NHS Gloucestershire Clinical Commissioning Group

Primary Care Commissioning Committee (PCCC)

Held in Public at 9.45am on Thursday 20th February 2020 in the Board Room, Sanger House, Brockworth, Gloucester GL3 4FE

No.	Item	Lead	Recommendation
1.	Apologies for Absence *Mary Hutton*	Chair	Information
2.	Declarations of Interest	Chair	Information
3.	Minutes of the Meeting held on 19th December 2019	Chair	Approval
4.	Matters Arising	Chair	Discussion
5.	Health Professionals in Primary Care Conference (presentation)	Helen Goodey	Information
6.	PCN Specifications (verbal)	Helen Goodey	Information
7.	NHS Operational Planning and Contracting Guidance 2020/21 (presentation)	Helen Goodey	Information
8.	Population Health Management (PHM) (presentation)	Chris Roche	Information
9.	Primary Care Quality Report	Marion Andrews-Evans	Information
10.	Primary Care Delegated Financial Report	Cath Leech	Information
11.	Any Other Business	Chair	
Date and time of next meeting: Thursday 23rd April 2020 at 9:45am in the Board Room at Sanger House.			

NHS Gloucestershire Clinical Commissioning Group

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Primary Care Commissioning Committee

(meeting held in public)

Minutes of the meeting held at 9.45 am on 19th December 2019

Boardroom, Sanger House

Present:		
Alan Elkin (Chair)	AE	Lay Member, Patient and Public Engagement
Colin Greaves	CG	Lay Member, Governance
Peter Marriner	PM	Lay Member, Business
Andrew Beard *(deputising for Cath Leech)*	AB	Deputy CFO
Mark Walkingshaw	MW	Director of Commissioning Implementation / Deputy AO
Marion Andrews-Evans	MAE	Executive Nurse and Quality Lead
In Attendance:		
Lauren Peachey	LP	Governance Manager (minutes)
Christina Gradowski	CGi	Associate Director of Corporate Governance
Andrew Hughes	AH	Associate Director, Commissioning
Helen Goodey	HG	Director of Locality Development and Primary Care
Declan McLaughlin *(Item 5)*	DMc	Senior Primary Care Project Manager
Jo White	JWh	Programme Director, Primary Care
Jeanette Giles	JG	Head of Primary Care Contracting
Stephen Rudd	SR	Head of Locality and Primary Care Development

Andrew Malley (Item 5)	AM	Director, Dransfield Property Limited
Dr Rachel Rutter (Item 5)	RR	GP, Stroud Valleys Family Practice
Dr Ewart Lewis (Item 5)	EL	GP, Locking Hill Surgery

1.	**Apologies**
1.1	Apologies were received from Mary Hutton, Cath Leech, Dr Andy Seymour, Julie Clatworthy and Jo Davies.
1.2	It was confirmed that the meeting was quorate. AE explained the format of the meeting to the visitors.
2.	**Declarations of Interest**
2.1	There were no declarations of interest raised.
3.	**Minutes of the Meeting held on 10th October 2019**
3.1	The minutes of the meeting held on 10th October 2019 were approved as an accurate record of the meeting subject to the following amendments being made: • Helen Goodey to be recorded as 'In attendance'; • Helen Edwards to be removed from 'Apologies'; • Item 5.12: to read 'The committee members recommended that the Primary Care Strategy (PCS) was taken to the Governing Body for approval'; • Item 7.12: to read 'The committee approved the business case for the new premises for Minchinhampton Surgery'.
4.	**Matters Arising**
4.1	**31/10/2019, Item 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. ***Update 3/12/2019***: Haydn Jones, Associate Director of Business Intelligence at the GCCG, confirmed that the IM&T

	costs were not reimbursable from NHS England. CG noted that funding would have previously been received for one-off IM&T costs and AB confirmed that this funding had ceased. ***Item to be closed***
5.	**<u>Business Case: New Premises Proposal for Primary Care Development in Stroud</u>**
5.1	DMc introduced Andrew Malley, Dr Rachel Rutter from Stroud Valleys Family Practice and Dr Ewart Lewis from Locking Hill Surgery. The full business case for the new premises proposal for primary care development in Stroud and the report on this business case was taken as read. The business case described: • the case for change, objectives, financial implications and a timeline for the establishment of a new Primary Care Centre in Stroud; • the timeline explained that the building was expected to be open in the Summer of 2021; • the proposal included the relocation of two practices in Stroud to the new development. These practices were 'Stroud Valleys Practice' and 'Locking Hill Surgery'.
5.2	It was highlighted that both Stroud Valleys Practice and Locking Hill were both in physically small practice premises that were considered no longer fit for purpose. These practices had been identified as a high priority for developments within previous Primary Care Estates and Infrastructure reports.
5.3	RR highlighted that both practices formed part of the Severn Health Primary Care Network (PCN). Locking Hill Surgery provided business management support and administered the PCN funds. RR highlighted that partners of both practices had recognised the value of working closely with each other and sharing skills and office functions. RR emphasised that the development of the proposed premises

	would support skill sharing and enhancing office functions.
5.4	EL highlighted that patient engagement exercises with both practices had proven to be very positive and the patients involved had expressed support for the proposed changes. It was made clear that patients had recognised that the current premises had physical limitations and the patients would benefit from improved premises.
5.5	RR stated that the proposed new premises would address a number of the current challenges faced by both practices, and meet future ambitions in line with local health priorities and the NHS Long Term Plan (LTP). EL explained that the proposed new premises would facilitate joint working, reduce duplication in how care was provided and enable shared clinical expertise between the practices. RR explained that this would support efficiency in some of the services which were both currently being offered separately such as care home visits, frailty care, and staff training.
5.6	Joint Protected Learning Time (PLT) meetings were currently being held between the practices. Furthermore, the clinical systems were due to be migrated onto the same system. In addition to this, the practices were also exploring shared GP management software. RR highlighted that the additional space in the proposed new premises, would further support working with the wider healthcare professionals such as social prescribers, pharmacists, and physiotherapists. EL noted that there was a mutual ambition between the two practices to increase medical student placement opportunities at the practices which had not been possible at either of the existing practices' premises. RR noted that the proposed premises included a shared teaching space.
5.7	AE thanked EL and RR for the presentation and noted that the full business case had been received and read by the committee members.
5.8	HG acknowledged the benefits for the proposed premises and emphasised that the need for premises development had been understood for some time. HG noted that the proposed developments supported new ways of working

	and practice resilience.
5.9	AE noted that, in addition to the growth of the population, the demands of the population were changing. AE emphasised that Primary Healthcare needed to continue to develop effective ways of working with the population.
5.10	CG commended the business case and stated that in terms of quality it was an exemplar. With regards to the District Valuers (DV) report and value for money CG stated that it was a strong case, however, queried the affordability of it within the current economic environment. AB advised that the costs had been incorporated into the Five Year Forward Plan and were, therefore, factored into the financial forecasts. CG asked if one-off IM&T costs had been included and AB responded that they had been. AH cautioned that the probability of development costs increasing over time was important.
5.11	DMc emphasised that the service delivery model would be put at risk if primary care premises were underdeveloped.
5.12	HG explained that historically there had been more single practice sites but there was now more commitment with exploring multi-practice sites to support efficiency and enable a more sustainable way of working. HG emphasised that, to support sustainable working and build resilience, practices needed to be supported to work closely together. HG emphasised that there had been well-known underdevelopment in primary care services. HG added that primary care services had been experiencing significant challenges and it was necessary to encourage GP practices to work in a more joined-up and sustainable way.
5.13	AE highlighted the importance of maintaining engagement with the public and ensuring they understood the benefits brought by changes in Primary Care. HG concurred and added that the engagement of practices with Patient Participation Groups (PPG) had been positive. Members acknowledged that effective communication removed uncertainty and clarified to the public, the new ways of organising health services.

5.14	CGi stated that the business case brought before members had also been presented before the Primary Care Operational Group (PCOG) and had received support from that group. It was noted that additional fees regarding one-off Information Management and Technology (IM&T) costs would not be funded by NHSE and were, therefore, factored into the costs outlined in the Business Case.
5.15	AM, RR and EL left the meeting at 10:10 am
5.21	**Resolution: The committee acknowledged the recommendation from PCOG and approved the business case for the development of a new facility for Locking Hill and Stroud Valley Family Practice, and the financial implications relating to the proposal.**
6.	**Primary Care Networks: Audit Report and Development Update**
6.1	SR gave a presentation on the Primary Care Networks: Audit Report and Development Update and summarised the results of the October/November 2019 audit report.
6.2	SR stated that substantial assurance had been received from the audit. The audit commended the strong project management and robust processes put in place to manage primary care commissioning. HG added that she was pleased with such an excellent report.
6.3	SR updated the committee members on developments in the PCNs. SR stated that the PCNs were experiencing challenges concerning employment models, Value Added Tax (VAT), liabilities and risks. There was also a significant challenge with regards to recruitment and retention of staff in these roles. SR explained that, over the next five years, PCNs would be part funded to recruit into five Additional Reimbursable Roles (ARRs) to include social prescribing link workers, clinical pharmacists, first contact physiotherapists, physician associates, and community paramedics. SR emphasised that these roles were expected to play a vital role in enabling the PCNs to fulfil their functions detailed in the service specifications, and provide additional practice resilience.

6.4	In addition to the aforementioned challenges, SR explained that some of the ARRs were 70% reimbursable and therefore there were further challenges associated with PCNs funding the additional 30% of the costs of these roles. The social prescribing link worker was the only role reimbursable by 100%.
6.5	SR presented before the committee the aggregated new potential funding which would be received based on full recruitment and the gap in funding per year by role. SR explained that the 30% gap in funding for Gloucestershire equated to just over £6million over five years. SR added that in addition to the 30% of costs required to fund the roles, there would be further cost implications in providing management support for the additional roles.
6.6	A statistical tool developed by SR, to be used as a calculator to support PCN modelling was presented to the committee. SR advised that this had been presented to the Clinical Directors and circulated to each PCN in Gloucestershire. HG commended the calculator as a useful tool which clearly showed the user the value of funding that would be required.
6.7	SR stated that there were some PCNs in Gloucestershire which had not yet recruited into any of the ARRs. SR explained that this had resulted in under-spend and NHSE had advised that this could be used to fund further recruitment for the PCNs who had already begun recruitment of the ARRs.
6.8	Members discussed various ways of closing the 30% funding gap. HG emphasised the challenges that SR had outlined and noted there was an expectation from NHSE that underspend relating to practice vacancy would be used to fund the 30% gap. MAE explained that for this reason the main areas of the country that would benefit the most from the ARRs were the areas that had not been able to recruit GPs. It was emphasised that there had been a number of successful initiatives in Gloucestershire to recruit GPs. AE raised concern that GP practices were small businesses and would find it challenging to identify the funding for the additional 30% of costs. HG noted that there had been a net

	reduction in investment into Primary Care.
6.9	In terms of PCN development, there were challenges which SR and HG explained. SR stated that NHSE had made available a maturity matrix which SR had used to develop a local 'roadmap' which highlighted the PCN elements which were contractual and non-contractual elements of PCNs. The 'roadmap' had been circulated to all PCNs in Gloucestershire and had been well received. All PCNs had utilised the 'roadmap' and it was noted that they had all met the contractual elements. The additional elements were compiled from best practice from other PCNs, locally and nationally, for example, appointing a business manager. The 'roadmap' prompted the PCNs to identify the next steps which they would take to achieve the elements specified.
6.10	SR reiterated that within the allocation from NHSE there was funding allocated for Clinical Director development.
6.11	AE commended the quality of work of the CCG Localities and Primary Care team. With regards to the challenges concerning workforce development, AE advised that care needed to be taken when recruiting into new roles to avoid destabilising other parts of the system and NHS services.
6.12	HG stated that recruitment of first contact physiotherapists had previously been a concern and very few Gloucestershire GP practices had advised that they were planning to recruit first contact physiotherapists as part of the ARRs. HG added that there was joined-up work with GHFT and GHC regarding the recruitment of the first contact physiotherapists. HG cautioned that the gap in funding could be higher than 30% following management costs and inflationary costs.
6.13	HG explained that the NHSE Wave pharmacists could form part of the clinical pharmacists ARR and there was a process in place to structure this. SR advised that the deadline for this process had been agreed for March 2020. In terms of the social prescribing link workers, HG stated that Gloucestershire PCNs were engaging with the current providers of social prescribing in the county and had been investigating the recruitment of senior social prescribing roles to enhance the existing service offered. HG

	emphasised that there was joined-up working in this area. JW highlighted that the additional roles would be needed in order to deliver the service specifications. HG added that sustainability in Primary Care was extremely challenged.
6.14	CG applauded the outstanding Primary Care audit report and noted that Gloucestershire was driving this work nationally. CG stated that there was a flaw in the approach around the funding for the ARRs. CG expressed the view that caution should be taken with regards to pursuing the funding that was being offered by NHSE since it came with cost implications for PCNs. CG observed that the PCNs were going to be attracted to the 70% funding but were going to experience challenges in funding the additional 30% to subsidise the ARRs. AE reiterated that without the ARRs it may not be possible to meet the service specifications which had been outlined in government plans.
6.15	HG emphasised that further consideration was required to address areas of inequality that could grow between the PCNs. HG clarified that funding arrangements could result in some PCNs being slow to recruit because they lacked the supplementary funding. CG reiterated that the funding arrangements were of concern and the inequity of the arrangements needed to be made clear to NHSE.
6.16	HG highlighted how the development of the PCNs had created opportunities to explore closer ways of working in Primary Care. Clinical Directors were succeeding in the role of driving the development of PCNs. HG stated that single practice PCNs were better prepared to manage the gap in funding from the ARRs.
6.17	HG explained that the new additional roles would not compensate for maintaining a strong GP workforce. Furthermore, the new personnel needed their time to be appropriately mentored as many of them would not have had the experience of working in Primary Care. MAE agreed and explained the benefit of encouraging an increase in healthcare students being able to obtain work experience in Primary Care. MAE added that without work experience in Primary Care, the induction time required would need to be extended. DMc agreed and further added that some of the

