NHS Lincolnshire Integrated Care Board

NHS Lincolnshire Integrated Care Board - Public Primary Care Commissioning Committee

Date: Wednesday 18th October 2023
Time: 11.40 am – 12.30 pm
Location: MS Teams

AGENDA

ITEM NUMBER		ACTION	ENC/ VERBAL	LEAD
STANDING ITEMS				
1.	Welcome, Introduction and Apologies for Absence: Sandra Williamson, Sarah Starbuck	-	Verbal	Dr Gerry McSorley
2.	Declarations of Pecuniary and Non-Pecuniary Interests and Conflict of Interests	-	Verbal	Dr Gerry McSorley
3.	To approve the minutes of the last Public Primary Care Commissioning Committee meeting dated 21st June 2023	Approve	Enc	Dr Gerry McSorley
4.	To consider matters arising not on the agenda.	-	Verbal	Dr Gerry McSorley
GENERAL ISSUES/PROGRESS UPDATE				
5.	To receive an update from the Director of Primary Care, Community and Social Value	Receive	Enc	Sarah-Jane Mills
STRATEGIC ISSUES				
6.	None noted			
SERVICE DELIVERY AND PERFORMANCE				
7.	To receive a report in relation to the Primary Care Access Recovery Plan	Receive	Enc	Nick Blake

FINANCE				
8.	None noted			
QUALITY				
9.	To receive an update in relation to Quality, Patient Safety, Experience and Effectiveness	Receive	Enc	Wendy Martin
GOVERNANCE AND ASSURANCE				
10.	To receive the Risk Register	Approve	Enc	Nick Blake
11.	To receive an update in relation to the Delegation of the Pharmacy, Optometry and Dental Services	Receive	Verbal	Nick Blake
MINUTES FROM COMMITTEES AND ESCALATION REPORTS				
12.	None noted			
INFORMATION				
13.	Any New Risks	Note	Verbal	Dr Gerry McSorley
14.	Items of Escalation to the ICB Board	Note	Verbal	Dr Gerry McSorley
INFORMATION				
15.	The next meeting of the Public Primary Care Commissioning Committee will take place on Wednesday 20th December 2023 at 11.40 am	Note	Verbal	Dr Gerry McSorley

Please send apologies to: Sarah Bates, ICB Deputy Board Secretary via email at: s.bates@nhs.net

The quorum of the Committee is a minimum of four voting members. This must include the Chair or Vice Chair.

Membership

Name	Position
Dr Gerry McSorley	Non-Executive Member (Chair)
Julie Pomeroy	Non-Executive Member
Anita Day	Non-Executive Member
Martin Fahy/Nominated Deputy	Director of Nursing and Quality
Sarah-Jane Mills	Director of Primary Care, Community and Social Value
Sandra Williamson	Director of Health Inequalities and Regional Collaboration
Emma Rhodes	Assistant Director of Finance
Anna Nicholls/Bal Dhami /Gary Lucking	NHSE/I
Councillor Sue Woolley	Health and Wellbeing Board Representative
Dean Odell	HealthWatch
Dr Reid Baker/Kate Pilton	LMC
Wendy Martin	Associate Director of Nursing
Dr John Parkin	Clinical Leader

***Definition of a Conflict of Interest**
Conflicts of interest can arise in many situations, environments and forms of commissioning, with an increased risk in primary care commissioning, out of hours commissioning and involvement with integrated care organisations, as clinical ccommissioners may here find themselves in a position of being at once commissioner and provider of primary medical services. Conflicts of interest can arise throughout the whole commissioning cycle from needs assessment, to procurement exercises, to contract monitoring.

Interests can be captured in four different categories:

Financial interests:
This is where an individual may get direct financial benefits from the consequences of a commissioning decision. This could include being:

- A director, including a non-executive director, or senior employee in a private company or public limited company, partnership or other organisation which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations;
- A shareholder (of more than [5%] of the issued shares), partner or owner of a private or not for profit company, business or consultancy which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations.
- A consultant for a provider;
- In secondary employment (see paragraph 52-53)
- In receipt of a grant from a provider;
- In receipt of research funding, including grants that may be received by the individual or any organisation in which they have an interest or role; and
- Having a pension that is funded by a provider (where the value of this might be affected by the success or failure of the provider).

Non-financial professional interests:
This is where an individual may obtain a non-financial professional benefit from the consequences of a commissioning decision, such as increasing their professional reputation or status or promoting their professional career. This may include
situations where the individual is:

- An advocate for a particular group of patients;
- A GP with special interests e.g., in dermatology, acupuncture etc.
- A member of a particular specialist professional body (although routine GP membership of the RCGP, British Medical Association (BMA) or a medical defence organisation would not usually by itself amount to an interest which needed to be declared);
- An advisor for the Care Quality Commission (CQC) or the National Institute for Health and Care Excellence (NICE);
- A medical researcher.
- GPs and practice managers sitting on the governing body or committees of the ICB should declare details of their roles and responsibilities held within member practices of the ICB.

Non-financial personal interests:
This is where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit. This could include, for example, where the individual is:

- A voluntary sector champion for a provider;
- A volunteer for a provider;
- A member of a voluntary sector board or has any other position of authority in or connection with a voluntary sector organisation;
- A member of a political party;
- Suffering from a particular condition requiring individually funded treatment;

- A financial advisor.

Indirect interests:
This is where an individual has a close association with an individual who has a financial interest, a non-financial professional interest or a non-financial personal interest in a commissioning decision (as those categories are described above). This should include:

- Spouse/partner
- Close relative e.g., parent, [grandparent], child, [grandchild] or sibling;
- Close friend;
- Business partner.
- Whether an interest held by another person gives rise to a conflict of interests will depend upon the nature of the relationship between that person and the individual, and the role of the individual within the ICB.

NHS Lincolnshire Integrated Care Board

NHS Lincolnshire Integrated Care Board - Public Primary Care Commissioning Committee Minutes of the Meeting held in Public on 21st June 2023

Present:	Dr Gerry McSorley	Non-Executive Member - Chair
	Ms Sarah-Jane Mills	Director of Primary Care, Community and Social Value
	Mrs Julie Pomeroy	Non-Executive Member - Vice Chair
	Mrs Emma Rhodes	Associate Director of Operational Finance
	Mrs Sandra Williamson	Director of Health Inequalities and Regional Collaboration
	Mrs Vanessa Wort	Associate Director of Nursing (for Mr M Fahy)
In Attendance:	Ms Sarah Bates	Deputy Board Secretary
	Mr Nick Blake	Acting Programme Director for Primary Care
	Mrs Shona Brewster	Head of Primary Care Ops and Delivery
	Mr Dean Odell	HealthWatch
	Dr John Parkin	Clinical Leader
	Mrs Sarah Starbuck	Head of Primary Care Commissioning and Development
	Councillor Sue Woolley	Chair – Health and Wellbeing Board
Apologies:		
23/083	Mrs Jacqui Bunce	Programme Director – Strategic Estates, Partnerships & Planning
	Mr Martin Fahy	Director of Nursing
	Mrs Wendy Martin	Associate Director of Nursing
	Mrs Kate Pilton	Chief Operating Officer, LMC

Dr McSorley welcomed members to the Public Primary Care Commissioning Committee meeting. Dr McSorley advised that the Committee is a meeting that is held in public and that members of the public have the facility to ask or raise queries through the chat function and that these will be responded to after the meeting. Dr McSorley requested that if members of the Committee were asked to speak or presenting reports that they introduce themselves beforehand.

23/084 DECLARATIONS OF INTEREST PECUNIARY OR NON-PECUNIARY

Dr McSorley reminded members of the importance in the management of Conflicts of Interest and asked members to consider each item carefully as the meeting progressed in order to identify any risk or conflicts that may arise during the course of the meeting. Members were also asked to consider if an interest required declaring before, during or after the meeting that relevant steps are taken to ensure that plans are in place to mitigate the risk.

There were no declarations of interest raised at the meeting.

23/085 ICB PUBLIC PRIMARY CARE COMMISSIONING COMMITTEE MEETING MINUTES DATED 15th FEBRUARY 2023

The minutes of the ICB Public Primary Care Commissioning Committee Meeting minutes dated 15th February 2023 were received and approved. The Public Primary Care Commissioning Committee agreed to:-

- Approve the minutes.

23/086 MATTERS ARISING NOT ON THE AGENDA

22/125 – Terms of Reference – it was noted that the Terms of Reference will be reviewed over the Summer period and brought back to a future meeting for approval.

GENERAL ISSUES/PROGRESS UPDATE

23/087 DIRECTOR OF PRIMARY CARE, COMMUNITY & SOCIAL VALUE

Ms Mills reported that there are no significant issues across primary care for escalation and that in terms of access this is broadly positive across all Practices.

An update was provided in relation to the management of long-term conditions and that there is a focus on hypertension, asthma and dementia and that support is being provided to Practices to improve these standards. It was noted that the performance framework will be reviewed so that it addresses the details highlighted within the Primary Care Recovery Plan.

In relation to the Glebe Practice, it was reported that the team have been working to support the development of a new site for the Practice. It was noted that the current Practice premises have physical constraints in terms of expanding the current capacity. A stakeholder exercise has been undertaken on the proposed move and the detail has been made available on the ICB website. Members agreed to approve the recommendation to continue to progress the plans.

Ms Mills advised that the SOLAS PCN which incorporates the Merton Lodge, Old Leake, Stickney and Spilsby Practices has joined the First Coastal PCN. In order to ensure that service provision reflects the needs of the local population the PCN has established two divisions: coastal and rural. Work is taking place to refresh the PCN work programme to reflect this change. The Public Primary Care Commissioning Committee agreed to:-

- Note the update.

STRATEGIC ISSUES

23/088 No items to note.

SERVICE DELIVERY AND PERFORMANCE

23/089 PRIMARY CARE RECOVERY PLAN UPDATE

Mr Blake advised that the Primary Care Recovery Plan is one of a number of Plans that have been produced by NHSE and has a specific focus on two key ambitions:-

- Tackling the 8.00 am rush and reducing the number of patients struggling to contact their Practice.
- For patients to know on the day they contact their Practice how their request will be dealt with – clinically urgent requests should be seen on the day and others usually within two weeks. People may be signposted to self-directed care of other services where appropriate.

Mr Blake provided an update on the four areas to deliver the ambitions within the plan:-

1. Empowering patients to manage their own health using the NHS App, self-referral and other services.
2. Implementing Modern General Practice Access supported by improved telephony systems, online consultation tools and avoiding asking people to ring back another day.
3. Building capacity with more staff offering more appointments.
4. Cutting bureaucracy by reducing some of the tasks that take primary care clinicians away from seeing patients and simplifying some of the indicators used to monitor practices and Primary Care Networks.

It was noted that the ICB continues to support Practices and patients making use of the NHS App and in making information available through the App: 28% of Practices in Lincolnshire have made patient records available through the App ahead of the Oct 2023 requirement, this is the highest in the region currently.

