NHS Gloucestershire Clinical Commissioning Group

Primary Care Commissioning Committee (PCCC)

Held in Public at 9.45am on Thursday 19th December 2019 in the Board Room, Sanger House, Brockworth, Gloucester GL3 4FE

No.	Item	Lead	Recommendation
1.	Apologies for Absence *Cath Leech, Helen Edwards*	Chair	Information
2.	Declarations of Interest	Chair	Information
3.	Minutes of the Meeting held on • 31st October 2019	Chair	Approval
4.	Matters Arising	Chair	Discussion
5.	Business Case: New Premises Proposal for Primary Care Development in Stroud	Declan McLaughlin	Approval
6.	Primary Care Networks: Audit Report and Development Update (presentation)	Helen Goodey/Stephen Rudd	Information
7.	Primary Care Quality Report	Marion Andrews-Evans	Information
8.	Primary Care Delegated Financial Report	Andrew Beard	Information
9	Any Other Business	Chair	
Date and time of next meeting: Thursday 20th February 2020 at 9:45am in the Board Room at Sanger House.			

NHS Gloucestershire Clinical Commissioning Group

3

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

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

Present:		
Alan Elkin (Chair)	AE	Lay Member, Patient and Public Engagement
Marion Andrews-Evans	MAE	Executive Nurse and Quality Lead
Julie Clatworthy	JC	Lay Member, Registered Nurse
Colin Greaves	CG	Lay Member, Governance
Andrew Hughes (*deputising for Mark Walkingshaw)*	AH	Associate Director, Commissioning
Helen Goodey	HG	Director of Locality Development and Primary Care
Haydn Jones *(deputising for Cath Leech)*	HJ	Associate Director of Finance (Business Intelligence)
In Attendance:		
Dr Tristan Cooper	TC	GP, Minchinhampton Surgery
Paul Atkinson	PA	Chief Clinical Information Officer
Declan McLaughlin *(item 5)*	DMc	Senior Primary Care Project Manager
Jo White *(item 5)*	JWh	Programme Director, Primary Care
Jeanette Giles *(item 5)*	JG	Head of Primary Care Contracting
Fiona Robertson *(item 6)*	FR	Associate Director for Digital Transformation, CSU
Lauren Peachey	LP	Governance Manager (minutes)

1.	**Apologies**
1.1	Apologies were received from Mary Hutton, Mark Walkingshaw, Cath Leech, Cllr Roger Wilson, Helen Edwards, Dr Andy Seymour, and Jo Davies,

1.2	It was confirmed that the meeting was quorate.
2.	**Declarations of Interest**
2.1	There were no declarations of interest raised.
3.	**Minutes of the Meeting held on 29th August 2019**
3.1	The minutes of the meeting held on Thursday 29th August 2019 were approved subject to the following amendments: • Becky Parish should be recorded as 'in attendance'; • Page 16: 'JS' should be changed to 'JC'. JC requested that the section was expanded on to further clarify the requirement of clinical supervision and clinical governance. JC requested that it was made clear that a non-medical clinician would require a professional supervisor.
5.	**Primary Care Strategy Final Version**
5.1	HG introduced the final version of the Primary Care Strategy (PCS) and highlighted the following key points: • The Governing Body approved the original PCS in 2016; • There was an NHSE requirement for CCGs to refresh the PCS to reflect the NHS Long Term Plan (LTP); • The PCS reflected development themes for the next five years which had evolved from the original strategy to form six goals; • HG presented the PCS to the Integrated Care System (ICS) Board during October and noted that the ICS Board members were offered the opportunity to feedback; • HG emphasised that there had been a substantial amount of stakeholder engagement and input in to the

	PCS; • The PCS was brought to the attention of the PCCC members for formal approval prior to being presented at the Governing Body on the 28th November 2019.
5.2	JC commended the Primary Care Team on the work that had been done to refresh the PCS. JC expressed concern that the PCS did not appear to show enough appetite for innovation with regards to Practice Nurses; for example additional detail on Practice Nurses within Primary Care in the report was far down the document. JC expressed concern that the information included in the PCS indicated no increased planning for the number of nurses working in Primary Care. JC however noted that there were some useful examples included within the PCS which expanded on the Primary Care nursing roles and recruitment. JC stated that there was a lot of work underway with regards to nurse recruitment and expanding the nursing role; however this was not being presented enough in the formal strategy. JC emphasised pressures were expected as a consequence of the volume of the nursing workforce due to retire. JC acknowledged that at this stage it may not be possible to offer more clarity around the future Practice Nurse roles and recruitment.
5.3	AE reiterated that, due to the volume of nurses who were expected to retire, there was an expected challenge in maintaining the current number of Practice Nurses. The lack of increase in planned primary care nurses may have been a reflection of this challenge.
5.4	HG acknowledged the feedback from JC and emphasised that nursing was recognised as a highly valuable service within Primary Care. HG highlighted an example of the Parachute Nursing Service, which had been led by GDoc and Julie Symonds, Deputy Director of Nursing at the GCCG. The service had been well-utilised and highly

	appreciated within Primary Care. However, HG reflected on the NHS England (NHSE) position with regards to the five additional reimbursable Primary Care roles and suggested that the reason why there were no additional nurses included as part of these roles was likely to be due to an ambition to protect the existing nursing services within the NHS. HG emphasised that Community and Primary Care nursing was key to integration.
5.5	AE highlighted there was need for strong links between nursing role in Primary Care and in the community. AE further noted that the community nursing role had expanded to cover aspects of nursing which were traditionally considered part of Primary Care nursing, and vice versa. HG agreed with AE and emphasised the benefit of an integrated way of working between the two nursing roles.
5.6	HG reiterated the need to protect the existing nursing service. MAE explained that whilst there had historically been a clear separation between primary care nursing and community nursing, she believed that this separation would dissolve and therefore result in a holistic service and integrated nursing resource for the population.
5.7	MAE stated that a Clinical Matron of Education and Clinical Development had recently been appointed. Part of this role was to identify the skills and expertise which were needed in Primary Care.
5.8	JW added that there were pilots underway which involved taking an integrated approach to working between primary care and community services. One such example included nurses undertaking minor illness work for GP practices, which benefited from Improved Access funding. The nurses were gaining experience in both injury and illness work and

	building portfolio roles.
5.9	From a governance perspective CG cautioned that there needed to be clarity in that the ICS Board had an interest in PCNs from a strategic perspective although it was not the role of the ICS Board to become involved in operational aspects of the PCNs. AE concurred and indicated that this was a challenging area which needed to be set out clearly.
5.10	AE emphasised that it was important that the ICS should not be de-stabilising to other parts of the NHS. HG concurred that decision making would remain with the PCCC. HG added that PCCC had the delegated authority to make decisions on the GP contracts. HG stated that the PCNs formed part of the ICS and therefore the ICS Board were rightfully positioned to steer structures from a strategic level.
5.10	AE expressed some concern that if the structures were not clearly set out then there would have been a risk of decision making devolving to the ICS. HG agreed and noted this would become an issue to be kept under review.
5.11	JC observed that there was a significant amount of detail included in the digital section of the PCS.
5.12	**RESOLUTION: PCCC recommended the Primary Care Strategy to go to the Governing Body for approval.**
4.	**<u>Matters Arising</u>**
4.1	**Item 8.1, 28/03/2019, Primary Care Premises Report** AH advised that this item was to be covered during the confidential section of PCCC **Item to be closed**
4.2	**Item, 8.4, 29/08/2019, Primary Care Quality Report:**

	Practice Nurse Newsletter MAE confirmed that the Practice Nurse Newsletter had been circulated. **Item to be closed**
4.3	**Item 8.5, 29/08/2019, Primary Care Quality Report: PALS support to the CCG** BP had included a summary of the support undertaken by the Patient Engagement Team within the PALS section of the Primary Care Quality Report. **Item to be closed**
6.	**<u>Primary Care Strategy Goal 5: Digitally Enabled</u>**
6.1	FR presented an update on the Primary Care Strategy Goal 5: Digitally Enabled. FR summarised the key points as follows: • There were a vast number of systems and ways of working across the ICS; • The aims were to develop ways to simplify and improve the ability of working digitally to identify actions that could be taken across the system. These would ensure a good foundation to find digital solutions to support better ways of working for clinicians and patients; • The digital aspect of the PCS was focussed on specific areas which included upgrading infrastructure, joining up business intelligence and reporting solutions, and streamlining systems and tools; • The digital strategy was divided into six work-streams.
6.2	FR explained that the first work-stream namely "Empowering the Person" focused on supporting patients and residents to use technology wherever it was appropriate for them to do so. This would include simplifying the route for appointment booking or repeat prescription services. FR described the two online consultation systems being rolled out across the county and the programme of work

	around consolidation of websites across General Practice in the county to facilitate patient usability. FR added that all practices were using Patient Online which enabled patients to access their records online and approximately 26% of patients were using this new tool.
6.3	AE queried the feedback from General Practice on the guidance which stated that practices were to ensure that 25% of daily appointments were made available online. PA advised that practice feedback indicated a low level of tension between two targets which included the aim of making 25% of daily appointments available online and the work underway which focussed on care navigation. PA highlighted the need to consider the ways in which these targets could be interpreted. AE agreed with this statement and noted the need to take a practical approach and understand the pressure and demand on the practices.
6.4	PA emphasised that it was not only GP appointments that could be booked online but could include a wider range of appointments, including phlebotomy appointments. PA explained that there was evidence which strongly suggested that patients who booked their own appointments were more likely to cancel if they were unable to attend.
6.5	FR continued the presentation and highlighted that an increasing number of patients were using Electronic prescribing Service (EPS). • The next version of EPS was due to be rolled out which would make it easier for patients to receive electronic prescriptions; • Gloucestershire population was above national average of people using the EPS.
6.6	FR provided an update on the second work-stream namely 'Digital Maturity' and advised that this work-stream focused on the systems that were being used and improving the digital maturity. FR noted that there had been a number of

	requests from practices to change systems and this was due to PCNs' realisation of the benefits of sharing an integrated system. FR noted the local cost burden of changing systems. Furthermore, due to a change in contract, a re-procurement of all GP clinical systems was going to be required over the next 12 months.
6.7	FR highlighted that there was work underway to support GPs to obtain advice from clinicians in secondary care. GPs were able to contact clinicians across a number of disciplines within secondary care. Initial reports indicated that this project had been making a positive impact. It had been indicated that, when a GP used this service, 57% of patients either avoided an Emergency Department attendance; or were managed in Primary Care; or were referred directly to the most appropriate service. PA added that there had been very positive feedback received from clinicians regarding this service.
6.8	FR summarised the third work-stream namely 'Information Sharing' and drew the attention of the committee to the following key points: • 'DocMan': a system to support the sharing of electronic documentation was being rolled out; • Joining up Your Information (JUYI) had been in place for just over 12 months and had had over 50,000 views. This was considered to be a high usage; • The next stage of JUYI was to share acute data and roll it out across GP practices; • There was work underway with One South West Local Health & Care Record (LHCR) to review how to share information across the South West; • Summary care records and 111 appointment booking were due to be implemented.
6.9	CG enquired as to whether Gloucestershire Hospitals NHS Foundation Trust (GHNSFT) was due to be transitioning from their current system to an Electronic Patient Record

	(EPR) system. FR advised that this was being implemented and the underlying data was to be taken from the existing database. This was going to be a two year programme.
6.10	In terms of the fourth work-stream namely 'Infrastructure', FR highlighted that over the next 12 months the equipment and software in GP practices would be upgraded and this represented a significant amount of work. In addition to this a Single Domain was to be implemented which would enable GP practices to more easily share documents and information. FR added that anti-virus software was going to be upgraded and cyber security tools were being developed. With regards to supporting collaboration, 'Skype for Business' was being trialled in the Cotswolds for the Multi-Disciplinary Team (MDT) meetings.
6.11	FR stated that the fifth work-stream namely 'Whole Systems Intelligence' which involved ensuring the right information could be provided to practices and other service in the system. FR added that Gloucestershire had a rich pool of joined up data which enabled a substantial source of pseudonymised data. FR clarified that the ambition was to link this data with adult social care data. In terms of demand and capacity management FR outlined a system called 'SHREWD' which allows real time data to be accessed. This system provided urgent care teams the ability to quickly identify system pressures and take prompt action at an early stage. FR explained that the pressure to the system however lay in that it relied on data being input at a real-time pace.
6.12	FR summarised that the final work-stream namely 'Workforce and Delivery' was key to supporting the digitally enabled aims.
6.13	FR concluded the presentation by explaining that there had

	been a Network Outage during October 2019 which took time to fully resolve. JC suggested to FR that this issue was formally reported as an incident. CG however expressed concern over the length of time it took to resolve the issue. FR responded that the problem was challenging to fully resolve quickly due lack of contract management of the N3 contract with British Telecommunications (BT). The link had been repaired quickly however it was not robust and continued to fail. CG noted with concern that, at a meeting with BT, FR had challenged them on network reliability and assurance had been provided that this issue would not happen. FR advised that a lesson had been learnt and a report had been submitted to the GCCG.
6.14	AE suggested that it would be helpful if there was a demonstration of the clinical systems. FR could arrange a demonstration which could take the committee through a patient journey on the system. It was agreed that a dedicated systems demonstration workshop would be held for members. **ACTION: Arrange system demonstration workshop. FR/PA to liaise with LP.**
6.15	**RESOLUTION: The committee noted the contents of the presentation.**
6.16	*PA and FR left at 10:50*
6.17	*Dr Tristan Cooper (TC) joined the meeting at 10:50*
7.	**<u>Business Case for a new Premises for Minchinhampton Surgery</u>**
7.1	AH introduced Dr Tristan Cooper, a partner from Minchinhampton Surgery who had joined PCCC to take questions from the committee with regards to the premises.