	ARRs required specific equipment and physical space for their roles
6.18	CG stated that the ARR was a national initiative which did not coordinate with the strategy which Gloucestershire had adopted. Fully staffed practices would find the roles less attractive compared to GP practices which had not been able to recruit GPs. HG stated however that she felt that Gloucestershire Primary Care would benefit from the additional investment.
6.19	MAE informed the committee that registered clinical pharmacists had traditionally undertaken a year of work experience in secondary care prior to receiving their registration. This year work experience had begun to take place in Primary Care which was a positive move. MAE stated that physiotherapist training had begun at Gloucestershire University in September 2019 and arrangements with the University had been made to enable trainee physiotherapists to gain experience in Primary Care.
6.20	HG stated that Primary Care in Gloucestershire had been selected to pilot paramedics with SWASFT as part of a national programme. HG added that this had already been tested locally and had proven to be positive. HG advised that there was a significant change due which would involve the 'Impact Fund' and 'Quality Dashboard' resulting in the performance management of PCNs based on admissions, attendances and prescribing.
6.21	PM enquired as to the local flexibility with regards to recruitment into the ARRs and HG responded that criteria had been nationally mandated.
6.22	HG stated that in addition to the ARR investment there were two pilots due to begin in Gloucestershire which involved two PCNs amalgamating their nursing teams into one team based on skill mix.
6.23	**Resolution: The committee noted the Audit Report and Development Update (presentation)**
7.	**<u>Primary Care Quality Report</u>**

7.1	The report was taken as read and MAE highlighted the key points to the committee members. MAE informed the committee that under the NICE Technology Appraisals (NICE TA) there had been guidance released around the prescribing of Rivaroxaban which had implications for spend and budget. MAE stated that information needed to be issued to GPs promptly in order to maximise its value.
7.2	With regards to clinical effectiveness, MAE advised the committee that there had been many discussions concerning prescriptions of Over the Counter (OTC) medicines and explained that the GCCG target had been set at a 50% reduction of prescribing OTC medicines. To date, approximately 25% reduction had been achieved in the county. MAE explained that although this was less than GCCG had hoped for it was important to note that Gloucestershire was the best performing county in the country against this measure.
7.3	MAE informed the committee that the new arrangements for safeguarding were beginning to be well embedded and from 1st January 2020 MAE would be taking over as chair of the Safeguarding Executive Group. The Safeguarding Executive Group had been holding discussions with regards to funding arrangements.
7.4	MAE explained that the Care Quality Commission (CQC) inspections were ongoing and the CQC ratings for GP practices in Gloucestershire had remained steady. Each practice had maintained their grade. There had been new arrangements put in place which involved changes around the required evidence and carrying out follow up phone calls.
7.5	MAE explained that the GCCG did not handle Primary Care complaints as a responsibility and thus the complaints received by the GCCG Patient Advice and Liaison Service (PALS) were not primary care related although NHSE were making some information available
7.6	MAE stated that the GCCG Patient Experience and Engagement Team had been involved in engagement activities across all localities and programme areas across the ICS. MAE further stated that there had been a review of

	the phlebotomy service across the county. MAE explained that the service processes across the county were varied and also stated that the PPG Network had met several times over recent months and had been well attended.
7.7	MAE outlined the prescribing initiatives taking place across Gloucestershire. MAE stated that despite such initiatives GCCG was experiencing significant challenges in meeting savings targets. The GCCG Medicines Optimisation Team had been exploring options for new prescribing initiatives. MAE informed the committee that there was pilot work with a specialist nurse which had been due to start around patients in the community who were using catheters.
7.8	MAE highlighted that the increased utilisation of Prescribing Support Pharmacists (PSPs) and Prescribing Support Technicians (PSTs) was expected to support savings within prescribing. Many PSPs had been securing posts as Clinical Pharmacists within Primary Care which had resulted in a workforce gap in this area. It was anticipated that there was going to be 28 vacancies by January 2020. There had been a switch from PSP posts to PST posts, to be supervised by the PSPs, and MAE explained that this was a more economic model.
7.9	MAE updated members that the Vitamin B12 prescribing guidelines had been approved and would be circulated to the committee for information in due course.
7.10	Regarding seasonal influenza, MAE presented comparative data which demonstrated that Gloucestershire had low rates of influenza compared to other areas in the country despite the slight increase in influenza being reported. MAE stated that there was an increase in 'influenza b', which was a less common strain of influenza. MAE explained that this strain more commonly affect children. MAE highlighted that three schools had been closed temporarily with suspected influenza and these were all in the Stroud locality.
7.11	MAE emphasised that the Stroud locality had the lowest uptake of influenza vaccinations; however, this year had seen an improvement of uptake from previous years. MAE informed the committee members that data around vaccination levels for 65-year-olds and over, in Primary

	Care, had recently been received and showed that activity was approximately on target. MAE advised the committee members that children's vaccinations had been delayed this season, and she reassured members that the delay was the result of ensuring that a more precise vaccine was made available.
7.12	MAE stated that there had been a significant increase in Norovirus in the county and this had resulted in a number of wards being temporarily closed at GHFT.
7.13	In terms of Primary Care education MAE informed the committee members that NHSE had provided £10,000 to take forward the 'Ten Point Plan' for practice nurse development. MAE emphasised that NHSE were keen to develop practice nurse leaders; therefore there was a good chance of getting additional funding to support this. MAE was pleased to inform the committee members that student nurses and Advanced Nurse Practitioners (ANPs) were to receive a £5,000 grant from September 2020. MAE advised that UCAS applications for the next intake had not yet closed. MAE stated that 13 practices had committed to taking on student nurses and explained that this was a significant increase on the previous year.
7.14	CG expressed concern that the issue around phlebotomy had been discussed previously but had not appeared to have progressed. MW acknowledged the concern and advised that a solution to progress the issue had been identified. MW explained that a working group had been set up to review the phlebotomy services and explore the options. The recommendation which had been identified from the review included the establishment of clear commissioning of the phlebotomy services across Primary Care. Discussions on the services were being progressed with the Local Medical Council.
7.15	The committee members held an in-depth discussion with regards to the cleaning standards at GHFT and MAE noted that this had been discussed at length at the December 2019 Quality and Governance Committee.
8	**<u>Primary Care Delegated Financial Report</u>**

8.1	The report was taken as read and AB stated that much of the information included had been discussed during the committee meeting.
8.2	AB briefed that, in terms of the primary care budget, at the end of month eight (November 2019), there was a year-to-date under-spend of £175,000. The forecast for the full year was a £278,000 under-spend.
8.3	AB stated that there had been an increase in sickness and maternity claims, and that part of this increase was due to backdated claims being submitted which could be submitted without prior knowledge. AB also stated that there was a further risk around the growth of list sizes which was high in the first two quarters of the year and had reduced in the recent quarter. In terms of the ARRs, a forecast under-spend was forecasted, however, AB explained that it was a possibility that the ARR under-spend would be reclaimed by NHSE.
8.4	AB stated that the draft budget for 2020/21 would be taken to PCCC in February 2020. AB further explained that PCCC could be required to recommend the final budget for approval at the Governing Body to take place in March 2020. It was agreed that an extraordinary PCCC would take place during March to review the budget.
8.5	**ACTION: Draft budgets to come to PCCC in February 2020. AB**
8.6	**ACTION: Extraordinary PCCC to be arranged during March 2020 prior to the Governing Body.**
8.7	**RESOLUTION: The committee noted the contents of the Primary Care Delegated Financial Report**
9.	**<u>Any Other Business</u>**
9.1	There was no other business raised.
	The meeting closed at 11:35
10.	**<u>Date and time of next meeting</u>**
	The next PCCC will be held on Thursday 20th February

	2020 at 9.45 am in the Board Room, Sanger House.

NHS Gloucestershire Clinical Commissioning Group

Agenda Item 4

Primary Care Commissioning Committee (PCCC)
Matters Arising – February 2020

Reference	Item	Description	Action with	Due Date	Status
27/06/2019 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	***ACTION: Fiona Robertson (FR) and Paul Atkinson (PA) to arrange a demonstration of clinical systems for PCCC members to be held as a workshop.***	PA/FR	February 2020	Open
19/12/2019	Primary Care Budget – draft	***ACTION: Draft budget to go to the February PCCC*** ***Update 10/02/2020:*** *The draft budget will no longer be going to PCCC in February. The final budget will be approved prior to the Governing Body 26th March 2020*	CL/Andrew Beard (AB)	February 2020	Open
19/12/2019	Primary Care Budget - Final	AB informed the committee that the final Primary Care budget will be taken to Governing Body at the end of March 2020. ***ACTION: The final budget to be approved virtually or at an Extraordinary session Prior to the March Governing Body in 2020. All.***	All	March 2020	Open

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GLOUCESTERSHIRE PRIMARY CARE TRAINING HUB

Health Professionals in Primary Care Conference

30th January 2020, Bowden Hall

5

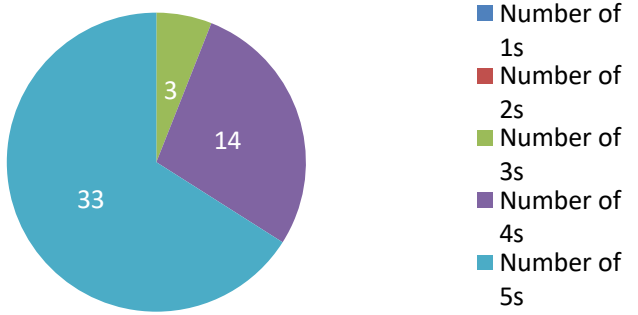
Objectives of the Conference

- The intention of the Health Professionals in Primary Care Conference was to showcase the new roles in primary care and to demonstrate the value they bring to general practice. The conference also provided an opportunity for health professionals to develop links and network as well as provide peer support.
- The conference began with presentations from: clinical pharmacists, physiotherapists, paramedics, physicians' associates and social prescribers. The presentations would cover what work these new roles take on and the positive impact they have on GPs.
- Following these presentations the attendees took part in various workshops which covered topics such as: employment law for PCNs, discussing how to support inductions and peer support sessions for the new roles.

Clinical Pharmacist Presentations

- The initial presentations of the conference were regarding clinical pharmacists and were delivered by Andrew Kings, a clinical pharmacists in Cheltenham Central, and Dr Hein Le Roux, a GP in NSG.
- Andrew Kings discussed clinical pharmacy from a first hand experience. He discussed how to be come a clinical pharmacist, what a typical day consisted of and what the successes and challenges had been so far.
- Dr Hein Le Roux, in comparison, presented from the perspective of a GP. He highlighted the workload that had been taken off GPs in his PCN, such as repeat prescribing and discharge summaries, which had freed up time for GPs to complete other work.
- These presentations were very well received, with attendees giving an average score of 4.6 out of 5.

Breakdown of Clinical Pharmacist scores:



"All very relevant informative, well presented. Structure to allied GP very useful to know/understand benefits. Great to hear about other roles and when they have been successful."

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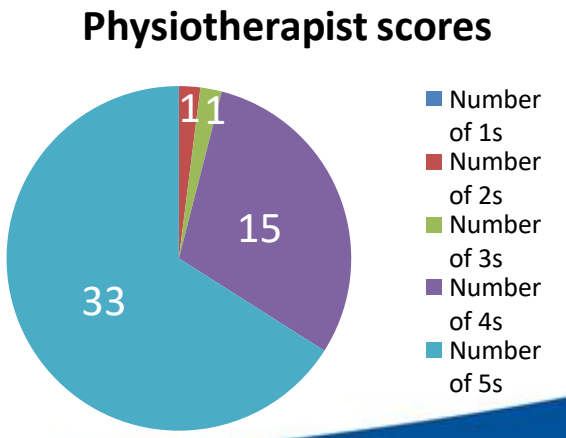
Physiotherapist Presentations

- The second round of presentations were regarding physiotherapists and were delivered by Kathryn Ker, an advanced physiotherapist in St Pauls, and Richard Bull, the operational director for St Pauls.
- Kathryn Ker discussed the workload, and what a typical day consisted of, for a physiotherapist in general practice. This included 20 minute appointments which involved assessment, diagnosis and then either onward or self-referral. Physiotherapists also completed data templates and outcome data for each patient seen.
- Richard Bull presented from the practice's perspective. He explained the use of innovation funding in the PCN to employ physiotherapists as this would save GP time, improve pathway for patients and improve the skill mix in the practice.
- Feedback for these presentations was also very positive with attendees scoring it an average of 4.6 out of 5.

