NHS
Gloucestershire
Clinical Commissioning Group

Primary Care Commissioning Committee (PCCC)

Held in Public

Meeting to be held at 9:45am on Thursday 28 March 2019 in the Board Room, Sanger House, Brockworth, Gloucester GL3 4FE

No.	Item	Lead	Recommendation
1.	Apologies for Absence	Chair	Information
2.	Declarations of Interest	Chair	Information
3.	Minutes of the Meeting held on • 31 January 2019	Chair	Approval
4.	Matters Arising	Chair	Discussion
5.	Primary Care Network contract to implement The NHS Long Term Plan	S. Rudd	Information
6.	Cheltenham, Prestbury Road Premises Development	AH	Approval
7.	Application for change of practice boundary from Leckhampton Surgery	JG	Approval
8.	Primary Care Premises Report	AH	Discussion
9.	Primary Care Quality Report	TM	Discussion
10.	Delegated Primary Care Financial Report	AB	Discussion
11.	Any Other Business	Chair	
Date and time of next meeting: Thursday at 9:45am on 25 April 2019 in the Board Room at Sanger House.			

NHS
Gloucestershire
Clinical Commissioning Group

Primary Care Commissioning Committee
(*meeting held in public)*

Minutes of the meeting held at 9.45am on 31 January 2019
Boardroom, Sanger House

Present:		
Alan Elkin (Chair)	AE	Lay Member - Patient and Public Engagement
Mark Walkingshaw	MW	Deputy Accountable Officer & Director of Commissioning *(Deputising for Mary Hutton)*
Joanna Davies	JD	Lay Member- Patient and Public Engagement
Colin Greaves	CG	Lay Member – Governance
Cath Leech	CL	Chief Finance Officer
Julie Clatworthy	JC	Registered Nurse
Marion Andrews-Evans	MAE	Executive Nurse and Quality Lead
Andrew Beard	AB	Deputy Chief Finance Officer (Deputising for Cath Leech)
Andrew Seymour	AS	Clinical Chair
Lesley Jordan	LJ	Lay Member - Governing Body
Alan Thomas	AT	Healthwatch Representative

In Attendance:		
Jeanette Giles	JG	Head of Primary Care Contracting
Helen Edwards	HE	Associate Director of Primary Care Locality Development
Andrew Hughes	AH	Associate Director of Commissioning
Christina Gradowski	CGi	Associate Director of Corporate Governance
Helen Goody *(Agenda Item 5)*	HG	Director of Locality Development and Primary Care
Jo White *(Agenda Item 6)*	JW	Primary Care Programme Director
Zaheera Nanabawa *(Agenda Item 7)*	ZN	Locality Development Manager & CCG Liaison Manager
Lisa Netherton	LN	Corporate Governance Officer

1.	**Apologies**
1.1	Apologies were received from Cllr Roger Wilson, Becky Parish, Kirsty Young and Stephen Rudd.
1.2	The Chair confirmed that the meeting was quorate.
2.	**Declarations of Interest**
2.1	The Chair asked members to declare any interests in relation to any of the agenda items. AS declared a general interest as GP provider, but no specific interest. AE advised AS could stay and be involved in discussions.
3.	**Minutes of the meeting held on 29 November 2018**
3.1	The minutes of the meeting held on Thursday 29 November 2018 were approved subject to the following amendments: • Section 1.1 The minutes should have included apologies for Andy Seymour (AS). • Section 5.6 should read 'very'. Also should be 'NMC' not 'RCS' • Section 6.1, Dr Alan Gwynn's name was miss spelt. • Page 11 Section 11. 'delated' should be 'deleted'. • Section 11.3 'PCC' should be 'PCCC'.
4.	**Matters Arising**
4.1	**29/11/2018, Item 5.6, Merger Application to merge Phoenix Surgery with Romney House Surgery.** AE asked about the update on due diligence going forward with the nursing population. HE commented it related to the 'very' part time hours. Deputy Director of Nursing Julie Symonds had reviewed the hours the nurses were working and was satisfied. However, staff hours were being continually reviewed. **The item was closed.**
4.2	**29/11/2018, Item 6.1, Inter-Practice Minor Surgery Enhanced Service.** HE mentioned the procedure list for this enhanced service was set out in the minor surgery enhanced service specification. The minor surgery enhanced service was currently being reviewed.

	AE was concerned about the volume of procedures. **The Item remained open.**
4.3	**29/11/2018, Item 6.2, Inter Practice Minor Surgery Enhanced Service.** AE confirmed with HE that this item was closed. HE confirmed. **The item was closed.**
4.4	**29/11/2018, Item 6.2, Inter Practice Minor Surgery Enhanced Service.** AE asked about the guidelines for clinicians. JC confirmed that she was working with JG on this and the item could be closed. **The item was closed.**
4.5	**29/11/2018, Item 6.3, Inter Practice Minor Surgery Enhanced Services.** AE noted that this item was closed. **The item was closed.** *Zaheera Nanabawa joined the meeting at 10:00*
4.6	**29/11/2018, Item 7.1 Primary Care Quality Report – Safeguarding.** AE noted that a video was available and had been circulated yesterday. **The Item was closed.**
4.7	**29/11/2018, Item 7.6 Primary Care Quality Report – Safeguarding.** CG commented that this related to C.Diff. He had emailed TM and MAE on the subject. It was an issue affecting the hospitals and the wider community. MAE had asked the Infection Control Nurse to prepare a report to circulate because infection levels in the community were higher. The root cause analysis findings revealed patients were susceptible if prescribed particular antibiotics, the use of which had now stopped. Although there were higher numbers in the community, most had acquired C.Diff as hospital based patients. AE asked about the three groups of antibiotics that were not currently used. MAE replied that the approved antibiotic had not been available therefore the acute trust had had to use another antibiotic. The antibiotic used had significantly increased the

	risk of C.Diff. The report would be circulated by MAE after this meeting. MW informed the meeting that the Quality and Outcomes Framework (QoF) now included the quality improvement module which looked at prescribing and the impact on C.Diff. AE asked that an updated report was provided on this for a future meeting. **The Item remained Open.**
4.8	**29/11/2018, Item 4.11 West Cheltenham Surgery (previously known as Springbank) – provision of general medical services from Hesters Way Living Centre.** AE noted that MH had requested an update 6 months after the transition plans were complete. HE gave a verbal update. The primary care team met regularly with the medical team after moving into a bigger practice. The practice team met regularly with the lead GP and management team. The practice team met on a daily basis and meet regularly with the GP lead and management team. The wait for a routine GP appointment is 2 weeks maximum, with on the day and emergency appointments available. Access offered was 0800 – 1830 Monday to Friday with improved access clinic availability together with other practices during weekday evenings and at weekends. In the future the practice aspired to become a training practice and part of a wider holistic team. The building at Springbank is staffed by a full time receptionist. GP and healthcare assistants run clinics three times a week. The practice were conscious of the 5,300 new homes planned for the area. HE had been in contact with the assistant Practice Manager, who confirmed that overall feedback had been positive from patients and the patient participation group. Positive comments included more space and good décor. AE commended the practice's hard work. Negative comments were confined to car parking at the Healthy Living Centre. AE commented that the principal issue of concern around Springbank was the continuity of care and service by GPs as he understood they were unable to appoint new GPs. Dr Sanjay Shyamapant had committed to regular GPs at Springbank. However, HE was able to report that this practice and Crescent

	Bakery have fully recruited now. GP vacancies were more of an issue outside Springbank and Hester's way. The practice had a multi skilled workforce with nurses and pharmacists. This was beneficial as it allowed them to move their staff and expertise around. HG had spoken with Dr Sanjay Shyamapant to obtain regular updates on West Cheltenham and the recruitment issue. CG asked how the numbers registering with the practice were looking. HG commented they had increased and JG confirmed they had increased by 300. MAE stated that she was very pleased that there were plans in place for the practice to become a GP training practice. She considered that the practices would be an excellent setting for trainees. However, she informed the meeting that, recent guidance had specified that Nurses also needed access to further training with payment included. It was noted that additional funding was required to train practice nurses. AE asked JC if she wished to keep this item open as ZN had an update, but this was for Doctors not nurses. JC felt the committee really needed an update on future planning to encourage further training and funding for nurses. **ACTION: MAE to report back to the committee** **The Item remained Open**
4.9	**29/11/2018, Item 6.4 Primary Care Workforce Health Inequalities Fellowship.** ZN provided an overview of the Primary Care Workforce Health Inequalities Fellowship. MAE informed the meeting that the access to training was not the issue, but releasing nurses from their practice was due to the difficulty of securing backfill arrangements. It was noted that the CCG had a Continuing Professional Development (CPD) contract with the University of the West of England (UWE) that needed to be utilised. HG commented that she, MAE and JC had picked this up around the parachuting nurse's service and needed to prioritise releasing nurses for training. It was

	suggested this issue was dealt with outside the meeting. There was a need to seek solutions to try and focus on training, instilling a good use of capacity. AE suggested that an update was brought back to the committee in 3-4 months' time. **ACTION: JC, HG and MAE agreed to meet and thereafter report back to the committee in 4 months' time.** **The item to remain Open.**
4.10	**26/7/18 Item 8.9 – Prescribing Update.** AE confirmed that this item would be scheduled for the March meeting. MAE informed the meeting that an updated brief 'here we are now' was circulated to committee members yesterday via Board Pad. **Item to remain Open.**
4.11	**Item 9.6 - Pharmacy Team Update.** MAE confirmed that this item was included within the Quality Report at Item 8.
4.12	**04/10/18, Item 5.18 Gloucester City Hub Development** On the April/May Agenda. **Item to remain Open.**
4.13	**0/10/18, Item 6.6 Application to close College Yard** AE asked that the quality impact assessment be revisited for completeness. MAE confirmed it was reviewed in January 2019. **The Item was closed**
4.14	**04/10/18, Item 7.13 Enhanced Service Learning Disabilities Health Checks** This was an item for the June Agenda.

	The Item to remain Open.
4.15	**04/10/18, Item 8.7 Quality Report Primary Care Patient Survey** Committee noted the update given. **The Item was closed.**
4.16	**04/10/18, Premises Improvement Grant.** AE – **The Item was closed.**
5.0	**<u>Primary Care Networks Presentation</u>**
5.1	HG in the opening presentation focused on the concept of Primary Care Networks (PCN). The CCG had received the Long Term Plan (LTP) which sets out the role of PCNs and the new GP contract had been published that day.
5.2	HG informed the meeting that the CCG was well placed to support the development of PCNs being an ICS early adopter (one of twelve). 'Place' as referred to in the LTP as the focus for integrated working including primary care was akin to the Integrated Locality Partnerships (ILP) being developed in Gloucestershire.
5.3	The core characteristics of the PCN were: • Not just GP practices – looking at the wider community and mental health services. • Practices working together with other local health and care providers. • Providing care in different ways to match people's different needs. The CCG had an advanced population health data set for Gloucestershire. • Focused on prevention and personalised care. • Uses data technology to assess population health needs and inequalities. • Making best use of collective resources
5.4	HG provided an overview of the PCN development matrix covering the key elements, Right Scale, Integrated Working, Targeted Care, Managing Resources and Empowering Primary

	Care. It was noted that Gloucestershire was seen nationally as being at the forefront of development with GPs working in clusters over the last two years. HG confirmed that work would be carried out locally to determine the extent to which the CCG's current PCNs aligned with the development matrix and where there were differences.
5.5	**Long Term Plan (LTP) – PCN Extracts** HG provided an overview of the PCN extract contained in the LTP. • There would be a £4.5b of new investment to expand community multidisciplinary teams aligned with new PCNs based on neighbouring GP practices. • To support this new way of working significant changes to QoF would be made. This would include a new Quality Improvement (QI) element. • A fundamental review of GP vaccinations and immunisation standards, funding, and procurement would be undertaken. • New investments in out of hospital work were key. • PCNs would be offered a new 'shared savings scheme' based on delivery of new national service specifications. • Streamlined patient pathways and action on over medication through pharmacist review. • Every ICS would have full engagement with primary care, including through a named accountable Clinical Director of each PCN.
5.6	HG informed the committee she had been to a presentation at 2g and GCS with 70 of their top clinical and managerial leaders. That had demonstrated that there was substantial enthusiasm for partnership working at both PCN and Integrated Locality Partnership level.
5.7	**PCNs Outlook by 2020/21** PCN would be a group of GP practices based on populations from 30,000 to approximately 50,000.

	• Encompassing a new physical and mental health care delivery model. • From 2020/21 PCNs would be assessed in terms of the unwarranted health outcomes of their local population, with a requirement to work with local community services making support available to people where it was most needed. • Local areas would be supported to redesign and reorganise core community mental health teams moving towards a new place-based, multidisciplinary service across health and social care aligned with PCNs. • Over the next five years every patient in England would have a new right to choose "digital first primary care"– usually from their own practice or, from one of the new digital GP providers. • There would be a roll out nationally of the 'enhanced health in care homes' vanguard scheme, linking PCNs to care homes, with named GP support for all patients.
5.8	**Workforce** HG provided an overview of workforce challenges and funding available to PCNs. • PCNs would attract and fund additional staff forming an integral part of an expanded multidisciplinary team. Initially, focusing on clinical pharmacists, link workers, first contact physiotherapists and physician associates. Over time, it would be expanded to include additional groups such as community paramedics. • Newly qualified doctors and nurses entering general practice would be offered a two-year fellowship. This would offer a secure contract of employment alongside a portfolio role tailored, where possible, to the aims of the individual and the needs of the local primary care system. • The Government has also committed to a new state-backed GP indemnity scheme from April 2019.
5.9	**Gloucestershire Primary Care Networks:** • Cheltenham - 48,000 – 58,000 patients. Three networks based on geography. • Forest of Dean - 64,000 patients. All eleven practices in one network.

