as possible.

- The CCG are completely aligned with the national drive to seek out new, more intuitive ways of enabling patients to access, engage in and drive their healthcare journeys using digitally enabled tools.

- We are committed to leaving no-one behind; we know that "Digital First" cannot mean *digital only* and that a comprehensive system and toolset are needed to make sure that everyone has the best experience and outcomes possible.

- Our GP practice partners are offering wider and more diverse access to online services; we, in the CCG, will continue to work with them and other partners to further enhance and improve those tools and the experience that patients and professionals have of using them.

- NHS England has commissioned research, for example, to better evaluate the impact of online consultations on general practice. The evidence so far bears out our own view; that technology and digital, implemented as part of a comprehensive primary care service, tend to enhance the experience of most service users and professionals.

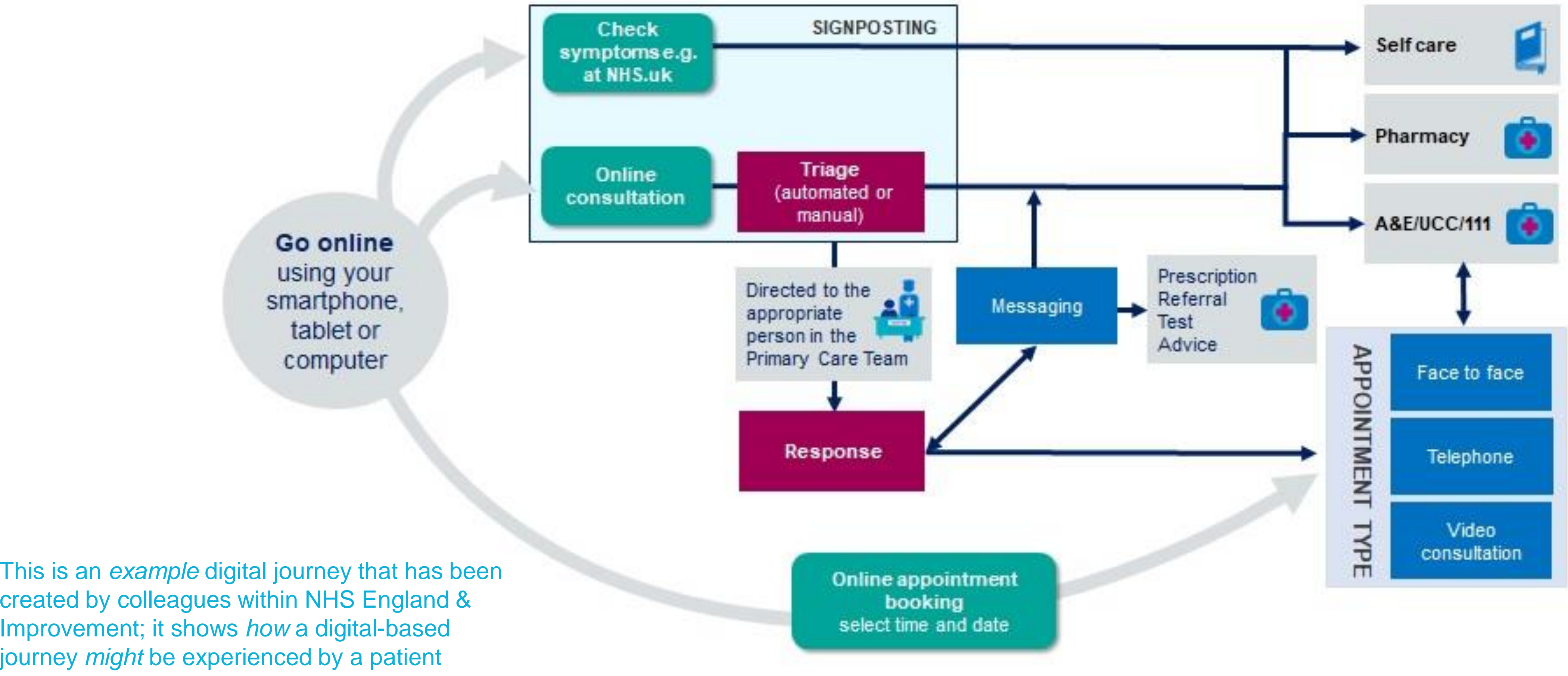
- For us, Digital First also encompasses all the emerging technology and capabilities that will enable better monitoring of patients and, particularly, chronic conditions; from remote monitoring in care and residential homes to working with partners to develop ways of providing supported monitoring and guidance to patients in their own homes.

Digital First: the promise

The NHS Long Term Plan has committed to offering all patients the right – and ability – to be offered digital first primary care by 2023-2024. As part of that commitment, a 'core digital offer' is set out in the GP Contract (annex C)

- Practices offering online consultations that can be used by patients, carers and by practice staff on a patient's behalf, to gather submitted structured information and to support triage, enabling the practice to allocate patients to the right service for their needs
- Two-way secure written communication between patients, carers and practices
- Signposting to a validated symptom checker and self-care health information (e.g. nhs.uk) via the practice's online presence and other communications
- Request and management of prescriptions online
- The ability to hold a video consultation between patients, carers and clinicians
- An up to date and accessible online presence, such as a website, that, amongst other key information, links to online consultation system and other online services prominently
- Shared record access, including patients being able to add to their record
- Online appointment booking

Digital First in Primary Care: a model journey



This is an *example* digital journey that has been created by colleagues within NHS England & Improvement; it shows *how* a digital-based journey *might* be experienced by a patient

Digital First

Already done

- As part of the emergency response to Covid-19, practices were supported to implement remote working capabilities
- One element of those capabilities was related to online, telephone and video consultations for patients
- Triage mechanisms were implemented in many practices

Funding

- £12.2m of funding has been allocated to the Midlands region for 2021/22; the allocation to our ICS (including the CCG and our partners) in 2021/22 is £545,000
- There will, likely, be further funding available in 2022/23 and 2023/24
- We will work with our ICS partners to ensure that the available funding is allocated to projects and programmes that will deliver the best outcomes

2020-2022

- We are actively engaging with partners across primary care, in particular in general practice, to review what has been implemented, what works well, what could be improved and what could be added or removed.
- That review will feed into a process for defining the specification for new and more appropriate applications (apps), hardware and technology to enable us to meet the commitments laid down in the NHS Long Term Plan.
- **During the next 6-12 months, we will procure and implement tools and apps chosen as a result of these reviews**

Alignment (to system)

- All Digital First Primary Care work is overseen at an ICS level
- Funding is allocated at the ICS level
- All DFPC work is, by necessity, a collaboration between partners
- N365 is the NHS version of Microsoft365 (M365) which is being rolled out across ICS partners (either the ”N” version in NHS partners or the “M” version elsewhere)

2022-25 plan

- There is an emerging field around technology that will enable a Digital First model in primary care and secondary care. Over the period we will, alongside our ICS partners, continue to engage with the market to find new and innovative solutions that persistently improve the experience and outcomes for patients and improve ways of working, collaborating, securely sharing and workload balancing for professional colleagues in clinical practice. These will include developing remote monitoring capabilities for patients in care and residential homes
- We will work with practices to roll out N365 in a reliable and robust manner

Benefits

- Easier, more direct access for patients, carers and clinicians to the right person, right data and right approach to enable the best possible outcome

Digital as standard: reducing reliance on paper

- As long ago as 1975 business periodicals were publishing articles on the idea of the 'paper free' office
- Despite the growth in use of computer and digital technology, between 1980 and 2000, the use of paper in the workplace is estimated to have more than doubled
- In the NHS, the use of paper is a particular problem: there is the obvious issue of storage and the less obvious issue that a patient who lives in Telford but requires urgent treatment elsewhere cannot be assured that their full medical notes will be available to the treating clinician or physician
- Steps have been taken over more recent years to make this better; electronic prescribing has – to an extent – reduced the use of manual scripts (although pharmacies still produce a printed version in order to dispense)
- There have been further developments, such as the phased introduction of the ICR (Integrated Care Record) which brings together the various electronic records related to an individual's health and care
- There are three key areas that we want to focus on over the next few years:
  - **Digitisation of patients notes**; we have a programme (in line with national recommendations) to digitise the Lloyd George Envelope (introduced in 1911 when the eponymous politician introduced the National Health Insurance scheme)
  - **Making our offices paper"free"**; this also facilitates a move to 'best place working' instead of being allocated to a specific building, floor, room and desk
  - Embedding MS Teams and other tools to **enable better communication, sharing and collaboration** using digital technology rather than passing pieces of paper around
- We also want to focus on how we share information across the ICS partners – all in aid of assuring and providing the very best possible outcome for all

Digital as standard: reducing reliance on paper

Already done

- Modelling of options has been undertaken
- ICR development has commenced and a phased approach has been developed
- Digitisation of notes (the Lloyd George Envelope) project has been created (the "Digitisation of Lloyd George Records (LGD) – wave 2b") between NHSEI and our ICS

Funding

- £416,950 funding has been made available by NHSEI for the ICS to implement the digitisation of notes
- NHSEI have been working with us and other CCGs, ICS and STPs to establish best procurement models to deliver this change

2020-2022

- Discussions and planning sessions for ICR continue
- Discussions and planning for Notes Digitisation is well-advanced and awaiting further national and regional guidance; we will develop a joint project with our partners for delivery of this key element of the overall ICR programme

Alignment (to system)

- ICR is a system-wide priority and work will cut across the partners of the ICS to ensure that, not only the process but also the outcomes are aligned and – ideally – alike across all partners; creating a single patient journey where possible
- The digitisation of notes project is an ICS wide piece of work under a memorandum of understanding (MOU) between NHSEI and the ICS

2022-25 plan

- We will conclude the digitisation of notes
- We will conclude the deployment of current phases of the ICR programme and will embark on further phases of development with our partners across the ICS

Benefits

- The wider anticipated benefits of the ICR programme are well documented elsewhere
- Considering technology as an enabler, the reduction in physical storage that is enabled by the technology is considerable; freeing up space in both primary and acute care settings that can be put to clinical or other uses
- We will also be able to better provide applicable and secure record access to clinicians at the point of need – when the patient is in front of them

Assuring cyber and data integrity

- The NHS does not have an enviable record when it comes to being fully assured of our cyber-security.
- Since 12th May 2017, when the NHS (across the UK) was attacked with the WannaCry ransomware and services across the nation were brought to a halt, considerable time and investment has been put into making the NHS as cyber secure as other organisations.
- All of our sites and practices, along with our partners in the ICSD have secure HSCN connections through which sensitive and important data is transmitted.
- We continue to work with colleagues from across the STP/ICS, NHS Digital, NHS England and Improvement, Midlands and Lancashire Commissioning Support Unit and our specialist providers of services to persistently assure our own, and our primary care partners, cyber security and safety
- In June 2021, Microsoft announced that Windows 11 will soon launch. We will watch developments closely.
- We will engage with our partners – including Microsoft – to ensure that, as soon as we can, we take advantage of new technology that is demonstrably of benefit to our organisations and, crucially, the patients and communities that we serve.

Assuring cyber and data integrity (continued)

- The NHS is custodian of some of the most personal and intimate data regarding individuals
- There are many rules which govern the use, purpose, storage and retention of all data held by the CCG, primary care and our partners in the STP/ICS
- Not least are our lawful obligations under the Data Protection Act 2018 (which incorporated into UK law the provisions of the General Data Protection Regulation (GDPR))
- It is of critical importance that not only do we assure compliance with the law and rules but, more prosaically, that we reduce our cost of maintaining vast storage capacities for both paper and digital records
- We will develop policies for the retention of data – working with our partners and closely advising our colleagues in primary care – to both assure what we're doing and to ensure that we bring down maintenance and administrative burdens
- The ICR programme (see *Digital as standard: reducing reliance on paper*) will be an enabler in this area
- Additionally, using better data and stripping away un-needed information, will allow us to focus more on population health management and monitoring – that in turn will inform and guide us as to what information and data we will need to retain or remove as time progresses
- We will also assure ourselves as to compliance with the NHS Digital Data Security and Protection Toolkit

Assuring cyber and data integrity

Already done

- Windows 10 is deployed across our environments; continual scanning and reporting takes place to ensure that this does not change
- Our server estate has been reviewed and upgraded where necessary
- Firewalls have been replaced and improved
- We have a full package of cyber security support, tools, with consulting and oversight provided via our NHS partners
- We undertook, with our NHS partners, the DSPT which demonstrated our continued compliance in accordance with the Data Security & Protection Toolkit

Funding

- Our cyber security services are provided within our framework and contract for ICT and digital support within the NHS family; we will continue to appraise how these services are delivered and will seek and plan for additional funding as necessary

2020-2022

- Review of all mobile devices is underway; to assure that all gateways into our systems as possible are either secured or removed
- Review of all data held in corporate systems, alongside providing review guidance to primary care partners, to assure compliance with DPA 2018
- We are working with partners on developing plans to roll-out either N365 or M365 to assure security and ensure that our operational apps remain the best in class
- Developing plans with our IT service partners to implement cyber security training for all colleagues (across the CCG and primary care)

Alignment (to system)

- At a system level, the ICS is developing a cyber security assessment model and action plan for all partners to engage and develop symbiotic/harmonious cyber security programmes; we are fully engaged and aligned with this approach

2022-25 plan

- We will work with our partners to conduct frequent testing for vulnerabilities, penetration, perimeter scanning; we will continue to measure our compliance with the Data Security & Protection Toolkit (or equivalent)
- We will develop policies to further embed data protection and retention best practice
- With our partners – including Microsoft – enable deployment of Windows 11 to our full estate at the first practical opportunity
- We will develop policies that require cyber and information security assessments for technology and digital elements of business cases and procurement exercises

Benefits

- We will be able to better and continually assure that we are resilient and able to operate in the event of cyber incidents
- We will be able to provide faster access to the right data to the right people at the right time
- We will also be able to assure ourselves and the wider community that the data we hold is necessary, relevant and properly controlled

Resilience through refresh

- It is a well-rehearsed aphorism that available technological capability *roughly* doubles every 18 months; that is to suggest that a brand-new piece of hardware purchased in January 2021 will be moving into obsolescence in July 2022
- We need to ensure that our hardware estate keeps pace with technological and software advances
- Hardware, for these purposes, includes (not exhaustively):
  - **INFRASTRUCTRE**: Servers, operating systems and server racks, network points, wifi access points, domain controllers, firewalls, cabling, air conditioning in server rooms and data centres etc.
  - **END USER**: Laptop, desktop, mobile device, tablet, operating systems and core business software (such as MS Office) etc.
- Refreshing hardware and software is a costly undertaking
- We will develop a management and asset strategy to ensure that we get the best functionality from our hardware for the most realistic period of time
- Working with our partners, we will develop a policy to categorise all hardware assets into a refresh cycle of either 3, 4 or 5 years
- End user devices will be at the lower range and infrastructure at the higher
- Also with partners, we will develop a policy for the rolling replacement of all devices over the course of their refresh cycle (i.e. so that within 3 years all laptops will be replaced – oldest first with the newer being replaced at, or shortly after, the 3 year cycle end)
- Working additionally with finance colleagues in developing a funding policy for these refresh cycles in order to avoid or mitigate unexpected capital costs or revenue pressures in any given year
- We will develop a policy that includes provision for all new software and app procurements to include details of refresh cycles, costs and funding plans which can be maintained and incorporated into appropriate budgets each year

Resilience through refresh

Already done

- Asset mapping across the whole organisation to establish our current hardware baselines
- Mobile telephony devices have been reviewed; further consideration will form part of the wider catalogue programme in 2020-2022

2020-2022

- Asset mapping across all primary care organisations to establish their current baselines
- Creating internal policies for hardware replacement and model policies for primary care
- Options assessment to establish catalogue of potential hardware (types, models, ideal use etc) with intention to align, insofar as possible, with ICS partners
- Evaluation of mobile device usage and need (in particular mobile phones)

2022-25 plan

- A programme of "rolling replacement" will be embedded in accordance with newly developed policies and funding models; this will be based on ensuring that our core infrastructure (networks, wifi, cabling etc) are reliable, resilient, secure and current – and – on ensuring that end-user devices (laptops, tablets, mobile devices etc) are equally reliable, secure and current

Funding

- Funding will be managed through the budget setting process in line with newly developed policies

Alignment (to system)

- We are, and will continue, to engage with our partners to ensure that we maintain a compatible and, where practical, unified approach to hardware and software change and development; we expect this to form an element of the system-wide digital strategy in due course

Benefits

- By ensuring that we are as stable and current as possible in terms of our digital and technology assets (hardware and software), we can look to avoid – or at worst – mitigate against such events as the 2017 WannaCry attack or similar such problems in the future; this also ties to wider cyber security considerations across the whole ICS and the NHS, UK and devolved administrations

Best place and collaborative working

- The 2020/21 lockdowns caused by the Coronavirus pandemic led to significant changes in how we work and where we work from
- Many colleagues, both in corporate and primary care, have found that flexibility of working arrangements has been beneficial
- We want to work with our partners and our own teams to develop best practice working arrangements – not “one size fits all” but a blended model that means working from the best place to do your job - and, ultimately, to deliver the very best outcomes for patients and the community
- That means a technology strategy that doesn’t tie everyone to a single type of device or a specific location; each user may have different needs based on the type of work they do – home, office, hospital, clinic, desktop, laptop, tablet, hybrid, mobile… the options are almost infinite based on individual need
- We will work with HR colleagues as they re-develop and embed agile and remote working policies to ensure that digital and technology is a ‘front and centre’ consideration
- We will develop a catalogue of ‘standard’ devices and tools that will be supported within our technology ecosystem and will work with our ICS partners to align our approach with theirs
- We will work across the system to make it possible, practical and desirable for our colleagues, and for people from all of our ICS partners, to work reliably and fully from any of our operational sites
- We will work with our partners to make the best possible use of technology to enable a collaborative approach to working that maintains the security and integrity of our systems and data
- We also know that our role is to provide digital and technology solutions that *enable* but which do not direct or force a working or collaborative style

Best place and collaborative working

Already done

- By necessity – due to the Covid-19 pandemic – we have vastly changed our working practices; many colleagues (across the CCG and primary care) are now working from locations other than a 'base' or office
- We have been working with colleagues across the ICS partnership to look at how to embed and enhance that new flexibility and what we can do with technology to make it easier

2020-2022

- Moving to "best place" based model
- Identifying and rolling out software for digital communications (e.g. *Unity:* mobile application to access internal telecoms systems)
- Review of office technology estate (inc. move from William Farr House)
- Development of a 'no fixed desk' policy and tools to enable shared / hot desks to be booked for periods of time

2022-25 plan

- Work with ICS and other partners to identify capacity and ability to provide connectivity across different partner estates for all users from all partners; also including the ability to work from those locations effectively (a 'touchdown' approach)
- Move to mobile (i.e. not desktop) device standard; including intuitive and logical networking capabilities
- Further development of unified communications to strip away duplicative or unnecessary technology and software (e.g. using MS Teams for telephony)

Funding

- Much of this work is dependent on access to technology and software that are funded/provided through other areas of this strategy (for example Microsoft 365 (N365) technology alongside mobile and flexible devices)

Alignment (to system)

- Across the ICS work is being done to make flexible/agile working a genuine and embedded practical option; we agree that it is an important option – not least because it allows for agility in responding to the unexpected, but also because it allows the professionals who work in our organisations to make the choice for themselves about where/how they are best to do their job

Benefits

- By providing technology that enables people – clinicians, primary care staff, CCG and our partners staff – to be flexible and mobile in how and where they operate, we provide opportunities to enhance collaborative working to achieve faster and better outcomes for those we serve

Summary of key projects and programmes

Corporate, system-wide and primary care

2020-2022

- **Device refresh** [2021-2022]: review estate and evaluate needs-v-device; from Q4 2021-2022 deploy catalogue and commence roll-out of approved devices
- **Remote access** [2021-2023]: Develop or procure reliable and resilient tools that are easy to use, operate and manage (procurement exercise likely Q4 with deployment following in Q1-Q2 2022-2023
- **N365 (Microsoft)** [2021-2023]: design and deployment of N365 (or M365) software in phases; pilot programme underway by Q4 with overall programme continuing into following year
- **Resilience policy and programme** [2021>]: development of policies for refresh and replacement of hard/software on a rolling basis; including a funding model and alignment with our partners
- **Publication of core digital and model digital policies** [2020-2022]: In collaboration and cooperation with primary care and our partners (including data retention, information governance etc.)

2022-2023

- **Remote access** [2021-2023]: As above – deployment of procured solution Q1-Q2
- **N365 (Microsoft)** [2021-2023]: As above – programme continues
- **Data cleansing and archiving** [2022-2023]: Development and embedding of policies and management tools to ensure continued compliance with DPA 2018/GDPR and to enhance our ability to manage data effectively across the estate
- **Print rationalisation and reduction** [2022-2023]: establish needs for secure and standard print in all locations; reduce reliance on physically printed matter as a means of reducing our environmental impact and providing additional data security by removing the risks inherent in printed material
- **Resilience policy and programme** [2021>]: development of device catalogues and ongoing deployment

2023 onward

- **Resilience policy and programme** [2021>]: continues with further system-wide alignment

Corporate and system-wide

2020-2022

- **Transition** to new, more resilient, network domain (from Athena)
- **Embed, enhance and improve** agile and 'best place' working practices; including desk booking/availability tools, assessments for home working needs etc.
- **Complete** deployment of Windows 10 to all corporate devices and embed continued reporting and assurance with our NHS partners
- **Review** and streamline the usage of mobile telephone devices across the organisation
- **Enable** the continued review of office estate – including the decamp from William Farr House and move to Ptarmigan House
- **Replace** out of warranty equipment identified by our partners in their review of our technology assets

2022-2023

- **Windows 11 programme** to develop plans for the deployment of Windows 11 across the corporate and system-wide technology stack; providing a model for future deployment to the primary and acute care estates
- **Other plans are dependent on the system-wide digital strategy (in development by ICS)**

2023 onward

- **Further plans are dependent on system-wide digital strategy (in development by ICS)**

Primary care

2020-2022

- **Single GP domain** [2020-2022]: deployment of domain controllers (hardware enabling access to secure networks) and firewalls into primary care sites; will provide additional security, resilience and auditability
- **Full fibre** [2020-2021]: deployment of full fibre-optic broadband (FTTP) to all GP/Primary Care sites; will enable super and ultrafast connectivity meaning that data can be securely, reliably and quickly accessed
- **Video/audio consultations** [2021-2022]: procurement of tools, applications and technology to enable reliable, easy to access and easy to understand video and audio consultation tools for patients, carers and clinicians. These tools form part of the Digital First approach and provide a resilient *option* for patients and clinicians to engage. We expect to enter a procurement cycle on Q3-Q4 2021-2022

2022-2023

- **Digitisation of notes (part of ICR programme)** [2022-2023]: Deployment of procured solution (procurement may be Q4 2021-2022) alongside our system partners
- **Evaluate and develop** public and private cloud capability (for storage and resilience) using Microsoft technologies where possible/practical
- **Windows 11 programme** to develop plans for the deployment of Windows 11 primary care estate – based on model and learning from corporate deployments
- **Further plans are dependent on GP IT Futures requirements**

2023 onward

- **Further plans are dependent on GP IT Futures requirements**

Looking beyond

Glancing into the future

The world of technology changes – rapidly. What is unachievable by digital means in 2021 may be commonplace by 2025. We will work with our ICS partners, NHS Digital, our local IT and digital partners and with other organisations to ”scan the horizon” for new, emerging or developing technologies that may improve how individuals work, how we or they engage with patients, how the organisation functions or collaborates with others.

We will encourage our ICS partners to form working relationships with organisations (e.g. Gartner) at a system-level, that can help us to undertake the considerable task of monitoring, reviewing and assessing the technology marketplace so that we can be at the leading edge, with early deployment and implementation, of utilising digital technology to enable those we serve to experience the best healthcare outcomes possible.

PRIMARY CARE COMMISSIONING COMMITTEE – February 2023

Agenda item no.	PCCC 23-06.34
Meeting date:	2nd June 2023
Paper title	Hodnet 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.
Signature:	*B Williams*
Committee/Advisory Group paper previously presented:	
Action Required (please select):	
A=Approval ✓ / R=Ratification / S=Assurance / D=Discussion / I=Information	
Previous considerations:	

1. Executive summary and points for discussion

Hodnet 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.

There are housing developments to the North and South of Hodnet Medical Practice, which is the reason for the practice making the request to reduce the boundary. The practice states they do not have the staff or facilities to provide a safe service if the patient list continues to increase.

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:

Consider declining the application to reduce the practice boundary on the basis that patient choice is restricted.

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 proposed reductions in the North and South.
D: Practice information.

5. What are the implications for:

Shropshire, Telford and Wrekin's Residents and Communities	
Quality and Safety	Potential risk that the practice will have challenges 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

Hodnet 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 a 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.

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:

- The patient list size is increasing and despite trying to recruit extra staff to support with the workload of having a growing list, the practice has not been successful in recruitment.

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

- There are 45 new homes in Hodnet village (potential 112 new patients).
- Due to housing developments in the Market Drayton/Tern Hill and Crudgington areas there's potentially 1800 patients that could choose to register at Hodnet Medical Practice or Market Drayton.

The two neighbouring GP practices, Shawbury Medical Practice and Market Drayton Medical Practice have been contacted to ask if the Hodnet application would have any implications for them.

- Market Drayton Medical Practice have advised the resulting significant increase in their patient list would have a profound impact on their ability to provide general medical services, particularly in the area of the access requirement of the new GP contract.

- It is 2.8 miles from Tern Hill to Hodnet village by car, it would take 5 mins. Travelling by bus could take approx. 12 minutes.

- Shawbury have advised that given the largest portion of the area in the south where the reduction is proposed is already in the Shawbury practice boundary and that many patients from the new houses at Crudgington are already registered with them and that the building work is on the High Ercall side of the A442 they are not sure why there would be a need to remove that area.

- It is 7.3 miles from Crudgington to Hodnet village by car, it would take 11 mins. By bus it would take over 2 hours with 2 changes.

The ICB is not able to predict how many of the patients from the new housing development will choose to register with either Hodnet or Market Drayton; therefore the potential is that if the application is declined Hodnet Medical Practice may experience operational challenges. If this was the case the practice can contact the ICB to discuss support options for example, the ICB could introduce a rota system of patient allocation to evenly distribute the workload of patient registrations.

Options
1 Approve the application to reduce the practice boundary for both locations (Tern Hill and Crudgington)
2 Approve the application to reduce the practice boundary at Crudgington only.
3 Approve the application to reduce the practice boundary at Tern Hill only.
4 Decline the application to reduce the practice boundary for both locations.

Option	RISK	BENEFIT
1	Reduces patient choice of GP practice in a rural area. Impact on Market Drayton's ability to provide access primary medical services.	Benefit to Hodnet medical practice is that this option will restrict the number of patient registrations so they can maintain the current level of service.
2	Reduces patient choice of GP practice in a rural area.	Benefit to Hodnet medical practice is that this option will restrict a small number of patient registrations so they can maintain the current level of service.
3	Reduces patient choice of GP practice in a rural area.	Benefit to Hodnet medical practice is that this option will restrict a small number of patient registrations so they

	Impact on Market Drayton's ability to provide access primary medical services.	can maintain the current level of service.
4	Hodnet medical practice may struggle to cope with the increased workload. Patients may have to wait longer for an appointment.	Provides two options for patient choice.

3. Conclusions

Hodnet medical practice are concerned there will be an impact on providing primary medical care services to their patients due to new housing developments at Tern Hill and Crudgington; Hodnet's practice boundary includes both areas.

Shawbury Medical Practice have registered the patients in the Crudgington area therefore it's unlikely that patients will choose to travel further to see a GP. There is however a concern that patients from the Tern Hill area may choose to register with Hodnet.

All GP practices are experiencing increased demand for services to which the ICB needs to balance maintaining patient choice which is already restricted in rural areas and supporting GP practices with the demand for services.

4. Recommendations

Primary Care Commissioning Committee are asked to

- Consider declining the application to reduce the practice boundary on the basis that patient choice is restricted.

Appendix A:

Primary Medical Care - Policy and
Guidance Manual

Template Application to Change the Practice Area

5" September 2022

Dear Primary Care Team

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:

Dr JR MEHTA
The Medical Centre
Hodnet,
Market Drayton
Shropshire
TF9 3NF
Tel: 01630 685230

2. Provide full details of the proposed practice area:

Proposed changes:

1. At Tern Hill, turn south on the A53, at Wollerton follow the tern river south to the lane passing south of Helshaw Grange. Follow this lane to Warrant Road, continue on this road across the A41 to Sutton Grange. At Sutton Grange turn left (north) follow the road to walkmill bridge where we reconnect with the existing boundary following the Tern river east to the A529.
2. On our southern boundary, at Walton follow Crab lane east then turning north onto Clarence Cottages Lane (Muckleton lane) continuing to Osbaston. At Osbaston straight through the cross roads then turning northeast on Shop Lane towards Rowton turning east at the crossroads into Rowton. Continue through Rowton and past Stone House to meet the A442. Turn south onto the A442 to Waters Upton turning left (second left) to follow field view through to meet our current boundary at Lower House.

The rest of the boundary remains the same.

3. Explain the reasons for the change of practice area:

A new development of 750 houses is planned at Tern Hill and another new development of 236 new houses is underway at Crudgington. Both of these developments are on the edge of our practice area and cover by other medical practices

We are noting an increase in patients – residing within our practice area - leaving neighbouring practices to register at Hodnet which has seen our list size rise above 3600 The list has historically rested between 3400-3500. A development of 45 houses is planned within Hodnet village, near the

surgery, which will see a further increase in our list size by approximately 110 extra patients will push us over 3700

.

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):	With an average of 2.4 people per UK household in 2021, the Tern Hill development could mean 1800 new patients. The Crudgington development could be 567 new patients. With a current list size of 3600, this would see an increase in our practice population of over 66%. The Tern Hill development is within Market Drayton Medical Centre's catchment area and Crudgington has many practices much closer than Hodnet. We have been trying to recruit a GP for several years now without success. We have had to widen the search to include an Advanced Nurse Practitioner but again, no success. We do not have the staff, space or facilities to accommodate this possible increase in our list size. Trying to provide services to the anticipated number of patients would not be safe or practical.

Signed by Dr J Mehta & Mrs R Mehta: [signatures]

Date: 13th February 2023

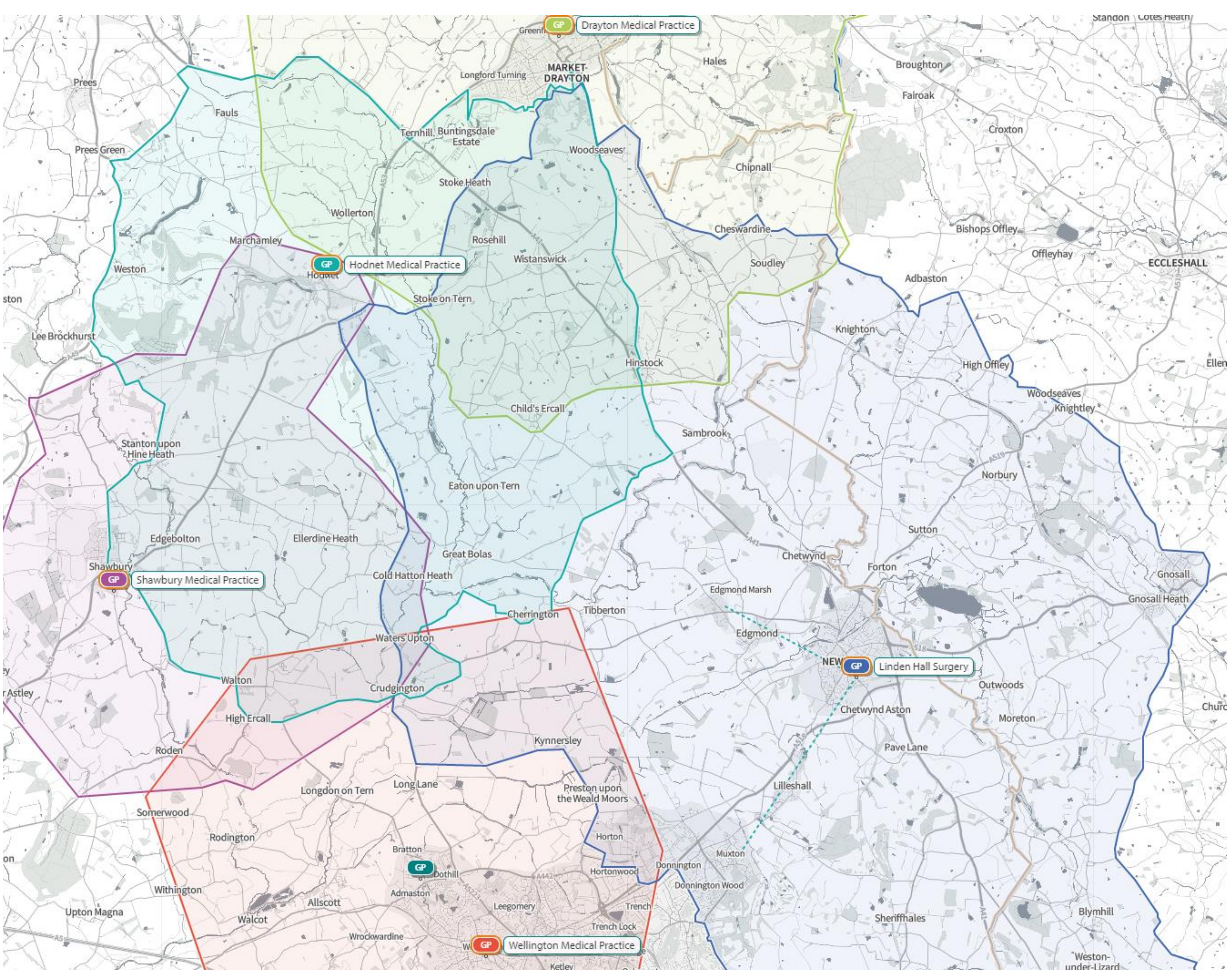
Appendix B: Proposed boundary for Hodnet Medical Practice.