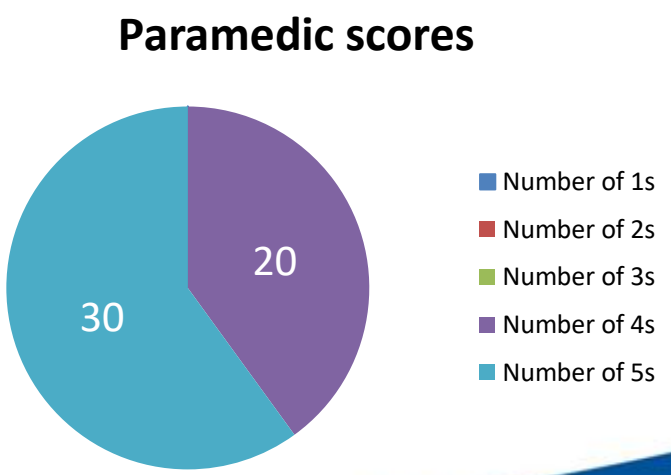
"The physiotherapy talk was excellent, great to share across PCNs"



Advanced Paramedic Presentations

- The third round of presentations were regarding advanced paramedics. The first presentation was given by Lisa Brindley, a paramedic in RHQ, and the second was presented by Dr Jeremy Welch, the clinical director of TWiNS.
- Lisa Brindley's presentation gave an overview of the home visiting service that she is taking part time, explaining the logistics of the service. She also covered the typical day of a paramedic in general practice. This could consist of home visits, immunisations, blood tests, liaising with other health professionals and general administration.
- Dr Jeremy Welch's presentation was focussed on the home visiting service. It explained how the service functioned, the breakdown of the cases and the reflections of the paramedics and GPs involved.
- The feedback for these presentations was also positive, scoring an average of 4.6 out of 5.

"Helpful overview of the roles and what they do. Exciting to see how they can be part of a team and help GP workload."



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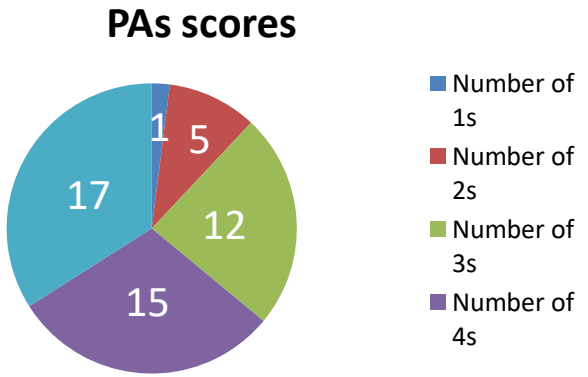
Physician's Associate Presentations

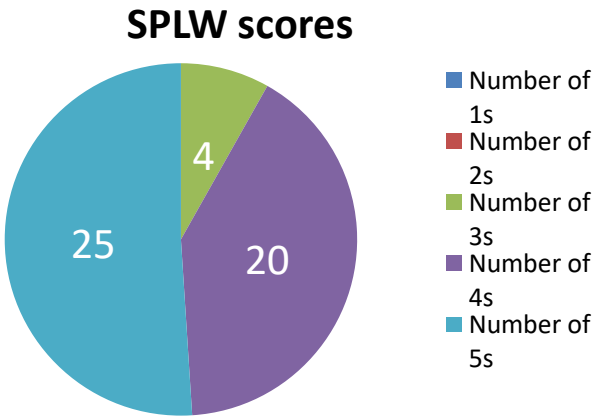
- The fourth round of presentations were regarding physician's associates. The first presentation was given by Dr Sam Kuok, a GP at Aspen, and the second was given by Julian Kingscote, a physician's associates at Aspen.
- Dr Sam Kuok discussed physician's associates in general and covered topics such as: why a PCN would recruit a PA, a typical workday, and some guidance on the role.
- Julian Kingscote discussed his background and journey to becoming a physician's associates. He also discussed the training and induction he received as a newly recruited physician's associates.
- Although feedback on these presentations was positive it had a slightly lower average score of 3.8 out of 5. The main theme of this feedback was confusion over what services a PA could provide.



Social Prescribing Link Worker Presentations

- The final round of presentations were centred on social prescribing link workers. The first presentations was given by Sam Couldrey, a SPLW in TWiNS, and the second presentation was given by Dr Sharon Drewett, a GP in NSG.
- Sam Couldrey discussed the skillset a SPLW has and what it is like to work in a PCN as a SPLW, as well as SPLW typical day in practice.
- Dr Sharon Drewett discussed the role and workload that a SPLW takes on and why a PCN should recruit SPLWs.
- The feedback for these presentations was very positive with an average score of 4.4 out of 5.

"All excellent speakers and interesting content."



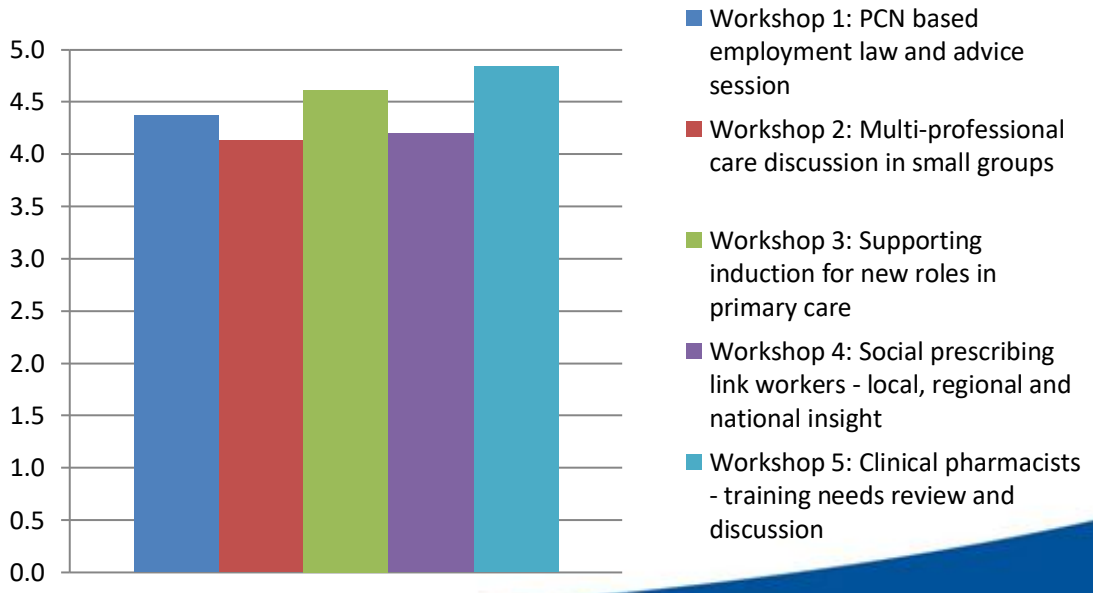
Workshops

- After the presentations the attendees could take part in a number of workshops. The workshops available were:
  - a PCN based employment law and advice session
  - a multi-professional case discussion in small groups
  - a workshop for supporting inductions for new roles in primary care
  - a workshop on SPLWs – local, regional and national Insight
  - a workshop on clinical pharmacists' training needs review and discussion

- Feedback on these workshops was very positive and no workshop averaged a score below 4 out of 5.

"Another very useful meeting, exploring multiple issues of opportunity and concerns"

Average scores for the workshops



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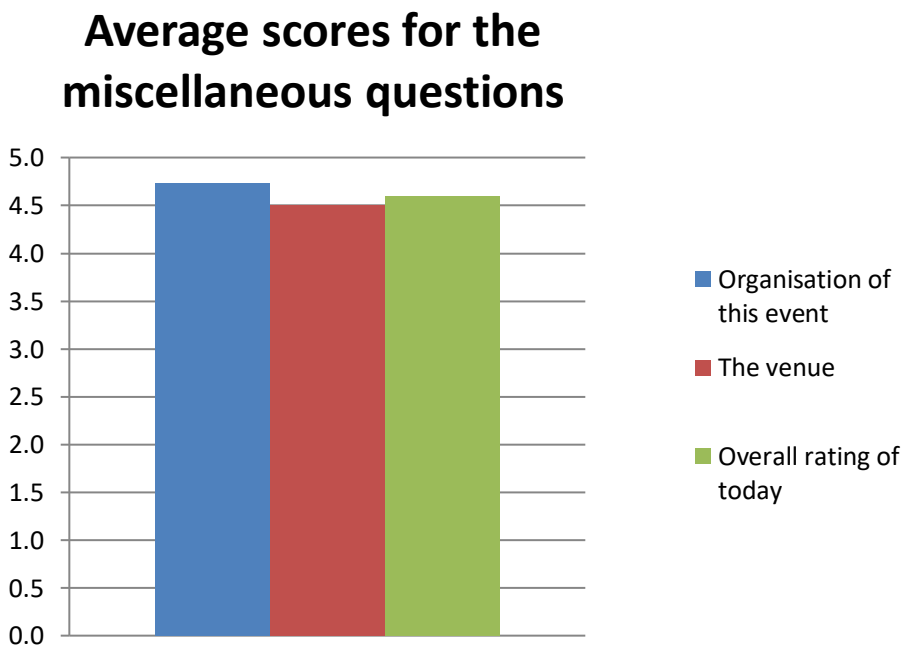
Overall Feedback

- The overall feedback for this conference was very positive, scoring 4.6 out of 5.
- Particular themes that were reoccurring in the comments left was how knowledgeable attendees felt about these additional roles after attending the conference.
- The conference was also praised for offering a chance for health professionals to make new contacts and network with others in the county that they typically wouldn't meet.

"Positive day. Great acknowledgement of the role AHPs can play in primary care. Together we are better."



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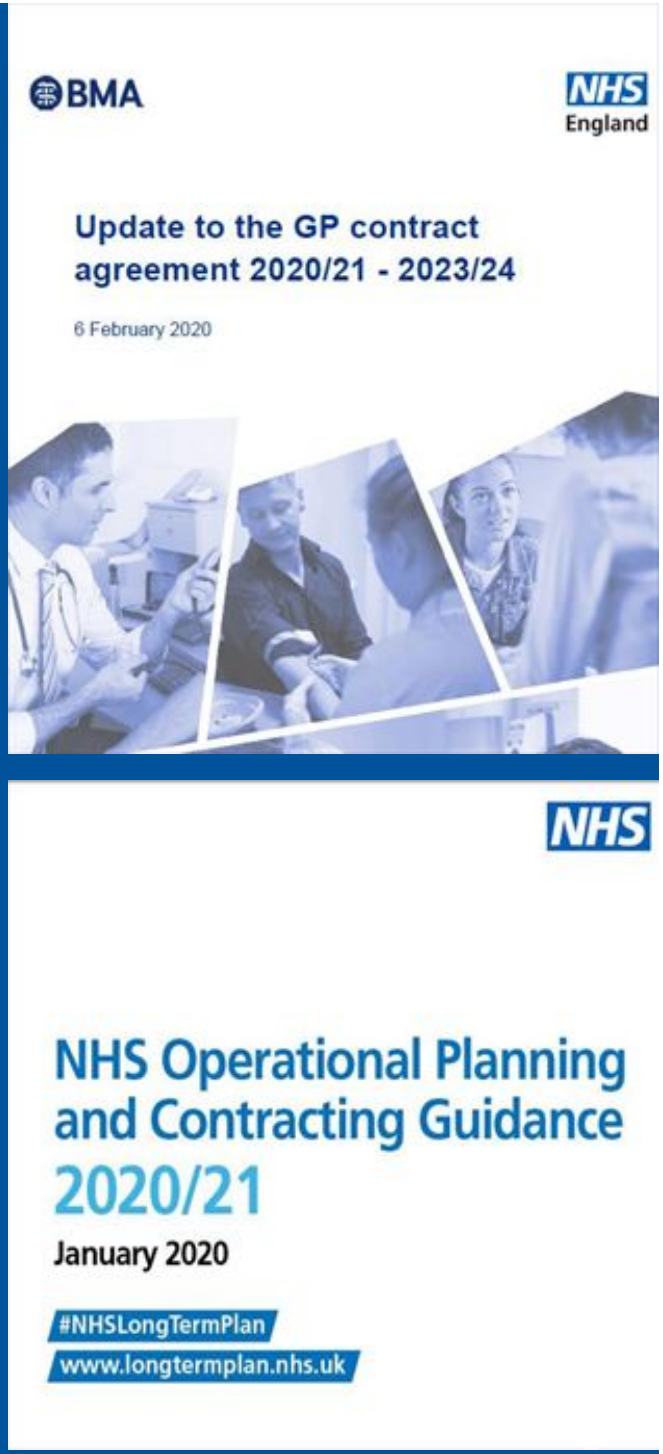
New GP Contract and NHS Operational Planning and Contracting Guidance: Primary Care

Primary Care Commissioning Committee

February 2020



Headlines

- **Additional Roles:** “100% funded”
- **Expanded to 26,000 roles** – “first order priority for NHS”
- **7 new roles added to ARR** – more may follow
- **6,000 more doctors** – through range of measures
- **Specifications** – reduction to three 20/21 (SMR; Care Homes; Cancer) and reduced in scope and scale
- **New to Partnership** £20k payment, plus £3k training
- **V&Is** – now essential service under new payment model
- **QOF** – points increase; asthma/COPD/HF overhaul
- **IIF** – operate similarly to QOF; eight indicators 20/21

Headlines: Financial

- **Practice Contract:** rises by additional £20m in 20/21
- **DES:** rises by £166m (from £552m to £718m) in 20/21 – reflecting increase in ARR scheme
- **ARR:** will be a total national fund of £1.4bn (prev £891m)
- **PCN ARR:** worth c.£340k per PCN 20/21; £1.1m 23/24
- **PLUS PCN funding entitlement:**