	• Gloucester City - 26,000 – 48,000 each. Five networks based predominantly on geography. • North Cotswold – 30,000 patients. All five practices in one network • South Cotswold – 60,000 patients. All eight practices in one network. • Stroud & Berkeley Vale – 18,000 – 40,000 patients. Four networks based on geography • Tewkesbury, Newent and Staunton - 43,000. All four practices within one network A total of 16 Primary Care Networks which are generally stable although there would be one or two changes to take account of the size of the population served.
5.10	HG emphasised that her slides on the Primary Care Offer were in draft form and were a mock- up of some ideas. Further work was required in light of the new PCN contract.
5.11	CG asked whether the Forest of Dean had difficulties being both a PCN and an ILP. HG commented that the Forest of Dean was one of the most effective ILPs and had a very good reputation. They had developed a new Complex Care at Home Service with partner organisations and had developed and delivered ambitious prescribing savings. They had had meetings focused on premises, resilience and had held a workshop on the future strategy for the Forest of Dean.
5.12	AS found the presentation very informative. He noted that the discussion was relevant to the new GP contract and would encourage current PCNs to look at their structures. There was a need to make sure that all PCNs continued to develop and that none were left behind. AE commented on the issue of differing boundaries between the new organisations (ILPs and PCNs) and those of the District Councils. HE advised that HG had met with the Chief Executive of Tewkesbury Borough Council (TBC). Further meetings had been arranged with the Chief Executives of Cheltenham Borough Council (CBC) and Gloucestershire City Council.

5.13	JC felt that the PCNs had to involve quality and the interfaces of care, in particular showcasing different skills and teams. She asked if the PCN infrastructure was affordable. She commented that the key roles would need a lot of development, but that had not been discussed yet. HG agreed that the leadership structure needed to be in place and that the contract needed to be specific on size, explaining as well that there would be a clinical GP lead. JC commented that the CCG had a clear and important opportunity to be supportive to Practice Nurses while developing PCNs. AE stated it would not be an easy process but the commitment was there and the possibilities were substantial. The committee thanked HG for the presentation.
6.0	**<u>Improved Access Update Presentation</u>** JW gave a presentation on GPFV Improved Access Reporting and Evaluation as at January 2019.
6.1	As part of the General Practice Forward View. Gloucestershire CCG was allocated £5.75 per head of weighted registered population for Improved Access. The Core Requirements to deliver Improved Access included: • Provision of pre-bookable & same day appointments. • Monday – Friday an additional 1.5 hours per day 6.30-8.00pm. • Saturday & Sunday provision. • Minimum 30 minutes per 1000 population additional capacity, rising to 45 minutes per 1000 population. JW informed the meeting that all 16 clusters across the county were included in the 14 live Pilot sites. It was noted that the above requirements were the minimum standards to which clusters were required to work. Piloting Improved Access at a network level had allowed the opportunity to design innovative models within the IA funding envelope to work together at scale and test new ways of working.
6.2	JW informed the meeting that the January and fortnightly

	stocktake to be in compliance with NHS England reporting required: • Percentage of the population benefiting from IA for 7 days. • Advertisement compliance (websites, in practice waiting rooms, wider urgent care settings, local community services). • Digital compliance online consultations, 111 direct booking weekday/weekends, DOS updated for all services. • Inequality compliance. • Workload tool compliance. • Feb/March – expecting detailed review of urgent/routine appointment availability.
6.3	JW provided an overview of the different types of Improved Access models that currently existed across the county. She selected a number of different models and talked through the plans that they had put in place to achieve the improved access standard. • Cheltenham Central – GDOC model, GP. • Cheltenham Peripheral – GDOC model GP. • Cheltenham St Pauls – GP IA, Physiotherapist. • Forest of Dean – GP IA, Phlebotomist. • Glos 1: Aspen – GP IA, Physiotherapist, Frailty Nurse. • Glos 2: HRQ – GP IA, Urgent ANP. • Glos 3 & 5: NEG & Inner City – GDOC model, shared provision. • Glos 4: SEG – GP IA. • North Cotswolds – GP IA, Shared provision Fridays only. • South Cotswolds – GP IA, Enhanced Same Day Minor Illness. • Berkeley Vale – GDOC model until the end of December 2018 and then local GP delivery from January 2019. • Stroud 2,3 & 4 – GP IA, Face Time , Phlebotomy. • Tewkesbury, Newent & Staunton – GP IA, Paramedic.
6.4	JW described the staff survey on Improved Access that had been undertaken. The survey sought to find out: • How IA had affected practices and practice staff; as well as the impact on the ground e.g. wait to routine appointments.

	• Staff opinion on the impact of IA on the practice, including pressure on appointments and waiting times. It focused on the impact of IA on the individual staff members, including day-to-day work life balance and further feedback. The survey also included questions about IT issues and governance.
6.5	The committee noted that the Improved Access scheme had been supported by a well-coordinated communications plan that included a web site survey that collated the number of clicks. • Posters in waiting rooms – survey, communication packs, PM newsletter. • Part of winter pressures advertising. • National Patient Survey that now included IA questions focusing on access to evening and weekend appointments.
6.6	JW talked through the South Cotswolds - Enhanced Same Day Minor Illness (ESDMI) Pilot. • Pre bookable Enhanced Same Day Minor Illness (ESDMI) clinic (nurse led) held at Cirencester Community Hospital Monday – Friday 9.00am – 6.00pm. • 1.2 WTE Urgent Care Practitioner. • September – November 2018. • 1,848 appointments offered. • 1,303 appointments booked (71% of total). • 1,272 appointments attended (69% of total). • Only 2% of booked appointments DNA. • Estimated time released back to the Network – 40 hours a week.
6.7	**Gloucestershire IA in numbers** • 97% patient satisfaction, 82.5% utilisation • GP led Improved Access Clinics – during weekdays, weekday evenings, weekends and Bank Holidays. • 15 IA clinics each weekday evening. • 7 out of 14 networks using IA funding to support new ways of working.

	• 20 Saturday morning IA clinics. • 3 shared IA clinics Saturday pm, Sundays and Bank holidays. • Delivered across 50 rotational locations.
6.8	The committee noted that all clusters were working towards 100% access to patients and their records which was a key challenge throughout all areas. The new contract required an Access Review throughout 2019. Funds were being provided until 2021 in line with the original plan. The aim was to share information throughout all practices. A dashboard had been developed throughout the networks which would provide practices with useful data. JC commented it was good to see an improving picture with a skill mix showing cost effectiveness. MAE drew attention to the DNA rate. She asked how it compared with normal GP appointments, as other patients could have taken the DNA slot. JW commented that with the data extraction tool this was a learning curve. It appeared to be influenced by the innovative method being used to book patients appointments. It was noted that the weekend appointments were harder to fill. JD considered that the poor take up of IA appointments was problematic, and a culture change amongst the general public was required. MW advised that given the difficulties of planning and releasing appointments the DNA rate was similar to that experienced by the hospitals. JW stated there were still challenges in Gloucester City with the delivery model, as this was the area with the greatest need and demand. It was noted that work was underway to develop a more robust model for Gloucester City. AE asked to see a copy of the DNA Report. JW confirmed that this information would be made available to the committee. **ACTION: JW to provide the DNA report.** CG commented on the excellent progress being made with the IA scheme. He asked about the plan for future procurement. JW advised that further details would be provided at the next committee meeting.

	ACTION: JW to provide further information about the procurement of IA at the next meeting. The committee thanked JW for her excellent up to date presentation.
7.0	**<u>Workforce Update presentation</u>**
7.1	ZN gave her presentation on the Primary Care Workforce. The following figures were provided for GPs: • Sept 17 (baseline): 434 headcount; 339 WTE • Sept 18 (latest): 461 headcount; 351 WTE The following figures were provided for Practice Nurses • March 17 (baseline): 294 headcount; 190 WTE • Sept 18 (latest): 314 headcount; 208 WTE • The Health Inequalities Fellowship – started Jan 2019 – with 3 GPs on scheme, there was a proposal for Health Inequalities showcase for autumn 2019. • A GP Retention scheme had been set-up placing GPs on 5 year bridging scheme and Newly Qualified GP scheme – matching continued • International GP Recruitment - Glos. Brochure developed. • GP Support Pack – had been produced in collaboration with NHSE • GP Fellows – Health Education England (HEE) funding had been obtained to support leadership projects through CEPN – 3 x post of 2 sessions for a 12 month period and additional 4 x 2 session posts. •
7.2	**Allied Healthcare Professionals in Primary Care Updates** • Mental Health Advanced Practitioners – the evaluation was completed. There would be a continuation of the scheme in two existing practices. • Work was underway to explore the potential of expanding into other practices linked to Health Inequalities – workforce planning.

	Advanced Physiotherapist Practitioner – stakeholder workshop for pilot review – 31st Jan 2019. There were plans in place to develop a new workforce that would cover: Clinical Pharmacists; Specialist Paramedics; Mental Health workers; Dementia Nurses; Community Matrons; Advanced Physiotherapists and Physician Associates. This would be undertaken by Dr Rachael Bunnett – through CEPN.
7.3	ZN provided an overview of ICS connectivity. • There was engagement with the ICS workforce steering groups and sub-groups – Dr L Eley was a member of the Local Workforce Action Board (LWAB). • Proud to Care recruitment event would be taking place in Spring 2019. • Mental health training for Practice Nurses in county had been organised in partnership with 2g. • ICS training offers included the South West Leadership Academy – 5 days system leadership programme; Learning Disability nurse modules; and 'Digital'. Work was also underway to explore primary care based apprenticeships ensuring that the apprentice levy was effectively used across Gloucestershire health and care organisations.
7.4	ZN gave an overview of the Primary Care Network based training and development programmes that were linked to workforce transformation – CEPN. • South Cots – Sexual Health. • North Cots – Student and newly qualified Nursing. • Stroud and Berkeley Vale – Frailty. • Cheltenham – Cardiology. • Forest of Dean – Reduction in Opiate Prescribing, Anti-biotic prescribing and Frailty. • Glos – NEGG – QI, Ethics, receptionist training + other mix. • Glos – Inner City, Motivational Interviewing/ better conversations, non-clinical resilience training. • Glos RHQ – Sexual Health, Joint injections and Pharmacy training.

	• Bids under review for Tewksbury. N&S, Aspen and SEG networks. ZN informed the committee that there were a range of collaborative projects underway with CEPN including: falls training, immunisation and vaccination training, efficient multi-morbidity management workshops, clinical governance training and dermatology champions and digital transformation.
7.5	AE in thanking ZN for her presentation gave his view that this was a critical area of work and asked ZN to return to discuss the findings so that the committee could focus on the items in more detail. **ACTION: ZN** to attend a future committee with an update on workforce.
8.0	**Primary Care Quality Report**
8.1	MAE directed the committee to Appendix 1 of the report and discussed the shortages of supply of certain drugs which had made the national news.
8.2	MAE highlighted the work around Influenza which was very topical at the moment. Unlike last year, Influenza in the population was at a much lower level in common with other infectious diseases, but Influenza was still the main concern. An introduction to Point of Care testing in Care Homes was made. MAE explained that the Rapid Response Team would attend a Nursing Home at the first sign of influenza or similar illness. They test patients immediately and within 15 minutes are able to determine whether the individuals had influenza and if they have, take appropriate action by isolating patients and giving antibiotics. This approach was very successful with only two patients having contracted flu. Test results had been compared with the outcome of traditional testing procedures and had been shown to be valid.
8.3	MAE advised that once the Rapid Response team were at the Care Home they provided advice to patients and care home staff

	regarding isolation procedures. MAE advised she was holding weekly flu calls every Wednesday morning involving acute, community and mental health providers and Care Homes where issues were discussed and advice given. These were proving to be very effective. MAE also explained that the take up of vaccinations amongst Care Home staff had improved significantly. Two pilots had been organised with Public Health where they provided the vaccination service. This scheme would be rolled out further next year. There was still a problem with the working age population in the general population not being inoculated against Influenza. Although admissions to hospital had been relatively low. People had become critically ill were all in the younger age group with pre-existing conditions in particular respiratory problems and diabetes. JD mentioned publicising the uptake for Influenza vaccinations on social media and MAE confirmed that this was happening.
9.0 9.1	**Delegated Primary Care Financial Report** AB reported that the financial position at the end of December 2018 projected that the CCG would break even. The main issues with the budget had been presented in previous reports. The committee noted that maternity and sickness claims had increased in the month and were driving an area of over spend within the budget. AB provided an update with regard to the GP pay award, it was currently understood that NHS England would not be providing additional funding to cover this. Therefore funds from the CCGs core allocation had been ring fenced to offset the cost. At the next committee meeting the delegated primary care budget would show an overspend.
9.3	AE noted that the delegated budget was under some pressure due to the GP pay award and potential increased spend if the target for Learning Disability annual health checks was reached. AB advised that usually at this point in the year the finance team

	would present a draft budget report and budget plan. A decision was taken not to bring this to the January committee because further technical financial guidance way yet to be released. In the light of this a review would be undertaken before the draft budget was released.
10.	**<u>Any Other Business</u>** **There was no other business.**
10.1	**The meeting closed at 11.10 am**
	Date and time of next meeting: **The next meeting will be held at 9.45am on Thursday 28 March 2019, Boardroom, Sanger House.**

Primary Care Commissioning Committee (PCCC)
Matters Arising – March 2019

Item	Description	Response	Action with	Due Date	Status
29/11/18 Item 6.1	Inter-Practice Minor Surgery Enhanced Service	AE stated that it was the scale of the services provided that was of interest and the actual procedures covered. HE responded that a list of procedures could be provided as an appendix to show the scale of minor operations being undertaken in practice Update: circulate this with the minutes. ***31/1/2019 Update:*** HE mentioned the procedure list for this enhanced service was set out in the minor surgery enhanced service specification. Minor surgery service is being reviewed. AE was concerned about the volume of procedures.	HE	Jan 2019	Open
29/11/18 Item 7.6	Primary Care Quality Report - Safeguarding	***31/1/2019 Update:*** Concerning C.Diff. MAE has asked the Infection Control Nurse to prepare a report to circulate because numbers were higher in primary care. Root cause analysis findings revealed patients were susceptible if on the same antibiotics. Most acquire C.Diff as hospital patients. MAE updated that an alternative antibiotic was being used. **ACTION: MAE** to circulate report after the meeting.	MAE		Open
28/06/18 Item 4.11	West Cheltenham Surgery	MH requested an update in 6 months, after the transition plans were complete.	HG	Jan 2019	For January agenda

