Primary Care Commissioning Committee (PCCC)

Held in Public at 9.45am on Thursday 31 October 2019 in the Board Room, Sanger House, Brockworth, Gloucester GL3 4FE

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Any Other Business

Chair

Date and time of next meeting: Thursday December 19 December 2019 at 9:45am in the Board Room at Sanger House.
Primary Care Commissioning Committee  
*(meeting held in public)*

Minutes of the meeting held at 9.45am on 29 August 2019  
Boardroom, Sanger House

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<th>Present:</th>
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<tr>
<td>Alan Elkin (Chair)</td>
<td>AE</td>
<td>Lay Member - Patient and Public Engagement</td>
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<td>Mark Walkingshaw</td>
<td>MW</td>
<td>Deputy Accountable Officer</td>
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<td>Dr Andy Seymour</td>
<td>AS</td>
<td>Clinical Lead</td>
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<td>Marion Andrews-Evans</td>
<td>MAE</td>
<td>Executive Nurse and Quality Lead</td>
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<tr>
<td>Julie Clatworthy</td>
<td>JC</td>
<td>Registered Nurse</td>
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<tr>
<td>Colin Greaves</td>
<td>CG</td>
<td>Lay Member – Governance</td>
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<tr>
<td>Cath Leech</td>
<td>CL</td>
<td>Chief Financial Officer</td>
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<td>Helen Edwards</td>
<td>HE</td>
<td>Associate Director of Primary Care and Locality Development</td>
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<td>(Deputising for Helen Goodey)</td>
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<tr>
<td>Becky Parish</td>
<td>BP</td>
<td>Associate Director, Engagement and Experience</td>
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<th>In Attendance:</th>
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<tr>
<td>Declan McLaughlin</td>
<td>DMc</td>
<td>Senior Primary Care Project Manager</td>
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<td>(item 5)</td>
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<td>Jo White</td>
<td>JWh</td>
<td>Programme Director</td>
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<td>(item 5)</td>
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<td>Zaheera Nanabawa</td>
<td>ZN</td>
<td>Programme Manager – Primary Care Workforce</td>
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<td>(item 5)</td>
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<td>Bronwyn Barnes</td>
<td>BB</td>
<td>Programme Manager, Primary Care, Localities &amp; Variation</td>
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<td>(item 5)</td>
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<td>Jeanette Giles</td>
<td>JG</td>
<td>Head of Primary Care Contracting</td>
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<td>(item 5)</td>
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<td>Karl Gluck</td>
<td>KG</td>
<td>Lead Commissioner, Mental Health, Autism and Advocacy</td>
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<td>(item 7)</td>
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<td>Fiona Robertson</td>
<td>FR</td>
<td>Associate Director for Digital Transformation, CSU</td>
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<td>Christina Gradowski</td>
<td>CGI</td>
<td>Associate Director of Corporate Affairs</td>
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<td>Lauren Peachey</td>
<td>LP</td>
<td>Governance Manager (minutes)</td>
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1. **Apologies**

1.1 Apologies were received from Cllr Roger Wilson, Helen Goodey, Andrew Hughes, and Jo Davies

1.2 It was confirmed that the meeting was quorate.

2. **Declarations of Interest**

2.1 JC had been involved in producing the NICE Quality Standards on co-existing mental illnesses and declared that this was relevant to item 7: The Locally Enhanced Service (LES) for Serious Mental Illness. It was agreed that this was professional interest and represented no financial gain and therefore AE confirmed that JC could continue to take part in discussions during PCCC.

The committee noted AS’s declaration of interest with regards to item 7: The LES for Serious Mental Illness and 8: Primary Care Quality Report.

3. **Minutes of the Meeting held on 27 June 2019**

3.1 The minutes of the meeting held on Thursday 27 June 2019 were approved subject to the following amendment:

Section 5.9: with regard to GHAC, CG requested that this section was re-worded to reflect that the population had outgrown the premises.

4. **Matters Arising**

4.1 **Item 4.9, 31.01.19, Nurse Training**

This matter would be covered during agenda item 6: Primary Care Workforce.

*Item to be closed*

**Item 6.14, 26.06.19, Learning Disabilities Health Checks**

Communications were to be arranged for Gloucestershire residents regarding the benefits of attending Annual Health
Checks. JG updated the committee that this had been discussed with the GCCG Communications Team.

Item to be closed

**Item 8.7, 26.06.19, Review of GP Education**

JC highlighted that there was some private training provision which was not available to all GPs including locums which was the issue that prompted the review of GP education. JC had raised the concern that some GPs may have been excluded from accessing certain training. Furthermore it was emphasised that the quality of the private training being offered could not be scrutinised.

HE advised that the Primary Care Training hub would need to be fully staffed to ensure sufficient capacity to fully address this review. It was agreed that a detailed update would be taken to the PCCC in February 2020.

**ACTION:** Review of GP Education to go on the February 2020 PCCC Agenda. This was to cover both quality and access to GP education.

**AS joined the committee at 09:51**

5. **Primary Care Strategy Refresh**

5.1 HE introduced the draft refresh of the Primary Care Strategy (PCS). HE requested that comments be fed back to the Primary Care Team.

HE began the presentation by summarising some of the key achievements over recent years as follows:

- there were new buildings for over 50,000 patients in several areas across Gloucestershire;
- there had been in excess of 113,000 extra improved access appointments;
- there were 14 PCNs and 20 Clinical Directors;
- the Complex Care at Home Service provided proactive preventative services in the Forest of Dean, Cheltenham and Gloucester;
- there were 1,413 registered patients per qualified
permanent GP compared to a national average of 1,728;
- Gloucestershire CCG (GCCG) was well regarded by Primary Care colleagues;
- 87% of patients in Gloucestershire who responded to the GP patient survey rated their experience as ‘good’.

HE acknowledged that although GPs in the county were supportive of the work that has been undertaken, there was a continued underlying concern that there were not enough GPs in the county to undertake the volume of work that was being seen.

AE highlighted the value of having the presentations available prior to the committee meeting.

### Primary Care at Scale: Partnerships and Integration

#### 5.2
BB presented on ‘Primary Care at Scale: Partnerships and Integration’ beginning with an overview of the Primary Care Networks (PCNs). BB emphasised that it was widely recognised that PCNs represented opportunities for the wider system and residents of Gloucestershire. BB highlighted that PCNs were supportive of the NHSE aspirations for PCNs including bringing care closer to home, stabilising the GP partnership model and bringing new roles into Primary Care.

#### 5.3
BB drew the committee’s attention to the following key points with regards to the PCNs in Gloucestershire:
- the PCNs would work towards seven service specifications; five of which would commence from April 2020;
- the sizes of the PCNs varied between approximately 30,000 and 63,500 patients and there were between one and eleven practices per network;
- the facilitation of the PCNs had been supported by the prior cluster arrangements which had been in place since 2016;
- PCNs, which officially commenced on the 1st July 2019, covered 100% of the county;
5.4 GCCG was supporting Clinical Directors with their facilitated meetings which were taking place on a six-weekly basis. In addition to this support they were also being offered a reimbursement scheme that related to a number of new roles which were being put in place.

5.5 BB continued the presentation by explaining that across the county there was a variance in the level of maturity within PCNs. There was reasonable expectation that this would be the case. A PCN Development Programme was planned which supported the development of the PCNs as well as providing support to the Clinical Directors.

The GCCG was working with the Clinical Directors to identify what the development needs were and had been utilising an NHSE provided maturity matrix.

5.6 BB informed the committee that there was senior-level sign up to Integrated Locality Partnerships (ILPs) from all member organisations. In five of the six ILPs there was an Operational and Strategic Partnership of leaders of health, social care and local government.

5.7 GCCG was successful in a bid to join Wave 2 of the NHSE Population Health Management (PHM) programme which represented a key aspect of PCN and system development.

5.8 With regards to the variance in PCN maturity, JC enquired as to whether there was anything more that GCCG could be doing to further support their development, and bring them in line with the more developed PCNs?

BB responded that the PCN development programme offered an opportunity to support the less mature PCNs where needed. BB emphasised the collaborative approach underpinning the PCN development.

HE added that the NHSE requirement was for PCNs to assess themselves against the maturity matrix. PCNs were informed of this requirement during September 2019. HE further informed the committee that the six-weekly PCN Clinical Directors meeting which was chaired by AS, the clinical lead for the GCCG, was well attended. Approximately half of the agenda was dedicated to updates from Clinical Directors and information exchange which
ensured areas requiring support were identified.

5.9 AS informed the committee that Jeremy Welch had accepted the position of ICS Liaison Lead and therefore will not be continuing in his role on the Governing Body.

5.10 CG acknowledged that ILPs were in their early stages of development and noted that the names of the ILPs leads had not yet been made available.

HE advised that the information on the ILPs leads and members could be provided and this could include work streams and ILP priorities. Emily Beardshall, Deputy ICS Director, has been working with the ILPs to ensure there was understanding on the Long Term Plan (LTP) and the work programme fit with the ICS agenda.

5.11 CL commented that it was necessary to consider how to adapt the way the CCG contracts with organisations going forward. The contractual arrangements were relevant to the Governing Body and linked into PCCC.

CG further queried how we could get oversight of the progress. CL responded that lines of communication were evolving and needed clarifying as part of the governance arrangements. AS added that the ILPs reported into ICS and then the ICS reported into the Governing Body.

AE noted that it was important that all partners were kept informed of the developments.

**Improving Access (IA)**

5.12 JWh presented on Improving Access (IA) and began by summarising the background of the Improving Access programme. Improved access delivered 113,000 additional appointments for practices that were delivering through the IA contract from August 2018 to July 2019. JW noted that, due to NHSE reporting criteria, slightly less than this figure was reported to NHSE.

5.13 JWh noted that most of the IA appointments were seen by GPs. JWh continued by explaining that this was largely due to the NHSE requirement that GP face to face appointments
were available. The remainder of the IA appointments were able to be provided by other clinicians such as paramedics, phlebotomists, practice nurses, advanced nurse practitioners, urgent care practitioners, and advanced physiotherapy practitioners. JW highlighted that this range of staff enabled people to be seen by the most appropriate clinician for their needs, without the need of an initial GP appointment.

5.14 Patient satisfaction was very good for IA. JW reported that 90% of Gloucestershire patients who had an IA appointment and responded to the questionnaire were satisfied with their appointment, and 96% would recommend the IA service to a friend or family member. Information about IA was available on GP surgery websites and leaflets in the waiting areas.

5.15 NHSE was undertaking an access review which included IA and Extended Hours. The intention of this review was to amalgamate these services into one contract provided by PCNs. JW highlighted that this work was in progress in Gloucestershire.

This involved pulling together two funding streams and similar service specifications. The access review highlighted PCNs responsibility to consider how their patients may access services outside of core hours.

The objective of the review was to improve patient access both within and outside of core hours and reduce variation in patient experience. In terms of reducing fragmentation JW noted that PCNs were working together to look at access to services.

Two practices in Gloucestershire were selected for the NHSE IA review.

5.16 JW concluded the IA presentation by summarising that, in the National GP Patient Survey published in July 2019, 87% of Gloucestershire patients rated their overall experience as “good” compared to 83% nationally.

5.17 MAE emphasised that in the long run it was important to
consider how the model could incorporate more nurses as the high proportion of GPs in the model was costly. MAE further highlighted that in many practices significant numbers of daily appointments were already being managed by Advanced Nurse Practitioners.

AE agreed with MAE and further added that this was an area which could add pressure to GPs which was why Gloucestershire needed to increase the diversity of the response to patients in order to respond to the need appropriately.

### Population Health Management

5.18 CL presented on Population Management (PHM). PHM was a data driven approach to analyse and improve planning and care at a population level. This supported the decision making process when deciding, which intervention would have the greatest impact.

CL described the three key elements of PHM:
- **Infrastructure**: to include IT and Information Governance and data structures;
- **Intelligence**: including analysis and data presentation;
- **Interventions**: including proactive clinical and non-clinical interventions.

It was noted that Gloucestershire was already working in this way however this PHM programme supported a more structured approach.

5.19 Gloucestershire already had a significant amount of the infrastructure in place however there was work to be completed on ICS level infrastructure. There was a place to `land the data` however there was a longer term piece of work to determine where the best place to `land the data` would be.

In terms of information governance, the commissioning data warehouse supported a pseudonymised data set. This meant that there was no patient identifiable information available. It was highlighted that pseudonymisation enabled
Over the last year there had been an investment in analyst training across the community. This training was supporting the analysts to map disease prevalence using Quality Outcomes Framework (QOF) data and mapping tools. Sollis, an existing tool, was being used to stratify the Gloucestershire population.

Alongside this there was an Integrated Locality Reporting (ILR) tool being developed for Primary Care.

In terms of interventions, CL noted that some existing interventions including Multi-Disciplinary Teams (MDTs), Complex Care at Home and South Cotswolds Frailty were taking the same approach.

CL concluded the presentation by reiterating that Gloucestershire was part of the Wave 2 PHM programme which would apply additional structure to the approach which was already being utilised. It was expected that the work was going to result in a road map for the linked data set and Information Governance would be supported to a greater degree in terms of how this was developed.

AE acknowledged the importance of the PHM programme particularly considering the areas of population deprivation in the county. AE highlighted that it was necessary to grow and develop skills to deal with the interventions. AE added that the interventions highlighted in the report did not appear to address the future in line with what we know about the impact of smoking and obesity.

CL responded that the tools that were in place were being used to support a number of interventions. Wave 2 of the PHM programme focussed on identifying growing trends and was to link in to the Long Term Plan (LTP). CL highlighted that we understood the themes and could use this programme to provide further oversight.

JC noted that this represented an opportunity to join up, for example, the disease specific pathways. There were a number of areas which could be managed differently when...
managed with big data.

CL noted that the information included in the presentation was focussed on the Primary Care Strategy. Some capabilities may not be developed in Gloucestershire alone and this may be progressed as part of a regional response. CL noted that this work was going to be further developed.

FR added that working with OPTUM highlighted that there were gaps in skills and capability around machine learning and AI.

5.24 CG highlighted that, at a strategic level, this was a Gloucestershire system issue and further queried whether Gloucestershire had the skills in the numbers that were needed. CG further emphasised that it was essential to ensure that a whole system approach was taken to manage this matter.

CL responded that there was a PHM Steering Group chaired jointly by Sarah Scott, Director of Public Health, and herself. This was well attended by multiple organisations. There was an analyst working group with the heads of analytics from each of these organisations. PHM was being driven as part of the CCG’s core agenda and GCC was also significantly involved.

CG queried how the high level data could be driven down to an individual level. CL replied that there were two work streams. One to consider the wider population health management, and an approach which may take the data specific to individuals and identify their key issues.

CG queried how this would work from an information governance perspective. CL noted that patients could only be re-identified by those who were directly involved with their care and not by anyone at the CCG.

**Digitally Enabled**

5.25 FR presented on the Digital Transformation programme and began by explaining the progress to date in terms of digital maturity in Primary Care. It was noted that Gloucestershire had progressed from a largely paper based service to
providing a mostly digital service. FR noted that there was still a lot of progress to be made prior to developing a more transformational way of working. FR highlighted that paper referrals to the acute sector were switched off in June 2018.

FR continued by highlighting that the Long Term Plan stated that “every patient has the right to be offered digital first Primary Care by 2023/24” which would enable patients to be able to access advice, support and treatment digitally. Over the last three years significant progress towards this had been made in Gloucestershire.

5.26 The NHS app had been implemented across Gloucestershire although FR noted that it had not yet been widely advertised. This was going to be advertised in line with a national communications campaign in the Autumn of 2019. Further to this an online symptom checker and triage tool, called Dr Link, was being trialled along with a tool called Footfall which supported patients in interacting with online services.

5.27 FR highlighted that Gloucestershire’s use of the Electronic Prescription Service was one of the highest in the country. In this service a prescription could be sent directly to a patient’s nominated pharmacy of their choice and thereby remove the necessity to attend the GP practice.

The Digital Programme supported PCNs to offer extended hours appointments which required access to patient records across multiple systems within the PCN. FR noted that there had been challenges regarding systems interoperating.

All practices in Gloucestershire had both public Wi-Fi and practice Wi-Fi and this supported clinicians to work more flexibly across practices.

5.28 FR summarised that there were a number of digital themes which were supported within the Primary Care Digital Strategy including offering digital support to enable clinicians to more easily direct patients to the right service; and increasing the types of referrals that could be made
electronically. In addition to this, improving information sharing was being progressed.

FR noted that there was also work around how best to support practices with reporting which included work around data quality and coding.

5.29 A road map had been developed within the strategy which had taken into account national guidance. The road map had been based on six work-streams. FR summarised some of the key projects, which were underway under each of the work-streams.

5.30 MW emphasised that although the digital programme was supported there was some concern over the level of investment that was required. CL advised that the detail was being worked on.

FR noted that the capital budget for Primary Care had been reduced for the current financial year. FR further added that funding from the digital element of NHSE Estates and Technology Transformation Fund had temporarily ceased to be available, resulting in a need to re-prioritise projects.

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<td>5.31 DMc presented on Estates and began by summarising the completed and approved schemes which derived from the Primary Care Infrastructure Plan from 2016. DMc highlighted that the 2016/21 version of the Primary Care Infrastructure Plan was an amalgam of the projects inherited from previous organisations and new GCCG aspirations. DMc noted that there were some priorities outstanding and summarised the progress with and challenges around these priorities.</td>
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<td>5.32 DMc reiterated that the Primary Care Infrastructure Plan had been refreshed. It was highlighted that consideration had been given to flexibility within new premises developments and this included multi-use rooms and ensuring rooms could be</td>
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booked and used by community and mental health partners.

5.33 **In terms of new priorities for 2021/26 DMc summarised the premises proposals for each of the ILPs. It was emphasised that the work being undertaken was focused on the county as a whole.**

Funding had been secured for two proposals one in Gloucester City and one in Wotton-under-Edge.

To conclude the presentation, DMc bought the attention of the committee to each of the premises proposals and the estimated delivery year and capital cost.

5.34 **RESOLUTION: The committee noted the Primary Care Strategy Refresh presentations.**

*Karl Gluck arrived at 11:14*

### 6. Primary Care Workforce

6.1 **ZN began the presentation on Primary Care Workforce by briefing the committee on the baseline workforce position for GPs and Practice Nurses in Gloucestershire. The number of GPs had increased although it was recognised that a growing number of GPs sought part time work or preferred to work in portfolio roles which resulted in the total of Whole Time Equivalents (WTEs) decreasing. In contrast to this, the WTE of Practice Nurses had increased.**

6.2 **There were concerns in the county with regards to the number of GPs not being considered enough, however ZN highlighted that in terms of benchmarking, Gloucestershire had come second in the region (low being good) for the number of patients per qualified permanent GP and it was noted that this was very positive.**

6.3 **There had been work to promote information around the PCNs and how this may impact the system. ZN had engaged with Proud to Care who were working with care homes and social care colleagues. Primary Care was represented at the Workforce Steering Group, OD Steering Group and Local Workforce Action Board (LWAB).**
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<td><strong>6.4</strong></td>
<td>ZN noted that there was a Primary Care Pharmacy education programme and highlighted that the pathway was complex. There were plans to establish a social prescribing e-learning platform.</td>
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<td><strong>6.5</strong></td>
<td>Advanced Physiotherapist Practitioners continued to play a key part within certain networks in the county. ZN emphasised that effective working relationships with partner organisations had supported the success of the Advanced Physiotherapist Practitioners in Gloucestershire. ZN highlighted that there were challenges in getting access to diagnostics and ICE. The committee was assured this had been raised as an issue to the One Gloucestershire Diagnostics Board.</td>
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<td><strong>6.6</strong></td>
<td>In terms of recruitment and retention, an Early Career GP Lead was employed on an initial 12 month basis for one session per week. The lead would focus on supporting F1 and F2 GPs, in particular, when they were deciding which area of medicine they were keen to pursue.</td>
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<td><strong>6.7</strong></td>
<td>ZN attended an International GP recruitment event in June 2019 and suggested that international recruitment may be hindered by Gloucestershire’s lack of an international airport. It had been recognised that GPs were hearing about moving to the UK through word of mouth rather than the International GP Recruitment scheme, a trend seen across the whole system.</td>
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<td><strong>6.8</strong></td>
<td>The Annual Workforce Survey was underway and this was supporting a robust representation of the workforce and supporting workforce planning. Part of the Annual Workforce Survey included questions around whether the GP practice was taking on learners and finding out reasons why not if that were the case.</td>
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<td><strong>6.9</strong></td>
<td>There were ten GP retainers in the county and the requests for GP retainers were increasing. The CCG contributed</td>
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funding towards this scheme in which eligible GPs may request to work for between one and four sessions per week.

ZN highlighted that there were a number of GPs who were looking to work in Cheltenham and North Cotswolds and not where there were workforce gaps in the county such as Gloucester City.

The newly qualified GP scheme had been running for two years. Four host practices took part in the scheme in 2019/20. ZN highlighted that this scheme was considered a success with six out of eight GPs who participated in this scheme remaining in the practices in which they were placed.

6.10 ZN concluded the presentation by summarising that the next steps were to roll out the Primary Care Workforce Website, and exploring how funding from the Primary Care Training Hub would enable PCNs to meet the expected challenges that lay ahead.

6.11 MAE updated on Practice Nurses. A new Clinical Development and Education matron had commenced in post and they would be focussing on training analysis. There were nurse coordinators in post for each locality in the county. They provided support and also looked at education and training needs. The nurse coordinators that formed part of the parachute nursing team were being well utilised to provide nursing support to cover unexpected short term gaps.

6.12 There was one qualified registered Nursing Associate in primary care in Gloucestershire and two trainees were due to begin in post. MAE noted that this was an area of great opportunity for Primary Care with Nurse Associates able to undertake a wide range of tasks.

6.13 MW emphasised the need to work in a planned and responsible way when it came to workforce planning and consider effects on the wider workforce across the system.
JS highlighted that, in terms of supervision, clinical governance needed to be built in to the process.

### RESOLUTION: The committee noted the Primary Care Workforce Presentation

#### 7. LES for Serious Mental Illness (SMI) Physical Health Checks

KG presented on the LES for Serious Mental Illness (SMI). The paper was taken as read and KG highlighted the following key points:

- compared to the rest of the population those with a mental health issue die on average 20 years earlier from health issues which could been prevented; there was a requirement to reach a minimum of 60% of people on GPs SMI registers having an annual health check;
- there was CQUIN in place with the 2gether NHS Foundation Trust to undertake annual health checks for their patients who were on the Care Programme Approach;
- there was a cohort of people with a SMI who were not known to 2gether and would thus not be part of a Care Programme Approach;
- the LES has been supported by the Enhanced Services Group and the Local Medical Committee (LMC);
- The budget for this was £150k which had been approved by the priorities committee during the financial year 2019/20.

#### 7.2 AE noted that there was a specific mention of Cardio Vascular Disease (CVD) as one of the conditions which supported the need and requirement for an annual health check. KG responded that a range of other conditions were included such as diabetes. The requirement for the SMI annual Health Checks also included offering appropriate interventions.

AE queried what the budget of £150k would achieve. KG
responded that the target population was approximately 3000 people. The aim was to have a programme in which practices would contact people on a regular basis and they would undertake the required six health checks and deliver interventions.

It was acknowledged that part of the programme would focus on data quality improvement. MW agreed that data quality would need to be improved and noted that Gloucestershire looked like an outlier because there was data that was not joined up. JC further added that care planning also needed to be joined up.

CG queried whether the funding was recurrent and noted that the minutes of the Priorities Committee specified £280k but did not specify if it was recurrent. CL advised that the initial £280k was reduced to £150k and confirmed that the funding was recurrent.

7.3 **RESOLUTION**: The LES for Serious Mental Illness (SMI) Physical Health Checks was approved.

7.4 **KG left the room at 11:35**

8. **Primary Care Quality Report**

8.1 The report was taken as read and MAE noted that more serious incidents were being reported and it was accepted that this was a reflection of improved reporting. MAE further explained that the reporting of serious incidents supported learning.

8.2 With regards to the changes in the National Friends and Family Test BP noted that the revised guidance from NHSE had not yet been received.

CCG PALs had received a number of enquiries regarding The Aspen Medical Practice. BP informed the committee that GCCG had been working with the Patient Participation Group (PPG) and there were reports of changes to the practice telephone system, which was having a positive impact.
8.3 AE enquired about what effect the revised National Friends and Family test may have on Primary Care and BP noted that this would remain unclear until the revised guidance was available. BP further added that it was expected that some of the revisions may include modifying some questions and the frequency of the questions being asked.

8.4 MAE bought to the committee’s attention the prescribing figures and highlighted that the £5m saving noted within the report, had since been agreed at £6m due to Category M drug price changes. It was noted that the impact of Brexit on the ordering of drugs remained unclear.

MAE noted that the first edition of the Practice Nurse Newsletter had been distributed.

**ACTION:** The Practice Nurse Newsletter to be circulated to PCCC members. MAE.

8.5 AE noted that it was positive that there had been an increase in NHSE complaint responses copied to GCCG PALS and BP acknowledged that this showed an improvement in regular communication.

AE queried the reasons behind the improving PALS relationship with MPs. BP suggested that this may be due to an increase in complex clients taking a large amount of time to manage in Primary Care, PALS and the MPs offices.

With regards to the Engagement Team supporting a number of teams within the CCG with surveys; AE requested that additional detail be included in the next Primary Care Quality report around this to further understand the diversity of work that was undertaken by the team.

**ACTION:** BP to include additional detail around the support undertaken by the Patient Engagement Team in the next report.

8.6 **RESOLUTION:** The committee noted the Primary care Quality Report.
## 9. Primary Care Delegated Financial Report

### 9.1
CL informed the committee of the current financial position and noted that there was an underspend which in part related to the Data Protection Officer (DPO). However, costs for this were due to be incurred and the contract was being put in place. In addition to this, seniority payments were also underspent however CL noted that this area was likely to change.

### 9.2
CL explained that there had been a small overspend of £15k which reflected the risks associated with dispensing and prescribing and volatility around sickness and maternity payments. CL noted that there was a variance on APMS and GMS contracts which reflected issues around the Marybrook contract.

CG noted that the variance in the APMS contracts was a concern. CL advised that much of the variance would be resolved following the Marybrook procurement. CG further enquired if the additional funds that had been invested into Marybrook in the short term, were reflected within this budget line. CL advised this would be brought through as and when required.

## 10. Any Other Business

### 10.1
There was no other business raised.

The meeting closed at 11:51

## 11. Date and time of next meeting

The next PCCC will be held on Thursday 31st October 2019 at 9.45am in the Boardroom, Sanger House.
<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>Response</th>
<th>Action with</th>
<th>Due Date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>28/03/2019</td>
<td>Primary Care Premises Report</td>
<td>Locking Hill and Stroud Valleys practices were progressing a third party led town centre development and likely to submit a business case in August. <strong>Update:</strong> AH was to present in August but will now present at October 2019 meeting as the practices are not ready.</td>
<td>AH</td>
<td>Oct 2019</td>
<td>Open</td>
</tr>
<tr>
<td>26/06/2019</td>
<td>Primary Care Quality Report: GP education and training</td>
<td>HG and MAE to discuss with Zaheera Nanabawa a proposal to undertake a review of GP education to cover the type of training offered and its quality. <strong>Update 29/08/2019:</strong> HE advised that the Primary Care Training hub would need to be fully staffed to ensure sufficient capacity to fully address this review. It was agreed that a detailed update would be taken to the PCCC in February 2020. <strong>ACTION:</strong> Review of GP Education to go on the February 2020 PCCC Agenda.</td>
<td>HE</td>
<td>February 2020</td>
<td>Open</td>
</tr>
<tr>
<td>29/08/2019</td>
<td>Primary Care Quality Report: Practice Nurse Newsletter</td>
<td>The Practice Nurse Newsletter to be circulated to PCCC members.</td>
<td>MAE</td>
<td>October 2019</td>
<td>Open</td>
</tr>
<tr>
<td>29/08/2019</td>
<td>Primary Care Quality Report: PALS support to the CCG</td>
<td>BP to include additional detail around the support undertaken by the Patient Engagement Team in the next report.</td>
<td>BP</td>
<td>October 2019</td>
<td>Open</td>
</tr>
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## Agenda Item 5

### Primary Care Commissioning Committee

<table>
<thead>
<tr>
<th>Meeting Date</th>
<th>Thursday 31 October 2019</th>
</tr>
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<tbody>
<tr>
<td>Report Title</td>
<td>Primary Care Strategy Refresh: 2019 – 2024</td>
</tr>
<tr>
<td><strong>Executive Summary</strong></td>
<td>The Gloucestershire Primary Care Strategy 2016-2021 was explicitly an enabler of the Gloucestershire STP, and later the ICS, and was approved by the Governing Body in September 2016. We have been asked by NHS England to refresh our Primary Care Strategy to ensure it reflects the NHS Long Term Plan. Regardless of this requirement, it is also a good opportunity to reflect on the significant progress made to date on the original strategy, before setting our course for the next five years as an ICS for primary care. As the original strategy was developed based on feedback from a very wide ranging stakeholder group, and was very well received, we have taken the approach of utilising that original strategy as the foundation for this one. The period in which this strategy is set will see the biggest change to primary care in at least fifteen years and is arguably one of the largest and most rapid changes in the history of the NHS. This is therefore an important document that sets out how we are responding in Gloucestershire to these changes. We are ahead of the game in many respects; our original Primary Care Strategy set a blueprint that many other areas...</td>
</tr>
</tbody>
</table>
across the country are now replicating due to the LTP. However, there is still much to do.

Refreshing our strategy has given us the opportunity to celebrate our achievements (Chapter 1), reflect on our patient feedback (Chapter 2), revisit our strategic intent (Chapter 3), including our vision to reflect the LTP and our maturing ICS, while our development themes for the next five years are evolved from our original strategy as the following six goals:

1. Primary Care at Scale: Partnerships and Integration
2. Improving Access and our Urgent Care Offer
3. Population Health, Improving Quality, Tackling Inequalities
4. Developing the Workforce
5. Digitally Enabled
6. Estates

These are then expanded with details of our plans and commitments in Chapter 4. This strategy will therefore replace the existing Primary Care Strategy 2016 - 2021, Primary Care Workforce Strategy 2017 – 2021 and includes an update to the Primary Care Infrastructure Plan 2016 - 2021, which takes into account progress made on priorities, NHS policy development at a national and local, a review of housing and associated population growth.

This version is an update to the early draft shared with the Committee in August and includes
feedback from the Committee along with all other feedback received following our stakeholder engagement that included:

- PCN Clinical Directors;
- ILP Chairs;
- Gloucestershire Patient Participation Group Network;
- County, District and Parish Councils;
- GHNHSFT, GCS, 2gether and SWAST;
- West of England Academic Health Science Network (WEAHSN);
- VCS Alliance;
- Healthwatch Gloucestershire;
- Gloucestershire Police and Crime Commissioner;
- Gloucestershire Local Medical Committee (LMC).

The content of this version has been shared with NHS England to meet the end September deadline and also formed part of our ICS Long Term Plan response. That content has now been aesthetically improved by the Graphics team within the document shared with the Committee today in seeking recommendation for approval to the Governing Body.

A Primary Care Strategy Implementation Plan is now being developed to sit underneath the Strategy, assigning ownership of delivery, timescales and reporting.
**Key Issues**

The key issue with our plans is the growth in workforce anticipated within primary care as a result of the advent of Primary Care Networks. The assumptions made in the forecasts are based on local intelligence for Year 1, then application of national allocations thereafter and so are likely to be less accurate over time. However, the growth in non-traditional primary care roles is exceptional and so a joined-up approach is required across the ICS to ensure recruitment to the roles does not destabilise any individual provider.

**Risk Issues:**

It is recognised there are risks associated with each of the six strategic goals, some of which are already developed and included. The same exercise will be undertaken for each strategic goal as part of the programme planning process.

An initial risk identified across the whole strategy is the pace of change for primary care. The document is necessarily lengthy owing to the extent of change our practices are facing as the Long Term Plan expands the role of primary care through Primary Care Networks, which become the organising principle for all other community and voluntary services. The national Primary Care Network Maturity Matrix and associated PCN Development Programme attest to this. PCNs - wider than general practice alone – need to be ready to commence delivery of the first five national service specifications from April 2020. This will see primary and community care working together for the first time on delivery of national specifications. We are well placed with our Director of Locality Development and Primary
Care now a joint appointment with our community trust, but the risk for our practices and our networks of remaining stable through this period of change, and our capacity to support that, will need to be well mitigated through joined-up working in our CCG and across our ICS.

<table>
<thead>
<tr>
<th>Management of Conflicts of Interest</th>
<th>Not Applicable</th>
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<tbody>
<tr>
<td>Financial Impact</td>
<td>GCCG receive a range of funding streams from NHS England in relation to the Primary Care Strategy, which relates mainly to our delegated authority for primary care commissioning, along with individual, specific, funding streams for delivering projects under the General Practice Forward View or the NHS Long Term Plan. Any plans for additional investment required as a result of this strategy will be subject to the usual CCG approvals process.</td>
</tr>
<tr>
<td>Legal Issues (including NHS Constitution)</td>
<td>Gloucestershire CCG needs to act within the terms of the Delegation Agreement with NHS England dated 26 March 2015 for undertaking the functions relating to Primary Care Medical Services and is therefore working within this remit in the development and delivery of this strategy. The CCG’s responsibilities with regards to premises are set out in The National Health Service (general medical services premises costs) Directions 2013, while currently any capital funding requirements are not delegated to the CCG and NHS England approval is required.</td>
</tr>
<tr>
<td>Impact on Health Inequalities</td>
<td>The Primary Care Strategy seeks to reduce identified health inequalities through, for example, our Primary Care Networks and Integrated</td>
</tr>
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</table>

(tab 5 primary care strategy - final version for agreement)
Locality Partnerships working collaboratively on a place-based approach to ensure that local needs are best met.

### Impact on Equality and Diversity

The Equalities Impact Assessment completed for the original Primary Care Strategy has been refreshed and updated for this new iteration. No adverse impacts have been identified. The Strategy, as part of our ICS Long Term Plan response, will also be compliant with our ICS approach to equality and engagement impact assessment described in the overarching document, as we implement the projects in execution of this Strategy.

### Impact on Sustainable Development

This strategy seeks to maximise the delivery of appropriate services in the community, which seeks to maximise the delivery of appropriate services in the community.

### Patient and Public Involvement

As for the original strategy, engagement with the public and patients has been focused through representative bodies, in particular the Patient Participation Group Network and Healthwatch Gloucestershire.

We are currently planning to develop a short guide of this strategy to create a format that is best suited to patients and the public.

### Recommendation

The Committee is asked to:
- Recommend the Primary Care Strategy for approval to the Governing Body (inclusive of any changes requested by the Committee)

### Author

Stephen Rudd
<table>
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<tr>
<th>Designation</th>
<th>Head of Locality and Primary Care Development</th>
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<tbody>
<tr>
<td><strong>Sponsoring Director (if not author)</strong></td>
<td>Helen Goodey, Director of Locality Development and Primary Care</td>
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</table>
Executive Summary

This Gloucestershire Integrated Care System (ICS) Primary Care Strategy 2019 – 2024 builds on the progress to date, with this document an explicit refresh of our original Primary Care Strategy published in 2016. We have laid the foundations for the implementation of the NHS Long Term Plan (LTP) with the continued ambition to provide safe, high-quality care from across our GP practices to support people to age well. This document, therefore, is explicitly not a rewrite or an abandonment of our original Strategy. Rather, it is a celebration of where we are and how we will take this momentum forward to deliver the NHS LTP for primary care over the next five years, improving integration and joined-up working as an ICS.