Other PCN Funding Streams - Indicative Values (2020/21 onwards)			
Funding Stream	**Paid to**	**Calculated as**	**Total for PCN**
Network Development Fund	PCN	£1.50/reg'd pt	£70,500.00
Clinical Director Funding	PCN	£0.69/reg'd pt	£32,430.00
Extended Hours	PCN	£1.45/reg'd pt	£68,150.00
Improved Access	PCN	£5.75/weighted pt	£270,250.00
Transformation Funding	PCN	£1.89/reg'd pt	£88,830.00
Network Participation Payment	Practices	£1.761/weighted pt	£82,767.00
		Total (non ARR):	**£612,927.00**

Workforce: ARR Scheme

- **Aim:** More appts, deliver specs, sustain general practice, free up £1.50/hd
- **Commits:** Funding continues throughout GP contract (providing sign up to DES); **becomes core cost base from 2024**
- **Roles – expanded from 5 roles to 12 roles:**
  - Clinical Pharmacists (now)
  - Social Prescribing Link Workers (now)
  - Physiotherapists (April 20)
  - Physician Associates (April 20)
  - Pharmacy Technicians (April 20)
  - Health and Wellbeing Coaches (April 20)
  - Care Coordinators (April 20)
  - Occupational Therapists (April 20)
  - Dietitians (April 20)
  - Podiatrists (April 20)
  - Paramedics (April 21)
  - Mental Health Practitioners (April 21)

Workforce: ARR

- Calculator updated
- Available on CCG Live
- All new roles added
- 100% funding (salary + on-costs)
- Indicative

Gloucestershire PCN Funding: Indicative Tool For Planning Purposes: Updated February 2020

Maximum Reimbursable ARR Amount per Financial Year

↓ Enter PCN Population ↓		2020/21	2021/22	2022/23	2023/24
Actual	Weighted				
		£0.00	£0.00	£0.00	£0.00

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)	
Clinical Pharmacist (NHSE transfer)	
Social Prescribing Link Worker	

For any queries about this calculator, please contact Stephen Rudd via the PCN inbox: glccg.pcn@nhs.net ... or click this box

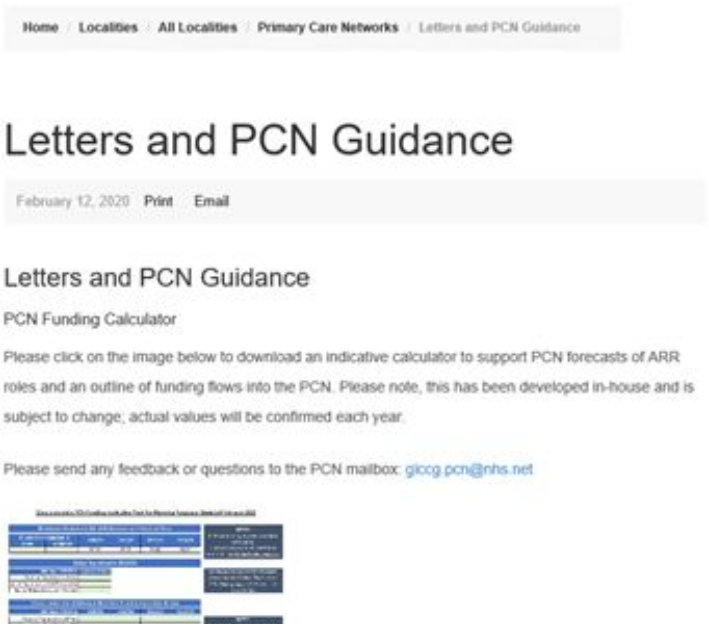
Please Enter the Additional WTE Per Year For Each Role Below

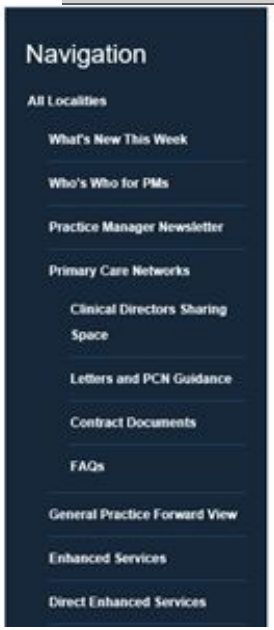
Additional PCN Role	2020/21	2021/22	2022/23	2023/24
Clinical Pharmacist (B7-8a)				
Social Prescribing Link Worker (B5)				
Physiotherapist (B7-8a)				
Physician Associate (B7)				
Paramedic (B7)	N/A			
Pharmacy Technician (B5)				
Occupational Therapists (B7)				
Dietitians (B7)				
Podiatrists (B7)				
Health and Wellbeing Coach (B5)				
Care Coordinator (B4)				
Mental Health Practitioner (TBC)	NHSE TO CONFIRM BANDING - CALC WILL BE UPDATED			

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

National restriction on Pharmacy Technicians for 20/21 & 21/22 for 1 per PCN (2 for PCNs >100,000 patients). Contact Gloucestershire CCG via PCN inbox if wish to recruit more.

Mental Health Practitioner banding TBC. Eligible for claims from 21/22.





Microsoft Excel Worksheet

Workforce: ARR Scheme

- **Plans:**
  - **PCNs to develop 4 year plans to spend 100% of ARR:** firm for 20/21; indicative 21/22 – 23/24, by June 2020;
  - **CCGs to aggregate plans into system-level**; demonstrating how we will spend 100%, offering CCG support with recruitment exercises / facilitating discussion / brokering arrangements and agree them with CDs by July 2020 to submit to NHSE;
  - **Fallback position: CCGs to calculate any underspend** to share with PCNs & LMC by end July 20; opportunity for redistribution to other PCNs; re-run in Oct;

Workforce: Traditional Roles

- From April 2020, **New to Partnership: £20k one-off payment** plus £3k business training (with on-costs, c.£25.5k – initially a loan until c.5 years)
- From April 2020, **£2k for GPs on I&R scheme with children <11 (per child)**
- From 2020/21, **Locum Support Scheme for PCNs:** funded CPD session in exchange for min. number of sessions
- From 2021, **GP trainee numbers increase from 3,500 to 4,000**
- From 2021, all **international med graduates offered 5-yr NHS contract**
- From 2022, **24/36 months of training to be spent in general practice**
- **Targeted Enhanced Recruitment** - £20k to attract GP trainees to under-doctored areas; 276 places 2019 – will rise to 800+ by 2022
- **Two year GP Fellowship** for all newly qualified GPs and nurses; GP trainees auto-enrolled from 2021
- **Mentorship scheme** – offering highly experienced GPs to mentor NQGPs

Specifications – as at 23 December 2019

Network Contract Direct Enhanced Service
Draft Outline Service Specifications

Originally five specifications consulted on for 2020/21 commencement (CVD and health inequalities to follow in 21/22):

- **Structured Medication Reviews and Optimisation**
- **Enhanced Health in Care Homes**
- **Anticipatory Care**
- **Personalised Care**
- **Supporting Early Cancer Diagnosis**

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Specifications – now

Network Contract Direct Enhanced Service
Draft Outline Service Specifications

Originally five specifications consulted on for 2020/21 commencement (CVD and health inequalities to follow in 21/22):

- **Structured Medication Reviews and Optimisation**
- **Enhanced Health in Care Homes**
- **Anticipatory Care – now 21/22**
- **Personalised Care – now 21/22**
- **Supporting Early Cancer Diagnosis**

- **Response by NHSE …**

Responding to feedback on the services

We have listened and responded to the concerns raised by general practice during the engagement on the draft service requirements by:

- **simplifying** the three services introduced in 2020/21
- **deferring two services from 2020/21** to 2021/22
- linking SMR volumes to clinical pharmacist **capacity**
- providing flexibility for the **frequency and form of medical input** to weekly 'home round' to be determined by the PCN
- introducing a new '**Care Home Premium**' of £120 per bed (£60 in year 1)
- clarifying that **existing LES/LIS funding duplicated by the DES must be reinvested** into primary medical care
- being clearer that **PCNs are only contractually responsible for their component** of the services.

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Specifications: Structured Medication Reviews

To be delivered from April 2020, PCNs must:

- **Identify people who would benefit most from receiving an SMR** including:
  - patients in care homes;
  - patients with complex and problematic polypharmacy, specifically those on ≥ 10 medications;
  - patients prescribed medicines that commonly and consistently associated with medication errors;
  - housebound, isolated patients and those with frailty – particularly with recent admissions / falls;
  - patients with severe frailty;
  - patients prescribed high numbers of addictive pain management medication.
- **Offer and deliver a volume of SMRs determined and limited by CP capacity,** demonstrating all reasonable on-going efforts to maximise that capacity;
- **Ensure invitations to patients explain benefits** and what to expect;
- **Ensure only appropriately trained clinicians undertake SMRs** (prescribing qualification, advanced assessment and history taking skills etc – likely to be Clinical Pharmacists, General Practitioners and Advanced Nurse Practitioners);
- **Clearly record all SMRs** within GPIT systems;
- **Actively work with CCG to optimise quality of prescribing** of (a) antimicrobial medicines, (b) medicines which can cause dependency, (c) metered dose inhalers where low carbon alternative appropriate, (d) nationally identified medicines of low priority;
- **Work with community pharmacies locally** to connect patients to New Medicines Service which supports adherence to newly prescribed medicines.

Specifications: Enhanced Health in Care Homes

To be delivered during 2020 (jointly between general practice and community services):

- **Scope: CQC registered care home, with or without nursing;**
- **Care Home Premium of £120/bed (£60/bed in 20/21 to represent 6 months)**
- **CCGs to reinvest any existing expenditure in primary care** – or top-up where existing service exceeds requirements;
- **By 31 July 2020 each PCN will:**
  - **Agree care homes for which it has responsibility with its CCG (one PCN per home)** and agreed plan with local partners (including community services) about how it will operate;
  - **Patients to be supported to re-register** with aligned PCN;
  - **Ensure lead GP(s)** with responsibility for service agreed **for each aligned care home;**
- **By 30 September 2020:**
  - Every person in PCN-aligned Care Home has **named clinical team** - MDT working across provider boundaries;
  - **Deliver weekly 'home round'** – shared between primary and community care. Home round must:
    - **Prioritise residents** according to need (based on MDT judgement and care home advice)
    - **Have consistency of staff in MDT**
    - **Include appropriate & consistent medical input (GP / geriatrician)** – frequency & form TBD by PCN
  - **PCNs to own and coordinate delivery of personalised, tailored, care** based on relevant assessment of need – **plan developed and agreed for every resident within 7 days** of admission / re-admission.
  - Identify and/or engage in locally organised shared learning opportunities;
  - Support discharge from hospital and transfers of care between settings;
- **No later than 31 March 2021 (and as soon as is practicable):**
  - **Protocols between Care Homes and system partners** for information sharing and shared care planning.

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Specifications: Supporting Early Cancer Diagnosis

From April 2020 PCNs will:

- **Review referral practice for suspected (and recurrent) cancers** by:
  - Enabling and supporting practices to improve quality of their referrals for suspected cancer;
  - Introducing a consistent approach to monitoring patients referred urgently with suspected cancer;
  - Ensuring patients receive high-quality information on their referral & how to access further support;
- **Contribute to improving local uptake of National Cancer Screening Programme** by:
  - Working with local system partners to agree PCN contribution to improve uptake;
  - Include at least one specific action to engage low-participation group locally;
- **Support delivery of above through community of practice between practice-level clinical staff that will:**
  - Support constituent practices to conduct peer-to-peer learning events to look at data and trends;
  - Support engagement with local system partners – incl PPGs, secondary care, Cancer Alliance, Public Health

Network Investment and Impact Fund

- **Reduced in Year 1 to reflect less specifications and reinvestment in other areas of GP contract** (£75m now £40.5m; remains £300m by 23/24)
- **Will work similarly to QOF, but for PCNs**
- **8 indicators in 20/21 across:** flu vaccinations for over 65s, LD health checks, social prescribing referrals, prescribing
- **Lower and upper thresholds**
- **From 21/22:**
  - At least £30m to support access; rising to £100m by 23/24
  - At least one-third for PCN specifications
  - £30m to support vaccs and imms
  - Will have aspiration payments system from 21/22

Network Investment and Impact Fund

Indicator	Indicator value (£m)	Indicative value for average PCN	Upper Threshold	Lower Threshold
Percentage of patients aged 65+ who received a seasonal flu vaccination (1 September-31 March)	8	£6,400	77%	70%
Percentage of patients on the LD register who received an LD health check	6.25	£5,000	80%	49%
Number of patients referred to social prescribing per 1000	6.25	£5,000	8 referrals per 1000 population	4 referrals per 1000 population
Gastro-protective prescribing - Percentage of patients prescribed a non-steroidal anti-inflammatory drug without a gastro protective (age 65+)	6.25[30]	£5,000	30%	43%
Gastro-protective prescribing - Percentage of patients prescribed an oral anticoagulant and anti-platelet without a gastro-protective (age 18+)			25%	40%
Gastro-protective prescribing - Percentage of patients prescribed aspirin and another anti-platelet without a gastro-protective (age 18+)			25%	42%
Metered Dose Inhaler prescriptions as a percentage of all inhaler prescriptions (excluding salbutamol)	6.25	£5,000	45%	53%
Spend per patient on 20 of the 25 medicines on the national list of items that should not routinely be prescribed in primary care	7.5	£6,000	PCN spending goal	60% above PCN spending goal

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Network Dashboard

- **From April 2020**
- **Key metrics:**
  - Investment and Impact Fund – by PCN and practice
  - Specification delivery
  - Population health and prevention
  - Workforce
  - Access
  - Hospital use

PCN Agreement

- **Auto-enrolment from 2021/22**
- **Opt-in/out-out window – this year until 31 May 2020; next year one month window**
- **Network Agreement continues as formal basis of working together and with non-GP providers:**
  - **By April 2020, Community Services Providers and Community Pharmacy –** with plan for delivering services together in 20/21
  - **By April 2021, Mental Health Providers**

Improving access for patients

Progress towards delivering the extra 50 million appointments as soon as possible will be driven mainly by increasing staff numbers.