	(previously Springbank Surgery) – provision of general medical services from Hesters Way Living Centre	***31/1/2019 Update:*** HE gave a verbal update. Now named West Cheltenham Surgery. The primary care team meets regularly on a daily basis after moving to a bigger practice. The wait for GP routine appointments was 2 weeks max. 8:00 – 1830 Monday to Friday as well as weekend appointments. The practice aspires to become a training practice. Overall feedback from the practice manager has been positive. AE commented main issue of concern was the continuity of care as difficulty with appointing new GPs. HE advised the practice is committed to appointing regular GPs. HG/HE are in regular contact and this practice and Crescent Bakery have fully recruited. Registration numbers had increased by 300. MAE stated there are plans in place for the practice to become a GP training practice. Item to remain open for an update involving future planning to encourage further training and funding. **ACTION: MAE to report back to the committee**	MAE		Open
26/7/18 Item 8.9	Prescribing	MAE explained that there was no prescribing data available so this would be brought to a future meeting. ***31/1/2019 Update:*** AE confirmed this item is scheduled for March 2019.	MAE	Mar 2019	Open
04/10/18 Item 5.18	Gloucester City Hub Development	The committee requested that an update on progress with developing the plans should be made to the Committee in six months' time. This will be on the April/June Agenda.	AH	April/ June 2019	Open
04/10/18 Item 7.13	Enhanced Service Learning Disabilities health checks	The committee requested that a strategic review was undertaken and an update brought to the committee in June 2019.	JG	June 2019	Open

29/11/2018 Item 6.4	Primary Care Workforce Health Inequalities Fellowship	***31/1/2019 Update:*** ZN provided an overview of the Primary Care Workforce Health Inequalities Fellowship. MAE informed the committee that there was an issue with releasing nurses for access to training. Also noted that the CCG had a CPD contract with UWE. HG/MAE and JC commented that this was around the parachuting nurse's service. Priority had to be given to release nurses for training. AE suggested that an update was brought back to the committee in 3-4 months' time. **ACTION: JC, HG and MAE to update the committee in 4 months at the August committee 2019 meeting.**	ZN JC/HG/ MAE	Jan 2019 Aug 2019	Open

One Gloucestershire
Transforming Care, Transforming Communities

Primary Care Networks

Primary Care Commissioning Committee

March 2019

General Practice and the Long Term Plan

"The biggest reform to GP services in 15 years" **HSJ**

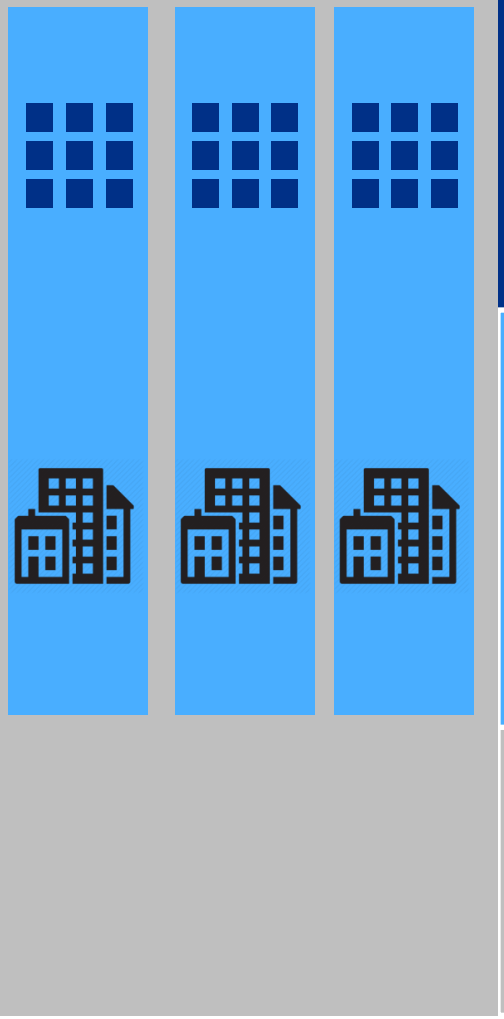
"The most important change to the GP contract since 2004 and a potential game changer" **BMJ**

"These are the most significant changes in 15 years" **BMA**

"The start of a new era for general practice" **NHSE**

Primary Care in an ICS

NHS England



Individual	Supporting individuals to manage their own care through self-care, care navigation and improving patient activation.
Neighbourhood 30~50k	Primary Care Networks that bring together local health and care professionals around natural local neighbourhoods of care – improving integrated ways of working and more joined-up pathways; and embedding population health approaches.
Place ~250-500k	Groups of local primary care networks that work alongside partners in secondary care, mental health and with CCGs and local authorities, to: • Integrate health and care services • Work preventatively to stop people becoming acutely unwell • Care models to redesign care
System 1+m	Providers and commissioners collaborating to: • Hold a system control total • Implement strategic change • Take on responsibility for operational and financial performance • Population health management

Introducing the Network Contract

- The **Network Contract will be a large Directed Enhanced Service (DES).** By 2023/24, it is expected to create national entitlements worth £1.799 billion (£1.2bn new funding), or £1.47m for a typical PCN covering 50,000 people, in return for phased and full implementation of all relevant NHS Long Term Plan commitments.

- The Network Contract has three main parts:
  - the national **Network Service Specifications** - these set out what all networks have to deliver (see next slide);
  - the national schedule of **Network Financial Entitlements**, akin to the existing Statement of Financial Entitlements for the practice contract; and
  - the **Supplementary Network Services.** CCGs and Primary Care Networks may develop local schemes, and add these as an agreed supplement to the Network Contract, supported by additional local resources.

- GPC England and NHS England are committed to 100% geographical coverage of the Network Contract by the Monday 1 July 2019 'go live' date.

- PCNs must be no smaller than 30,000 (unless by exception, such as very close to threshold with significant rurality); but can be larger than 50,000

New Network Services

Seven new service specifications will be introduced to deliver *NHS Long Term Plan* primary care goals in a phased way.

The following services will start by **April 2020:**

- **Structured Medications Review and Optimisation** (increasing in scope and scale each year)
- **Enhanced Health in Care Homes**
- **Anticipatory Care** requirements for high need patients typically experiencing several long-term conditions
- **Personalised Care**
- **Supporting Early Cancer Diagnosis**

The following services will start by **2021:**

- **CVD Prevention and Diagnosis**
- **Tackling Neighbourhood Inequalities**

Introducing the Network Contract

- To be eligible for the Network Contract DES, a **PCN needs to submit a completed registration form to CCG no later than 15 May 2019**, and have all member practices signed-up to the DES.

- **CCGs are responsible** for confirming that the registration requirements have been met to NHSE by **no later than Friday 31 May 2019**.

- Once the registration requirements are met and GMS/PMS/APMS contracts have been varied to include the DES, the **PCN can start receiving national investment from 1 July 2019**.

- **A 'typical' practice can also receive over £14,000 each year** from April 2019 as a new SFE payment, in return for their active participation in a PCN.

- In the highly unlikely event that a practice doesn't want to sign-up to the Network Contract, **its patient list will need to be added to another local PCN.**

Introducing the Network Contract

- All PCNs will have a **Network Agreement**, even those with one large practice. The Network Agreement is also the formal basis for working with other community-based organisations and must be signed by all constituent GP practices include patient data sharing requirement.

- A PCN must appoint a **Clinical Director** as its named, accountable leader, responsible for delivery (see next slide).

- PCNs must **define their business model** – funding will flow to one account and need to determine who will employ new workforce roles.

- **PCNs will also benefit from:**

  - **0.25 WTE Clinical Director** support funding (per 50,000 population);
  - **a recurrent £1.50 per registered** patient from CCG allocations;
  - many CCGs also **provide support in kind for their PCNs** e.g. through seconding and paying for staff to help with particular functions;
  - during 2019, **NHS England will establish a significant new national development programme** for PCNs.

Named Accountable Clinical Directors

- **0.25 WTE/50,000 funding considered a 'contribution'** towards costs
- Not solely responsible for operational. delivery of services – this a **collective responsibility**
- **Clinical Directors must play critical role in ICS**
- National leadership development programme being established
- Role **specification, appointment rules and term of office:** guidance being developed by NHSE but very likely to be local determination.

Delivery of Network Contract

- **“Network Dashboard”**
  - Available by April 2020
  - Will set out for each PCN progress against following metrics:
    - Population health and prevention
    - Urgent and planned care
    - Prescribing
    - Hospital discharge
    - Seven new specifications (from previous slide)
  - Additional Roles Reimbursement Fund subject to delivery against the seven specifications and additional funding available through Network Investment and Impact Fund…

- **“Network Investment and Impact Fund”**
  - Starts 2020; fund of £75m rising to £300m by 2023/24
  - Fund linked to performance against metrics in “Network Dashboard”
  - Networks to agree with ICS how funding is reinvested – intended for additional workforce and service expansion
  - NOTE: Savings against prescribing budget (post-savings plan) funded locally by CCG and uncapped

Workforce

- NHS England making recurrent funding available (through "Additional Roles Reimbursement" scheme) for up to estimated 20,000+ additional staff in five groups by 2024 (linked to training numbers qualifying each year):
  - **Social prescribing link workers** (up to B5) (reimbursement from 2019/20)
  - **Clinical pharmacists** (B7/8a) (reimbursement from 2019/20)
  - **First contact physiotherapist** (B7-8a) (reimbursement from 2020/21)
  - **Physician associates** (B7) (reimbursement from 2020/21)
  - **First contact community paramedics** (B6) (reimbursement from 2021/22).

- Scheme **covers 70% of actual ongoing salary costs of additional clinical pharmacists**, physician associates, first contact physiotherapist and first contact community paramedics. **100% reimbursement of the cost for social prescribing link workers**.

- **For 19/20, PCNs of at least 30,000 population able to claim for one WTE clinical pharmacist and one WTE social prescribing link worker** (CCG discretion allows two CPs and no link worker and vice versa). Above 100,000 PCN size, this allowance doubles.

- **Future years reimbursement for roles will be dependent on delivery of the seven new service specifications** (see earlier slide).

- **NHSE Clinical Pharmacist scheme to be subsumed** into this scheme (details awaited).

- **PCNs to determine employment and delivery model**.

Workforce

- **GPFV schemes extended until 2023/24:**
  - International Recruitment
  - Retention and retainer schemes
  - Practice resilience (now “often as part of a network”)
  - Specialist MH support for GPs
  - Time for Care programme (now “often in networks”)
  - Nursing initiatives extended (e.g. placements, apprenticeships etc)

- **New fellowship scheme** for newly qualified nurses and GPs

- **Significant proportion of community mental health staff** to be aligned with PCNs

- **Pension:** Annual allowance cap restriction could be solved by a new “partial pension”; Gov’t investigating. Plus no additional cost for general practice to bear as a result of employer contribution rate increase consultation.

PCNs: Digital

- A digital NHS ‘front door’ through the **NHS App to all practices in 2019**
- **All patients will have right to online and video consultation by April 2021**; all practices to have access to national funding; select supplier from national framework
- **All patients will have online access to their full record,** including the **ability to add their own information, by April 2020; new registrants by April 2019**
- All practices to have **at least 25% of appts available for online booking by July 19**
- **All practices to have up-to-date online presence with key information standardised as metadata for other platforms by April 2020**
- **All patients have access to online correspondence by April 2020**
- New ‘**digital first’ practices will be reviewed for safety and benefit** to whole NHS. This means reviewing current arrangements including out-of-area arrangements.
- **ICSs to make predictive analytical tools available to PCNs**
- All patients able to **order repeat prescriptions online by April 2019**

Further Changes

- **Direct booking from 111** – one appointment per whole 3,000 registered patients
- **Contraception** now an essential service
- **Duty of Co-operation** – to share data between providers to support care provision
- **Marketing campaigns** – GP practices to support 6 NHSE annual campaign
- **All practices to register an email address and mobile phone** (at least one if not several phones) for MHRA CAS alerts by October 2019
- **QOF changes:** 175 points retired, new 175 points relating to:
  - **74 for two QI modules** (CCGs expected to not duplicate payment, so must work with LMC to reinvest in other areas if so):
    - prescribing safety
    - EOL
  - **101 for 15 more clinically appropriate indicators covering 5 areas**:
    - Diabetes (43 points)
    - BP control (41 points)
    - Cervical screening (11 points)
    - Pulmonary rehab (2 points)
    - Weight management for MH patients (4 points)
  - **QOF Exception reporting replaced** by “personalised care adjustment” system

Further Changes

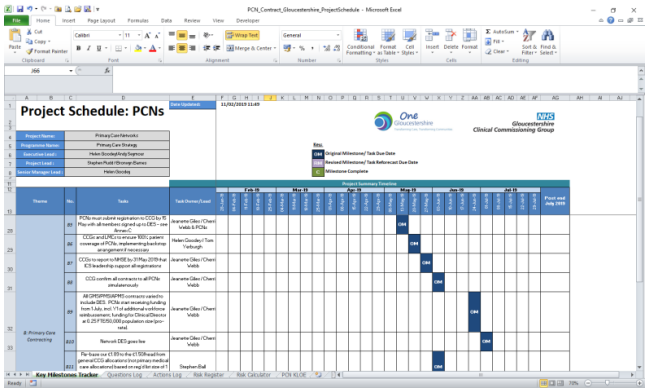
- **Extended Hours** must be commissioned for 100% of patients (in addition to IA) and moved to Network DES from July 2019. To be merged with IA through 2020.
- **Subject access requests costs** - £20m additional funding added to global sum for next three years to cover these costs. By which time, Lloyd-George records fully digitised and patients have full access to digital records.
- **GDPR**: CCGs to offer DPO function to practices, either directly or via CSU.
- **GP activity and waiting times data published monthly from 2021**; to expose variation between practices and networks
- **New measure of patient-reported experience of access**
- **National test-bed established** for PCNs to test new QOF indicators, QI modules etc.
- **Vacs and Imms** – IoS fees uplifted to £10.06 for: childhood seasonal influenza; pertussis; seasonal influenza and pneumococcal polysaccharid
- Further changes relate **to MMR catch-up, HPV, last year of medical records movement payment, use of NHS logo, shared parental leave for GPs**.

