Annexe 1

Joined up care CCG

NHS Gloucestershire Clinical Commissioning Group

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# Primary Care Infrastructure Plan 2016 to 2021

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# 2. Introduction & background

NHS Gloucestershire Clinical Commissioning Group (GCCG) has had delegated authority for primary care commissioning since April 2015. In respect of premises, the CCG responsibilities are mostly set out in The National Health Service (general medical services premises costs) Directions 2013 and includes:-

- Managing the rents reimbursed to practices for the provision of general medical services in buildings owned by Practices or another body, where the Practice is a tenant and is charged a lease;
- Managing the reimbursement of business rates for the provision of general medical services in buildings owned by Practices or another body, where the Practice is a tenant and is charged a lease;
- Determining improvement grant priorities- the NHS is able to provide some funding to help surgeries improve, or extend their building;
- Determining new primary care premises priorities;
- Funding new premises annual revenue requirements as a result of additional/ new rent reimbursement requirements of new premises.

Currently, any capital funding requirements is not delegated to the CCG and NHS England approval is required.

As part of delegated authority, GCCG has developed this five year prioritised Primary Care Infrastructure Plan (PCIP) to set out where investment is anticipated to be made in either, new, or extended buildings, subject to business case approval and available funding for the period 2016 to 2021.

# Part A -Where are we and where do we need to be?

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# 3. strategic context

# 3.1 The future direction of primary care service provision

A number of strategic plans recognise that day to day primary care services still need to be delivered but some care, currently provided in hospital settings, also needs to become a much larger part of what the NHS does in local facilities.

The wider range of services - extended primary care- is expected to include increased community services, Out of Hours services and other specialist based services such as diagnostics, more case management of vulnerable patients and more working with non-statutory bodies. These services will respond to local need and help keep people independent.

This broader range of services need to be available 24hrs per day and seven days per week and for some services will require practices to work together to improve urgent access at evenings and weekends. It is expected that Doctors will lead the provision of this extended primary care . The services will be better integrated, be at the heart of a stable care system and will remain connected with the local communities they serve.

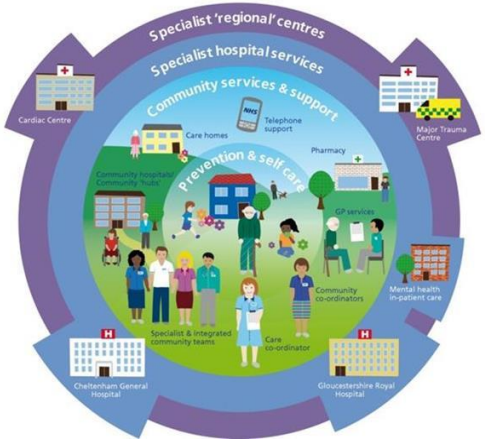
GPs will work even closer with nursing disciplines, other community health practitioners, hospital specialists mental health and social care – so there is a wider team including District Nursing , community matrons (case managers) health visitors, midwives and social workers.

Practices are increasingly expected to employ bigger teams , which in turn work together as well as with other health and social care providers through formal networks. Reference has also been made to emerging 'Super' practices – one practice operating from a number of sites – essentially general practice operating at a larger scale. Increasingly, local primary care services will be delivered for around 25,000 to 100,000 people.

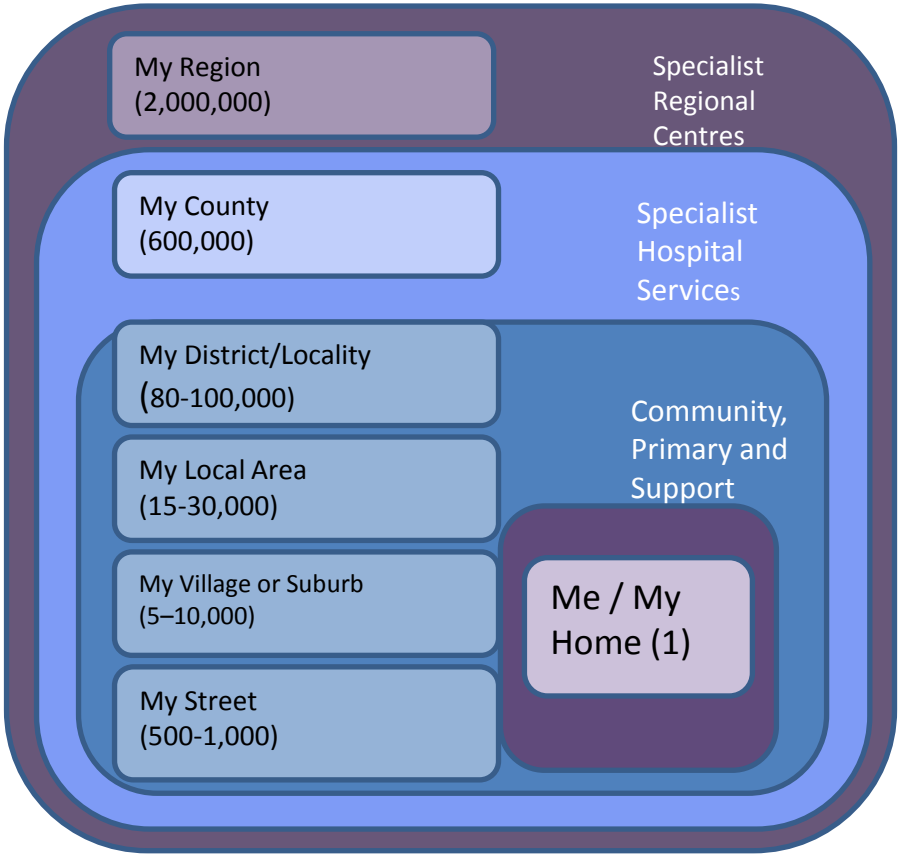
In order to deliver this emerging service strategy, literature refers to the development of local primary care hubs that practices are likely to be co-located within and/ or access for diagnostics, extended care and out of hospital services.