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

Integrated
Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford
and Wrekin

Greenfields
MARKET DRAYTON
Little Drayton
Prees
Fauls
Ternhill
Buntingsdale Estate
Woodseaves
Prees Green
Stoke Heath
Wollerton
Rosehill
Marchamley
Wistanswick
Weston
Hodnet Medical Practice
Hodnet
Stoke on Tern
Hinstock
Child's Ercall
Stanton upon Hine Heath
Eaton upon Tern
Edgebolton
Ellerdine Heath
Great Bolas
Shawbury
Heath Lanes
Cold Hatton Heath
Tibberton
Cherrington
Walton
High Ercall
Kynnersley


Drayton Medical Practice
Hodnet Medical Practice
Shawbury Medical Practice
Linden Hall Surgery
Wellington Medical Practice
MARKET DRAYTON
Hales
Prees
Fauls
Prees Green
Tern Hill
Buntingsdale Estate
Woodseaves
Chipnall
Stoke Heath
Wollerton
Marchamley
Rosehill
Wistanswick
Cheswardine
Soudley
Weston
Stoke on Tern
Lee Brockhurst
Hinstock
Child's Ercall
Sambrook
Stanton upon Hine Heath
Eaton upon Tern
Edgebolton
Ellerdine Heath
Great Bolas
Cold Hatton Heath
Shawbury
Cherrington
Tibberton
Edgmond Marsh
Edgmond
Chetwynd
Forton
Waters Upton
Walton
Crudgington
High Ercall
Kynnersley
Roden
Longdon on Tern
Long Lane
Preston upon the Weald Moors
Somerwood
Rodington
Bratton
Horton
Withington
Allscott
Walcot
Wrockwardine
Upton Magna
Broughton
Fairoak
Croxton
Bishops Offley
Offleyhay
ECCLESHALL
Adbaston
Knighton
High Offley
Woodseaves
Knightley
Norbury
Sutton
Gnosall
Gnosall Heath
Outwoods
Chetwynd Aston
Moreton
Pave Lane
Lilleshall
Muxton
Donnington
Donnington Wood
Sheriffhales
Blymhill
Weston-under-Lizard
Hortonwood
Leegomery
Trench
Trench Lock
Admaston
Dothill

Appendix D: Practice Information

- Hodnet Medical Practice is a well-established GP practice providing primary medical care under a General Medical Services (GMS) contract since April 2023 and prior to this was a Personal Medical Services (PMS) contract.
- List size @ Q4 2022-23 (1st Jan 2023) is 3,590 patients. The practice report to be 3,671 on 20th April 2023.
- CQC rated as Good.
- Purpose built premises except for the original black and white listed building which serves as Dr Mehta's consultation and examination room. These rooms are awaiting building consent for refurbishment and are not currently used to see patients.
- Staff and patient parking is provided via the Lyon Hall carpark next door
- The practice has 2 partners (1GP and 1 non-clinical)
- Other clinical roles include 4 Nurses and 1 Healthcare Assistants (HCA)
- The practice is open 08.30 to 18.00 Monday to Friday. – *although Thursday afternoon for emergency only whilst Nursing Home rounds are performed.*

DRAFT

Primary Care Commissioning Committee – 2 June 2023

Agenda item no.	PCCC 23-06.35
Meeting date:	**2 June 2023**
Paper title	**CRP LCS Review**
Paper presented by:	**Janet Gittins and Clare Stallard**
Paper approved by:	**Emma Pyrah**
Paper prepared by:	**Janet Gittins and Clare Stallard**
Signature:	J Gittins
Committee/Advisory Group paper previously presented:	
Action Required (please select):	
A=Approval [ ] R=Ratification [ ] S=Assurance [ ] D=Discussion [ ] I=Information [ ]	
Previous considerations:	

1. Executive summary and points for discussion

- The existing Primary Care Locally Commissioned Service (LCS) for Near Patient Testing for 'C reactive protein (CRP)' in patients attending with lower respiratory tract infection has been in place since 2016 with Telford and Wrekin practices only. The key aim of the service was to improve antimicrobial stewardship specifically around patients who have suspected respiratory tract infections.
- Recent work to review the CRP LCS has identified a gap in the quality assurance requirements within the existing specification and complexity associated with multiple different point of care devices in practice with different purposes and ownership. Support for CRP EQA completion and IQC oversight has been introduced by the Medicines Management team.
- It is difficult to conclude with certainty whether use of Point of Care C-Reactive Protein (CRP) Testing across TWCCG has had a direct impact on antibiotic prescribing for LRTIs due to available data being influenced by many other national and local initiatives that have been put in place since 2016 which have all supported a decrease in antibiotic prescribing.
- Review is required to align and ensure the LCS offer is consistent and equitable across Shropshire, Telford & Wrekin (STW) practices other than where there is evidence for variation to meet local population need, which in the case of antimicrobial stewardship would not be applicable.
- This paper is set out in two sections. Part 1 reviews the current CRP LCS and Part 2 looks at options for the repurposing of finances should the recommendation in Part 1 be agreed by the committee.

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

Pledge	
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 to review the CRP LCS and options to repurpose this budget should the part 1 recommendation be agreed.

Part 1: Recommendation:

Based on the prescribing data review, varied uptake across practices, inequity of LCS offer across the patch, complexity associated with POCT and multiple machines placed in primary care, lack of robust long-term clinical governance and oversight, and the financial position of the ICB, the recommendation of the ICB is to support Option 3 to decommission the current LCS.

Part 2: Recommendation

Based on the absence of local and national data to support wide-scale use of CRP testing across STW for multiple infections and admission avoidance purposes, a pilot would be required to enable full evaluation and outcome review to support this wider roll out. This would however, still not address the complexity associated with POCT and multiple machines, lack of robust long-term clinical governance and oversight within the ICB (currently being provided by Medicines Management as interim measure), and the financial position of the ICB. Without additional funding available to support wider roll out if the pilot was successful, this would not be a viable option. The recommendation of the ICB is to support Option 3 to repurpose the CRP budget into the current LCS budget offering an increased uplift on payments made for existing agreed services across STW.

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

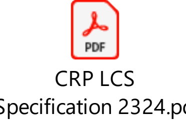
NA

5. Appendices

I. Clinical guideline [CG191] Published date: December 2014 Pneumonia in adults: diagnosis and management

II. Primary Care Respiratory Update: The place of point of care testing for C-reactive protein in the community care of respiratory tract infections https://www.pcrs-uk.org/sites/default/files/PoC%20Testing%20FINAL3.pdf

III. Locally Commissioned Service Specification: Near Patient Testing for CRP in patients attending with lower respiratory tract infection.



CRP LCS Specification 2324.pd

6. What are the implications for:

Shropshire, Telford and Wrekin's Residents and Communities	POC testing for CRP removed
Quality and Safety	N/A
Equality, Diversity, and Inclusion	N/A
Finances and Use of Resources	Current LCS is a cost pressure to the ICB
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:**	

Part 1 – Review of Telford and Wrekin CCG LCS for CRP in Respiratory Functions

1. Background

The Locally Commissioned Service (LCS) for Near Patient Testing for ‘C reactive protein (CRP)’ in patients attending with lower respiratory tract infection has been in place since 2016. The introduction of point of care testing (POCT) for ‘C reactive protein (CRP)’ intended to improve antimicrobial stewardship by providing practices with additional clinical information for patients presenting with a suspected lower respiratory tract infection (LRTI) when an antibiotic is being considered but the clinical diagnosis is uncertain from the presenting symptoms.

The outcome expected from the LCS, was ‘A reduction in the inappropriate use of antibacterial agents used in the management of respiratory tract infections, in line with national antibiotic stewardship programme’

To deliver this point of care testing, practices were provided with Afinion AS100 devices that were placed in practices. These machines were purchased by Telford and Wrekin CCG for the purpose of conducting CRP testing, however they were also used to conduct NHS health checks for the Local Authority. Machines were placed across all practices in Telford and Wrekin, with CRP testing

Since the service was first commissioned in 2016 by Telford and Wrekin CCG it has continued without review of direct impact. Review commenced as part of the LCS review however has been delayed until now due to staff changes and protection through and after the pandemic.

2. Report

A review of the service has identified the following:

- Issues surrounding the governance of the service; External Quality Assessment (EQA) was put in place to conduct these tests, these EQA costs were shared between the CCG and Local Authority at the stage of implementation however Internal Quality Control (IQC) was omitted and there was an identified gap in clinical oversight of completion, this has recently been identified and subsequently instated. Contracts are currently in place for both External Quality Assessment (EQA) and Internal Quality Control (IQC) for 6 months of 2023-24. It is also important to note there are clinical training needs associated with the use of POCT to ensure competency in conducting tests and appropriate quality assessment.
- There are currently 21 machines (historical Affinion AS100 devices) in place across 13 Telford and Wrekin GP practice sites. These machines are now outside of their warranty. Additional Affinion 2 machines have been introduced for SMI health checks, and new Local Authority machines will be implemented in Telford Practices for the NHS health checks imminently, with Telford and Wrekin withdrawing from the historical shared EQA arrangements. Communication on clarification of use and quality assurance

requirements has been circulated to practices on 09th May to minimise potential for error and clinical risk.

- Only a small number of practices have been actively claiming for test reimbursement under this LCS. Data shows that during the last 2 years 2021/22 and 2022/2023, only 6 practices have made a claim. These are; Ironbridge, Charlton, Stirchley, Woodside, Charlton, Teldoc and Wellington Road. For 2022/23 annual activity ranges from 30 CRP tests claimed at Ironbridge to 465 at Stirchley.

STW ICB has recently shared the LCS offer for 2023-24 which includes the CRP LCS for Telford and Wrekin Practices only. Two practices have not signed up to deliver the CRP LCS, Hollinswood and Linden Hall. This will make 4 machines redundant which will shortly be collected from practices and re-purposed for use across the ICS.
Point of care testing devices require regular sample tests for quality assurance (QA). There is a requirement for practices to conduct two levels of QA in order to ensure the AS100 POCT devices are working correctly.

3. Finances

The ICB holds an annual budget of £25,000 to cover costs associated with this LCS.

Costs associated with services for the periods 2020/21, 2021/22 and 2022/23 are set out below:

Funding Stream	Value (£) and Description	Budget 2020/21	Cost 2020/21	Budget 2021/22	Cost 2021/22	Budget 2022/23	Cost 2022/23
Primary Care	£5 per test	£40,281	£4,948	£15,710	£23,620	£25,332	£34,895

Practices can claim £5 per CRP test conducted. In 2022-23 a total of 870 CRP tests claims were made in equating to £4,350.

Costs for cartridges and QA are now fully covered by the ICB following withdrawal of the Local Authority and ICB arrangement.

External Quality Assurance (EQA) and Internal Quality Control (IQC) completion are essential for ensuring the results obtained are accurate and precise. Contracts are now in place for the 21 machines to cover QA requirements for CRP testing only. The costs for this are;

CRP IQC and cartridges	£3,033.66	6 months
CRP EQA sampling	£1,912.47	6 months
Total	£4,946.13 (for 6 months)	

Clinical oversight to ensure completion of these tests is now provided by the Medicine Management team of the ICB until a decision on the longer-term approach to POCT/CRP in Primary Care is determined.

The 21 Afinion devices are no longer under warranty and should any device fail, there is no budget to replace these.

4. Clinical Value/ Local Evidence Review

High-quality evidence from various primary care settings shows that CRP POCT with guideline-based cut-offs and indications reduces antibiotic use for patients presenting with Repiratory Tract Infections (RTIs) and Infective Exacerbations of COPD (IE-COPD).

In order to achieve maximum patient enrolment and draw appropriate conclusions on impact and derived clinical benefit, CRP POCT should be implemented in practices with at least one of the following:

- high users of antibiotics despite efforts to improve stewardship by the practice and local Medicine Management Team;
- a large cohort of COPD patients, which could be in areas of high socioeconomic deprivation;
- a large proportion of COPD patients attending accident and emergency departments;
- or a large proportion of COPD patients who frequently exacerbate.

Further information on the place for CRP Point of Care Testing for respiratory indications in the community can be found here: https://www.pcrs-uk.org/sites/default/files/PoC%20Testing%20FINAL3.pdf

Local evidence review:

It is difficult to conclude with certainty whether use of Point of Care C-Reactive Protein (CRP) Testing across TWCCG has had a direct impact on antibiotic prescribing for LRTIs due to available data being influenced by many other national and local initiatives that have been put in place since 2016 which have all supported a decrease in antibiotic prescribing. In addition to this, POCT equipment was implemented across all practices in Telford and Wrekin as opposed to targeted intervention in practices as described above and uptake and implementation of testing has been very varied from practice to practice.

Baseline data was not collected at the time of implementation or subsequent ongoing review of direct impact, therefore a retrospective review of prescribing data was conducted of data from between 2015-2020 (pre-COVID impact) however it should be noted that antimicrobial prescribing data can also be influenced by national and local targets/incentives and this is reflected by a general trend of decreasing prescribing rates across all practices in T&W and Shropshire and not just those using CRP POCT.

Total antibiotic prescribing between 2015-2020

- This reduced nationally since 2015 which was mirrored by both SCCG and TWCCG.
- Many initiatives have been put in place to support reduction in total antibiotic prescribing, both nationally and locally.
    - Nationally (NHSE Quality Premium with continued lower targets, government National Action plans to tackle antimicrobial resistance, PHE campaigns, increased provision of education and training resources)

  - Locally (Prescribing Development Schemes (PDS), increased provision of education and training resources, local health economy E.coli BSI improvement plan)
- Between 2015-2017, antibiotic prescribing in SCCG was below national average and then continued to track this average into 2020.
- TWCCG had a higher level of prescribing than SCCG from 2015-17 then started to show a greater decrease compared to SCCG and nationally. This continued into 2020.
  - It should however be noted that targets set for antibiotic prescribing with PDS schemes differed between SCCG and TWCCG. TWCCG set lower ambitious "stretch" targets than compared to nationally and those for SCCG.
  - From Dec16 to Mar20, all practices utilising CRP showed a decrease in overall antibiotic prescribing volume with % decreases ranged from 2.4% to 17%, however it should be noted that non-CRP POCT practices also showed big decreases (2.2% to 25%).

Doxycycline and amoxicillin prescribing

- These antibiotics are generally used to treat lower respiratory tract infections (LRTIs) for which CRP testing is used to diagnose likelihood where there is uncertainty.
- From 2015/16 to 2019/20, change in prescribing of these antibiotics for practices using CRP across TWCCG has been variable:
  - % changes range from +4.5% to -28%
- For the same period, change in prescribing for practices not using CRP POCT has also been variable however noting reductions have been greater in some cases
  - % changes range from +23% to -57%
- TWCCG saw a 19% decrease in the prescribing of these antibiotics and SCCG saw a 3.7% decrease for the same period however NB: TWCCG had higher baseline prescribing rates compared to SWCCG and a lower antibiotic target for the PDS.

Summary of local data review:

- It is difficult to determine whether use of Point of Care C-Reactive Protein (CRP) Testing across TWCCG has had a direct impact on antibiotic prescribing for LRTIs due to many other national and local initiatives that have been put in place since 2016 which have all supported a decrease in antibiotic prescribing.
- In addition, TWCCG used "stretch" targets within their PDS to further incentivise a reduction in antibiotic prescribing which may have influenced prescribing rates further
- Increased use of remote consultations post- Covid-19 pandemic will make CRP testing more challenging in some cases.

5. GP Board

A draft of this paper has been shared with the STW GP Board for discussion and comment. Although this is not a decision-making body, the comments made are noted below to take into consideration.
It is clear that those using CRP POC testing across Telford find this helpful to;
- aid decision making/triage with an example given of abdominal pain,
- cope with high demand time e.g. during winter pressures, and to
- potentially reduce the need for an emergency admissions.

It should be noted however that the LCS is for aiding decision making in the diagnosis and management of LRTIs with the aim of reducing inappropriate antimicrobial prescribing. Some of the uses discussed above fell outside of the LCS specification.

There was consensus that;

- national evidence supports POC CRP testing for respiratory when this is a targeted intervention implementing in areas of high antimicrobial usage or COPD prevalence.
- a pilot project needs to be for a time limited period with a clear remit and evaluation criteria which was not in place in this instance. There is no demonstratable data available to draw a definitive conclusion and evidence the outcomes and benefits of this CRP LCS to justify further wide-scale roll out at this stage

A discussion took place around the idea to re-pilot a CRP LCS which gave conflicting feedback with some member views being that there is no need for another pilot, but others recognising that a re-pilot would capture the missing evidence from the current pilot.

It was noted that the preferred option would be to open up this CRP LCS to all STW practices but only if this was viable and fully resourced, it should also be noted however that this was for conditions outside of LRTI's such as Urinary Tract Infections (UTIs) and other possible infections, for which there is currently limited/no national evidence to support this. As there is currently no additional investment available to fund such an expansion, this is not a viable option.

6. LCS Requirements

STW ICB aims to commission LCS that add value, addressing identified population needs across the whole of Shropshire, Telford and Wrekin. A LCS must;

I. align legacy LCS across the whole of STW, unless specially targeted for example to address health inequalities.
II. be robust with good clinical evidence and governance and
III. be affordable within the designated ICB LCS budget.

STW ICB has given commitment that all current LCS funds are ringfenced for continued use in Primary Care.

7. Conclusions

Taking all of the above into consideration, the following options are put forward for colleague's to agree on a final recommendation for the future of the CRP Testing LCS across NHS STW.

- **Option 1 – Do nothing.**
  The service continues to operate as it does currently only in Telford and Wrekin, noting the need for long-term governance and clinical oversight to be agreed, machine warranty expiry and continued inequity across STW.

*This option does not meet any of the above criteria listed in section 6 due to the lack of demonstratable local evidence, current devices not under warranty and being a current cost pressure.

- **Option 2 – Commission the CRP LCS across the whole of STW.**

*This option does not meet criteria ii or iii listed in section 6 due to the lack of demonstratableevidence (both local and national- see also section 5), and limited budget.

- **Option 3 – Decommission the LCS**
  Decommission the LCS and utilise funding in other areas of Primary Care with higher clinical priority and impact. This will require a review of potential areas of impact-data driven.

*This option aligns to the LCS requirements and criteria noted in section 6.

8. Recommendations

Based on the prescribing data review, varied uptake across practices, inequity of LCS offer across the patch, complexity associated with POCT and multiple machines, lack of robust long-term clinical governance and oversight, and the financial position of the ICB, the recommendation of the ICB is to support Option 3 to decommission the CRP LCS.

<u>Part 2 - What to do with resource from decommissioning the CRP LCS</u>

If the recommendation in Part 1 of this report is agreed, STW ICB will need to explore options for commissioning a new LCS.

One idea put forward and discussed with the GP Board was to re-pilot the LCS with the highest prescribing Practices across Shropshire, Telford & Wrekin by withdrawing and implementing the existing machines in newly identified practices. This option would require governance and clinical oversight processes to be agreed and funding to cover costs due to machine warranty expiry.

Options for the CRP LCS Budget

- **Option 1: Re-pilot the CRP LCS**

Limited funds make this option impractical. Finding increased resources either within the LCS budget or elsewhere in the ICB budget is part of a much larger piece of work that is currently on pause.

- **Option 2: Keeping the funds for use elsewhere in ICB**

This would break the informal agreement made to keep the LCS budget ring fenced for LCS in primary care.

- **Option 3: Recycle the CRP budget into the wider LCS budget.**

This could mean that rather than the 5% uplift recently offered to practices for 2023-24 delivery of LCS, this is increased using the CRP LCS budget of £25,332 which would benefit all practices.

Recommendation

Based on the absence of local and national data to support wide-scale use of CRP testing across STW for multiple infections and admission avoidance purposes, a pilot would be required to enable full evaluation and outcome review to support this wider roll out. This would however, still not address the complexity associated with POCT and multiple machines, lack of robust long-term clinical governance and oversight within the ICB (currently being provided by Medicines Management as interim measure), and the financial position of the ICB. Without additional funding available to support wider roll out if the pilot was successful, this would not be a viable option. The recommendation of the ICB is to support Option 3 to repurpose the CRP budget into the current LCS budget offering an increased uplift on payments made for existing agreed services across STW.

9. Appendix

IV. Clinical guideline [CG191] Published date: December 2014 Pneumonia in adults: diagnosis and management

V. Primary Care Respiratory Update: The place of point of care testing for C-reactive protein in the community care of respiratory tract infections https://www.pcrs-uk.org/sites/default/files/PoC%20Testing%20FINAL3.pdf

VI. Locally Commissioned Service Specification: Near Patient Testing for CRP in patients attending with lower respiratory tract infection.

Service Specification No.	
Service	Near patient testing for CRP in patients attending with lower respiratory tract infection
Commissioner Lead	
Provider Lead	Telford and Wrekin GP Practices
Period	1st April 2023 - 31st March 2024
Date of Review	TBC

1. Population Needs

1.1 National/local context and evidence base

Tackling high antibiotic prescribing to try to reduce antibiotic resistance is a top priority both nationally and internationally. In the UK, GPs issue around 80% of all prescribed antibiotics although research shows that they only have a small impact on symptoms. Reducing unnecessary antibiotic prescribing in primary care, is therefore one approach to reducing their unnecessary use overall.

It has been shown that point of care testing (POCT) for ‘C reactive protein (CRP)’ can give GPs extra information and help them to better target antibiotics to those people most likely to benefit from taking them.

C-reactive protein (CRP) is an acute phase protein that rises in the blood stream non-specifically in response to inflammation. Liver failure can impair the production of CRP and chronic inflammatory conditions can result in persistently elevated levels. CRP levels can become elevated in response to viral infections but generally rise to higher levels in bacterial infections, especially severe bacterial infections. CRP POCT use can therefore help to guide decision making, **however it is not a replacement for clinical decision making and results should be interpreted in the context of the clinical assessment**.

The main role that CRP POCT is likely to have in general practice is in guiding antibiotic prescribing decisions. Its use may help improve clinical decision making and may make an important contribution to antimicrobial stewardship within general practice. CRP POCT can also potentially help with patient education and managing expectations for an antibiotic.

NICE pneumonia guidelines recommended the use of CRP testing to enhance the assessment of patients with LRTI. Specifically, the test has a role in patients without a clinical diagnosis of pneumonia but in whom there is still uncertainty about whether an antibiotic is needed.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	✓
Domain 2	Enhancing quality of life for people with long-term conditions	
Domain 3	Helping people to recover from episodes of ill-health or following injury	
Domain 4	Ensuring people have a positive experience of care	✓
Domain 5	Treating and caring for people in a safe environment and protecting them from avoidable harm	✓

2.2 Local defined outcomes

A reduction in the inappropriate use of antibacterial agents used in the management of respiratory tract infections, in line with national antibiotic stewardship programme.

3. Scope

3.1 Aims and objectives of service

C reactive protein (CRP) testing is now available as a point of care test (CRP POCT) that can be used in primary care. NICE recommends its use in the diagnosis and appropriate management of lower respiratory tract infections in adults.

The purpose of this enhanced service is to improve antimicrobial stewardship by reimbursing practices for use of a near patient test (CRP) in patients presenting with lower respiratory tract infection when an antibiotic is being considered but the clinical diagnosis is uncertain from the presenting symptoms. The ES will improve patient safety by reducing inappropriate antibiotic prescribing and support the ICB to meet its antibiotic prescribing target.

3.2 Service descriptions/care pathway

- See Appendix 1: Point of Care C-Reactive Protein (CRP) Testing in Primary Care for patients with Lower Respiratory Tract Infections pathway.

- The pathway includes details on:
    - Patients to be considered for CRP testing
    - Interpretation of CRP test
    - Treatment guidelines following CRP assessment
    - Recording requirements (EMIS template for clinical assessment and practice payment claim form)
    - External Quality Assurance of Afinion analyser

- Practices will be expected to order CRP assays directly from Abbott – the ICB will pay for all CRP assays.

- Practices will be required to store the CRP assays as per the manufacturer's instructions

Audit Requirements

For claims to be valid, practices must ensure that they record the outcome of all CRP POCT on the practice audit form. The audit form must be returned to the ICB on a monthly basis.

(See Appendix 1 - Point of Care C-Reactive Protein (CRP) Testing in Primary Care for patients with Lower Respiratory Tract Infections care pathway)

Payment

Each completed and recorded test will be reimbursed at £5

Claims must be submitted to the ICB at the end of each month (no later than 10 working days from end of each month) using the claim / audit form in the CRP care pathway (Appendix 1).

3.3 Population covered

The Provider shall provide services to all appropriate patients registered with a practice within Telford & Wrekin.

3.4 Any acceptance and exclusion criteria and thresholds

None

3.5 Interdependence with other services/providers

The Provider shall ensure that, where appropriate to the service, they work with other appropriately trained professionals.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

Clinical guideline [CG191] Published date: December 2014

Pneumonia in adults: diagnosis and management

4.2 Applicable standards set out in guidance and/or issued by a competent body (e.g. Royal Colleges)

None

4.3 Applicable local standards

Prescribing of any antibacterial treatment following CRP assessment must be in line with local Antibiotic prescribing policy.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements

All practices must ensure that they complete the required quality control assessments.

5.2 Applicable CQUIN goals

None

6. Location of Provider Premises

The Provider's premises are located at:

All GP premises within Telford & Wrekin.

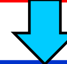
7. Individual Service User Placement

Appendix 1 Point of Care C-Reactive Protein (CRP) Testing in Primary Care for patients with Lower Respiratory Tract Infections

Patient presents with symptoms of lower respiratory tract infection.

Cough as the main symptom and with at least 1 other lower respiratory tract symptom (such as fever, sputum production, breathlessness, wheeze or chest discomfort or pain) and no alternative explanation (such as sinusitis or asthma).

Consider a point of care C-reactive protein (CRP) test if after clinical assessment a diagnosis of pneumonia has not been made and it is not clear whether antibiotics should be prescribed.



Use results of the CRP test to guide antibiotic prescribing as follows:

- **CRP concentration less than 20mg/litre** - Do NOT routinely offer antibiotic therapy.
- **CRP concentration is between 20 mg/litre and 100 mg/litre** - Consider a delayed antibiotic prescription (a prescription for use at a later date if symptoms worsen).
- **CRP concentration is greater than 100 mg/litre** - Offer antibiotic therapy.

Treatment Guide

Community acquired pneumonia (CAP) - Severity assessment in primary care

When a clinical diagnosis of CAP is made, determine whether patients are at low, intermediate or high risk of death using the **CRB65 score**.

CRB65 score is calculated by giving 1 point for each of the following prognostic features:

- confusion (abbreviated Mental Test score 8 or less, or new disorientation in person, place or time)
- raised respiratory rate ($\geq$ 30 breaths per minute)
- low blood pressure (diastolic $\leq$ 60 mmHg or systolic $\leq$ 90 mmHg)
- age $\geq$ 65 years of age.

Stratify patients for risk of death as follows:

- 0: low risk (< 1% mortality risk)
- 1 or 2: intermediate risk (1-10% mortality risk)
- 3 or 4: high risk (> 10% mortality risk)

Use clinical judgement in conjunction with the CRB65 score to inform decisions about whether patients need hospital assessment as follows:

- score of 0 or 1: consider home-based care
- score of 1-2 consider hospital referral
- score of 3-4 urgent hospital referral

The CRB65 score should not replace clinical judgement in deciding if a person should be admitted. Other factors should also be considered in making the decision. These include:

- The person's wishes.
- Their social support.
- Pre-existing conditions.
- Pregnancy.
- General frailty.

Do NOT routinely offer microbiological tests to patients with

Antibacterial therapy

Low Severity Community Acquired Pneumonia

FIRST LINE:
Amoxicillin 500mg - three times daily for 7 days

ALTERNATIVE TREATMENT OPTION (Penicillin allergic):
Doxycycline 200mg STAT on day 1 then 100mg twice daily for a further 6 days

See antibiotic prescribing guidelines for further information:
http://www.telfordccg.nhs.uk/infections

Moderate Severity Community Acquired Pneumonia

Consider hospital referral

Patient Counselling

Explain to patients with CAP that after starting treatment their symptoms should steadily improve, although the rate of improvement will vary with the severity of the pneumonia, and most people can expect that by:

1 week: fever should have resolved,
4 weeks: chest pain and sputum production should have substantially reduced,
6 weeks: cough and breathlessness should have substantially reduced,
3 months: most symptoms should have resolved but fatigue may still be present,
6 months: most people will feel back to normal.

Explain to patients they should seek further medical advice if symptoms do not begin to improve within 3 days of starting the antibiotic, or earlier if their symptoms are worsening.

Reporting POC CRP Testing for patients with lower respiratory tract infections

Complete the respiratory review template on your EMIS system confirming that you have requested a point of care CRP test.

The review template will also enable you to record examination findings, the actual CRP level and the outcome of the review in terms of prescribing of an antibacterial.

The practice will also be asked to keep a simple record of the date a CRP test was completed and the CRP level. This will facilitate the quarterly practice payment.

External Quality Assurance (EQA)

Each practice site will receive a whole blood sample on a monthly basis. The sample will need to be analysed and the result reported back to the external QA provider. The ICB will receive confirmation that each site has completed the monthly QA process and an assurance that their monitor is reading to the specified accuracy.

If there are any concerns about the accuracy of the monitor following EQA further analysis of the monitor/assay procedure may be requested.

Practices will not receive payment for CRP analysis if they do not participate in the EQA process.

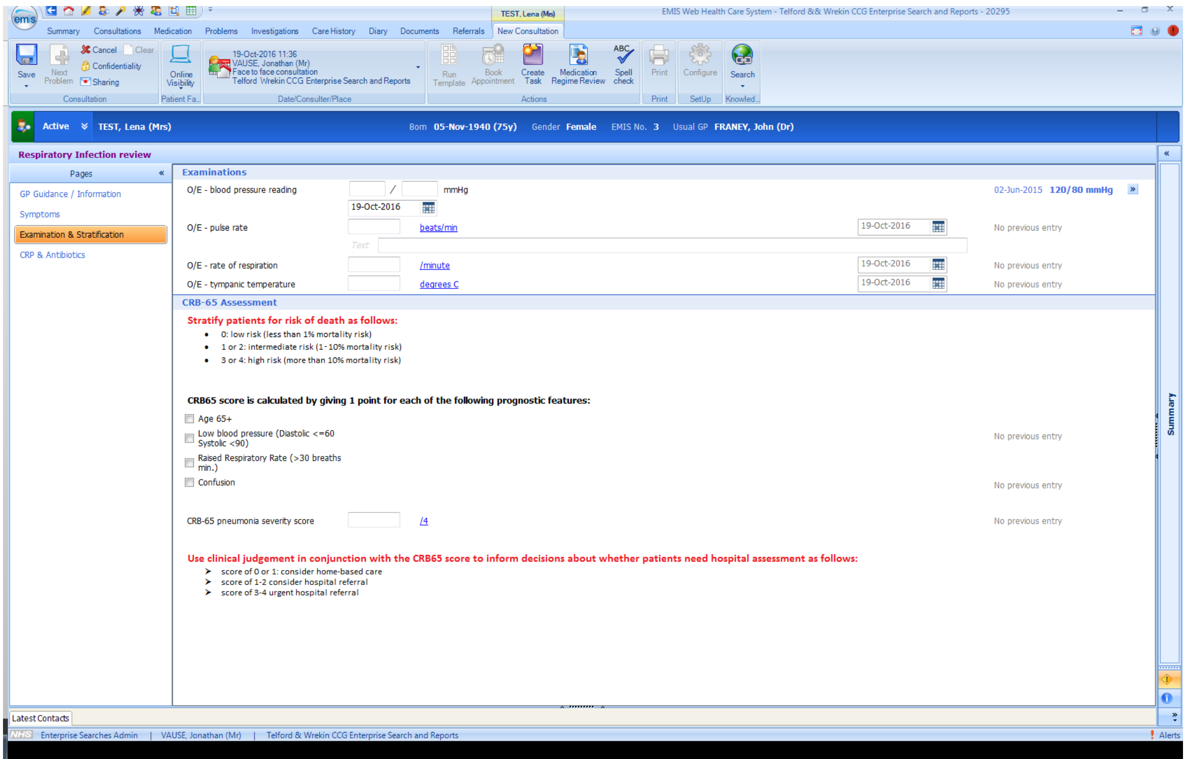
Practice payment

Each practice will receive payment for actively using the CRP testing capability. A fee will be reimbursed for every completed test.

Payment will initially be based on return of a quarterly submission form, outlining the date each test was completed and the associated CRP level.

Additionally, practices will be encouraged to complete the respiratory review template. This will further underpin practice payments as it will allow central data extraction of CRP and confirmation of any outcome linked to CRP testing. The EMIS template will be uploaded centrally onto your clinical systems.

EMIS: **Respiratory Infection Review Template.**



Point of Care C-Reactive Protein (CRP) Testing – Practice Payment Claim Form

Practice	
Period Claimed	

Date	Unique patient identifier	CRP level	Was an antibiotic prescribed? (please tick ☑)		
			Antibiotic Prescribed	Delayed Antibiotic Prescription given	No Antibiotic prescribed

Date	Unique patient identifier	CRP level	Was an antibiotic prescribed? (please tick ☑)		
			Antibiotic Prescribed	Delayed Antibiotic Prescription given	No Antibiotic prescribed

Primary Care Commissioning Committee Part 1 – 2nd June 2023

Agenda item no.	PCCC 23-06.36								
Meeting date:	**2nd June 2023**								
Paper title	**2022/23 Month 12 Primary Care Financial Position**								
Paper presented by:	**Jill Price** **Finance Business Partner**								
Paper approved by:	**Claire Skidmore** **Chief Finance Officer**								
Paper prepared by:	**Angharad Jones** **Finance Business Partner**								
Signature:	C Skidmore								
Committee/Advisory Group paper previously presented:	**N/A**								
Action Required (please select):									
A=Approval		R=Ratification		S=Assurance		D=Discussion		I=Information	X
Previous considerations:	**Not applicable**								

1. Executive summary and points for discussion

Financial Position – Month 12, March 2023:

The outturn for Co-Commissioning budgets (those delegated to the ICB from NHSE) is an underspend of £3,081k. 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 outturn is an underspend of £561k.

For information, the outturn for other Primary Care budgets (those that form part of the ICB's core budget) is an overspend of £3,718k. The main driver of the overspend is increased Prescribing expenditure associated with National Price Concessions.

The Primary Care Efficiency Schemes out turned at £1.982m, delivering in excess of plan by £201k.

There was a slight underspend of £42k on the ICB Capital allocation, this was due to a couple of GP Practices withdrawing their Improvement Grant scheme bids.

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 2022/23 outturn position for the delegated budgets
Note the 2022/23 outturn position for non delegated primary care and the volatility seen in the prescribing budget driven by factors outside of the ICB's control
Note the 201k overachievement against Primary Care Efficiency Schemes
Note the slight underspend of £42k against the ICB Capital allocation

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. M12 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 2022/23 outturn position for the delegated budgets **Note** the 2022/23 outturn position for non delegated primary care and the volatility seen in the prescribing budget driven by factors outside of the ICB's control **Note** the 201k overachievement against Primary Care Efficiency Schemes **Note** the slight underspend of £42k against the ICB Capital allocation	**Action approved at Board:**	
		If unable to approve, action required:	
Signature:		**Date:**	

2022/23 Month 12 Financial Position

Introduction

1. The financial performance reported in this paper is for Month 12 – March 2023.

Delegated Budget

Table 1: M12 Realigned Budget Position Delegated

Primary Care Delegated	2022/23 Budget £'000	2022/23 Outturn £'000	2022/23 Variance £'000
General Practice - GMS	52,993	51,839	1,154
QOF	7,911	7,576	335
Enhanced Services	15,091	15,439	(348)
Premises Cost Reimbursements	7,153	6,903	250
Dispensing & Prescribing	2,939	3,177	(238)
Other GP Services	1,261	(667)	1,928
Total Primary Care Delegated	**87,348**	**84,267**	**3,081**

2. The above table shows the outturn 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: M12 In Year Underlying Position Delegated

Primary Care Delegated	2022/23 Budget £'000	2022/23 Outturn £'000	2022/23 Variance £'000
General Practice - GMS	52,993	51,839	1,154
QOF	7,911	7,876	35
Enhanced Services	15,091	15,439	(348)
Premises Cost Reimbursements	7,153	7,225	(72)
Dispensing & Prescribing	2,939	3,177	(238)
Other GP Services	1,261	1,231	30
Total Primary Care Delegated	**87,348**	**86,787**	**561**

3. General Practice GMS - variance is due to list size growth being lower than originally planned. 2% growth was built into the plan. The actual growth seen was an average of 0.28% per quarter. The Global Sum payment is recalculated each quarter based on the latest list size data which is released on a quarterly basis.