7.2	The business case for the new premises proposal was taken as read and AH summarised the following key points: • The business case explained the rationale of relocating the Minchinhampton Practice at Bell lane to a purpose built centre at Cirencester Road; • The new premises would be large enough for a list size of approximately 9000 patients; • The premises would include facilities to support GP training; • Subject to approval the premises would be open in Autumn 2021; • The total capital costs were estimated at £3.65m; • There were upwards of 50 car parking spaces planned; • AH confirmed that the full revenue rental requirements was £182,600; • The total annual revenue requirements net request was £224,598 and there was an existing reimbursement of rates of £49,222 per annum therefore resulting in a net request of £175,376; • The business case had factored in the GP IT requirements; AH stated that the business case adequately set out the case for change, objectives, key benefits and outcomes, and the financial implications for the new premises.
7.3	HJ asked AH to elaborate on the whether this would be a departure from the Premises Costs Directions. AH advised that this was not a departure and explained that there was a reimbursement model which was followed.
7.4	AE commended AH on the report on the business case and stated that the explanation given in the report supported effective decision making.
7.5	MAE noted that there was an active Patient Participation Group (PPG) at Minchinhampton Surgery and it was

	encouraging to note that the group had been actively involved in the planning, and their ideas had been included in the design. TC concurred and advised that, subject to approval, the PPG would continue to be involved this project.
7.6	JC enquired about potential hidden costs of building on the site. TC advised that there had been no indication that there would be additional costs, however there had been a contingency fund allocated. JC added that there were going to be surveys undertaken at the site upon the approval of the business case.
7.7	With regards to sizing AH explained how the practice size was determined including space for training and on site pharmacy. The size of the premises had factored in population growth.
7.8	MAE asked if there would be any issues regarding planning permission and AH responded that the premises development were subject to planning approval. TC added that the former owner of the land had stipulated that the land should be used for public good and the Parish Council was in support of this. MAE noted that this was encouraging.
7.9	HG enquired about the population growth and AH advised that there were housing developments planned nearby which would be in the catchment area of the new premises.
7.10	CG enquired about the 'one off' IM&T cost and asked if there would be reimbursement from NHSE. **Action: HJ to confirm the IM&T cost and asked if there would be reimbursement from NHSE.**
7.11	CG further enquired about the issue of transport and observed that the new premises would be out of town. TC responded that there was a bus route and a bus stop nearby; however the bus ran infrequently. TC informed the

	committee that there was a very active PPG volunteer driving scheme.
7.12	**RESOLUTION: The committee formally supported the business case for the new premises for Minchinhampton Surgery, and the financial support specified within the business case.**
8.	**Primary Care Quality Report**
8.1	MAE informed the committee that CareUK 111 Southwest had recently been inspected by the CQC and was awarded an 'Outstanding' rating. The CCG had written a formal letter of congratulations to CareUK 111 commending them on their efforts. MAE clarified that this related specifically to the CareUK 111 service and not the Out of Hours service.
8.2	MAE informed the committee that the National Institute of Clinical Excellence (NICE) had issued a Technology Appraisal (TA) with regards to the use of direct-acting oral anticoagulants (DOACs). This had been issued with tight restrictions. The NICE TA recommended that DOACs were to be prescribed for a specific cohort of patients who had peripheral vascular disease and heart failure. The current guidance had a cost impact of approximately £500,000 per annum.
8.3	With regards to safeguarding MAE noted that the update would be limited to the areas which had a direct impact on Primary Care. MAE explained that the independent review of the Multi-Agency Safeguarding Hub (MASH) had been completed. Due to the demanding workload going into the MASH the CCG Core Group had agreed the investment for a Band 6 WTE Nurse. MAE explained that when the additional nurse was in post, GPs would start to receive feedback on their referrals.
8.4	In terms of CQC inspections MAE advised that the new Annual Regulatory Reviews (ARRs) system was underway with a significant number of practices having completed this

	process. This involved practices providing information to the CQC followed by a phone call in which the information was discussed. There would be a follow up visit by the CQC if there were still concerns following the phone call. All practices who had a review score of good or outstanding had maintained their score and it was expected that several practices would be improving their rating from good to outstanding in the following year.
8.5	MAE advised members that if a GP surgery changed their registration they were subject to a full CQC inspection within their first year. CG asked if CQC still reserved the right to undertake an unannounced inspection at General Practice and MAE confirmed that they had such right. MAE advised that there had been a significant incident at a GP surgery in Gloucestershire in which a patient had passed away on the premises. MAE explained that this had been reported to the CQC and the CQC was satisfied with how the incident had been handled by the GP surgery.
8.6	MAE highlighted that a good amount of progress had been made at the Dean Neurological Centre care home. Hannah Williams, from the CCG, continued to visit the care home on a regular basis. MAE had been contacted by other CCGs querying whether they could place patients at the Dean Neurological Centre and MAE advised that they could place patients at this care home. MAE added that a new service director for the Dean Neurological Centre had been appointed and was due to commence in post from the end of November 2019.
8.7	With regards to patient experience MAE highlighted that there was additional information about the 'other' category of calls within the Patient Advice and Liaison Service (PALS) team. MAE provided a brief update on the issues

	that were raised. MAE summarised that a number of these calls were not appropriate for the GCCG PALs and included requests for phone numbers for other services and GHFT PALS.
8.8	MAE summarised that the GCCG Patient Experience and Engagement and Communications Teams had been involved in planning Fit for the Future engagements.
8.9	MAE stated that some changes were due to be made to the Friends and Family Test (FFT). AE commented that the changes were subtle; however the case studies provided in the FFT NHSE guidance were useful. AE enquired as to whether the FFT had produced case studies or encouraged change within the Gloucestershire system. MAE responded that there were no changes known with regards to this specifically relating to Gloucestershire.
8.10	MAE explained that GCCG Engagement Team continued to provide support to General Practice particularly where there were significant practice changes underway. MAE added that the PPG network continued to be well attended.
8.11	In terms of Primary Care Education MAE highlighted that the CCG had received an increase in funded places for Non-Medical Prescribers from NHSE for the academic year 2019/20. MAE noted that the CCG had provided additional funding in addition to these places. Furthermore NHSE had funded £10,000 to support practice nurse development. The GCCG Clinical Learning and Development Matron had commenced post and had been working with local providers to identify training needs and support practice nurses.
8.12	With regards to a prescribing update MAE stated that there was a prescribing savings plan being worked through,

	however there were significant challenges arising from Category M pricing changes. In addition to this there was a lack of some lower cost prescriptions being available resulting in more expensive prescriptions being issued. MAE stated that the shortage was an ongoing issue. MAE highlighted that there had been concern raised due to the recruitment of Prescribing Support Pharmacists (PSPs) to GP practices to work as Clinical Pharmacists as this resulted gaps in prescribing support coverage in the county. MAE stated that the recruitment of additional PSPs and pharmacist technicians was underway.
8.13	MAE provided an update on the work underway with Prescribing Support Dieticians to include supporting the implementation of Over The Counter (OTC) prescribing guidelines such items such as Vitamin D. New guidance relating to the prescribing of Vitamin b12 was being formalised with the aim of ceasing prescribed vitamin b12 injections and encouraging patients to purchase oral supplements of vitamin b12 over the counter following recent evidence on the effectiveness of oral supplements of vitamin b12.
8.14	In terms of flu vaccinations MAE stated that there was a seasonal flu vaccination plan in place. MAE added that from November onwards, there were weekly multi-agency telecoms in place in which real-time information could be shared and actions could be identified regarding infection control and managing outbreaks. MAE also stated that flu vaccinations for the under 65s had been delayed; however these were due to begin arriving. MAE added that there had also been a shortage of the nasal spray flu vaccinations for children of primary school age which were also due to begin arriving.

8.15	**RESOLUTION: The contents of the Primary Care Quality Report were noted.**
9.	**Primary Care Delegated Financial Report**
9.1	The report was taken as read and HJ summarised the following key points: • As at 30th September 2019 there was a year to date underspend of £117,000 on the delegated primary care budget; • The reasons for the underspend were outlined within the report; • There were a number of risks to the budget which had been explained within the report; • The CCG was forecasting a £23k overspend against the delegated budget for 2019/20.
9.2	AE asked HJ to expand on the internal processes which had been put in place to try to mitigate the risk relating to sickness and maternity pay. HJ responded that spend commitments were being reviewed and identifying where there could be slippage elsewhere within that system. AE expressed that there was a concern that the CCG was receiving post-dated claims. JG added that the Primary Care team were meeting with practice managers on a regular basis and during these meetings they were reminding them to submit their claims on a timely basis.
9.3	AE requested that HG to elaborate on the risk around pharmacists and HG responded that this risk reflected the NHSE wave pharmacists who were expected to form part of the Primary Care workforce and the financial costs to the GCCG for this year. HG clarified that the cost of these pharmacists would be reimbursable from the financial year 2020/21.

9.4	With regards to the figures in the report CG observed that the budget was not balanced and speculated that this was due to changes within the GMS and APMS contracts. HG agreed that this was due to a temporary contract. CG stated that this issue was expected to be resolved for the following year.
9.5	**RESOLUTION: The committee noted the contents of the Primary Care Delegated Financial Report.**
10.	**Any Other Business**
10.1	There was no other business raised.
	The meeting closed at 11:35
11.	**Date and time of next meeting**
	The next PCCC will be held on Thursday 19th December 2019 at 9.45am in the Board Room, Sanger House.

NHS Gloucestershire Clinical Commissioning Group

Agenda Item 4

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

Item	Description	Response	Action with	Due Date	Status
26/06/2019 8.7	Primary Care Quality Report: GP education and training	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. ***Update 29/08/2019:*** 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.***	HE	February 2020	Open
31/10/2019	Goal 5 of Primary Care Strategy: Digitally enabled	Fiona Robertson (FR) and Paul Atkinson (PA) to arrange a demonstration of clinical systems for PCCC members to be held as a workshop.	PA and FR	February 2020	Open
31/10/2019 7.10	Business Case for a new Premises for Minchinhampton Surgery	With regards to the one off IM&T costs, CG enquired as to the amount and if this was reimbursable by NHSE. ***ACTION: Haydn Jones (HJ) to confirm the IM&T cost and asked if there would be reimbursement from NHSE.*** ***Update 3/12/2019:*** *HJ confirmed that there was no longer any reimbursement for these costs from NHS England.*	HJ	December 2019	Closed

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 5

Primary Care Commissioning Committee

Meeting Date	**Thursday 19th December 2019**
Title	**Report on the Business Case for the Development of a Primary Care Centre in Central Stroud for Locking Hill Surgery and Stroud Valleys Family Practice**
Summary	This document sets out the Case for Change, objectives, financial implications and timeline for the establishment of a new Primary Care Centre in Central Stroud, i.e. 1 King Street, and the proposed relocation of Locking Hill Surgery (LHS) and Stroud Valleys Family Practice (SVFP). The Business Case responds to the following challenges: • An existing surgery, i.e. LHS, identified as a very high priority for potential development in the CCG's Primary Care Infrastructure Plan as not meeting requirements for the long term; Both existing surgery buildings no longer deemed satisfactory, over the long term, in respect of estate conditions and functionality facet surveys; • For the provision of primary care services, where the existing surgery buildings are significantly smaller than they should be for the existing number of patients and preventing an identified range of services 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;

	• 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; • So that both practices can facilitate the expansion of training opportunities at student, foundation and GP Registrar levels where there is a lack of facilities, as well as student nurses; • To ensure there are suitable facilities available for planned increase in patient numbers over the next fifteen years with an anticipated combined list size increase to at least 15,161 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 1,235m^2 Net Internal Area along with 40 reimbursable car parking spaces. It should be noted that patients will actually be able to park in any of the 360 spaces available in the adjacent Five Valleys Shopping Centre free of charge, if they have an appointment. The reimbursable area agreed is 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. The developer is currently in negotiations to lease vacant space to Community and Mental Health teams.