# 3.2 Gloucestershire CCG strategy – A people and Place approach to joined up care

***To improve health and wellbeing, we believe that by all working better together - in a more joined up way - and using the strengths of individuals, carers and local communities, we will transform the quality of care and support we provide to all local people***




Services plans responding to a 'people and place' perspective / Place based commissioning based on certain population sizes




Key focus for primary and community will be joined up care for the populations of around 30,000 to 40,000 people

Some geographical areas are already undertaking service reviews e.g. Forest of Dean to consider this emerging model. The development of primary care infrastructure could be required to deliver the agreed new models of care

# 3.3 Out of Hospital care

Support primary care to undertake pro-active case management and co-ordination of care of patients in context of Gloucestershire out of hospital care. At the same time supporting the CCG ambition to reduce pressure on the hospital based urgent care system;

Support GP practices to make more use of voluntary services for their patients

Enabling Active Communities (helping people to help themselves)

Develop ways of working to ensure the interface between in and out-of-hours primary care services works more effectively

Ensure GPs continue to develop a key role in ensuring co-ordination of integrated care; through the consideration of how primary care can better support the integration of care for patients with long term conditions developed through a clinical programme approach);


Extend the range of services offered in primary and community care recognising diverse demography and health needs of the population across Gloucestershire including diagnostics, rehabilitation, mental health, therapies and outpatients

Person led planning including what to do when long term conditions or frailty exacerbate;

One summary care record – Joining Up Your Information (JUYI); Focus on prevention across all clinical programme areas and health and wellbeing;

Working with well developed and active voluntary sector organisations and community groups;

Simplify access to, and integrate urgent primary care, to avoid unnecessary emergency hospital care;

Ensure greater utilisation of technology to support new ways of working within primary care;

# 3.4 The challenge of the existing estate

Across England, 40% of practices surveyed by the British Medical Association felt premises were not adequate to deliver existing services and 70% were too small to deliver extra services.

GCCG needs to ensure there is sufficient capacity for future need, whilst maximising use of facilities and delivering value for money as limited financial investment is available to fund requirements.

There needs to be a focus on enhancing patients' experience and improving the environment for staff to provide the best care. GCCG commissioned an estates survey in the Spring of 2015 that has highlighted spatial constraints in some buildings, that the condition of some buildings are no longer suitable for the long term and the functionality/ layout in some buildings is not satisfactory.

Whilst there are a number of committed developments and improvements, the survey suggests that Gloucestershire needs a programme to improve the quality and capacity of primary care buildings.

Whilst it is still essential to ensure core primary care services are available, there is a also a need to modernise premises to ensure more services can be delivered out of hospital and that some of this additional capacity will not be done at the single practice level. Further, improved and/ or enlarged infrastructure can be both catalyst for delivering change or an enabler to deliver agreed service models.

# 3.5 Rising population

This plan is using the period up to 2031. The registered population is set to rise from 622,000 in 2015 to 713,000 in 2031. An increase of over 90,000 people over a fifteen year period.

There will be significant housing developments in different parts of the County. The impact will fall more on some practices compared to others.

A number of existing committed schemes will deal with some of growth in population.

Significant pressure remains in the Brockworth and Coopers Edge areas; the far southern Gloucester City fringe/ west and north west of Stonehouse; West and North West of Cheltenham, Bishops Cleeve; parts of Cirencester and parts of the Forest of Dean.

Assumptions have been made on where patients are likely to register (patient flow).

There are opportunities to work with District Councils and housing developers to ensure contributions are made towards costs of new health centres required because of the construction of new homes

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# 4. The Current state

# 4.1 Current buildings


There are currently 82 practices providing general medical services to 630,000 registered patients.

Services are provided in 108 buildings. There are 73 main buildings, housing 82 practices and 35 branches. Although some practices operate more as split sites

58 of the buildings are owned by the Practices themselves. 32 of the buildings are leased, where the GP Practice is a tenant. 1 building is part leased and part owned. In one situation, the Practice is expecting to have to vacate their main leased site within the next 5 years

For 17 buildings , the ownership status is not available

On current registered list sizes, 90% of practices are in buildings smaller than current recommended sizes

Almost a quarter of practices are in buildings significantly smaller that current recommended sizes – that is 45% of more smaller. A breakdown by Practice is attached at appendix 1a

Taking into account future population growth, the proportion of practices in building significantly smaller than current recommended sizes increases to one third. A breakdown is attached at appendix 1b

# 4.2 Conditions and suitability of estate

A key part in determining future investment priorities relates to the current building condition, the building functionality and other key aspects relating to the estate. GCCG commissioned a six Facet survey. The survey is part of a suite of guidance referred to as NHS Estatecode. Originally aimed at hospital buildings, it can also used to for primary care buildings . The survey is aimed at helping to inform maintenance programmes and are also used to help inform future strategic investment. It is a set of standardised core information and comprises of a combination of six separate surveys: -