Gloucestershire ICS is proud of the continued hard work from its providers, CCG and voluntary organisations; whilst there are challenges facing not just Gloucestershire, but the NHS at a national level, we are ambitious in what we can do to deliver further benefits to our patients. Our strategic vision is for patients to stay well for longer, access out of hospital care – where appropriate – and to further integrate general practice with other local, primary and community care providers. This strategic vision will be delivered through six goals, detailed below.
For general practice to deliver these six goals, with further details of how they will be delivered throughout the course of this Strategy, it is imperative that Gloucestershire works as an integrated health and care community. Therefore this Strategy is designed to enable, and be enabled by, the work of our provider colleagues, as well as being an integral part of the Gloucestershire LTP. There are a number of innovative new models of care detailed throughout this Strategy, but we recognise the importance of supporting a sustainable and resilient general practice too – the combination of these ambitions will enable Gloucestershire’s primary care, and wider ICS, to thrive.
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# Glossary

Listed below are some of the commonly used abbreviations used within this document, which are stated here in full for ease.

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
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<tbody>
<tr>
<td>APMS</td>
<td>Alternative Provider Medical Services</td>
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<td>BMA</td>
<td>British Medical Association</td>
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<tr>
<td>HEE</td>
<td>Health Education England</td>
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<tr>
<td>GCCG</td>
<td>Gloucestershire Clinical Commissioning Group</td>
</tr>
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<td>GCC</td>
<td>Gloucestershire County Council</td>
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<tr>
<td>GDoc</td>
<td>Gloucestershire Doctors – an organisation in which Gloucestershire GP practices are shareholders</td>
</tr>
<tr>
<td>GHCHNHSFT</td>
<td>Gloucestershire Health and Care NHS Foundation Trust</td>
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<tr>
<td>GHNHSFT</td>
<td>Gloucestershire Hospitals NHS Foundation Trust</td>
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<tr>
<td>GMS</td>
<td>General Medical Services – the contract most commonly held between the commissioners and the GPs practices for delivering primary care services</td>
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<td>HCA</td>
<td>Health Care Assistant</td>
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<tr>
<td>ICS</td>
<td>Integrated Care System</td>
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<tr>
<td>ILP</td>
<td>Integrated Locality Partnerships – an aggregation of PCNs within a locality</td>
</tr>
<tr>
<td>ILR</td>
<td>Integrated Locality Reporting – an in-house developed business intelligence tool</td>
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<tr>
<td>LMC</td>
<td>Local Medical Committee</td>
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<tr>
<td>LTP</td>
<td>NHS Long Term Plan</td>
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<tr>
<td>LSOA</td>
<td>Lower Super Output Area</td>
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<tr>
<td>MDT</td>
<td>Multi-Disciplinary Team</td>
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<td>NHS</td>
<td>National Health Service</td>
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<td>ONS</td>
<td>Office for National Statistics</td>
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<tr>
<td>PALS</td>
<td>Patient Advice and Liaison Service</td>
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<tr>
<td>PCIP</td>
<td>Primary Care Infrastructure Plan</td>
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<td>PCN</td>
<td>Primary Care Network</td>
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<td>PCTH</td>
<td>Primary Care Training Hub</td>
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<td>PHM</td>
<td>Population Health Management</td>
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<td>PPG</td>
<td>Patient Participation Group</td>
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<td>QOF</td>
<td>Quality and Outcomes Framework</td>
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<tr>
<td>SAR</td>
<td>Standardised Admissions Ratio</td>
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<tr>
<td>VCS</td>
<td>Voluntary and Community Sector</td>
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1. Foreword, Introduction and Context

Gloucestershire has 74 GP practices across 100 sites, with 650,000 registered patients. Our number of patients is predicted to grow to over 675,000 by 2023, with almost 25% growth in 75-84 year olds during that period, as seen at Figure 1. A summary position of our 74 practices can be found at Appendix 1.

![Figure 1: Gloucestershire’s Population and Geographical area](image)

We are one Integrated Care System (ICS), with one Clinical Commissioning Group, one local authority, one acute trust, one community and mental health trust and all partners are committed to meeting the need of our patients through working together to deliver one coherent plan. This Primary Care Strategy therefore forms part of that overall ICS Strategy, and is supportive of Gloucestershire’s Joint Health and Wellbeing Strategy.
1.1 Progress so far

In Gloucestershire we are proud of the progress we have made in developing general practice since we took delegated commissioning arrangements in April 2015. One of our initial aims was to stabilise the current practices to provide a footing on which to develop primary care. We then listened to the feedback of our patients, our member practice staff and our partners and published a five year Primary Care Strategy in September 2016. This committed us to deliver against six components over the five years of the Strategy – see Figure 2.

![Figure 2: Our original six key strategic components (Gloucestershire CCG, 2016)](image)

As we approach three years since its publication, we can reflect on some significant achievements:

**Access:**

- Evening and weekend appointments made available to every patient in our county, 7 days a week including bank holidays, along with additional appointments in the day to increase access to our primary care services. Totalling over 100,000 additional appointments offered per year (105,000 appointments in 18/19); patients can now see a clinical pharmacist, paramedic, mental health practitioner, physiotherapist, nurse or GP in these additional clinics we have commissioned to improve access.
At least two High Impact Actions, as defined by NHS England (NHSE) within the General Practice Forward View (NHS England, 2016), have been undertaken by all of our practices. We also secured: the Productive General Practice programme for more than half of all our practices, which alone resulted in releasing thousands of hours of clinical and administration time; two cohorts of local improvement leaders courses specifically tailored for general practice that aligned with the ICS’s Quality, Service Improvement and Redesign programme; and workshops for each locality on service improvement activity linked to the High Impact Actions. Furthermore we have supported, through NHSE funding and approval, care navigation and clinical correspondence training for staff in practices in order to support patients to see the right professional, alongside freeing up clinician time to spend with patients.

**Primary Care at Scale:**

- We initially developed 16 primary care clusters of c.18,000 to c.65,000 registered patients, all live by January 2017, with CCG investment of a recurrent £1.89/head transformation (against the national requirement of £1.50/head non-recurrent) to each cluster. All clusters invested in workforce, with clinical pharmacists, community matrons and paramedics working across practices in their clusters for the first time, often working with our ICS partners. This created a strong foundation for Primary Care Networks (PCNs), of which we now have migrated to 14 (see Appendix 2) to ensure the minimum requirement of 30,000 registered patients. Our PCNs are therefore already relatively mature, compared to many other parts of the country, and the CCG, and ICS, is committed to ensure they continue to thrive and are at the centre of our system.

- Established a GP leader in every cluster, with leadership development opportunities locally and nationally, with one GP leader from every locality a member of the ICS’s New Models of Care Board, ensuring a strong Primary Care representation within the ICS. Again this has been an organic process for us to migrate to Clinical Directors of our 14 PCNs, most of which are our previous GP leaders.

**Integration:**

- Through trialling and refining the approach in Cheltenham, Forest of Dean and Stroud & Berkeley Vale, working with our ICS partners we are now rolling out Integrated Locality Partnerships (ILPs) across our county. Our 14 PCNs are organised into 6 ILPs: Cheltenham, Cotswolds, Forest of Dean, Gloucester, Stroud & Berkeley Vale and Tewkesbury. Appendix 2 provides details of the constituent practices within each PCN and how the PCNs aggregate to the ILPs. Appendix 3 provides details about each ILP.

- ILPs are the organising principle of our ICS’ place-based ambitions and are where all of our partners are able to play a full and active part in shaping the Strategy and delivery of services for their local populations within their defined ‘place’. Launched collectively by our ICS Lead (CCG Accountable Officer), ICS Chair (independent lay chair) and ICS Place CEO Sponsor (Chief Executive of Gloucestershire Health and Care NHS Foundation Trust), they are often led by senior GPs with representation from senior leadership teams from our ICS partners, including Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT), Gloucestershire Health and Care NHS Foundation Trust (GHCNSHFT) and the local authority.
Within the three pilot areas, the collaboration between professionals and organisations has brought new insights and collective responsibility to design and deliver new services, bringing together their expertise and workforce to focus care around their patient needs. This introduced mental health practitioners and community dementia nurses into general practice, launched a Complex Care at Home scheme and commenced Multi-Disciplinary Team (MDT) meetings where clinicians discuss patients who require joined-up care and design tailored packages of support.

Greater use of technology:

- We have significantly improved our digital patient offer and will continue to do so. The NHS App is live across almost all of our practices, we are trialling online symptom-checking and triage in ten practices across the county, and have procured – through a national procurement framework – a total website replacement product for more than half of our practices that provides our patients with much greater online connectivity with their practice. We have also been supporting patients and their practices to increase the number of people registered for online services (increasing 5 percentage points over the last 2 years), reducing time spent for patients waiting to get through on the telephone to busy practice receptions.

- Prescriptions are being managed far more effectively electronically in Gloucestershire. Utilisation is higher than national average for Electronic Prescribing and markedly so for Electronic Repeat Dispensing, which offers convenience for patients and efficiencies for practices.

- We have supported all our PCNs to be able to deliver services for the patients across their practices for improving access to appointments. This was enabled through shared records across their IT clinical systems and direct booking between practices. Trials are ongoing to undertake virtual consultations, getting contemporaneous consultant input to support patient consultations and preventing hospital attendance, and video technology for supporting MDT meetings across professionals.

- We have rolled out Wi-Fi across all our practices, both for our patients while waiting and also for our practice and PCN staff working across surgeries to provide easy mobility between sites, underpinned by an improved network infrastructure.

- We are also in the process of rolling out the Joining Up Your Information (JUYI) project, which is bringing together information across a range of clinical systems, across primary and secondary care, to provide clinicians with the information they need – such as medical conditions and medication taken – to provide safe and high-quality care for patients.

- All practices are live with Summary Care Records (SCRs) with some of the highest levels of SCR Additional Information in the country being uploaded to support the most complex patients.

- As an ICS we also achieved Paper Switch Off for patient referrals from practices in June 2018, streamlining the referral process and offering greater patient choice and flexibility.

Estates:

- Our Primary Care Infrastructure Plan (PCIP) 2016 – 2021 described a set of priorities informed by intelligence gathered from a six facet survey, along with a number of legacy schemes that had not yet come to fruition prior to GCCG taking delegated commissioning arrangements.
Since then we have delivered new primary care premises for five practices across our county:

- **Cheltenham**: Cleevelands Medical Centre
- **Gloucester**: Kingsway Health Centre and Churchdown Surgery
- **Tewkesbury**: Mythe Medical Practice and Church Street Medical Practice

We have also delivered significant extensions and refurbishments for four other practices:

- **Cheltenham**: Stoke Road Surgery
- **Gloucester**: Hadwen Medical Practice and Longlevens Surgery
- **Stroud & Berkeley Vale**: Culverhay Surgery

New surgery buildings have also been approved for existing practices in Cheltenham, Cotswolds, Forest of Dean and Gloucester City. A further seven schemes are also already in progress across the county. Full details of all schemes delivered and in progress can be found at Appendix 4.

To achieve this significant improvement in our estate has required investment, and has seen our revenue contribution increase from £7.7m per year in 2015/16 to £8.6m per year in 2019/20, with further growth planned as the buildings open which are detailed in Appendix 4.

**Developing the workforce**

- We published our Primary Care Workforce Strategy 2018-2021 in March 2018, replacing the workforce plan annexed to the original Primary Care Strategy. This Strategy set out five strategic commitments (Figure 3). While the Strategy was only published a little over a year ago, we have already made substantial progress and are on track, or ahead, for the workforce targets we set out:

  - **General Practice Workforce**
  - **Developing the team**
  - **Reducing Workload**
  - **Attracting talent to traditional roles**
  - **Introducing new roles**

  **Figure 3: Our original five workforce strategic components (Gloucestershire CCG, 2018)**
As at March 2019, according to the NHS England national data set, we have 1,413 patients per qualified permanent GP, which compares to the national average of 1,788, which ranges from 1,222 patients per GP to 2,558 patients, meaning we have one of the best ratios in the country. We also see a similar position for our practice nurses (2,063 against a national average of 2,513).

In addition to GPs and nurses, we have seen considerable growth in our wider clinical workforce due to the schemes previously outlined, including clinical pharmacists, paramedics, physiotherapists, physician associates, mental health workers, community dementia nurses and community matrons. These new roles total more than 35 WTE staff working in general practice in Gloucestershire, mostly working across practices within their PCNs. As for GPs and nurses, we also are better than the national average in terms of the numbers of these staff per patient against the national average (2,459 against a national average of 3,100).

As set out as a part of our planned developments within our Strategy, we have now developed a local primary care data extraction that is stored within our local warehouse, enabling analysis of demand over time, by practice, PCN and ILP. Coupling this with the data from the national workforce reporting is enabling us to start developing reports for PCNs that include this capacity and demand over time.

In terms of reducing workload, we have evaluated the impact of care navigation to date and procured a solution for trialling in two PCNs that addressed the learning to ensure a greater impact on workload reduction. This learning will then be used to create a tailored countywide offer for rollout, utilising the local Directory of Services.

Our Community Education Provider Network (CEPN) has migrated to a Primary Care Training Hub (PCTH) which is embedded in our CCG Primary Care team. The PCTH has undertaken significant work in engaging with higher education institutes to develop our staffing pipeline, creating a Primary Care Workforce Centre website, host multi-disciplinary primary care events, and run network based training and education schemes.

We have successfully developed and launched a Health Inequalities Fellowship to tackle the long-standing recruitment issues in Gloucester City. GP Fellows gain specialist knowledge and expertise to support populations with increased health and social challenges. They work as GPs for five clinical sessions per week, complete a project and a Post-Graduate Certificate in Public Health. This innovative scheme has attracted attention from other areas of the country and was shortlisted in the NHS Parliamentary Awards 2019.

Table 1: Primary Care Workforce Data

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<tr>
<th></th>
<th>September 2017 (original baseline)</th>
<th>March 2019 (latest data)</th>
<th>Original March 2021 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>GPs WTE (excluding locum, registrars, retainers)</td>
<td>339*</td>
<td>351</td>
<td>368</td>
</tr>
<tr>
<td>GP headcount (excluding locum, registrars, retainers)</td>
<td>434</td>
<td>458</td>
<td>471</td>
</tr>
<tr>
<td>Nurses WTE</td>
<td>179**</td>
<td>213</td>
<td>179***</td>
</tr>
<tr>
<td>Nurses headcount</td>
<td>280</td>
<td>317</td>
<td>280</td>
</tr>
</tbody>
</table>

(*) revised by NHSD to 341 in later data cleansing; (**) revised by NHSD to 204 in later data cleansing; (***) trajectory held at September 2017 figures due to the large number of impending retirements)
Further initiatives include our Newly Qualified GP scheme, our Next Generation GP scheme, our GP Retainer scheme and participation in the NHSE International GP Recruitment scheme.

Our workforce programme is embedded within the ICS workforce programme, with initiative sharing on organisational development, recruitment planning and bringing our recruitment schemes together under the ‘Proud to Care’ and ‘One Gloucestershire’ brand.

1.2 Why we need a new Strategy

Clearly fantastic progress has been made against our original Strategy, but in light of the NHS Long Term Plan (LTP) (NHS England, 2019) and new GP contract framework (BMA & NHS England, 2019), we must now refresh the Strategy to ensure our ambitions are reframed and refocused. Full details of the contract can be found by following the link within the References Chapter, however in brief this new contract announced:

- A permanent solution to rising indemnity costs through a new NHS Resolution Clinical Negligence for General Practice, which started on 1 April 2019;
- A reformed Quality and Outcomes Framework (QOF), including new Quality Improvement modules developed by the Royal College of General Practitioners (RCGP), the National Institute of Clinical Excellence (NICE) and the Health Foundation;
- Major investment in a diversified workforce for primary care, through PCNs;
- An automatic entitlement for practices to a new PCN contract;
- Plans to simplify and improve access;
- Plans for ‘digital-first’;
- A phased introduction of seven new national service specifications for primary care to align primary care with the LTP deliverables;
- A five-year funding guarantee;
- A PCN dashboard and an investment fund based on PCN impact to maximise the benefits for patients and the wider NHS for this additional investment.
The LTP, meanwhile, set out five major, practical changes to the NHS service model to meet the challenges facing health systems (Figure 4).

**Figure 4: The Long Term Plan’s five major practical changes**

1. Boost ‘out-of-hospital’ care, and finally dissolve the historic divide between primary and community services
2. Re-design and reduce pressure on emergency hospital services
3. Give people more control over their own health, and more personalised care when they need it
4. Implement digitally-enabled primary and outpatient care
5. Focus on population health, improving cancer outcomes, improving mental health services, and integration via ICSs

Furthermore, Gloucestershire has become an Integrated Care System (ICS) since our original Strategy, a strong part of which is due to the work we’ve done in primary care and joining up with the rest of the system. This document, therefore, is explicitly not a rewrite or an abandonment of our original Strategy. Rather, it is a celebration of where we’re at and building on this strong foundation to deliver against the LTP for our patients over the next five years.

The next chapter of this Strategy considers patient feedback regarding primary care and demonstrates how that feedback shapes our strategic planning and supports informed decision making. The following chapter sets out our strategic intent for 2019-2024, defined through our mission, vision, values and goals. These goals are then specified in more detail in Chapter 4, ‘Our Strategic Plan’. Our governance structure is then detailed at Chapter 5, followed by our approach to engagement and equality.

The period in which this Strategy is set will see the biggest change to primary care in at least fifteen years and is, arguably, one of the largest and most rapid changes in the history of the NHS. Therefore this is an important document that sets out how we are responding to these changes in Gloucestershire. We are ahead of the game in many respects; our original Primary Care Strategy set a blueprint that many other
areas across the country are now replicating as a result of the LTP. However, there is still much to do. I am proud to be a GP in this county; prouder still to be the Clinical Chair. We have a fantastic set of primary care professionals in this county, who care passionately about our patients. I know we will make a success of everything detailed in this Strategy, it is what we’re good at – delivering safe, high-quality primary care by working together with patients and our partners.

Dr Andy Seymour
Clinical Chair – Gloucestershire CCG
2. Listening to and learning from our patients’ experiences

2.1 Introduction

Our patients are at the heart of ‘the how’, ‘the why’, ‘the when’, ‘the where’ and ‘the what’, of everything we do. We have a range of feedback mechanisms for our primary medical care services, from national surveys to local feedback through our Patient Advice and Liaison Service (PALS) and Patient Participation Network. Furthermore, all our practices have Patient Participation Groups (PPGs) who act as critical friends to their practice, providing insight on the patient experience. In this chapter, some key information from national datasets are shared and considered, followed by local insight from our patients. In Chapter 6, we share how we’ve engaged, and will continue to engage, with patients and all our stakeholders in the development and implementation of this Strategy.

2.2 National GP Patient Survey

The latest national GP Patient Survey (Ipsos MORI, 2019), relates to the publication in July 2019. The data captured by this survey is wide-ranging, measuring patients’ experiences across a range of topics and themes, such as appointment making, perceptions of care, management of health conditions, practice opening hours and much more. Therefore for completeness, all data from the survey can be found at [https://gp-patient.co.uk/](https://gp-patient.co.uk/), while the link to the slide pack for Gloucestershire’s specific report can be found in the References chapter.

The overall results are well summarised by the following question:

**Overall, how would you describe your experience of your GP practice?**

<table>
<thead>
<tr>
<th>Result</th>
<th>Gloucestershire CCG</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2016</td>
<td>2019</td>
</tr>
<tr>
<td>Good</td>
<td>89%</td>
<td>87%</td>
</tr>
<tr>
<td>Poor</td>
<td>4%</td>
<td>4%</td>
</tr>
</tbody>
</table>

*Table 2: GP patient reported experience 2019 against 2016 (Ipsos MORI, 2019)*
While it is disappointing that our position is not quite as strong as it has been previously, Gloucestershire practices overall have maintained a position above the national average figures, as we achieved in 2016, the date of our inaugural Primary Care Strategy. The Gloucestershire position has predominantly deteriorated due to some acute practice issues brought about by changes leading up to the reporting period. We are aware of these issues and are supporting those practices affected. Consequently, we see a range of patients scoring their practice as ‘good’ from 63%, up to 99% of all patients rating their practices at this level. The spread across our county is represented by this map, demonstrating that Gloucester City is an area that particularly needs further support to improve their patient experience.

Similarly, the GP Patient Survey in 2018 (Ipsos Mori, 2018) found nationally that young people (16-24 year olds) were less satisfied than other adult patients at 77.3%. Again, Gloucestershire outperformed this national statistic, with 84% of young patients rating their overall experience as ‘good’, however it demonstrates that we can still do more to improve their experience when compared to our overall figures at Table 2. Some other notable results from the survey are:

<table>
<thead>
<tr>
<th>Question</th>
<th>Gloucestershire</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generally, how easy is it to get through to someone at your GP practice on the phone?</td>
<td>80% (Easy)</td>
<td>68% (Easy)</td>
</tr>
<tr>
<td>Which ... practice online services have you used in the past 12 months?</td>
<td>75% (None)</td>
<td>76% (None)</td>
</tr>
<tr>
<td>In the last 12 months, have you had enough support from local services or organisations to help you to manage your condition(s)?</td>
<td>84% (Yes)</td>
<td>78% (Yes)</td>
</tr>
<tr>
<td>How satisfied are you with the general practice appointment times that are available to you?</td>
<td>69% (Satisfied)</td>
<td>65% (Satisfied)</td>
</tr>
</tbody>
</table>

Table 3: National Patient Survey extract (Ipsos MORI, 2019)
These figures suggest that, while we continue to outperform the national average, we need to continue to maintain such performance and seek to stretch ourselves to perform even better. We will be predominantly focusing on: developing and promoting our online patient services, creating an even more comprehensive service for our patients in their local communities and continuing to improve access to general practice to ensure appointments are available at times when our patients need them. Our Strategy has been informed by these findings and seeks to directly address them.

The CCG will continue to monitor and promote the national GP Patient Survey and encourage practices to discuss their individual results with their PPGs to identify areas for local improvement and action. Furthermore, our Associate Director for Engagement and Experience is on the national steering group to help inform further development of the GP Patient Survey, while our local PPG Network – which represents the PPGs across our county – have also been involved in the development.

We are aware that there is a national review underway of the Friends and Family Test and we are awaiting the outcome of this from NHSE to understand how we will be required to implement the changes.

### 2.3 GCCG Patient Advice and Liaison Service (PALS)

Our PALS team receive between 200 – 300 patient contacts per quarter, of which c.30-55 contacts relate to primary care. The most common theme relates to telephony systems, which resonates with the GP Patient Survey, which despite the fact that we outperform the national average, we strive to do even better and recognise there is local variance and some practices need further support to improve. Bolstering our digital offer will also alleviate some of these pressures on telephony.

### 2.4 Summary

This chapter considered the range of patient feedback we receive and highlighted some of the areas patients would like us to focus and we continue to test these with our patients through the PPG Network (see Chapter 6). The next chapter sets out our Strategic Intent, taking into consideration this feedback from our patients, alongside national and local data and intelligence on our performance, feedback from our practices, the ambitions of our ICS and the commitments made to patients in the NHS LTP.
3. Our Strategic Intent

3.1 Our Mission

To provide safe, high-quality care from across our GP practices to support people to age well.

3.2 Our Vision

In order for patients in Gloucestershire to stay well for longer and receive joined-up out of hospital care where possible, we will provide a sustainable, safe and high quality primary care service, provided in modern premises that are fit for the future.

To achieve this, we will:

- **Dissolve the historic divide** between organisations through the closer alignment and greater integration between our ICS organisations through our Primary Care Networks and Integrated Locality Partnerships;

- Provide patients with more **control over their own health, anticipatory care** and personalised care when they need it and support **early cancer diagnosis**;

- **Utilise population health to tackle inequalities**, assessing our local population by risk of unwarranted health outcomes to **make services available where they are most needed**;

- **Grow our multi-disciplinary primary care teams**, attracting and retaining high quality staff through promoting Gloucestershire as a great place to live and work, creating a better work-life balance for staff, and offering excellent training opportunities;

- Ensure **good access** to primary care **7 days a week**, meaning better support for patients while also **reducing urgent demand** at our hospitals to enable them to care for the most acutely unwell patients;

- **Digitally-enable primary care to maximise the use of technology**;

- Support Primary Care Networks and Integrated Locality Partnerships to explore how they can provide a **greater range of services** for larger numbers of patients.
3.3 Our Values

Integrity  Caring  Sustainable  Trustworthy  High-Quality  Accessible  Confidentiality  Safety  Dependable  High-Quality  Compassion  Respect  Compassion  Confidentiality

3.4 Our Goals

To deliver our Vision and achieve our Mission, we will pursue a set of strategic goals that align not only with the ambitions of NHS England’s LTP (NHS England, 2019), but also our local ambitions as an ICS. These goals build on the original six components of our Primary Care Strategy 2016 – 2021 (Gloucestershire CCG, 2016) (please see figure 2 in the foreword), which have been revisited following the publication of the LTP and the new GP contract (BMA and NHS England, 2019). They are underpinned by an enabling goal of sustaining and improving the quality of general practice.

Primary Care at Scale: Partnerships and Integration

- Supporting the foundation of our system: general practice
- Creating, sustaining and maturing Primary Care Networks (PCNs) for 100% of our registered patient population
- Developing Integrated Locality Partnerships across our six localities, working in collaboration to deliver place-based care and integrated teams

Improving Access and our Urgent Care Offer

- Evening and weekend provision
- 7 days a week
- Online and face-to-face
- More clinical staff available to see patients at their practice
Population Health, Improving Quality, Tackling Inequalities

- Tackling health inequalities
- Addressing unwarranted variation
- Developing and delivering local plans in our ‘places’
- Services tailored to population segmentation and stratification

Developing the Workforce

- Expanding our workforce for increasingly Multi-Disciplinary Teams working across and within practices
- Attracting and retaining high quality staff
- Tailored recruitment plans for hard-to-recruit areas
- Training and development opportunities for all our workforce

Digitally Enabled

- Put technology in place to support patients to access the right professional
- Digital information sharing to provide care plans and records to join up care
- Data insights to understand demand and capacity patterns and pre-empt health deterioration
- Digital access to empower patients to participate in their own health plans and access help remotely
- Enabling remote collaborative working, providing flexibility of care provision and to make the most of expertise in our Integrated Care System (ICS)
- Automation of back office processes and reducing technical barriers; freeing up time to care and increasing back office responsiveness

Estates

- Continuation of extensive estates programme
- Refresh of plans and priorities to reflect growth and ambitions
- Strategy alignment with both external Long Term Plan (LTP) and internal ICS plans
4. Our Strategic Plan

Our Strategic Plan for Primary Care, under the delegating commissioning arrangements from NHSE, resides within our overall ICS LTP as a key system enabler (see Figure 6). This Strategy and the goals that follow within this chapter are only achievable through a partnership approach that is led by the ICS, where PCNs and ILPs are front and centre of our ICS’s plans.

**Integrated Care System Development Programme**

- **Enabling Active Communities**
  - Prevention and Self Care Strategy
  - Asset Based Community Models
  - Focus on Carers and Carer Support
  - Social Prescribing/Cultural Commissioning

- **Clinical Programme Approach**
  - Transforming Care across the whole pathway
  - Clinical Programme Approach: Developing pathways and focus towards prevention across 12 priority areas including, respiratory, musculoskeletal, eye health, diabetes, circulatory, mental health, children and maternity, learning disability, cancer, frailty, end of life, dementia

- **Reducing Unwarranted Clinical Variation**
  - Medicines Optimisation
  - Reducing Unwarranted Clinical Variation
  - Diagnostics, Pathology and Follow-up Care
  - Supported by Population Health Management

- **One Place, One Budget, One System**
  - Urgent Care Model and 7 Day Service
  - People and Place – 30,000 Community Model
  - Devolution and Integrated Commissioning
  - Personal Health Budgets / Integrated Personalised Commissioning

**System Enablers**

- Joint Digital Strategy
- Primary Care Strategy
- Joint Estates Strategy
- Joint Workforce Strategy

**Figure 6: Our ICS Development Programme**

Our ICS is underpinned by the shared mission to have a Gloucestershire population that is healthy and well, where they are empowered to take personal responsibility for their own health and care and are reaping the personal benefits that this can bring: less dependent on health and social care services for support; living in healthy, active communities; benefitting from strong networks of community services and support; are able, when needed, to access consistently high-quality, safe care in the right place, at the right time.

The ICS’s vision is:

**To improve health and well-being, we believe that by all working better together, in a more joined up way, and using the strengths of individuals, carers and local communities, we will transform the quality of care and support we provide to all local people**
The ICS’s key strategic objectives are as follows:

- Place a far greater emphasis on personal responsibility, prevention and self-care, supported by additional investment in helping people to help themselves.

- Place a greater emphasis on joined up community based care and support, provided in patients’ own homes and in the right number of community centres, supported by specialist staff and teams when needed.

- Continue to bring together specialist services and resources where possible reducing the reliance on inpatient care across our system by repurposing the facilities we have in order to use them more efficiently and effectively in future.

- Develop new roles and ways of working across our system to make best use of the workforce we have, and bring new people and skills into our delivery system to deliver patient care.

This Primary Care Strategy enables these key strategic objectives along with all of the four ICS programme areas (Enabling Active Communities, Clinical Programme Approach, Reducing Unwarranted Clinical Variation and One Place, One Budget, One System) to deliver through setting out a clear development trajectory for primary care. With c.90% of all NHS patient contacts being with general practice (NHS England, 2015) and our ambitions for access, integration, Population Health Management, workforce expansion and digital-enablement described over the following pages, the ICS will focus on delivering this Strategy for the benefit of our patients, with the PCN Clinical Directors key to our decision making.

This means that, for example, our Clinical Programme Approach will mature to allocate programme budgets and clinical priorities across our new primary care system architecture of PCNs and ILPs as described in this Strategy. This matrix of priorities will need to consider our ICS priorities, as defined within our local LTP response, Health & Wellbeing Strategy priorities, along with priorities by Place – i.e. at ILP level – and those priorities determined both nationally and locally for PCNs. We are already beginning to consider how this might look (see Figure 6), however as all PCNs are at their initiation stage, and at different stages of their maturity, we need to support their development (see ‘Goal 1’) in 2019/20 in readiness for the national ‘asks’ from 2020/21, while also progressing our priorities as an ICS. We are testing these approaches with our newly appointed Clinical Directors across the PCNs, and ILP Chairs, to develop the most appropriate mechanism to align the ICS, the ILPs and PCNs, to ensure our system is delivering the right outcomes for patients across Gloucestershire, while also providing the freedom to innovate locally to ensure services are moulded to patient need.
Triangulating our ICS ambitions and priorities, the NHS LTP and the feedback from our patients, has led to the development of the six goals of this Strategy introduced in Chapter 3. Delivering these six goals will mean, as an ICS, we focus on:

- Supporting primary care to undertake pro-active case management and co-ordination of care of patients to increase out-of-hospital care where appropriate, successful implementation of which will reduce the pressures experienced on hospital based urgent care;
- Supporting patients to self-care and make more use of voluntary services in our communities, often accessed through social prescribers in our PCNs;
- An eradication of the boundaries experienced by our patients between our in-hours and out-of-hours primary care services;
- Ensuring primary care and PCNs, through our PCN-appointed Clinical Directors, are empowered to deliver care as needed for their patient population, co-ordinating an integrated care offer for all patients while developing specific pathways of care for those patients with long term conditions through the Clinical Programme Approach;
- Extending the range of services offered in our PCNs, recognising the diverse demography and health needs of our population, including diagnostics, rehabilitation, mental health, therapies and outpatients;
- Ensure greater utilisation of digital technologies to join-up care, focus on prevention and improve access to primary care services.

The rest of this Chapter now explores the six goals of this Strategy in more detail.
4.1 Goal 1: Primary Care at Scale: Partnerships and Integration

General Practice as the foundation of our system

Our practices are the bedrock of our whole system and we care passionately about the general practice partnership model and the hardworking clinical, administration and management staff who work within them. The partners are equally passionate about their patients and their staff and together we form an unequalled team in delivering improved quality and safety, driving leadership and innovation and treasuring the partnership model that delivers the fantastic care our patients deserve. We have a strong relationship with our Local Medical Committee (LMC), our local GP Provider Company (GDoc) and engage frequently across our member practices. This includes practice visits by senior executives, senior GP leadership meetings, whole county forums and weekly electronic newsletters, along with a dedicated Primary Care and Localities Directorate who have close working relationships across all practices and other teams and key personnel who frequently interface with general practice. Recent feedback demonstrates that our member practices feel well supported by and have a close relationship with the CCG.

The platform on which our ICS is built must have strong foundations. Through developing the close relationship over the course of the previous Strategy, we know there continues to be some practices struggling with their sustainability and resilience. We have put measures in place to support these practices, as we set out to do under the previous Strategy, and we recognise we must continue to invest. Over the course of this Strategy we will continue to ensure the sustainability and resilience of our practices. Our measures will include:

- Investing in workforce, separate from practice and PCN staff, who can be placed in practices for short periods of time to support acute workforce pressures caused by unexpected but extended illness (see Goal 4);
- Close working with the LMC to work together to support those practices most in need, supporting mergers or other solutions where appropriate;
- Prioritise GPFV resilience funding to our practices most at risk;
- Continue investing in general practice and PCNs, inclusive of recurrent ‘transformation’ funding, our Primary Care Offer (see Goal 3) and other enhanced services that bring investment into general practice.

By securing these foundations, we have the necessary infrastructure in place to provide patients with integrated care built up from our patients, through to general practice, through PCNs to ILPs to the ICS (see Figure 8) who hold overall responsibility for ensuring the success of our ILPs, PCNs and GP practices for the benefit of our patients; the reason this Strategy exists. For details of which practices are in which PCN, please see Appendix 2. This is the structure we are rolling out in 2019/20 and will be the basis of reorganising our ICS partners around over the course of this Strategy, starting with our community teams.
Primary Care Networks

What is a Primary Care Network (PCN)?

Introduced nationally by NHS England through the NHS LTP and the GP Contract Reform 2019-2024, PCNs have been created across England, with over 1,250 PCNs in existence from 1 July 2019. These are based on minimum registered list sizes of 30,000 patients – not usually more than 50,000 – commissioned through general practice in the form of a Directed Enhanced Service (DES) that forms the network contract. A mandated network agreement, with associated schedules, sets out the relationship and operating protocols of the PCN. Guaranteed real-terms investment of £4.5bn has been pledged for primary and community care from 2019/20 to 2023/24.

The core characteristics of a Primary Care Network are:

- **Practices working together and with other local health and care providers**, around natural local communities that make sense geographically, to provide coordinated care through integrated teams

- **Providing care in different ways to match different people’s needs**, including flexible access to advice and support for ‘healthier’ sections of the population, and joined up multidisciplinary care for those with more complex conditions

- **Focus on prevention and personalised care**, supporting patients to make informed decisions about their care and look after their own health, by connecting them with the full range of statutory and voluntary services

- **Use of data and technology to assess population health needs and health inequalities**, to inform, design and deliver practice and population scale care models; support clinical decision making, and monitor performance and variation to inform continuous service improvement

- **Making best use of collective resources** across practices and other local health and care providers to allow greater resilience, more sustainable workload and access to a larger range of professional groups.

Source: NHSE, 2019
NHSE has set out five aspirations for PCNs across the country, which we have adopted in Gloucestershire and informs our specific commitments to our PCNs over the course of this Strategy:

1. Stabilise the GP partnership model;
2. Create 20,000 new staff working in general practice through an ‘Additional Roles Reimbursement’ scheme (see Goal 4 for our local commitments in this regard);
3. Create a wider platform for investment;
4. Dissolve the historic divide between primary and community care – which we will achieve through our PCNs and ILPs and have expanded the remit of our Director of Locality Development and Primary Care to be a joint appointment across CCG and the merging 2gether Trust and GCS;
5. Have a clear, quantified, positive impact for the NHS system and our patients, with fewer patients being seen in hospital and more being seen and treated in our communities.