In terms of modern GP access, a benchmarking exercise on GP Practice telephony systems and identifying those Practices that could be supported to move on to an advanced telephony system has been a recent priority area of work. It was noted that funding will be available to support the 16 Practices currently not using advanced telephony systems and this should be available in July with a 1st July 2023 deadline for sign up for those Practices wishing to move to advanced telephony. A query was raised regarding how many Practices would take advantage of this offer before the deadline. Mr Blake responded and advised that discussions are ongoing with the remaining Practices and that it is expected that all 16 Practices will take up the offer. It was agreed that an update would be provided at the next meeting.

Action: Mr Blake

In relation to building capacity it was reported that around £3.2m of ARRS (Additional Roles Reimbursement Scheme) funding for Lincolnshire had not been utilised last year and that current plans for 2023/34 forecast an underspend of around £732K against a maximum possible budget of £19.97 million. Work to maximise the use of available ARRS funding in 2023/24 is underway with planning and delivery coordinated across the ICB and Primary Care Network Alliance e.g. recruitment of Palliative and End-of-Life Care Coordinators. Systems are in place to monitor the use of ARRS funding over the year and to develop and implement additional recruitment opportunities through this funding stream.

In terms of the cutting bureaucracy element the key area of focus is improving the primary-secondary care interface. This will include developing a local consensus on how primary and secondary care can work more effectively together and explicitly agree where some tasks are best carried out e.g. supporting secondary care clinicians to issue fit notes for the required period as opposed to requesting patients contact their GP.

The Public Primary Care Commissioning Committee agreed to:-

- Note the update.
- Update on the 16 Practices signing up to advanced telephony to be shared at the next meeting.

FINANCE

23/090 No issues to note.

QUALITY

23/091 QUALITY, PATIENT SAFETY, EXPERIENCE AND EFFECTIVENESS UPDATE

it was noted that higher risk Practices are considered at the Countywide Primary Care Quality and Performance Oversight Meeting, which meets monthly to further assure the mitigation of any significant concerns. An update was provided in relation to:-

- ***Hawthorn, Skegness*** had a CQC inspection in August 2022 and rated as Inadequate and placed in Special Measures. It was noted that improvements have been made and a further CQC re-inspection took place in April 2023 of which it is anticipated an improved position will be reported.
- ***Branston Practice*** – was inspected by the CQC in November 2022 and rated as Inadequate and placed in Special Measures. Improvements were evidenced at a follow up CQC inspection in January 2023 and a further planned full reinspection by the CQC is scheduled for the end of June 2023.
- ***Trent Valley Practice*** – has a Requires Improvement CQC rating post CQC inspection in September 2022. The ICB is satisfied that appropriate improvement actions have been progressed by the Practice. The CQC will undertake a planned full reinspection of this Practice in the summer 2023 with a date for this to be confirmed.
- ***Caskgate Practice*** – has had a recent CQC inspection. This Practice has known GP workforce challenges following Partner retirement and illness, also known outdated challenging accommodation, requiring relocation. The published outcome of the CQC inspection is awaited.
- ***Richmond Medical Practice*** – has also had a recent CQC inspection. The published outcome of this CQC inspection is awaited.

- ***Lakeside Medical Practice*** – had been placed in Special Measures post CQC inspection in June 2021. The Practice remained in Special Measures pending the outcome of the most recent CQC re-inspection, which occurred at the end of November 2022. The CQC Report from this inspection is published and the Practice rating although still Requires Improvement improved with better domain ratings, particularly notable is the move out of an Inadequate rating for the Safety domain. The Practice is now removed from the CQC Special Measures regime. The ICB and LMC continue to support the Practice with their continuing improvement action areas.
- ***Spalding Practice*** – is now removed as a risk rated Practice as full list dispersal now achieved and Practice closure.

Since the last Public Primary Care Commissioning Committee delegated responsibility for the quality of Pharmacy, Optometry and Dental Provision transferred to the ICB from NHS England. It was noted that the ICB is working collaboratively with the other East Midlands ICBs and Nottingham & Nottinghamshire ICB are hosting the transferred staff from NHS England aligned to these services. Any quality issues are reported and discussed through a separate dedicated Quality Forum which is attended by the Associate Director of Nursing and Quality. This will enable any pertinent issues and themes to be escalated through into existing established ICB governance processes, including this committee. The Public Primary Care Commissioning Committee agreed to:-

- Note the update.

GOVERNANCE AND ASSURANCE

23/092 RISK REGISTER UPDATE

Mr Blake provided an update in relation to the Risk Register and advised that two risks have had their scores increased which relate to-

- ***Scan House***
  The risk has increased and current risk rating is 16. It was noted that Scan House Solutions Ltd provides off-site storage for patient files and that the ICB received informal notification that the company was planning on entering into liquidation in June. This has presented an immediate issue with GP Practices routine access to patient files. An alternative service provider has been identified through a waiver process for 12 months with NEC, work to transfer files to NEC premises is ongoing and being expedited. The risk will reduce significantly once the files have been transferred.

- ***Lack of Spirometry Provision in Primary Care***
  The risk has increased and the current risk rating is 16. This area of work is progressing however, the investment case was not approved and the planned market engagement event postponed. Further work on the financial case is ongoing.

The Public Primary Care Commissioning Committee agreed to:-

- Note the update.

23/093 PHARMACY, OPTOMETRY AND DENTAL UPDATE

Item deferred to the next meeting.

MINUTES FROM COMMITTEES AND ESCALATION REPORTS

23/094 None noted.

INFORMATION

23/095 ANY NEW RISKS

None noted.

23/096 ITEMS OF ESCALATION TO THE ICB BOARD

- **Primary Care Recovery Plan:** NHS England published the Delivery Plan for recovering access to Primary Care which is part of a range of recovery plans for the health system**.**

23/097 DATE AND TIME OF NEXT MEETING

Wednesday 16th August 2023 at 11.40 am

Not Delivered/Off Track
In Progress
On Track to Deliver
Delivered

NHS Lincolnshire Integrated Care Board
Public Primary Care Commissioning Committee Action Log Dated 21st June 2023

Minute Number	Meeting	Item	Action Required	Responsible Officer	Date to be Completed By	Progress as at Month/ Year	Status
23/089	21.06.23	Primary Care Recovery Plan Update	• Update on the 16 Practices signing up to advanced telephony to be shared at the next meeting.	Mr Blake	August/ September 2023	All practices on analogue phone systems have signed up to move to digital telephone systems and are engaging with a national support team to progress this, we anticipate all Practices will have transferred over to new systems by 31 March 2024. The Primary Care Digital Team are monitoring progress and providing additional support where required.	

NHS
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PUBLIC PRIMARY CARE COMMISSIONING COMMITTEE

Agenda Number:	5
Meeting Date:	18 October 2023
Title of Report:	Director of Primary Care, Communities & Social Value Report
Report Author:	Sarah-Jane Mills Director of Primary Care, Communities & Social Value
Presenter:	Sarah-Jane Mills Director of Primary Care, Communities & Social Value
Appendices:	

To approve ☐	For assurance ☐	To receive and note ☒	For information ☐
Recommendation or particular course of action, e.g approve the strategy, endorse the direction of travel.	**Assure the Board/Committee that controls and assurances are in place.**	**Receive and note implications, may require discussion to help share/develop item.**	**Note, for intelligence of the Board/Committee without in-depth discussion.**

Recommendations

The Committee is asked to note the contents of this report.

Summary

CURRENT PERFORMANCE

Current Performance There are no significant performance issues of risks issues to flag to the Committee this month, performance on Access remains broadly positive.

Indicator	Standard / Target	Period	YTD Target	YTD Performance	
CQC					
Number of practices rated as Inadequate by CQC	0	Latest	0	2	
Number of practices rated Requires Improvement by CQC	-	Latest	-	3	
There are no changes in published CQC ratings from the previous report - work to support practices delivering improvement plans continues. Richmond Medical Centre have received a draft report which is expected to be published imminently, the draft rating is Inadequate with the practice expected to be placed in special measures.					
Access:					
GP appointments - % seen by a GP	34%	Aug-23	-	34.3%	
GP appointments - % seen face-to-face	63%	Aug-23	-	69.6%	
GP appointments – booked appointment: same day (all Nat Cats)	48%	Aug-23	-	44.8%	
GP appointments – booked appointment: within 14 Days (all Nat Cats)		Aug-23	-	80.3%	
Mins of Enhanced Access per 1000 adj pop	63	Aug-23		53.9	
Enhanced Access Utilisation Rate	80%	Aug-23		75.4%	
Access performance is broadly in line with previous months with no significant variation.					
Health Conditions:					
LD Health Check Delivery rate (Year End Target)	85%	Aug-23	214	255	20.9%
SMI Health Check Delivery rate	60%	Sep-23	3,321	2405	52.7%
CVD - hypertension (Year End Target NCD011)	50%	Aug-23	-	17.8%	
Diabetes – 8 care processes (Year End Target)	58.90%	Final Year Position	-	54.8%	
Asthma – NCD 105	72.10%	Jul-23	-	68.9%	
Dementia Diagnosis Rate * New methodology with some non submitters	67%	Aug-23		64%	
Weight management - obesity register	88,177	Mar-23	-	94193	
Weight Management - referrals	-	Mar-23	-	3,301	
% Weight Management - referrals		Mar-23		3.5%	
LD health check delivery is above plan year-to-date and indicates practices are delivering health checks earlier in the year.					
Workforce					
GP fte/100,000	20	Jul_23	-	53.4	
Nurses FTE/100,000	26	Jul_23	-	40.8	
ARRS funding utilisation has slipped from the previous month's report with around £1.4m underspend now forecast.					

Measure	Description
CVD	% of patients for whom there is evidence of clinically appropriate follow-up to confirm or exclude a diagnosis of hypertension by 31 March 2023
Diabetes	% of Type 1 & Type 2 Diabetic patients who have received 8 Diabetic Care Processes – including blood pressure, serum cholesterol, body mass index, kidney checks - which includes urine albumin and serum creatinine, smoking and patient's feet must be examined on a regular basis.
Asthma	The number of Patient on the Asthma Register who received three or more inhaled corticosteroid (ICS, inclusive of ICS/LABA) prescriptions over the previous 12 months.
LD	% of LD patients 14+ who have received a Health Check since 01 Apr 22 (working toward end of year position)
SMI	% of Patient who have received all 6 Physical Health Check elements in the last 12 Months (rolling Value)

ENABLER WORKSTREAMS

Digital

The current focus of the digital team's work includes engaging with practices and promoting patient access to records, online patient registration and WebV. Development of a primary care intranet with the communications team is a priority and will support improved processes for sharing information with GP practices. The digital team continue to support practices moving from analog to cloud based telephony systems and to review the development of PCN and practice websites.