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 of 94%, with the remainder of the budget repurposed for Strep A Additional Capacity and a Fair Shares Winter Pressures Payment to practices.

5. Enhanced Services – The Additional Roles Reimbursement Scheme (ARRS) represents 48% of the annual budget on Enhanced Services. The outturn for ARRS was 100%

utilisation of the baseline allocation as well as a further £1.9m additional drawdown from the central fund. The year end variance is due to an increase in other enhanced services following up to date analysis received from the NHSE GMAST team.

6. Premises Cost Reimbursements – The Month 12 outturn is an underspend of £250k, within this there is £322k of income in relation to the non-recurrent rates rebates efficiency scheme. The non recurrent nature of this income is reflected in the underlying position of £72k overspend.

7. Dispensing and Prescribing – The final outturn is an overspend of £238k this overspend is as a result of the National increase in dispensing fees from October 2022.

8. Other GP Services – The £30k underspend driven by Locum spend being less than originally anticipated and budgeted for. This underspend is partially offsetting the adverse variance on Premises Cost Reimbursements.

9. The difference between the reported position and the underlying position is £2.5m. 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 underspend of £561k, there are known future commitments in relation to premises, in particular new developments, that will reduce this underspend significantly.

Non Delegated Budget

Table 3: M12 Reported Position Non Delegated

Primary Care Non Delegated	Budget Year To Date £'000	Actual Year To Date £'000	Variance Year To Date £'000
Prescribing	84,733	89,862	(5,129)
Central Drugs	2,436	2,637	(200)
Oxygen	918	1,082	(165)
Prescribing Incentive Schemes	377	243	133
Out of Hours	4,391	4,422	(30)
Enhanced Services	5,676	3,576	2,100
Primary Care Pay	3,059	2,622	437
Primary Care Other	1,344	1,305	39
Primary Care IT	2,823	2,790	34
GP Forward View	2,224	2,346	(122)
Primary Care Planning Adjustment	(815)	0	(815)
Total Primary Care Non Delegated	**107,167**	**110,885**	**(3,718)**

11. The outturn position is an overspend of £3.7m. The main driver for the reported overspend is Prescribing which is being partly offset by the release of prior year benefits in relation to Enhanced Services.

12. Prescribing data is two months in arrears. The forecast is based on the National EPACT system forecast which is updated on a monthly basis. In addition to this a further £1m has been included into the forecast in relation to NCSO and Category M drugs based on the average monthly increase seen in the EPACT forecast throughout the financial year. The main driver of the overspend is the cost pressure from NCSO (No Cheaper Stock Obtainable) price concession and Category M Drugs tariff, totalling £3.5m higher than 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 2022 – January 2023.

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%
November	832,849	£ 8,288,590	£ 9.95	9.1%	2.6%	6.4%
December	890,726	£ 8,899,805	£ 9.99	10.4%	4.4%	5.8%
January	838,966	£ 8,505,630	£ 10.14	17.9%	6.7%	10.5%
Year to Date				**6.6%**	**4.0%**	**2.5%**

Efficiency

Table 4: M12 Efficiency Schemes

Efficiency Scheme	Full Year Plan £'000	Full Year Outtun £'000	Forecast Variance £'000
DOAC	884	336	(548)
Optum	247	393	146
Prescribing Decision Support	500	648	148
Procurement of Decision Support Tool	0	28	28
VAT Rebate on Decision Suport Tool	0	45	45
Switch Programme	150	215	65
NR Safer Medicines (LCS)	0	133	133
NR Prescribing Decision Support	0	136	136
DOLCV	0	49	49
Total	**1,781**	**1,982**	**201**

14. 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 agreed.

15. The outturn position was £1,982k being £201k in excess of plan. 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

16. 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 Outturn.

Capital Scheme	22/23 Plan £'000	22/23 Forecast £'000	22/23 Variance £'000
GP IT Hardware Replacement	286	286	0
Additional GP IT Hardware Replacement	315	315	0
N365 Deployment	282	282	0
GP Improvement Grants	305	263	42
Total	**1188**	**1146**	**42**

Conclusion

17. Delegated budgets delivered 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 outturned at an overspend of 3.7m, due to the increased expenditure on Prescribing due to Price concessions.

18. The Primary Care Efficiency Schemes out turned at £1.982m, which was an overachievement of £201k.

19. There was a slight underspend of £42k on the ICB Capital allocation, this was due to a couple of GP Practices withdrawing their Improvement Grant scheme bids.

Appendix 1

Month 12 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
General Practice - GMS	52,721	51,839	881
General Practice - PMS	0	0	0
QOF	7,845	7,576	269
Enhanced Services	14,129	15,439	(1,310)
Premises Cost Reimbursements	7,651	6,903	748
Dispensing & Prescribing	2,955	3,177	(221)
Other GP Services	1,429	(667)	2,096
Co Commissioning Planning Adjustment	618	0	618
Total Primary Care Delegated	**87,348**	**84,267**	**3,081**

Primary Care Commissioning Committee Part 1 – 2nd June 2023

Agenda item no.	PCCC 23-06.36								
Meeting date:	**2nd June 2023**								
Paper title	**2023/24 Primary Care Financial Plan**								
Paper presented by:	**Jill Price** **Finance Business Partner**								
Paper approved by:	**Claire Skidmore** **Chief Finance Officer**								
Paper prepared by:	**Angharad Jones** **Finance Business Partner**								
Signature:	C Skidmore								
Committee/Advisory Group paper previously presented:	**N/A**								
Action Required (please select):									
A=Approval		R=Ratification		S=Assurance		D=Discussion	x	I=Information	x
Previous considerations:	**Not applicable**								

1. Executive summary and points for discussion

2023/24 Financial Plan:

For context, the system submitted a very challenging £60m deficit plan for 23/24, the ICB element of this is a £14.7m in year deficit. The plan includes a 6.7% system efficiency target and a significant level of risk.

Detailed plans have been worked through which currently show a breakeven plan for Delegated co-commissioning based on the 2023/24 GP contract. It is expected that there will be a £1.1m underspend in year to offset the planning adjustment within the non-delegated budgets.

Non-Delegated budgets equate to £111m, include £3.1m planned efficiencies within Prescribing and £1.1m planning adjustment which assumes a non-recurrent underspend within the Delegated budgets.

The Primary Care Planning Adjustment is similar to the adjustment applied in 22/23 budgets due to the delegated expenditure budget plan having to match the incoming allocation for co commissioning. After setting an expenditure plan for the delegated budget, this is £1.1m less than the allocation. The finance team therefore make an expenditure budget adjustment to

match total allocation with the benefit of this underspend then being pushed into and reported in the non-delegated budget area.

From 1st April 2023 responsibility for commissioning Pharmacy, Optometry and Dental Services transferred from NHS England to ICBs. Overall, for West Midlands there is an imbalance of 0.42% but this varies between ICBs by up to 7.8% of allocation. For STW this equates to 3.41% and is the 2nd highest deficit in the West. For the purpose of the plan submission, an adjustment was made to reserves at an ICB level to ensure a breakeven position was presented. For STW ICB this was a negative reserves adjustment of £1.7m. This adjustment has only been applied on a non-recurrent basis and therefore is a risk for the ICB.

The ICB has a small capital allocation of £883k for GP Services. The 2023/24 STW Capital Plan is now published on the ICB website.

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 detailed budget plans and related assumptions for Delegated Co-commissioning to operate within as approved by board
Note the non-delegated budget plans and assumptions.
Note the breakeven plan submitted for POD services, which contains a £1.7m negative reserves adjustment, expected to be mitigated in year through the agreed risk management framework.
Note the recurrent risk related to the non-recurrent nature of the £1.7m POD adjustment.
Note the capital plan for GP services which is published on the ICB website.

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

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	23/24 recurrent exit position forms the basis of long term financial planning
Citizen and Stakeholder Engagement	No impact

Request of Paper:	**Note** the detailed budget plans and related assumptions for Delegated Co-commissioning to operate within as approved by board **Note** the non delegated budget plans and assumptions. **Note** the breakeven plan submitted for POD services, with a £1.7m negative reserves adjustment, expected to be mitigated in year through the agreed risk management framework. **Note** the recurrent risk related to the non recurrent nature of the £1.7m POD adjustment. **Note** the capital plan which is published on the ICB website.	**Action approved at Board:**	
		If unable to approve, action required:	
Signature:		**Date:**	

2023/24 Financial Plan

Introduction

1. The system plan submitted to NHS England on the 4th May 2023 was a £60m deficit plan for 23/24, the ICB element of this is a £14.7m in year deficit. The agreed plan is challenging with a 6.7% system efficiency target and a significant level of risk. The system is in financial recovery and is at NOF4, which is the highest level of the NHS Oversight Framework and comes with intensive support.

Delegated Co-Commissioning Planning 23/34

2. The ringfenced Delegated Co-Commissioning allocation for GP Services for 2023/24 is £91.504m.

3. The ICB has been notified of an additional £105k non recurrent allocation for 2023/24 in relation to the Impact and Investment Fund and the Weight Management Service which has been included in the expenditure plans below. However, this additional allocation will need to be approved for release into the budgets as per the ICB's new approval process for new monies into the system.

4. The GP Contract for 2023/24 has now been published and below is a summary by budget category of budget setting for the Delegated Co-Commissioning allocation, based on what is in the contract guidance. Planning assumptions are detailed below.

Category	23/24 Budget £'000
Global Sum	53,920
QOF	8,143
PCN Enhanced Services	16,715
Other Enhanced Services	803
Premises Reimbursements	8,144
Dispensing & Prescribing Fees	3,218
GP Other	665
Total	91,609

5. Global Sum – The budget is based on the new Global Sum value of £102.28 per patient. Quarter 1 payments are known and have been built into the plan, list size growth is also applied based on the growth seen per quarter in 22/23, which equates to 0.84%.

6. QOF – The budget is based on the new QOF point value of £213.43. The plan is based on 98% achievement by all GP Practices.

7. PCN Enhanced Services – The ARRS baseline budget is as per published, £7.680m. The Impact and Investment Fund (IIF) has been repurposed for 23/24. The Capacity and Access payment is based on £2.765 per adjusted population and is paid to PCNs on a monthly basis. £1.185 per adjusted population is allocated to the PCN Improvement Plan, the budget is based on 100% achievement. The remainder is then based on 5 IIF indicators, the budget has been based on 100% achievement by PCNs.

8. Other Enhanced Services – 1% list size growth has been applied across Minor Surgery and LD Health Checks based on full year list size growth seen between 21/22 and 22/23. For the Special Allocation Scheme, the budget has been set based on Q3 & Q4 activity. Weight Management Service expenditure is planned to breakeven against the additional allocation received.

9. Premises Reimbursements – Where practices are due valuations in year, a 5% increase has been applied based on advice from NHSE estates team. Increase in rents and rates have also been applied where there are new premises developments due to complete in year. There is a £100k contingency built in for any new requests for premises developments. Part of this has already been allocated against the recent request from Shrewsbury PCN. We are expecting c£200k in rates rebates income in year which will result in an underspend within this area.

10. Dispensing and Prescribing Fees - 1% growth has been applied across this area. The latter part of 22/23 saw a step increase in costs due to an uplift to the dispensing fees applied in October 2022. According to the Standard Financial Entitlements the fees decrease from April 2023 and therefore expenditure should return back to historical trend.

11. GP Other – The locum plan has been based on an average of the last 3 years spend. CQC fees are based on the national calculator results for each practice. Other smaller spend areas within this category have been based on 22/23 forecast outturn.

12. It is expected that these budgets will underspend by £1.1m in year to offset the opposite entry (Primary Care Planning Adjustment) included within the non delegated budgets. The Primary Care Planning Adjustment is similar to the adjustment applied in 22/23 budgets due to the delegated expenditure budget plan having to match the incoming allocation for co commissioning. After setting an expenditure plan for the delegated budget, this is £1.1m less than the allocation. The finance team therefore make an expenditure budget adjustment to match total allocation with the benefit of this underspend then being pushed into and reported in the non delegated budget area.

Non Delegated Planning 23/34

13. Below is a summary of the non delegated budgets for 23/24 and the assumptions applied to the main budget lines.

Primary Care Non Delegated	**2023/24 Budget £'000s**
Prescribing	90,305
Central Drugs	2,633
Oxygen	1,183
Out of Hours	6,041
Enhanced Services	4,692
Primary Care Pay	3,272
Primary Care Other	71
Primary Care IT	2,646
Service Development Funding (SDF)	1,327
Primary Care Planning Adjustment	(1,100)
Total Primary Care Non Delegated	**111,070**

14. Growth of 3.8% have been applied to both the Prescribing and Central Drugs budgets as per the system agreed planning assumptions based on latest guidance and benchmarking information. The Prescribing budget includes an estimate of a £2m cost pressure in relation to NICE drugs that are due to come on-stream in-year and an efficiency target of £3.1m.

15. The Oxygen contract is managed Regionally, the budget has been uplifted based on latest negotiations.

16. The Out of hours contract has been uplifted by 3% as per the system agreed planning assumptions based on latest guidance and benchmarking information.

17. Service Development Funding is a non recurrent funding stream, the indicative budgets based on the same split as 22/23 is shown below. £452k for Digital First is also included within the Primary Care IT budget. Further guidance is expected imminently around the actual split for 23/24.

Description	2023/24
Training hub	103,000
Local GP Retention	98,000
Practice Nurse Measures	25,000
Primary Care Networks	222,000
Flexible Staff Pools	120,000
Leadership & Management	369,000
Fellowships	309,000
Supporting Mentors	73,000
Other - To be allocated	8,000
TOTAL BUDGET	**1,327,000**

18. The Primary Care Planning Adjustment is similar to the adjustment applied in 22/23 budgets due to the delegated expenditure budget plan having to match the incoming allocation for co commissioning. After setting an expenditure plan for the delegated budget, this is £1.1m less than the allocation. The finance team therefore make an expenditure budget adjustment to match total allocation with the benefit of this underspend then being pushed into and reported in the non delegated budget area.

<u>Pharmacy, Ophthalmology and Dental (POD) Delegation Planning 23/24</u>

19. From 1st April 2023 the responsibility of commissioning Pharmacy, Optometry and Dental Services transferred from NHS England to Integrated Care Boards.

20. For Midlands Region it has been decided that those staff previously working within these services for NHSE will now transfer to two hosted teams, one in the East and one in the West. The host ICB for the West Region is NHS Birmingham and Solihull.

21. Below is summary of the March Plan submission for POD Delegated Services, as submitted by NHSE Midlands Region.

Primary Care POD Delegated	2023/24 Budget £'000s
Primary Care Dental	22,702
Community Dental	3,855
Secondary Care Dental	8,277
Ophthalmic Services	5,748
Pharmacy Services	10,178
Other Delegated Expenditure	(152)
Total POD Delegated	**50,608**

22. Regional baseline allocations were based on 2019/20 Long Term Plans adjusted to 2022/23. Allocations were then uplifted by tariff and pay awards.

23. The calculated allocations for 2022/23 based on this methodology were 1.59% higher than the affordable financial quantum for 2022/23 so a downward adjustment to ensure national affordability was then applied.

24. ICB level budgets were calculated on the same basis based on information collected through the baseline exercise undertaken to allocate budgets using population data or geographical location of services as appropriate in line with national guidance.

25. Growth as defined in the 2023/24 planning guidance wa then applied to determine ICB level allocations for 2023/24.

26. 2023/24 expenditure plans were calculated as follows:

    - Primary Care expenditure plans were based on 100% delivery of 2022/23 contract levels uplifted for contract price growth.
    - Secondary Care Dental contracts maintained 2022/23 recurrent activity levels adjusted from a host region basis to a population basis.
    - Pharmacy expenditure was based on 2022/23 EPACT2 data adjusted for growth as advised in the planning guidance. Changes were made to reflect national adjustments to single activity fee and COVID transitional payments.
    - Ophthalmic services expenditure is based on 2022/23 activity data to January 2023 uplifted by 4.3% in line with national guidance.

27. Activity growth above that included within contract values has been reserved to create a recurrent investment fund and 1% contingency across all services. For the purpose of the 2023/24 financial plan, these reserves have been allocated to ICBs on the basis of GP weighted population. Actual usage in year will be based on the profile of investments and requirements for the application of contingencies.

28. Although balanced overall, the application of the above methodology for the calculation of allocations and expenditure plans did not result in a balanced financial plan at ICB level. The main reason for this is the differing basis of calculation – i.e. allocations based on 2019/20 recurrent outturn and expenditure plans based on 2022/23 contract levels and outturns. There are several differences between the basis of these two approaches:

- Differential application of growth linked to approved investments between 2019/20 and 2022/23.
- Contract hand backs.
- New procurements between 2019/20 and 2022/23
- Allocation of reserves on GP weighted populations rather than historical spend profile.

29. Overall, for West Midlands there is an imbalance of 0.42% but this varies between ICBs by up to 7.8% of allocation. For STW this equates to 3.41% and is the 2nd highest deficit in the West. For the purpose of the plan submission, an adjustment was made to reserves at an ICB level to ensure a breakeven position was presented. For STW ICB this was a negative reserves adjustment of £1.7m. This adjustment has only been applied on a non recurrent basis and therefore is a risk for the ICB.

30. Early agreement was reached that initially, finances would be managed on a collective basis for delegated POD budgets. From this agreement a financial risk management framework was developed to agree the principles of managing risk across the Midlands.

31. The adjustment to the finance plan to demonstrate break even at an ICB level has been assumed based on the directions of the risk management framework. The framework also provides methodology for sharing risk and rewards in several scenarios including an overall overspend or underspend.

32. Although predominantly intended to be non-recurrent, the framework does allow consideration of recurrent adjustments in exceptional circumstances.

33. A paper was presented to ICB CFOs proposing that this be applied to opening differences in ICB allocations to provide a recurrent balanced opening position at individual ICB levels. CFOs agreed that this should not be applied but that more work was required to map budgets and variances in year before any recurrent adjustments might be considered. This position and proposed action was subsequently supported by Chief Executives.

Capital

34. The ICB has a small capital allocation of £883k for GP Services, split between Primary Care IT and GP Improvement Grants as detailed below. These assets sit on the NHSE Statement of Financial Position (balance sheet) and do not appear in the ICB accounts or asset register. As per the requirement of The Health and Care Act 2022, the 2023/24 STW Capital Plan is now published on the ICB website.

Description	£'000s
GPIT Hardware	576
GP Improvement Grants	307

Conclusion

35. Detailed plans have been worked through which currently show a breakeven plan for Delegated co-commissioning based on the 2023/24 GP contract. It is expected that these

budgets will underspend by £1.1m in year which will manifest in the non delegated budget given the national mandate to match delegated expenditure plans to incoming allocation.

36. Non Delegated budgets equate to £111m, including £3.1m efficiencies within Prescribing and the £1.1m planning adjustment noted above

37. A breakeven plan was submitted for the POD Delegated services, with a £1.7m negative reserves adjustment for the ICB. This is expected to be mitigated in year through the agreed risk management framework. This adjustment has only been applied on a non recurrent basis and therefore is a risk for the ICB.

38. The Capital allocation for GP Services is £883k. The 2023/24 STW Capital Plan is now published on the ICB website.

Primary Care Commissioning Committee 2 June 2023

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<tr><td colspan="2">Paper title</td><td colspan="8">Workforce and Training Hub Update</td></tr>
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<tr><td colspan="2">Paper approved by:</td><td colspan="8">Emma Pyrah</td></tr>
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1. Executive summary and points for discussion

This report provides committee with a high-level description on progress made against STW Primary Care Workforce and Training Hub (WTH) workstreams which are summarised under the headings below. These areas of work form the basis of the Workforce and Training Hub Strategy which is currently in development.

1. **Learner Placement Capacity –** the remit of Training Hubs is to 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

   - A Multi-Professional Education Quality Lead is now in post for 0.2 FTE to lead on progressing the quality learner environment framework across STW primary care organisations. It is considered that a more streamlined audit system for placement providers will support creating capacity for all learner types.

   - 0.6 FTE Student Nurse Placement Facilitators have been recruited and starting in June 2023.

   - Clinical Facilitators support student placements for their professions.

- Placement numbers for non-medical staff groups remain low.

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

   Key points

   - The vast majority of the ICB's 22/23 Additional Roles Reimbursement Scheme (ARRS) funding was utilised by the 8 PCNs – an improvement from the position with the 21/22 funding. Due to the increased effort made by PCNs on recruitment there are now over 280 ARRS funded staff (headcount) working across the 8 PCNs.
   - The GP and GPN Strategy Delivery Plans provide the detail of initiatives supporting these staff groups and are embedded in the paper below.
   - The system People Strategy is currently being drafted. Primary Care is being represented through attendance of WTH team members at development meetings.

3. **Recruitment of Primary Care Workforce –** covering all roles @ 31 March 2023.

   Key points
   Slight change from previous reporting:

   - Stable numbers of GPs, but more working fewer hours, leading to a drop of 43 WTE since September 2015
   - A significant drop (29%) in the number of WTE partners
   - A slight drop in the number of GPNs
   - A significant increase in the number of Advanced Practitioners
   - A big 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
   As per previous reporting:

   - 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.

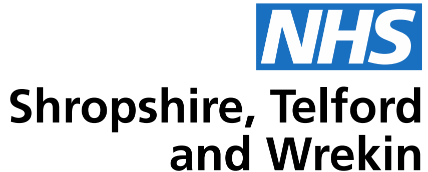
5. **Workforce Retention** - Supporting the retention of the primary care workforce across all key transitions including promoting primary care as an employment destination. Supporting training, education and development programmes.

   Key points

   - NHSE/I funded GP retention initiatives continue to be developed – mentoring, Fellowships and support roles for specific GP groups.

- Return to regular face to face PLT for GPs and Advanced Practitioners. 5 PLT sessions booked for 23/24. GP Hot Topics update sessions planned for September this year.
- A comprehensive 2023 Training, Education and Development offer is available across all staff groups (see embedded document in the table below for detail).
- Ethnically Diverse Staff Survey – closed mid-March with 209 responses (circa. 12% return).   A face-to-face event took place in May to discuss the key findings of the survey and start work on an action plan. An analysis of survey, key themes and proposed actions will be provided to the subsequent PCCC meeting in the form of a full report.

Further detail on the current position, challenges and next steps on all of the above can be found 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, Trainee Nurse Associates, 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 and internal supervisor and assessor 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**. A Multi-Professional Education Quality Lead has now been recruited to help move this agenda forward and develop our approach. Facilitators work closely with universities in relation to the provision of placements for their professional groups in STW. All activity in relation to this will be aligned now with the Education Quality Lead who will have oversight. A more robust system is being developed to collate data on learner types and numbers for 23/24. Next steps include piloting HEE Quality Framework approach with a PCN to assess impact and initiatives to increase supervisor roles.
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 April 23 to March 24. This data is being used to assess the extent to which the ICB will be utilising the overall 23/24 ARRS budget. The latest data suggests that, unlike previous years, the 8 PCNs will be close to fully using the ICB allocation. This is being closely monitored to ensure that there is no overspend and suitable funding to meet this demand has been agreed with NHSE.	The ICB will be working with the PCNs to monitor their ARRS staff recruitment (plans and actual recruitment) during 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 ARRS roles, would be of most use to them.

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 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.	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. This work has not yet taken place but will be commenced as soon as resources allow.
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. For the summer 2023 cohort of newly-qualified GPs practices that are interested in recruitment this cohort have been asked to submit adverts which have been shared with the soon-to-qualify GP Trainees. **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.	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 continue encourage practices to become sponsoring employers to enable them to recruit IMGs following their CCT (over half of the GPVTS Doctors are IMGs).

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 74 fully approved GPs on the Platform and a small, but growing, number of nurses, ANPs and other clinicians. Use of the Platform by practices has been low but is gradually growing. A detailed report on the use of this Platform will be provided to PCCC in time for a decision to be made about whether or not to re-commission the service.

Ongoing engagement will take place with practices to increase take-up of the Lantum platform.

Data

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

Cohort	Sept 2015		March 2023	
	Headcount	FTE	Headcount	FTE
GPs (fully qualified)	321	285	316	242
GP Partners	241	229	189	163
Practice Nurses	183	117	161	106
ANPs	34	25	69	54
Direct Patient Care	155	97	216	150

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 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. 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 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 has been offered to PCNs to support new roles and existing professions post-qualification and beyond preceptorship year.	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. Next steps to include further identifying funding to extend facilitator contracts to the end of March 2024 in line with ARRS scheme funding window and provide support to other staff groups such as Personalised Care Roles. Clinical Supervision model of practice training has been delivered to two cohorts of clinicians. Plans to be developed around creating a suite of resources for practices and PCNs for a multi- disciplinary clinical supervision framework and policy template which practices and PCNs can use as a standard.
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 was developed in 2022 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	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. The ICB will use the findings of the PCC work to:

intelligence on the experiences, challenges and concerns of our GPs, and a survey of practices as employers of GPs. Five surveys have been carried out: Medical Students, Foundation Year Doctors, GP Trainees, Fully-Qualified GPs and Practices as GP Employers. The results of these surveys are being analysed and will be presented to a subsequent PCCC meeting.

- Recruiting a number of GP lead roles to champion different specific sub-cohorts of GPs. Appointments have been made to all 7 advertised roles: Female GP lead, Older GP lead, Career Breaks GP lead, GP Locum Champion, Ethnically Diverse GP Champion, GP Marketing lead and a Differential Attainment GP lead (working with IMG doctors on the VTS). All of these GPs are working to action plans and KPIs which will be reported at the end of the 23/24 financial year.
- 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 with applications from five others to join as the next cohort in August/September 2023.
- STW GPs are able to access free, confidential mentoring, provided by a trained, local team of mentors. Funding for this is provided by NHSE.

GPN Retention

- Clinical Supervision training opportunity delivered.
- Development of a career pathway for HCAs from Care. Certificate level through to Nurse Associate Apprenticeship and opportunities to progress to registered nurse qualification.
- Supporting development of registered nurses new to general practice/newly-qualified through the Fundamentals programme.
- Broad CPD offer to upskill with opportunity for career progression to Advanced Practice.

- better focus future funding with a view to retaining more of the GP workforce
- help the team of GP leads to identify relevant projects, initiatives and programmes of work
- assist practices in improving their approach to recruitment, induction and retention of their GPs.

GP Strategy Action Plan (to be reviewed in the summer of 2023)

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egy%20Action%20Pla

GPN Key Deliverables Action Plan (to be reviewed in the summer of 2023)

GPN%20Strategy%2
0key%20deliverables

• GPN/AP peer network active including supervision, updates and trainee MSc Advanced Practitioners away days. • Supporting flexible working via accessing short term cover enabling staff to be retained within STW.	
PLT GP and Advanced Practitioner sessions will be face- to-face in 2023 covering Diabetes and Cancer. Other staff groups to be offered some virtual training.	Training is currently being commissioned for the year ahead.
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. 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 in 22/23 with over 210 eligible staff accessing this funding. Training commissioned using this monies over has so provided upskilling opportunities for over 350 GPNs and AHPs working in general practices across STW in the last 3 years. NHSE/I has recently confirmed CPD funding will continue for 23/24. 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.	 Shropshire, Telford and Wrekin Training H

PLT	Dates	Area
Summer PLT 1 JUNE 2023 Diabetes	Wednesday 14 June 2023	Shrewsbury & North Shropshire
	Thursday 22 June 2023	Telford & South Shropshire
Autumn PLT 2 SEPTEMBER 2023 Cancer	Thursday 7 September 2023	Shrewsbury & North Shropshire
	Wednesday 27 September 2023	Telford & South Shropshire
Winter PLT 3 NOVEMBER 2023	Wednesday 22 November 2023	Shrewsbury & North Shropshire
	Thursday 30 November 2023	Telford & South Shropshire
Spring PLT 4 MARCH 2024	Thursday 7 March 2024	Shrewsbury & North Shropshire
	Wednesday 13 March 2024	Telford & South Shropshire

Development of a Training and Education Newsletter to include training and education data that can be shared with PCNs and Practices

STWTH continues to support primary care colleagues with funding for individual training requests and bespoke development opportunities. 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. In March 2023, STWTH received additional funding from HEE to support spirometry upskilling in Primary Care. This is being used to support an additional 34 clinicians to complete training in this area at various levels.	

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

GP Strategy Final July 22 PDF

GPN Strategy 21-23 PDF

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:**	

DRAFT

GENERAL PRACTICE NURSE STRATEGY OPERATIONAL PLAN 2022/2023

Update history

Date	Update completed by
4.8.22	JS & SE
15.12.22	JS, SE, PC, HM

Key:	
Green- achieved	Amber: In progress, on track
Red: Delayed and mitigating actions agreed	Blue: Not due

2022/2023					
Objective	**Milestones**	**By when**	**Lead role**	**Progress/evidence**	**RAG status**
Embed Preceptorship programmes across Primary Care Networks	Continued attraction of newly qualified nurses to Primary Care Continued offer of fellowships programme and fundamentals courses	ongoing	TH	**4.8.22** Funding in relation to GPN and other system funding for pc has not yet been confirmed. As a result this has impacted on recruitment support packages for NQN to PC. Continued promotion of student placement and attendance at careers fairs. Fellowships offer being utilised for 3 NQNs across STW. Fundamentals offer for 22/23 being progressed with 6 starting in Sept 22 with some candidates being NQNs. **15.12.22** Additional fundamentals places booked for January 2023.	
Encourage Student Placements to be shared across PCN footprint	Increase in number of Practices hosting student nurses PN placements shared across PCN which could attract more Practices	April 23	Practice placement facilitators	**4.8.22** current resource 0.2 FTE ICS Placement Facilitator until 31 Aug 22. Joint HEI/TH meetings to expand capacity with Delivery Plan. TH KPIs also for increasing placement capacity. Activity directly with HEIs and practices to fill placement requests. Currently 12 active placement providers with 5 developing.	

DRAFT

				15.12.22 Additional NHSE funding used to create placement facilitator role after previous resource finished – out to advert. without the facilitator there has been a challenge to find capacity to support increasing student placements.	
Employ lead for TNA/NA and HCA development	Recruitment into the lead roles	December 22		**28/04/2022** Post had been advertised but no applications, to readvertise **4.8.22** HCA Facilitator appointed on fixed-term contract for one year. Linking Practices and HCAs with STW Academy. **15.12.22** HCA facilitator supported by additional hours of PCNF support staff and promoting the TNA role to practices.	
Support GPN's and HCA across PCN footprints to work at different organisational levels.	Support for HCA award programme Appointment of HCA lead Continue support for leadership programmes and masters courses for ANP	April 23	TH PCNF HCA Lead AP Lead	**4.8.22** 5 HCA candidates for Staffs Uni Award for Sept 22. HCA Lead appointed. Leadership and MSc programme promoted to all. **15.12.22** ongoing	
Promote engagement with research and development in primary care to improve services and care.	Nurses involved in research programmes	April 23	PNCF AP Lead	**4.8.22** AP Lead currently developing plan for APs, plan for MSc students and supporting four pillars.	

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				tACP away days to focus on clinical supervision and research base/audit Promote further research opportunities for ACPs and GPNs **15.12.22** funded ANP and PN training including women's health	
Promotion of ANP role and work to dispel the myths associated to underutilisation of ANPs		ongoing	AP lead	**4.8.22** ACP forums and developing a stategy to focus on ACP roles. Working with STW ICS Clinical Leads to expand the VTE USS pilot and CXRAY referrers numbers **15.12.22** ongoing	
Promote the GPN role via marketing and engagement with local school, colleges and universities.	Attendance at local career events Promotion directly with local schools and colleges	ongoing	PCNFs	**4.8.22** H+S care Carers event STW ICS June 24th 2 x Wolves Uni Career events School Leavers Career event March 22 Springpod to schools careers webinar event	
Explore the development of a GPN Nurse bank in conjunction with local GP locum bank	Work with ICB Primary Care workforce lead to explore opportunity for creation of local GPN bank alongside work to establish a local GP locum bank.	December 22	TH	**28/04/2022** Being investigated as part of the GP Lantern Locum platform Locum PN to be added to Lantern as a pilot **4.8.22** Lantum platform now live and being promoted to GPNs and other staff groups. **15.12.22** Nurses now enrolled onto lantum to offer bank shifts	

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Develop and support local GPN education forums.	Ongoing forums continuing External PLTs for PNs	ongoing	TH QL PCNF	**4.8.22** Ongoing forum including ERIC training and external speakers. At least 2 x a month. External speakers planned for PLT events and ACP forum **15.12.22** Autumn PLT event	
Investigate the role of a lead GPN's for Primary Care Networks If achievable to support funding for the role	Engage with ANPs/PNs to see what they envisage a role might entail Scope role of lead GPN for PCNs Share with Primary care for comments Create JD/PS Look at funding opportunities	April 23	TH QL AP Lead PCNF	**4.8.22** Lack of notification about funding restricting possibility of lead PCN nurse sessions **15.12.22** as above	
Encourage nurses to engage with digital technology and to become Digital Champions Promote the use of Virtual Group Consultations in service delivery for the management of Long-Term Conditions	Delivery of a local programme to train primary care staff in virtual group consultations. Aim for at least one practice per PCN initially. Utilise local digital nurse champions to support roll out.	March 2023	PCNF Training hub Quality Lead CCG	**28/10/21** 3 Practices signed up, continuing to promote **27/04/2022** 3 Practices signed up for intensive package for VGC Delayed due to pandemic **4.8.22** Ongoing promotion with Practices but no further engagement at present. **15.12.22** continue to promote but no new uptake	
Support the implementation of	Completion of questionnaire to gain baseline for current			**27/04/2022** Delayed due to Covid	

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clinical supervision within general practice either face to face or electronic means. PNA model	clinical supervision and ascertain preferred method of supervision. Creation of local best practice guidance/SOP for PN clinical supervision Explore PNA model			Identified outside facilitator to lead the creation of a strategy and provision of MDT training which is in development. To be carried forward to 2022/23. Investigation of role of PNA in primary care **4.8.22** Working with Katherine Yates for MDT clinical supervision model of Practice which has a GPN arm to it. Awaiting dates to provide to Practices. **15.12.22**	
Implement a workforce plan which focuses on recruitment and retention.	Use STP wide initiatives such as People Plan to direct Primary Care specific initiatives	March 23	Training Hub Quality Lead CCG	**28/10/21** PLAN: understand nurses coming up for retirement Identify vacancies across PCN Support for Practices in recruitment of new nursing staff **27/04/2022** Part of strategy Training and development for specific roles such as HCA/TNA and fellowship programme for newly qualified PNs	

				4.8.22 Awaiting ICS workforce plan and how this will link into GPN. **15.12.22** as above	

Key Deliverables 2021/22 and 2022/23

Domain	2021/2022				2022/2023				Ongoing
Recruit	Continue to develop workforce review and training needs analysis	Increase number of Newly-qualified nurses: Linking Year 3 students to practices looking to recruit and with Fundamentals Programme in Q3.	Implement a workforce plan which focuses on recruitment and retention.	Develop and promote student placements to practices including placements for those on Return to Practice programmes.	Embed Preceptorship programmes across Primary Care Networks	Encourage Student Placements to be shared across PCN footprint	Employ lead for TNA/NA and HCA developm ent		Promote the GPN role via marketing and engagement with local school, colleges and universities.
Retention	Supporting GPN's to identify and unlock their	Develop and promote opportunities for nurses to advance in	Support the development of Health Care Support Workers,	Support/ Promote increasing the number of Assessors	Support GPN's and HCA across PCN footprints to work at	Promote a range of support for GPNs such as Motivational	Promote engagem ent with research and developm	Promotin g and encouragi ng staff to attended	Explore the development of a GPN Nurse bank in conjunction

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	leadership potential.	their role at all levels.		and supervisors	different organisational levels.	interviewing, coaching and managing change.	ent in primary care to improve services and care.	MECC courses	with local GP locum bank ……
Retention	Support the implementation of clinical supervision within general practice either face to face or electronic means.	Create opportunities for GPNs to maintain clinical and professional development and share good practice or learning when incidents occur.							Develop and support local GPN education forums.
Reform	Develop a CCG wide GPN Newsletter and promote the responsible use of social media to facilitate communication by peers.	Encourage nurses to engage with digital technology and to become Digital Champions	Ensure prevention is embedded within GPN / HCA role Link into personalised care programme	Promote the use of Video Group Consultations in service delivery for the management of Long-Term Conditions	Promotion of ANP role and work to dispel the myths associated to underutilisation of ANPs	Triage training programme			Develop and facilitate working relationships for GPN's across Primary Care Networks and the CCG.