PCNs are wider than just general practice; they must include all of primary and community care staff, working together to deliver preventative, out of hospital, care for their patient population. So while GP practices are at their heart, and the initial partners from July 2019, they must grow from April 2020 to begin including these other partners. This will enable them to commence the new service specifications that will go live from April 2020, with some mirrored service specifications for community teams to support the staff integration and joint working:

- **Structure Medications Review and Optimisation**
- **Enhanced Health in Care Homes**;
- **Anticipatory Care** for high need patients with several long term-conditions;
- **Personalised Care**
- **Supporting Early Cancer Diagnosis**

From April 2021, there will be a further two specifications:

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

From April 2020, every PCN will receive a new national Network Dashboard to measure impact, including A&E attendances, admissions, prescribing and performance against these new service specifications. Also commencing in 2020 is a new national Network Investment and Impact Fund, linked to performance against metrics in the Network Dashboard. This will mean that PCNs that can evidence a positive, demonstrable, impact in these measures will receive further investment to support their growth.
What this means for Gloucestershire

Having set out a commitment in our previous Primary Care Strategy to create clusters of c.30,000-50,000 patients and achieving this with 16 clusters, we were particularly well placed for the development of PCNs. As shown at Figure 8 above and at Appendix 2, our member practices have coalesced to create 14 PCNs, largely similar to those original cluster configurations, which all went live from 1 July 2019. Gloucestershire ICS has been allocated funding from NHSE to support the development of our 14 PCNs and their Clinical Directors (see Goal 4). The PCN Development Programme has been co-produced by NHSE and Primary Care colleagues across the country, including representatives from Gloucestershire and is expected to run for five years. It comprises six support domains which represent the essential elements systems will use to meet local needs (see Figure 9).

![Figure 9: The six PCN Development Programme Domains](image)

We are working in close collaboration with our PCNs and their respective Clinical Directors to ensure there are appropriate development options for our PCNs’ requirements. This work is informed by completion of NHSE’s PCN maturity matrix, which gives each PCN the opportunity to identify their development needs in relation to their own vision and goals, along with their requirements to meet these aspirations. Utilising this feedback, and iteratively capturing progress and new goals over the course of this Strategy, we will support the mobilisation, implementation and ongoing delivery of the programme to fulfil the various development needs across our county. Our explicit aim under this Goal is for our PCNs to be supported to achieve ‘Step 3’ maturity by 2023/24. This will mean a joined-up ICS programme of work and investment in urgent care (see Goal 2), population health management (Goal 3), our workforce (Goal 4), our IT (Goal 5) and our estates (Goal 6).

We will also support all our PCNs to reach their maximum potential through providing dedicated management support from the ICS to support their planning and development, along with local metrics ahead of the national dashboard (see Goal 3).
Integration with wider Primary Care

During 2019/20, it is expected that PCNs will begin to develop wider relationships with their partners to deliver integrated care and by April 2020, it is expected that Community Pharmacy will be a key partner in local PCNs. Community pharmacists are highly trained healthcare professionals, passionate about providing high quality services to their patients. Community pharmacists have the potential to play a greater role in clinical service delivery, helping people to stay well. Whilst the supply of medicines remains an ongoing and critical part of what community pharmacy provides, there is an opportunity to focus on minor illness and the prevention and detection of ill health. The agreement reached between the Government, the NHS and the Pharmaceutical Services Negotiating Committee (PSNC) describes the joint vision for how community pharmacy will support delivery of the NHS LTP. The community Contractual Framework 2019/20 – 2023/24, published on the 22 July, outlines the deal which has been agreed:

- Commits almost £13 billion to community pharmacy through its contractual framework, with a commitment to spend £2.592 billion in each of the next five financial years;

- Is in line with the GP contract, providing 5-year stability and reassurance to community pharmacy;

- Builds upon the reforms started in 2015 with the introduction of the Quality Payments Scheme to move pharmacies towards a much more clinically focused service;

- Confirms community pharmacy’s future as an integral part of the NHS, delivering clinical services as a full partner in local PCNs;

- Describes new services which will immediately be offered through community pharmacy as well as a programme to develop evidence-based additions to those services. Foremost amongst the new services is the new national NHS Community Pharmacist Consultation Service, connecting patients who have a minor illness with a community pharmacy which should rightly be their first port of call (see Goal 4);

- Underlines the critical role of community pharmacy as an agent of improved public health and prevention, embedded in the local community;

- Recognises that an expanded service role is dependent on action to release pharmacist capacity from existing work, including developments in information technology and skill mix, to deliver efficiencies in dispensing and services that release pharmacist time;

- Continues to prioritise quality in community pharmacy and to promote medicines safety and optimisation; and

- Underlines the necessity of protecting access to local community pharmacies through a Pharmacy Access Scheme.

We recognise that attempting to align all our ICS partners to 14 PCNs would be resource-intensive and inefficient and prevent planning at a district – or ‘place’ level. For this reason, we have created Integrated Locality Partnerships (ILPs), where PCNs come together with their ICS partners to develop and plan services at this larger footprint.
Integrated Locality Partnerships (ILPs)

We know that to have sustainable health and care services in Gloucestershire we need to work collaboratively as one integrated system to deliver the vision and ambitions of our ICS. This neatly dovetails with the LTP, reflecting the journey we've already commenced of taking collective responsibility for managing resources, delivering NHS standards, and improving the health and wellbeing of the population we serve through breaking down the barriers between our individual organisations to deliver better health and care. We have embraced the opportunity to do more at pace and at scale, encouraging a population based approach to improving health and care through the delivery of place based care. Over the course of this Strategy, we will continue to align with the other public services working across Gloucestershire in order to address the wider social determinants of physical and mental health. This will be achieved through our six ILPs (see Appendix 2 for breakdown on ILPs and PCNs; Appendix 3 provides a profile for each ILP). We will build on the Health and Wellbeing Strategy using Population Health Data (see ‘Goal 3’) to drive the identification and prioritisation of the most appropriate response to the management of care. By removing silos of provision, we will encourage providers over health outcomes not levels of activity, working together in an integrated delivery model.

Case Study: Cheltenham St Paul’s PCN

This PCN is made up of 5 co-located practices serving around 50,000 patients. The practices work together in their network along with other providers such as GHCNHSFT and SWAST to provide a wider skill mix.

Shared physiotherapist appointments are provided through a GHCNHSFT employed physiotherapist, while home visiting and other urgent appointments are provided by a paramedic employed by SWAST. This has enabled the GPs to spend longer with patients with more complex needs, reducing hospital admissions and improving GP morale and patient satisfaction.
We will deliver this place-based care through our PCNs described above, which will see multi-disciplinary teams working together to serve their populations and making the most of the many supportive ‘community assets’ such as voluntary and community groups that also work within our neighbourhoods, i.e. PCNs, while strategic planning and delivery on larger footprints will be organised at ILP level. As seen in figure 10, we are proposing a person-centred, place-based model of proactive community based care, closer to home, with primary care at its core. This entails not just integrating health and social care but a joined-up approach with education and skills, welfare and benefits, leisure, housing and community safety programmes to deliver a more appropriate mix of medical and social interventions to tackle the root cause of health inequalities.

This means:

- There will be more support for people to stay healthy and independent and develop active communities that promote prevention and self-care;
- Local people with long-term conditions will benefit from more joined-up care and support in their own home, GP surgery, community or hospital;
- Staff should find it easier to work with colleagues from other organisations to support shared health priorities and deliver better outcomes for patients;
- Seamless care between primary care and NHS community services – that fundamentally removes the historic separation of these parts of the NHS and brings community services together (across physical and mental health);
- Joined-up care planning, coordination and delivery between primary care and social care – with NHS and social care staff working together in MDTs and hubs;
- We will leverage our strength as one system to integrate with wider partners in fire, housing, leisure, police, Voluntary and Community Sector (VCS) organisations and education – with shared responsibility and mature relationships;
- We will fully harness the opportunities from technology – for digital provision of care for patients, real-time single care records and Business Intelligence systems, including predictive modelling for risk stratification and care segmentation (see Goal 5);
- Sustainable workloads for staff and more attractive and structured career pathways – that enable MDT working and new integrated care roles, portfolio-based careers and support for staff to move between care sectors.

In working together, our ICS partner organisations will have greater freedom and control to make decisions about service configuration, meaning services and support can be best targeted towards local need. We are committed to moving forward with system-wide models of care, making sense of the problems we face together and encouraging innovative solutions at all levels.
Integrated Locality Partnerships – how will they work?

Our ICS system partners have collectively agreed that ILPs will have the following characteristics and responsibilities:

- Be an Operational and Strategic partnership of senior leaders of health and social care providers and local government, supporting the integration of services and teams at PCN level;
- Unblock issues for PCNs and sharing responsibility, finding local solutions to delivering ICS priorities and tackling issues which arise locally which can only be resolved collectively;
- Focus on cultural change and the way we work together, rather than on structural change;
- Provide clinically-led integration of decision making, involving staff and local people in decisions, to support more people in the community and out of hospital;
- Develop multidisciplinary workforce models which will operate at PCN level with staff empowered to work in innovative ways to meet the needs of patients regardless of organisational boundaries;
- Collectively produce an ILP Plan to deliver improved population health including prevention and public health and reduced inequalities with aligned priorities agreed to improve outcomes.

In time, our ambition is to see the membership of ILPs broaden to include partners whose work impacts on health and wellbeing and the wider determinants of health, for example social prescribing, education and employment and working alongside a range of other partners and local communities.

We recognise that this development will take time as there will inevitably be cultural, technological and resourcing hurdles as we integrate our teams. To tackle this, we will create the right environment and senior leadership to create shared incentives, a shared sense of place and a shared set of priorities (see Table 3 below); with one set of patients, we know that by doing this our teams will coalesce around delivering the best possible outcomes for their shared, common, goal: the health and wellbeing of their patients.

<table>
<thead>
<tr>
<th>ICS Clinical Priorities</th>
<th>Anticipated as: Respiratory, Cardio Vascular Disease (CVD), Diabetes and Frailty including Dementia.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health &amp; Wellbeing</td>
<td>Social Isolation, Adverse Childhood Experiences (ACEs), Physical Activity, Health Lifestyles (with initial focus on healthy weight), Housing and Health, Mental Wellbeing, Early Years/Best Start in Life.</td>
</tr>
<tr>
<td>Strategy Priorities</td>
<td>预防和减少不平等框架（NHS长期计划响应）</td>
</tr>
<tr>
<td>Prevention and reducing inequality framework (NHS Long Term Plan response)</td>
<td>Smoking, Obesity, Alcohol, Air pollution, Antimicrobial resistance, Health inequalities</td>
</tr>
<tr>
<td>Local Priorities</td>
<td>PCN defined inclusive of national service specifications and priorities determined through local and national datasets</td>
</tr>
</tbody>
</table>

Table 4: The six PCN Development Programme Domains
Summary of our priorities for Goal 1

**Goal 1: Primary Care at Scale: Partnerships and Integration**

Our strategic commitments to this goal during the timeframe of this Strategy are as follows. We will:

- Continue to ensure the sustainability and resilience of our individual GP practices as the foundation of our whole system.
- Support the development of each PCN across the Maturity Matrix to achieve ‘Step 3’ maturity by 2023/24, with dedicated resource made available.
- Align and integrate all of our primary and community care provision through our PCNs to address the wider social determinants of physical and mental health.
- Support the maturity of our ILPs – the aggregation of our PCNs at ‘Place’ level – to remove silos of provision, incentivising providers over health outcomes not levels of activity, working together in an integrated delivery model. This will include wider partners in fire, housing, leisure, police and education.
4.2 Goal 2: Improving Access and our Urgent Care Offer

We want patients in Gloucestershire to continue to have good access to high quality primary medical services through their local GP practice when they need to getting the right care, in the right place at the right time. To do this we will increase the ways in which patients can access both digital services and face-to-face services. In turn, this will ensure valuable resources are used carefully and appropriately so that patients get the best care when they need it, whilst keeping GP services sustainable and fit for the future.

While many of our GP practices are thriving, like many other services, they are very busy and in some cases overstretched. As can be seen at Figure 10 below, the average number of appointments attended per 1,000 population per working day for our county has been steadily rising. In 2017/18, our GP practices saw an average of 22.2 appointments per 1,000 patients (based on average list size over 2017/18), or c.14,250 appointments per day. By 2018/19, this had risen to an average of 23.4 appointments, or 15,200 appointments per day (based on average list size over 2018/19). Early data from 2019/20 suggests a continuation of this increasing trend. Capturing this primary care activity data is a recent capability and one that we committed to in our original Primary Care Workforce Strategy. Through this new data source we have also identified variation by practice, PCN and locality, which we commit to analysing and triangulating with other data sources so we can understand the drivers for this variation and develop our plans and support accordingly.

![Average appointments per 1,000 population per working day](image)

**Figure 11: Average attended appointments per 1,000 population per working day, April 2017 – March 2019 (based on extracted, anonymised, data from Gloucestershire GP clinical systems)**

In line with the aims of the NHS LTP, Gloucestershire practices – through their PCNs – will be employing more new roles in primary care to improve access for patients and to support prevention and early intervention. A variety of these roles already exist in county and further expansion of these roles is detailed in Goal 5.
**Improved Access**

To improve access to GP services our practices have been working together to provide general medical services 8am to 8pm, 7 days a week including bank holidays. In Gloucestershire we have provided over 100,000 additional appointments in the past year through the delivery of Improved Access; Improved Access provides both routine and same day pre-bookable appointments between 6.30pm to 8pm on weekdays and at weekends and bank holidays. We have various delivery models designed to meet the needs of patients and to support the sustainability and resilience of general practice, with many models rotating evening appointment sessions around practices in their respective PCNs to improve access, even in the most rural areas.

Saturday afternoon, Sunday and Bank Holiday Improved Access appointments are delivered through a countywide service which operates from three urban locations and provides support to urgent care services for minor illness presentations requiring a GP. Pre-bookable, on-the-day appointments are available through NHS 111 into our countywide service and this is being expanded into general practice as part of the commitment made in the LTP and the GP Contract Reform, with a minimum of 1 appointment per 3,000 registered patients a day being made available for 111 booking, rising in 3,000 bandings. “Click or Call” will be the key messages for our patients, to ensure effective signposting and management of timely access, with a plan for robust engagement and communication to ensure excellent utilisation, including advertising on digital and other media platforms. Further detail on how digital technologies will support our urgent care offer is detailed at Goal 5.

By 2021, Improved Access will be integrated with Extended Hours commissioned from PCNs. The detail of this will be informed by a national Access Review through 2019, which has one main objective: to improve patient access both in hours and at evenings and weekends and to reduce unwarranted variation in experience. The Access Review will include:

- Review of current and previous models of service delivery and evidence of the benefits and costs of service provision and impact on the wider system;
- Identifying ways to reduce fragmentation of care and offer a more joined up service for patients;
- Looking at the workforce and workload and how to support patients and staff to make best use of services, including using digital technologies;
- Engaging with patients and the public through bespoke patient and voluntary sector focused events;
- Finding ways to make best use of available general practice appointments that offer continuity and choice for patients;
- Reviewing care navigation and demand management to ensure the most appropriate use of general practice services;
- Understanding reasons for unwarranted variations in waiting times with a view to improving satisfaction;
- Understanding the relationship between workload pressure, workforce wellbeing and the delivery of good quality care;
- Developing a comprehensive offer for out of hospital care including when practices are closed or unavailable;
Making the most effective use of resources in the NHS’ investment in this area;

Understanding any likely issues with inequalities in access to routine and urgent appointments in general practice and the community.

These developments will also help to reduce unnecessary attendances in urgent and emergency care settings and will form part of a greater network of services to include prevention and self-care, clinical advice and assessment over the telephone and on-line, pre-bookable appointments where required for both minor illness and injury presentations, and access to outstanding specialist hospital care for when patients are very unwell – a service offer that reflects the diversity of the Gloucestershire county and patient acuity.

**Joining up the urgent care offer**

Our commitment to further developing our out of hospital ambulatory offer will also aim to appropriately reduce acute hospital admissions or assessments and therefore, our plans are integrated with the ICS urgent care offer, described in our overall Gloucestershire long term plan. These plans will be supported by Point of Care testing in the community and professional access to specialist clinical advice so that more people can be treated closer to home where appropriate.

As can be seen at Figure 12, general practice makes a significant contribution to urgent on the day demand in our county, with nearly 5,000 people being seen on an average weekday.

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**Analysis of 2018/19 activity data shows that on an average day in Gloucestershire:**

- **4980 people** seen in a GP Surgery for an urgent on the day appointment
- **125 people** contact GP out of hours
- **206 people** attend an MIU
- **362 people** call 111
- **255 people** call 999
- **395 people** attend A&E at a hospital

*Figure 12: Daily Gloucestershire ICS urgent care activity by point of care delivery*
Increasingly patients will have seamless access to appropriate services in primary care with GP practices working closely with local pharmacies and community services through their PCNs, alongside local dentists and optometrists.

Pharmacies will provide consultations to give advice on minor health issues and provide urgent prescriptions to reduce demand on general practice and other urgent care services. Patients will be able to access these services at their local community pharmacy or through calling 111. Community pharmacy will become the “first port of call” for low acuity conditions needing a consultation or face to face advice and for medicines access and advice. Gloucestershire are piloting with NHS England a scheme to provide further capacity through community pharmacy, called the Community Pharmacist Consultation Service – further details can be found at Goal 4, commitment 2.

PCNs integrating and joining-up the delivery of urgent care will be a vital element of the primary and community service offer, along with the additional workforce, digital enablement and estates plans described in this document, as we strive to improve patient experience while providing excellent quality care and sustainable services.

Summary of our priorities for Goal 2

Goal 2: Improving Access and our Urgent Care Offer

Our strategic commitments to this goal during the timeframe of this Strategy are as follows. We will:

- Commit to analysing and triangulating our primary care activity data to understand the drivers for variation and develop our plans accordingly;

- Fully engage with the national Access review and support PCNs who wish to integrate extended hours and improved access early, in order to sustainably provide better access to appointments for our patients;

- Further develop our out of hospital ambulatory offer to bring care closer to home for our patients, supported by Point of Care testing in the community;

- Continue to build collaborative working between urgent, primary and community care,

- Support the rollout other modes of improving access, such as digital enablement.
4.3 Goal 3: Population Health, Improving Quality and Tackling Inequalities

The King’s Fund (2019) describe four pillars of population health – see figure 12 below – improving health requires action across all four. As an ICS, and with the infrastructure of PCNs and ILPs described in Goal 1, we have already begun this journey, but we have much more to do. This is described within this Goal, but should also be read in conjunction with our ICS’s long term plan.

Population Health Management (PHM) therefore aims to improve population health, mental and physical, whilst reducing health inequalities within and across a defined population, through data driven planning and delivery of proactive care to achieve maximum impact. PHM includes segmentation, stratification and ‘impactability’ modelling to identify local ‘at risk’ cohorts and involves:

- Designing and targeting interventions to prevent ill-health;
- Reducing unwarranted variations in outcomes;
- Improving care and support for people with ongoing health conditions;
- Identifying those patients who are most at risk of suffering ill-health.

It is a national LTP expectation that ICSs deploy PHM solutions to understand the areas of greatest health need and match and design NHS services to meet them. Therefore we need to ensure we have the tools and systems in place to support these requirements and, while national datasets are being developed to support PCNs with this planning, we have pursued our own local dataset development to commence early work with our PCNs and ILPs. This has been co-produced by ICS partners, including GCC’s Public Health team, to bring together an initial overview for each ILP; these can be found at Appendix 3. This is developing insights such as the relationship between deprivation and the average number of long term conditions (LTCs) our patients have by age (see Figure 13), which shows that the average patient in the most deprived quintile will have one LTC by the age of 45-49, whereas the average patient in the least deprived quintile will be in a similar position but 10 years later. This demonstrates how we need to respond as an ICS to tackle these health inequalities within our county.
We have also undertaken some initial population segmentation, which we will continue to develop and refine, along with population risk stratification, proactive case finding and identification of high intensity users for MDTs. These will continue to be developed to provide population health intelligence for our PCNs, ILPs and the ICS with the aim of addressing the health inequalities within our system. We are also finalising a dynamic tool for Integrated Locality Reporting (ILR) (see below).

**Figure 14: relationship between deprivation and long-term conditions by age**

We have also undertaken some initial population segmentation, which we will continue to develop and refine, along with population risk stratification, proactive case finding and identification of high intensity users for MDTs. These will continue to be developed to provide population health intelligence for our PCNs, ILPs and the ICS with the aim of addressing the health inequalities within our system. We are also finalising a dynamic tool for Integrated Locality Reporting (ILR) (see below).

**Developing our PHM capabilities**

In order to provide PHM, we will be working as an ICS to iteratively develop the following three capabilities over the course of this Strategy, utilising feedback from our PCNs and ILPs and as we continue to develop our technology to implement appropriate IT infrastructure to optimise performance, storage and accessibility (see Goal 5).
This PHM development will be led by a system-wide PHM Steering Group Co-Chaired by the CCG Chief Finance Officer and the Director of Public Health at GCC. This will also require development of our ICS Data Asset, which will be achieved through data acquisition projects such as the Social Care Data Sharing Project. This will then create a person-centred linked data set, including the primary care record:

Furthermore, our ICS has been successful in its bid to NHSE to become a Wave Two site under the NHSE and NHS Improvement Integrated Care Systems PHM Development Programme. This gives us the opportunity to use the data and analysis carried out by the national PHM team alongside Gloucestershire clinicians, analysts and managers to demonstrably improve health outcomes and tackle inequalities for selected local population cohorts. The programme will involve completing a 20 week supported cycle with three PCNs and we plan to then share this learning across the system. Utilising the experience will enable us to more fully develop our plans and support our capability development over the course of this Strategy. PHM is a module within the PCN Development Programme, designed to directly support preparation for the Anticipatory Care national service specification in 2020, so we will link the development needs and opportunities borne from each programme.

A PHM strategy has been developed to support the ICS, which aims to have PHM embedded across our system and key priority Clinical Programme Groups by 2022. PHM will support our decision making and to tailor our services to the needs of our population. The PHM outcomes for the ICS are:

- The ICS understands the health and care needs of its population.
- Data is developed into intelligence and used to predict health outcomes and the impact that these have on the Gloucestershire health and care system.
- Data is developed into intelligence to reduce health inequalities.
- Care interventions are designed and implemented in a personalised way based on advanced population analytics and evidence.
- Care interventions are focused on proactive prevention and early intervention.
Over the coming years, our PHM solutions will become increasingly sophisticated in identifying those groups of people who are at risk of adverse health outcomes, predict which individuals are most likely to benefit from different health and care interventions, as well as identifying health inequalities. This will also support greater transparency of health and social care data on population health outcomes and organisational performance. Through our work with the national PHM development programme, we are taking a lead in progressing complex solutions to linking and using data for local PHM solutions, ensuring that they enable achievement of the LTP goals (e.g. develop and build on locality data to better identify inequalities and unwarranted variation in processes and outcomes).

Integrated Locality Reporting

To support our practices, PCNs and ILPs to begin to understand their practices, populations and priorities we are developing an ILR tool. The ILR tool, initially Excel based (see screenshots below), will be made available to all PCNs during 2019/20 – ahead of the national Network Dashboard – to allow early planning and implementation at neighbourhood and place level and is being developed in partnership with our Clinical Directors and ILP Chairs as well as our wider system partners. Our ambition is that this will continue to mature and will complement the nationally available datasets to give the most practical and informative intelligence to enable action that benefits our populations. The ILR tool allows users to interact with analytics developed from our current ICS dataset, providing a high-level view of populations and resource usage, it will provide timely and appropriate information to help shape priorities, deliver a consistent ICS message, support PHM and integrated system working (Figure 14).

![Figure 14: The concept of our ILR tool]

Furthermore, the ILR tool will measure performance, outcomes and evaluate impact. It includes the following range of metrics:

- Demography and PHM;
- Primary Care Metrics, inclusive of CQC ratings, appointment data, workforce data, patient feedback;
- Secondary Care urgent care utilisation, such as Emergency Department and Emergency Admissions data;
- Secondary Care planned care utilisation, such as day care utilisation, elective inpatients and outpatient data;
Prescribing data;
Community data, such as rapid response and physiotherapy utilisation.

We will continue to develop this tool over the course of this Strategy to move to a business intelligence platform – improving functionality and accessibility – and integrate further data from across our ICS including NHS111, out of hours, ambulance data from SWASFT, social care and public health measures. We will also include in-depth analysis in conjunction with our Clinical Programme Groups.

Our ILR will also support our wider data driven approach to case finding, for example in our use of link data to develop clinically informed searches to pro-actively identify patients suitable for a particular service or intervention.

**Improving Quality and Tackling Variation and Inequalities**

Our approach to improving primary care quality will be through an ICS-wide quality framework and objectives, with quality surveillance and assurance and committees in common. Our framework will consider the safety and treatment of our patients, the effectiveness of care and treatment, our patients’ experience of care and the fundamentals standards of care. This will be detailed within an ICS Quality Strategy underpinned by provider plans, including for Primary Care, led by the CCG Quality Team.

Through the work described above, we will be improving the quality of care for our patients and tackling variation, but these are not our only measures.

**Primary Care Offer**

Our ‘Primary Care Offer’ is a local enhanced service offered to all of our practices. In place and being iteratively developed since 2014/15, we have 100% of our practices signed up to this service that invests £3m in new services for our patients in general practice, improving quality and reducing variation. The scheme is reviewed annually to ensure the priorities are aligned across the CCG and – now – our ICS, allowing us to also align incentives across our system for the benefit of our patients. Our 2019/20 scheme focuses on:

| Pain                      | • Appropriate prescribing for pain  
|                          | • Lower back pain - support for patients  
| Frailty                  | • Management of severely & moderately frail patients  
|                          | • Education on falls and frailty  
|                          | • Hospital discharges for frail patients  
| Atrial Fibrillation      | • Raising awareness on best practice management  
| Expanding tele-dermatology | • Supporting patients to get quicker diagnosis and treatment through GP access to consultant advice through tele-dermatology  
| End of Life              | • Rolling out Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) for our patients  
|                          | • Anticipatory Prescribing for palliative patients  

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Tab 5 Primary Care Strategy - Final Version for Agreement
We will continue to support and enhance the delivery of the Primary Care Offer with additional resources for our practices that also seek to tackle inequalities and improve quality:

- Practice prescribing support, provided by both pharmacists and a smaller team of qualified pharmacy technicians, assisting with the progress of the local prescribing improvement plan, supporting cost efficiency and safety aspects. Each practice will continue to receive at least half a day of Prescribing Support Pharmacist or Prescribing Support Technician support per week, depending upon individual practice need.

- The provision of specific prescribing support software to assist clinicians in making cost effective choices, as well as providing prescribing safety and quality messages based on local and national guidance at the point of prescribing.

- A prescribing dashboard to provide practices with direct access to their prescribing performance figures of relevance to the local prescribing savings plan initiatives, helping them to track their progress against specific key performance indicators of prescribing quality. This includes the reduction in prescribing of low clinical value, maximising beneficial clinical outcomes with an emphasis on safety, governance, professional collaboration and patient engagement.

- Reducing medication errors, including prescribing, dispensing, administration and monitoring errors, via our Prescription Ordering Line.

- Reducing medication waste through campaigns and communications online and in GP practices.

- Maintaining the focus on medication safety through audit, medicines review with a focus on frailty, polypharmacy and high risk medicines combinations.

- Continue to support practices undergoing change, such as branch closures, staff changes and premises developments, along with CQC required improvements, with dedicated support to ensure high quality patient care is maintained.

- Working with our ICS colleagues in GCC, in accordance with Public Health Section 7a, to improve uptake in vaccinations, immunisations and screening to tackle health inequalities as we await the national review;
In addition to the national PCN service specifications which will be in place from 2020/21 (see Goal 1), further key focus areas for us during the course of this Strategy will be:

- Supporting integration of pharmacists into new roles including GP practices, localities and care homes, where residents will get regular clinical pharmacist led medicines reviews;
- Promoting self-care, including use of community pharmacies and increasing uptake of electronic repeat dispensing.

We also commit to improving coverage of health checks for people with a learning disability, along with:

- Improving the quality of registers for people with a learning disability;
- A concerted effort to increase the number of people with a learning disability receiving the flu vaccine, given the level of avoidable mortality associated with respiratory problems;
- Introducing the QOF Quality Improvement module for learning disability in 2020/21;
- Aiming to achieve early delivery of the 75% target for comprehensive health checks, aiming to achieve the 75% goal collectively and in every PCN.

**Summary of our priorities for Goal 3**

**Goal 3: Population Health, Improving Quality and Tackling Inequalities**

Our strategic commitments to this goal during the timeframe of this Strategy are as follows. We will:

- **Develop our PHM capabilities** to support our practices, PCNs, ILPs and our ICS with the intelligence to improve care quality, efficiency and equity;
- Take the learning from our **Wave 2 PHM work** in three PCNs in 2019/20 to develop an offer for all 14 PCNs from 2020/21 onwards;
- **Further develop our Integrated Locality Reporting tool** and move to a business intelligence platform – improving functionality and accessibility – and integrate further data from across our ICS;
- **Continue to invest in improving quality and tackling inequalities** through a range of measures, including looking for more opportunities at practice, PCN and ILP level, to target resources effectively through our Primary Care Offer and other enhanced services.
4.4 Goal 4: Developing the Workforce

Over the last two years we have made significant progress on the aims of our Primary Care Workforce Strategy 2017 – 2021, which are summarised in Chapter 1.1. The lessons learnt have helped us to understand the opportunities and challenges to consider for future design, delivery and implementation of our successful schemes. Successful workforce recruitment, development and transformation underlie many of the key changes introduced as part of the LTP and indeed this Strategy. While we remain committed to our original principles described in our Primary Care Workforce Strategy, this section explicitly replaces this Strategy, building upon that existing approach and the commitments made. We have integrated this approach with the NHS Interim People Plan, in order to have a workforce which provides safe, high quality care and supports the sustainability of our practices and our local NHS. We continue to work with co-produced local initiatives with our stakeholders and work closely with NHSE/I and HEE, as well as relevant professional bodies to support the outlined commitments.

The GP-led Gloucestershire Primary Care Training Hub (PCTH) is a key enabler for supporting future workforce transformation developments, working closely with key stakeholders such as HEE, Public Health and ICS organisations, including established providers and voluntary and community based organisations. As well as the function of the PCTH we have appointed to the role of Clinical Learning and Development Matron to be based within the Quality Directorate. This role will be responsible for leading primary care education, working with individual clinicians, practices and education providers to ensure training needs are captured and addressed and that Gloucestershire is represented at a wider regional level.

Commitment 1: Understanding demand and capacity

Together with colleagues in the CCG Information team, NHSE and HEE, we continue to collate information through primary care workforce data extraction for review and for projecting future workforce demand and capacity. This includes national tools such as the National Workforce Reporting System (NWRS), GP Workforce Trajectory Analysis Report, STP/ICS GP Workforce supply and demand tool and the Primary Care Nursing Workforce General Practice Nursing data tool. For the future we will include the NHS Digital Practice Data portal into this collation to support the workforce planning process. As shown in Chapter 1, we also benchmark ourselves nationally and locally to determine progress, which demonstrates we are doing well against our peers for recruitment and retention of staff in general practice.

Furthermore, as we continue to improve our local primary care data, as described in Goals 2 and 3, we will utilise this demand trend data to ensure our workforce plans address those areas of greatest need. We will also continue to undertake a localised annual workforce baseline survey which enables us to understand the recruitment status of practices and PCNs to develop and implement appropriate support for our GP practices. We will supply all this data to our PCNs so they can be better equipped and empowered to locally plan for their workforce growth needs and pipeline development.
Our current primary care workforce baseline and planned trajectory

As set out in Chapter 1, we have grown our GP and nurse workforce in accordance with – or above – our planned trajectory since 2017. However, we recognise this has required considerable effort from the PCTH, the wider CCG, NHSE and HEE colleagues and the practices themselves. We will not only maintain this momentum, but build on it, to continue to grow our workforce to meet rising patient demand and retain and develop the skilled workforce we already have in place. The commitments that follow describe how we will do this.

In order to have an accurate baseline for this Strategy, we have utilised all of the tools already described, along with a further one-off workforce survey of all practices to ascertain the baseline of those roles impacted by the new PCN contract that allows reimbursement for additional roles above those in post as at 31 March 2019. This is described in more detail in Commitment 3 below. We have then utilised information from NHSE, HEE and local intelligence on likely workforce changes due to growth, leavers and retirements, along with the roles PCNs can employ over the term of this Strategy, to make assumptions on our trajectory. This is built by quarter over the five years to March 2024 and is shown in more detail at Appendix 5. The trajectories are explicitly draft, as the assumptions are predicated on each PCN utilising their full additional roles allocations to recruit to these levels along with holding a steady state (with leavers and retirements fully recruited to) for those roles where no intelligence is available to support a different assumption. Therefore these trajectories will be updated on an annual basis to reflect the latest positions and to update the underlying assumptions as more data, nationally and locally, becomes available.

With all this in mind, Table 5 below provides the baseline position as at 31 March 2019 and the potential trajectory by March 2024:

<table>
<thead>
<tr>
<th>Role</th>
<th>March 2019 Actual Full Time Equivalent (FTE)</th>
<th>March 2024 Forecast Full Time Equivalent (FTE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GPs (all including Registrars)</td>
<td>415.8</td>
<td>447.8</td>
</tr>
<tr>
<td>Nurses</td>
<td>212.8</td>
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<td>Health Care Assistants</td>
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<td>Dispensers</td>
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<td>Phlebotomists</td>
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<td>Pharmacists</td>
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<td>Pharmacy Technicians</td>
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<td>3.3</td>
<td>3.3</td>
</tr>
<tr>
<td><strong>TOTAL Clinical FTE</strong></td>
<td><strong>838.2</strong></td>
<td><strong>1,050.4</strong></td>
</tr>
</tbody>
</table>

Table 5: Baseline and forecast primary care workforce 2019-2024
**Joined-up ICS workforce planning**

To ensure demand and capacity planning in primary care is integrated with our wider Gloucestershire ICS workforce plans, we regularly engage with colleagues and workforce leaders across our providers and will continue to strengthen this relationship over the next couple of years. Primary care GP and managerial workforce leads engage regularly with the Gloucestershire Local Workforce Action Board and are active members of the two ICS steering groups – Organisational Development and Workforce – and their associated sub-groups (see structure at Figure 16 below). Our workforce planning is undertaken in a shared and integrated way to ensure that growth in no one part of our system destabilises any other part, and we commit to ensuring this continues as the range of new roles are introduced to PCNs over the coming five years.

*Figure 16: Gloucestershire ICS Workforce Governance Structure*

We understand that GP practices are different in their infrastructure systems and cultures in comparison to the larger providers in the ICS. Engaging with ICS colleagues within these groups allows us to highlight both the challenges and opportunities faced by primary care, creating awareness of approaches and best practice by sharing learning – as well as working with larger providers to support innovative new ways of working across the ICS within primary care. This is demonstrated in our work to introduce new specialist roles in primary care, such as mental health workers, physiotherapists and paramedics by working with ICS colleagues to introduce these roles through a measured, safe and sustainable methodology. This experience will prove vital as we look to the same approach to introduce the new roles in our PCNs described in the NHS LTP (described in more detail in Commitment 3).

**Commitment 2: Reducing Workload**

In Gloucestershire, the success and learning of projects undertaken over the last 18 months have delivered a variety of enablers on this commitment which will continue into the future. Two good examples of this are training to up-skill practices’ front and back office staff in handling clinical correspondence and navigating patients to the most appropriate service for them.