Supporting digital inclusion within primary care is ongoing – this includes the installation of digital health kiosks within 10 practice sites and making tablets available on loan to patients to support access to digital health opportunities.

The team are supporting practices to enable proactive patient access to care records over October.

Communications

A new intranet is being developed to share key information from the ICB with primary care providers. This will replace the regular bi-weekly email briefing. The intranet is being developed in SharePoint and is planned to be launched in October.

The team continue to promote public awareness campaigns including NHS App, MDTs, and access and are supporting primary care providers to share these widely within their local communities.

A detailed communications and engagement plan is being developed to support the Access Recovery Plan and build on national communications resources to raise awareness of online access, digital health, the changing primary care team and self-referral pathways.

The team are working closely with NHSE and regional ICBs to develop comms & engagement plans for PODs.

WINTER PLANNING

There is no national winter pressure funding available to Primary Care this year, the focus for GP practices and PCNs will be on recovering access through the work Capacity and Access Improvement Plans. Primary care actions on access have been included in the system winter plan narrative, further work to understand potential pressures and impact of initiatives across the health and care system, including primary care, is planned for October.

Same Day Access Hubs

System funding has been made available to support winter pressures initiatives with business cases requested: the Primary Care Team proposal for same day access primary care hubs in three localities has been approved, these will provide on-the-day care for patients which should free up time for GP practices for non-urgent care management. The total business case value is £170k.

ARI Hub Update

All three Acute Respiratory Infection Hubs are now live, the services are operating 7 days per week. These are being provided by:

- South Lincolnshire Rural PCN
- The Welby Group
- LADMS

Patients will benefit from this service by having rapid access to respiratory care in the community, closer to where they live. The service also reduces risk of nosocomial infection by reducing patients needing to access urgent and emergency care services.

The Hubs will have capacity to see 22 patients per day and will be in place until 31 March 2024 (so maximum potential for 11,550 patient contacts). There will be a prospective evaluation of the impact of the hubs with a view to making a case for recurrent commissioning of the service

Frailty and contingency capacity

The Primary Care Team have submitted proposals to use system slippage funding to provide additional capacity to provide proactive frailty care and management over the winter period and to provide funding support to practices with significant capacity issues e.g. where an outbreak has reduced practice staffing capacity and is impacting on the delivery of care.

Total funding proposed is £653k for Proactive Frailty Management and £51k for Practice Resilience and Capacity funding. A decision on funding proposals is expected by 13 October.

COVID AND FLU VACCINATION POSITION STATEMENT

Due to national monitoring of the emerging new Coronavirus strain, the Covid vaccination programme for Autumn/Winter 23-24 has been bought forward to start on 11th September 23 from a previous October start date.

Care home residents and staff are to be prioritised early in the programme with an incentive scheme to complete these by 22nd October 2023.

Vaccination of housebound patients is also monitored locally by the ICB team. The programme will be delivered in Lincolnshire by a combination of PCNs, Community Pharmacy, and Vaccination Centres.

PCNs in the main now provide clinics at practice level with the exception of K2 Sleaford and Grantham & Rural who vaccinate from The Meres in Grantham with supplementary clinics in Sleaford.

Community Pharmacy coverage in Lincolnshire has increased from 11 to 18 pharmacies.

Two Vaccination Centre services will provide clinics from one fixed Vaccination Centre at The Grandstand in Lincoln as well as roving clinics and care home/housebound vaccinations where PCN and Community Pharmacy supplementation is required.

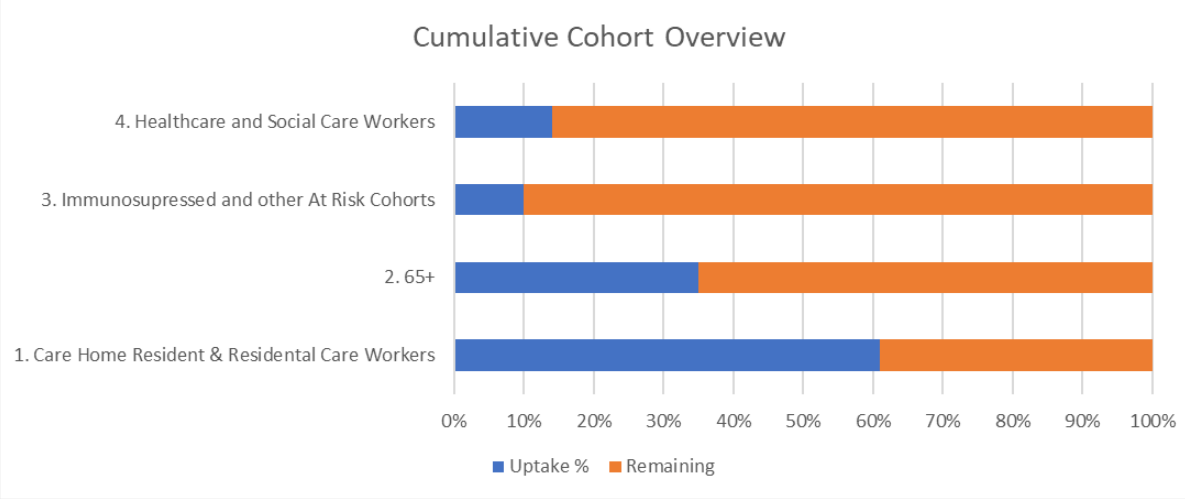
ULHT are providing vaccination for NHS staff as well as continuing with clinics for complex patients and at-risk children aged 6 months to 4 years.

General Practices and Community Pharmacies will provide the annual flu vaccination service as is usual and co-administration will be offered to patients where possible.

Please see the tables below for data on vaccine delivery over the first three weeks. When comparing vaccination uptake to the same stage of the programme last year (end of week 3) 8% more vaccinations have been given this year. There is a continuing an increase week on week of the number of people coming forward for vaccinations with sufficient capacity to accommodate the demand.

Cumulative Cohort Overview

Cohort	Eligible	Uptake	Remaining	Uptake %
1. Care Home Resident & Residental Care Workers	5,348	3,276	2,072	61%
2. 65+	176,883	61,503	115,380	35%
3. Immunosupressed and other At Risk Cohorts	100,630	9,996	90,634	10%
4. Healthcare and Social Care Workers	53,113	7,178	45,935	14%
Total	335,974	81,953	254,021	24%



How does this paper support the ICB's core aims to:	
Aim 1: Improve outcomes in population health and healthcare.	Work across the primary care programme aims to support practices and PCNs engage with improved population healthcare and outcomes.
Aim 2: Tackle inequalities in outcomes, experience and access.	Access, patient experience and tackling inequalities are priorities within the directorate work programme.
Aim 3: Enhance productivity and value for money.	Delivery of the Access Recovery Plan and supporting primary care resilience improve productivity and value for money.
Aim 4: Help the NHS support broader social and economic development.	Social value remains a central theme within the development of modern primary care service and Integrated Neighbourhood Care.
Conflicts of Interest	**Summary of conflicts**
No conflict identified	

Risk and Assurance
Risks are highlighted within the body of the report.

Implications (legal, policy and regulatory requirements)	
Does the report highlight any resource and financial implications?	Yes, these are highlighted within the body of the report.
Does the report highlight any quality and patient safety implications?	Yes, these are highlighted within the body of the report.
Does the report highlight any health inequalities implications/	Yes, these are highlighted within the body of the report.
Does the report demonstrate patient and public involvement?	Yes, these are highlighted within the body of the report.
Does the report demonstrate consideration has been given to the Lincolnshire System Greener NHS Plan? (which can be found here)	No.

Inclusion			
Has a Data Protection Impact Assessment been undertaken?	Yes ☐	No ☐	N/A ☒
Has an Equality Impact Assessment been undertaken?	Yes ☐	No ☐	N/A ☒
Has a Quality Impact Assessment been undertaken?	Yes ☐	No ☐	N/A ☒

Report previously presented at:
Not applicable.

Is the report confidential or not?
Yes ☒ No ☐

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PUBLIC PRIMARY CARE COMMISSIONING COMMITTEE

Agenda Number:	7
Meeting Date:	18 October 2023
Title of Report:	Primary Care Access Recovery Plan
Report Author:	Nick Blake, Programme Director – Primary Care
Presenter:	Nick Blake, Programme Director – Primary Care
Appendices:	Appendix 1 – Access Recovery Plan update

To approve ☐	For assurance ☐	To receive and note ☒	For information ☐
Recommendation or particular course of action, e.g approve the strategy, endorse the direction of travel.	**Assure the Board/Committee that controls and assurances are in place.**	**Receive and note implications, may require discussion to help share/develop item.**	**Note, for intelligence of the Board/Committee without in-depth discussion.**

Recommendations

The Primary Care Commissioning Committee is asked to note progress on delivery of the Primary Care Access Recovery Plan. Please note, additional detail on Primary Care Network Capacity and Access Improvement Plans has been included this month.

Summary

Local delivery of the Primary Care Access Recovery plan is moving forward, progress against the four priority areas within the plan is summarised below, more detail is available in the appended update report (Appendix 1).

Empowering Patients

- There has been positive engagement on accelerated access to patient records via the NHS App with 32 practices enabling this and low levels of block exemption coding. The requirement is for all practices to have access enabled with no more than 50% of patients exemption coded.
- Six of seven self-referral pathways are in place as well as direct referrals from optometry to ophthalmology. Although MSK self-referral activity is being reported LCHS have confirmed that no formal self-referral pathway exists. A number of systems have reported issues with implementing all pathways and NHSE are now focussing on improving performance to meet the national 50% increase in self-referral activity target by 31 March 2024. Work is underway to improve reporting and data quality.
- Community Pharmacy Consultation Scheme uptake remains low, rurality and location of pharmacies alongside the high proportion of dispensing practices are two key issues in relation to this – discussion with NHSE on how to improve performance and learn from other areas is ongoing.

Modern GP Access

- Capacity and Access Improvement Plan (CAIP) milestones have been met by PCNs and the ICB, delivery and any further support requirements have been reviewed with PCNs over September.
- Progress on completing Support Level Framework (SLF) diagnostics with practices is required – discussions with the Quality Team to use planned practice visits as opportunities to complete the SLF diagnostic are moving forward. Further SLF training with the Primary Care Team is being undertaken to bolster capacity.

Building Capacity

- Work with PCNA on optimising the use of ARRS funding is ongoing, forecasting at Month 6 has identified further slippage against the total possible funding – current underspend is forecast at £1.4 million. Further slippage was expected and is due, in part, to having effective monitoring processes. NHSE have indicated that future funding will not be out-turned based so there is no risk of budget reduction in 2024/25 based on spend this year.
- Further slippage was expected and is due, in part, to having effective monitoring processes. NHSE have indicated that future funding will not be out-turned based so there is no risk of budget reduction in 2024/25 based on spend this year.