	The practices have also 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 (planning approval having already been obtained), the extensively refurbished and modernised building is expected to be open in the Summer of 2021.
Conflicts of interests	None identified
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 Stroud Town Centre will be substantially affected, leading to loss of reputation and impact of service delivery and commissioning strategies. This is especially the case in respect of the patients of Locking Hill Surgery.
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;

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<td>Total revenue implications (rent and rates) will be £368,902 per annum, inclusive of VAT. This will be partially offset by existing reimbursement of £109,115 per annum. A net additional recurrent investment of £259,787 is required.

The business case sets out all the relevant IM&T costs. From a CCG perspective a one-off £114,858 will be required for GPIT capital and HSCN requirements. It is assumed that the GPIT costs will be required to be utilised over the financial years 2020/21 and 2021/22.

In line with Premises Directions 2013, the Practices have also requested consideration of at least a contribution towards the following costs:

<table>
<tr><th>Item</th><th>Cost</th></tr>
<tr><td>Monitoring Surveyor</td><td>£29,840 (Capped)</td></tr>
<tr><td>Stamp Duty Land Tax</td><td>£45,522</td></tr>
<tr><td>Legal Costs (Lease)</td><td>£25,200</td></tr>
<tr><td>Total</td><td>£100,562</td></tr>
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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.</td>
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<td>Legal Issues (including NHS Constitution)</td>
<td>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.</td>
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Impact on Health Inequalities	No health inequalities assessment has been completed for this report.
Impact on equality and Diversity	An Equality Impact Assessment (EIA) has not been completed for this report.
Impact on Sustainable Development	As this scheme is over £2m in value, the developer has completed a BREEAM pre assessment. As this is a Refurbishment of an existing building the CCG has been advised that project will proceed with the objective of meeting at least the 'Very Good' rating. However, the Developer aspires to achieve the 'Excellent' rating as would have been required if the proposal was for a new build.
Patient and Public Involvement	Both practices have an active Patient Participation Group (PPG) and have engaged fully with the PPGs (both separately and together) on the proposals. The practices undertook an extensive engagement programme from 20th October – 18th November 2019 including: • patient surveys resulting in the production of a FAQ document; • a joint formal public engagement event; • displays in their patient waiting rooms and information on practice websites; • information disseminated on social media. The result of the patient survey were generally very positive and also useful in that the feedback highlighted where more information and clarification was needed, e.g. patient parking. If the Business case is approved, the project team will continue to seek engagement from staff, patients, the PPG and other stakeholders throughout the detailed design of the building and construction of the building.

5

Recommendations	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 Locking Hill Surgery and Stroud Valleys Family Practice and the financial implications relating to the proposal; • To confirm that no additional fee support will be available to the Practice for eligible costs.
Author	Declan McLaughlin
Designation	Senior Primary Care Project Manager
Sponsoring Director	Helen Goodey Director of Locality Development and Primary Care

Primary Care Commissioning Committee

Thursday 19th December 2019

Report on the Business case for the development of new premises for Locking Hill Surgery and Stroud Valleys Family Practice 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 in Central Stroud, i.e. 1 King Street, and the proposed relocation of Locking Hill Surgery (LHS) and Stroud Valleys Family Practice (SVFP).

2.0 Background

2. Introduction– 'As is'

2.1 Practice profiles

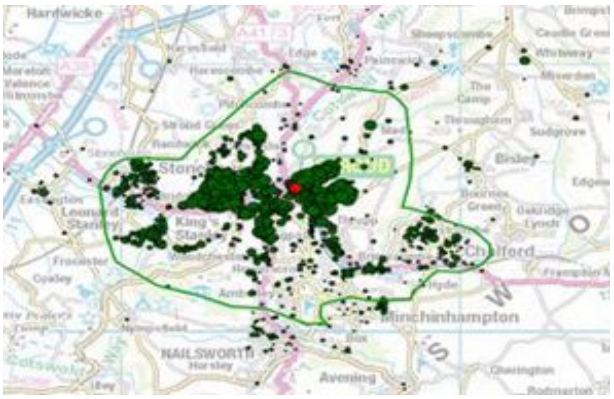
2.1.1 Locking Hill Surgery

The practice was established in the 1920's; having been formed from two single-handed practices each serving different parts of the town. In 1963 both practices came together into a single partnership, and grew steadily, moving in to the current, purpose-built premises at Locking Hill in 1982.

The practice is situated in the centre of Stroud, on a steep sloping site at the junction of Locking Hill and Slad Road. The property is in a high-risk flood area and has extensively flooded in the recent past, however, the practice has continued to remain operational in challenging circumstances.

The practice catchment area overlaps with the other practices in the town and within the primary care network, extending to a number of small villages to the east, as well as into smaller towns such as Stonehouse to the west. A large number of patients

reside in the area known locally as the top of town, one of the more deprived areas in the district. The Practice Boundary is graphically set out in the map below:



The practice's current workforce at the end of November 2019 was as follows:

	Head Count	**WTE**
GP partners	4	4
Salaried GPs	4	2.33
Nurse Practitioners/ECP's	2	1.88
Practice Nurses	1	0.5
Health Care Assistants	1	1
Reception & Administration staff	13	9.6
GP Assistant in Primary Care [in training]	1	1
Medical and Nursing Students	0	0
Clinical Pharmacist	1	0.6
GP Registrars	0	
Practice Manager	1	1
Business Manager & CQC Registered	1	1

Manager		
Total Staff	**29**	**20.58**

Other key factors to the practice's profile is provided in the table below:

Item	Value
List size (Baseline for original PCIP) in July 2014	9,248
List size (Baseline for refreshed PCIP) January 2019	9,643
Project list assumption (set out in refreshed PCIP) in April 2031	Minimum of 10,020
CQC rating	Requires Improvement
Minor surgery sessions per week	0
Dispensing	No
Improved access sessions per week	2
Current building size GIA m^2	386
Number of consultation and examination rooms	6
Number of treatment rooms	2
Minor surgery rooms	0*
Rent reimbursement	£55,936 per annum
Business rates reimbursement	£9,410 for 2018/19

** 1 room taken out of operation in September 2019 as it did not meet statutory requirements.*

The Business Case highlights that the practice performs well across a number of national clinical indicators.

However, when compared to the CCG average, the surgery has a higher proportion of patients over 65 years (22.6% against 20.6%), and 14.85% of these people live at home, whereas the CCG average is 11.9%. .

The surgery also has a corresponding increase in patients with a long-term condition, and whilst some of this is related to age, other lifestyle and socio- economic factors play an important role, such

as low income, poor housing and un-employment. There is a marked increase, compared to the CCG average, in patients with Cancer, COPD, CHD, Diabetes and smoking.

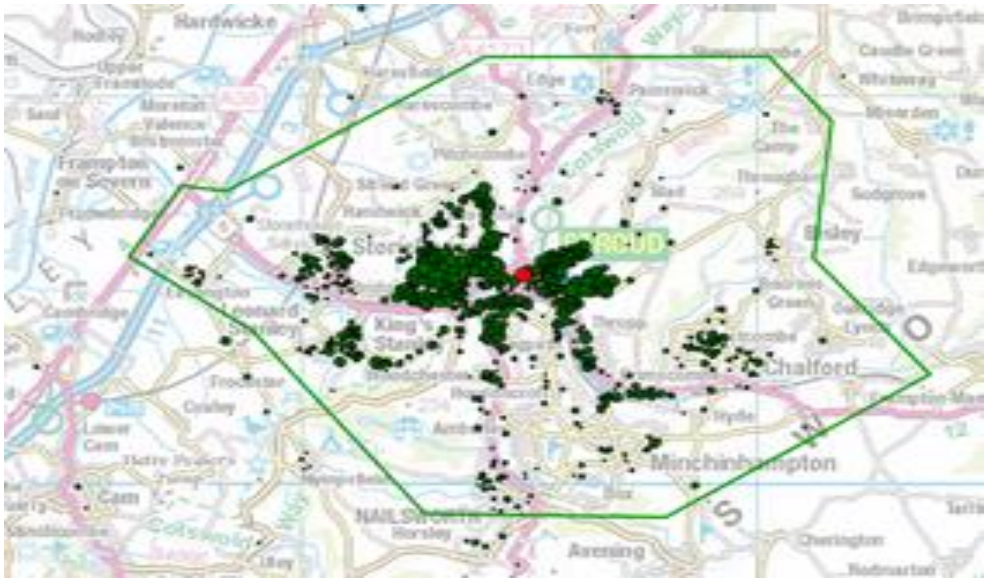
As new models of care are rolled out to meet the needs of this cohort of patients, the practice will have limited capacity to respond to new initiatives because of the constraints imposed by the current building.

2.1.2 Stroud Valleys Family Practice

The practice was established in central Stroud and moved into the new Beeches Green Health Centre in 1974.

The building was also being shared, on the upper floors, with social care, dentistry and some other health care services e.g. Health Visiting and Family Planning services but the majority of these moved out into new premises over 10 years ago leaving both upper floors vacant.

The practice has found it hard to grow its list size due to the public perception that there is only one GP practice (Beeches Green Surgery) based at the site. Therefore, around 5 years ago, in a bid to improve visibility and attract more patients, the practice rebranded from 'Dr Staniforth & Partners' and became Stroud Valleys Family Practice. The location, boundary of the practice and spread of registered patients are shown below:



The currently 25 staff working within the Stroud Valleys Team including 3 GP partners, 2 salaried GPs and a GP retainer, the full complement of staff is as follows:

	Head Count	**WTE**
GP partners	3	2.1
Salaried GPs	2	1.1
Retainer GPs	1	0.1
Practice Nurses	3	1.31
Health Care Assistants	2	1.28
Practice Manager	1	1
Assistant Practice Manager	1	0.7
Reception & Administration staff	7	3.8
Medical Students	Variable numbers	Not employed by practice
GP Registrars	1	1
Other staff (not employees)	4	Not employed by practice
Total Staff	**At least 25**	**At least 12.39**

(Note: WTE for a GP is 9 sessions, WTE for other staff is 37.5 hours / week).

Several of the clinicians have specialist interests including the following:

- Advanced contraceptive device fitting (implants and coils) once every month / 6 weeks;
- Women's health including fitting of ring pessaries;
- Minor ops one session per month;
- Dermatoscopy;
- Respiratory disease including spirometry (accredited via ARTP);
- Advanced weight management provision for patients with obesity;

Other healthcare professionals providing services from the practice's space include:

- Community Psychiatric Nurses one session per week;
- Midwives – GHNHSFT one session per fortnight;

- District nurses - when clinical space is required for assessment of a patient or for certain procedures as they do not have their own clinical space;
- Diabetic eye screening mobile unit – GHNHSFT annually for 1 week;
- Aortic aneurysm screening – GHNHSFT annual visit for 1 week – 10 days;
- Social prescribing practitioner one session per month.

Other key factors to the practice's profile is provided in the table below:

Item	Value
List size (Baseline for original PCIP) in July 2014	4,093
List size (Baseline for refreshed PCIP) January 2019	4,765
Project list assumption (set out in refreshed PCIP) in April 2031	Minimum of 5,141
CQC rating	Good
Minor surgery sessions per week	1 per month
Dispensing	No
Improved access sessions per week	2
Current building size GIA m2	295
Number of consultation and examination rooms	6 (with 3 shared separate examination rooms)
Number of treatment rooms	1
Minor surgery rooms	1
Rent reimbursement	£38,217 per annum
Business rates reimbursement	£5,104 for 2018/19

3. Strategic Case

3.1 National policy

3.1.1 Five Year Forward View[1]

The precursor to the NHS Long Term Plan, this national policy sees General Practice at the heart of the NHS. The GP Forward

[1] NHS England, October 2014

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;
- 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.

3.1.2 Long Term Plan[2]

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

[2] NHS England, January 2019

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)

3.1.3 Primary Care Networks[3]

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);
- Tacking Neighbourhood Inequalities.