**Clinical Correspondence and Care Navigation**

Training for admin and reception staff on Clinical Correspondence has been completed by more than 20 practices in Gloucestershire so far. This training aims to have 80% of letters in primary care being processed without GP intervention. We are aiming to create a countywide offer by procuring a bespoke training solution for our PCNs to ensure every practice can benefit from this by the end of 2020/21.
Care Navigation training allows for staff to become more aware of the variety of services which exist to support a patient’s healthcare across the system. The aim of care navigation is to release 5% of demand for GP appointments. While we initially supported our practices and localities to source their own training, our evaluation of this determined that we needed to create a core offer for our practices that was centrally procured on their behalf. We are currently trialling this approach in three of our PCNs, integrating care navigation training with our local Directory of Services, consisting of input from providers, workshops, online training and in-practice soft skills training. We commit to evaluating this approach before procuring a countywide rollout model by the end of 2019/20. These skills are likely to become even more important for our practices as they work together in their PCNs to bring more skills into the network and increasingly work as a larger team incorporating primary and community care.

Clearly technology will also support the approaches described here and workload reduction through enhanced digital solutions features as outlined in Goal 5: Digitally Enabled.

**Reducing the workload – Supporting GP practices with additional resources**

The CCG is working with G-Doc for the delivery of a new model of in-practice support through the provision of practice nurses for those practices in need. This new model provides qualified/experienced nurses directly to the practice for in-house mentoring in chronic disease and sexual health courses. It also offers mentoring support for new practice nurses and nurses new to general practice. For those nurses who have been in post for up to 3 years there will be access to mentoring support for immunisations, smears, travel and in-house training. Within the new model there is a practice nurse coordinator for each of the localities within Gloucestershire, which will be aligned to the PCN going forward. These nurses act as an advocate for the practice nursing staff within the county and work within the targets laid down in the 10 point plan (NHS England, 2017), help to raise the practice nurse profile and standardise clinical and competency based practice. The Nurse Coordinators will also support the input back to the CCG regarding training needs analysis and arrangements for protected learning, alongside the Deputy Director of Nursing for the CCG. The ‘Parachute Nurse Service’ will provide general/specialist practice nurses to GP surgeries in crisis – so at times of staff sickness or recruitment problems, help can be sought to enable practices to run business as usual.

The NHS LTP and new GP PCN contract include a large investment in increasing the numbers of staff working in primary care, increasingly through a diversified skill mix within the workforce, which is described at Commitment 3 below. Clinical pharmacists are one such role that is becoming increasingly mature in Gloucestershire, and as such, practices and patients are appreciating the services they can offer. With this in mind, the CCG has made available a number of experienced ‘parachute’ clinical pharmacists that also support general practice at times of crisis, using the same model as the nursing service, meaning that practices can continue to deliver great patient care even at times of burdening workload.

The Gloucestershire CCG’s place-based approach described at Goal 1, including the establishment of ILPs, strongly recognises that self-care and prevention approaches are integral to patients’ wellbeing. To this effect, the conversations which are currently taking place include working collaboratively with the local authority, district councils and VCS organisations for better outcomes for patients. Already this collaboration has resulted in the development of interventions such as the Complex Care at Home teams in Gloucester, Cheltenham and the Forest of Dean, which also support workload reduction in general practice. Through the PCTH we have funded three VCS organisations to support the implementation of place-based physical activity projects which include awareness of fall prevention in areas of Gloucester and Forest of Dean to support health inequalities. We are committed to working across our ICS to continue service developments.
which help patients and the self-care and prevention agenda in both primary care and across non-medical settings, where appropriate.

The following section, Commitment 3, is also vital to reducing the workload for GPs in general practices, supporting them to manage their overburdened workloads while improving patient access and maintaining high quality and safety, through the introduction of further new clinical roles.

**Community Pharmacy**

We are currently participating in an NHSE pilot to support digital referral from the general practice front door to a community pharmacist. Across practices in England there are now GP reception teams that work with care navigators to support the process of booking patients to see the most appropriate member of the multidisciplinary team.

Pharmacists are already part of the practice team in many of our practices and PCNs (see below). However, for minor illness consultations community pharmacists are well placed to take referrals straight from the practice in the patient’s own neighbourhood. This pathway will create some additional capacity for the practice to book patients into appointments that might otherwise have been filled that day or in a few days’ time depending on the nature of the symptoms the patient reports.

The aim is for community pharmacists to work closely with the local GP teams by agreeing escalation routes and coordinating care. The practice will send a referral to a Community Pharmacist Consultation Service (CPCS) pharmacy, transferring the patient details electronically via the practice’s clinical system. To support the project monitoring and as part of evaluation, regular reporting from participating pharmacies will be undertaken using anonymised data.

The pilot is running from September 2019 to March 2020 and will be evaluated independently to inform service design and future commissioning decisions.

**Commitment 3: Introducing new roles**

Through the successful implementation of our original Primary Care Strategy and Primary Care Workforce Strategy, as evidenced in the baseline data shown in Commitment 1, we have supported the introduction of new, non-traditional, roles through CCG ‘Transformation’ funding: recurrent funding made available by the CCG. This funding has enabled specialist advanced roles to be based in primary care settings to both improve patient care and support the resilience of our practices. Further new roles have been introduced through how we have deployed Improved Access, asking our PCNs - then ‘clusters’ - to develop innovative workforce schemes to release the funding. At the time of writing this Strategy, introducing new roles to PCNs is a core feature of the LTP and the new GP contract. We are therefore well placed in Gloucestershire to evolve the work we’ve already started, through practices already well used to employing and sharing staff collectively in their networks and by taking an ICS approach to workforce expansion.

Under the new GP contract, PCNs – live from 1 July 2019 across Gloucestershire (see Goal 1) – receive national recurrent funding for new workforce, starting from 2019/20. This funding allocation, called “Additional Roles Reimbursement” and the bulk of the new funding for general practice under the new GP contract, grows annually to match the increasing expectations of PCNs arising from the seven new national service specifications (see Goal 1). Where roles are 70% funded, it is the requirement of the PCN to find the further 30%. The dates these new roles are available from is also synced with sufficient numbers, nationally, of these staff becoming available following training. These new roles are as follows:
Social Prescribing Link Workers – available from 2019/20; 100% reimbursed

Clinical Pharmacists – available from 2019/20; 70% reimbursed

Physician Associates – available from 2020/21; 70% reimbursed

First Contact Physiotherapists – available from 2020/21; 70% reimbursed

First Contact Paramedics – available from 2021/22; 70% reimbursed

For 2019/20, each PCN in Gloucestershire can claim reimbursement for 1 WTE clinical pharmacist and 1 WTE social prescribing link worker. From 2020/21, this changes to a financial allocation that increases year-on-year (more than tripling in value from 2020/21 to 2023/24) and it will be up to the PCNs to determine which of these roles they wish to employ, making decisions based on the new service specifications, their practices and their patient needs. Using national assumptions, we anticipate this will lead to nearly 200 of these staff joining general practice in Gloucestershire (see Commitment 1), but we will revisit these assumptions on an annual basis.

Under these assumptions, by 2024, we estimate that a typical Gloucestershire PCN will have:

- Five Clinical Pharmacists
- Three Social Prescribers
- Three First Contact Physiotherapists
- Two Physician Associates
- One First Contact Paramedic

PCNs will be employing these roles through mechanisms of their choice, which could be via one practice employing on behalf of the PCN or through a hosted employment by GDoc or one of our local trusts, as determined by their preferences and in line with the requirements of the national contract. Across the ICS, we will support the introduction of these new roles in a controlled and planned way, to ensure the sustainability of our system and building the pipeline for the future, as we are aware that there is a finite pool of people available within the local and regional areas from which these staff can be employed. To this end, we have already been working with ICS system partners on the development of split role posts which allow for advanced practitioners to work in primary care, whilst their employment is hosted by an organisation that supports the staff member through provision of clinical supervision, professional speciality
based training and contacts into a community or secondary care setting. We have found that this assists with longer-term staff development, system resilience, communication and establishment of relationships across primary care and existing services.

Furthermore, through the PCTH and in partnership with HEE and our PCNs, we commit to developing a range of projects to enable opportunities for these new staff to have access to primary care based training and development for assurance of competence of advanced skills, and will enable discussions to take place across the Gloucestershire ICS colleagues to develop career pathways for specialist roles across the system. Our aim is to work across the ICS to develop skills based competency frameworks for these new roles in primary care. We recognise that these roles are in their infancy and will require the goodwill, knowledge and support of GPs, Practice Managers, professional leads (including our Local Pharmacy Committee), HEE, higher education institutes and commissioning leads to make this successful for patients, practices, PCNs and our system.

Commitment 4: Attracting talent to traditional roles

GP recruitment

Training for GPs in Gloucestershire is of high quality, and we will be doing more to encourage those people who train in Gloucestershire to remain working in the county. We will work with our PCNs and GP practices, through the PCTH and by working with HEE, to facilitate:

- Quality assurance of primary care based training in Gloucestershire;
- Consistency of good practice;
- Raising standards of training quality in primary care;
- Understand contractual elements with higher education institutes to ensure training capacity for increasing numbers of medical undergraduate students can be catered for in Gloucestershire;
- Development of multi-disciplinary training for primary care roles;
- Group/peer mentoring approach.

Our GP trainers and educators work hard to support learners and trainees in primary care and are currently implementing changes within the MB21 University of Bristol undergraduate medical school curriculum. This curriculum change, introduced in 2019, includes medical students spending treble the amount of time in primary care, providing significantly more exposure to promote this career option. We will continue engagement with lead GPs who are creating innovative solutions to learners and educator placement.

The CCG has worked with the BMJ to develop a ‘Be a GP in Gloucestershire’ campaign over the last few years. This campaign has now come to an end but we have secured a discounted package for all Gloucestershire GP practices who wish to advertise for GP roles in this national journal which has both paper and online readership.
We have created the Primary Care Workforce Website, which will continue to develop over the course of this Strategy, to be a single website for all aspects of primary care workforce in Gloucestershire. Recognising that GPs are choosing to work in different and more flexible ways than the traditional GP partnership model, we do not wish to lose these GPs to our county. We will therefore host locum vacancies for all practices in county on the site, where practices can upload information on their immediate workforce gaps.

Learning from the successfully designed and delivered GP recruitment schemes – the Newly Qualified GP scheme and the Health Inequalities Fellowship – which have attracted GPs into vacant posts in Gloucestershire; we will apply the principles of these fellowships to further specialist areas of general practice, such as frailty. These schemes will evolve to incorporate the fellowships as required for PCNs under the national contract, while also to meet our population healthcare needs and attract GPs to remain working in Gloucestershire. We will also develop, through the PCTH, a GP Career Promotion Role. This role will work to engage with medical students, sharing opportunities with them about the primary care experience.

The GP Retainer scheme’s eligibility criteria enable a career bridging experience for GPs who are eligible for flexible working arrangements, due to work-life balance and as part of the annual workforce survey, to practices that have gaps and are able to support the GPs through the scheme. To support GP retention within county, we will continue to widely promote the national GP Retainer scheme and match up GPs to practices.

During 2019 we delivered the ‘Gloucestershire Next Generation GP Programme’ to ‘Engage, Energise and Empower’ early career GPs. The aim of the programme was to inspire early career GPs (trainees and first 7 years post CCT) to be informed leaders as well as excellent clinicians, with the insight and connections they need to change and improve the system in which we work. Informed by the evaluation of this programme, which we will undertake, we will continue to engage with this cohort of early career GPs to develop excellence in primary care and support GP resilience, retention and the next cohort of GP clinical leaders.

A partnership approach with HEE has enabled the recent recruitment of three GP fellowship roles within the county, covering leadership, education and for attracting new talent to primary care. These roles will begin supporting a number of key workforce issues, including engagement with schools to promote all careers in primary care, developing support for primary care leaders, and offering support packages to mid-career GPs. We are also committed to explore further GP retention activities, building on the work we already do with those approaching or considering retirement age to retain them in county, to expand to mid-career GPs or those requiring support to prevent exiting their career.

**Nurse recruitment**

The CCG and GDoc are developing strategies and working collaboratively with other provider and commissioning teams in the South West to review and implement an action plan aligned to that of the General Practice Forward View ‘Ten Point Plan’ for General Practice Nursing. The plan describes what we are working on over the next few years in order to recruit, retain and return nurses back into general practice. It also focuses on how Gloucestershire will build capacity and capability in primary care to manage the ever increasing workload and joint working with other community teams to address the future challenges.
To support the principles of the 10 Point Plan for General Practice Nurses and Health Care Assistants (HCAs), a new team of Practice Nurse Coordinators are in post across the County who are part of a comprehensive Nursing service provided by GDoc and commissioned by the CCG. The aim will be to raise the profile and awareness of all career opportunities in Primary Care and engage with the workforce to support clinical competencies and ongoing educational development.

Over the course of this Strategy, these roles will mature to engage with universities in promoting student nurse placements within Gloucestershire, linking with the principles of the General Practice Nursing 10 Point Plan and encouraging more student nurses to consider a career in Primary Care. This will dovetail with working closely with our local nurse coordinators to plan a rolling programme practice nurse education, based on a training needs analysis. We plan to then make this education programme available on a central website for all the practice nurses to access.

Nursing Associate is a new role within nursing teams in Gloucestershire and one that we are looking to expand and develop over forthcoming months and years. Nursing Associates work with healthcare support workers and registered nurses to deliver care across all fields of nursing. In primary care their duties are likely to include: undertaking clinical tasks such as venepuncture and ECGs; performing and responding to clinical observations such as blood pressure, temperature, respirations and pulse; promoting health and preventing ill health; improving the safety and quality of care and contributing to integrated care. This new support role sits alongside existing nursing teams to deliver hands-on care for patients.

GDoc have recently expanded their nursing team to include phlebotomists and (HCAs). This will help support practices further by ensuring the right skill mix for the clinical competencies required. This model encourages increased efficiency for registered nurse hours. Additional mentorship and support for the HCAs will be provided by the Nurse Coordinators and Matron for Clinical Learning and all HCAs will be invited to join Gloucestershire’s education events and training. Our Educational Matron will also be working with the University of Gloucestershire to promote student nurse placements, linking with the principles of the ‘ten point plan’ and encouraging more student nurses to consider a career in primary care.

**Commitment 5: Developing the team**

We have commenced, and commit to expand, working with higher education institutions in our region, to increase placements for all roles in primary care so that learners at under-graduate and post-graduate level have increased exposure to GP practices and can consider primary care as a career destination. We will also work with these institutes to create mechanisms for our experienced advanced practitioners working in primary care to be able to influence their relevant subject curriculum.

Experiential learning and on the job training is another area that we will cultivate, as we know that training away from the work environment can pose a challenge to our committed staff, who may have caring responsibilities as well as take precious time away from providing patient care. Experiential learning has recently expanded to include a City and Guilds qualification for staff at practices, which is on the job training for staff to support a GP, or a number of GPs, in the smooth running of clinics, called a GP Assistant Role – see the Case Study blue box right.

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**Case Study: GP Assistants**

The GP Assistant role has been developed by Wiltshire CCG, with the training funded by HEE for rollout across our South West region, and has been taken up by a number of our Gloucestershire practices. The GP Assistant undertakes the more routine administration and clinical tasks on behalf of the GP, thus freeing up their time on their clinical skills in supporting patients.
We will use the learning from this project to evolve the on the job training approach to be based in practices, such as working with G-Doc to explore design and delivery of an accredited HCA training course, based in experiential learning environments.

We will continue to host annual events for our practice managers and have recently completed a survey of Practice Manager training and support needs and will be working with GDoc and the LMC to deliver tailored initiatives to practice manager’s needs and embed a peer support system.

As referred to in Commitment 2 of this chapter, we will continue to support clinical and admin colleagues through delivery of care navigation and clinical correspondence training. Through funding from the PCTH, some PCNs have undertaken training for frontline receptionists and back office staff around resilience and patient facing skills which has been well received – we will continue to highlight areas of best practice through our Primary Care Workforce Website so other PCNs are aware of benefits and can choose to implement as part of their training offer to their staff.

We will work with ICS colleagues on the development of an ICS wide Apprenticeship Hub, looking to increase apprenticeships for admin, clerical and clinical roles at both entry and advanced level for functions in primary care.

All primary care colleagues will continue to have access to change management training and development through the One Gloucestershire Quality Service Improvement Redesign (QSIR) programme. One Gloucestershire ICS is involved in the pilot development for a High Potential Talent Scheme which will be available for managers and clinical staff working in and supporting primary care to increase their knowledge, skills and capability, through having increased exposure to other parts of our system through placements in other settings within the ICS.

PCN Development and Leadership

Over the last 3 years we have been developing leaders in primary care through local programmes such as two Gloucestershire cohorts of General Practice Improvement Leaders, investing in visits to other areas or searching courses or other opportunities for local self-identified leaders to develop their knowledge and skills. Primarily, it has been these members of staff which have come forward to take leadership roles in PCNs, either as Clinical Directors or as management leads. At the time of writing, we are awaiting the national support offer for PCN and Clinical Director development, but we feel confident that the work we have already been doing, through local organisational development and leadership programmes, has given our PCNs and their leaders a competent basis from which to accelerate their plans. However, we know we need

Case Study: Developing the wider workforce

Over the last two years, new roles in primary care have developed in partnership with host employers across the ICS, including mental health practitioners employed by 2gether NHS Foundation Trust and physiotherapist practitioners employed by Gloucestershire Care Services (now the merged organisation of Gloucestershire Health and Care NHS Foundation Trust). The PCTH has financially supported advanced level education modules to enable the development of these new roles. We plan to expand this in accordance with the PCNs growing their multi-disciplinary workforce over the course of this Strategy.
to continue this development and ensure all PCN and ILP leaders have access to high quality development and education. The national PCN Development Support Prospectus has seven domains:

- Organisational development and change;
- Leadership development support;
- Supporting collaborative working;
- PHM;
- PCN set up and support;
- Social prescribing and asset based community development;
- Identifying, evaluating and sharing learning on PCN sites.

We will assess, with our PCNs, what their individual needs are and whether these needs are met by the national programme. If not, we commit to working with them to design a sustainable programme over the next five years to ensure the development of our PCN workforce, and that their new leaders have access to such development opportunities. Alongside this, we will enable fellowships for GPs who are newly qualified – and for other members of the general practice team – who aspire to be local leaders of their PCN or ILP, building on our existing award winning fellowships in county.

**Case Study: South Cotswold Sexual Health in Rural Areas**

Due to changes in the public health funding structures which led to a reduction of sexual health services in some rural areas, supported by the Primary Care Training Hub, colleagues in the South Cotswold PCN chose to increase skills by:

- Conducting a Training Needs Analysis on Sexual Health
- Delivering large group training and awareness of sexual health issues
- Specialist Training on Intra-Uterine Devices, Implants, Pessaries, Vasectomy Training and Menopause Training

**Case Study: Stroud Frailty**

Colleagues in the Stroud and Berkeley Vale area have developed a plan where all three of their PCNs will be investing into staff resources and training infrastructure to meet the needs of frail patients in the locality. The funding available from the Gloucestershire Primary Care Training hub will also support the development of 100 volunteers living in the Stroud and Berkeley Vale locality area to become more aware of frailty based issues within their communities and support the aims and values for Stroud as a ‘Compassionate Town’.
Summary of our priorities for Goal 4

Goal 4: Developing the Workforce Strategic Commitments

Our strategic commitments to this goal during the timeframe of this Strategy are as follows. We will:

- Continue to **Understand Demand and Capacity** at Primary Care level using a number of data sources, local and national intelligence as well as continuing discussions with system wide partners and stakeholders to support workforce transformation for better patient care.

- Enable GP practice to **Reduce the Workload** by supporting them with training and development opportunities and providing additional resources where required.

- Offer support and quality assurance around the **Introduction of New Roles** to support practices and PCNs through funding for new roles and training/development based on professional best practice.

- Continue to work closely with our practice and PCNs to **Attract Talent to Traditional Roles** by working with educational providers and improving communications on the innovative ways to recruit and retain this precious staff resource.

- Continue to **Develop the Team** working with wider educational stakeholders to deliver appropriate and relevant training to support staff through a variety of learning mechanisms.
4.5 Goal 5: Digitally Enabled

As outlined within Chapter 1, we have made significant progress since the original Primary Care Strategy in rolling out digital initiatives for both our patients and our care professionals. Our plans for the next five years are no less ambitious, while the NHS LTP sets out a number of digital initiatives, as shown at Table 6 below. As a minimum, we will deliver these initiatives to the target dates and national aspirations, however we will be looking to go further with these aspirations in order to extend the benefit to our patients and our workforce.

**Long Term Plan Targets: Digital Primary Care Provision**

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Start Date</th>
<th>Description</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>All practices will ensure at least 25% of appointments are available for online booking by July 2019</td>
<td>July 2019</td>
<td>Care Plans available in the Summary Care Record</td>
<td>April 2021</td>
</tr>
<tr>
<td>SNOMED-CT Implementation across all Primary Care systems</td>
<td>Oct 2019</td>
<td>100% Cyber Standards Compliance</td>
<td>April 2021</td>
</tr>
<tr>
<td>E-correspondence for transfers of care</td>
<td>Dec 2019</td>
<td>GP activity and waiting times published monthly</td>
<td>April 2021</td>
</tr>
<tr>
<td>Supporting the promotion and utilisation of the NHS App</td>
<td>Autumn 2019</td>
<td>All patients to be offered online and video consultations</td>
<td>April 2021</td>
</tr>
<tr>
<td>Move over to the GPIT Futures supplier framework</td>
<td>Dec 2019</td>
<td>Population Health Management solutions in pace across every ICS</td>
<td>April 2021</td>
</tr>
<tr>
<td>Every patient with a long-term condition will have access to their health record through the Summary Care Record accessed via the NHS App</td>
<td>Jan 2020</td>
<td>Community mobile access to records and plans</td>
<td>April 2022</td>
</tr>
<tr>
<td>Digitisation of Lloyd George records</td>
<td>Feb 2020</td>
<td>CIO or CCIO at Board Level in every organisation</td>
<td>April 2022</td>
</tr>
<tr>
<td>Full online access to patient data for all patients</td>
<td>April 2020</td>
<td>All practices will be offering and promoting electronic ordering of repeat prescriptions and using electronic repeat dispensing for all patients for whom it is clinically appropriate as a default</td>
<td>On-going</td>
</tr>
<tr>
<td>Eradicate faxes</td>
<td>April 2020</td>
<td>Personalised care and health budget model rolled out</td>
<td>April 2024</td>
</tr>
<tr>
<td>All patients to will have the right to online consultation</td>
<td>April 2020</td>
<td>Digital-first primary care will become a new option for every patient improving fast access to convenient primary care.</td>
<td>April 2024</td>
</tr>
<tr>
<td>All patients have access to online correspondence unless opted out</td>
<td>April 2020</td>
<td>Autism and Learning Difficulty flag in care records</td>
<td>April 2024</td>
</tr>
<tr>
<td>All practices updating SCR in as real-time as possible</td>
<td>April 2020</td>
<td>Implement Artificial Intelligence Clinical Decision Support</td>
<td>April 2024</td>
</tr>
<tr>
<td>All practices will need to have an up to date and informative online presence including a patient facing email</td>
<td>April 2020</td>
<td>Whole system capacity alerts available to GPs and patients</td>
<td>April 2024</td>
</tr>
<tr>
<td>Patients able to add own information to own health records</td>
<td>April 2020</td>
<td>Delivery of Personal Health Records via LHACR, including reminders and alerts</td>
<td>April 2024</td>
</tr>
<tr>
<td>1 practice appointment per day per 3000 patients with a minimum of 1 appointment per practice per day offered to 111 for Direct Booking</td>
<td>April 2020</td>
<td>Increased CEO and Non-executive Director digital leadership</td>
<td>April 2024</td>
</tr>
<tr>
<td>Secure sharing of information with Care Homes</td>
<td>Dec 2020</td>
<td>The information technology revolution in the NHS also needs to make it a more satisfying place for our staff to work*</td>
<td>April 2024</td>
</tr>
</tbody>
</table>

*Table 6: National digital requirements that we will implement locally*
**Supporting the Primary Care vision**

Our Primary Care Strategy, and indeed our ICS’s long term plan, is underpinned by significant developments in the use of digital technology, whilst the NHS Long Term Plan sets down ambitious targets to transform the model of care to digital-first. By targeting “greater utilisation of digital technologies to join-up care, focus on prevention and improve access to primary care services”, we will realise Gloucestershire’s anticipatory and personalised locality based care model and address some of the key challenges facing primary care in the county.

<table>
<thead>
<tr>
<th>Vision Area</th>
<th>Digital enabler theme</th>
<th>Challenge addressed</th>
</tr>
</thead>
</table>
| Continue the dissolution of the historic divide between services through PCNs and ILPs. | Joined up infrastructure delivered at scale  
Standardisation of digital processes  
Convergence of systems and standards | Technology barriers to care staff working together and sharing information. |
| Provide patients with more control over their own health, anticipatory care and personalised care when they need it and support early cancer diagnosis. | Digital-First Access  
Enabling hub and remote delivery of services | An increase in patients with complex health conditions that need earlier diagnosis and more appropriate care. |
| Ensure good access to primary care 7 days a week, meaning better support for patients while also reducing urgent demand at our hospitals to enable them to care for the most acutely poorly patients. | | Inadequate access for patients (feedback shows 14% are unsatisfied with appointment times locally; while this compares favourably to the national average (18%) we want to improve further (Ipsos Mori, 2019)). Lack of clarity on where to access care out of hours. |
| Support PCNs and ILPs to explore how they can provide a greater range of services for larger numbers of patients. | | Pressure on acute services and related delays to patient care. Availability of expertise in specialisms. Commercial digital services taking lower complexity patients with potential for practice destabilisation. |
| Utilise population health to tackle inequalities, assessing our local population by risk of unwarranted health outcomes to make services available where they are most needed. | Real-time insights on demand and capacity  
Population Health Management tool adoption  
Data driven continual improvement processes and cultures | Health inequalities across populations, potential unmet demand and potential late diagnosis. |
| Grow our multi-disciplinary primary care teams, attracting and retaining the best staff through promoting Gloucestershire as a great place to live and work, creating a better work-life balance for staff, and offering excellent training opportunities. | Digital, Data and Technology learning programmes with care professionals, support staff and patients  
Robust digital service design and operational processes | Increasingly difficult to recruit GPs, especially in certain pockets of our county. Increase in demand and workload. Difficulty embedding technology into working processes. |
Our Digital Primary Care Vision for 2024

For patients and care professionals, we will be creating a more streamlined and satisfying experience of care and care provision.

**For our patients:** more digital options to access and manage personalised care throughout their journey.

**For our care professionals:** providing care more appropriately, efficiently, informed and collaboratively.
In delivering on these digital themes, the following capabilities will be focused on:

- **Enhanced referrals and decision support** to connect patients to best care options for them, and offer guidance to clinicians to deal with a wider range of needs locally;

- **Information sharing** to provide care plans and records to a person’s circle of care;

- **Insights to understand demand and capacity patterns** and pre-empt deterioration of health;

- **Patient Access** to empower patients to participate in their own health plans and access help remotely;

- **Remote and collaborative working** to move care to where it is most needed and make the most of limited resources;

- **Automation and reduced technical barriers** to free up time to care, increase back office responsiveness and speed up care for patients.

**The next stage: Digital Service Transformation at scale**

In order to now fully deliver on the promise of digital technology in primary care, we need to move towards being Digitally Transformative (see Figure 17):

![Figure 17: Moving to digital transformation (FutureGov, 2017)](image)

Being ‘Digitally Transformative’ means developing the way we prioritise and deliver services, so that digital capabilities are built into the wider service transformation of our PCNs, ILPs and ICS, rather than being layered on existing processes, or treated as parallel activities. This requires multidisciplinary digital service design teams, partnering with digitally skilled practice teams and patients to redesign services that meet clear needs using effective new processes.
The first part of this shift is to build more skills in change management, business analysis and agile service design within our delivery teams. This will emphasise delivering the greatest value, addressing evidenced user needs and remapping processes to realise benefits. The second challenge to transformation can be overcome through developing the underlying digital skills and literacy of the primary care workforce. Through raising the levels of all professionals via broader digital capability training, and the career development of clinical and non-clinical digital champions in each PCN, we will have a more empowered and distributed way of designing and implementing successful solutions. Frontline staff can also then play a role in educating patients around the benefits of digital interactions, alongside broader digital marketing and education programmes in the ICS, as patient digital literacy will be key to achieving our digital-first ambitions.

We also need to start doing more at scale; the focus of the new General Practice IT operating model is for individual practices to embed shared ICS-wide technologies into PCN and ILP-wide processes, rather than managing their own IT solutions and suppliers. The provision of analytics, networks, security and digital solutions, increasingly needs to be collectively managed at ICS level for economies of scale, expertise requirements, consistency of patient experience and performance. This model will also increase our ability to share data and workforce across sites, removing the current barriers that exist to PCN and cross-organisational working. Opportunities for innovation will still exist for individual practices through structured evaluation processes with a view to scale, but we need to make ensure that we are not creating silos and barriers to join up care with one-off initiatives.

**Being Digital-First**

Evidence from the national patient survey suggests that three-quarters of our patients have not used an online service to access services from their practice in the last 12 months (Ipsos MORI, 2019). Therefore, we are seeing an opportunity for the adoption of a fuller and more consistent patient-facing digital service in Gloucestershire, which could be offered in a virtual clinical hub or multiple hubs, which will be part of our design consultation with our PCNs. A well developed, remotely accessed, digital-first service could increase access to services for patients, potentially add to the clinical workforce through flexible working patterns, and reduce the administrative burden on practices. Creating such an offer negates the need for other commercial services, thereby maintaining continuity of care from local clinicians for our patients and maintaining stability for our practices. In addition, we would be able to divert a number of necessary consultations to more efficient direct online consultations. We will utilise lessons learned from digital-first exemplar sites (Ipsos MORI, York Health Economics Consortium & Salisbury, 2019), but we recognise that this is an opportunity we must explore further in our plans with central funding support.

**The Need for Flexibility in Our Plan**

The technology landscape for primary care is changing quickly with new solutions offered at a national level, such as the NHS App, Windows 10 and Office 365. New suppliers are beginning to enter the market through the GP Futures framework this year, which could give us more options to realise our vision. In addition, locally we are undertaking major infrastructure and clinical system changes in the ICS, including increased practice mergers and an acute Electronic Patient Record (EPR) system change that will improve interactions with secondary care. This Strategy therefore needs to remain agile, setting a course, but being flexible as new capabilities and options become clearer.

To allow us to move forward in such a changing landscape we have developed eleven principles to act as criteria for prioritising digital primary care activities and how we undertake digital transformation at scale.
These will allow us to meet the NHS LTP targets, support the ambitions of this Strategy and offset risks to the sustainability of high-quality care.

**Our 11 Principles of Digital Enablement**

1. **Reduce the bureaucratic burden**: reduce blockers, friction and workload for routine activities in practices and help to focus energies on where the greatest value can be added.

2. **Deliver joined up infrastructure at scale**: support mobile working, collaboration and reliability.

3. **Standardise digital processes**: to allow data to flow accurately and consistently across settings, support the workforce to move between care settings more swiftly and reduce clinical variation with greater decision-making support.

4. **Converge systems and standards**: to allow for better information sharing, easier staff mobility and technical support at scale to deliver efficiencies.

5. **Enable hub and remote delivery of services**: to provide flexible provision of care and IT services from where capacity and expertise exists.

6. **Design for Digital-First access**: making digital interactions an easy and attractive way to interact, by scaling self-care, self-service and being more responsiveness to needs. In turn, this increases capacity for those unable to use digital solutions.

7. **Deliver real-time insights on demand and capacity**: to allow timely resource management and service planning.

8. **Deliver accessible and accurate PHM tools**: to identify cohorts, interventions and impacts in an easy to interpret way.

9. **Offer Digital, Data and Technology learning programmes with care professionals, support staff and patients**: to increase adoption and understanding of how new digital capabilities and insights can change patterns of care.

10. **Ensure robust and agile digital service design and operational processes**: to deliver the most needed, usable, secure and sustainable solutions. This includes investment in robust pilot evaluation, creating blueprints and co-ordinated plans to scale up quickly where successful.

11. **Data driven, continual improvement processes and cultures across the workforce**: to enable quality and improvement practices to be used to enhance our digital and wider services.

**Our Roadmap**

In developing our roadmap, we have scheduled activities required in the LTP and the GP Contract to the supporting capabilities to deliver the ICS primary care model. The roadmap is a live document that will adapt with the changing primary care landscape, technology shifts, financial circumstances and information on PCN needs as they develop. Our current roadmap is shown by theme in the sections that follow.
ICS Digital Roadmap workstream: Empower the Person

<table>
<thead>
<tr>
<th>2020/21</th>
<th>2021/22</th>
<th>2022/23</th>
<th>2023/24</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS App &amp; GP Online Consult</td>
<td>OP&amp;Care Home Online Consult</td>
<td>Digital 1st for GP</td>
<td>PHR &amp; Maternity Record</td>
</tr>
<tr>
<td>Website &amp; app consolidate</td>
<td>Self Care Apps re-review</td>
<td>E-redbook</td>
<td>App alerts</td>
</tr>
</tbody>
</table>

### Empower the Person

**Aim:** Empower patients to participate in their own health planning and access clinically robust guidance remotely.

### Primary Care Vision

- Improved access to care 7 days a week
- More patient control over their own health

### Digital Capability area

- Patient access
- Remote and collaborative working

### User needs

#### Patients

- “Quicker access to care, so I can reduce my pain and anxiety, and those around me.”
- “See the right expert first or as soon as possible.”
- “A clear and simple route to get help so I can improve someone in my care’s situation”
- “Help myself to tools and advice to improve my health”

#### Clinicians

- “See appropriate patients for my skillset”
- “Reduce the time spent doing unrewarding admin”

#### Practices, PCNs and ILPs

- “Make best use of the resources we have”

### Benefits

- Improve access
- Reduce demand where appropriate
- Triage to more suitable care settings
- Identify new conditions earlier
- Improve known condition outcomes
- Reduce admin and clinical productivity
- Offset risks of commercial competition
- Create more flexible and efficient resourcing models

### Phases

1. Design consistent access routes and core capabilities
2. At scale digital-first delivery with patient input
3. Personalised and remotely guided care

### Programmes

<table>
<thead>
<tr>
<th>NHS App and 111 Online</th>
<th>Online and Virtual Consultations</th>
<th>Digital-First Access</th>
<th>Self-care and Online Therapies</th>
<th>Remote Monitoring and Patient Generated Data</th>
<th>Personal Health Records and Personalise Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>A consistent front door to our services and patient control of their record and plans.</td>
<td>Ability for patients to access appointments remotely and at the most convenient time.</td>
<td>Online remote access to 7 day and extended hours clinical advice and services.</td>
<td>Always on digital coaching for people to manage their long-term conditions.</td>
<td>Sharing of vital changes in health with clinicians for those at risk of deterioration.</td>
<td>Personalised recommendations and co-creation of care plans with people based on their holistic needs.</td>
</tr>
</tbody>
</table>
Roadmap workstream: Digital Maturity & Capabilities (Clinical systems)

<table>
<thead>
<tr>
<th>2020/21</th>
<th>2021/22</th>
<th>2022/23</th>
<th>2023/24</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fax removal</td>
<td>Lloyd George digitisation</td>
<td>Decision Support review</td>
<td>GP Futures migrations?</td>
</tr>
<tr>
<td>Enhanced GP Templates</td>
<td>PCN clinical system mergers</td>
<td>Digital-only patient letter options</td>
<td>Primary Care e-rostering</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Clinical systems

Aim: Develop highly usable and functional clinical IT systems to support assessment, diagnosis, prescription and the capture of sharable meaningful information.