- Facet 1 – Physical Condition Survey (including mechanical and electrical aspects). A risk-based survey providing practical information for assessing building stock condition, which covers 23 elements;
- Facet 2 – Functional Suitability Review Assesses the appropriateness of the function/facility in relation to the activities taking place;
- Facet 3 – Space Utilisation Review Assesses the physical use of the building, identifying low use, empty and overcrowded rooms;
- Facet 4 – Quality Audit Based on factors which relate to the quality of the internal spaces when assessed. Enables premises to be judged and compared with one another. It determines those that are most and least pleasant for both staff and visitors;
- Facet 5 – Statutory Compliance Review -An assessment of statutory requirements , the elements of this audit help practices understand there position against their legal obligations. This audit identifies the extent to which the facilities comply with these statutory regulations;
- Facet 6 – Environmental Management Review - An assessment of the policies and procedures at the practice relating to the management of water consumption, energy usage, waste control and procurement (if applicable). It should be noted that facet 6 is not available for the Gloucestershire survey.

NHS England guidance recommends for primary care premises developments, attention should be placed on current buildings where the physical condition (facet 1) and/ or the functionality suitability review are deemed to be unsatisfactory. It should be noted that practices who are already progressing committed developments did not participate in the survey.

A summary of scores for Gloucestershire Practices without a committed development is provided at appendix 2. Scores of A and B are deemed as acceptable and scores of C & D are deemed not satisfactory. With regards to scores of C&D - this does not mean that the building is about to fall down or is dangerous, but is more likely to require improvement in the future. The scores for facet 1 and facet 2 have been taken forward as part of the prioritisation methodology and full reports have been shared with practices.

# 4.3 Current premises budget

The delegated premises budget agreed with NHS England for 2015/ 2016 is made up of the following items

| Item | 2015/ 2016 budget £m* |
|---|---|
| Rent | 5.632 |
| Rates | 1.765 |
| Clinical waste | 0.134 |
| Refuse | 0.109 |
| Water rates | 0.076 |
| Grand Total | 7.716 |

The CCG medium term financial plan indicates that there will be significant financial challenges and the CCG premises will need to align with Quality & Productivity challenges. The CCG is producing wider Strategic Estates Plan, which the Primary Care Infrastructure Plan is a key element. One of the key aims of the plan, is maximum utilisation of the existing health and social care infrastructure and develop join approaches that maximise any future investment. It will also be important to utilise all funding sources such as the national Primary Care Modernisation Fund.

*Source: NHS Gloucestershire CCG

# 4.4 Committed developments

As at April 2016, there are a number of committed developments in different stages of delivery. These deliver some of the solutions to the challenges faced and, of course, are excluded from the strategic prioritisation

| Locality | Practice | Scheme | Status |
|---|---|---|---|
| Cheltenham | Sevenposts surgery | New building in Bishops Cleeve, closure of existing main site on Prestbury Road and closure of existing branch in Bishops Cleeve | Approved subject to District Valuation Value for Money confirmation |
| Cheltenham | Stoke Road Surgery | Refurbishment and extension to existing building | Approved and construction started |
| Gloucester City | Churchdown | New building in new location and closure of existing facilities | Approved |
| Gloucester City | Hadwen Medical Practice | Refurbishment and extension of Glevum surgery site | Approved |
| Gloucester City | Longlevens surgery | Extension to existing building | Approved and construction started |
| Gloucester City | Rosebank health | GP led scheme- new building in the Kingsway area of Gloucester City to deliver services to new population | Approved |
| North Cotswolds | Stow Surgery | Third Party Development - Closure of existing building and new building | Approved subject to District Valuation Vale for money confirmation |
| Tewkesbury | Church Street & Mythe | GP Led development – new building on Community Hospital site and closure of all existing Tewkesbury town centre medical facilities | Approved and construction started |

# 4.5 Summary – the gap and challenges

In summary, the PCIP needs to respond to the following challenge:

- An emerging direction of travel for primary care service provision where bigger, extended teams are providing a greater range of services across 7 days for a larger population being served in larger facilities or networked facilities across a given area of typically around 30,000 to 100,000 patients;
- There will be significant population growth in Gloucestershire over the next 15 years and in a small number of geographical areas, this growth will be exceptional;
- There are a number of practices presently who are providing services in facilities significantly smaller than would be expected. This position worsens over the next ten to fifteen years if there is no investment in new buildings, or extended buildings;
- For a number of practices in Gloucestershire, the current physical conditions and functional suitability of the main surgery building are no longer satisfactory;
- There are likely to be a very small number of unique situations, which the CCG will need to take into account as part of the strategic prioritisation process;
- In some instances, the PCIP will be informed by other service strategies such as the Forest of Dean community services review;
- Due to financial constraints, the CCG will not be able to invest in all the schemes it would like to. Therefore, it will need to first strategically prioritise against these challenges and subsequently will require business cases for each proposal to ensure they provide a compelling Case for Change and represent Value for Money.