Initial actions arising from NHS England's review of access to General Practice have now been agreed as set out below. The review will complete in 2020, to inform contract discussions in 2020/21.

- **better data**
  - an improved appointments dataset will be introduced in 2020 as part of the practice contract.
  - a new, as close to real time as possible and transparent measure of patient experience will be designed and tested in 2020, for nationwide introduction by no later than 1 April 2021.
- **digital-first services** - every PCN and practice will be offering a core digital service offer to all its patients from April 2021.
- **extended hours** - a nationally consistent offer will be developed and discussed with GPC England and patient groups, reflecting what works best in existing local schemes.

Vaccination and immunisations payments have been reformed to encourage improvements in coverage

- Vaccinations and immunisation becomes an essential service
- The global sum that practices receive will be protected, and we have a agreed a clearer set of core delivery standards
- The item of service fees for the delivery of each dose of all routine and annual vaccines will be £10.06. In addition to flu and adult vaccines, this will cover:
  - Diphtheria, tetanus, poliomyelitis, pertussis, haemophilus influenza type B (HiB) and hepatis B (6-in-1);
  - Rotavirus;
  - Pneumococcal conjugate vaccine (PCV);
  - Meningococcal B Infant;
  - Haemophilus influenza type B and Meningitis C (HiB/MenC).
- Practices with lower (less than 80%) coverage will automatically repay a portion of their item of service fees on that vaccine according to the formula:

  repayment = value of the IoS fee x 50% of eligible cohort size

Coverage incentives will operate for vaccinations which benefit from a herd immunity effect or which are policy priorities

- For routine schedule vaccinations this incentive will operate at practice level and form part of a new QOF domain from April 2021
- The Childhood Immunisation DES will be retired
- The new QOF domain will reward incremental improvements in performance, unlike the current dual threshold-based approach of the Childhood Immunisation DES

- PCNs are ideally placed to take the lead on improving flu vaccine coverage
- In autumn 2020 we will introduce an incentive in the IIF for flu coverage for 65+ cohort
- During 20/21 we will review the existing QOF indicators incentivising flu vaccination and consolidate an updated set of indicators within the IIF for April 2021
- We hope there will be an aligned incentive for community pharmacy in the Pharmacy Quality Scheme (PQS)

New core standards have been agreed

- All practices will have a named lead
- Practices should ensure the availability of sufficient trained staff and convenient, timely appointments to cover 100% of their eligible population
- Practices should ensure their call/recall and opportunistic offers are being made in line with national standards
- Practices should participate in agreed national catch-up campaigns
- Practices should adhere to defined standards for record keeping and reporting of coverage data
- Practice expectations around routine, pre and post-exposure vaccinations clarified.

The changes will be phased in over 2 years

2020/21	2021/22
• Introduce clearer core contractual standards • Introduce an IoS payment for MMR 1 and 2 at £10.06. • Introduce an incentive worth £6.5m into the IIF for networks to improve seasonal flu vaccine coverage for the over 65 age group, in collaboration with community pharmacies.	• Expand the application of the IOS of £10.06 and introduce repayments • Introduce the new QOF domain for routine vaccinations • Restructure and consolidate all flu incentives at network level • Retire the existing Childhood Immunisation DES

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QOF indicators

- **Asthma domain:** Improvements to the register, diagnosis and ongoing care of patients
- **COPD domain:** Improvements to the accuracy of diagnosis and ongoing care of patients
- **Heart failure domain:** Improvements to the accuracy and timeliness of diagnosis and a focus upon ongoing review and medication optimisation
- **Diabetes domain:** A new indicator will be introduced to incentivise practices to offer an annual HbA1c test in people known to have non-diabetic hyperglycaemia.

QOF QI

Cancer and learning disability will be the focus of the quality improvement domain in 2020/21

Module: Early cancer diagnosis

- Aims to improve participation in the national breast, cervical and bowel cancer detection and screening programmes; and
- Aims to improve referral and safety netting practices for patients suspected of having cancer. It has been developed to support the roll out of the PCN early cancer diagnosis service specification.

Module: The Care of People with a Learning Disability

- Aims to promote :
  - increased uptake of annual health checks
  - optimisation of medication in line with STOP
  - identification and recording of reasonable adjustments
  - the patient engagement with community resources through social prescribing to maintain health and well-being

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Improvements to Maternity Services

- From 2020, all practices will be required to deliver a maternal check at 6-8 weeks after birth, as an additional appointment to that for the 6-8 week baby check. An additional £12m will be invested through global sum to support all practices to deliver this.

- The Maternity Medical Services additional service will become an essential service.

- The child health surveillance additional service will also become an essential service.

- We will revise the contract's current definition of the "postnatal period" from 2 to 8 weeks, to bring it in line with NICE guidance on best practice.

2020/21: ICS/CCG responsibilities for primary care

Specifically, in 2020/21, STPs/ICSs and CCGs must:

- **Increase overall spending from CCG** (core services) allocations on aggregate of: primary medical care, community services and Continuing Healthcare (inclusive of £1.50/hd to PCNs).
- **Work with PCNs to maximise recruitment under ARR** (see next slide).
- **Support the recruitment and retention of extra doctors** working in general practice.
- Work with PCNs to **support improvements in practices with long waits for routine appts.**
- Provide **monthly data to each PCN on number and cost of A&E attendances**.
- **Ensure full delivery of online consultation systems** where not already in place; and ensure full delivery of **direct booking from 111 to in-hours appointments**.
- Lead the transition to the new **GPIT Futures Digital Care Services Framework** arrangements.
- Work with PCNs to **deliver national service requirements from 2020/21** (when finalised) including systems support mobilisation. Funding invested by CCGs which duplicates to be **reinvested within primary medical care**.
- **Provide support to implement the NHS's comprehensive model of personalised care** and meet 2020/21 system trajectories for personalised care and support planning, Personal Health Budgets and social prescribing.

2020/21: Primary Care Workforce

- **Develop ICS primary care workforce plan** (final details to follow in GP contract update), **to be developed jointly with PCN CDs via the PCTH** and reflects local population health need and demand. **The plan must:**
  - set out **how ARR will be fully used** (**firm intentions 20/21, indicative intentions 21-24**). **CCGs to actively support PCNs** who are unable to recruit to roles by:
    - facilitating work across org's to develop **rotational posts / lead employer models**
    - supporting PCNs to **advertise posts, including through batch recruitment**
    - working with local stakeholders to **match people to unfilled roles**
    - supporting / driving conversations with **PCTHs and HEIs** to influence workforce supply.
  - be designed specifically to **retain as many GP trainees as possible**; taking up substantive roles in the local primary care workforce by 31 March 21 (incl. portfolio roles);
  - include an action plan to **maximise retention** with a specific focus in areas which have **greatest workforce challenges and where attrition is highest**. This includes essential actions which are shown to have positive impact on retention of GPs;
  - targeted action to **retain as many general practice nurses** as possible (further national schemes to follow).

2020/21: Primary Care Workforce

- **CCGs to submit separate specific workforce plan for primary care for 20/21** via the Strategic Data collection Service (SCDS)
- **Data collection to move to monthly from practices and PCNs**
- **Data will be expected, forecast quarterly, for**:
  - GPs (split by type)
  - Nurses
  - Pharmacists
  - Physiotherapists
  - Physician Associates
  - Paramedics
  - Pharmacy Technicians
  - Social Prescribing Link Workers
  - Other AHPs

PCN Development in 2020/21

- **Final national scheme to follow**
- **Three main priorities** for PCN development support in 2020/21 are:
  - **supporting workforce redesign and team development**;
  - **improve patient access** and **practice waiting times**;
  - **building operational relationships with community providers** (including pharmacies) to support integrated care.

Premises Costs Directions

- **Removed restriction on commissioner contribution to premises improvements –** grant funding now up to 100%. Grant values increased, abatement and guaranteed use periods reduced;
- **Agreed measures to support "last man standing"**
- **New Directions mean:**
  - Commissioners will reimburse VAT on rent;
  - Reimburse SDLT on acquiring land / premises
  - Rent reviews not require contractors to undertake own valuation
  - And much more in new PCDs (details to follow)

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Any Questions?

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Population Health Management Development Programme

Update to PCCC

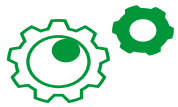
Population Health Management (PHM)

- One Gloucestershire Integrated Care System (ICS) is part of NHS England PHM Wave 2
- Cheltenham is piloting this PHM approach for the ICS
- GP Leads; Dr Atkinson (Central); Dr Pascoe-Watson (Peripheral); Dr Long (St Pauls)
- PHM aims to **use data** to design new models of proactive care and deliver improvements in health and wellbeing across an entire population

PHM is based on three capabilities to mature towards action:

Infrastructure:
What are the basic building blocks that must be in place?

Intelligence:
Opportunities to make an impact on outcomes and value, improve care quality, efficiency and equity



Interventions: *proactive clinical and non-clinical interventions to prevent illness, reduce the risk of hospitalisation and address inequalities.*

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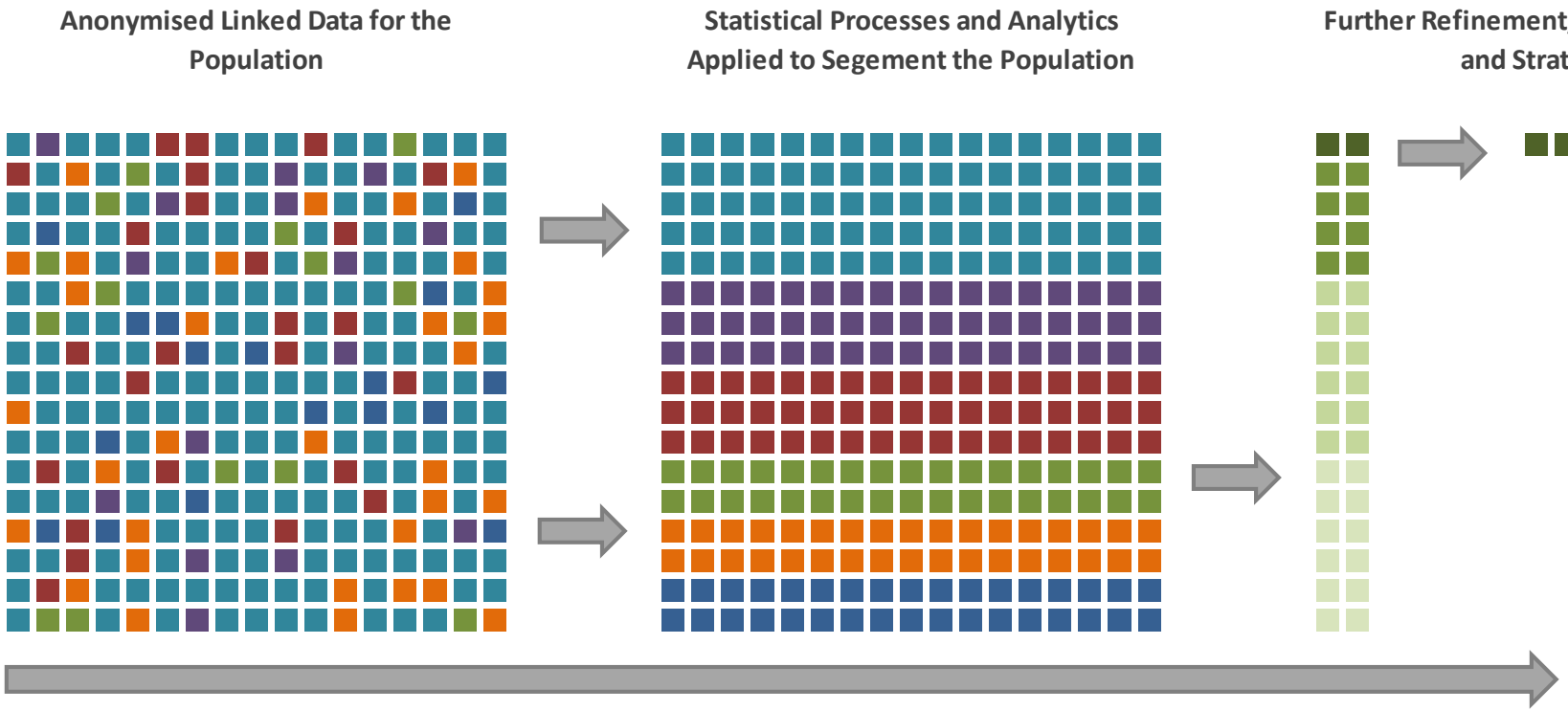
Cohort Identification Process



Review and Disucssion with Analysts and Clinicians throughout to Inform Refinement of the Cohort as well as Consideration being given on Potential Intervention

Once data driven cohort identification is agreed, anonymised data is re-ID back to practices for clinical validation and review with feedback loop in to the process as required

Cheltenham PHM Cohort Selections

Central Cohort – 85 Patients

We have selected a cohort of people that live alone, coded as depressed but are not on a repeat prescription for medications relating to depression.