Primary Care Vision

- Improved access to care 7 days a week
- Support more joined up PCNs and ILPs

Digital Capability area

- Enhanced referrals and decision support
- Remote and collaborative working

User needs

Patients
- “I want the same care and processes wherever I am”

Clinicians
- “I need to access the full patient record so I can make safe and more appropriate decisions”
- “Reduce the time spent doing unrewarding admin”

Practices, PCNs and ILPs
- “Make best use of the resources we have”

Benefits

- Increase admin and clinical productivity
- Create more flexible and efficient resourcing models
- Reduce clinical variation in care provision
- Reduce medication costs
- Improve clinical outcomes
- Improve referral appropriateness

Phases

1. Consolidate systems and standardise processes
2. Develop improved decision support and mobility
3. Personalise decision support

Programmes

<table>
<thead>
<tr>
<th>GP system Convergence and Enhancements</th>
<th>Clinical Guidance and Decision Support</th>
<th>Medicines Decision Support</th>
<th>eRostering</th>
<th>Paperless Communications and Corporate Systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Synchronising GP systems and improving their efficiency.</td>
<td>Developing increasingly advanced guidance and decision support for care staff personalised to the patient.</td>
<td>Providing insights and guidance to improve the precision and efficiency of medicines prescribing and administration.</td>
<td>Sharing information about schedules, capacity gaps and skills needs. This will match care professionals to demand in increasingly rapid and targeted ways.</td>
<td>Getting rid of the fax infrastructure, digitising of Lloyd George Records and the replacement of paper letters to patients.</td>
</tr>
</tbody>
</table>
### Roadmap workstream: Information Sharing

<table>
<thead>
<tr>
<th>2020/21</th>
<th>2021/22</th>
<th>2022/23</th>
<th>2023/24</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Image and Labs sharing</td>
<td>Docs &amp; correspondence sharing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinician to Clinician Messaging &amp; real-time collaboration</td>
<td>System-wide direct booking &amp; e-referrals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCN record sharing &amp; booking</td>
<td>Patient flow monitor &amp; alerting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute, Social Care feeds in JUYI</td>
<td>Shared Care Plans</td>
<td>LHACR Direct care, PHR and PHM delivery</td>
<td></td>
</tr>
<tr>
<td>MH &amp; Urgent real-time demand &amp; capacity</td>
<td>Real-time acute bed state</td>
<td>Full automated real-time demand &amp; capacity</td>
<td></td>
</tr>
</tbody>
</table>

### Information Sharing

**Aim:** Providing a holistic view of the patient’s needs and the ability to co-produce care plans with clinicians. Sharing a wide range of care options in the context of demand and capacity insights, to direct people to their best care options and enable services to be developed around them.

### Primary Care Vision

- Support PCNs and ILPs to work in a joined up way through data sharing
- Provide patients with anticipatory care and personalised care
- Support PCNs and ILPs to provide a greater range of services for larger numbers of patients

### Digital Capability area

- Information sharing
- Remote and collaborative working

### User needs

- **Patients**
  - “I need my information to be available when I access care across settings & locations”

- **Clinicians**
  - “I need to communicate across integrated care teams”

- **Practices, PCNs and ILPs**
  - “We need to share workload across practices to meet demand for general and specialist expertise”

### Benefits

- Improve timeliness and usefulness of information
- Increase admin and clinical productivity
- Create more flexible and efficient resourcing models
- Improve referral appropriateness
- Triage to more suitable care settings
- Speed up care pathways
- Co-ordinate care across settings
- Improve clinical outcomes

### Phases

1. Share digitised paper processes, care transfers and team collaboration
2. Share structured information about treatments, extended care options and capacity options
3. Personalise treatments and care route options base of improved data richness
**Programmes**

<table>
<thead>
<tr>
<th>Clinical Documentation, Letters, Imaging and Diagnostics Sharing</th>
<th>Service Information</th>
<th>Clinical Messaging and Task Management</th>
<th>Shared Care Records and Plans</th>
<th>Referrals and Direct Appointment Booking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Digitising and structuring data from clinical documents across the ICS. Sharing observations, investigations and medicines information.</td>
<td>Developing the Directory of Services to offer more comprehensive care options and demand information. Development of real-time data feeds on system demand and capacity. Developing dashboards, predictive models and alerting to support operational decision making.</td>
<td>Enabling clinicians to have real-time digital communication across a range of care experts to inform clinical decisions and co-ordinate multi-team care.</td>
<td>Providing a set of care records and plans that multiple care providers and carers can view and contribute to. To make sure that care is co-ordinated around a person and their circle of care.</td>
<td>Allowing booking of appointments directly between care settings from digital services (such as GPs and pharmacy) Providing digital ways to refer into services and personalising the services suitable for patients.</td>
</tr>
</tbody>
</table>

**Roadmap workstream: Infrastructure**

<table>
<thead>
<tr>
<th>2020/21</th>
<th>2021/22</th>
<th>2022/23</th>
<th>2023/24</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICS Network Redesign</td>
<td>Single desktop &amp; sign on</td>
<td>Wifi Upgrade</td>
<td>ICS-wide Unified Comms</td>
</tr>
<tr>
<td>ICS Cyber Security Programme</td>
<td>ICS Data Centre &amp; Server Consolidation (inc cloud review)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Windows 10</td>
<td>Office 365 roll out</td>
<td>Collaboration tools</td>
<td></td>
</tr>
</tbody>
</table>

**Infrastructure**

**Aim:**
Deliver robust, secure joined up primary care infrastructure at scale to support mobile working, collaboration and reliability.

**Primary Care Vision**
- Support PCNs and ILPs to work in a joined up way
- Support PCNs and ILPs to provide a greater range of services for larger numbers of patients.

**Digital Capability area**
- Information sharing
- Automation and reduced technical barriers

**User needs**

**Patients**
- “I want the same care and processes wherever I am”

**Clinicians**
- “I need to access the full patient record so I can make safer and more appropriate decisions”
- “I need to communicate across integrated care teams”

**Practices, PCNs and ILPs**
- “We need to share workload across practices to meet demand for general and specialist expertise”
- “Make best use of the resources we have”
### Benefits
- Increase admin and clinical productivity
- Create more flexible and efficient resourcing models
- Reduced travel costs
- Reduce operational costs

### Phases
1. Network upgrade and modernise IT estate
2. Virtualise IT infrastructure and move software to the cloud
3. Move infrastructure to the cloud and mobilise workforce

<table>
<thead>
<tr>
<th>Programs</th>
<th>Modernise the Network</th>
<th>Desktop and Software Upgrade</th>
<th>Cyber Security, Asset and Identity Management</th>
<th>IT Service Management</th>
<th>Mobile and Remote Working</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upgrade to high speed modern health network on a single domain, with public sector access. Deliver internet based voice services to save costs, route calls and provide call demand analysis.</td>
<td>Upgrade to new generations of devices, desktop software and cloud based office software. Provide a single virtual desktop to allow access for care professionals to access the range of tools needed across settings. Manage delivery of all updates remotely.</td>
<td>Enhance cyber security teams and tool sets across the network to spot and stop threats. Develop single sign in option across a range of systems needed in PCNs.</td>
<td>Development of IT Service desktop processes and accreditation. Extend support to match staff working patterns and needs.</td>
<td>Provide devices, mobile device management and secure high speed mobile access to staff. Developing common collaboration tools for use across the ICS. Developing partnerships to improve mobile coverage and speeds.</td>
<td></td>
</tr>
</tbody>
</table>

### Roadmap workstream: Whole Systems Intelligence

<table>
<thead>
<tr>
<th>Year</th>
<th>PHM reporting tool roll out</th>
<th>ML low level in use</th>
<th>PHM as BAU in Clinical Progs, PCNs &amp; Localities</th>
<th>ICS PHM platform implement &amp; procure</th>
<th>LHACR data for research &amp; insights</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020/21</td>
<td><img src="image_url" alt="Image" /></td>
<td><img src="image_url" alt="Image" /></td>
<td><img src="image_url" alt="Image" /></td>
<td><img src="image_url" alt="Image" /></td>
<td><img src="image_url" alt="Image" /></td>
</tr>
</tbody>
</table>

### Whole Systems Intelligence

**Aim:** Delivering Population Health Management infrastructure, analytical solutions and data solutions, to allow more personalised care to be delivered.

**Primary Care Vision**
- Support PCNs and ILPs to work in a joined up way
- Provide patients with anticipatory and personalised care
- Utilise population health to tackle inequalities, assessing our local population by risk of unwarranted health outcomes to make services available where they are most needed.

**Digital Capability area**
- Insights to understand demand and capacity patterns and pre-empt deterioration of health.
### User needs

<table>
<thead>
<tr>
<th>Patients</th>
<th>Clinicians</th>
<th>Practices, PCNs and ILPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>“My information to be available when I access care across settings and locations”</td>
<td>“Access the full patient record so I can make safe and more appropriate decisions”</td>
<td>“Share workload across practices to meet demand for general and specialist expertise”</td>
</tr>
<tr>
<td></td>
<td>“Access common guidance and admin resources for my PCN, so I can re-use best practices and collaborate”</td>
<td>“We need to understand demand on the system, so we can try to manage our services to meet it”</td>
</tr>
</tbody>
</table>

### Benefits

- Improve timeliness and usefulness of information
- Create more flexible and efficient resourcing models
- Improve referral appropriateness
- Triage to more suitable care settings
- Improve clinical outcomes

### Phases

1. Data quality, demand & capacity basics and PHM infrastructure design
2. Real-time demand and capacity, personalise interventions based on current data sets
3. Personalise treatments and care route options base of improved data and AI pattern matching.

### Programmes

<table>
<thead>
<tr>
<th>Data quality</th>
<th>BI and Data Visualisation for PHM</th>
<th>PHM Platform</th>
<th>Governance</th>
<th>Education and Engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developing a data quality programme to report back to teams managing systems and teams using them to target improvements and tools to correct issues.</td>
<td>Deploying and configuring industry standard data visualisation tools for analysts and shared dashboards for self-service to up to date data.</td>
<td>Designing, procuring and delivering an architecture to allow for analysis of clinical data to anticipate potential future conditions at person level.</td>
<td>Development of Information Sharing Agreements, policies and standards to allow new type of data to be used across settings, for secondary use purposes and precision medicine.</td>
<td>Developing the analytical skills within the ICS, both in specialists and non-specialist leaders who need to interpret the data. Public engagement programmes to clarify how the data insights will be used and can help.</td>
</tr>
</tbody>
</table>
**Roadmap workstream: Workforce development and digital delivery capabilities**

<table>
<thead>
<tr>
<th>2020/21</th>
<th>2021/22</th>
<th>2022/23</th>
<th>2023/24</th>
</tr>
</thead>
<tbody>
<tr>
<td>Champions Network</td>
<td>Literacy Framework Adoption</td>
<td>Digital governance &amp; process reshape</td>
<td>Informatics Development</td>
</tr>
</tbody>
</table>

### Workforce development and digital delivery capabilities

**Aim:**

Develop the primary care leadership, care staff and informatics delivery teams to design and use digital technology and data to improve models and provision of care. Help our patients understand the opportunities to access digitally enabled care.

**Primary Care Vision**

- Support PCNs and ILPs to work in a joined up way
- Provide patients with anticipatory care and personalised care
- Support PCNs and ILPs to provide a greater range of services for larger numbers of patients.
- Grow our multi-disciplinary primary care teams.

**Digital Capability area**

- Enhanced referrals and decision support
- Information sharing
- Insights
- Patient Access
- Remote and collaborative working

### User needs

**Patients**

- “I want to help myself to tools and advice to improve my health”

**Clinicians**

- “I need to access common guidance and admin resources for my PCN, so I can re-use best practices and collaborate”
- “I need to be confident and competent with digital tools and processes, so I can use them efficiently, safely, accurately and reassure citizens of their benefit”

**Practices, PCNs and ILPs**

- “We need to share workload across practices to meet demand for general and specialist expertise”

### Benefits

- Reduce admin clinical productivity
- Create more flexible and efficient resourcing models
- Gain greater benefits for investments in new technical capabilities

### Phases

1. Develop training and development programmes
2. Embed digital transformation processes at all levels

### Programmes

<table>
<thead>
<tr>
<th>Digital Leadership</th>
<th>Digital Literacy and Culture</th>
<th>Clinical Informatics Development</th>
<th>Digital Champions</th>
<th>Digital Delivery and Governance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developing PCN, Locality and ICS level leadership teams so they can lead for digital transformation programmes.</td>
<td>Assessing and raising all primary care staff to a basic level of rounded digital capabilities.</td>
<td>Development of career pathways and skills development programmes for clinical staff to lead, design and deliver on digital technology use and data driven decision making.</td>
<td>Developing a network of digital champions across PCNs. Through training and development programmes, champions will be developed to skilfully manage the PCN digital services and change projects.</td>
<td>Developing the primary care digital service delivery teams’ capacity and capability to deliver in more agile and user centred ways. Process analysis and digital service design practices will be supplemented by quality and value focused agile technical delivery in new team structures.</td>
</tr>
</tbody>
</table>
In developing such an ambitious and wide-ranging plan, we recognise the potential risks that exist in delivery and the need to ensure appropriate mitigations are in place. These are detailed at Appendix 7.

Next Steps

The next steps for this digital element of our Strategy are to qualify resources and cost ranges, as well as readiness to refine what is possible in the timeframes. Further work is also needed with newly formed PCNs and a range of patients, to understand their needs in more detail. We will also align to the wider ICS Digital Strategy to ensure this is embedded in the system-wide plan, ensuring joined up and sustainable care is offered in Gloucestershire in accordance with our long term plan.

Summary of our priorities for Goal 5

Goal 5: Digital Enablement Strategic Commitments

Our strategic commitments to this goal during the time-frame of this Strategy are as follows. We will:

- Deliver robust, secure joined up primary care infrastructure at scale to support mobile working, collaboration and reliability.
- Empower patients to participate in their own health planning and access clinically robust guidance remotely.
- Develop highly usable clinical digital systems to support assessment, diagnosis, prescription and the capture of sharable meaningful information
- Provide a holistic view of the patient’s needs and the ability to co-create care plans with their circle of care.
- Share a wide range care options in the context of demand and capacity insights, to direct people to their best care options and develop our services around them.
- Deliver Population Health Management infrastructure, analytical solutions and data solutions, to allow more personalised care to be delivered.
- Develop the primary care leadership, care staff and informatics delivery teams to design and use digital technology and data to improve models and provision of care.
4.6 Goal 6: Estates

Our original Primary Care Infrastructure Plan (PCIP) 2016-2021, as described earlier, has made a significantly positive difference to the primary care estate across our county since its publication, with completed or approved schemes and remaining priorities summarised at Appendix 4. This investment in our estate has seen our annual delegated premises budget rise from £7.7m in 2015/16 to £8.6m in 2019/20, which demonstrates our commitment to invest in our primary care surgery premises for the benefit of our patients.

In refreshing our Primary Care Strategy, we have also taken the opportunity to refresh our PCIP, which is now extended to 2026 and is included within this Strategy at Appendix 4.

In summary, the PCIP has been updated to reflect the changing landscape reflected in this Strategy, including PCNs, ILPs, the LTP, a review of housing plans and population growth, and the need to increasingly align primary care estate with the ICS estate. This still includes the need to deliver improved general practice estates to accommodate planned population increases, changes in working practice within primary care, aspects of ‘Enabling Active Communities’ (see start of this Chapter) around voluntary sector service delivery and supporting a resilient and sustainable primary care. In addition it extends to maximising opportunities to share space within the ICS to facilitate service integration, making it easier for our community and voluntary sectors to utilise our estate to mobilise services while minimising running costs.

The 74 practices in our county are providing services from 100 buildings, where 60 of the buildings are owned by the practices themselves, 39 buildings are leased and one building is part-leased and part-owned. Housing forecasts and population growth by district council (Table 7) allows us to make assumptions on the registered list size growth for all of our practices, shown as an aggregated position for each of our six ILPs at Table 8, which has been utilised in developing our estates planning assumptions over the course of the refreshed PCIP.

<table>
<thead>
<tr>
<th>District</th>
<th>Number of new houses April 2019 to March 2031</th>
<th>Population growth assumption**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cheltenham</td>
<td>9,368</td>
<td>15,176</td>
</tr>
<tr>
<td>Corshwolds</td>
<td>5,030</td>
<td>8,149</td>
</tr>
<tr>
<td>Forest of Dean*</td>
<td>3,417</td>
<td>5,535</td>
</tr>
<tr>
<td>Gloucester</td>
<td>10,325</td>
<td>16,727</td>
</tr>
<tr>
<td>Stroud</td>
<td>7,295</td>
<td>11,818</td>
</tr>
<tr>
<td>South Gloucestershire</td>
<td>1,370</td>
<td>2,219</td>
</tr>
<tr>
<td>Tewkesbury (incl Wychavon)</td>
<td>4,887</td>
<td>7,917</td>
</tr>
<tr>
<td>Total</td>
<td>41,692</td>
<td>67,541</td>
</tr>
</tbody>
</table>

*Forest of Dean housing plans to 2026
** Based on 1.62 people per household - assumes a 1/3 of homes are bought/tented by single individuals and that 10% result from individuals leaving existing households (a dilution effect of existing homes)

Table 7: Housing and population growth assumptions by District
<table>
<thead>
<tr>
<th>ILP</th>
<th>Baseline (July 2014)</th>
<th>PCIP 2016 version growth assumption</th>
<th>PCIP predicted list size 2031 in 2016 plan</th>
<th>List size Jan 2019</th>
<th>Allocation of number of homes*</th>
<th>List size growth assumption**</th>
<th>Revised list size estimate in 2031</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cheltenham</td>
<td>151,475</td>
<td>21,000</td>
<td>172,475</td>
<td>158,483</td>
<td>10,219</td>
<td>16,555</td>
<td>175,038</td>
</tr>
<tr>
<td>Cotswolds</td>
<td>85,707</td>
<td>18,000</td>
<td>103,707</td>
<td>90,405</td>
<td>5,030</td>
<td>8,149</td>
<td>98,554</td>
</tr>
<tr>
<td>Forest of Dean***</td>
<td>62,495</td>
<td>11,000</td>
<td>73,495</td>
<td>63,678</td>
<td>2,974</td>
<td>4,818+ 3,441</td>
<td>71,937</td>
</tr>
<tr>
<td>Gloucester</td>
<td>165,612</td>
<td>25,500</td>
<td>191,112</td>
<td>174,477</td>
<td>13,536</td>
<td>21,928</td>
<td>196,405</td>
</tr>
<tr>
<td>Stroud &amp; Berkeley Vale</td>
<td>120,003</td>
<td>9,000</td>
<td>129,003</td>
<td>121,509</td>
<td>6,368</td>
<td>10,316</td>
<td>131,825</td>
</tr>
<tr>
<td>Tewkesbury***</td>
<td>42,253</td>
<td>6,000</td>
<td>48,253</td>
<td>43,945</td>
<td>3,565</td>
<td>5,775+ 510</td>
<td>50,230</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>627,545</strong></td>
<td><strong>90,500</strong></td>
<td><strong>718,045</strong></td>
<td><strong>652,497</strong></td>
<td><strong>41,692</strong></td>
<td><strong>71,492</strong></td>
<td><strong>723,989</strong></td>
</tr>
</tbody>
</table>

*Based on an assessment of existing housing strategies and discussion of these plans with District Councils. It is recognised plans change and these are forecast assumptions.

** Based on 1.62 people per household - assumes a 1/3 of homes are bought/rented by single individuals and that 10% result from individuals leaving existing households (a dilution effect of existing homes)

***Additional 5 years list size growth added from April 2026 to March 2031 based on average annual estimated housing growth until 2026. Two practices in Tewkesbury ILP included.

Table 8: List growth assumption by ILP

The strategic prioritisation of our estates programme going forward considers five elements, including the condition of the building, the capacity of the building at the time of our six facet survey in 2015 and the capacity of the building by 2031, see figure 18 below. This prioritisation exercise has identified six priority premises proposals, summarised at Table 9 below.

Figure 18: Determining Key Priorities for Infrastructure
This creates a comprehensive programme across the county for 2019 – 2026 as summarised at Table 10 below. Delivery of this programme will result in our primary care estates delegated budget rising from £8.6m in 19/20 to £9.2m by 2020/21 and to £11.6m by 2025/26.

### Summary of our priorities for Goal 6

<table>
<thead>
<tr>
<th>ILP</th>
<th>Premises proposal</th>
<th>Estimated delivery year (open)</th>
<th>Estimated m2 (GIA)</th>
<th>Estimated capital cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cheltenham</td>
<td>Development/replacement of facilities for the Overton Park and Yorkleigh surgeries, ideally as colocated services in one building for around 22,000 patients</td>
<td>2024/2025</td>
<td>1,626</td>
<td>£6.7m</td>
</tr>
<tr>
<td>Forest of Dean</td>
<td>Review of primary care facilities requirements across Drybrook and Mitcheldean to support long term provision of local services with a single site for around 11,000 patients</td>
<td>2025/2026</td>
<td>869</td>
<td>£3.5m</td>
</tr>
<tr>
<td>Gloucester City</td>
<td>Review of options for the development of Bartongate surgery in Gloucester City for around 9,000 patients - expected extension</td>
<td>2020/2021</td>
<td>980</td>
<td>£4.0m</td>
</tr>
<tr>
<td>Cotswolds</td>
<td>Review of options for the development or replacement of Cheltenham Road surgery in Gloucester for around 10,000 patients in addition to improvement of Highnam surgery</td>
<td>2021/2022</td>
<td>869</td>
<td>£3.8m</td>
</tr>
<tr>
<td>Stroud &amp; Berkeley</td>
<td>Development of Chipping surgery in Wotton-under-Edge, which was adopted as a priority in 2018/2019 as being delivered through improvement grant</td>
<td>2022/2023</td>
<td>1,315</td>
<td>£4.7m</td>
</tr>
<tr>
<td>Gloucester City</td>
<td>New surgery to replace the Brockworth and Hucclecote surgeries and cover major population growth with total list size of 23,000 - 25,000</td>
<td>2020/2021</td>
<td>2026 onwards for new surgery</td>
<td>2026 onwards for new surgery</td>
</tr>
<tr>
<td>Gloucester City</td>
<td>Development of existing Bartongate surgery through refurbishment of overall building to accommodate up to 9,000 patients – brought forward as improvement grant funding likely to be available</td>
<td>2020/2021</td>
<td>150</td>
<td>£0.5m</td>
</tr>
<tr>
<td>Gloucester City</td>
<td>New surgery to replace the Brockworth and Hucclecote surgeries and cover major population growth with total list size of 23,000 - 25,000</td>
<td>2021/2022</td>
<td>1,892</td>
<td>£8.0m</td>
</tr>
<tr>
<td>Stroud &amp; Berkeley</td>
<td>Refurbishment and extension of Chipping Surgery in Wotton under Edge to accommodate up to 10,500 patients brought forward as ETTF improvement grant funding available</td>
<td>2019/2020</td>
<td>1,300</td>
<td>£1.6m</td>
</tr>
<tr>
<td>Stroud &amp; Berkeley</td>
<td>Joint development of new facility for Locking Hill and Stroud Valleys Family Practice for around 15,500 patients</td>
<td>2021/2022</td>
<td>788</td>
<td>£4.4m</td>
</tr>
<tr>
<td>Stroud &amp; Berkeley</td>
<td>Development of Beeches Green Health Centre for around 9,000 to 10,000 patients</td>
<td>2025/2026</td>
<td>808</td>
<td>£3.1m</td>
</tr>
<tr>
<td>Stroud &amp; Berkeley</td>
<td>Replace the existing Minchinhampton surgery for around 8,500 patients</td>
<td>2021/2022</td>
<td>808</td>
<td>£2.5m</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>£62.3</strong></td>
</tr>
</tbody>
</table>

### Table 9: Summary of new premises priorities 2021 - 2026

The full version of our refreshed PCIP, and accompanying appendices, can be found at Appendix 4.
5. Governance

This Primary Care Strategy is an ICS document as part of our Long Term Plan response. The governance of our One Gloucestershire ICS centres around matrix working between the four key elements of the system:

- Partner Organisational Board
- Integrated Locality Partnership at place level
- Transformation Programmes
- Enabler Programmes

The main forum of the ICS is the ICS Board which is responsible for ensuring that the system delivers its vision, of which this Strategy is a key enabler, the governance of which is shown at Figure 19. Further details on the ICS Governance can be found in our Long Term Plan.

**Figure 19: Our ICS Governance Overview**

Beneath the ICS governance structure, this Primary Care Strategy’s governance will be through the Primary Care Operational Group and Primary Care Commissioning Committee, delivered through the PCNs and ILPs, with reporting through to the New Models of Care Board and up through to the ICS Board and ICS Executive. Following finalisation of this document, a comprehensive Primary Care Strategy implementation programme plan will be developed across the six goals, assigning responsible owners from across the ICS to demonstrably track progress.
Overall responsibility for the sign-off and implementation of the Strategy resides with the CCG Governing Body, as the statutory organisation with responsibility for primary care commissioning through delegated authority from NHS England. This governance structure is shown at Figure 20.

**Figure 20: Primary Care Strategy Governance Overview**
6. Engagement and Equality

This Strategy utilises and explicitly builds upon continuous engagement which was initially undertaken for the first iteration of the Primary Care Strategy (2016 – 2021). We have worked with and alongside our Patient Participation Group (PPG) Network and with our PALs team to develop both the previous iteration and this one. We view engagement as a continuous dialogue, working together to ensure our Strategy and implementation plans are built around and with our patients. This includes patient representatives supporting the development of specifications and being fully involved members of our procurements, such as our recent online consultation procurement panel. We will continue to involve our patients in this way and we are planning to include patient representatives on our ILPs across the county.

We have also been engaging with the public to capture their views on our Long Term Plan for Gloucestershire. We have been working with Healthwatch Gloucestershire, the county’s independent health and social care champion, to ensure that local people are at the centre of everything we do and that their voice is heard. We will be developing a patient-facing version of this Strategy, working with the PPG Network, Healthwatch Gloucestershire and our PALS team.
We have been engaging with patients using material such as the booklet below, to explain: our plans, how our practices are forming PCNs to deliver more local services and appointments, how we’re growing our primary care workforce, how we’re developing our urgent care offer, the support offer for long term conditions and our plans for the future and how we’re supporting our workforce and developing more digital services.

6.1 Healthwatch Gloucestershire

Healthwatch Gloucestershire is the county’s independent health and social care champion; Healthwatch Gloucestershire exists to ensure that people are at the heart of care. The service is commissioned from Evolving Communities by Gloucestershire County Council, with a contribution from the CCG to enhance the provision of information to local residents.

Dedicated teams of staff and Healthwatch Gloucestershire volunteers listen to what people like about local health and care services, and what could be improved. These views are then shared with decision-making organisation e.g. the CCG, so together a real difference can be made. We work closely with Healthwatch Gloucestershire, with their volunteers taking part in CCG led programmes and activities and the CCG and other ICS Partners commission Healthwatch to gather feedback from local people.

For further information and support about patient engagement and equality visit: https://www.gloucestershireccg.nhs.uk/about-you/
or contact the Patient Engagement and Experience team: glccg.consultation@nhs.net
7. Financial Investment

As described earlier, this Primary Care Strategy is explicitly an enabler to the One Gloucestershire ICS’s LTP and therefore supports our ICS vision for how public-funded health and care services can support a healthier Gloucestershire, which is socially and economically strong and vibrant. Through delivery of this Primary Care Strategy, we believe this will significantly contribute to achieving an improved and more sustainable health and care system.

The NHS LTP and the new GP contract framework announced significant additional funding for primary care over the course of 2019 – 2024. This additional investment funds the aspirations described nationally in Chapter 1 of this document, while our local plan for achieving those national aspirations and our local ICS Strategic Intent for Primary Care are outlined in Chapter 3 and detailed in Chapter 4.

Our local share of this additional national funding is shown in the growth of our allocations below at Table 11.

<table>
<thead>
<tr>
<th>Primary Care Allocation</th>
<th>2019/20</th>
<th>2020/21</th>
<th>2021/22</th>
<th>2022/23</th>
<th>2023/24</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allocation</td>
<td>86,659</td>
<td>90,792</td>
<td>96,046</td>
<td>100,380</td>
<td>104,926</td>
</tr>
<tr>
<td>Growth</td>
<td>6.32%</td>
<td>4.77%</td>
<td>5.79%</td>
<td>4.51%</td>
<td>4.53%</td>
</tr>
<tr>
<td>Growth per capita</td>
<td>5.56%</td>
<td>4.02%</td>
<td>5.06%</td>
<td>3.81%</td>
<td>3.85%</td>
</tr>
<tr>
<td>Opening DfT per capita</td>
<td>-2.15%</td>
<td>-2.49%</td>
<td>-2.38%</td>
<td>-2.24%</td>
<td>-2.11%</td>
</tr>
<tr>
<td>Final closing DfT</td>
<td>-2.99%</td>
<td>-2.87%</td>
<td>-2.69%</td>
<td>-2.51%</td>
<td>-2.32%</td>
</tr>
<tr>
<td>Allocation Adjustment</td>
<td>-2,494</td>
<td>-2,607</td>
<td>-3,494</td>
<td>-2,947</td>
<td>-1,917</td>
</tr>
<tr>
<td>Allocation after Adjustment</td>
<td>84,165</td>
<td>88,185</td>
<td>92,552</td>
<td>97,433</td>
<td>103,009</td>
</tr>
</tbody>
</table>

Table 11: Gloucestershire’s Primary Care Allocation: 2019 – 2024

The above funding covers GMS/PMS/APMS contract expenditure, as well as premises costs and other nationally set allowances, and includes uplift for cost inflation and growth. In addition, as part of its programme allocation, the CCG funds:

- The drug costs of GP prescribing: c.£84m
- Local Enhanced Services: c.£7m
- Primary Care IT: c.£1.8m
- PCN Transformation Funding: c.£1.2m
- Social Prescribing: c.£0.6m

The revenue impact to the CCG of the PCIP is set out within the main document at Appendix 4, section 9.9.
We will also continue to receive national allocations from NHSE for specific programmes. For example, the legacy General Practice Forward View schemes described in this document, which includes schemes such as: Improved Access and training for care navigation for GP practice receptionists. The LTP sets out national funding of £1.8bn by 2023/24 for additional workforce (described in Goal 4 and included in our allocation above) and a Network Investment and Impact Fund (described in Goal 1) of £300m by 2023/24. While we do not yet know the value of these allocations for Gloucestershire over the course of this Strategy, we do commit to ensuring all of this funding is ring-fenced to PCNs to ensure they receive the funding they need to deliver the Vision described by this Strategy, and ultimately, the ICS, for the benefit of our patients.
8. Conclusion

This Primary Care Strategy sets out how Gloucestershire ICS is responding to the national and local context of primary care as we enter the biggest change to the sector for at least 15 years, if not longer. We are facing unprecedented pressures due to national workforce shortages, increasing workload, changing patient demographics and associated need, while maintaining our ambition to deliver high quality care that is centred around our patients.

We have set out a strategic intent to dissolve the historic divide between primary and community care organisations through the closer alignment and greater integration between our ICS organisations through our PCNs and ILPs. This is at the heart of our plans and will enable us to:

- Provide patients with more control over their own health, anticipatory care and personalised care when they need it, and support early cancer diagnosis. We will utilise population health to tackle inequalities, assessing our local population by risk of unwarranted health outcomes to make services available where they are most needed;

- Grow our multi-disciplinary teams, attracting and retaining the best staff through promoting Gloucestershire as a great place to live and work, creating a better work-life balance for staff, and offering excellent training opportunities;

- Ensure good access to primary care seven days a week, meaning better support for patients while also reducing urgent demand at our hospitals to enable them to care for the most acutely poorly patients;

- Digitally-enable primary care to maximise the use of technology;

- Support PCNs and ILPs to explore how they can provide a greater range of services for larger numbers of patients.

The six Goals described in this document set out a range of commitments to achieve this vision and we look forward to working with our patients, our member practices, our LMC, our ICS colleagues and all our stakeholders to deliver this Strategy. We will resource them appropriately, providing clinical and managerial support to ensure we achieve them. We will now develop detailed action plans and key performance indicators for each of these Goals.
9. References


- NHS Digital (2018). Quality and Outcomes Framework (QOF): England 2017-18. Retrieved from https://app.powerbi.com/w?v=r=eyJrJlujODliN2M3NTQtOGFjMC00NjMxLTk5ZWMtMjg2MmQ0NDI3Nzk5iwiwCi6iUwZjYWwNzFmLWJiZmUtNDAxYS04ODAzLTY3Mzc0OGU2MjIlMImSi5mIj9

- NHS Digital (2019). Quality and Outcomes Framework (QOF): Achievement, Prevalence and Exceptions. Retrieved from https://app.powerbi.com/w?v=r=eyJrJlujODliN2M3NTQtOGFjMC00NjMxLTk5ZWMtMjg2MmQ0NDI3Nzk5iwiwCi6iUwZjYWwNzFmLWJiZmUtNDAxYS04ODAzLTY3Mzc0OGU2MjIlMImSi5mIj9


Appendices
Appendix 1: Gloucestershire Primary Care: Our GP Practices

We have 74 GP practices across our county, which can be found by clicking the button below.

These 74 practices are spread across 100 buildings across the county. They have a combined 650,000 patients and are organised into 14 PCNs and 6 ILPs – details of which can be found at Appendix 2.

The majority of our practices (64) are contracted under the GMS contract, with 4 PMS contracts and 3 APMS contracts. The average QOF figures for Gloucestershire in 2017/18 was 544.54 points (97.41%), rising to 550.18 (98.42%) in 2018/19 (NHS Digital, 2019), compared with the 2017/18 national average of 538 points (96.24%) (NHS Digital, 2018).