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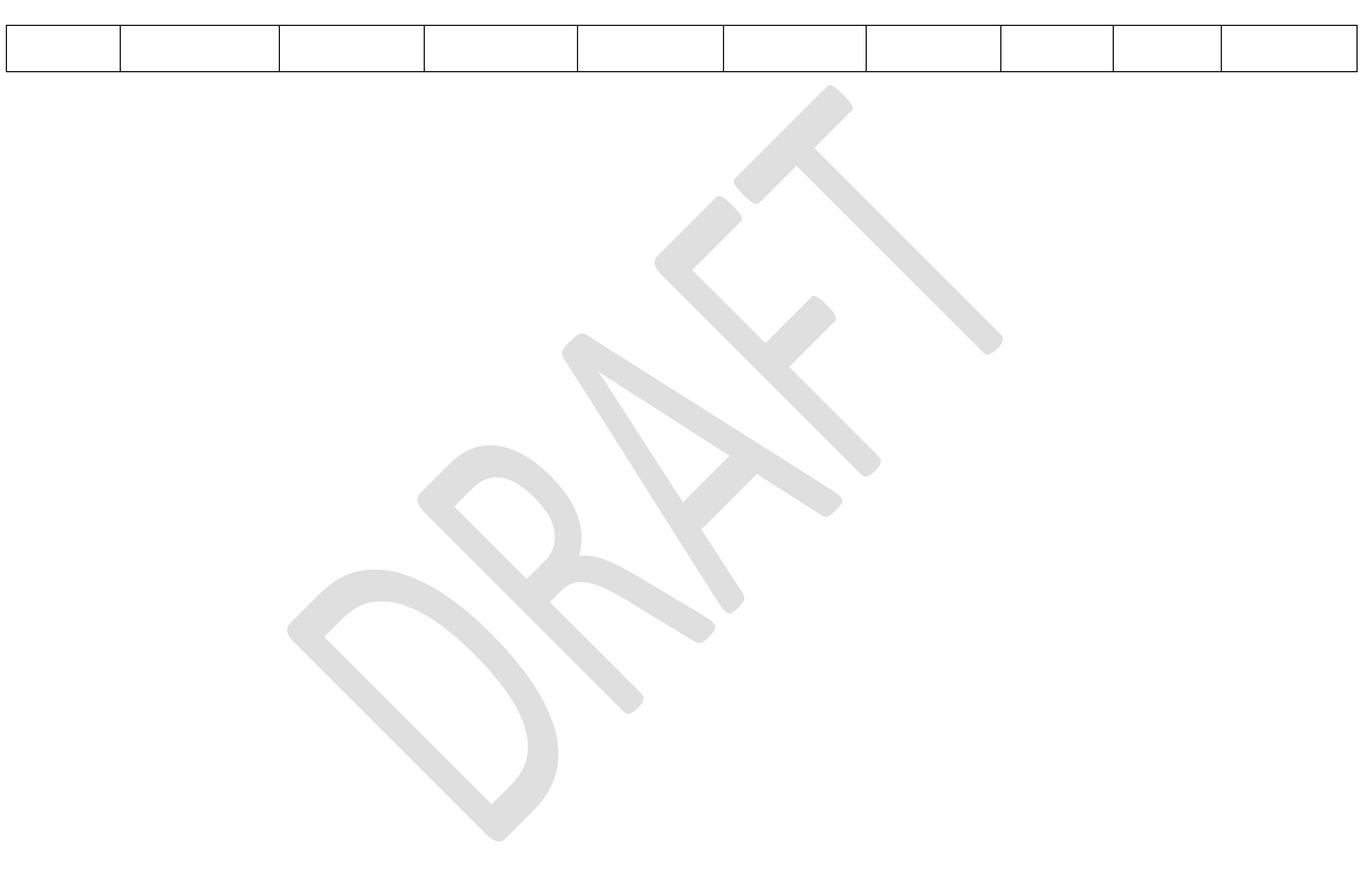
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General Practitioner Strategy - Action Plan.

Date of Action Plan Update: 15th August 2022

Strategy Theme	No.	Actions	Intervention Stage(s)	Priority H/M/L	Lead Responsibility	Short-Term Target/Timescale	Output Measurement	Outcome/Impact Measurement	Funding issues	Comments	Update - March 2023	RAG Rating
Marketing the Role of the Shropshire, Telford & Wrekin GP	1	Identifying and contacting key leaders in local schools and colleges to provide information on the GP career to students considering studying medicine at university	1	L		Provide information to all sixth forms in STW by May 2023	No. of schools provided with information	No. of A level students choosing medicine	Limited additional funding needed - source: Local GP Retention Fund	This action could be fairly straightforward if it simply consists of providing some written/video information to all six form heads of science. More work would be involved if visits/talks were arranged	Interview being held for GP Marketing Lead being held in March - if an appointment is made this action will be addressed by the GP lead.	
	2	Identifying and contacting key leaders in local medical schools other than Keele University to provide information on the GP career to medical students	2	H		Identify key contacts and agree approach by Dec 2022	No. of medical schools provided with information	No. of medical students joining STW GPVTS	Limited additional funding needed - source: Local GP Retention Fund	As with Action 1, this could be achieved with minimal work if the information is written, more work if visits/tasks were arranged.	Interview being held for GP Marketing Lead being held in March - if an appointment is made this action will be addressed by the GP lead.	
	3	Working with relevant HEE colleagues to ensure that all Foundation Year doctors are provided with information on the GP career, with a view to encouraging and incentivising them to join the STW VTS, including the TERS	3	M		Agree with HEE, by March 2023, the process to provide relevant information to FY doctors	The provision of agreed information to FY doctors	No. of FY doctors joining STW GPVTS, including the no. joining the TERS	Limited additional funding needed - source: Local GP Retention Fund	This action may require less work as it's likely that HEE already provide the sort of information we're proposing to FY doctors. We will, however, need to work more proactively on the TERS agenda - i.e. understanding which practices are included in the 22/23 scheme.	Interview being held for GP Marketing Lead being held in March - if an appointment is made this action will be addressed by the GP lead.	
	4	Liaising with local VTS programmes to learn from their strengths, initiatives and approaches	4	M		Identify key contacts and agree approach by Dec 2022	No. of local VTS programmes contacted	Idenfication and implementation of good practice from other VTS programmes	No additional funding needed	We already have some contacts across the region - it shouldn't be too difficult to identify further contacts.	Interview being held for GP Marketing Lead being held in March - if an appointment is made this action will be addressed by the GP lead.	
	5	Working with local media, MPs and other "influencers" to increase the profile of the GP career	1, 2, 3	H		Develop some comms material with the ICS comms team by Oct 2022	Run local comms campaigns across 3 different media	Overall increase in the no. of fte GPs in STW	Limited additional funding needed - source: Local GP Retention Fund	Conversations have already begun with both the ICS People Team about increasing the STW profile, and with the ICS comms team about specific GP comms material/campaigns	Initial discussions with some stakeholders, including PCN CDS and the ICS Comms team. General acceptance that this is a good idea. Some work being developed to promote ARRS MDTs.	
	6	Working across the ICS to ensure that all STW ICS marketing approaches include references to GPs, and that they take account of the specific issues affecting potential GP recruits from minority ethnic communities, different ages and genders.	3, 4, 5	H		Agree generic approach/principles with the ICS comms team by Oct 2022	Inclusion of specific/bespoke GP comms in all relevant ICS marketing materials	Overall increase in the no. of fte GPs in STW	No additional funding needed	As with Action 5 some conversations around this issue have already begun with the ICS comms team	Interview being held for GP Marketing Lead being held in March - if an appointment is made this action will be addressed by the GP lead.	
	7	Providing information and guidance to secondary care clinicians on the opportunities of joining the STW VTS	4	L		Develop some comms material with the ICS comms team by May 2023	The provision of agreed information to secondary care clinicians	The no. of secondary care clinicians joining the STW VTS	Limited additional funding needed - source: Local GP Retention Fund	Key contacts at SaTH will need to be identified, along with the cohort of secondary care clinicians that we will be seeking to target	Interview being held for GP Marketing Lead being held in March - if an appointment is made this action will be addressed by the GP lead.	
	8	Working with colleagues in secondary care to ensure that the specific challenges and issues faced by GPs are fully understood	3 to 8	H		Identify key contacts and agree approach by Oct 2022	Development of a comms/information campaign	Levels of satisfaction with primary/secondary care interaction by GPs	Limited additional funding needed - source: Local GP Retention Fund	As Action 7, the main issue here is to identify key contacts and cohorts of secondary care clinicians. Input from a small number of GPs will also be needed	Some work was developed by the ICS Deputy Medical Director, Dr Deborah Shepherd - this will be picked up with the current ICS Medical Director	
Supporting the Recruitment and Deployment of GPs	9	Developing regular, structured "speed-dating" events for GP Trainees and local practices who are interested in recruiting newly-qualified GPs	4	H	Phil Morgan + VTS TPD	Speed-dating event arranged for Dec 22/Jan 23	Number of ST3s and Practices attending the event	No. of ST3s/NQGPs successfully securing employment in STW practices	No additional funding needed	These events have been run before, both by the VTS and by the CCG. A joint approach might be more effective.	A speed-dating event planned, in principle, for May/June for those ST3s CCT-ing in spring/summer 2023. Waiting for details of these ST3s from the VTS admin team.	
	10	Increasing the number of Training Practices and GP trainers via a coordinated campaign, in conjunction with the WM Deanery	4 to 8	M		Agree approach with WM Deanery by March 2023	Increase in the no. of Training Practices	Increase in the number of placements in Training Practices	No additional funding needed	It may be the case that sufficient/adequate work is already being done in this area. It might also be the case that there are only a small number of potential practices that we could target to become training practices	No action taken yet	
	11	Developing a suite of Marketing copy/tools to use with local media in support of recruitment campaigns	4 to 8	H		Develop some comms materials with the ICS comms team	Inclusion of specific/bespoke GP comms in all relevant ICS recruitment campaigns	Overall increase in the no. of fte GPs in STW	Limited additional funding needed - source: Local GP Retention Fund	As with action 6, some conversations around this issue have already begun with the ICS comms team and the ICS people team recruitment and retention group	See actions 5 and 6	
	12	Increasing the number of GP "locums" registered on the Lantum platform	5 to 8	H	Phil Morgan	50 fully on-boarded GP Locums by Oct 2022	Increase in the no. of GP locums on the Lantum Platform	Increased ability of Practices to fill GP shifts via Lantum	Funding already in place	This is work that is already planned, working in partnership with Lantum and Shropdoc	This is progressing well - there are currently 65 fully authorised GPs on the Platform,	
	13	Working with the SSGPN, and other relevant stakeholders, to identify what further support is needed to ensure that local practices have access to GP locums	5 to 8	L	Phil Morgan & Dr Losa Shui	Agree set of actions by Jan 2023 (Dr Shui on Mat Leave)	Increased access to GP locums by practices	Increased ability of Practices to fill GP shifts	Funding already in place	Dr Losa Shui is the ICB Newly-Qualified GP Locum Champion - she already has a work programme which this could be added to	Interview being held for GP locum Lead being held in March - if an appointment is made this action will be addressed by the GP Locum lead.	
	14	Developing a series of support tools and/or training to enable practices to plan ahead for GP recruitment	4 to 8	M	Dr Tim Lyttle	Agreed actions by March 2023	Provision of suite of support tools to practices	Increased practice ability and satisfaction in their ability to plan GP recruitment	Limited additional funding needed - source: Local GP Retention Fund	Some workforce planning tools are available in other parts of the NHS/STW ICS. We need to identify whether they are suitable for practices.	This will be one of the outcomes from the ongoing work commissioned from Primary Care Commissioning (PCC)	
	15	Using Population Health data to assist practices in planning the recruitment of GPs	5 to 8	M		Agree approach by March 2023	Provision of tool(s) to assist practices	Increased practice ability and satisfaction in their ability to plan GP recruitment	No additional funding needed	Work is already being carried out between PCNs and the ICS/CSU data analytics team around population health data in order to inform ARRS recruitment. This could be extended to assist the recruitment of GPs	No action taken yet	

	16	Providing information, support and guidance to GP trainees on Skilled Worker (Tier 2) visas who wish to remain in STW post-CCT	4 & 5	H	Phil Morgan & Dr Muhammad Zeb	Bespoke support to IMG doctors - ongoing	Ability of IMG doctors to access information and support for their post-CCT career	Increased percentage of IMG doctors retained in STW	Funding already in place	Dr Muhammad Zeb is the ICB Ethnically Diverse GP Champion - he already has a work programme which includes the provision of this support	Interview being held for Ethnically Diverse GP Champion being held in March - if an appointment is made this action will be addressed by that person.
	17	Providing information, support and guidance to practices who wish to recruit IMG doctors following their CCT.	4 & 5	H	Phil Morgan & Dr Muhammad Zeb	Bespoke support to practices interested in becoming sponsoring employers - current	Increased ability of practices to recruit IMG GPs	Increased percentage of IMG doctors retained in STW	Funding already in place	We are already providing detailed advice and guidance, with the assistance of a colleague from H&W ICB, to practices on applying to become a sponsoring employer. A key development under this issue is Shropdoc's application to become a sponsoring employer for IMG doctors.	We are making steady progress with this. A small number of practices (approx 4) have attained sponsoring status in the past few months following our advice/assistance. We continue to work with the H&W ICB colleague
	18	Ensuring that the specific estates/property challenges linked to an increased GP workforce are taken account of in ICS estates strategies	4 to 8	M	Dr Tim Lyttle, Phil Morgan & Darren Francis	Roll-out of planned programme of work	Improved links between estates and recruitment	Increased ability of practices to "house" new staff, including GPs	Funding already in place	A version of this work is already in place with the 8 STW PCNs. The work could be extended to ensure that issues relating to GP workforce are included in ICS estates strategies	This work is part of the project being rolled out by a company commissioned by NHSE
Engaging and Networking	19	Developing the role of the STW First 5 GP Network by maintaining funding and identifying further support opportunities	5 & 6	H	Phil Morgan & First 5 GP Network leads	Confirming ongoing funding and action plan from Network by Dec 2022	Funded workplan for the Network	Increased retention of First 5 GPs in STW	Additional funding needed - source: Local GP Retention Fund	The STW First 5 Network is currently funded for 2022/23 but further funding will need to be identified and agreed for 2023/24.	Funding for the First 5 Network for 23/24 has been agreed
	20	Further engaging with SSGPN to ensure a joined-up and coordinated approach to comms for sessional/locum GPs	5 to 8	L	Phil Morgan & Dr Losa Shui	Integrated/joined-up approach to comms by March 2023 (Dr Shui on Mat Leave)	Improved comms and information provision for Locum GPs	Increased level of satisfaction by Locum GPs with information provision in STW	Funding already in place	Dr Losa Shui is the ICB Newly-Qualified GP Locum Champion - she already has a work programme which this could be added to. A specific part of the work should be the growth of the STW TH Locum Website	Interview being held for GP locum Lead being held in March - if an appointment is made this action will be addressed by the GP Locum lead.
	21	Further engaging with Shropdoc to ensure a joined-up and coordinated approach to comms for sessional/locum GPs	5 to 8	L	Phil Morgan & Dr Losa Shui	Integrated/joined-up approach to comms by March 2023 (Dr Shui on Mat Leave)	Improved comms and information provision for Shropdoc Locum/sessional GPs	Increased level of satisfaction by Locum GPs with information provision in STW	Funding already in place	Dr Losa Shui is the ICB Newly-Qualified GP Locum Champion - she already has a work programme which this could be added to. Some work is already underway via the Lantum platform work (see action 12)	Interview being held for GP locum Lead being held in March - if an appointment is made this action will be addressed by the GP Locum lead.
	22	Establishing additional GP networks via engagement with GPs and practices – for example "older/late career GPs" and "women mid-career GPs"	5 to 8	M	Dr Tim Lyttle	Decisions on setting up new networks by March 2023	Established networks by mid-2023	Increased retention of key GP cohorts linked to new networks	Additional funding needed - source: Local GP Retention Fund	Some initial discussions have taken place around the setting up of new networks, including links with similar networks in other systems.	Interviews for network leads are taking place in March - one appointment has been made "Female GP Network Lead" with.
	23	Reviewing and strengthening existing liaison and networking with the other three Primary Care contractor groups	5 to 8	L		Agreement in principle by early-2023 for ongoing liaison between the four contractor groups	Detailed plan in place by mid-2023	Increased GP satisfaction with pathways and referrals	No additional funding needed	This is linked to the changes at national level in the commisisoning of all four Primary Care contractor groups. Any work carried out for this Action will need to link with wider system work	No action taken yet
Ensuring Professional Development Opportunities are available	24	Providing further support to doctors on the VTS, especially ST3s, to assist both in their qualification and to ensure that they are prepared for life as a qualified GP - this should include addressing issues of differential attainment	4	H	Phil Morgan, Dr Losa Shui, Dr Priya George & Dr Muhammad Zeb - plus VTS TPDs	Agreement in principle with VTS TPDs to develop joint support plan	Detailed plan in place by Sept 2022	Increase in the no. of ST3 doctors retained in STW practices post-CCT	Additional funding needed - source: Local GP Retention Fund	A number of discussions have already taken place between the ICB, the two GP Champions, the clinical lead for the GP Fellowship scheme and the VTS TPDs. However, these have not yet resulted in a detailed support plan for VTS doctors.	Interview being held for GP Differential Attaingment Lead being held in March - if an appointment is made this action will be addressed by that person
	25	Further promote and extend the current GP Fellowship Scheme (for newly-qualified GPs)	4	H	Phil Morgan & Dr Priya George	Plan in place to promote and extend the scheme	Increase in the number of GP Fellows	Increased retention of newly-qualified GPs in STW	Funding already in place	The STW GP Fellowship scheme is already in place and has grown both in terms of numbers of GP Fellows and scope over the past 18 months	This is progressing well - there are currently 20 GPs on the Fellowship scheme with a range of activities and a generally high-level of satisfaction
	26	Ensuring that all GPs are aware of all development opportunities provided by the RCGP	4 to 8	M	Phil Morgan	Assessment of RCGP development opportunities	Clear comms to all GPs, linking them to RCGP development opportunities	Increased take up by GPs of RCGP development opportunities	No additional funding needed	Some ad-hoc comms have been provided to GPs on some of the issues addressed by the RCGP. This action is focused on making that more regular and comprehensive	No action taken yet
	27	Working with the VTS, the Training Hub and GP Trainees to develop training around Supervision skills	4 to 8	M	Phil Morgan and the STW TH	Agreement by Oct 2022 for a plan to address this area of training	Number of GPs/GP trainees attending training around Supervision skills	Improved levels/quality of supervision in STW practices	Additional funding needed - source: Local GP Retention Fund	Some ad-hoc training around GP supervision skills has previously been commissioned by the CCG - this needs to be re-visited	Various training courses have been run and/or are planned
	28	Developing/commissioning training for GPs to enable them to strengthen their focus on public health – e.g. to better understand the social determinants of health, health inequalities and the use of community assets	4 to 8	M	Phil Morgan and the STW TH	Agreement by Oct 2022 for a plan to address this area of training	Number of GPs/GP trainees attending training around Public Health issues	Improved level of understanding, by GPs, of a range of Public Health issues	Additional funding needed - source: Local GP Retention Fund	This is not an area of training that has previously been delivered in a structured way in STW	No action taken yet
	29	Encouraging salaried/sessional GPs to consider becoming a partner	5 to 8	H	Phil Morgan	Plan for the promotion of Partnership agreed by Oct 2022	Delivery of plan, including promotion of the national NHSE/I "New to Partnership" scheme	Increased no. of GP partners in STW	No additional funding needed	As the "New to Partnership" scheme is nationally run the CCG has not had much involvement in the promotion of the scheme to date	A survey is due to be carried out by PCC (as part of the work referred to above) which, among other things, will seek to understand why salaried GPs are reluctant to become partners
	30	Ensure GPs are sufficiently trained and able to meet the challenges of remote consultations	4 to 8	M	Phil Morgan and the STW TH	Agreement by Oct 2022 for a plan to address this area of training	Number of GPs/GP trainees attending training around remote consultation	Improved level of understanding, by GPs, of the issues linked to remote consultation	Additional funding needed - source: Local GP Retention Fund	This is not an area of training that has previously been delivered in a structured way in STW	No action taken yet
	31	Continuing to provide GPs with relevant education opportunities via the PLT sessions	4 to 8	H	STW TH and GP Education leads	Plan already in place	Delivery of Plan by the STW TH	Increased satisfaction by GPs of PLT arrangements	No additional funding needed	The STW Training Hub is managing the programme of PLT, working with the ICB GP Education leads, Dr Melanie Thompson and Dr Damien Thompson	This is now bau

	32	Ensuring that GPs are aware of the "direction of travel" for the STW ICS	4 to 8	M	Phil Morgan	Plan in place to provide information by Sept 2022	Delivery of plan	Increased awarness and understanding of the ICS by GPs/practices	No additional funding needed	Some work on this has already taken place with Edna Boampong - further work needed	The setting up of the GP Forum should address this	
	33	Providing information and, where needed, support to GPs around the Appraisal/Revalidation processes	5 to 8	L		Plan in place to provide information by March 2023	Delivery of plan	Increased confidence in GPs going through the appraisal and/or revalidation process	No additional funding needed	This is a new area of work for the ICB - we would need to liaise with the relevant NHSE/I Revalidation/Appraisal team	No action taken yet	
	34	Ensuring that all STW GPs are aware of, and able to access, the local GP Mentoring offer, as well as other mentoring opportunities e.g. from the RCGP	4 to 8	H	GP Mentor Leads, Dr Tim Lyttle & Phil Morgan	Agree updates to TH Webpage by Sept 22 and linked comms plan	Comms plan delivered	Increase in the number of GPs (non Fellows) accessing the GP Mentoring offer	Funding already in place	This is work in progress. There is currently information on the TH Website but it needs updating and a comms plan put in place to ensure that GPs are aware of the mentoring offer.	Some progress has been made with this - but more promotion of the mentoring scheme is needed	
	35	Ensure that all GPs are aware of, and can access, the National PC Coaching Offer – "Looking after you too" and "Looking after your Team"	4 to 8	H	Dr Tim Lyttle, H&WB lead and Phil Morgan	Draft comms for inclusion in Bulletin by Sept 22	Comms included in Bulletin	Number of GP accessing the "Looking after you too" service and/or qualitative feedback from GPs	No additional funding needed	This is something that ought to be currently signposted to in ICB/ICS websites.	No action taken yet	
Ensuring Personal Support is available	36	Ensure that GPs are aware of the support available to them to address issues relating to their ethnicity, gender, age, disability or any other protected characteristic	4 to 8	H	Clinical Lead for EDI, Ethnically Diverse GP Champion and Phil Morgan	Develop comms to ensure all current support is advertised to GPs, by Oct 2022	Comms included in Bulletin	Number of GPs requesting support, increase in diversity of GP staff group	No additional funding needed	Work in this area has already started - more needs to be done to consolodate and communicate the various sources of support	The Primary Care Ethnically Diverse GP Network has been established - a survey on discrimination has been undertaken with results and an action plan to be reported to PCCC in June	
	37	Providing information and support for GPs around the NHS Pension scheme	8	M	Phil Morgan	Commission a bespoke session for GPs on pensions	Session held on pensions for GPs	Satisfaction with session	Limited additional funding needed - source: Local GP Retention Fund	It may be the case that this could be commissioned locally at minimal cost - if not, an external provider will need to be identified	No action taken yet - this could be part of the role of the Older GP Network lead, if appointed	
	38	Developing support and information for GPs to assist in the challenges around child care	4 to 7	H		Identify the key issues around childcare for GPs by Feb 2023	Provision of advice and support for GPs around childcare	Feedback from GPs on effectivenss /impact of advice	Limited additional funding needed - source: Local GP Retention Fund	In addition to the provision of information it may be the case that some funding might be needed to support specific GPs with this agenda	No action taken yet - this could be part of the role of the Female GP Network lead	
	39	Providing a more structured approach to information and support for GPs nearing/considering retirement – possibly by the creation of an "older GP Champion"	8	H	Dr Tim Lyttle	Scoping of the role of "Older GP Champion" and/or Network by October 2022	Appointment of Older GP Champion and/or establishment of the Older GP Network	Qualitative feedback from older GPs on the impact of the Champion/Network	Limited additional funding needed - source: Local GP Retention Fund	This is something that has been looked at, with some colleagues contacting other systems who run similar schemes. See action 22.	No action taken yet - this could be part of the role of the Older GP Network lead, if appointed	
	40	Training on working in and/or supervising an MDT	5 to 8	M		Identifying the key issues involved in GP involvement in MDTs	Production of information materials and/or training for GPs on working in an MDT	Increased GP confidence in working in an MDT	Limited additional funding needed - source: Local GP Retention Fund	This needs some more thought and discussion as the action is fairly vague	No action taken yet	
	41	Developing a more structured approach to career breaks for mid to late career GPs	7 & 8	M	Dr Tim Lyttle	Identifying the key issues involved for GPs wanting career breaks	Production of information for GPs interested in career breaks	Increased number of GPs on mid-to-late career breaks	Some additional funding may be needed	This needs some more thought and discussion as the action is fairly vague	No action taken yet - this could be part of the role of the Career Breaks GP Network lead, if appointed	
	42	Working with local community and acute health providers to develop exchange programmes for GPs and consultants	5 to 8	M		Identifying the key issues involved in exchange programmes	Agreement with local community and acute health providers on how to run an exchange programme	Increased number of GPs taking part in exchange programmes	Some additional funding may be needed	This needs some more thought and discussion as the action is fairly vague	Some work has been developed in this area including joint new GP/new consultant induction sessions	
Developing Career Opportunities/New Ways of Working/Improving Working Arrangements	43	Working with neighbouring ICBs/systems to develop exchange programmes for GPs	5 to 8	M		Identifying the key issues involved in exchange programmes	Agreement with neighbouring ICBs/systems on how to run an exchange programme	Increased number of GPs taking part in exchange programmes	Some additional funding may be needed	This needs some more thought and discussion as the action is fairly vague	No action taken yet	
	44	Encouraging mid to late career GPs to train as mentors and/or coaches	7 & 8	M	Dr Tim Lyttle, STW GP Mentor leads	Updated information on TH Website by Sept 2022	Number of mid to late career GPs training as mentors and/or coaches	Improved career satisfaction felt by mid to late career GPs	No additional funding needed	The ICB receives funding from NHSE/I for training new mentors.	Some progress has been made with this - but more promotion of the mentoring scheme is needed	
	45	Pay attention to the issue of unfunded transfer of work from secondary care to GPs	5 to 8	H		Identify key aspects of the issue by Dec 2022	Agreement between GP and Secondary Care	Increased levels of satisfaction felt by GPs to transfer of work	No additional funding needed	This action needs clarifying and making more specific	No action taken yet	
	46	Review those pathways where GPs are not needed and simplify GP input where it is needed	5 to 8	M		Identify key aspects of the issue by March 2023	Agreement on revised pathways	Increased levels of satisfaction felt by GPs	No additional funding needed	This action needs clarifying and making more specific	No action taken yet	
	47	Review, with colleagues across the ICS, what areas of work GPs could stop delivering and identify work that, although not currently being delivered, could be carried out by GPs	5 to 8	M		Identify key aspects of the issue by March 2023	Agreement on revised areas of work	Increased levels of satisfaction felt by GPs	No additional funding needed	This action needs clarifying and making more specific	No action taken yet	
	48	-Address, as far as possible, any disincentives/incentives for GPs to work in different parts of General Practice	5 to 8	M		Identify key aspects of the issue by March 2023	Revisions to the current arrangements	Increased levels of satisfaction felt by GPs	No additional funding needed	This action needs clarifying and making more specific	No action taken yet	

The Eight Key Intervention Stages

In order to understand what specific actions are needed against each of the themes listed above, this Strategy identifies eight "Key Intervention Stages" within the lifecycle of a GP's career.

1. **School/sixth-form students choosing medicine courses at universities**
2. **Medical Students**
3. **Foundation Year Doctors**
4. **GP Trainees on the STW VTS**
5. **Newly-Qualified GPs**
6. **First5 GPs**
7. **Mid-Career GPs**
8. **Late-Career GPs**

Dr Hay

GP Champions
and Leads

UG education is interlinked with recruitment and retention , evidence shows that if medical students work in GP and have a positive experience they are more likely to pursue GP as a career choice. I think in "professional development" it's an idea to consider supporting GPs to develop an interest in medical education-some early years doctors think GP is non academic and therefore choose secondary care options, supporting an interest in medical education can result in improved recruitment etc, so for example local doctors getting more involved with their Medical School, maybe interviewing etc and finding out more about

More focus on supporting the growth/number of partners, perhaps with a funded "Partner Champion"

The need to support mid and late career GPs so that they can see more of an equality around the provision of funded support

Increased focus on supporting GPs and Trainees from ethnic minority backgrounds

The importance of mentoring for mid and late career GPs, including, if possible, out-of-area mentors

Shropshire, Telford & Wrekin ICS General Practitioner (GP) Strategy

July 2022

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1. Introduction

Why do we need a GP strategy?

Like most parts of the country, Shropshire, Telford & Wrekin (STW) has struggled over recent years to increase the number of GPs across our practices.

For the most part, unlike some of the other roles in General Practice, there has not been a strategic approach to the attraction, recruitment and retention of GPs to our local area. Many individual projects, initiatives and workstreams are in place, including strong links with our local medical school Keele University, and a thriving GP Vocational Training Schemes (VTS), but these are not yet sufficiently integrated and resourced.

Decisions about recruitment and retention have, for the most part, been taken by each of the individual General Practice businesses meaning that, traditionally, the ICS has not had a specific role in this area. However, a more pro-active approach should now be taken, working with various stakeholders (see list below) to, among other things, further increase the profile of the GP role among local schools and colleges by engaging with all forms of local media.

Despite some focused, national funding streams which have been managed by the ICS, many practices and GPs will not have benefited from these funded initiatives.

Although there is a growth in the number of other clinical roles across our practices and PCNs, there will always be a need for a significant GP cohort to provide both direct care to patients and to supervise the other clinical roles. This is particularly the case in a system like STW where the traditional model of relatively small, partner-led practices, still predominates.

One of the key issues facing our local area is the need to ensure that the GP workforce is, as far as possible, as diverse as possible in terms of ethnicity, age and gender. There has not, until recently, been a focus on these issues across our system.

NHS

The National Picture

Since the launch of the GP Forward View in 2016 there has been a strong, central government push for an increase in the number of GPs – with a target of 5,000 additional GPs by 2021, being set.

In order to assist with meeting this target additional places have been funded on the local GP Vocational Training Schemes (VTS), including for a significant number of overseas doctors. One positive outcome of this is that it has led to over 60% of our current VTS doctors being International Medical Graduates (IMGs). However, this increases the challenge of encouraging and enabling these doctors to remain in STW once they have qualified (see below for current work around the Skilled Worker Visa scheme).

The development of Primary Care Networks (PCNs) in 2019 has had a positive impact on the number of additional clinical roles employed in General Practice – but at the same time it has put more pressure on GPs to ensure that these roles are properly supervised and managed.

NHS

Local Context

There are a wide range of current initiatives and projects across STW aimed at addressing some of the national and local challenges of attracting, recruiting and retaining GPs. Many of these are coordinated by the ICS in partnership with different local stakeholders (see below) but others have not, to date, been integrated into a strategic approach. The key local projects and initiatives include the following:

Project / Initiative	Funding / Description	Impact to Date
Outreach work with local schools	A number of senior, local GPs work with some of our secondary schools and further education colleges to raise the profile of the role of the GP.	Although this work has good, local impact, it is not coordinated across the ICS.
Local clinical leadership at Keele University Medical School	A number of senior, local GPs work as lecturers at Keele University Medical school and lead on the placement of medical students in STW practices. This work includes encouraging medical students to consider GP as a career choice.	Many of our practices accept medical student placements, but there are increasing challenges around space in practices, supervision time and, for the students themselves, issues around accommodation and transport.
GP Fellowship Scheme	Back-fill for Fellows plus Development Funding Provides support, networking and development for newly-qualified salaried/partner GPs	20 GP Fellows on STW scheme, with 5 in year 2. Generally positive feedback, but further improvements needed
Supporting Mentors Scheme	Funding to train GPs to be mentors and then to provide mentoring to local GPs	Ten trained Mentors providing mentoring mainly, at present, to GP Fellows

Local Context (continued)

Project / Initiative	Funding / Description	Impact to Date
Local GP Retention Fund	Funding available to practices to provide bespoke support to individual GPs/groups of practice GPs to increase the likelihood of their staying in the profession	29 bespoke training and development projects/initiatives funded for 22/23 totalling £100k.
GP Locum Bank	An online digital booking platform to assist local locum/sessional GPs to identify and book sessions in practices	More than 40 practices have signed up, along with nearly 30 GPs.
Newly-Qualified GP Locum Champion	A funded GP, providing networking and support to those newly-qualified GPs who choose to work as a locum	This is a new role which started in February 2022
Ethnically Diverse GP Champion	A funded GP, providing networking and support to GP Trainees, and qualified GPs, from a BAME and/or overseas background – with specific focus on the issues around Skilled Worker Visas	This is a new role which started in February 2022
New to Partnership	A nationally run scheme to support clinicians, including GPs, who wish to become a partner	The ICS does not manage this scheme – analysis of the data is needed.