From April 2020, every PCN will also receive a new national Network Dashboard to measure impact, including A&E attendances, admissions, prescribing and performance against these specifications. Also commencing in 2020 is a new national

[3] NHS England January 2019

Network Investment and Impact fund, linked to performance against metrics in the Network Dashboard. This will mean that PCNs, which demonstrate a positive, demonstrable, impact in these measures, will receive further investment to support their growth.

The current premises available to both practices present daily challenges to delivery of the model of care required to meet the needs of our population into the future. For example:

- The practices cannot combine their resources to create a neighbourhood hub which would form the focal point for enhanced service delivery in the local community;
- They are unable to provide space for more trainees and therefore this limits the future pipeline of new staff entering primary care, and the wider NHS;
- There is no additional space available to provide more clinical and diagnostic services and host the additional staff required , or to provide a place to support the work of the wider health & social care team who will be a key element of successful joint working in the newly formed Primary Care Network;
- The lack of additional space limits the potential for the practices to look to offering new models of working like multi-patient appointments which support the direction of National policy in managing long-term conditions.

3.2 Local Strategic Context

3.2.1 Gloucestershire Integrated Care System (ICS)[4]

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.

[4] Gloucestershire ICS Operational Plan 2019/ 2020

The ICS vison 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.

The practices recognise and support the vision of the Gloucestershire ICS and are active in supporting delivery of its objectives.

Both practices are limited by their current estate in terms of meeting these objectives, for example:

- They are working in undersized premises that are redundant in terms of meeting future health needs and meeting infection control and other building design requirements;

- The current premises hinder service integration, for example meeting space is limited, there are insufficient rooms available for the wider health & social care team to meet and see patients of the practice;
- Social Prescribers cannot currently see patients within the practice as there is no space for them to do so;
- The current accommodation was not designed to meet the needs of an ageing population with an increasing burden of long-term conditions, for example:
- Door widths and corridors are not accessible for wheelchair users or those in mobility scooters;
- The design and layout are confusing for patients with memory loss and sensory impairment;
- The signage does not meet current standards.

There is a lack of Disabled parking spaces at Locking Hill Surgery and the sloping site creates access problems for patients needed to arrive in adapted vehicles.

Treatment room space is limited, with inadequate storage. This means that patients with complex needs, who require more specialist treatment, can take much longer to receive care.

Neither site is close to public transport and Locking Hill Surgery cannot provide a safe dropping off point for patients and their carers.

3.2.2 Gloucestershire Primary Care Strategy[5]

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 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.

[5] Gloucestershire CCG November 2016

3.2.3Gloucestershire Primary Care Infrastructure Plan 2016/ 2021[6]

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, Locking Hill Surgery was identified as a priority for infrastructure development.

3.2.4Stroud & Berkeley Vale Integrated locality Partnership (ILP)[7]

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.

The practices are active in their support of the objectives of the ILP and the PCN. Dr Hampton currently shares the Clinical Director of the Severn Health PCN and Locking Hill act as the nominated account holders for the network.

The practices see the network as a key element in the delivery of the ICS and ILP objectives, however delivery of this vision is hindered by out of date premises which offer little opportunity for wider service integration and they cannot become a hub within the local community.

[6] Gloucestershire CCG March 2016

[7] **Gloucestershire CCG: July 2019**

4.2.5 Severn Health Primary Care Network

Both practices are currently part of Severn Health Network (along with Prices Mill, Regent Street, High Street, Stonehouse Health Clinic & Frampton surgeries).

Dr Anne Hampton, a partner of Stroud Valleys Family Practice, also holds a job share Clinical Director position and Locking Hill Surgery currently manage and administer the network funds.

The registered population of the network in January 2019 was 41,609 and the population projection is 45,598 patients by 2031, with significant housing growth in the Stonehouse area of the network.

Services are provided over 7 different buildings and a review of the Primary Care estate is required to help assess opportunities for more efficient service delivery.

The total current space available within the network equates to around 2,392m2 GIA versus an expected of 3,798 m2 GIA for the 2031 population.

The networks initial plans are to recruit additional pharmacists to support the patients and the primary care team manage medicines more effectively and safely.

The network is also reviewing how support is provided to the Care Homes in the area.

Core plan relate to increasing numbers of allied health professionals e.g. pharmacists, physiotherapists and social prescribers and an increase in services not just for patients of one surgery but also for those across the network.

Both practices have been involved in the successful initiation of improved access appointments across the wider Stroud area.

The practices are aware that, in line with the NHS long-term plan, more initiatives towards working at scale will become possible over time.

The current acute & emergency care consultation process may also result in opportunities for the Network (and the practices) to take on more minor illness/acute work together or to look at ways of re-modelling our on the day demand.

The Network is also keen to explore new ways to work with our secondary care consultants to provide more secondary care specialist services within the community e.g. through case-based discussions, 'virtual' clinics or other new projects.

Space for such initiatives, as well as close working with other practices, will be vital for their success.

3.3 Practice assessment

Current operating Constraints

Locking Hill Surgery

The current size of the surgery has a significant impact on how clinical services are delivered as well as on how the administration and management team function and are as follows:

1. The car park is undersized for the registered patient population and there are frequent problems with a lack of spaces available. Minor accidents are frequent in the car park and there is a lack of safe pedestrian circulation;

2. The lack of consulting and treatment rooms available means that GP's and other Healthcare practitioners have to frequently leave their rooms and hot desk in other parts of the building if they are not seeing patients.

   It is not always possible to provide a suitable hot desk and GP's often come in on weekends and on days off during the week to keep up with their admin.

   Moving staff out of their clinical rooms has implications for working efficiency and potentially safety as hot desk PC's may not be configured in the same way as in the consulting room, other reference materials may not be available to the clinician and room layouts, including the storage of supplies and consumables, may also be different;

3. Treatment Room 1 at Locking Hill Surgery does not meet the requirements of the Minor Surgery DES and therefore patients registered with the practice now must be referred elsewhere for minor Surgery.

   The room is also used as a workstation and this conflicts with a clinical environment;

4. Treatment Room 2, used by the Nurses for dressings and specialist clinics, is too small to allow access to the patient couch from 3 sides;

5. The room used by our HCA for Phlebotomy is very small and the HCA cannot access all sides of the patient couch;

6. Access to the main clinical areas is problematic for those with limited mobility as the site is located on a hill with the main car park at ground floor level and the clinical rooms at first floor level. There are no lifts in the building;

7. Patients with limited mobility struggle to navigate narrow corridors where door widths do not meet current standards for wheelchair access;

8. Storage space is very limited, presenting problems for stock inventory and records management;
9. The admin and management teams are located on the ground floor of the building. This area does not meet the requirements of the Equalities Act and there are insufficient spaces for the number of staff employed;

10. The staff amenities are inadequate for the number of staff working at the practice and there are no facilities for disabled staff members;
11. The staff kitchen is undersized and too cramped for the number of staff members.

<u>Stroud Valleys Family's Practice</u>

1. Neither the current nurse treatment room nor the HCA room are large enough to allow access to the couch on all 3 sides. In fact, this is only available in 1 room within the whole surgery (the minor procedures room);

2. The HCA room, which is used for dressings and spirometry, as well as phlebotomy, is too small for purpose;

3. The building and heating system are old and inefficient, and the temperature is out of our control, generally being either too cold or too hot which is uncomfortable for both staff & patients;

4. The carpark, although overall large, is shared with Redwood House (social services, district nursing & dentistry) and patients often struggle to find adequate parking especially at busy times;

5. Accessibility for those with mobility difficulties or wheelchair users is not ideal with a very narrow central corridor and tight corners which are difficult to navigate within the building;
6. Poor communications infrastructure in terms of broadband connectivity speeds making the prospect of skype or e-mail consultations a significant challenge;

7. Lack of total consulting room space limits the ability of the practice to utilise its entire qualified staff for training and mentorship (medical students, GPs, practice nurses) meaning the practice must limit the number of placements it can offer due to lack of space;

8. The Practice has no facility for group meetings, group training, seminars, video conferencing, and library or study area. Any group training must take place in the Practice waiting room when the Practice is closed;

9. The main admin space/back office is completely open to the waiting area which causes issues relating to patient confidentiality when admin staff are answering/making calls.

3.3.2 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 that Locking Hill (LHS) are not satisfactory across all areas and for Stroud Valleys (SVFP)it is for four of the five of the facets:

Practice Name	Condition Grade	Function Grade	Quality Grade	Space Grade	Statutory Grade
LHS	C	D	C	D	D
SVFP	C	C	C	B	D

3.3.3 Population growth

The Table below sets out core GMS allowances for each practice taking into account minimum predicted list size growth. Based on existing combined surgery sizes of 681m2 GIA, the table below highlights the current requirements are 46% less.

Practice	Minimum predicted list size by 2031 (PCIP Projection)	GIA m2 allowance for core GMS (excludes training) and based on separate developments
Locking Hill	10,020	835
Stroud Valleys	5,141	428
Total	**15,161**	**1,263**

3.4 Case for Change summary

The case for change summary is as follows:

- Existing premises are no longer deemed satisfactory, now and into the future, in respect of estate conditions and functionality facet surveys and this impacts on matters such as patient experience, privacy and dignity, access as well as on the range of services the practices are able to provide;

- The practices are unable to provide the full range of primary care services within their existing buildings, which are significantly smaller than they should be for their registered populations and which hinder or prevent a wider range of services to be provided. This limits delivery of the objectives set out in the vision of the ICS, the ILP and the network;
- There are insufficient facilities, such as clinical rooms, training space, minor surgery rooms or diagnostic services, to extend the range of services available to their population and ensure that national and local service strategies can be implemented for the population served;
- The current facilities prevent the practices meeting workforce strategy objectives, in terms of providing suitable facilities for existing staff as well as the expected increase in staff numbers over the next five to 10 years, including additional resource from PCN Development plans;
- The practices cannot provide sufficient space to meet the training requirements for the Severn Deanery, limiting the number of places offered at student, foundation and GP Registrar levels where there is a lack of facilities, as well as placements for Student Nurses, Physiotherapists, Pharmacists and other health professionals;
- The current facilities cannot support the planned increase in patient numbers over the next 10 years with an anticipated combined list size of at least 15,161;
- The practices cannot support the delivery of more resilient and sustainable primary care teams and support the development of primary care network models of care; as sharing skills, expertise and facilities is highly limited;
- The current premises hinder delivery of the Business Development Plans of the Practices, for example facility sharing back office functions and management structures, developing standard process and protocols.

4.0 Economic & Commercial case

4.1 Key objectives, options and appraisal

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

- The Practices have sufficient physical capacity to be able to deliver a full range of high-quality services in a modern, safe and fit for purpose environment, into the future;
- The Practices are able to meet the objectives set out in national and local strategies, particularly in relation to the expansion in the range of services as well as successful delivery of GMS/PMS requirements;
- The Practices have successfully responded to workforce and training challenges; ensuring that they are able to attract, train and retain new members of staff, and that they can become more resilient by sharing skills and facilities;
- The Practices future plans are deliverable in terms of being acceptable to patients, wider stakeholders and represent Value for Money.

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

The full results of the scoring process are outlined in the table below:

	Criteria								
Option	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**Total**
Do nothing	0	0	1	4	8	3	0	5	21
Improve existing premises	0	0	1	4	8	3	0	5	21
Redevelop Locking Hill site	1	1	1	4	2	2	3	3	17
Development of a single site for both practices at an identified site	10	10	10	8	8	4	7	10	67

The clear preference in the unweighted option was therefore to progress a 3rd party development joint premises development.

Weighted scores:

Option	Criteria	1	2	3	4	5	6	7	8	Total
	Weighting	20	25	15	5	15	5	15	0	
Do nothing		0	0	15	60	120	45	0	0	235
Improve existing premises		0	0	15	20	120	15	0	0	170
Redevelop Locking Hill site		20	25	15	20	30	10	45	24	189
3rd party development of King Street		200	250	150	40	120	20	105	0	885

The clear preference when weighted scores are applied is for a joint premises solution.

4.2 The proposal

The preferred option is to develop a new surgery building on an alternative site and an alternative site is available. This Business Case sets out a proposal for the establishment of a new medical centre at number 1 King Street, Stroud.

The proposed site is located in the Town Centre, close to the bus station and within a four to six-minute walk of each of the existing surgeries.

It should be noted the proposal is concerned with the total refurbishment and partial rebuild of an existing building.

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. It is also takes into account additional elements to meet training requirements.