As at the end of October 2019, our practice CQC ratings are as follows:

- 4 Gloucestershire practices are rated as ‘outstanding’
- 68 practices are rated as ‘good’
- 2 practices are rated as ‘requires improvement’

In addition to our Primary Care Offer, described in Chapter 4 (Goal 3), we offer a range of local enhanced services to our practices to provide to their patients, including:

- Anti-coagulation service
- Older People Care Homes support
- LD/PD Care Homes support
- Deep Vein Thrombosis service
- Diabetic patient support
- High Risk Drug Monitoring
- Secondary to Primary Care services – supporting more care out of hospital
- Provision of Minor Surgery to Non-registered Patients
- Ear Irrigation
- Prophylaxis with Antiviral Drugs In and Out of Season

We also offer some targeted enhanced services to particular practices where specific additional needs are identified.
## Appendix 2: Our Primary Care Networks and Integrated Locality Partnerships

<table>
<thead>
<tr>
<th>Integrated Locality Partnerships</th>
<th>Primary Care Networks (PCNs)</th>
<th>Practices</th>
<th>List Size (1 Jan 2019)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cheltenham</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cheltenham Central</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Berkeley Place Surgery</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Crescent Bakery Surgery</td>
<td></td>
<td></td>
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<tr>
<td>Overton Park Surgery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Royal Crescent Surgery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Underwood Surgery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yorkleigh Surgery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cheltenham Peripheral</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleelvelands Medical Centre</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Leckhampton Surgery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sixways Clinic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stoke Road Surgery</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Winchcombe Medical Centre</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>St Paul’s</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Corinthian Surgery</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>The Portland Practice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Royal Well Surgery</td>
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<td></td>
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</tr>
<tr>
<td>St Catherine’s Surgery</td>
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<td></td>
</tr>
<tr>
<td>St George’s Surgery</td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cotswolds</strong></td>
<td></td>
<td></td>
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<tr>
<td>North Cotswold</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Campden Surgery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cotswold Medical Practice</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Mann Cottage Surgery</td>
<td></td>
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<td></td>
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<tr>
<td>Stow Surgery</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>White House Surgery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cirencester Health Group</td>
<td></td>
<td></td>
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<tr>
<td>Hilary Cottage Surgery</td>
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<tr>
<td>Phoenix Health Group</td>
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<td></td>
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</tr>
<tr>
<td>Rendcomb Surgery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upper Thames Medical Group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>South Cotswold</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blakeney Surgery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Brunston &amp; Lydbrook Practice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coleford Family Doctors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dockham Road Surgery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drybrook Surgery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Forest Health Centre</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Lydney Practice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mitcheldean Surgery</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Newnham Surgery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severnbank Surgery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yorkley &amp; Bream Practice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Forest of Dean</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Forest of Dean</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Networks</td>
<td>Services Provided</td>
<td>Population</td>
<td></td>
</tr>
<tr>
<td>-----------------------</td>
<td>------------------</td>
<td>-------------</td>
<td></td>
</tr>
<tr>
<td>Gloucester City</td>
<td>Aspen Medical Practice, Rosebank Health, Hadwen Medical Practice, Quedegeley Medical Centre</td>
<td>29,763</td>
<td></td>
</tr>
<tr>
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<tr>
<td>Tewkesbury, West Cheltenham, Newent &amp; Staunton</td>
<td></td>
<td>47,284</td>
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The Primary Care Networks can be seen diagrammatically on the following page.
Figure A1: Our 14 Primary Care Networks
Appendix 3: Our Six Integrated Localities: Summaries and Profiles

Cheltenham ILP

The Cheltenham locality covers a mainly urban population comprised of Cheltenham, Winchcombe and Bishops Cleeve. The total area covers around 155,144 patients in sixteen practices. The locality includes three PCNs: Central, Peripheral and St Pauls (see Appendix 1 for further details of constituent practices).

People and Place

- Life expectancy for men (80.4%) is higher than the County (80.2%) and England average. Life expectancy for women (83.1%) is lower than the County average (83.7%) but higher than England.
- Cheltenham is the 3rd most deprived district in Gloucestershire and the district has 3 Lower Super Output Areas (LSOA) that rank in the top 10% most deprived in England - St Mark’s 1, Hester’s Way 3, and St Paul’s 2. About 13% (2,500) of children live in low income families.
- Cheltenham’s worst ranking domain is “Crime and Disorder” with 26% of the district population living within 19 LSOAs that fall into the most deprived national quintile for this domain.
- The Locality has a slightly younger profile than the county as a whole although it should be noted that several practices have an older demographic.

Lifestyle and Prevention

- The number of adults in Cheltenham District doing the recommended level of physical activity dropped from 74% in 2015/16 to 72% in 2016/17.
- In 2017/18 the directly age standardised rate of admission episodes for alcohol specific conditions in Cheltenham District was significantly higher (at 616 per 100,000 population compared to 570) than England.
- Smoking prevalence is around 11%, which is lower than the county average of 14%.

Long Term Conditions

- 31.7% of adults; 12.1% of older people (65+) and 1.9% of children have Long Term Conditions (LTCs).
- Prevalence of smoking (23.4% vs 15.9%), COPD (2.2% vs 1.9%) and depression (19.1% vs 15.5%) in St Paul’s PCN are all higher than the county rates.
- Prevalence of all LTCs in Central PCN is lower than the county rate.
- Prevalence of Cancer (5% vs 4%), CHD (3.4% vs 3.2%) and dementia (1% vs 0.9%) in Peripheral PCN are all higher than the county rate.

Screening and Immunisations

- Screening coverage and uptake is significantly lower than the county for bowel and cervical screening.
- Flu vaccination coverage is significantly lower than the county.
- MMR vaccination coverage is significantly lower than the county.
Avoidable Mortality

- Neoplasms continue to be the leading cause of avoidable mortality for women followed by cardiovascular disease and unintentional injuries.

- For men the leading cause of avoidable mortality is cardiovascular.

Click here to view full profile for Cheltenham
Cotswolds ILP

The Cotswolds is a mainly rural locality with two PCNs – North Cotswolds and South Cotswolds (see Appendix 1). It spreads out across a wide geographical area including Gloucestershire, and parts of Warwickshire, Oxfordshire and Worcestershire. The total area covers around 90,405 patients.

People and Place

- The Cotswolds ILP area has an older population profile than the CCG average. There are a high proportion of people aged 65+ and 85+ which has implications for age-related Long Term Conditions, while a higher rate of Cotswolds patients live on their own compared to the CCG norm (13.6% vs 11.9%).

- The growth in the registered list size for Cotswolds over the past 2 years has exceeded CCG growth, showing higher levels of month-on-month growth, (3.4% vs 2.5%). Greater growth still can be seen in the 65+ age bracket which has grown by 5.6% over the same time period, whereas the CCG has grown by 2.9%.

- Cotswolds is one of the 20% least deprived districts/unitary authorities in England, however about 8% (1,100) of children live in low income families and ranks as the most deprived district in the county for ‘Barriers to Housing and Services’.

- Life expectancy for both men and women is higher than the England average.

- The rate of people reported killed or seriously injured on roads in Cotswold is significantly higher than across Gloucestershire and England.

- The number of people with caring responsibilities is higher than the Gloucestershire average.

- The gap in employment rate between those with long term conditions and those without is 19.2% which is 8.7% higher than for Gloucestershire.

- The percentage of children in Cotswold achieving a good level of development by the end of reception is higher than in the county as a whole. However, if we look at those eligible for free school meals there are inequalities; the level of development is much lower (and lower than the same cohort at county level).

Lifestyle and Prevention

- The number of young people drinking alcohol has fallen from 56% in 2010 to 37.6% in 2018 but this is still higher than the overall rate for Gloucestershire (34.8%).

- The % of adults doing 150 minutes of exercise per week has fallen to 64.5% compared with 69.2% for Gloucestershire

- Smoking prevalence for adults is lower than the Gloucestershire rate but for young people it is marginally higher

Long Term Conditions

- Cotswolds generally has a lower rate of long term conditions than the CCG as a whole, aside from cancer (4.7% vs 3.9%) and coronary heart disease (3.3% vs 3.2%).
Stroke prevalence in Cotswolds place is marginally higher than the CCG norm (2.1% vs 2.0%).

In North Cotswolds, compared with the county, there is higher prevalence of cancer and CHD and a lower prevalence of smoking.

In South Cotswolds, prevalence of long term conditions is lower than the county.

**Avoidable Mortality**

The leading causes of avoidable mortality for women in Cotswold in 2018 were cancer; CVD and unintentional injuries

The leading causes of avoidable mortality for men in Cotswold in 2018 were cardiovascular disease; cancer and respiratory disease
Forest of Dean ILP

The Forest of Dean ILP is one PCN consisting of all eleven practices which covers almost 64,000 patients.

People and Place

- The health of people in Forest of Dean is varied compared with the England average. Life expectancy for men is higher than the England average.

- Projected overall growth rates are lower for the Forest of Dean than for Gloucestershire and England as a whole.

- The Annual Population Survey (October 2015 – September 2016) indicates that 3.1% of the population are from an ethnic minority group.

- 19.1% of patients are under 18 years old and 24.2% are 65 years and older.

- The locality has higher numbers of older people than the county average for both males and females and lower numbers of working age adults.

- The Forest of Dean is the district in Gloucestershire that displays the fewest extremes in deprivation however about 13% (1,800) of children live in low income families.

- The district has no LSOAs that rank in the top 10% most deprived in England, but 1 that ranks in the top 20% - Cinderford West 1.

- “Barriers to Housing and Services” is the Forest of Dean’s most deprived domain of deprivation with 25% of the district’s population living within LSOAs in the most deprived national quintile.

- The proportion of social and private homes that failed to meet the decent homes standard is significantly higher than the Gloucestershire average and the highest in the County.

- The Forest of Dean has a higher number of patients with caring responsibilities (18.3%) than both the England (16.7%) and Gloucestershire (17.2%) average.

- The locality has the highest unemployment rate in the county at 3.9%.

- The gap in employment rate between those with a long term condition and overall employment is almost twice as high in the Forest compared to the county.

- The percentage of children in the Forest of Dean achieving a good level of development by the end of reception is lower than in the county as a whole and for those eligible for free school meals, the level of development is lower than in both the locality and the county.

Lifestyle and Prevention

- Prevalence of obesity in reception age children is currently higher than the county with an upward trend.

- Prevalence of obesity in Year 6 children is also slightly higher (19.2%) than the county prevalence (17.8%).
The number of adults in the Forest of Dean doing the recommended level of physical activity dropped from 68.2% in 2015/16 to 65.8 in 2016/17 and this is the second lowest activity level in the county.

Smoking prevalence is around 15%, which is higher than the county average of 14%.

Forest has the second highest percentage of young people drinking alcohol in the county at 38.6%.

**Long Term Conditions**

- The Forest has a higher than county prevalence for cancer, CHD, COPD, dementia, depression, diabetes, obesity and smoking.
- Prevalence of stroke in the Forest is 2.5%, which is higher than both the CCG (2%) and England (1.8%).

**Screening and Immunisations**

- For those over 65 years of age coverage of seasonal flu vaccination is 71.1% which is slightly lower than the Gloucestershire average (74.7%)
- Seasonal flu vaccination coverage for pregnant women is 45.8% which is lower than the county rate of 49.4%.

**Avoidable Mortality**

- Neoplasms continue to be the leading cause of avoidable mortality for women in the Forest locality, followed by unintentional injuries and cardiovascular disease.
- For men, the leading cause of avoidable mortality is cardiovascular disease, followed by unintentional injuries and neoplasms.
- Respiratory disease is the fourth highest cause of mortality for both men and women.
Gloucester City ILP

Gloucester City covers a mostly urban patient population of around 175,000 patients and includes four PCNs: Aspen, HQR, Inner City and North & South Gloucester – full details of constituent practices can be found at Appendix 1.

People and Place

- The health of people in Gloucester is varied compared with the England average. Life expectancy for both men and women is lower than the county and England average.

- 10 out of 13 of Gloucestershire’s top 10% most deprived LSOAs nationally are located in Gloucester district and Gloucester has the highest proportion of all districts living in the most deprived areas (23% of district). About 16% (4,100) of children live in low income families.

- 27% of the district population are living within 22 LSOAs that fall into the most deprived national quintile for “Education Skills and Training”.

- The Standardised Admission Ratio (SAR) is a summary estimate of admission rates relative to the national pattern of admissions and takes into account differences in a population’s age, sex and socioeconomic deprivation. Gloucester City’s SAR at 120 is higher than the countywide SAR value and 20% above expected.

- When comparing first outpatient appointment rates for the Gloucester City population, by specialty and indexed to the CCG rate, it appears that for all specialties apart from Paediatrics, the levels are below the county position.

- Gloucester City has the second highest rate of unemployment in the county.

- 0.2% of social and private homes failed to meet the decent homes standard which is slightly lower than the county average and the lowest of the six districts.

- Hospital admissions for violent crime (rate per 100,000) is almost double the county rate.

- The percentage of children in Gloucester achieving a good level of development by the end of reception (67%) is lower than in the county as a whole (69.2%), while for those eligible for free school meals, this drops further to 48.3%.

Lifestyle and Prevention

- Childhood obesity for Year 6 children is significantly higher than the county rate.

- The number of adults in Gloucester doing the recommended level of physical activity is at 64.4%, the lowest level in the county.

- Smoking prevalence is around 21% of the population of Gloucester City, which is much higher than the county average of 14%.

Long Term Conditions

- Prevalence in lifestyle related conditions are notably above the overall CCG rate. Smoking prevalence
is 3.5% higher in Gloucester City than in the CCG population as a whole, with Inner City practices also having some of the highest rates of COPD. Obesity and Diabetes are also significantly above CCG prevalence for all PCNs, most notably for Aspen.

- 10.3% of older adults across the locality have a Long Term Condition but this varies considerably by PCN and Practice.
- The Locality has a higher than county prevalence for depression, diabetes, obesity and smoking.
- The rate of Asthma and COPD admissions for Gloucester City registered patients is considerably above the rate per 1000 population for the CCG as a whole.

**Screening and Immunisations**

- Overall levels of screening coverage and uptake are below the county rate for breast, bowel and cervical cancer.
- Seasonal Flu vaccinations for 2-4 year olds and ‘at risk’ individuals are lower than the county rate.
- Childhood vaccinations for DTaP/IPV and MMR are lower than the county rate.

**Avoidable Mortality**

- Neoplasms, cardiovascular disease, respiratory disease and unintentional injuries are the biggest causes of avoidable mortality in the locality for both men and women.
Stroud & Berkeley Vale ILP

The ILP area covers a mixture of rural spaces and small towns and villages to the south of the county with a total patient population of almost 122,000. There are three PCNs in the locality, made up of a total of eighteen GP Practices: Berkeley Vale, Severn Health and Stroud Cotswold (see Appendix 1 for full details).

People and Place

- Stroud is one of the 20% least deprived districts/unitary authorities in England, however about 10% (1,900) of children live in low income families. Life expectancy for both men and women is similar to the England average.

- Stroud district ranks well in the county in terms of overall deprivation, and consistently well across the domains of deprivation.

- The district’s worst ranking domain in the IMD 2015 is “Barriers to Housing and Services” with 8,745 people (8% of district population in 2015) living within 5 LSOAs that fall into the most deprived national quintile for this domain.

- The Stroud & Berkeley Vale registered list size has shown steady growth since 2017, showing slightly lower levels of month-on-month growth compared to the overall CCG position. This trend is consistent across the three PCNs.

- ONS Population projections show that the number of older people (65+) are set to increase by 56.6% by 2041.

- The percentage of children in Stroud achieving a good level of development by the end of reception (71%) is slightly higher than in the county as a whole (69.2%). However, for those eligible for free school meals, the level of development is much lower (49%).

- The locality has more patients living in care homes compared to the CCG average.

- The SAR is lower (0.93) than the countywide SAR value and 7% below expected unplanned admissions. At a PCN level both Berkeley Vale and Severn Health have a SAR of 95, however Stroud Cotswolds is lower at 88 meaning the admissions are 12% lower than expected.

Lifestyle and Prevention

- The number of young people drinking alcohol is significantly higher than the county average.

- The number of young people smoking is significantly higher than the county average.

Long Term Conditions

- Prevalence of depression in the Berkeley Vale PCN is higher than the county average.

- All three Stroud & Berkeley Vale PCNs have a higher rate in the ‘Health Older People’ and ‘Older People with LTCs’ segments, when compared to the indexed CCG position. Severn Health has a higher rate of ‘End of Life’ patients compared to the County, however, it should be noted that this represents a small volume of patients. Berkeley Vale has a slightly higher rate of ‘Children with LTCs’ compared to the County.
● Stroud and Berkeley Vale have a slightly higher prevalence of Cancer and Dementia compared to the overall CCG rate, with lower prevalence in lifestyle related conditions.

**Avoidable Mortality**

● The leading causes of avoidable mortality for both men and women are cancer, CVD and unintentional injuries, followed by drug use disorders for men and respiratory disease for women.
Tewkesbury ILP

Tewkesbury Locality covers Newent, Staunton, Tewkesbury Town Centre and parts of West Cheltenham. The locality has one PCN and has a total patient population of around 47,000; full details of constituent practices can be found at Appendix 1.

People and Place

- The health of people in Tewkesbury Borough is generally better than the England average. Tewkesbury is one of the 20% least deprived districts/unitary authorities in England, however about 11% (1,700) of children live in low income families. Life expectancy for both men and women is higher than the England average.

- Tewkesbury Borough has 2 LSOAs that rank in the top 20% most deprived in England. These are Tewkesbury Prior’s Park 2 and Tewkesbury Prior’s Park 3.

- Tewkesbury Borough’s worst ranking domain is “Barriers to Housing and Services”, with 22% of the district’s population living within areas ranked in the most deprived national quintile.

- The change in the registered list size for the locality has been consistently higher than the overall CCG position, showing growing variation month-on-month.

- The SAR for the locality is at 111, 11% above expected.

- When comparing the outpatient procedure distribution for the TWNS population by specialty and indexed to the CCG rate, Rheumatology, T&O and Urology all have a higher % of the overall activity compared to the CCG average.

- The percentage of term babies born below 2500g is significantly higher (3.3% in 2016) than the county value (2.2% in 2016).

- The percentage of children in Tewkesbury achieving a good level of development by the end of reception is broadly in alignment with the county rate of 69.2%, however for those eligible for free school meals the level of development is much lower (46.7%).

- Tewkesbury has a slightly higher (17.7%) number of patients with caring responsibilities than both the England (16.7%) and Gloucestershire (17.2%) average.

- The rate of people reported killed or seriously injured on roads in Tewkesbury between 2015 and 2017 is significantly higher (57.6 per 100,000 population) than across Gloucestershire (45.3) and England (40.8).

Lifestyle and Prevention

- Prevalence of obesity in reception age children is broadly in line with the county average (10% vs 9.9%), although with an upward trend. For Year 6 children prevalence is 19.5% compared to 17.8%.

- The percentage of young people drinking alcohol in Tewkesbury Borough is falling at 37.8% (47.9% in 2010), but is still higher than the county rate of 34.8%.
- Prevalence of smoking amongst young people aged 14 to 15 is the third highest in the county at 10.5%, compared with the county rate of 9.2%.

- Smoking prevalence is around 16% (county average of 14%).

**Avoidable Mortality**

- In line with the county and nationally the three biggest causes of avoidable mortality are neoplasms, cardiovascular disease and respiratory disease.

[Click here to view full profile for Tewkesbury]
Appendix 4: Our Primary Care Infrastructure Plan: 2019 to 2026

Click the buttons below to view the documents:

- Main Primary Care Infrastructure Plan (PCIP) document
- PCIP: Appendix 1
- PCIP: Appendix 2
- PCIP: Appendix 3
- PCIP: Appendix 4
- PCIP: Appendix 5
- PCIP: Appendix 6
Appendix 5: Full workforce trajectories 2019-2024
Cheltenham ILP

Notes:

- September 2017: Primary Care Workforce Strategy Baseline
- All figures represent WTE

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<td>Other Direct Patient Care</td>
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* Updated to include staff captured in baselining exercise for Additional Roles Reimbursement, including those funded by CCG (e.g. transformation clinical pharmacists) to form 31 March 2019 baseline
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<th>Total Clinical FTE</th>
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* Updated to include staff captured in baselining exercise for Additional Roles Reimbursement, including those funded by CCG (e.g. transformation clinical pharmacists) to form 31 March 2019 baseline.
## Appendix 6: Digital Risks and Mitigations

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<tr>
<th>Risk</th>
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<th>RAG</th>
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<tbody>
<tr>
<td>Operational impacts of investing in solutions that don’t realise the benefits required for the new model, or add extra effort to practices.</td>
<td>Digital, clinical and admin resource digital delivery skills development.</td>
<td>Amber-Red</td>
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<tr>
<td>Competition from commercial Digital only services harvesting patients with lower complexity or not providing holistic sustainable care</td>
<td>Develop digital-first alternative solution and accelerate online consultation programme and national solution adoption.</td>
<td>Amber</td>
</tr>
<tr>
<td>Data and Security risks from not being able to manage a plethora or systems managed individually at a practice level against data privacy incidents and security attacks</td>
<td>Network upgrade, software upgrades, cyber programme delivery and system consolidations.</td>
<td>Amber-Red</td>
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<tr>
<td>Demand risks of increasing the number of people directed to inappropriate settings or creating unnecessary surges in demand through digital-first services</td>
<td>Developing user tested digital patient pathways and robust evaluation activities into new patient facing technology projects.</td>
<td>Amber</td>
</tr>
<tr>
<td>Care continuity risks of information existing in silos or being incomplete across settings, with an increasingly multi-disciplinary and multi-organisational care model</td>
<td>Information sharing programmes. Procurement from NHS frameworks and approved through an ICS Technical Design Authority and Digital Board.</td>
<td>Amber</td>
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<tr>
<td>Lack of funding and resources to deliver such a large programme, based on the small amount in place now.</td>
<td>Look to consolidate programme teams where there’s duplication, work with other ICS’ for scales of economy, converge the number of systems and options in use, look for alternative funding options and develop skills to improve productivity.</td>
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</tr>
<tr>
<td>Retention and recruitment risks if digitisation results in greater bureaucracy to complete tasks, doesn’t reduce demand and creates an arduous always-on work pattern</td>
<td>Invest in user centred design practices and business process analysis ahead of wholesale changes. Don’t go ahead with projects that add additional burden to staff.</td>
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<tr>
<td>Capability risks if staff are not supported to use and advocate the use of technologies and digital processes;</td>
<td>Embed digital projects into broader change programmes and develop digital workforce programmes.</td>
<td>Amber-Red</td>
</tr>
<tr>
<td>Quality of care risks if more virtual and remote models of care reduce care professionals' ability to understand and collaborate with patients on their care improvement</td>
<td>Developing user tested digital patient pathways and robust evaluation activities into new patient facing technology projects.</td>
<td>Amber</td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td>Patient access inequalities, if care access rules are inconsistent or exclude those not using particular channels</td>
<td>Undertake accessibility and equality impact assessments for new digital services to reduce chances of digital exclusion. Work with other organisations and staff on patient digital literacy programmes.</td>
<td>Amber</td>
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<tr>
<td>Financial and supplier risks if each practice or PCN goes alone in the selection of tools and technology platforms. This will miss opportunities to gain economies of scale, as well as making GPIT support more expensive and less responsive to needs</td>
<td>Encourage alignment and options papers on technology choices with PCN Directors and teams, reviewed at ICS level.</td>
<td>Amber-Red</td>
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<tr>
<td>Converging on a single supply may mean that a failure or issue with a single supplier will affect the whole system rather than just part of it.</td>
<td>Evaluate long-term roadmap of supplier and carefully manage service level agreements, in conjunction with user groups and central GPIT teams.</td>
<td>Amber-Green</td>
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Digital Primary Care Strategy
2020 – 2024 - Update
Our vision

We will work together to deliver digital convergence and collaboration across the ICS and to ensure that digital technology is one of the key drivers facilitating service transformation and sustainability.

We will invest in a sustainable and underpinning technical infrastructure to support the delivery of transformational service changes, driven by care professionals and focused on empowering people to take control of their own health and care.
Our delivery goals

Deliver a modern flexible infrastructure to support care professionals to work effectively across settings and remotely by aligning investments, experts, solutions and standards.

Providing a holistic view of the citizen’s direct care needs with their circle of care, and supporting those groups to collaborate with the most appropriate care providers on developing the plan of care.

Join up intelligence based on linked data to make better, more informed decisions as a single care system and with regional partners.

Provide streamlined systems and tools to support fast and collaborative care, no matter where you are or which organisation you belong to.

Offering people and their circle of care consistent and usable digital access to personalised health information, advice, referrals and self-care tools.
Our Roadmap

In developing our roadmap, we have mapped activities required in the Long Term Plan, GP Contract, GP Futures to the supporting capabilities to deliver the ICS Primary Care model.

The roadmap consists of 6 workstreams:

1. Empower the Person
2. Digital Maturity & Capabilities (Clinical Systems)
3. Information sharing
4. Infrastructure
5. Whole systems intelligence
6. Workforce & Delivery
1. Empower the person

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</thead>
<tbody>
<tr>
<td>NHS App</td>
<td>Online Consultations</td>
<td>Digital First access</td>
<td>Long Term Condition digital coaching</td>
<td>Remote monitoring</td>
<td>Personalise health and care digital delivery</td>
</tr>
<tr>
<td><strong>Live in Glos</strong></td>
<td><strong>e.g. 5 practices live with Dr Link and 18 with common website (Footfall)</strong></td>
<td><strong>70% EPS utilisation; 26% patients have online access to their record</strong></td>
<td><strong>e.g MapMyDiabetes and KiActive</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Tab 6 Primary Care Strategy – Digitally Enabled (Goal 5)
Online consultation status

GP Websites - Footfall Status

- Signed Contract: 6
- Contract Sent: 20
- Not in Scope: 2
- In Build: 24
- In Preview: 2
- Live: 2

GP Websites - DrLink

- Inactive: 5
- Live: 65
- Offer DrLink: 4
- To Be Withdrawn: 0
Digital First/Online Services

NHS App – Live in Gloucestershire

Patient Online Accounts – Minimum of 10% with an aim of 30% of active accounts. Overall percentage for Gloucestershire practices is 26.53%

Appointment Availability – 25% bookable online – (No data available) New guidance states practices are to make 25% of daily appointments available on line.

Record Access – New patients given access to their patient record at registration – (No data available)
Electronic Prescribing Service

25% of prescriptions are electronic repeat dispensing – Gloucestershire is currently at 18% with the national average currently at 14%

80% of repeat prescriptions sent electronically – Gloucestershire is currently at 84%
# 2. Digital Maturity & Capabilities (Clinical systems)

<table>
<thead>
<tr>
<th>GP system convergence &amp; enhancements</th>
<th>Clinical guidance &amp; decision support</th>
<th>Medicines decision support</th>
<th>eRostering</th>
<th>Paperless comms and corporate systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>GPIT Futures migrations</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Clinical systems</strong></td>
<td><strong>Current Systems</strong></td>
<td><strong>Requests to change</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emis</td>
<td>18</td>
<td>13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TPP</td>
<td>50</td>
<td>60</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision</td>
<td>6</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>74</strong></td>
<td><strong>74</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multi-channel, spine connected (Phone, email, picture etc) hosted A &amp; G Service across Urgent Care &amp; Elective Pathways implemented in 34 practices across 4 specialties with 300+ calls to date</td>
<td>e.g. Optimise RX</td>
<td>Primary care e-rostering</td>
<td>Getting rid of fax; Lloyd George digitisation; digital only patient letter options</td>
<td></td>
</tr>
</tbody>
</table>
Primary Care - Clinical Systems Status

GPSOC contracts have expired and NHSE’s GP IT Futures Programme requires practices to re-procure and implement their clinical systems from the new framework by January 2021.

Current GP clinical system distribution

<table>
<thead>
<tr>
<th>Type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>TPP Practices</td>
<td>74</td>
</tr>
<tr>
<td>EMIS Practices</td>
<td>49</td>
</tr>
<tr>
<td>Vision Practices</td>
<td>19</td>
</tr>
</tbody>
</table>

**Pie Chart**
- TPP Practices: 66%
- EMIS Practices: 26%
- Vision Practices: 8%
# Primary Care - Systems Migration Status

## Year 19/2020

<table>
<thead>
<tr>
<th>PRACTICE</th>
<th>SYS to SYS</th>
<th>Oct-19</th>
<th>Nov-19</th>
<th>Dec-19</th>
<th>Jan-20</th>
<th>Feb-20</th>
<th>Mar-20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract Frame Work</td>
<td>GPSoC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rosebank</td>
<td>VISION to Sys1</td>
<td>Pre Go Live Tasks</td>
<td>Go Live</td>
<td></td>
<td></td>
<td></td>
<td>Post Go Live Tasks 13 Nov 19 - 31 MAR 2020</td>
</tr>
<tr>
<td>Lockinghill</td>
<td>EMIS to Sys1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Year 20/2021

<table>
<thead>
<tr>
<th>PRACTICE</th>
<th>SYS to SYS</th>
<th>Apr-20</th>
<th>May-20</th>
<th>Jun-20</th>
<th>Jul-20</th>
<th>Aug-20</th>
<th>Sep-20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract Frame Work</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bartongate</td>
<td>EMIS to Sys1</td>
<td>Blocked due to end of Year (Practice &amp; Suppliers)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Forest Health Care</td>
<td>VISION to Sys1</td>
<td>Blocked due to end of Year (Practice &amp; Suppliers)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glos City Health</td>
<td>VISION to Sys1</td>
<td>Blocked due to end of Year (Practice &amp; Suppliers)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hadwen</td>
<td>TBC</td>
<td>Blocked due to end of Year (Practice &amp; Suppliers)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pavilion</td>
<td>EMIS to Sys1</td>
<td>Blocked due to end of Year (Practice &amp; Suppliers)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quedgely</td>
<td>TBC</td>
<td>Blocked due to end of Year (Practice &amp; Suppliers)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staunton &amp; Corse</td>
<td>EMIS to Sys1</td>
<td>Blocked due to end of Year (Practice &amp; Suppliers)</td>
<td>Request for May 2020 Migration</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stonehouse</td>
<td>EMIS to Sys1</td>
<td>Blocked due to end of Year (Practice &amp; Suppliers)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drybrook</td>
<td>EMIS to Sys1</td>
<td>Blocked due to end of Year (Practice &amp; Suppliers)</td>
<td>Request for Apr/May 2020 Migration</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Clinical guidance and decision support - Ardens Project Status

- Templates: 49
- S1-Ardens Live: 45
- EMIS-ArdensQ Live: 19

Graph showing the status of templates and live systems with SystmOne, EMIS, and Vision.
Clinical Advice & Guidance - Cinapsis

CINAPSIS – Advice & Guidance

• 572 Total Referrals since Jan 19 – 177 Previous 4 weeks (17/9 – 18/10)
• Average Referrers wait for connected call response is 19 seconds
• 86% calls connected/answered on first attempt
• 47 practices ‘Live’
• 143 Referrers from 38 Practices have used the service
• From first 247 calls 141 patients (57%) avoided ED either managed in Primary care or AMIA/AEC etc

Specialties (Live) Cases – Acute Medicine (421) / Acute Paeds (91) / Dermatology (52) / Respiratory (7)
• Frailty Assessment & Trauma & Orthopaedics currently in Training mode.
• Assisting CQC in building inspection framework for digital triage applications – meeting
## 3. Information Sharing

<table>
<thead>
<tr>
<th>Programmes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical documentation correspondence and diagnostics sharing</strong></td>
</tr>
<tr>
<td>Countywide Docman implementation in progress</td>
</tr>
</tbody>
</table>
Information Sharing

• **Electronic documentation & Image sharing** – Docman implementation in GHFT/GHC in progress; imaging sharing being scoped

• **Shared records - JUYI** - 52k views since go live Sept 18; 7k views per month
  – Next phase sharing Trakcare, test results, and social care data & rollout to GP practices
  – Linking with One South West Local Health & Care Record (LHCR)

• **Shared records – SCR** - Additional Information (6% of patients have a SCR AI record, 40k patients

• **Appointment Booking from 111** into practices being scoped
4. Infrastructure

<table>
<thead>
<tr>
<th>Programmes</th>
<th>Modernise the network</th>
<th>Device and software upgrade</th>
<th>Cyber Security &amp; IT service management</th>
<th>Mobile working</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementation of new, faster replacement NHS network (N3) across the county</td>
<td>Windows 10 and hardware upgrades in progress</td>
<td>Single domain implementation in progress</td>
<td>Public and Corporate WIFI implemented across all organisations</td>
<td></td>
</tr>
</tbody>
</table>
Infrastructure

Modernise the Network - Health Social Care Network HSCN) migration – 10 site surveys undertaken, 9 practices have initial circuits installed. First migrations due early December.

GP Single Domain – 16 practices migrated to the single domain.
Windows 10 Enterprise – 4 sites are live with 11 sites scheduled for Win10 upgrades.

Office 365 – awaiting news of national licence agreement

Cyber security tools in deployment

Collaboration tools e.g. skype for business in pilot in Cotswolds
5. Whole Systems Intelligence

<table>
<thead>
<tr>
<th>Programmes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data quality</strong></td>
</tr>
<tr>
<td>Implementation of Ardens in primary care to support data quality and consistency of clinical coding</td>
</tr>
</tbody>
</table>

Tab 6 Primary Care Strategy – Digitally Enabled (Goal 5)

Primary Care Commissioning Committee Part 1 31st October 2019 09:45am 31/10/19
PHM reporting

- PHM development programme piloting actuarial and PCN level reporting
- Local linked pseudonymised dataset in place linking primary care; acute, community, mental health data; work ongoing to link adult social care data
- Options being developed for the architecture of an ICS wide data repository and reporting tool linking with LHCR
Demand & Capacity Management - SHREWD

SHREWD displays urgent care information from organisations within the Gloucestershire system, in real time, helping urgent care teams to quickly identify system pressures and take prompt action, preventing pressure building at an early stage.

- **October 1st** - Go Live and Alamac switch off
- **Providers live** – Urgent care partner organisations and CCG Urgent Care team.
- **Data feeds** – TrakCare, GHC, GCC and SWASFT.
- **OPEL Algorithms** - designed to reflect the status of services across urgent care and used as a key component to help facilitate escalation calls for operational leads to act accordingly.
Gloucestershire Overview

Resilience → Whole System Resilience

ED Flow

Average Length of Time in ED

DTA

ED Flow

4hr % Performance (Since Midnight)

4 Hr Breaches (Since Midnight)

12 Hr Breaches (Since Midnight)

Patients in Department

Patients in Department - Majors

Patients in Department - Minors

Attendances (Last Hour)

Attendances (Since Midnight)
6. Workforce and Delivery

<table>
<thead>
<tr>
<th>Programmes</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Digital Leadership</td>
<td>Digital Literacy &amp; Culture</td>
</tr>
<tr>
<td>PCN PHM development as part of PCN development programme</td>
<td>Apprenticeship scheme in place for analysts</td>
</tr>
</tbody>
</table>
Digital workforce programme

- Analyst workforce development programme in place
- Digital workforce group established
- Planning to establish digital champions network and CCIO Forum
- Organisations have agreed to adopt the HEE Digital Capabilities Framework for staff
N3 network outage – 14th October

**Incident description:** 18 GP practices lost connectivity to windows and to clinical systems to varying degrees on 14th October

**Saturday 16th October**
3pm - Identified issue with N3 COIN
7:30pm – BT finally confirmed an issue at the exchange in Bristol

**Sunday 17th October**
9:30am – BT on site of Bristol Exchange with replacement kit. Engineers chased hourly for ETA
7:30pm- Issues reported resolved by BT

Monday 18th October
2am – Issue reoccurs
7am BT confirm fix time of 9:30am
9:30am – No Fix from BT. Decided to move VPN connections to Cirencester COIN. Issues were with domain authentication. Local N3 servers were available with access to clinical system however desktop profiles were not loading
9:30am – 5pm – Worked with practice to get access to clinical system via local N3 connection. Chased BT hourly
4pm – BT resolved issue
5pm – VPN traffic moved back to GLOS

Mitigations being put in place for future: Greater resilience on the new GP Coin & upgrades of the servers to allow local authentication onto the single domain
Agenda Item 7

Primary Care Commissioning Committee

<table>
<thead>
<tr>
<th>Meeting Date</th>
<th>Thursday 31st October 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title</td>
<td>Report on the Business Case for the development of a Minchinhampton Surgery</td>
</tr>
<tr>
<td>Summary</td>
<td>This document sets out the Case for Change, objectives, financial implications and timeline for the establishment of a new Primary Care Centre that will relocate the existing Minchinhampton Practice at Bell lane to a purpose built centre at Vosper Field, Cirencester Road. The Business Case responds to the following challenges:</td>
</tr>
<tr>
<td></td>
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</tr>
<tr>
<td></td>
<td>• An existing surgery identified as a priority for potential development in the CCG’s Primary Care Infrastructure Plan as not meeting requirements for the long term;</td>
</tr>
<tr>
<td></td>
<td>• A surgery building no longer deemed satisfactory, over the long term, in respect of estate conditions and functionality facet surveys;</td>
</tr>
<tr>
<td></td>
<td>• For the provision of primary care services, where the existing surgery building is significantly smaller than it should be for the existing number of patients and preventing an identified range of services from currently being provided;</td>
</tr>
<tr>
<td></td>
<td>• To ensure there are suitable facilities to extend the range of services available at local practices and ensure national and local service strategies can be implemented for the population served;</td>
</tr>
<tr>
<td></td>
<td>• To meet workforce strategy objectives, to ensure there are suitable facilities for existing staff and an expected increase in staff numbers over the next five to 10 years;</td>
</tr>
<tr>
<td></td>
<td>• So that the practice can facilitate the expansion at</td>
</tr>
</tbody>
</table>
student, foundation and GP Registrar levels where there is a lack of facilities;

- To ensure there are suitable facilities available for planned increase in patient numbers over the next fifteen years with an anticipated list size increase to at least 8,225 patients;

- To facilitate the delivery of more resilient and sustainable primary care and support the development of primary care network models of care;

- To minimise the costs of essential new infrastructure and ensure these costs are justified, represent value for money and support sustainable development.