Cutting Bureaucracy

- Discussion with the Care and Clinical Directorate to agree an approach to managing this work is underway, the development of a behaviour charter is proposed setting out the roles and responsibilities of GP practices and secondary providers across service interfaces. The Primary Care team is monitoring and collating feedback from GP practices; ULHT have reintroduced their GP hotline to enable practices to contact ULHT specialties directly. A Health Care Professional Single Point of Access is being developed through winter funding and should support GP practice reach clinicians in other part of the health system more efficiently. Progress on developing this is required over October – with roll-out from November.

The development of a System Level Access Improvement Plan is underway, this is due to be presented to PCCC in November ahead of submission to the ICB Board on 27 November. The Plan will include:-

- ICB vision and improvement approach – including links with planned care and urgent care recovery plans.
- An overview of PCN Capacity and Access Improvement Plans
- An overview of plans and delivery of all ICB actions falling under the Access Recovery Plan
- Access performance measures and trajectories
- Finances – how national funding is being used and maximized
- Communications and engagement – including co-production and the patient voice

The Plan is due to come in draft form to PCCC in November for review and feedback ahead of being presented to the ICB Board.

How does this paper support the ICB's core aims to:	
Aim 1: Improve outcomes in population health and healthcare.	Assessment of population need has been considered as part of the baseline data assessment for investment to improve capacity and access.

Aim 2: Tackle inequalities in outcomes, experience and access.	Variation in access to services highlights the impact of inequalities, delivery of the plan aims to reduce and mitigate inequalities in outcomes, experience and access.
Aim 3: Enhance productivity and value for money.	Delivery of the Access Recovery Plan will enhance practice productivity and value for money. The plan also reduces activity impacts on other parts of the health care system.
Aim 4: Help the NHS support broader social and economic development.	Investment through PCNs and GP practices positively affects local economies.
Conflicts of Interest	**Summary of conflicts**
No conflict identified	

Risk and Assurance
Risks are managed through Directorate governance processes, risks that require escalation will be included on the PCCC risk register. There is a risk of reduced workforce capacity over the next three months while PCNs / practices deliver vaccination programmes and then move into winter pressures. To ensure momentum is not lost further engagement with PCN managers is planned to ensure delivery of PCN improvement plans.

Implications (legal, policy and regulatory requirements)	
Does the report highlight any resource and financial implications?	PCN's and practices are being funded to provide the additional capacity and access. Self-referral pathways may change demand and activity for some services.
Does the report highlight any quality and patient safety implications?	Quality and patient safety is expected to improve through delivery of the Access Recovery Plan and PCN plans.
Does the report highlight any health inequalities implications/	There is variation in access to primary care services across the County. Approaches to mitigate variation will be part of the System Level Access Improvement Plan.
Does the report demonstrate patient and public involvement?	Patient surveys/feedback and PPG groups are being used to support baseline data and delivery of PCN plans.
Does the report demonstrate consideration has been given to the Lincolnshire System Greener NHS Plan? (which can be found here)	N/A.

Inclusion			
Has a Data Protection Impact Assessment been undertaken?	Yes ☐	No ☐	N/A ☒
Has an Equality Impact Assessment been undertaken?	Yes ☐	No ☐	N/A ☒
Has a Quality Impact Assessment been undertaken?	Yes ☐	No ☐	N/A ☒

Report previously presented at:
Not applicable.
Is the report confidential or not?
Yes ☐ No ☒

Appendix 1 – Access Recovery Plan update report

NHS
Lincolnshire
Integrated Care Board

Primary Care Access Recovery Plan

Update – 9 October 2023

13/10/2023

Primary Care Access Recovery Plan - Plan on a Page - Key Milestones

KEY: Complete · On track · Slippage · Off track · Date TBC

	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	23/24 Milestones
SELF REFERRAL					Seven self-referral pathways in place.			Agree further pathway expansion				
PHARMACY			Launch of Community Consultation Scheme and expansion of Oral Contraception (OC) and Blood Pressure (BP) services.			Roll out of extended OC and BP services		Roll out Pharmacy First pre-winter Final date to launch common conditions service (31/12/23)				
TRANSFORMATION	Nominate practices & PCNs for General Practice Improvement Programme (GPIP)				Maximise use of ICB transition cover and transformation support funding 23/24			ICB nominate practices to participate in GPIP hands-on support				50m additional appts Maximise use of ICB transition cover and transformation support funding 24/25
CONTRACTING		Confirm completion of Capacity and Access Improvement Plans (CAIP) pre-work - IIF baselining and recovery planning	Confirm PCN CAIP submission and approval		Develop system level improvement plan re primary-secondary care interface.	ICB CMOs to establish local mechanism to support primary/sedoncary interface Oct-Nov '23	System Access Plan to ICB Board (27 Nov) Secondary care providers able to issues electronic fit notes.	Confirm practices are using online registration (2000 national target)				Assess CAIP dellivery and 30% IIF funding
DIGITAL	Benchmark GP telephony	Practices confirm request to move from analogue to CBT	Directly bookable appts available online	Final date for funding of high quality online tools (31/8)		Interoperable digital solutions between pharmacies and practices live nationally.	100% patients have access to prospective records (other than exceptions)	Review - interoperable solutions between pharmacies and practices High quality tools deadline			All practices signining up to offer move to Cloud Based Telephony (CBT) NHS App rollout - 90% of practices enable core functions	
WORKFORCE				PCN ARRS workforce plans submitted to ICB (via Workforce Planning Portal)	Ensure maximum practice and PCN coverage against number of care navigators nominated.	Second round of PCN workforce planning.					Regional nomination of care navigators	6,000 additional GPs
COMMUNICATIONS					National 111 campaign launch		Digital GP acccess campaign launch		Common conditions service, promote OC and BP checks from community pharmacies			

Summary

- LCHS have confirmed there is no formal MSK self-referral pathway although around 6% of referrals each month are recorded as self-referrals
- This means Lincolnshire has 6 of 7 pathways in place, NHSE have confirmed that they are now focussing on activity improvement (50% increase in self-referrals by 31 March 2024)
- Planned ARRS funding usage has slipped – forecast underspend is now c.£1.4 million (from £0.7m in September). This is in part due to improved monitoring. Work is ongoing with PCNA to implement plans to reduce underspend.
- System Level Access Plan in development
- Prospective access to patient records has improved although there is some risk that some practices will not achieve the end of October requirement
- Lincolnshire ICB's approach to the Support Level Framework is being developed with the quality team, additional Primary Care team members are being trained to deliver the approach

Empowering patients – **Improving information and NHS app functionality**

Key elements (PCARP checklist – PCN/practice actions):

- Patient prospective records access
- Online bookable appointments
- Online repeat medication ordering
- NHS app messaging where possible

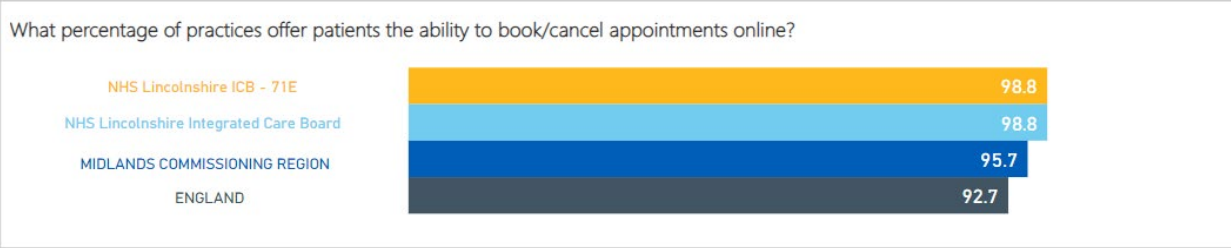
Prospective access to records

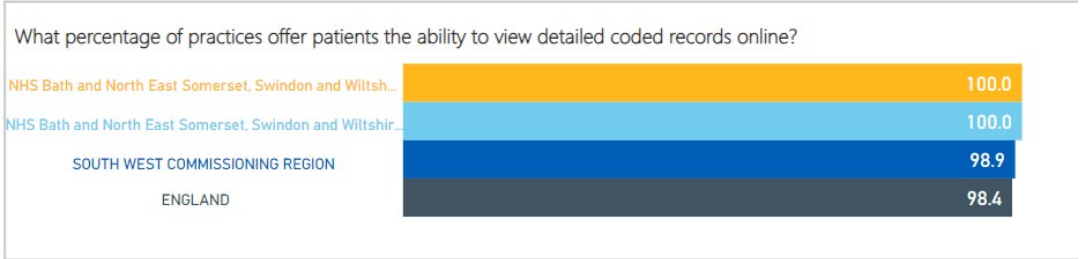
A

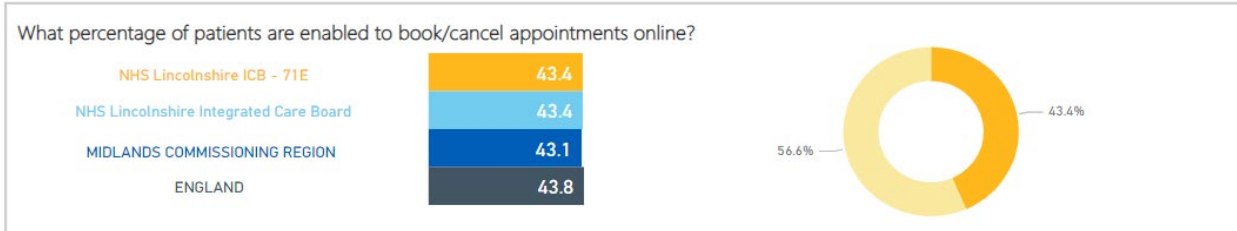
- Good engagement from practices
- 40% of Lincolnshire Practices have enabled access – 32 practices. Discussions with PCNs to support practices to enable took place over September. Further comms and engagement with practices planned for October
- NHSE will be confirming what will happen with regards practices that do not have access enabled (this is a contractual requirement)

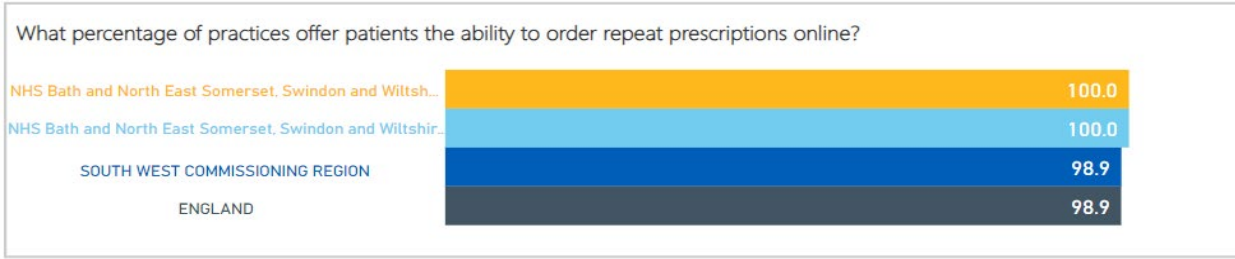
Empowering patients – **Improving information and NHS app functionality**

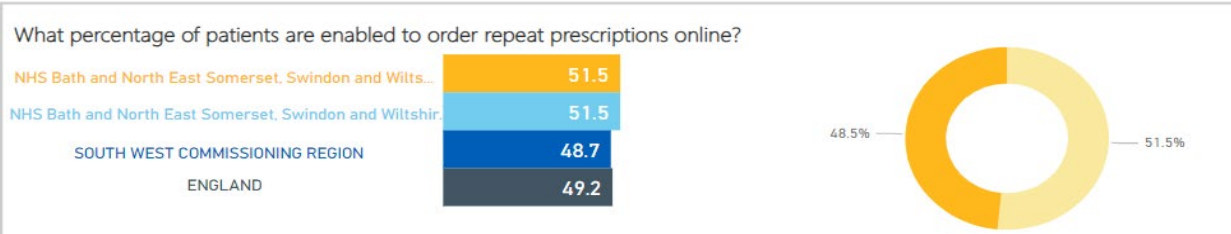
Online services G











- Lincolnshire is in line with regional and national online access delivery
- Secure NHS app messaging – ICB funded AccuRx secure messaging is being linked to NHS App to allow secure messaging (100% coverage).
- Currently reviewing utilisation and looking at use of clinical system to support messaging (future ambition).