Local Context (continued)

As can be seen from the graphs below these initiatives are beginning to have a positive impact on the number of GPs in our local system with a slight, if inconsistent, increase in both the number of GPs and the wte GPs over the past 18 months. However, there is a worrying, steady decrease in the number of GP Partners.

GP Workforce Dashboard

Staff Group Trend

NHS Health Education England

Clear All

Region Name	ICS Name	CCG Name	Staff Group	Staff Role
Midlands	All	NHS Shropshire, Telford and Wrekin ..	GP (excl Registrars)	All

FTE - GP (excl Registrars) - All - May 2022

Headcount - GP (excl Registrars) - All - May 2022

Change in colour denotes move from quarterly to monthly publications by NHS Digital
Please note that selecting all Staff Group options will result in an incomplete time series due to NHS Digital limiting historic publications for some Staff Groups before September 2017

Local Context (continued)

GP Workforce Dashboard

Staff Group Trend

Health Education England

Clear All

Region Name	ICS Name	CCG Name	Staff Group	Staff Role
Midlands	All	NHS Shropshire, Telford and Wrekin ..	GP (excl Registrars)	GP Partners

Change in colour denotes move from quarterly to monthly publications by NHS Digital
Please note that selecting all Staff Group options will result in an incomplete time series due to NHS Digital limiting historic publications for some Staff Groups before September 2017

Diversity of the GP workforce

- The percentage of STW GPs who are aged 55 or over is slightly higher than the national average – 23.6% compared with 23.4%

- The gender mix of GPs in STW is fairly even with slightly more female GPs than males.

- The latest data* (May 2022) on ethnicity shows that GPs are by far the most ethnically diverse group of staff in STW practices, with 12.4% declaring their ethnicity as “Asian/Asian British”, 5.8% as “Black/African/Caribbean/Black British, 3.9% as from other minority ethnic groups and 65% as “white”. However, 13.2% of GPs did not have their ethnicity recorded (a higher percentage than the other staff groups), which could alter the balance of these figures. To put the GP data into context, 82% of the full Primary Care workforce is white.

  *these figures only include qualified GPs, not Registrars/Trainees – definitions are those used by NHS Digital

- The proportion of international medical graduate (IMG) doctors on the STW VTS is over 60%.

Key Stakeholders

The following list comprises of those local, regional and national organisations and individuals who are key to STW ICS being able to implement the actions under-pinning this strategy.

In most cases there are already good engagement and communication channels, but these are often not sufficiently strategic, nor are they always adequately joined-up.

Where relevant, these stakeholders are referred to in the Action Plan below.

- Local Secondary schools careers advisors and work experience leads
- Sixth Form Colleges, including leads for mature students
- Local Universities/HEIs
- STW GPVTS – both the Trainees and the TPDs
- STW Local GP Practices
- Health Education England – GP Deans etc.
- Royal College of GPs
- NHSE/I Regional Medical Directorate, Workforce leads etc.
- Shropshire Sessional GP Network
- Shropshire Doctors Cooperative
- The Local Medical Committee
- STW ICS Medical Director and Clinical Leads
- STW ICS GP Education Co-Lead
- STW ICS GP Education Co-Lead
- STW ICS GP Mentor Leads
- STW ICS Ethnically Diverse GP Champion
- STW ICS Newly-Qualified GP Locum Champion
- Secondary Care consultants
- Retired GPs (with experience and knowledge of STW General Practice)
- Local MPs
- Local press and media
- Patient Participation Groups

2. The Three Main Elements of this Strategy

The three main elements of this strategy

In line with the STW ICS People Plan, and workforce strategies in other systems, this Strategy is based around three, main elements:

- **Attracting** – encouraging/persuading people to become GPs
- **Recruiting** – enabling the recruitment of qualified GPs across STW
- **Retaining** – ensuring that those GPs who are recruited, choose to stay

Although the issues in this Strategy relate specifically to GPs (who are one of the few clinical groups to be almost exclusively found only in General Practice) there are a number of Attracting, Recruiting and Retaining projects and initiatives being carried out by the ICS People Team which are relevant to GPs. These include:

- International Recruitment
- An STW Employment/Recruitment Brand
- Collaborative Recruitment, and
- A Retention Strategy

The ICS' Primary Care Team is represented on the People Team working groups and the linkages and relevant responsibilities are detailed in the Action Plan below.

As can be seen in the Governance section below, progress against the Action Plan in this Strategy will be reported, among other ways, to the ICS People Board, as part of wider reporting on the implementation of the STW ICS People Plan.

3. Key Attraction, Recruitment and Retention Themes

Key attraction, recruitment and retention themes

In order to make the **Attract**, **Recruit** and **Retain** elements relevant for General Practice, and for General Practitioners more specifically, the following themes will be used in this Strategy to provide more detail around intended actions:

- Marketing the Role of the GP
- Supporting the Recruitment and Deployment of GPs
- Engaging and Networking
- Ensuring that Professional Development is available
- Ensuring that Personal Support is available
- Developing Career Opportunities/New Ways of Working

The Action Plan set out later in this document contains a series of actions, grouped around these themes. For each action the plan identifies:

- which of the Intervention Stages the action is addressing (see section 4 below)
- the Priority of the action
- which person or organisation has overall Responsibility for delivering the action
- the ideal Timescale for the action to be delivered
- how success in delivering the action is to be Measured

NHS

4. The Eight Key Intervention Stages

The Eight Key Intervention Stages

In order to understand what specific actions are needed against each of the themes listed above, this Strategy identifies eight "Key Intervention Stages" within the lifecycle of a GP's career.

1. School/sixth-form students choosing medicine courses at universities
2. Medical Students
3. Foundation Year Doctors
4. GP Trainees on the STW VTS
5. Newly-Qualified GPs
6. First5 GPs
7. Mid-Career GPs
8. Late-Career GPs

The following table provides a summary of current ARR activities, projects and interventions in each of the eight intervention stages and identifies some challenges. The Action Plan in section 5 sets out a number of specific actions designed to address these challenges.

NHS

Intervention Stage	Summary of Current STW Position	Challenges/Comments
1. School/sixth-form students choosing medicine courses at universities	• A number of senior, local GPs work with some of our secondary schools and further education colleges to raise the profile of the role of the GP. • However, there is no coordinated, strategic approach to working with these institutions to promote the GP role in our local area.	• Work in this area is ongoing, but not coordinated across the ICS • Schools/colleges may need convincing of the merit of further engagement • However, this would require a significant time input which would need to be assessed against the potential impact of the work • Working with careers advisors in secondary schools may be helpful to ensure that GCSE and A level choices enable students to apply to medical school
2. Medical Students	• Promotion of the GP role in our local area with medical students is carried out by a number of senior, local GPs who work as lecturers at Keele University. • These GPs work with practices to increase the number of practices willing and able to take medical students – most of our practices are currently accepting students • There are no formal links with other local medical schools	• Although the work at Keele, including the placement of medical students, is effective in raising the profile of the role of the GP for students, similar work with other medical schools may be beneficial. • However, this would require a significant time input which would need to be assessed against the potential impact of the work • A further cohort to consider are those mature students who choose to study medicine later in their lives/careers
3. Foundation Year Doctors	• A large number of local practices take Foundation Year placements (FY2). • However, there is no coordinated, local approach to liaising with the FY doctors and practices to understand their experience and discuss their career choices.	• This is a new area of work for the ICS • There would need to be engagement with both the Foundation Year doctors, the relevant HEE stakeholders, and their placement practices • However, this would require a significant time input which would need to be assessed against the potential impact of the work
4. GP Trainees on the STW VTS	• A large number of local practices take GP Trainee placements (ST1, ST2 and ST3). • Although these Trainees have individual supervisors, and link with the TPDs, there is no coordinated, local approach to liaising with the GP Trainees and practices to understand their experience and discuss their career choices.	• This is a new area of work • There would need to be engagement with both the GP Trainees, and their placement practices • It would require a significant time input, but the impact would almost certainly be consistent with the potential impact in terms of retaining the trainees in STW practices • A specific challenge would be to understand more about trainees' placement in secondary care – i.e. what are they learning about General Practice when they are on placement

Intervention Stage	Summary of Current STW Position	Challenges/Comments
5. Newly-Qualified GPs	• STW have had in place, since January 2021, a nationally-funded GP Fellowship Scheme. • This scheme is currently supporting 20 newly-qualified GPs who are receiving support and training across a number of areas	• The challenge with this scheme is to maintain the momentum built up over the past 12 months • Further liaison with the VTS, specifically with ST3s, should help to maintain the comparatively high number of GPs joining this scheme • An area not well developed to date is an assessment of specific skills that new GPs need which might not be adequately covered on the VTS – e.g. time management, risk management, and continuity of care
6. First5 GPs	• The ICS is funding the STW First 5 GP Network, led by two local GPs • The network has around 40 members and, among other things, is commissioning training for its members	• Maintaining the funding of this network • Growing the network
7. Mid-Career GPs	• Practices have been invited to bid for funding against a series of example projects/initiatives that are aimed at retaining mid-career GPs • However, there has not been a specific focus, to date, on this cohort of GPs	• Given the limited funding available, the challenge is to maximise the impact for those GPs who request support • This cohort of GPs is less able than others to access structured funding streams • National data suggests that many GPs in this cohort, particularly female GPs, choose either to reduce their hours and/or leave the profession entirely
8. Late-Career GPs	• Practices have been invited to bid for funding against a series of example projects/initiatives that are aimed at retaining late-career GPs • However, there has not been a specific focus, to date, on this cohort of GPs	• Given the limited funding available, the challenge is to maximise the impact for those GPs who request support • This cohort of GPs is less able than others to access structured funding streams • Key challenges in supporting this group of GPs includes pre-retirement advice and developing initiatives to retain the extensive knowledge and experience they have built up over many years in the profession.

Other Generic Issues

In addition to the specific issues linked to the eight Intervention Stages above, there are a number of other generic, cross-cutting issues that should be addressed via inclusion in the Action Plan:

- Workforce Planning – more specifically, working with individual practices/PCNs to identify current pressures on the numbers of GPs, likely retirements, the need for recruitment etc.
- Cross-sector working – developing the linkages, formal and informal, between general practice and the other three contractor groups within Primary Care, and between general practice and local NHS Trusts
- Raising the profile of GPs via working with local media and politicians

NHS

5. Action Plan

Action Plan

An Action Plan, to ensure implementation of the GP Strategy, has been developed and can be found by clicking here.

If you have any comments about any of the actions please contact Phil Morgan, Primary Care Workforce Lead, on Philip.morgan3@nhs.net.

NHS

6. Governance

Governance

Overall arrangements

- This Strategy will, initially, be reviewed and approved by the STW ICS Primary Care Commissioning Committee.
- Further reviews of the Strategy, together with approvals of changes/developments in content, will be the responsibility of the relevant ICB committee
- Operational responsibility for delivering the action plan will rest with the STW ICS Primary Care Team, led by the Primary Care lead for Workforce, working with colleagues on the Training Hub Delivery Group.

Monitoring the Action Plan

- Monitoring reports will go to the Training Hub Delivery Group

Reporting progress against the Action Plan

- Progress reports will be provided to the ICS Primary Care Commissioning Committee and the relevant committee following the transition to the ICB.

7. Other Resources

Other Resources

A range of other resources, information and support is available to STW GPs, including:

- The STW Training Hub
- NHSE Futures GP Career Support Hub
- The Royal College of GPs
- HEE WM GP School
- NHS Digital Workforce Data
- Shropshire Sessional GP Network

NHS

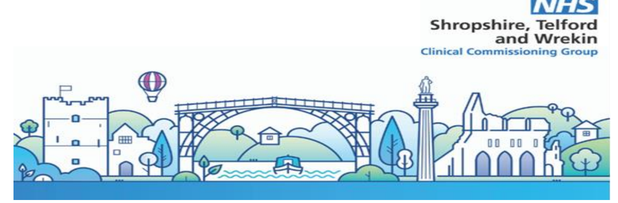
Shropshire, Telford & Wrekin ICS General Practitioner (GP) Strategy

July 2022

General Practice Nurse Strategy 2021 - 2023

Shropshire, Telford and Wrekin GPN Strategy

CPD Programmes accessible to all	Standardised approach to Advanced clinical practice education and mentorship	Leadership and Management Programmes
Embedding prevention in clinical practice	Peer support networks and clinical supervision	Preceptorship Programmes for newly-qualified nurses and nurses new to General Practice
Increasing Student Nurse and Return to Practice Placements in Primary Care Supporting Supervisor and Assessor roles	Digital Nursing Development	Nursing Apprenticeships and HCA development



Version	Date	Amendment History
Final Draft July 2021	10/08/2021	Updated following PCCC, STW ICS People Board
GPN Strategy Final version	12/10/2021	

Reviewers

This document has been reviewed by:

Name	Title/Responsibility	Date	Version
Zena Young	Executive Director of Nursing & Quality	17/06/2021 04/08/2021	GPN Strategy Draft 20210617 GPN Strategy Final Draft July 2021
Claire Parker	Director of Partnerships	04/08/2021	GPN Strategy Final Draft July 2021
Victoria Rankin	ICS Workforce Lead	09/08/2021	GPN Strategy Final Draft July 2021
Heidi Davis	HEE GPN Lead WM	09/09/2021	GPN Strategy Final Draft July 2021
Helen Abbott	ICS AP Lead Primary Care	30/03/2021	GPN Strategy Draft 20210325

Approvals

This document has been approved by:

Group/Committee	Date	Version
STW CCG Primary Care Commissioning Committee	04/08/2021	GPN Strategy Final Draft July 2021
STW ICS Training Hub Delivery Group and Board	21/07/2021	GPN Strategy Final Draft July 2021
STW ICS Transformation Board and People Board	09/08/2021	GPN Strategy Final Draft July 2021

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DOCUMENT STATUS

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INTRODUCTION TO THE STRATEGY FROM SHROPSHIRE, TELFORD AND WREKIN CCG EXECUTIVE DIRECTOR FOR QUALITY

General Practice Nurse development has been seen by Shropshire, Telford and Wrekin (STW) Integrated Care System (ICS) as an area of focus in order to retain an agile workforce to support the needs of the population.

Investment from Health Education England and NHS England/Improvement has enabled us to begin our journey of GPN development and this strategy builds on this over the next 2 years whilst locally the landscape evolves to encompass Primary Care Networks and Integrated Care Systems.

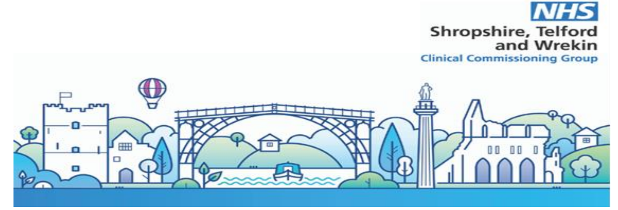
This strategy is based on the 3 overarching principles from the GPN 10 Point Action Plan – Recruit, Retain, Reform and explores local opportunities to achieve these ambitions. It also reflects the need to ensure the nursing workforce has opportunities to continue with professional development and is able to deliver safe, harm free care.

We are all conscious of the increasing demands on all health care sectors and this has been shown more clearly in 2020 with the added pressures the Covid-19 pandemic has brought. Primary Care has always been at the forefront of delivery of healthcare to the population and nurses and Health care Assistants are key to this delivery as they continue to take on more varied and challenging roles. The shortfall of nurses coming into the NHS needs to be addressed so this strategy aims to map out career opportunities for nurses to join Primary Care including those who have had a career break, how we can ensure they remain, and how nurses can be at the forefront of new innovations such as the use of digital technology.

It is an exciting program of work to develop the skills of our nurses working in primary care, whilst addressing healthcare priorities and needs of our system and we look forward to implementing this over the next 2 years

Zena Young

Executive Director of Nursing & Quality, Shropshire, Telford and Wrekin CCG



CONTEXT

General Practice Nursing has been steadily emerging in primary care since 1960s. With big changes in the General Practice contracts both in 1990 and 2004 leading to the role of General Practice Nurse (GPN) developing and growing and GPNs taking on more responsibility for the management of patients living with long term conditions. As the diversity of the role develops to include new emerging roles such as Nursing associates and continued increase in nurses using advanced clinical skills this continues to highlight that additional training and support is required to maximise opportunities for nurses to work beyond traditional treatment room tasks.

Following on from this, the GPNs role has progressed and developed far beyond those early days to become autonomous professionals, able to diagnose, treat and refer where required. With the introduction of the Advanced Nurse Practitioner along with development of Health Care Assistant roles and the introduction of the new role of Nursing Associate, GPNs continue to play a vital role in driving innovation to meet the changing needs of people in their communities.

Investment in support and development of GPNs remains central to the provision of high-quality care within Primary Care.

The general practice nursing workforce continue to hold a place at the forefront, leading change by delivering better health outcomes in primary care, and by making primary care 'the place to be' for ambitious nurses who deliver quality care and empower our population to live well.

The more recent creations of Primary Care Networks have led to opportunities for working and resourcing training at scale, giving GPNs and Primary Care even more opportunities to develop, diversify and grow as professionals and as a speciality.

GPNs across the ICS were given an opportunity to review this document and as a result of this consultation the Strategy was endorsed and the following quotes were given as feedback.

LEADER

COORDINATOR

GENERAL PRACTICE NURSE

PATIENT CENTRED

HIGHLY SKILLED and EDUCATED

EDUCATOR and FACILITATOR

Makes me enthusiastic for the future of GPNs in STW

Love the themes

Good accessible document

I feel like GPNs should be recognised more and this strategy really reinforces our position in Primary Care and our role in its future

This strategy highlights that our profession's future depends on students and our own professional development and really builds on these themes

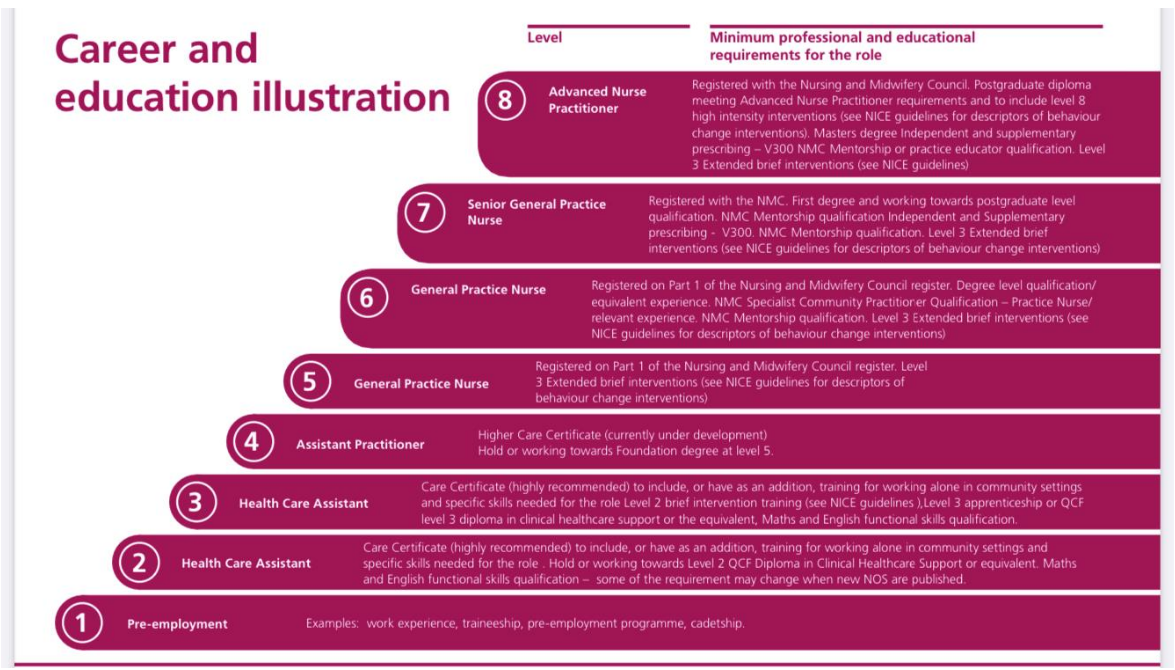
POLICIES AND DRIVERS

The strategy has aligned the content to reflect and support the actions within national and ICS documents such as;

- GPN 10 Point Action Plan
- NHS Long Term Plan
- NMC Standards of Proficiency for Registered Nurses
- HEE District Nursing and General Practice Nursing Services Education and Career Framework
- RCGP GPN Competency Framework
- RCGP General Practice Advanced Nurse Practitioner Competencies
- QNI Transition to General Practice Nursing Resource
- ICS People Strategy

"The Future of Primary Care – Creating Teams for Tomorrow" (Primary Care Workforce Commission, July 2015) identified that community and general practice nurses often did not have the same career structures or training development opportunities as Medical staff within Primary Care. This was quickly followed by the publication "District Nursing and General Practice Nursing Service – Education and Career Framework (HEE, October 2015) which outlines a clear framework to start building nursing careers in primary care, which considered pre-registration entry requirements and pathways, considering alternatives to traditional routes, such as Nursing Apprenticeships and shaping the future nursing workforce.

General Practice – Developing confidence, capability and capacity. A ten-point action plan for General Practice **Nursing (**NHSE 2017) described the nursing element of the GPFV and supports nurses and health care support workers to focus on the 3 gaps outlined in the FYFV. These being Health and Wellbeing, Care and Quality and Funding and Efficiency.

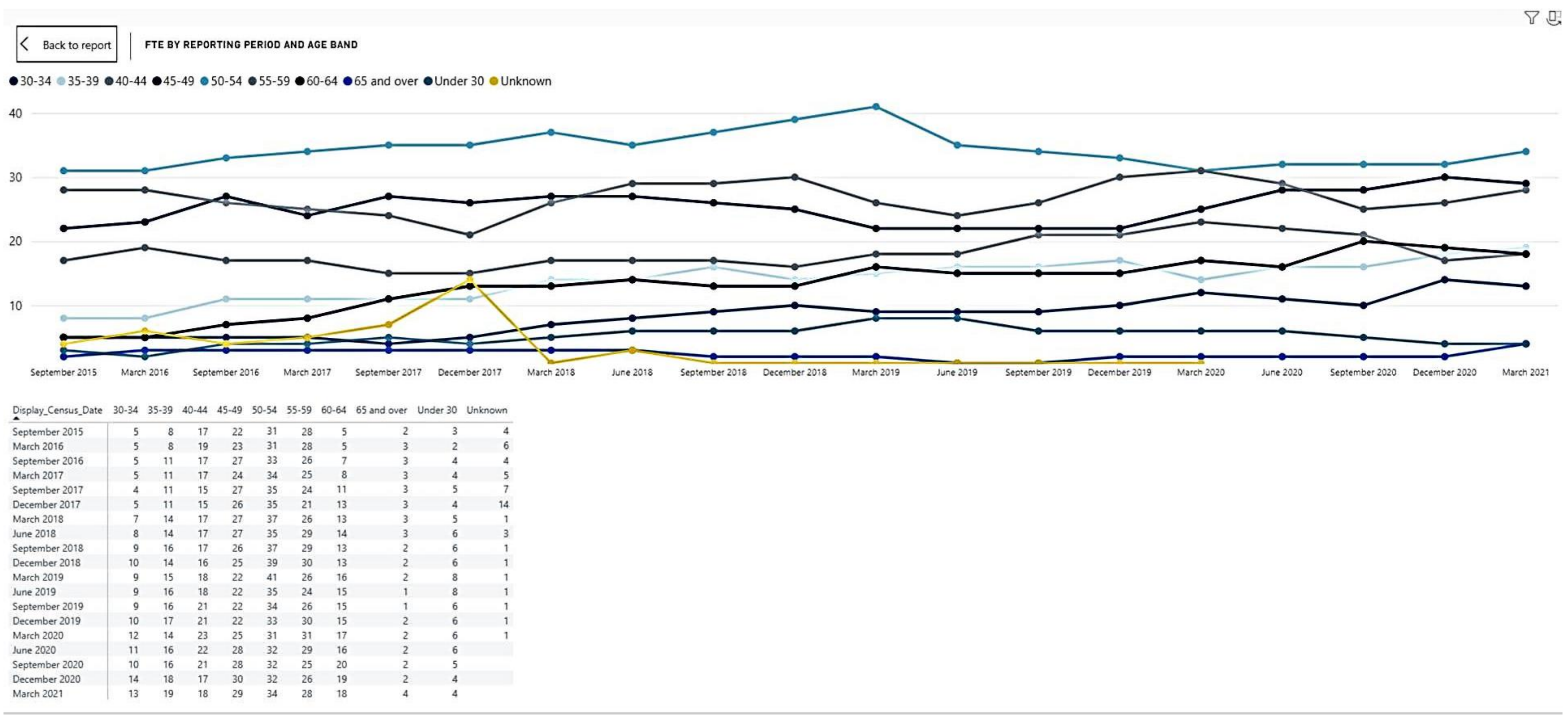


Career and education illustration

	Level	Minimum professional and educational requirements for the role
8	Advanced Nurse Practitioner	Registered with the Nursing and Midwifery Council. Postgraduate diploma meeting Advanced Nurse Practitioner requirements and to include level 8 high intensity interventions (see NICE guidelines for descriptors of behaviour change interventions). Masters degree Independent and supplementary prescribing – V300 NMC Mentorship or practice educator qualification. Level 3 Extended brief interventions (see NICE guidelines)
7	Senior General Practice Nurse	Registered with the NMC. First degree and working towards postgraduate level qualification. NMC Mentorship qualification Independent and Supplementary prescribing - V300. NMC Mentorship qualification. Level 3 Extended brief interventions (see NICE guidelines for descriptors of behaviour change interventions)
6	General Practice Nurse	Registered on Part 1 of the Nursing and Midwifery Council register. Degree level qualification/ equivalent experience. NMC Specialist Community Practitioner Qualification – Practice Nurse/ relevant experience. NMC Mentorship qualification. Level 3 Extended brief interventions (see NICE guidelines for descriptors of behaviour change interventions)
5	General Practice Nurse	Registered on Part 1 of the Nursing and Midwifery Council register. Level 3 Extended brief interventions (see NICE guidelines for descriptors of behaviour change interventions)
4	Assistant Practitioner	Higher Care Certificate (currently under development) Hold or working towards Foundation degree at level 5.
3	Health Care Assistant	Care Certificate (highly recommended) to include, or have as an addition, training for working alone in community settings and specific skills needed for the role Level 2 brief intervention training (see NICE guidelines),Level 3 apprenticeship or QCF level 3 diploma in clinical healthcare support or the equivalent, Maths and English functional skills qualification.
2	Health Care Assistant	Care Certificate (highly recommended) to include, or have as an addition, training for working alone in community settings and specific skills needed for the role . Hold or working towards Level 2 QCF Diploma in Clinical Healthcare Support or equivalent. Maths and English functional skills qualification – some of the requirement may change when new NOS are published.
1	Pre-employment	Examples: work experience, traineeship, pre-employment programme, cadetship.

The 2015 Queen's Nursing Institute Practice Nurse survey findings indicated that 33.4% of General Practice Nurses (GPNs) were due to retire by 2020 and 43.1% did not feel their nursing team had the appropriately qualified and trained staff to meet the needs of patients. In terms of support for education only 53% reported their employer supported their professional development and 27% of employers offered placements for pre-registration nursing students, compared to 61.5% offering placements to medical students. Only 35% felt that their salary reflected their role (which varied widely) within the practice as did employment terms and conditions.

Locally across the STW GPN workforce age demographics as of March 2021 (and relating to FTEs) are:



Display_Census_Date	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65 and over	Under 30	Unknown
September 2015	5	8	17	22	31	28	5	2	3	4
March 2016	5	8	19	23	31	28	5	3	2	6
September 2016	5	11	17	27	33	26	7	3	4	4
March 2017	5	11	17	24	34	25	8	3	4	5
September 2017	4	11	15	27	35	24	11	3	5	7
December 2017	5	11	15	26	35	21	13	3	4	14
March 2018	7	14	17	27	37	26	13	3	5	1
June 2018	8	14	17	27	35	29	14	3	6	3
September 2018	9	16	17	26	37	29	13	2	6	1
December 2018	10	14	16	25	39	30	13	2	6	1
March 2019	9	15	18	22	41	26	16	2	8	1
June 2019	9	16	18	22	35	24	15	1	8	1
September 2019	9	16	21	22	34	26	15	1	6	1
December 2019	10	17	21	22	33	30	15	2	6	1
March 2020	12	14	23	25	31	31	17	2	6	1
June 2020	11	16	22	28	32	29	16	2	6	
September 2020	10	16	21	28	32	25	20	2	5	
December 2020	14	18	17	30	32	26	19	2	4	
March 2021	13	19	18	29	34	28	18	4	4	

The NHS Long Term Plan and the GP Framework Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan, both published in 2019, strengthened the work to date of General Practice Nursing and supports future developments in line with this strategy.

OUR VISION

This strategy is a response to the “General Practice-Developing confidence, capability and capacity: A ten point plan for General Practice Nursing” (NHSE 2017) and the success is dependent on working collaboratively with stakeholders and becomes part of the wider ICS strategy. It will give direction for General Practice Nurse development across Shropshire, Telford and Wrekin CCG to become confident and skilled Nurses, drawing on their already existing skills to achieve their potential whilst responding to the needs of the local workforce.

This strategy will support a consistent and visionary response to challenges faced by the General Practice Nursing workforce and support implementation of the national GPN 10 Point Plan

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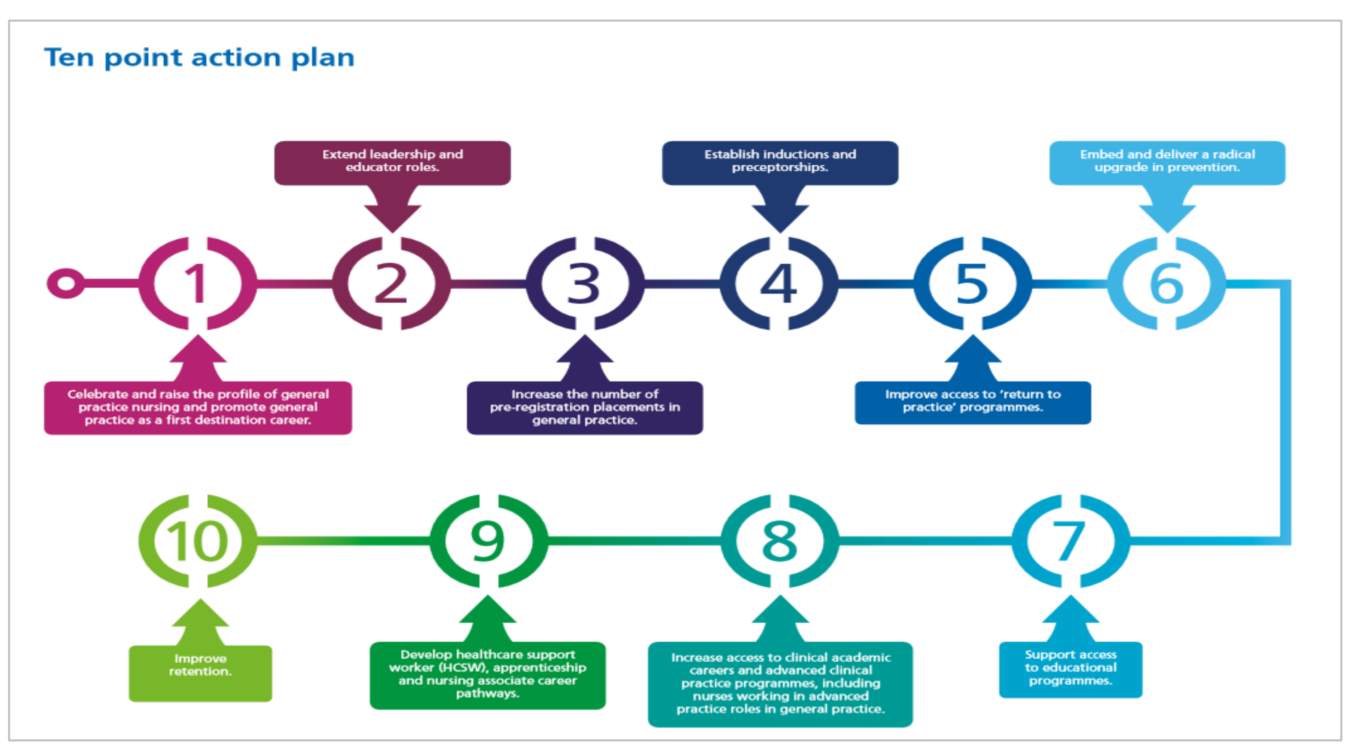
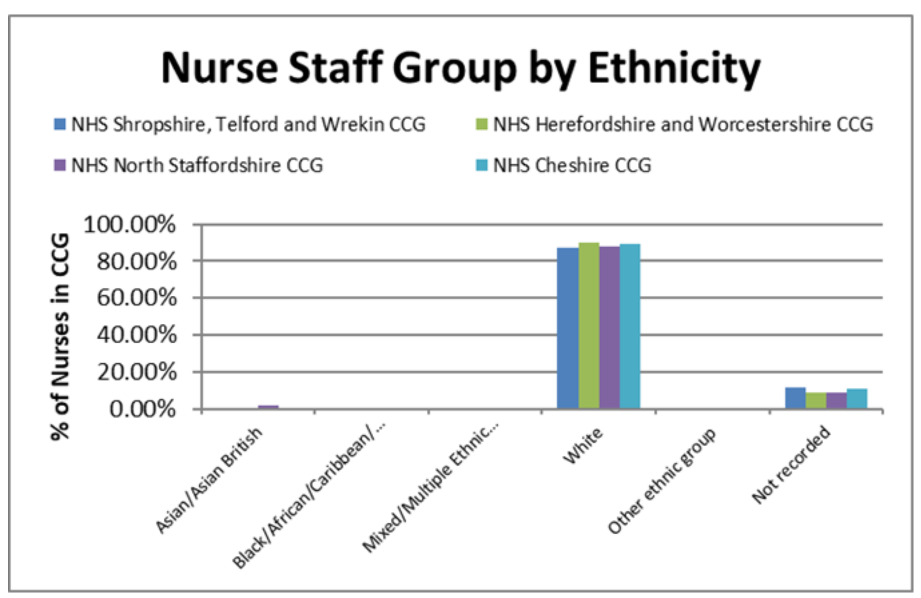
Shropshire, Telford & Wrekin
Primary Care Training Hub

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group


Ten point action plan
Extend leadership and educator roles.
Establish inductions and preceptorships.
Embed and deliver a radical upgrade in prevention.
1
2
3
4
5
6
Celebrate and raise the profile of general practice nursing and promote general practice as a first destination career.
Increase the number of pre-registration placements in general practice.
Improve access to 'return to practice' programmes.
10
9
8
7
Improve retention.
Develop healthcare support worker (HCSW), apprenticeship and nursing associate career pathways.
Increase access to clinical academic careers and advanced clinical practice programmes, including nurses working in advanced practice roles in general practice.
Support access to educational programmes.