In order to deliver general medical services, the building will be a maximum of 735m² net internal area along with up to 53 car parking spaces. This is the reimbursable area agreed in line with NHS regulations/ Premises Directions 2013 and includes training. It excludes pharmacy and any facilities required from other health care users outside of these Regulations. Currently no other health service organisations require facilities. The practice have made a commitment, in principle, that visiting services will have access to bookable rooms and will agree a fair and transparent process for this.

The Practices and their professional advisors submitted an electronic version of the business case. It has been made available to members. This paper provides a summary of key contents plus additional content where the author has deemed inclusion to be relevant

Subject to NHS approval and planning approval, the new building is expected to be open in October 2021

| Conflicts of interests | None identified |

Conflicts of interests
| Risk Issues:  
| Original Risk  
| Residual Risk  |
| From a CCG perspective, there is a key risk that should the new surgery development not proceed, the long term provision of suitable primary care premises for a growing population in Minchinhampton Centre will be substantially affected, leading to loss of reputation and impact of service delivery and commissioning strategies. |

| Financial Impact  |
| There are different financial elements that members need to consider and support in relation to the commissioning of primary care facilities and Premises Directions 2013: |

- New reimbursable recurrent current market rent requirements;  
- Reimbursable rates requirements;  
- Discretionary non recurrent fee support as defined by Premises Directions 2013;  
- One off reimbursable IM&T costs funded primarily through GPIT;  

Total revenue implications (rent and rates) will be £224,598 per annum inclusive of VAT. This will be partially offset by existing reimbursement of £49,222 per annum. A net additional recurrent investment of £175,376 is required.

The business case sets out all the relevant IM&T costs. From a CCG perspective a one-off £58,822 will be required for GPIT capital and HSCN requirements. It is assumed some of this will be required for the financial year 2020/2021 and some of it for 2021/2022.

In line with Premises Directions 2013, the Practice has also requested £24,000 fee support towards legal costs. Recognising that PCCC members have previously advised that additional fee support might be available in exceptional circumstances (January 2018 PCCC), the author of this report cannot provide any exceptional circumstances. Consequently, it is advised that no fee support be made available.
### 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.

<table>
<thead>
<tr>
<th>Impact on Health Inequalities</th>
<th>No health inequalities assessment has been completed for this report.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impact on equality and Diversity</td>
<td>An Equality Impact Assessment (EIA) has not been completed for this report.</td>
</tr>
<tr>
<td>Impact on Sustainable Development</td>
<td>As this scheme is over £2m in value, the developer has completed a BREEAM pre assessment. The project will proceed with the objective of meeting the excellent rating.</td>
</tr>
<tr>
<td>Patient and Public Involvement</td>
<td>There is an active Patient Participation Group (PPG) and a Charitable Trust. The Practice has engaged fully with both on the proposals. A formal engagement event has been held. Indicative site layout and floor plans were displayed and members of the design team, CCG and GPs were available to discuss the proposals. Plans have been available to view on the Practice website. Questionnaires have been completed. The results of these have led to a redesign of the internal layout as well as changes now to primary care service delivery. The Practice continues to engage with patients as the project has proceeded; this includes updating patients on the progress of the project, explaining what the benefits of the scheme are intended to be and continuing to invited comment on the proposals. The development is a fixed agenda item at all PPG meetings.</td>
</tr>
<tr>
<td>Recommendations</td>
<td>Following review and discussion members of the Committee are asked to consider and agree the following Primary Care Operation Group recommendation: -</td>
</tr>
<tr>
<td>-----------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>• To formally support the Business Case for the development of a new facility for Minchinhampton and the financial implications relating to the proposal;</td>
</tr>
<tr>
<td></td>
<td>• To confirm that no additional fee support will be available to the Practice for legal costs</td>
</tr>
<tr>
<td>Author</td>
<td>Andrew Hughes</td>
</tr>
<tr>
<td>Designation</td>
<td>Associate Director, Commissioning</td>
</tr>
<tr>
<td>Sponsoring</td>
<td>Helen Goodey</td>
</tr>
<tr>
<td>Director</td>
<td>Director of Locality Development and Primary Care</td>
</tr>
</tbody>
</table>
Primary Care Commissioning Committee

Thursday 31st October 2019

Report on the Business case for the development of new premises for Minchinhampton Surgery

1.0 Purpose

The purpose of this paper is to set out the Case for Change, objectives, financial implications and timeline for the establishment of a new Primary Care Centre that will relocate the existing Minchinhampton Practice at Bell lane to a purpose built centre at Vosper Field, Cirencester Road on the edge of Minchinhampton

2.0 Background

3. Introduction– ‘As is’

3.1 Practice profile

Built in 1971, Minchinhampton surgery is located in Bell Lane, Minchinhampton. It is owned by the Practice Partners
A practice profile is provided in the table below

<table>
<thead>
<tr>
<th>Item</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>List size (Baseline for original PCIP) in July 2014</td>
<td>7,172 patients</td>
</tr>
<tr>
<td>List size (Baseline for refreshed PCIP) January 2019</td>
<td>7,656 patients</td>
</tr>
<tr>
<td>Project list assumption (set out in refreshed PCIP) in April 2031</td>
<td>At least 8,225 patients</td>
</tr>
<tr>
<td>Number of GPs Actual number and (WTE)</td>
<td>6 GPs (4.25 WTE)</td>
</tr>
<tr>
<td>Actual number nurses and nurse practitioners</td>
<td>4 people (2.5 WTE)</td>
</tr>
<tr>
<td>Number of other clinically employed roles</td>
<td>3 people (1.05 WTE)</td>
</tr>
<tr>
<td>Number of administrative staff</td>
<td>17 people (7.75 WTE)</td>
</tr>
<tr>
<td>Number of F2/ GP trainees etc at any one time</td>
<td>2 people</td>
</tr>
<tr>
<td>Visiting staff/ services where not employed by practice.</td>
<td>Hearing aid clinic once per month – 2hrs 4th Tuesday</td>
</tr>
<tr>
<td></td>
<td>Practice support pharmacist – Tuesday pm</td>
</tr>
<tr>
<td></td>
<td>Social Prescriber – 2hrs Thursday lunchtime</td>
</tr>
<tr>
<td></td>
<td>Midwife – Wednesday pm</td>
</tr>
<tr>
<td></td>
<td>Acupuncture (Minchinhampton Trust) – Tuesday pm</td>
</tr>
<tr>
<td></td>
<td>Counsellor (Minchinhampton Trust) – Thursday afternoon</td>
</tr>
<tr>
<td></td>
<td>Retinal and Aortic Aneurysm screening – ad hoc</td>
</tr>
<tr>
<td></td>
<td>Mental Health Nurse – alternate Tuesday – all day</td>
</tr>
<tr>
<td></td>
<td>Let’s Talk IAPT – Monday pm</td>
</tr>
<tr>
<td></td>
<td>Dementia Nurse – Wednesday all day</td>
</tr>
<tr>
<td>CQC rating</td>
<td>Outstanding</td>
</tr>
<tr>
<td>Minor surgery sessions per week</td>
<td>Alternate Mondays</td>
</tr>
<tr>
<td>Improved access sessions per week</td>
<td>Tuesday &amp; Wednesday 6.30pm – 8.00pm</td>
</tr>
</tbody>
</table>
The Business Case highlights that the practice performs well across a number of national clinical indicators. However, it has a significantly above average number of older people and particularly older people with long-term conditions. As new models of care are rolled out to meet the needs of this cohort of patients, the practice will have limited capacity to respond to new initiatives because of the constraints imposed by the current building.

### 4. Strategic Case

#### 4.1 National policy

4.1.1 Five Year Forward View<sup>1</sup>

The precursor to the NHS Long Term Plan, this national policy sees General Practice at the heart of the NHS. The GP Forward View clearly stipulated that primary care is central to the country’s health system and supported the view of the British Medical Journal – “if general practice fails, the whole NHS fails”. There are a range of plans across a number of thematic areas. Commitment to invest in primary care infrastructure is to achieve the following:

- Improving access;
- Supporting the development of neighbourhood hubs to move care from hospitals into primary care;
- Providing additional clinical space to deliver primary care services so as to reduce unplanned admissions to hospital, and to improve seven-day access;
- Increasing the capacity for training;

<sup>1</sup>NHS England, October 2014

<table>
<thead>
<tr>
<th>Current building size GIA m²</th>
<th>340m²</th>
<th>In respect of the current list size, the surgery if developed today would be around 680m² GIA excluding training</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of consultation and examination rooms</td>
<td>6 consultation and 2 side rooms used for examination</td>
<td></td>
</tr>
<tr>
<td>Number of treatment rooms</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Minor surgery rooms</td>
<td>No dedicated room</td>
<td></td>
</tr>
</tbody>
</table>
- Improving the premises to enable a wider and expanded workforce to be employed within primary care;
- Developments that bring practices together into a single building.

4.1.2 Long Term Plan

The NHS Long Term Plan builds on the Five Year Forward View and articulates a need to further integrate care to meet the needs of a changing population over the next decade. Focus is on the following:

- A new service model in which patients get more options, better support and properly joined-up care at the right time;
- The NHS will strengthen its contribution to prevention and health inequalities;
- Care and quality outcomes improvement (cancer, mental health, diabetes, multi-morbidity, healthy ageing, including dementia, children’s health, cardiovascular and respiratory conditions, learning disability and autism amongst others);
- Workforce development;
- Upgrade technology and digitally enabled care across the NHS;
- Increased financial investment of 3.4% over the next 5 years to support implementation

In respect of primary care, the key focus of service development and delivery over the next few years includes the stabilisation of the GP partnership model; the creation of 20,000 new staff working in general practice through additional roles; further dissolving the historic divide between primary and community care; a clear, quantified, positive impact for the NHS system and patients, with fewer patients being seen in hospital and more being seen and treated in communities.

Set out in the Long Term Plan, a key mechanism for delivering this is the establishment of 1,250 Primary Care Networks (PCNs) based on minimum registered list sizes of 30,000 patients – not usually more than 50,000 – commissioned through general practice in the form of a Directed Enhanced Service (DES)

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2 NHS England, January 2019
4.1.3 Primary Care Networks

Primary Care Network (PCN) level service provision is wider than just General Practice. It includes all primary and community care staff, working together to deliver preventative, out of hospital, care for their patient population. So while GP practices are at their heart, and the initial focus from July 2019, they must grow from April 2020 to begin including these other partners. This will enable them to start commencing the new service specifications that will go live from April 2020, with some mirrored service specifications for community teams to support the staff integration and joint working:

- Structure Medications Review and Optimisation;
- Enhanced Health in Care Homes;
- Anticipatory Care for high need patients with several long term-conditions;
- Personalised Care;
- Supporting Early Cancer Diagnosis;
- CVD Prevention and Diagnosis (from April 2021);
- Tackling Neighbourhood Inequalities.

4.2 Local Strategic Context

4.2.1 Gloucestershire Integrated Care System (ICS)

Gloucestershire is an approved shadow ICS where local organisation have a shared mission where everyone works together to have a Gloucestershire population that is healthy and well, taking personal responsibility for their health and care, and reaping the personal benefits that this can bring e.g. less dependent on health and social care services for support; is living in healthy, active communities and benefitting from strong networks of community services and support; is able, when needed, to access consistently high-quality, safe care in the right place, at the right time.

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3 NHS England January 2019
4 Gloucestershire ICS Operational Plan 2019/2020
The Minchinhampton practice is committed to ensuring that the new building would be an asset not just for primary care but for the provision of wider services through bookable space for ICS members. Meetings have already been convened with Gloucestershire Health & Care NHS Foundation Trust to establish the detail of maximising the use of the new building.

The ICS vision is ‘to improve health and wellbeing, we believe that by all working better together, in a more joined up way, and using the strengths of individuals, carers and local communities, we will transform the quality of care and support we provide to all local people’.

In order to facilitate the delivery of this strategy, the ICS needs a modern and flexible estate infrastructure, supporting the service ambitions and day to day working of Gloucestershire’s ICS to maximise health and well-being, improve the quality of care and patient experience, and deliver financial efficiency. More specifically:

- The strategic development and configuration of acute hospital sites to deliver new clinical models;
- The development of community infrastructure to deliver One Place, One Budget, One System requirements and the clinical programme approach;
- Deliver improved GP estate to accommodate planned population increases, changes in working practice within primary care and facilitate aspects of enabling active communities around voluntary sector service delivery and supporting a resilient and sustainable primary care;
- Bringing the estate up to date and reduce backlog maintenance requirements across the ICS;
- Dispose of surplus and unused estate no longer required;
- Maximising opportunity to share space to facilitate service integration, make it easy for community and voluntary sector to utilise estate to enable active committees, minimise running costs, and generate capital receipts.
4.2.2 Gloucestershire Primary Care Strategy

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. Within the strategy, 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 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.

4.2.3 Gloucestershire Primary Care Infrastructure Plan 2016/2021

A strategic prioritisation has been completed and this identified core schemes for taking forward for business case development. Taking into account the current condition of the building, planned housing developments, the developing service model, Minchinhampton was identified as a priority for infrastructure development.

4.2.4 Stroud & Berkeley Vale Integrated locality Partnership (ILP)

The Gloucestershire version of NHSE’s Place model, the ILP is the operational and Strategic partnership of senior leaders of health and social care providers and locally elected government and lay representatives informing and supporting integration at the PCN level, unlocking issues and sharing responsibility for finding local solutions to deliver ICS priorities and tackling issues which arise locally which can only be resolved collectively.

ILPs will need to translate ICS objectives to meet the needs of their local population while enabling the PCNs to realise their plans to implement multi-disciplinary teams around the needs of their patients.

There will be an ILP Plan to for the defined population including prevention and public health, with aligned priorities agreed to improve outcomes.

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5 Gloucestershire CCG November 2016
6 Gloucestershire CCG March 2016
7 Gloucestershire CCG: July 2019
4.2.5 Stroud Cotswold Primary Care Network

There are five Practices in the Network including Beeches Green Surgery (4.3 miles away), Frithwood surgery (4.4 miles away), Minchinhampton, Painswick surgery (8.2 miles away) and Rowcroft surgery (4.2 miles away). The registered population in January 2019 was 40,156 and the population projection is 41,636 patients by 2031. Services are provided over 5 different buildings. Total current space equates to around 2,239 m² GIA versus expected of 3,366 m² GIA for 2031 population.

The practice is actively engaged with the Primary Care Network (PCN). Dr Simpson is one of the clinical directors and is lead clinician for Improved Access. He regularly attends plenary and strategy meetings. The PCN is working towards the national challenge of expanding the primary care workforce via the PCN, including social prescribers, pharmacists, physiotherapists and mental health workers. This will dramatically expand the primary care team and the need for space to host them. The PCN also plans to develop a Coordinated Care Pilot which will target frail patients and try to prevent illness and reduce hospital admissions.

The Network is currently actively working on the development of a frailty team, to incorporate the input of the clinical pharmacist posts supported by PCN funding, but also using other funds to appoint to nursing and HCA posts.

Given the physical constraints on the practice to host any PCN staff, the practice is concerned to ensure that its patients can also benefit from this development.

4.3 Practice assessment

4.3.1 Operational assessment

Due to the physical constraints of lack of accommodation, the practice is unable to effectively separate clinical, treatment and administrative areas as guidance suggests. Instead, staff hot desk between different rooms, and often operate from a room that is not designed or equipped for the use it is being put to.

The building is operating at capacity, and so the practice has to restrict clinical activity and has difficulty accommodating and scheduling services as they would wish.
As well as the consulting space, the administration area is fully utilised which constrains the practice in several respects, not least because they simply don’t have the space to house all of their staff effectively.

The operational constraints imposed by the building are widespread; perhaps the most significant is the inability to run services concurrently because of room shortages but, inter alia, the following represents a summary of the critical issues:

- Current treatment and consulting rooms do not meet modern requirements in terms of size, layout, infection control and shape;
- There is no privacy for patients at the front reception desks due to the confined space in the reception areas and the proximity of the waiting areas;
- There is no private room for patients who may be distressed or an interview room for patients needing confidentiality;
- There are no mother & baby feeding/changing facilities;
- There is limited space in the surgeries to provide additional services to the community such as patient information areas for health promotion and education or to accommodate specialist groups such as mother and baby clinics;
- Due to the nature and construction of the current building future flexibility is constrained. There is no capacity on the site to economically extend the current buildings;
- There is no car parking at the current site;
- The premises do not have capacity to meet any growth in local population.

The practice faces a significant challenge in meeting patient expectations whilst also transferring a number of services previously provided in hospital to primary care space. Most recently the practice was approached regarding the provision of microsuction clinics requiring two sessions per week. This could not be pursued due to lack of accommodation.
The GP Forward View identifies that there is a requirement to double the rate of growth in the medical profession over the next five years and as a consequence there is a need to have local placement to support training. The Practice has 3 qualified GP trainers but the lack of room space means that there are limitations. Despite having 3 trainers, only two trainees at a time can be accommodated. Dr Beard is interesting in becoming a GP trainer but this would provide little benefit within the current premises. The training of nurses and nurse practitioners is severely limited due to the premises. Further, the ability of the existing staff to do more to manage long term conditions is hampered by the building constraints.

4.3.2 Building condition

NHS England guidance recommends for primary care premises developments, attention should be placed on current buildings where the physical condition (facet 1) and the functionality suitability review are deemed to be unsatisfactory, which is a score of C or D. The table below highlights the scores for the practice for five of the facets it shows that the Practices scores are not satisfactory across four out of five grades.

<table>
<thead>
<tr>
<th>Practice Name</th>
<th>Condition Grade</th>
<th>Function Grade</th>
<th>Quality Grade</th>
<th>Space Grade</th>
<th>Statutory Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minchinhampton</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>B</td>
<td>D</td>
</tr>
</tbody>
</table>

4.3.3 Population growth

Minchinhampton surgery has grown from 7,172 since July 2014 to 7,656 in January 2019. Stroud District Council’s development plan shows how the area will develop during the period up to 2031. It is forecast there will be an additional 7,295 dwellings built developed during this period. The CCG estimates that there will be an average of 1.62 people per household. It is estimated that the residents of 351 homes will register with Minchinhampton surgery, an additional 569 patients. It is assumed the list size will grow to at least 8,225 patients over the next five to ten years.

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8 Gloucestershire CCG data analysis for refresh of Primary Care infrastructure Plan, July 2019 (Plan not available at time of writing)
4.4 Case for Change summary

The Case for Change for this proposal can be summarised as follows:

- Existing surgery identified as a priority for potential development in the CCG’s Primary Care Infrastructure Plan as not meeting requirements for the long term;

- To consider the implications of a surgery building no longer deemed satisfactory, over the long term, in respect of estate conditions and functionality facet surveys;

- To consider the provision of primary care services where the existing surgery building is significantly smaller than it should be for the existing number of patients and preventing an identified range of service from currently being provided;

- To ensure there are suitable facilities to extend the range of services available at local practices and ensure national and local service strategies can be implemented for the population served;

- In order to meet workforce strategy objectives, to ensure there are suitable facilities for existing staff and an expected increase in staff numbers over the next five to 10 years;

- To consider how the practice can facilitate the expansion at student, foundation, GP Registrar and nursing levels where there is a lack of facilities;

- To ensure there are suitable facilities available for planned increase in patient numbers over the next fifteen years with an anticipated list size increase to at least 8,225 patients;

- To facilitate the delivery of more resilient and sustainable primary care and support the development of primary care network models of care;

- To minimise the costs of essential new infrastructure and ensure these costs are justified, represent value for money and support sustainable development;
5.0 Economic & Commercial case

5.1 Key objectives, options and appraisal

The objectives/critical success factors of the investment based on the Case for Change are identified below:

- To enable transformation of service provision and meet the needs of national and local strategies, particularly an expansion in the range of services;
- To support the delivery of the practice business plan;
- To meet workforce and training challenges;
- Provides sufficient capacity for the long term delivery of primary care in quality infrastructure;
- Is deliverable in terms of being acceptable to patients, wider stakeholders and represents Value for Money.

The Business Case set out a range of options, which were assessed against these and a preferred option was identified.

<table>
<thead>
<tr>
<th>Objective/critical success factors (x does not meet, Y does meet and P, partially meets)</th>
<th>A: Do Nothing</th>
<th>B: Extend/refurbish existing site</th>
<th>C: Rebuild on existing site</th>
<th>D: Second building/branch</th>
<th>E: New site</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supports the transformation to meet the needs of national and local strategies,</td>
<td>X</td>
<td>P</td>
<td>Y</td>
<td>P</td>
<td>Y</td>
</tr>
<tr>
<td>Provides capacity for the long term delivery of primary care in quality infrastructure;</td>
<td>X</td>
<td>P</td>
<td>Y</td>
<td>P</td>
<td>Y</td>
</tr>
<tr>
<td>Meets workforce and training challenges</td>
<td>X</td>
<td>X</td>
<td>Y</td>
<td>P</td>
<td>Y</td>
</tr>
<tr>
<td>Supports the delivery of the practice business plan</td>
<td>X</td>
<td>X</td>
<td>P</td>
<td>X</td>
<td>Y</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Summary</th>
<th>Baseline</th>
<th>Discount</th>
<th>Discount</th>
<th>Discount</th>
<th>Preferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is deliverable in terms of being acceptable to patients, wider stakeholders and represents Value for Money.</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>
5.2 The proposal

The preferred option is to develop a new surgery building on an alternative site and an alternative site is available. This business sets out a proposal for the establishment of a new Minchinhampton Primary Care Centre at a purpose built centre on Cirencester Road on the edge of Minchinhampton approximately 0.7 miles distance from the existing surgery.

A schedule of accommodation has been prepared in accordance with the previous web-based design guidance (Primary and social care premises: planning and design guidance), with reference to Health Building Note 11 (HBN11). In addition, reference has also been made to the more recent guidance – NHS Space Use Allowances – which uses patient numbers as the main driver for gross internal area. The facility will be designed in line with all relevant guidance as set out below.

<table>
<thead>
<tr>
<th>Area</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>HBN</td>
<td>As far as is reasonably practical, the new premises will be HBN compliant. Any specific derogation will be notified to the DV by the design team and will only serve to increase the quality of the building.</td>
</tr>
<tr>
<td>HTM</td>
<td>A Mechanical and electrical (M&amp;E) summary has been provided by the engineer. Generally, the M&amp;E scheme will be compliant with HTMs on the core services.</td>
</tr>
<tr>
<td>BREEAM</td>
<td>The scheme is being designed to achieve BREEAM Excellent. A pre assessment has been carried out and is included in the Business Case. The score achieved was Excellent.</td>
</tr>
<tr>
<td>Firecode</td>
<td>Fire strategy drawings will be provided and relevant Firecode provisions will be incorporated at RIBA Stage 4.</td>
</tr>
</tbody>
</table>

For reimbursable areas, the building will have a Gross Internal Area of 808m². In order to deliver general medical services, the building will be a maximum of 735 m² net internal area (NIA) along with up to 53 car parking spaces.

The NIA is the reimbursable area agreed in line with NHS Regulations/ Premises Directions 2013 and includes training. It excludes pharmacy and any facilities required from other health care users outside of these regulations. Currently no other health service organisations require facilities.
The practice have made a commitment, in principle, that visiting services will be have access to bookable rooms and will agree a fair and transparent process for this. An artist’s impression is provided below.

The proposal makes provision for a number of additional consulting rooms, nurse consultation rooms, and treatment rooms, with provision for minor operations and GP training facilities. These are summarised below. Crucially there is also room on the site for future expansion of the building.

<table>
<thead>
<tr>
<th>Type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Existing clinical rooms (of appropriate size and functionality)</td>
<td>8</td>
</tr>
<tr>
<td>Proposed clinical rooms in total</td>
<td>12</td>
</tr>
<tr>
<td><strong>New split as follows</strong></td>
<td></td>
</tr>
<tr>
<td>New consultation rooms</td>
<td>7</td>
</tr>
<tr>
<td>New treatment rooms</td>
<td>2</td>
</tr>
<tr>
<td>New minor procedures rooms</td>
<td>1</td>
</tr>
<tr>
<td>New medical training rooms</td>
<td>2</td>
</tr>
</tbody>
</table>
5.3 Benefits and outcomes

The business case sets out a range of benefits, expected to be achieved through the delivery of this proposal. A summary of key benefits and additional system benefits is provided below:

<table>
<thead>
<tr>
<th>Theme</th>
<th>Benefit and outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>• A building large enough serve up to 9,000 patients</td>
</tr>
<tr>
<td></td>
<td>• Increased number of services available including the following:</td>
</tr>
<tr>
<td></td>
<td>➢ Host new primary care network (PCN) team workers, including social prescriber, pharmacist, physiotherapist, physician’s assistant, and mental health worker.</td>
</tr>
<tr>
<td></td>
<td>➢ Host MDT meeting for the PCN.</td>
</tr>
<tr>
<td></td>
<td>➢ Bid for services when they go out for tender where these services align with staff expertise and local need.</td>
</tr>
<tr>
<td></td>
<td>➢ Based on the increase in clinical accommodation there is the potential to increase sessions (subject to staffing) as follows</td>
</tr>
<tr>
<td></td>
<td>➢ GP from 43 per week to 60</td>
</tr>
<tr>
<td></td>
<td>➢ Nurse/HCA from 24 to 35</td>
</tr>
<tr>
<td></td>
<td>➢ Double the offering in sexual health, minor ops, midwife, community pharmacist, respiratory clinic, counselling, dementia and mental health.</td>
</tr>
<tr>
<td></td>
<td>➢ Improved disabled access</td>
</tr>
<tr>
<td></td>
<td>➢ Improved provision for children through family friendly facilities and waiting areas;</td>
</tr>
<tr>
<td></td>
<td>➢ Improved reception and waiting areas to provide more appropriate space and comfort for patients;</td>
</tr>
<tr>
<td></td>
<td>➢ Increased patient satisfaction</td>
</tr>
<tr>
<td></td>
<td>➢ Enables improvements to security and confidentiality</td>
</tr>
<tr>
<td>Staff/practice</td>
<td>• Expansion of training at student, foundation year, and GP registrar levels which at present cannot be</td>
</tr>
</tbody>
</table>
| Wider health & wellbeing system | • An opportunity to decommission existing surgery buildings which are not fit for purpose;  
|                              | • In respect of primary care provision, provides long term assurance and confidence to the residents of Minchinhampton;  
|                              | • Supports delivery of key service strategies of the Gloucestershire Integrated Care System, particularly around placed based service provision and delivery of the CCG’s primary care strategy;  
|                              | • Meets the commitment of the CCG in respect of delivering one of the priorities of the PCIP. |
6.0  Financial elements

6.1 Capital cost-

This will be a GP led development via a specific consortium of GP partners who will fund the capital cost of the project, Total capital costs are estimated at £3.65m.

Funding will be secured to develop the project and through the signing of the proposed lease, the practice will rent from the legal owners of the building (connected parties) and seek revenue reimbursement to cover these costs through Premises Directions 2013.

Legally, the new development will be owned (and developed) by a GP consortium. Therefore, the consortium, which will form a development company, will enter into a minimum of a 25-year Tenant Internal Repairing (TIR) lease with the practice.

6.2 Existing revenue costs

Currently, for the provision of general medical services, the practice receives a total of £42,348 for rent reimbursement per annum. It should also be noted that the practice has business rates costs reimbursed and these are currently £6,874.

6.3 Revenue - actual rental costs for new building

The rental costs associated with the building (assessed as representing Value for Money by the District Valuation service with Interim report available to members on request) and eligible for reimbursement, are set out in table below: -

<table>
<thead>
<tr>
<th>Item</th>
<th>Annual total</th>
<th>VAT</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rent reimbursement for general medical services (735m2 net internal area @ £225 per m2)</td>
<td>£165,375</td>
<td>0</td>
<td>£165,375</td>
</tr>
<tr>
<td>53 Car parking spaces @ £325 per annum</td>
<td>£17,225</td>
<td>0</td>
<td>£17,225</td>
</tr>
<tr>
<td>full revenue rental requirements</td>
<td>£182,600</td>
<td>0</td>
<td>£182,600</td>
</tr>
</tbody>
</table>
6.4 Reimbursement of business rates

As part of premises directions, business rates are also reimbursed to Practices for provision of GMS services. The estimate for the new facility is £41,998.

6.5 Fee support

The ability of the CCG to fund one-off fees related to premises developments are set out in The National Health Service (General Medical Premises Costs) Directions 2013. These include support towards costs such as project management (1% of construction costs), monitoring surveyor (1% of construction costs), stamp duty land tax and legal fees.

Recognising that PCCC members have previously advised the additional fee support might only be available in exceptional circumstances (following review at the January 2018 PCCC meeting), the author of this report cannot provide any exceptional circumstances for supporting a request for £24k towards legal fees. Consequently, it is advised that no fee support be made available.

6.6 IM&T specification and funding requirements

As part of the PCIP, it was also agreed that all reimbursable IM&T costs would be set out in business cases for proposed new surgeries (this had not been the case with legacy proposals) so that the CCG had full understanding of future costs to be built into GPIT and other applicable IM&T budgets. A standardised approach (facilitated by CSU IM&T specialists) has been developed and has been used to agree the IM&T specification. The costs are split out into five separate budgets due to coming from different sources of money.

- **GPIT Capital** – This covers all essentially GPIT hardware as mandated in the GPSoc operating model (PCs, Printers, and Scanners etc.)
- **HSCN budget** – This covers the new HSCN (replaces N3) Data circuit
- **Building Budget** - This covers Comms Cabinet, PDU in comms room etc.
- **Wireless Budget** – Wireless access points;
• Practice Costs – Non GPIT funded items such Telephone, AV equipment etc.

The business case sets out all the relevant costs. From a CCG perspective, the £58,822 will be required for GPIT capital and HSCN requirements it is assumed for the financial year 2020/2021 and some for 2021/2022

6.7 Annual recurrent revenue summary

<table>
<thead>
<tr>
<th>Item</th>
<th>amount £</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total annual revenue requirements (rents, rates and inclusive of VAT)</td>
<td>£224,598</td>
</tr>
</tbody>
</table>

**Funded by**

<table>
<thead>
<tr>
<th>Item</th>
<th>amount £</th>
</tr>
</thead>
<tbody>
<tr>
<td>Existing rent and rates reimbursement</td>
<td>£ 49,222</td>
</tr>
<tr>
<td>Additional recurrent investment into primary care delegated budget</td>
<td>£175,376</td>
</tr>
</tbody>
</table>

7 Management case

7.1 Programme management

This is a GP Led Development involving the GP Partners. The Project Owner is Dr Tristan Cooper, who is the lead GP for this work. The GP developer has commissioned their preferred professional team in the development of the BC and for the redevelopment:

• Alistair Black FRICS - Development Management.
• Carl Dean Associates - Quantity Surveying Services (including cost estimate and Employer's Agent).
• Westhart Partnership - Architectural services.
• Alistair Black FRICS - Business case authoring.
• Business Finance Plus – Lending advice and loan sourcing.
7.2 Programme plan

The high level timeline is set out in the table below

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Target Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Business Case &amp; Final Approval</td>
<td>October 2019</td>
</tr>
<tr>
<td>Design Complete</td>
<td>December 2019</td>
</tr>
<tr>
<td>Planning Application</td>
<td>January 2020</td>
</tr>
<tr>
<td>Agreements to lease secured</td>
<td>February 2020</td>
</tr>
<tr>
<td>Planning Approved</td>
<td>April 2020</td>
</tr>
<tr>
<td>Out to tender</td>
<td>July 2020</td>
</tr>
<tr>
<td>Tender return</td>
<td>September 2020</td>
</tr>
<tr>
<td>Begin Construction</td>
<td>November 2020</td>
</tr>
<tr>
<td>Building Completed</td>
<td>October 2021</td>
</tr>
<tr>
<td>Commissioning and Service commencement</td>
<td>October 2021</td>
</tr>
</tbody>
</table>

7.3 Patient engagement

There is an active Patient Participation Group (PPG) and a Charitable Trust. The Practice has engaged fully with both on the proposals. A formal engagement event has been held. Indicative site layout and floor plans were displayed and members of the design team, CCG and GPs were available to discuss the proposals. Plans have been available to view on the Practice website. Questionnaires have been completed. The results of these have led to a redesign of the internal layout as well as changes now to primary care service delivery.

The Practice continues to engage with patients as the project has proceeded; this includes updating patients on the progress of the project, explaining what the benefits of the scheme are intended to be and continuing to invited comment on the proposals. The development is a fixed agenda item at all PPG meetings.
### 7.4 Key risks

The Business Case provides a risk register. The risk register is reviewed on a regular basis by the Project Team. The top 3 open risks are outlined in the table below.

<table>
<thead>
<tr>
<th>Ref</th>
<th>Category</th>
<th>Description of Significant Risk</th>
<th>Initial Risk</th>
<th>Actions to reduce risk to Residual Risk &amp; assurance regarding actions taken</th>
<th>Mitigated</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Capital Approval</td>
<td>Capital costs exceed BC cost estimate</td>
<td>3 5 15</td>
<td>Affordability envelope will be agreed at BC stage. Risk of cost overruns to sit with developer.</td>
<td>2 5 10</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Open</td>
</tr>
<tr>
<td>4</td>
<td>Operational Impacts</td>
<td>Delays in approval of lease</td>
<td>4 5 20</td>
<td>Developer is already engaged in dialogue with the Practice. Agreed HoTs will be issued with the BC to set the principles of the AFl.</td>
<td>2 5 10</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td>Open</td>
</tr>
<tr>
<td>11</td>
<td>Commercial</td>
<td>Scheme not affordable to CCG and Practice</td>
<td>3 4 12</td>
<td>Carry out analysis to ensure the facility is affordable. Ensure organisations are aware of the costs and their magnitude at BC stage.</td>
<td>2 4 8</td>
</tr>
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<td></td>
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</table>

From a CCG perspective, the key risks regarding this proposal is that should the new surgery development not proceed, the long term provision of suitable primary care premises for a growing population will be substantially affected, leading to loss of reputation and impact of service delivery and commissioning strategies.
8.0 Recommendation

Following review and discussion, members of the Committee are asked to consider and agree the following Primary Care Operation Group recommendation:

- To formally support the Business Case for the development of a new facility for Minchinhampton and the financial implications relating to the proposal;
- To confirm no additional fee support will be available to the Practice for legal costs.

Andrew Hughes
Associate Director, Commissioning
4th October 2019
Quality Report

Primary Care October 2019

Introduction
This report provides assurance to the Primary Care Operational Group and Primary Care Commissioning Committee that quality and patient safety issues are given the appropriate priority within Gloucestershire CCG and that there are clear actions to address such issues that give cause for concern.

The Quality Report includes updates on:
- CareUK 111
- NICE
- Clinical Effectiveness
- Research and Development
- Safeguarding
- Patient Experience and Engagement
- Primary Care
- Prescribing Update
- Infection Control
- Immunisation and Vaccination
CareUK 111
CareUK 111 Southwest has recently been inspected by the CQC and was rated as ‘Outstanding’.