A. "People we can help"
B. Multi-morbidity – at least 6 acute & chronic conditions
C. Depression, anxiety, stress, low mood diagnosis
D. Not suffering from serious mental illness
E. Living alone

Peripheral Cohort – 78 Patients

We have selected a moderately frail cohort of patients who are at risk of falls based on a number of variables as below. We have excluded patients in Care Homes

A. Assessment of "Moderate" frailty.
B. Exclude nursing and residential homes (as these patients have more care input)
C. Contributors to risk of falls including polypharmacy (ACB score) and people who live alone (regression analysis)

St Paul's Cohort – 61 Patients

We have selected a cohort that may be: isolated, high use of services, increased cost to system, limited by their social and medical circumstances, worse health outcomes, lower quality of life, unplanned admissions, earlier death.

A. Housebound
B. 5+ outpatient/acute contacts in prior 12 months
C. Not EOL or palliative care
D. 10% most deprived postcode

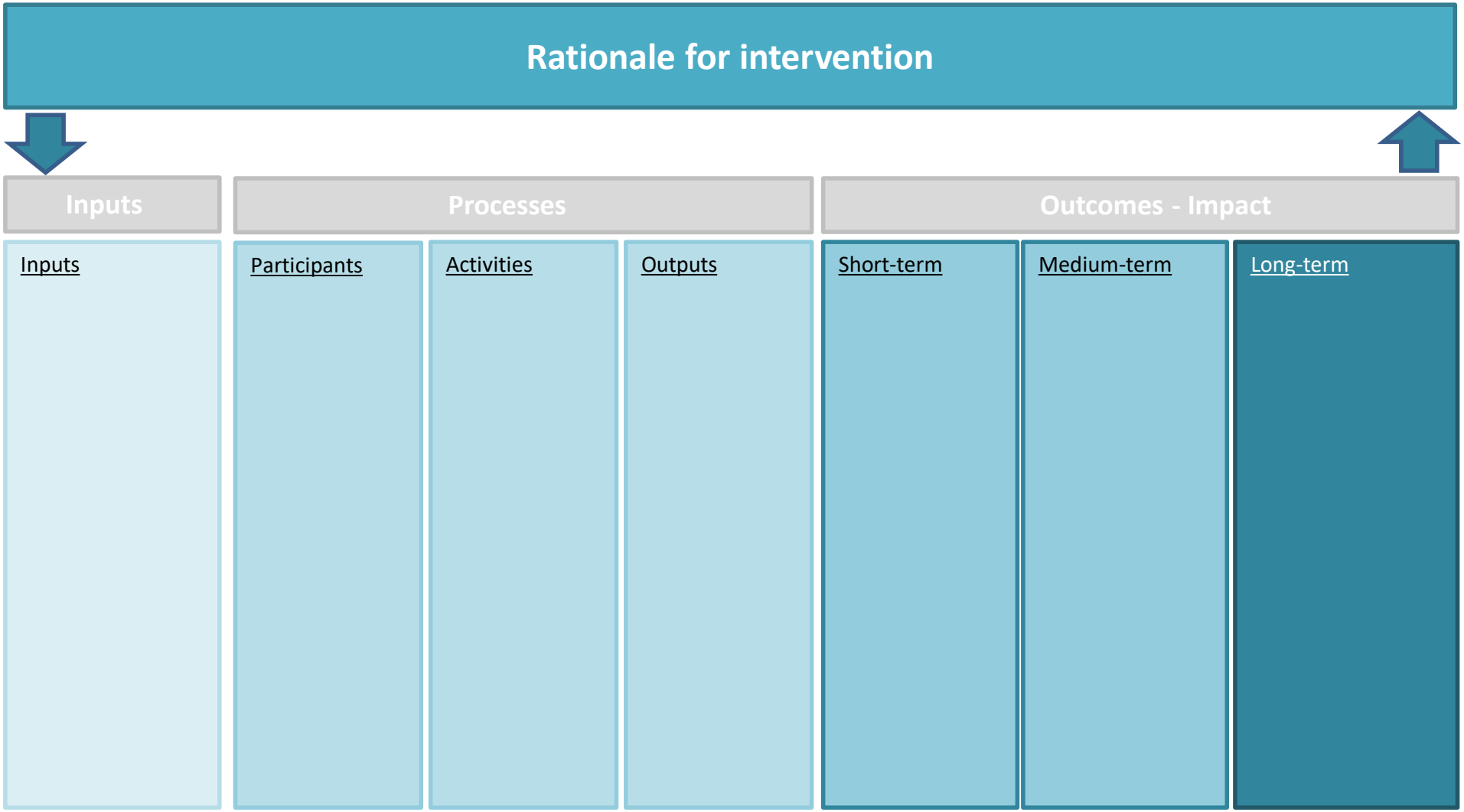
Approx.

0.15%

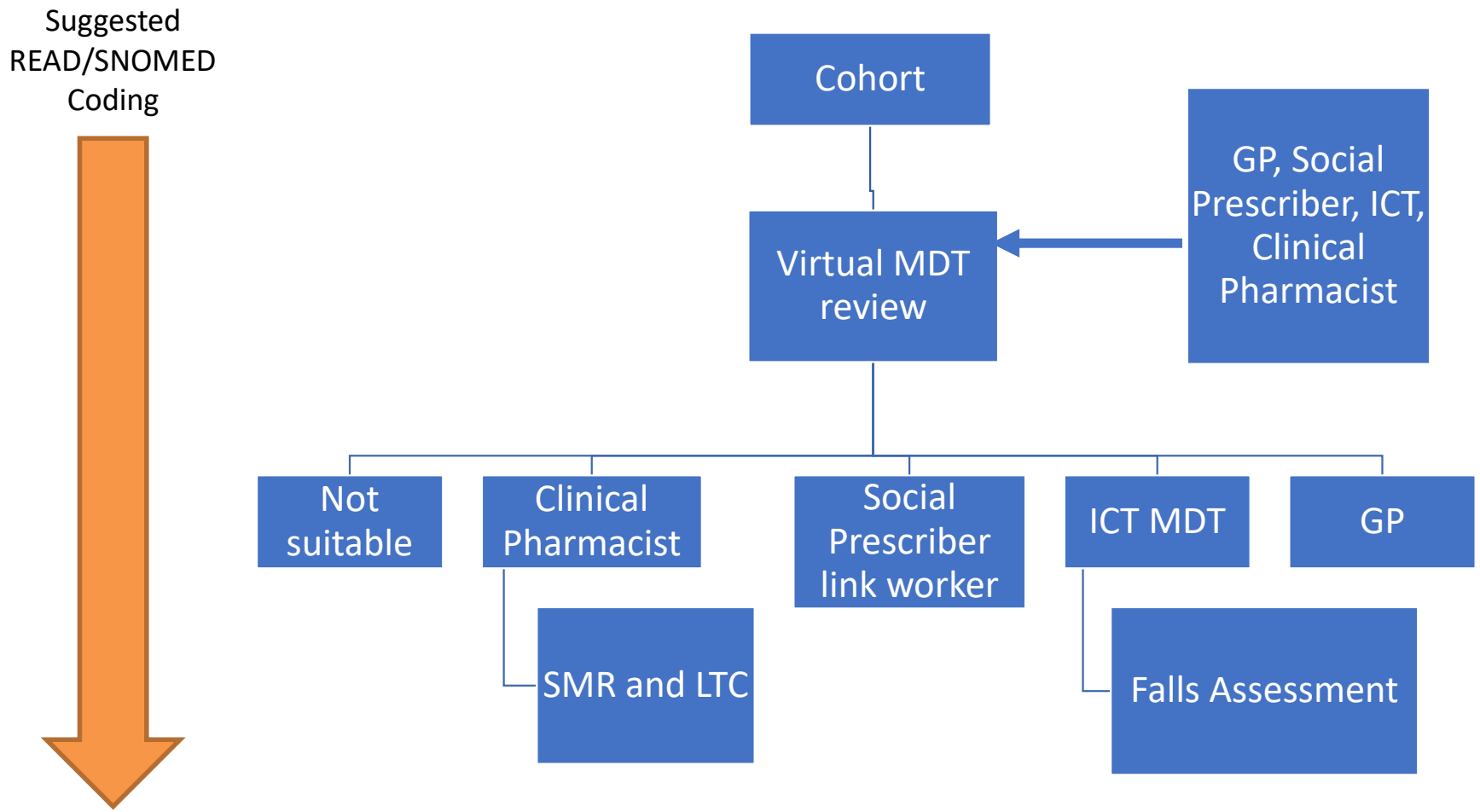
of PCN Populations

One Gloucestershire
Transforming Care, Transforming Communities

Logic Model


Rationale for intervention
Inputs
Processes
Outcomes - Impact
Inputs
Participants
Activities
Outputs
Short-term
Medium-term
Long-term

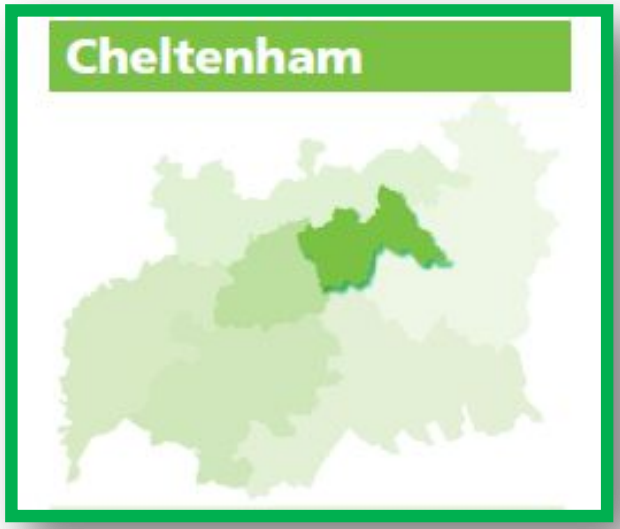
Process for Cheltenham Central



ICS PHM stakeholders in Cheltenham

Integrated Locality Partnership/
Primary Care Networks

General Practice Staff
- GPs
- Clinical Pharmacists;
- Nurses;
- Social Prescribers;
- Practice Managers



NHS Gloucestershire Clinical Commissioning Group

NHS Gloucestershire Health and Care NHS Foundation Trust

with you, for you

Gloucestershire County Council

Cheltenham Borough Council

NHS Gloucestershire Hospitals NHS Foundation Trust

Cheltenham Borough Homes
great homes | stronger communities | inspired people

NHS England

CCP Caring for Communities and People

Gloucestershire VCS Alliance
An independent voice for the voluntary and community sectors

One Gloucestershire

PHM: Next Steps

- Re-ID patient lists
- Test & learn if cohort is appropriate
- Additional ALS to agree measurement, coding and reporting
- Finalise Interventions
- Action Learning Sets for each network to implement the intervention
- Start interventions; for example:
  - Pilot an MDT
  - Hold a “one stop shop” clinic
  - Social Prescribing assessments
  - Personalise care plans
- Reporting end Evaluation
- Share good practice between the networks
- Celebration event Monday 23rd March 2020
- ICS Countywide PHM rollout planning

Feedback and Learning

- Started basic/generic but built in complexity and content
- Face to Face sessions so far have been more productive/effective
- Optum have been somewhat reactive to the feedback
- We were already providing a similar analytics offer as a system
- Presentation and approaches being replicated for other ILPs/PCN
- Additional session focused specifically on data and evaluation
- **A lot of benefit from partnering analysts with clinicians in ALS**
- **Systematic approach to cohort identification is beneficial**
- **Learning how to deliver PHM cycle**
- **Development of PCNs around a shared purpose**

Quality Report

NHS Gloucestershire Clinical Commissioning Group

Agenda Item 9

Primary Care February 2020

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
- Primary Care intelligence

Quality Report

NHS Gloucestershire Clinical Commissioning Group

NICE

The number of NICE TAs published is below (as of 3/2/20)

	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		13	18	13	5	49	including
Number relevant to GCCG	1	3	2	2	8		3	4	5	1	13	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.

Clinical Effectiveness

Clinical Effectiveness Group (CEG)

The last meeting of the Clinical Effectiveness Group was held on 28th November 2019.
The Jan 2020 meeting was postponed until March 2020.

Stock Shortages

Since the beginning of December 2019, due to the increase in stock shortages for medicines the CCG has produced a 'Stock-flash' alert for GP practices which updates them with the latest information. It is compiled from a variety of lists but the main source of this information is from Department of Health and Social Care (DHSC), therefore the frequency of these alerts is dependent on when this list is updated which is around every two weeks. This is then sent to practice managers directly by the GCCG Primary Care Team. The content is commercially sensitive, so it is not more widely circulated.

9

Safeguarding

Children:

Serious Case Reviews (SCR) / Child Practice Reviews (WT2018)

Gloucestershire Safeguarding Children Executive (GSCE) continues to progress all SCRs. This report shows no change in status from the previous quarter: four SCRs are ongoing: 'ID', 'ET', 'AD', and 'GH' (out of county linked with Essex).

Reports pending Gloucestershire Safeguarding Children Executive (GSCE) sign off and publication are 'Acorne''LB/ED' (joint DHR/SCR – awaiting Domestic Homicide Review Panel and Home Office submission.

Ofsted update: Gloucestershire Children Services are due imminently (Jan / Feb 20) their full inspection as they continue their improvement journey.

GSCE update: Marion Andrews Evans is now Chair of the Safeguarding Executive. The GSCE overview presentation is attached for your information.

Quality Report

Executive
Presentation V5 DRJ I

Multi-Agency Audit: GSCE has requested a clear annual programme of multi-agency case audits to be actioned through the Performance Subgroup. Initially the theme will be drawn from SCR findings (i.e. neglect, 'hidden' men, information sharing, understanding risk and escalation),

Adults:

Safeguarding Adult Reviews (SAR)

Current SARs:
NC - SAR referred from LeDeR. NC died of malnutrition on 22nd January 2018. He lived in supported accommodation, and had moderate learning disability and cerebral palsy. He deteriorated mentally and physically after the death of his mother, 3 months prior to his death. The SAR will also consider an overview of his life.