Equality, Diversity and Inclusion (EDI)
GPN Strategy acknowledges the continued need to support both the local statement of intent and pledges and national commitment to EDI within the nursing workforce which across Shropshire, Telford and Wrekin is made up as illustrated below for all Providers within the ICS area:



https://stwics.org.uk/key-documents/248-racial-equality-pledges-for-stw-ics/file

We will continue to work with local system partners, via the ICS Equality, Diversity and Inclusion Group, to explore ways of increasing the diversity of our GPN workforce. We see this as an important step to making our workforce more representative of the

communities which we serve. One development which may assist in this, and which is being launched in October 2021, is the launch of the STW Primary Care Ethnically Diverse Network. This new group should provide all Primary Care staff, including GPNs, with an opportunity to consider and address some of the challenges to increasing the diversity of the workforce.

LINKS TO OTHER STRATEGIES

Although the overall focus of this document to define key deliverables to achieve the ambition to recruit, retain and reform General Practice Nursing across Shropshire, Telford and Wrekin it is acknowledged that this cannot be achieved alone and the strategy is linked to other local initiatives including:

Shropshire, Telford and Wrekin ICS People Plan – The GPN Strategy aligns with the ambitions of the ICS People plan including their focus on;

- Nursing Programmes
  - UCS offer Nurse Degree
  - Develop nursing offer with Wolverhampton University @ Priorslee
  - Increase numbers of Nurse Associates
  - Introduce Nursing Apprentices (Health and Care)
- ARR
  - Joint recruitment processes – ensuring system offer and EDI
  - Retention action plan
  - Development
  - Nursing development and leadership offer improvement.

ICS Nursing and Health care Support Worker Council

The purpose of the ICS Nursing & Health Care Support Workers Council (N&HCSWC) is to:

- Work in partnership to provide strategic leadership and accountability to develop and deliver in year priorities as set out in the approved ICS people plan - ‘’focus on nursing ‘
- Proactively lead, influence, shape and advise on nursing, HCSW and other related aspects of the ICS clinical and workforce strategies and transformation agenda.

Allied Health Professional (AHP) Strategy

The purpose of the AHP Strategy is to:

- Provide a simple and clear framework for all AHPs to align and contribute to the work of STW ICS and its ambition.
- Maximise the impact AHPs have in delivering on the NHS Long Term Plan (LTP), People Plan (PP), the STW 6 ticket item transformation themes strategic workforce priorities, and implementation of new National AHP Strategy AHPs Listen.
- Provide a workforce that meets the needs of service users by ensuring there is a sustainable supply of AHP registered and unregistered workforce.

STRATEGIC AIMS

Domain 1: Recruitment

Workforce; Having the right staff in the right place at the right time

Practice Nursing is a core profession within Primary care and has evolved to provide diverse and highly skilled roles. As Primary Care continues to change in the services offered and a workforce which is multidisciplinary to meet these new requirements there is a need to continue to offer developmental opportunities across all grades of staff, ensuring we 'grow our own' workforce from pre-registration interest in nursing through to highly specialist roles.

To achieve these aims the ICS and CCG will;	Aligns to:
• Develop and implement a workforce plan which focuses on recruitment and retention. • Embed Preceptorship programmes across Practices and Primary Care Networks. • Continue to develop workforce review and training needs analysis to ensure effective management of nursing resources and the development and placement of existing and new roles. • Promote the GPN role via marketing and engagement with local school, colleges and universities. • Develop and promote student placements to practices including placements for those on Return to Practice programmes. Encouraging the role of Practice Nurse to routinely include Practice Supervisor and Assessor functions. • Develop and promote opportunities for nurses to advance in their role at all levels.	GPN 10 Point Action Plan – 1; 3; 4; 5; 7; 8; 9; 10

• Support the development of Health Care Support Workers, including the promotion of level 2 and level 3 Nursing Associate and Registered Nurse apprenticeships. • Identify how to support the EDI local and national drivers and intentions – see above	

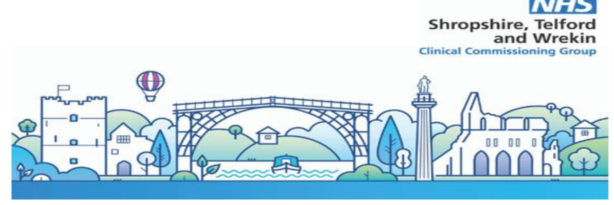
Domain 2: Retention

Education, Development and Support

As the pace of change in Primary care accelerates and the pressures on Practice Nurses increase there is a need to ensure a robust support system is in place to maintain a sense of belonging and ensure retention of staff. In these particularly difficult times during a pandemic alternative to face-to-face contact needs to be sought to ensure Practice nurses maintain their clinical and professional development and have opportunities to share their thoughts, ideas and concerns with others.

Leadership

With the changes to Practice nurse structures with increased opportunities to move to advanced roles nurses need to continue to develop their roles within the workforce to ensure they have the skills to become leaders within Primary care. With the advent of Primary care Networks (PCNs), nurses need to be equipped to seek out and move into leadership roles when opportunities arise.



Excellence in care

Facilitating provision of the best care possible is central to everything the ICS does. Continual improvement requires care to be underpinned by best practice evidence, research with measurable outcomes, ensuring right thing is done at the right time. This domain should be considered in conjunction with ICS and CCG patient and carer engagement programmes and local work around patient safety and improvement.

To achieve these aims the ICS and CCG will;	Aligns to:
• Develop and support local GPN education forums. • Develop mentors and increase student placement opportunities in primary care taking into account capacity. • Invest in the future workforce through engagement with apprenticeships at all levels from HCA to Registered Nurse. • Support access to HEE sponsored programmes in advanced clinical practice and specialist nursing. • Ensure that nurses at all levels receive a strong induction, with on-going preceptorship where possible and have the support and opportunity to develop their careers. This will be implemented via the Induction Framework and the Retention Programme • Develop new ways of working to help nurses to develop within the profession and retain nurses in general practice. • Maintain strong collaborative working with the Shropshire, Telford and Wrekin Training Hub to ensure wider provision of free and accessible training to nurses at all levels. • Support the implementation of clinical supervision within general practice by a variety of means. • For all GPNs to feel they have a collective voice and can contribute to the future of health care	GPN 10 Point Action Plan – 2; 4; 6; 7; 8; 9

across Shropshire and Telford & Wrekin CCG. • Create opportunities for GPNs to maintain clinical and professional development and share good practice or learning when incidents occur. • Facilitate access to formal leadership programmes via the Training Hub. • Promote and encourage applications to the Queens Nursing programmes to lead in projects locally in primary care. • Supporting GPNs to identify and unlock their leadership potential. • Support GPNs to work at different organisational levels. • Listen to, value and learn from patient opinions and their experiences. • Encourage nurses and HCAs to be actively involved in programmes that promote the patient and carer voice e.g. Friends and Family Test, Patient Participation Groups, “Friends of” groups. • Continually listen and involve patients to help inform our own learning needs e.g. via patient testimonial for revalidation. • Encourage engagement with local and national guidelines e.g. NICE as examples of best practice. • Promote engagement with research and development in primary care to improve services and care. • Ensure that all patients have their communication needs met appropriately.	

Domain 3: Reform

Communication including use of digital technology

Due to the pandemic, we have seen significant changes in the way Primary care communicates both with patients and with staff with some opportunities to work at home. Although the changes were made due to necessity it is now opportune to reflect and consider how these alternative communications can be used in the future to improve patient experience and support staff work-life balance.

To achieve these aims the ICS and CCG will;	Aligns To:
• Encourage engagement with digital platforms to connect with peers. • Encourage nurses to engage with digital technology and to become Digital Champions enabling them to promote patient focused technologies to deliver nursing care that enhance quality care delivery. • Develop and maintain communication methods such as intranet web and global communication e mails. • Develop a CCG wide GPN Newsletter and promote the responsible use of social media to facilitate communication by peers. • Develop and facilitate working relationships for GPN's across Primary Care Networks and the CCG. • Support and promote Video Group Consultation and Triage Training. • Personalised Care.	GPN 10 Point Action Plan – All action points

KEY DELIVERABLES

Domain	2021/2022				2022/2023				Ongoing
Recruitment	Continue to develop workforce review and training needs analysis.	Increase number of Newly-qualified nurses: Linking Year 3 students to practices looking to recruit and with Fundamentals Programme in Q3.	Implement a workforce plan which focuses on recruitment and retention.	Develop and promote student placements to practices including placements for those on Return to Practice programmes.	Embed Preceptorship programmes across Primary Care Networks.	Encourage Student Placements to be shared across PCN footprint.	Employ lead for TNA/NA and HCA development.		Promote the GPN role via marketing and engagement with local school, colleges and universities.
Retention	Supporting GPNs to identify and unlock their leadership potential.	Develop and promote opportunities for nurses to advance in their role at all levels.	Support the development of Health Care Support Workers.	Support/ Promote increasing the number of Assessors and supervisors.	Support GPNs and HCAs across PCN footprints to work at different organisational levels.	Promote a range of support for GPNs such as Motivational interviewing, coaching and managing	Promote engagement with research and development in primary care to improve	Promoting and encouraging staff to attended MECC courses.	Explore the development of a GPN Nurse bank in conjunction with local GP locum bank. ......

						change.	services and care.		
Retention	Support the implementation of clinical supervision within general practice either face to face or electronic means.	Create opportunities for GPNs to maintain clinical and professional development and share good practice or learning when incidents occur.							Develop and support local GPN education forums.
Reform	Develop a CCG wide GPN Newsletter and promote the responsible use of social media to facilitate communication by peers.	Encourage nurses to engage with digital technology and to become Digital Champions.	Ensure prevention is embedded within GPN / HCA role. Link into personalised care programme.	Promote the use of Video Group Consultations in service delivery for the management of Long-Term Conditions.	Promotion of ANP role and work to dispel the myths associated to underutilisation of ANPs.	Triage training programme.			Develop and facilitate working relationships for GPN's across Primary Care Networks and the CCG.

GPN STRATEGY OPERATIONAL DELIVERY PLAN

A separate document has been created to allow the monitoring of the key deliverables identified in the GPN strategy.

REFERENCES

GPN 10 Point Action Plan
https://www.england.nhs.uk/publication/general-practice-developing-confidence-capability-and-capacity/

NHS Long Term Plan
https://www.longtermplan.nhs.uk/

NMC Standards of Proficiency for Registered Nurses
https://www.nmc.org.uk/standards/standards-for-nurses/standards-of-proficiency-for-registered-nurses/

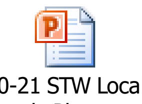
HEE District Nursing and General Practice Nursing Services Education and Career Framework
https://www.hee.nhs.uk/sites/default/files/documents/Interactive%20version%20of%20the%20framework_1.pdf

RCGP GPN Competency Framework
https://www.rcgp.org.uk/-/media/Files/Policy/A-Z-policy/2015/RCGP-General-Practice-Nurse-competencies-2015.ashx?la=en

RCGP General Practice Advanced Nurse Practitioner Competencies
https://sybwg.files.wordpress.com/2017/02/rcgp-np-competencies.pdf

QNI Transition to General Practice Nursing Resource
https://www.qni.org.uk/wp-content/uploads/2017/01/Transition-to-General-Practice-Nursing.pdf

STW ICS Local People Plan 20-21



20-21 STW Local People Plan.pptx

STW ICS commitment to Equality, Diversity and Inclusion Statement of Intent
https://stwics.org.uk/key-documents/248-racial-equality-pledges-for-stw-ics/file

Zena Young – Executive Director of Nursing & Quality, Shropshire, Telford and Wrekin CCG

Patricia Clifton – Shropshire, Telford and Wrekin Practice Nurse Facilitator

Sara Edwards – Shropshire, Telford and Wrekin Training Hub Programme Manager

Helen McAlinden – Shropshire, Telford and Wrekin Practice Nurse Facilitator

Jane Sullivan – Senior Quality Lead, Shropshire, Telford and Wrekin CCG

Primary Care Commissioning Committee

Agenda item no.	PCCC 23-06.38
Meeting date:	**2nd June 2023**
Paper title	Performance and GP Access Improvement Report
Paper presented by:	Berni Williams, Contracts and Delegated Commissioning lead
Paper approved by:	Gareth Robinson, Executive Director Delivery and Transformation
Paper prepared by:	Berni Williams, Contracts and Delegated Commissioning lead
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.

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

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:**	

GP Access Performance Report – 2 June 2023

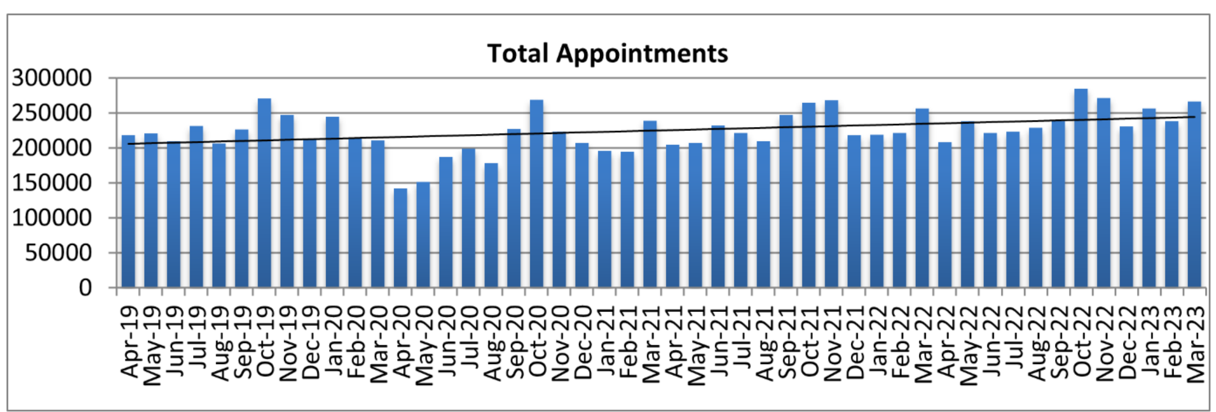
1. GP Appointments

1.1 The most recent data for GP appointments is for March 2023[1] when there were 265,824 appointments recorded (figure1).

1.2 When comparing to the same period in 2019, April to March 2023 data shows:

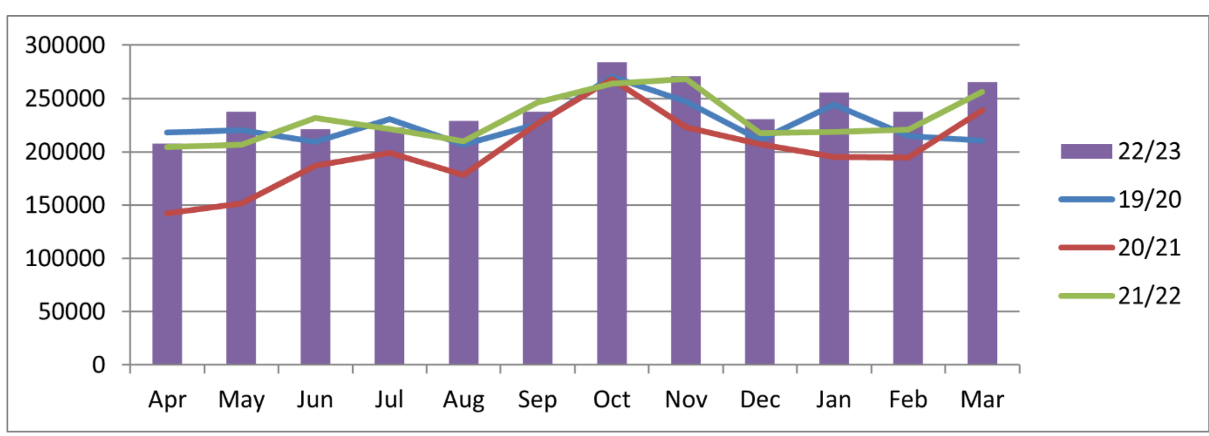
- 161,178, additional appointments (5.9% increase).
- 7 out of 10 patients seen face-to-face

Figure 1 – April 2019 to March 2023 – Total all appointments.



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

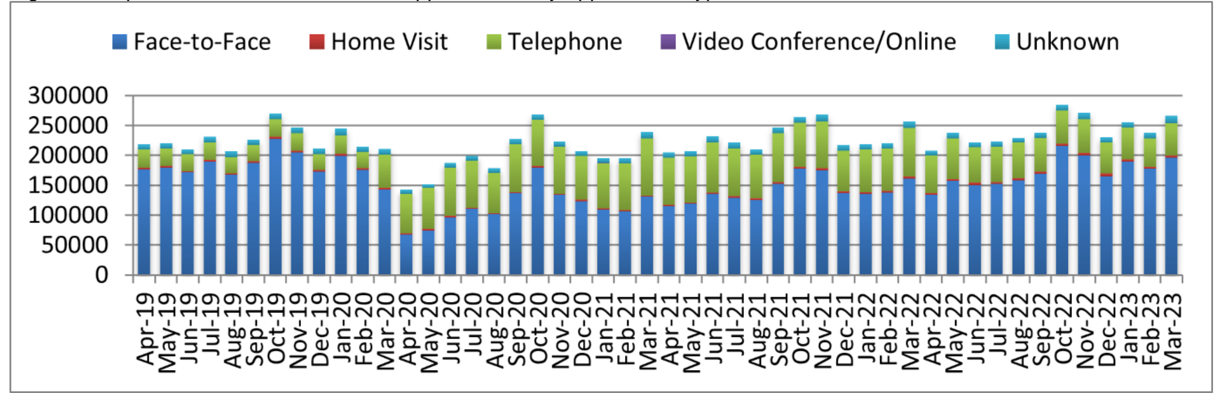
Figure 2



1.4 There has been 81% increase in remote access (402,110 remote appts in 2019, 729,253 remote appts in 2022/3) (figure 3).

[1] Appointments in General Practice report - NHS Digital

Figure 3 – April 2019 to March 2023 – All appointments by appointment type.



1.5 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 apart from an increase in other practice staff. (figure 5).

Figure 4 – appointment by professional

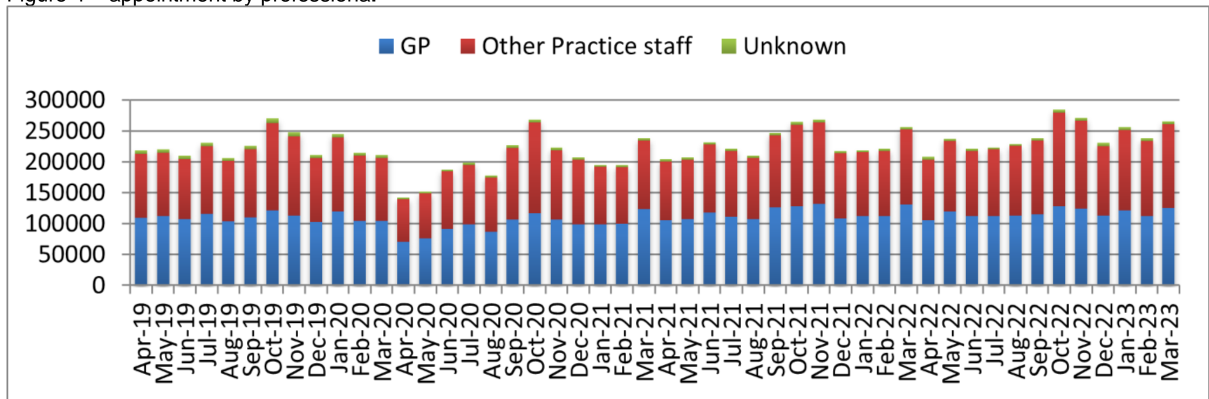


Figure 5 – appointment by professional numbers and percentage.

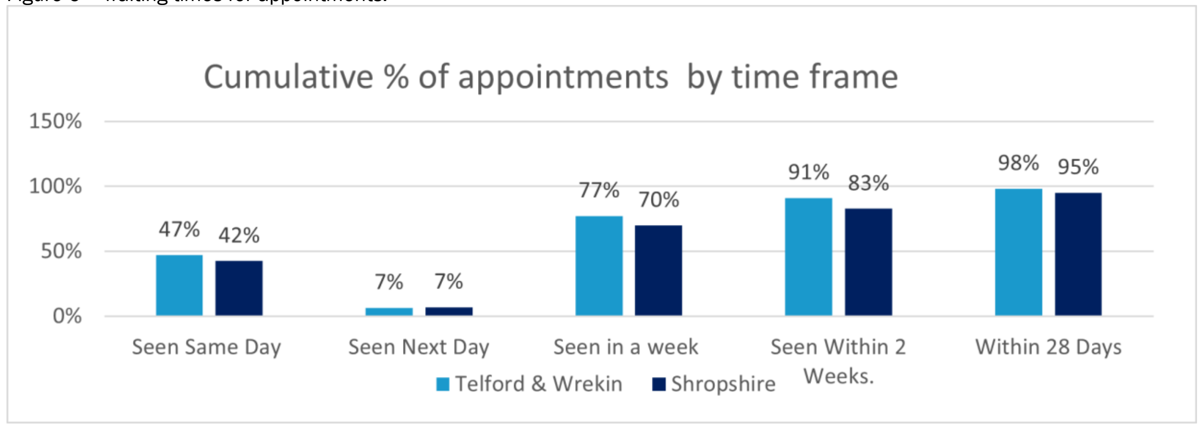
	GP	Other Practice staff	Unknown	Grand Total
Mar-20	104334 49.54%	101571 48.23%	4700 2.23%	210605 100%
Mar-23	125142 47.08%	135217 50.87%	5465 2.06%	265824 100%

1.6 The graph below shows the waiting times for appointments. This indicates that:-

- 54% of patients are seen same day/next day in T&W and 49% in Shropshire
- 91% of patients in T&W and 83% of patients in Shropshire are seen within 2 weeks (figure 6).

1.7 The number of practices that have restored to pre-pandemic levels is 47/51. This is 2 more than previously reported. The team have worked with practices to ensure the appointment mapping and data quality are correct. Work is ongoing with the remaining practices to understand barriers to restoration.

Figure 6 – waiting times for appointments.



1.8 Benchmarking our performance with the other systems in the region, shows that STW is on par or is doing more favourably e.g. face to face. The heatmap below shows how ICBs compare across several different metrics using the March 2023 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.

System	Appts Per 10,000 weighted patients	Recovery to 2019 levels (WD)	% Face to Face *		% Appts with a GP that are Face to Face	% GP Appointments	% Same Day	% within 14 Days	% DNAs
Birmingham and Solihull ICB	4,885	111%	70%	↑	61%	53%	49%	87%	7%
Black Country ICB	4,761	108%	74%	↑	67%	50%	44%	85%	6%
Coventry and Warwickshire ICB	4,868	114%	65%	↑	56%	56%	51%	89%	5%
Derby and Derbyshire ICB	5,312	109%	75%	↑	70%	47%	41%	77%	3%
Herefordshire and Worcestershire ICB	6,102	110%	63%	↑	50%	50%	45%	84%	4%
Leicester, Leicestershire and Rutland ICB	6,188	112%	75%	↑	67%	44%	42%	81%	4%
Lincolnshire ICB	5,637	116%	70%	↑	61%	35%	46%	82%	3%
Northamptonshire ICB	5,318	108%	68%	↑	61%	44%	46%	84%	3%
Nottingham and Nottinghamshire ICB	5,219	106%	70%	↑	62%	47%	43%	78%	4%
Shropshire, Telford and Wrekin ICB	4,866	106%	74%	↑	67%	47%	45%	84%	4%
Staffordshire and Stoke-on-Trent ICB	4,652	111%	74%	↑	69%	45%	45%	86%	5%
Midlands	5,211	110%	71%	↑	63%	48%	45%	83%	5%
England	5,103	112%	70%	↑	62%	48%	43%	83%	5%

* Indicator is comparison to March 22

Favourable – Less Favourable

2. PCN Appointment Data

2.1 Presently the GPAD data does not yet include all activity recorded in appointment books ***managed directly by PCNs***, meaning that the recording of enhanced access (EA) and Additional Roles Reimbursement Scheme (ARRS) activity nationally is incomplete.

2.2 NHS England states that work is underway to ensure appointment data for activity recorded in appointment books managed directly by Primary Care Networks (PCNs), including enhanced access (EA) and Additional Roles Reimbursement Scheme (ARRS) is included in the publication. To enable this, NHS England wants to work with general practice, PCNs and system suppliers to ensure that GP appointment data captures all appointments at PCN level. NHS England also wants to provide support that makes it easier for PCNs and practices to collect and provide this appointment data automatically (this is in line with the PCN Network Contract Directed Enhanced Service

(DES)). NHS England have requested consent from all PCNs to collect the data (appointments directly managed by the PCN) in line with the GP Appointments Data Direction and Data Provision Notice (DPN). Consent has been given by all 8 of the STW PCNs.

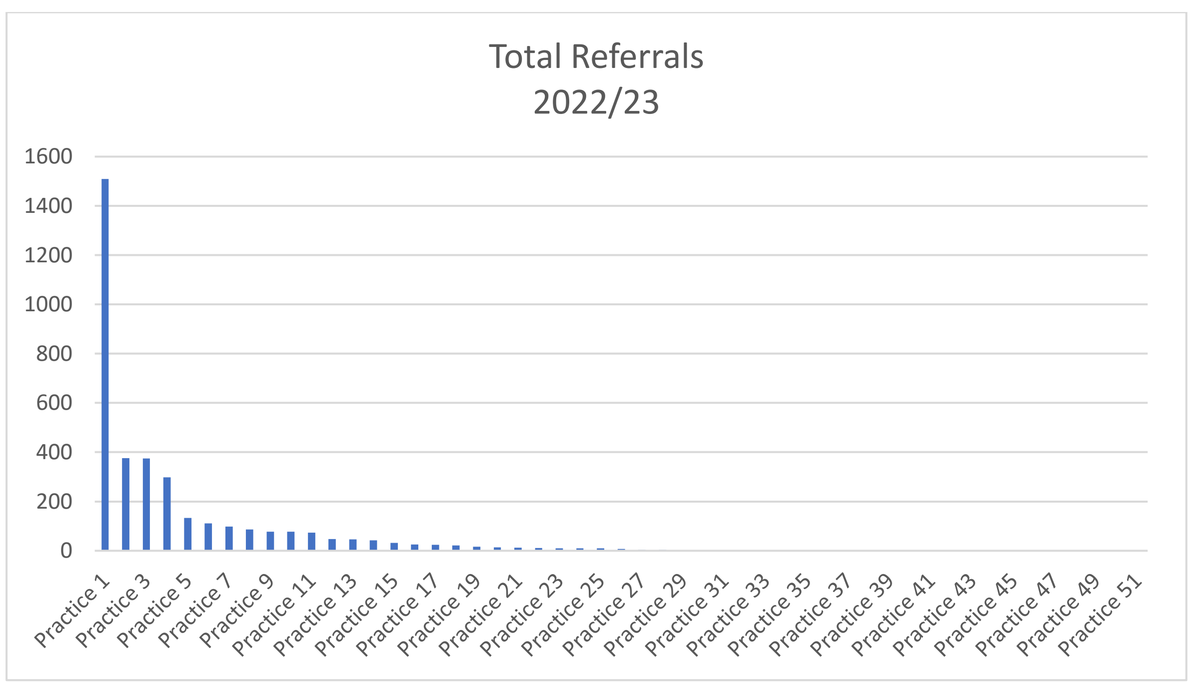
Other access modes

3. **Community Pharmacy Consultation Service (CPCS)**

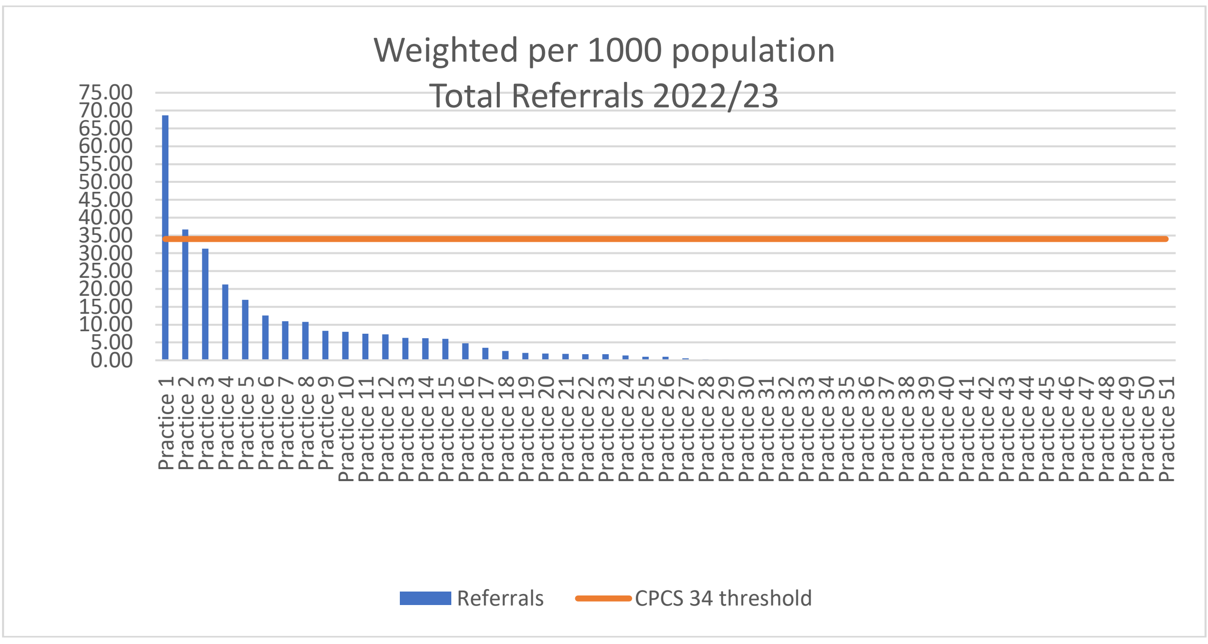
3.1 General Practices and Community Pharmacies in STW continue to provide access to patients with a minor ailment. The table below shows the number of referrals into the service; December has the highest number of referrals which can be attributed to the unprecedented demand for primary care services during that period. The primary care team will be working with the newly appointed ICS Community Pharmacy Clinical Lead to improve our referral rates.

Month	**Jun 22**	**Jul 22**	**Aug 22**	**Sept 22**	**Oct 22**	**Nov 22**	**Dec 22**	**Jan 23**	**Feb 23**	**Mar 23**
Referrals	306	287	171	199	301	476	698	324	342	414

3.2 The graph below shows the total referrals this year by practice. The highest number of referrals is 1,509 there are 18 practices that have not yet implemented the service.



The historic IIF target was 0.65 referrals per 1,000 patients per week and the payment threshold was 0.034 which is 34 referrals per 1,000. The graph below shows the referral rate per 1,000 patients by practice however for 2023/24 this is no longer an IIF indicator.



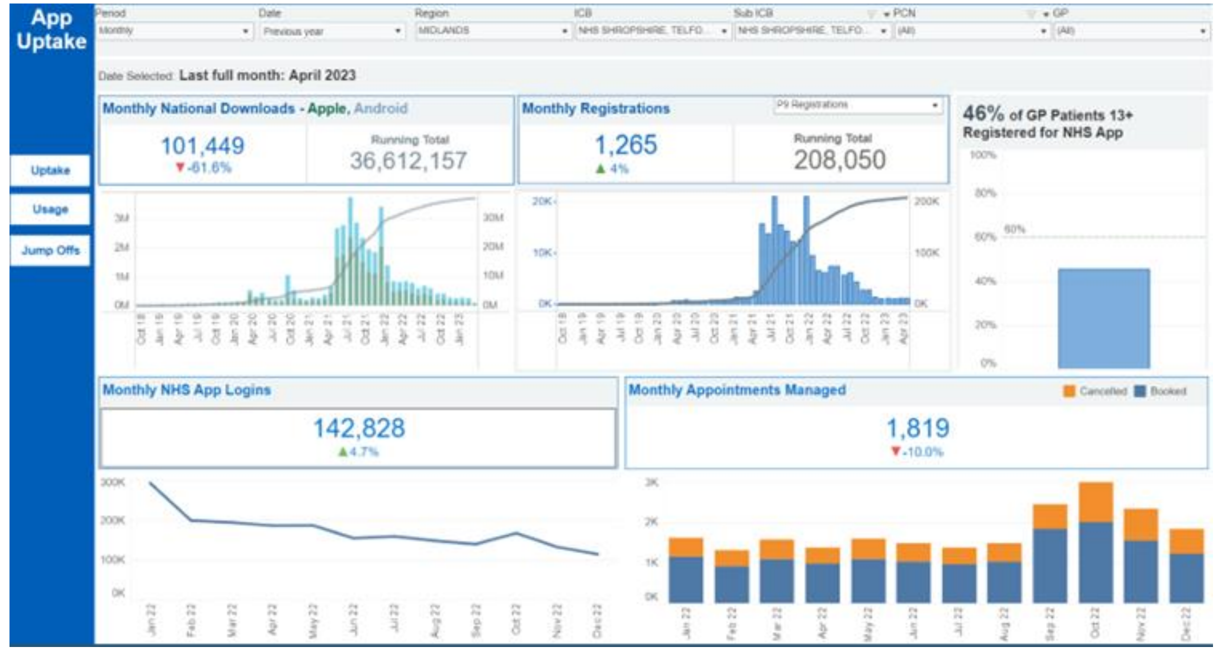
3.3 The historic target is not included as a requirement in the IIF; however, there is a reference in the new GP contract 2023/24 for the GP recovery plan. There is a substantial section in the plan about the expansion of the range of service offered by community pharmacy as an alternative to General Practice.

4. NHS App

4.1 The NHS App is a simple and secure way to access a range of NHS health services online. Full access will allow patients to order repeat medications, book appointments, view their health record and if the GP or hospital offers other services, patients may be able to:

- Message their GP surgery or healthcare professional online,
- Consult a GP or healthcare professional through an online form and get a reply.

4.2 The graphic below shows the NHS App uptake data. 46% of patients in STW (208,050) are registered users. In April 2023 STW had 1,819 appointments managed via the NHS App.



4.3 There are potential cost savings to be made due to reduction in SMS messages or letters if more patients move to using the NHS App.

5. On-line consultations

5.1 Patients are able to contact the GP practice using a secure and confidential online form on their website. An online form is a quick and easy way of letting the GP practice know what's wrong or raise a concern. It can be more convenient for some people, e.g. people that do not like to use the phone.

5.2 The reporting and collation for online consultation data is currently a resource heavy manual exercise.

5.3 Data should be available early in 2023/24 via the newly procured service provider.

Delivery plan for recovering access to primary care

Why we need a Delivery Plan for Recovering Access to Primary Care

The Autumn Statement committed the NHS to publish a recovery plan for primary care.

The plan focuses on recovering access to general practice and **supports two key ambitions:**

1. **To tackle the 8am rush and reduce the number of people struggling to contact their practice.** No longer will patients be asked to call back another day to book an appointment.
2. **For patients to know on the day they contact their practice how their request will be managed.**
   a. If their need is clinically urgent it will be assessed on the same day by a telephone or face-to-face appointment. If the patient contacts their practice in the afternoon they may be assessed on the next day, where clinically appropriate.
   b. If their need is not urgent, but it needs a telephone or face-to-face appointment, this will be scheduled within two weeks.
   c. Where appropriate, patients will be signposted to self-care or other local services (eg community pharmacy or self-referral services).