# Part B -How are we going to get there? Our strategic priorities and delivery

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# 5. Primary Care Infrastructure Plan

# 5.1 PCIP – methodology, approach and assumptions

- It is assumed that no new general medical service (GMS) contracts will be commissioned so that population growth and new service requirements will be delivered by existing contractors, or merged contractors;
- Only main sites have been considered and at this stage no branches. However engagement has indicated that the CCG might need to consider practices with split sites that have equal operating status;
- In considering future priorities, any practices with a committed development or significant extension are not included;
- Take into account current building condition – to what extent is the building not satisfactory?
- Take into account building functionality – to what extent is the building not satisfactory?
- Is the building 45% or more smaller than it should be to deal with current/ future predicted registered list size;
- Take into account housing and population growth and the assumptions of patient flow to practices and how this impacts on current facilities;
- Are there any specific unique factors to consider or wider tactical considerations;
- Following the early strategic determination of priorities, consideration then needs to be given to emerging service models and how priorities can be configured to best support this- i.e. more than one practice in a building – hubs;
- Identified priorities will also need to consider other concurrent service strategies such as the Forest of Dean community services review when identifying proposed solutions;
- It should be noted the PCIP will set out agreed priorities but any proposal will still need the development of a full business case before formal approval;
- The PCIP will support national Primary Care Transformation Fund bids and the CCG coordinate proposals with local practices in future years;
- It is assumed the national Primary Care Transformation Fund will be used to offset some of the capital costs – thus reducing revenue requirements (15 year rental abatement) and/ or to fund capital costs to support out of hospital service developments not part of GMS Premises Directions reimbursement;
- There needs to be patient engagement regarding specific proposals. This commenced with discussion of the this strategy at a Gloucestershire wide Patient Participation Group event in January 2016;
- Priorities will be grouped in assumed order of importance;
- An initial Financial framework has been produced to set out resource implications for identified priorities.

# 5.2 PCIP – Strategic prioritisation


**Prioritisation explained**

- High level assessment across five elements
- Assessment of how many of the five elements a practice appears in
- Essentially a point for each element – normally maximum of 5 points
- If the building condition was assessed as unsatisfactory in the recent estates survey, one point
- If the functionality of the building was assessed as unsatisfactory in the recent estates survey, one point;
- If the physical capacity of building (the gross internal area in square metres) is 45% or more smaller than current sizing regulations (as per NHS England guidance), 2 points, which recognises the added importance of prioritising practices that have a lack of space now in 2016;
- If physical capacity of building (the gross internal area in square metres is estimated to be 45% or more smaller than current sizing regulations (as per NHS England guidance) allow , 1 point;
- If there are specific, unique factors these have been taken taken into account with additional points ad rationale added. For example, the extreme population growth predicted over the next fifteen years in and around Brockworth
- Priorities have then been grouped

**Priority Groups explained**

Appendix 3 set out priorities in groups

- Strategic groupings 1 and 2 are schemes the CCG is expected to consider its top priorities
- Strategic groups 3 and 4 are schemes the CCG that are expecting to be important over the medium term
- Strategic groupings 5 & 6 are schemes that are less likely to considered for development during this period
- Strategic grouping 7 is not expected to be considered for the period 2016 to 2021

# 5.2 PCIP – Key strategic priorities -

A full breakdown of scores and groupings is attached at appendix 3 . The schemes below have been identified as the top priorities. As a result of additional information and data , the scoring might need to be changed through periodic review. This plan assumes the proposals below will be the minimum taken forward by the CCG over the next five years.

| Locality | Premises proposal |
|---|---|
| Cheltenham | Replace up to5 practices with 1 or 2 new surgery sites ( Berkeley Place, Crescent Bakery, Yorkleigh Surgery , Royal Crescent and Overton Park surgeries) |
| Cheltenham | Development of surgery provision for the West/ North West of Cheltenham due to new housing developments |
| Forest of Dean | Replace Cinderford Health Centre with a new health facility for the 2 surgeries currently residing within the new Building – Dockham Road and Forest Health care |
| Forest of Dean | Replacement of Coleford Health Centre with new surgery building |
| Gloucester City | Replace the existing Rikenel building with purpose built facility |
| Gloucester City | Either a new surgery or two surgeries, if one not achievable, to replace the Brockworth and Hucclecote surgeries and cover major population growth over the next 15 years |
| South Cotswolds | Whilst individually, the four Cirencester Town Centres do not appear as top priorities, collectively and with planned housing developments due to take place, there is a Case for Change for a new model of primary care , which will necessitate infrastructure development |
| South Cotswolds | Replace Romney House with a new surgery building in Tetbury |
| Stroud & Berkeley Vale | Replace the existing Beeches Green with new building to accommodate the Health Centre, Stroud Valley Family Practice and also Locking Hill |
| Stroud & Berkeley Vale | Replace the existing Minchinhampton surgery |
| Stroud & Berkeley Vale | Review surgery provision in Stonehouse and north/ north west of Stonehouse , particularly for Regent street and Stonehouse health clinic either as a joint development or single developments. |

The next few pages set out more locality specific priorities and issues, including existing commitments set out earlier

# 5.3 (i) -Cheltenham locality priorities

Additional population growth over the next 15 years expected to be around 21,000 additional people

Sevenposts surgery – closure of two sites and new build on new site (Bishops Cleeve)- approved by NHS England

Stoke Road (Bishops Cleeve) –Extension to existing building around - approved

Winchombe – extension to existing building including space for physiotherapy

Leckhampton & Portland surgery - further review on population growth in this area likely to be required