The building will have a Gross Internal Area of 1,300 m2. In order to deliver general medical services, reimbursement will be a maximum of 1,235 net internal area (NIA) along with up to 40 funded 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. The sizing is calculated as follows:

Practice	Minimum list size by 2031	GIA (m2)
Locking Hill	10,020	835
Stroud Valleys	5,141	428
4 F2 GP training (including PCE)		96
Saving from shared space		-59
Total	15,161	1,300

The proposal makes provision for a number of additional consulting rooms, nurse consultation rooms, and treatment rooms, with provision for minor operations / recovery suite, and GP training facilities. These are summarised as follows:

Type	Number
Existing clinical rooms	19
Proposed clinical rooms in total	31
The Proposed Clinical Rooms will be Split as follows:	
New consultation rooms	19
New treatment rooms	6
New minor procedures rooms	2
New medical training rooms	4

4.3 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:

Item	Benefit/Outcome
Patients	- Increased privacy and dignity - Improvements to the range of services offered - More training and education - Access to additional roles and services such as Social Prescribers, Community Pharmacists, Para Medics and Physiotherapists - A reduction in the need to travel to secondary care settings for tests - Improved accessibility - Closer to other amenities in the town such as shops, banks, pharmacies - Close to local public transport and on a taxi rank - Improved parking - Increased appointment capacity and shorter waiting times - A safer clinical environment with improvements in infection control and building environment - Designed to meet the needs of patients with mobility problems/frailty and other impairments
Staff/ Practice	- Healthier & more pleasant environment for working - Additional training placements - Improved staff amenities encouraging healthier travel to work options such as cycling - Improved recruitment and retention - Sharing of workload and increased resilience - Sharing of clinical skills and knowledge and best practice - A higher standard of treatment environment with sufficient storage space - A more secure environment with appropriate access - controls - A wider variety of roles - A single clinical system - Standardised processes
Wider Health & Wellbeing system	- Increase value for money through sharing of space - Closer integration of service delivery - A focal point for the wider health and social care community

5.0 Financial elements

5.1 Capital cost-

The project will be a third-party development funded and owned by Stroud Regeneration Limited, a wholly owned subsidiary of Dransfield Properties Limited.

The proposed tenants will be Locking Hill Surgery and Stroud Valleys Family Practice who are expected to sign a 25 year Tenant Internal Repairing lease.
The indicative capital cost for the GMS element of this development is circa £4.9 million. Stroud Regeneration Limited will fund this investment.

The procurement will be for a fixed price tender and in line with CCG requirements, the costings of the successful tender will be made available to the CCG, as part of the assurance and due diligence of the financial appraisal included within this Business Case.

5.2 Existing revenue costs

Current annual costs:

Locking Hill Surgery Rent Business Rates (2018 / 2019) Total	 £56,384 £9,410 £65,794
Stroud Valleys Family Practice Rent Business rates (2018 /2019) Total	 £38,217 £5,104 £43,321.
GRAND TOTAL	**£109,115**

5.3 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 an Interim report issued to the CCG) and eligible for reimbursement, are set out in table below:

GMS RENT REIMBURSEMENT	Amount
Rent 1,235 m^2 NIA @ £198.75	£245,456
Car Parking Spaces 40 @ £320	£12,800
Total Rent	£258,256
VAT	£51,651
GRAND TOTAL	**£309,907**

5.4 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 £58,995.

5.5 Fee support

In line with Premises Directions 2013, the Practices have also requested consideration of at least a contribution towards the following costs:

Item	Cost
Monitoring Surveyor	£29,840 (Capped)
Stamp Duty Land Tax	£45,522
Legal Costs (Lease)	£25,200
Total	**£100,562**

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.

5.6 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 £114,858 will be required for GPIT capital and HSCN requirements.

It is assumed that the GPIT costs will be required to be utilised over the financial years 2020/21 and 2021/22.

5.7 Annual recurrent revenue summary

Item	Amount
Total annual revenue requirements (rents, business rates and inclusive of VAT)	£368,902
Funded by:	
Existing Rent & Rates Reimbursement	£109,115
Additional Recurring Investment	**£259,787**

6 Management case

6.1 Programme management

The project will be a third-party development funded and owned by Stroud Regeneration Limited, a wholly owned subsidiary of Dransfield Properties Limited.

The proposed tenants will be Locking Hill Surgery and Stroud Valleys Family Practice who are expected to sign a 25 year Tenant Internal Repairing lease.

Key people and organisations involved in the preparation of this document:

Property Owner	Dransfield Properties Limited as Stroud Regeneration Limited Dransfield House 2 Fox Valley Way Sheffield S36 2AB	Contact: Andrew Malley Tel: 01226 360 644 Email: Andrew.Malley@Dransfield.co.uk
GP Practice (1)	Locking Hill Surgery Locking Hill Stroud Gloucestershire GL5 1UY	Contact: Stuart Sedgwick-Taylor/dr Ewart Lewis Tel: 01453 764 222 Email: s.sedgwick-taylor@nhs.net Ewart.Lewis@nhs.net
GP Practice (2)	Stroud Valley Family Practice Beeches Green Health Centre Stroud Gloucestershire GL5 4BH	Contact: Annette Brown / Rachel Rutter Tel: 01453 764696 Email: annette.brown3@nhs.net / rrutter@nhs.net

Project architect	Dixon Dawson Architects Moor Oaks Lodge Moor Oaks Road Broomhill Sheffield S10 1BX	Contact: Guy Dixon Dawson Tel: 01142683888 Email: GuyDixonDawson@dixondawson.co.uk
Mechanical and Electrical Engineers	ESDP Chapel Court Chapel Road Astwood Bank Redditch Worcestershire B96 6AL	Contact: Keith Littlejohn / Michael Bromage Tel: 01527 893 880 Email: keith.littlejohn@esdp.com / Michael.Bromage@esdp.com

6.2 Programme plan

A risk register has been developed, which is kept under review, and subject to business case approval and a milestone table is provided.

Item	Target date/ status
Planning permission/ change of use	Achieved
NHS approval	December 2019
Finalised design	January 2020
Agreement to lease	January 2020
Tender documents issued	End of January 2020
Tender completed and mobilisation	End of June 2020
Construction commences	End of September 2020
Construction completed and building open	End of June 2021

6.3 Patient engagement

Both practices have an active Patient Participation Group (PPG) and have engaged fully with the PPGs (both separately and together) on the proposals.

The practices undertook an extensive engagement programme from 20th October – 18th November 2019 including:

- patient surveys resulting in the production of a FAQ document;
- a joint formal public engagement event;
- displays in their patient waiting rooms and information on practice websites;
- information disseminated on social media.
  The result of the patient survey were generally very positive and also useful in that the feedback highlighted where more information and clarification was needed, e.g. patient parking.

If the Business case is approved, the project team will continue to seek engagement from staff, patients, the PPG and other stakeholders throughout the detailed design of the building and construction of the building.

6.4 Key risks

There are always potential risks associated with any proposed development, and these are set out, along with a description of how these risks will be mitigated, in the table below.

Likelihood and severity have been scored on a scale of 1 – 5, with 1 being low and 5 being high. These have been multiplied to arrive at a risk score which has been coded according to severity and the top three identified below:

Risk	Description	Severity (1-5)	Likelihood (1-5)	Score	Management Strategy to Mitigate
Accessibility / Car parking	Risk of availability of spaces within the public car park	3	2	6	Space identified for disabled and GP parking; 360 spaces available for patient use free of charge. Developer currently extending multi-storey car park works due to complete May 2020.
Construction	Design and build contract fails to deliver building to appropriate standard	2	4	8	Highly experience architectural firm with track record to lead similar projects Practices to appoint experienced tenants' surveyor/project manager. Detailed specification to be agreed as part of legal documentation that obliges the developer and its contractor to meet all required building standards.

Public perception	Significant numbers of local residents objecting to the scheme	3	2	**6**	Informal consultation to date has not found any significant concerns about the scheme Senior CCG management assisting

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.

7.0 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 Locking Hill Surgery and Stroud Valleys Family Practice and the financial implications relating to the proposal;

- To confirm that no additional fee support will be available to the Practice for eligible costs.

Declan McLaughlin
Senior Primary Care Project Manager
4th December 2019

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Primary Care Networks: Audit Report and Development Update

Primary Care Commissioning Committee

Helen Goodey and Stephen Rudd

19 December 2019

Primary Care Networks – CCG Audit: Oct-Nov 2019

The internal audit work for 2019/20 focused on the arrangements for establishing the Primary Care Networks. Areas tested were:

- **Commissioning and Procurement of Services** – focused on role of Primary Care Network Development Group, delivery of DES, assessment of PCN maturity.
- **Contract Oversight and Management Functions** – in relation to DES monitoring, inclusive of extended hours.
- **Finance** – relating to methodology for allocation of funds and payment mechanisms
- **Governance** – concerning PCN coverage, CD appointment and development, links to ICS, reporting to PCCC.

Primary Care Networks – CCG Audit: Oct-Nov 2019

EXECUTIVE SUMMARY		
LEVEL OF ASSURANCE: (SEE APPENDIX I FOR DEFINITIONS)		
Design	Substantial	There is a sound system of internal control designed to achieve system objectives.
Effectiveness	Substantial	The controls that are in place are being consistently applied.

SUMMARY OF RECOMMENDATIONS: (SEE APPENDIX I)	
High	0
Medium	0
Low	0
TOTAL NUMBER OF RECOMMENDATIONS: 0	

"Our overall assessment of substantial assurance is given … in respect of PCN development as part of the delegation agreement work required … it is clear that there are robust processes in place to manage the establishment of the primary care environment. Appropriate procedures and controls are in place to mitigate the key risks.

- There are clear governance arrangements in place with the PCCC, PCNDG, CD and ILP Chairs Meeting
- The CCG has demonstrated strong project management …<with>… clear involvement from the early stages with GPs and practices, the public and wider health and social care
- The CCG is working with PCNs with regard to the maturity matrix … <which> gives a range of maturity as would be expected. More mature PCNs have indicated to the CCG that they want to ensure that the less developed networks are developed through providing support
- Methodology for allocating and payments follow NHSE DES contract guidance"

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Workforce Development – New Roles

Additional staff in five groups by 2024

- **Social prescribing link workers** (up to B5) 100% funding from 2019/20
- **Clinical pharmacists** (B7-8a) 70% from 2019/20
- **First contact physiotherapist** (B7-8a) 70% from 2020/21
- **Physician associates** (B7) 70% from 2020/21
- **First contact community paramedics** (B6) 70% from 2021/22

- **Challenges** relating to employment models, VAT, liabilities and risks;
- **Challenge** of finding, recruiting and retaining staff at these bands
- **Challenge** of funding 30%...