NHS England engaged with a wide range of stakeholders to develop and refine the plan, including patient and professional representative groups as well as used the insight gathered from Dr Fuller's stocktake. It also includes key themes to be engaged on during 2023/24, including the GP contract and Pharmacy First, to support delivery of the longer term vision.

Recovery plans

The Delivery Plan for Recovering Access to Primary Care is one of three NHS strategic recovery plans addressing priority areas

Elective recovery plan

Key ambitions:

- That the **waits of longer than a year for elective care are eliminated** by March 2025
- **95% of patients needing a diagnostic test receive it within six weeks** by March 2025.
- 75% of patients who have been urgently referred by their GP for suspected cancer **are diagnosed or have cancer ruled out within 28 days** by March 2024
- **Improve both waiting times and patients' experience of waiting** for first outpatient appointments over the next three years.

Urgent and Emergency recovery plan

Key ambitions:

- **Patients being seen more quickly in emergency departments:** with the ambition to improve to 76% of patients being admitted, transferred or discharged within four hours by March 2024, with further improvement in 2024/25.
- **Ambulances getting to patients quicker:** with improved ambulance response times for Category 2 incidents to 30 minutes on average over 2023/24, with further improvement in 2024/25 towards pre-pandemic levels.

Primary Care Recovery Plan

Key ambitions:

- **To tackle the 8am rush and reduce the number of people struggling to contact their practice.** No longer will patients be asked to call back another day to book an appointment.
- **For patients to know on the day they contact their practice how their request will be managed.**

The problem the Delivery Plan for Recovering Access to Primary Care is addressing

Strained capacity

- **20-40% increase in contacts** since pre-pandemic, exacerbated by care backlogs

- **>30% increase in people >70** since 2010, with more **long-term conditions**

- **12% more appointments** since pre-pandemic

- **Only ~7% increase in doctors** working in general practice since pre-pandemic

Decreasing patient satisfaction

- **Average satisfaction** with general practice fell from **83% to 72%** last year.

- Over **85% of practices** saw their **satisfaction fall**

- **1 in 5 people unable to get through** or get a reply from their practice when last tried

- **Poor contact creates patient dissatisfaction** with practice overall

 Spurce: GPPS 2022, DHSE pulse check Nov 2022, GPAD Dec 2022, NHSE survey via IGPM Feb 2023

The plan headlines

The plan focuses on four areas to support recovery and deliver the ambitions. The page overleaf outlines more detailed information.

1		**Empower patients**	• Improving NHS App functionality	• Increasing self-referral pathways	• Expanding community pharmacy	
2		**Implement new Modern General Practice Access approach**	• Roll-out of digital telephony	• Easier digital access to help tackle 8am rush	• Care navigation and continuity	• Rapid assessment and response
3		**Build capacity**	• Growing multi-disciplinary teams	• Expand GP specialty training	• Retention and return of experienced GPs	• Priority of primary care in new housing developments
4			• Improving the primary-secondary	• on the	• and up	

1	**Empower patients** by rolling out tools they can use to manage their own health, and invest up to £645m over two years to expand services offered by community pharmacy.	• **Enable patients in over 90% of practices to see their records and practice messages,** book appointments and order repeat prescriptions using the **NHS** App by March 2024. • **Ensure integrated car boards (ICBs) expand self-referral pathways by September 2023, as set out in the 2023/24 Operational Planning Guidance.** • **Launch Pharmacy First, so that by the end of 2023 community pharmacies can supply prescription-only medicines** for seven common conditions. This together with OC and BP expansion could save 10m appointments in general practice a year once scaled, subject to consultation. • Expand pharmacy oral contraception (0OC) and blood pressure (BP) services this year, to increase access and convenience for millions of patients. This is subject to consultation
2	**Implement 'Modern General Practice Access'** so patients know on the day how their request will be handled based on clinical need and patient preference. We are re-targeting £240m -- for a practice still on analogue lines this could mean £6Ok support over 2 years.	• Support all practices on analogue lines *to* move to digital telephony, including call back functionality, if they sign up by July 2023 • Provide all practices with digital tools and care navigation training for Modern General Practice Access, and fund transition cover for those that commit to adopt this approach before March 2025 • Deliver training and transformation support to all practices from May 2023 through a new National General Practice Improvement Programme
3	**Build capacity** so practices can offer more appointments from more staff than ever before.	• **Make** available an extra £385m in 23/24 to employ 26k more direct patient *care* staff and deliver 50m more appointments by March 2024 (compared to 2019). • Further expand GP specialty training - and make it easier for newly trained GPs who require a visa to remain in England • Encourage experienced GPs to stay in practice through the pension reforms announced in the budget and create simpler routes back to practice for the recently retired • Change local authority planning guidance this year to raise the priority of primary care facilities when considering how funds from new housing developments are allocated
4		• **Streamline the Investment and Impact Fund (IIF) from 36** to five indicators - re-target £246 million - and protect 25% *of* Quality and Outcomes (QO)F) clinical indicators. • **Reduce time spent liaising with hospitals by requiring ICBs to report progress** on improving the interface with primary care, especially the four areas highlighted from the Academy of Medical Royal Colleges Report, in a public board update this autumn. •

Model of general practice for patients

Website

Call

Visit the surgery

Your GP surgery

Face-to-face appointment

Phone consultation

Video consultation

Text or email message

Home visit

Refer you to another service

Offers to implement Modern General Practice Access to practices and PCNS

Digital telephony - Financial and procurement support for digital telephony to any practice who, by July 2023, indicates that they need to move from analogue to digital telephony

Digital tools for on line consultation, messaging and appointments - Funding of uplifted framework tools for online consultation, messaging, self-monitoring, and appointment booking tools

Transformation support - A range of offers from the National General Practice Improvement Programme:

- Universal: on line resources, local improvement communities, and webinars available to all practices
- Intermediate: specific support to practices and PCNs needing support to make changes
- Intensive: targeted, hands-on support for practices in most challenging circumstances

Transition cover - for significant improvement efforts in selected practices - worth -£13.5k/practice of flexible funding covering (e.g., extra practice shifts, locums, peer support)

Care navigation training - every practice and PCN allowed to nominate one member of staff to undertake training.

Repurposed IIF to support time for transformation:

- Reduced IIF indicators from 36 to 5 (on top of 25% reduction in QOF indicators) releasing staff capacity
- £172m to be unconditional 'Capacity and access support' paid monthly (-£11.5k/month/average PCN)
- £74m for ICB commissioner to discretionarily dispense on performance and addressing GPAD

Increase in ARRS flexibility & ARRS numbers

- Increasing ARRS funding by £385m
- Increase flex. by including apprentice physician associates and Advanced Clinical Practitioners Nurses

Funding to support the plan

- 1. Retarget over **£240 million** of funding in 2023/24 for **new technologies and support offers** for primary care networks (PCNs) and practices that help them **plan and implement Modern General Practice Access,** including **online tools, digital telephony, care navigation training and transformation support.**

- 2. Invest up to **£645 million** over the next two years to **expand community pharmacy services,** subject to consultation.

- 3. Redirect **£246 million** of the **streamlined IIF towards improving access;** 70% will be given to PCNs unconditionally to support driving change (~£11,500 per month for the average PCN), with the remaining 30% awarded by ICBs conditional on PCNs achieving agreed improvement in access and patient experience.

- 4. Delivering on our commitment to make a further **£385 million** available in 2023/24 to reach the existing target of **26,000 more direct patient care staff** and **50 million more appointments in general practice** by March 2024.

- 5. Continue to allocate **System Development Funding (SDF) to ICBs,** which for 2023/24 totals **~£170 million.** NHS England expects systems to use a large part of this to **support primary care transformation.**

- 6. Given the scale of proposed change, NHS England will launch a **major communications campaign** to explain the evolving nature of primary care to the public and how they can best use the NHS.

Key Timelines 23/24

9 May Delivery Plan for Recovering Access to Primary Care published by NHSE
May new national General Practice Improvement Programme starts
May Pharmacy First consultation starts
30 June PCNs submit their capacity and access improvement plans
1 July take up of digital telephony funding offer for practices expires
July ICB signs of PCN improvement plans
September start of national GP access comms campaign - **to be confirmed**
30 September self referral pathways in place
31 October all practices provide prospective access for patients to their records
Oct/Nov System level access improvement plans which include summary of practice/PCN improvement plans to Board
Oct/Nov report in public board updates and plans for improving the primary–secondary care interface (four focus areas highlighted in the recovery plan)
31 March 2024 care navigation training for all practices to be completed
Mar/April 2024 PCNs provide evidence of achievement of improvement to the ICB in order to receive the 30% improvement payment

Primary Care Team Actions and Next Steps

- Primary Care Networks are already underway with establishing their baseline against the national requirements in the Capacity and Access Improvement plan published at the end of March. Two have taken up the Primary Care Team offer of support.
- Standing agenda item on the monthly PCN Development meetings.
- ICB Action Plan in development, ensuring it covers all the areas for action set out in the NHSE checklist published on 19th May.
- Sharing new information with PCNs and practices as it comes through. Quite a challenge as it is coming through in an ad hoc way rather than in one cohesive package
- Attending national and regional webinars to get the latest information.
- Encouraging the practices we feel would most benefit from the practice improvement support offer to sign up either to the intensive or intermediate level of support.

Primary Care Team Actions and Next Steps (Continued)

- Exploring options for resourcing the delivery of the diagnostic Support Level Framework with each practice over the coming 18 months. ICBs are expected to resource the required facilitation capacity for this work (1 x 3 hour session, x2 facilitators). A degree of pragmatism is required given limited capacity in the team. Although the guidance states that all practices should have been through this diagnostic by the end of March 24 a degree of pragmatism will be required due to capacity constraints in the Primary Care Team. We will need to identify and prioritise those practices who would most benefit in conjunction with PCN leads. There may be a need to commission external support for this work due to the limited capacity within the team. Available funding will be a key limitation. Other ICBs have expressed the same position.

- Digital lead will work with the practices who are on analogue telephony systems to ensure they are supported to take the necessary action to sign up for the national funding support to migrate to digital by the national deadline. We only have 3 out of 51 practices in this position.

- Service Development Funding national guidance received 22nd May confirming the funding amount for 23/24 and what the monies has to be used for. There is an expectation that the ICB will describe in the plan that must go to Board in the autumn what this funding has been used for. The Primary Care Team are working through this guidance to ensure the ICB is deploying the funding in line.

Primary Care Team Actions and Next Steps (Continued)

- Primary Care Team linking with relevant ICB commissioners to establish what self referral pathways are in place, which are planned by when and identify gaps.

- Focus group of the GP Board considering how we take forward the primary – secondary care interface work in a collaborative solution focussed way with General Practice and SATH and any other relevant NHS providers

Primary Care Commissioning Committee

Agenda item no.	PCCC 23-06.39								
Meeting date:	2nd June 2023								
Paper title	**Pharmacy, Optometry and Dentistry Update**								
Paper presented by:	Emma Pyrah, Associate Director of Primary Care								
Paper approved by:	Gareth Robinson, Executive Director Transformation and Delivery								
Paper prepared by:	Emma Pyrah								
Signature:									
Committee/Advisory Group paper previously presented:									
Action Required (please select):									
A=Approval		R=Ratification		S=Assurance	x	D=Discussion		I=Information	x
Previous considerations:									

1. Executive summary and points for discussion

The delegation from NHS England (NHSE) to Integrated Care Boards (ICBs) of Primary Pharmacy Services, Optometry Services and Primary and Secondary Dental Services from 1st April 23 is in accordance with NHSEs long-term policy ambition of giving systems responsibility for managing local population health needs, tackling inequalities, and addressing fragmented pathways of care.

Key developments:

- The national delegation agreement has been signed by the ICB.

- The ICBs in the Midlands have worked together to develop arrangements to jointly commission POD on an East and West footprint. Birmingham and Solihull ICB will host the West footprint commissioning team from 1st July 23. A Hosting Agreement is drafted and is expected to be signed off by ICBs in June.

- A Midlands wide governance group led by Simon Whitehouse ICB CEO for Shropshire &Telford ICB and Toby Sanders ICB CEO for Northamptonshire have developed a set of governance documents required to establish a Joint Committee and set of joint working arrangements. These have been agreed and supported by all ICBs and NHSE. The governance structure is set out in Appendix 1.

- In relation to how the ICB/Primary Care Team are linking in to the governance structure and wider hosted service:-

- **Tier 1 Board** – CEO level, Simon Whitehouse attends
- **Tier 2 Joint Commissioning Group** – Director level, Emma Pyrah attends
- **Tier 3 Pharmacy, Optometry and Dentistry specific groups** – Commissioner level, hosted service commissioner attends. There is no requirement that ICBs attend these groups however the Primary Care Partnership Managers will attend for the next 12 months to develop links and relationships and increase ICB knowledge based on the detail of contracting and commissioning of POD.
- **Finance** – Finance and Activity Group – Angharad Jones attends
- **Quality** – Quality leads meeting – Jane Sullivan attends
- A number of meet the team events have been held by the hosted service, which members of the Primary Care Team have attended. Next one scheduled for June.
- **Links with STW Commissioning lead** – Darrell Jackson is our ICBs POD lead in the hosted service. He covers STW and Staffordshire. Monthly catch up meetings are being diaried with him and the Primary Care Team. This will enable ongoing dialogue to ensure the opportunities of delegation to ICBs is maximised and avoid duplication.

It is early days with the embedding of the governance arrangements into a cohesive way of working.

- Performance data is currently provided to the Joint Commissioning Group and the Board at a regional level ICB specific information packs will be available in June which will include information on quality issues, counterfraud issues and complaints.

- This multi-ICB approach has been developed with consideration to the future delegation of other NHSE commissioning functions that will also be delivered on a West Midlands footprint.

- In addition, NHSE will delegate a subset of specialised services from April 24 to ICBs. During 23/24 ICBs will be expected to jointly plan these services with NHSE through a set of joint arrangements prior to formally picking up full delegation from April 24.

- Across the West Midlands footprint there is c18m non recurrent underspend and 5m recurrent. This is largely due to under performance on forecast dental activity. CEOs have asked for consideration to be given to a proportion of this going towards ICB deficit reduction. Detailed work to understand the required investment to meet population need in dentistry is required before any decisions can be made. The CSU has undertaken an analysis to support the development of Primary Dental Care Services and published a report which has been shared with Board and JCG and will soon be provided at an ICB level. A workshop with ICBs, finance, public health is being arranged for end June/early July to better understand the outputs and determine what is required and what can be done within the resources available.

- Attached for information are:

  - the strategic vision and priorities for POD for information (Appendix 2).
  - the investment plan for 23/24. All critical elements were approved by Tier 1 Board in May (Appendix 3).

Which of the ICB Pledges does this report align with?

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

2. Recommendation(s)

NHS Shropshire, Telford and Wrekin Integrated Care Board 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.

No

4. Appendices

1. What are the implications for:

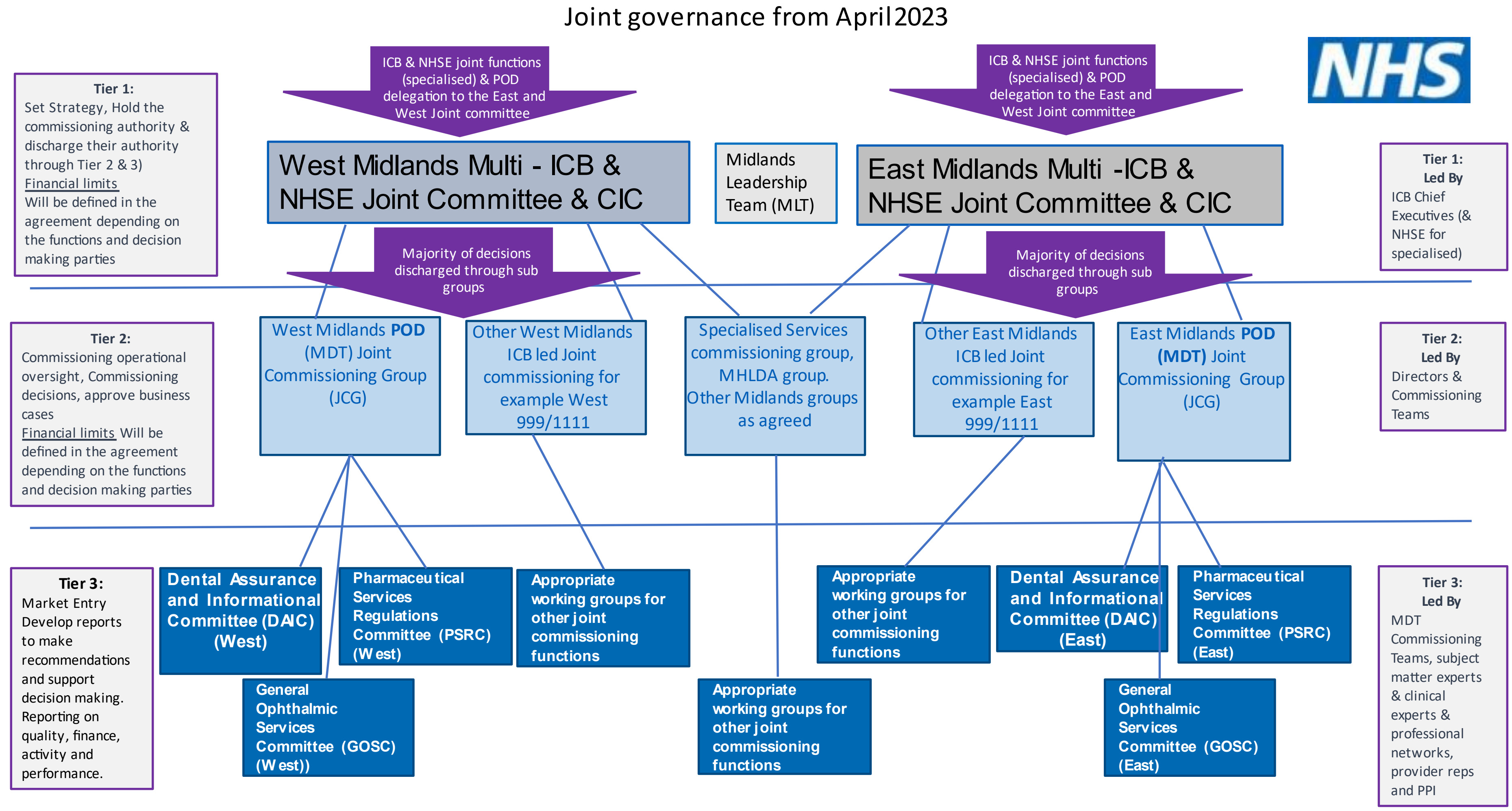
Shropshire, Telford and Wrekin's Residents and Communities	Enables greater focus on local population health needs, tackling inequalities, and addressing fragmented pathways of care.
Quality and Safety	No issues arising from paper
Equality, Diversity, and Inclusion	Aim to improve inequalities
Finances and Use of Resources	Amendments to financial scheme of delegation Appendix 4
Regulation and Legal Requirements	Delegation of PODS to ICBs National Policy
Conflicts of Interest	None from the content of the paper
Data Protection	Has been addressed through delegation agreements
Transformation and Innovation	Delegation provides future opportunities
Environmental and Climate Change	None from the contents of this paper
Future Decisions and Policy Making	The delegation agreement enables ICBs to set strategy and ensure closer integration

Action Request of Paper:	
Action approved at Board:	

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

Meeting:	
Meeting date:	
Agenda item no.	
Paper title	

Appendix 1 Midlands Governance Framework 23/24



Appendix 3

Enc 5	Agenda Item: #
Report to:	West Midlands Joint Committee
Date:	12th May 2023
TITLE:	Primary Care POD investment plan 2023/24
Presenting Officer:	Rebecca Woods
Report written by	Lucy Blackshaw

1. Purpose:

Following the inaugural West Midlands Joint Committee (WMJC) at their April 2023 meetings an overview of the planned West Midlands Primary Care Pharmacy Optometry and Dental (POD) 'Very High' priority investment schemes was submitted, but it was agreed to be deferred until the May meeting and for a further review of the proposed schemes, to be assessed against critical and non critical criteria.

It was agreed on the 9th of February 2023 that the non-recurrent funding available for 2023/24 is £18m. In addition, we have been notified on the 11th of April 2023 that and additional £5,827k will be available recurrently.

2. Recommendation to West Midlands Joint Committee

It is recommended that West Midlands Joint Committee:

- **NOTE** the paper
- In the context of the ICB financial challenges **APPROVE** the commencement of:
  - all the critical Very High Priority non-recurrent Dental Schemes which total **£6,975,416** plus £31,500 i.e. £7,006,916 Releasing £10,993,084 non recurrently
    the 2 critical recurrent Very High Priority Dental Schemes identified which total £**520,000**.

Consideration to be given to whether recurrent dental funding of the remaining £5,307,000 should be retained to improve dental access following the outcomes of the Strategy Unit work, or whether this funding is to be included in the flexibilities to support ICB financial positions.

Consideration to be given to whether to repurpose recurrent flexibilities, on a fixed term basis, to support the current critical vacancies in the Dental part of the POD commissioning team to be funded from programme costs rather than running costs. This would support ICBs to deliver percentage savings in running costs.

3. Report Body

3.1 Background and context

The Commissioning Finance team had advised of £18m non-recurrent and £5,827,000 recurrent flexibilities for dental schemes as of April 2023 across the 6 West Midlands ICBs. Based on a prioritisation process, a range of investment schemes were proposed as detailed in the appendix.

In the context of the significant financial challenges within the ICBs, this list of schemes has been reviewed to identify those that are critical as they bring either risk to: patient care, delivering system performance targets, urgent care system sustainability or would increase risk of legal challenges.

In summary there are £7,006,916 critical non recurrent schemes and £520,000 critical recurrent schemes. Please refer to table below for detail – rationale for continuing with the schemes is highlighted in orange for ease of reference.

This includes a £4m infrastructure scheme for those ICBs where there is significant dental contract underperformance by Corporates and in 2024/25, Commissioners will be able to unilaterally rebase these contracts. There are alternative local providers who could take on additional NHS activity, but who are constrained by physical space and this infrastructure scheme would help practices prepare to take on this activity and provide an opportunity to improve dental access in these severely challenged systems. It is a strategic scheme which will impact on improvements in access in 24/25.

There is also a scheme for a POD programme manager to support POD transition into ICBs. This is for £31,500 and is currently being funded by 2 ICBs on behalf of the 6. This proposal would equal the expenditure across the 6 ICBs.

This would release £10,993,084 non recurrent flexibilities and potentially £5,307,000 recurrent. Consideration could be given to re-purposing £387,137.50 of recurrent flexibilities to programme fund Dental commissioning vacancies to release running cost savings.

Key risks to note are:

- it is understood that any proposed changes to the dental ring fence agreement would need to be approved by NHSE nationally
- NHSE Regional team through the Assurance Framework will be requiring evidence that ICBs are meeting population need, ensuring that any underspend is used to bolster access and that budgets are being utilised for purpose and to best use.
- Dental access continues to be an extremely high-profile political issue with the Commissioning team frequently receiving MP questions, patient complaints and requests for information from Health Overview and Scrutiny Committees. Investment schemes to date have been the only messages that have been able to be included in our responses to support positive change in access. There was also a Health Select Committee held on 25th April 2023 with a focus on NHS Dental Services.
- From 1st April 2023 ICBs have taken on responsibility for POD services and the proposal to use the dental ring fence to support ICB system financial deficits will detrimentally impact on the relationship between ICBs and the dental profession and may result in even more contract hand backs
- The Vice Chairman of the British Dental Association is a dentist in the Birmingham and Solihull ICB area, who is very politically active and provided evidence to the Health Select Committee on 25th April 2023

Very High Scheme Description	2023-24 Planned investment West (£)	Rationale / Risk
Primary Care – Dental TOTAL		
Non-Recurrent		
Extend temporary children's weekend access sessions in Herefordshire pending procurement with Wye Valley Trust – in contract round and agreed.	30,000	This is critical to enable a level of access for children via Wye Valley Trust until the Herefordshire 2 dental practice procurement concludes. This has been included within the contract round.
Ortho case starts and assessments for Walsall and Birmingham (Phase 2 dispersal of patients to providers that may be located in multiple ICBs)	628,216	This is critical to manage patients as a result of multiple orthodontic contract handbacks
Continuation of Children's CDS Support practice scheme, including looked after children where relevant.	1,087,200	Community Dental Support practices are the safety net for patient access. This is critical to relieve pressure on 111 and A&E and this scheme focusses on access for children, including those most vulnerable
Weekend Access scheme	1,000,000	Critical – dental access remains very high profile and this scheme has been delivered over the last 2 years to support access including urgent care and supports 111 services. Since this scheme ended in April 2023. Feedback has already been received from Community Dental Services raising concerns that demand on their services has now increased significantly and is not sustainable.
New: Clinical Advisors/Subject Matter Experts (SME's) to support with Dental procurement programme	50,000	This is critical to enable the commissioning team to have access to Clinical Expertise to support procurement processes. This is over and above normal BAU capacity
Call off contract with AGCSU for SME's (for example HR, IG, Social Value) to support tender exercises and also patient engagement exercises	100,000	This is critical to enable the commissioning team to have access to Subject Matter Expertise to support procurement processes.
New: BDH Orthodontics Long Waits (phase 1) Transfer of 20 patients from BDH to PC provider	40,000	Is critical as it relates to RTT very long waiters.
New: BDH Orthodontics Long Waits (phase 2) Transfer of 20 patients from BDH to PC provider	40,000	Is critical as it relates to RTT very long waiters.
	£2,975,416	

Very High Scheme Description	2023-24 Planned investment West (£)	Rationale / Risk
New: Infrastructure funding for proactive premises extensions in strategic and challenged areas, to then support delivery of additional activity in Dental Practices ahead of 24/25 when the contract changes. This scheme will enable existing practices to extend or refurbish to enable them to take on additional activity next year where gaps exist.	12,000,000 Revise to: 4,000,000	Herefordshire and Staffordshire have a high number of corporate providers which are not delivering contracted activity. In 24/25 Commissioners will be able to unilaterally rebase the contracts. There are existing NHS good quality providers who could take additional NHS activity but are constrained by physical space. This 'improvement grant' will enable premises developments as part of a strategic plan to improve access in the 2 most challenged ICBs from 24/25. It takes a year for some of these projects to be completed. The original investment was for a 6 ICB scheme but could be reduced to priority ICBs.
	Total: £6,975,416	
"Golden Hello" to support dental providers in the recruitment and retention of dental workforce for Rural Worcestershire, Herefordshire and Shropshire. This is a targeted scheme for areas where recruitment is an issue. £15k per dental clinical workforce (Dentist and potentially orthodontists) note this excludes any specific tenders on the workplan	225,000	Pause Golden Hellos have been used to incentivise recruitment into challenging areas i.e. Shropshire, Herefordshire and parts of rural Worcestershire, to date. The team were going to review the priority areas for 2023/24.
OHP - toothbrush and tooth paste to support the cost-of-living crisis Herefordshire and Worcestershire	100,000	Pause
New: Care Navigators to facilitate access through in hours urgent care for vulnerable patients. 4 West ICS's (excluding Shrops and Staffs) via LDNs	50,000	Pause
New: Infrastructure fund for new Orthodontic contract Walsall	100,000	Pause
New: Infrastructure fund for new Orthodontic contract in Coventry/Warwickshire	100,000	Pause
New: Infrastructure fund for new Orthodontic contract Birmingham	100,000	Pause
New: "Golden Hello" to support dental providers in the recruitment and retention of dental workforce. This is a targeted scheme for areas (TBC) where recruitment is an issue. £7,500 per qualified dental nurse or therapist.	225,000	Pause
New: Out of Hours for BSOL for a temporary caretaker contract in BSOL due to contract hand back	38,816	Pause
New: Targeted theatre intervention for GA for Children	500,000	Pause for 2023/24.

		This is a commitment to a BCHC business case for a new theatre but Commissioners have recently been advise that this has been delayed due to developer issues.
	£9,213,816	**Release**
Recurrent		
Routine in hours urgent care provision for patients from 111 for West Mids (in areas where no DAC all ICBs excluding Shrops and Staffs)	220,000	Is critical to enable access to urgent dental care for patients in these 4 ICBs to help relieve pressures on 111 and A&E.
New: Legal advice to support the 6 ICBs with tenders, investments, BAU issues etc	300,000	Is critical to enable commissioners to operate at reduced risk of legal challenge.
	Total : 520,000	Retain as critical schemes
New: Additional Warwickshire routine Dental access (Rugby) either via EOI or procurement, as access benchmark very low and previous termination	600,000	Pause
CDS investment (Phase 2) following gap analysis and benchmarking against the new spec	1,833,828	Pause
	2,433,828	**Release**
Primary Care – POD TOTAL		
Non-Recurrent		
New: Programme Manager to support POD transition into ICBs	31,500	Currently role is being funded by 2 ICBs and this proposal would share the cost across 6 ICBs.
	Total : 31,500	

POD Strategy and Planning 2023 onwards

Commissioning Pharmacy, Optometry and Dental from April 2023.

Background and Context

- From 1st April 2023. the responsibility of commissioning Pharmacy, Optometry and Dental Services transfers to Integrated Care Boards.
- This presentation will provide a brief summary of the strategic direction for POD services:
  - Including the 2023/24 planning guidance,
  - An overview of the proposed investments for 23/24 to support delivery of the strategic ambitions, and
  - A summary of associated risks.

Strategic Vision

- Although there is no explicit reference to POD Services within the 2019 Long Term Plan, the principles below have been used to guide the local commissioning of these services to complement the national contract changes.
  - Boosting ‘out of hospital’ care and dissolving the divide between primary and community services
  - Reducing the pressure on emergency hospital services
  - People to have more control over their own health and have more personalised care when they need it
  - Digitally enabled primary and outpatient care
  - Local NHS organisations to increasingly focus on population health
  - Action on prevention and health inequalities
  - Focus on care quality and outcomes.

Strategic Direction – Pharmacy and Optometry

- Pharmacy services:
  - Additional services have been negotiated nationally through the community pharmacy contractual framework and have been complemented by the Region commissioning additional enhanced services.
  - Regional services include UTI, impetigo, infected eczema, infected insect bites, etc… which use the skills knowledge and expertise of community pharmacists to enable patients who meet certain criteria to access local community pharmacy services to help manage demand for GP practice appointments and reduce attendances at A&E.
  - The next phase of this work is to map where pharmacies are providing these services and to cross reference this to areas of population need to inform further engagement with pharmacies to provide services.
- Optometry:
  - The vision for the Region has been to procure an electronic eyecare referral system (EeRS), which uses ICB footprint developed clinical algorithms to ensure patients are appropriately referred on into services.
    - There is the ability to attach digital images taken within the optometry practice to the referral, which reduces duplicate imaging of patients.
    - This digital development brings optometry practices into the 21st Century and enables direct referral of a patient; informing the GP that a referral has been made, without the need for a patient to see a GP.
    - EeRS will also provide a platform to support future transformation change programmes in ophthalmology pathways.

Strategic Direction – Dental Services

- In relation to Dentistry, the most recent work underway to transform the NHS Dental contract aims to ensure that patients who are most at need can access dentistry and the following changes have been announced:
  - Enhanced Units of Dental Activity (UDA) to support patients who have higher clinical needs whilst recognising the range of different treatment options currently remunerated under Band 2.
  - Recognising that recruitment and effective delivery of care in some parts of the country is restricted by very low UDA values which impacts on patient access and a minimum indicative UDA value of £23 was introduced from 1st October 2022.
  - Renewed guidance and monitoring of patient recall periods.
  - Improve the use of clinical skill mix in NHS dental care to support access to services.
  - Improve information for patients by requiring more regular updating of the Directory of Services
- Phase 2 of contract reform is now being considered by the national team.
- Regional team recent innovations to improve access to dentistry over the last few years have included the weekend access scheme, orthodontic waiting list initiatives, golden hellos to support recruitment in ‘dental deserts’, additional guaranteed urgent appointments, development of child friendly Community Dental Support practices, and working in partnership with Local Authorities and voluntary sector to provide care to the most vulnerable, including those who are homeless by providing dedicated sessions and appointments, in addition to toothbrushes and toothpaste. Many of these schemes have subsequently also been adopted by the national team.

Workforce Challenges: There are two regional workforce projects taking place in collaboration with primary care training hubs to tackle these by reviewing the dental nurse training programme to ensure that this is fit for purpose, and on enhanced training for optometrists in glaucoma, independent prescribing, paediatrics and Age Related Macular degeneration in those areas where ICBs are looking to commission activity in community settings, so there is a trained workforce to enable changes to be implemented.

Planning Guidance 2023/24

- The 2023/ 24 Planning Guidance makes more explicit reference to POD services.

- One of the national objectives for 23/24 is to improve patient safety, outcomes and experience by reducing elective long waits and making it easier for people to access primary care services by:

  a. Eliminating over 65 week waits for secondary care dental patients by March 2024.

  b. Recovering dental activity by providing units of dental activity (UDAs) to pre-covid levels.

  c. Transferring lower acuity care away from GP and NHS 111 services by increasing participation in the community pharmacy consultation service (CPCS) and increasing coverage across ICBs of the range of extended care services commissioned with community pharmacies.

  d. Continuing to address health inequalities and delivery on the Core20Plus5 approach as part of the commissioning of dental and pharmacy services and plans for improvements in oral health improvement

  e. A requirement to expand direct access and self-referral where GP involvement is not clinically necessary by September 2023.

West Midlands Strategic Objectives and Priorities

23/24 Objectives and Priorities	Overarching Driver								Geography							
	BAU	Restoration *	LTP *	Transformation *	Integration/Collaboration *	Quality *	Health inequalities inc Core 20 plus 5 *	Finance *	All Midlands Region	All West Midlands	Birmingham & Solihull	Coventry & Warwickshire	Herefordshire & Worcestershire	Shropshire and Telford & Wrekin	Staffordshire & Stoke on Trent	The Black Country & West Birmingham
1. Recovery of dental services across whole pathway to address waiting lists and backlogs (non recurrent schemes)	x	x				x	x	x	x	x						
2. Dental Procurement programme (recurrent initiatives)	x	x	x			x	x	x			x	x	x			x
3. Improve access to primary care dentistry for vulnerable population.		x	x		x		x	x	x	x						
4. Embedding POD services into ICB infrastructures	x	x	x	x	x	x	x	x	x	x						
5. Collaborative working across contractor groups of GP and Pharmacy within ICBs to deliver population needs	x	x	x	x	x	x	x	x	x							
6. Optometry / ophthalmology pathway transformation programme (including the deployment of a region wide Eyecare electronic Referral System (EeRS))	x	x	x	x	x	x	x	x	x	x						
7. Integrated Commissioning of 'infrastructure services' for all Primary Care contractor Groups including clinical waste, interpretation, Occupational Health services, IG support including training	x	x				x	x		x							
8. Development of and increased capacity of managers and clinicians to support ICS delegation and Regional reserved functions		x	x	x					x							
9 Oral Health Improvement infrastructure				x		x	x	x	x							
10 Orthodontics	x	x				x	x	x	x							
11 Dental strategy	x	x				x	x	x	x							

Note: Overarching drivers highlighted in green with an * indicates this aligns to the 2023/24 Planning Guidance

POD Priorities for 2023/24

- Development of a dental strategy (Planning priority b)
- Recovery of dental services across whole pathway to address waiting lists and backlogs (Planning priority a & b)
- Dental Procurement programme (Planning priority b)
- Improve access to primary care dentistry for vulnerable population (Planning priority d)
- Oral Health Improvement programmes (Planning priority d)
- Orthodontics, including a strategic review of commissioning strategy (Planning priority b)
- Collaborative working across contractor groups of GP and Pharmacy within ICBs to deliver population needs, including extended care and GPCPCS (Planning priority c & d)
- Optometry / ophthalmology pathway transformation programme (including the deployment of a region wide Eyecare electronic Referral System (EeRS)) (Planning priority e)
- Integrated Commissioning of 'infrastructure services' for all Primary Care contractor Groups including clinical waste, interpretation, Occupational Health services, IG support including training
- Embedding POD services into ICB infrastructures
- Development of and increased capacity of managers and clinicians to support ICS delegation

POD Priorities for 2023/24

A wide range of non-recurrent and recurrent investment schemes for 2023 / 24 have been identified and prioritised as Very High, High, Medium and Low, but until the budget setting process has concluded the level of flexibility to support investments is currently unknown and there is a need to agree the potential level of 2023/24 dental clawback to provide financial non recurrent flexibilities for 2023/24.