Gloucestershire Primary Care Networks

Locality	Primary Care Networks
Cheltenham (c. 48,000 – 58,000 patients)	Three networks based on geography
Forest of Dean (c. 64,000 patients)	All eleven practices in one network
Gloucester City (c.26,000 – 48,000 each)	Five networks based predominantly on geography
North Cotswold (c. 30,000 patients)	All five practices in one network
South Cotswold (c. 60,000 patients)	All eight practices in one network
Stroud & Berkeley Vale (c. 18,000 – 40,000 patients)	Four networks based on geography
Tewkesbury, Newent and Staunton (c. 43,000)	All four practices within one network
Total	**16 Primary Care Networks**

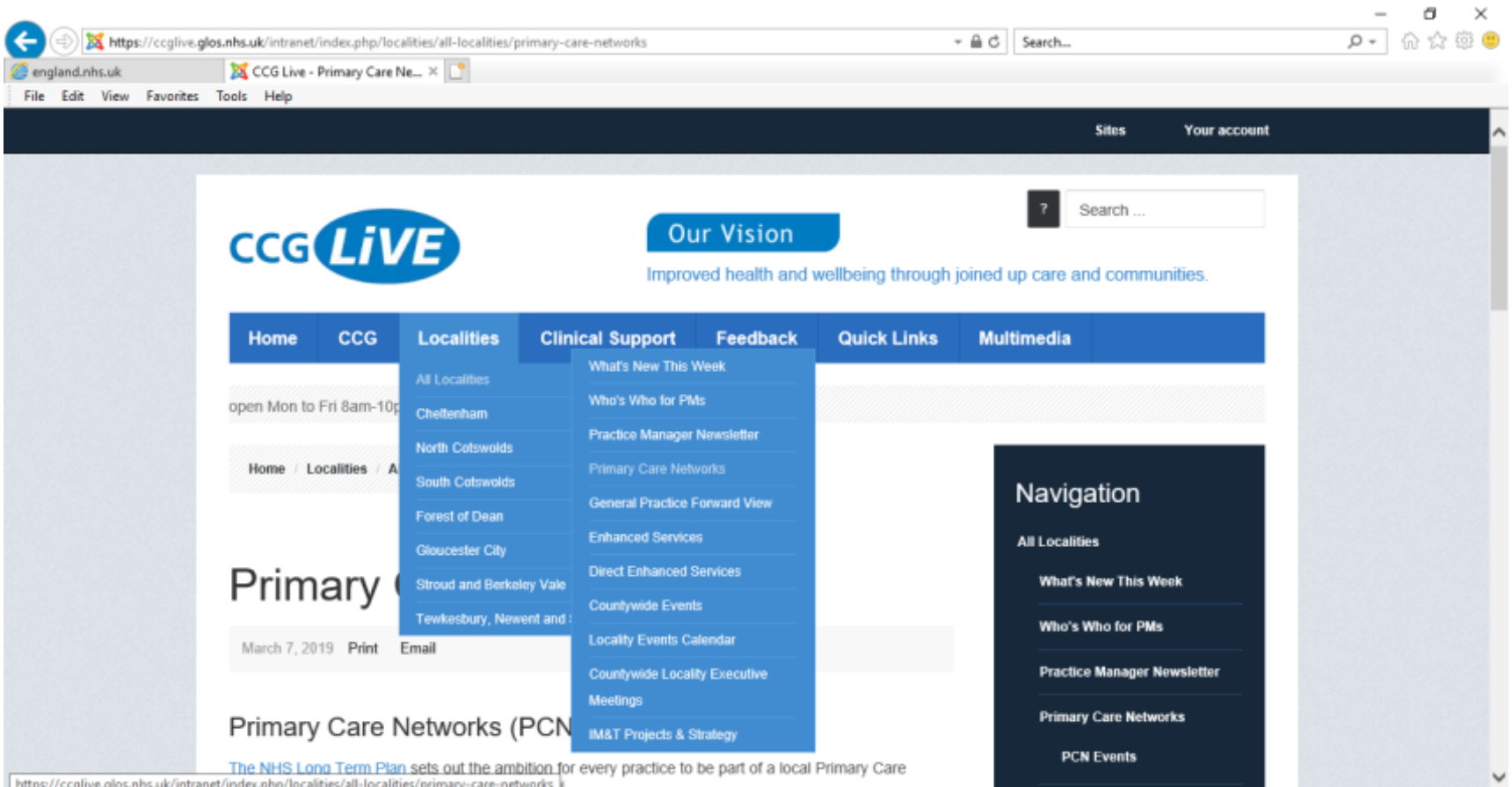
Impact for Gloucestershire

- Huge programme of work across CCG/ICS required for PCNs – plus Integrated Locality Partnerships
- **Project planning commenced**
- Actions from now through to 2021
- Significant impact on practices too
- Some quite short timescales for all involved
- PCN Working Group being established
- Will need to involve community and acute partners through maturity
- Funding – existing and new



Accessing CCG Live pages

- PCN Events: upcoming and previous NHSE event slides
- Contract Framework and other key documents and links
- Mailbox details, correspondence and FAQs



NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 6

Primary Care Commissioning Committee

Meeting Date	**Thursday 28th March 2019**
Title	**Cheltenham, Prestbury Road Premises Development confirmation of interim District Valuation Value for Money and BREEAM approach**
Summary	The CCG primary care strategy supports the vision for a safe, sustainable and high quality primary care service, provided in modern premises that are fit for purpose. The CCG has a clear five-year prioritised Primary Care Infrastructure Plan (PCIP), which was approved by the CCG Governing Body in March 2016 and looked forward to Gloucestershire 2031. The plan sets out 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 2021 to 2026. A strategic prioritisation was completed and the redevelopment/ replacement of Berkeley Place, Crescent Bakery and Royal Crescent surgeries were key priorities, taking into account the current condition of the buildings, planned housing developments and the current size of the existing buildings. The CCG indicated its preference in the plan for this to be taken forward as part of single development. The business case for the establishment of a new Primary Care Centre that will relocate the Berkeley Place, Crescent Bakery and Royal Crescent Practices to a purpose built centre on Prestbury Road in Cheltenham for around 25,000 patients by the New Year of 2021 was discussed in detail in the private session of the Primary Care Commissioning Committee in January 2019, due to commercially sensitive matters. Members of the committee were also asked to confirm formal CCG support for the onward submission of the Business Case to the Estates & Technology

	Transformation Fund (ETTF) for a £3.22m capital grant. The ETTF is managed by NHS England (NHSE). At the time of writing this paper, a NHSE panel were due to review the OBC on the 14th March 2019. Any grant awarded needs to be able to be paid by March 2020. As a consequence of any capital grant, there is also a negotiated reduction in increased revenue costs deemed to meet Value for Money. Whilst recognising the importance of an ETTF capital grant to help reduce increased revenue costs to the CCG, the PCCC approved the Practices Business Case with, or without, an ETTF award, recognising the strategic importance of delivering a long term solution. However, ratification could only take place when the DV issued an interim report and the practices submitted a BREEAM plan for excellent. These have now been received.
Risk Issues: **Original Risk** **Residual Risk**	The key risk regarding this proposal is that should the new development not proceed, the long term provision of suitable primary care premises for a growing population will be substantially affected.
Financial Impact	Total revenue implications (rent and rates) will be £563,202 per annum with a net additional recurrent investment of £391,280. However, on the basis that an ETTF capital grant is made, it is estimated that there will be a further reduction of £105,120 per annum for 19years 8 months. The revenue implications also include an interim top up payment (expected to be required on a sliding scale for 6 years). This is for abnormal costs, mostly relating to land purchase costs and able to be considered through Premises Directions 2013 (paragraph 33). If no ETTF capital grant is paid, the CCG will need to cover GPIT costs amounting to £163k and needed in the financial year 2020/ 2021. The DV interim report (available to PCCC members on request) has set out the level of current market rent in respect of Value for Money. In light of the CCG's decision to support an interim supplementary payment, enacted through section 5 of the Premises Directions 2013 and due to the unusual circumstances of this

	project, it is his opinion this is proportionate, fair and reasonable. In summary, the DV is of the opinion that subject to all of the terms and conditions recommended in their report being fully complied with, the proposed scheme satisfies NHS requirements and represents value for money to the NHS, and the DV confirms that they recommend the scheme for CCG approval.
Legal Issues (including NHS Constitution)	The CCG will need to apply NHS Premises Directions to rights and responsibilities of the practice and the CCG. In terms of the NHS Constitution the author considers 'You have the right to expect your NHS to assess the health requirements of your community and to commission and put in place the services to meet those needs as considered necessary' and 'You have the right to be cared for in a clean, safe, secure and suitable environment' as the most pertinent NHS Constitution rights applicable to this scheme.
Impact on Health Inequalities	No health inequalities assessment has been completed for this report.
Impact on equality and Diversity	No equality and diversity impact assessment has been completed for this report.
Impact on Sustainable Development	The Building Research Establishments Environmental Assessment Method (BREEAM) is the national standard for assessing the sustainability of new construction developments. It aims to differentiate between developments with higher environmental performance by providing a sustainability ratings across 9 indicators (management, health and wellbeing, energy, transport, water, materials, wastes, land use and technology and pollution)There are 6 performance levels (unclassified, pass, good, very good, excellent and outstanding) There is a national government requirement that generally for new public buildings, the rating should be excellent. The NHS oversees compliance with this, although the NHS stipulates this applies to schemes that cost over £2m to complete.

	It is recognised, there may be instances where exceptional circumstances that might limit the ability of the designers to fully achieve an excellent rating, or where, again for exceptional reasons, the costs of meeting requirements would clearly not represent value for money. Such instances need to be considered by specialist BREEAM assessors and any derogation from the appropriate requirement needs to adequately explained and robust. As this scheme is over £2m in value, the practice has commissioned a BREEAM Pre – assessment report for the new building. The development is seeking excellent rating. This has been reviewed by the CCG. The project will proceed with the objective of meeting the excellent rating. All reasonable endeavours will be made to achieve, or come close to achieving excellent by the opening date and there will be sufficient evidence to show this.
Patient and Public Involvement	The Practices have consulted with their Patient Participation Groups [PPG]. PPG members are fully involved in the development. The last patient engagement event was held on the 18th December 2018. Future engagement events are planned as the project develops. Patients and stakeholders will be kept up to date via the Practices' web pages and the wider support of the CCG.
Recommendation	Following receipt of the District Valuation interim report and submission of the Practices BREEAM pre assessment report with a plan for excellent, members are requested to ratify the **formal approval granted** at the private session of the PCCC meeting in January 2019 to develop a new Primary Care Centre at Prestbury Road, Cheltenham.
Author	Andrew Hughes
Designation	Associate Director, Commissioning
Sponsoring Director	Helen Goodey Director of Locality Development and Primary Care

Report written 11th March 2019

Agenda Item 7

Primary Care Commissioning Committee

Meeting Date	**Thursday 28 March 2019**
Title	**Application to contract the practice area from Leckhampton Surgery**
Executive Summary	An application to reduce their practice area has been received from Leckhampton Surgery. A map of the practice area is set out within each practice's contract. It has been established that Leckhampton Surgery had been working to a reduced practice boundary for a number of years (and pre-dating CCG delegation arrangements). The amended contractual boundary will enable the practice to continue to work within the practice boundary it has been working to for many years. It will also ensure Leckhampton's focus on meeting the needs of the new housing developments in their area over the coming years, while not removing any patients from their list who currently reside in the area affected.
Risk Issues: **Original Risk** **Residual Risk**	The inability to offer patients care with local practices is the principal risk with a boundary change. However we believe this is a low risk as patients will continue to have choice of primary care from other local practices and the practice had been working to a reduced boundary for many years.
Financial Impact	Not applicable
Legal Issues (including NHS	Gloucestershire CCG (GCCG) needs to act within the terms of the Delegation Agreement

Constitution)	with NHS England dated 26 March 2015 for undertaking the functions relating to Primary Care Medical Services. A change to the practice area must be considered a variation of the contract and the definition of these areas amended under a variation notice. It therefore requires agreement by GCCG under delegated commissioning arrangements. The PCCC approved a GCCG Standard Operating Procedure for an application to change practice area in November 2015, which also sets out the prevailing guidance, legislation and regulations to be considered. This protocol has been followed in handling this application. The NHS Constitution provides patients with the right to choose their GP practice and to be accepted by practices unless there are reasonable grounds to refuse. This boundary change would not impinge on this constitutional right.
Impact on Health Inequalities	Assessed as low impact. The area affected by the boundary change is in an area of low deprivation. It is also served by other practices.
Impact on Equality and Diversity	Assessed as low as the application applies to new registrations only. Existing patients will continue to have access to services at Leckhampton surgery. New patients to the area will have a choice of alternative practices.
Impact on Quality and Sustainability	Assessed as positive impact through the Quality and Sustainability Impact Assessment.
Patient and Public Involvement	The practice has engaged with their Patient Group in relation to maintaining their practice

	area to the same footprint they had been working to. Feedback indicated their approval of this.
Recommendation	The PCCC is asked to: • Consider the recommendation from the Primary Care Operational Group meeting on 19th March 2019 which was to recommend for approval the application from Leckhampton surgery to amend its boundary; • Make a decision regarding Leckhampton Surgery's application to amend its practice boundary.
Author	Jeanette Giles
Designation	Head of Primary Care Contracting
Sponsoring Director (if not author)	Helen Goodey, Director Locality Development and Primary Care

Agenda Item

Primary Care Commissioning Committee

Thursday 28th March 2019

Application to contract the practice area from Leckhampton Surgery

1 Introduction and background

1.1 At a practice visit in March it was evident that Leckhampton Surgery had been working to a reduced practice boundary for a number of years (pre-dating CCG delegation).

Whilst there is no record of receipt of an application to reduce practice area either by NHS England prior to 1.4.15 or subsequently by Gloucestershire CCG, it is clear, the practice had thought they were working to an approved boundary.

1.2 An application has been received from Leckhampton Surgery to reduce their contracted practice area (see map 1). The rationale behind Leckhampton's application is to amend the boundary to that which they have been working to for many years. If Leckhampton had to revert back to their contractual boundary it would be perceived by them as an increase in boundary area which would put significant pressure on their existing service and building (which is currently running at full capacity).