New surgery building for the North West/ West of Cheltenham and further work on patient flow assumptions for existing practices. Current assumption that the new building would register this population and be managed by an existing practice

Development of new surgery site(s) for up to 5 Town Centre surgeries

# 5.3 (ii) Gloucester city locality priorities

Overall local population set to rise by 27,000 in 2031 with significant growth in Churchdown, Innsworth, Brockworth, Coopers Edge and Southern fringes of the City

Hadwen medical practice- large extension to building and refurbishment with 840m2 additional space to existing building approved . At December 2015, planning permission granted but construction not yet started - expected Spring of 2017

Churchdown surgery –new building approved and at December 2015, planning application waiting to be submitted

New surgery to cover population expansion in and around the Kingsway area of Gloucester City approved

To deliver the existing committed to extend Longlevens surgery with 3 consultation rooms, health promotion room and other support space

To develop a new surgery site to replace the current Gloucester City Health surgery contained within the Rikenel building in the Centre of the City and consider the infrastructure requirements of other patients in the City Centre area

To develop and deliver ideally one surgery site , or two , if not achievable to deal with increasing population in Brockworth, Coopers Edge and Hucclecote to replace the existing Brockworth and Hucclecote surgeries

To review the options to assess the requirement for a business case for the infrastructure requirements of the patients served by Cheltenham Road surgery

# 5.3(iii) North & South Cotswolds priorities


Population growth estimated to grow by over 4,000 people by 2031

Stow surgery- approval for new build on specific site. Practice currently working with developer on design and layout and will require Value for Money confirmation

No other high priorities identified but building constraints for Chipping Camden likely to become an issue over the medium/ longer time (currently 32% below recommended size but by 2031 this becomes 44%


Population expected to rise by 14,000 over the next 15 years. Growth focused in Chesterton part of Cirencester and in and around Tetbury. Further refinement of the assumed patient flow for new Chesterton development required to finally determine impact on local surgeries

Romney House in Tetbury key priority as Practice have advised that it will need to vacate the building as the owner wishes to sell the property. Business Cass to set out and test options

Four Cirencester practices are currently exploring a new model of primary care across the Town. Whilst the strategic prioritisation has currently indicated that currently these practices are relatively less of a priority, changes to existing infrastructure are expected to be necessary to deliver this new model. This is anticipated to be no more than two sites housing the four practices .

# 5.3 (iv) Stroud & Berkeley Vale priorities

Stroud & Berkeley Vale population expected to be over 9,000 higher in 2031

Locking Hill, The Health Centre Beeches Green and Stroud Valleys Family Practice very high priority for CCG and there is a commitment from practices to develop a single scheme on the existing Beeches Green Health Centre site to deal with current spatial constraints, the recent closure of another Town Centre surgery as well as other population growth

Development of new surgery for Minchinhampton

The Stonehouse area (including up to Huntsgrove area and fringe of Frampton) is likely to experience significant population growth over the next 10 to 15 years. Prioritise Stonehouse Town Centre practices to agree a long term solution

No other significant priorities identified relative to other practices across Gloucestershire.

# 5.3 (V) Forest of Dean, Tewkesbury, Newent & Staunton priorities

Population expected to increase by around 11,000 people over the next 15 years

Brunston Practice – extension to existing building for consultation rooms and practice manager rooms

Redevelopment of Cinderford Health Centre

Redevelopment of Coleford Health Centre and explore the potential for Brunston surgery to be part of any proposed new development

Need to ensure primary care premises developments align with proposals of the current review of community services across the Forest of Dean e.g. the potential for the development of Lydney Health Centre



Over 6,000 Increase in population by 2031

Completion of a new Tewkesbury Primary Care Centre and the closure of the current Tewkesbury Town Centre surgery buildings

Reviewing planned housing developments on former Ministry of Defence site at Ashchurch and further impact on primary care infrastructure

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# 6. Delivering the Plan

# 6.1 Delivering the priorities – business case processes

For the 2016 to 2016 PCIP there will be a two stage process:-

Stage 1 -A relatively short proposal will be completed. Due to the timing of this plan being at the same time as the submission of proposals to NHS England's Primary Care Transformation Fund for 2016 onwards.

Stage 2 – the completion of a detailed business case. Following stage 1 approval, a detailed business case will be completed to demonstrate, viability and service benefits and is the key document for obtaining CCG support and the necessary funding. It will need to be compliant with the principles set out in the HM Treasury's (HMT) Five case model style of business case development and contain, at a minimum the following and be referred to as the Business Case for 'X' development : -

- Executive summary;
- Strategic context and the case for change;
- Options and options appraisal;
- The preferred option;
- Financial appraisal;
- Commercial case including benefits and outcomes, value for money and affordability assessment;
- Patient and stakeholder engagement/ consultation, including, where appropriate other health and wellbeing partners ;
- Travel plans;
- Risk analysis;
- Project development adviser team and project timetable.

Practices and their developers have flexibility in producing their business case so long as it meets the criteria set out above. The specific practice/ practices will be responsible for the completion of documentation. However, CCG resource will be available to facilitate , help and advise.