It is critical that this is agreed from the start of the financial year to enable contractors to respond in a positive way to deliver improvements. Once the level of flexibility has been confirmed, the schemes will be reviewed and prioritised and will need to be considered for approval through the POD Joint Commissioning Group. Upon agreement, these investments will be progressed as part of the team's annual work plan.

Non recurrent schemes

- Infrastructure funding for dental practices – to be strategically invested in practices who are demonstrating commitment to the NHS, but are constrained from taking on additional activity due to the physical constraints of their premises. This will be targeted in areas of anticipated unilateral activity rebases, due to historic contractual under performance from 2024/25.
- Weekend access scheme – additional sessions to support access, especially urgent care
- Consideration of a new patient dental tariff to compensate practices for increasing the numbers of new patients and enable a reduction in 6 months activity checks
- Orthodontic case starts in areas of significant contract handbacks
- Continuation of Children's Community Dental Support practices
- Continuation and expansion of golden hello recruitment schemes in hard to recruit areas for dentists and the wider dental workforce
- Oral health improvement – tooth brushes and toothpaste to most vulnerable
- Access to subject matter expertise to support procurements. E.g HR advice, patient engagement, clinical advice
- Infrastructure investments to incentivise procurements opportunities for contractors.

Recurrent schemes:

- Improved access to urgent care in areas without Dental Access Centres and for severe and multiple disadvantaged groups
- Investments following Community Dental Service gap analysis
- Additional UDA access to address population need

Risks

	Description	Rating	Mitigation	Rating
1.	Dental contract terminations and activity handbacks	16	Work with contractors to explore alternative options to handback. Expressions of Interest / procurement to retain activity National contract reform Regional contract investment schemes (e.g. golden hellos)	6
2.	Ability of dentistry to recover to pre-covid levels, due to significant workforce pressures	16	Work with contractors to explore challenges and contractual options to explore and to inform investment schemes National contract reform Regional investment schemes	9
3.	Access to urgent dental care, including out of hours	12	Working with 111 to support direction of patients Commissioning of urgent dental care capacity through procurements and investment schemes	6
4.	Reduced ability for orthodontic providers to accept new cases	12	Exploring further collaborative working arrangements and private providers.	9
5.	Ability to sign off acute contracts for secondary care dental by end March 2023 due to lack of alignment on national guidance	16	Working with national team to clarify understanding	6
6.	Risk to sustainability of orthodontics and maxfax services in H&W due to impact of service changes in Wye Valley	16	Working group established across 2 providers to manage patients Strategic planning agreements between all partners.	9 To be reviewed following workshop
7.	Sustainability of pharmacy and optometry services due to financial pressures and pharmacy workforce challenges	9	National contract negotiations	4
8.	Discontinuation of pharmacy services in a major supermarket retailer and the potential impact on wider local pharmacy services	12	Reviewed impact and other pharmacies are in the local area. However additional activity may not be easily absorbed	8
9.	Capacity of POD team to deliver additional programmes of work in addition to increasing BAU pressures	16	Easing of vacancy control measures with transfer to ICB host	4

Primary Care Commissioning Committee

Agenda item no.	PCCC 23-06.40
Meeting date:	**2nd June 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 10 – GP Access – key controls column updated to reflect the recently published GP Access Recovery Plan by NHSE
STW14 – Shrewsbury Hub – Project now on full pause in line with national instruction – Item closed
STW16 – Occupational Health – New permanent contract started – item closed

New risks
STW17 – Highley Medical Practice – risk added in relation to securing sufficient capital for the long term premises plan

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: G Robinson Owner: G Robinson	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-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 2023 GP Access Improvement Plan requirements changes to GP Contract and PCN DES - includes a particular focus on digital and telephony	PCN capacity and access and improvement plans ICB required to report to Board in early Autumn on the ICB GP Access Improvement Plan Primary Care Team will have 2 touchpoint meetings with individual PCNs to review progress against their improvement plan (Sept and Jan)	Practices are autonomous businesses with their individual service delivery models	3 x 3=9 Moderate risk	PCNs required to develop a practice level access and capacity improvement plan for ICB sign off by 30 June 23	3 x 3=9	Exec: G Robinson Lead: E Pyrah	18.3.23 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: G Robinson 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: G Robinson 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-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	G Robinson Lead: E Pyrah		Open

STW -17		E Pyrah 18.3.23	**Highley Medical Practice - Long term premises solution** - risk that insufficient capital can be secured to reconfigure the interior of the Severn Centre to accommodate the GP practice meaning that the practice has to continue indefinitely from a portacabin whilst an alternative permanent premises solution can be found		Multi-stakeholder project group Multi stakeholder support for the long term plan Regular updates to PCCC				Multiple funding streams are being applied for to maximise potential to secure sufficient funding.	3x3 = 9 Moderate	G Robinson Lead: E Pyrah		Open
Closed Risks													
S-02		PCCC 03/19	There is not an agreed process for the completion of practice visits. There is a risk therefore that there may be emerging issues affecting quality that the CCG is not aware of/cannot support improvement. This means that there is a potential for variation/poor quality of care or inefficient systems and processes.	1. Potential to share good practice across the system. 2. Potential to save process improvements and reduce hand-offs/inefficiencies in practices	1. Maintain and build relationships with GP practices to monitor quality standards. 2. Update quality dashboard regularly. 3. Primary Care to develop a dashboard and process for more effective monitoring of Primary Care Quality.	1. CQC reports and regular meetings with CQC. Regular liaison with NHSE/I. 2. Quality dashboard updated and presented to PCCC quarterly. 3. Regular reporting to Quality and Audit Committee on risks and achievements	1. Infrequent opportunities to review/work with practices 2. Inconsistent opportunities - levels of engagement with practices	3x3=9 Moderate	1. Maintain focus to identify triggers/early signs of issues 2. Triangulate data from multiple sources 3. Close liaison with other professionals/agencies 4. Review complaints/GPPS 5. Work to standardise practice visit approach across the emerging new CCG	3x3=9 Moderate	Exec: Z. Young Owner: S.Ellis/C. Ralph	26/11/20 Actions updated Request for this to be closed with new risk identified for Practice visits which incorporates work across STW CCG.	Closed
STW-01	T+W 4+5 Shrop	C/F Telford 24/06/19 C. Ralph	**Primary Care Networks (PCN)** These new organisations will have to establish how they will work together as a network and share resources. There is a risk of potential delay and/or conflict as the new roles and the new ways of working are established. This would mean that their is inconsistent development of PCNs across the CCG which may affect service provision and access to our patients.	1. There is a potential opportunity for PCNs to create additional competition in the market for services traditionally provided by acute/community services. 2.Opportunity to increase the resilience of practices by sharing resources and effort overtime	1. National guidance for PCN development and the associated network agreements signed by all practices 2. Clinical leadership identified by members of each PCN PCNs to follow guidance from NHSE in regards to their establishment. 3. Guidance on the delivery of DES' for 2020 released 4. 8 PCNs now exist within STW CCG - only one practice remains as an orphan practice but patients are allocated	Notes of PCN meetings/assurance meetings - PCN Development meetings re-established, PCN delivering vaccination programme through existing Enhanced services, PCN development feeding into refreshed single CCG governance. Regular formal and informal meetings in place to engage, collaborate and deliver shared working arrangements. PCN's engaged at place	None	3x3=9 Moderate	1. Take opportunities to seek out the views of practices on the PCN development processes (ongoing) 2. Establish regular meetings with CDs to enable monitoring of progress by August 2020 3. Support PCNs to complete/re-visit baseline assessments as part of the developmental programme by September 2020	1x3=3 Low	Exec: C. Parker Owner: S.Ellis/C. Ralph	Reviewed 1 4 21 Tjones Covid has impacted upon planned development work however risk remains low as new ways of working together arising form Covid opportunities Agreed CLOSE at PCCC June 2021	Closed
STW 06 Previously S-04		PCCC 12/20	Primary Care Services in Whitchurch are under increased pressures due to difficulty in recruiting staff and managing services across several unsuitable small sites. There is a risk that Churchmere Medical Group hand back their contract if the situation continues. The planned closure of Dodington Surgery at end March 2021 adds to this pressure.	To secure the future of Primary Care services in Whitchurch by building a purpose built health care facility - The Pauls Moss Development proposal..	1. GMS Contract in place. 2. Pauls Moss programme proposals in place, although currently awaiting judicial review decision. 3. CCG agreed a transformational funding package to support Churchmere Medical Group to merge with Dodington Surgery and to manage services across 3 sites.	1. Regular contact with Churchmere senior partners. 2. NHSE support with merger and ETTF monies for expansion space costs. 3. Flexible use of new ARRS roles to increase clinical capacity, 4. Judicial review against Pauls Moss development was not upheld there fore the build will now go ahead		2x1=2 Very low	1. Ensure regular contact with CMG to identify issues early. 2. Ensure close liaison with Pauls Moss Development partners to be alerted to judicial review decision and any further appeals. 3. Explore CCG options should a new contract holder be needed	2x1=2 Moderate	Exec: C. Parker Owner: C Parker	Reviewed 1 4 21 Tjones Amended C Parker June 21 Recommend for closure as further risks incorporated into financial risks	Closed
STW - 04		Jane Sullivan 04/21	**Quality Visits** Due to Covid 19 pandemic scheduled Practice Quality Visits have been paused since March 2020. Although remote monitoring has continued a Practice Quality Visit allows for further exploration of subjects and conversations between CCG and Practice to gain assurance and understanding. There is a risk that practices not receiving quality visits may be rated inadequate or RI by CQC without the support of the quality and primary care team as part of the practice visit programme due to Covid-19 outbreaks	1. Potential to share good practice across the system. 2. Potential to save process improvements and reduce hand-offs/inefficiencies in practices	1. Primary care and Quality Lead continue to meet quarterly with CQC to share intelligence. 2. Continue to monitor Practice performance using existing sources of assurance and speak to Practices individually if concerns identified.	1. CQC intelligence 2. Significant event reporting to CCG by Practices 3. Monitoring of Patient experience - PALs/Healthwatch/MP letters/ complaints shared with CCG by NHSE/GP Patient Survey/FFT/N2N 4. Quarterly Quality report submitted to Quality and Performance committee 5. EDEC	1. Missed opportunities during visits to explore specific areas with Practices in further depth. 2. Missed opportunities to share good practice and learning with CCG which discussions during a visit can generate.	3x2= 6 low	1. Proposal to establish a Task and Finish Group to re-establish Practice Quality Visits from Autumn 2021 with identified agenda and terms of reference to provide a unified approach across the CCG. 2. Data and intelligence will be reviewed prior to visit to ensure that they are individual to each Practice and target areas for assurance.	3 x 2 = 6 Low	Claire Parker Zena Young	Newly added 1 4 21 T Jones Amended C Parker June 21 Recommended for closure. A Task & Finish Group was arranged to agree visits to concerning areas. Visits have taken place with only January's planned visits postponed due to system level 4.	Closed
STW 07		PCCC 06/21 C Parker	**Covid Expansion Fund** Allocation of practice Covid expansion fund was incorrectly calculated in the national guidance and left a shortfall of 1.2m for the allocation received which was absorbed into the CCG baseline		1. Funding not utilised as part of the pulse oximetry service was put back into the baseline circa £200k		1. In ability to take any funding from primary care to ensure services are funded appropriately	3x3=9 Moderate		3x3=9 Moderate	Exec: C Parker & C Skidmore	New risk added June 2021	Closed

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
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		Closed
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:G Robinson Lead: E Pyrah		Closed
STW-16		B Williams 9.1.23	**GP Occupational Health Service** - SHT given notice to end contract from 1st April 2023 - a new service provider is being negotiated to start 1st May 2023 this will leave a month where there is no contracted provider.		Regional contract framework for providers already in place			4x4=16 High	NHS England leading on securing a new provider - ICB PC contracting lead involved with negotiating an interim service.	3 x 4 = 12 HIGH	G Robinson Lead. B Williams		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 – Friday 2nd June 2023

Agenda item no.	N/A
Meeting date:	Friday 2nd June 2023
Paper title	Primary Care Update Report
Paper presented by:	Emma Pyrah
Paper approved by:	Gareth Robinson
Paper prepared by:	Janet Gittins, Bernadette Williams, Darren Francis, Rachel Rogers and 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	X
Creating system sustainability	
Workforce	

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

N/A

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.

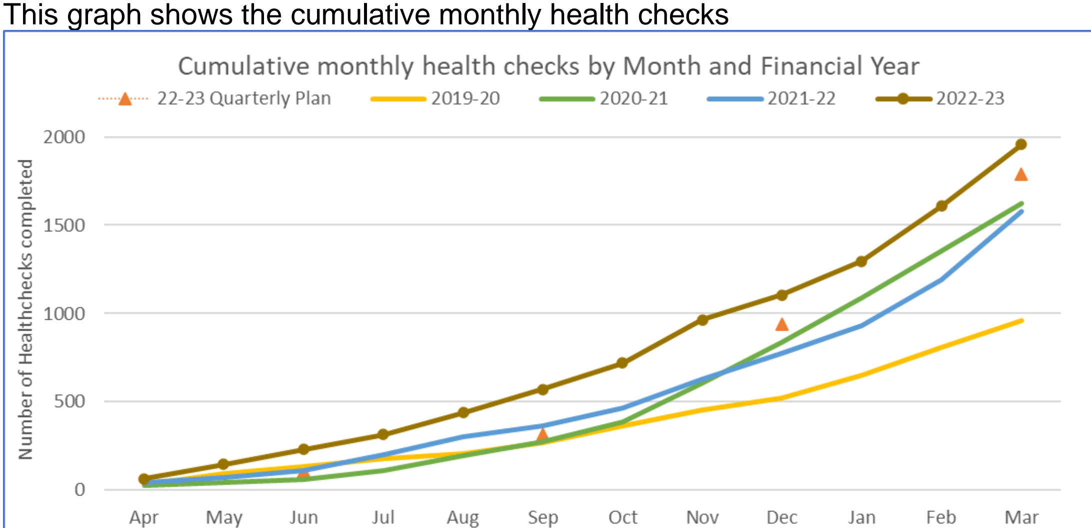
Shropshire, Telford and Wrekin's Residents and Communities	N/A
Quality and Safety	N/A
Equality, Diversity, and Inclusion	N/A
Finances and Use of Resources	N/A
Regulation and Legal Requirements	N/A
Conflicts of Interest	N/A
Data Protection	N/A
Transformation and Innovation	N/A
Environmental and Climate 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:**	

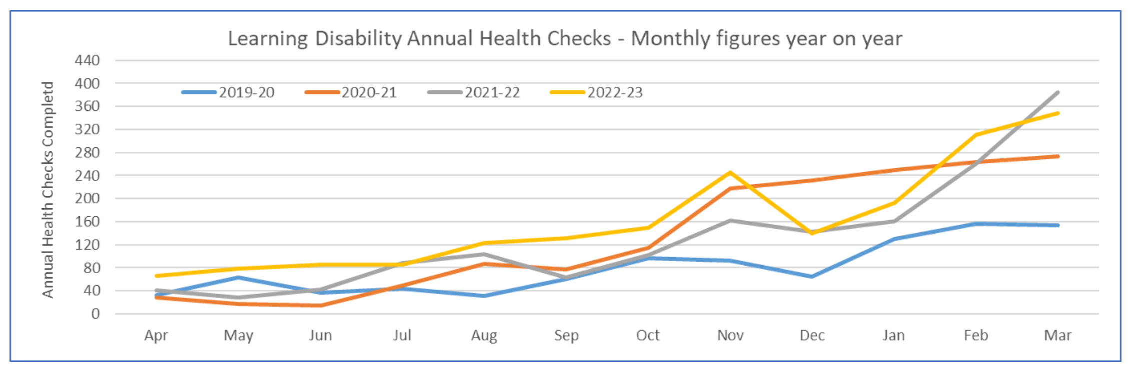
Partnership Managers Update – Janet Gittins and Team

Learning Disability Annual Health Checks (LDAHCs)
The 2022-23 end of year position shows that practices achieved over the 75% target and completed 77% of LDAHCs for people on the practIce LD register.
For March 2023, STW practices showed an increase in the number of LDAHCs completed in comparison to previous years, as shown in the chart below. Practices completed a total of 1956 LDAHCs compared to 1577 in 2021-22. Special congratulations go to the 27 STW practices that achieved over 80% and the 7 practices that achieved 98% or 100%.

This graph shows the cumulative monthly health checks



This second graph below shows the full year's actual activity data monthly with the noticeable dip in December due to the holiday period, winter pressures and the need for practices to provide urgent Strep A capacity in response to demand.



Practice LD registers have also continued to grow during 2022-23 from 2441 in April 2023 to 2556 in March 2023.
MPFT are commissioned to continue to support General Practice with this work through cleansing registers, contacting patients, and providing home visits and follow ups as required.
The 2023-24 LDAHC Improvement Plan is currently being finalised with key actions to continue to improve local data and the quality of LDAHCs received.

Macmillan Community Care Pilot Project

The Macmillan Team have worked with 20 STW practices to deliver holistic Cancer Care Reviews (CCRs) alongside the clinical element, completed by practices, to people living with cancer within 12 months of their diagnosis.
Current Status:

- At the end of March 2023, 957 CCRs have been completed since January 2022, with 86 non-clinical CCR's completed by the team in March 2023.
- With the pilot ending on 31 May 2023, two Cancer Care Coordinators have found alternative employment and left the team in March. This has had an impact on team capacity who are continuing to work with 13 practices to deliver CCRs.
- PCNs are now recruiting to their ARRS Cancer Care Coordinator roles with 3 members of this Macmillan Team securing these posts to continue with elements of this work.
- To support the development of new Cancer Care Coordinator ARRS roles within PCNs as well as other general practice staff who have a focus on cancer, HEE/NHSE funding is being used to plan education and learning opportunities.
- This training offered throughout 2023-24 will be coordinated through the STW Training Hub.
- Conversations with Macmillan to bid for additional funding beyond this pilot, have changed focus as Macmillan are looking for an integrated bid across the STW system for a project that impacts directly on patients and meets their current priorities. STW ICB Primary Care Partnership Manager is working with the SaTH Cancer and Macmillan Leads to work through this and to formulate a bid.

Macmillan Pilot Independent Evaluation
An independent evaluation of the Macmillan pilot project commenced at the end of November with the final report completed in April 2023. This was carried out by STW Communications Team through interviews with people living with cancer who have received a CCR by the Macmillan team, practice staff and the Macmillan team. The report also examines feedback given from the internal evaluation work with over 166 responses from patients.
Key Headlines

- There is widespread belief across STW, from both clinicians and patients that the pilot programme has significantly improved the quality of Cancer Care Reviews, and that the service is a demonstratable invaluable success.
- Within the practices that participated in the programme, Cancer Care Reviews are consistently being offered to all patients in a timely manner.
- Patients have received high quality and personalised care, from a warm and knowledgeable team of Macmillan Community Care Coordinators who have successfully integrated into the GP practices that they work within. There have been challenges reaching this position, however the project leadership and Community Care Coordinator team have worked hard to achieve it.
- All parties interviewed in support of this review agreed that they would be concerned for the support and care of patients across the system if the pilot programme ended without alternative provision or plans in place.

Next Steps

- Learning from this pilot, as well as key contacts and resources gained by the team, will be shared with PCNs.
- PCNs will pick up some elements of this pilot work through the new ARRS Cancer Care Coordinator roles or Social Prescribing Teams to continue to improve of the quality of CCRs offered.
- HEE/NHSE and Macmillan funding is being used to pull together a series of cancer training and education opportunities for Primary Care staff in 2023-24.

- Macmillan have shown an interest in investing in a new STW system wide integrated project. Discussions have begun with SaTH Macmillan teams looking at a community service to support the most complex patients post discharge from treatment, again following a Health Needs Assessment approach.

PCN Cancer Leads
Cancer leads from the eight PCNs continue to meet bi-monthly in a peer support capacity to share good practice, news and discuss issues. Updates from the STW Cancer Strategy Board and West Midlands Cancer Alliance are shared and discussed. Work in PCNs is ongoing to deliver the requirements of the DES with work focused on inequalities, screening uptake, improving performance and processes.

National Diabetes Prevention Programme (NDPP)

In 2022/23 a total of 1608 referrals were made, against a target of 2964. Several reasons are behind this, namely pressures (workforce, winter, strep A crisis and strikes) and prioritisation of contractual obligations by General Practice. With a target reduction and further incentives (see below) it is logical to assume that performance this year will improve.

Following our previous update that incentivised payments to General Practice for referrals into this service will stop, national changes have been made for 2023/24.
NDPP is now an eligible service to refer into under the Weight Management Enhanced Service (ES) and Practices are entitled to claim £11.50 per eligible referral under this ES.

In 2023/24 NHSE are more focused on "uptake to MS1" (attending first session) and have set a target of 920. Assuming there is a 50% uptake rate to MS1, STW will be looking to achieve 1840 referrals in total.
In April 101 eligible referrals were made, which have been made on the assumption that incentivised payments had stopped, which highlights an overall commitment to the programme.

Digital Weight Management Programme (DWMP)
End of year data from NHSE confirms that STW was the second highest achiever of referrals to this programme in the Midlands, achieving 134% of our target.
87% of STW Practices made referrals, compared to 61% regionally.

Weight Management Enhanced Service
In 2023/24 Practices can claim £11.50 per eligible referral into any one of the services listed below:

- DWMP
- NDPP
- Local Tier 2 Weight Management Services (currently only being provided in Telford & Wrekin by Healthy Lifestyles)
- Low Calorie Diet (being rolled in in STW in April 2024)
- Tier 3 Specialist Services - Secondary Care weight-loss interventions (e.g., Pharmacotherapy)
- Tier 4 Specialist Services - Medical and surgical management of complex obesity (e.g., Bariatric surgery

50 Practices have signed up to this DES for 2023/24, two more than the previous year.

Severe Mental Illness (SMI) Health Checks

The end of year position for SMI shows that practices achieved 56% against the 65% target to ensure that people on the SMI register receive the 6 key checks as part of an annual review. This is a marked improvement on 2021-22 which was at 40% but further work is needed to reach the target.

Bi-weekly meetings with MPFT continue to explore ways to improve this rate, and to ensure that the 6 core fields of the Health Check are completed and recorded on EMIS by the MH Practitioners who support Primary Care with this work. An action plan to drive improvements for 2023-24 is being developed which includes amendments to the current MPFT service specification.

General Practice Quality Visits 2023-24

STW ICB has a duty to ensure Primary Care providers comply with their contractual obligations and offer services that meet the requirements of their contract. This includes ensuring Primary Care providers offer safe, appropriate, timely and high-quality care and it is therefore necessary to have robust assurance processes in place.

Quality Visits were an established part of the Primary Care and Quality Teams annual work programme. The visits were stood down in the pandemic and were due to be restarted in the latter part of 2022/23 but the significant challenges of last winter meant that this did not happen.

STW ICB is finalising plans to commence quality practice visits in Q2 2023/24. It is proposed to visit 12 practices by Autumn 2023 prior to the additional pressures that comes with the winter season. The aim of the visits is to provide support and assistance to practices while gaining assurance in quality and care improvement which can be used as evidence by the practice to support any CQC review or inspection. An overview of current data and informal intelligence is reviewed to help choose practices to visit. This includes complaints and comments from NHSE, STW ICB and CQC, Patient Survey 2022, GP Appointment Data and attendance at Emergency Department.

Locally Commissioned Services (LCS) Review

As reported previously the outcomes of the LCS review last year were impossible to achieve for a range of reasons, therefore all LCS have been rolled forward into 2023/24. Two of the LCS will be reviewed by the end of Q1 (Post Bariatric Surgery and CRP both of which are T&W only). These are believed to be high potential for decommissioning as limited added value. If this proves to be the case a recommendation will come forward to the next PCCC. In terms of the other LCS, dialogue is underway with the GP Board to see if there is a way forward to co-design a better model of commissioning enhanced services from General Practice than the current one which, due to their voluntary nature, results in gaps in service and inequity of access. The ICB currently invest £4.7m in LCS.

CVD/ Hypertension Delivery

The successful funding application to the Innovation for Healthcare Inequalities Programme (InHIP) to undertake community-based CVD prevention in target populations that suffer health inequalities has injected fresh energy and capacity into the overall CVD Prevention Programme. Full details of the operational model will be shared when complete.

Alongside this work it is recognised that as Primary Care emerges from the significant pressures of winter there is a need to undertake a stocktake of PCN CVD DES activity and agree the most effective way of supporting activity via the CVD Operational Group. There will be an opportunity to express interest in an upcoming funded role as CVD Prevention Clinical Lead to support this workstream over the course of 2023/24.

Veteran Friendly Practices

There are 31 practices (62%) practices now accredited as Veteran Friendly with the aspiration to achieve 100% by the end of 2023/24. A targeted plan is currently being developed with partners to promote and inspire interest and support of the programme that will take full advantage of and consolidate the extensive range of information and evidence available.

Estates Update – Darren Francis

Whitchurch – ETTF New Build

- On site works underway and construction still due and on target for completion by September 2024

Shifnal – ETTF New Build

- Construction has now begun on site and completion is expected by Jan/Feb 2024 (latest)

Capital Funding for Estates Projects

- One claim from 2022/23 still remains to be completed (Broseley MP)
- Call for bids for 2023/2024 round of BAU capital funding has been sent to practices asking for bids to be confirmed (including required 3 quotes) by 21 July 2023. A paper is then due to be taken to the August PCCC for approval of bids received and any prioritisation, if required
- Section 106 applications work progressing with Councils to generate pipeline of capital funding for practices in absence of any national schemes being available
    - Current amount secured for future developments from Shropshire Council so far is more than £2.1m
    - Telford Council currently do not accept s106 applications and nor does it have a CIL set up (Community Infrastructure Levy) - there is a wider system-wide initiative being developed to put pressure on Telford Council for s106/CIL funding in future
    - 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
- Most PCNs have now either completed their clinical strategies or they are in final draft form. There has been feedback from PCNs expressing concern about the quality of the support and input they have received from CHP and their associates. CHP have taken this on board and responded
- Once the clinical stage has been completed, PCNs will move to the estates strategy development
- All estates strategies due for completion of final drafts by end June 2023 with completed versions ready by end July (latest)
- Once PCN work completed, the output will be combined into a single Primary Care Estates and Workforce Strategy – 1st draft expected in late July 2023

Contracting Update – Bernadette Williams

STW Contract changes

Contract variations have been requested for the following practices and are being processed by General Medical Advise Support Team (GMAST):

Practice name	Details
Portcullis (Ludlow)	Resignation of partner (CT)

In April 2023, a national GMS variation has been issued. GMAST will send the document to all STW practices.

Application for practice boundary change

Practice name	Details
Hodnet Medical Practice	Application received to reduce the practice boundary

GP Occupational Health

NHSE have secured an interim provider following Shropshire Community Health Trust giving notice on the contract to provide GP Occupational Health. The service ceased at the end of March 2023. Royal Wolverhampton Trust will provide the service in the interim, then from 1st July 2023 Team Prevent will become the new service provider for the longer term.

Other provider services

The following contracts have been awarded for another year:

- Security service for the Special Allocation Scheme (Advanced Solutions)
- Translation and Interpretation service for GP practices (Language Line)

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.

Network rationalisation Project

Redcentric who provide our practice HSCN broadband connectivity and Wi-Fi have been commissioned to implement a 'multi-service' broadband connection across our estate. The work will allow us to decommission excessive circuits and move Wi-Fi traffic to the resilient backup link. This will allow the IT team to remove excess network equipment from within the comms cabinets.

Notes Digitisation

Project is ongoing with 6 of the 8 practices having their notes boxed and taken offsite to be sorted and scanned into a digital format. Quality assurance checks are shared back to a

practice to view via a secure portal to approve the quality based on a percentage per list size.
The next phase of the work is for EMIS to upload the notes into the clinical system.

NHSE 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.
At present the Lloyd George envelopes must be retained post scanning of the patient notes as they are the property of the Secretary of State and cannot be destroyed without their approval.
NHSE is in the process of securing Secretary of State permission to allow their destruction once scanned but until this is announced the envelopes needs to be retained.

N365 (Office 365) Apps for Enterprise / SharePoint / OneDrive
N365 Apps for Enterprise has been pushed out to all desktops giving access to the latest Microsoft Office suite. Following on from this we are working with our IT provider on finalising their proposal to deploy Microsoft SharePoint to practices and PCN's. This will support agile working as we move local shared drives to the secure cloud and likewise individual end-users' documents to their cloud-based OneDrive storage allowing full access from anywhere securely with an internet connection.

Online Consultation Procurement
Procurement has been completed via the GPIT Futures Framework. Provider has been awarded and the ICB and provider have been busy with engagement to practices offering webinars for kick-off sessions, 1-1's prior to going live. Further comms to support practices with the onboarding is ongoing, the ICB have access to a PowerBI portal to see progress and to support practices where required.

IT Equipment replacement Project
Phase 3 is near completion which involved the replacement of old equipment into 20 practices, the final 3 sites are booked in for their hardware before this phase is fully completed.

Winter Monies
The ICB were successful in securing additional winter monies to continue from the existing hardware deployment project. A proposal has been shared by our IT provider for the deployment of this hardware and is due to commence in June and complete by October 2023.

Primary Care Commissioning Committee

<table>
<tr><td colspan="3">Agenda item no.</td><td colspan="7">N/A</td></tr>
<tr><td colspan="3">Meeting date:</td><td colspan="7">2nd June 2023</td></tr>
<tr><td colspan="3">Paper title</td><td colspan="7">Shrewsbury Health and Wellbeing Hub</td></tr>
<tr><td colspan="3">Paper presented by:</td><td colspan="7">Emma Pyrah</td></tr>
<tr><td colspan="3">Paper approved by:</td><td colspan="7">Gareth Robinson</td></tr>
<tr><td colspan="3">Paper prepared by:</td><td colspan="7">Emma Pyrah</td></tr>
<tr><td colspan="3">Signature:</td><td colspan="7">E Pyrah</td></tr>
<tr><td colspan="3">Committee/Advisory Group paper previously presented:</td><td colspan="7">N/A</td></tr>
<tr><td colspan="10">Action Required (please select):</td></tr>
<tr><td>A=Approval</td><td></td><td>R=Ratification</td><td></td><td>S=Assurance</td><td></td><td>D=Discussion</td><td></td><td>I=Information</td><td>x</td></tr>
<tr><td colspan="3">Previous considerations:</td><td colspan="7">N/A – this is a monthly update report from the Primary Care team</td></tr>
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1. Executive summary and points for discussion

The purpose of this report is to provide Committee with a summary of the status of the project following the announcement in January 2023 from the national programme that the 6 Cavell pilots were to pause.

As you will be aware from previous communications, the national Estates Team at NHS England issued a letter in January 2023 which instructed that the national Cavell Centre Programme, and its constituent six pilot programmes, should be paused pending approval of the national business case.

At this point, the Programme Team for the Shrewsbury Health and Wellbeing Hub (the local name for the Cavell Centre Programme) took the decision to continue work on the site options appraisal, which was already underway, as we had contractual commitments with technical experts supporting the options appraisal work. We wanted to bring this phase of work to completion.

We have previously shared with committee our intention to hold a multi-stakeholder workshop to identify a preferred site option and prioritised site list. This would be the final site appraisal stage and on completion would be a key milestone to progressing to formal consultation later in the year.

Since January, we have received no further communication of when the business case will be going forward for approval. We are also aware that even if the business case did go forwards, there are still no guarantees that the capital funding would be made available in the current economic climate.

Given that indications now point to the pause being medium to long term, NHS Shropshire, Telford and Wrekin has reluctantly taken the decision to pause all further work and expenditure at this point. We will therefore not be holding the site options workshop that was originally planned and await further information from the national team. We will keep committee updated on any further communication that is received.

It is important to clarify that this is a national directive for all six pilot programmes, and that the local projects as part of the Cavell Centre Programme cannot influence the decision. Clearly, this is a hugely disappointing position given the significant amount of work that has been undertaken and the very clear case for change. The ICB and the Programme Team maintain its commitment to the project and to pursuing the right sustainable solution for General Practice in the South of Shrewsbury.

This does pose an extremely challenging situation to our practices if we are not able to access the £40-£60m national capital allocation for the programme. As has previously been shared, the case for changing how General Practice needs to be sustained over time has not altered.

At this point, there is no mechanism for securing this level of funding which means we now need to plan for an alternative future. As part of that, it is important to recognise that the uncertainty over the future of this development further emphasises the fragility of the status quo for the practices and their patients.

Our primary care estates strategy is currently under review, and we will need to consider the real prospect of not receiving this funding and addressing the current fragility of those respective practices. We will do all we can to avoid practice closures, but we will need to consider the consequences of practices that may no longer be able to continue to provide services, and as a result hand back their contract. Our considerations will need to include how this will affect patients, staff and neighbouring practices should patient lists be dispersed.

To inform this thinking, we are now in discussions with the six practices about next steps and revisiting each practice individually to explore what could be achieved to support them going forward. However, it is important to note that this will be to stabilise the practices as best we can. It is not about futureproofing or sustaining them in the way that the development of the hub approach would have allowed given the very limited amount of capital funding that is available to NHS Shropshire, Telford and Wrekin.

We are also pursuing other potential sources of capital funding for the ICB such as private finance and via the Council.

A robust comms handling plan has been enacted to manage the publication of this message. Project team attended HASC on 15th May to announce the full pause and comms materials were circulated to a wide range of stakeholders including Project Board, Stakeholder Reference Group, patients and the media later that day.

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.

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

5. Appendices

N/A

6. 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	
Citizen and Stakeholder Engagement	

Request of Paper:		**Action approved at Board:**	

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