Empowering patients – **Increased self-directed care**

Key elements:

- Messaging software for patients to communicate with practices (practice action – ***ICB assessment***)
- Establish 7 self-referral pathways (***ICB action by 30 September 2023***)

Messaging software G

- Online total-triage consultation tools are available to all practices and enable messaging
- This includes county-wide access to AccurRX messaging plus and extended Florey questionnaires

Self-referral pathways A

Pathway	In place?	Update
Community Musculoskeletal Services	No	CDCS data indicates that c.6.5% of LCHS physio referrals are self-referred, however, no formal pathway is in place. Engagement with MSK providers planned for November.
Audiology services specifically for age-related hearing loss	Yes	
Weight Management Services	Yes	
Community Podiatry	Yes	CDCS data indicates minimal levels of self-referral – further discussion with LCHS on pathway and coding required in August.
Wheelchair Services	Yes	People known to the service can self-refer.
Community Equipment Services	Yes	LCHS and LCC offer self-referral pathways, NRS are developing a self-referral app for self-funders.
Falls services	Yes	

Implementing Modern GP Access – **Better Digital Telephony**

Key elements:

- ID practices with non-CBT and sign up practices to move to CBT (***ICB action by 1 July***)
- Call back and queuing enabled (***practice action – ICB assessment by April 2024***)

Cloud based telephony G

- All milestones achieved
- The ICB is assisting 21 practices to move to full CBT, dedicated procurement support from NHSE national hub and practices expected to move to new system by year-end. Funding is available from NHSE to support transfer to CBT (c.£630k).

Call back and queuing enabled G

- Stage 2 of CBT programme, additional funding to support existing CBT practices to introduce this functionality may be available (not confirmed).

Implementing Modern GP Access – **Simple online requests**

Key elements:

- High quality online tools funded and selected from national framework (***ICB action by 31 Aug***)
- Tools implemented (***practice action – Sep 2023; ICB assessment in Apr 2024***)

High quality online tools G

- All practices have choice of online consultation system and have implemented systems
- AccuRx, Floreys, SMSplus and video available
- Training modules available to all practices to optimise usage and implementation
- Ardens templates are available to all practices
- Agilio TeamNet available to all practices

Implementing Modern GP Access – **CAIPs**

Key elements:

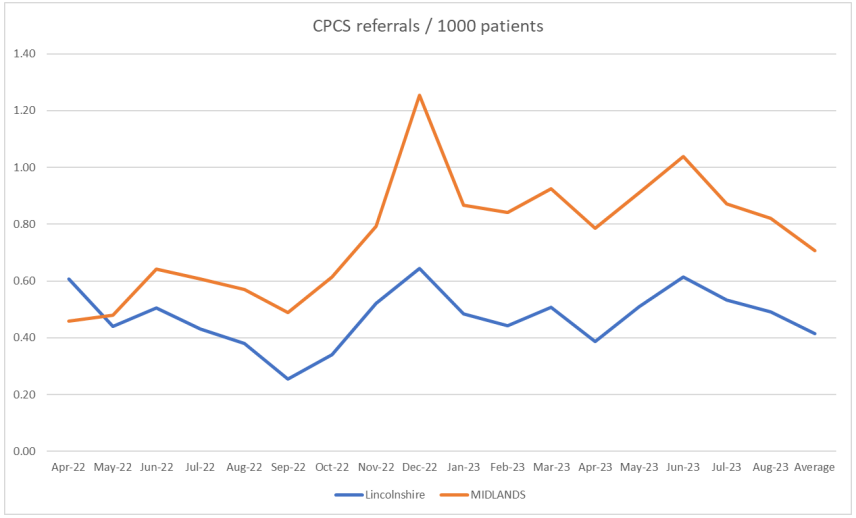
- PCNs develop and agree PCN Capacity Access Improvement Plans ***(PCN/ICB action by 17 Jul***)
- Support Level Framework diagnostic and GPIP engagement

Access Improvement Plans G

- CAIP reviews completed with all PCNs in September
- Further work with PCNs to review use of available funding and ensure monitoring will support evidencing of the impact of the PCN work on access and underpin payment of IIF funding (30% based on CAIP delivery)
- Promotion of GP Improvement Programme ongoing
- Support Level Framework diagnostic to be combined

Other access information

- CPCS use in Lincs remains low – refreshing approach over September and building on existing engagement



- Access recovery remains generally positive – % appts booked with 14 days is below Midlands average

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	4,663	117%	69%	↑	62%	53%	49%	87%	6%
Black Country ICB	4,518	115%	72%	↑	64%	51%	45%	86%	6%
Coventry and Warwickshire ICB	4,698	114%	63%	↑	54%	55%	51%	89%	5%
Derby and Derbyshire ICB	4,949	109%	74%	↑	69%	47%	39%	76%	3%
Herefordshire and Worcestershire ICB	5,663	110%	63%	↑	51%	49%	45%	84%	4%
Leicester, Leicestershire and Rutland ICB	5,958	116%	75%	↑	68%	44%	42%	79%	4%
Lincolnshire ICB	5,344	119%	70%	↑	60%	35%	44%	81%	3%
Northamptonshire ICB	4,944	108%	67%	↑	58%	45%	46%	84%	3%
Nottingham and Nottinghamshire ICB	4,935	113%	71%	↑	63%	46%	41%	77%	4%
Shropshire, Telford and Wrekin ICB	4,523	106%	71%	↑	65%	46%	45%	84%	4%
Staffordshire and Stoke-on-Trent ICB	4,345	116%	72%	↑	67%	46%	47%	86%	5%
Midlands	**4,923**	**113%**	**70%**	↑	**62%**	**47%**	**45%**	**83%**	**4%**
England	**4,802**	**115%**	**69%**	↑	**61%**	**47%**	**43%**	**83%**	**4%**

Favourable

Less Favourable

Implementing Modern GP Access – **CAIPs**

Support Level Framework & GPIP

A

- SLF diagnostic requires work across ICB primary care and quality teams and is behind plan – work is underway to develop a mitigation approach and this is being progressed over October.
- Further discussions with ICB teams have progressed well and focussed around SLF and the resilience framework
- ICB to support practices engage with next phase of intensive GPIP programme (one practice participated in Phase C, others plan to participate in the next phase), although this reflects very positive engagement with Accelerate last year – 31 practices had already been through the intensive improvement programme last year)

Building Capacity – **Recruitment and Retention**

Key elements:

- Larger MDTs ***(PCN action with ICB support***)
- Retention and return of experienced GPs (***PCN/practice action***)

Larger MDTs G

- ARRS plans at Month 6 (September) total £18.99M, £1.38M below total allocation (£20.4M)
- Low uptake of some roles – Physicians Associates, Dieticians. No Podiatrists in plans
- Working with LPFT to increase Mental Health ARRS roles
- Monthly reporting process in place - more accurate ARRS workforce planning and utilisation of funding
- Working with Clinical Directors to develop underspend plans in place (PEOL Care Co-ordinators)

Retention and return G

- Primary Care People Group est. 2022 reporting into PCNA, ICB PCCSV Group & LICS People Board
- Primary Care People Plan launched in April ’23, feedback from stakeholders and annual refresh, including alignment of LT WF Plan and PCARP
- Work programme covers the 4 main themes – Growing/Valuing/Developing & Retaining our People
- Retention work well established with partners - scoping exercise underway to inform future actions and support plans (policy development/recruitment/training etc)
- Quarterly regional workforce ‘check in’ on 6/9 provided overall assurance regarding ARRS management, workforce planning, care navigation training, GP fellowships and retention.

Cutting bureaucracy – **Primary-secondary care interface**

Key elements:

- Review and agree approach to AoMRC recommendations – report on progress (***ICB action – Nov 23***)

Interface issues

G

Discussions within Care and Clinical Directorate underway to agree the clinical engagement and leadership approach and framework for addressing interface issues – the following actions have been agreed:

- Establish a behaviour charter that is promoted across all providers
- Process for identifying and reporting interface issues
- Establish an operational group, chaired by LMC, with reps from primary and secondary care that will address interface issues
- Establish quality group that will look at how we can learn from issues
- Develop networking opportunities for clinicians across providers so that we can help build relationships
- The Primary Care Team are logging interface issues coming through usual communication routes

Communication and engagement

Key elements:

- Coordinate system comms to support patient understanding – digital access, MDTs, self-referral etc **(ICB action)**

Lincolnshire ARP communications plan

A

- A more detailed and focussed plan is under development by the Primary Care comms team and will build on national communications resources and in discussion with workstream leads
- Revised communication plan due 13 October

System Level Access Improvement Plan

	RAG	Comments
Vision & Improvement Approach	G	Alignment to PCARP & system plans; NHS IMPACT
Health Inequalities	G	EHIA developed; support equality, diversity & inclusion
PCN/practice actions	G	Overview of PCN plans; assurance and issues ID'd
ICB actions	A	Delivery plan checklist; SLF; workforce; CCS/AMR
Assuring delivery	A	Clear trajectories & milestones; progress to date
Finance	A	Use of funding; monitoring and assurance
Communications	A	Delivery plan (patients & staff); non-GP care routes
Co-production & patient voice	A	Plan co-produced with patients and local communities

- Support session with NHSE regional team held on 11 September 2023
- Plan to be presented in public ICB Board – 27 November & update to Board in Feb/Mar

Risks and issues

Risks and issues			
Risk/Issue	Owner	Rating	Mitigation
PCCSV directorate capacity to deliver – risk to delivery of ICB planning requirements	NB	12	Team review underway – including potential recruitment
Quality team capacity to support with SLF approach – reputational risk to ICB	SSt	12	Discussions underway with Quality Team
SLF delays have a knock-on impact on support offer – risk to CAIP delivery and practice/PCN resilience	SSt	12	As above – review of potential outsourcing to third party

NHS
Lincolnshire
Integrated Care Board

PUBLIC PRIMARY CARE COMMISSIONING COMMITTEE

Agenda Number:	9
Meeting Date:	18th October 2023
Title of Report:	Quality Update Report
Report Author:	Wendy Martin, Associate Director of Nursing & Quality
Presenter:	Wendy Martin Associate Director of Nursing & Quality
Appendices:	N/A

To approve ☐	For assurance ☒	To receive and note ☐	For information ☐
Recommendation or particular course of action, e.g approve the strategy, endorse the direction of travel.	**Assure the Board/Committee that controls and assurances are in place.**	**Receive and note implications, may require discussion to help share/develop item.**	**Note, for intelligence of the Board/Committee without in-depth discussion.**

Recommendations

To ensure the PCCC are aware of any significant Quality concerns for General Practice, where Quality covers the domains of patient experience, patient safety and clinical effectiveness. The Committee to receive assurance on the mitigations in place to address the highlighted concerns.