Total additional potential ARR funded new roles (WTE above baseline); modelling from Primary Care Strategy

Role	2019/20 9 months*	2020/21	2021/22	2022/23	2023/24	Total
Clinical Pharmacists	17	7.5	7.5	7.5	7.5	**47**
Social Prescribers	11	7.75	7.75	7.75	7.75	**42**
Physiotherapists	0	10.5	10.5	10.5	10.5	**42**
Physician Associates	0	7	7	7	7	**28**
Paramedics	0	0	4.7	4.7	4.7	**14**
Total	28	32.75	37.45	37.45	37.45	**173**
Cumulative Total	**28**	**60.75**	**98.2**	**135.65**	**173**	

This would provide BMA aspiration of each PCN having: 5 CPs, 3 SPLWs, 3 Physios, 2 Physician Associates and 1 Paramedic

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Note: 2019/20 recruitment already looking unlikely

Aggregated new potential ARR funding and gap per year by role (£m)

Role	Funding Stream	2019/20 9 months	2020/21	2021/22	2022/23	2023/24	5 Year Total
Clinical Pharmacists	70%	£0.48m	£0.95m	£1.275m	£1.6m	£1.95m	£6.27m
	30%	£0.21m	£0.4m	£0.55m	£0.69m	£0.84m	£2.7m
Social Prescribers	100%	£0.28m	£0.66m	£0.96m	£1.27m	£1.58m	£4.75m
	0%	£0	£0	£0	£0	£0	£0
Physiotherapists	70%	-	£0.41m	£0.84m	£1.28m	£1.74m	£4.27m
	30%	-	£0.18m	£0.36m	£0.55m	£0.75m	£1.8m
Physician Associates	70%	-	£0.26m	£0.54m	£0.8m	£1.1m	£2.7m
	30%	-	£0.11m	£0.23m	£0.35m	£0.48m	£1.2m
Paramedics	70%	-	-	£0.15m	£0.3m	£0.46m	£0.9m
	30%	-	-	£0.06m	£0.1m	£0.2m	£0.39m
Total	Funded	£0.76m	£2.3m	£3.76m	£5.3m	£6.86m	£18.9m
	Gap	£0.21m	£0.7m	£1.2m	£1.7m	£2.26m	£6.1m

Notes:

- ***2019/20 recruitment already looking unlikely***
- ***Assumes all workforce recruited to as per assumptions, from April each year (so likely slippage)***
- ***Likely to be more '70%' funding available to fund more staff than is here; lower forecast due to Glos baseline***
- ***30% alone may be insufficient to fund workforce costs to attract and retain staff***

Aggregated new potential ARR funding and gap per year by role (£m)

Role	Funding Stream	2019/20 9 months	2020/21	2021/22	2022/23	2023/24	5 Year Total
Clinical Pharmacists	70%	£0.48m	£0.95m	£1.275m	£1.6m	£1.95m	£6.27m
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Social Prescribers	100%	£0.28m	£0.66m	£0.96m	£1.27m	£1.58m	£4.75m
	0%	£0	£0	£0	£0	£0	£0
Physiotherapists	70%	-	£0.41m	£0.84m	£1.28m	£1.74m	£4.27m
	30%	-	£0.18m	£0.36m	£0.55m	£0.75m	£1.8m
Physician Associates	70%	-	£0.26m	£0.54m	£0.8m	£1.1m	£2.7m
	30%	-	£0.11m	£0.23m	£0.35m	£0.48m	£1.2m
Paramedics	70%	-	-	£0.15m	£0.3m	£0.46m	£0.9m
	30%	-	-	£0.06m	£0.1m	£0.2m	£0.39m
Total	Funded	£0.76m	£2.3m	£3.76m	£5.3m	£6.86m	£18.9m
	Gap	£0.21m	£0.7m	£1.2m	£1.7m	£2.26m	£6.1m
ARR unspent			£0.55m	£0.83m	£1.7m	£2.99m	£6.1m

Notes:

- ***2019/20 recruitment already looking unlikely***
- ***Assumes all workforce recruited to as per assumptions, from April each year (so likely slippage)***
- ***Likely to be more '70%' funding available to fund more staff than is here; lower forecast due to Glos baseline***
- ***30% alone may be insufficient to fund workforce costs to attract and retain s***

Calculator to support PCN modelling and see funding flow

Maximum Reimbursable Amount per Financial Year

↓ Enter PCN Population ↓		2020/21	2021/22	2022/23	2023/24
Actual	Weighted				
64,036	71,573	£308,500.00	£498,200.00	£761,100.00	£1,069,600.00

NOTES:
1. All cells in light green are data entry cells.
2. Actual values to be confirmed annually - use for indicative purposes.

Roles Recruited in 2019/20

Additional PCN Role	Number of WTE
Clinical Pharmacist (New)	0.00
Clinical Pharmacist (NHSE transfer)	0.00
Social Prescribing Link Worker	2.00

Please Enter the Additional WTE Per Year For Each Role Below

Additional PCN Role	2020/21	2021/22	2022/23	2023/24
Clinical Pharmacist	3.00	0.00	3.00	0.00
Social Prescribing Link Worker	0.00	1.00	1.00	1.00
Physiotherapist	3.00	0.00	0.00	0.00
Physician Associate	0.00	0.00	0.00	3.00
Paramedic		3.00	0.00	0.00
Total ARR WTE Per Year	**6.00**	**4.00**	**4.00**	**4.00**

NOTE: Assumption of April start date for each role (highest cost scenario)

ARR Reclaimed by Role	2020/21	2021/22	2022/23	2023/24
Clinical Pharmacist	£116,907.00	£119,532.00	£243,942.00	£248,922.00
Social Prescribing Link Worker	£70,778.00	£108,579.00	£147,764.00	£188,515.00
Physiotherapist	£116,907.00	£119,532.00	£121,971.00	£124,461.00
Physician Associate	£0.00	£0.00	£0.00	£120,117.00
Paramedic		£94,437.00	£96,375.00	£98,352.00
Total Projected ARR Claim	**£304,592.00**	**£442,080.00**	**£610,052.00**	**£780,367**

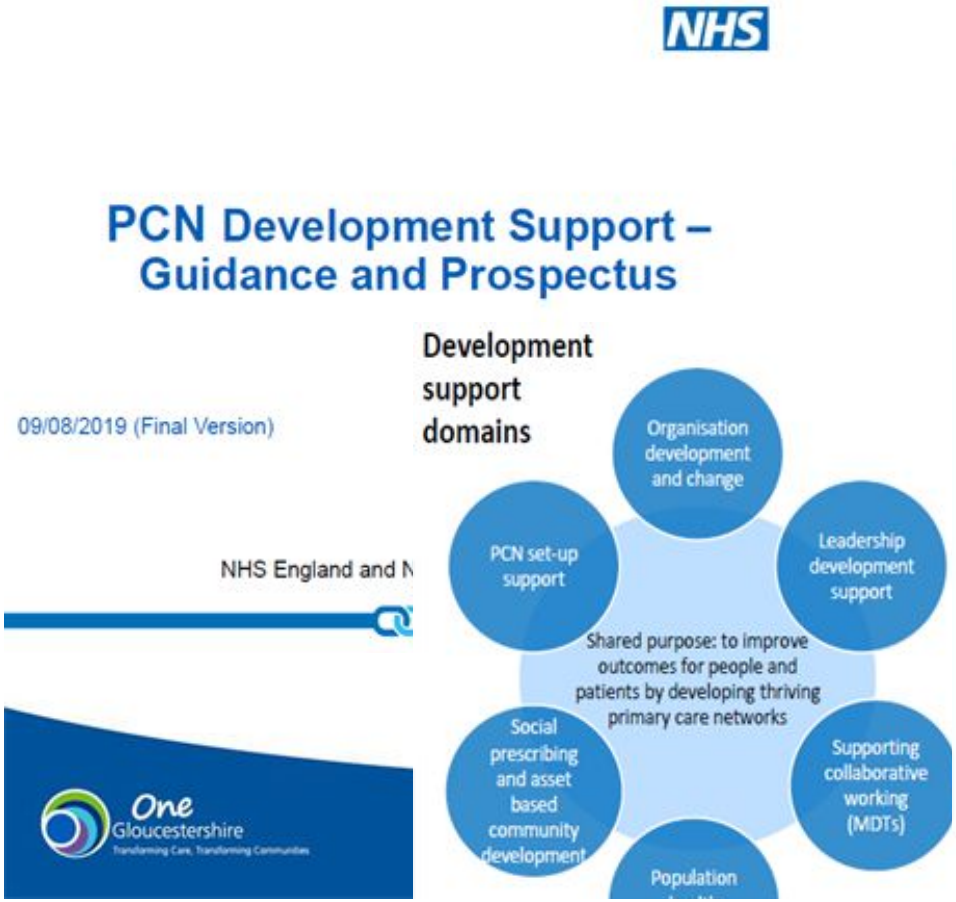
Microsoft Excel Worksheet

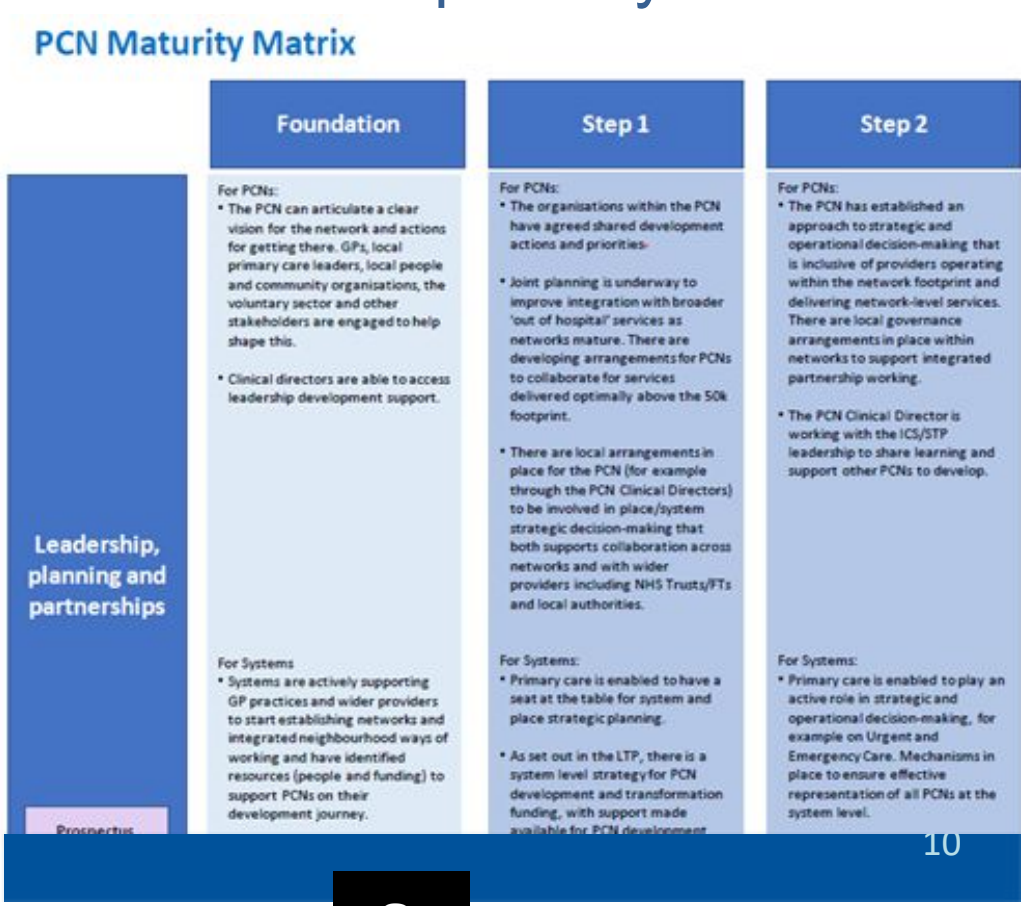
ARR Current Position

PCN	NHSE Transferred CPs	2019/20 ARR roles already in place	2019/20 ARR roles currently being recruited to	Anticipated Gaps?
Central Cheltenham	1.2 WTE CP - *resigned*		None	1 WTE CP 1 WTE SPLW
Cheltenham Peripheral		1.2 CP One more CP starting on 10/12/19	1 WTE SPLW – *looking at employment model with CCP, anticipated January 2020*	*None - any funding above allocation being provided by PCN unless additional funding becomes available*
Cheltenham St Pauls	1 WTE	1 WTE SPLW	1.6 WTE CPs - *from January 2020* 1 WTE CP - *agreement reached 13/11/19 out to recruit now*	*None - any funding above allocation being provided by PCN unless additional funding becomes available*
North Cotswolds		1 WTE CP	1 WTE SPLW	None
South Cotswolds		None		1 WTE CP 1 WTE SPLW
FOD			2 WTE SPLWs - *start dates TBC*	None
Aspen	0.6 WTE CPs		1 WTE CP – *started 11/11/19* 1 WTE SPLW – *starting Dec 19*	None
NSG	3.6 WTE CPs		2 WTE SPLWs - *going out to advert soon*	*None*
RHQ	0.8 WTE CP	0.73 WTE SPLW	1 WTE SPLW - *starting Dec 19* 0.26 WTE SPLW - *starting Jan 2020*	None
Inner City	0.9 WTE (CP)		1 WTE (CP) 1 WTE (SPLW) – *start Jan 2020*	None
Berkeley Vale	0.6 WTE CP - vacancy	1 WTE SPLW		1 WTE CP
Stroud Cotswolds		None		1 WTE CP 1 WTE SPLW
Severn Health		None	2 WTE CP – *still progressing*	None
TWiNs	3.0 WTE	1 WTE CP	1 WTE SPLW	None

PCN Development

- Given these challenges, some PCNs are struggling to get started, creating risks around their ability to deliver from 2020
- NHSE published PCN Development Support Prospectus, Domains and an associated Maturity Matrix to access share of Gloucestershire's £472k allocation … but quite dry





What is Expected of PCNs by 2020/21 with Development Support?