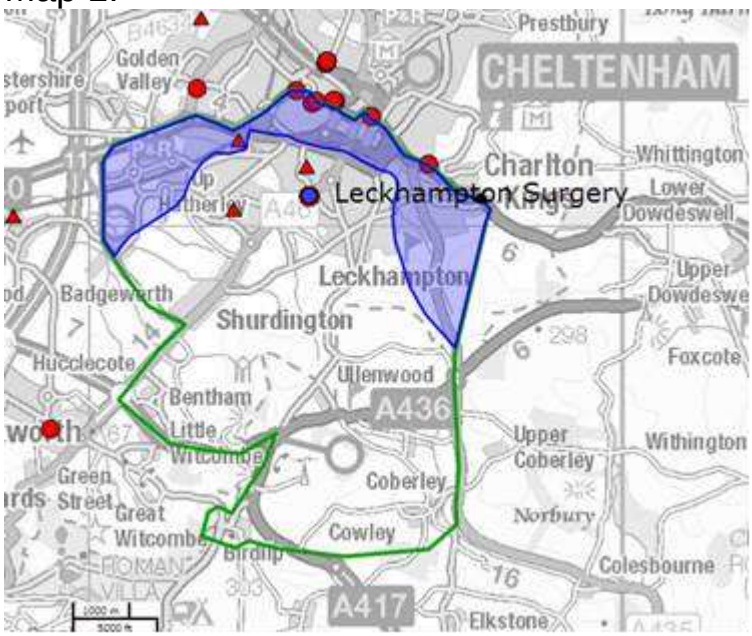
1.3 There has been no other boundary change or any list closure requests in this area.

2. Proposal to reduce Practice boundary

2.1 Leckhampton surgery is shown as a blue dot on the map below and its contracted boundary is outlined in green. Neighbouring GP Practices are shown as red dots and the red triangles on the map are branch surgeries. The area which the practice has applied to remove from their contracted practice area is shaded in purple. The map scale

is shown on the bottom of the map.

Map 1.



Leckhampton will not remove any patients from their list in the area affected and at the practice visit on 5.3.19 the CCG confirmed it would not support the removal of any patients.

The practice will also accept patients who move into a registered household e.g. new baby, older child moving back in with parents, relative moving in.

3. Practice profile

3.1 Leckhampton has a GMS contract. It currently has a list size of 13,284 patients (as at 1.1.19) and its list size has grown by 4.23% since 1.4.15.

List size actual 1.4.15	List size actual 1.4.16	List size actual 1.4.17	List size actual 1.4.18	List size actual 1.1.19
12,745	12,823	12,899	13,010	13,284

3.2 A copy of current practice patient spread is shown in Map 2 in Appendix 1.

The majority of the area the practice wishes to withdraw from is not a deprived area (see Map 3 in Appendix 1). The

practice area as a whole also scores well for health (see Map 4 in Appendix 1).

3.3 Information with regard to patients currently registered with Leckhampton in the area affected:

- Consultation rates for the patients living in the proposed boundary change area are in line with consultation rates for patients living in other areas of the practice boundary and there is no apparent variation in demand.

- Leckhampton has confirmed there are no nursing homes, care homes or other residential care establishments in the areas that will be potentially removed from the boundary.

3.4 The practice was built to accommodate 10,000 patients and Leckhampton believe it is currently operating at full capacity.

Some new housing developments are currently being built and a further 491 dwellings (approx. 1,080 patients) are planned by 2024. In light of current building and future housing developments, the primary care premises team anticipate the practice population could grow to 14,200 by 2031.

4. Alternative GP coverage for the area affected

4.1 The location of alternative neighbouring practices is shown on Map 1.

4.2 Patients who move into the area affected by the boundary change would continue to have choice of GP practice.

4.3 Furthermore an analysis of alternative practices' performance in comparison to Leckhampton, relating specifically to the national patient survey, QOF and availability of male and female GPs, has been undertaken (see Appendix 2), demonstrating overall there is no significant difference and therefore no anticipated impact on patients.

The majority of patients in the area affected currently register with Overton Park, Portland and Sixways.

5. Practice consultation

5.1 Leckhampton has consulted with its Patient Participation Group, on the basis of an increase in practice area compared to what the practice had been working to over recent years. The PPG members who responded did not support an increase in area, and many comments suggested that the practice was working at capacity in relation to access to appointments, building and car parking capacity.

5.2 The surgery also contacted:

Painswick Surgery
Brockworth Surgery
Churchdown Surgery
Rendcomb Surgery
Underwood Surgery
Corinthian Surgery
Berkeley Place Surgery
Portland Practice
Royal Crescent
St Catherine's Surgery
St George's Surgery
West Cheltenham Surgery

5.3 Two written comments were received.

- Rendcomb Surgery had no objection to Leckhampton serving a reduced area.

- Portland Practice noted they were struggling with increasing list size and maintaining a sustainable practice especially at their Hatherley branch surgery. If there was an increase of patients at Hatherley they would need to reconsider their decision regarding patients living outside of their boundary in the Leckhampton and Charlton Kings area.

6 CCG engagement for the application to reduce Leckhampton's Practice area

6.1 As per the Standard Operating Procedure (SOP) for the application to change practice area Gloucestershire CCG have engaged with:

- Neighbouring practices (14 practices)
    - Berkeley Place Surgery
    - Corinthian Surgery
    - Crescent Bakery Surgery
    - Overton Park Surgery
    - Portland Surgery
    - Royal Crescent Surgery
    - Royal Well Surgery
    - Sixways Clinic
    - St Catherine's Surgery
    - St George's Surgery
    - Underwood Surgery
    - Yorkleigh Surgery
    - Churchdown Surgery
    - Rendcomb Surgery

- Healthwatch Gloucestershire
- NHS England
- The Local Medical Committee.

6.2 **The responses:**

Portland Practice commented as follows:

'The proposed boundary change presents a problem for us specifically in the NW (Benhall/Hatherley) as these patients will register at our Hatherley Branch surgery. Two essential points that need to be registered are:

1. Hatherley is already too small to cope with the current patient numbers and workload and it cannot physically accommodate more (it is only a branch surgery).
2. It will put further strain on our new PCN as all of these patients live outside the St Paul's locality and will lead to destabilisation of the St Pauls network.'

Yorkleigh practice commented as follows:

'We do not have any objections, concerns regarding the

application request from Leckhampton Surgery to amend their practice boundary.'

Any additional responses received before the meeting will be presented verbally at the meeting.

7. Quality and Sustainability Impact Assessment (QSIA)

7.1 A QSIA was completed by the Deputy Director of Quality (see Appendix 3).

All quality areas were scored as positive.

8. Summary

8.1 Leckhampton partners have been working to the 'amended' boundary map outlined in their application for a number of years. The application recognises the need to formally approve this boundary so the correct practice area is embedded in their GMS contract.

8.2 When the CCG met the practice to discuss their request to amend their boundary, the practice had originally been planning to apply for a reduction in the south of the area but have agreed not to apply to include this as it could be an area of development.

8.3 Leckhampton do not intend to remove any patients from their list in the area affected.

8.4 As Leckhampton Surgery have been working to the amended boundary for many years, it would suggest that patients moving into the area register with alternative practices and therefore any boundary change should not have a significant detrimental impact on neighbouring practices.

8.5 The reduction in boundary will enable the practice to be more appropriately positioned to meet the needs of the current and planned housing developments in its area over the coming years, while not removing any patients from their list who currently reside in the area affected.

8.6 Leckhampton Surgery could remove patients who historically fall outside of their contractual boundary, but as a patient centred practice they would prefer not to take this step which would add to the workload of their neighbouring practices. Their preference is to seek CCG approval for a change in boundary albeit a boundary they had been working to for many years.

9. Recommendation

9.1 The PCCC is asked to:

- Consider the recommendation from the Primary Care Operational Group meeting on 19th March 2019 which was to recommend for approval the application from Leckhampton surgery to amend its boundary;
- Make a decision regarding Leckhampton Surgery's application to amend its practice boundary.

10. Appendices

Appendix 1 – Maps.

Maps for PCCC paper.docx

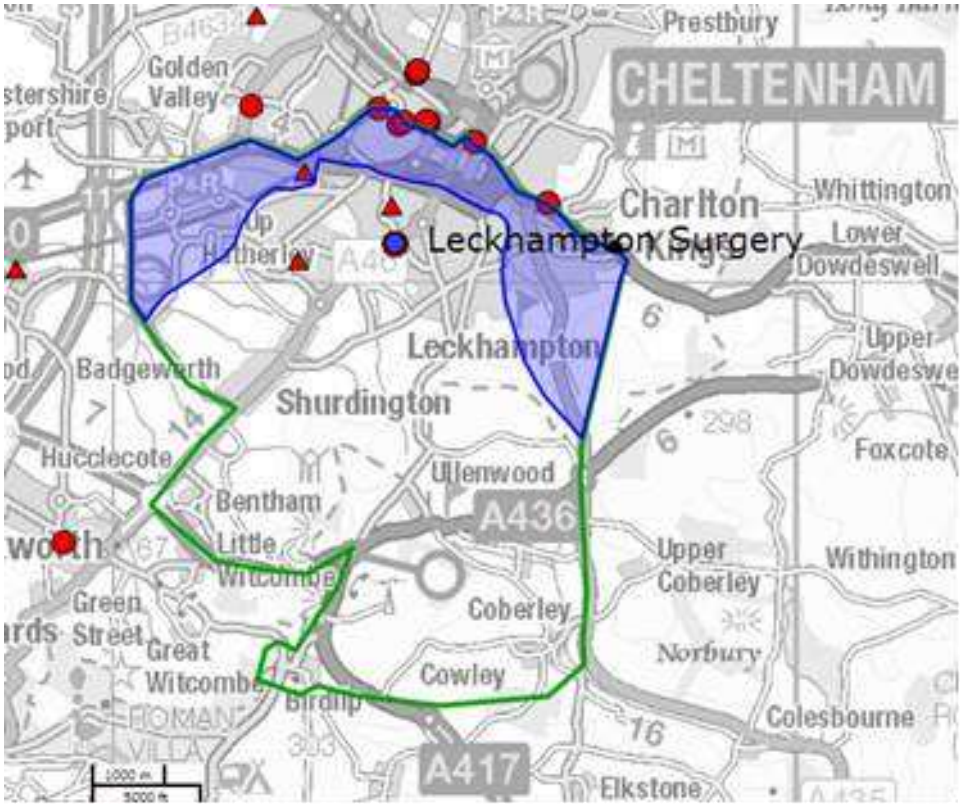
Appendix 2 – Analysis of alternative practices' performance in relation to national patient survey and QOF and availability of male and female GPs.

Appendix 2 - GP Patient Survey, GPs &

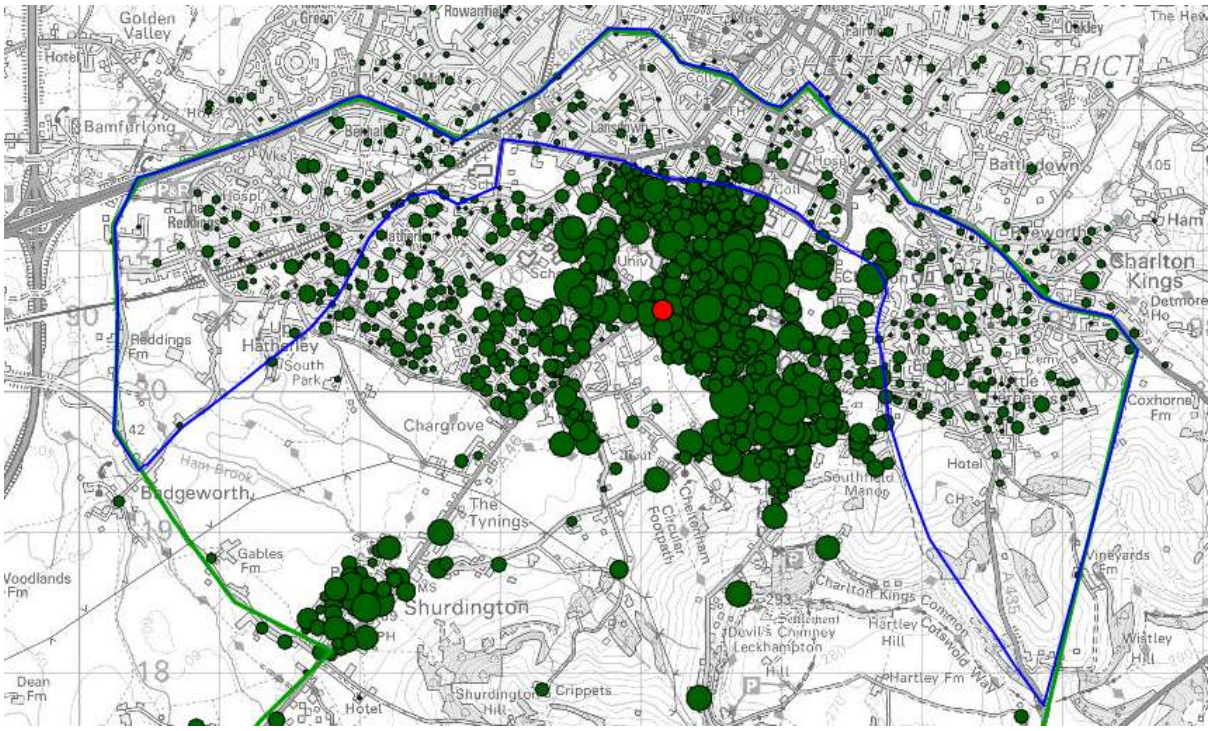
Appendix 3 - Quality and Sustainability Impact Assessment.

QSIA for amended boundary application.