# 6.2 Delivering the priorities – use of primary care transformation fund

To send a clear signal that the NHS England £1bn four year Primary Care Infrastructure Fund is designed to improve services, from 2016/ 2017 onwards it will be known as the Primary Care Transformation Fund (PCTF). The bulk of the fund will be deployed to improve estates and accelerate digital and technological developments in general practice, and will be subject to an initial bidding process. At the end of October 2015, CCGs received a letter asking that they make recommendations to NHS England to support the funding of improvements or developments in practices in its area, initially by the end of February 2016 but currently is from the end of April 2016 onwards. The recommendations will need to demonstrate that they meet one or more of the criteria set out below:-

- Increased capacity for primary care services out of hospital ( It is assumed this could include space that does not normally qualify for rent reimbursement);
- Commitment to a wider range of services as set out in your commissioning intentions to reduce unplanned admissions to hospital; ( It is assumed therefore this could include spaces that do not qualify for rent reimbursement);
- Improving seven day access to effective care;
- Increased training capacity.

It is noted that CCG recommendations should also reflect the wider local Strategic Estates Plan .The CCG should also produce phased funding plans (limited to 31 March 2019 for the PTCF) for recommended developments, which take into account their long-term affordability. The PCIP approach completely reflects this.

In respect of the PCTF, the CCG is working with identified prioritised practices on significant development proposals as well as offering other practices as offering other practices to opportunity to set out smaller improvement requirements so that an agreed submission can be made to NHS England within required timescales.

Subject to NHS England approval, the planning assumption is that pre project costs will be drawn down from the fund early to complete business cases during 2016/ 2017 and then subsequently a proportion of capital costs will be funded by the PCTF for the provision of general medical services (GMS) and/ or out of hospital services that might not normally qualify for GMS rent reimbursement. In line with Premises Directions, for GMS aspects, this will result in a revenue rental abatement for 15 years . This will lower the revenue costs than would be the case without PCTF funding during this time period. It should be noted that full revenue costs are set out in this plan, which assumes no PTCF funding is received by the CCG.

# 6.3 Engagement and stakeholder involvement approach

NHS England (NHSE) has recently published the Patient and Public Participation Policy and Statement of Arrangements and Guidance on Patient and Public Participation in Commissioning.
https://www.england.nhs.uk/ourwork/patients/ppp-policy/

These documents make it clear that responsibility for primary care commissioning engagement sits with 'delegated' CCGs under their duty to involve. Therefore , the NHSE policy and arrangements do not apply. This clarification from NHSE allows for the extension of the GCCG approach to engagement, which meets the CCG's duty in respect of the services we commission (section 14Z2 of the Health and Social Care Act, 2012), to primary care commissioning engagement. The GCCG Strategy for Engagement and Experience: *Our open culture* sets out GCCG's approach to engagement . It sets out our intention to promote 'Equality' and working in 'Partnership' and the desire to enable 'Anyone and Everyone' to have a voice. To achieve this we provide 'Information and good Communication', focus on 'Experience' feedback and undertake good 'Engagement and Consultation'.
http://www.gloucestershireccg.nhs.uk/feedback/gccg-engagement-and-experience-strategy/.

In respect of a proposed primary care premises development, the CCG sees two key stages and an engagement checklist is provided opposite: -

- Engagement during the completion of a business case where options are being considered
- Following approval, continued engagement through the detailed design and construction period


**Engagement checklist**

- ☐ A patient reference group in place *[which could be the patient participation group (PPG)]*
- ☐ Engagement Cycle: Agreed scope and level of engagement including collation, analysis and reporting of feedback [*It is expected that engagement will be on different options available and once the preferred option is agreed, further engagement on detailed design, layout and how the building will work day to day]*
- ☐ Identified a person(s) or project group to manage the engagement process
- ☐ A sound rationale for the change is described
- ☐ All stakeholders identified *[Our open culture identifies GCCG strategic partners. In respect to primary care infrastructure engagement and consultation GCCG will always involve relevant PPGs, Healthwatch Gloucestershire, relevant elected representatives and GCCG Lay Members.]*
- ☐ Identified engagement methods to be used
- ☐ Timetable for the engagement confirmed
- ☐ Engagement equality impact assessment completed
- ☐ Budget/resources to support the work identified