Summary

Quality surveillance of each General Practice is undertaken by the ICB Nursing & Quality and Locality Teams. Wide ranging Quality information pertaining to each Practice is considered in detail through the Locality Primary Care Quality & Operational Assurance Groups that usually meet monthly. This enables a Quality Risk Register to be constructed for each of the ICB General Practices, which highlights the issues, but also the actions being taken by the ICB, in conjunction with the relevant Practice and associated Primary Care Network, to mitigate any concerns.

Higher risk Practices are also considered at the county wide Primary Care Quality and Performance Oversight Meeting, which meets monthly, to further assure the mitigation of any significant concerns. The ICB GP Clinical Leads also regularly meet together and with the wider GP cohort through Clinical Forums, which also enables risks/concerns to be highlighted and addressed.

There are known and ongoing significant quality issues with a few of our General Practices which rate higher on the ICB Quality GP Risk Register and these are considered fully through the Private PCCC. The ICB locality and quality teams and the LMC work to support any General Practices with required improvements. An enhanced level of support is provided to our higher risk Practices with assurance secured by the ICB that Practices are progressing required improvement actions promptly. To note below specifically:

Branston Practice had a CQC inspection in November 2022 and was rated as inadequate overall and placed in special measures. **Improvements were evidenced at follow up inspection in January 2023 and there was a further planned full reinspection by the CQC at the end of June 2023. Publication of the CQC report from that inspection is imminent.**

Caskgate Practice (Gainsborough) had a CQC inspection in May 2023. This Practice had known GP workforce challenges following partner retirement and illness, also known outdated unsuitable accommodation, requiring relocation. The CQC published the outcome of the May 23 CQC inspection in early August 23. The Practice was rated inadequate overall and placed in special measures.

Richmond Practice (North Hykeham) also had a CQC inspection in May 2023. Warning Notices were received by the Practice post inspection which the Practice has taken action to address. The full published outcome report of this CQC inspection is awaited.

Hawthorn Practice, Skegness; & Trent Valley, Saxilby Practices were specifically reported via this report at the last public PCCC. Both these Practices were reinspected with improved ratings received for both. Each is now rated overall Requires Improvement with the CQC.

How does this paper support the ICB's core aims to:	
Aim 1: Improve outcomes in population health and healthcare.	Quality improvement supports all 4 aims
Aim 2: Tackle inequalities in outcomes, experience and access.	
Aim 3: Enhance productivity and value for money.	
Aim 4: Help the NHS support broader social and economic development.	
Conflicts of Interest	**Summary of conflicts**
No conflict identified	

Risk and Assurance
Relates to the Quality of General Practice as per PCCC & Corporate Risk Register

Implications (legal, policy and regulatory requirements)	
Does the report highlight any resource and financial implications?	Yes – detail within the report
Does the report highlight any quality and patient safety implications?	Yes – detail within the report
Does the report highlight any health inequalities implications/	N/A
Does the report demonstrate patient and public involvement?	N/A
Does the report demonstrate consideration has been given to the Lincolnshire System Greener NHS Plan? (which can be found here)	N/A

Inclusion			
Has a Data Protection Impact Assessment been undertaken?	Yes ☐	No ☒	N/A ☐
Has an Equality Impact Assessment been undertaken?	Yes ☐	No ☒	N/A ☐
Has a Quality Impact Assessment been undertaken?	Yes ☐	No ☒	N/A ☐

Report previously presented at:
Not applicable
Is the report confidential or not?
Yes ☐ No ☒

NHS
Lincolnshire
Integrated Care Board

PUBLIC PRIMARY CARE COMMISSIONING COMMITTEE

Agenda Number:	10
Meeting Date:	18 October 2023
Title of Report:	Primary Care Risk Register
Report Author:	Nick Blake, Acting Programme Director – Primary Care and Communities
Presenter:	Nick Blake, Acting Programme Director – Primary Care and Communities insert the full name and job title/position of the person who is presenting the report at the meeting)
Appendices:	Appendix 1 – Primary Care Risk Register Appendix 2 – GP Practice Fragility Risk Assessment

To approve ☐	For assurance ☐	To receive and note ☒	For information ☐
Recommendation or particular course of action, e.g approve the strategy, endorse the direction of travel.	**Assure the Board/Committee that controls and assurances are in place.**	**Receive and note implications, may require discussion to help share/develop item.**	**Note, for intelligence of the Board/Committee without in-depth discussion.**

Recommendations

The Primary Care Commissioning Committee is asked to:

- Consider the Risk Register and plans to mitigate identified risks.
- Note that the management of a number of key risks will only be achieved through the development of a comprehensive Primary Care, Communities and Social Value strategy.
- The foundation of the Strategy requires the rapid development of Primary Care Networks.
- Note the update relating to the risk assessment of General Practice fragility submitted to the ICB Risk Management Group for review on 6 October

Summary

Risk summary listed by risk rating

Description	*Rating*
Energy costs & financial pressures – impact on GP practices	20
Risk to Enhanced Services – inflationary uplift	16
Demand pressures on GP practices	16
Resettlement scheme impact on GP practices	16 ↑
APMS Contracts	12
Paediatric Referrals - can take up to 2 years.	12
Secondary care pathway changes	12
Oral Anticoagulation - fragility and resilience	12
Leg Ulcer Service Provision	12
Secondary care referrals - increased waiting times	12
Lack of Spirometry provision in primary care	8 ↓

The Risk Register has been reviewed and updated by the risk owners. The following is a summary of the reviews by risk with a 'Current Risk Rating' score of 12 and over (>12) and where there has been change in risk rating or updates over the last month. Only actions and comments updated from the previous month are included below, full detail can be found within the appended Risk Register (Appendix 1).

Risk ID26 - Primary care capacity to respond to the health needs of people under the resettlement programmes or asylum seekers.

The risk rating for this risk has been increased from 12 to 16 (Impact rating increased to 4), due to capacity issues to carry out proactive health assessments for people accommodated at coastal hotels. Access to care for people accommodated at a site in the West of the County is an emerging issue.

Risk ID23 – Spirometry provision in primary care

The risk rating has reduced from 16 to 8 (Likelihood rating reduced to 2),funding to commission the service has been approved. The commissioning process is underway and progressing for community delivery of spirometry and FENO services to support respiratory condition diagnosis and management.

GP resilience risk assessment

A risk assessment of GP practice fragility was submitted to the ICB Risk Management Group for consideration and review in line with the ICB's Risk Management Framework[1] . It aims to set out the multiple factors affecting GP practice fragility and resilience and potential consequences should risks materialise – for more detail please see Appendix 2.

Overall, risk was proposed as Likely (4) with Major consequence (4) using the standard ICB risk matrix, the Group felt that the Likelihood associated with the risk was potentially too high and proposed a rating of Possible (3). This was based on the view that practice failure or significant resilience issues are unlikely to be experienced on a weekly basis alongside moderating the risk assessment in line with other ICB risk assessments to ensure consistency of approach.

[1] ICB Corporate 013 - ICB Risk Management Strategy Policy

The Risk assessment will be updated and resubmitted based on the Group's feedback. The feedback from the Risk Group does pose a wider question on the consistency of application the ICB's risk matrix across Committees and programmes and how feedback is incorporated into risk assessment and management processes.

How does this paper support the ICB's core aims to:	
Aim 1: Improve outcomes in population health and healthcare.	The Primary Care risk register supports effective management of risks and issues relating to patient outcomes and care.
Aim 2: Tackle inequalities in outcomes, experience and access.	The Primary Care risk register supports effective management of risks and issues relating health inequalities, experience and access.
Aim 3: Enhance productivity and value for money.	The Primary Care risk register supports effective management of risks and issues relating to productivity and value as well as mitigating potential financial risks to the ICB and wider system.
Aim 4: Help the NHS support broader social and economic development.	N/A
Conflicts of Interest	**Summary of conflicts**
No conflict identified	

Risk and Assurance
The risk register identifies how risks are being managed and aims to provide assurance to PCCC.

Implications (legal, policy and regulatory requirements)	
Does the report highlight any resource and financial implications?	Yes, there are potential additional costs related to Scan House and reindexing of files by NEC. Resource and financial implications of risks and issues are detailed within Appendix 1.
Does the report highlight any quality and patient safety implications?	Yes, potential loss of patient files or information. Patient safety and quality issues are detailed within Appendix 1.
Does the report highlight any health inequalities implications/	No.
Does the report demonstrate patient and public involvement?	No.
Does the report demonstrate consideration has been given to the Lincolnshire System Greener NHS Plan? (which can be found here)	No.