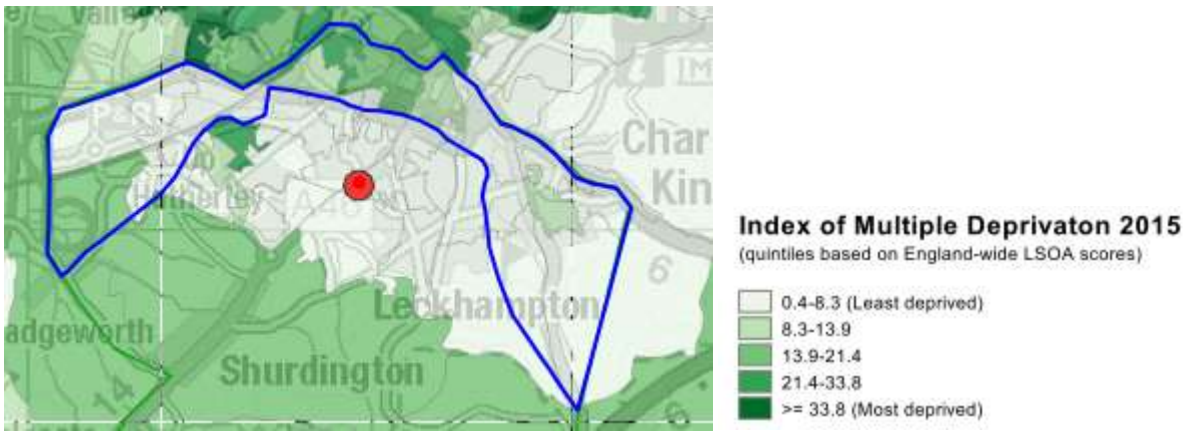
Map 1



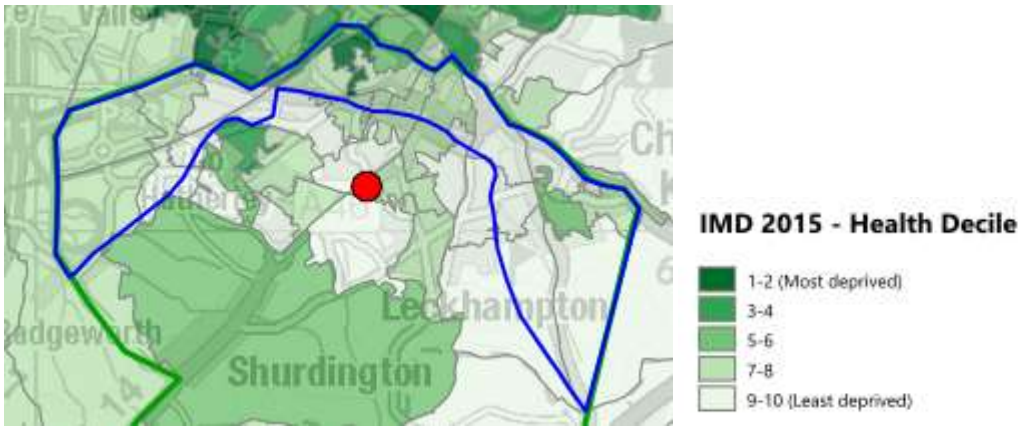
Map 2 - current practice patient spread



Map 3. Index of Multiple Deprivation



Map 4. Index of Health Deprivation



	Local (CCG) Average	National Average	The Leckhampton Surgery (L84040)	Sixways Clinic (L84015)	Berkeley Place Surgery (L84030)	Corinthian Surgery (L84056)	Crescent Bakery Surgery (L84616)	Overton Park Surgery (L84041)	The Portland Practice (L84033)	Royal Crescent Surgery (L84059)	Royal Well's Surgery (L84049)	St Catherine's Surgery (L84058)	St George's Surgery (L84008)	Stoke Road Surgery (L84048)	Yorkleigh Surgery (L84022)	Underwood Surgery (L84003)	Churchdown Surgery (L84047)	Rendcomb Surgery (L84063)
Data from GP Patient Survey - published in July 2018. Questions used on NHS Choices																		
The proportion of respondents to the GP patient survey who gave a positive answer to 'Generally, how easy is it to get through to someone at your GP surgery on the phone.	**83%**	**70%**	**87%**	72%	88%	86%	74%	86%	44%	93%	84%	84%	85%	80%	91%	84%	78%	100%
The proportion of respondents who are satisfied with the general practice appointment times available	**70%**	**66%**	**85%**	51%	62%	78%	63%	67%	57%	63%	67%	63%	70%	62%	89%	77%	74%	95%
The proportion of respondents rating their experience of making an appointment as good or very good	**76%**	**69%**	**87%**	66%	74%	86%	65%	72%	56%	76%	80%	71%	67%	71%	91%	81%	79%	97%
The proportion of respondents who felt they had confidence and trust in the healthcare professional they saw/spoke to during their last general practice appointment	**97%**	**96%**	**98%**	100%	97%	97%	98%	99%	98%	100%	99%	89%	94%	98%	96%	100%	99%	99%
The proportion of respondents to the GP patient survey who described the overall experience of their GP surgery as good or very good.	**89%**	**84%**	**96%**	83%	88%	84%	88%	89%	85%	96%	91%	73%	85%	83%	96%	95%	92%	99%
Data from NHS National Performer List - Jan 2019																		
Male & Female GPs available			**YES**	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Data from 2017-18 CQRS yearend report																		
2018-19 QOF Overall Achievement	97.41%		**Higher than GCCG average score achieved**	Higher than GCCG average score achieved	Lower than GCCG average score achieved	Higher than GCCG average score achieved	Lower than GCCG average score achieved	Higher than GCCG average score achieved	Higher than GCCG average score achieved	Lower than GCCG average score achieved	Higher than GCCG average score achieved	Higher than GCCG average score achieved	Lower than GCCG average score achieved	Lower than GCCG average score achieved	Lower than GCCG average score achieved	Higher than GCCG average score achieved	Higher than GCCG average score achieved	Higher than GCCG average score achieved

NHS Gloucestershire Clinical Commissioning Group

Quality and Sustainability Impact Assessment Tool

This tool involves an initial assessment (stage 1) to quantify potential impacts (positive or negative) on quality from any proposal to change the way services are commissioned and/or delivered. Where potential negative impacts are identified they should be risk assessed using the risk scoring matrix to reach a total risk score.

Quality is described in 6 areas, each of which must be assessed at stage 1. Where a potentially negative risk score is identified and is greater than (>) 8 this indicates that a more detailed assessment is required in this area. All areas of quality risk scoring greater than 8 must go on to a detailed assessment at stage 2.

Scoring

A total score is achieved by assessing the level of impact and the likelihood of this occurring and assigning a score to each. These scores are multiplied to reach a total score.

The following tables define the impact and likelihood scoring options and the resulting score: -

LIKELIHOOD		IMPACT	
1	RARE	1	MINOR
2	UNLIKELY	2	MODERATE / LOW
3	MODERATE / POSSIBLE	3	SERIOUS
4	LIKELY	4	MAJOR
5	ALMOST CERTAIN	5	FATAL / CATASTROPHIC

Risk score	Category
1 - 3	Low risk (green)
4 - 6	Moderate risk (yellow)
8 - 12	High risk (orange)
15 - 25	Extreme risk (red)

A fuller description of impact scores can be found at appendix 1.

		IMPACT				
		1	2	3	4	5
LIKELIHOOD	1	1	2	3	4	5
	2	2	4	6	8	10
	3	3	6	9	12	15
	4	4	8	12	16	20
	5	5	10	15	20	25

Please take care with this assessment. A carefully completed assessment should safeguard against challenge at a later date.

Stage 1

The following assessment screening tool will require judgement against the 6 areas of risk in relation to Quality. Each proposal will need to be assessed whether it will impact adversely on patients / staff / organisations. Where an adverse impact score greater than (>) 8 is identified in any area this will result in the need to then undertake a more detailed Quality Impact Assessment. This will be supported by the Clinical Quality & Nursing team.

Title and lead for scheme: Application to amend practice boundary for Leckhampton Surgery, Cheltenham

Brief description of scheme:
For at least the last three years (prior to CCG delegated commissioning authorisation), the Leckhampton surgery has been working to a boundary that was found to be different to their contracted boundary. This was identified on submission to the CCG of their most recent electronic declaration. The building that accommodates the Leckhampton surgery was planned and built to the specification for maximum capacity that is currently exceeded. The intention of the surgery is not to remove any of the affected patients from their current list. The surgery does not have any care home residents that live outside the proposed new boundary.

Answer positive/negative (P/N) in each area. If N score the impact, likelihood and total in the appropriate box. If score > 8 insert Y for full assessment

Area of Quality	Impact question	P/N	Impact	Likeli-hood	Score	Full Assessment required
Duty of Quality	Could the proposal impact positively or negatively on any of the following - compliance with the NHS Constitution, partnerships, safeguarding children or adults and the duty to promote equality?	P	2	3	6	N
Patient Experience	Could the proposal impact positively or negatively on any of the following - positive survey results from patients, patient choice, accessibility, personalised & compassionate care?	P	2	3	6	N
Patient Safety	Could the proposal impact positively or negatively on any of the following – safety, systems in place to safeguard patients to prevent harm, including infections?	P	2	3	6	N
Clinical Effectiveness	Could the proposal impact positively or negatively on evidence based practice, clinical leadership, clinical engagement and/or high quality standards?	P	2	2	4	N
Prevention	Could the proposal impact positively or negatively on promotion of self-care and health inequality?	Y	2	2	4	N
Productivity and Innovation	Could the proposal impact positively or negatively on - the best setting to deliver best clinical and cost effective care; eliminating any resource inefficiencies; low carbon pathway; improved care pathway?	Y	3	1	3	N

Please describe your rationale for any positive impacts here:

Duty Of Quality – **Positive.** Practice resources, including workforce, will be stretched to provide services and resources to increased numbers of patients if the practice continued to adhere with its contractual boundary (which the practice has not recognised for a number of years). The additional pressure on services and resources has the potential to adversely affect the quality of service delivered.

Patient Experience – **Positive.** If Leckhampton Surgery reduced its contractual boundary they should have more time to devote to the treatment of patients, which would have a beneficial effect on its patients care. Comments from the Patient Participation Group, were consistently supportive of a formal agreement to amend the boundary area to what had been in use for a considerable period of time.

Patient Safety. **Positive** as a reduced boundary would reduce pressure on the practice.

Clinical Effectiveness –**Positive.** Clinical effectiveness is reliant on the clinical staff maintaining current best practice and the use of evidence based medicine. This requires the surgery staff to spend time updating their personal clinical and practical knowledge, and adopting current clinical knowledge within the surgery policies and procedures.

Prevention – **Positive.** – There is potentially a positive impact as the practice will have time to encourage increased promotion of self-care. An example of this could be the increased use of minor ailments services provided at Community Pharmacies or access to NHS Choices website.

Productivity and Innovation – **Positive**. Whilst the boundary area will decrease there will still be an increase in registered patient numbers as a result of housing developments within the revised boundary. This may lead to an increased use of time saving and innovative electronically delivered methodology and services.

Signature:	Designation:	Date:
Teresa Middleton	Deputy Director of Quality	11th March 2019

Agenda Item 8

Primary Care Commissioning Committee

Meeting Date	**28th March 2019**
Title	**Primary Care Premises Report**
Summary	The primary care premises development workstream is made of a number of key components: - • Ensuring the delivery of committed premises developments to practical completion; • Progressing the priorities identified in the Primary Care Infrastructure Plan (PCIP), including proactively working to kick start development opportunities and supporting business case development; • Ensuring local practices take full advantage of national funding initiatives such as the Estates and Technology Transformation Fund (ETTF); • Working with other key delivery partners particularly NHS Propco where joint responsibility for business case development exists; • Managing local improvement grant processes; and • Ensuring the CCG operates within Premises Directions and uses these regulations appropriately. Whilst individual proposals are presented to the PCCC for decision, members of the meeting have requested a workstream report three times per year. This report sets out key progress for all areas of work up to the end of February 2019. This summary section sets out key objectives of the 2018/ 2019 and the rest of the report provides specific detail. **2018/ 2019 plan** By the end of the financial year, 4 schemes expected to be fully completed and open (Cleevelands, Glevum, Kingsway and Stow) and one (Cinderford) being partially constructed. A number of business cases were expected (but not guaranteed) to come forward for consideration during 2018/ 2019. More specifically: -

	• A Business case for new Minchinhampton surgery completed and ready for CCG consideration; • A Business case for new Gloucester City Centre Primary Care Hub completed, ready for CCG consideration; • A Business case for new Phoenix surgery in Cirencester completed and ready for CCG consideration; • A Business Case for a multi practice Cheltenham Town Centre surgery completed and ready for CCG consideration; • A review of delivery approach for Beeches Green completed and strategic approach agreed with a Business case significantly progressed; • A Business case for a new Brockworth & Hucclecote surgery completed and ready for consideration by the CCG; • A Business case for a new surgery in Tetbury, completed and read for consideration by the CCG; • Completion of the 2017/ 2018 and progression of the 2018/ 2019 improvement grant programmes
Risk Issues: Original Risk Residual Risk	There will be insufficient suitable primary care premises to meet core quality standards, to deliver the range of service required for the future model of primary care and be able to provide services for the expected increased population.
Financial Impact	The premises workstream report includes financial elements, where applicable. The Premises Development Team continue to review the current timetable to ensure alignment of delivery with the CCG's medium term financial plan as well as the potential for further prioritisation of schemes.
Legal Issues (including NHS Constitution)	The CCG applies NHS Premises Directions to the rights and responsibilities of the practice and the CCG. In terms of the NHS Constitution the author considers 'You have the right to expect your NHS to assess the health requirements of your community and to commission and put in place the services to meet those needs as considered necessary' and 'You have the right to be cared for in a clean, safe, secure and suitable environment' as the most pertinent NHS Constitution rights applicable to this scheme.
Impact on Health Inequalities	No health inequalities assessment has been completed for this report.