# 6.4 Financial assumptions

| Locality | Premises proposal | Estimated List size | size m2 (gross internal area) | capital cost 1,725 per m2 + fees at 12% plus VAT and average land costs | m2 rate inclusive of any VAT | Assumed annual current market rent | Less existing paid | Net revenue increase £ |
|---|---|---|---|---|---|---|---|---|
| Cheltenham | Replace up to5 practices with 1 or 2 new surgery sites ( Berkeley Place, Crescent Bakery, Yorkleigh Surgery , Royal Crescent and Overton Park surgeries) | 47,031 | 3,083 | £7.65m | £200 | £587,800 | £263,906/ £92,497 | £323,894 |
| Cheltenham | Development of surgery provision for North West of Cheltenham due to new housing developments | 10,000 | 833 | £2.43m | £200 | £166,600 | £0 | £166,600 |
| Forest of Dean | Replace Cinderford Health Centre with a new health facility for the 2 surgeries currently residing within the new Building – Dockham Road and Forest Health care | 13,850 | 1,000 | £2.82m | £200 | £200,000 | £40,000/0 | £160,000 |
| Forest of Dean | Replacement of Coleford Health Centre with new surgery building | 7,773 | 667 | £2.05m | £200 | £133,400 | £35,000/0 | £98,400 |
| Gloucester City | Replace the existing Rikenel building with purpose built facility on a different site | 8,405 | 750 | £2.24m | £200 | £150,000 | £18,500/ £ 0 | £131,500 |
| Gloucester City | Preferably, a new single surgery or two single developments to replace the Brockworth and Hucclecote surgeries and cover major population growth (section 106 assumed) | 26,892 | 1,833 | £4.75m | £200 | £366,600 | £120,950/ £54,827 | £245,650 |
| South Cotswolds | Replace Romney House with a new surgery building in Tetbury | 10,952 | 874 | £2.53m | £200 | £174,800 | £56, 200/ £25,064 | £118,600 |
| South Cotswold | Development of surgery provision for Cirencester Town primarily due to significant population growth in area known as Chesterton (section 106 assumed) with 1 or 2 surgery sites | 17,326<br><br>18,908 | 1,136<br><br>1,208 | £3.13m<br><br>£3.30m | £200<br><br>£200 | £227,200<br><br>£241,600 | £115,274/ £42,536<br>£125,760/ £19,280 | £111,926<br>£115,840 |
| Stroud & Berkeley Vale | Replace the existing Beeches Green with new building to accommodate the Health Centre, Stroud Valley Family Practice and also to include Locking Hill | 26,327 | 1,796 | £4.66m | £200 | £359,200 | £134,200/ £0 | £235,000 |
| Stroud & Berkeley Vale | Replace the existing Minchinhampton surgery | 7,271 | 667 | £2.05m | £200 | £133,400 | £38,000/ £14,924 | £95,400 |
| Stroud & Berkeley Vale | For Stonehouse and north/ north west of Stonehouse , either a joint development between Regent street and Stonehouse health clinic or a new single development through Regent Street and review of remaining Town Centre buildings | 10,549 | 850 | £2.47m | £200 | £170,000 | £36,600/ £25,865 | £133,400 |
| Sub total | Annual revenue | | | | | £2.91m | £0.91m | £1.94m |
| Sub total | Assumed annual rates (based on 40% of annual current market rent) | | | | | £1.16m | £0.275m | £0.87m |
| **Grand total** | | **205,284** | | **£40.08m** | | **£4.07m** | **£1.18m** | **£2.89m** |

# 6.5 Fees & other cost assumptions

The CCG will follow the National Health Service (General Medical Services – Premises Costs) Directions 2013. Key elements regarding fees that may be reimbursed are as follows: -

1. In the case where notional rent payments are to be paid in respect of newly built or refurbished practices, the reimbursable professional expenses are: -

- The reasonable costs of project manager to oversee the interest of and give advice to the contractor, up to a maximum reimbursable amount, which is 1% of the total reasonable contract sum relating to the construction or refurbishment;
- Reasonable surveyors, architects and engineers fees, which, taken together may be paid up to a maximum reimbursable amount, which is 12% of the total reasonable contract sum relating to the construction or refurbishment;
- Reasonable legal costs in connection with the purchase of a site (where applicable) and the construction or refurbishment work.

2. Where the practice premises are, or are to be, leasehold premises, the professional expenses are: -

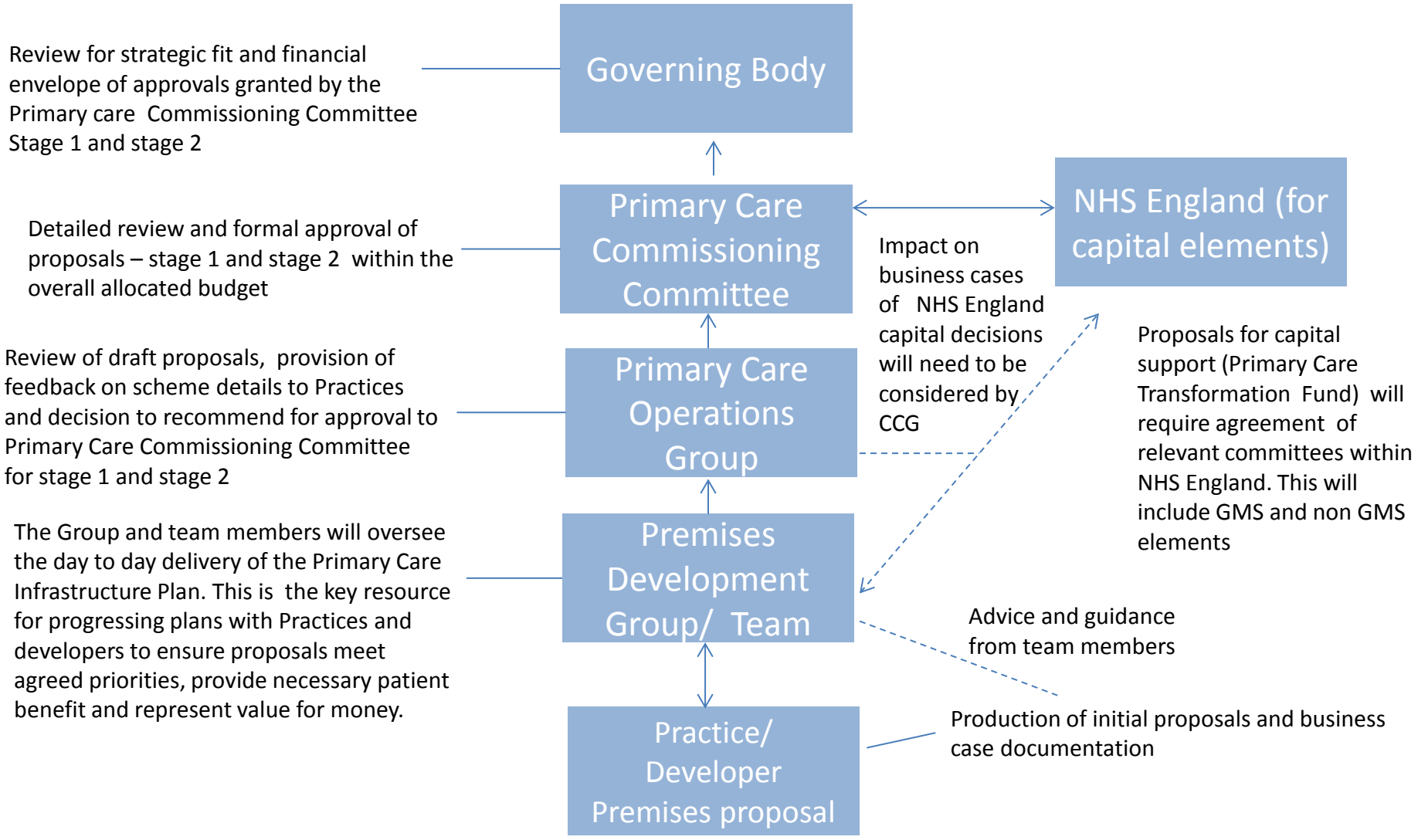
- The reasonable costs of engaging a project manager to over the interest of and give advice to the Contractor, up to a maximum reimbursable amount, which is 1% of the total reasonable contract sum relating to the construction or refurbishment work;