Inclusion			
Has a Data Protection Impact Assessment been undertaken?	Yes ☐	No ☐	N/A ☒
Has an Equality Impact Assessment been undertaken?	Yes ☐	No ☐	N/A ☒

Has a Quality Impact Assessment been undertaken?	Yes ☐	No ☐	N/A ☒
Report previously presented at:			
Not applicable.			
Is the report confidential or not?			
Yes ☐ No ☒			

Appendix 1 – Primary Care Risk Register

Appendix 2 – GP fragility risk assessment

Item 10b

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

1-3	Low risk
4-6	Moderate risk
8-12	High risk
15-25	Extreme risk

PCCC Risk Register - 2022/23 - an Integrated Primary Care Risk Log to capture risks and issues that aren't practice or PCN specific but that affect primary care, including wider system issues

CRR - Overall Score of 12 or more (>12)

			Inherent Risk Rating				Current Risk Rating							
ID	Date Opened	Description	Likelihood	Impact	Rating	Controls in place	Likelihood	Impact	Rating	Mitigation	Action points/Updates (SMART ACTIONS)	Last review date	Lead Officer	Risk Owner	Timeline
24		**Energy costs** - high energy costs are affecting GP practice resilience and financial viability.	4	3	12	1. The National Energy Bill Discount scheme is in place - eligibility for the scheme depends on contract status and eergy are costs are linked to wholesale prices which may vary.	4	5	20	1. Ongoing monitoring of impact on GP practices and on national support available. 2. Finance and commissioning review of processes to respond to practice financial challenges to support development of a framework. 3. Checks with other systems to see if the same challenges are evident and what the response is.	1. Increasing number of practices reporting financial hardship / resilience problems. 2. Knock on effect of significantly increased fuel bills to cash flow. 3. In some circumstances heating is being turned down impacting on staff in particular but also patients. 4. The Government EBR scheme ends on 31 March 2023, this has been replaced by the EBDS scheme. 5. Ongoing monitoring of situation and impact on GP practices. 6. Discussion with LMC and ICB finance team on 13 July re framework for assessing financial pressures on practices and PCNs - work to develop this further planned for July and to link with practice support programme. The Resilience Framework has been drafted and is being developed further. 7. Resilience framework to support practices is being developed	09/10/2023	Sarah-Jane Mills	Nick Blake	Ongoing
26		**Primary care capacity to respond to the health needs of people** under the resettlement programmes or asylum seekers. Additional national funding is not indicated currently.	4	3	12	1. Raised through system resettlement forums, escalated to ICB Executive.	4	4	16	1. Monitoring impact on affected practices - ICB Teams (Quality and Primary Care) supporting where appropriate. 2. Enhanced Service specification development on hold due to changes in funding arrangements. 3. Work to mobilise the large site at Scampton underway - this work is supported by an ICB and LA team and has it's own risk register 4. If any further asylum accommodation is stood up the risks will require further review.	1. Specific risks related to the Asylum Seeker families. Pathway in place for both routine / urgent prescriptions and transportation of pathology samples via Age UK (cost impact). 2. Support is currently being provided to 1 hotel in the Grantham area with families, 1 at Bicker Bar and 5 in the Skegness area with single males. There is different modalities of support to the hotels depending on if they are housing families or single males. 3. Primary medical, screening and MH services are all stretched providing this non commissioned care. 4. ARAP (Afghan Resettlement) hotel accommodation has now stopped and families housed. 5. Currently working through the mobilisation of a large site north of Lincoln on RAF Scampton. Working with K2 as a Strategic Partner to develop a primary care service. Pathway work is underway with other stakeholders. The 'go live' date is changeable due to emerging issues and risks. 6. Risk score increased to 16 - due to capacity proactive health assessments not carried out at coastal hotels; ongoing issues with transport to and from health appointments at Stoke Rochford Hall (SRH); emerging issue with potential loss of health service accommodation at SRH	11/10/2023	Sarah-Jane Mills	Shona Brewster	Ongoing
30	10/01/2023	**Demand pressures on GP practices**	4	4	16	1. GPAS system managed by the LMC - provides regular updates on GP practice pressures using an agreed approach 2. Daily monitoring through the ICB primary care team and where practices report pressures directly to the team 3. Primary care sitrep reports to the ICB UEC team and wider system 4. IIMARCH process for reporting GP practice staffing absences where impacting on services	4	4	16	1. Access programme support - Livi, Lantum, Accelerate programme etc. 2. Winter Pressures funding. 3. NHS111 DoS updates to mitigate dispositions to GP practices where appropriate.	1. Risk raised and discussed at the Primary Care, Communities and Social Value Steering Group. 2. Agreed rapid review within the ICB team to identify resource to manage the issue with LMC and GP practices. 3. Further detailed review within the Directorate to consider how to engage GP practices, refine monitoring and develop a clear support offer, escalation and business continuity/mitigation plans – the development of monitoring processes and comms to practices have been completed. Work relating to practice Business Continuity Plans is ongoing. 4. Targetted assistance to manage demand and capacity through the national Support Level Framework. 5. PCN Capacity and Access Plans are due by 30 Jun '23 - these have been reviewed by the ICB and support idneitification underway including Support Level Framework diagnostic. National Support Programme will support practices in mitigation of demand issues. 6. An approach to delivering the Support Level Framework diagnostic is under development with the ICB Quality Team, practices are being supported and	09/10/2023	Sarah-Jane Mills	Nick Blake	Ongoing

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

1-3	Low risk
4-6	Moderate risk
8-12	High risk
15-25	Extreme risk

PCCC Risk Register - 2022/23 - an Integrated Primary Care Risk Log to capture risks and issues that aren't practice or PCN specific but that affect primary care, including wider system issues

CRR - Overall Score of 12 or more (>12)

			Inherent Risk Rating				Current Risk Rating							
ID	Date Opened	Description	Likelihood	Impact	Rating	Controls in place	Likelihood	Impact	Rating	Mitigation	Action points/Updates (SMART ACTIONS)	Last review date	Lead Officer	Risk Owner	Timeline
31	04/05/2023	**Risk to Enhanced Service Provision due to low level inflationary uplift**	4	4	16	1. Inflationary uplift based on national planning and operational guidance 2. Enhanced services receive this uplift in line with other primary and community contracts 3. Clinical Review Group established as a governance route for all enhanced services issues	4	4	16	1. Consideration of a locally applied top up to national inflationary uplift 2. Contracts stipulate a 6 month notice period for both provider and commissioner 3. Potential to explore the market for alternative provision	1. Concern raised by providers through various routes, including at formal meetings. This concern also raised by the LMC and a meeting has taken place 2. Risk to provision from providers giving notice has increased due to low level inflationary uplift also linked to the cost of living crisis - increase in costs and wages 3. Patient care could be compromised resulting in access, quality and safety concerns. This will also increase the health inequalities 4. Potential impact to the system i.e planned care pathways 5. Alternative provision is unlikely to be sourced locally, going out to the market would have a level of risk 6. Risks escalated to PCCC via SRO operational update. Specific concerns for Phlebotomy, Treatment Room. See risk ID 21 for INR and 22 for Leg Ulcers 7. LMC and BMA encouraging practices to give notice on service 8. Briefing paper highlighting risks and issues with recommendations and next steps is now completed. Funding identified within the Primary care budget for an additional 2.5% tariff increase 9. GP Contract uplifted following DDRB recommendation by 6%	10/10/2023	Sarah-Jane Mills	Shona Brewster & Sue Oakman	Jun-23
18		**Paediatric Referrals** - GP referrals into paediatric services can take up to 2 years. This impacts on patient outcomes but is outside of primary care control.	4	3	12	1. Raised with DDON Wendy Martin and Clinical Leads as an issue. Further discussions with CYP commissioners planned.	4	3	12	1. Current system pathway issue, further exploration and identification of approach to address the issue required.	1. Current position with paediatric referrals is being kept under review with clinical leads and through locality forums. 2. Discussion with LPFT and ICB MH commissioning team re ADHD referral process underway and progressed over March. 3. Discussion and review between Quality Team and Primary Care Team underway - review with Clinical Leads scheduled for 1 Jun. 4. Development of CYP dashboard underway. 5. CYP pathways to be linked to LTC pathway programmes - all age approach to be taken.	09/10/2023	Sarah-Jane Mills	Sarah-Jane Mills	Apr-23
21	26/07/2022	**Oral Anticoagulation -** fragility and resilience of Warfarin services with practices giving notice to stop delivering the service	4	3	12	1. Enhanced service continuing but fragile due to reducing numbers of patients who are moving onto a DOAC, which was expedited due to Covid. 2. Issues for providers to maintain skills and competencies. 3. Service is no longer cost or clinically effective to provide at a practice level	4	3	12	1. 6 month notice period built into contracts which provides additional time for Commissioners/Contractors to find alternative provision 2. LCHS already providing INR services, and can be used as provider of last resort 3. K2 Federation pilot not progressed, but now working with First Coastal PCN to work up test pilot to be operational from April 2024	1. Risk rating remains unchanged 2. As of mid July 4 practices have now given notice to cease delivering the service - Heart of Lincoln, Harrowby Lane, Stickney and Willingham by Stow	10/10/2023	Sarah-Jane Mills	Shona Brewster & Sue Oakman	Oct-23
22	26/07/2022	**Leg Ulcer Service Provision**	3	3	9	1. Enhanced Services Clinical Review Group developing and updating specification in conjunction with a fuller review of wound management, but investment is required due to additional requirements to deliver a gold standard service linked to doppler assessment, shorter initial observation and conservative management, recall (compression stocking requirements). There is also no service for complex wounds commissioned currently commissioned. 2. Remuneration uplifted as per 22-23 Ops/planning guidance (1.8%) for treatment room and leg ucler services. Leg ulcer services remaining under pressure with NICE Guidance increasing demand, further compounded by lack of clinic space to manage increased demand and accommodate staff	3	4	12	1. Additional funding as part of the 23-24 contracting negotiations agreed - 404K for leg ulcers and 206K for treatment room (non-recurrent for 23-24) 2. Deep dive of LCHS AQP/DCA activity/capacity to be undertaken - T&F group in place to monitor as part of contractual oversight. Reporting back to CMB. 3. Strategy in development on commissioning services from PCNs and best model of funding. 4. Audit being undertaken in primary care Mid Oct - Mid Nov to understand levels of complex wounds/ulcers which are being managed in treatment room ES. Data to support case for enhanced tariff for complex wounds, so additional funding will help with resilience.	1. Operational delivery risks are being managed as part of contractual monitoring. 2. Additional investment provided to LCHS to fund staffing for service coverage where required. 3. LCHS have undertaken audit of service, transparency on total caseloads, waiters and risk management of patients waiting to access services. Reports now shared with ICB and funding request circa £600k for TR and LU. Update from LCHS contract lead requested as LCHS had asked for additional funding as part of the 23-24 contracting round as investment into the leg ulcer services 4. Task and Finish group has now commenced to oversee deep dive by LCHS into demand and capacity of Leg Ulcer Services and Treatment room services 5. Additional non-recurrent funding provided to LCHS to resolve the fragility of service provision. LCHS have been asked to consider their provision of this service on a larger scale this could be developed as a wider wound management service - leg ulcers, complex wounds, lymphodema etc.	10/10/2023	Sarah-Jane Mills	Shona Brewster & Sue Oakman	Jul-23

		Rare	Unlikely	Possible	Likely	Almost Certain
		1	2	3	4	5
Consequence						
Negligible	1	1	2	3	4	5
Minor	2	2	4	6	8	10
Moderate	3	3	6	9	12	15
Major	4	4	8	12	16	20
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PCCC Risk Register - 2022/23 - an Integrated Primary Care Risk Log to capture risks and issues that aren't practice or PCN specific but that affect primary care, including wider system issues

CRR - Overall Score of 12 or more (>12)