Impact on equality and Diversity	No equality and diversity impact assessment has been completed for this report.
Impact on Sustainable Development	The Building Research Establishments Environmental Assessment Method (BREEAM) is the national standard for assessing the sustainability of new construction developments. It aims to differentiate between developments with higher environmental performance by providing a sustainability ratings across 9 indicators (management, health and wellbeing, energy, transport, water, materials, wastes, land use and technology and pollution)There are 6 performance levels (unclassified, pass, good, very good, excellent and outstanding). There is a national government requirement that generally for new public buildings, the rating should be excellent. The NHS oversees compliance with this, although the NHS stipulates this applies to schemes that cost over £2m to complete.
Patient and Public Involvement	The Primary Care Infrastructure Plan sets out a clear engagement and involvement approach and provides a recommended checklist. All specific business case proposals will include patient engagement feedback.
Recommendation	Members of PCCC are asked to comment on and note the contents of this report
Authors	Andrew Hughes & Declan Mclaughlin
Designation	Associate Director, Commissioning & Senior Primary Care Project Manager
Sponsoring Director	Helen Goodey Director of Locality Development and Primary Care

Agenda Item 8

Primary Care Commissioning Committee
Thursday 29th November 2018

Premises Development Workstream progress report
April 1st 2018 to February 28th 2019

Theme	Progress
Legacy proposals (8schemes in total) **(please note Longlevens, Devereux Centre, Stoke Road Churchdown and Glevum completed and now business as usual)**	**Cleevelands medical centre, Bishops Cleeve (Sevenposts) –** Building work fully completed and building officially opened on the 7th February 2019 Project closed and will no longer be reported.
	Kingsway – Fully completed and formally opened on the 15th December 2018. Project closed and will no longer be reported
	Stow Surgery - Construction of the new surgery continues. Originally, the new building was due to be open by the end of 2018. However, due to slight delays in construction, the building is now expected to be completed and open by the end of May 2019.
PCIP approved schemes	**Cinderford Health Centre –** Approved by the Committee in January 2018 and planning permission achieved in November 2018, the developer is in the process of tendering for a construction partner, is finalising the agreement to lease with both practices and it is expected this will be fully in place before the end of March 2019. Based on this, construction is expected to start by the end of June 2019.
PCIP/ new proposals (Including reference to ETTF funding)	**PCIP summary -** Work continues on developing the business cases for all identified priorities within the PCIP. It is anticipated a number of completed business cases will come forward during 2018 for consideration by the PCCC. Subject to business case approval, estimated additional revenue requirements remain in line with the PCIP and are aligned with the CCG's medium term financial plan. It should be noted that the 2018/ 2019 plan was for up to seven business cases being completed for consideration. The current trajectory is that two business cases are anticipated. Specific scheme progress is

	set out below.
	Stroud Town Centre/ Beeches Green The Beeches Green Surgery, Stroud Valleys Family Practice (located in Beeches Green Health Centre) and Locking Hill Surgery facilities were identified as key priorities in the CCG's Primary Care Infrastructure Plan (PCIP). Practices have been following a twin track approach. In November 2018 an ICS capital bid to the Department of Health for a NHS Propco scheme of £6.8m (2,072m2 GIA for around 26,000 patients) to redevelop the existing Health Centre site was not approved. Two practices (Locking Hill and Stroud Valleys) are now progressing a 3rd Party led Town Centre development and it is anticipated that a Business Case will be completed for the August PCCC. Beeches Green Surgery has confirmed its strategy is to remain at the existing Health Centre and work with NHSPropco and the CCG on long term requirements.
	Cheltenham Town Centre – A new Cheltenham Town Centre primary care facility remains a key priority for the CCG. The proposal will include Berkeley Place, Crescent Bakery and Royal Crescent surgeries and will need to accommodate around 25,000 patients through a GP Led scheme.A detailed and commercially sensitive business case was presented to the PCCC 'in confidence' session in January 2019 and was fully supported by the CCG . It was agreed that it would be formally ratified when a DV letter of intent became the formal interim VFM report and the practices provided the BREEAM pre assessment report with a plan for excellent. It remains the case there is an allocation of £3.22.m from the ETTF fund. As the CCG has now supported the proposal. NHSE will consider the business case to confirm ETTF support at a panel planned for March 14th 2019. NHSE support will reduce the revenue consequence to the CCG. Subject to Local Authority Planning approval, is expected to start before the end of 2019 and the new building open by the New Year of 2021.

	Cirencester Cirencester Group Practice (Avenue and St Peter Road sites) are exploring options for a new single site. The Upper Thames Group requirements could be considered as part of this. The Phoenix Group continue with its preferred option for relocation as part of the Chesterton Housing development. The expectation is that a business case will be completed for this before the end of 2019.
	Brockworth & Hucclecote - The development of new primary care facilities for Brockworth & Hucclecote remains a key priority. The CCG team has been working closely with both practices, their advisors, Tewkesbury Borough and Edenstone Homes. A site has been identified at Whittle Square and the practices are proceeding to buy the site subject to NHS approval and Planning approval. It is anticipated that a business case will be completed either in time for the June or August Primary Care Commissioning Committee. The current assumption is that subject to successful commercial negotiations, NHS approval and planning approval, construction would start no earlier than the Autumn of 2020.
	Coleford Health Centre - The redevelopment/ replacement of the current health centre remains a strategic priority for the CCG. Following the Citizen Jury recommendation that if a new Community Hospital is to be built it should be in, or around, Cinderford, and ratification of this by both the CCG Governing Body and the GCS Board both practices in the town are now wishing to progress a GP led scheme for one new surgery in the town for around 12,500 patients. It is hoped that the business case can be progressed and completed before the end of the calendar year/ early New Year 2020
	Minchinhampton – Proposal for a new surgery on the edge of the village to replace the existing site The DV has issued an interim VFM report to confirm the level of rent and agreed the rent review process. The CCG now looks forward to receiving the business case from the Practice once it has completed outstanding elements.
	Romney House, Tetbury. Following pre app advice, the practice is currently pursuing one particular site. A business case is now expected during the financial year 2019/ 2020.

	Regent Street, Stonehouse - The PCIP assumed a new surgery would be built on the west of Stonehouse as part of the new housing development led by Regent Street surgery. The practice was also considering the potential refurbishment and extension of their existing surgery as their medium/ long term plan. Together with a proposed improvement at the High Street Medical Centre in Stonehouse, this would likely negate the requirement for a new surgery requirement. However, both practices are now reviewing their options.
	North West Elms, West Cheltenham - The plan remains for a new GP building to serve a population of around 10,000 by 2028/ 2031. The housing development is likely to be phased over a number of years. The current assumption is that temporary facilities will be provided in the first phase (up to 1,000 homes) by the Developer approximately 2022/2023. When housing levels meet an agreed trigger, permanent facilities will then developed as part of the community/ neighbourhood section 106 arrangements.
	Gloucester City Primary Care Hub- the CCG Premises team have been working with two practices, their advisors and the County Council to develop proposals for a primary care hub to serve around 18,000 patients Currently, the business case is being developed and the plan is for this to be completed for consideration at the June 2019 PCCC meeting. Subject to the practices agreement, NHS approval, County Council approval for the larger overarching business case (the primary care hub is one element of the development proposals) and planning approval, the overall timeline remains with a new facility planned to be open by the Autumn of 2020.
Improvement Grants key highlights	**2017/2018 schemes PCCC approved and NHSE funded** – The CCG was successful in obtaining an award of approx. £260k from NHSE to fund the improvement grants already approved by the CCG and larger additional projects. Selected larger Individual Project updates as follows: - • **Royal Well (Cheltenham)** – **Project Status** – The practice is commissioning the successful contractors and is aiming to have the works completed by the end of March 2019 for its £10k project to refurbish its reception area;

	• **Staunton & Corse (Tewkesbury)** – The small extension with total cost of around £71k and £40k grant support was completed in November 2018 **2018/ 2019 Improvement Grant process -** In March 2018, the CCG wrote inviting practices to submit their improvement grant applications by the 31st July 2018 with the objective of presenting recommendations to the PCCC at the September 2018 meeting. In August 2018 NHSE invited Improvement Grant applications from Central & Southern CCGs and Gloucestershire CCG was successful in obtaining funding of circa £108.5k for 3 projects The PCCC approved funding from the CCG Budgets of £35.5k for 3 smaller improvement projects in Charlton Kings, Bussage and Chipping Campden that are in various stages of completion. In October 2018, NHSE advised that there was the potential for larger premises improvement projects to be funded from recycled money from the Estates & Technology Transformation Fund. Again proposals were invited from Central & Southern CCGs and Gloucestershire CCG submitted and one proposal is being taken forward. • **Chipping, Wotton-under-Edge (Stroud & Berkeley Vale)** – A major reconfiguration and expansion of existing space with a projected total estimated project cost of £575k. In January 2019 NHSE confirmed an Improvement Grant award of £379,500 plus £57,500 for GPIT costs. It was noted that it would be unreasonable for the practice to complete the project by the end of March 2019 and therefore the award will be accrued into 2019/20 subject to the practice meeting defined conditions and objectives in 2018/19.

Summary & Conclusions

From 2016/17 to 2018/19 the table below illustrates that the Estates Teams has managed to secure 29 IGs with a total value of circa £1.6m from various sources, i.e. ETTF, NHSE Capital & the from the CCG via recommendation from PCCC.

Summary of IG Awards Obtained From 2016/17 to 2018/19

Year	No. of Proposed Projects	Total Project Costs	Total IG Award	Overall % IG Contribution
2016/17	8	£ 769,024	£ 454,800	59.14%
2017/18	13	£ 357,015	£ 227,072	63.60%
2018/19	8	£ 1,288,500	£ 907,910	70.46%
Total	**29**	**£ 2,414,539**	**£ 1,589,782**	**65.84%**

Although, the Strategic Estates Development Team has made notable achievements in the procurement of IGs that success has thrown up various issues.

Practices submitting proposals that were either not accurately or fully costed. For example, not commissioning or only partial architects plan that will enable accurate cost estimates and highlight any unforeseen issues, e.g. planning permission, structural issues including listed status.

Practices can potential submit funding proposals for projects up to a million pounds in costs and therefore to help ensure success need to invest time and money in preparatory work including professional fees. Although this initial investment is at risk as unless an IG award is made reimbursement cannot be made, it can cause issues later on in the process.

	For example, IG awards have been granted on the basis of the initial estimate put forward but when practices have initiated the required preparatory work have found the actual costs of the project are far greater and therefore felt unable to proceed as the initial IG award does not increase. Internal partnership issues, e.g. partners leaving/joining or potential merger talks have meant that some practices have withdrawn projects until these internal issues have been resolved and future planning is clearer.
Review of PCIP and forward look for 2021 to 2026	As part of the premises workstream 2018/2019 the PCCC agreed that there should be a review of the PCIP 2021 to 2026. It was agreed that a refresh of the PCIP and forward look for the period 2021 to 2026 will be completed. This work is in progress and an updated PCIP is expected to be presented at the April or June 2019 PCCC.

Quality Report

NHS Gloucestershire Clinical Commissioning Group

Primary Care March 2019

<table>
<tr><th>CQC Key Line of Enquiry</th><th>Quality Lead Commentary</th></tr>
<tr><td>Are they safe?</td><td>Serious Incidents and Significant Events

Serious Incidents in GP practices are normally referred to as Significant Events. The majority of Significant Events are reviewed internally in practices, and some are also uploaded to the National Reporting and Learning System (NRLS) via a GP Eform. Three incidents have been reported through the NRLS in the Fourth Quarter, to mid-March. These include an issue about the loss of phones and power in a practice and two about poor discharge process.</td></tr>
<tr><td>Are they effective?</td><td>CQC
General Practices

Four GP Practices in Gloucestershire have a current CQC overall rating of ‘Outstanding’; the majority have a rating of ‘Good’ and 2 have a rating of ‘Requires Improvement’.

Included in these figures are the 2 GP Practice CQC ratings published in the last 3 months: 1 with overall rating of ‘Good’ and 1 with an overall rating of ‘Requires Improvement’. The ‘Requires Improvement’ report contains an ‘Inadequate’ rating for ‘Safe’ with medicines management highlighted as a key issue. The CCG is supporting this Practice with Pharmacist support</td></tr>
<tr><td>Are they caring?</td><td>Friends and Family Test (FFT)
The FFT results for GP Practices in Gloucestershire present a mixed picture. The full data for the most recently published data (September 2018) is available on the FFT website at:

https://www.england.nhs.uk/publication/friends-and-family-test-data-january-2019/

The GP FFT dataset includes FFT responses for the latest month from GP practices. Data is submitted directly to NHS Digital’s Calculating Quality Reporting System (CQRS) each month. The overall results for all GP practices combined in Gloucestershire in is as below for January 2019.

<table>
<tr><th>Responses January 2019</th><th>Total Responses</th><th>Percentage Recommended</th><th>Percentage Not Recommended</th></tr>
<tr><td>England</td><td>284,174</td><td>90%</td><td>6%</td></tr>
<tr><td>Gloucestershire</td><td>761</td><td>91%</td><td>5%</td></tr>
</table>

Gloucestershire results are normally about the same as the English average. Unfortunately, a growing number of practices are not submitting data on time. In January 38 practice failed to submit data. This is similar to other areas, but does mean that results are cannot be viewed as a</td></tr>
</table>

full picture of satisfaction with Primary Care.