- The reasonable legal costs incurred by the contractor;

In the case where other fees may need to be paid by the Contractor, such as Stamp Duty Land Tax (SDLT), there is no obligation for the CCG to reimburse any of these costs to the Contractor.

It is assumed that the normal practice will be that fees will either be part of the overall financial appraisal considered for rent reimbursement, paid by the Practice or paid by the 3rd Party Developer . Only in exceptional circumstances, will the CCG consider reimbursement . In such circumstances, there will be no commitment to 100% reimbursement

# 6.6 Decision making and approval process



# 6.7 Risks & Risk management

Key initial strategic risks associated with this programme are set out in the table below. Risks will be managed through the Premise Development Group and reported through the CCG Risk Management process as part of the Directorate of localities and Primary Care Risk Register. Each development will also be required to produce, manage and if required, escalate key risks to the CCG.

| Risk | Probability | Impact | Initial risk | Controls & assurance | Revised risk score |
|---|---|---|---|---|---|
| There is insufficient clarity on the aims and objectives of the programme, which means the benefits are not achieved , only partially achieved, delayed and/ or there is disagreement on proposed outputs and outcomes | 3 | 5 | 15 high risk | • Programme owner in place;<br>• Strategic Plan developed;<br>• Business case process established<br>• Governance arrangements agreed | 1x5=5 Low risk |
| There is insufficient programme resource to deliver the requirements of the programme , which leads to delay in completing | 3 | 4 | 12 Medium risk | • Programme team in place<br>• Additional resource being commissioned to work with partners<br>• Focus on key priorities<br>• Implementation in waves | 2x3 =6 Low risk |
| There is a risk that agreed developments are not supported by local people, patients and key stakeholders, which hinders implementation | 3 | 4 | 12 Medium risk | • Engagement framework developed<br>• Engagement with helping to agree key strategic priorities<br>• Clear communication strategy<br>• Enactment of engagement plan<br>• Feedback mechanisms for key referrers to ICT | 1x4 = 4 Low risk |
| There is insufficient financial resource to fund the development of necessary premises requirements, which means that practices are unable to provide the right level of service to patients leading to less effective care | 3 | 5 | 15 High risk | • Financial framework developed<br>• Use of PCTF to offset some costs<br>• Development of larger Centres, wherever possible to maximise estate efficiency<br>• Prioritising developments<br>• Scheduling developments | 2x4= 8 Low risk |

# 6.8 Key programme timelines

| Item | Planned date | status |
|---|---|---|
| Primary Care Infrastructure plan (PCIP)brief agreed | September 2015 | Completed |
| Initial strategic prioritisation | October 2015 | Completed |
| Initial engagement with CCG Member Localities and other CCG committees/ groups | October to December 2015 | Completed |
| Primary Care Transformation Fund (PCTF)letter issued by NHS England outlining CCGS to act as coordinators of proposals | End of October 2015 | Completed |
| Production of draft PCIP and issued. | December 2015 | Completed |
| PCTF detailed guidance and application process issued | December 2015 | Draft guidance issued February 2016 |
| Review by Primary Care Operational Group | January 2016 | Completed |
| Review by Primary Care Commissioning Committee | January 2016 | Completed |
| Review by CCG Governing Body in development session | January 2016 | completed |
| Engagement with patients and stakeholders | January to March 2016 | PPG network event January 2016 |
| Development and completion of PCTF proposals | January to April 2016 | On track |
| Agreement and submission of PCTF proposals by CCG to NHS England, aligned with PCIP | End of April / May 2016 | On track |
| PCIP refined and updated | March 2016 | Completed |
| Considered and approved by Primary Care Commissioning Committee and CCG Governing Body | March 2016 | Completed |
| PCIP agreed and programme implemented with commencement of prioritised business cases writing | April 2016 onwards | completed |