New SARs for March 2020:

- PH - a homeless man who died in Cheltenham (Nov19). Mental Health services were involved. This is the first SAR GSAB has undertaken related to homelessness.
- Non-statutory thematic review – concerning five sex workers who were all supported by Nelson Trust, and died within a two year period. None had care needs but there is significant relevance to Adverse Childhood Experiences (ACE's)s and substance misuse.

Multi-agency Audit: GSAB Performance and Quality Assurance Subgroup continue to undertake planned multi-agency thematic case audits, drawn from both Section 42 enquiry factors and learning from SARs. CCG Specialist Nurse Safeguarding consistently attends and engages directly with Primary Care with direct feedback to GP Practices and GP Forums.

Primary Care Quality Assurance: In July 2019 the internal audit on GCCG Child Safeguarding highlighted commissioners need to be assured that commissioned organisations have effective safeguarding arrangements in place (NHSE Assurance and Accountability Framework 2019, Section 11, Children Act 2004, Care Act 2014) both for NHS and independent healthcare providers.

Understanding that Quality Assurance visits to all 74 GP practices are impractical and unachievable based on GCCG Safeguarding team capacity, the Named GP was already leading a progressive piece of work to undertake QA of Primary Care by means of a planned PCAGG audit. This comprised an automated safeguarding 'Read Code' audit combined with a QA questionnaire (sent out in July 2019), which the LMC subsequently advised practices not to complete. As a result, a one page Statement of Assurance compliance by each Practice was agreed with the LMC and sent out to practices in October 2019 with a request to either complete the questionnaire, or the Statement of Assurance.

The Safeguarding Team has had extremely poor return result from this; only 24/74 practices responded despite the deadline being extended into November 2019.

This risk was identified at the audit as 'medium', with some assurance at that time to the Board that we had mitigated against this risk through our action for Practices to self-assess as stated. This work has not produced the expected timely response.

The Safeguarding Team will address this through work with the GP fora and are commencing a register to capture each GP Practice position on engagement and contributory work (i.e. DHR/SCR/SARs). In addition we will continue to lobby the LMC for their recognition and support on this very important matter.

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. 11 NRLS reports were made in Quarter Three (Oct – Dec) 2019.

- 7 – No Harm
- 3 – Low Harm
- 1 – Moderate Harm

The 'Moderate Harm' event related to a dispensing error which gave rise to a patient taking an unintentional overdose. The patient has now recovered.

Wherever possible, NRLS reports are always investigated.

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 during Q3 2019.

Type	Q2 18/19	Q3 18/19	Q4 18/19	Q1 19/20	Q2 19/20	Q3 19/20*
Advice or Information	1 (PC 12)	110 (PC 22)	38 (PC 8)	38 (PC 11)	21 (PC 8)	51 (9 PC)
Comment		11 (PC 4)	0	1	0	1
Compliment	2	2	2	2	4	1
Concern	110 (PC 14)	75 (PC 22)	72 (PC)	50 (PC 10)	35 (PC6)	46 (PC 12)
Complaint about GCCG	5	7	5	7	12	12
Complaint about provider	18	18 (PC 5)	35	33 (PC 7)	33 (PC2)	36 (8PC)
NHSE complaint responses copied to GCCG PALS	0	0	1	10*	15*	16**
Other	52 (PC 5)	34 (PC 4)	67 (PC 9)	74 (PC 6)	87 (PC15)	57 (16 PC)
Clinical Variation (Gluten Free)	2	0	1	1	1	0
Total	**288**	**257 (PC 57)**	**221**	**216 (PC 34)**	**208 (PC46)**	**220 (PC 53)**

contacts						

*(*Please note not a compete Q*)

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

GCCG 12 Complaints

This breaks down as follows:

- 3 x commissioning (communications CYPS, Pain services and Health & Social Care).
- 2 x MP complaints from constituents (Autist Pathway & Neurological Services for young person).
- 6 x CHC complaints (retrospective funding, fast track and outcome, Personal Health Budget).
- 1 x over the counter prescribing of QV wash.

Themes identified from GCCG PALS Contacts Q3 19/20

Due to the timing of this report we do not have a narrative of themes at this time.

Quality Report

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* (FFTF) Engagement**

Output of Engagement
https://www.onegloucestershire.net/yoursay/fit-for-the-future-output-of-engagement/

The FFTF Output of Engagement Report and Appendices was published on 6 January 2020. A presentation of the highlights from the Engagement was presented to the Health Overview and Scrutiny Committee on 14 January 2020. The contents of the Output of Engagement Report will be reviewed in detail by NHS partners and will help inform the development of potential solutions and options for change.

Engagement Activity Summary:

- Over 3300 local people took part in planned activities
- Over 50 events
- 1230 FFTF online surveys completed
- 1252 FFTF surveys (template) received from Cheltenham MP
- 153 FoD Hospitals surveys completed

Feedback focussed on the following themes:

- Centres of excellence: Both positive and negative feedback about this approach to future hospital service configuration
- Quality/Equity/Sustainability
- Access
- Population growth/demographic
- £Funding
- Workforce / Technology
- Communications/pathways
- Access to GP services
- Integration
- Workforce

Next steps

First stage

- Consideration of Output of Engagement Report
- Citizens' Jury
- Solutions Appraisal

Second stage

- Development of business cases
- NHS England Assurance

Third stage

- Consultation (as required)
- Consideration of Output of Consultation
- Decisions

Centres of excellence Citizens' Jury – w/c 20 January 2020

An independent Citizens' Jury will meet in January 2020 to begin its work to look at how specialist hospital services in Gloucestershire could develop in the future. 18 local residents have been recruited as Jurors by Citizens' Jury Community Interest Company (CIC), to reflect the county's diverse population.

Jury members will consider feedback from the *Fit for the Future* public and staff engagement, together with evidence on the potential for change across Gloucestershire's two main hospital sites – Cheltenham General and Gloucestershire Royal.

Jurors will hear from NHS doctors about current services, from public and patient representatives and from a variety of other speakers on relevant topics. They will consider, and be asked for their views on, the idea of developing the *centres of excellence* approach to providing hospital services. This approach reflects the way a number of services are already delivered across the Trust.

They will also make recommendations on their priorities for development of three specialist hospital services - general surgery, image guided surgery and emergency and acute medicine.

This Jury forms part of the FFTF Engagement. A second Citizens' Jury is planned for later in the year to make recommendations to us about how the three specialist hospital services should be provided. Ultimately, it is the responsibility of One Gloucestershire NHS partners to pay attention to the feedback received during the Engagement and during any subsequent public Consultation.

Phlebotomy

A Patient and Public engagement workshop was held on 29 November 2019 which enabled testing of some ideas and identification of the top priorities patients would like from a Phlebotomy Service. A survey has been developed and tested with patients to enable a baseline for patient experience of the current Phlebotomy service to ensure any changes are an improvement. Any 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.

Examples of CCG Engagement Team support in primary care: HOSC visit to Aspen Medical Centre and Hucclecote and Brockworth redevelopment

The CCG Engagement team supported a visit of members from Gloucestershire Health overview and Scrutiny Committee to Aspen Medical Centre. This visit included an opportunity for HOSC members to meet and ask questions of senior partners, Aspen staff and PPG members. This was followed by a tour of the centre. The visit was very successful and allowed good practice and learning to be shared.

Members of the CCG Engagement Team have been liaising closely with Hucclecote Surgery and Brockworth 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. The practices have run a survey which has been completed by 253 patients across both practices. The general feedback has been positive regarding the new practice estate development. The practices have also held a joint drop in engagement event attended by over 80 people.

Countywide Patient Participation Group (PPG) Network

The PPG Network last met on 22 November 2019. There was a varied agenda for this last PPG Network meeting of 2019:

- 15 Steps Challenge with PPG's, Sophie Ayre – Social Inclusion Development Worker Gloucestershire Health and Care NHS Foundation Trust
- Knead 2 Know project – positive later life planning in the community, Rob Fountain – CEO, Gloucestershire Age UK and Abby Guilding, Wiggly Worm
- Spotlight on… Use of technology in your PPG, Kevin Gannaway-Pitts – PPG member Aspen Medical Practice PPG
- Personalised Care in Gloucestershire, Joanne Appleton – Programme Manager, Personalised Care NHS Gloucestershire Clinical Commissioning Group

The next PPG Network Meeting is scheduled for 14 February 2020.

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 Performance

Quality Report

Prescribing performance figures commencing from April 2019 to November 2019 are used in this update report. This delay is due to the lag time for data processing at the NHSBSA (those who process prescription spending data).

A prescribing dashboard is 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 track their progress.

CCG "spend vs. budget" for the first eight months forecasts an overspend at the end of the year; There is a challenging savings target for 2019-2020, and is influenced 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),
- 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 availability before significant changes have occurred, to long term non-availability.
- Increasing use of Direct Oral Anti-Coagulants (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. As small numbers of practices migrate from certain prescribing system software, they move towards eligibility for Optimise, which will increase the use and benefit seen.

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 change in staffing levels following recruitment of some of our PSPs by GP practices, subsequently moving into the role of Clinical Pharmacists. This has created gaps in our practice support coverage. A recruitment process has occurred recently to recruit replacement staff and expand the number of PSTs, who are instrumental for the savings plan to be realised. The newly recruited staff commenced in January 2020 and have undertaken their induction programme and are now deployed to their practices.

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. An updated GCCG position on vitamin D has been published on G-care, as well as a patient information leaflet.

One of the Prescribing Support Dietitians is a qualified Non-Medical Prescriber (NMP) and will be supporting the upcoming NMP study day for nurses. This is in addition to providing dietetic input to the CVD/Hypertension education day for health care assistants, nurses and pharmacists, and the community blood pressure testers training events.

Vitamin B12 Prescribing and Infant Formula

A new pathway for vitamin B12 testing and treatment has been developed by the Pathology working group and supported by the Prescribing Support Dietitian and is now published on G-care, along with a patient information leaflet. This was required due to an increase in the requests for serum testing and evidence that suggests high dose oral supplementation can be as effective as intra-muscular injections in some circumstances. This 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. The Dietitians will be supporting various educational events to support practitioners and their patients with this.

Nutrition and Hydration in Care Homes

Our Prescribing Support Dietitians with the Quality Project Matron have been working on a project named INNRICH (Improving Nutrition & hydration and Nursing Resources In Care Homes) which forms part of the frailty CPG. This follows a successful 2 month pilot in August and September 2019. In the pilot project the positive impact of a hydration and nutrition intervention on care home residents' health was demonstrated, however this was limited when appropriate nursing actions were not implemented.

The aim of the project is to reduce hospital admissions relating to chest infections, UTIs, pressure sores/wounds, skin tears, falls and constipation. To achieve this the project includes nutrition and hydration intervention and training as well as resources for care home nursing team members to promote consistent implementation of policies, procedures and processes.

Over a period of 12 months, ten Gloucestershire care homes will receive a structured education programme to support them to implement a hydration and nutrition intervention as part of effective holistic nursing care. The success of the INNRICH project will be monitored by the use of audit which the care homes will need to complete and return to the INNRICH project leads monthly for the next 12 months.

The INNRICH project leads organised an information session about the project in January for Care Home managers and senior nurses. The information session was advertised to all Gloucestershire care homes and 34 Care Homes signed up to attend. Out of these 34 care homes 10 will be recruited to take part in the INNRICH project via an application process and subsequent selection.

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 for 2020.

Seasonal Influenza 2019/20

Countywide Flu Planning Group

The weekly Public Health England influenza report for the South West, as of Week 4 2020 (20/01/2020 to 26/01/2020). 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) have ceased but if required will re-start. The group shares real-time information and actions on vaccination rates, flu infection control and managing outbreaks while activity levels.

Vaccination for high-risk groups

At risk groups - Flu vaccination uptake percentage			
65 +	**<65**	**Pregnant**	**Carers**
74.9%	44.4%	43.9%	39.5%

Vaccination levels for 65year olds and above is similar to last year however it is lower for the other 'at risk' groups. This has been attributed to the delay in the availability of the quadrivalent vaccine for 'at risk' adult's 18-64 years.

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 dependent on the result.

Norovirus

Quality Report

Gloucestershire Clinical Commissioning Group

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.

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 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.

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.

GLOUCESTERSHIRE SAFEGUARDING CHILDREN EXECUTIVE - GSCE

"Nothing is more important than children's welfare. Children who need help and protection deserve high quality and effective support as soon as a need is identified.

We want a system that responds to the needs and interests of children and families and not the other way around. In such a system, practitioners will be clear about what is required of them individually, and how they need to work together in partnership with others"

Working Together to Safeguard Children 2018.

Gloucestershire
Safeguarding Children
Executive

9.1

1. Gloucestershire Safeguarding Children Executive - **Purpose**

- ‘Working Together 2018 (WT2018) represents a significant milestone in the development of Gloucestershire's collective arrangements to safeguard children and young people.
- It places a ‘shared and equal duty’ on NHS Gloucestershire Clinical Commissioning Group, Gloucestershire Constabulary and Gloucestershire County Council where, in the past, the local authority was the sole accountable body for local arrangements.
- We embrace those responsibilities and view this as a real opportunity to further embed child safeguarding considerations across our own agencies and the wider local partnership.

Marion Andrews Evans
Executive Nurse
Gloucestershire Clinical Commissioning Group

Chris Spencer
Director of Childrens Services Gloucestershire County Council

Craig Holden
Assistant Chief Constable
Gloucestershire Constabulary

Gloucestershire **Safeguarding Children** Executive

2. Gloucestershire Safeguarding Children Executive - Arrangements

- WT2018 states 'Partners must set out how they will work together and with relevant agencies to safeguard and promote the welfare of children'.