- **Understand their journey**: using Maturity Matrix (or local equiv.)
- Functioning increasingly well as a **single team**
- Clear and agreed **multi-disciplinary teams** with community partners
- Build on existing relationships, form **links with local people and communities**: working most effectively for their benefit
- Utilising funding entitlement for **additional roles**
- Considering **future estate needs**, jointly with community partners
- Ready to deliver **national service specifications** from April 2020
- Developing the role of PCNs **to shape and deliver the ICS plan**

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PCN Development

- We have therefore developed a simple 'Roadmap'
- Creates evidenced based assessment
- Forms basis of bids for PCN share of funding allocation
- Dr Olesya Atkinson supporting as PCN Development GP Fellow
- Bids to be considered: PCNDG > PCOG > PCCC sign off

Gloucestershire PCN Roadmap

	No	What?	Why?	By When?	How?	Complete? (Y/N)	Next Steps - PCN to populate with ideas/actions if not yet complete
Q1 19/20	1	PCN partner selection	Contractual requirement	15-May-19	Locally agreed PCN configurations, with CCG & LMC support		
	2	Appoint Clinical Director	Contractual requirement	15-May-19	Locally agreed process, to be set out in Network Schedules		
	3	Complete Network DES registration form	Contractual requirement	15-May-19	PCN to complete, supported by CCG (maps, ODS codes etc)		
	4	Agree practice to hold PCN funds	Contractual requirement	15-May-19	PCN to determine		
	5	Complete Schedule 1 of Mandated Network Agreement	Contractual requirement	15-May-19	PCN to complete, supported by CCG (names, ODS codes etc)		
	6	Submit PCN registration documents to CCG	Contractual requirement	15-May-19	PCN to complete, supported by CCG		
	7	Agree PCN workforce baseline	Contractual requirement	30-Jun-19	PCN and CCG to work together to agree baseline		
	8	Complete Mandated Network Agreement (all schedules)	Contractual requirement	30-Jun-19	PCNs to complete		
	9	All practices sign Mandated Network Agreement	Contractual requirement	30-Jun-19	PCNs to complete		
	10	PCN Data Sharing Agreement in place	Contractual requirement	30-Jun-19	PCNs to ensure in place, supported by CCG as req'd		
	11	PCN to confirm to CCG No's 8-11 (above) complete	Contractual requirement	30-Jun-19	Email to PCN inbox		
Q2-4 19/20	12	PCNs go live	Contractual requirement	01-Jul-19	Points 1 -11 above		
	13	Extended Hours to 100% of PCN population	Contractual requirement	01-Jul-19	PCN to determine		
	14	Practices > PCNs transfer NHS Clinical Pharmacists (where applicable)	Contractual deadline	30-Sep-19	Liaise with CCG and NHSE		
	15	QOF QI Peer Review meetings as PCN	Contractual requirement	31-Mar-20	Network Peer Review meeting as per GMS QOF guidance 19/20		
	16	Agree your shared purpose - what can PCN be for us, our businesses, our	Network members feel ownership	31-Mar-20	Access PCN Dev Support: 'PCN Set-up' (e.g. facilitation support)		
	17	Develop ideas/projects to support purpose	Identify how the network can deli	31-Mar-20	Access PCN Dev Support: 'PCN Set-up' (e.g. facilitation support)		
	18	Agree roles for Additional Roles Reimbursement (ARR) for 2019/20	Increase capacity and resilience	31-Mar-20	Access PCN Dev Support: 'PCN Set-up' (e.g. facilitation support)		
	19	Agree employment model for ARR 2019/20	Determine employer	31-Mar-20	Access PCN Dev Support: 'PCN Set-up' (e.g. legal support)		
	20	Agree ARR governance, e.g. liability share, T&Cs alignment etc	ARR governance	31-Mar-20	Access PCN Dev Support: 'PCN Set-up' (e.g. legal support)		
	21	Employ ARR 2019/20 roles	Support 'purpose' / Prep 20/21	31-Mar-20	Access PCN Dev Support: 'PCN Set-up' (e.g. backfill / specific support etc)		
	22	Identify clinical workforce lead for ARR to integrate new positions	Integrating new roles to PCN, imp	31-Mar-20	Access PCN Dev Support: 'PCN Set-up' (e.g. backfill / specific support etc)		
	23	Appoint Business Manager	Support CD workload, free up CDs	31-Mar-20	Access PCN Dev Support: 'PCN Set-up' (e.g. backfill / specific support etc)		
	24	Consider Clinical Director Deputy / Joint Clinical Director position	Support CD workload / absence, s	31-Mar-20	Access PCN Dev Support: 'PCN Set-up' (e.g. backfill / specific support etc)		
	25	Revisit & update Network Agreement (all schedules) to reflect Y1	Good governance	31-Mar-20	Access PCN Dev Support: 'PCN Set-up' (e.g. legal support if req'd)		
	26	Discuss and agree roles for ARR in 20/21, including employment	Support 'purpose' / Prep 20/21	31-Mar-20	Access PCN Dev Support: 'PCN Set-up' (e.g. facilitation support)		
	27	IT sharing platform in place for PCN	Online collaboration / rotas etc	31-Mar-20	Access PCN Dev Support: 'PCN [illegible]upport)		

Clinical Director Development

- Developing a similar process for CDs with Dr Atkinson
- Based on CD leadership capabilities, as described by NHSE, and linking to resources that can support development
- Setting up resources and sharing pages on CCG Live: PCN area
- Engaging Time for Care Team to create offer for CDs and PCNs for 2020/21 onwards

Area of capability	Why does it matter	Examples of external support to further develop the capability – note, these are not exhaustive
Change management	Leading complex change processes to deliver quantified impacts	General Practice Improvement Leads programme from the Time for Care team: https://www.england.nhs.uk/gp/gpfv/redesign/gpdp/capability/
Establishing and developing a team, engaging and influencing others	Collaborative leadership to get the best out of self, team, system Overcome resistance and make change sustainable	General Practice Improvement Leads programme from the Time for Care team: https://www.england.nhs.uk/gp/gpfv/redesign/gpdp/capability/

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Questions

Quality Report

NHS Gloucestershire Clinical Commissioning Group

Primary Care December 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:

- NICE
- Clinical Effectiveness
- Research and Development
- Safeguarding
- CQC
- Patient Engagement
- Prescribing Update
- Infection Control
- Seasonal Influenza 2019/20
- Primary Care Education

Quality Report

NHS Gloucestershire Clinical Commissioning Group

NICE

The number of NICE TAs published is below (as of 19/11/19)

	Q1 (Apr -Jun 18)	Q2 (Jul - Sept 18)	Q3 (Oct - Dec 18)	Q4 (Jan - Mar 19)	Total (April 18 to Mar 19)	Q1 (Apr - Jun19)	Q2 (Jul - Sept 19)	Q3 (Oct - Dec 19)	Q4 (Jan - Mar 20)	Total (April 19 to date)	
Number issued	11	14	15	20	60	18	16	8		42	including
Number relevant to GCCG	1	3	2	2	8	3	5	4		12	terminated TAs

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.
A holding statement has been published with regard to NICE TA607 Rivaroxaban for preventing atherothrombotic events in people with coronary or peripheral artery disease. The cost implication is being analysed and local specialist opinion is being sought in order to ensure prescribing guidelines are available before the mandatory implementation date.

7

Clinical Effectiveness

Clinical Effectiveness Group (CEG)

Guidance on conditions for which over the counter items should not routinely be prescribed in primary care

To further support the implementation of this guidance an updated leaflet and a new poster have been developed. The leaflet has been distributed to GP practices, community pharmacies, health visitors, midwives, tissue viability team, district nurses and GHNHSFT to support 'self-care week' (w/c 18th Nov). The poster is currently being printed but will be distributed as soon as possible.

Emollient Formulary

To further support the implementation of the revised local "Emollient Formulary", template letters to patients from the CCG have been produced as a resource for GP surgeries.

The last meeting of the Clinical Effectiveness Group was held on 28th November 2019. The next is scheduled for 23rd January 2020.

Safeguarding

GCCG Strategic Safeguarding Health Group (bi-monthly) for children and adults respectively now oversee and monitor implementation of all actions for health following these Safeguarding Reviews. This is alongside each organisation's Safeguarding Operational meetings and their CQRGs.

Serious Case Reviews (SCR) and Safeguarding Adult Reviews (SAR)

Children:
Serious Case Reviews

- Gloucestershire Safeguarding Children Executive (GSCE) continues to progress all SCRs. Four SCRs are ongoing: 'ID', 'ET', 'AD', and GH (out of county).

- There is delay to final GSCE sign off for Acorne due to GCC legal input. The LB/ED (joint DHR/SCR) has been partly signed off and will go to DHR Panel in December for Home Office submission.
- SCR ('Megan') re-review is completed. Learning related to 'Special Guardianships' (SGO) is in place. The earlier (2015) recommendations have been progressed.

Published reports can be accessed at http://www.gscb.org.uk/i-work-with-children-young-people-and-parents/serious-case-reviews-and-learning-from-reviews-and-audits/

Adults:
Safeguarding Adult Reviews

Gloucestershire Adult Safeguarding Board is commissioning a new SAR referred from LeDeR. The subject, 'NC', lived in supported accommodation, and had moderate learning disability and cerebral palsy. He had lived with his mother for 52 years until she became ill in 2016, when he moved into supported living. NC's mother died in November 2017 and NC deteriorated mentally and physically after her death. NC died of malnutrition on 22nd January 2018. The time period covered by the review is 22/07/17 to 22/01/18, with an overview of NC's life prior to this.

CQC Inspections

As has been previously reported the Gloucestershire GP practices are in the vast majority good with four outstanding and two 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 undergo the ARR process and some will have focused inspections.

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.

Patient Experience and Engagement

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 of Q2 2019.

Type	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Q1 19/20	Q2 19/20
Advice or Information	111 (PC 27)	1 (PC 12)	110 (PC 22)	38 (PC 8)	38 (PC 11)	21 (PC 8)
Comment	11		11 (PC 4)	0	1	0
Compliment	4	2	2	2	2	4
Concern	97 (PC 23)	110 (PC 14)	75 (PC 22)	72 (PC)	50 (PC 10)	35 (PC6)
Complaint about GCCG	2	5	7	5	7	12
Complaint about provider	22	18	18 (PC 5)	35	33 (PC 7)	33 (PC2)
NHSE complaint responses copied to GCCG PALS	1	0	0	1	10*	15*
Other	32 (PC 4)	52 (PC 5)	34 (PC 4)	67 (PC 9)	74 (PC 6)	87 (PC15)
Clinical Variation (Gluten Free)	0	2	0	1	1	1
Total contacts	**280**	**288**	**257 (PC 57)**	**221**	**216 (PC 34)**	**208 (PC46)**

Quality Report

**** NHSE complaint investigations & responses copied to GCCG PALS:*** *NHSE are now consistently sharing complaints for logging only.*

Themes identified from GCCG PALS Contacts Q2 19/20

Marybrook Surgery

The PALS email contact was included within the letter to Marybrook patients regarding the future of the practice. In total five contacts by email had been received which were responded to directly by the Primary Care team.

Aspen Medical Centre

In Q2 there have been a total of six contacts relating to Aspen Medical Centre:

- One contact – compliment made to their Patient Advocate
- Two contacts - NHSE complaints team
- Three contacts - under 'other' requesting information leaflets and medical records

GCCG Complaints

There has been a relatively high number of GCCG complaints recorded during Q2. This breaks down as follows:

- 4 x commissioning (autism pathway, IFR/IVF, wheelchair provision – joint with GHaCNHSFT and a joint primary care/GCCG) and;
- 8 x CHC complaints (retrospective funding, fast track and outcome of local resolution meetings).

Examples of contacts received and recorded under "other":

- Requesting of booklets/leaflets such as planning for your future care/dying matters/Non-Emergency Patient Transport Service/2week wait.
- Request for information such as Mental Capacity Act specifically for section 49/117.
- Requesting contact telephone numbers for different NHS and non-NHS services; sometimes these can be for services such as British Gas, Warm & Well scheme, bus passes.
- Calling CGG PALS but requiring either Mental Health/Hospital/Community PALS support so redirection numbers give.
- Reimbursement for travel costs.
- Notification of change of address or telephone number (many of the callers believe we have access to records and can make direct changes).
- Requests for help with filling out forms ranging from universal credit and benefits to Attendance Allowance and Personal Independence Payments.
- Unable to get through to services on the telephone e.g. other PALS services or hospital departments (we do take numbers/emails with consent and forward messages on their behalf).

Quality Report

NHS Gloucestershire Clinical Commissioning Group

Engagement activities

Currently the CCG Engagement Team is involved in activities across all localities and the majority of programme areas across the ICS. The following are examples of recent and current engagement activities:

***Fit for the future* Engagement**

https://www.onegloucestershire.net/yoursay/fit-for-the-future/

One Gloucestershire NHS partners have 'paused' the current programme of staff and public engagement Fit for the Future in response to the Government's announcement that a General Election will be held on Thursday 12 December 2019.