CareUK believe they are the first 111 provider to be rated as ‘Outstanding’.

The full inspection report can be read online at:

Particularly noteworthy comments about CareUK 111 include:

- a well-embedded culture of high quality sustainable care;
- a strong focus on continuous learning, quality improvement and risk management from complaints and incidents and performance management which included joint working and shared governance with partner organisations;
- a strong focus on staff wellbeing;
- a strong focus on continuous learning and improvement at all levels of the organisation;
- the service routinely reviewed the effectiveness and appropriateness of the care it provided.

The CCG has written to CareUK to congratulate them on their achievement.

NICE
The number of NICE TAs published is below (as of 26/9/19)

<table>
<thead>
<tr>
<th>Q1 (Apr-Jun 18)</th>
<th>Q2 (Jul-Sep 18)</th>
<th>Q3 (Oct-Dec 18)</th>
<th>Q4 (Jan-Mar 19)</th>
<th>Total (Apr 18 to Mar 19)</th>
<th>Q1 (Apr-Jun 19)</th>
<th>Q2 (Jul-Sep 19)</th>
<th>Q3 (Oct-Dec 19)</th>
<th>Q4 (Jan-Mar 20)</th>
<th>Total (Apr 19 to date)</th>
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<tbody>
<tr>
<td>Number Issued</td>
<td>11</td>
<td>14</td>
<td>15</td>
<td>20</td>
<td>60</td>
<td>15</td>
<td>18</td>
<td>16</td>
<td>34</td>
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</tbody>
</table>

The Gloucestershire Joint Formulary is up to date with regards to inclusion of all relevant NICE TAs demonstrating that treatments are available in Gloucestershire within the required time frame.
Quality Report

Clinical Effectiveness
Clinical Effectiveness Group (CEG)

Items which should not be routinely prescribed in primary care
In June 2019 NHS England published an update to the recommendations “Items which should not be routinely prescribed in primary care: Guidance for CCGs”.

The CCG is working with primary and secondary care providers to ensure that version 2 of this guidance is embedded into local prescribing guidance.

In light of this guidance the local “Emollient Formulary” has been updated within the skin chapter of the Gloucestershire Joint Formulary. Work is underway to produce some local resources to support key messages around the management of dry skin conditions and the use of emollients as soap substitutes.

Research and Development

Progress of previously agreed R&D

The CCG no longer has direct responsibility for funding excess treatment costs. This responsibility has been transferred to Bristol, North Somerset and South Gloucestershire CCG (BNSSG CCG) and GCCG has had its budget top-sliced to reflect the previously agreed funding.

On the 4th September Research for Gloucestershire (R4G) held its first event at the University of Gloucestershire. The event was well attended and was an opportunity to share research activities across the county.

Safeguarding

Gloucestershire Safeguarding Children Executive (GCSE) update:

- The new Delivery Board meetings, involving relevant partners, commenced on the 10th September 2019. The next meeting in December will include a workshop to support purposeful engagement and activity from representatives, in line with GSCE Strategic aims for Safeguarding Children.
- GSCE Support Unit will pilot a 6 month appointment of a Performance Improvement Officer to review and analyse the partnerships performance data. This aims to address the need for quality data from case audit alongside, comparison to national data and emerging themes.
- A financial review is ongoing within the GSCE Support Unit. The current Serious Case Review (SCR) budget is insufficient for the number of statutory reviews commissioned this year; therefore a contingency budget has been agreed.
Quality Report

Multi-Agency Safeguarding Hub (MASH).

An Independent Review of the current health care service provision of MASH has been completed and the final report was considered at GCCG Core Group in August 2019. The immediate funding for a B6 WTE Nurse was agreed by Core Group requiring reporting back to CCG Core in December on activity and impact. The report has also been shared with the MASH Partnership Board (reporting further to the Glos Safeguarding Children Executive). The wider service recommendations will be presented to MASH Board on 31st October.

Children in Care:

The Committee will be aware that from November 2018 the CCG directly employs the Designated Nurse for Children in Care (CiC), Pauline Edwards. GCCG has requested an independent review of CiC, which is being preceded by analytical work by GCC/GHC service leads. GCCG will be fully updated following an interim report to JCPE.

Concurrent changes of note:

- GCCG has provided additional funding for the interim appointment (to 31st March 2020) of Named Nurse, CiC. Current Lead Nurse (B7) will undertake this role with immediate effect.
- GHC is providing the temporary extra staffing resource needed to ensure CiC Team completes a ‘catch up’ programme for outstanding health checks.

Serious Case Reviews (SCR) and Safeguarding Adult Reviews (SAR)

Children:

- Gloucestershire Safeguarding Children Executive (GSCE) are progressing all SCRs. Four SCRs are ongoing: ‘ID’, ‘ET’, ‘AD’, and GH (out of county).
- Pending final GSCE sign off are Acorne and LB/ED (joint DHR/SCR).
- SCR (‘Megan’) will be further reviewed to scrutinise learning suggested related to ‘Special Guardianships’. Other recommendations and learning aspects have progressed.


The implementation of any actions for health following these reviews is monitored via the Strategic Safeguarding Health Forum and CQRGs.

Adults:

Safeguarding Adult Reviews

There currently no new SARs being undertaken.
Quality Report

Domestic Homicide Reviews (DHR)

Safer Gloucestershire has collective oversight of DHRs. Those currently commissioned with ‘Standing Together’ have demonstrated a distinctly positive impact in terms of the organisation and professionalism applied to the current DHR administration and process.

The following DHRs are ongoing:

- DHR JD: Criminal processes are completed and this DHR is pending final draft report.
- DHR LB/ED (joint DHR/SCR): Pending GSCE ratification of the SCR element of the report prior to the final draft going to the Community Safety Partnership. The Home Office will receive the report after this.
- DHR ML: Chronology and IMRs are underway.

CQC Inspections

As has been previously reported the Gloucestershire GP practices are in the vast majority good with 4 outstanding and only 2 with a require improvement rating.

The new system of Annual Regulatory Reviews (ARRs) is now well underway with a significant number of practices having successfully completed this process. A few practices have required a follow up focused inspection following the ARR phone discussion but all have met the CQC criteria. All practices to date that have been through the new ARR process have maintained their good or outstanding rating. One practice did very well and were close to having their rating changed from good to outstanding and it is anticipated that by next year’s review the outstanding rating will be achieved.

Over the next few months a further group of practices will be subject to the ARR process and a few will have focused inspections. The inspections predominantly focus on the domains of ‘effective’ and ‘well led’.

Serious incidents and significant events in Primary Care

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. Seven incidents have been reported through the NRLS during July, August and September. Six were classed as no harm, with one as moderate harm.

One practice also reported that a patient had died whilst on the premises. Although this is not related to the quality of care given by a GP, it is notifiable to the CQC.
A second single item Quality Surveillance Group for The Dean was held on 22nd August. The Dean remains on heightened surveillance, however the ‘turn-around’ team deployed by Ramsay Group have stabilised the unit to a degree. Admissions remain suspended and this will be reviewed in by Ramsay, CQC and GCCG. Ramsay have appointed a new hospital director to The Dean, we are awaiting confirmation of a start date.

Since the last reporting period no new concerns have been highlighted by residents, families or other commissioners.

Ramsay continues with their program of training and have provided assurances that the unit is staffed appropriately both in terms of numbers and skill set. Improvements with medicines management are noted although there are further actions to be completed. Personalised care planning remains an area of concern but we understand that focussed improvement work in this area has just commenced.

A clear clinical audit process is in place and Ramsay are sharing those findings with the CCG. The Quality Lead for care homes meets at The Dean on a weekly basis with the interim executive team.

CQC will be able to provide narrative relating to their enforcement action and monitoring arrangements moving forward.

Patient Experience and Engagement

GCCG Experience

**GCCG Patient Advice and Liaison Service (PALS)**
The table below gives a breakdown of the types of enquiries the CCG PALS team has responded to up to end Q1 2019. An update on Q2 2019 activity, including more detail on the ‘other’ category of contacts, will be prepared for the next meeting of Q&G Committee.

<table>
<thead>
<tr>
<th>Type</th>
<th>Q4 17/18</th>
<th>Q1 18/19</th>
<th>Q2 18/19</th>
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<th>Q4 18/19</th>
<th>Q1 19/20</th>
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</thead>
<tbody>
<tr>
<td>Advice or Information</td>
<td>63 (PC20)</td>
<td>111 (PC 27)</td>
<td>1 (PC 12)</td>
<td>110 (PC 22)</td>
<td>38 (PC8)</td>
<td>38 (PC 11)</td>
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<td>11</td>
<td>11 (PC 4)</td>
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<tr>
<td>Compliment</td>
<td>2 (PC1)</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
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<tr>
<td>Concern</td>
<td>55 (PC 19)</td>
<td>97 (PC 23)</td>
<td>110 (PC 14)</td>
<td>75 (PC 22)</td>
<td>72 (PC)</td>
<td>50 (PC 10)</td>
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</tbody>
</table>
**Quality Report**

<table>
<thead>
<tr>
<th>Complaint about GCCG</th>
<th>2</th>
<th>5</th>
<th>7</th>
<th>5</th>
<th>7</th>
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<tbody>
<tr>
<td>Complaint about provider</td>
<td>9 (PC 2)</td>
<td>22</td>
<td>18</td>
<td>18 (PC 7)</td>
<td>35</td>
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<tr>
<td>NHSE complaint responses copied to GCCG PALS</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>68</td>
<td>32 (PC 4)</td>
<td>52 (PC 5)</td>
<td>34 (PC 4)</td>
<td>67 (PC 5)</td>
</tr>
<tr>
<td>Clinical Variation (Gluten Free)</td>
<td>3</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>1</td>
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<tr>
<td>Total contacts</td>
<td>202</td>
<td>280</td>
<td>288</td>
<td>257 (PC 57)</td>
<td>221</td>
</tr>
</tbody>
</table>

* NHSE complaint responses copied to GCCG PALS: Numbers for NHS England complaints in Q1 are higher than previous month. NHSE complaints Team more frequently sharing complaints with GCCG PALS.

**Themes identified from GCCG PALS Contacts**

PALS has received a high volume of calls, many of which have been of a complex nature. In Q1 PALS has responded to frequent contact from a few individuals and experienced challenging behaviours.

There has been an increase of MP Enquiries; the PALS team have developed good working relationships with MP’s case workers.

**Announcement on future changes to the Friends and Family Test FFT**

NHSE shared news of changes to the FFT in July 2019. These are based on the findings from the project NHSE ran between June 2018 and March of this year, in which GCCG participated. The recommendations were accepted, almost in their entirety, and NHSE have detailed the new processes in revised guidance published in early September 2019 https://www.england.nhs.uk/fft/fft-guidance/.

The changes NHSE are announcing mean that from next April:
- All providers will use a new FFT mandatory question and six new response options;
Quality Report

- NHSE will have removed mandatory timescales where some services are currently required to seek feedback from users within a specific period, which affects emergency departments, inpatients and maternity, to allow more local flexibility and enable people to give feedback at any time, in line with other services;
- NHSE will have greater emphasis on use of the FFT feedback to drive improvement;
- NHSE will be well advanced in exploring new, more flexible, arrangements for ambulance services where the FFT has proved difficult to implement in practice.


Fresh FFT case studies
NHS has published a refreshed set of FFT case studies on our website. You can find them at: https://www.england.nhs.uk/fft/friends-and-family-test-development-project-2018-19/case-studies/

Engagement

Fit for the future Engagement

https://www.onegloucestershire.net/yoursay/fit-for-the-future/

Since the last meeting of the Q & G Committee, the GCCG Engagement and Communications Teams have been heavily involved in planning and delivery of two Fit for the Future engagements. The first focussing on Developing urgent and hospital care in Gloucestershire and the second continuing the conversations with local people regarding A New Community Hospital for the Forest of Dean. This engagement is an opportunity to talk about ways services could be organised so that local people can get the very best urgent advice, support and care across the county and benefit from two thriving specialist hospitals in the future in Cheltenham and Gloucester.

The short film https://www.onegloucestershire.net/yoursay/fit-for-the-future/#collapseWatch provides an introduction to the areas we are looking at in this engagement: Urgent advice, assessment and treatment services; Improving specialist hospital services and sharing our thoughts on centres of excellence: Accident, Emergency and Assessment Services (including A&E); General Surgery (Emergency and Planned) and Image guided interventional surgery hub. We are also engaging with people in the Forest of Dean area about the new hospital for the Forest of Dean.

Ways to get involved

There are a number of ways to get involved and share views over the next few months:

- Complete the FREEPOST survey in the discussion booklet or go to the online survey;
- Come to an NHS Information Bus Public Drop-In Event/Stand at local venues;
- Participate in or observe an independently facilitated participation event (workshops, Engagement Hearing, centres of excellence Citizens Jury);
- Follow us on Twitter: @One_Glos;
- All the details, including events information can be found at www.onegloucestershire.net
Quality Report

Independently facilitated engagement opportunities

Local Solutions Development Workshops

A series of Workshops (public/staff) with invited representatives from protected characteristic groups and Healthwatch Gloucestershire Volunteers to develop potential solutions to achieve our shared priorities and meet the challenges we face.

Engagement Hearing

An opportunity for members of the public to share their thoughts and ideas about what should be taken into account, what is essential in arriving at the best solution, plus any new ideas or alternative proposals they may have. Hearings are live events held in public, live streamed to the internet, and recorded.

Citizens’ Jury

The Citizens’ Jury will consider the outcome of engagement, together with evidence regarding the need for change and local priorities. The Jury will focus on the subject of improving specialist hospital services and developing centres of excellence and make recommendations for the best potential solutions to take forward and evaluation criteria.

Locality Workshops

Locality Workshops, made up of local people and clinicians, will consider the subject of ensuring everyone can access high quality community urgent care services in the future. In the Forest of Dean, participants will also be considering

Solutions Appraisal Exercise in public

Solutions Appraisal Exercise will be completed by clinicians, other health professionals, together with representatives of the members of the public involved in developing the proposed solutions

Surveys

The CCG Engagement Team is currently supporting a wide range of teams from across the CCG to gather feedback from patients, service users, GPs and practice staff. The CCG uses Smart Survey software to develop bespoke online and paper questionnaires.

The information gathered through surveys is analysed and used to inform further service/care pathway developments, work of clinical programmes and service/pilot evaluations. Current surveys are shown below;
## Quality Report

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Survey Type</th>
<th>Access</th>
<th>Audience</th>
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<tr>
<td>Tewkesbury Home Visiting Service</td>
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<td>Patients</td>
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<tr>
<td>Gloucester telephone repeat Prescription service - March 2018</td>
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</tr>
<tr>
<td>Urgent and Emergency care in Gloucestershire</td>
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<td>Improved access - Cheltenham St Pauls</td>
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<td>Improved access - Cheltenham Central</td>
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<td>Improved access - Cheltenham Peripheral</td>
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<td>Improved access - Forest of Dean</td>
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<td>Improved access - Gloucester Aspen</td>
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<td>Improved access - Gloucester SEG</td>
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<td>Improved access - Gloucester Inner City</td>
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<td>Improved access - North Cotswolds</td>
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<td>Improved access - Stroud</td>
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<td><strong>Improved access</strong> - Tewkesbury, Newent, Staunton</td>
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<td>Maternity Voices contact form</td>
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<td>Information Bus Comments</td>
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<td>Information Bus day summary</td>
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<td>Treatment for Eye Condition</td>
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<td>Tell Us your experience: My COPD</td>
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<td>Patients</td>
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<td>Headache Teaching in General Practice</td>
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<tr>
<td>What’s new in Mental Health</td>
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<td>Gloucester telephone repeat prescription service 2019</td>
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<td>Telehealth (Remote Monitoring)</td>
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<td>Primary Care Annual Workforce survey 2019</td>
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<td>Pulmonary Rehabilitation Inpatient Survey 2019</td>
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<td>Pulmonary Rehabilitation programme Patient Survey 2019</td>
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<td>fit for the future - A new hospital for the forest of dean</td>
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<td>Support for your mental</td>
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</table>
Engagement support in Primary Care

Practice support

The GCCG Engagement Team continues to support practices undergoing change, such as branch closures, staff changes and premises developments. Currently the CCG is providing specific support to practices in Stroud and Berkley Vale, Gloucester City, Cheltenham, Forest of Dean and South Cotswolds Localities.

Countywide Patient Participation Group (PPG) Network

The PPG Network met on 16 August 2019. Topics covered include: Fit for the future, Gloucestershire Primary Care Strategy update and Diabetes. PPG members also facilitated ‘spotlight’ roundtable discussions focussing on ‘organising events’.

PPGs, PCNS and ILPs

Involvement of PPG in PCNs and ILPs continues to grow across the county with different areas trying different approaches. The CCG Engagement Team provides support where required and is researching current PPG involvement in order to identify any gaps and opportunities for joint working and shared learning.

CQC General Practices

Four GP Practices in Gloucestershire have a current CQC overall rating of ‘Outstanding’, the majority (68) have a rating of ‘Good’ and two have a rating of ‘Requires Improvement’.
Quality Report

Included in these figures are the 2 GP Practice CQC reports published in March and April 2019 giving overall ratings of ‘ Requires Improvement’. Both of these contain a ‘Requires Improvement’ rating for ‘Safe’ with medicines management highlighted as an issue: the CCG is supporting these Practices with Clinical Pharmacist support.

A new system of CQC ‘ monitoring ‘ is being introduced for practices that are good or outstanding. This is a review of documents provided by the practice, examination of available data and a conference call with the practice to confirm and challenge the information available. There will be no planned visits unless the information provider is inadequate.

Primary Care Education

GCCG is providing Immunisation Update sessions for Practice Nurses and Health Care Assistants who provide vaccinations in September/October 2019. 2 Sessions have been undertaken to date with initial feedback being extremely positive. Further sessions will be planned for the New Year.

The GCCG Clinical Learning and Development Matron is now in post and working with local providers to identify training needs and support Nurses in practices. The Clinical Learning and Development Matron will represent the CCG at regional level to identify development areas and ensure Gloucestershire is involved in service developments.

GCCG has received a revised allocation of 16 Health Education England which is an increase in funded places for Non-Medical Prescribers for the academic year 2019/20. We are currently asking for expressions of interest from primary care for this training and will review and prioritise these applications to ensure equity in allocation.

The GDoc Practice Nurse Coordinators are now in post and working on a locality basis to provide peer support. Feedback on these coordinators has been positive and they are being used to identify nurses who have training needs or provide signposting as necessary. The Clinical Learning and Development Matron meets with these coordinators on a regular basis to ensure feedback from localities acted upon promptly.

Prescribing Update

Prescribing figures

Prescribing figures commencing from April 2019 to June 2019 are now available. This apparent delay is due to the lag time for data processing at the NHSBSA (those who process prescription spending data).

A prescribing dashboard is now available, which is updated monthly, to provide GP practices with direct access to their prescribing performance figures of relevance to the local prescribing savings plan initiatives, which will help them to track their progress.

CCG “spend vs. budget” for this first quarter seems to be on track (slightly under budget). However anticipate a challenging savings year ahead in 2019-2020, as a result of-
Quality Report

- Category M changes, raising the costs of some medicines (we’ve no control over either which drugs are classed as Category M, or how the prices change)
- No Cheaper Stock Obtainable (NCSO, which result from shortages of final product or ingredients) driving costs up (these are largely unforeseeable), and of course,
- Brexit which is likely to influence medication supplies, and ultimately costs (as supply delays may be a driver for NCSO changes).

Optimise Rx Prescribing Support System

Optimise Rx software is available in the vast majority of GP practices. The messages it highlights refer to cost effective choices, as well as prescribing safety and quality messages based on local and national guidance, to prescribers at the point of prescribing, with reviews of our local profile being carried out regularly. Cost efficiencies achieved are reported by this system regularly. This continues to demonstrate the benefits of this system in supporting our wider prescribing initiatives, from a cost and quality aspect. Two further practices have recently opted to activate Optimise Rx, and we are pleased that they will benefit from the system’s quality, safety and good practice messages that Optimise Rx highlights, as well as cost-effectiveness messages.

Prescribing Targets within the Quality Premium

The combined targets from the initiative to reduce gram negative infections and inappropriate prescribing as well as the antibiotic prescribing targets for Primary Care are set out below. Currently all targets are met.

Clinical Pharmacists

We are currently in the process of recruiting a further ‘Parachuting’ Independent Prescribing Pharmacist to join our Clinical pharmacist team. Independent prescribing clinical pharmacists working in Gloucestershire GP practices are helping reduce GPs’ medication and prescribing pressures. Clinical pharmacists are also undertaking polypharmacy reviews and de-prescribing in frailty. GPs are then able to focus more time on their more complex patients, and reduce the likelihood of hospital admissions for a proportion of patients. Health Education England have made more funding available to support non-medical prescribing training which will assist in the development of more Clinical Pharmacists for primary care.

Practice Prescribing Support - Pharmacists (PSP) and Technicians (PST)

Ongoing practice prescribing support, which is provided by both pharmacists and a team of qualified pharmacy technicians, remains a great benefit to GP practices, assisting with the progress of the combined local Prescribing Improvement Plan (PIP) and Primary Care Offer (PCO), which cover cost efficiency, safety and quality aspects.

This support is provided to the majority of practices, with the aim to provide each practice with at least half a day of PSP or PST support per week, depending upon individual practice need. However, there have been significant staff changes with staff leaving CCG employment to move to Primary Care Networks, retirements and maternity leave. We now have PST support in twenty practices which, and we have had to start spreading them more thinly to cover practice gaps to replace the three clinical pharmacists that have been recruited to PCNs. Eight of these practices are now getting approx. 0.5 days per week of PST support rather than the 1 day which was the intention as a replacement for their 0.5 days per week previous PSP cover.
Concern has been raised due to the recruitment of PSPs to GP practices as Clinical Pharmacists which will create gaps in our support coverage. In addition some PCNs have been slower to recruit Clinical Pharmacists than others creating a varying level of PSPs and Clinical Pharmacists across the county. A recruitment process has commenced to recruit replacement PSPs and PSTs, who are instrumental for the savings plan to be realised.

Prescribing Support Dietitians

Our Prescribing Support Dietitians continue to work with GP practices to support the implementation of NHSE's Over The Counter (OTC) prescribing guidelines, where prescribing of vitamins and minerals such as Vitamin D are being restricted across primary care except for those with agreed exceptions such as osteoporosis or deficiency. Historically, a number of patients at risk of falls were routinely prescribed Vitamin D however current research suggests that Vitamin D supplementation does not prevent falls or fractures. Patients, who wish to continue to take Vitamin D, because they are at risk of developing deficiency for example, are being encouraged to purchase it OTC.

Vitamin B12 Prescribing and Infant Formula

Vitamin B12 prescribing is being reviewed due to an increase in the requests for serum testing and evidence that suggests high dose oral supplementation is as effective as intra-muscular injections. The new pathway developed by the Pathology working group and supported by the Prescribing Support Dietitian aims to reduce inappropriate testing and encourage oral supplementation where appropriate. The impact on laboratory costs, prescribing costs and nurse time will be monitored.

The Infant Feeding pathways are also being reviewed with the specialist teams to ensure women are properly supported to breastfeed and that conditions such as Cow's Milk Protein Allergy are effectively diagnosed and managed. This includes guidance on appropriate and timely reintroduction of cow’s milk so that the child’s diet is not unnecessarily restricted and that the use of expensive hydrolysed and amino acid based formulas are rationalised appropriately.

Nutrition and Hydration in Care Homes

The dietitians are working with the Frailty CPG as well as the county-wide UTI working group and the Care Homes Support Team to improve frailty and UTI's in Care Home residents through projects aimed at improving nutrition and hydration. Measurements will include the number of falls, the presence and severity of pressure ulcers, the number of UTIs and chest infections and the use of medicines such as antibiotics and laxatives.

Medicines Optimisation in Care Homes (MOCH)

Our MOCH pharmacists continue to work closely with their allocated care homes, and are making progress in developing the service and identifying the most effective ways to integrate with the care home, practices and staff involved. Their aim is to improve repeat prescribing within Care Homes, and encourage and support regular medication review for this cohort of patients. Recently they have been focussing on improving care home use of “homely remedies”, reducing the need for GPs to visit for simple conditions which are often suitable for self-care. Any improvements in medicines optimisation for this often vulnerable population will ultimately lead to improved therapies, reduced side effects, and reduced avoidable hospital admissions.
Quality Report

INFECTION CONTROL UPDATE

Updated 19/9/19

Methicillin-Resistant Staphylococcus Aureus (MRSA) Bacteremia

From 1st April 2018 to 31st March 2019 there were fourteen incidences, eight cases attributed to community acquisition and six cases to hospital acquisition. Six of the cases are linked to intravenous drug misuse. A review group was formed, led by GCC Public Health Protection consultant with countywide representation from health providers. Implementation of an action plan is progressing well and on-going.

1st April 2019 – 30th August 2019 there has been three MRSA Bacteremia cases in Gloucestershire. One case had a hospital onset and two cases a community onset.

Clostridium difficile Infections (CDI)

The threshold set by NHS Improvement (NHSI) for Gloucestershire countywide is 156 cases of CDI in 2018/19. From 1st April 2018 to 31st March 2019 there were 184 CDI cases reported countywide. Of these 184 cases 59 (32%) were hospital acquired and 125 cases (68%) community acquired.

In 2019/20 the threshold target for the CCG is 194 cases which equates to 16 or less cases per month.

Overall the number cases of CDI being reported in 2019/20 in Gloucestershire is showing a downward trend compared to 2018/19. See table below.

There are new reporting categories in place, namely Hospital Onset Healthcare Associated (HO-HA), Community Onset Healthcare Associated (CO-HA), Community Onset Indeterminate Associated (CO-IA) and Community Onset Community Associated (CO-CA).

Community Onset

In 2019/20 78% of patients first developed symptoms of CDI in the community. Post Infection Reviews indicate there are delays in community clinicians sending stool samples when a patient presents with diarrhoea and diarrhoea management is not consistently optimal. Delays in diagnosing CDI risks patients developing a more severe form of the illness and requiring longer treatment.

A ‘think CDI’ campaign is in progress raising awareness to consider CDI particularly in high risk patients when presenting with diarrhoea. Key high risk factors are over 65 years of age, recent treatment with antibiotics or hospital admission. This work promotes early identification of CDI through prompt stool testing, optimising the treatment of patients with CDI and ensuring patients in the community have the information to prevent spread of infection.

A monthly Assurance Panel chaired by the CCG reviews all the monthly CDI cases reported as hospital onset. The meeting routinely reviews the outcomes of action plans and lessons learnt from Post Infection Reviews (PIR). The panel further overseas the CDI reduction strategy. Under this strategy is an action plan for each Trust as well as collaborative actions undertaken to reduce CDI.
An example of an action is the development of an educational initiative to improve diarrhoea management. It will include sampling, isolation, and avoiding the use of Loperamide when CDI suspected to be offered along the pathway from GP through to hospital services.

**Gram Negative Bloodstream Infections (GNBIs)**

- **Escherichia coli (E.coli) Infections**

  The national ambition, announced by the Government in 2016, is to halve the number of healthcare-associated Gram-negative bacteraemia by March 2021.

  In 2017/18, the threshold was exceeded by 19 cases. In 2018/19, the threshold was exceeded by 29 cases. Despite this increase we have been informed by NHSE that we have the lowest rate of E.Coli in the south west region.

  The Quality Premium for 2017/19 (two years) includes an annual threshold target of 257 incidences of E.coli Bloodstream infections in Gloucestershire.

  April 2019 – August 2019, One hundred and thirty E.coli bacteraemia cases were reported of which twenty-four cases (18%) with hospital onset and one hundred and six cases (82%) with a community onset.

  A countywide UTI reduction plan is in place and reviewed quarterly. Further planned work for 2019/20 is to extend the action plan to include other causes of Gram Negative Blood Stream Infections.

**Seasonal Influenza 2019/20**

**Countywide Flu Planning Group**

The Countywide Flu Planning Group, chaired by the CCG, has been meeting monthly throughout the summer months to ensure our preparedness for the 2019/20 winter. This Group includes representatives from CCG, GCC Public Health, GHFT, GHC and 2gether. Building on the successes and learning from last winter, key areas addressed include working with partners on access to vaccines, continuing improvements in vaccination rates in all eligible groups, reducing the impact of respiratory outbreaks and links with our winter resilience plans. From November onwards, the weekly multiagency telecoms will be restarted to share real-time information and actions on vaccination rates, flu fighting infection control and managing outbreaks.

**Vaccination for high-risk groups**

A task and finish group over the summer has brought together our local partners, including the GHFT midwives to review how we might improve vaccination rates in pregnant women. This has resulted in improved collaboration and recognition of the challenges to make every contact count.
Specifically there is an issue with data flows which is recognised nationally, but we are to share more data locally to monitor our progress.

We are developing our communication plans to further promote and support people in clinically high-risk groups to have the vaccine, but also in paid and informal / family carers.

**Availability of vaccines**

We are maintaining close contact with GPs to understand our local picture in relation to availability of vaccines: last year it was the vaccine for 65+ year-olds that was delayed, this year it is the Quadrivalent vaccine for adults 18-64 years. This may impact on our local service providers delivering the staff vaccination CQUIN this year, the target for which is 80%

**Antivirals**

We have updated our local policies and procedures for the use of antivirals prophylactically when there is an outbreak e.g. in a Care Home. Local GPs have signed up to an Enhanced Service and OOHs the service will be provided by Care UK.

**Minimising the Impact of Outbreaks**

Following the successful evaluation of the pilot scheme for Point of Care Testing (PoCT) in Care Homes, funding has been obtained for Phase 2 for winter 2019/20. Within this service, the GHC Point of Care Tester attends the care home as requested by PHE and takes the swabs for results available within minutes to determine whether or not the resident has Flu. This enables a timely response for prescribing of antivirals, antibiotics or neither.

The development of this scheme has been led by GCC Public Health, working in partnership with CCG, GHC, Gloucestershire Care Providers Association (GCPA), GCC Brokerage and SW PHE. Positive impact was demonstrated for care home residents and for system patient flow: this was attributed to the operational model and to the strength of our collaborative working.

We are very pleased to report that this has been recognised nationally: our PoCT for care homes pilot has been shortlisted for the HSJ ‘Health and Local Government Partnership’ Award. The judging panel was on 23rd September and the awards are to be announced on 6th November.
Primary Care Commissioning Committee

<table>
<thead>
<tr>
<th>Meeting Date</th>
<th>31st October 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Title</td>
<td>Delegated Primary Care Financial Report</td>
</tr>
<tr>
<td>Executive Summary</td>
<td>At the end of July 2019, the CCG’s delegated primary care co-commissioning budgets show a £117k year to date underspend and a forecast a small overspend of £23k for the year.</td>
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<tr>
<td>Risk Issues: Original Risk (CxL) Residual Risk (CxL)</td>
<td>None</td>
</tr>
<tr>
<td>Management of Conflicts of Interest</td>
<td>None</td>
</tr>
<tr>
<td>Financial Impact</td>
<td>The current position and forecast has been included within the CCG’s overall financial position.</td>
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<tr>
<td>Legal Issues (including NHS Constitution)</td>
<td>None</td>
</tr>
<tr>
<td>Impact on Health Inequalities</td>
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</tr>
<tr>
<td>Impact on Equality and Diversity</td>
<td>None</td>
</tr>
<tr>
<td>Impact on Sustainable Development</td>
<td>None</td>
</tr>
<tr>
<td>Patient and Public Involvement</td>
<td>None</td>
</tr>
<tr>
<td>Recommendation</td>
<td>The PCCC is asked to • note the content of this report.</td>
</tr>
<tr>
<td>Author</td>
<td>Andrew Beard</td>
</tr>
<tr>
<td>Designation</td>
<td>Deputy Chief Finance Officer</td>
</tr>
<tr>
<td>Sponsoring Director (if not author)</td>
<td>Cath Leech Chief Finance Officer</td>
</tr>
</tbody>
</table>
Delegated Primary Care Commissioning financial report as at 30th September 2019

1 Introduction

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

2 Financial Position

2.1 The financial position at 30th September 2019 regarding the delegated primary care budget is a year to date underspend of £117k.

2.2 This underspend partly relates to GMS Global Sum, where during the budget setting process some lists sizes were still based on estimates rather than actuals, and were slightly higher than the actual position.

Rent budgets have also contributed to the year to date underspend, with budgets including the expected impact of in-year rent reviews, although, at this stage, not all have either been actioned or confirmed.

2.3 Initial budget projections showed that potential commitments under the new contract are over £2.1m higher than the delegated allocation provided by NHSE.

As such, the CCG has supplemented the delegated allocation with budget transfers from the CCG’s programme allocation. Therefore, the budget for the year is £86.315m.

At month 6, the CCG is forecasting a year end overspend of £23k. This overspend is mostly in relation to Dispensing and Prescribing, and offset by Seniority payments which has a forecast underspend
of c£67k.

2.4 Risks:

- Whilst growth is built into budgets for Sickness and Maternity claims, it can be hard to forecast accurately as claims can arrive, backdated, without any prior knowledge, although internal processes have been put in place to try to mitigate this issue. Current projections suggest that the CCG will stay within budget, but this position can fluctuate based on claims received.
- Estimates on the growth of list sizes were made within the CCG budget setting process, and as such, if population growth is more than expected, this will represent a pressure. The assumed growth uplift was 1.27%, however annual growth in April 19 was 1.38% and 1.32% in July.
- Some slippage in the appointment of reimbursable posts under the new framework has been projected within the forecast, actual appointment dates have yet to be established.
- NHS England Wave Pharmacist can be transferred into the PCN’s in addition to the additional roles. Worst case calculations show c.£250k of costs in 2019/20. However, it is currently assumed that this pressure will be mitigated by additional slippage in appointing to “additional roles”. More accurate forecasts will be possible in November when the actual costs of the transferred in staff are known.

2.5 The CCG is currently forecasting a small overspend position against delegated budgets (£23k) in 2019/20.

3 Recommendation(s)

3.1 The PCCC are asked to:

Note the contents of the paper
### Area 2019/20

<table>
<thead>
<tr>
<th>Area</th>
<th>Total Budget</th>
<th>In Month Budget</th>
<th>In Month Actual</th>
<th>In Month Variance</th>
<th>Year to Date Budget</th>
<th>Year to Date Actual</th>
<th>Year to Date Variance</th>
<th>Forecast Variance</th>
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</thead>
<tbody>
<tr>
<td>Contract Payments - GMS</td>
<td>£52,627,478</td>
<td>£4,233,192</td>
<td>£4,138,337</td>
<td>(94,855)</td>
<td>£26,313,476</td>
<td>£26,106,975</td>
<td>(206,501)</td>
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<td>£263,841</td>
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<td>£969,457</td>
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<td>Other GP Services</td>
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<td>£211,821</td>
<td>£191,995</td>
<td>(19,826)</td>
<td>£1,789,901</td>
<td>£1,694,809</td>
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<td>(67,000)</td>
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<td>QOF</td>
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<td>PCN</td>
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<td>£853,322</td>
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<td><strong>TOTAL</strong></td>
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<td><strong>£7,260,100</strong></td>
<td><strong>£7,407,682</strong></td>
<td><strong>147,582</strong></td>
<td><strong>£43,045,433</strong></td>
<td><strong>£42,928,024</strong></td>
<td><strong>(117,409)</strong></td>
<td><strong>22,843</strong></td>
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</tbody>
</table>

### Funding Allocation

| £84,165,000 |

**Global Sum per weighted patient moved from £88.96 to £89.88 in April 2019**

**The value of a QOF point increased from £179.26 to £187.74 in April 2019**

**Other GP Services includes:**

- Legal and Professional Fees
- Locum/adoption/maternity/paternity payments
- Seniority
- Other General Supplies and Services
- Doctors Retainer Scheme