Patient Advice and Liaison Service (PALS) Activity

Jan & Feb Q4 2018/19 not a complete quarter (PC) - numbers relating to GP Primary Care

Type	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19 (Jan & Feb)
Advice or Information	58 (PC16)	63 (PC20)	111 (PC 27)	1 (PC 12)	110 (PC 22)	31 (9 PC)
Comment	7	0	11		11 (PC 4)	0
Compliment	3	2 (PC1)	4	2	2	1
Concern	41 (PC15)	55 (PC 19)	*97* (PC 23)	110 (PC 14)	75 (PC 22)	50 (10 PC)
Complaint about GCCG	5	2	2	5	7	5
Complaint about provider	21 (PC4)	9 (PC2)	22	18	18 (PC 5)	16
NHSE complaint responses copied to GCCG PALS	1	0	1	0	0	1
Other	8	68	32 (PC 4)	52 (PC 5)	34 (PC 4)	40
Clinical Variation (Gluten Free)	0	3	0	2	0	0
Total contacts	**144**	**202**	**280**	**288**	**257**	**144**

Themes identified from PALS Contacts

	PALS have received several contacts relating to the Aspen Medical Centre. This has been with accessing appointments, prescriptions, and excessive waiting times on the telephone. One patient had been waiting over 25 minutes on the phone, advised 2nd in the que only to have the call disconnected. Two of the patients PALS have spoken with said they are considering registering somewhere else. With regards the other contacts received by PALS, there have been no particular themes evident. The figures for Quarter 4 include January and February 2019 only. **Practice Participation Groups** Only 1 practice in Gloucestershire is now reporting that it does not have an active PPG at this time. Support from the CCG Engagement Team has been offered to assist this practices with establishing a PPG. GCCG's lateest PPG Network meeting took place on 8th February. 32 PPG members attended representing 25 Gloucestershire GP practices. The group were given an introduction to the Long Term Plan by Becky and informed of further opportunities to become engaged in this work. Healthwatch Gloucestershire and GCCG led a discussion about utilising less traditional engagement and feedback methods alongside the traditional. The aim of offering variety is to enable wider engagement particularly those from seldom heard groups. The network received presentations on the following topics: • Build Your Circle Campaign – Lucy Mellor (Demand Management Champion, GCC) provided information on the new Build Your Circle Toolkit which has been developed to empower people to take more control of their lives through building an understanding of adult social care and signposting them to information available. The network was asked for feedback on the new toolkit. • Working with Gloucestershire Deaf Association – Caroline Smith (Senior PPE Manager – GCCG) shared a film that has been produced in collaboration with Gloucestershire Deaf Association and GCCG to raise awareness of the British Sign Language interpretation service available to Deaf BSL users accessing GP services. • 2Gether NHS Foundation Trust (2GT)/ Gloucestershire Care Services NHS Foundation Trust (GCS) merger information update – Hazel Braund (Programme Director – Better Care Together, 2GT and GCS) provided the network with an update on the bringing together of mental health, learning disability and physical community health services. Hazel informed the network that there will be opportunities for partners and stakeholder to get involved to help develop plans for the new organisation. • Integrated Locality Partnership and Primary Care Networks – Helen Edwards (Associate Director of Locality Development and Primary Care Networks (PCNs), GCCG) updated the network about the Integrated Locality Partnership pilots within Gloucestershire and what that means including how they link with PCNs. Helen also provided an update about what PCNs are and how these are developing throughout the County. The PPG members were very engaged in a discussion about this and requested further information about which practices are in which PCN.
Are they responsive?	**Gloucestershire CCG Primary Care Prescribing Costs Position (ePACT prescribing data to December 2018).**

The CCG's overall prescribing cost for 2018-2019 is forecast to be on track to achieve the £5m savings plan, as well as delivering a surplus. This "surplus" has reduced compared with earlier surplus forecasts in the Autumn due to changes in the "No Cheaper Stock Obtainable" (NCSO) inclusion/price lists, which fluctuate frequently, and over which CCGs have no control.

The Annual Prescribing Improvement Plan (PIP) review meetings have recently occurred within many localities. The meetings have been well attended, and representatives of the GP practices have discussed their savings and improvement outcomes in general. These meetings allow a good opportunity for Practices to share their experiences with colleagues, often identifying mitigating circumstances and finding out how colleagues have approached and managed similar challenges.

Dysphagia Management

The NHS issued a Patient Safety Alert in June 2018 requesting NHS organisations eliminate imprecise terminology including 'soft diet' and 'thickened' for those receiving modified texture foods and fluids for the management of dysphagia. To do this, the PSA recommended the implementation of the IDDSI framework by 1st April 2019.

The International Dysphagia Diet Standardisation Initiative (IDDSI) http://iddsi.org/ developed standardised terminology and definitions for texture modified foods and fluids for people with dysphagia. The framework consists of a continuum of eight levels (0-7).

The CCG Dietitian has been supporting GHT, GCS and 2g to implement this framework and will be fully compliant by 1st April 2019. GP practices will be made aware of IDDSI and that new patients will be assessed by Speech and Language Therapy using the IDDSI descriptors.

To further support improvements in patient safety in the management of dysphagia, the One Gloucestershire Medicines Optimisation Group has approved the implementation of a 'one thickener' policy to standardise the preparation of modified texture fluids. All appropriate inpatients will be prescribed Nutilis Clear (Nutricia) from 15th March 2019 and new patients in the community will be issued with this.

Methicillin-Resistant Staphylococcus Aureus (MRSA) Infections

NHS Improvement (NHSI) has set a countywide threshold target of six MRSA Bacteremia infections for 2018/19. From 1 April 2018 to 10 March 2019 there have been thirteen cases. Seven cases have been attributed to community acquisition and six cases have been attributed to hospital acquisition. Five of these cases are linked to intravenous drug misuse. A review group is in place. It is led by a Public Health consultant and has countywide representation from health providers.

Methicillin-sensitive Staphylococcus aureus (MSSA) Bacteraemia Infections

During the period 1 April 2018 to 28 February 2019 122 MSSA Bacteraemia Infections cases were reported. 87 cases (71%) were community acquired and 35 cases (29%) hospital acquired infections. Currently there is no threshold target for MSSA.

Clostridium difficile Infections (CDI)

The threshold set by NHS Improvement (NHSI) for Gloucestershire countywide is 156 cases of CDI in 2018/19. From 1 April 2018 to 28 February 2019 there were 173 CDI cases reported

countywide. Of these 173 cases 55 cases (32%) were hospital acquired and 118 cases (68%) community acquired.

Data from Public Health England (PHE)
It is known that a percentage of the cases currently described as community onset had a recent hospital admission. However from 1st April 2019 changes are being made to the data capture system to report cases differently. After this date the percentage of people with a hospital onset is likely to increase with a decrease in community onset.

CDI cases in Gloucestershire 2015/16 – 2018/19					
CDI	**Threshold 2018/19**	**2018/19** Up to 28/02/19	**2017/18**	**2016/17**	**2015/16**
Community onset		68	127	121	108
Hospital onset (CGH & GRH)		55	77	44	48
Total no.	156	173	204	177	157

Data from Post Infection Reviews (PIR)
The two key risk factors highlighted are hospital admissions and antibiotic use.

- Hospital Admission
  There is a strong association between hospital admission and the onset of CDI. During 2018/19 the Countywide Action Plan to reduce CDI has had a hospital focus including improving the environmental hygiene.

- Antibiotic Use
  The PIRs demonstrated a link between co-amoxiclav use and CDI.

Data from Risk Factor analysis
Primary care issues identified through an analysis of risk factors shows the need to;

- Manage CDI risk factors as part of a comprehensive CDI reduction strategy. Examples include compliance with antibiotic, PPI and loperamide prescribing guidelines

- Best Practice guidelines for treatment/management of CDI not met consistently. Examples include delays in stool sampling, delays in commencing treatment until a stool test result received from lab confirming CDI and not using a severity rating scale to determine severity of illness and treatment required.

What can be done to reduce the number of CDI cases with a community onset

- Change in data capture system by PHE effective from 1st April 2019.
  The number of cases with a community onset should drop while the number of cases associated with hospital admission will increase.

- Action Plan to reduce CDI in Gloucestershire
  During 2018/19 the CCG has led on the formation of the CDI Assurance meeting to coordinate a countywide strategy to reduce CDI in Gloucestershire. A monthly meeting is held with representation from all the health providers. The strategy includes surveillance, Post Infection Reviews, lessons learned, risk factor management,

promoting best practice, audit and widely disseminating learning.

- Examples of actions taken in response to learning during 2018/19 include;
  - The Hospital and Primary Care prescribing guidelines have been changed for antibiotics to lower the use of co-amoxiclav and improve compliance with guidelines for PPIs and loperamide
  - Promoting best practice for treatment/management of CDI. Specific issues addressed include responding promptly with CDI suspected and following the guidelines
  - A focus on environmental cleaning in hospitals

- Actions planned for 2019/20
  - Continued leadership by the CCG for the CDI Assurance Meeting. The strategy being reviewed to include latest guidance from NHS Improvement.
  - Training for Practice Nurses in Infection Prevention and Control.
  - Development of a Primary Care Infection Prevention and Control Group to support Infection Control Champions.

Escherichia coli (E.coli) Infections

The Quality Premium for 17/19 (two years) includes an annual threshold target of 257 incidences of E.coli Bloodstream infections.

To date in 18/19, the number of cases 267 cases is above the trajectory of 148 cases. Of the 267 cases 82% were community acquired and 18% hospital acquired. In 17/18, the threshold was exceeded by 19 cases.

Flu vaccinations

The Health Care Acquired Infection Group, chaired by the GCCG, continues to hold weekly telephone conferences in response to an increase in the numbers of Care Homes closed with respiratory outbreaks and information that influenza was beginning to circulate more widely.

The CCG continues to support our GP Practices by monitoring of issues relating to accessing vaccines and acting as the local co-ordinating lead following NHSE guidance. The CCG supported local re-distribution of the aTIV vaccines for people aged 65 years and over, and also liaised with NHSE who sourced surplus aTIV across the South West.

Preliminary data from ImmForm on Gloucestershire flu vaccination rates show that most care groups are within 5% of, figures from last year. The CCG launched an 'It's Not Too Late To Vaccinate' campaign and more targeted comms for people in high risk groups via social media. However, GP Practices are to be commended for the higher rates of vaccinations for 2 and 3 year olds.

Flu Vaccinations Evaluations

Evaluation on the effectiveness of the flu vaccination campaign is currently being undertaken. Results should be available in April/May and will be shared with relevant CCG Committees. The outcomes from these evaluations will inform future planning.

Primary Care Education Update

	On 4th & 5th March 2019 GCCG hosted a 2-day Introduction to Travel Health for Gloucestershire Practice Nurses who were new to this service. The course was well attended with 21 attendees. A shorter update session for more experienced nurses in planned for later in the year. GCCG is working with GDoc to develop a 'Parachute Practice Nurse' service which will aim to provide peer support and mentorship to nurses in county. The service specification is currently being developed and it is hoped this resource will be available in the next finance year. In addition the Quality Team will be conducting a Training Needs Analysis for Practice Nurses over the coming months which will inform the planning of future training delivery and ensure it meets the needs of both practices and nurses.

NHS
Gloucestershire
Clinical Commissioning Group

Agenda item 10.

Primary Care Commissioning Committee

Meeting Date	**19th March 2019**
Report Title	**Delegated Primary Care Financial Report**
Executive Summary	At the end of February 2019, the CCG's delegated primary care co-commissioning budgets shows a year to date overspend of £502k with a forecast overspend of £641k. This overspend is offset by an equivalent underspend within the CCG's programme budget.
Risk Issues: **Original Risk (CxL)** **Residual Risk (CxL)**	None
Management of Conflicts of Interest	None
Financial Impact	The current position and forecast has been included within the CCG's overall financial position.
Legal Issues (including NHS Constitution)	None
Impact on Health Inequalities	None
Impact on Equality and Diversity	None
Impact on Sustainable Development	None
Patient and Public Involvement	None
Recommendation	The PCCC is asked to • note the content of this report.
Author	Andrew Beard
Designation	Deputy Chief Finance Officer
Sponsoring Director (if not author)	Cath Leech Chief Finance Officer

Delegated Primary Care Commissioning financial report as at 28th February 2019

1 Introduction

1.1 This paper outlines the financial position on delegated primary care co-commissioning budgets at the end of February 2019.

2 Financial Position

2.1 The year to date financial position as at 28th February 2019 on delegated primary care budget highlights an overspend of £502k.

2.2 The year to date pressures in the position include:

- GP Pay awards – this predominantly relates to the increased costs of GP pay awards (approved in July 2018 and backdated to April where no central funding was made available to the delegated budget in order to offset costs). However, as mentioned in the previous report, the CCG has managed to ring-fence funding previously identified as programme resource (i.e. outside of delegated budgets) to cover this additional cost

- Maternity and sickness – these areas continue to be a significant pressure. The year to date overspend, currently stands at £308k. This has decreased slightly since the last report, with some claimants returning to work earlier than their initial claim forms suggested.

- Enhanced Services (DES). The Learning Disabilities Enhanced Services is overspending, with the February position being just less than £100k overspent.

- Dispensing and Prescribing costs have reduced slightly more than expected in the last month, however, the cumulative effect of previous high months, and the impact of the forecasts required (due to data being 2/3 months behind in this area),

result in a year to date overspend of £270k.

2.3 Within the position, the main underspending area relates to a continuation of savings from business rates, which, following a national review, resulted in reduced bills for most practices. Some gains reflect the full year impact of those recognised in the last year with further gains being made in 2018/19.

2.4 As in previous months, overspends in the above areas have also been partially mitigated through full utilisation of the 0.5% planned contingency fund.

3 Recommendation(s)

3.1 The PCCC is asked to:

Note the contents of the paper

NHS
Gloucestershire
Clinical Commissioning Group

Gloucestershire CCG

2018/19 Delegated Primary Care Co-Commissioning budget

February 2019

	Area	2018/19 Total Budget	In Month Budget	In Month Actual	In Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	Forecast Variance
		£	£	£	£	£	£	£	£
SPEND	Contract Payments - GMS	51,032,022	4,252,601	4,283,225	30,624	46,778,681	47,314,564	535,883	631,385
	Contract Payments - PMS	3,651,196	304,263	200,850	(103,413)	3,346,896	3,313,000	(33,896)	(36,977)
	Contract Payments - APMS	1,838,754	153,229	294,314	141,085	1,685,520	1,992,083	306,563	331,700
	Enhanced Services	2,276,629	189,584	188,062	(1,522)	2,085,561	2,101,147	15,586	17,002
	Other GP Services	2,417,026	201,286	258,238	56,952	2,214,281	2,171,502	(42,779)	(28,218)
	Premises	8,454,224	704,406	633,693	(70,713)	7,748,590	7,246,136	(502,454)	(547,774)
	Dispensing/Prescribing	3,021,353	229,855	157,032	(72,823)	2,793,497	3,063,762	270,265	324,834
	QOF	8,470,246	705,775	695,146	(10,629)	7,763,605	7,716,899	(46,706)	(50,952)
	TOTAL	**81,161,450**	**6,740,999**	**6,710,560**	**(30,439)**	**74,416,631**	**74,919,094**	**502,463**	**641,000**

FUNDING ALLOCATION **81,161,450**

£349,550 of funding allocation original earmarked for "Indemnity payments" has now been reallocated to GPFV schemes, per guidance from NHS England (£81,511,000 - £349,550 = £81,161,450)
Global Sum (GMS contract payments) has now been published and represents a 3.01% increase on 2017/18
Global sum per weighted patient moved from £85.35 to £87.92 in April 2018
Other GP Services includes:

- Legal & professional fees
- Seniority
- "Parachuting" Pharmacists
- Doctors retainer scheme
- Locum/adoption/maternity/paternity payments
- Other general supplies & services