- These arrangements are set out in Gloucestershire's Published document found on the Boards website

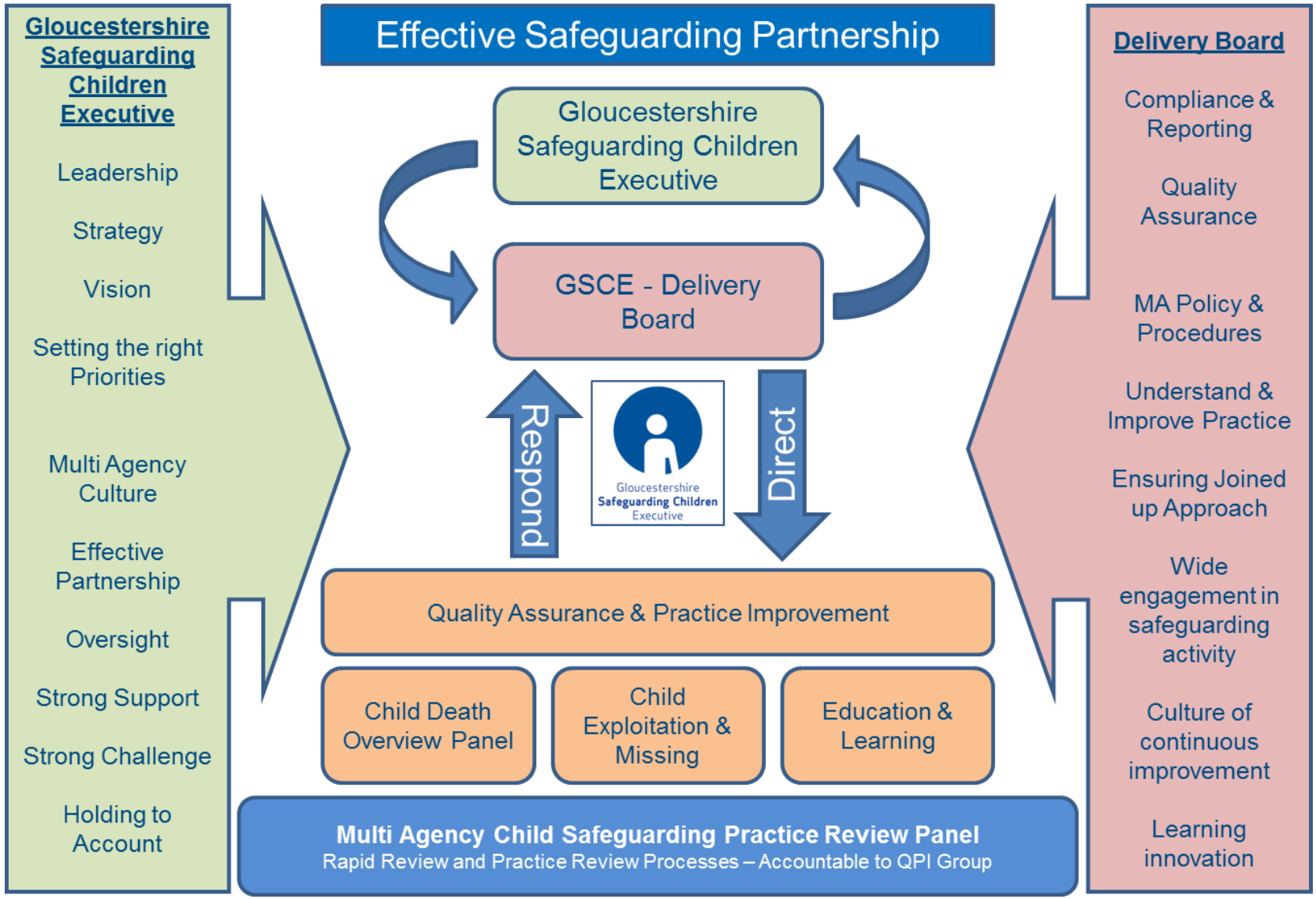
Gloucestershire
Safeguarding Children
Executive

3. Gloucestershire Safeguarding Children Executive - **Arrangements**

What are the local 'Arrangements' intended to achieve?

1. The collective effectiveness of local child safeguarding
2. Information is shared effectively to facilitate more accurate and timely decision making
3. Meeting statutory duty for Child Safeguarding Practice Reviews & Child Death Reviews
4. Setting out and monitoring Multi Agency Policies and Procedures
5. Holding schools and agencies to account under Section 11 of the Children Act 2004 and Section 175 of the Education Act 2002
6. Multi agency learning is promoted and embedded

Gloucestershire **Safeguarding Children** Executive



This graphic sets out how the partnership works and its underlying principles.

Gloucestershire Safeguarding Children Executive

3. Gloucestershire Safeguarding Children Executive – **Independent Scrutiny**

What are the local 'Arrangements' for Independent Scrutiny

- To provide independent, objective scrutiny of the effectiveness of local multi-agency arrangements to safeguard and promote the welfare and well being of all children in Gloucestershire.
- Gloucestershire's Independent Scrutineer is Kevin Crompton
- In addition the GSCE Delivery Board has recruited a Lay Member and utilises Independent Reviewers for Child Safeguarding Practice Reviews

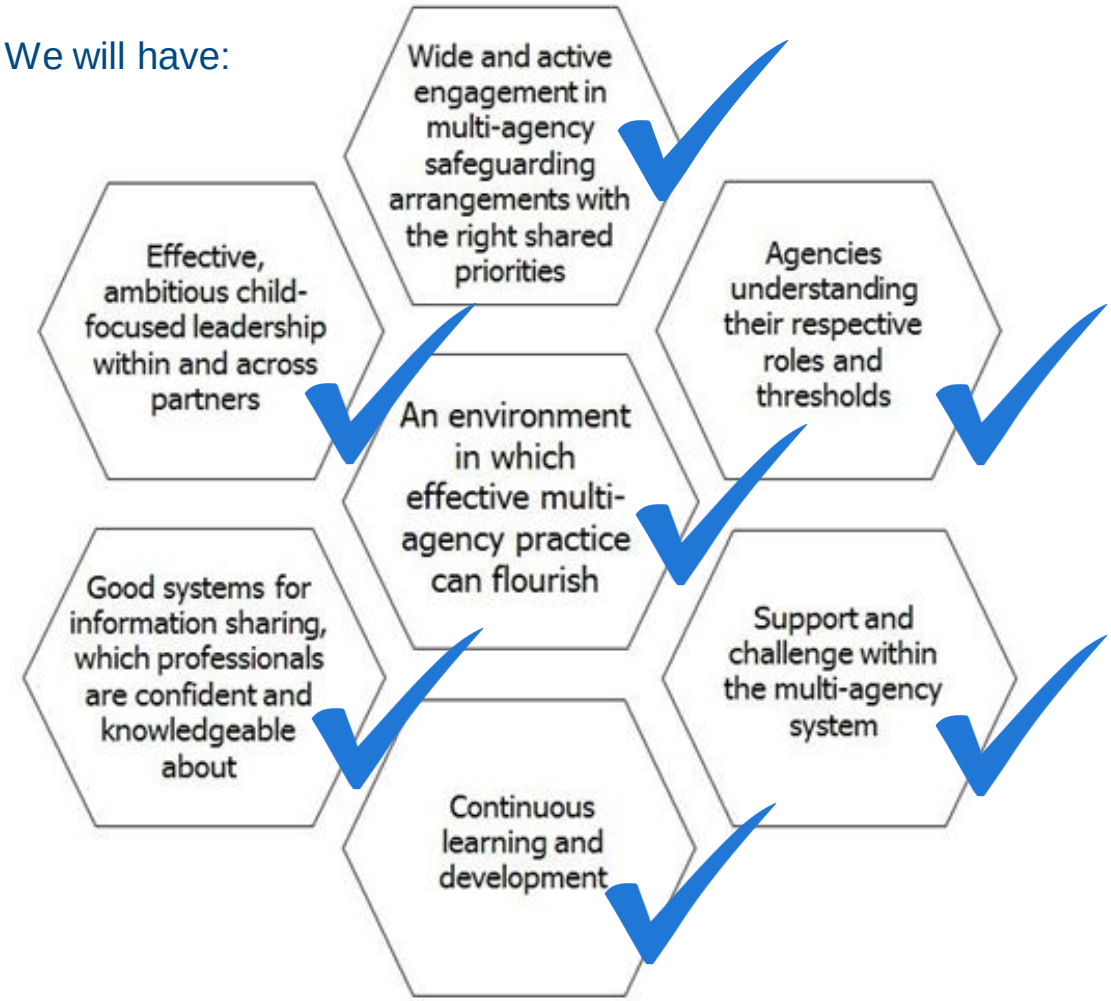
Kevin Crompton
GSCE Independent Scrutineer

Gloucestershire
Safeguarding Children
Executive

4. Gloucestershire Safeguarding Children Executive – **Success factors**

How do we know we have an effective partnership?

We will have:



"Success is measured when fewer children are subject to abuse, neglect or physical harm in the county"

Gloucestershire **Safeguarding Children** Executive

9.1

NHS
Gloucestershire
Clinical Commissioning Group

Agenda item 10

Primary Care Commissioning Committee

Meeting Date	**20th February 2020**
Report Title	**Delegated Primary Care Financial Report**
Executive Summary	At the end of January 2020, the CCG's delegated primary care co-commissioning budgets show a £223k 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 - February 2020

Delegated Primary Care Commissioning financial report as at 31st January 2020

1 Introduction

1.1 This paper outlines the financial position on delegated primary care co-commissioning budgets at the end of January 2020.

2 Financial Position

2.1 The financial position at 31st January 2020 of the delegated primary care budget is a year to date under spend of £223k.

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 also pressures within the budgets. The most significant of these relating to dispensing and prescribing, which is currently forecast to overspend by £105k. This forecast is considered prudent as recent months have demonstrated an underspending position. However, this reduction does not constitute an ongoing trend and cannot, therefore, be relied upon to continue.

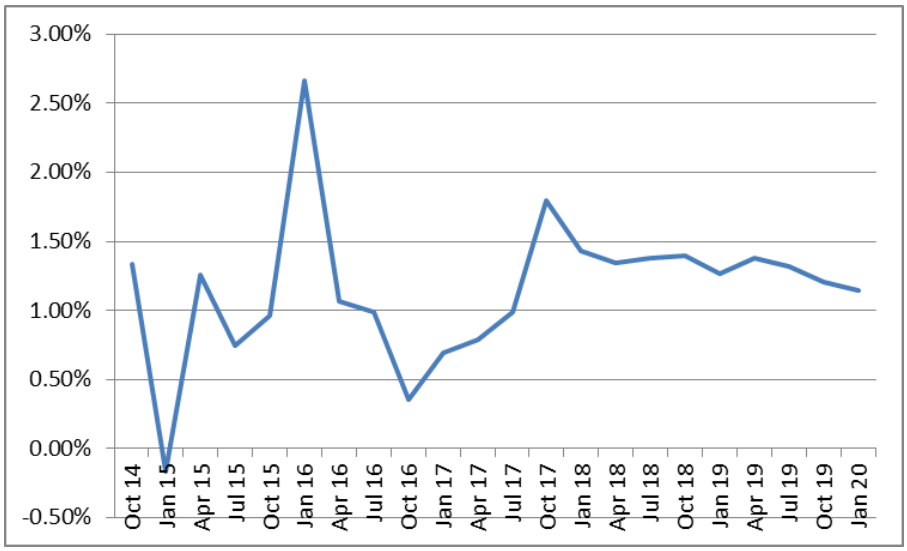
The year to date overspend shown against the APMS Contract Payments relates to Quality payments being made to the temporary Marybrook contract and the Transformation payments on the GHAC contract.

2.4 Risks:

- Whilst growth was built into 2019/20 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.

2.5 List size:

- Growth in list size has been reducing over recent quarters
- Having been consistently at around 1.3-1.4% for about 18 months, the last two quarters have shown annualised growth of 1.20% and 1.14%.
- Although this reduction helps to reduce the pressure on budgets, it remains an excess of the 0.7% increase included within the CCG's allocations.



2.6 The CCG is currently forecasting an under spend 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

			Jan-20						
	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	4,447,188	61,631	43,855,704	43,642,324	(213,380)	0
	Contract Payments - PMS	3,166,111	263,841	273,339	9,498	2,638,413	2,677,441	39,028	
	Contract Payments - APMS	2,120,964	176,746	216,767	40,021	1,767,465	2,398,906	631,441	(0)
	Enhanced Services	2,178,680	201,344	134,063	(67,281)	1,774,833	1,769,579	(5,254)	(0)
	Other GP Services	3,007,221	250,455	350,428	99,973	2,504,847	2,366,940	(137,908)	(67,000)
	Premises	8,703,966	725,175	746,104	20,929	7,252,072	7,325,762	73,690	(114,000)
	Dispensing/Prescribing	3,510,880	270,180	171,569	(98,611)	2,950,719	2,563,581	(387,138)	105,920
	QOF	8,958,115	746,429	721,314	(25,115)	7,464,452	7,240,277	(224,175)	(111,326)
	PCN	1,986,715	188,810	255,442	66,632	1,608,562	1,608,897	335	(92,000)
	TOTAL	**86,260,130**	**7,208,537**	**7,316,215**	**107,678**	**71,817,068**	**71,593,707**	**(223,361)**	**(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