			Inherent Risk Rating				Current Risk Rating							
ID	Date Opened	Description	Likelihood	Impact	Rating	Controls in place	Likelihood	Impact	Rating	Mitigation	Action points/Updates (SMART ACTIONS)	Last review date	Lead Officer	Risk Owner	Timeline
25		**Secondary care referrals** - increased waiting times for diagnosis and care in acute settings is affecting patient outcomes but outside of primary care control.	4	3	12	1. Raised with ICB cancer and planned care teams as an issue. Further discussions with clinical leads and ongoing monitoring through clinical fora.	4	3	12	1. Current acute trust capacity and bed flow issues alongside demand, further exploration of issues and monitoring required.	1. Current position with acute referral waits to be kept under review with clinical leads and locality forums. Any consequent impact on primary care to be monitored and mitigated where possible. 2. System planning work includes workstreams that should improve wait times - this will be kept under review. 3. Primary-secondary interface and management of people waiting for secondary care will be part of the Access Recovery workstream - this will mitigate some issues for primary care. 4. Industrial action may impact on wait times for some patients.	09/10/2023	Sarah-Jane Mills	Nick Blake	Ongoing
32	09/05/2023	**Secondary care pathway changes** - impacting on GP practices and patient care	4	3	12	1. Secondary providers do share pathway changes through the ICB PCCSV team but this isn't always consistent and may be at the time or after a change has been implemented 2. PCCSV GP Clinical Leads will review any pathway changes when shared 3. Care and Clinical Directorate can review pathways	4	3	12	1. Ensure all pathway changes are reviewed by GP Clinical Leads 2. Raise the issue and agree potential solutions with the Care and Clinical Directorate, ICN Medical Director and system partners	1. Risk raised through through the PCCSV Steering Group 2. Development of approach and principles to review proposed changes with Care and Clinical Directorate in June. 3. Interface group now meeting under the Care and Clinical Directorate.	09/10/2023	Sarah-Jane Mills	Nick Blake	Sep-23

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

	1-3	Low risk
	4-6	Moderate risk
	8-12	High risk
	15-25	Extreme risk

Scoring matrix: 1
2
3
4
5

IT'S THE CURRENT RISK THAT DETERMINES WHETHER THE RISK GOES ONTO THE >12 SHEET OR THE <12 SHEET. ONLY THOSE RISKS WITH A SCORE OF >12 GOES TO PCCC
If the score is 12 they go to the meeting

NHS Lincolnshire Integrated Care Board

NHS Integrated Care Board Risk Assessment Form

Nb: This document captures data required for the Risk register database. It should be used in conjunction with information in the ICB's current Risk management strategy, policy, procedural documents, and Risk Appetite Statement.

Assessor(s)

Name:	**Nick Blake**	**Designation/ Role:**	**Programme Director – Primary Care and Communities**	**Date:**	**30/08/23**

Risk Analysis and Description:

Source of Risk: (How identified)	General Practice service fragility.
Risk Description:	Pressures on General Practices impact on resilience and sustainability with the potential for services to be less accessible, reduce in capacity and fail.
Cause(s): (Due To /Hazards)	The principle pressures and issues are, individually and in combination: • Demand – General Practice patient appointment levels in July 2023 were 19% higher than the same period in 2019. The patient population is getting older with increasing numbers of people living with one or more long-term condition requiring primary care management. The population disease burden and levels of deprivation are variable with consequent variability in patient need and complexity. • System - interface issues with system partners and pressures elsewhere in the health and care system can have an impact on primary care services. • Workforce – recruitment and retention of clinical and non-clinical staff is an ongoing issue for primary care service delivery and enabling service and system transformation programmes. Recruitment and retention of General Practitioners is an ongoing risk – increased pressure of work may lead to doctors considering reducing their hours, early retirement or moving away from NHS general practice. • Estates – primary care estate is a limiting factor for some services in terms of providing accessible care and on workforce accommodation. • Financial – increasing costs, e.g. utilities, consumables, locum cover and workforce salaries. • Contractual – the outcome of future national contract and funding negotiations may impact on service resilience.
Effect(s): (Resulting in)	Increased fragility of primary care services already under pressure – the relative resilience of GP practices is variable across the County, single-handed GP practices can be more susceptible to demand and capacity pressures .
Consequence(s)	Potential reduction of loss of service provision in some localities with adverse consequences on patient outcomes, patient experience, access to care, health inequalities, developing population health management approaches and increased pressures on other parts of the health and care system e.g. increased demand on urgent and emergency care services. Core GP services may be prioritised over delivery of additional services (e.g. Local Enhanced Services, PCN Network DES, seasonal vaccination campaigns), risk of disruption is higher for these additional services and for overall patient access (e.g. Enhanced Access provision may be affected) . Reduction in service quality and effectiveness in meeting population and individual health and wellbeing needs.

	Periods of demand pressure can lead to enhanced assurance and monitoring requirements which have an impact on GP practice capacity, this affects smaller practices with less management and administrative capacity disproportionately. Delivery of system priorities and mandated operational requirements may be affected adversely, impacting on ICB reputation and public confidence. Resource diversion within the ICB to manage increasing service fragility and potential failure, this will impact on delivery of other priorities and workstreams with the potential for the ICB not to meet operational and planning requirements and statutory obligations. Financial impact on the system driven by funding alternative primary care provision to mitigate impacts on patients and system partners. Potential activity increase in community and acute services, particularly in relation to urgent care.

Risk Ratings: (See guidance)	**INITIAL/INHERENT**			**CURRENT (With Control/Mitigation)**			**TARGET**		
	Consequence	**Likelihood**	**Rating (CxL)**	**Consequence**	**Likelihood**	**Rating (CxL)**	**Consequence**	**Likelihood**	**Rating (CxL)**
Assessed Scores	4	4	16	4	4	16	3	2	6

Risk Context:

3 Line Defence:		**1st Service Assurance** (*functions that own and manage risks*)	**2nd Corporate Assurance** *(functions that oversee or who specialise in compliance or the management of risk)*	**3rd Independent Assurance** *(functions that provide independent assurance)*	**Risk Type:** *(Strategic (BAF), Corporate (CRR), Care Group, Department)*	**Corporate**
Risk Appetite: **High, Medium, Low**		TBC	TBC	TBC		

Risk Management Responsibilities

Executive Lead: *(Designation)*	**Director of Primary Care, Communities and Social Value**	**Control Owner** *(Designation)*	**Programme Director – Primary Care and Communities**			
Assurance Committee/ Management Committee or Meeting	**Primary Care and Delegated Functions Committee**		**Review Frequency:** *(See guidance)*	**Monthly**	**Review Due:**	**September 2023**

Action and assurance:

What is already being done? *(controls/mitigation)*	**Do you need to do anything else to control this risk?** *(Actions needed)*	**Risk Rating** *(LX C with all control/mitigation in place)*	**Assurance** *(how is/will the control/mitigation be tested)*	**Action by whom and when?**
Monitoring General Practice resilience in place: build on GPAS to develop practice level	Review current monitoring systems to ensure they provide effective surveillance of issues.	16	The proposed review and any agreed actions.	Shona Brewster – by 31 December 2023

OPEL system and feed into Shrewd.				
Monitoring General Practice risks and issues through ICB Quality and Assurance Oversight meetings and governance.	Review quality assurance processes and ensure they provide effective surveillance of issues.	16	The proposed review and any agreed actions. Reports are presented to PCCC on a monthly basis.	Wendy Martin – ongoing
Process in place for practices to raise issues and request support via the ICB Primary Care and Quality teams.	Ongoing monitoring of issues and themes, management and escalation via primary care and quality governance structures.	16	Monitoring through ICB management teams.	Shona Brewster – ongoing
Support to GP practices is available via the ICB, LMC and the national GP Improvement Programme – practical support, operational process improvement, locum staffing via Lantum	Review of support offer. Ensure support is effective in supporting GP practices address fragility issues and reduce risk at a practice level. Finalise and implement ICB Primary Care Resilience Framework.	12		Shona Brewster – 31 December 2023

Likelihood X Consequence = * Risk Score

1 Negligible	1 Rare
2 Minor	2 Unlikely
3 Moderate	3 Possible
4 Major	4 Likely
5 Catastrophic	5 Almost Certain

1-3	• **Acceptable risk required no immediate action** • **Review annually** • **Place on the appropriate section of the Risk Register.**
4-6	• **Action planned within 1 month to reduce risk** • **Commenced within 3 months** • **Place on the appropriate section of the Risk Register**
8-12	• **Action planned immediately** • **Review Monthly** • **Place on the appropriate section of the Risk Register**
15-25	• **Immediate action required** • **Placed on Corporate Risk Register**

Risk Scoring Matrix

Likelihood ➢ Consequence ⮟	**1 Rare**	**2 Unlikely**	**3 Possible**	**4 Likely**	**5 Almost Certain**
5 Catastrophic	5 Mod	10 High	15 Ext	20 Ext	25 Ext
4 Major	4 Mod	8 High	12 High	16 Ext	20 Ext
3 Moderate	3 Low	6 Mod	9 High	12 High	15 Ext
2 Minor	2 Low	4 Mod	6 Mod	8 High	10 High
1 Negligible	1 Low	2 Low	3 Low	4 Mod	5 Mod

Guidance on Risk Descriptors *('A Risk Matrix for Risk Managers', NPSA 2008)*

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury 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 for 4-14 days 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 complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) 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 patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ 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 objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical

					report
Adverse publicity/ reputation	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 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 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage 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

Likelihood score (L)

What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/ recur, possibly frequently
Time Framed Frequency	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
Probability: Will it happen or not?	<0.1% (<1in 1000)	%0.1-1% (1 in 1000 to 1 in 100)	1-10% (1 in 100 to 1 in 10)	10-50% (1 in 10 – 1 in 2)	> 50% More than 1 in 2)

Risk scoring = consequence x likelihood (C x L)

	Likelihood				
Likelihood score	**1 Rare**	**2 Unlikely**	**3 Possible**	**4 Likely**	**5 Almost certain**
5 Catastrophic	5 Moderate	10 High	15 Extreme	20 Extreme	25 Extreme
4 Major	4 Moderate	8 High	12 High	16 Extreme	20 Extreme
3 Moderate	3 Low	6 Moderate	9 High	12 High	15 Extreme
2 Minor	2 Low	4 Moderate	6 Moderate	8 High	10 High
1 Negligible	1 Low	2 Low	3 Low	4 Moderate	5 Moderate

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

1 - 3	Low risk
4 - 6	Moderate risk
8 - 12	High risk
15 - 25	Extreme risk

The risk matrix above can be used to provide an initial breakdown of the hazards into 4 Categories as follow

Low Risk	Acceptable risk requiring no immediate action Review annually Place on the appropriate section of the Risk Register
Moderate Risk	Action planned within one month to reduce risk Commenced within 3 months Place on the appropriate section of the Risk Register
High Risk	Actions planned immediately Review Monthly Place on the appropriate section of the Risk Register
Extreme Risk	Immediate Actions required Reviewed weekly by ET Placed on the Corporate Risk Register