The pause, which is in line with NHS England guidance in relation to the Pre-Election Period (PEP), means that the Citizens' Jury and Solutions Appraisal Exercise, both scheduled to be held in December 2019.

The NHS partners of One Gloucestershire would like to thank everyone who has taken the time to share their views and ideas since the engagement programme got underway in August 2019.
All feedback received is being collated into a comprehensive Engagement Report and will be used to inform the development of potential solutions for future local NHS services.

Phlebotomy

A Patient and Public engagement workshop was arranged for 29 November 2019 to enable a baseline for patient and public views of what matters to them when using Phlebotomy services. Feedback will be used to develop solutions for local potential service developments.

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.

Example of CCG Engagement Team support in primary care: Stroud Town Centre Development

Members of the CCG Engagement Team have been liaising closely with Stroud Valleys Family Practice and Locking Hill Surgery (and their respective PPGs) to support engagement with their

combined practice patient populations on the proposal to relocate the two practices into a purpose built facility as part of the redevelopment of the Five Valleys Shopping Centre. The practices have run a survey which has been completed by 240 patients across both practices. The general feedback has been positive regarding the new practice estate development. The practices have also held a drop in engagement event attended by 60 people.

Countywide Patient Participation Group (PPG) Network

The PPG Network met on 11 October and 22 November 2019. The Network meeting on 11 October was an independently facilitated FFTF engagement session for PPGs focussing on Urgent advice, assessment and care in communities. The Network meeting in November focussed on the Mental Health 15 Steps Challenge in Primary Care pilot; Knead 2 Know: Encouraging more conversations about later life planning; and Personalised care. A PPG member from the Aspen Centre also facilitated a 'spotlight' discussion focussing on 'PPGs using websites, apps and social media'.

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. It is intended to design and present a countywide PCN engagement offer in the New Year for consideration by ILPs, PCNs and the CCG Locality Development Team.

Prescribing Update

Prescribing figures

Prescribing figures commencing from April 2019 to June August 2019 are used in this update report. This apparent delay is due to the lag time for data processing at the NHSBSA (those who process prescription spending data). More recent data has been received on 2nd December, this is currently being checked for accuracy and will be reported in due course.

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 the first five months suggests an overspend at the end of the year, and this year has a challenging savings target for 2019-2020 particularly as a result of -

- 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,
- Increasing "Out Of Stock" (OOS) situations causing necessary switching to less cost effective products (which remain available). These shortages can last an indeterminate

length of time, ranging from coming back in stock before significant changes have occurred, to long term non-availability.

- Brexit which is likely to influence medication supplies, and ultimately costs (as supply delays may be a driver for NCSO changes).
- Increasing use of DOACs (in particular for primary care) as a result of further NICE TA publications

Optimise Rx Prescribing Support System

Optimise Rx software remains available in the vast majority of GP practices. This system continues to demonstrate its benefits in supporting our wider prescribing initiatives, from a cost and quality aspect. Since the last report, one further GP practice has opted to activate Optimise Rx following their change to an "Optimise Rx eligible" prescribing system.

Practice Prescribing Support - Pharmacists (PSP) and Technicians (PST)

Practice prescribing support continues to be provided by both pharmacists and an expanding team of qualified pharmacy technicians (which we are gradually increasing to provide greater coverage) Current concern has been raised due to the recruitment of some of our PSPs by GP practices, taking on the role of Clinical Pharmacists. This will create short-term gaps in our support coverage. A recruitment process has occurred recently to recruit replacement PSPs and expand the number of PSTs, who are instrumental for the savings plan to be realised. The newly recruited staff are expected to commence in January 2020.

Prescribing Support Dietitians

Our Prescribing Support Dietitians continue to work with GP practices to support them with the appropriate prescribing of nutrition related products as well as 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.

The Dietitians are part of the Gloucestershire NHS Community Dietitian's Network, a collaboration of the 6 dietitians working across GHC and GCCG. The network recently hosted an educational event for 50 nurses working in GP practices and community nursing teams in Gloucestershire. This was the first event of its kind in Gloucestershire and Professor Jane Melton, Professional Lead for Allied Health Professionals- One Gloucestershire Integrated Care System gave the opening address and described the event as 'a fabulous, pioneering and visionary training day…… a great example of actions taken to ensure the best, holistic care and collaborative nutritional practice'. The feedback from the event showed that that all attendees increased their confidence in providing nutrition and dietary advice to their service users, and would increase the frequency that they do this.

Quality Report

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, as per previous report.

Clinical Pharmacists

Independent prescribing clinical pharmacists working in Gloucestershire GP practices are helping reduce GPs' medication and prescribing pressures, as well as undertaking polypharmacy reviews and de-prescribing in frailty. These are key areas of focus this year.

Community Onset C.Difficile infections

In 2019/20 (up to 31st Oct) 75% 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.

Quality Report

Seasonal Influenza 2019/20

Countywide Flu Planning Group

The weekly Public Health England influenza report for the South West, as of 28th November indicates that the currently confirmed influenza activity is very low and similar to that across England.
The planned weekly multiagency telecoms (CCG, GCC Public Health, GHFT, GCS and 2gether) will be restarted to share real-time information and actions on vaccination rates, flu fighting infection control and managing outbreaks once activity levels increase.

Vaccination for high-risk groups

Vaccination levels for 65year olds and above is approximately on target for this stage in the programme. However, due to the delay in the availability of the quadrivalent vaccine for 'at risk' adult's 18-64 years, the current vaccination rate is low when compared to this time in last year's programme.

Availability of live influenza vaccines

There has been a national delay in receiving stocks of the live attenuated quadrivalent influenza vaccine (LAIV), given as a nasal spray, to children aged 2 to 17 in an eligible group. Those in 'at risk' groups are being prioritised and the schedule of school visits is being revised to take place as soon as possible

Minimising the Impact of Outbreaks

The Point of Care Testing (PoCT) in Care Homes is available seven days a week. Within this service, the GHCNHSFT 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.

Norovirus

Gloucestershire Integrated Care System is experiencing an increase in incidence of norovirus. The current level is much higher than the same time last year. This situation is putting the whole system under pressure, at this already busy time of the year. Care homes have been alerted through a letter, from CCG Director of Nursing and Gloucestershire Director of Public Health. The letter also provides some basic care advice and signposting to the Public Health England Norovirus tool kit.

System wide outbreak control meetings are regularly taking place led by GHNHSFT Director of Nursing. Weekly infectious intestinal disease activity data is received, which contribute to the understanding of the infection outbreak. This situation is further adding to the pressures currently being experienced by our emergency services ,emergency departments care homes and education services.

Quality Report

Primary Care Education

The Gloucestershire Primary Care Training Hub continues to embed and support project streams for training and development in primary care. A new website funded through the CCG called the Gloucestershire Primary Care Workforce Website has been developed and accessible at https://glosprimarycare.co.uk

GCCG delivered immunisation update sessions for Practice Nurses and Health Care Assistants in September/October 2019. The updates were received excellent feedback. New dates for 2020 are being finalised for March, May and September and will include travel health updates. The annual Non-Medical Prescribing update on the 18th March 2020 is available for Nurses, Pharmacists and Primary Care Health Care professionals within the Multi-Disciplinary Team. The Advanced & Community Workforce Development course allocations (total 17) for 2019/20 have been successfully filled and reviewed by the Clinical and Development Matron across each locality. There are 8 places remaining for the Non-Medical Prescribing Course.

To support workforce planning, training skills and assessment data is currently being collated from each practice by the GDoc coordinators. The Clinical Learning and Development Matron has been visiting Practice Managers to review how recruitment is progressing, what supports those in practice and, considering what opportunities are available for those considering retirement. New starters to Practice Nursing are being supported with their induction and training by the GDoc coordinators. The benefits of this support means that the training and educational needs are individualised.

Practices can access the parachute nursing service directly via GDoc and a report on where they have been required to work is reviewed monthly by the Clinical Learning and Development Matron and GDoc Lead Nurse.

As a result of the Matron's work with practices we now have 10 practices hosting student nurse placements as of February 2020, whereas we only had 1 last year. We have also identified 6 HCA's who would like to undertake the Nursing Associate programme.

NHS
Gloucestershire
Clinical Commissioning Group

Primary Care Commissioning Committee

Meeting Date	**19th December 2019**
Report Title	**Delegated Primary Care Financial Report**
Executive Summary	At the end of November 2019, the CCG's delegated primary care co-commissioning budgets show a £175k year to date underspend and a forecast an under spend of £278k for the year.
Risk Issues: Original Risk (CxL) Residual Risk (CxL)	None
Management of Conflicts of Interest	None
Financial Impact	The current position and forecast has been included within the CCG's overall financial position.
Legal Issues (including NHS Constitution)	None
Impact on Health Inequalities	None
Impact on Equality and Diversity	None
Impact on Sustainable Development	None
Patient and Public Involvement	None
Recommendation	The PCCC is asked to • note the content of this report.
Author	Andrew Beard
Designation	Deputy Chief Finance Officer
Sponsoring Director (if not author)	Cath Leech Chief Finance Officer

Primary Care Commissioning Committee - December 2019

Delegated Primary Care Commissioning financial report as at 30th November 2019

1 Introduction

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

2 Financial Position

2.1 The financial position at 30th November 2019 of the delegated primary care budget is a year to date under spend of £175k.

2.2 This underspend partly relates to rent where the levels of increase in rent have not met those expected when rent budgets were set, thus leading to a year end forecast underspend of £114k.

There is also a £111k one off gain in 2019/20 in relation to an over accrual on QOF Achievement, a £92k underspend expected in relation to Additional Roles Reimbursement for the PCN DES and an under spend of £67k is also expected in relation to Seniority, which has had lower than anticipated spend so far this year.

2.3 There are pressures within the budgets, as well as the possible savings noted above. The most significant of these relates to dispensing and prescribing, which is currently forecast to overspend by £105k. This is currently based on figures from August and September due to the delay in national data being received in this area.

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 still suggest that the CCG will stay within budget, but there have been a higher than expected number of claims in the last month, and if this continues, this would result in an overspend position.

- 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%. Annual growth in April 19 was 1.38% and 1.32% in July, though this did come down in October to just 1.20%
- Whilst a forecast under spend has been reported against the Additional Roles Reimbursement, it is understood that there is a possibility that underspends in this area may be at risk of being reclaimed by NHS England. There is no definitive guidance as yet to confirm this, but NHS England are believed to be considering it as an option.

2.5 The CCG is currently forecasting an overspend position against delegated budgets (£278k) in 2019/20.

3 Recommendation(s)

3.1 The PCCC are asked to:

Note the contents of the paper

NHS
Gloucestershire
Clinical Commissioning Group

Gloucestershire CCG

2019/20 Delegated Primary Care Co-Commissioning Budget

Nov-19

	Area	2019/20 Total Budget	In Month Budget	In Month Actual	In Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	Forecast Variance
		£	£	£	£	£	£	£	£
SPEND	Contract Payments - GMS	52,627,478	4,385,557	4,383,035	(2,522)	35,084,590	34,812,101	(272,489)	0
	Contract Payments - PMS	3,166,111	263,841	268,902	5,061	2,110,731	2,145,171	34,440	
	Contract Payments - APMS	2,120,964	176,746	241,282	64,536	1,413,973	1,940,857	526,884	(0)
	Enhanced Services	2,178,680	201,344	263,947	62,603	1,372,145	1,427,492	55,347	(0)
	Other GP Services	3,007,221	2,215	(48,493)	(50,709)	2,003,937	1,747,894	(256,044)	(67,000)
	Premises	8,703,966	725,175	719,185	(5,990)	5,801,722	5,740,293	(61,429)	(114,000)
	Dispensing/Prescribing	3,510,880	340,823	287,759	(53,064)	2,372,092	2,354,888	(17,205)	105,920
	QOF	8,958,115	746,429	735,618	(10,811)	5,971,594	5,797,468	(174,126)	(111,326)
	PCN	1,986,715	188,810	132,628	(56,182)	1,230,942	1,220,530	(10,412)	(92,000)
	TOTAL	**86,260,130**	**7,030,940**	**6,983,863**	**(47,077)**	**57,361,727**	**57,186,692**	**(175,034)**	**-278,407**
	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
>Seniority
>Doctors Retainer Scheme
>Locum/adoption/maternity/paternity payments
>Other General Supplies and Services